Commission for Behavioral Health

Early Psychosis Intervention (EPI) Strategic Plan (DRAFT)

Overview

May 16, 2025

Purpose

FINAL AS OF December 10, 2024 **Non-exhaustive**

The purpose of this document is to provide an overview of the draft Early Psychosis Intervention Strategic Plan. This document has been created at the request of the Commission for Behavioral Health (CBH). All information is based on inputs from CBH, published scientific research, Scaling Coordinated Specialty Care for First Episode Psychosis: Insight from a National Impact Model , and expert interviews

The approaches and considerations included in this document are preliminary and may be further developed based on additional inputs from CBH.

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Context for the effort

Final as of May 14, 2025

The Commission recognizes opportunities for early intervention and recovery that can prevent premature death or injury, contribute to improve family connectedness, and improve quality of life for the over 20,000 individuals that experience first-episode psychosis each year

The Commission also recognizes three priority downstream challenges for persons who experience psychosis without early prevention and intervention: 1) criminal justice involvement, 2) hospitalization and 3) homelessness.

With the passing of Prop 1, California has an opportunity to strengthen its behavioral healthcare system by bolstering access to early intervention for psychosis. To do so, the Commission has developed:

- **A landscape analysis** of early psychosis
- **An economic analysis** of the impact of scaling EPI, building on the national first-episode psychosis model
- **A strategic plan** to scale EPI over a 3-year horizon

Source: CBH, Scaling Coordinated Specialty Care for First-Episode Psychosis: Insights from a National Impact Model (2024)

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Potential impact of psychosis on individuals' lives and livelihoods

Final as of December 11, 2024

Impact on caregivers

Impact for individuals experiencing psychosis

Health Care

Employment

Housing

Criminal Justice

Caregiving

Source: 1. Simon, Stewart, et al | 2. Simon et al | 3. Kadakia et al | 4. NSDUH | 5. Guhne et al | 6. BLS | 7. Ayano et al | 8. Lin et al | 9. Wasser, Pollard, et al | 10. Arizona State University research | 11. Cham et al | 12. Gupta et al | 13. Wasser et al.; 14. Stanford Justice Advocacy Project

CBH Commission for Behavioral Health

The CSC model provides a holistic intervention model for treating early psychosis

Final as of December 11, 2024

Involves Client only Involves Client & Family

California CSC model

Select examples of observed impact of CSC on participants

- On average, CSC **reduces inpatient days by 33%** and average number of **ED visits per year by 36%**[1]
- Reduces likelihood of being **unemployed by ~42%** (from 50% to 29%)[2]
- Improves **education and employment rates** increased **by 2x** (from 40% to 80% in six months) [3]
- Reduces need for **homelessness services** amongst the FEP population **by 48%**[4]
- Participants experience a **76% reduction in the risk of committing a first crime** and are significantly less likely to be convicted of any crime when enrolled in CSC[5]

1. Rosenheck et al | 2. Dickerson et al | 3. Nossel et. al.. | 4. Tsiachristas et al | Pollard et al.

Source: CBH, Based on empirical studies

Estimates indicate that 1 in 10 Californians in need have access to CSC

Final as of December 11, 2024

1. Early Psychosis Intervention (EPI) Advisory Group | 2. Hirschtritt et al. | 3. Niendam et al. | 4. EPI-CAL calculator estimating the number of EPI programs needed; the Incidence of early psychosis in California is 21,000 individuals. Assuming the average # of clients served by each EPI program is 75. the number of programs needed to serve 100% of annual incidence is 277 | 5. Interview with Executive Director of EPI-CAL, 17th April 2024 | 6. Peralta et al.

But many face barriers to access:

- Insufficient insurance coverage[1, 2]
- Availability of CSC facilities[3, 4, 5]
- Inconsistent screening, diagnosis, and care coordination[6, 1,]

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California: Summary of findings of initial EPI model

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Over a 10-year period expanded access can generate significant value…

Over a 10-year span, expanding Coordinated Specialty Care (CSC) access from 10% to 90% of individuals with needs is estimated to:

- **Positively impact over 135k individuals experiencing psychosis** and their families
- **Generate $21B of overall value for the entire ecosystem[4]** compared to a system addressing only 10% of need

