Improving the Early Identification of Youth at Clinical High Risk for Psychosis and Increasing Access to Care

County Name: Orange

Total Amount Requested: Not to exceed $38,000,000

Duration of Project: 5 years

General Requirement:

- ☒ **Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population**
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system

Primary Purpose:

- ☒ **Increases access to mental health services to underserved groups**
- ☐ Increases the quality of mental health services, including measured outcomes
- ☐ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes

PRIMARY PROBLEM

According to the National Institute of Mental Health (NIMH, 2015), approximately 3% of the population lives with a diagnosable psychotic illness, and an even higher percentage experience subthreshold symptoms. When left untreated or undertreated, psychosis can significantly impact the daily lives and functioning of individuals, placing them at heightened risk for legal, social, and comorbid physical and mental health challenges. Suicidality is a particularly pressing clinical concern for those experiencing psychosis, with 5% of people with schizophrenia dying by suicide (Hor et al.., 2010) and 66% of people at-risk for psychosis having suicidal ideation (Taylor et al.., 2015).

Unfortunately, a person with a diagnosable psychosis condition typically does not receive appropriate and effective healthcare until about two years after they first cross the threshold for psychosis (Marshall et al.., 2005). Research has found that person-centered and recovery-oriented intervention, offered early, can lead to positive outcomes (McGorry et al., 2008). First Episode Psychosis (FEP) programs, including Orange County's OC CREW program, shorten the duration of untreated psychosis (DUP) by providing evidence-based, comprehensive services during the first 24-months of psychosis onset, thereby improving the overall life course trajectory of people served. More recently, national (EPINET) and related statewide (i.e., EPI-CAL) efforts to create standard clinical measures, uniform data collection methods, data sharing agreements, and integration of client-level data have linked over 100 FEP clinics with the goal of improving early psychosis care through practice-based research.

Over the past decade, research has also found that intervention offered during the clinical high-risk (CHR) state *before* the initial onset of psychosis may delay, mitigate the severity of, or even prevent the onset of full-threshold psychosis (Okuzawa et al., 2014). Despite the promise of prevention and intervention, one large community study found that 95% of people who developed psychosis had not been previously identified as being at CHR, despite the fact that the vast majority of people who develop psychosis exhibit CHR signs prior to full illness (Fusar-Poli et al.., 2017). Thus, evidence suggests that current systems of care miss a critical opportunity for early intervention among those who develop psychosis.

OPERATIONALIZING THE PSYCHOSIS SPECTRUM

Clinical High Risk (CHR) for Psychosis

Clinical High-Risk for Psychosis ("CHR") is a commonly adopted term among specialists and researchers in North America to describe a state associated with increased risk for developing psychosis. Some symptoms include:

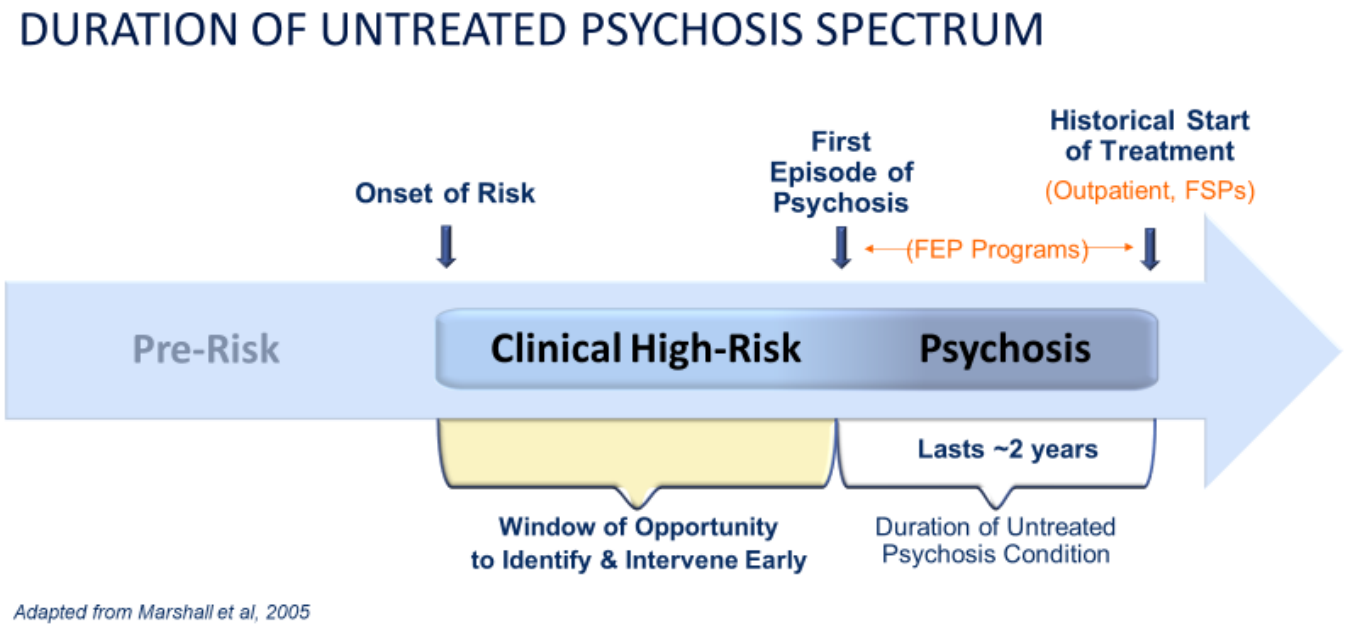
- Trouble concentrating or thinking clearly
- Confusion about what is real or imaginary
- Hearing or seeing things that aren't there
- Feeling that the world has become strange or unreal
- Preoccupation with unusual beliefs or superstitions
- Feeling suspicious or paranoid, while maintaining insight
- Disorganized speech, racing thoughts or slowed down thoughts
- Problems with social activities at work or school
- Mild withdrawal from family and friends

First Episode of Psychosis (FEP)

The first time a person meets full criteria for an established psychotic disorder (e.g., schizophrenia). FEP is characterized by loss of insight between what is real and what is not real regarding psychotic symptoms, increase in distress over symptoms, and/or significant functional impairment.

Psychosis

A mental health condition characterized as disruptions to a person's thoughts and perceptions that make it difficult for them to recognize what is real and what is not. These disruptions are often experienced as seeing, hearing and believing things that are not real or having strange, persistent thoughts, behaviors and emotions.



Adapted from Marshall et al, 2005

Challenges and delays in the early identification of psychosis

The duration of untreated psychosis (DUP) may be lengthy, in part, due to how a youth typically enters the behavioral health care system. Youth typically engage in mental health services after being referred by a concerned parent or caregiver. In some cases, their friends, classmates, teammates, teachers, religious/spiritual leaders, pediatricians or other important people may be the first to notice change and share their concerns with the youth or with their parent, depending on the child's age. In other circumstances, youth may come to the attention of community service providers who are helping them with housing instability, unemployment, declining academic performance, childcare, social isolation or familial difficulties, etc. (Andorko et al. 2021). These individuals (collectively referred to as the youth's "social network") can potentially act as responders who refer youth to appropriate care; however, most are unable to recognize CHR symptoms, resulting in youth often not getting connected to care until *after* they exhibit observable symptoms of psychosis. This can be particularly problematic if law enforcement is called to respond to what others perceive to be concerning or potentially dangerous behavior, as the youth may end up involved in the justice system, resulting in further delays (and additional distress and trauma) before receiving mental health support.

In addition, existing identification and referral practices to support youth experiencing CHR do not address the fact that the people most likely to be aware of the earliest emergence of potential psychosis symptoms or high-risk states are the youth themselves. Yet before they talk with others about what may be emerging psychosis risk – and before shifts in behavior and functioning become noticeable and concerning to the people around them on a daily basis – youth turn to the internet for answers and guidance. Despite searching online to learn more about their own mental health, a 2018 Mental Health America (MHA) survey of their online users found that only 20% of screeners with psychosis were interested in actively following up with 'those who can help' (19%) or a therapist (1%). These MHA user preferences appear to be stable based on subsequent web analytics and suggest an opportunity to increase interest in engaging in more active support-seeking behavior.

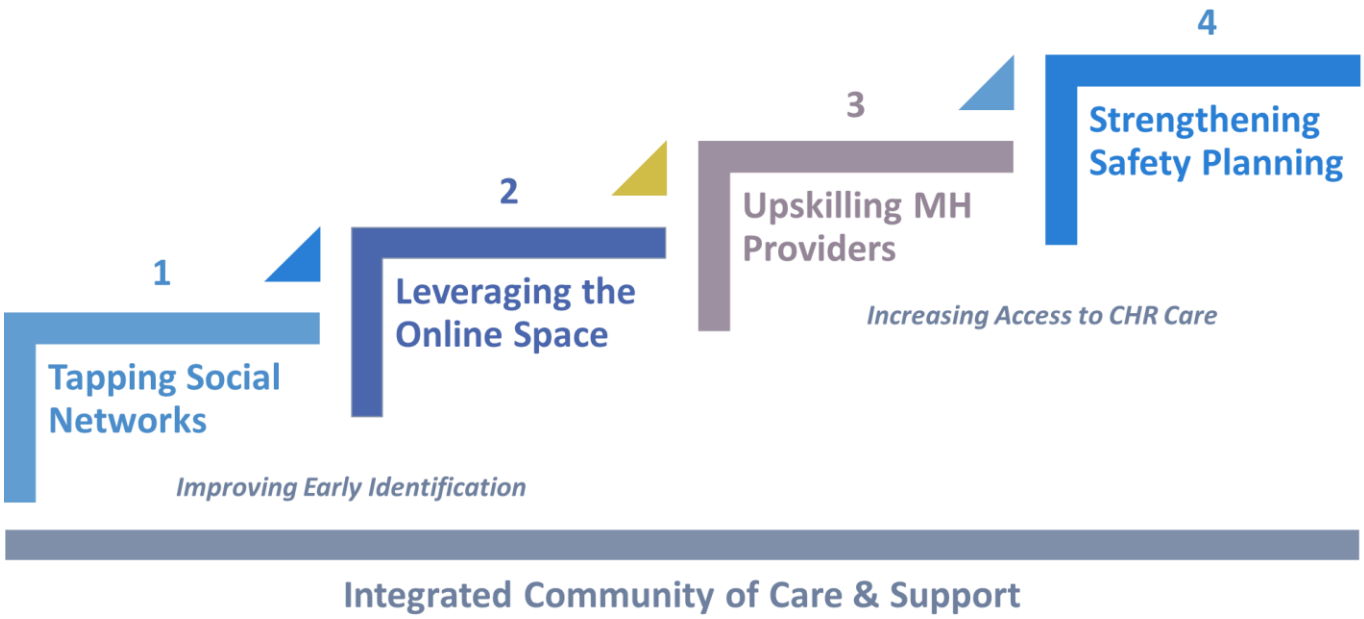
As the need is growing, the workforce is shrinking

