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Reorienting the focus from an individual to a community-level lens to improve the pathways through care for early psychosis in the United States

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Abstract

The implementation of coordinated specialty care in the U.S. over the past decade has led to the improvements of clinical and functional outcomes among individuals in the early stages of psychosis. While there have been advancements in the delivery of early intervention services for psychosis, it has almost exclusively focused on short-term change at the individual level. In light of these advancements, research has identified gaps in access to care and delivery of services that are driven by different levels of determinants and have the biggest impact on historically excluded groups (e.g., ethnoracial minoritized communities). Interventions or efforts that place an emphasis on community level (structural or sociocultural) factors and how they may influence pathways to care and through care, specifically for those who have been historically excluded, have largely been missing from the design, dissemination and implementation of early psychosis services. The present paper uses a structural violence framework to review current evidence related to pathways to care for early psychosis and the physical/built environment and conditions (e.g.,

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urbanicity, residential instability) and formal and informal community resources. Suggestions on future directions are also provided, that focus on enriching communities and creating sustainable change that spans from pathways leading to care to ‘recovery.’ In all, this lays the groundwork for a proposed paradigm shift in research and practice that encompasses the need for an emphasis on structural competency and community-driven approaches.

Keywords

Community factors; Early psychosis; Mental health; Neighborhood characteristics; Structural competency; Structural violence

1. Introduction

Over the past few decades, notable advancements have been made to improve care for early psychosis in the United States (U.S.) (Powell et al., 2021; Read and Kohrt, 2021). These efforts have primarily centered on understanding biological and behavioral changes as they relate to the duration of untreated psychosis, the onset of psychosis, and the implementation and outcomes of coordinated specialty care (CSC) (Anglin et al., 2020). While there is promise in improving individual outcomes for those in the early stages of psychosis, a growing body of literature has documented inequities spanning across pathways *to* care, from those first distressing symptoms until one is engaged in treatment, and beyond to the pathways *through* care, after the receipt of services. (Anglin et al., 2021; Oluwoye et al., 2021b).

Documenting pathways to care such as the extent to which appropriate mental health care is accessible for various communities (e.g., rural, economically disadvantaged) is a crucial endeavor, especially given that delays in accessing the appropriate services can worsen symptom severity, reduce quality of life, and impair engagement in treatment (Myers et al., 2023; Oluwoye et al., 2020). Yet, prior work on disparities in care for early psychosis have focused on individual- and interpersonal-level factors (Heun-Johnson et al., 2021; Oluwoye et al., 2018). This body of research has primarily drawn attention to ethnoracial disparities in service utilization, clinical presentation, and psychosocial factors (Li et al., 2011; Nagendra et al., 2018; Oluwoye et al., 2018, 2021b). For example, research has identified that compared to their white counterparts, Black individuals with first-episode psychosis begin care with more severe disorganized symptoms and higher rates of homelessness (Nagendra et al., 2018). Moreover, as individuals and their families move along the pathway through care for first-episode psychosis, research has found that treatment is relatively less effective at improving positive symptoms for Black individuals or engaging Black families in psychoeducation (Oluwoye et al., 2018). Disparities in treatment effectiveness have also been identified among those who come from lower socioeconomic backgrounds (Bennett and Rosenheck, 2021).

Disparities can be generally attributed to the downstream effects of structural racism and class-based inequities and represent failures in the mental health systems to adequately provide and engage historically underserved groups experiencing psychosis (Anglin et al., 2021). For instance, primarily Spanish-speaking Latinx immigrants, who tend to have low

English proficiency, are likely to disproportionately experience prolonged delays to care after the onset of psychosis (Santos et al., unpublished results).The higher risk for extended delays to care for this group within the Latinx population appears to be due to the design of the mental health system within the U.S., which is set up to serve the needs of English proficient individuals (Snowden et al., 2011). Efforts to increase equity of the mental health services access have been made to address the cultural and linguistic needs of diverse populations, including immigrant subgroups, in places like California (Snowden et al., 2011), but these have not successfully leveled barriers to care. In a subset of the Southern California sample of Latinx individuals with early psychosis, an examination of pathways to care revealed that the community mental health service system failed to offer care in Spanish to some Spanish speaking families once they were able to initiate access to care, further extending the delay (Hernandez et al., unpublished results). Taken together this body of literature creates an example that exemplifies how pathways to care for early psychosis are not solely influenced by individual-level factors (e.g., insurance type) but rather how the mental health system has made it inherently more difficult for groups of individuals that come from specific communities and neighborhoods to receive high quality care (Snowden et al., 2011).

