New Journeys Policy and Procedure Manual

Washington State New Journeys Coordinated Specialty Care

Table Of Contents

Introduction to Early Identification and Intervention for Psychosis

SPECIAL THANKS

This manual was created in collaboration with the Washington State Health Care Authority (HCA), University of Washington (UW), Washington State University (WSU), and various New Journeys team members throughout the state. A special thank you to Becky Daughtry, Maria Monroe-DeVita, Dawn Miller, Katherine LaBranche, Oladunni Oluwoye, Cammie Perretta, Jennifer Peterson, Amber Ranney, Lauren Renard, Khairul Siddiqi, Mackenzie Tennison, Shelby Terry, and John Throckmorton for their contributions to the ongoing improvement and advancement of this manual through monthly workgroup meetings.

PURPOSE & GOALS OF THIS MANUAL

The purpose of this manual is to provide guidelines to ensure consistency in the goals, principles, and delivery of ***New Journeys*** services across Washington State.

This manual is a living document and will be reviewed and revised at least annually. The most current version of this document will be available on the Health Care Authority (HCA) New Journeys and first episode psychosis webpage and may also be accessed on the New Journeys Website.

New Journeys is an adaptation of NAVIGATE, an evidenced based practice for early intervention of psychosis. New Journeys promotes rapid referral and treatment of symptoms of psychosis soon after they appear. Studies show that early intervention for psychosis can change the trajectory of the illness, resulting in a decreased duration of untreated psychosis, reduced need for inpatient hospitalization, improved social and vocational outcomes, a decreased risk of subsequent episodes, and ultimately a decreased risk of long-term disability associated with Schizophrenia Spectrum disorders (Kane et al., 2016).

The broad vision of New Journeys in Washington State is to:

(1) Make screening for early psychosis among youth and young adults a universal health practice
(2) Ensure availability of evidence-based health and recovery support interventions to those in need, with the ultimate objective of decreasing the duration of untreated psychosis (DUP)
(3) Improve the quality of life for individuals experiencing early psychosis and their families

Note on the use of the word “program”

For the purposes of this manual, the word “program” is used to refer to the implementation of the New Journeys Model by a New Journeys team.

CHAPTER 1: NEW JOURNEYS TEAM MEMBER GUIDE[1]

Welcome to New Journeys! New Journeys is a collaboration between HCA, UW, WSU, and various behavioral health agencies throughout the state of Washington. New Journeys is based on NAVIGATE, an evidenced-based Coordinated Specialty Care (CSC) model for youth and young adults ages of 15-40 who are experiencing first episode psychosis (FEP). The primary focus of the model is strategic community outreach and education about FEP as well as targeted program recruitment to decrease DUP in the community in which the team serves. Each New Journeys team serves no more than 30 individuals, at any given time, and teams are expected to provide services wherever an individual is most comfortable, including in home, community, and clinic settings.

Current funding (through the Team Based Rate, TBR) allows individuals to receive treatment from New Journeys for a maximum of 24 months. In 2022, the average duration of participation with a New Journeys team was 22 months (Elson S. Floyd College of Medicine – Washington State University, 2022). However, teams may determine if treatment beyond 24 months is clinically appropriate and may continue to provide services using typical outpatient billing codes, once an individual is no longer eligible for the TBR. Please see Chapter 6 for additional details.

Within New Journeys, the multi-disciplinary team members work collaboratively with the individual experiencing psychosis, as well as their natural supports, to provide evidenced based treatment for FEP. Teams have a responsibility to a) instill hope in individuals about their ability to recover from FEP, b) help them establish and work towards personal meaningful goals, thereby empowering them to make progress towards the lives they want to lead and c) provide the best treatment available for their illness.

Getting Started

To become an established, New Journeys site, potential contractors collaborate with HCA to establish funding and become integrated into the New Journeys Network. Once a site is contracted with HCA, they enter the startup phase. During the startup phase, team members are hired, training is completed, and internal infrastructure to support New Journeys activities are developed. During startup phase, teams will establish an internal referral and screening process and begin case building. Case building occurs once a team is ready to accept referrals and begin providing New Journeys services. Teams will admit no more than three (3) individuals per month to ensures that service intensity expectations can be met. Typically, teams require two years of case building to be considered fully performing and become an attested New Journeys team with a full caseload (25-30 individuals enrolled). An attested provider refers to a team that has completed start-up and is recognized by the New Journeys network as having completed the necessary training to provide New Journeys services and is ready to accept referrals. An attestation form is completed and submitted to HCA documenting the basic training, staffing and fidelity requirements have been met. These phases are discussed in greater detail in Chapter 8.

One of the first tasks of a new site is to staff the multi-disciplinary team. The team consists of several different professional specializations to support an individual in their recovery from FEP. Staffing a full New Journeys team can take time and may require concerted recruitment efforts on behalf of the agency (example Job Descriptions can be found in Appendix A). Agencies can share their job postings with the UW Implementation Team to be shared on the UW SPIRIT Lab Website and with the WSU Measurement Delivery and Evaluation Team to be shared on the New Journeys Website.

[1] Parts of the New Journeys Team Member Manual have been reprinted and adapted with permission from NAVIGATE Consultants and NAVIGATE manual co-authors Susan Gingerich and Kim Mueser (2020). The original manual was written by Kim T. Mueser and Susan Gingerich, with contributing authors (in alphabetical order): Jean Addington, Mary F. Brunette, Cori Cather, Jennifer D. Gottlieb, David W. Lynde, and David L. Penn. The author of the revision of 2020 is Susan Gingerich.

The New Journeys team members are depicted in Figure 1. Team members include: Program Director/Family Education Provider (1.0 FTE), Psychiatric Care Provider (0.25 FTE), Individual Resiliency Training (IRT) Therapist (1.0 FTE), Supported Employment and Education (SEE) Specialist (1.0 FTE), Peer Support Specialist (0.5 FTE), Case Manager and/or Registered Nurse Care Manager (0.5 FTE)[2]. Variations in this staffing model should be approved by HCA and the UW implementation team. More information on each role can be found in Chapter 5.

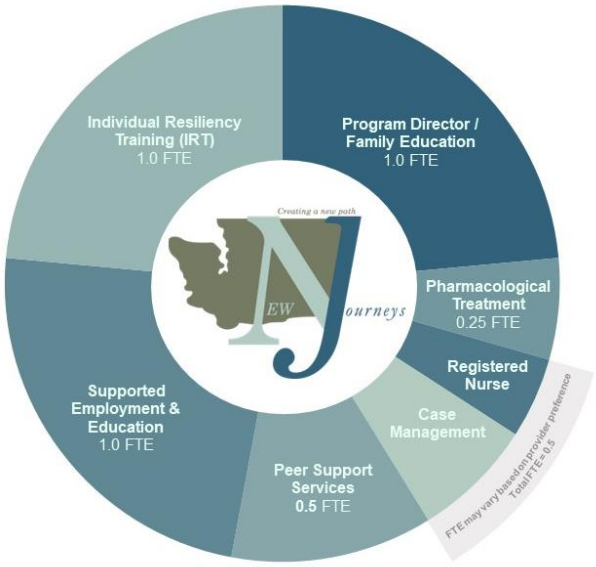


Figure 1. FTE for New Journeys Team Members

Eligibility Criteria

New Journeys is a treatment match model, which means that not everyone who is referred to a New Journeys will be eligible for services. A primary role of each team's Program Director is to complete appropriate screening, including differential diagnosis for each referral that is received. This in-depth screening process becomes a vital service to the community and ensures individuals being referred receive services that best meet their individual needs. Referral, Screening, and Admission are discussed in greater detail in Chapter 12 of this manual. Teams screen referrals for eligibility using the eligibility criteria outlined in Table 1.

[2] Teams may choose to substitute a nurse care manager (~0.2 FTE) for all or part of the case manager FTE count.

Table 1. New Journeys Eligibility Criteria

Eligibility Criteria	**The psychosis is NOT known to be *caused* by:**
1. **Ages 15-40** 2. **Psychotic symptoms have been present between 1 week and 2 years** 3. **Primary diagnosis of one of the following:** • **Schizophrenia** • **Schizoaffective disorder** • **Schizophreniform disorder** • **Brief psychotic disorder** • **Delusional disorder** • **Other specified psychotic disorder** 4. **IQ over 70**[3]	1. Mood disorder with psychotic features 2. Pervasive developmental disorder and/or autism spectrum disorder[4] 3. Psychotic disorder due to another medical condition including medication induced psychotic disorder 4. The temporary effects of substance use or withdraw

Performance Indicators

There are many differences between New Journeys and regular outpatient care. As discussed previously, New Journeys is an evidenced based practice that provides a multi-disciplinary approach to care. As such, case load sizes are lower and additional time is needed for activities such as differential diagnosis of referrals, training and consultation (beyond licensing and agency requirements), fidelity review activities, outreach and education to the community about FEP, etc. The low caseloads, additional support from other team members, and ongoing training make New Journeys a desirable model to be a part of. As teams are starting up, it is important bring awareness to several areas of performance for New Journeys teams. They are divided into the following categories, which are outlined in Table 2 below: Participant services, staff training and consultation, cross-systems collaboration, funding and sustainability, communications, and fidelity monitoring.

[3] The NAVIGATE model is not suited to provide treatment to those experiencing co-morbid intellectual disability with an IQ below 70. This is due to the likely need for ongoing, intensive supports that are above and beyond what NAVIGATE/New Journeys is able to provide but can be provided within the Developmental Disabilities system. Program Directors are not responsible for assessing an individual's IQ but should be aware of this eligibility criterion when gathering collateral information and records during the screening process.

[4] During differential diagnosis, a Program Director should differentiate between psychotic like symptoms that are sometimes seen in autism spectrum disorder and new and emerging symptoms of psychosis indicative of a psychotic disorder. NAVIGATE/New Journeys does not include any training or specific interventions focused on managing the symptoms, behaviors, and cognitive impairments associated with autism. New Journeys providers can work to determine the severity of the symptoms associated with autism and whether or not psychosis is the primary presenting problem. The UW Implementation Team provides consultation related to Differential Diagnosis to help assist Program Directors in these situations.

Table 2. Performance Indicators

Area	Goals	Interventions
Participant Services	Meet individuals where they are at: inspire hope and eliminate barriers to treatment that are traditionally experienced by those experiencing FEP. New Journeys aims to reduce the risk of individuals dropping out of services and works to increase their overall quality of life.	Provide an array of Medicaid and State funded services as outlined in the New Journeys Model. Including but not limited to: • Community Education and Outreach • Screening of referrals and differential diagnosis of FEP • Behavioral Health intake evaluations and assessments • Individual Treatment Services • Family Education and Treatment • Therapeutic Psychoeducation • Case Management • Psychiatry/Medication Management • Community Support Services • Peer Support • Supported Employment/Education (SEE) • Other New Journey services such a psychoeducational group and/or multifamily groups. • Interpreter Services
Staff Training and Consultation	Ongoing education and consultation for New Journeys staff	Each team member should attend New Journeys specific training, including but not limited to: • WSU orientation and training • UW startup training • Monthly role specific consultation calls • Monthly ECHO Clinics • Monthly Differential Diagnosis call • Pat Deegan Common Ground Academy + Library • Other orientation and training opportunities as identified by the UW implementation team and WSU evaluation team
Fidelity Monitoring	To evaluate adherence to the model, areas of success, and identify areas for additional support and training.	• Each New Journey team will participate in annual Fidelity Monitoring • Each team will utilize the New Journeys Assessment Battery and enter data into the New Journeys data platform • Selected members of each New Journeys team will be trained as peer reviewers for the fidelity review process
Funding and Sustainability	Each agency will develop internal processes with the agency to optimize reimbursement to support a financially sustainable program that is adequately supported to provide services to fidelity.	• Administration will set up budgets, manage resources, and maximize billing practices to support the teams to function to fidelity of the model • Administration will optimize braided funding sources through contractual agreements available in their region

Using the NAVIGATE Manuals

As you are getting started, it is important to not only become familiar with the materials in this manual but also with the NAVIGATE model of CSC from which New Journeys was developed. New Journeys uses the NAVIGATE materials, including the NAVIGATE manuals for the following team roles and respective interventions: Program Director, Family Education, Individual Resiliency Training (IRT), Supported Employment and Education (SEE) , and Psychiatric Care Provider. When NAVIGATE was developed, they did not yet have a Peer Specialist or Case Manager on the team. As a result, there is currently no Case Manager manual. New Journeys does use the Peer manual developed by OnTrackNY. A Nurse Care Manager Manual was developed by the UW Implementation team and available to teams with Nurse Care Managers.

The NAVIGATE manuals will familiarize team members with the background and conceptual framework of each intervention and provide critical tools to implement each service component. No one is expected to master all the material contained in each manual at one time. Learning for each team member takes place throughout their role; through the implementation of the manual and materials in sessions with individuals and their natural supports, by participating in team meetings and supervision, as well as by engaging in monthly consultation calls, ECHO Clinics, and ongoing training with the UW Implementation Team (more information about consultation and ECHO is included in Chapter 7 and Appendix B).

As you learn about NAVIGATE and use the interventions outlined by your role, it may be helpful to have your manual with you during sessions and become familiar with the session guidelines, handouts, and worksheets in advance. Such preparation helps with a mutual learning process between the clinician, the individual, and natural supports. Everyone has something important to teach the other and the shared learning experience will be helpful to working together on the individual's goals.

CHAPTER 2: RATIONALE FOR TREATING FEP WITH COORDINATED SPECIALTY CARE (CSC)

The Long-term Disability of Schizophrenia

Schizophrenia is a major mental illness characterized by psychosis, negative symptoms (e.g., apathy, social withdrawal, anhedonia), and cognitive impairment. Depression and substance abuse commonly co-occur with schizophrenia spectrum diagnoses. Individuals with schizophrenia spectrum disorders can have challenges in the areas of work, school, parenting, self-care, independent living, interpersonal relationships, and leisure time.

Among adult psychiatric disorders, schizophrenia is the most disabling. Only 1% in the general population has schizophrenia, but over 30% of all spending for mental health treatment in the U.S. in 2001 was accounted for by schizophrenia—about $34 billion (Mark et al., 2005). The high cost of treating schizophrenia is only one dimension of the impact of the illness, which has major effects on individuals, families, and society. The toll that schizophrenia takes, including premature death, family caregiving, unemployment, criminal justice costs, and physical and emotional distress, is striking (Samnaliev & Clark, 2008). According to the World Health Organization, the combined economic and social costs of schizophrenia place it among the world's top ten causes of disability worldwide (Murray & Lopez, 1996). Considering the magnitude of the impact of schizophrenia, interventions designed to treat the disorder effectively at the earliest possible point (e.g., during the first episode of psychosis) have the potential to improve individual's long-term trajectory, and to reduce the global burden of the illness.

Why Coordinated Specialty Care (CSC)?

On average, people may experience new psychotic symptoms for months, and sometimes even years, before receiving any psychiatric treatment (Häfner et al., 2003; Perkins et al., 2005). There are multiple reasons an individual may delay treatment, including the stigma of mental illness and schizophrenia, a lack of awareness of the signs of psychosis and the resources to treat such disorders, individuals may be aware that something unusual is happening but may not know that the changes are signs of a treatable mental illness (Corrigan, 2004; Judge et al., 2005). These factors can prevent individuals from getting the support they need, and may result in individuals with psychosis facing houselessness, incarceration, and isolation from natural supports due to mental illness-related behaviors (Teplin, 1994; Teplin et al., 1996).

