

# Scaling Coordinated Specialty Care for First-Episode Psychosis: Insights From a National Impact Model

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McKinsey  
Health Institute



**NASMHPD**



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*Author's Note: This document reflects a framework based on initial outcomes, lived experiences, and existing research. It should not be used as a basis for clinical advice, as an implementation guide, or as a sole financial planning tool for budgeting or actuarial models.*

# Executive Summary

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Across the United States, there is a clear need to expand access to evidence-based care for early psychosis (i.e., the first few years after symptom onset). Despite the proven success of coordinated specialty care (CSC) for people experiencing early or first-episode psychosis (FEP), there are not enough CSC programs to match demand – only 10%–25% of individuals experiencing early psychosis currently receive CSC. (This range takes into account that data on both FEP incidence and availability of CSC programs is limited and that incidence is likely underreported.)<sup>1</sup>

## COORDINATED SPECIALTY CARE

Coordinated specialty care (CSC) is a multidisciplinary, team-based approach that employs person-centered and shared decision-making principles to offer an array of services aimed at recovery and symptom remission in early psychosis (e.g., psychotherapy, medication management, family education and support, service coordination, supported employment, and peer support). Multiple trials have shown that CSC reduces hospitalizations, emergency department visits, criminal justice involvement, and symptoms and also improves vocational engagement and quality of life.<sup>2</sup>

Many people experiencing FEP unfortunately receive the wrong treatment at the wrong time – for example, delayed, unnecessary, or inappropriate care. Studies show that a prolonged duration of untreated psychosis leads to worse clinical and functional outcomes.<sup>3</sup> Delayed or incorrect treatment takes a heavy toll on individuals and their loved ones, with costly consequences. Schizophrenia alone, which is one of several disorders associated with psychosis, costs the U.S. economy an estimated \$343 billion a year in direct health care costs, unemployment, and lost productivity for caregivers.<sup>4</sup>

To increase awareness of this issue and catalyze action, the National Alliance on Mental Illness (NAMI), National Council for Mental Wellbeing (NCMW), National Association of State Mental Health Program Directors (NASMHPD), and McKinsey Health Institute (MHI) partnered to identify and codify the benefits of scaling CSC for early psychosis.

This collaboration resulted in the development of a national impact model that estimates the economic impact of scaling CSC in the United States. Over 10 years, expanding access to CSC from the baseline rate of 10%–25% to a rate of 90% could provide evidence-based care for approximately 600,000–800,000 additional individuals experiencing FEP and generate about \$115 billion to \$140 billion in system savings. Projected savings include the cost to deliver CSC to an expanded population over time.

## “90-90-90” VISION FOR MENTAL HEALTH

The aspirational target of 90% in our national impact model is aligned with The Kennedy Forum’s goal to achieve “90-90-90” in mental health by 2033: 90% of individuals are screened for mental or substance use disorders, 90% receive the evidence-based care they need, and 90% of those treated can manage their symptoms and achieve recovery.<sup>5</sup>

## ADDING YEARS TO LIFE AND LIFE TO YEARS

The global burden of mental and substance use disorders and their comorbid physical health conditions is about 330 million disability-adjusted life years (DALYs), on par with cardiovascular disease and cancer. In the United States, this burden is about 23 million DALYs per year.<sup>6</sup> By scaling evidence-based interventions, society can reclaim more than 130 million life years globally (based on addressable burden).<sup>7</sup> Scaling access to care for early psychosis in the United States and globally could decrease the burden of psychosis to society while adding years to life and life to years.

There is an opportunity and an imperative for US stakeholders (e.g., policymakers, providers, and payers) to invest in scaling CSC for people experiencing FEP – improving lives while also generating an economic return.

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This whitepaper provides background context on FEP, an overview of CSC, and insights on the impact of scaling access to care nationally. The insights that follow reflect learnings from more than 20 in-depth interviews with national leaders in the field, as well as the perspectives of clinicians, caregivers, and people with lived experience with FEP.

The authors hope these insights will inform and catalyze action across the ecosystem – by supporting advocacy; informing federal, state, and local decision-makers; and ultimately improving the lives and livelihoods of individuals experiencing FEP and their families.

# Introduction

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## Background on First-Episode Psychosis

Psychosis is a cluster of symptoms that can be extremely challenging to manage (e.g., delusions, hallucinations, disorganized thinking or behavior, or a loss of interest in the world). These symptoms can manifest in many ways and may be a sign of serious mental illness (SMI) such as schizophrenia, schizoaffective disorder, bipolar disorder, or severe depression. Some of these symptoms can also appear in other serious but more manageable conditions (e.g., depression or ADHD). As a result, young people, families, and schools often need help navigating what qualifies as first-episode psychosis (FEP).

Individuals experiencing psychosis may find it difficult to make sense of the world around them as well as their own thoughts, feelings, and perceptions. They may struggle to recognize what is real and what is not.<sup>8</sup>

People often experience symptoms of psychosis for the first time in young adulthood — in their late teens to mid-20s. NAMI defines early psychosis, or FEP, as the early period (up to five years) after the onset of psychotic symptoms related to an SMI.<sup>9</sup> In this paper, “first-episode psychosis” and “early psychosis” are used interchangeably to reflect the initial stage of a psychotic disorder.

More than 100,000 individuals experience FEP each year in the United States.<sup>10</sup> With the right timely mental health treatment and social supports, these individuals can lead full, long, and productive lives. Without appropriate resources, however, they may experience a lifetime of significant health and socioeconomic challenges.

