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An Evaluation Pilot Study of Amplify, a headspace-Inspired Early Intervention Clinic

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Objective: The United States is experiencing a mental health crisis among youths and young adults. Most serious mental health conditions emerge during the transition to adulthood, and unmet mental health needs continue to rise among young adults. Following Australia's success with headspace, several countries are implementing integrated youth mental health programs, which warrant evaluation in the United States. The purpose of this study was to detail the service engagement, acceptability, and preliminary outcomes of the Amplify integrated youth mental health clinic during its first year of operation.

Methods: The University of Texas at Austin Dell Medical School implemented Amplify in a community college setting. Participants completed online standardized self-report measures at enrollment and 60 and 180 days later. Staff recorded service delivery in an electronic health record. Data were analyzed for Amplify's first year of operation (January 1–December 31, 2023).

Results: During year 1, Amplify employed a program director, licensed clinical program manager, therapist, supported employment and education specialist, community navigator, part-time psychiatrist, and receptionist. Amplify delivered 1,308 services to 74 youths, 60 of whom consented to participate in the study. Most participated in two types of services. Mean±SD use per participant was 18±18 service units (i.e., sessions). Service satisfaction was high at 60 and 180 days. Mental distress significantly decreased from enrollment to 60 and to 180 days.

Conclusions: More research on Amplify is needed to further operationalize the model and demonstrate its value to U.S. public and private health care systems and payers.

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Psychological distress among young adults, particularly symptoms of anxiety and depression, is currently at its highest recorded level in U.S. history (1, 2). Most people (75%) who develop a serious mental illness (e.g., schizophrenia or bipolar disorder) will do so before their 25th birthday (3). Compared with other age groups, young adults are the least likely to participate in mental health services (4). In addition, unmet mental health service needs for young adults increased from 30% in 2008 to 47% in 2020 among 18- to 25-year-olds in the United States (5). Longer duration of untreated serious mental health symptoms is associated with poorer long-term outcomes and greater personal and familial distress (6–8). In the past decade, the United States invested heavily in early psychosis identification and intervention services and research (9). First-episode psychosis affects approximately 1% of young people annually (10). Corresponding efforts to intervene in subsyndromal or earlier phases of other mental disorders (e.g., anxiety and mood disorders) or general acute mental distress have yet to be established in the United States. Compared with psychosis, the prevalence of these conditions poses much larger population-level public health, social, and economic challenges (11).

HIGHLIGHTS

- Inspired by Australia's headspace, Amplify is an integrated, community-based mental health approach designed for U.S. adolescents and young adults that blends clinical, vocational, peer, and community navigation support.
- Study findings suggest that Amplify is feasible for, is acceptable to, and has a positive impact on young adult community college students in Austin, Texas.
- The United States must develop strategies to effectively fund community mental health initiatives, such as Amplify, that require complex braided funding to cover both multidisciplinary traditional (therapy, psychiatry) and nontraditional (supported education and employment, community navigation, peer support) services.

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To date, several countries have developed and implemented low-barrier, transdiagnostic, and integrated mental health care specifically for young people. In the 1990s, Australia began to focus on early psychosis treatment and quickly pivoted to a more general youth mental health approach called headspace, which identified individuals needing specialty care (e.g., for early psychosis) and provided brief services for mild-to-moderate health concerns (12). This approach blends evidence-based psychosocial, psychiatric, and primary care services. Promising outcomes led other countries and territories, including Ireland (13), Canada (14), New Zealand (15), France (16), Hong Kong (17), and Singapore (18), to adopt and replicate similar approaches in their unique contexts. These programs all embrace the "one-stop shop" and "no-wrong-door" philosophies to connect individuals to the "right care the first time"; tend to serve 12- to 25-year-olds; and prioritize youth culture and codesign of collaborative, multidisciplinary, and integrated care that helps individuals achieve their life goals (as opposed to addressing mental health symptoms and related distress) (12). They prioritize screening, assessment, and short-term early intervention for young people with mild-to-moderate mental health needs, while connecting those with more serious symptoms to specialty care (e.g., coordinated specialty care for first-episode psychosis) (12, 19, 20).