1.1. Structural violence framework

We draw on structural violence framework, a concept introduced by Johan Galtung and refined in clinical medicine by Paul Farmer, to consider the larger social structures interfering in mental healthcare broadly, and more specifically access to care for individuals experiencing early episodes of psychosis who are members of historically excluded communities (Farmer et al., 2006; Galtung, 1969). Structural violence, in its application to public health, provides a social lens to practices (e.g., psychiatry) that are largely focused on the individual (e.g., symptoms). It describes the ways in which societal and community forces such as economic, political, legal, religious, and cultural forces can impair human need to the extent that certain groups cannot reach their full potential. These forces further inflict invisible, but profound violence through disparate access to mental health services, as an example. In its evolution and application to public health, many have demonstrated the ways in which structural violence shapes risk of both illness (e.g., schizophrenia) and obstructed access to care (Farmer, 2004; Kelly, 2005). The influence of structural violence can be seen in everyday settings and experiences within ones' environment, including racism and poverty, resulting in health inequities. For individuals in the early stages of psychosis who also are members of historically excluded communities, the consequence of structural violence is demonstrated by the disparate distribution of mental health concerns, in which they are more likely to not only develop psychosis, but to be misdiagnosed, and consequently endure obstructed access to mental health services thus resulting in poorer outcomes. Simply put, structural violence helps magnify the necessity for expanding beyond individual-level factors to include community-level factors when addressing pathways to care.

1.2. Structural violence, environment, and community

The physical/built environment refers to neighborhood conditions, such as abandoned buildings, level of crime, as well as community resources that have been constructed or modified by people, such as housing, schools, and jails. Both objective measures of these resources as well as subjective perceptions of their availability have been associated with mental health outcomes (Evans, 2003). The physical/built environment is a measure of structural violence as noted—walkability, transportation availability, resource density, policing are each structural means by which pathways to care can be made more difficult and can ultimately obstruct access to care.

Communities provide an alternative lens for understanding the collective response to structural violence in the physical/built environment. Communities are groups that individuals associate with due to shared common interest or set of norms that are not determined solely by place (Bradshaw, 2008). Through a community lens, we can identify the ways in which people respond to disparity, including informal and formal community resources, and the sociocultural environment and community norms which are extremely important to understanding how inequities in care are reinforced and identifying aspects to communities that are key to addressing inequities. A community lens also shows the limits of internal reach and resources because of the disparate conditions experienced by historically excluded communities, resulting from structural violence. Physical/built environment of communities can both facilitate and hinder availability and access to resources (i.e., social capital), familiar spaces, and supportive and trusted networks (i.e., social support) (Leyden, 2003).

1.3. Purpose

In this paper we use a structural violence framework (Farmer et al., 2006; Galtung, 1969), to conceptualize the interaction between societal and community factors and pathways to care for early psychosis, and explore how it intersects with historically minoritized communities. Specifically, we conduct a narrative review of existing literature on community-level factors influencing pathways to care for early psychosis. Building on the review of relevant literature, we then outline future directions and include examples of work that have been done in other areas to demonstrate the potential application to work conducted in the area of early psychosis. Lastly, we highlight the need to shift the focus from more traditionally emphasized individual- or behavior-focused treatments to more holistic, community-centered approaches that address multiple levels of determinants.