Due to stigma, a lack of awareness, and/or limited access to care, FEP may be misdiagnosed or go untreated for months to years. Duration of untreated psychosis (DUP), defined as the time between the first psychotic symptom and the start of treatment with antipsychotic medication, is a key prognostic factor for serious mental illness and is associated with poorer outcomes. Conversely, a shorter DUP is associated with improved outcomes. Untreated symptoms increase the risk of individuals with FEP developing a substance use disorder, engaging in self-harm, or becoming unemployed.<sup>11</sup>

While every experience with FEP is unique, research shows the significant impact that psychosis can have on health, employment, housing, and incarceration:

- ▶ **Early mortality.** Individuals with psychotic disorders have a life expectancy that is an average of 10 to 15 years shorter than that of peers, and they exhibit an increase in mortality due to suicide of 15 to 30 times.<sup>12</sup> Notably, 12-month mortality rates after FEP are 24 times greater than in peers aged 16 to 30.<sup>13</sup> This significantly elevated mortality rate underscores the importance of intensive clinical attention for young people experiencing psychosis.
- ▶ **Hospitalization.** People with psychotic disorders often have higher utilization of the health care system, including higher rates of hospitalization and emergency department visits.<sup>14</sup>
- ▶ **Chronic-disease burden.** Individuals with psychotic disorders are 3.5 times more likely to die due to cardiovascular disease, tobacco use, or substance use than individuals without psychosis.<sup>15</sup>

- ▷ **Unemployment.** As little as 10% of people with schizophrenia are employed competitively at any given time.<sup>16</sup> Lack of employment or underemployment can lead to lifelong disability and need for social supports.
- ▷ **Homelessness.** Approximately 20% of people who are experiencing homelessness are affected by psychosis, compared to 3% of the general population.<sup>17</sup>
- ▷ **Criminal and legal system.** Studies demonstrate that roughly 40% of individuals with FEP experience involvement with the justice system before entering specialized early intervention (more than twice the national average),<sup>18</sup> with more than two episodes of incarceration, on average — typically for lower-level, nonviolent crimes.<sup>19</sup>

FEP can also weigh heavily on individuals who provide caregiving support. Stress associated with caregiving can lead to anxiety, depression, and adverse physical health outcomes.<sup>20</sup> There may be shame or stigma related to discussing a loved one's mental illness, which can lead to caregiver isolation.<sup>21</sup> Additionally, the time commitment of caregiving can lead to missed days of work and income loss and may negatively affect a caregiver's professional aspirations.<sup>22</sup>

*No one brings you a casserole when your loved one gets diagnosed with a serious mental illness, the way they do when someone gets diagnosed with cancer. The family advocate that helped me while my brother was at [a CSC program] told me this, and it has since stayed with me because it's so true. On the outside looking in — people don't really understand what's going on with you and your loved one. There are so many layers of how you feel misunderstood in terms of how you're contributing to society or what you're doing with your life when you're just trying to survive. ... When COVID hit, I was unemployed for a while, and during this time, I was 100% dedicated to my brother's well-being. At this time, there was no way I would be able to work and provide care to my brother simultaneously. I had applied to be his caretaker through IHSS and was denied twice, even with all that I had been doing with him and letters from my brother's MDs on the [CSC program] team. I found myself needing help applying for things like EBT and unemployment, again, in order to survive. Now I work hybrid and part time. Even when I'm working, my brother's well-being is always in the back of my head. It's much easier to provide support for him when I'm home and can be fully present with him. But financially, and without the burnout I've faced, I'd be better off if I could work full time.*

**SISTER, CAREGIVER, FAMILY PEER SUPPORT SPECIALIST**

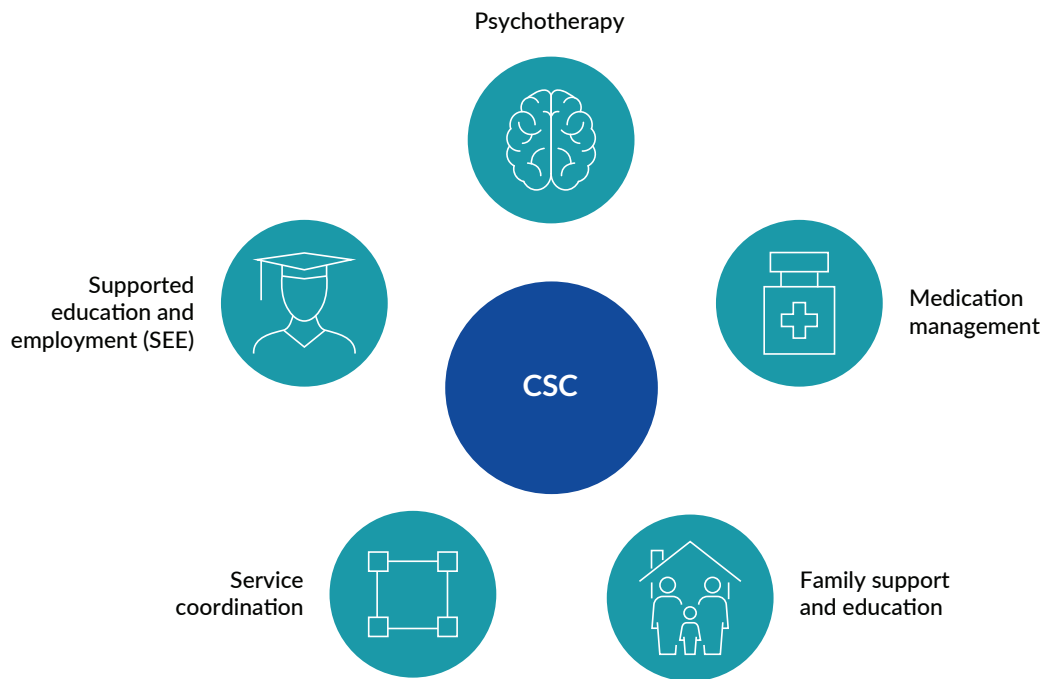
Employers are another stakeholder group affected by FEP and caregiver burden. Employers may not realize how FEP disease and caregiver burden affects their workforce. Increasing understanding — and access to early treatment — could not only improve clinical outcomes but also ultimately help improve productivity and reduce absentee rates.

## Background on Coordinated Specialty Care

Coordinated specialty care (CSC) is the standard of care for early psychosis in the United States, according to the American Psychiatric Association (APA),<sup>23</sup> the National Institute of Mental Health<sup>24</sup> (NIMH), and the Substance Abuse and Mental Health Services Administration (SAMHSA).<sup>25</sup> It is also the gold standard internationally, with demonstrated clinical and cost-effectiveness and broad implementation in Australia, Canada, and the United Kingdom, among other countries.<sup>26</sup>

CSC is an evidence-based, recovery-oriented approach to treatment that has been shown to improve clinical, social, and functional outcomes for people experiencing early psychosis. CSC typically includes five core components: cognitive or behavioral psychotherapy, medication management, family education and support,