Even when treatment for a first episode of psychosis is successfully initiated, individuals often face challenges when the treatment does not adequately address their specific needs and goals. Treatment may be incomplete, for example it may include medication but no education of illness self-management skills (such as the prevention of relapses) and no skills training for improving their functioning and quality of life. When medication is provided, non-adherence is a major problem, which leads to increased relapse rates and increased problems with daily functioning (Robinson et al., 1999). Research has shown that, when compared to treatment as usual, CSC can be an effective tool in addressing these issues and helping an individual get the support they need (Kane et al., 2016).

CSC is based on models originally implemented in other countries, primarily Australia, England, New Zealand, and Canada. CSC is considered the gold standard, evidence-based approach to delivering effective treatment for individuals and families experiencing a first episode of psychosis. Early intervention with evidence-based treatment decreases the DUP, improves outcomes over a lifetime, and results in reduced healthcare costs and improved quality of life for individuals and their natural supports. The goal of CSC is to fundamentally change the trajectory and prognosis of schizophrenia through coordinated and systematic treatment in the earliest stages of the illness (Heinssen, Goldstein, & Azrin, 2014).

The National Institute of Mental Health (2022) defines Coordinated Specialty Care as[5,6]:

> *"a recovery-oriented, team approach to treating early psychosis that promotes easy access to care and shared decision-making among specialists, the person experiencing psychosis, and family members.*
>
> *Specifically, coordinated specialty care involves multiple components:*
>
> ***Individual or group psychotherapy** is tailored to a person's recovery goals. Cognitive and behavioral therapy focuses on developing the knowledge and skills necessary to build resilience and cope with aspects of psychosis while maintaining and achieving personal goals.*
>
> ***Family support and education programs** teach family members about psychosis as well as coping, communication, and problem-solving skills.*
>
> ***Medication management** involves health care providers tailoring medication to a person's specific needs by selecting the appropriate type and dose to help reduce psychosis symptoms.*
>
> ***Supported employment and education** services aim to help individuals return to work or school, using the support of a coach to help people achieve their goals.*
>
> ***Case management** allows people with psychosis to work with a case manager to address practical problems and improve access to needed support services."*

History of Treatment Programs for FEP

Major advances in treatment programs have been made for people with a first episode of psychosis over the last 20 years. However, until the National Institute of Mental Health's (NIMH) Recovery after Initial Schizophrenia Episode (RAISE) research initiative, all of the treatment development and research on model programs for FEP occurred outside of the U.S., primarily in Australia, New Zealand, Europe, and Canada. For example, in an Australian treatment program (Early Psychosis Prevention Intervention Center: EPPIC), 65 individuals were treated and followed for 8 years after initial treatment (Mihalopoulos et al., 2009). At 8-year follow-up, people who received EPPIC treatment had decreased symptoms, displayed fewer positive symptoms of psychosis, were more likely to be in remission, and were more likely to be participating in employment compared to those in control groups. Additionally, the specialized EPPIC program cost one-third as much as treatment as usual because it was more effective at reducing the long-term impacts of psychosis.

[5] New Journeys has also included Peer Support and Nurse Care Management as service components to the CSC model being used across the state

[6] New Journeys considers both family members and other natural supports in implementation of the model

Limitations of Treatment Models Developed Abroad for the U.S. Context

Some of the treatment programs that were developed abroad are not feasible to implement in the U.S. for several reasons. First, the treatment programs developed abroad have usually been offered in systems where the entire population in a particular area is covered by a regional medical system that takes responsibility for the health of the population, allowing for the use of fully employed teams, outreach, and public education approaches. In contrast, the U.S. has fragmented treatment and payment systems, in which no single organization or service takes full responsibility for the treatment of people with psychosis. Also, the comprehensive treatment models for FEP programs prior to the RAISE research initiative had been provided in large cities that allowed for use of a full-time team. However, in the U.S., mental health services are usually provided by local community mental health centers (CMHCs) that often serve smaller geographic catchment areas, such that staffing a first episode program presents challenges.

Second, an important part of FEP programs developed abroad has been the use of a major public health campaign to educate the general population about psychosis and its treatment. These campaigns have been combined with outreach and education to people who are likely to have contact with individuals first experiencing psychotic symptoms, including teachers, police, doctors, emergency room staff, and clergy. In the U.S., such major public education campaigns and outreach efforts have not been a priority. In some ways, the U.S. system appeared in the past to focus more on preventing people from entering treatment until the symptoms were so bad that treatment was unavoidable, rather than trying to engage individuals with psychosis into treatment early in order to improve their lives and prevent long-term disability.

In summary, the NAVIGATE program (or, as our adaption is known in Washington State, New Journeys) is the result of a response to the need to develop a program for the comprehensive treatment of people with FEP that can be implemented and funded within the current U.S. public health care system.

NAVIGATE Outcomes

In 2008, NIMH funded two large-scale studies through the RAISE initiative. One of those studies (RAISE Early Treatment Program – RAISE-ETP) included the first multi-site study comparing the NAVIGATE model of CSC to Community Care (i.e., usual care) with 404 individuals in community mental health settings experiencing FEP. Participants were assigned NAVIGATE vs. community care from 34 different agencies across 21 U.S. states. Seventeen of these 34 mental health sites in the U.S., including urban, suburban, and rural settings, and sites serving people from diverse ethnic and cultural backgrounds, provided NAVIGATE services[7].

Compared to participants who received treatment as usual, NAVIGATE participants:

- Stayed in treatment longer
- Experienced more improvement in overall symptoms and quality of life
- Were more likely to receive prescriptions that conformed to best practices
- Experienced fewer medication side effects

Summary of CSC Outcomes and Cost-Effectiveness

Since the development of the NAVIGATE model in the RAISE-ETP study, studies have found that CSC programs improve outcomes for individuals experiencing FEP. Individuals who receive treatment with a CSC team experience significant improvements in quality of life and psychiatric symptoms. Specifically, CSC teams help reduce the impacts of positive and negative symptoms of psychosis, depression, mood, and anxiety. In addition to impacting psychiatric symptoms, CSC teams have positive impacts on functional outcomes, including education, employment, social and

[7] To learn more about the results of the RAISE-ETP research project, you can find a list of publications up to March 2020 cited at the end of this chapter.

interpersonal skills, and global functioning (Uzenoff et al., 2012; Brieitborde et al., 2015; Daley et al., 2020; Dixon et al., 2015; Kane et al., 2016; Calkins et al., 2020; Kohler et al., 2020; Tanzer et al., 2021, Oluwoye et al., 2020). It should be noted that clinical and functional outcomes can differ based that on race, ethnicity, socioeconomic status of individuals, and DUP.

Cost-effectiveness from the initial NAVIGATE program in the RAISE-ETP study concluded that CSC programs are more cost-effective than typical community care, with CSC program benefits exceeding costs when adjusted for Quality Adjusted Life Years (a generic measure of disease burden; Rosenheck et al., 2016). Although CSC did not reduce the number of individuals receiving Social Security Administration disability benefits, individuals experiencing lower functioning and higher disability from psychosis was found to increase enrollment in disability benefits (Rosenheck et al., 2017; Humensky et al., 2017; Smith et al., 2018). Since the initial RAISE-ETP study, CSC programs have continued to indicate cost-effectiveness, as individuals engaged in these programs have fewer emergency room visits, hospitalizations, and inpatient services than individuals not engaged in CSC programs (Srihari et al., 2015; Liffick et al., 2016; Murphy et al., 2018; Nossel et al., 2018; Calkins et al., 2020).

CHAPTER 3: HISTORY OF NEW JOURNEYS IN WASHINGTON STATE

Washington State New Journeys

In 2014, Congress appropriated funds to the Substance Abuse and Mental Health Services Administration (SAMHSA) to address the needs of individuals experiencing early serious mental illness. This grant is called the Community Mental Health Services Block Grant (MHBG), and includes funding for all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and 6 Pacific jurisdictions. SAMHSA directed states to use a five percent (5%) set aside from their portion of the MHBG to serve youth ages 15 to 25 experiencing a first episode of psychosis. In 2015, the set aside was increased to ten percent (10%).

This funding provided the opportunity for Washington to launch ***New Journeys***, CSC model based on NAVIGATE. New Journeys was developed through the Division of Behavioral Health and Recovery (DBHR) partnerships with UW and WSU to provide services to individuals experiencing FEP, curated specifically to the needs of youth and young adults here in Washington.

After the success of the initial New Journeys Pilot site in Yakima in 2015, The Children, Youth, and Family Behavioral Health Workgroup (CYFBWG) advocated for Second Substitute Senate Bill (2SSB) 5903. which was passed in 2019. This legislation was accompanied by state Proviso funds that were designated for statewide expansion of New Journeys, along with MHBG funds.

This legislation called for the creation of a Statewide Implementation Plan for evidence-based recovery supports, development of a financing strategy for Medicaid, and statewide expansion of New Journeys based on incidence of FEP in Washington's population. The Statewide Implementation Plan of Coordinated Specialty Care for Early Psychosis was prepared by the Washington Council for Behavioral Health (WCBH) and was submitted to the Legislature on January 28, 2021. This plan outlined the steps for strategic statewide implementation and strategies for funding evidence-based recovery services for FEP.

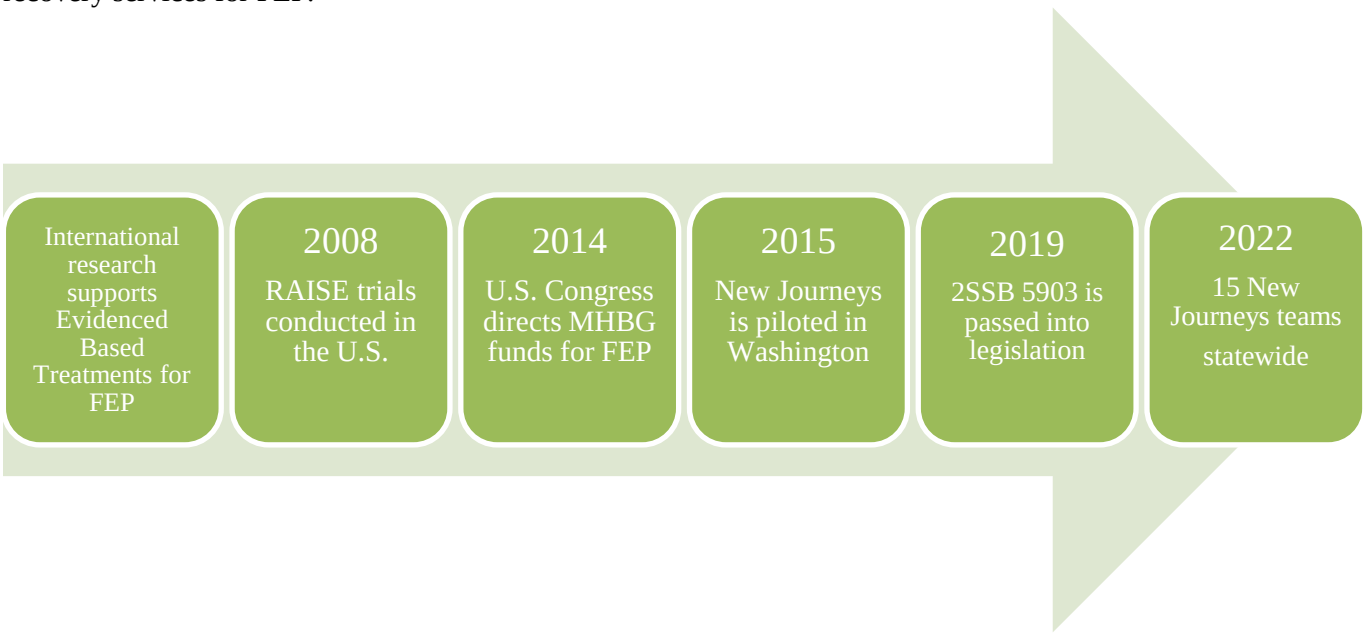


Figure 2. Timeline of Washington State New Journeys Implementation

Since that time, New Journeys has increased from a single team in 2015 to 11 teams in 2022. An additional four teams launching in 2023 bringing the total to 15 teams statewide. These new teams will provide increased access in the Spokane, Great Rivers, Salish, and North Sound regions. Continued expansion aims to provide equitable access to these vital services throughout the state, including in geographical areas that may have reduced availability of resources. Expansion efforts will also provide opportunities to address the unique needs that are present in the various areas of our state, including work on adapting the model to better fit the needs of rural and Tribal communities.

Figure 3. New Journeys Team Locations as of September 2023

New Journeys Outcomes

Like NAVIGATE and other CSC models, New Journeys has also yielded many positive outcomes since this model was implemented in Washington State in 2015 (Oluwoye et al., 2020). From 2015 to September 2022, a total of 1,189 referrals were made to New Journeys teams across the state. Of the 1,189 referrals, 730 individuals met eligibility requirements, and 612 received services (84%). (Elson S. Floyd School of Medicine, 2022).

The New Journeys 2022 Evaluation Report suggests that individuals who participated in New Journeys experienced (Elson S. Floyd School of Medicine, 2022):

- A reduction in reported symptoms of psychosis
- A significant decrease in reports of depression
- A significant decrease in reports of anxiety
- A decrease in reported psychiatric hospitalizations
- Improvements in quality of life
- An increase in school enrollment from baseline at 17% to 44% after receiving services
- Attendance or procurement of at least part-time work or volunteering increased from 20% reported at enrollment to 55% post-enrollment
- Report a decrease in overall substance use since enrollment