THE AMPLIFY MODEL

In consultation with young people with lived experience of mental illness and local mental health agency leaders, the University of Texas (UT) at Austin Dell Medical School adapted and implemented a headspace-inspired model, named Amplify, in Austin (21). Through stakeholder consultation, we identified the following foundational principles: replicating the headspace values, serving young people with stage 1a and 1b (subthreshold) symptoms of serious mental illness (19), and building a more connected continuum of care. Young adults with lived experience residing in Central Texas formed the Emerging Voices Advisory Council to provide input on Amplify's structure, physical space, philosophy, and practices. Local public mental health system leaders helped Dell Medical School identify solutions to gaps in care in order to inform Amplify's design and early efforts. In addition, 6 years of mixed-methods research examining adolescent and young adult mental health service experiences in Austin further informed the model's philosophy and practice (22–27). Although headspace inspired a new category of multidisciplinary mental health care for adolescents and young adults, it has experienced public backlash for quickly expanding before building a large evidence base (28, 29). The goal of Amplify was not to replicate headspace but instead to use it as inspiration, while also drawing from best practices of integrated care and U.S.-based initiatives such as the system of care (30) and the Substance Abuse and Mental Health Services Administration's (SAMHSA's) early serious mental illness initiative (31).

Amplify is an integrated approach that blends evidence-based practices to match clients' needs and goals. Amplify uses the theories of positive youth development (32) and emerging adulthood (33) as well as several evidence-based (and evidence-informed) practices to guide policies and processes. Such evidence-informed practices include headspace (34), collaborative care (35, 36) (particularly the tenets of measurement-based care and population health), the individual placement and support model of supported employment (37), psychiatry that follows American Academy of Child and Adolescent Psychiatry (38) and American Psychiatric Association guidelines (39), motivational interviewing (40), trauma-informed care (41), and cognitive-behavioral therapy (42).

The Amplify team meets weekly to discuss client participation and progress toward goals in order to identify opportunities for offering other service lines to meet needs as swiftly as possible. Amplify embraces a discovery-oriented philosophy (43) that values promoting client self-discovery by using a person-first and alliance-first approach. Team members demonstrate understanding and respect to foster strong working alliances (44) with clients by cocreating the vision for their work, codeveloping tasks, and bonding. Amplify team members are aware of the challenges that young people face today (e.g., concurrently navigating relationships, work, school, independence, and independent living) (33). Team members expect client instability and validate transition-to-adulthood challenges, while also exploring what matters to and motivates each unique client. Amplify services are flexible. They are available in person or virtually and include brief text message check-ins or more traditional 50-minute sessions with different staff members, depending on the client's evolving needs. During the first year of implementation, clients could select which services they wanted instead of receiving only services indicated by their screening measures. Table 1 shows Amplify's staff roles, staff responsibilities, and evidence-based practices.

As with the headspace model, a tenet of the Amplify model is to create an attractive, youth-friendly space in a community location already frequented by young people (34). To pilot the Amplify model before more widespread implementation in the community, we partnered with Austin Community College (ACC) to house the first Amplify clinic, which opened in January 2023 on ACC's Eastview campus. Amplify was initially funded through local foundations and donors, making it possible to implement, evaluate, and revise the model's structure, processes, and practices before introducing insurance billing constraints. (For more information about Amplify's philosophy, operations, and research, see https://dellmed.utexas.edu/units/department-of-psychiatry/center-for-youth-mental-health.)

Implementing Amplify with a discrete population of 18- to 29-year-olds allowed for initial tailoring and service provision for a particularly underserved population. Mirroring trends in the U.S. mental health service landscape, more service options were offered for 12- to 17-year-olds (vs. for older youths) with mild-to-moderate mental health

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TABLE 1. The Amplify clinic's staff roles, staff responsibilities, and evidence-based practices

