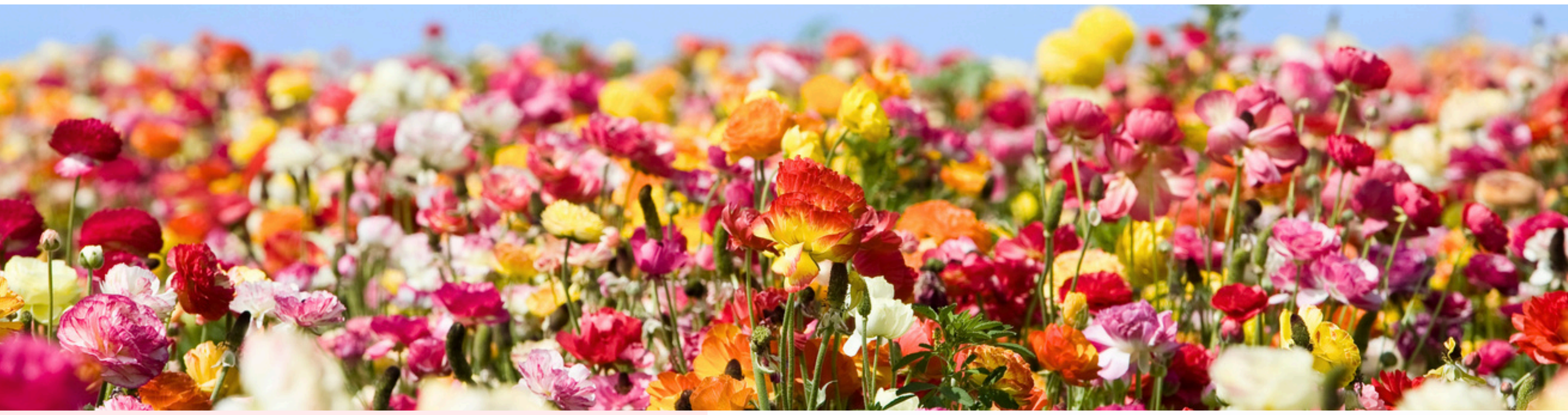
MARYLAND EIP

MARYLAND EARLY INTERVENTION PROGRAM (MEIP):
A COLLABORATIVE FOR THE EARLY IDENTIFICATION AND
TREATMENT OF MENTAL ILLNESS WITH PSYCHOSIS

MAY 2026

MARYLAND EIP SPRING NEWSLETTER



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THE OUTREACH & EDUCATION TEAM

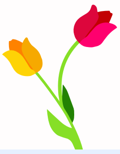
The Maryland Early Intervention Program: A Collaborative for the Early Identification and Treatment of Mental Illness with Psychosis (Maryland EIP; MEIP) offers specialized programs with expertise in the early identification, evaluation, and comprehensive psychiatric treatment of adolescents and young adults with, or at risk for, psychotic disorders. Using an integrated approach, the Maryland EIP is committed to reducing disability by equipping young individuals and their families with tools to address their health and mental health needs, move successfully through the developmental stages of growth, and establish a life of their choosing. **For more information, contact us:**

www.MarylandEIP.com
☎ **1-877-277-MEIP** (6347)
MarylandEIP@som.umaryland.edu
6-minute introduction video

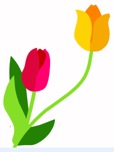
CELEBRATING SPRING'S ARRIVAL WITH THE MARYLAND EIP

Springtime is finally settling in. With the weather ricocheting between sweltering heat and blustery cold, and a slew of world events spreading through our communities and news feeds, it has been easy to feel anxious or overwhelmed. **Now is as good of a time as ever to ground ourselves in the present and take care of our mental health.** Below, we describe an easy and helpful exercise to do just that. **Additionally, May is Mental Health Awareness month** — observed annually to come together, share resources, and support each other's well-being. **Let's light up green in Maryland!**

This edition of our newsletter features an enlightening interview with **Dr. Oladunni Oluwoye**, *Associate Professor in the Department of Community and Behavioral Health at Washington State University* and health services researcher who works to improve family engagement and address inequities and disparities across the continuum of care for early psychosis. **We are enormously grateful to Maia Crumbie**, *doctoral student in the Department of Psychology at the University of Maryland, Baltimore County*, for initiating and conducting the interview as well as composing the Research Highlights on p. 6.