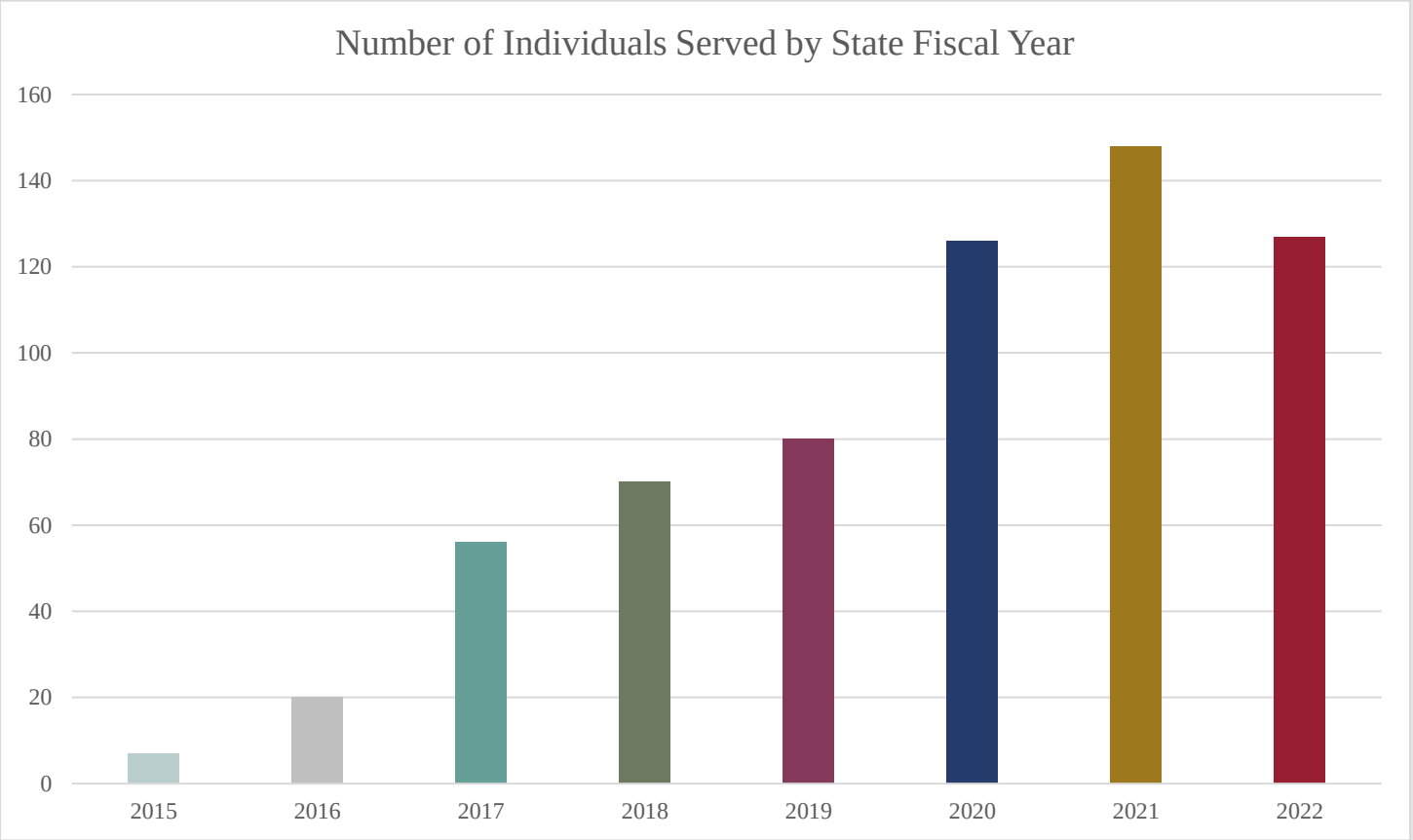


Figure 4. New Journeys Enrollment by State Fiscal Year (SFY). *This figure illustrates the number of individuals who started services with New Journeys since 2015. State fiscal year falls between October 1st and September 30th; as such, the 2022 SFY as captured by this report does not include the last month of the year. Data on enrollment date was missing for eleven individuals.*

Addressing the Need in Washington State

Incidence rates of psychosis in Washington State match those across the U.S. and worldwide. In SFY 2021, Washington State Department of Social and Health Services' Research and Data Analysis (RDA) Division identified 4,388 Medicaid enrollees under the age of 65 in Washington who received their first psychotic diagnosis. Among them, 1,956 were between the ages of 15 and 40 and received at least one psychotic disorder diagnosis covered by New Journeys (Figure 5). However, this is likely a conservative estimate of the incidence of FEP, because it does not include individuals who were experiencing symptoms but did not encounter a Medicaid provider. This estimate only accounted for individuals enrolled in Medicaid or dually enrolled in Medicare during two of the last three years. Individuals newly enrolled in Medicaid or those with commercial insurance were not accounted for.

FEP Cases Among Medicaid Enrollees
SFY 2021 TOTAL STATEWIDE = 4,388

Potential Cases Meeting New Journeys Criteria
SFY 2021 TOTAL STATEWIDE = 1,956

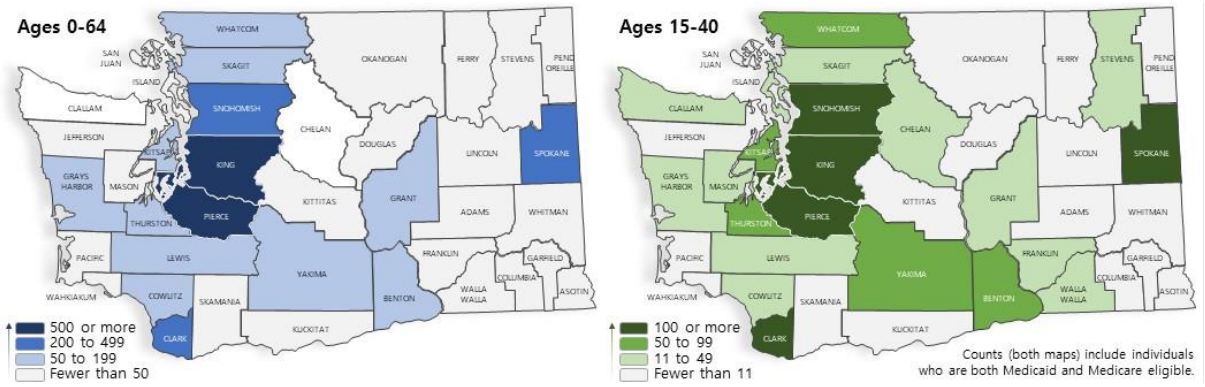


Figure 5. Estimated First Psychotic Diagnoses among Medicaid Enrollees by County

CHAPTER 4: CONCEPTUAL FRAMEWORK

People diagnosed with a schizophrenia spectrum disorder may experience an array of symptoms including psychotic experiences, negative symptoms, cognitive impairment, depression, and anxiety. Psychotic symptoms may include hallucinations, delusions, and/or disorganized thinking/behavior. Individuals may also experience prominent negative symptoms, such as a lack of expressiveness or motivation, which are defining characteristics of schizophrenia and schizophrenia spectrum disorders. Problems with cognitive functioning can present as confused thinking, which may interfere with work, independent living, and social relationships (Green, 1996; McGurk & Mueser, 2004). Depression and anxiety are also common features of schizophrenia, although they are not included in the diagnostic criteria. Depression and/or high levels of anxiety may be the first sign of the illness before the onset of psychotic symptoms (Häfner et al., 1999), and depression often remains one of the most persistent syndromes among people with schizophrenia (Häfner & an der Heiden, 2008).

Due to the complexity of challenges an individual experiencing psychosis may face (including long term disability, increased risk of hospitalization, and increased risk of homelessness. This topic is outlined in further detail in Chapter 2), young people experiencing FEP are especially vulnerable to suicidal ideation and suicide attempts (Power, 2004). Moreover, one-half of individuals with this illness develop substance use disorders (abuse or dependence). Overall, these symptoms negatively impact components of an individual's recovery and resiliency, including social/leisure functioning, well-being, and role functioning. However, there is hope! Early detection and intervention of psychosis can fundamentally change the trajectory of the illness. CSC teams utilize various strategies to help individuals experiencing FEP live their life, rather than being defined by their symptoms or diagnosis. New Journeys, and the NAVIGATE model, utilized multiple recovery-oriented frameworks outlined throughout the rest of this chapter.

Recovery and Resiliency

New perspectives on recovery and resiliency do not focus on the severity or persistence of psychiatric symptoms, rather the focus is on a person's ability to experience a rewarding and meaningful life. As Pat Deegan puts it, recovery orientation is shifting the focus from "what's the matter with you" to "what matters to you. Anthony (1993) defined recovery as, "the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness." This way of thinking about recovery and resiliency is consistent with models of positive health, which identify mental health is improved through leading a life of purpose and having quality connections with others (Ryff & Singer, 1998). New Journeys utilizes this recovery-oriented approach that builds on an individual's capacity for resiliency.

The *President's New Freedom Commission Report* (2003) affirmed the pursuit of recovery and resiliency as an important focus of mental health treatment. According to the *Report*, "Recovery is the process in which people are able to live, work, learn, and participate fully in their communities". The Commission also called for a transformation of the mental health system and argued for a system level approach focusing on service recipients and their families as partners in the mental health system. Treatment choice should be guided by shared decision-making with recovery and resiliency as the primary goal.

New Journeys embraces this view of recovery and resiliency. Specifically, we define recovery and resiliency as:

- *Social/leisure functioning* (e.g., quality of social relationships, involvement in leisure activities, independent and self-care living skills)
- *Role functioning* (e.g., school, work, parenting)
- *Well-being* (e.g., self-esteem, hope, sense of purpose, enjoyment of life)

Illness Management

Illness management approaches to treating schizophrenia derived from the stress-vulnerability model (Liberman et al., 1986; Nuechterlein & Dawson, 1984; Zubin & Spring, 1977). Illness management helps people achieve recovery and

resiliency by teaching information about the symptoms of mental illness, helping them control their symptoms, and helping them prevent relapses so that they are better able to pursue their personal goals.

The Stress-Vulnerability Model

The Stress Vulnerability model (see Figure 6) demonstrates that schizophrenia spectrum disorders are a result of both biological vulnerabilities and the stress an individual encounters and how they manage it. Biological vulnerabilities, or genetic predispositions, are determined early on in life through factors of heritability and prenatal health. Ongoing biological vulnerabilities may include alcohol and drug use and whether or not someone takes their medications as prescribed. Stress factors, may include certain personal experiences, including adverse childhood events, lifetime trauma exposure, and lack of adequate resources are associated with an increased risk of psychosis and schizophrenia (Varese, F., 2012; Hunt et al, 2018). Recent research has also shown that social determinants of health such as low socioeconomic status, urbanization, and residing in communities with low ethnic density increase risk appear to increase the risk of schizophrenia (González-Pardo and Pérez-Álvarez, 2013; Zubin and Spring, 1997).

The indicators in the stress-vulnerability models are risk factors, not guarantees. Individuals may experience these factors without developing psychosis. The onset and course of psychosis symptoms are impacted by these biological and psychosocial factors and are unique to each individual.

The principles of illness management, based on the stress-vulnerability model, indicate that the outcomes of schizophrenia can be improved by reducing biological vulnerability and stress.

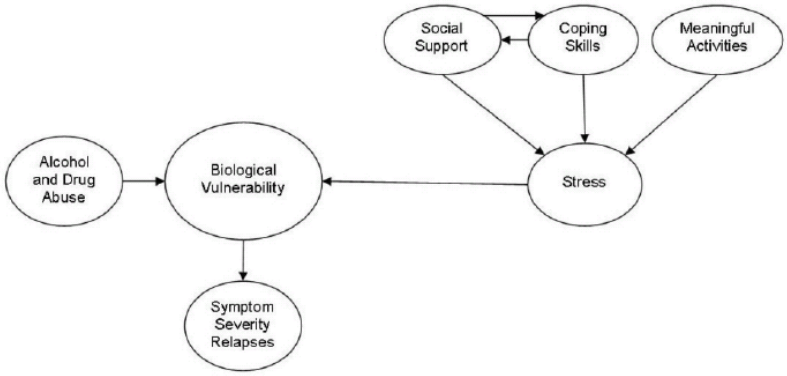


Figure 6. Stress-Vulnerability Model (Zubia and Spring, 1977)

Stress, such as upsetting life events, can lead to relapses and a decline in functioning. The impacts of stress on an individual's vulnerability can be mitigated through things such as positive *social support*, the use of *coping skills*, involvement in meaningful activities, and access to necessary resources.

Substance abuse is another important biological factor that can impact a person's vulnerability, leading to relapses of psychosis and hospitalizations.

Biological vulnerability can be reduced in two ways. First, taking antipsychotic medications as prescribed can reduce biological vulnerability by changing the way nerve tracts in the brain function. Tracts that use the neurotransmitters dopamine and serotonin are believed to play a central role in the symptoms of schizophrenia, and the functioning of these systems is improved by using antipsychotic medications. Second, since substance use can worsen biological vulnerability, minimizing use and engaging in *substance use treatment* can also reduce this vulnerability when applicable.

Treatments that reduce stress in the environment, increase social support, or increase coping skills can also reduce symptom severity and prevent relapses. Environmental stress in the family can be reduced by providing *family education* aimed at teaching the natural supports about the nature and principles of treatment for schizophrenia, obtaining their support for the individual's involvement in treatment, and learning low-stress strategies for communicating and solving problems together. Environmental stress can also be reduced by helping the individual get involved in meaningful activities that structure the person's time without being overly demanding. An individual's coping skills can be bolstered

in several ways, including providing participants with information about schizophrenia and its treatment, and teaching them strategies for:

- Managing stress
- Monitoring symptoms
- Preventing or minimizing symptom relapses
- Coping with symptoms
- Using social skills to garner social support

Psychiatric Rehabilitation

Treatment should focus directly on helping people work towards recovery and resiliency outcomes. Three psychiatric rehabilitation approaches are used in NAVIGATE to address different parts of recovery and resiliency; supported employment/education targets improved role functioning and achievement of personal meaningful goals, social rehabilitation targets social and leisure functioning, and resiliency training targets personal well-being. In addition, family (and/or other social) support can facilitate progress toward participant goals.

- **Building Hope and Resilience**. New Journeys aims to support individuals in developing a sense of well-being, including positive emotions, self-esteem, hope, and a sense of purpose. Resilience, the ability to spring back from adverse life experiences (Neenan, 2009), is relevant when considering the life altering effect of a psychotic episode. The IRT component of NAVIGATE emphasizes hope and resiliency. This is especially important for people with a first episode of psychosis, who may have a sense of hopelessness and loss of control (Perry, Taylor, & Shaw, 2007).
- **Supported Education and Employment**. Supported Employment is the most effective approach for improving competitive employment outcomes in people with severe mental illness (Bond et al., 2008). A trained employment specialist provides individual services to all participants who have a goal of gaining employment. The goal is to find competitive work in community settings (not sheltered or transitional work) with a rapid job search, rather than through long vocational assessments or prevocational trainings. The employment specialist pays attention to the individual's preferences (e.g., type of job and decision about disclosures of mental health symptoms to employers) and provides follow-along support after the individual starts a job, rather than discontinuing support after the individual obtains a job (Becker & Drake, 2003). The principles that have been developed in the field of supported employment are applied by New Journeys teams to help people with FEP to also achieve their educational goals (Killackey et al., 2008; Nuechterlein et al., 2008).
- **Social Rehabilitation or Skills Training Methods**. People who develop psychosis often have impaired social functioning and may have lost friends and other social supports following a psychotic episode. In response, social rehabilitation methods help people develop better social, leisure, and independent living functioning (Kurtz & Mueser, 2008). To improve social skills, team members provide modeling, utilize role playing, provide feedback, and practice of skills in sessions and in natural settings. Efforts to help social adjustment can make a big difference in someone's social functioning (Falloon et al., 1998; Herrmann-Doig et al., 1993; Petersen et al., 2005).
- **Family and Other Natural Supports**. Family, friends, and others in a participant's network can provide vital social support. In addition, they can help the individual with illness management and other types of rehabilitation and provide direct assistance in attaining goals. (Compton & Broussard, 2009; Mueser & Gingerich, 2006).

Special Issues for People Experiencing First Episode of Psychosis

New Journeys, and the NAVIGATE model, were informed by three specific challenges for many people with FEP: (1) engagement, (2) getting back on their developmental track, and (2) processing the trauma of the onset of psychosis.

Special Issues of Engagement

Young adults utilize outpatient mental health services less than any other age group. Moreover, data suggests that 46% of those who meet the criteria for Severe Mental Illness (SMI) do not receive treatment. Unfortunately, individuals with SMI who do not receive treatment are at an increased risk of spending time in hospitals, jails, and crisis situations, and research indicates youth and young adults benefit from support to navigate transitions between these situations (IOM, 2015; CMHS, 2011; National Survey of Drug Use and Health, 2018). New Journeys provides this support during a vital time in someone's life through targeted community education (to facilitate identification of FEP in community settings and through establishing and referral processes to New Journeys), enhanced engagement and outreach efforts to those referred and enrolled in services (including seeing someone wherever they're most comfortable including clinic, home, school, and community settings), and meeting individuals where they are in their recovery process.

