Lessons Learned from Sacramento, Napa and Solano

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Key Ideas I've Learned…

- Hire people who want to work in this population, BUT previous clinical experience with chronic SMI can be a strength and a challenge. Important for clinicians to have HOPE and belief in recovery. Early psychosis patients are not the same as individuals with chronic illness.
- Build a strong and collaborative clinical team with all the key roles AND enough effort (FTEs) to function effectively and meet your community's needs. Be ready to support and pay for ongoing training to maintain fidelity to the assessment and treatment models.
- Develop partnerships with other agencies and YOUR COUNTY – create a Community Advisory Board – to help you target your approach.
- A comprehensive and consistent outreach plan is critical – target points of first contact for mental health. Then be patient. It will take up to a year for you to build a consistent referral network.
- Be ready for referral sources to be frustrated with and confused by your limitations (eg. Age limits, duration of illness limits). This is not your typical outpatient community mental health program.

Key Ideas I've Learned…

- Be creative and willing to work out of the box about funding, documentation, etc. MHSA funds are very flexible – some of the model's elements aren't covered by Medi-cal. Consider other funding sources – Medi-cal, local foundations, donors, etc to support your work.
- Be broad, but not too broad in who you choose to serve. Do you have staff with the clinical skills needed to serve the population (e.g. ages) you are proposing to serve?
- This is a collaborative care model and it is recovery oriented. "They don't want help!" Yes, they do! Use the client's goals (e.g. get a job) as motivators toward care and recovery.
- See "family members" (can be defined in a variety of ways) as an asset and not a burden. They are often still involved and we need them to stay involved. Early Psychosis happens in transition age youth (TAY) and clinicians are apt to exclude their parents due to confidentiality concerns. BUT young adults need their families – and we need to engage them.

Key Ideas I've Learned…

- Remember that you are working toward recovery and reconnecting them to their natural supports, not trying to provide life-long care. You will reach capacity and need to "graduate" individuals to less optimal care. You need to be ready for that – and you need to prepare your client for what is available in the real world.

- It is essential to collect outcome data for these programs because it our responsibility to show that they are effective for EVERYONE in California. We have to show – in measurable ways – that we are having a meaningful impact on individuals' lives. This is <u>not</u> about typical metrics of productivity or # of individuals who are served – its about changing symptoms, changing functioning. There are limited mental health resources and we need to show that this matters!

- You need an established EP program who can guide you. This field is developing rapidly. There is a lot to learn and incorporate into practice to stay consistent with the model and ensure fidelity. How is the state (or how are the counties) willing to support building training and consultation capacity in order to meet these needs?