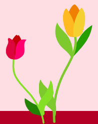
This month we are looking forward to our **virtual spring Advisory Council Meeting** on **May 27th from 12-1:15pm ET**, where we will explore strategies for enhancing referral networks within the Maryland EIP.

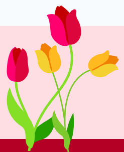


THE 5-4-3-2-1 SENSORY GROUNDING ACTIVITY

During anxious moments when your mind begins to race or your heartrate increases, this five-step exercise can bring you back into your body and into the present moment. Before you begin, pay attention to your breath and remember that slow, deep breaths can help you return to a calmer state.
Once you have steadied your breath, go through the following steps:

- Notice and acknowledge **FIVE things you see around you**, such as a piece of furniture, a spot on the sidewalk, or a tree outside your window.
- Notice and acknowledge **FOUR things you can touch around you**, such as your hair, a piece of clothing you are wearing, or the ground beneath your feet.
- Notice and acknowledge **THREE things you hear**, such as the sound of an air conditioning unit, a bird chirping nearby, or a car passing by on the street.
- Notice and acknowledge **TWO things you can smell**, such as the scent of your skin, a piece of fruit in your kitchen, or a plant outside.
- Notice and acknowledge **ONE thing you can taste**, such as a sip of a beverage, or a piece of gum.





KEEP MARYLAND EIP SERVICES IN MIND THIS SEASON

OUTREACH & EDUCATION SERVICES

For behavioral health and primary care providers, schools, and consumer organizations. For more information or to schedule a presentation to your organization, **contact Cameron Sheedy: csheedy@som.umaryland.edu**

CLINICAL SERVICES

For 12-30-year-olds at risk for, or already experiencing, early psychosis and their family members. Providers include the **Strive for Wellness Clinic**, the **MPRC First Episode Clinic (FEC)**, the **Division of Community Psychiatry's RAISE Connection Program**, and **Johns Hopkins Early Psychosis Intervention Clinic (EPIC)**.

CONSULTATION SERVICES

For providers regarding identification and treatment for individuals experiencing symptoms that may be predictive of future psychosis, who have early signs of psychosis, or are in the initial stages of psychosis.

TRAINING & IMPLEMENTATION SUPPORT SERVICES

For professionals establishing Early Intervention Teams (EITs) to collaborate, share resources, provide support, and coordinate service delivery with others providing early psychosis services throughout Maryland.

SPOTLIGHT ON OUR NEW DIRECTOR

Welcoming Dr. Bennett Into Her New Role!

We are so pleased to have Dr. Melanie Bennett as the new Program Director for the Maryland EIP. Dr. Bennett is a Professor and Director of the Division of Psychiatric Services Research in the Department of Psychiatry at the University of Maryland School of Medicine. She has longstanding involvement in early psychosis treatment and research. She participated as an investigator in the National Institute of Mental Health's Recovery After Initial Schizophrenia Episode Implementation and Evaluation Study. In this role she contributed to the development of the psychosocial intervention components of Coordinated Specialty Care that are specified in treatment manuals used in Maryland and several other states.