The 2022 New Journeys Annual Report demonstrates successful service utilization and improved functional outcomes for individuals engaged with a New Journeys team, citing that individuals and their natural supports collectively attended nearly 80% of all scheduled appointments with New Journeys teams across the state in 2022. This success is largely a result of community-based services and the engagement and outreach provided by the team which functions to remove barriers to accessing care and ultimately decreases dropout rates in this underserved population (Oluwoye et. al 2022).

Getting Back on Track

The onset of psychosis can knock young people off their developmental path (such as completing high school/GED, going to college, getting their first job, developing intimate relationships, or parenting a young family). The longer psychosis goes untreated, the more disruption in functioning the individual may experience. When an individual recently experienced a psychotic episode, they are often acutely aware of their functional problems, which may add to feeling demoralized and hopeless (Birchwood et al., 1998; Lewine, 2005).

For many, the first step is identifying actionable and feasible goals. When planning treatment, developmentally appropriate goals that are based on the individual's age, culture, family, and personal history should be identified. New Journeys clinicians work with participants to identify and address goals that are designed to support development. This focus helps to engage and retain people in treatment because it maximizes the relevance of the program to their lives.

Processing the Trauma of Psychosis Experiences

People who experience psychosis may experience frightening hallucinations and delusions. Individuals who also report traumatic treatment experiences, such as involuntary hospitalization, physical restraints, and/or forced medication administration Williams-Keeler et al., 1994). These traumatic experiences can lead to distressing symptoms of posttraumatic stress disorder (PTSD), such as upsetting memories of psychotic symptoms or negative treatment experiences, avoidance of stimuli that remind the person of the traumatic events, and increased physiological arousal (Mueser et al., 2010). Furthermore, these events may trigger stigmatizing beliefs about mental illness that contribute to maladaptive functioning (Corrigan, 2004; Penn et al., 2005).

Within New Journeys, there is a specific module in the IRT manual called "Processing the Psychotic Episode," this module can be important to help an individual process the experience of psychosis and begin feeling hopeful about the prospect of recovery (Jackson et al., 2009). This conversation also provides the team an opportunity to address inaccurate and stigmatizing beliefs that the individual may have. Open dialogue about psychosis can aid in enhancing an individual's resiliency as they face the challenges before them while developing and using coping strategies. This resiliency building process allows people to avoid developing maladaptive coping responses that may occur in the absence of targeted treatment (e.g., withdrawal, resignation, substance use, or disengagement).

The choice, timing, and intensity of the different interventions are determined jointly by the individual, their natural supports, and the New Journeys team. Person-centered treatment planning meetings and treatment review meetings with

the individual and family occur regularly to choose services, monitor progress toward treatment goals, and modify treatment plans to be as responsive and helpful to the participant as possible.

Two Phases of New Journeys

In the initial phase of treatment with New Journeys, people often require intensive support and have an increased need for outreach for engagement. This phase requires active efforts on the part of the team that is more time intensive than what is generally available with regular outpatient services. As time goes on, and the individual's symptoms begin to stabilize, and they take steps toward their goals, they may begin to decrease the frequency of their support from the New Journeys team as they develop confidence moving forward with their goals. For some individuals, a greater duration of activities to assist in engagement and stabilization may be needed while for others, this will be a brief aspect of their time with the New Journeys team. While these typical phases are described below in greater detail, it is important to note that teams must be responsive to the needs of an individual and service intensity may fluctuate during an individual's time with New Journeys.

Engagement and Stabilization Phase

During the engagement and stabilization phase of New Journeys, the treatment team works closely to engage with the individual and their family/natural supports to assess areas of greatest need. The primary purpose of this phase is to illicit motivation for treatment, address immediate needs, and manage distressing symptoms. New Journeys encounter data indicates this phase lasts through the first six months of treatment, although individual experiences may vary due to clinical status (i.e., whether the individual is experiencing acute symptoms of psychosis or whether the symptoms are remitting). The goals of this phase are to:

- Engage the individual and natural supports in treatment, including meeting members of the New Journeys team and having short (20 minute) meetings with each, if possible
- Initiate assessment, goal setting, and treatment planning
- Initiate and adjust medication to treat symptoms
- Address urgent basic needs, such as housing, medical problems, and legal issues

Connecting the individual and their natural supports in services as soon as possible following the psychotic episode is critical. During this critical period, an individual's natural supports are most likely to engage in their loved one's treatment and may be more open to acknowledging stress, expressing concerns, and receiving help from mental health professionals due to a sense of urgency to stabilize a situation and better understand what is happening to their loved one. Providing an individual's natural supports with education during the Engagement and Stabilization phase can immediately start to reduce some of the guilt, blame, or depression experienced by relatives and enlist their long-term involvement in the individual's treatment.

Engaging an individual experiencing symptoms in New Journeys care is facilitated by both the early exploration of the individual's goals for treatment based on their own preferences and values and the assessment of areas of need. This work sets the stage for treatment planning. Staff first help participants identify and set individualized treatment goals in the Engagement and Stabilization Phase and continue this process in the Recovery/Resiliency Phase. As an individual meets the various members of the New Journeys team and learns about their roles, they become oriented to the overall program and hopefully gain motivation to participate in services as they begin to understand how New Journeys can help them achieve their goals.

During the Engagement and Stabilization phase, it is important for a New Journeys participant to engage with the team's Psychiatric Care Provider for the initiation of medications and/or management of side effects of medication. The use of low dose antipsychotic medication is usually necessary to reduce or stop psychotic symptoms. Once psychotic symptoms are controlled or eliminated, individuals can participate in other aspects of treatment more fully and effectively.

Pharmacological treatment often helps engage participants by reducing distressing symptoms as staff try to understand and work with them to address their most prominent concerns.

For many participants and their families, the ability of the New Journeys team to resolve urgent individual and/or family needs is a prerequisite for successful engagement in the model. Case Management addresses these urgent needs such as housing, health, and legal issues. As the team addresses basic needs and develops a therapeutic relationship with the individual, stress on both the individual and their families/natural supports can be reduced, aiding in their overall stabilization, and thus reinforcing participation in New Journeys.

It is also key for new participants to connect to a peer specialist during the Engagement and Stabilization Phase. Participants often appreciate the opportunity to talk to someone who has experienced their own mental health challenges, which can help them to feel less isolated and more hopeful about their future.

The Recovery/Resiliency Phase

Once stabilization efforts have been made, the Recovery/Resiliency Phase can begin. During this phase, individuals are often more able/ready to engage fully in the various interventions within New Journeys. While an individual likely has begun engaging with the various interventions prior to six months of engagement, they are often better able to utilize these supports as their treatment progresses.

The length of this phase varies depending on each individual's needs and progress toward their personal goals. Most individuals will remain active in New Journeys treatment for two years. Collaborative treatment planning meetings, including the individual and relatives or other key persons and New Journeys team members, are held at the beginning of treatment, and occur at least every six months thereafter.

New Journeys teams typically offer all interventions to families and individuals, but there is not a requirement to participate in everything. However, it is strongly encouraged that all participants have the opportunity to engage in all aspects of the New Journeys model. When an intervention is offered, it is important that participants and their families are educated about what benefit the interventions might have because it is difficult for individuals and families to make informed decisions about participating without comprehensive information about each intervention.

CHAPTER 5: CORE COMPETENCIES OF NEW JOURNEYS TEAM MEMBERS

Core Competencies

Core competencies are the basic skills necessary for all members of the New Journeys team. They include shared decision-making, strengths and resiliency focus, motivational enhancement skills, psychoeducational teaching skills, cognitive-behavioral teaching skills, and collaboration with natural supports. As described above, in addition to being trained in these core competencies by the UW Implementation Team, the Northwest MHTTC and MHTTC Network offers an array of new, free, online training opportunities.

These competencies are described below.

Shared Decision-Making

In contrast to traditional hierarchical decision-making in which "patients" are expected to passively follow the "doctor's orders," shared decision-making means that treatment decisions are made by the service recipient and clinician(s) together, as partners, and based upon the individual' desired goals. When family members or other natural supports are involved in the individual's life, they can also be involved in the decision-making process. An assumption of shared decision-making is that the individual participant makes the decision about their treatment based on various information they are provided about a topic to make informed decisions. This process of informed decision making often includes the individual's natural supports (Deegan et al., 2008). Using this perspective, each partner in the process contributes their own specialized knowledge and experience to making decisions.

Clinicians who ignore the person's desires or use coercion to control a participant's treatment undermine the therapeutic relationship (Fenton, 2003). In shared decision-making, treatment providers give evidence-based information about treatment and the participant gives information about his or her values, goals, and preferences. The two collaborators then discuss and negotiate a treatment plan that both believe is reasonable (Towle & Godolphin, 1999). Collaborating with participants and respecting their ability and right as individuals to make their own treatment decisions recognizes the choice ultimately lies with them, not the provider. This approach helps enhance the overall therapeutic relationship and serves to empower the individual and break down internalized stigma (Corrigan, 2005).

Strengths and Resiliency Focus

Traditionally, goal setting in psychiatric treatment and rehabilitation has been focused on the reduction or elimination of illness-related problems or "deficits," such as symptoms, inappropriate behavior, or social withdrawal. For individuals who have already had many setbacks in their lives, the traditional focus can worsen self-esteem. Instead, New Journeys focuses on the strengths and resiliency factors of a person experiencing symptoms and their natural supports.

When clinicians help participants and their natural supports focus on their individual strengths and resiliency, participants and natural supports become more aware of (and feel better about) their personal positive attributes. They become more aware of how they have previously used these abilities to cope with life's challenges and achieve goals, and how they can use these attributes in the present and future. Focusing on strengths and resiliency not only makes people feel better about themselves and their efforts, but it also helps clinicians tailor treatment to each individual and their natural supports within their unique community.

A strengths-based approach is consistent with positive psychology, which focuses on strengths and well-being, rather than on limitations and negative emotions. The strengths-based approach also lends to developing strategies for reaching one's potential and deriving meaning from one's life, including self-acceptance, positive relationships with others, and ability to manage day to day tasks. People experiencing FEP respond well to this focus on personal growth and developing meaning in their life (Uzenoff et al., 2008).

Cultural Considerations

Culture has a powerful impact on the individual participant and their loved ones understanding of; a) the psychotic experience, b) their help-seeking behaviors and attitudes, c) what matters to them in recovery, d) their preferences for treatment, and e) their response to treatment interventions offered. Engaging individuals and their families in open discussions about culture (e.g., their spiritual or religious beliefs, influence of their racial/ethnic backgrounds, gender identity, experiences of marginalization or discrimination, what culturally respectful care means to them) reinforces the process of shared decision-making and is imperative to build collaborative partnerships. Consistent with a resiliency focus, these conversations also help identify driving cultural values, cultural/familial strengths, and skills developed through cultural membership. It is important to remember that cultural influences (e.g., cultural messages about gender, race, and ethnicity, religious or spiritual beliefs, beliefs about achievement, etc.) can be both constraining and enabling toward recovery goals.

While discussing culture with participants and their natural supports, it is also important to avoid any inadvertent assumptions about individual cultural backgrounds, to respect the constantly evolving nature of culture, and to acknowledge cultural heterogeneity. Understanding the participants culture can help determine if any cultural adaptations in treatment would be beneficial and can help the team identify and address cultural dilemmas that arise in their work with service-recipients and their supports. The expression of culture in people's lives is closely connected to other social determinants of health, including education level, economic stability, neighborhood factors, health/access to health care and social/community contexts (Office of Disease Prevention and Health Promotion, 2020). These determinants are important to consider in care delivery, given the impact these could have on recovery trajectories.

New Journeys challenges old assumptions and traditional ways of thinking and introduces new ways of conceptualizing and understanding serious mental illness. Team members are encouraged to engage in self-reflection about their own cultural lenses and backgrounds and consider how it may influence their understandings of psychosis, treatment recommendations, and beliefs about service-recipients. In doing so, it is important to maintain a stance of cultural humility, or "the ability to maintain an interpersonal stance that is other-oriented or open to the other" (Hook et al., 2013, p. 354). Additionally, cultural factors related to organizational or team culture, professional discourses about normality, and the mental health system may be relevant to discuss, especially when they appear to be interfering with team cohesion and/or service recipients' recovery goals.

Motivational Enhancement Skills

Motivational Interviewing (MI) is a person-centered approach to helping individuals who are ambivalent about making decisions or making changes in their lives. It was developed by Miller and Rollnick (Miller and Rollnick, 2013) and has been widely adopted in settings providing treatment to people with challenges in many areas, including mental health, substance use, physical health, involvement with the criminal justice system, school, nutrition, and weight management. It is highly encouraged that New Journeys team members take advantage of training opportunities in motivational interviewing. Information about training and other aspects of motivational interviewing can be found on the website.

Motivation refers to the intention and determination to follow through with an action. Problems with sustaining motivation to follow through on desired plans and goals is one of the defining negative symptoms of schizophrenia (also known as "avolition"). Low motivation often contributes to disengagement in treatment and problems with psychosocial functioning. New Journeys team members can use specific motivational techniques to help participants become more motivated.

One of the most basic approaches to enhancing the service recipient's motivation to participate actively in treatment is the identification and progress towards an individual's personal meaningful goals. Clinicians may help participants to break down long-term goals into smaller objectives and more manageable steps. Then, the clinicians can explore how learning new information and skills (including skills about the treatment and management of one's psychiatric disorder) can help the participant achieve their goals.

Other examples of motivational enhancement include:

- Expressing empathy regarding the challenges the participant faces.
- Supporting self-efficacy by instilling hope that the person is capable change.
- Encouraging participants to think and dream about what they want out of their lives, and how they can achieve their goals.
- Reframing past challenges and setbacks as opportunities to identify personal strengths and survival skills that can be used in the future.
- Weighing the "pros" and "cons" of a health behavior (e.g., what are the advantages and disadvantages of taking medication, getting regular exercise, or avoiding alcohol and drugs?).
- Reinforcing "change talk" when the individual is considering making a change that is consistent with treatment recommendations or with their personal values and goals.
- "Rolling with reluctance" instead of opposing it when the individual is ambivalent about change, by affirming that ambivalence is normal. Instead of arguing with the participant's point of view, clinicians can explore the individual's ambivalence and learn more about their point of view. This helps the clinician more effectively address the individual's concerns about an anticipated change.

Psychoeducational Teaching Skills

Psychoeducation involves providing information about psychiatric disorders and their treatment to participants and their natural supports. Service recipients and their supports need to understand the nature of various treatment options, and which options are available, in order to participate in the informed, shared decision-making that is the backbone of New Journeys.

Team members can use a variety of teaching strategies to help people understand the information taught within New Journeys and highlight information relevant to them as individuals. Common teaching strategies include:

- Breaking down large pieces of information into smaller "chunks"
- Using and reviewing written handouts together or summarizing the content of handouts in a conversational way
- Asking questions to check understanding of information
- Inviting questions about the psychiatric disorder and its treatment
- Asking participants for their experience related to the material.
- Adopting the language of the individual and natural supports to ensure that terms and concepts are understandable to them.
- Avoiding conflict by seeking common ground when there are disagreements between the clinician and individual or members, or between the individual and natural supports, on topics such as diagnosis, symptoms, treatment experiences or the explanatory model for understanding psychosis.

Cognitive-Behavioral Therapy (CBT) Teaching Skills

A broad range of CBT approaches have been developed over the past several decades for both clinical and non-clinical populations (Bellack et al., 2004; Gingerich & Mueser, 2005; Kingdon & Turkington, 2004).