**FIGURE 1. CSC PROGRAM COMPONENTS**



Source: Substance Abuse and Mental Health Services Administration. (2023). *Coordinated Specialty Care for First Episode Psychosis: Costs and Financing Strategies*. <https://store.samhsa.gov/sites/default/files/pep23-01-00-003.pdf>

service coordination, and supported employment and education.<sup>27</sup> Programs are relatively heterogenous, and many programs have added peer support as a sixth component of care, given the key role that peers play in recovery. CSC services are usually provided for a period of about two years — sometimes longer.<sup>28</sup>

- ▶ **Psychotherapy** can be one-on-one or group-based and is typically oriented toward cognitive behavioral therapy, focusing on resilience, symptom management, and coping skills. Psychotherapy is typically delivered by a therapist with a master’s-level qualification (e.g., a licensed clinical social worker) or by a PhD psychologist.
- ▶ **Medication management** is typically delivered by a specialist physician (e.g., a psychiatrist) or an advanced practice provider (e.g., a psychiatric nurse practitioner or physician assistant) and involves identifying and tailoring the right psychiatric medications to the unique needs of each client, with drug type and dosage selected to address specific needs and minimize side effects.
- ▶ **Family support and education** involves educating family about psychosis alongside coping and communication skills to best engage with and support loved ones. This is typically delivered by a therapist with a master’s-level qualification (e.g., a licensed clinical social worker) or a peer specialist in some models. Broader support from community organizations (e.g., mental health nonprofits, schools, and workplaces) can help amplify the family support and education offered by CSC. The level of community support available varies widely. Resources may be limited or strained in certain communities, leading to a greater reliance on CSC for family support.
- ▶ **Service coordination** involves collaborative communication among providers (e.g., psychiatric providers, nurses, supported education and employment [SEE] specialists, and case managers) to discuss topics such as care progression, medication needs, and the clients’ treatment and life goals. This is typically delivered by a therapist with a master’s-level qualification (e.g., a licensed clinical social worker) or a case manager in some models.

- ▶ **Supported education and employment** involves sessions with a SEE specialist who acts as a coach to help clients plan for life goals and return to education or the workforce to achieve these established goals. This is typically delivered by a person trained for the role, without any master's-level qualification required.

*I experienced a psychotic episode at the age of 35 that resulted in a hospital admission. Upon release, I was fortunate enough to receive over three years of early intervention service support, which included a care coordinator, psychotherapy, medication, family support, and access to peer support. Thanks to a robust and early response, not only have I been able to recover but, more important, I also have been able to find meaning and purpose: I now work within mental health services to improve outcomes for others.*

**J.G., HEALTHY BRAINS GLOBAL INITIATIVE LIVED EXPERIENCE COUNCIL MEMBER**

*The CSC program saved my life through providing much-needed early intervention with a core treatment team who cared deeply about my recovery, my holistic well-being, and who I am as an individual. I received wraparound services at a critical turning point in my illness progression, enabling me to complete my undergraduate studies in engineering at a top 15 nationally ranked university despite taking some time off due to psychosis-related symptoms. I received much-needed medication that largely eliminated all positive and negative symptoms, and I have learned practical strategies that are helping me recuperate my executive cognitive functioning over time. My treatment team provided much encouragement and practical hope tailored to my needs, and they were the ones who urged me to continue using my joy in music and the arts as foundational pillars to my wellness. Because of CSC, I have learned valuable skills about individual resiliency and strengths-based strategies – many concepts that I still apply day-to-day in my ongoing recovery, continued advocacy, and current paid work in the mental health field. I have since recovered well enough to work and volunteer in several regional and national leadership roles for initiatives focused on serious mental health conditions like my own. I have many to thank in my recovery journey due to CSC's immense impact on my life, and I certainly would not be able to be the advocate I am today for others like me without those absolutely essential services.*

**D.Y.**

CSC has shown several positive outcomes for people experiencing psychosis relative to those who receive care as usual or community care, including:

- ▶ a 33% reduction in inpatient days and a 36% reduction in emergency department visits,<sup>29</sup> driven by improvement in both mental health and physical health
- ▶ a 42% reduction in the likelihood of being unemployed<sup>30</sup>
- ▶ a twofold improvement in education and employment rates (from 40% to 80% in six months)<sup>31</sup>
- ▶ a 48% reduction in the need for homelessness services among the FEP population<sup>32</sup>
- ▶ a 76% reduction in the risk of committing a first crime<sup>33</sup>



*I think what has been really impactful are these individuals who come in at one of the most challenging times of their lives – often having come from the hospital or having been to jail. Getting to work with them and their families to find a path forward, walk with them on that path, and then be able to celebrate their amazing successes has been a real highlight. I think when most folks hear the diagnosis of psychosis, they think everything is over. Unfortunately, we as providers often reinforce that notion. Our own stigma creates a bleak outlook for the folks we’re intending to serve. And I believe that when CSC is done well, we are partners in supporting people toward their dreams. I’ve had the privilege of seeing folks go to college, go to grad school, get married, have kids, and live their lives – just as they should. And that’s the dream I want to be possible for all folks who have psychosis and for their families.*

**EXECUTIVE DIRECTOR OF A CSC PROGRAM**

Lack of access to early intervention has costly consequences: Without CSC, people experiencing FEP tend to use more-expensive options for care (e.g., emergency department or inpatient hospitalization).<sup>34</sup> Indirect costs are also higher for people without CSC access (e.g., costs associated with housing, unemployment, criminal justice, and caregiver burden).<sup>35</sup>

