Supplemental Table

Recommendations to improve equity in CHR-P work, organized by identity category

Identity	Recommendation
Developmental Stage	1. Continue to develop and test developmentally appropriate and culturally sensitive psychosis-risk screening tools. 2. Train child/adolescent/school and adult mental health providers in the identification of youth at CHR-P and relevant developmental factors (e.g., developmental and clinically relevant cognitive biases, puberty, family functioning, social relationships) to consider across adolescence and young adulthood. 3. On a larger scale, aim to decrease the bifurcation of child and adult mental health systems in the United States by creating more bridges between these systems, including transition-age mental and medical health youth clinics and general youth early intervention clinics.
Race, Ethnicity, Culture	1. When evaluating potential attenuated psychotic symptoms, clinicians must consider the cultural context of the youth (e.g., are the experiences culturally normative? are the potentially "unusual" beliefs shared by family?) and also how the cultural background of the clinician impacts assessment. 2. Clinicians must also identify "personally relevant" interventions for diverse groups to reduce disparities and increase engagement. 3. Clinicians must be prepared to confront racial diagnostic biases that at least partially contribute to racial disparities in psychotic disorder diagnoses.
Faith	1. Clinicians must consider youth's and family's faith, spirituality, and religious beliefs and coping strategies during assessment and treatment. This will help determine whether beliefs are being misconstrued as attenuated psychotic symptoms. Faith and spiritually can also be harnessed as a relative strength in treatment. 2. Consultation with faith leaders and organizations could also inform the development of more culturally sensitive assessment tools and interventions. a. Such tools and interventions may include a consideration of familial beliefs, as well as spiritual/religious values and beliefs.

Immigration Status	1. Migrants may not be readily identified by current CHR-P programs. The reasons for this disparity need to be identified and addressed in future research to ensure that immigrants at CHR-P have access to and engage with specialized CHR-P clinics. a. Direct outreach to immigrant communities will be necessary, as migrants may be less likely to locate and seek treatment. 2. Increasing the number of multilingual providers will also enhance our ability to treat the growing population of immigrant youth and for those whose primary language is not English. 3. It will be important to obtain personal and family history of migration when working with individuals at CHR-P. We recommend explicitly asking patients upon intake or within the early stages of treatment about their migrant status. We also recommend assessing for trauma related to migration and referring individuals at CHR-P to trauma-related treatment as necessary.
Geography/ Residence	1. Urbanicity should be included in models of prediction for psychosis. Current models focus primarily on symptoms and basic demographic characteristics, but urbanicity shows a consistent and robust impact on the development of psychosis in some countries. a. Relatedly, researchers must continue to tease apart the factors that are driving the link between urbanicity and psychosis. 2. There must be a consideration of potentially unique risk factors in rural environments for individuals at CHR-P (e.g., isolation, material deprivation) and efforts to expand access and reach (such as provision of telehealth and related equipment).
Gender	• Differing combinations of symptoms and socialized expectations according to gender may contribute to different functional outcomes, for which targeted interventions including psychoeducation on the heterogenous expression of psychosis risk, communication training, and broad stigma reduction efforts are warranted. • Targeted outreach where underrecognized psychosis may present and greater flexibility in accepted age-range for CHR-P clinics may be an important factor for increased treatment equity. • Providers must ensure continual accrual of knowledge and practice of sensitivity and awareness to establish an environment of acceptance and support. o Practical examples include offering one's own pronouns and eliciting and using clients' pronouns, ensuring safe access to non-binary restrooms, avoiding othering or exoticizing individuals regarding identity, and validation of gender identity regardless of presenting symptoms of unusual thought content.