The DUP may also be lengthy, in part, due to a shortage of specialists in FEP and CHR. The prevailing model for FEP/psychosis workforce development is to train a small number of behavioral health clinicians who become specialists in FEP best-practices. This approach to workforce development has obvious advantages, resulting in California being staffed with some of the most highly trained and skilled professionals in the FEP field. However, the level of community need continues to outpace the rate at which new specialists can be trained, especially in the CHR stage of illness, resulting in individuals potentially going without treatment during a critical period in which evidence-based intervention can have the most far-reaching impact. Unfortunately, healthcare provider knowledge gaps on the psychosis spectrum may become even more consequential over the next several years as there is some suggestion that COVID-19 viral exposure may be associated with the onset of psychosis (Brown et al., 2020).

PROJECT PROPOSAL

Overview

This project is proposing four changes to existing mental health practices that are nested within an overall coordinated system of care designed for youth who are at CHR for psychosis:



An important overarching principle of these related efforts is to ensure that care and services for youth and their families are culturally responsive and linguistically appropriate. The meaningful incorporation of culturally relevant factors will be facilitated through on-going collaborative meetings during which consumers, family members, peers, local providers and project staff co-develop outreach and training materials, as well as provide guidance on the development and evolution of the project overall.

Project Details

Improving Early Identification of Youth at Clinical High Risk for Psychosis

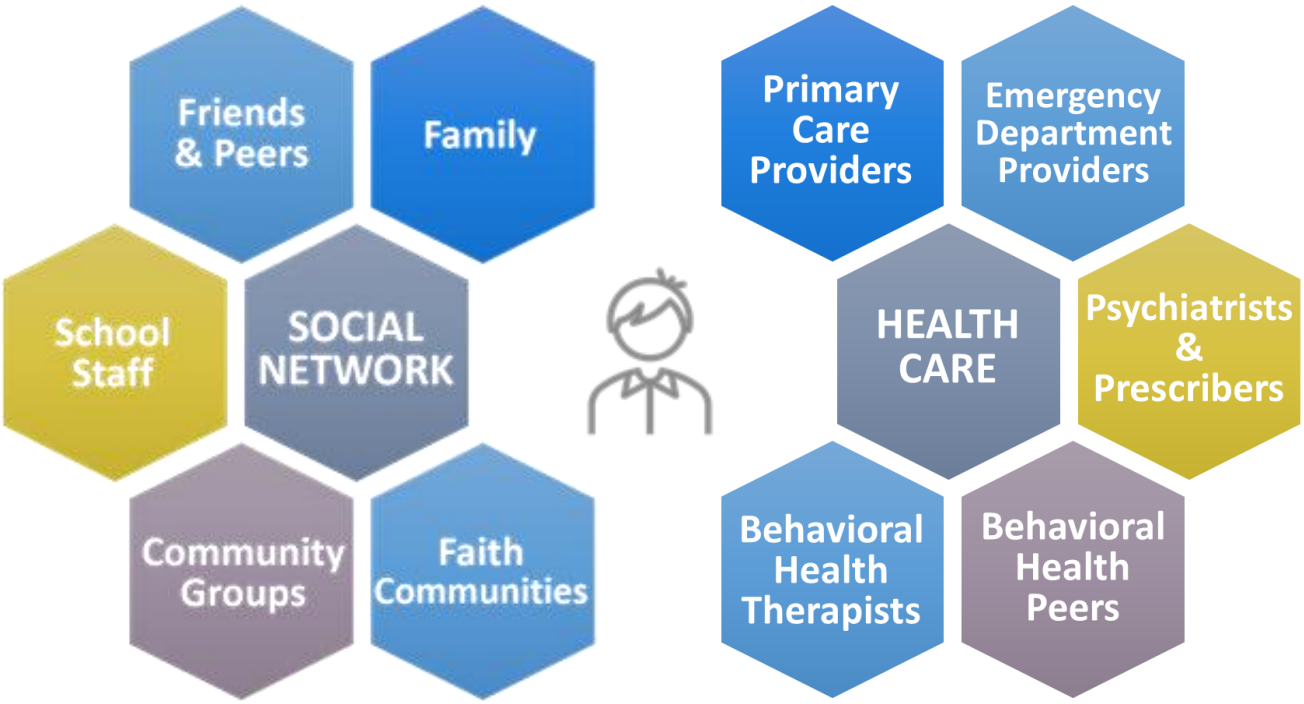
Far more individuals experience CHR than a psychosis condition, with only about 25% of those at risk going on to develop psychosis within three years (Fusar-Poli et al.., 2015). Individuals at CHR nevertheless report feeling distressed and experiencing disruptions in their daily lives, thus underscoring the importance of supporting them during the risk phase, even if they don't go on to be diagnosed with a psychosis condition in the future. For those youth who do develop psychosis, having early intervention would support recovery, improve school and employment outcomes, and improve stabilization at home.

There are two challenges with intervening early with youth at CHR, before they experience a first episode of psychosis. First, the people most likely to detect changes in their mood, behavior or thinking are not necessarily informed about what such changes might mean or how to respond. Second, before shifts in behavior and functioning become noticeable and concerning to the people around them, youth often turn to the internet for answers and guidance. Thus, this project will seek to improve early identification of youth at CHR by:

- Increasing the knowledge and skills of potential responders within young people's naturally existing social networks and campus security so they feel (a) better equipped with how to recognize a young person who may be at CHR for psychosis, and (b) more comfortable with knowing when and how to refer youth for screening and/or treatment services, and
- Engaging with youth online and identifying ways to increase the likelihood that those who may be at CHR for psychosis move from the online space to seeking available mental health services

Change 1: Tapping into Young People's Social Networks

To improve the knowledge and skills of potential responders, this project proposes to develop informational materials and trainings for two broad categories of potential responder groups identified through prior research (Andorko et al., 2021; Joa et al., 2008; Rietdijk et al., 2011, Lloyd-Evans et al., 2011) and the local community planning process for this project: their social network and healthcare providers.



Trainings and materials will be co-developed in partnership with peers, family members and community/cultural leaders (i.e., LGBTQ, Veterans/Military-connected individuals, monolingual individuals) and attempt to improve awareness, knowledge and skills of potential responders by:

- Countering prevailing myths and misconceptions surrounding psychosis that may hinder a potential responder from talking to a young person they are concerned about
- Educating potential responders about the effectiveness of early intervention to reinforce messages of hope and resilience
- Describing conditions and factors that might place a youth at increased risk for CHR
- Alerting potential responders to the fact that youth in a CHR state may first come to them to talk about problems in their social relationships, school functioning, home life, suicidal thoughts or behaviors, etc. rather than about possible symptoms of CHR for psychosis
- Providing potential responders with tips on how and when to explore for the possible presence of CHR symptoms during conversations with a youth in distress
- Integrating suicide prevention training into CHR training to better equip all potential responders with the knowledge and skills that will help them more fully support the socioemotional health of the youth since two-thirds of youth who experience CHR also experience suicidal thoughts or behaviors (Taylor et al., 2015).
- Educating potential responders about best practices in referring youth to care
- Proactively outreaching after a training with refresher information, reminders about tips/strategies, and targeted resources/referral

Materials will be tailored for the potential responder groups being trained. While it is recognized that law enforcement is not a part of a youth's social network, it is worth noting that training developed for this group is regarded as critical to improving the overall effectiveness of early intervention, as previous research has found that negative interaction with law enforcement is a risk factor in and of itself for psychosis experiences (DeVylder et al., 2017).

Based on community feedback, the project proposes to focus on campus security and campus law enforcement officers rather than law enforcement more broadly as the former group is more likely to work with and respond to adolescents and Transitional Age Youth (TAY).

Change 2: Leveraging the Online Space

This project also proposes to implement a novel, digital strategy that leverages Mental Health America's (MHA) decades worth of experience in online mental health screening and referrals. MHA hosts the nation's leading website for all mental health screening, with a link to MHA Screening often loading at or near the top following an internet search for questions such as "*How can I tell if I'm depressed or sad*" or "*Am I going crazy*?" In 2021, 10,000 screeners were completed by OC residents, 800 of which were the Prodromal Questionnaire-Brief (PQ-B) screener, a psychometrically validated self-report measure for assessing psychosis risk syndromes among adolescents and young adults (Loewy et al., 2011). Of the total PQ-B screens completed on MHA Screening, 74% scored at-risk and only about 1 in 5 people who screened at-risk expressed interest in seeking support or care.

To improve online engagement with young people and increase their interest in engaging in mental health services, self-identified[1] Orange County youth who score in the at-risk range on the PQ-B can choose to explore one or more of three digital resources that will automatically load on the MHA Results landing page:

OC CHR Screening-to-Support Weblink

Enhanced Psychoeducational Materials

Personalized Normative Feedback Tool

The **OC CHR Screening-to-Support Weblink** will connect youth with CHR- or psychosis-related concerns to the appropriate level of care based on their clinical needs identified through a stepped screening and assessment process that separates the diagnostic process into naturally occurring, smaller segments (see the *Process to Confirm Identification of Youth A CHR through Stepped Screening* under "Population to be Served" section). Thus, only those youth who continue to report experiences placing them in the "positive screening" range will ultimately complete the comprehensive assessment. Youth who exit the screening pipeline at an earlier stage will be offered referrals and supports matched to their level of need. Resources may include general online resources, Orange County specific resources, outpatient services, and specialized care in a new CHR Clinic or the County's existing FEP program (OC CREW).