Role	Responsibility and evidence-based approach
Program director	Responsible for program operations and maintaining strong alliances with project partners
Program manager (licensed therapist)	Coordinates team collaboration to meet client needs; provides individual supervision to team members
Therapist	Engages and supports participants in therapy to reach personal goals via cognitive-behavioral therapy and motivational interviewing
Community navigator	Connects participants to resources and supports within the community by using a social determinants of health approach
Supported employment and education specialist	Supports career exploration, securing and maintaining employment, accessing reasonable accommodations, and securing academic supports and resources on and off campus; uses the individual placement and support model of supported employment and education for young adults
Psychiatrist	Provides psychiatric evaluation and medication management by using the coordinated specialty care prescribing practice of "start low, go slow"; provides medical and psychiatric diagnostic consultation to the team
Receptionist	Supports screening, scheduling, resource sharing, and information sharing

distress (vs. more serious conditions) in the geographic area that Amplify served. Amplify aimed to avoid replicating preexisting services; therefore, the community college and Amplify leaders codetermined the clinic's targeted client age range to be 18–29 years. The model was implemented as a stand-alone service within the community college, which also had a counseling center (10 counselors for 39,000 students).

For the pilot phase, criteria to participate in Amplify included being 18 to 29 years old, being enrolled in the community college where Amplify was located, and having a score of ≥10 on the 10-item Clinical Outcomes in Routine Evaluation (CORE-10) (45). Exclusion criteria included having an active psychiatric crisis or a diagnosis of a serious mental illness. In the future, Amplify aims to serve young people no matter how mild their needs are. Yet, during the first year, limited capacity (75–100 individuals) led to prioritizing individuals with subthreshold symptoms. Young people who were experiencing a psychiatric crisis or symptoms of serious mental illness, particularly mania or psychosis, were immediately linked with a nearby public mental health provider. To enroll in Amplify, young people completed a brief online survey and met with a staff member to learn about Amplify services and discuss their needs. Over the first year, the Amplify team streamlined the intake process and improved nontraditional service (i.e., community navigation, supported employment and education specialist services) descriptions to encourage young people to learn about and try service options beyond therapy. Length of care was driven by client choice during year 1. Amplify staff met clients in person or virtually (via HIPAA-compliant Zoom videoconferencing), depending on client preferences and staff capacity. The purpose of this study was to detail the service engagement, acceptability, and preliminary outcomes of the Amplify clinic during its first year of operation.

METHODS

Setting

The Amplify model was piloted at ACC's Eastview campus. The college's average semester enrollment is approximately 39,000 students; approximately 65% are between 18 and 29 years old, and 65% identify as Hispanic or Black, Indigenous, and other people of color (BIPOC) (https://oira.austincc.edu/data-and-reports/student-data/quick-facts-acc-student-profile). The UT Austin Institutional Review Board approved this study.

Eligibility and Recruitment

Participants included in this study enrolled in Amplify between January 1, 2023, and December 31, 2023, and consented to Amplify research activities (e.g., standardized measure completion). Amplify leaders partnered with student counseling center leadership to generate referrals and with the Dell Medical School communications team to design a public website and marketing tools for Amplify.

Data Collection Procedures and Measures

Young adults referred to Amplify completed an online screening in REDCap (HIPAA-compliant and Title I data-secure Web-based data collection software) to obtain basic demographic information, reasons for seeking care, and CORE-10 data (45). The CORE-10 is a brief version of the 34-item CORE–Outcome Measure that measures mental distress. Items are rated on a 5-point scale (0, not at all, to 4, most or all of the time) to provide a total clinical score of general functioning. A score ≤9 is considered healthy or indicative of low-level mental health need (45).

At 60–75 days and 180–195 days after enrollment, Amplify participants completed the CORE-10 again, as well as an adapted version of the headspace Youth Service Satisfaction Scale (YSSS) (46). The YSSS was created with input from youths and has acceptable to excellent psychometrics (46). Items are rated as strongly disagree, disagree, neither agree nor disagree, agree, or strongly agree.

Amplify staff recorded service participation (type, date, start and end time, and meeting details) in the UT Health Austin electronic health record within 5 days of delivery. Ideal enrollment length or ideal number of services used over

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time had not yet been determined, because our goal was to examine how participants engaged with the service model.

Analysis

Service participation and standardized measures were analyzed by using descriptive and related-samples Wilcoxon signed rank tests (a nonparametric t test). All analyses were conducted with IBM SPSS Statistics software.