Positive verbal reinforcement is often considered the most basic and powerful of all CBT skills. Therefore, all New Journeys team members need to be able to use *positive verbal reinforcement* to encourage individuals' participation in New Journeys, including setting personal goals, following through on home assignments, taking steps towards goals, following treatment recommendations, and remaining actively involved in collaborative treatment planning and treatment reviews.

New Journeys team members also need to know how to use *shaping*, or the reinforcement of successive approximations to a desired goal. This means that clinicians praise even very small steps in the intended direction, such as taking steps towards the individual's personal goal, improvements in symptom management, or involvement in making treatment decisions with the team.

In addition, there are many other CBT methods that are effective with FEP participants, including:

- **Skills training approaches** (e.g., modeling, role playing, feedback, and home practice) to teach skills for:
    - Social situations (e.g., conversation skills, job interviewing, substance refusal, discussing medication issues with the Prescriber)
    - Relaxation
    - Having fun
    - Coping with symptoms (e.g., hallucinations)
    - Managing urges or cravings for alcohol or drugs
    - Developing a Relapse Prevention Plan (often called A Wellness Plan) to prevent return of symptoms of psychosis
- **Cognitive restructuring** to change inaccurate or self-defeating thinking that lead to negative feelings, such as depression, suicidal thinking, anxiety, self-stigmatizing beliefs, and distress related to psychotic symptoms.
- **Self-monitoring** to develop awareness of specific behaviors that may be targeted for change, such as smoking, overeating, or use of alcohol or drugs.
- **Conducting a functional or contextual analysis** to aid in understanding environmental or individual factors that contribute to or maintain behaviors of concern.
- **Behavioral tailoring** to incorporate new and more adaptive behaviors into the individual's daily routine (e.g., taking medication) by developing natural environmental prompts for the behavior (e.g., placing the medication next to the coffee pot so the individual is visually prompted to take it in the morning when they routinely make a pot of coffee).

Basic knowledge of CBT teaching skills is critical to the overall success of the program, and as such, all New Journeys team members will incorporate at least some CBT teaching into their work with the participant and their natural supports.

Collaboration with Natural Supports

"Natural supports" refers to people who have a relationship and regular contact with the individual receiving service who can help the participant manage their psychiatric illness or make progress towards personal goals (Rapp & Goscha, 2006). Examples of natural support include family members, friends, romantic partners, employers, and self-help group members.

Engaging with an individual's natural supports to take collaborative steps towards their treatment goals is important for several reasons. First, because of their regular contact with the individual, natural supports are in an ideal position to help individuals to take steps towards personal goals or encourage them to follow up on treatment recommendations. Second, participants who have natural supports that are engaged in their care have fewer psychotic symptoms and better treatment trajectories. Third, engaging with natural supports can elucidate resources that may be available to the individual that would otherwise not have been tapped (e.g., a job lead, a useful suggestion, a potential role model). Work with natural supports also aims to help individuals repair relationships that may have been damaged during an acute episode of psychosis to encourage long term supportive relationships.

Finally, it's important to note that some natural supports may inadvertently undermine the participant's treatment adherence (e.g., by discouraging taking medication), facilitate or encourage the use of alcohol or drugs (e.g., by indiscriminately giving the person money that is spent on substances or using substances with the individual), or interfere

with progress towards goals (e.g., discouraging the individual from returning to school or work because of fear that stress will provoke a relapse). Psychoeducation and skills-focused support for natural supports can help minimize these factors.

New Journeys Team Members

Each New Journeys team is staffed by an interdisciplinary team who works together to provide specialized interventions that address the range of biological, psychological, and social needs an individual may have. Team members work in a collaborative fashion with the individual receiving service and their natural supports. Team members must be flexible in providing community visits and outreach. At times, the team members may be asked to work outside of typical business hours to meet with service recipients. The team member interventions include: 1) Family Education, 2) Medication Management, 3) Individual Resiliency Training, 4) Supported Employment and Education, 5) Peer Support Services, 6) Case Manager and/or Nurse Case Manager (see Figure 1). The frequency of sessions or meetings is tailored to the individual's (and natural supports) needs, goals, and preferences.

Each team role has a team members manual (except for case management) which can be downloaded from the New Journeys Network website.

Program Director/Family Education Provider (1.0 FTE)

The Program Director/Family Education Provider is often set up as a dual role. The ideal candidate for the Program Director/Family Education Clinician is a licensed clinician with experience in diagnostic screening and assessment of psychotic disorders, and expertise in working with individuals with schizophrenia-spectrum disorders and their families. Clinicians should also have experience utilizing evidence-based practices such as multi-family groups and experience connecting individuals and their supports with an array of tools and resources.

The Program Director monitors and oversees all team operations, leads regular team clinical meetings, and supervises the other team clinicians. The program director is also responsible for outreach and community education (community relations), developing a strong referral network within the agency and region, and leading the screening process for referrals. Initially, they are the primary contact person for individuals experiencing psychosis and their families and spearhead efforts to engage participants in the treatment model. The ideal candidate for this role has expertise in building cross-system connections with other providers in the region.

The Family Education Clinician (sometimes also referred to as a Family Education Provider, Family Education Specialist, FES, or simply Family Educator):

- Uses shared decision making with individuals and their families
- Provides education about psychosis and how to manage it
- Introduces and develops problem-solving skills to assist in improving communication
- Works form a strengths-based, recovery-oriented approach to psychosis

The Family Education Clinician helps an individual's natural supports learn about psychosis and its treatment while developing strategies for coping with stress and communicating effectively. Family education usually begins in the engagement and stabilization phase and continues for several weeks into the recovery/resiliency phase. The Family Education model is usually delivered over 12-14 sessions, on a weekly or every-other-week basis, with additional sessions when needed. Some natural supports may remain engaged with Family education throughout the entire duration of their loved one's time with New Journeys, while others may not.

Psychiatric Care Provider (0.25 FTE)

The Psychiatric Care Provider can be a Psychiatrist or a Psychiatric Advanced Registered Nurse Practitioner (ARNP). This team member should be experienced in working with individuals experiencing psychosis using a recovery orientation. Medication management is guided by evidence-based practices for FEP service recipients using a shared

decision-making framework to guide individualized medication assessment and treatment. Medication treatment relies on the use of antipsychotic medication to reduce or stop psychotic symptoms and prevent relapses, while working to minimize side effects such as weight gain, metabolic changes, involuntary movements, and sedation.

The Psychiatric Care Provider is responsible for psychiatric diagnosis, medication management for psychiatric and substance use disorders, acute management of suicidality and safety concerns, and physical health care needs in coordination with the team nurse (when possible) and primary care provider. They work collaboratively with the clinical team in treatment planning, including participating in regular team meetings and family meetings as needed.

Individual Resiliency Training (IRT) Therapist (1.0 FTE)

The IRT therapist (sometimes referred to as the IRT Clinician, IRT Specialist, or simply IRT) serves as the team's master's level therapist. Individual Resiliency Training is a Cognitive Behavioral Therapy based treatment for early psychosis. The curriculum in IRT is broken into modules and is paced on a weekly or every-other-week basis. The IRT therapist may also participate in clinical assessment activities, as appropriate/directed by the Program Director. They work collaboratively with the clinical team in treatment planning, including participating in regular team meetings and family meetings.

The IRT assists with providing culturally competent, trauma-informed, strengths-based, and measurement-based care for participants enrolled on the New Journeys team. The IRT therapist focuses on helping individuals identify and enhance their strengths and resiliency factors, develop symptom management strategies, and teach skills to support their success in achieving their personal goals. Examples of personal goals may include but are not limited to: engaging in meaningful activities, employment, education, and positive relationships.

Strong candidates for the IRT position are recovery-oriented and have previous experience working with individuals with psychosis and their supports. Clinicians should have previous experience treating young adults with:

- Psychiatric symptoms
- Substance use
- Health-risk behaviors
- Life stressors

The evidence-based therapeutic interventions included in IRT include but are not limited to:

- CBT for psychosis
- Illness Management and Recovery (IMR)
- Motivational Interviewing
- Harm Reduction
- Integrated Dual Disorder Treatment

Supported Employment and Education (SEE) Specialist (1.0 FTE)

The Supported Employment and Education (SEE) Specialist is an experienced bachelors or master's level clinician with experience as a supported education or supported employment specialist or as a vocational specialist. This team member works from a recovery orientation and focuses on assisting individuals experiencing psychosis to achieve recovery goals related to education and employment. The SEE Specialist completes most of their work outside the office. They work collaboratively with the participant on their job search and job placement, research educational options, and provide in vivo training in interviewing skills. In addition, the SEE Specialist provides follow-up support to individuals who have attained a job or who are enrolled in school. It is highly desirable that the SEE Specialist have flexibility to provide services outside of the traditional 9am-5pm work hours as needed to best support individuals in achieving their employment and educational goals.

Supported Education and Employment services begin as soon as possible based on the participant's preference. Even if participants do not initially identify a desire to work or attend school, it is still important for them to have an initial meeting with the SEE Specialist so they are aware of the supports available and can explore their interests. The SEE Specialist works with interested individuals who choose to pursue work or education regardless of the presence of ongoing symptoms or substance use. Services should continue to be provided throughout an individual's time in New Journeys to support the individual while they return to work or school.

Peer Support Specialist (0.5 FTE)

The Peer Support Specialist (sometimes referred to as the Peer Specialist or simply the Peer) has completed training in the Washington State Certified Peer Counselor Training Program and has lived experience with mental health challenges. It is preferred that candidates for this position have relatable experiences of psychosis to the individuals they will be serving. Ideally, the Peer Support Specialist will be a young adult, however, anyone will be considered for the position as long as they have an understanding of youth culture and the ability to engage with young people as a peer.

Peer Support Specialists demonstrate understanding of equity and how it intersects with service delivery. Because of the collaborative nature of the position, peers must be able to work in changing situations with a diverse group of people, interacting either in groups or individually. When and if appropriate, Peer Support Specialists support the individuals they partner with through sharing their own experiences from their journey toward recovery in order to instill a sense of hope and empowerment, while establishing and maintaining appropriate professional boundaries. If Peer Support Specialists share their stories, they do so through a trauma-informed and culturally aware approach to support individuals with the challenges they may be facing in their recovery and in setting and achieving goals.

Peer Support Specialists assist with engagement of individuals experiencing psychosis in services throughout treatment to ensure that they have the information and resources they need to direct their treatment and to use an empowered voice in the treatment planning process. The Peer Support Specialist acts as a cultural bridge between the mental health system and the participant and their natural supports, assisting them in navigating the language and terminology of the treatment process and the resources available. They also help in identifying needs and engaging with natural supports. Qualified Peer Support Specialists may also assist in recovery support through facilitating or co-facilitating groups such as Illness Management and Recovery (IMR), Wellness Recovery Action Plans (WRAP) or WRAP for work, and assisting in Integrated Primary Care (IPC) activities, among others. Collaboration with the other clinicians on the team is key to the peer specialist's role.

Case Manager and/or Nurse Case Manager (0.5 FTE)[8]

Case Manager

The Case Manager is a bachelors level clinician who has experience providing support to individuals experiencing mental health challenges, including psychotic disorders and serious mental illness. As with other team member roles, this clinician should embrace a strengths-based, recovery orientation to their work with service recipients and families. It is vital that this team member be aware of local resources, such as housing, recreational programs, and transportation. The Case Manager will assist with care coordination, acquiring records, treatment planning, sharing relevant resource information, and participant scheduling. In addition, the Case Manager will track programmatic metrics to assist with quality improvement and assurance efforts needed to maximize clinical care and participant satisfaction.

Nurse Care Manager

The Nurse Care Manager on a New Journeys team focuses on supporting healthy behaviors, wellness, and care coordination. All New Journeys participants should have an initial nursing assessment at the beginning of treatment to identify chronic disease risk factors and targets for self-management support (for example, regular physical activity,

[8] Teams may choose to substitute a nurse care manager (~0.2 FTE) for all or part of the case manager FTE count

healthy diet, sleep hygiene, and sexual health). The Nurse also has a critical role in supporting medication management, including providing education, monitoring for side effects, and supporting adherence to medications. In addition, the Nurse has primary responsibility for ensuring that timely recommended metabolic monitoring is completed and tracked by the team. The nurse typically meets with the individual experiencing psychosis weekly over the first month, every 2 weeks for the next 5 months, and then monthly during the rest of the two-year treatment, although this varies based on individual need.

CHAPTER 6: FUNDING, SERVICE ARRAY, AND CODING

Funding and Sustainability

Startup and case building funds are provided through direct contracts with HCA/DBHR using MHBG 10% set aside and/or Proviso funds. These funds are provided to help launch new teams while allowing them to build their caseloads slowly over the course of 15 to 24 months. Teams are eligible to use these funds to support the startup of a New Journeys team in their region. The use of these funds and associated invoicing processes are determined by each agency's direct contract with HCA/DBHR.

The New Journeys TBR 24 Month Lifetime Limit

Across the United States, most of the CSC models provide services for up to 24 months with some variation across models (Table 3). New Journeys is based on the NAVIGATE model, which assumes a 24-month service timeline. On average, individuals and families usually work closely (e.g., weekly) with one or more members of the team for 6 to 12 months, followed by less frequent services (e.g., bi-monthly or monthly for the next 12-18 months). Sites may use clinical discretion to continue providing services past the 24-month mark by using regular outpatient billing processes established by their agency as their workload allows.

Table 3. Components of CSC Programs (Wilsie & Daughtry, 2021)

State	Washington (New Journeys)	New York (On Track)	Oregon (EASA)	Illinois (First, IL)	Portland, Maine (PIER Program)
Length of Service	Up to two years (24 months)	Up to two years (24 months)	Up to two years (24 months)	Three-five years, pending client needs	Up to two years (24 months)
Services	• Pharmacological Treatment • Individual and Group Psychotherapy • Case Management • Individual Resiliency Training Therapy (IRT) • Supported Employment and Education • Peer Support Services • Family Education	• Medication Management • Individual and Group Psychotherapy • Family and Individual Psychoeducation • Peer Support • Caregiver/Family Supports and Services • Educational & Employment Support • Case Management • Structured Behavioral Interventions (e.g., social and coping skills) • Individualized safety planning	• Outreach and engagement • Assessment, diagnosis, and treatment planning • Group and Individual counseling • Medication support • Education and support for individuals, families/primary support systems • Crisis/relapse planning • Navigating rights and available benefits • Mentoring/peer connection • Independent living skills development • Occupational therapy • Educational and Vocational Support	• Psychiatric care (medications and interventions) • Individual resiliency training (coping and problem-solving abilities) • Supported employment/education • Family psychoeducation • Case management (care coordination, education on community resources, crisis management)	• Community outreach and education • Comprehensive assessment • Individual and family counseling • Multifamily group • Medication Management • Employment and educated support • Care management • Care Coordination • Psychiatric Consultation & Medication • Peer mentoring/support

Team Based Rate

The term TBR is sometimes used interchangeably with terms like case rate, bundled payment, or service-based enhancement. New Journeys teams typically apply to become an "Attested New Journeys Provider' at the end of the first year of startup and case building. The term "attested provider" refers to a team that has a) completed startup activities outlined in Chapter 8, b) Completed the necessary training to provide New Journeys services, and c) is ready to accept referrals. To become and attested site, an attestation form (requested from the sites HCA Contract manager) is completed and submitted to the contract manager at HCA. This form documents that the basic New Journeys training, staffing, and fidelity requirements have been met. Teams who are in the startup phase are NOT eligible to be added to the MCO/BH-ASO contracts to receive the TBR (described below) and should instead use regular outpatient billing codes, outlined in the SERI guide, to bill for direct services and use the A-19 provided by HCA/DBHR to bill for services, materials, and other activities that are not reimbursed by insurance.