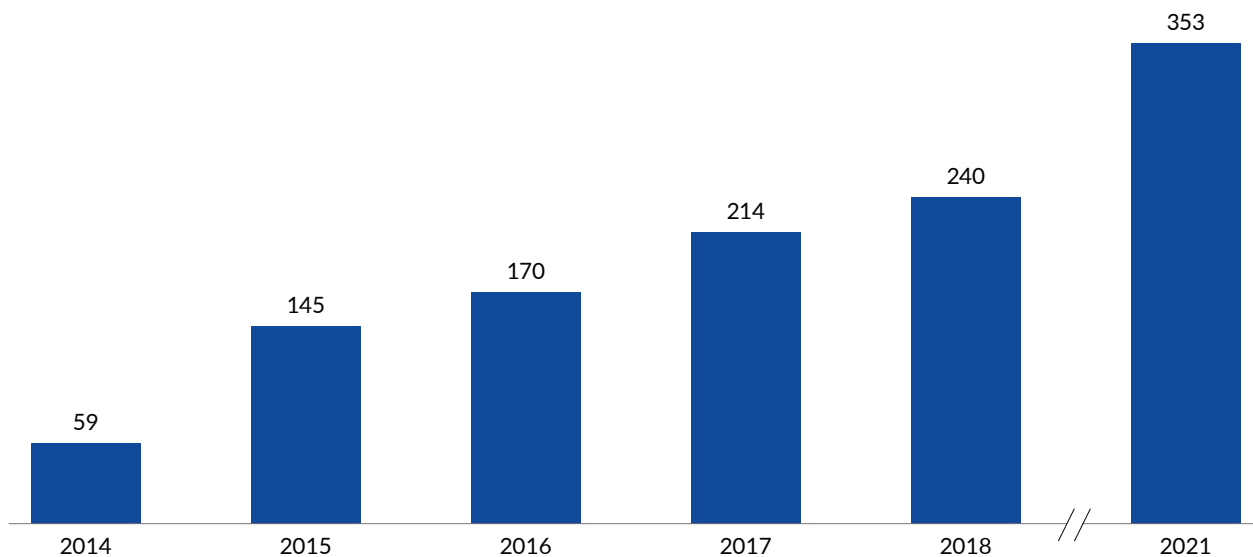
# Current State of CSC in the United States

While the availability of CSC programs in the United States has grown rapidly in the past decade, access remains insufficient to meet the demand for care. The United States lags behind other countries such as Australia, Canada, and the United Kingdom in the implementation of CSC at scale.

The first CSC program in the United States, Early Assessment and Support Alliance (EASA), was launched in 2000. Growth in CSC programs was initially slow; by 2008, there were 12 programs in the United States. The number of CSC programs has increased rapidly since then, with 170 programs by 2016 and 353 programs by 2021, as reported by the Early Psychosis Intervention Network (EPINET).<sup>36</sup> Each CSC program may serve 15 to 30 individuals at a time, based on capacity and available resources. Despite recent growth, the number of CSC programs remains insufficient to meet the needs of individuals experiencing FEP today.<sup>37</sup>

Notably, access varies widely at the state level – for example, in California, it is estimated that one in 10 individuals experiencing FEP have access to CSC.<sup>38</sup>

**FIGURE 2. NUMBER OF CSC PROGRAMS FOR EACH YEAR A SNAPSHOT HAS BEEN PRODUCED BY THE EARLY PSYCHOSIS INTERVENTION NETWORK**



Source: Kazandjian, M., Neylon, K., Ghose, S., George, P., Masiakowski, N. P., Lutterman, T., & Rosenblatt A. (2022). *State Snapshot 2021-2022: Early Psychosis Programming Across the United States*. Early Psychosis Intervention Network. [https://nationalepinet.org/wp-content/uploads/2022/12/EPINET\\_State\\_Snapshot\\_FINAL\\_508\\_COMPLIANT.pdf](https://nationalepinet.org/wp-content/uploads/2022/12/EPINET_State_Snapshot_FINAL_508_COMPLIANT.pdf)

Access to and participation in CSC programs is further affected by both system-level and individual-level factors, including level of awareness and engagement, stigma, insurance type, race and ethnicity, and geography. The following are a few illustrative data points:

- ▶ **Awareness.** There is an ecosystem-wide lack of awareness when it comes to recognizing the signs and symptoms of psychosis as well as knowing where to seek care. Even when individuals do seek care, they may be misdiagnosed or undertreated. There is a need to educate young people, their loved ones, and community members on how to recognize FEP and on recommended options for treatment. Unfortunately, many parents, teachers, health care providers, law enforcement professionals, and other community leaders do not have the knowledge necessary to guide young folks to the appropriate services.
- ▶ **Engagement.** There is high variability in programs' ability to engage individuals with early psychosis, driven by stigma and other social determinants of health (e.g., lack of access to transportation, unstable housing, and poverty).
- ▶ **Stigma.** Negative attitudes and discrimination related to mental disorders and psychosis may affect an individual's or family's decision to pursue treatment for early symptoms. Some people may choose not to recognize and address their medical condition due to a fear of judgment from their caregivers, health care providers, and broader community. Research has shown that stigma has a disproportionate impact on youth and their likelihood to seek care.<sup>39</sup>
- ▶ **Insurance type.** Insurance plays a key role in access to CSC. In addition to receiving funding from the SAMHSA Mental Health Block Grant (MHBG) set-aside, most CSC programs are covered by Medicaid and/or limit enrollment to Medicaid-eligible individuals.<sup>40</sup> This is particularly challenging for young people who may be covered by their own private insurance plan or that of a parent or caregiver. Private insurers typically do not pay for services without an independent certification, and CSC services lack an independent approval process. Developing a CSC certification process may enable coverage by more private insurers. Additionally, while Medicaid covers many components of CSC, insurance typically does not cover program outreach or supported education and employment; few CSC programs bill for these components of care due to complexity, adding to the financial burden experienced by programs.<sup>41</sup>
- ▶ **Race and ethnicity.** Black individuals face greater barriers to care compared with other racial and ethnic groups. Black individuals are more likely to be diagnosed with schizophrenia compared with White individuals<sup>42</sup> – however, they have disproportionately lower access to CSC. Black individuals with access to CSC programs tend to enroll later in the course of their psychosis, as compared with White individuals, or after they have more-severe symptoms.<sup>43</sup> More research is needed on CSC access and engagement across other racial and ethnic groups (e.g., Hispanic, Asian, and Indigenous populations).
- ▶ **Geography.** Most CSC programs are based in urban centers, where there is greater availability of providers and resources relative to rural areas.<sup>44</sup>

These key factors influence not only access to care but also an individual's outcomes during and after CSC. For example, geographic proximity to a CSC program is strongly correlated with outcomes – increased distance from a CSC program is linked to a reduced likelihood of graduation. Individuals who live farther away from their CSC programs tend to have lower socioeconomic status, may have limited access to phones or internet to stay connected with their care teams, and may have less flexible schedules to attend CSC appointments at the recommended frequency.<sup>45</sup> It comes as no surprise, then, that CSC has been shown to be more effective for individuals with high socioeconomic status who are able to travel to and prioritize CSC appointments and programming.<sup>46</sup>

There are several examples of CSC programs working to address inequities in access and outcomes. An executive director of a CSC program in California shared the impact her program has had on a diverse population:

*I'm proud of our ongoing focus on diversity, equity, and inclusion – we work hard to make services available and accessible to the diverse communities of [the city] through language concordance and translation. We have worked hard to incorporate and elevate lived experiences. This is an area of active work. We really want to make sure that the voices of folks with lived experiences are part of our clinical team – and are respected as members of our clinical team.*

**EXECUTIVE DIRECTOR OF A CSC PROGRAM**

# Insights From a National Impact Model

The National Alliance on Mental Illness (NAMI), National Council for Mental Wellbeing (NCMW), National Association of State Mental Health Program Directors (NASMHPD), and McKinsey Health Institute (MHI) partnered to develop an impact model that estimates the benefit of scaling CSC in the United States. The analysis and insights that follow are intended to provide an evidence-based projection of expected costs and benefits to help articulate the value of scaling CSC for advocates, policymakers, providers, and payers alike.