…with net benefits occurring by year 3 and significant impact by year 5

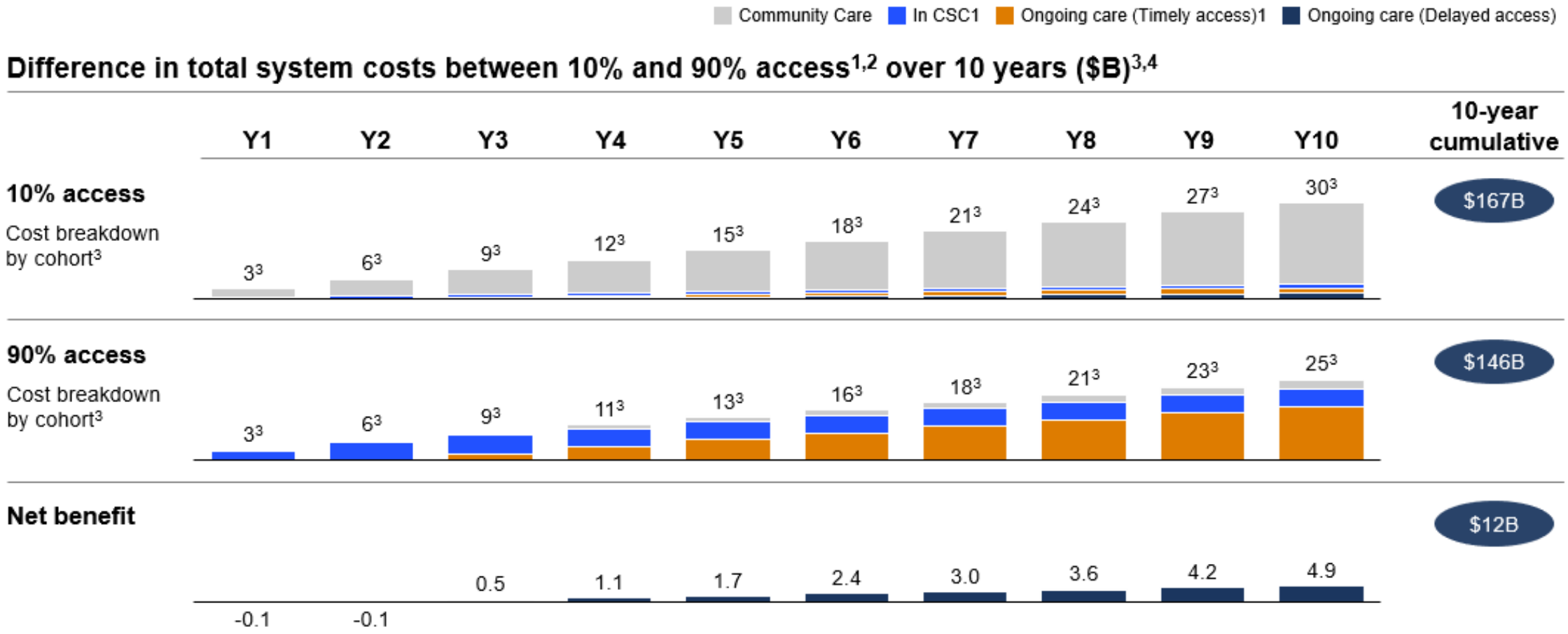
By year 5, expanding CSC access from 10% to 90%[1] of individuals with needs is estimated to:

- **Provide access to an additional ~17k individuals that year** (9x the number of individuals with access when there is 10% access) while reducing overall system costs[2]
- **Shift $0.9B in annual Healthcare costs[2] from inpatient settings to CSC** and ongoing outpatient care
- **Generate $1.7B in potential non-healthcare cost savings[3]** that year

1. Representing percent of individuals receiving timely access in their first year and delayed access in their second year of experiencing psychosis | 2. Annual impact is based on an estimated CA incidence of approximately 21K / year for first-episode psychosis based on Radigan et al. for Medi-Cal and uninsured population and Simon et. al. for 19-34 aged population that has commercial insurance. First presentation with psychotic symptoms in a population-based sample and accounts for a 5-year period in which individuals are either in community care or in CSC and ongoing care for 2 and 3 years, respectively. | 3. Healthcare is inclusive of inpatient and residential care, outpatient visits, ED visits, medications, and physical health. Individuals not receiving CSC are considered to receive community care, estimated at 37 visits / year and $102 / visit (adjusted to 2024 USD) based on data from the NIMH RAISE-ETP study. For individuals receiving CSC, outpatient care is estimated at the cost of a team to deliver CSC or ongoing care. | 4. Individuals not receiving CSC are considered to receive community care, estimated at 37 visits / year and $102 / visit (adjusted to 2024 USD) based on data from the NIMH RAISE-ETP study. Costs are based on the salaries (adjusted to 2024 USD) of a team to deliver CSC or ongoing care as estimated in Humensky et al (2013). Interactive tool to estimate costs and resources for FEP initiative in NY.