2. Review of literature

2.1. Physical/built environment and conditions

Relatively few studies have evaluated how the physical/built environment and its conditions impact pathways throughout care for individuals in the early stages of psychosis. Even in places where CSC have been implemented, adverse environmental factors (e.g., neighborhood disadvantage, perceived neighborhood disorder) influence age of onset, duration of untreated psychosis, access to care, and self-reported recovery (Ku et al., 2020; Oluwoye et al., 2021a).

Ku and colleagues present two examples on how various community-level characteristics are associated with age of onset and the duration of untreated psychosis among a predominantly

Black/African American sample of service users (Ku et al., 2020, 2023). For instance, residential Ku et al., 2020, 2023 instability, defined as the number of times a family has moved in a short period of time or the percentage of people in a community who change their address, is associated with earlier age at onset of psychosis. Residential instability has the ability to hinder underserved families in developing social capital such as supportive relationships and social connections with others, and determining the strength of these relationships (Desmond et al., 2015).

Similar to individual socioeconomic status, neighborhood socioeconomic disadvantage has often been linked to mental health disparities. Disparities associated with neighborhood socioeconomic status are the direct result of structural violence (e.g., social stratification, residential segregation, redlining) (Bailey et al., 2017). Perceived neighborhood disorder (i.e., how residents perceive local levels of crime and safety), including physical attributes (e.g., trash, abandoned cars, vacant buildings), and social attributes (e.g., gang activity, public drunkenness) as well as lower neighborhood socioeconomic status have been found to predict a longer duration of untreated psychosis (Elo et al., 2009; Ku et al., 2020).

There are few studies that have examined the association between the physical/built environment and access to services. Oluwoye and colleagues attempted this with CSC location data from Washington State and found that rural and lower income neighborhoods have less access to CSC relative to urban and more affluent counterparts (Oluwoye et al., 2021a). In another study of CSC, Mathis et al. (2018) evaluated access to treatment in a diverse sample, where 67% of participants identified as an ethnoracial minority, by examining the percentage of participants in a CSC’s catchment area that was underserved (i.e., areas in which the number of actual referrals was significantly lower than the estimated number of cases). The authors found that 28% of the total program catchment area was undeserved, and that the underserved area was primarily rural. Taken together, neighborhood rurality and socioeconomic status appear to be important factors associated with the accessibility and geographical placement of CSC.

2.2. Formal and informal community resources

As noted earlier, structural violence is manifested in the physical/built environment and is associated with the presence or lack of formal and informal community resources. Formal resources can be defined as settings where services are provided by trained professionals (e.g., mental health agencies) or individuals formally trained to provide social services (e.g., counselors). Informal resources can include social settings (e.g., local support groups) and other informal support within a community (e.g., pastors, community health workers).

2.2.1. Formal community resources—CSC has become the benchmark for providing early intervention services over the last decade. As previously mentioned, several studies have shed light on disparities at intake, possibly indicating inequities on the pathways to care, and following the receipt of services. The U.S. has seen a substantial increase in number of CSC programs, with more than 350 CSC implemented in 49 states. (Everett and Heinssen, 2019; Rosenblatt, A, 2018). To the best of our knowledge the large majority of CSCs have been implemented in community-based mental health agencies or hospital-based settings, all of which represent formal resource settings. Many CSCs are only funded by the Mental Health Block Grant (see George et al., this issue), which inadvertently places limits on where and the type of settings in which programs can be implemented (Powell et al., 2021). Research has been conducted to develop and enhance strategies of existing programs to improve pathways to CSC within communities that are serviced.

For instance, the Mindmap campaign in New Haven, CT consisted of a multifaceted efforts that expanded channels of communication to include a larger community network using social media (e.g., Facebook, Instagram, YouTube, Twitter, Reddit, and LinkedIn) and placed a greater reliance on websites, which allowed for tailoring messages to specific groups especially more youth-oriented segments, and for tracking traffic to the website and to social media channels. (Melle et al., 2004; Srihari et al., 2014, 2022). The Mindmap campaign generated phone calls from the community to the Specialized Treatment Early in Psychosis (STEP) program. The STEP program then responded to these calls within 24 hours and conducted weekly reviews of all queries to identify and address delays to providing treatment. This campaign provides as example of early detection and an early intervention program (i.e., CSC) that was staffed by trained personnel to identify the emerging signs of psychosis and with the needed resources to provide the critical outreach services to reduce delays.