## METHODOLOGY

The methodology and assumptions used in the national impact model were informed by more than 20 in-depth interviews with national experts in policy and care delivery, as well as by the synthesis of existing research on the topic. Our approach to the model is summarized below at a high level. A detailed technical appendix is available upon request.

### 1. Define the baseline population of individuals experiencing FEP.

The incidence of FEP is estimated to be approximately 122,000 individuals per year in the United States, based on data in broadly cited papers by Simon et al.<sup>47</sup> and Radigan et al.<sup>48</sup>

### 2. Define a baseline and aspirational scenario to compare over a 10-year time horizon.

- Baseline scenario: 10%–25% of individuals experiencing FEP have access to CSC.<sup>49</sup>
- Aspirational scenario: 90% of individuals experiencing FEP have access to CSC.

### 3. Define population segments within the FEP population.

To compare impact across the two scenarios, the FEP population was categorized into four population cohorts:

- individuals receiving community care (i.e., individuals who did not receive CSC in the same or following year after their first experience of psychosis)
- individuals receiving CSC (i.e., 10%–25% of the FEP population in the baseline scenario versus 90% of the FEP population in the aspirational scenario)
- individuals receiving ongoing care after early access to CSC (i.e., individuals who received CSC in the same year as their first experience of psychosis)
- individuals receiving ongoing care after delayed access to CSC (i.e., individuals who received CSC in the year after their first experience of psychosis)

#### 4. Determine the direct and indirect impact of CSC for each population segment.

Impact was assessed across five categories (health care, employment, housing, criminal justice, and caregiving) based on available data in empirical research comparing outcomes for individuals receiving CSC to treatment as usual. Notably, there are some areas of impact that were not included due to a lack of empirical research. More research is needed to estimate the potential impact of CSC on the costs of community-based crisis services (e.g., mobile crisis units), screening and outreach services, educational services for students with disabilities, and the long-term operations of state-run or privately owned psychiatric hospitals.

The model accounts for the recurring annual cost of operating a CSC program (i.e., average annual cost of the workforce required to deliver effective care). It does not account for the potential up-front cost of recruiting additional team members or the cost of screening and outreach to individuals experiencing early psychosis. CSC program start-up costs vary widely by state and by program based on scope of services offered and approach to funding. As an example, the Illinois Division of Mental Health provides about \$225,000 to fund start-up costs for each new CSC program in the state.<sup>50</sup> Additional up-front costs to recruit new team members and expand screening and outreach also vary widely by geography based on existing workforce capacity and level of awareness about CSC programs.

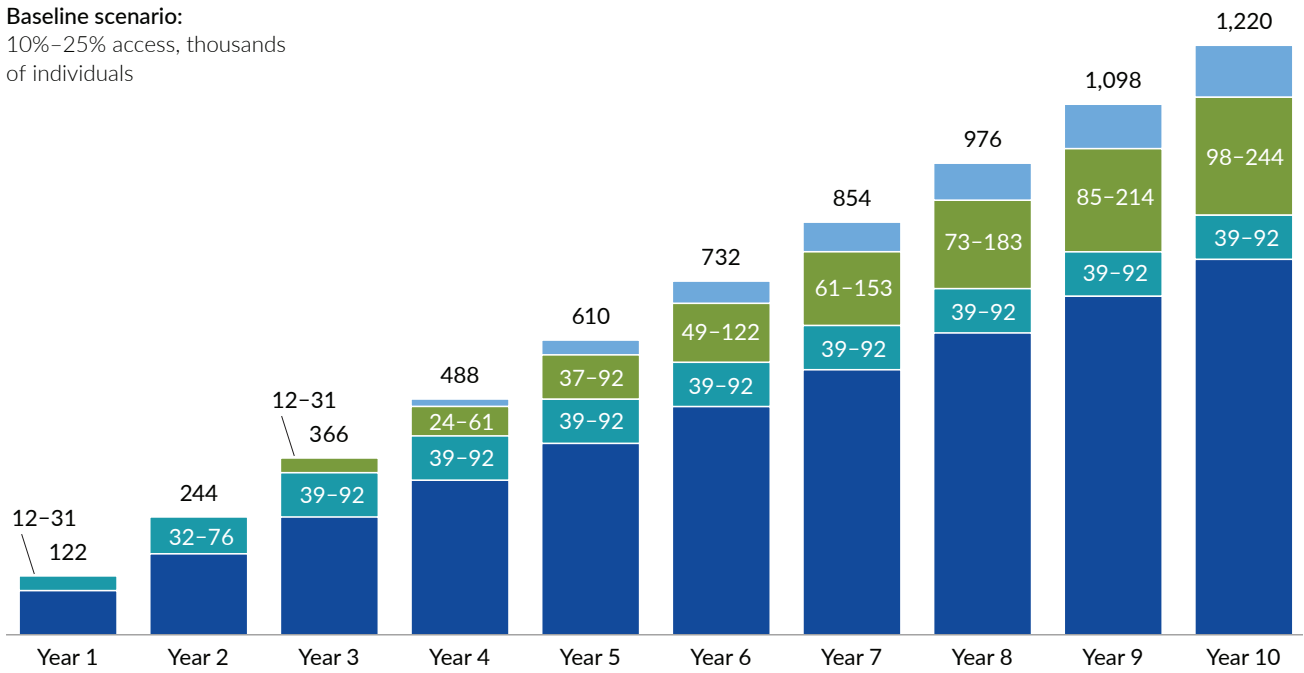
Availability of CSC programs determines what proportion of the FEP population is engaged in CSC versus community care over time.

