EPINET
Early Psychosis Intervention Network

CSC in California

Strengths and Challenges to Growth

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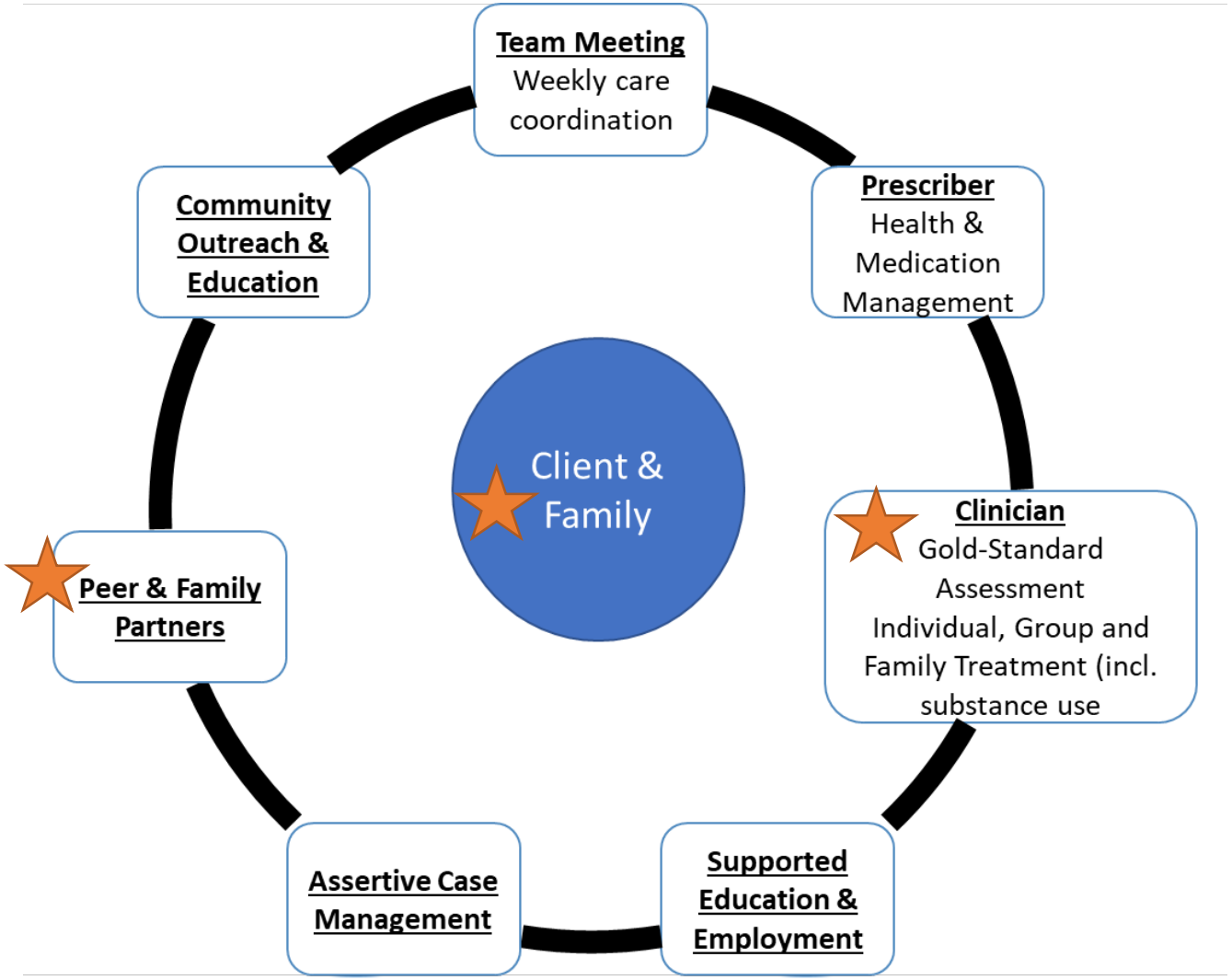
CA Coordinated Specialty Care model (CSC)