Since the MEIP's inception, Dr. Bennett has led the Training and Implementation Support Services team. She currently co-directs Connection Learning Healthcare System – a hub of the National Institute of Mental Health's Early Psychosis Intervention Network (EPINET) that links Coordinated Specialty Care programs in Maryland and Pennsylvania by collecting common data that can be used to examine treatment outcomes, identify service gaps, rapidly implement solutions, and understand if solutions were successful. **As MEIP Program Director, she is excited to support the work of the program to help young people and families connect to and benefit from effective first episode psychosis care in Maryland.**

CENTERING CULTURALLY RESPONSIVE FAMILY ENGAGEMENT:

AN INTERVIEW WITH DR. OLADUNNI OLUWOYE

BY MAIA CRUMBIE

Dr. Oluwoye is an Associate Professor in the Department of Community and Behavioral Health at Washington State University. She co-leads the **APPROACHES to Community Mental Health Co-Lab** and is also a faculty member in the **Promoting Research Initiatives in Substance Use and Mental Health (PRISM) Collaborative**. Dr. Oluwoye's research interests have focused on increasing racial health equity in mental health, with an emphasis on improving access to treatment and treatment delivery in community-based settings. As a health services and disparities researcher her work seeks to improve the pathway to mental health services, including Coordinated Specialty Care for early psychosis, for ethnoracial minoritized families. Much of this work is guided by the use of frameworks centered on culturally informed intervention development or adaptation combined with implementation science methodologies. Dr. Oluwoye is a certified health education specialist and licensed mental health counseling associate. She has extensive experience in the prevention of substance use among racially and ethnically diverse groups, qualitative and quantitative data collection and analysis, mixed-methods research, and program development and evaluation.

Can you tell us a bit about your background and any pivotal experiences that shaped your focus on early psychosis and treatment engagement?

I got my bachelor's in Psychology and my master's in Clinical Psychology from Alabama A&M University. That's where I started focusing on disparities and really getting into research and exposed to research. Then I got my PhD in Health Promotion and Education from the University of Cincinnati. While there, I continued to focus on disparities and substance use prevalence, especially among youth and young adults. I wanted to think about that from a public health standpoint while also leaning on my training as a master's level clinician. I ended up getting a postdoc at Washington State University in the College of Medicine, which is where I am now, focused on intervention development, co-occurring substance use, and serious mental illness.

Once I got to Washington, I was introduced to early psychosis intervention because at that point Coordinated Specialty Care (CSC) was in its first year and just being developed, so it had launched at one site. And I was just like, *oh, this is really cool — we get to figure out what the data portions look like and lean into program evaluation.* I got really interested in implementation science and I wanted to think about that from the lens of CSC since it was in its early development. I think that's where I got mostly pulled into team-based care — the interdisciplinary nature of it — and really focused on families. Especially just from my own family's experiences, in Alabama and then in Nigeria, and looking at how vastly different that is and how cultural aspects influence how you think about psychosis and mental illness. I would say that was probably the most pivotal moment for me in terms of building out things that I was already interested in, and exploring how they were applicable to Coordinated Specialty Care.

(continued)

How do you define "engagement," particularly in the early stages of psychosis, and how has that definition evolved through your research?

I think that engagement is really just service utilization. And when we think about service utilization, we're thinking about in-person attendance — people attending their appointments. And sometimes attendance is the easiest way for people to conceptualize engagement, but there are limitations to that. I think sometimes those words get conflated with each other, and I know that I do that from time to time within my work, but that isn't really the true heart of engagement. A lot of people actually are wanting to engage, they're just not able to attend appointments. And I don't think service utilization captures people's willingness to engage either. Sometimes people are only able to participate in 10- or 15-minute phone calls or by staying in touch in very informal ways that don't fall under traditional expectations of what appointments look like. I think there is a lot of variation and a wide continuum in terms of what engagement really is.

In your work developing culturally responsive family engagement strategies, including projects like FAMES or the Family Peer Navigator model, what have you learned about what facilitates early engagement versus sustained engagement?