[1] The MHA Screener does not enable cookies or track IP addresses. Thus, Orange County residents are only identified when they voluntarily opt in to provide their zip code.

Enhanced Psychoeducational Materials on Psychosis will be posted to the MHA website and updated to include information on CHR, FEP and the benefits of early intervention. Materials will be co-developed with peers, consumers, family members, local providers and trusted cultural ambassadors to reach and support the diverse populations living in Orange County more effectively, with an initial focus on the populations identified through the local community planning process: LGBTQ, parents/caregivers, Veterans/Military-connected individuals, monolingual individuals (Spanish, Vietnamese, Korean, Mandarin, Tagalog, Khmer, Arabic, Farsi).

Because MHA has observed that many adolescents and TAY take screeners in English, culturally appropriate translations of these materials may heavily focus on parents and extended family members who may speak a language other than English. The intent is to provide this information so that family can better support the youth who may be experiencing CHR (e.g., awareness of what symptoms may look like, what resources are available, when to seek different level of care).

The **Personalized Normative Feedback (PNF) Tool** is intended to motivate youth who do not initially click on the CHR Screening-to-Support link after receiving their positive screening results and encourage them to connect to care. This project will be the first to marshal the PNF technique to try and increase the likelihood that youth at CHR will self-refer to mental health assessment and other clinical services by exploring (and addressing) youth and family perspectives on barriers to care, beliefs and misperceptions of psychosis.

WHAT IS PERSONALIZED NORMATIVE FEEDBACK?

One major influence on young adults' behavior is peer social norms, which PNF leverages to motivate positive behavior change. The social norms approach was originally developed to reduce problematic alcohol use among U.S. college students (LaBrie et al., 2013), and was built on the belief that students who engage in problematic drinking nearly always overestimate alcohol use among their peers and mistakenly hold the position that excessive drinking is a socially desirable behavior. In turn, these misperceptions lead to continued problematic drinking without reflection on how their drinking behavior might be excessive or unhealthy. PNF interventions aim to correct a person's misperceptions and motivate positive behavior changes by providing more accurate information on how common or acceptable the targeted behavior is among that person's peer group.

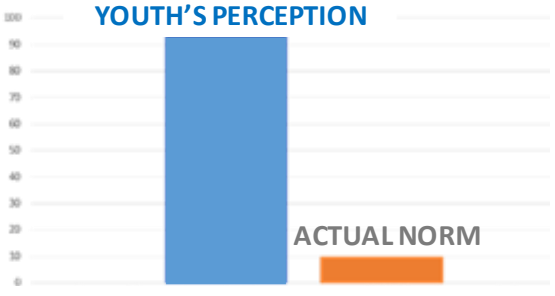
PNF Intervention Example

Step 1. Youth is asked:

"What % of people your age think less of a person who has received mental health treatment?"

Step 2. Youth's response is compared to actual group norm:

% of people your age who think less of a person who has received mental health treatment



"You thought 95% of people your age would think less of a person who received mental health treatment. Based on a survey of over 10,000 young adults, only 10% said they would think less of a person."

Increasing Access to CHR Care

Even before the COVID-19 pandemic, consumers and families across the country felt the weight of the behavioral healthcare workforce shortage. Since then, the gap between the number of people with behavioral health needs and the number of available clinicians has only widened, which is all the more concerning given initial indicators that COVID-19 viral exposure may be associated with the onset of psychosis (Brown et al., 2020) and other mental health conditions.

Change 3: Upskill Community Providers Supported through a CHR Clinical Learning Hub

This project aims to expand the number of healthcare professionals qualified to work with youth at CHR by building upon providers' existing skills and adapting them for CHR-appropriate care. More specifically, this project proposes to adopt a modular approach to care, which represents one of the first efforts to move CHR modular therapy from clinical research into clinical practice.

Engaging the mental health workforce more broadly, as opposed to training more behavioral health CHR specialists, offers several advantages when implementing a community-wide approach to increasing access to CHR-focused care. First, generalists are more likely than psychosis specialists to interact with youth at CHR as they, by definition, have not yet met criteria for a full-threshold psychosis condition, which is a prerequisite for a FEP or other psychosis program.

WHAT IS A MODULAR APPROACH TO TREATMENT?

Modular psychotherapy is an approach in which evidence-based therapies are broken down into small, self-contained functional units (modules) that each focus on a specific, evidence-based intervention (i.e., deep breathing, muscle relaxation, activity scheduling, etc.; Chorpita et al., 2005). Different modules can then be connected together to create a care plan tailored to the unique needs and preferences of the client and family. This approach is in contrast to most evidence-based practices (EBP) that generally use a one-size-fits-all, scripted manual outlining one course of treatment to be applied to all clients. Modular psychotherapy has been in practice for several decades, and successfully applied to the treatment of anxiety, depression and conduct behavior in children (Chorpita et al., 2005).

Second, youth at CHR face challenges that do not always fall squarely in the realm of psychosis (e.g., mood, anxiety, attention, trauma, substance use, life transitions). In many cases, youth articulate these challenges as the presenting problems that become the focus of clinical care. General mental health providers are equipped to address these challenges regularly in their practice, and may be able to address additional mental health concerns that individuals at CHR may experience.

Lastly, and perhaps most importantly, upskilling a youth's existing provider creates opportunity for youth to have choice on where and from whom they receive care. It also minimizes disruptions to care by reducing potentially unnecessary transitions to a CHR specialist and may even enhance treatment gains when support is provided by a provider with whom the youth and family already have trust and rapport.

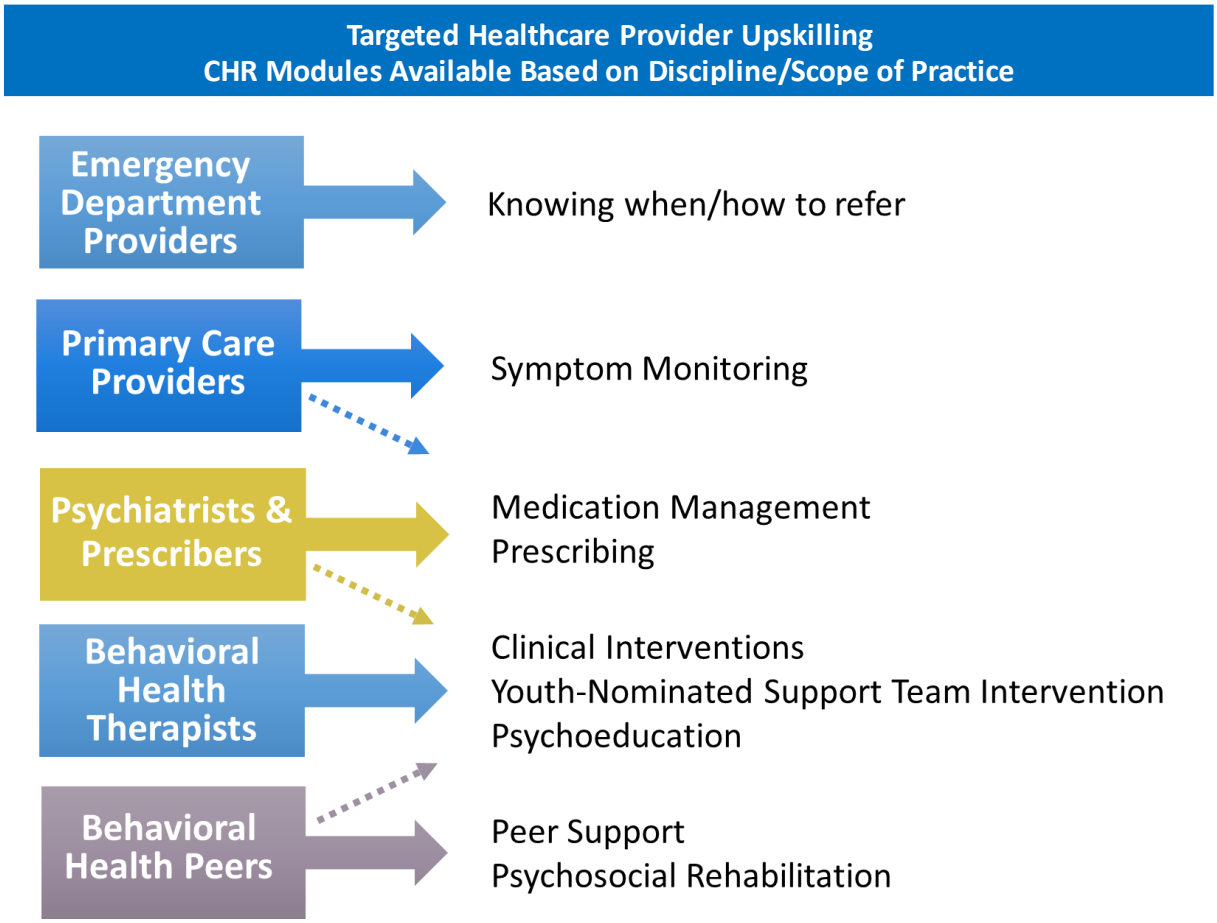
Establishing CHR care in Orange County

Increasing Orange County's capacity to support youth at CHR will begin by establishing a CHR Clinic where specialists work directly with youth and their families to provide CHR assessment, treatment and supportive services. This Clinic will be co-located with a FEP program and general (mild-to-moderate)

outpatient clinic. Together, they provide a continuum of care that complements the service most likely to be needed by youth who go through the CHR Screening-to-Support pipeline and are not screened as CHR.