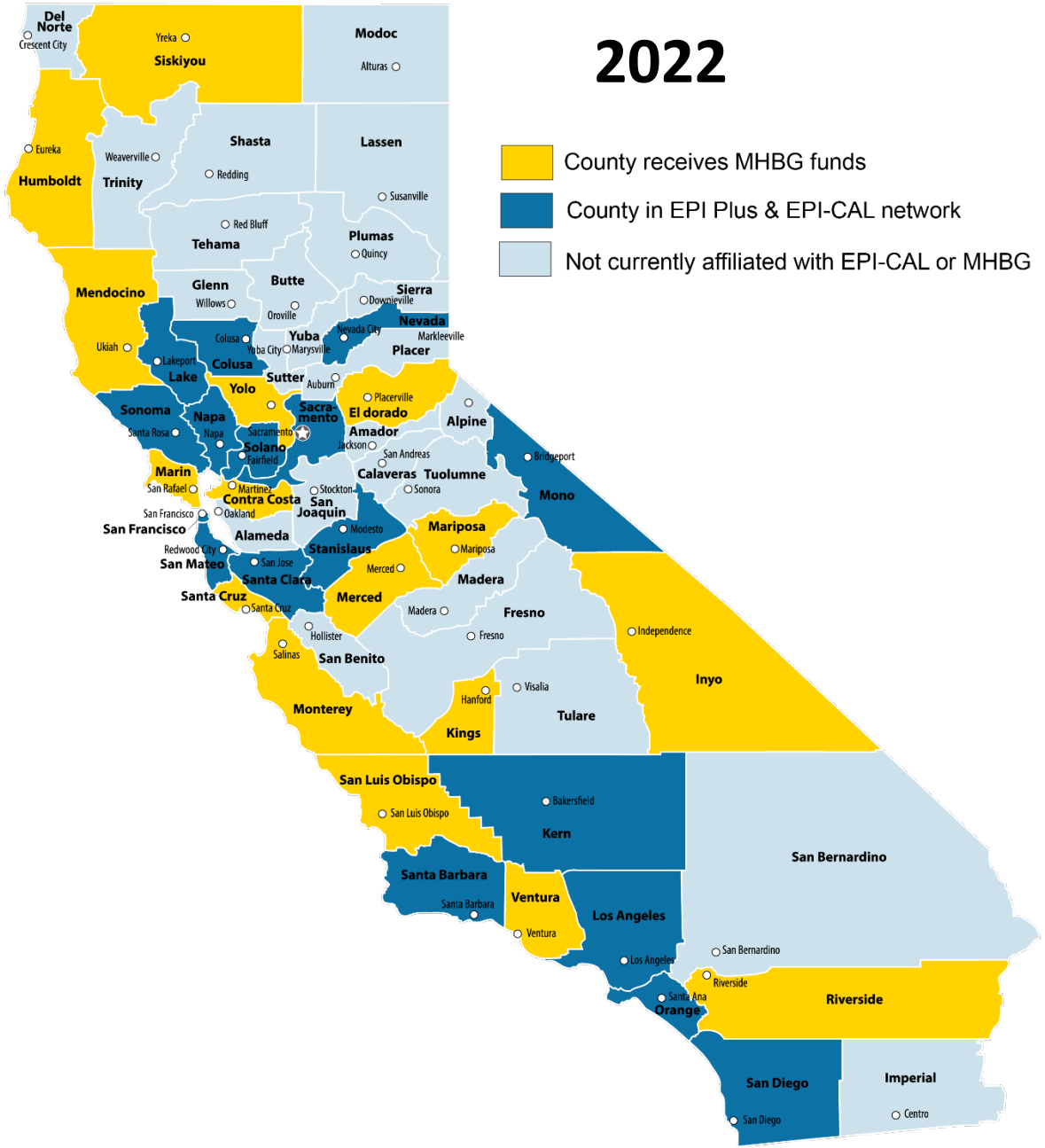


- "Standard community treatment" = therapy (individual, group and family), medication management, and case management

- EP programs = team-based approach with rapid access; comprehensive assessment; individual & group psychotherapy; family psychoeducation & support; case management; integrated medication management, and supported education and employment to improve role functioning (Heinssen, Goldstein, Azrin, 2014)
  - Coordinated Specialty Care (CSC)