What is the Team Based Rate?

The New Journeys TBR is a two-tiered, Medicaid funded, service-based enhancement. The TBR is stratified into two tiers to reflect the higher levels of engagement and stabilization needs during the initial 6 months of treatment and a lower level of service provision for the remaining 18 months of the model. There is a lifetime maximum of 24 months of the TBR per individual[9].

- Tier 1: Engagement and Outreach = intake through the first 6 months of enrollment
- Tier 2: Recovery and Resiliency = months 7-24 of enrollment

HCA partnered with stakeholders, as directed by legislation in Second Senate Substitute Bill 5903, to develop and implement a Team Based Rate for Medicaid. The implementation became effective July 1, 2022. In integrated care, the New Journeys TBR is a Medicaid funded SBE that is reimbursed monthly in addition to the per member per month (PM/PM) capitated payment. The TBR is a non-directed, team-based model with split funding which includes certain State Plan Mental Health Outpatient services under the rehabilitative services section. The actual services delivered to New Journeys participants will vary depending upon their individual needs and treatment plan. The TBR is determined by an actuary process and was based upon service utilization data from the New Journeys teams in Washington. Once a New Journeys team has an approved attestation form, the provider can access the TBR `by contracting with each of their regions MCOs and BH-ASO's for reimbursement through the TBR for New Journeys services.

How Does an Attested Site Bill for the Team Based Rate?

Once an attested provider has contracted with their regions MCOs and BH-ASOs, the provider will receive the New Journeys TBR when submitting an encounter for a New Journeys eligible service. At least one service per eligible individual during the calendar month must be entered into ProviderOne to initiate the process for payment of the TBR (see SERI interim guidance dated 11/10/2021). The modifier "HT" must be submitted in combination with the specific, allowed CPT/HCPCS codes on the encounter:

- Tier 1: Engagement and Outreach = T2022 HT
- Tier 2: Recovery and Resiliency = T2023 HT

Billing and reporting requirements may vary and will be defined by each provider's MCO/BH-ASO contracts. Providers may be expected to monitor limits to age, diagnosis, and benefit lifetime maximum to prevent accidental over billing of the TBR.

Funding for Non-Medicaid Activities

[9] The tiers to the TBR are based on averages of time and intensity of treatment. These averages assume that some individuals will need more than 6 months of intensive engagement and outreach while others will need less intensive engagement.

Attested New Journeys providers who are eligible for the TBR are also eligible to receive additional funds to account for the various non-Medicaid activities they participate in as a CSC team. These state funds are made available through MCO Wrap Contracts and should be accounted for during the contracting process with each of the regions MCOs and BH-ASO. These non-Medicaid components of the New Journeys model are funded over and above the TBR and account for 36% of the team's time to which is taken up in non-Medicaid activities required for New Journeys model fidelity. Examples of non-Medicaid activities include:

Table 4. Non- Medicaid Activities Accounted for in the TBR

Non-Medicaid Activities	
Concurrent delivery of services	➢ More than one provider participating in a session based on individual request, treatment goals, or safety ➢ Family psychoeducation w/o individual with simultaneous service w/individual (e.g., the participant is being seen by the IRT or SEE while family psychoeducation takes place) ➢ Co-leading groups
First episode training and consultation	➢ Training needs for New Journeys teams which are over and above provider and professional requirements (i.e., training in the New Journeys model, attendance of monthly, role based, consultation calls, ECHO clinics, etc.)
Fidelity review activities	➢ Peer fidelity reviews
Care coordination and consultation	➢ Medication delivery ➢ Other case management tasks that may not meet medical necessity ➢ Collateral contacts
Time spent traveling to community-based appointments	➢ Staff time spent in travel w/o individual o Searching activities o Traveling to appointments outside of the agency's office
Weekly multidisciplinary team meetings	➢ Collaboration/coordination among multi-disciplinary team members ➢ Supervision needs above and beyond traditional outpatient needs
Outreach and engagement	➢ Screening referrals both over the phone and in person prior to intake to determine eligibility and/or engage in services
Educational and vocational support activities	➢ Engagement and job development with employers ➢ IEP development with the schools
Weekly and monthly measures for WSU evaluations (outcome analyses)	➢ Time spent completing data entry outside of sessions ➢ Using data in real time to inform the treatment process in team meetings/treatment planning outside of sessions ➢ Other activities needed to complete monthly metrics ➢ Monthly meetings with WSU
Other expenses accounted for by TBR funding:	➢ Phones ➢ Insurance ➢ Educational support items ➢ Supplies ➢ IT, EHR and computer support ➢ Capital items needed for the team

CHAPTER 7: ADMINISTRATIVE SUPPORT GUIDE

New Journeys Specific Requirements

This section will outline the infrastructure requirements a provider must have in place to be eligible for consideration as a New Journeys provider. Each established New Journeys team must: 1) be recognized by HCA/DBHR, 2) have an approved, current HCA/DBHR attestation, and 3) actively participate in the New Journeys Fidelity Review requirements. For a current list of approved providers, please contact the HCA Program Manager at HCAfepinbox@hca.wa.gov.

Federal and State Requirements: The services provided under New Journeys are Medicaid services, therefore agencies are required to meet all applicable federal standards related to the provision of mental health services covered under Medicaid. All Behavioral Health Agencies (BHA) need a license with the Department of Health (DOH). This means that if a group of people want to bill Medicaid using one agency NPI number, they have to be licensed with DOH. Information on current BHAs, application process to become a BHA, and certification options can be found here: WAC 246-341-0300.

Training and Implementation Support

The New Journeys Network and Washington State Center of Excellence in Early Psychosis (WA-CEEP) is a collaboration between UW, WSU, and HCA that encompasses efforts to support the New Journeys Network (Network contact list is available in Appendix G). The New Journeys Network includes an active collaboration that involves implementation, evaluation, and quality management to support New Journeys CSC teams deliver the highest quality of care and adhere to the purpose and goals for WA.

The WA-CEEP is fully funded by grants, contracts, and philanthropic donations to support and address four priority areas that include:

- Providing training, consultation, implementation, and sustainability support to the Washington State New Journeys early intervention programs to address FEP
- Educating and supporting key stakeholders in the community seeking information and resources on early psychosis (e.g., mental health care recipients, families and natural supports, providers)
- Developing resources for the assessment and management of clinical high risk for psychosis (CHR-P)
- Advancing research on early psychosis, particularly as it relates to promoting implementation science and clinical outcomes

Additional information about CEEP can be found at the CEEP website.

New Journeys Website and Resources

The New Journeys website and UW SPIRIT Lab website provide a comprehensive overview of the New Journeys program as well as resources such as referral forms, team directories, training resources, and consultation and ECHO Clinic consultation schedules. The New Journeys website also includes a secure login for New Journeys CSC team members where additional information may be downloaded and viewed.

Among the many training materials on the New Journeys website are the NAVIGATE manuals and relevant materials from past consultation calls.

Training and Consultation

Each New Journeys team member is expected to participate in initial startup training provided by the UW Implementation Team and WSU Evaluation Team, consisting of an orientation to CSC, New Journeys team member roles, and more in-depth training specific to their role on the New Journeys team. In addition to start-up training, each team member is expected to engage in ongoing monthly consultation through the following:

- **Monthly Role-Specific Consultation calls:** Program Directors, Family Education Specialists, Psychiatric Care Providers, IRT Therapists, SEE Specialists, Nurse Care Managers, and Peer Specialists each have dedicated time to connect with one another and receive consultation from UW specialist trainers (See current consultation call schedule on the New Journeys website under "Consultation Calls". Please note, there are not current consultation calls for Case Managers).
- **Monthly ECHO Clinics:** This is a time when all of the New Journeys teams across the state meet in a virtual format and participate in case consultation and training in topics attuned to the needs of individuals experiencing FEP (Up to date schedule and past recordings of didactics can be found here).
- **Training and Consultation for Screening and Differential Diagnosis:** The team member(s) responsible for screening new referrals as well as the team Psychiatric Care Providers are provided with several training resources to assist with managing referrals and timely screening and admission:
    - **Structured Clinical Interview for DSM-5 Disorders (SCID-5) Training:** This two-day training is typically offered in collaboration with Ryan Melton, PhD, from the EASA Center of Excellence. The SCID is the preferred tool for teams to use to guide initial screening for new referrals.
    - **Monthly Differential Diagnosis Consultation Calls:** These monthly calls, facilitated by Ryan Melton, PhD, are offered to anyone conducting screening of new referrals on the New Journeys team (see the New Journeys website under "Consultation Calls" for the current schedule).
    - **Central Assessment of Psychosis Service (CAPS):** CAPS extends specialized expertise in screening and assessment of psychosis and psychosis-risk states by offering remotely delivered psychological testing (tele-evaluation) and professional consultation (teleconsultation) to help accurately identify youth and young adults earlier in the course of a psychotic illness. New Journeys teams that have entered into a site-of-practice agreement with University of Washington may receive a CAPS evaluation to enhance diagnostic accuracy for young people presenting with challenging diagnostic pictures.
- **Training for Measurement Delivery and Data Platform:** This is a time dedicated for in-depth tutorial of New Journeys data platform, REDCAP, the set-up and use of iPad devices, and delivery of measures. These tutorials are generally conducted virtually and allows teams to walk through the system and ask questions in the moment.
- **Monthly Facilitation Meetings with Program Managers:** WSU Evaluation team will schedule one-on-one meetings in a virtual format with Program Directors to provide feedback on quality of data entry, address issues with system or upcoming, gather feedback on experiences, and provide suggestions.
- **Pat Deegan Common Ground Academy + Library:** This online resource provides recovery-oriented training and resources which compliment other materials in the New Journeys model.
- **Quarterly Contractor Meetings:** These meetings allow for regular communication between New Journeys Contractors in the startup and case building phase with HCA. During this meeting teams will report out on their deliverables. These meetings also allow for regular technical assistance and updates.
- **Technical Assistance Meetings:** These meetings will be scheduled with HCA to provide assistance during the start-up and case building phases. They may be scheduled regularly, requested by the site, or requested by HCA.

In addition to these training opportunities, New Journeys team members may have other opportunities for ongoing training. These opportunities may include specialized training on particular area of practice (e.g., Psychosis REACH training for Family Education Specialists, CBT for Psychosis (CBTp) training for IRT Specialists, Cultural Formulation

Interview) as well as an annual New Journeys Symposium, which offers a chance for team networking and ongoing training across the whole New Journeys Network. Another free training resource for team members to address specialized skills and core competencies (e.g., culturally responsive care, motivational interviewing) is the Northwest Mental Health Technology Transfer Center (MHTTC) and the MHTTC Network.

The average time that New Journeys team members spend in training and consultation specific to this evidence-based model is 65 hours per year (see Table in Appendix B). This is in addition to an average of 48 hours of agency-based training and other training required for licensure. This adds up to 113 training hours per clinician per year.

Fidelity Monitoring

The UW implementation team leads the annual fidelity review process utilizing the NAVIGATE-adapted version of the First Episode Psychosis Services Fidelity Scale (FEPS-FS). Secondary co-reviewers are recruited from the New Journeys teams, aiming for at least one trained co-reviewer per team. Fidelity reviews consist of a two-day site visit by at least two fidelity reviewers (one from UW and one from a different New Journeys team) annually.

During the two-day site visit, reviewers will observe a team meeting, conduct interviews with New Journeys team members, and review program documents and participant health records. After the review, the fidelity reviewers independently rate all items on the NAVIGATE Adapted FEPS-FS, then develop consensus ratings across the 47 items. The UW reviewer takes the lead on writing up the fidelity feedback report with input from the second reviewer, which is then reviewed and finalized with the team. Table 5 (below) provides an estimate of team member time spent on fidelity reviews when they are implemented in the future.

Those sites receiving startup and case building funds through direct contracts with HCA/DBHR may have extra fidelity requirements, such as annual site visits and quarterly contractor meetings. New Journeys teams needing extra support will be referred to the UW Implementation team for technical assistance.

Table 5. Fidelity Review

Fidelity Review Activity	Approximate Time Spent
Preparation for and participation in fidelity reviews	18 hours per year
At least one New Journeys team member trains and participates as a secondary reviewer for the other teams' fidelity reviews	18 hours per year (Intro training, 2 day fidelity review)

CHAPTER 8: STARTUP AND CASE BUILDING

Since New Journeys is a collaboration between HCA, UW, WSU, and various other agencies across the state, the process of integrating into the New Journeys Network can feel complex and it can be difficult to know which entity to reach out to for support. Figure 7 (below) was developed to assist new teams and team members in understanding the role each ancillary support. In short, HCA's primary role is to support funding the startup of new teams across the state, the UW SPIRIT Lab Implementation team's primary role is training the team members and supporting them with ongoing consultation and education opportunities, and the WSU Measurement Delivery and Evaluation team's primary role is the training and implementation of measurement-based care and the evaluation of the New Journeys Network.

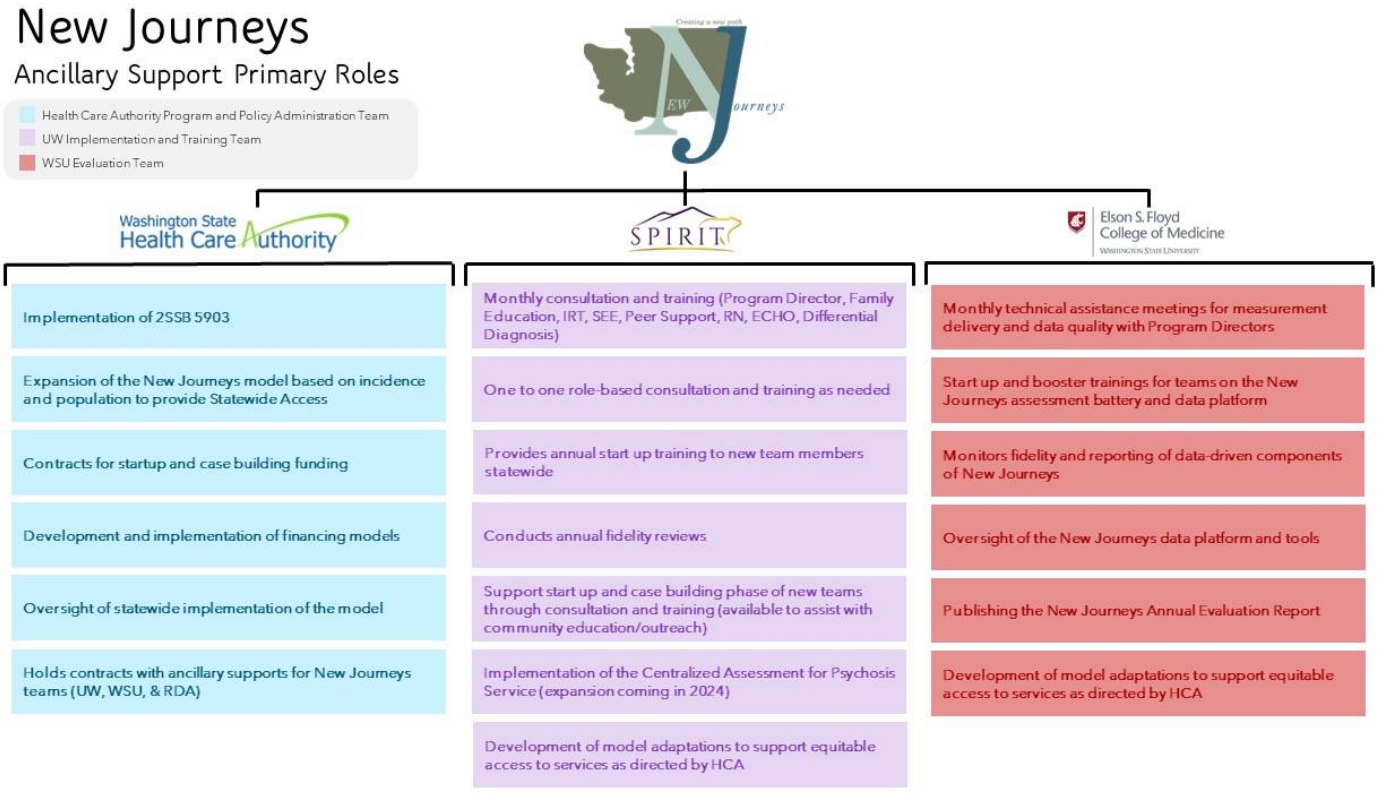


Figure 7. Network Ancillary Supports

Startup

New Journeys teams that are new to the network will have a period of time (referred to as the "startup phase") before they begin enrolling participants. The startup phase may be financially supported by a direct contract with the DBHR at the HCA. These funds are provided to the agency or provider to cover expenses before services and encounters can be reimbursed through other funding structures (such as insurance reimbursements), also known as "startup activities". Startup activities include anything that a site may need to do to establish a New Journeys team prior to providing any direct services. This phase may last between two and six months. This varies by the region/agency in which New Journeys is being established.