California: Over a 10-year span, a system that addresses 90% of need will generate $21B in savings compared to a system addressing only 10% of need

Final as of December 11, 2024



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Source: Secher et al (2014) Ten Year Follow-up of the OPUS Trial

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DRAFT California EPI Strategic Plan: Vision

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The desired future state is to **ensure Californians experiencing psychosis and their families have equitable access to high-quality, appropriate, holistic early psychosis care**

To this end, the State may consider:

- Building on its pioneering focus on behavioral health
- Creating alignment across public and private sectors to expand access
- Promoting fidelity across formats of care using a comprehensive learning health agenda and training for providers
- Bolstering a population-based approach for indicated adults and adolescents with needs
- Using widespread public education to destigmatize, identify, and address psychosis early on
- Engaging diverse perspectives and centering community voices in learning, design, and implementation

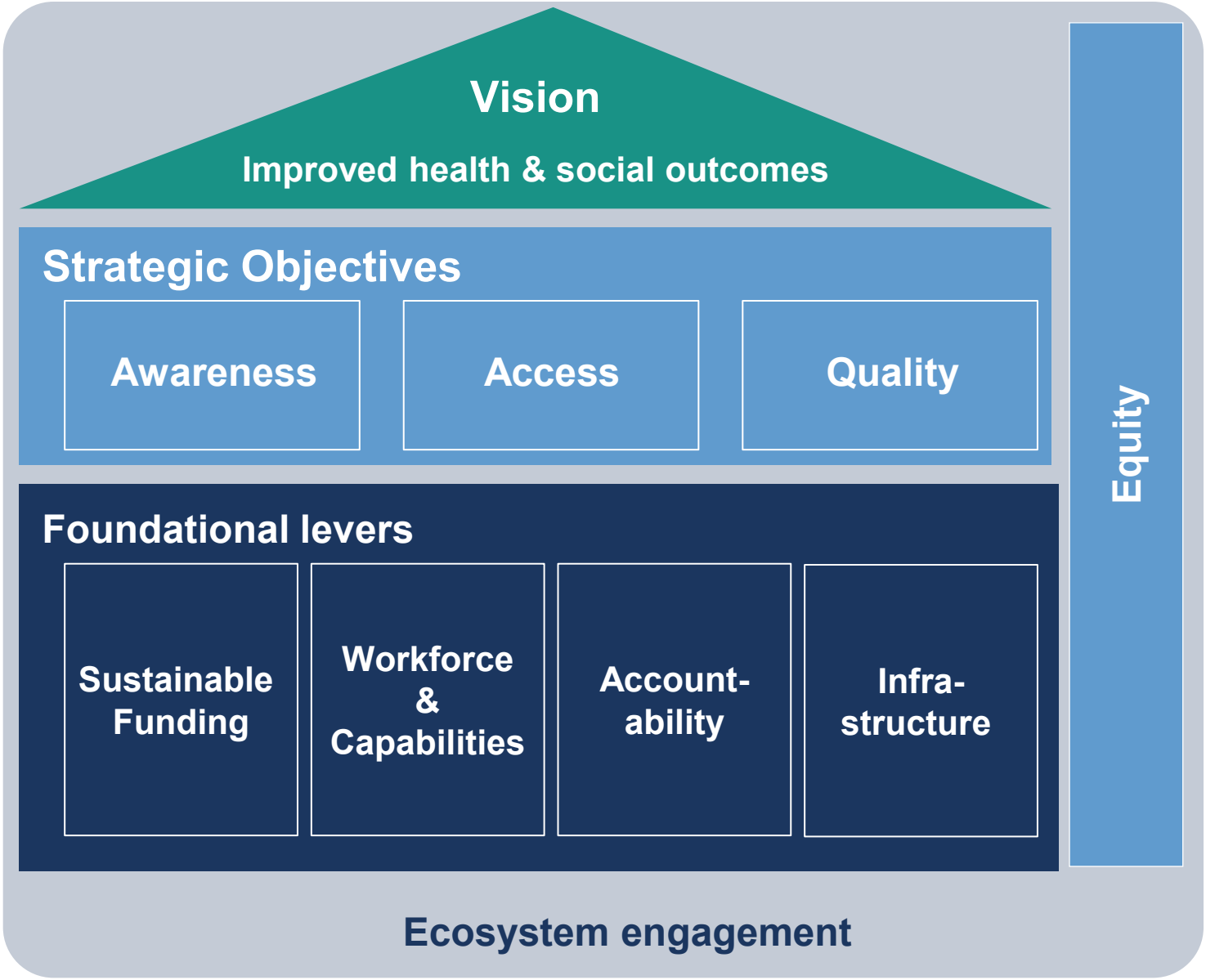
The plan targets measurable and specific goals over a three-year time horizon that could include elements such as:

- Increase access to timely, affordable, high-quality EPI care and reduce time to treatment
- Right-size the need for high acuity and high-cost downstream resources (e.g., state hospital inpatient psychiatric beds)
- Address some drivers of social needs (e.g., education and employment, housing)
- Enhance the State's capacity and capabilities to provide high-quality EPI services by expanding the behavioral health workforce

Source: Discussion with CBH and Advisory Group on April 29, 2024

DRAFT California EPI Strategic Plan: Dimensions

Final as of July 10, 2024



Source: CBH

DRAFT California EPI Strategic Plan: Proposed Implementation Support workstreams

Final as of July 10, 2024

Integrated coordination

Establish a central team to coordinate among ecosystem partners their initiatives to ensure successful and timely implementation of the plan

Change management

Identify and deploy change champions and sponsors across ecosystem partners to promote adoption and implementation of the strategic plan

Performance management

Identify metrics and track progress to promote accountability across initiatives and partners and measuring impact

Communications plan

Develop and roll out coordinated communication and engagement strategies to ensure clarity, consistency, and alignment in messaging and provide regular updates on progress

Source: CBH

Appendix

Overview of strategic objectives (1/2)

Final as of December 11, 2024

Not exhaustive

Objective	Key objectives	Example next steps	Example potential milestones
B Awareness	**Improve awareness of symptoms of early psychosis**, particularly among individuals who may play a role in identifying these signs and connecting individuals to care **Establish and strengthen expectations of access to high-quality EPI services** through publicized targets	**Create one-stop resource centers** for psychosis care-seekers **Build an EPI[2] champion/ambassador program** where individuals who have gone through EPI programs themselves share their lived experiences and knowledge with the community **Build partnerships** with existing BH awareness campaigns **Develop a public communications strategy** that facilitates a call to action by Californians	**Align with advisory group and partners** on the timeline for awareness building based on EPI[2] system readiness **Identify potential partnerships** to support awareness building **Convene a workgroup** with a charter to design a public engagement strategy
C Access	**Ensure that 90% of individuals within the 1st year of onset of psychosis have timely, affordable, appropriate, and convenient access** to CSC[1] programs designed to inspire trust **Consider a shorter goal timeline to access in the long-term**, given the WHO recommends specialized treatment no more than 90 days after symptom onset	**Strengthen care referral networks** through partnerships with health systems, health plans, criminal/legal system facilities, housing services providers, and community- and faith-based organizations **Explore alternative funding sources** (e.g., service-based reimbursement or programmatic funding sources) **Establish county-level archetypes and corresponding care models** for convenient access **Strengthen community and health system partnerships** and care referral networks	**Convene community-led working groups** to evaluate access barriers, build a workplan, and identify solutions **Track and report on impact** (e.g., average DUP, average wait times, % of individuals receiving CSC within 1 year, # of partners engaged in program design)

1. Coordinated Specialty Care
2. Early Psychosis Intervention

Source: Discussions between CBH and Early Psychosis Intervention (EPI) Advisory Group. Additional detail captured in draft Ea rly Psychosis Intervention Strategic Plan

Overview of strategic objectives (2/2)

Final as of December 11, 2024

Not exhaustive

Objective	Key objectives	Example next steps	Example potential milestones
D Quality	**Promote a clearly defined CSC[1] model as the standard of care** for treatment of early psychosis **Improve fidelity to the CSC model** for EPI[2] programs in California **Continuously improve the CSC model** and care delivery to enhance experience and outcomes	**Align on a single CSC program model for CA** and promote the implementation of all CSC components for EPI (including non-clinical) **Research and pilot standards of care for step-down services** (e.g., community-based services) **Align on approach / tools to measure fidelity** **Identify quality metrics** and consider incentive mechanisms for EPI linked to fidelity, outcome, and client goals	**Establish an evidence-based standard of care and continuous quality improvement strategy** through a workgroup of relevant ecosystem partners **Identify, track, and report metrics** across dimensions of quality **Build a statewide performance management mechanism**
E Equity	**Reduce barriers to care by co-designing EPI programs with communities** to ensure culturally competent, contextually appropriate, and holistic solutions **Improve tracking of equity metrics** and establish measurable goals **Develop a more diverse healthcare workforce** to better address the needs of California's diverse population	**Assess key barriers for vulnerable communities** **Identify trusted community partners** to co-create solutions to access barriers **Build out specialized care options for individual population groups** as needed **Collaborate with communities to set measurable equity goals** (e.g., parity in access and outcome metrics)	**Align on a definition for equity** in the context of scaling early psychosis care in California **Convene a working group** to identify priority populations and key barriers **Evaluate and expand community partnership models**