Our challenge in California

- Everything is county by county – trying to build statewide leadership and support through EPI-CAL
- No uniformity across state in implementation of EP services – treatment models, populations served, funding can all differ
  - Also have commercial insurance-funded clinics at Universities
- Access to EP is limited – programs are small and not able to reach entire community OR nonexistent in low population density areas
- No statewide approach to data collection to demonstrate impact



Implementation of CSC

Strengths

- Consider psychosis continuum
  - At-risk → full psychosis
  - Nonaffective & Affective Disorders
  - Substance use, Post Partum
- Focus on symptoms, not diagnosis
- Developmental view – serve youth down to age 8
- Focus on serving “family,” not just client
- Consideration of social determinants, trauma, racism

Implementation of CSC

Challenges

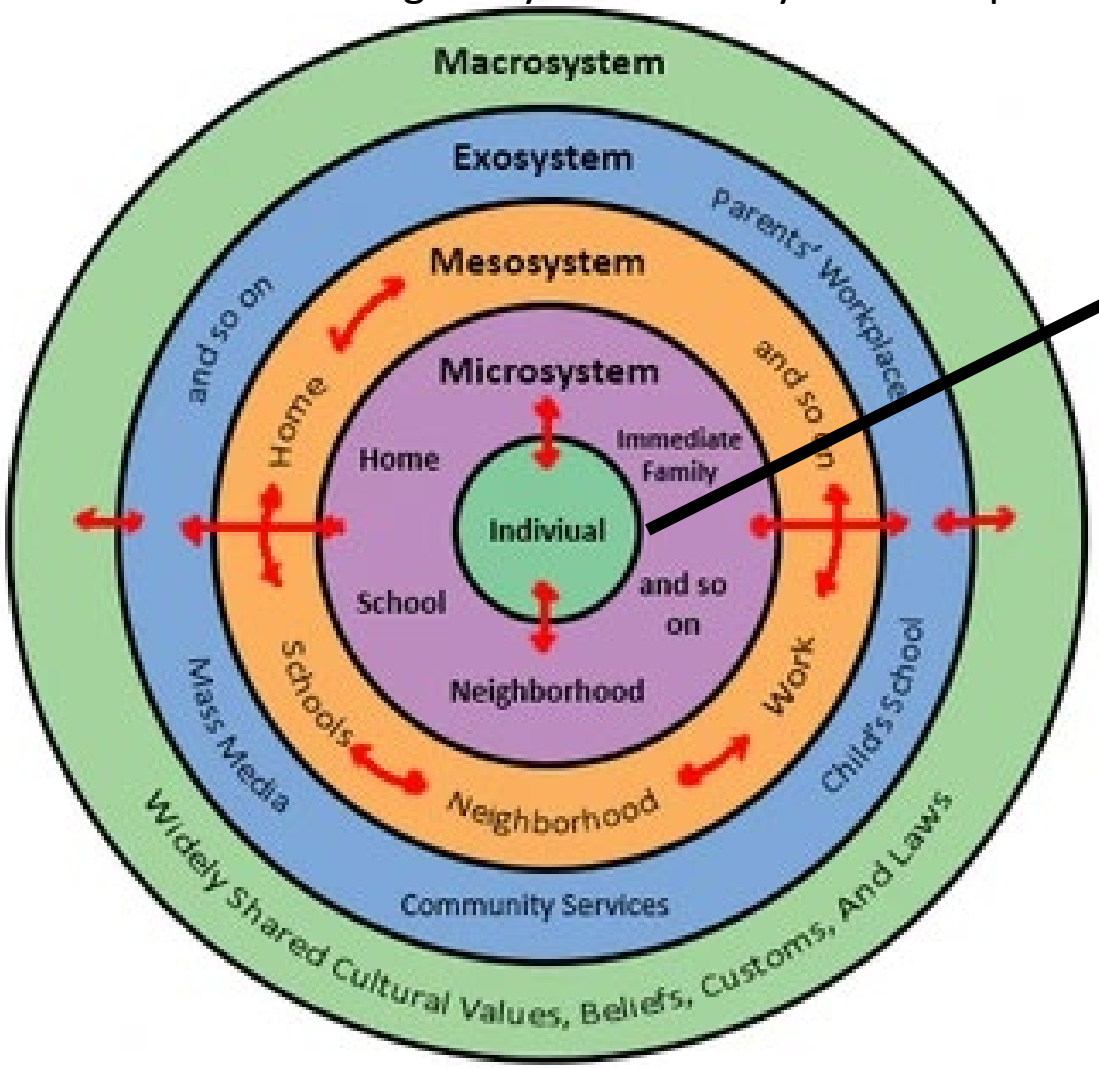
- Lack of stable and sufficient funding
  - County funds constantly shift; Commercial insurance doesn't cover it
  - Can't build a program to serve population need
  - Hard to staff a CSC team and pay a competitive salary, esp. in low population or rural areas
- Lack of appropriately trained & diverse workforce; high rates of turnover
  - Adult practitioners – not recovery or systems oriented
  - Youth practitioners – little training with SMI
  - Language capacity, integration of culture
- Partnering with community to ensure steady and appropriate referrals
- Strong historical focus on biology and medication does not always align with individual's experience or culture
- Program time limits (2-3 years) that doesn't match client needs or recovery trajectory
- Lack of step-down or transition care *after* CSC