RESULTS

Amplify Enrollees

During the study period, 101 youths completed the initial online screening. Of these, 84 responded to Amplify staff outreach to set up an initial assessment meeting. After the initial assessment, 10 youths were linked to services elsewhere: six to public mental health services because of acute mental health symptoms and four to a local low-cost counseling service center for long-term psychotherapy. Seventy-four individuals enrolled in Amplify. (See Figure S1 in the online supplement to this article for study participation details.)

Demographic Characteristics

Enrolled participants' mean±SD age was 23±3 years. Approximately 47% (N=35 of 74 enrolled participants) identified as Hispanic or Latino, 27% (N=20) as White, 18% (N=13) as Black, 7% (N=5) as Native American, and 2% (N=1) as other race-ethnicity. About 53% (N=39) identified as female, 30% (N=22) as male, 10% (N=7) as nonbinary or agender, and 8% (N=6) as transgender. Approximately 45% (N=33) identified as heterosexual, 22% (N=16) as bisexual, 10% (N=7) as gay or lesbian, 8% (N=6) as questioning, 7% (N=5) as asexual, 7% (N=5) as pansexual, and 3% (N=2) as queer. Finally, approximately 58% (N=43) were full-time students, and the rest were part-time students.

Service Participation

In its first year of operation, Amplify delivered 1,308 service units (i.e., sessions) to Amplify enrollees. The minimum number of unique service events for each enrollee was one, and the maximum number was 82. The mean±SD number of services used was 18±18, and the median was 11. Most enrollees (77%, N=57) engaged in two different types of services. In addition, most (96%, N=71) engaged in therapy services, 59% (N=44) in supported employment and education specialist services, 54% (N=40) in community navigation services, and 26% (N=19) in psychiatric services.

TABLE 2. Amplify study participants' satisfaction with services at 60 and 180 days after enrollment[a]

	60 days (N=26)		180 days (N=27)	
Item	N	%	N	%
1. I am overall satisfied with Amplify.	25	96	22	81
2. I would suggest Amplify to a friend.	26	100	26	96
3. It felt like Amplify was designed for the needs of adolescents and young adults.	25	96	27	100
4. I felt comfortable at Amplify.	25	96	26	96
5. It was easy for me to get to Amplify.	22	85	26	96
6. I attended an appointment at Amplify at a time that suited me.	25	96	27	100
7. I felt that Amplify staff listened to me.	25	96	26	96
8. I was involved in the decision making of what happens next.	24	92	26	96
9. I felt my views and worries were taken seriously.	24	92	27	100
10. I got help for the things I wanted help with.	21	81	26	96
11. I felt able to raise concerns I had.	21	81	24	89
12. I feel that my mental health improved.	19	73	25	93
13. I can more effectively deal with my problems.	16	62	24	89
14. I feel that other aspects of my life improved.	16	62	25	93
15. I know more about my mental health in general.	18	69	24	89

[a] Satisfaction was rated with a modified version of the Youth Service Satisfaction Scale. Items rated as "agree" or "strongly agree" are reported here.

Participant Measure Completion

Of the 74 individuals who enrolled in Amplify, 81% (N=60) provided informed consent for the associated Amplify research study. All 60 completed measures at enrollment, 26 completed measures at 60 days after enrollment (including 14 who completed measures only at this time point), and 34 completed measures at 180 days after enrollment (including 22 who completed measures only at this time point). At the time this article was written, all participants had passed the 6-month time point. Of the 14 who completed the 60-day measures but not the 180-day measures, two had been discharged from services. (Details of Amplify participation and completion of measures are available in the online supplement.)

Service Satisfaction

Among participants who completed study measures, service satisfaction was high (items with a response of either agree or strongly agree) at 60 days (N=26) and 180 days (N=27) after enrollment (Table 2). Satisfaction was slightly higher at 180 days (vs. 60 days) after enrollment for the items "I feel that my mental health improved" and "I know more about my mental health in general." Satisfaction was lower at 180 days after enrollment for the items "I am overall satisfied with Amplify" and "I would suggest Amplify to a friend."