After 10 years in the baseline scenario of this illustrative model, only 98,000 to 244,000 individuals would have received early access to CSC and would now be in ongoing care. By contrast, in the aspirational scenario, 878,000 individuals would be in ongoing care after early access to CSC. Over 10 years, this translates to an additional 634,000 to 780,000 individuals receiving early access to CSC services in the aspirational scenario, as compared with the baseline.

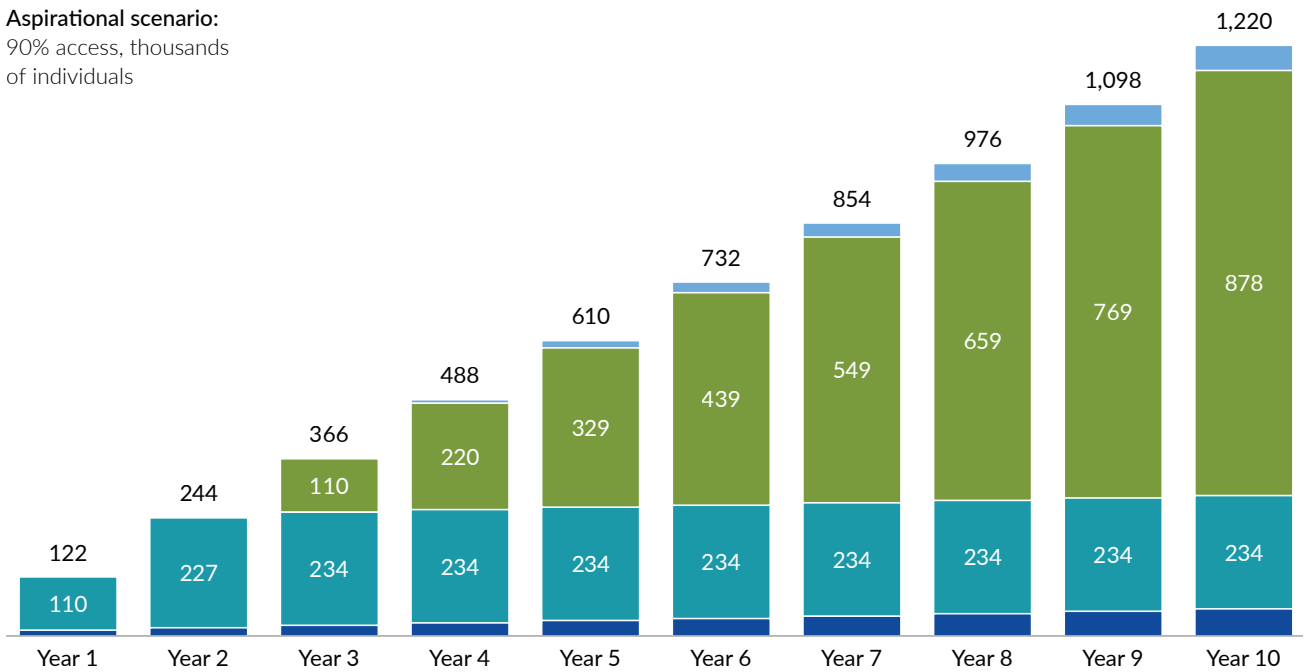
**FIGURE 3. FEP POPULATION BY COHORT OVER 10 YEARS**

Community care   In CSC   Ongoing care (early access)   Ongoing care (delayed access)

**Baseline scenario:**  
10%–25% access, thousands  
of individuals



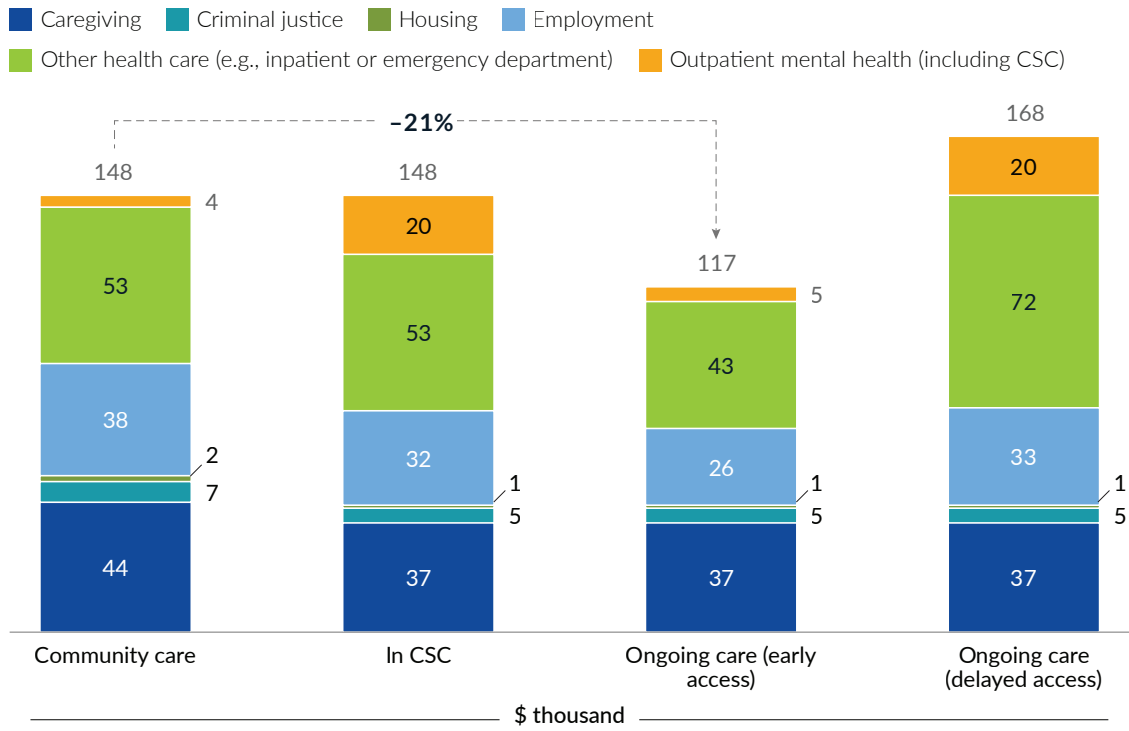
**Aspirational scenario:**  
90% access, thousands  
of individuals



Source: National impact model

Access to CSC – and particularly early access to CSC – has a significant impact on cost at the individual level across all categories of impact included in the model. Annual cost per person for individuals who receive early access to CSC is 20% lower than for those who remain in community care and do not receive CSC services.