Concentrated CSC efforts and outcomes have initiated discussions about the need for expanding how and where early interventions take place, including the expansion of mental health services to other formal settings such as the criminal legal system and education settings (Ford, 2015; Wasser et al., 2017). Prior work in these settings have been centered on identifying individuals early using screening tools and reducing treatment delays (Kline et al., 2014; Ramsay Wan et al., 2014). Youth and young adults spend most of their time in school-based settings, and school personnel (e.g., teachers, nurses, mental health counselors) have frequent contact with students and their families. They are also in a unique position to potentially identify changes in academic performance, social interactions, and other behaviors early. Because of this, school-based settings have often been a place for the early identification and treatment of mental health concerns including early psychosis (Kline et al., 2014). Research and practice in this area have attempted to capitalize on the existing infrastructure of schools to implement screening tools but have fallen short of integrating services into these settings (Kline et al., 2019; Meyer et al., 2020).

Regarding work in the criminal legal system, studies have demonstrated that policing (e.g., police victimization) and interactions with the criminal legal system induce psychosis and other symptoms (DeVylder et al., 2017, 2018). Other studies have reported that individuals in the early stages of psychosis, especially ethnoracially minoritized individuals, are more likely to have interactions with the criminal legal system (Prince et al., 2007; Ramsay et al., 2011). Several viewpoints have been published that provide recommendations on extending clinical services (Ramsay Wan et al., 2014; Wasser et al., 2017), such as utilizing crisis intervention teams (CITs) to increase referrals to appropriate mental health services and improve relations between the community and law enforcement. Given the need, there have been no published studies that have examined the impact of early psychosis specific services in these formal settings. That is not to say that efforts are not currently under way. Compton and colleagues have developed a two-part intervention for jails that includes a Targeted Educational Campaign and Specialized Early Engagement Support Service to initiate referrals to CSC for individuals upon their release (Compton et al., 2023). To date, findings have only been reported on the Targeted Educational Campaign, that improved knowledge and attitudes towards psychosis among correction officers in the first six months post-training (Compton et al., 2023).

2.2.2. Informal community resources and the sociocultural environment—To the best of our knowledge, only one group of investigators has specifically focused on early psychosis and leveraging the sociocultural environment to improve pathways to care for a ethnoracially minoritized groups. López et al. (2009) developed and evaluated campaign messaging to increase psychosis literacy among Spanish-speaking on both sides of the US-Mexico border. They employed novel messaging tactics, drawing on popular cultural icons to facilitate the recall of the key psychotic symptoms of delusions, hallucinations, and conceptual disorganization (López et al., 2009). In multiple studies, these researchers demonstrated that different messaging formats (such as *telenovelas*) can increase psychosis literacy in both the general public and among professionals (e.g., Casas et al., 2014). Moreover, lay health workers (in this case, *promotores*) were trained to deliver psychoeducation in person, which increased community residents' knowledge of psychosis, illness attributions and professional help-seeking more broadly (Calderon et al., 2015, 2021).

Drawing on this formative research, a multifaceted campaign called *La CLAve* ("clue" or "guide" in Spanish) focused on increasing psychosis literacy in both public and professional audiences in a largely Spanish-speaking community in Southern California (López et al., 2022). López et al. (2022) presented a case that highlights the contribution of informal and formal sources as well as the importance of accessible services, and further illustrates the value of a multifaceted campaign. Notably, they found there no single public or professional sector accounted for most referrals to specialty mental health care. By establishing conversations with multiple community-embedded sectors, informal and formal sources of support and resources, (e.g., a swap meet and a pharmacy) as well as the professional sector (here represented by the police), they made it possible for an individual with first episode psychosis to receive appropriate needed care. Although the *La CLAve* campaign found that Spanish-speaking Latinx individuals are indeed a high-risk group for significantly delayed initiation of antipsychotic medication, this project focused only on the supply side of pathways to care; no companion mental health education or early treatment information campaign was mounted to address the demand side.