Mental Distress

A significant decrease in mental distress (as measured by the CORE-10) was observed from baseline (median±SD=21.3±6.79) to 60 days after enrollment (median=16.5±7.06, W=−2.537,

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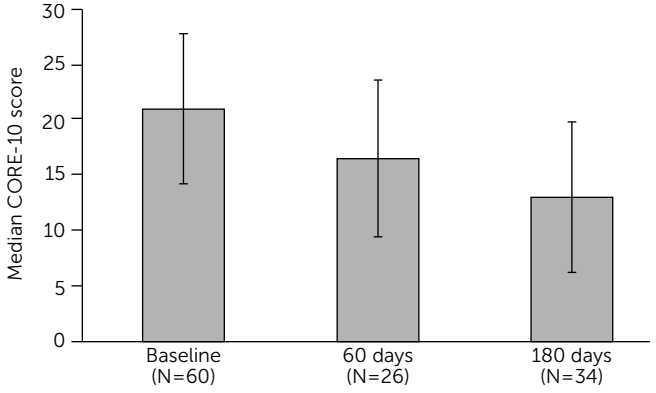
FIGURE 1. Median 10-item Clinical Outcomes in Routine Evaluation (CORE-10) scores from baseline to 60 and to 180 days after enrollment[a]



[a] Total possible scores range from 0 to 40, with higher scores indicating more severe levels of mental distress. Error bars represent standard deviations.

p=0.011). A significant decrease in mental distress was also observed from baseline to 180 days after enrollment (median=13.0±6.79, W=−4.307, p<0.001) (Figure 1).

DISCUSSION

This article describes an integrated youth mental health clinic evaluation during the first year of implementation with a racially and ethnically diverse group of young adults enrolled in an urban community college. Findings suggest that the Amplify model was acceptable to and promising for young adults. Most participants who completed a screening then enrolled in Amplify, and most enrollees then participated in two service modalities. Amplify participants reported high service satisfaction and experienced decreases in mental distress.

Importantly, because of fundraising efforts during the first year of implementation, Amplify services were free to young adults enrolled in the community college where Amplify was housed. The United States finances health care differently compared with the countries that have implemented integrated youth mental health programs (12, 47). Expanding Amplify is financially complicated without changes to Medicaid and commercial insurance policies that would cover additional beneficial services beyond therapy and psychiatry, such as peer support, supported employment and education, and community navigation services, which are typically not covered in the United States for individuals with mild-to-moderate mental distress. To sustain, grow, and further study Amplify in a U.S. context, we are now braiding funding by billing Medicaid and commercial insurance when possible and by covering nontraditional services through foundation grants as well as county and state contracts. Meanwhile, we are documenting related challenges and funding gaps in order to develop solutions to this structural problem. This work complements federal efforts to fund, evaluate, and sustain transition-age youth multidisciplinary or integrated mental health services (e.g., SAMHSA's Healthy Transitions projects) across several U.S. states, as well as state and university efforts to replicate the headspace-inspired allcove model (https://allcove.org) across California.

Two notable differences between headspace and our implementation of an integrated youth mental health clinic were observed during Amplify's first year. First, although Amplify aimed to link individuals scoring below 10 on the CORE-10 to other services, everyone screened scored at or above the threshold. This circumstance could have occurred because the community college counseling center referred students with more complicated needs to Amplify or may represent rising and unmet mental health needs among young adults. Therapy waitlists plague university counseling centers even when access to therapy is limited to a few sessions (22, 48) (https://younginvincibles.org). Affordable community-based therapy options for young adults are limited, and many young adults (especially marginalized individuals) distrust mental health providers (49–51). Compared with non-Hispanic White youths, Hispanic and Black youths are almost 50% less likely to access mental health care (51). Not having access to mental health care or to providers who are racially and ethnically diverse and in tune with the experience of young adulthood may be related to the second notable difference: Amplify participants, on average, elected to engage in many more services (mean=18) than did headspace participants. About half of headspace participants attended one service, and the other half typically attended fewer than eight (48). Limited information exists on the average number of sessions accessed through integrated youth mental health clinics over time, and stepped care service matching practices remain vague. Research is needed on how integrated youth mental health clinics use clinical expertise and data to match services to client needs over time. Amplify participants tended to request therapy and needed additional education to understand how other service types or modalities could meet their needs. Amplify is now implementing and evaluating new measurement-based care strategies to maximize positive outcomes through fewer services, incorporate successful transition and exit practices, and reach more young people before their symptoms become acutely distressing.