1. Coordinated Specialty Care
2. Early Psychosis Intervention

Source: Discussions between CBH and Early Psychosis Intervention (EPI) Advisory Group. Additional detail captured in draft Ea rly Psychosis Intervention Strategic Plan

Overview of foundational levers (1/3)

Final as of December 11, 2024

Not exhaustive

Objective	Key objectives	Example next steps	Example potential milestones
F Sustainable funding	**Refine reimbursement models and rates to fully cover the cost of EPI** for Californians with early psychosis, regardless of insurance coverage **Quantify and secure funding** required to scale high-quality and equitable access to EPI[2] **Incentivize public and private investment** in EPI programs	**Examine and address barriers** to accepting Medi-Cal and commercial reimbursement, other billing challenges **Conduct landscape analysis** of reliable funding streams alongside partners **Consider allocating funds for EPI at the state level** rather than the county level **Investigate incentive models** to encourage private investment in programmatic funding	**Develop and convene working groups** to: • Align on funding needs and potential sources • Refine the reimbursement model, where needed • Secure programmatic funding • Track impact
C Workforce and Capabilities	**Increase interest in EPI careers** **Recruit new individuals into the EPI workforce,** and align incentives to reduce attrition of the CSC[1] workforce **Optimize capacity** of workforce **Enhance capability** of workforce **Measure and monitor workforce supply and demand** for EPI programs	**Increase recruitment efforts** to attract the needed workforce based on capacity and capability requirements[3] **Identify solutions to optimize the efficiency of the existing workforce** and enhance their capacity to provide CSC **Expand the peer-led workforce** **Invest in growing the pipeline** for students in behavioral health professions	**Conduct a current state supply and demand assessment** of the EPI workforce, by region and by expertise/role Develop and implement a **comprehensive recruitment and retention strategy** for EPI **Establish and track KPIs[3]** to measure progress

1. Coordinated Specialty Care
2. Early Psychosis Intervention
3. Key Performance Indicators

Source: Discussions between CBH and Early Psychosis Intervention (EPI) Advisory Group. Additional detail captured in draft Ea rly Psychosis Intervention Strategic Plan

Overview of foundational levers (2/3)

Final as of December 11, 2024

Not exhaustive

Objective	Key objectives	Example next steps	Example potential milestones
H **Account-ability**	**Establish a governance structure and mechanism** to define roles and responsibilities in expanding access to EPI[2] programs **Develop a monitoring and evaluation framework** to track progress against established goals **Establish an ongoing improvement process** for continuous iteration	**Align on which organizations will be responsible for refining and implementing the EPI strategic plan,** and what the roles and responsibilities of team members will be **Establish KPIs**[1] **to measure the impact of expanded EPI access**, and a system to track relevant metrics **Develop a process to gather learnings** from implementation and refine as needed	**Identify existing structures** for accountability, monitoring and evaluation, and process improvement **Identify the leadership team** to implement the EPI strategic plan **Establish framework** for monitoring, evaluation, and reporting
I **Infra-structure**	**Design and build the infrastructure needed to deliver care to 90% of individuals who need it,** with a focus on ensuring equity and quality of care	**Explore and scale multiple archetypes of care deployment models** (e.g., telehealth, omnichannel care delivery, remote monitoring) **Identify resources for infrastructure development** (e.g., partnerships, technical support, data interoperability, care coordination) **Ensure training for effective use of technology** (e.g., identify training gaps, design tailored training programs)	**Design a phased plan to develop facilities** and provide resourcing of equipment and clinicians **Build infrastructure to support omnichannel delivery** of EPI **Support workforce and existing programs** with appropriate technology and digital infrastructure

1. Key performance Indicators
2. Early Psychosis Intervention

Source: Discussions between CBH and Early Psychosis Intervention (EPI) Advisory Group. Additional detail captured in draft Ea rly Psychosis Intervention Strategic Plan

Overview of foundational levers (3/3)

Final as of December 11, 2024

Not exhaustive

Objective	Key objectives	Example next steps	Example potential milestones
J Ecosystem engagement	**Enhance integrated care delivery network, by ensuring coordination among ecosystem partners** to enable timely and seamless access to all components of CSC[1] for clients and their families	**Improve awareness, education, and training for early psychosis** (e.g., provide training on symptom identification and referral pathways for clinicians and community members) **Enable improved information sharing for care coordination** (e.g., expand the use of psychiatric advanced directors to provide information on care needs and preferences, explore options to improve data sharing and interoperability) **Establish stronger alliances among ecosystem partners for CSC care delivery** (e.g., consider establishing state-wide or county-wide partnerships for housing, education, employment and other needs as appropriate)	**Convene key ecosystem partners** to highlight benefits of expanded access to EPI[2] **Identify and deploy digital resources** and operating model changes **Track impact** (e.g., number of partners engaged, level of awareness)