3. Future considerations: challenges and opportunities

The review of current and relevant literature on community and neighborhood factors or the integration of community highlighted above, showcases the limited work that has been done in this area in the U.S. To address limitations and move the needle forward to improve pathways to care for individuals in the early stages of psychosis, a community approach is needed to make sustainable advances that increase supports and infrastructure that take into consideration social determinants. Below, we summarize some of the existing needs illustrated through both existing research and gaps in research, including increased attention to historically excluded communities, informal community support systems, and culturally informed and responsive dissemination materials and campaigns, as well as focused attention on diversifying the mental health workforce (Box 1).

3.1. Establishing community-based collaborations to address community needs

In order to make a substantial impact on pathways through care for historically excluded communities, engagement and representation of community members from various settings and systems, are needed to improve the physical/built environment as well as the infrastructure of formal and informal resources. To do this we require effective bi-directional partnerships with community members and leaders (e.g., formal and informal resources, policy makers, academic institutions) (Moe et al., 2018). At present, community advisory boards remain a primary means for amplifying and empowering the voices of people with lived experiences and including them in development and implementation of interventions. Yet, they provide segmented contributions to projects that are still by and large not led by community members. Community-based participatory approaches establish shared power, effective community engagement, and relationship building that can be sustained beyond funding periods as they require equal involvement of community at all stages of interventions. These efforts can include at minimum the use of promotores/community health workers in the research and development interventions as demonstrated in *La CLAve* (López et al., 2009; Stacciarini et al., 2011).

3.2. Integrate services or programs into existing community resources

To provide equitable pathways through care, formal and informal settings should be leveraged, where informal settings can serve as a bridge to formal resources, thus improving access to mental health services. Little has been done to identify informal community resources that can provide services, referrals or information related to psychosis. Faith-based institutions and community centers are examples of existing informal resources that embody both a sense of community and a place of trust for families and are often heavily invested in the overall community environment and conditions (e.g., living conditions, resources, revitalization). For instance, many churches and other faith-based organizations have established ministries focused on improving the well-being of their congregation while community centers and community health centers have established programs to educate youth and young adults and family-focused events. In the Black/African American community, faith-based institutions have served as venues to identify, treat, and connect individuals and their families to appropriate services for depression and substance use (Bellamy et al., 2021; Hankerson et al., 2015; Jordan et al., 2021). Similarly, in the Latinx community faith-based settings have also been the audience to improve mental health literacy (Caplan and Cordero, 2015). These settings serve as examples for where future partnerships might be established to launch community campaigns to bring awareness about psychosis and effectively connect individuals and families to services.

On the other hand, CSCs are continuously being adapted to provide culturally responsive care and to extend reach to certain communities. For instance, in Washington implementation efforts are currently underway, through a partnership with a Native community to establish a community advisory board, modify the New Journeys model to fit within existing Tribal health services, develop working relationships with other Tribal services and resources, and to meet the needs of the larger community. In other areas, the implementation of police-based or nonpolice crisis response teams increases referrals to behavioral health services and reduce arrests, which should be further explored.

3.3. Community-integrated dissemination and implementation efforts to improve literacy and navigation

Developing and disseminating culturally accessible and up to date messaging content to increase knowledge about psychosis, early identification, and connection of families to appropriate services is extremely important in addressing community and societal-level determinants (e.g., access to mental health services, stigma). The development of *La Clave* potentially serves a guide to developing messaging tailored for a specific ethnoracial group (i.e., Latinx) given the lack of research and programming focused on messaging around psychosis and services for other ethnoracially minoritized groups (e.g., Black/ African American, American Indian/Alaska Native). In addition to effective and culturally appropriate messaging, we require focused attention on how messages are delivered and by whom (e.g., the variability of credible and trust-worthy sources across different ethnoracial groups).