I'll give you a little bit of a snapshot about both of those projects. So, Family Peer Navigator's purpose is to address the pathways to care so that we see more people engaged in that initial appointment. It helps with the bridging portion. FAmily Motivational Engagement Strategy (FAMES) helps with sustained engagement during the first three months of treatment, which I would say is the critical window to ensure clients and families are engaged and stay engaged. Family Peer Navigator is just for Black families whereas FAMES is for all families, so they approach culturally responsive care and culture from different angles. FAMES is not limited to thinking about ethnoracial diversity. That is one thing that we have had to let families know, that we're actually not just talking about race or ethnicity. We're talking about where you reside, how you grew up, what religious beliefs and practices you engage with that make up your unique culture, and having a good understanding of that.

With Family Peer Navigator, I think the biggest thing that I've learned is that the grant was particularly built upon the importance of racial congruency, and I don't actually think that is the most important component. I think it matters, but I also don't think in terms of feasibility and scalability that you can develop something purely for Black families with only Black providers or peers. There's a shortage on one side that impacts the sustainability of that. That intervention is also delivered remotely, and so Black families don't even see the person on the other end, they just speak to somebody on the other end. And so, I think what matters most is integrating culturally responsive tools, and having providers and peers be very much aware of their own positionality when entering into those spaces in order to facilitate conversation. I do think there's an element of importance to having racial congruency because there's an effortless connection that can happen, and sometimes a comfort that comes from feeling like someone may have a better understanding of your experiences or be sympathetic to those experiences. That dynamic just naturally comes out in a professional way that may not be as present if there's incongruency. So that's one thing that I learned from Family Peer Navigator.

> ***I think what matters most is integrating culturally responsive tools, and having providers and peers be very much aware of their own positionality when entering into those spaces in order to facilitate conversation.***

(continued)

The other thing is a lot of people are not looking for services, and so how do you create something for Black families who are looking for resources that may actually not be mental health services? Or there are actually a lot of people who are not even eligible for Coordinated Specialty Care because they are beyond the first episode of psychosis. That has made me fundamentally aware of how many people that we are missing, because they didn't even know about Coordinated Specialty Care, and they don't meet the eligibility criteria.

In the pilot phase of FAMES, what I've learned is that families need options. It's not enough to simply say we have a scheduled appointment for you during this 8-to-5 work window because people just don't have that time. They have work, they have other priorities, and so I think it's incumbent upon agencies to think about flexibility, and think about appointment times that are provided in the evenings and over the weekend, when more people are available. If you open that up, I'm pretty sure we wouldn't be seeing the disparities that we see in terms of engagement or service utilization. We also need more flexibility in what engagement looks like and how we capture data related to it. Are we having phone calls with people — even just 20-minute phone calls? That's engagement. Are we sending emails because a particular client is super responsive by emails? That's still engagement. And so how can we be more broad in how we're capturing engagement to map onto service utilization?

When thinking about early intervention, how do historical and structural factors, such as mistrust or prior experiences with care systems, shape how Black families initially interact with services?

Oh, it absolutely shapes all of it. And this is primarily why I like to focus on pathways to care and knowing that there's a pathway across the continuum of care — it doesn't just stop at Coordinated Specialty Care. It involves all of the interactions. It involves those positive experiences, which we talk about most, but it also involves all of those negative experiences that people may have along the way that influence how they show up in Coordinated Specialty Care during that initial meeting. I think the biggest lift that I tell clinicians and CSC providers is really, in that first month you're combatting all of those negative experiences that people have had. And how do you do that in such a short time frame where people are not immediately becoming disengaged because either they're burnt out or they don't trust providers? Especially for families, they may be like, *ok, I got my kiddo here and I am glad that they found the right place, but I need to take a step back*. That is another form of disengagement and I don't think we consider those family components enough. I think for a lot of ethnoracially diverse families, there are complex pathways to care, and as clinicians, we should be aware of that when we approach and enter into different spaces with families.