1. Coordinated Specialty Care
2. Early Psychosis Intervention

Source: Discussions between CBH and Early Psychosis Intervention (EPI) Advisory Group. Additional detail captured in draft Ea rly Psychosis Intervention Strategic Plan

Final as of December 10, 2024

Published research | Health Sector | Private Sector | Civil Society | Public Sector | Human Services

Example journey with no Coordinated Specialty Care (CSC) access

Noah

Bird watcher, gamer, foodie
Uses commercial insurance

At 15, Noah begins to hear voices telling her to self-harm. After a serious self-injury, Noah's family calls 911 and Noah is taken to the ER. After 36 hours, Noah is admitted to an inpatient unit, is not asked about symptoms of psychosis, and is discharged from the hospital with a referral to outpatient treatment that she chooses not to pursue

Noah's untreated psychosis hinders their ability to successfully complete high school. Noah drops out in 11th grade

1

Mean age of onset = 20 years; Range= 15 – 35 years[1]

2

A first episode of **psychosis can disrupt educational goals**, including attainment of a college education without proper supports[2]

Individuals experiencing psychosis have been observed to have **higher utilization of the healthcare system**, including higher rates of emergency department visits **excess healthcare cost is $62.3B** for those affected by schizophrenia[3]

3

Noah's symptoms worsen, suicidality increases, and she experience repeated ED visits and hospitalizations. Noah is not assessed for psychotic symptoms[4] so her providers prescribe antidepressants and CBT[5]

4

Frustrated by the lack of improvement, Noah's family seeks help from an out of network provider who continues to treat Noah for depression and suicidality

- Caregivers for people with psychosis report **higher levels of emotional or physical tension** related to caregiving than other caregivers[6]
- Time commitments of caregiving often lead to **missed days of work and lost income for caregivers**, and may even negatively impact their professional aspiration[6]

~20% of people who are homeless experience psychosis and ~10% have schizophrenia[7]

5

Noah has difficulty keeping a job or friends and alternates between living at home and being unhoused. Paying for Noah's mental health care out of pocket, her parents experience emotional and financial stress, often missing work

- Per NSDUH[8], 3.1M adults aged 18 to 64 (8.4% of the age group) experiencing any mental illness are unemployed (compared to 5.3% of the general population)[9]

~1 in 4 people experiencing mental disorders have histories of police arrest[10]

6

Noah begins to smoke and use alcohol and illicit drugs. She has frequent law enforcement encounters for minor, nonviolent offenses (e.g., possession, trespassing)

People with schizophrenia are **3x more likely** to experience serious problems with **drug or alcohol use** during their lifetime than the general population[11]

7

After her 13th arrest, Noah agrees to residential treatment for co-occurring disorders. Noah, now 25, is diagnosed with schizoaffective disorder. Noah's insurance does not cover the wraparound services recommended for follow up

8

Noah applies for SSI[12] and enrolls in Medicare and Medi-Cal. Noah gets resources to help manage her mental health and achieves recovery from SUD.[13] Hepatitis and diabetes reduce Noah's quality of life

- Individuals experiencing psychosis are 3.5x more likely to die due to **cardiovascular disease, tobacco use, and substance use** and exhibit 15x-30x increase in mortality due to suicide[14]
- Individuals experiencing psychosis have a **shorter life expectancy by an average of 10-15 years and are 8x as likely to die during the year following their diagnosis** as people in the general population[14]

Published research | Health Sector | Private Sector | Civil Society | Public Sector | Human Services

Example journey with timely Coordinated Specialty Care (CSC) access

Kai

Art history lover, soccer player, mystery novel reader
Uses Medi-Cal

Kai begins experiencing paranoia and intrusive thoughts at age 16[1]

1

Mean age of onset = 20 years; Range= 15 – 35 years[2]

2

Kai's symptoms become distressing; as their school performance slips, a school counsellor trained in EPI[3] flags possible symptoms to their parents[1]

3

CSC programs **improve symptoms of schizophrenia and psychosis** (based on measures of both PANSS[4] / CGI[6]) observed over 24 months[5]

After consulting with their parents and providers, Kai decides to enroll in a CSC program and waits two months for space to open in a nearby county program

4

CSC programs provide employment and educational supports to help patients attain **normal levels of functioning**[7]

5

Participation in CSC program on average reduces **inpatient days** by 33% and average number of **ED visits** per year by 36%[8]

Kai pursues their life passions for art history and soccer with minimal health setbacks; their routine care helps them maintain health and stay a vital member of their community