As one example in the Black/African community, fraternity and sororities are a trusted resources with a long-standing history of empowering the Black/African community. For this reason health agencies have partnered with different fraternities/sororities to address health disparities (Omega Psi Phi Fraternity, Incorporated, 2017; Sigma Gamma Rho Sorority, Incorporated, 2022). The *Brother, You're on My Mind* toolkit resulted from a partnership between Omega Psi Phi Fraternity, Incorporated and the National Institute of Minority Health and Health Disparities and focuses on educating the community about depression and stress among Black/African American men. The free toolkit includes educational materials (e.g., factsheets, presentations, handouts), community partnership and outreach tips, materials to aid event planning and promotion (e.g., social media messaging and images, flyer template, event planning checklist). The role of each fraternity chapter (~700 chapters) in this initiative is to disseminate printed materials at locations such as barbershops, churches, health fairs, to work with religious congregations and health ministries to focus on mental health, to have mental health professionals speak to members during chapter meetings and create local partnerships to host larger community workshops.

3.4. Addressing the workforce shortage and diversifying the workforce

The U.S. has longstanding mental health workforce shortages (Smith and Jury, 2016), including within CSC services (Pollard and Hoge, 2017), limiting the provision and availability of services in certain communities that have been traditionally underserved. Pipelines are required to train masters-level social work, counseling, and psychology providers across an array of formal community resources, including educational settings, mental health agencies, and criminal legal settings, to identify early warning signs of a psychotic disorder, make referrals accordingly, and to provide culturally responsive care. Investigators at the University of Maryland sought to amplify this pipeline through a focused training for social workers, who represent a large part of the mental health service delivery workforce. Training included a web-based training program for social workers to identify and screen individuals and then make referrals to appropriate services (Andorko et al., 2022). The intention of this training extends the potential reach through early identification and referral by training social workers in formal and informal settings, which could be extended to other professions.

In addition to creating training opportunities for various mental health professionals, there is a concerted effort to diversify the workforce to include more providers and administrators with similar ethnoracial identities that represent communities that are served (Kyere and Fukui, 2022). This calls for incorporating curriculum on early psychosis in graduate and professional programs to address shortages and emphasize the need to create pipelines from minority-serving colleges and universities (e.g., Historically Black Colleges and Universities). Beyond this, the mental health workforce could be substantially expanded by training community health workers, peer support specialists, and family peer navigators, to support identification and treatment of early psychosis. These paraprofessionals can be recruited from the same communities in which they serve, and consequently may share the same ethnoracial identity, language, socioeconomic status, and other life experiences with their clients. Shared experiences can facilitate profound inroads with community resources (e.g., faith-based institutions) and increase community trust in campaigns and interventions as demonstrated in *La Clave*.

3.5. Structural competency across various systems of care

Structural competency applied to the field of early psychosis is the ability and humility to recognize how the pathway to early psychosis or the presentation of symptoms is directly influenced by the complexity of structural constraints (Metzl and Hansen, 2014). Structural competency reinforces the need to shift our focus from only addressing individual factors and disparities to a community focus that considers environment, conditions, supports and resources (Kirmayer et al., 2018; Metzl and Hansen, 2018).

The Yale Department of Psychiatry Structural Competency Community Initiative was developed to introduce residents to structural health inequities through the lives of people with lived experiences of mental illnesses living in local neighborhoods (Bromage et al., 2019). The one-week program includes formal reading assignments, a group kick off located within the community where residents are introduced to peer advocates and community leaders, small group exercises to discussion racial and/or economic disparities depicted in art, tours of neighborhoods and debrief sessions led by peer advocates and community leaders. After community tours, residents are asked to select a specific theme (e.g., spirituality, community resilience) for their presentation which is evaluated by community leaders and facilitates further discussion on structural determinants. The initiative amplifies structural mechanisms of health that are often disregarded, whether intentionally or unintentionally, by mental health providers. It further expands the definition of healthcare to include the very structural determinants we argue are essential to creating equitable pathways to care for individuals in the early stages of psychosis and their families. While this program focuses broadly on mental health care, it provides a template for creating similar provider-level interventions in CSC.