Upskilling the general healthcare/behavioral health provider workforce

The CHR Clinic will also serve as a community training and support hub where community healthcare providers can learn CHR-focused skills and best practices that fall within their existing scope of practice. To incentivize participation, ***providers can receive continuing education credits towards their profession at no cost to them***. For example, all healthcare providers will be trained in modules on the identification and referral of youth at possible CHR, and all except emergency medicine will be trained in symptom monitoring. Community mental health providers can also receive additional training in different CHR modules focused on various best practices in CHR care, as demonstrated in this sample outline:



Importantly, CHR specialists will support and sustain community providers' on-going learning through a Project ECHO-inspired "CHR community of practice," as well as through stepped consultation services open to providers, youth at CHR and their families:

ONE-TIME CONSULTATIONS
Scheduled CHR case consultation for providers. Records shared ahead of time. Authorization to disclose (ATD) required.

ON-GOING TEAM CONSULTATIONS
Monthly, scheduled case consultation with youth, family, and provider(s). ATD required.

OC CHR OFFICE HOURS
Drop-in as needed for support, questions, etc. Casual, flexible, anonymous.

OC CHR POST-TRAINING OFFICE HOURS
Drop-in as needed to reinforce learning and use of new skills. Supports fidelity to best practices. Anonymous.

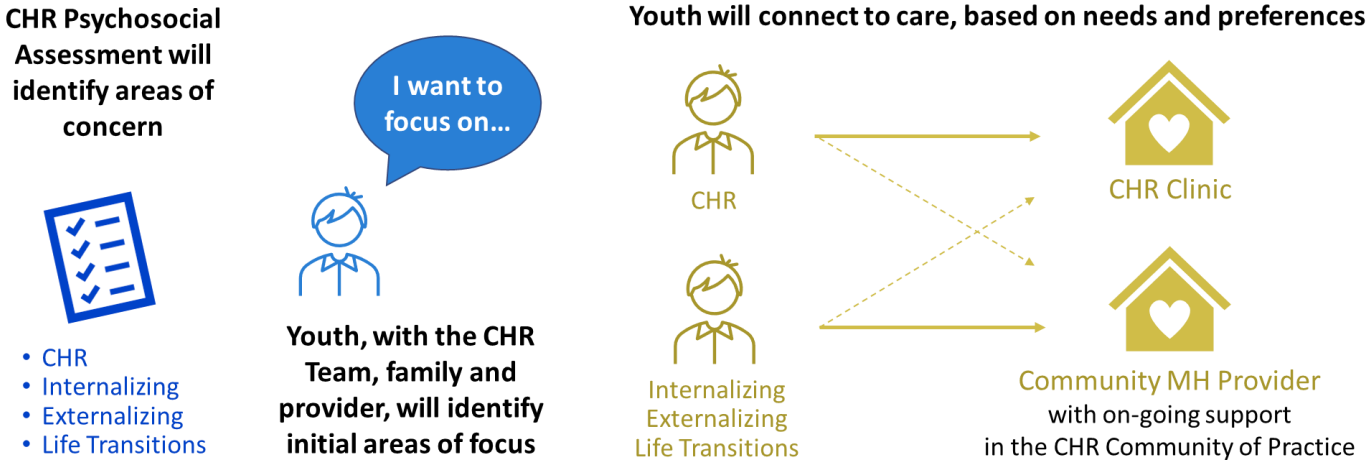
WHAT IS PROJECT ECHO?

The University of New Mexico's Project ECHO ("Extension for Community Healthcare Outcomes") is an evidence-based learning framework used to create a virtual "community of practice" in which general practitioners learn how to provide quality, specialty care from specialists and from each other. Through weekly sessions of case-based learning, mentoring and peer support, general practitioners learn evidence-based and best practices from experts in the field, thus building their capacity to manage complex or serious conditions safely and effectively. The case-conference/grand rounds-style format also encourages participants to learn from each other, which the County will leverage to create *opportunities for sharing culturally-responsive practices and strategies, with the goal of simultaneously building cultural competence across the network of providers*.

Determining between community provider CHR care and CHR specialty care

As depicted in the figure below, youth at CHR who wish to focus on their CHR concerns will be referred to the CHR Clinic for more specialized care. Youth at CHR who wish to focus on their **non**-CHR concerns will, pending appropriate training of and agreement from their community provider, be offered the option of continuing with their current provider. Over time, this option would also extend to when focusing on CHR-related concerns.

If the provider is not comfortable with or is unable to provide care to these youth, or the youth prefers working with a CHR specialist, the youth will have the option to transition to the CHR Clinic. Importantly, for any youth who reports suicidal ideation/behavior, these symptoms will be collaboratively addressed and monitored to optimize the youth's safety.



Change 4: Strengthening Safety Planning

Over two-thirds of youth at CHR for psychosis are also at risk for suicide (Taylor et al., 2005), and while most CHR providers incorporate a safety plan, typical safety planning may not always be sufficient for youth at CHR. This is because a core feature of safety planning is the identification of trusted people who will support the young person during times of stress and/or increased suicidal ideation/behavior. However, many youth at CHR also struggle with social isolation, suspiciousness, and unusual thought content, which can not only contribute to suicidality but also actively work against the youth's willingness to engage their support team during times of need.

Thus, the current project proposes to address this limitation by adapting **Youth-Nominated Support Teams** (YSTs) for youth at CHR. It will do this by enhancing the psychoeducation aspects of the YST protocol with information on CHR, including how to recognize when changes in functioning or CHR symptom expression may signal heightened risk for suicide (e.g., voices encouraging self-harm, feelings of hopelessness related to self-perception of "going crazy," etc.); how social isolation, suspiciousness, and unusual thought content may impact the young person's ability to engage their support team; and appropriate ways for the nominated team members to support the youth.

WHAT IS A YOUTH-NOMINATED SUPPORT TEAM?

Youth-Nominated Support Teams are an evidence-supported suicide prevention strategy that evolved to address the fact that, during safety planning, the people who youth often name to be in their support network are typically not familiar with how to support someone experiencing suicidal ideation or behaviors. In YSTs, the people nominated by the youth as their supports are integrated into the clinical team and educated on how to be a source of support in the young person's life.

YSTs have been shown to reduce suicide risk among adolescents with recent suicidal ideation and attempts (King et al.., 2006; 2009; 2019a; 2019b).

Importantly, YSTs not only provides a structured approach to address suicide risk but are notably distinct from other typical CHR interventions due to their emphasis on social support. Thus, in addition to changes in self-reported suicidal ideation and behaviors, this project will also explore whether the YST intervention reduces social isolation, increases hope, and/or encourages treatment engagement among youth at CHR with co-occurring suicidality.

Populations to be Reached

The target populations intended to be reached by this project are described below, separated by the focus of the innovative change.

To improve early identification of youth at clinical high risk for psychosis, the County will launch an on-going marketing and outreach campaign designed to connect with three broad categories of potential responder groups (i.e., Social Networks, Healthcare Providers, Campus Law Enforcement), leveraging existing HCA contact lists provider/organization contacts, outreach programs, college stigma reduction

initiatives, etc. Per a suggestion received during community feedback, the County will also seek to provide outreach materials and psychoeducation in libraries and other public venues.

Estimated numbers of **events and educational trainings** to be provided are listed below by group:

POTENTIAL RESPONDER GROUPS:	OUTREACH EVENTS/TRAININGS	
Social Networks	**Annually**	**5-Year Total***
Family Members and Caregivers Including through community-specific events that may better reach the priority groups identified: LGBTQ, Veterans/Military-connected individuals, monolingual individuals (Spanish, Vietnamese, Korean, Mandarin, Tagalog, Khmer, Arabic, Farsi)	24	72
School/Campus-Based Potential Responders Including teachers, coaches, school counselors, alumni groups that support parents preparing to send their children off to college. **Friends and Peers** will also be outreached through school resources.	27	100
Family-Oriented Community Organizations and Faith Groups Including Family Resource Centers, Religious Organizations, etc.	15	52
Estimated Subtotal	**66**	**224**
First Responders	**Annually**	**5-Year Total***
Campus Security, Campus Law Enforcement Officers **Estimated Subtotal**	**12**	**42**
Healthcare Providers	**Annually**	**5-Year Total***
Primary Care Providers Including pediatricians, family practice physicians, hospital social workers and others who work in emergency departments	12	42
Psychiatrists and Other Prescribers Including Psychiatry Fellows and Residents, Psychiatric Nurse Practitioners, etc.	6	20
Peers/Peer Specialists, Mental Health Specialists People with lived experience, non-clinician mental health workers, Promotoras, etc.	12	42
Behavioral Health Therapists Including LCSWs, psychologists, MFTs, etc. (licensed, trainees)	24	120
Estimated Subtotal *Numbers are for outreach and potential responder trainings and do not include CHR community of practice or clinical consultations*	**54**	**224**
ESTIMATED TRAININGS: GRAND TOTAL	**132**	**490**

** 5-Year Total is prorated to account for project start up and wind down.*

To increase access to CHR care for youth at CHR for psychosis, the County will seek to engage youth through two referral sources:

- Potential responders from the youth Social Network, Healthcare Providers, Campus Security/Law Enforcement
- The MHA Online Screener

The target age range is approximately 14-25 years, however the project will not exclude individuals who fall outside of this age range. The demographic characteristics of youth engaging in the screening pipeline will be continually monitored, and marketing and outreach efforts will be adjusted, as needed, to try and ensure that Orange County youth from underserved or unserved communities are reached.