6

Supported by peers and clinicians in the CSC program's education model, Kai completes high school, graduates from the CSC program, chooses to enroll in college, and joins a support group at a community behavioral health center

7

Kai decides to move into their own apartment after living with their parents for a few years. Kai's parents are grateful to see them thrive

8

CSC program participation reduces average cost of **lost productivity** due to caregiving duties by 28%[10]

Following a relationship breakup, Kai's mental health suffers. After discussion with their therapist, Kai decides to stay with family temporarily. Their parents use their knowledge from family psychoeducation to help Kai re-balance

- CSC program participation reduces **need for homelessness services** amongst the FEP population by 38%[11]
- CSC programs reduce average cost of providing **supportive housing** per person of program participants[11]

Kai maintains and grows a strong friend group, serves as a youth leader at an arts center, and explores dating

- **The CSC model** focuses on both the client and their **family / caregivers / support**[9]
- Program participation reduces average **incremental healthcare costs** through improved health outcomes for caregivers by 29%[10]

9

After college, Kai starts a new relationship and begins their dream career as a museum program coordinator

CSC program participation reduces likelihood of being **unemployed** by ~42% (represents reduction from 50% to 29%)[12]

10

By addressing early symptoms of psychosis with timely, evidence-based care, Kai moves into adulthood equipped to manage their mental health with supportive community services; they maintain strong relationships and live an active lifestyle. Today, Kai has a promising career, owns a home, and plays soccer with a local team

To support successful execution over the next 3 years, four potential Implementation Support workstreams have been identified

Final as of December 11, 2024

Integrated coordination
Establish a dedicated central team to coordinate among ecosystem partners and across initiatives to ensure successful and timely implementation of the plan

Performance management
Identify metrics and track progress to promote accountability across initiatives and partners and measuring impact

Change management
Identify and deploy change champions and sponsors across ecosystem partners to promote adoption and implementation of the strategic plan

Communications plan
Develop and roll out coordinated communication and engagement strategies to ensure clarity, consistency, and alignment in messaging with California agencies, ecosystem partners, and other interested parties and provide regular updates on progress

Year 1
- **Workgroups:** Convene workgroup(s) to define goals and design strategies and align on roles and responsibilities.
- **Landscape analyses:** Review behavioral health landscape, including identifying gaps, estimating infrastructure, funding, and other requirements to fill those gaps, and outlining barriers to impact.
- **Strategies and partnerships:** Develop strategies for working with populations CBH has identified as areas of focus and source partnerships accordingly.

Year 2
- **Pilots:** Act on planned initiatives and pilot approaches, from engagement to funding, based on prioritization. Appropriately utilize embedded community partnerships and facilitate necessary training.
- **Performance indicators:** Define and implement measurements of success while simultaneously gathering pilot participant and partnership feedback to determine adjustments needed to pilots.

Year 3
- **Data analytics:** Continuously collect performance data in service of improving awareness, access, quality, and equity of care.
- **Effort refinements:** Based on analytics, redirect resourcing and refine goals to ensure adherence to the priority needs of target populations.

Source: CBH

Advisory group members

Final as of December 10, 2024

● Attended April Advisory Group Meeting(s) ● Attended May Advisory Group Meeting(s) ● Interviewed for additional input ● Submitted offline feedback on the Strategic Plan

Category	Group		Name
Communities and Individuals	Individuals with lived experience	●●●	Brandon Staglin
	Individuals with lived experience		Claire Conway
	Individuals with lived experience	●●●	Keris Myrick
	Family members	●●	Gladys Mitchell
	Children and Youth	●	Radha
	Tribal communities	●●	Virgil Moorehead
Ecosystem Stakeholders	Payors - CalPERs		Julia Logan
	CHA	●●	Paul Rains
Local Implementors	County Leaders	●●●	Supervisor Ellenberg
	Rural	●●	Phebe Bell
	Public Safety	●	Sheriff Bill Brown
	EPI Programs	●●●	Ann Boynton
	EPI Programs	●●	Steve Adelsheim
	EPI Programs	●●	Kerry Ahern
	EPI Programs	●●●	Tara Niendam

Category	Group		Name
National Leaders	National Council for Mental Wellbeing	●	Chuck Ingoglia
	NAMI		Daniel H. Gillison, Jr.
	NAMI	●	Darcy Gruttadaro
	NASMHPD	●●	Brian Hepburn
	NIMH	●	Robert Heinssen
	Brookings Institute	●	Richard Frank
State Leaders	Healthcare - Dept Managed Care	●●●	Amanda Levy
	Healthcare - DSH	●●	Ambarin Faizi
	Healthcare- Cal HSS	●●●	Stephanie Welch
	CBH Commissioners	●●	Jay Robinson
	CBH Commissioners	●●	Mark Bontrager
	Healthcare - CBHA	●●	Le Ondra Clark Harvey
	Healthcare - DHCS	●	Paula Wilhelm
	Healthcare - Cal HSS	●●	Sohil Sud