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> *Are we sending emails because a particular client is super responsive by emails?*
> *That's still engagement.*

RESEARCH HIGHLIGHTS FROM THE MEIP NETWORK

1. Early identification and intervention for psychosis-spectrum experiences can improve long-term outcomes, yet treatment-seeking is often delayed by barriers such as stigma and negative past experiences in care. **Bridgwater et al. (2025)** examined mental healthcare decision-making and barriers to care among 1,904 Mental Health America respondents who completed an online psychosis screening. Individuals with higher levels of psychotic-like experiences (PLEs) were more likely to report needing care and having a plan to seek it, but they also reported lower confidence in their ability to follow through. They were also more likely to endorse barriers such as not knowing what to do next and feeling too overwhelmed to act, with qualitative responses highlighting emotional barriers such as fear and hopelessness. These findings suggest a need for interventions that not only encourage help-seeking but also reduce emotional barriers and make the process of accessing care easier to navigate.
   Bridgwater, M. A., Petti, E., Savill, M., Oh, H., Lucas, K., Nguyen, T., Schiffman, J., & Karcher, N. R.

2. Learning healthcare systems are increasingly being used to connect research, clinical care, and quality improvement in first episode psychosis services. **Marstellar et al. (2025)** describe the development of the Connection Learning Healthcare System (CLHS), a two-state network across Pennsylvania and Maryland that links academic institutions, behavioral health systems, and coordinated specialty care programs. The authors explain how CLHS was built by coordinating data collection, consultation, research, and dissemination across 23 programs. Drawing on implementation science, the paper emphasizes data feedback, learning culture, knowledge translation, stakeholder engagement, and policy alignment as core components of the model. The discussion suggests that future system improvement depends not only on shared data infrastructure but also continued attention to collaboration and mechanisms that support ongoing learning across sites.
   Marsteller, J. A., Goldberg, R. W., Boumaiz, Y., Jumper, M. B. E., Taylor, J., Saravana, A., Buchanan, R. W., Chengappa, R., Conroy, C. G., Dickerson, F., Ered, A., Jones, N., Kohler, C. G., Kreyenbuhl, J., Lucksted, A., Margolis, R. L., Medoff, D., Phalen, P., Sarpal, D. K., & Smith, W. R.

3. Early psychosis services involve multiple stakeholders making it important to understand not only outcomes, but also how care is experienced and implemented. **Reznik et al. (2025)** use examples from the Early Psychosis Intervention Network (EPINET) to argue that qualitative methods can strengthen multiple phases of a learning health system (e.g., adaptation and assessment of barriers, implementation, evaluation, sustainment). Across these examples, qualitative work helped identify client and provider needs and inform intervention and service development. The authors argue that future health trials should integrate qualitative methods from the beginning, support them with appropriate infrastructure, as well ensuring stronger representation of lived experience and marginalized perspectives in research teams.
   Reznik, S. J., Lucksted, A., Myers, N., Jones, N., Savill, M., Pagdon, S., Ereshefsky, S., George, P., Goldman, H., Hayes, S. L., Klodnick, V. V., Nye, K. E., & Williams-Wengerd, A.

RESEARCH OPPORTUNITIES

Strengthening Disability Benefit, Work & School Services in Early Psychosis

With funding from the National Institute of Mental Health, **researchers from the University of Maryland School of Medicine and the University of Pittsburgh School of Social Work are seeking to understand more about youth and young adult decisions related to school, work, and disability benefits** — both while receiving early psychosis intervention services and after discharge.

Study visits include **a brief interview and online survey (3 visits) and a longer interview (3 visits, optional)**. All participants will be compensated $60 for each study visit, totaling up to $360.

Who is eligible to participate? Participants of early intervention in psychosis programs aged 18 and older. Former participants and participants aged 15-17 years old may also be eligible; contact for more information.

Email, call, or text with any questions:
pathways@pitt.edu
(813) 415-5532

or complete this **interest form** to have a member of the research team contact you:

Exploring the Crisis Stabilization Experience

Researchers from the University of Maryland, Baltimore Country Department of Psychology are interested in evaluating the experience for individuals brought into the emergency department for psychiatric crisis stabilization and gathering insights into how this process could be improved.