	○ Gender-affirmative and responsive models of care have robustly shown to result in significant reduction of depression, anxiety, substance abuse, and suicidality, and thus use of Gender-Affirmative care across interventions may significantly influence an individual's prognosis for psychotic experiences. • Collaborations with transgender and gender-expansive care agencies and individuals are essential in continuing to develop particular models of care for addressing serious mental illness within these populations.
Sexual Orientation	1. As acceptance and knowledge of orientation-diversity increase, disclosure is likely to grow and CHR-P clinics may facilitate a sense of safety in identity expression for CHR-P youth by committing to affirming all individuals, abandoning heteronormative assumptions and practices, or stereotypical notions that may lead to invalidation or erasure of identity.
Socioeconomic Status/Class	1. Ensure equitable access to care (discussed further below in regard to financial barriers and related factors). 2. Researchers must consider contextual environmental factors separately (e.g., neighborhood crime vs. neighborhood SES) when evaluating their association with CHR-P pathology.
Ability Status	1. Assess for objective and subjective ability status among youth at CHR-P and family members—and adapt outreach and services as necessary— in order to provide equitable and personalized care. 2. Scholars recommend normalization of "access check-ins", directly discussing and assessing needs of each individual served. Considerations of access, appreciation of neurodivergence, and dissolution of "sanist rhetoric" (e.g., ableism focused on neurodivergent individuals) are imperative in equitable treatment. 3. Provide outreach to, and adapted services (when necessary) for, traditionally underserved groups in this domain (e.g., people with MS, intellectual disability, Autism Spectrum Disorder, etc.).
Overarching Recommendations	
Clinical:	1. Clinicians must be trained to consider relevant sociocultural factors that could be misconstrued as symptoms or exacerbate symptomatology (this includes shared religious and spiritual beliefs, as noted, as well as experiences of discrimination and community violence, etc.).

a. For example, when evaluating suspiciousness as a potential CHR-P symptom, clinicians should inquire about the context of one's experiences in order to ensure that a normative reaction to a particular environment is not being pathologized.
b. Promoting equity in CHR-P treatment means designing and using interventions that target the mental health consequences of discrimination and other relevant sociocultural factors in REM CHR-P youth including racial stress, trauma, and acculturation. This requires clinicians to be both competent and comfortable with discussing these topics.

2. Clinicians and researchers alike must engage trusted community stakeholders, organizations, and leaders within REM and other underserved communities to build trust and destigmatize mental health services for youth.
    a. Churches and other faith-based organizations are ideal contexts for community-based partnerships to reduce stigma as well as increase awareness of CHR-P syndromes and treatment options in populations that are not typically served by mental health providers.
    b. This stigma reduction should take place on both the public level (e.g., during outreach, and in other professional and personal roles) and on the patient level (e.g., during engagement, assessment, and treatment).
        - Providing education and stigma reduction should be core components of care, especially given high rates of family disengagement among recent immigrants and those with a history of marginalization.

Research:

3. Future studies with youth at CHR-P need to collect and report on basic transcultural data (e.g., native language, ethnicity, place of birth, migration).
4. Qualitative, mixed methods, and community-based research methods are needed to truly understand intersectionality in CHR-P youth.

Policy/Systemic:

5. CHR-P services must make a commitment to reducing financial barriers for REM youth and other underserved youth (e.g., low SES), including accepting public insurance programs (e.g., Medicaid) and offering pro bono or sliding-scale fee services.
    a. Although some CHR-P programs have research funding allowing individuals to receive evaluation and/or services at no-cost, all programs should ensure that they have options for

individuals without insurance or ability to pay out-of-pocket costs that allow for the same level of care as those with means.

6. Continuing to offer telehealth services for CHR-P youth beyond the COVID-19 pandemic will help to increase accessibility.
    a. Transportation costs for in-person visits should also be a consideration for CHR-P programs. While telehealth visits would negate the need for transportation, individuals may not have the resources (e.g., a computer or other device, internet service) or interest to participate in telehealth. CHR-P programs should work individually with families to ensure that they have basic resources to access care.
7. CHR-P practitioners and researchers need to demonstrate tangible commitment and allyship to historically excluded communities (e.g., through social justice actions and solidarity with local communities; engaging in participatory practices; committing to diverse representation within clinics and clinic leadership; committing to ongoing education and self-study related to matters of injustice and power imbalance; etc.).
8. CHR-P practitioners and researchers should not wait for or assume patient and family identities to be self-evident. All incoming patients/participants should be treated with consideration of their potential intersectional identities and engaged accordingly. Clinicians and researchers should also consider fluidity, fluctuation, and clarification of identities over time.
    a. To this end, CHR-P clinics will benefit from building and training a competent and culturally aware and humble workforce through specialized psychosis assessment and intervention training.

Note. CHR-P = Clinical High Risk for Psychosis. REM = racial/ethnic minority.