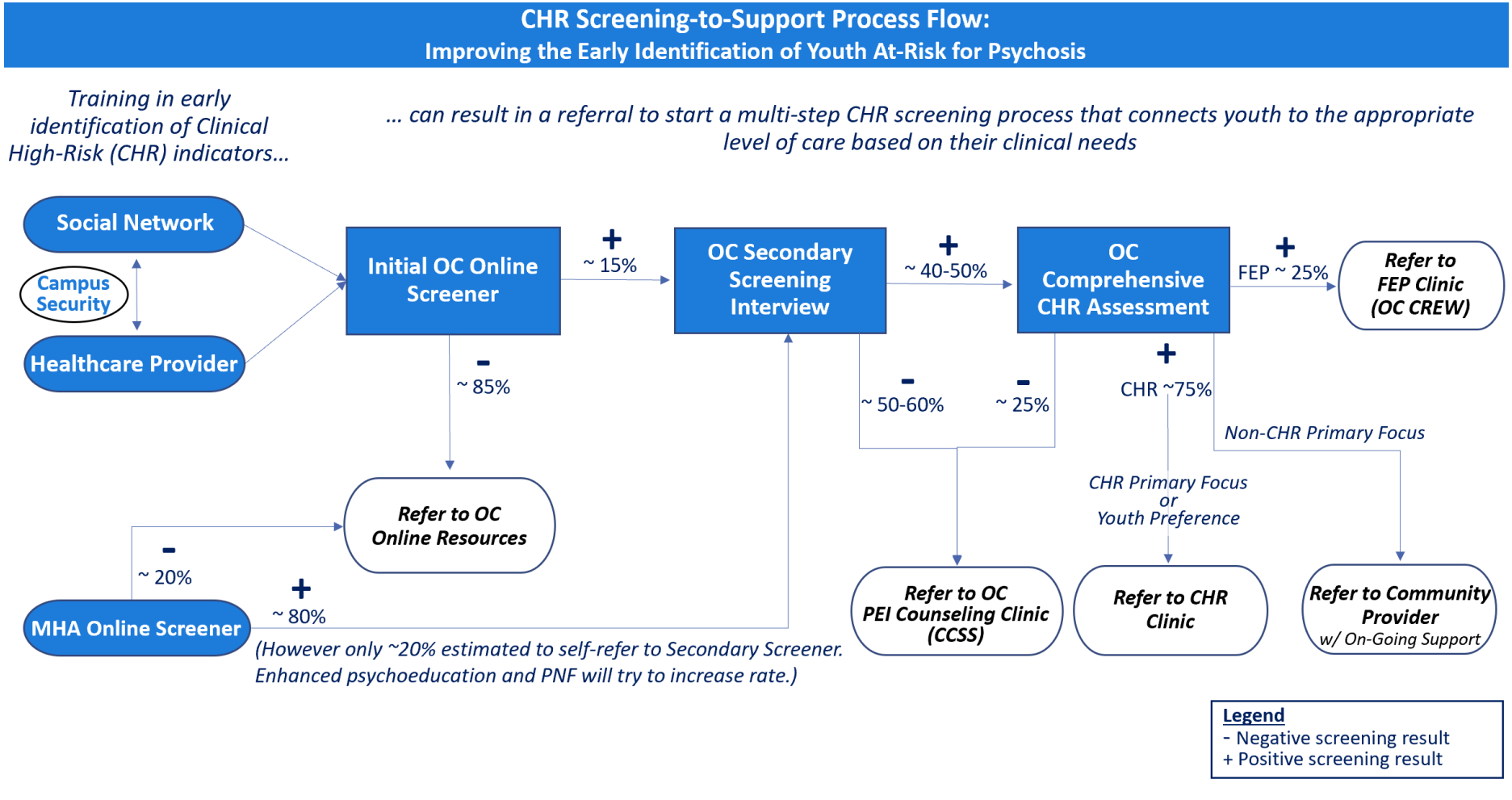
Individuals referred through channels outside of the two sources described above will be accepted into the project and screened and referred to services in the same manner, using the measures listed below in the process described on the following page.

OC CHR Screening-to-Support Pipeline Measures	
STEP IN PIPELINE	**MEASURE(S)**
INITIAL SCREENER: MHA Online Screener *(youth self-refers from MHA Screener)* **INITIAL SCREENER: Initial OC Online Screener** *(referred by potential responders)*	• Prodromal Questionnaire-Brief (PQ-B) • User Demographics, can be anonymous • Abbreviated PRIME Screen • Youth Demographics, can be anonymous
OC SECONDARY SCREENING INTERVIEW *(conducted over the phone or via telehealth)*	• Abbreviated Structured Interview for Psychosis Risk Syndromes (Mini-SIPS) • Abbreviated Structured Interview for the DSM-5 (SCID) Screen • Youth Demographics, including identifying information • *Youth referred from the MHA Online Screener will also complete the Abbreviated PRIME to allow for comparison with the PQ-B*
OC COMPREHENSIVE CHR PSYCHOSOCIAL ASSESSMENT *(conducted in-person)*	• Full Structured Interview for Psychosis Risk Syndromes (SIPS) • Full Structured Clinical Interview for the DSM-5 (SCID) • Self-report questionnaires (life functioning, social/family relationships) • Youth Demographics not provided earlier

Process to Confirm Identification of Youth at CHR through Stepped Screening and Estimated Numbers to be Served

Accurately identifying young people at CHR for psychosis can be a nuanced and lengthy process because the individual's symptoms are subtle and fluctuating and can closely resemble other mental health conditions (e.g., anxiety, trauma, obsessive-compulsive disorder). As such, the process for early identification and, when appropriate, referral to care needs to be both effective and efficient, striking a balance between being thorough while avoiding unnecessary burden.

To maximize the potential impact of increased community-wide awareness on CHR for psychosis and the benefits of early intervention, this project will create a multi-step screening and assessment weblink (i.e., CHR Screening-to-Support Pipeline) that separates the diagnostic process into naturally occurring, smaller segments. Thus, only those youth who continue to report experiences placing them in the "positive screening" range will ultimately complete the full, comprehensive assessment. Youth who do not screen positive and exit the CHR screening pipeline at an earlier stage will be offered referrals and supports matched to their level of need.



Based on the estimated number of youth to be screened from the two project-identified referral sources, the estimated number of youth to be screened and referred to appropriate services are listed below:

STEP IN SCREENING PIPELINE By Referral Source	ESTIMATED NUMBERS OF PEOPLE REACHED			
	ANNUALLY	Screened Positive	OVER 5-YEARS	Screened Positive
INITIAL SCREENER				
MHA: All Screens by OC Residents*	10,000	-	50,000	-
MHA: PQ-B Screens by All OC Residents*	800	592 (74%)	4,000	2,960 (74%)
MHA: All PQ-B Screens by OC Youth*	500	400 (80%)	2,500	2,000 (74%)
Adjusted for Countywide Marketing Campaign:				
MHA: All PQ-B Screens by OC Youth	**1,000**	**800 (80%)**	**5,000**	**4,000 (80%)**
Social Network/Healthcare/Campus Security	**1,000**	**150 (15%)**	**5,000**	**750 (15%)**
Total Youth	**2,000**	**950**	**10,000**	**4,750**
SECONDARY SCREENER				
MHA (youth)	**160**	**80 (50%)**	**800**	**400 (50%)**
Social Network/Healthcare/Campus Security	**30**	**12 (40%)**	**150**	**60 (40%)**
Totals	**190**	**92**	**950**	**460**
COMPREHENSIVE CHR ASSESSMENT				
MHA (youth)	**64**	**48 (75%)**	**320**	**240 (75%)**
Social Network/Healthcare	**10**	**7 (75%)**	**50**	**35 (75%)**
Totals	**74**	**55**	**370**	**275**

** Based on 2021 Orange County MHA user data*

ESTIMATED NUMBER OF YOUTH REFERRED TO OUTPATIENT SERVICES					
ANNUALLY			OVER 5-YEARS		
PEI Clinic	CHR Clinic	FEP (OC CREW)	PEI Clinic	CHR Clinic	FEP (OC CREW)
98 from secondary screener* 18 from comprehensive assessment*	41	14	490 from secondary screener* 90 from comprehensive assessment*	205	70

LEARNING GOALS AND EVALUATION STRATEGY

As described above, the primary purpose of this project is to improve early identification of youth who are at CHR for experiencing psychosis and increase their access to mental health services. The County proposes to implement several creative solutions for building knowledge on the potential signs of CHR for psychosis and for increasing access through four inter-connected changes. On the following pages are tables that delineate the learning goals and accompanying data sources by each of the four proposed changes to existing mental health practices.

CHANGE 1: **GOAL: Improve the knowledge and skills of potential responders within young people's naturally existing social networks so they feel a) better equipped with how to recognize a young person who may be experiencing symptoms of CHR for psychosis, and b) more comfortable with knowing when and how to refer youth for screening and/or treatment services.**	
LEARNING OBJECTIVE	**PROPOSED DATA SOURCES**
• How many trainings/events were offered (overall, per potential responder group)? • Were some trainings/events attended more than others? • Were some potential responder groups more likely to accept/decline events/trainings? • Did attendance rate change following changes to outreach method, training format and/or materials used? What appeared to be contributing to attendance rates (e.g., changes in language/phrasing, examples, images, etc.)?	• Project administrative data, including training registration and attendance • Qualitative analysis of changes to materials, content, etc. and correspondence, if any, to shifts in registration/ attendance
• What was attendees' level of satisfaction with, knowledge gained, and intention to use the skills they learned at the training? • Did attendee responses differ based on type of potential responder group and/or the type of event/training attended? • Did satisfaction change following changes to training format and/or materials used? What appeared to be contributing to satisfaction levels (e.g., changes in language/phrasing, examples, images, etc.)	• Post-training surveys • Project administrative data • Qualitative analysis of changes to materials, content, etc. and correspondence, if any, to shifts in satisfaction ratings
• Did a person leaving an event/training know how to get a young person to the right resources?	• Post-survey responses; • Analysis of web traffic, referrals on the OC CHR Screening-to-Support pipeline