Participation involves **a short, online survey and an approximately one-hour virtual interview.** Participants will be compensated $25.

Who is eligible to participate? Healthcare providers and peer support specialists who have experience working with psychiatric crisis stabilization, are aged 18 and older, and are fluent in English.

All records and results will be kept confidential. Participation is completely voluntary.

Contact Meghan Mette if you are interested or have any questions:
mmette1@umbc.edu

COLLABORATOR UPDATES

ON OUR OWN OF MARYLAND'S TAY PROJECT

On Our Own of Maryland (OOOMD) is a statewide peer-operated behavioral health advocacy and education organization promoting equality, justice, autonomy, and choice for individuals with mental health and substance use needs. **The Transitional Age Youth (TAY) Project empowers Young Adults 18 to 29 to share their experiences and shape the behavioral health system where they receive care.**

Ongoing opportunities:

- **Mentorship & Leadership:** Gain access and connections to opportunities that will further your personal and professional goals. This can be done through 1:1 virtual meetings.
- **Access to Conferences & Events:** Opportunities to attend and participate in conferences, workshops, and community events that support leadership development, learning, and networking.
- **Certified Peer Recovery Specialist (CPRS) Support:** Young adult Peer Support Specialists or those working towards certification can receive guidance, training support, and assistance navigating the certification process.
- **Free Trainings**: Access to ongoing learning opportunities covering a range of topics that support advocacy, leadership, and professional growth for young adults. Many offer CPRS CEUs!

For more information or to get involved, contact TAY Project Coordinator, Kris Locus: krisl@onourownmd.org

MARYLAND COALITION OF FAMILIES

The Maryland Coalition of Families (MCF) offers family peer support at no cost to parents and caregivers across Maryland. As experienced caregivers, we provide support, guidance, and hope to people who love or care for someone with a behavioral health challenge and advocate to improve the systems they rely on. Our Family Peer Support Specialists provide emotional support, resource connection, systems navigation, support groups, and educational workshops to families who have a loved one with mental health, substance use, or problem gambling disorders.

Our services include:

- Assistance to identify and access resources, services, and programs for themselves or their loved one.
- Providing guidance to navigate complex systems including healthcare, education, or child welfare.
- Offering strategies for self-care.
- Build natural support systems with others on similar journeys.
- Building natural support systems to connect with others on a similar journey.
- Helping parents and caregivers share their stories and use their voice to raise awareness, reduce stigma, and advocate for change.

For more information, please visit www.mdcoalition.org

NAMI MARYLAND

Spring is a season of renewal and at NAMI Maryland, it's also a time to take action.

We're proud to launch our new campaign: **Spring Into Action.** This initiative is all about growth, connection, and hope. Across Maryland, too many individuals and families are navigating mental health challenges without the support they need. Together, we can change that.

Our Goal: $50,000 to expand free programs that directly impact our community, including: Peer-led support groups; Mental health education and outreach; Resources for families and caregivers; Youth and community engagement initiatives

Every dollar helps ensure that no one faces mental health challenges alone.
There are so many ways to get involved:

- **Donate**: Make a gift today to support life-changing programs
- **Participate:** Join an upcoming NAMI Maryland event
- **Share:** Help us spread awareness by sharing our campaign
- **Engage:** Follow along and contribute your voice on social media

No action is too small, because every step forward matters.
This season, let's grow something meaningful together.

NAMI | Maryland
National Alliance on Mental Illness

Spring INTO ACTION

Spring is a time for new growth
and a reminder that change begins with us.
Let's spring into action to build stronger minds,
stronger communities, and a brighter future for all.

ADVOCATE
For policies that support mental health for all.

EDUCATE
Raise awareness and reduce stigma.

SUPPORT
Provide resources and hope to those in need.

HELP US RAISE
$50,000

SCAN ME

Hope Starts with Action.
namimd.org