Note: Advisory group members were identified by CBH

Source: CBH

Individuals with lived experience interviews

Final as of December 11, 2024

Invitations were extended via a number of channels to Individuals with Lived Experience and CSC providers to share their experiences with early psychosis and the impact of intervention models

These requests were sent via a number of contacts between June and September

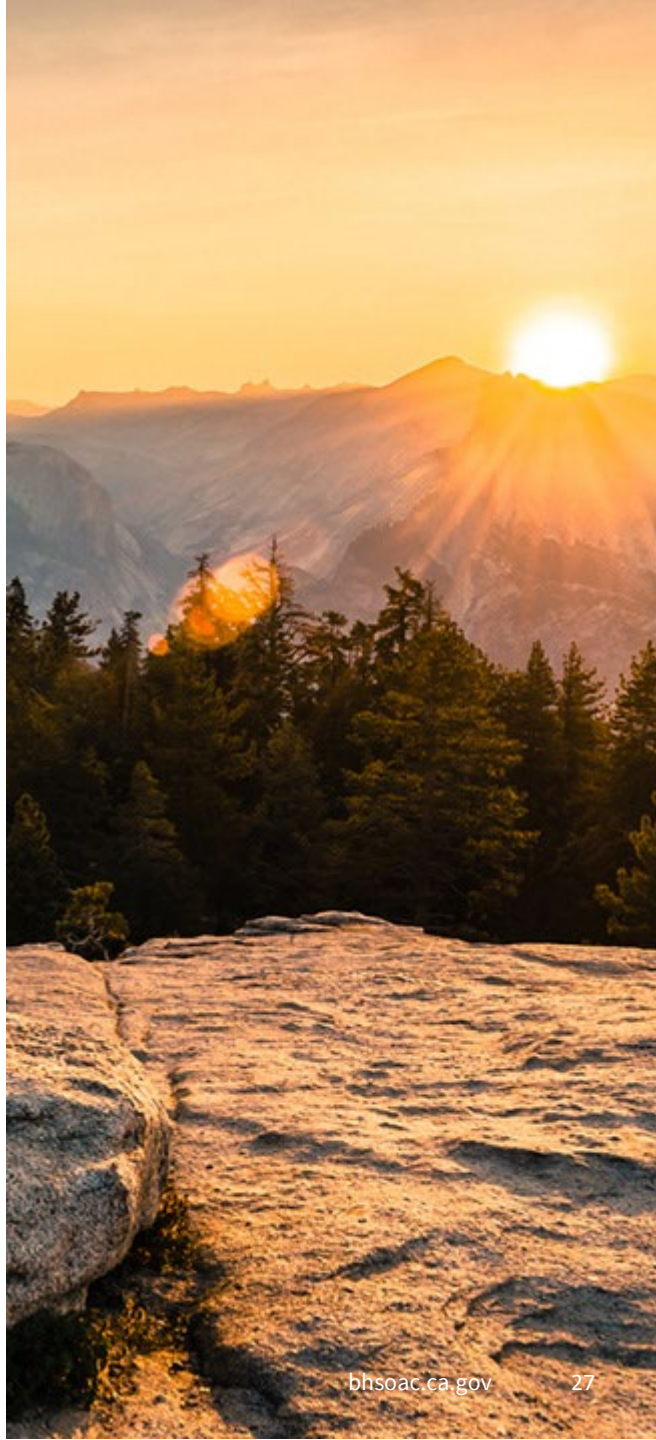
Initial point of contact	Organization and network	Outcome
Tara Niendam	**EPI-CAL network**	Put out calls through listserv, identified a caregiver willing to participate in the interview
Brandon Staglin	**Strong365**	Chantel Garret reached out to national network of youth with lived experience
	Accelerating Medicines Partnership® Schizophrenia (AMP® SCZ)	Carlos Larrauri reached out to personal network and Dr. Hardy at Stanford university
	University of Pittsburg	Nev Jones to reach out to network for individuals willing to share experience
Working team	**National Alliance on Mental Illness (NAMI), NASMHPD, National Council for Mental Wellbeing (NCMW)**	Put out calls through their respective listservs and networks, identified one member from Florida that was not included in the California report
	AlphaSights	AlphaSights put out a call for experts who would be compensated but none were identified

Through this process**, two individuals agreed to be interviewed**

A key barrier to additional interviews may be ongoing stigma related to psychosis

Proposed Motion

That the Commission accept the Early Psychosis Care Strategic Plan.



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