CHANGE 2 **GOAL: Engage with young people online, where many youth first go for information, and identify ways to increase the likelihood that youth who are clinical high risk move from the online space to seeking available mental health services through a stepped screening process**	
LEARNING OBJECTIVE	**PROPOSED DATA SOURCES**
On the MHA Results page, what percent of youth who receive a positive PQ-B screen first click on: • OC CHR Screening-to-Support pipeline? • Enhanced Psychoeducation material(s)? • Personalized Normative Feedback Intervention (PNF)?	• Click-through rates (first click after results page loads) on each of the options
• After reading enhanced psychoeducational materials on the MHA website, what percent opt into the OC CHR Screening-to-Support pipeline? • How do these rates compare to the direct click on the OC CHR Screening-to-Support pipeline? • Do some psychoeducational materials have higher rates of opting into the OC CHR Screening-to-Support pipeline than other psychoeducational materials? • Do some materials perform better with different cultural groups?	• Comparison of click-through rate for OC CHR Screening-to-Support pipeline when results page first loads vs rate after reading Enhanced Psychoeducation material • Web analytics on the different Enhanced Psychoeducation pages (e.g., times viewed, unique views, length of time spent on page, etc.) • Youth demographic data provided on the MHA Screener
• After choosing to respond to a PNF intervention on the MHA website, what percent opt into the OC CHR Screening-to-Support pipeline? • How do these rates compare to the direct click on the OC CHR Screening-to-Support pipeline? • Do some PNF interventions on the MHA results page result in higher rates of opting into the OC CHR Screening Link than other PNF Interventions? • Do some interventions perform better with different cultural groups?	• Comparison of click-through rate for OC CHR Screening-to-Support pipeline when results page first loads vs rate following PNF Intervention • Comparison of click-through rates to the Screening-to-Support pipeline by PNF Intervention type • Youth demographic data provided on the MHA Screener
• Does the OC CHR Screening-to-Support pipeline seem easy to use?	• Analysis of user completion and drop off rates at each point of the OC CHR Screening-to-Support pipeline
• Do the screening and assessment tools in the OC CHR Screening-to-Support pipeline appear to be effective and appropriate for OC youth?	• Predictive accuracy of primary and secondary screening relative to each other and to the SIPS clinical interview, by different target populations/cultural groups

• Pending availability of data, can data analytics models using MHA user data effectively identify youth who may be at CHR as well as the PQ-B Screener? • Pending availability of data, do data analytics models work better for some target populations than others?	• Datamining of MHA data • Screening rates on the Secondary Screening Interview for youth referred from a MHA data analytics model vs the MHA PQ-B screener • User demographic data
• What is the average age of the youth referred by potential responders (compared to the average age of OC CREW participants), and are there differences in age depending on the potential responder group who referred the youth (including MHA Screener)?	• Project administrative data • Aggregated OC CREW client demographic data
• What is the average duration of untreated mental illness (DUMI, i.e., CHR) of the youth referred, and are there differences in duration depending on the potential responder group who referred them (including MHA Screener)?	• Aggregated youth data from the OC CHR Screening-to-Support pipeline

CHANGE 3 GOAL: Expand the number of mental health providers qualified to work with youth at CHR by training them on an innovative, modularized approach to care that builds upon providers' existing skills and adapts them for youth at CHR for psychosis, and support their learning by leveraging University of New Mexico's Project Echo model	
LEARNING OBJECTIVE	**PROPOSED DATA SOURCES**
• Are community providers joining and participating in the CHR learning community? • Are community providers using the stepped consultations? • What is their satisfaction with the CHR learning community? With the stepped consultations? • Are some consultation types more effective and/or utilized than others?	• Project administrative data • Analysis of survey responses from providers
• How many youth at CHR are being supported in the CHR Clinic vs. with community providers? • What is their engagement/retention in treatment?	• CHR Clinic administrative data • Clinic appointment attendance and/or client/parent report of appointment attendance (per IRB/consent form and/or ATD for clients with community providers)
• Do youth who are receiving CHR care report changes in their symptoms, distress, functioning, insight/awareness? • Do changes differ based on the youth's primary clinical concern (i.e., CHR, non-CHR)? • Do changes differ based on whether they are being supported by a CHR specialist or a community-based provider?	• Analysis of scores on various youth self-reported measures, diagnostic interviews, clinician ratings, drawing upon learnings from the EP LHCN
• How satisfied are youth with their CHR care? What is the therapeutic alliance between youth and providers? • How satisfied are parents/caregivers with their child's CHR care? • Are there differences based on whether the youth is being supported by a CHR specialist or a community-based provider?	• Analysis of survey responses from youth, family members

CHANGE 4 GOAL: Improve one the core elements of CHR intervention – safety planning – by implementing and evaluating the Youth-Nominated Support Teams (YST) approach adapted to CHR population.	
LEARNING OBJECTIVE	**PROPOSED DATA SOURCES**
• How many providers were offered YST training? • How many providers opted into YST training? • Were some provider groups more likely to accept/decline YST trainings than others? • Did attendance rate change (improve/decline) following changes to outreach method, training format and/or materials used?	• Project administrative data
• Did youth with suicidal ideation/behaviors whose providers received the YST intervention, compared to those whose providers did not, show: ○ Greater improvements in self-reported suicide ideation/behaviors, hopelessness, social connectedness? ○ Lower crisis evaluation or psychiatric hospitalization rates, shorter lengths of stay? ○ Increased engagement/retention in treatment?	• Youth self-reported measures • Comparison of crisis evaluations, psychiatric hospitalization episodes, hospital length of stay • Clinic appointment attendance (i.e., frequency of appointments, % of appointments kept) and/or client/parent report of appointment attendance (per IRB/consent form and/or ATD for clients with community providers)
• How satisfied are youth with their CHR care? What is the therapeutic alliance between youth and providers? • How satisfied are parents with their child's CHR care? • Are there differences based on whether the youth is being supported by a CHR specialist or a community-based provider?	• Analysis of survey responses from youth, family members

RESEARCH ON INN COMPONENT

There are existing programs that serve people at CHR (e.g., programs at UC Davis, Rutgers, Maryland), however, the current proposal is innovative relative to these projects in numerous of ways as outlined in the table below.

COMPARISON OF CURRENT PROJECT ELEMENTS TO OTHER PROGRAMS			
CURRENT PROJECT	**UC DAVIS**	**UNIVERSITY OF MARYLAND**	**RUTGERS UNIVERSITY**
Awareness and referral campaign targeting 8 key community groups	Some outreach	Outreach focused on MH community only	Outreach focused on MH community only
Specific focus on campus law enforcement	No	No	No
MHA screening to referral initiative	Partnership with MHA largely around research at the screening level, not screening to referral	No	No
MHA Personalized Normative Feedback to motivate treatment seeking	No	No	No
Creating and testing screening-to-interview-to-referral pipeline	Some efforts in this domain	No evaluation of impact; no secondary screening; no large-scale community web-based partnership	Some screening
Upskilling the existing healthcare workforce through Modularized Care for CHR	Some training to workforce, but focus is on identification and specialty care referral	Modularity training limited to CHR specialists	No
Specialized services for reducing suicidality through implementation of Youth-Nominated Support Teams (YST)	No	No	No
Specialized consultation partnership with the community through the Project ECHO model	Consultation is available, although not offered in the ECHO model	Consultation not as extensive, no specific group consultations, no ECHO model programming	Limited consultation

Early Psychosis Learning Health Care Network (EP LHCN)

Orange County is participating along with several other California counties on the Early Psychosis Learning Health Care Network (EP LHCN) Innovation Project. The EP LHCN aims to support quality improvements, consumer engagement and provider use of measurement-based care in early psychosis (EP) programs, focusing on standardizing measurement tools, data collection and analysis practices, and enhancing consumer and program decision-making through the use and availability of data; this project does not provide direct services, and it is being implemented in Orange County's FEP program, OC CREW. The project proposed here will continue the best practices, trainings and outcomes measurement strategies identified through the EP LHCN and expand its impact by creating a coordinated screening, assessment, intervention and consultation/training system focused on supporting Orange County youth at CHR for psychosis and their families, as well as the network of providers who work with them on a daily basis.

Personalized Normative Feedback (PNF)

A broad range of studies has demonstrated the effectiveness of PNF in alcohol use, cannabis use and gambling (Saxton et al., 2021). This project will adapt the PNF intervention for youth at CHR for psychosis and evaluate whether it increases help-seeking behavior among young people who believe their peers will look down on or think poorly of them for seeking help for mental health conditions when, in fact, surveys have shown that the majority of Americans report having positive views about mental health treatment (APA, May 2019). *This project will be the first to marshal the PNF technique to try to increase the likelihood that youth identified as at-risk will self-refer to mental health assessment and clinical services*.

Project ECHO

First launched in 2003 by Dr. Sanjeev Arora from University of New Mexico Health Sciences to train primary care providers on how to treat hepatitis C, Project ECHO now has global reach and over 1,600 programs, many of which are focused on medical conditions and care. This project will model the Project ECHO format to create a learning and consultation framework focused on the assessment and treatment of psychosis spectrum conditions, with a particular emphasis on CHR and EP syndromes. Based on a review of the Project Echo program dashboard at the time of posting, there are currently six active or planned ECHO programs focused on the psychosis spectrum in the United States: 1 CBT for psychosis program at the University of Washington; 4 EP/FEP programs in Ohio, Washington, Arizona and Connecticut, and 1 Schizophrenia and Complex Psychosis program in Ohio. There are currently no ECHO programs focused on the psychosis spectrum in California and no programs focused on CHR for psychosis in the country. While the University of New Mexico had a Behavioral Health and Addiction ECHO program, it has been on hiatus since January 2020 and was largely focused on the treatment of mood disorders rather than on the psychosis spectrum.

CONTRACTING

Orange County plans to contract out this project to vendors with subject matter expertise in assessment, intervention services and evaluation for individuals at CHR for psychosis, and with Mental Health America for online screening and referrals of youth who are potentially at CHR. OC Health Care Agency staff will monitor the contracts for quality and compliance.

COMMUNITY PROGRAM PLANNING

This project aligns with the County's strategic priorities that were identified in partnership with local community stakeholders during the development of the MHSA Three-Year Plan for Fiscal Years 2019-2020 through 2022-23:

- Improving Mental Health Awareness, including for/among youth and LGBTQ individuals (page 17)
- Suicide Prevention, among people of all ages including youth (page 18)
- Increasing Access for Behavioral Health Services, with youth and people of color identified as a priority population (page 19)

It also aligns with results from a January 2022 community planning survey where several stakeholders provided feedback on the importance of addressing a person's lack of insight and/or awareness into their mental health challenges. This is a particularly important topic for young people at CHR as the marked lack of insight into whether unusual thoughts or experiences are based in reality is a key differentiator between being at CHR and developing psychosis.