Amplify has begun several quality improvement initiatives on the basis of year 1 implementation data. First, Amplify recently integrated the collaborative care model (35, 36) to expand access to general medical and psychiatric care. Second, Amplify is in the process of integrating near-age peer support specialists into primary care, increasing the number of supported employment and education specialists and therapists on staff, formalizing substance use harm reduction practices, and using UT Health Austin electronic health records for public and commercial insurance reimbursement. Next year, Amplify will expand eligibility to the public (i.e., nonstudents) and adolescents and will continue to evaluate client service participation, service

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satisfaction, mental health, and wellness. Program leaders created a profit-and-loss plan to sustain Amplify and believe that shifting the model to mostly short-term care (90–180 days), compared with a mostly drop-in model, will increase sustainability in a U.S. context. Finally, Amplify introduced a Power BI dashboard to monitor participation, survey responses, and progress toward goals and to offer qualitatively analyzed screening, intake, and service notes to improve service matching based on evolving needs and goals. Future articles will present findings from these initiatives.

This study had several limitations. The study lacked randomization and use of comparison or control groups to further assess Amplify's unique impact. Although decreases in mental distress were detected over time, they may have occurred because of time, regression to the mean, or change to participants' circumstances. This study did not analyze personal goal attainment or work and school outcomes (e.g., course completion, graduation, or dropout), which are longer-term outcomes to be examined in the future. Additional limitations included a low rate of participant consent for research activities and difficulty collecting follow-up measures. Since study completion, Amplify has adjusted its data collection processes, removed the research consent form, and adopted a consent-to-treat form that includes the collection of information for measurement-based care and quality improvement purposes. Further specification, refinement, and research on the Amplify model are needed. Next steps include the development of a fidelity scale that can capture Amplify's principles, practices, and systems as well as examination of reasons for enrollment and exit and of associated participant characteristics and clinical needs.

CONCLUSIONS

This study demonstrates the promise of an integrated youth mental health clinic (similar to Australia's headspace) in the United States. More research on Amplify and similar models is needed to demonstrate value to public and private health care systems and payers in the United States.

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Ms. Emerson is no longer with the University of Texas at Austin and made additional contributions to this article in a personal capacity.