The below checklist can serve as a guide to startup activities. During startup, your primary contact for startup activities related to HCA contracts, billing (including A-19 invoicing), and monthly reporting is your HCA Contracts Manager. Questions related to startup, program development, community education and outreach, training, clinical consultation, etc.

can be directed to the UW Implementation Team. Any questions related to the Implementation of measurement informed care and REDCap can be directed to each teams assigned WSU coordinator.

NEW JOURNEYS STARTUP AND CASE BUILDING CHECK LIST

This checklist provides an overview of many of the activities new sites will have to undertake during the startup and case building phase. Activities are further identified as falling under one of the following categories:

HCA Contractual Startup Activities

- ☐ Determine geographic boundaries of the team being launched
- ☐ Contract for startup and case building financial supports
- ☐ Attend a "Kick-off Meeting" with HCA staff once team members are hired and the team begins taking on participants
- ☐ Establish monthly reporting procedures. Monthly reports document billable and non-billable deliverables within the following categories:
    1. Program Development & Implementation Activities
    2. Staff Training & Professional Development
    3. Community Outreach, Education, & Training
    4. Participant Engagement & Outreach Services
- ☐ Annual submission of Attestation as an approved New Journeys site, to be eligible to collect TBR (Medicaid Service based enhancement). Sites are not eligible for the TBR during the first year of startup.

Program Development & Implementation Activities

- ☐ Become familiar with New Journeys documents and available resources
- ☐ Orient the leadership group and other key partners to early psychosis intervention and how it relates to existing missions, initiatives, and priorities
- ☐ Develop program budget
- ☐ Secure adequate space for meeting referrals, conducting assessments, providing all interventions, and attending weekly team meetings
- ☐ Establish access to agency vehicles or support for use of personal vehicles for travel to community-based appointments
- ☐ Secure computers, tablets, and telephones for New Journeys team members
- ☐ Identify administrative and clerical staff to support New Journeys
- ☐ Once teams start case building, they should contact their HCA Contract manager to establish a timeline for collecting the TBR, including when it would be most appropriate for their site to establish contracts with the regions Behavioral Health Administrative Service Organizations (BH-ASO)/ Managed Care Organizations (MCO) for New Journeys TBR *(*Eligibility begins after year one of startup)*
- ☐ Arrange for Information Technology (IT) support
- ☐ Set up the agency Electronic Health Record so that individuals engaged with the New Journeys team can be identified within the agency

- ☐ Arrange low barrier systems of communication to identify referrals, conduct screening and admissions, and schedule appointments (these processes may be different from regular outpatient services intake protocols)
- ☐ Establish pathways to invoice all payors, including billing Medicaid and private insurance
- ☐ Get support for risk management, including security personnel and legal services
- ☐ Connect and develop protocols with the local crisis response system such as Designated Crisis Responders (DCRs) and Evaluation & Treatment (E&T) centers for the purpose of after-hours alerts and referrals from the community
- ☐ Develop partnerships with adjacent New Journeys teams based on service location
- ☐ Establish an intake process that aligns with New Journeys specialized outreach and screening expectations and with the agencies existing protocol (example in Appendix C)
- ☐ Establish processes for managing referrals outside of Medicaid
- ☐ Establish internal protocols for accepting internal and external referrals into the New Journey's program within the agency
- ☐ Plan for securely storing Protected Health Information (PHI) and sensitive data

Team Development

- ☐ Orient to the New Journeys Network and a contact person with HCA, UW, and WSU
- ☐ Recruit and hire New Journeys Team members (sample HR approved job descriptions in Appendix A)
- ☐ Develop team norms
- ☐ Establish team schedule for training and supervision (block these things out on the clinicians' calendars)
- ☐ Engage in team building activities

Staff Training & Professional Development

- ☐ Ensure that all team members have relevant copies of manuals and handouts
- ☐ Coordinate within the New Journeys Network to complete onboarding with UW and WSU, including attendance of clinical trainings for team member roles, Differential Diagnosis, etc. (recordings of previous trainings available here)
- ☐ Complete orientation with WSU to initiate data collection protocols using the New Journeys measurement delivery and data platform
- ☐ Participate in monthly UW consultation calls (outlined in Appendix B. An up-to-date calendar of the calls can be found here).
  - ☐ Ensure the appropriate dates/times are blocked out on *all* team members calendars
- ☐ Complete monthly data entry and meetings with WSU
- ☐ Participate in Fidelity Monitoring (year 2 and beyond) and/or annual site visit with HCA dependent upon contract requirements
- ☐ Establish regular time that team members can engage in cross training between roles and share tools/resources
- ☐ Set times for:
  - ☐ Weekly team meeting (sometimes held more than once weekly)
  - ☐ Supervision of staff
  - ☐ Meeting with Agency director and/or CEO

Community Outreach & Education

- ☐ Develop materials and tools for marketing, early intervention education and outreach

- Ensure agency website has a New Journeys tab
- Procure brochures and flyers (some materials available on the New Journeys website and can also be requested in print from WSU)
    - If more than one agency exists in the region, collaborate with the other team(s) on establishing marketing materials/plan
- Create a presentation for community education (example is available in Appendix D, an editable PPT version of this document is also available from the UW Program Director Trainer)
- Centralized phone line for referrals

☐ Create and implement a community education plan

☐ Provide education/referral resources within existing agency/network

☐ Identify and coordinate with other parallel and related efforts in your region/county

☐ Establish an Advisory Committee and/or participate in existing regional committees to serve as an advisory committee for the New Journeys team in that region (see Chapter 12 for more details)

☐ Build a SEE network by conducting outreach to employers (e.g., joining chamber of commerce, identifying groups to join, etc.)

Participant Engagement & Outreach Services

☐ Establish plan for managing referrals, screening, and intake (including the development of referral forms as needed; the New Journeys referral form can be found in Appendix E)

☐ Establish plan for case building, including plan to intake 2-3 individuals per month for a maximum of 30 participants enrolled

☐ Establish timeline for soft launch and readiness to accept internal referrals

☐ Establish timeline for community launch and readiness to accept external referrals

Case Building

Once a team has worked through initial startup tasks and is ready to begin providing New Journeys services to the community, they enter what is known as the "case building phase." During the case building phase, teams continue to complete/refine startup activities, such as developing procedures, building a community referral base, and delivering community education. However, they are also ready to begin taking referrals.

Oftentimes, teams will start seeing participants via a soft launch. A soft launch refers to a period of time in which the only referrals processed are from within the agency. These referrals are often identified by providers within the agency when information about New Journeys was shared internally. These initial referrals/existing individuals who were identified as possible candidates for New Journeys are then screened and enrolled in New Journeys if they are eligible. This soft launch allows the new teams to begin integrating and further improving the processes they have developed for screening, referral, and intake while also allowing team members to begin using the New Journeys model.

Shortly after, or perhaps at the same time as the soft launch, teams will begin accepting referrals from outside the agency. Some teams will celebrate the launch of New Journeys in their community by hosting a launch event or open house. This allows community members, stakeholders, and other resources to learn more about New Journeys and the referral/screening process.

For New Journeys teams, it is best practice to build their caseloads incrementally over time. For a full team, it may take between 15 and 24 months to reach full capacity, because teams should not admit more than three participants per month. This allows teams to not only provide intensive services for new participants and refine processes for person-centered

treatment planning with the individual and their family/natural supports, but to do so while still engaging in initial training.

This lower level of service provision also allows for completion of the Comprehensive Assessment (CA). The New Journeys CA has three primary aims: (1) to facilitate engagement of the participant with the New Journeys team, including developing a shared understanding of their experience and history, (2) to provide a mechanism for completing team-based, integrated assessment and person-centered treatment planning, and (3) to incorporate measurement-based care.

CHAPTER 9: TEAM PROCESSES

To effectively coordinate care of participants, the New Journeys team members are expected to participate in weekly team meetings, supervision meetings, comprehensive assessment meetings, and person-centered treatment planning and review meetings (these meetings are conducted with the participant and their natural supports present). The frequency, duration, and nature of these meetings are summarized below.

Weekly Team Meetings

This meeting occurs with all members of the New Journeys team and should occur at minimum weekly, although many teams typically meeting multiple days each week. Weekly team meetings are typically led by the Program Director and usually last at least 60 minutes, depending on the number of participants in the program and the complexity of individual treatment needs. The recommended agenda for a team meeting is as follows:

- Team members share examples of positive things that have happened with participants and families over the past week.
- Program director shares a brief update on recruitment and enrollment.
- Team reviews each enrolled individual, starting with a quick reminder of the individual's strengths and goal(s), followed by a brief report from each team member. During this review, identify challenges and make plans to address them, including who plans to do what and when. Each team member gives input on their work with the individual and/or an individual's natural supports, such as:
    - Psychiatric Care Provider: medication issues, side effects, and symptom management
    - Family Education Clinician: engagement and involvement of an individual's natural supports, what module they are covering in family education, any issues or concerns
    - IRT Specialist: individual engagement and involvement, what module they are covering in IRT, any issues or concerns, and opportunities for team members to reinforce or elicit adaptive behaviors
    - SEE Specialist: individual engagement and involvement, what stage they are at with SEE (e.g., career Inventory, identifying goals, job or school search, application process, employed or in school, follow-along supports), any issues or concerns
    - Peer Specialist: individual engagement and involvement, activities they are doing with the participant, identified strengths and natural supports, and any issues or concerns
    - Case Manager: individual engagement and involvement, case management activities they are doing with the participant, any issues or concerns
- As each participant's care is reviewed, note when their initial treatment planning meeting or their next treatment review meeting is scheduled. If their next treatment plan is approaching, preliminary planning is done during the team meeting to prepare. A preliminary or "penciled-in" plan is made for use during the treatment planning or review meeting itself. Please see Appendix F for an example template for reviewing and documenting information reviewed for each program participant in each weekly team meeting.
- At least weekly, the team should focus part of the meeting on reviewing and updating data entry and quality, as well as cross-training between roles to help all team members learn more about how to best support each role's work with each participant.

Supervision Meetings

- The New Journeys Program Director meets with the IRT Specialist on a weekly basis for one hour to provide clinical supervision for implementing the IRT intervention. If there is more than one IRT Specialist, they can

receive supervision together. Brief guidelines for supervision of IRT are provided in the Program Director's Manual, and more extended guidelines are in the IRT Manual.

- The New Journeys Program Director meets with the SEE Specialist on a weekly basis for one hour to supervise the implementation of SEE and to ensure that the services are fully integrated with the other components of New Journeys. Brief guidelines for supervision of SEE are provided in the Program Director's Manual, and more extended guidelines are in the SEE Manual.
- Depending on the guidelines and requirements of the agency, peer support specialists and case managers may also receive weekly supervision with the Program Director. Brief guidelines are provided in the Program Director's Manual.

Comprehensive Assessment Meetings

- CA meetings should be conducted by various team members in tandem with one another as soon as the individual and/or natural supports are engaged in services.
- Once each team member completes their respective portion of the CA, the team comes together and uses the information gathered to complete the integrated summary sections of each section. Then, they collaboratively complete the Putting It Together (PIT) case formulation, preferably with the individual and/or other natural supports.
- The New Journeys Comprehensive Assessment template and a case example of the Integrated Summary and PIT can be found on the here.

Person-Centered Treatment Planning and Review Meetings

- Within the first month of a participant's enrollment in New Journeys, a one-hour collaborative treatment planning meeting is held with the individual, their natural supports (if applicable), the Program Director, and any other New Journeys team members who are or will be significantly involved in the individual's treatment. It is beneficial for all team members to attend; however, it is not required. Subsequent collaborative treatment review and planning meetings are held every six months.

CHAPTER 10: MEASUREMENT-BASED CARE AND EVALUATION

Measurement-Based Care and Decision-Making

Measurement-based care (MBC) decision making is considered an evidence-based practice that typically involves the use of standardized measures to guide treatment practice or treatment planning (Lewis et al., 2018). Studies on measurement-based care suggest that when it is used in outpatient behavioral health settings, it improves participant outcomes (Lambert, 2002; 2003). New Journeys team members are required to collect and complete measures as part of the evaluation, but it also serves as way assist teams in decision making and treatment planning. The New Journeys measurement battery and data platform provides the tools (i.e., built-in measures, automatic scoring, graphical feedback) for this purpose.

New Journeys team members can use the data platform to collect and administer measures to assess individual participants' progress and clinical outcomes throughout treatment. Benefits to using a measurement-based care approach include:

- Improvement to individual clinical outcomes
- The ability to observe changes over time that can be used by teams in weekly and treatment planning meetings
- Enhancement of clinician judgements with the use of objective assessments
- The ability for participants to receive feedback about their treatment progress in real time

Evaluation & Outcomes

WSU collects program specific information pertaining to outreach activities, engagement and retention of youth and families with New Journeys, clinical outcomes of participants, and experiences from individuals and their supports. WSU generates quarterly and yearly reports which provide both qualitative and quantitative data analysis to inform program development and implementation.

All sites in the New Journeys network are required to utilize the New Journeys measurement-based care delivery and data platform, which is hosted in REDCap, a system maintained through WSU. REDCap is a widely used database management system that enables high-quality measurement collection and robust quality assurance processes. It also provides an integrated database while simultaneously allowing remote site staff access to their participants' data.

The New Journeys data platform incorporates several features to support the delivery of measurement-based care and ensuring high quality meaningful data, while also maintaining confidentiality. This includes real-time data quality checks, safety monitoring, participant calendaring system, individual case reports, and graphical feedback tools on select measures to monitor participant progress over time. Notably, New Journey teams will only have access to their team's data.

REDCap Server Security

WSU's REDCap is hosted on a secure and highly available Amazon Web Service infrastructure. Some of the key aspects of the AWS environment and infrastructure include:

- Deployed in an isolated, three-tiered Virtual Private Cloud on AWS
- Database backups are performed daily and automatically to enable operational and disaster recovery
- Encrypted data by default at rest and in flight (in accordance with HIPAA)
- Managed services to provide automated patching and maintenance of OS, middleware, and database software
- Assessed by WSU Information Security Services who works to protect confidentiality and integrity of data resources and compliance with HIPAA standards.