Staff from the OC Health Care Agency also facilitated three community planning meetings for this (and one other) Innovation project proposal in February 2022. Using the OC MHSA email distribution lists built over the years, invitations to the meetings were sent to consumers, family members, mental health providers, healthcare providers, the faith-based community, transitional age youth, the OC Behavioral Health Advisory Board, former Orange County MHSA Steering Committee members, law enforcement, justice agencies and other stakeholder groups. Due to COVID-19, all meetings were virtual. A synopsis of each meeting is provided below:

February 3, 2022, from 4-6pm over Zoom (over 70 attendees)

- HCA staff, subject matter experts in CHR and Personalized Normative feedback, and a Mental Health America Chief Program Officer introduced the concept, general framework, and proposed project elements
- Presenters answered attendees' questions, including about whether the impact of substance use is taken into account during assessment for CHR status (*yes*), what screeners were used (*verbally answered and then included on slides for the subsequent meeting*), would the training modules be in person or online (*likely hybrid*), and was CIT approached when considering outreach and training for law enforcement (*the project concept was described to one of the CIT Steering Committee coordinators who indicated that the group was interested in additional training in psychosis)*
- Attendees also provided the following feedback, which was incorporated into this project proposal:
    - If the County is to proceed with screening, it is important to make sure people screened can be served; that they are not identified as having needs but are unable to receive appropriate care
        - See *Step 3: Increasing Access to CHR Care*
    - Translation is not enough; we need to be responsive to culture and the [nuances in the language] of the culture
        - *Attention to culture and language are reflected throughout the proposal, including in dollars set aside within the budget specifically for hiring diverse staff, engaging in project co-development with various communities, etc.*
    - Concern over whether aim 3 was too broad as well as commercial insurance reimbursement

        - *Scope and strategies for increasing access to care continued to be refined over the subsequent community planning meetings*
    - Request for additional information and details on proposed interventions and screening tools, as well as estimated numbers to be served and literature citations
        - *Information requested provided in subsequent meetings and incorporated into this proposal*
- Attendees expressed their support to continue community planning for this project

February 8, 2022, from 4-6pm over Zoom (over 50 attendees)

- In response to feedback and questions from the February 3rd meeting, HCA staff provided a recap of the Project Aims and additional detail on the proposed screenings and measures, a draft workflow of what is now named the OC CHR Screening-to-Support pipeline, and details on the model for increasing access to CHR care. The stepped consultation model, in particular, generated excitement from the community.
- To help develop out different aspects of the project proposal, attendees also provided feedback on the following:
    - Additional potential responder groups to prioritize/include for outreach and training on early Identification of CHR signs:
        - Family Resource Centers, [student] peers on school campuses, training for UCI medical students, alumni groups as parents prepare to send their students off to college, stigma reduction initiatives such as offering psychoeducation in libraries and other public venues, hospital social workers [including in ED]
    - Discussion on the prioritization of training for law enforcement (LE), as well as how to handle situations in which LE may identify a youth at possible CHR outside of business hours
    - Different healthcare provider types to offer training
        - i.e., pediatricians, family practice
- Attendees expressed their support to continue community planning for this project and focus on reviewing the proposed budget at the next meeting

February 10, 2022, from 4-6pm over Zoom (approximately 40 attendees)

- HCA staff provided a recap of the Project Aims with estimated positive and negative screening rates at each step of the OC CHR Screening-to-Support pipeline, estimated numbers of outreach events/ trainings per potential responder group
- To help develop out different aspects of the project proposal, attendees also provided feedback on the following:
    - Which groups should initially be engaged to co-develop the enhanced, culturally responsive/linguistically appropriate psychoeducation material:
        - Spanish-, Vietnamese-, Korean-, Mandarin-, Tagalog--, Khmer-, Arabic- and Farsi-, speaking communities, LGBTQ, Veterans (Military-connected families)
- HCA staff then reviewed a draft budget, presenting fixed costs, as well as a dynamic budget model where attendees could see how costs shifted as the numbers of youth screened changed; attendees were also presented with the costs for each cultural group and non-English language to the MHA Screener materials, all of which was approved/supported by attendees and reflected in the current proposal and budget.
- HCA staff also asked for feedback on options on how to implement and evaluate the suicide prevention intervention, Youth-Nominated Support Teams (YSTs). Attendees expressed a strong

preference for a program evaluation approach (where providers are offered and decide whether they would like to receive training in YSTs for CHR) rather than a quasi-experimental or experimental design with random assignment of providers to a YST training condition. Moreover, several attendees also expressed a strong preference against withholding a potentially valuable (and low-risk) intervention through a randomized controlled trial design when there weren't preexisting, naturally occurring limits to available resources related to the intervention.

- Following review and discussion, attendees supported a budget based on projections on outreach to high school students for early identification, referrals from social network potential responders, and youth identified through the MHA Online Screener. This resulted in an estimated 5-year budget of approximately $36.5 million. A community stakeholder proposed a project budget of "Not to Exceed $38 million over 5 years" to account for possible additional youth identified and in need of services and other unanticipated project costs, which was supported by attendees with no disagreement, although one stakeholder had emailed prior to the meeting to say they did not support proceeding with the project other than the MHA Online Screening component as long as participants were tracked from start to end through an experimental design covered by an IRB.

MHSA GENERAL STANDARDS

Community Collaboration

This project demonstrates community collaboration through its coordinated approach involving the County, healthcare providers, a variety of community-based organizations, consumers and families. Over the course of the project, the project team will solicit feedback and input on how to develop culturally responsive CHR services, psychoeducational materials and online interventions.

Cultural Competency

The project will seek to identify and address disparities in access to services/care and strive to integrate diverse belief systems related to mental health across various project activities, including the development of training strategies, psychoeducational materials and interventions, and the language and images used throughout. Through community collaboration, the team will explore topics and needs that elevate cultural responsivity related to the following factors: understanding and beliefs about mental illness and psychosis, resource needs, engagement strategies and healing practices associated with diverse cultures.

Ongoing staff trainings will be provided, and staff will be recruited with an emphasis on having the workforce resemble the served population with respect to key demographic characteristics (including but not limited to race and ethnicity, income status, people who have been minoritized based on their gender and sexual orientation, immigration status).

Client-Driven

Peers, consumers and families will co-develop the materials used in trainings, outreach and online psychoeducation, thus demonstrating the client-driven nature of this project. In addition, during initial care planning youth choose what areas they would like to focus on and, whenever possible, with whom/where they would like to receive care.

Family-Driven

Family members will be involved in the co-development of outreach, training and psychoeducation materials. Their involvement in their child's care at the CHR Clinic also highlights how families will help

drive the development and delivery of services, with an emphasis placed on their role in understanding the local needs of youth at CHR and their ability to help support suicide reduction through YST participation.

Wellness, Recovery and Resilience-Focused

Services provided will be recovery-oriented and promote consumer choice, self-determination, flexibility and community integration to support wellness and recovery. Psychoeducational resources will cover concepts and principles that incorporate hope, empowerment, self-responsibility and meaningful purpose in life.

Integrated Service Experience for Clients and Families

This project demonstrates an integrated service experience for clients and families through the availability of consultation services that involve the youth, family, providers and, when appropriate, the youth's nominated support people. In addition, housing the CHR Clinic within a broader hub of mental healthcare services will create an integrated, non-stigmatizing, comprehensive continuum of care for youth and their families.

CULTURAL COMPETENCE & STAKEHOLDER INVOLVEMENT IN EVALUATION

The project evaluation will ensure that it is culturally informed and includes meaningful stakeholder participation by working directly with various groups to co-develop survey feedback and satisfaction tools. Working meetings will include but not be limited to language-specific meetings for non-English speaking/cultural communities, LGBTQ, military-connected families, peers, youth and family members. During periodic community stakeholder update meetings, feedback on evaluation strategies and interim findings will also be solicited and incorporated into subsequent analyses.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Should the project results identify that outreach methods for early identification, screening and referral are effective, the County can consider funding these project elements with MHSA Prevention and Early Intervention funding. Training and on-going support of behavioral health care providers in the provision of CHR care could be sustained through MHSA Workforce Education and Training funding. Finally, services provided through the CHR Clinic could be sustained through MHSA Prevention and Early Intervention funding. Use of MHSA funds would be pending support through a local community planning process.

COMMUNICATION AND DISSEMINATION OF FINDINGS

Project findings, results and updates will be shared through the following:

- Presentations and discussions in project stakeholder meetings (frequency TBD)
- Orange County MHSA Update meetings
- Outreach to community providers, community partners, healthcare professionals
- During and through the CHR community of practice for community providers
- Statewide conferences, meetings and relevant national conferences.
- Articles published in online and peer-reviewed journals

TIMELINE

Expected Start Date: July 1, 2022

Expected End Date: June 30, 2027

Proposed Project Timeline:

YEAR ONE

Category	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CHR Clinic (Assessment, Intervention, Provider Training/Consultations)	• Hire CHR clinical staff	• Hire and train clinical staff	• Hire and train clinical staff • Pilot and refine screening process • Develop consultation model	• Hire and train clinical staff • Pilot and refine screening process • Develop consultation model
Youth-Nominated Support Team (YST) Intervention	• Hire YST Specialist	• Create CHR YST psychoeducation materials	• Pilot training • Modify training based on feedback	• Host broader YST training for providers
Potential Responder Community Outreach/Trainings	• Hire Community Outreach staff	• Outreach/training development	• Outreach/training development • Pilot outreach • Modify outreach based on feedback	• Outreach/training development & refinement
MHA Platform: Personalized Normative Feedback, Enhanced Psychoeducational Materials, and Linkage to Care	• Create data pipeline w/ HCA • Curate current OC resources • Analyze MHA data • Evaluate materials for translation • Hire and train outreach/writing staff	• Create data pipeline w/ HCA • Develop MHA Platform • Analyze MHA data • Curate materials for translation • Hire and train outreach/writing staff	• Finalize data pipeline w/ HCA • Develop MHA Platform • Develop PNF survey beliefs and misperceptions • Select target populations for community engagement • Host target population specific meetings • Translate materials	• MHA Platform development • Deploy PNF survey • Analyze PNF survey • Host target population specific meetings • Translate materials
Research/ Evaluation	• Hire research staff • IRB Application	• Hire and train research staff • IRB Application	• Hire and train research staff	• Train research staff • Evaluate outreach/training