3.6. (Re)Investing in communities to support infrastructure

Despite limited research in the field of early psychosis on community-level factors, we continuously see disparities along the pathway throughout mental health care that are not solely driven by the individual but rather community-level factors (Alegría et al., 2022). Community participation and mobility as well as indicators of community ‘citizenship’ are directly correlated with physical and mental well-being among people who have serious mental illnesses (Brusilovskiy et al., 2020; Ponce and Rowe, 2018). We also see increased community engagement among those who are able to access mental health care (Townley et al., 2022). For many communities throughout the U.S., especially communities with fewer services, it is essential to increase community investment and enhance social infrastructure. This includes expanding the reach of community resources like libraries to create safe havens and inlets to pathways to care (Wahler et al., 2020). Place-based investments additionally support community health by addressing social determinants that impact overall well-being, as evidenced through the Center for Community Investment’s partnership with hospitals and health systems. Partnerships like this support development of affordable housing and address unequitable policies and practices in the community affecting historically excluded communities.

4. Discussion and conclusions

In order to develop a more equitable healthcare system, we require a paradigm shift to adequately account for the role of the built/physical environment and the often-informal community level responses to obstructions created through structural violence to better understand their impact on the overall wellness of individuals experiencing psychosis. At present, most research on pathways through care for people with early psychosis conceptualize environmental influences in terms of household or family environment (interpersonal level), adverse life events (e.g., exposure to trauma), or facilitating help seeking. Current literature presented in this paper highlights the plausible association between the larger environment (neighborhood and community level) and pathways through care for individuals who experience psychosis. However additional research is needed, evident by the limited work that demonstrates the impact of neighborhood-level factors on access to care (pathways to) and clinical outcomes (pathways through).

We are witnessing an expansion of CSC across the nation and subsequently new research, which continues to demonstrate the benefits of these early intervention programs for individuals experiencing psychosis and their families (Heinssen and Azrin, 2022). Establishing clinical services, however, is insufficient, especially for historically excluded groups, because it ignores the pathway by which individuals with psychosis and their families get there, if they get there. For many communities (e.g., rural and Native communities) access to these programs is non-existent. This invokes a question as to whether we are reinforcing inequities in care by creating programs such as CSC that are relatively expensive, have variability in financial support, and may not be sustainable for certain communities with limited resources and infrastructure.

Our call for the need to shift our focus is centered around implications of structural violence and the tenets of structural competency. Through these lenses, we can restructure how and where resources are distributed to meet the needs of communities and compel providers to consider social determinants and structural factors when providing care for individuals with early episodes of psychosis. In doing so, we create greater opportunity for health and well-being among historically excluded communities, whose obstructed access to care otherwise results in disproportionately poor outcomes.

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Box 1

Research and service gaps and priorities for early psychosis

- Additional research to understand the link between neighborhood-level characteristics and access to care, clinical outcomes (e.g., development of psychotic disorders), and service utilization.
- Research that focuses on how to build partnerships and collaborations with existing and established informal community-based organizations to address increase mental health literacy, reduce delays in accessing treatment, and to support the overall wellness of individuals with early psychosis and their families.
- The development of dissemination materials and campaigns that represent and are for Black/African American, American Indian and Alaska Native, Asian, and other ethnoracially minoritized communities.
- Implementation research focused on the integration of services or programs into existing community-based resources (e.g., faith-based in-stitutions, community centers) to help identify, refer, connect, and treat individuals in the early stages of psychosis.
- Recognize that there is shortage in the availability of mental health care workers and invest in the pipeline of not only researchers from underrepresented groups but master-level clinicians from underrepresented groups.
- Development of implementation strategies that are centered on structural competency across multiple sectors of mental health care.
- Increase funding for research that seeks to understand the structural mechanisms obstructing access to coordinated specialty care and other mental health services.
- Recognize that investment is needed in communities with unmet needs (e.g., disadvantaged communities, rural communities) to improve existing infrastructure and conditions.