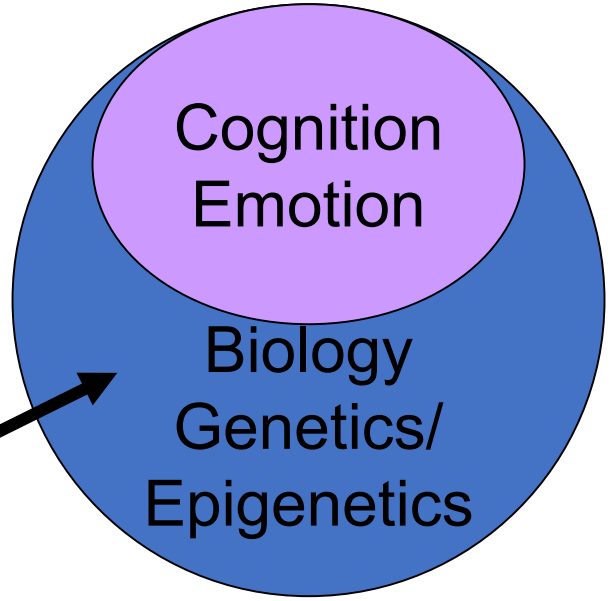
Suggestions for Next Steps

1. Funding that is stable and population-level
   - Youth with EP have been under/un-treated in typical community care – leads to very poor outcomes, disability, death, homelessness, incarceration.
   - Using CA Census data and incidence estimates from Radigan et al., 2019 and Simon et al., 2017 suggests total annual incidence of ~28,000 psychosis cases in CA → 357 clinics serving 75 people per year.
2. Workforce
   - Need ongoing training, supervision and professional development, but there is no infrastructure for this. Each state must create it and maintain it (funding?)
   - How to we work with accrediting groups (AMA/APA, APA, NASW, etc) to ensure graduates have appropriate training?
   - Peers are essential, but not sufficient.

Suggestions for Next Steps

Bronfenbrenner's Ecological systems theory of development





3. Biopsychosocial Model

- Need to treat the whole person, acknowledge the role of social determinants and trauma
- Focus on individual's goals for recovery
- Allow enough time for them to move through treatment at their pace
- Enhance natural supports, connections to family and community
- Address systemic issues that contribute to marginalization

Questions?

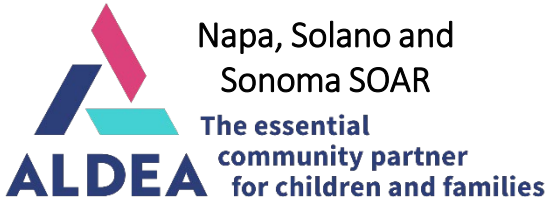
San Diego

Stanislaus

UCSD

Orange
County
CREW

San Mateo



5 PIER Programs

NIH National Institute of Mental Health
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