**FIGURE 4. ANNUAL COSTS PER PERSON BY COHORT AND BY COST CATEGORY**



Source: National impact model

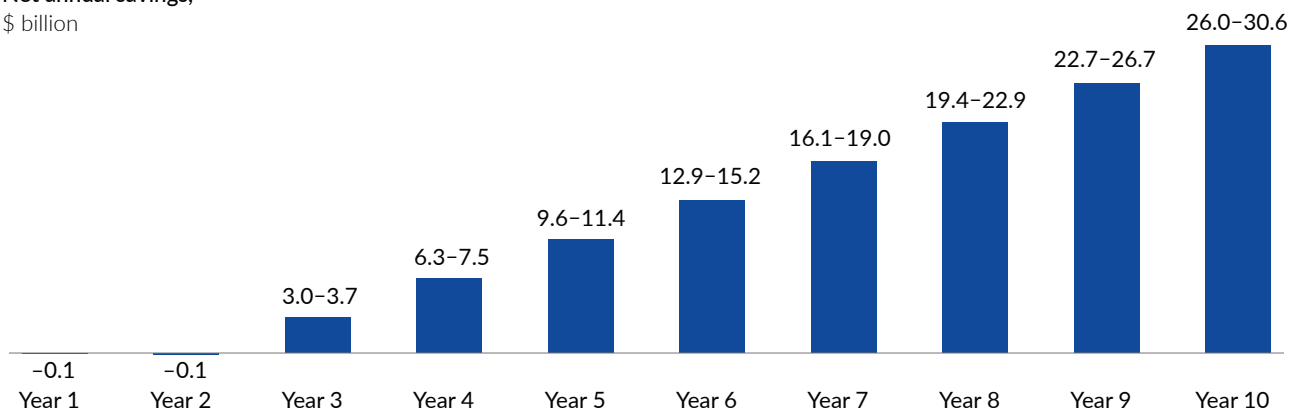


Increasing the availability of CSC programs has the potential to not only improve the lives and livelihoods of individuals experiencing FEP but also generate economic returns.

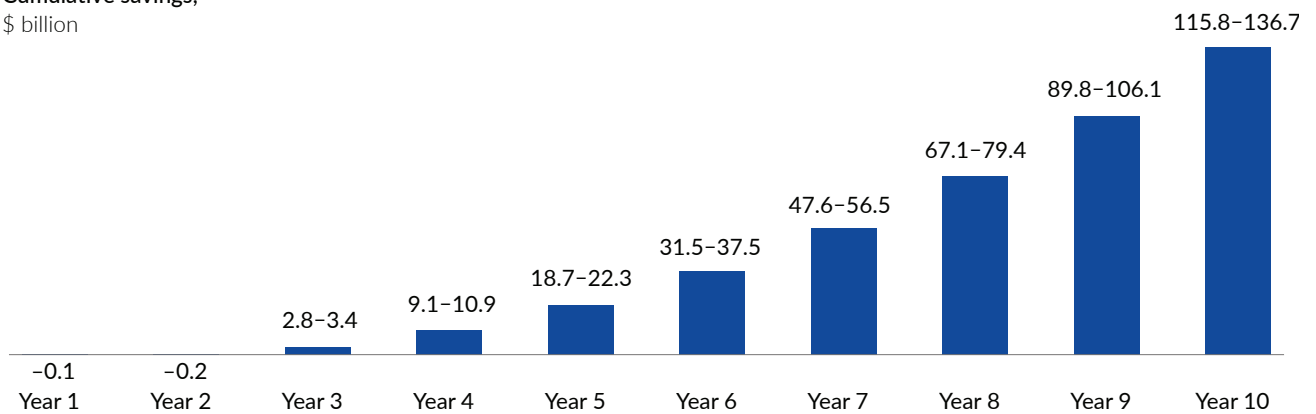
Over 10 years, a system that addresses 90% of need could provide early access to CSC for an additional approximately 600,000 to 800,000 individuals experiencing FEP and could generate up to \$115 billion to \$137 billion in cumulative savings, as compared with our current system, which addresses 10%–25% of need.