YEAR TWO

Category	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CHR Clinic (Assessment, Intervention, Provider Training/Consultations)	• Hire and train CHR clinical staff • Screening, assessments • Pilot and refine consultation model	• Screening, assessments, intervention • Implement consultations	• Screening, assessments, intervention, consultations	• Screening, assessments, intervention, consultations
YST Intervention	• Host YST consultation hours	• Host YST provider training • Host YST consultation hours	• Host YST provider training • Host YST consultation hours	• Host YST provider training • Host YST consultation hours
Potential Responder Community Outreach/Trainings	• Outreach to various groups • Training for various groups	• Outreach to various groups • Training for various groups	• Outreach to various groups • Training for various groups	• Outreach to various groups • Training for various groups
MHA Platform: Personalized Normative Feedback, Enhanced Psychoeducational Materials, and Linkage to Care	• Analyze PNF survey • Host target population specific meetings • Translate and post available psychoeducation	• Develop PNF norms survey • Host target population specific meetings • Translate and post available psychoeducation	• Develop and deploy PNF norms survey • Host target population specific meetings • Create, translate and post culturally responsive, enhanced psychoeducation	• Analyze PNF norms survey • Host target population specific meetings • Create, translate and post new culturally responsive, enhanced psychoeducation
Research/ Evaluation	• Evaluate training, screening process • Disseminate findings	• Evaluate training, screening process	• Evaluate training, screening process • Disseminate findings	• Evaluate training, screening process

YEAR THREE

Category	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CHR Clinic (Assessment, Intervention, Provider Training/Consultations)	• Screening, assessments, intervention, consultations	• Screening, assessments, intervention, consultations	• Screening, assessments, intervention, consultations	• Screening, assessments, intervention, consultations
YST Intervention	• Host YST provider training • Host YST consultation hours	• Host YST provider training • Host YST consultation hours	• Host YST provider training • Host YST consultation hours	• Host YST provider training • Host YST consultation hours
Potential Responder Community Outreach/Trainings	• Outreach to various groups • Training for various groups	• Outreach to various groups • Training for various groups	• Outreach to various groups • Training for various groups	• Outreach to various groups • Training for various groups
MHA Platform: Personalized Normative Feedback, Enhanced Psychoeducational Materials, and Linkage to Care	• Create and launch PNF intervention • Create, translate and post culturally responsive, enhanced psychoeducation	• Create, modify and launch PNF intervention • Create, translate and post culturally responsive, enhanced psychoeducation	• Create, modify and launch PNF intervention • Create, translate and post culturally responsive, enhanced psychoeducation	• Create, modify and launch PNF intervention • Create, translate and post culturally responsive, enhanced psychoeducation
Research/ Evaluation	• Evaluate training, screening process • Disseminate findings	• Evaluate training, screening process	• Evaluate training, screening process • Disseminate findings	• Evaluate training, screening process

YEAR FOUR

Category	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CHR Clinic (Assessment, Intervention, Provider Training/Consultations)	• Screening, assessments, intervention, consultations	• Screening, assessments, intervention, consultations	• Screening, assessments, intervention, consultations	• Screening, assessments, intervention, consultations
YST Intervention	• Host YST provider training • Host YST consultation hours	• Host YST provider training • Host YST consultation hours	• Host YST provider training • Host YST consultation hours	• Host YST provider training • Host YST consultation hours
Potential Responder Community Outreach/Trainings	• Outreach to various groups • Training for various groups	• Outreach to various groups • Training for various groups	• Outreach to various groups • Training for various groups	• Outreach to various groups • Training for various groups
MHA Platform: Personalized Normative Feedback, Enhanced Psychoeducational Materials, and Linkage to Care	• Create, modify and launch PNF intervention • Create, translate and post culturally responsive, enhanced psychoeducation	• Create, modify and launch PNF intervention • Create, translate and post culturally responsive, enhanced psychoeducation	• Continue PNF intervention • Continue culturally responsive, enhanced psychoeducation	• Continue PNF intervention • Continue culturally responsive, enhanced psychoeducation
Research/ Evaluation	• Evaluate training, screening process • Disseminate findings	• Evaluate training, screening process • Disseminate findings	• Evaluate training, screening process • Disseminate findings	• Evaluate training, screening process • Disseminate findings

YEAR FIVE

Category	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CHR Clinic (Assessment, Intervention, Provider Training/Consultations)	• Screening, assessments, intervention, consultations	• Intervention, consultations		
YST Intervention	• Host YST provider training • Host YST consultation hours	• Host YST provider training • Host YST consultation hours	• Host YST consultation hours	
Potential Responder Community Outreach/Trainings	• Outreach to various groups • Training for various groups	• Wrap up trainings		
MHA Platform: Personalized Normative Feedback, Enhanced Psychoeducational Materials, and Linkage to Care	• Continue PNF intervention • Continue culturally responsive, enhanced psychoeducation	• Continue PNF intervention • Continue culturally responsive, enhanced psychoeducation		
Research/ Evaluation	• Evaluate learning objectives • Disseminate findings	• Evaluate learning objectives • Disseminate findings	• Evaluate learning objectives • Disseminate findings	• Evaluate learning objectives • Disseminate findings

BUDGET NARRATIVE

If approved, Orange County will use available Innovation funding from FY 2019-20 onward, as well as unspent funds from previously approved Innovation projects.

DRAFT BUDGET BY FISCAL YEAR AND BUDGET CATEGORY						
CHR Outreach, Clinical and Consultation Services						
PROJECT MANAGEMENT	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**TOTAL**
Total Staffing Costs (5.4 FTE) Principal Investigator, Project Director, Clinic Manager, Administrative Manager, finance/clinical admin staff; Includes salaries and benefits (S&B)	590,850	704,600	704,600	704,600	704,600	**3,409,250**
POTENTIAL RESPONDER & PROVIDER TRAINING						
Total Staffing Costs (5.75 FTE) Clinical outreach coordinator, outreach specialist, program development specialist, training coordinator, training development lead (CEU/CME), Peer/Family Outreach Specialist; includes S&B	379,925	572,975	572,975	572,975	286,488	**2,385,338**
CHR SCREENING & ASSESSMENT SERVICES						
Total Staffing Costs (4.9 FTE) Licensed clinical supervisor, case manager, Clinical Screener, Clinical Assessor, Peer/Family Clinical Specialist; includes S&B	469,431	506,156	506,156	506,156	335,303	**2,323,203**
CHR CLINIC & CONSULTATION SERVICES						
Total Staffing Costs (10.1 FTE) Licensed clinical supervisor, therapists, YST Suicide Prevention Specialist, Clinical Psychologists, Psychiatrists/Residents/Fellows, Psychiatric NP; includes S&B	830,400	1,704,000	1,704,000	1,704,000	1,704,000	**7,646,400**
COMMUNITY CO-DEVELOPMENT						
Consultant Fees: Cultural ambassadors, leaders & evaluation specialists from diverse communities, peers, consumers, family members; Equity advisor (including but not limited to language)	119,000	119,000	119,000	119,000	119,000	**595,000**
Translation costs, Interpreter fees	200,000	200,000	170,000	170,000	170,000	**910,000**
Stipends for consumers, peers, family members from diverse communities participating in focus groups	15,000	15,000	15,000	15,000	15,000	**75,000**
Events & transportation assistance for youth/families	12,000	12,000	12,000	12,000	12,000	**60,000**
RESEARCH STAFFING						
Total Staffing Costs (4.5 FTE) Lead Clinical Researcher, Data Analyst, Clinical Research Staff, Research Staff; includes S&B	245,000	360,000	360,000	360,000	360,000	**1,685,000**
Stipends for research participants	10,000	10,000	10,000	10,000	10,000	**50,000**

SERVICES & SUPPLIES	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
Startup costs, lease, insurance, marketing campaigns, computers, equipment, software, training materials, mileage, telehealth support, etc.	380,000	405,000	530,000	530,000	530,00	**2,375,000**
Directs Subtotal						
Indirects @ 15%	501,492	713,027	745,888	756,602	695,705	**3,412,714**

MHA & MHA ONLINE SCREENER						
	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
Research Team; Total Staffing Costs (n=5): Program Officer, Research Associate, Program Coordinator, Data Scientist/ Computer Scientist and Web Developer/ Webmaster; includes S&B	473,220	473,220	473,220	473,220	473,220	**2,366,100**
Community Engagement Team; Total Staffing Costs (n=5): Digital/Clinical Content Manager, Community Engagement Manager Lead, Community Engagement Manager/Writer (3) includes S&B	561,000	561,000	561,000	561,000	561,000	**2,805,000**
Peer and Family Consultant Fees/Stipends/Focus Group Costs	285,000	285,000	285,000	285,000	285,000	**1,425,000**
Translation Costs	201,000	201,000	201,000	201,000	201,000	**1,005,000**
Supplies: meeting costs, web server, legal costs, AB Testing Software, laptops	181,900	181,900	181,900	181,900	181,900	**909,500**
Indirects @15%	255,318	255,318	255,318	255,318	255,318	**1,276,590**

BUDGET TOTALS						
	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
CHR Budget: Directs	3,251,606	4,608,731	4,703,731	4,703,731	4,246,391	**21,514,191**
CHR Budget: Indirects	487,741	691,310	705,560	705,560	636,959	**3,227,129**
MHA Budget: Directs	1,702,120	1,702,120	1,702,120	1,702,120	1,702,120	**8,510,600**
MHA Budget: Indirects	255,318	255,318	255,318	255,318	255,318	**1,276,590**
HCA Indirects @ 18% Indirects/Admin for operational costs plus costs of software/licensing fees (i.e., Screening-to-Support digital pipeline, Project ECHO)	679,982	684,482	701,582	701,582	701,582	**3,469,210**
GRAND TOTAL	6,376,767	7,941,961	8,068,311	8,068,311	7,542,369	37,997,719
TOTAL INNOVATION FUNDING AMOUNT REQUESTED: NOT TO EXCEED						**38,000,000**