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REFERENCES

1. Protecting Youth Mental Health: The US Surgeon General's Advisory. Washington, DC, US Department of Health and Human Services, Office of the Surgeon General, 2021
2. Youth Risk Behavior Survey Data Summary & Trends Report: 2011–2021. Atlanta, Centers for Disease Control and Prevention, 2023
3. Kessler RC, Berglund P, Demler O, et al: Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry 2005; 62: 593–602
4. National Substance Use and Mental Health Services Survey (N-SUMHSS) 2022: Data on Substance Use and Mental Health Treatment Facilities. SAMHSA pub no PEP23-07-00-002. Rockville, MD, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, 2023
5. Key Substance Use and Mental Health Indicators in the United States: Results From the 2020 National Survey on Drug Use and Health. HHS pub no PEP21-07-01-003. Rockville, MD, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, 2021
6. Das JK, Salam RA, Lassi ZS, et al: Interventions for adolescent mental health: an overview of systematic reviews. J Adolesc Health 2016; 59:S49–S60
7. Dagani J, Signorini G, Nielssen O, et al: Meta-analysis of the interval between the onset and management of bipolar disorder. Can J Psychiatry 2017; 62:247–258
8. Howes OD, Whitehurst T, Shatalina E, et al: The clinical significance of duration of untreated psychosis: an umbrella review and random-effects meta-analysis. World Psychiatry 2021; 20: 75–95
9. RAISE-ing the Standard of Care for Schizophrenia: The Rapid Adoption of Coordinated Specialty Care in the United States. Bethesda, National Institute of Mental Health, 2023. https://www.nimh.nih.gov/news/science-updates/2023/raise-ing-the-standard-of-care-for-schizophrenia-the-rapid-adoption-of-coordinated-specialty-care-in-the-united-states. Accessed March 5, 2025
10. Radigan M, Gu G, Frimpong EY, et al: A new method for estimating incidence of first psychotic diagnosis in a Medicaid population. Psychiatr Serv 2019; 70:665–673
11. Goldman HH: Coordinated specialty care: an impetus to improve all mental health services? Psychiatr Serv 2020; 71:415
12. McGorry PD, Mei C, Chanen A, et al: Designing and scaling up integrated youth mental health care. World Psychiatry 2022; 21: 61–76
13. O'Reilly A, O'Brien G, Moore J, et al: Evolution of Jigsaw—a national youth mental health service. Early Interv Psychiatry 2022; 16:561–567
14. Malla A, Iyer S, Shah J, et al: Canadian response to need for transformation of youth mental health services: ACCESS Open Minds (Esprits ouverts). Early Interv Psychiatry 2019; 13:697–706
15. MacFarlane M, Harris M, Michael S, et al: Evaluation of Youth One Stop Shops: Final Report Version 1.1. Wellington, New Zealand, New Zealand Ministry of Health, 2009
16. Benoit L, Cottin P, Moro MR: What is a "maison des adolescents"? A history of integrated youth health care services in France. Early Interv Psychiatry 2018; 12:1000–1005