**FIGURE 5. SYSTEMWIDE SAVINGS OVER 10 YEARS**

Net annual savings,  
\$ billion



Cumulative savings,  
\$ billion

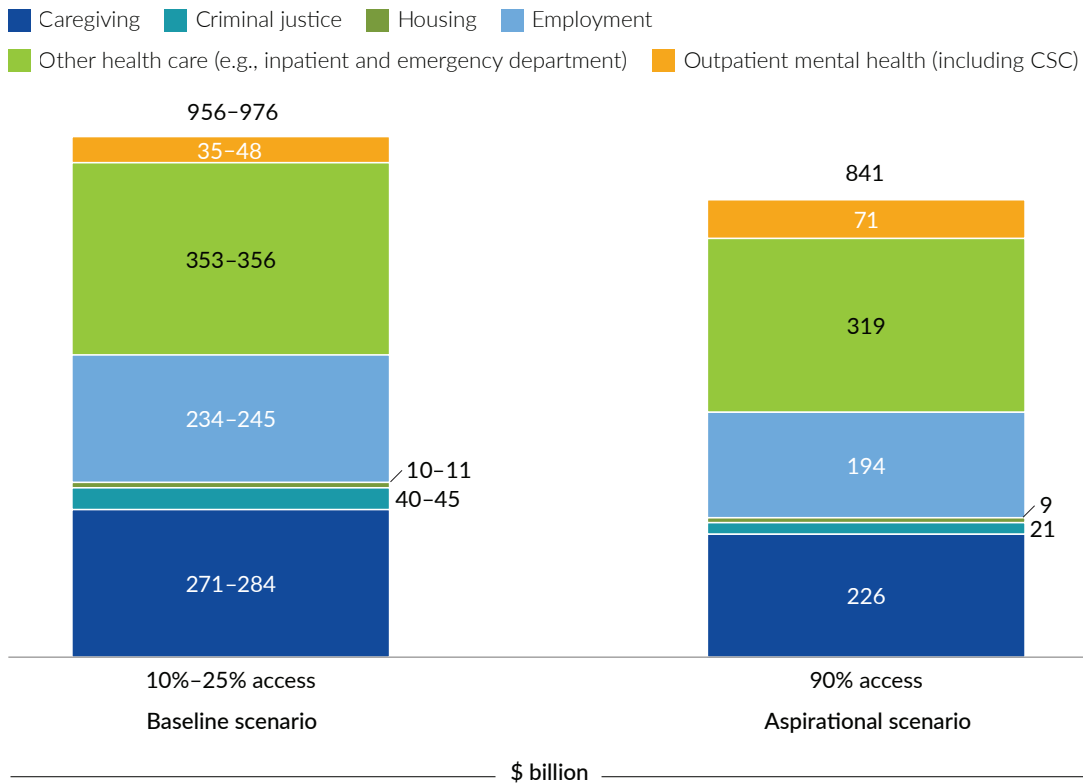


Source: National impact model

System-level savings over 10 years are driven by a reduction in costs across the five cost categories included in the model:

- ▷ **Health care.** Outpatient mental health, including CSC, represents an increase of about \$23 billion to \$36 billion in costs to deliver CSC and outpatient mental health services for an expanded population. Other health care, including inpatient and emergency department care, represents about \$34 billion to \$37 billion in savings, driven by reductions in emergency department visits, inpatient hospitalizations (including reduced length of stay), residential care, and medications for both mental and physical health.
- ▷ **Employment.** This represents about \$40 billion to \$51 billion in savings, driven by increased workforce participation and increased access to supplemental security income and Social Security disability insurance.
- ▷ **Housing.** This category represents about \$1 billion to \$2 billion in savings, driven by a reduction in the number of individuals living on the street or in shelters and by movement into supportive housing.
- ▷ **Criminal justice.** This represents about \$19 billion to \$24 billion in savings, driven by reduced involvement in the criminal justice system.
- ▷ **Caregiving.** This category represents about \$45 billion to \$58 billion in savings, driven by decreased burden on caregivers leading to increased workforce participation and reduced health care costs for caregivers.

**FIGURE 6. CUMULATIVE COSTS OVER 10 YEARS BY COST CATEGORY**



Source: National impact model

# Turning Insights Into Action — Next Steps and Considerations

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The national impact model provides a set of key insights on the impact of scaling CSC programs for individuals experiencing FEP. These insights may be used to inform and catalyze action across stakeholders.

The significant human and economic benefits at stake call for an ecosystem approach to scaling CSC. Simply expanding the number of spots in CSC programs is not enough. Even if there is capacity for a majority of individuals in need, there are additional barriers to access that may prevent individuals from seeking, receiving, and adhering to treatment. These barriers include a lack of awareness of CSC programs, insufficient screening, inadequate coverage by insurance, societal and familial attitudes, and more.

To support CSC program expansion, ecosystem players must work toward a fundamental shift in how we think about and address early psychosis. People experiencing early psychosis can live long and fulfilling lives with the support of early intervention programs such as CSC.

The following actions are needed to support effective implementation of CSC at scale:

## **Secure sustainable funding for CSC**

- ▶ Educate policymakers, payers, employers, and other stakeholders (e.g., education, law enforcement, juvenile/criminal justice, and housing) on the economic benefits of increasing access to CSC.
- ▶ Ensure that CSC is fully covered by all payers and insurance types.
- ▶ Where there are gaps in funding, provide enough resources to ensure the delivery of evidence-based care (e.g., continue to grow the SAMHSA MHBG).
- ▶ Secure sustainable funding for expansion of existing CSC programs.

## **Address workforce shortages**

- ▶ Establish (or strengthen) recruitment, training, and retention programs to enhance the quantity, quality, and diversity of the CSC clinical workforce, including people with lived experience with psychosis.
- ▶ Provide comprehensive training for new CSC staff, including a solid foundation on psychosis, the evolution of early intervention for psychosis, myths and misconceptions about SMI, and strategies for remaining calm and focused while interacting with actively psychotic individuals.<sup>51</sup>
- ▶ Improve staff retention by prioritizing candidates with close ties to the local community, offering high-quality supervision and mentorship, providing transparency around funding status and sources, and fostering an open, supportive culture among staff and program leaders.<sup>52</sup>

## **Establish infrastructure and accountability for CSC programs**

- ▷ Scale care models, particularly for rural geographies or underserved populations, by identifying infrastructure needs, developing strategic partnerships, and using technology as appropriate (e.g., telehealth).
- ▷ Establish governance structures to ensure responsibility, measure progress, and facilitate continuous improvement in access, cost, quality, and outcomes of CSC.
- ▷ Align efforts across stakeholders and geographies to strengthen effectiveness.

## **Enhance awareness, screening, and outreach for individuals with early psychosis**

- ▷ Expand community awareness of the symptoms of psychosis, especially early psychosis, and the availability of effective treatment options (e.g., offer school, youth, and family education resources; programs to reduce stigma and discrimination; and patient education materials to elevate expectations for timely, high-quality, and equitable care via CSC).
- ▷ Expand provider and first-responder awareness of FEP and CSC programs (e.g., educate physicians, nurses, social workers, educators, law enforcement, correctional officers, and other first responders on the signs and symptoms of psychosis as well as the availability of CSC).
- ▷ Increase the consistency of screening and accuracy of diagnosis for early psychosis (e.g., refine diagnostic and referral guidelines and standardize eligibility and intake processes for CSC).
- ▷ Continue federal investment and evaluation of clinical high-risk models.
- ▷ Proactively identify, and offer CSC to, individuals experiencing early psychosis (e.g., through partnership with local providers, health insurance plans, schools, faith-based organizations, and child welfare and other human services organizations).

Ensuring access to high-quality, evidence-based, and inclusive early psychosis intervention is one way to meaningfully improve the lives of those experiencing early psychosis and those who love them.

Too often, those who experience psychosis believe hope is lost. Implementing CSC at scale can help thousands of additional individuals remain in the community, retain housing, hold jobs, form deep connections, and boost their physical, mental, social, and spiritual health – while also generating economic returns.

At local, regional, and national levels, we must show compassion toward individuals experiencing early psychosis. We can do this by building awareness around early psychosis and investing in CSC as an evidence-based solution that could change the trajectory of people's lives. Together, stakeholders can ensure individuals are not denied the chance to access timely, holistic, and equitable care via CSC programs.

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