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17. Tang JY, Wong GH, Hui CL, et al: Early intervention for psychosis in Hong Kong—the EASY programme. Early Interv Psychiatry 2010; 4:214–219
18. Lee YP, Ngaiman NKB, Poon LY, et al: Evaluating Singapore's CHAT assessment service by the World Mental Health Organisation (WHO) "youth-friendly" health services framework. Front Psychiatry 2019; 10:422
19. McGorry PD: The specialist youth mental health model: strengthening the weakest link in the public mental health system. Med J Aust 2007; 187:S53–S56
20. Read H, Kohrt BA: The history of coordinated specialty care for early intervention in psychosis in the United States: a review of effectiveness, implementation, and fidelity. Community Ment Health J 2022; 58:835–846
21. Zagorski N: UT Health Austin's Program Supports Student Mental Health. Washington, DC, Psychiatric News, 2024. https://psychiatryonline.org/doi/10.1176/appi.pn.2024.01.1.20. Accessed March 5, 2025
22. McCormick KA, Chatham A, Klodnick VV, et al: Mental health service experiences among transition-age youth: interpersonal continuums that influence engagement in care. Child Adolesc Social Work J 2023; 40:525–536
23. Cohen DA, Klodnick VV, Reznick SJ, et al: Expanding early psychosis care across a large and diverse state: implementation lessons learned from administrative data and clinical team leads in Texas. Adm Policy Ment Health 2023; 50:861–875
24. Cohen DA, Klodnick VV, Kramer MD, et al: Predicting child-to-adult community mental health service continuation. J Behav Health Serv 2020; 47:331–345
25. Cohen DA, Klodnick VV, Stevens L, et al: Implementing adapted individual placement and support (IPS) supported employment for transition-age youth in Texas. Community Ment Health J 2020; 56:513–523
26. Cohen DA, Londoño T, Klodnick VV, et al: "There wasn't any build up to it, it was just like, now you have to go over." Disengagement during the child to adult community mental health service transition. J Adolesc Res 2023; 38:666–696
27. Londoño T, Klodnick VV, Emmerson K, et al: Creative technology-based strategies for engaging young people with serious mental health conditions in longitudinal mental health services research. Child Adolesc Social Work J 2023; 40:313–324
28. Iorfino F, Carpenter JS, Cross SP, et al: Social and occupational outcomes for young people who attend early intervention mental health services: a longitudinal study. Med J Aust 2022; 216:87–93
29. Kisely SR, Bastiampillai T, Allison S, et al: More smoke and mirrors: fifteen further reasons to doubt the effectiveness of headspace. Australas Psychiatry 2023; 31:282–291
30. Stroul BA, Blau GM (eds.): The System of Care Handbook: Transforming Mental Health Services for Children, Youth, and Families. Baltimore, Paul H Brookes Publishing, 2008
31. Early Recognition and Effective Treatment of Early Serious Mental Illness. Pub no PEP24-01-006. Rockville, MD, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2024
32. Lerner RM: The positive youth development perspective: theoretical and empirical bases of a strengths-based approach to adolescent development; in Oxford Handbook of Positive Psychology, 2nd ed. Edited by Lopez SJ, Snyder CR. New York, Oxford University Press, 2009
33. Arnett JJ: Emerging adulthood. A theory of development from the late teens through the twenties. Am Psychol 2000; 55: 469–480
34. Rickwood D, Paraskakis M, Quin D, et al: Australia's innovation in youth mental health care: the headspace centre model. Early Interv Psychiatry 2019; 13:159–166
35. Asarnow JR, Rozenman M, Wiblin J, et al: Integrated medical-behavioral care compared with usual primary care for child and adolescent behavioral health: a meta-analysis. JAMA Pediatr 2015; 169:929–937
36. Lyon AR, Whitaker K, Richardson LP, et al: Collaborative care to improve access and quality in school-based behavioral health. J Sch Health 2019; 89:1013–1023
37. Drake RE, Bond GR, Becker DR: Individual Placement and Support: An Evidence-Based Approach to Supported Employment. New York, Oxford University Press, 2012
38. American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Community-Based Systems of Care and AACAP Committee on Quality Issues: Clinical update: child and adolescent behavioral health care in community systems of care. J Am Acad Child Adolesc Psychiatry 2023; 62:367–384
39. Silverman JJ, Galanter M, Jackson-Triche M, et al: The American Psychiatric Association practice guidelines for the psychiatric evaluation of adults. Am J Psychiatry 2015; 172:798–802
40. Hettema J, Steele J, Miller WR: Motivational interviewing. Annu Rev Clin Psychol 2005; 1:91–111
41. Bath H: The three pillars of trauma-informed care. Reclaiming Child Youth 2008; 17:17–21
42. Butler AC, Chapman JE, Forman EM, et al: The empirical status of cognitive-behavioral therapy: a review of meta-analyses. Clin Psychol Rev 2006; 26:17–31
43. Klodnick VV, Malina C, Fagan MA, et al: Meeting the developmental needs of young adults diagnosed with serious mental health challenges: the emerge model. J Behav Health Serv Res 2021; 48:77–92
44. Cirasola A, Midgley N: The alliance with young people: where have we been, where are we going? Psychotherapy 2023; 60: 110–118
45. Barkham M, Bewick B, Mullin T, et al: The CORE-10: a short measure of psychological distress for routine use in the psychological therapies. Couns Psychother Res 2013; 13:3–13
46. Rickwood D, Nicholas A, Mazzer K, et al: Satisfaction with youth mental health services: further scale development and findings from headspace—Australia's National Youth Mental Health Foundation. Early Interv Psychiatry 2017; 11:296–305
47. Public Policy Committee of the American College of Physicians, Ginsburg JA, Doherty RB, et al: Achieving a high-performance health care system with universal access: what the United States can learn from other countries. Ann Intern Med 2008; 148:55–75
48. Rickwood D, McEachran J, Saw A, et al: Sixteen years of innovation in youth mental healthcare: outcomes for young people attending Australia's headspace centre services. PLoS One 2023; 18:e0282040
49. Hiller-Venegas S, Gilmer TP, Jones N, et al: Clients' perspectives regarding peer support providers' roles and support for client access to and use of publicly funded mental health programs serving transition-age youth in two Southern California counties. J Behav Health Serv Res 2022; 49:364–384
50. McLeod B, Meyer D, Murray G, et al: Contact with recovered peers: buffering disempowering service experiences and promoting personal recovery in serious mental illness. BJPsych Open 2019; 5:e98
51. Racial/Ethnic Differences in Mental Health Service Use Among Adults. HHS pub no SMA-15-4906. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2015

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