REDCap provides the capability to remove all identifiers from our dataset prior to exporting for analysis and reporting. There are 18 pieces of information that are considered identifiers for the purposes of HIPAA compliance.

It is important to note that not all of these identifiers are required as part of the registry and/or evaluation. The required identifiers have been bolded:

1. **Name**
2. Fax number
3. **Phone number**
4. **E-mail address**
5. Account numbers
6. **Social Security number**
7. **Medical Record number**
8. **Health Plan number**
9. Certificate/license number
10. URL
11. IP address
12. Vehicle identifiers
13. Device ID
14. Biometric ID
15. Full face/identifying photo
16. Other unique identifying numbers, characteristics, or codes
17. **Postal address (geographic subdivisions smaller than state)**
18. **Date precision beyond year**

Adherence to Measurement Delivery

The WSU evaluation and measurement delivery technical assistance team will monitor measurement delivery and completion with all New Journeys teams. WSU will meet with Program Directors monthly to discuss data quality and completion rates and address concerns related to the REDCap platform and measurement delivery. New Journeys teams are expected to maintain a monthly **completion rate of 70%** of all measures. Reports are available quarterly to each team and are also utilized in the New Journeys Annual Evaluation Report.

Two registry forms (Information Statement and Consent Form - Client and Family/Support Person Versions) are to be completed at the time of screening/intake; one by the individual and one by a family member/support person. These registry forms provide teams and support persons information about key components of New Journeys and what they will be asked to do as part of receiving services. For instance, the registry form explains how the surveys will be used to 1) inform treatment planning by New Journeys teams; 2) evaluate the impact of each New Journeys team; and 3) evaluate New Journeys in an aggregated way to determine the impact of the model.

In addition, participants are also asked to complete the New Journeys HIPAA release form. This form allows the New Journeys Evaluation team to access administrative data from HCA that is used as part of the ongoing data evaluation.

Summary of New Journeys Measurement Battery

The following measures are captured in the New Journeys measurement delivery and data platform (REDCap) and can be utilized by teams to perform measurement-based care decision-making. The New Journeys Comprehensive Assessment provides an outline of how these measures can be used to inform care. All measures can be found in New Journeys Measurement Battery.

Psychosis

To assess for symptoms of psychosis, the **Community Assessment of Psychic Experiences – Positive Scale 15 (CAPE-P15)** is completed quarterly. The CAPE-P15 is a self-report measure that is used to assess lifetime frequency of positive psychotic experiences. However, for New Journeys, it was modified to instead assess frequency in the last 30 days. Fifteen questions are formatted on a Likert Scale from 0-3 with 0 being "Never" and 3 being "Nearly always". Scores are determined by averaging the responses across the questions the individual answered. Total scores can range from 0 – 3, where any score greater than or equal to 1.47 indicates that the individual is currently having a clinically significant psychotic experience. The fifteen questions are broken down into three subscales: persecutory ideation, bizarre experiences, and perceptual abnormalities. The measure introduces a statement, for example, "In the past 30 days, have you felt as if there is a conspiracy against you?" and the participant answers from zero to three ("never" to "nearly always"). For any questions which were endorsed as 'Sometimes,' 'Often,' or 'Nearly always,' a question will populate to

have the individual rate their distress from the experience. The distress scale ranges from 'Not distressed' to 'Very distressed'. This scale is used to identify, prioritize, and address the experiences causing the individual the most distress.

The Clinician Rated Dimensions of Psychosis Symptom Severity (CRDPSS) is used to assess for symptoms of psychosis. This measure is completed once a month by a New Journeys team member rather than by the participant. The measure was adapted by WSU and includes 5 questions that assess the presence of: hallucinations, delusions, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Responses are on a 5-point Likert Scale (0 = "Not present," 4 = "Present and severe"). Each of these questions is scored independently. Scores range from 0-20. A higher score indicates more severe psychotic symptoms.

Depression

The **Patient Health Questionnaire 9 (PHQ-9)** is completed monthly. The purpose is to assess for, but not diagnose, symptoms of depression. Questions are formatted on a Likert scale from 0-3 with a maximum total score of 27. "None" is a score less than five, "Mild" is a score from five to nine, "Moderate" is a score of ten to fourteen, "Moderately Severe" is a score of fifteen to nineteen, and "Severe" is a score of twenty or greater. ***It is recommended that a score cutoff of 10 or higher is used when detecting major depression; this would suggest further assessment by the clinical team for the participant.***

Anxiety

The **Generalized Anxiety Disorder 7 Item (GAD-7)** measure is completed monthly. The purpose is to assess for, but not diagnosis, anxiety symptoms. Questions are formatted on a Likert scale from 0-3 with a maximum total score of 21. "None" is a score less than five, "Mild" is a score of five to nine, "Moderate" is a score of ten to fifteen, and "Severe" is a score of fifteen or greater. ***It is recommended that a score cutoff of 10 or higher is used when detecting an anxiety disorder; this would suggest further assessment by the clinical team for the participant.***

Functional Outcomes

This assessment identifies **goals related to participant's health, education, and employment**, and is to be completed quarterly. This measure has specific relevance to the SEE position as it tracks the participant's goals for education and employment, including how many days the individual attended work and school. This measure also identifies hospitalizations, other admissions (e.g., detox facility, residential substance use treatment, crisis stabilization), and legal involvement. This allows providers to determine sources of stress to address and support the individual more holistically.

Medical and Physical Health

To assess physical health, **Medical and Physical Health Indicators** are completed quarterly. This measure tracks any changes in the individual's weight and BMI, medication prescription and adherence, and perceived side effects from medication which could influence care and quality of life. Individuals are also asked if they currently have a primary care physician and the date of their most recent appointment.

Substance Use

To track an individual's substance use across time, the **Lifetime Drug Use Survey** is completed at intake. The **Monthly Drug Use Survey** is then completed monthly. These measures are essentially the same; however, the former asks about lifetime use, whereas the latter asks about use in the previous month. This measure was developed using the Fagerstrom to assess for tobacco use, and the Phenx toolkit on substance use to assess for alcohol, marijuana, and other substance use. Participants are asked if they have ever used a specific substance or used a specific substance in the last month. If yes, it asks how many days they used that substance. This information informs care with the treatment team. For example, if an individual has used a substance such as cannabis and are experiencing an increase in symptoms, the IRT can integrate the module on substance use to explore the association between substance use and the increase in symptoms. The SEE can

also apply this measure to address the effects of substance use through motivational interviewing and assessing the goals the individual may have regarding employment, particularly if the individual's employment requires drug testing.

Service Utilization

The **Service Utilization** measure is completed monthly by the providers. In this measure, providers are asked how many sessions were scheduled for each component of the New Journeys model and how many the individual or their supports attended. Additional positions, such as a Case Manager and Registered Nurse, are also tracked to account for all services provided to per month. Contact, outside of scheduled appointments, with the individual and their supports are also tracked.

OPTIONAL MEASURES

The following optional measures can be used if desired by teams to personalize their measurement-based care decision-making.

Prodromal Questionnaire-Brief – (PQ-B)

To assess for at-risk symptoms of psychosis, the **Prodromal Questionnaire-Brief (PQ-B)** is completed by the clinician at screening. The PQ-B is used to assess at-risk symptoms and distress, but not to diagnose psychosis. This measure has twenty-one items, and if participants select yes to the corresponding question, a follow-up question will populate to have the individual rate their distress. The distress scale ranges from 'Strongly disagree' to 'Totally agree.'

Family Satisfaction

The **Youth Services Survey for Families (YSS-F)** is used to measure how satisfied natural supports are with the services they are receiving. This survey tracks satisfaction across four domains: access, appropriateness, participation in treatment, and cultural sensitivity. This measure has 26 items, all of which are rated on a 5-point Likert scale ranging from "strongly disagree" to "strongly agree." Two additional open-ended questions are asked regarding what the supports feel is most helpful about services. This includes the type of services that they and their loved one have received in the last 6 months and what could be done to improve services. This measure assists in further developing New Journeys as a model and identifying gaps in care and services.

Discrimination Questionnaire

The **Discrimination Questionnaire** is completed once by the individual at intake. It assesses major discriminatory experiences in the individual's lifetime. This measure inquires about the participants experiences facing discrimination in various circumstances (e.g., unfairly fired, stopped & searched by the police, discouraged from continuing education, etc.). It also asks what they believe is the main reason for such discrimination and when it occurred. This measure assists providers in identifying stress the individual experiences, since it can lead to worse mental and physical health including depression and anxiety. This measure can also inform providers such as the SEE Specialist when supporting the individual in the goals for education and employment. For example, if the individual believes they were previously discriminated against for their sexual orientation at work, the SEE Specialist can assist the individual in finding employment at companies who have expressed their support for the LGBTQ+ community.

COMPASS-10

The **COMPASS-10** is used to assess feelings of **depression, anxiety, and suicidal ideation.** The Compass- 10 asks 10 yes or no questions which assess feelings of anger and suspicion, and symptoms of psychosis, including hallucinations, disorganized speech, unusual thoughts, and negative symptoms. At the end of each question, there is a 6-point Likert Scale (0 = "Not Present," 6 = "Very Severe"). For some questions, additional spaces are available to allow providers to better capture an individual's emotional state and experiences. Providers may choose to have the individual describe how

these symptoms/emotions manifest and impact them using their own words and describe if they have talked to anyone about these symptoms/emotions.

Process of Recovery

The **Process of Recovery measure** is completed quarterly and assesses positive qualities of a person's wellbeing. It is comprised of 15 questions each on a 5-point Likert scale ranging from "Disagree Strongly" to "Agree Strongly". It is advised that the measure be completed by the IRT as it can help inform strength-based recovery modules that the individual may benefit from as well as the current level of resiliency of the participant.

Trauma Measures (CATS/LECL, PCL)

The **Trauma Measure** can be completed at Intake. This assesses individuals' experiences of trauma throughout their lifetime. There are two different measures that can be used based on the age of an individual. Individuals aged 17 and younger should complete the **Child & Adolescent Trauma Screen (CATS)** while the **Life Events Checklist (LECL)** is used for individuals 18 and older**.** When trauma is endorsed on the LECL the **PTSD Checklist (PCL)** should also be completed. When trauma is endorsed on the CATS, clarifying information about how the event(s) have affected the individual should be asked. It is advised that this measure is completed with the IRT to inform discussions about trauma and how it may be impacting the individual's psychosis, anxiety, or depression. This can help to guide the development of skills to manage ongoing distress.

Delivery of Measures

Table 6. Measurement Delivery Across Team Members

Example 1

	New Journeys Team Position			
	Director & Family Education Clinician	**IRT Therapist**	**SEE Specialist**	**NP/Psychiatrist**
Intake Only	• Consult, Referral & Screening • Family Participant Demographics			
Monthly		• PHQ-9 • GAD-7 • Lifetime/Monthly Drug Use • CRDPSS		
	Service Utilization – components completed by all roles			
Quarterly Only		• CAPE-P15	• Functional Outcomes	• Medical and Physical Health Indicators
Bi-Yearly Only	• Demographic Follow-up			
**All measures except for the demographic follow-up must be completed at baseline. Monthly measures are completed quarterly and bi-yearly; quarterly measures are also completed bi-yearly.*				

Example 2

	New Journeys Team Position					
	Director	**Family Education Clinician**	**IRT Therapist**	**SEE Specialist**	**Case Manager**	**Nurse/NP/Psychiatrist**
Intake Only	• Consult, Referral & Screening	• Family Participant Demographics				
Monthly			• PHQ-9 • GAD-7 • CRDPSS		• Lifetime/ Monthly Drug Use	
	Service Utilization – components completed by all roles					
Quarterly Only			• CAPE-P15	• Functional Outcomes		• Medical Measure
Bi-Yearly Only					• Demographic Follow-up	

Table 6.2 Measurement Completion Frequency

		Frequency			
	Measure	**Intake Only**	**Monthly**	**Quarterly**	**Bi-Yearly**
Required	Patient Health Questionnaire – 9		X		
	Generalized Anxiety Disorder – 7		X		
	Functional Survey			X	
	Lifetime Drug Use / Monthly Drug Use		X		
	Clinician Rated Dimensions of Psychosis Symptom Severity		X		
	Community Assessment of Psychic Experiences – Positive 15			X	
	Medical Measures			X	
	Demographic Follow Up				X
	Service Utilization		X		
Optional	Prodromal Questionnaire Brief Version	X			
	Discrimination Scale	X			
	COMPASS-10	X			
	Trauma Measures (CATS / LECL, PCL)	X			
	Process of Recovery			X	
	Youth Services Survey for Families				X

CHAPTER 11: REDCAP ONBOARDING

New Journeys utilizes measurement-based care through the use of standardized measures that guide treatment practice and planning. These measures are entered into and stored in an encrypted database called, REDCap. Overall, the information that is entered into the database is used to not only inform individual treatment, but also to facilitate a better understanding of the longitudinal clinical and functional outcomes of New Journeys teams across the state. Specifically, this information is used in 5 different ways; 1) to generate a New Journeys Annual Report, 2) to provide additional information during the fidelity review process, 3) to inform the need for additional training for New Journeys team members, 4) to inform programmatic/model advancements, and 5) to advise state level decision making (including ongoing expansion, adaptation needs, and continued funding of the model).

When new teams are in the startup phase, they connect with the WSU evaluation team to complete REDCap training. It is advised that teams wait to complete their REDCap training until staff is hired and the team is ready to begin case building. This gives the team the opportunity to learn how to use REDCap while utilizing the system. Many team members who used this method noted that it facilitates improved learning and application of the database.

WSU Affiliation

Since REDCap is housed on a secure WSU server, all individuals who access REDCap must become affiliated with WSU. All teams are assigned a WSU evaluation coordinator who will facilitate this process and ensure team members gain access the database. Program Directors should inform their assigned coordinator when a new team member needs access to the system in the regularly scheduled monthly meetings or by sending an email with the team members name, role on the team, and email address. Once this information is received the WSU coordinator will send a survey to the person who needs access, which will ask for the following information:

- Legal first name
- Legal last name
- Date of birth
- Marital status
- Gender
- Work address
- Work phone number
- Confirmation of email address
- Last 4 digits of their social security number

Those who have ever worked for, applied to, volunteered at, or were enrolled at WSU will be asked to provide their legal first and last name and their WSU ID.

This information is used solely to establish an affiliation with WSU and will never be shared with any other party. The information will be housed on the REDCap database until an active WSU affiliation has been established at which time all provided demographic information from the New Journeys clinician will be removed from the REDCap database.

Once this information has been provided, a WSU New Journeys evaluation coordinator will create the affiliation and give the New Journeys team member their WSU ID. They will be asked to create a WSU email address, password, and dual verification (Okta account). Nobody on the WSU evaluation team will have access to any New Journeys team member's password or dual verification, so it is important that all affiliated personnel document their ID, email, and password in a secure location. Should the password or dual verification not work, New Journeys team members are advised to send an email to the Crimson Service Desk (crimsonservicedesk@wsu.edu). The Crimson Service Desk can reset passwords and dual verifications, but will ask for confirmation of name, WSU ID, and date of birth.

Once a WSU email address is established, the New Journeys team members should tell the WSU coordinator know. The WSU staff member will whitelist the email into a directory of people who are allowed access to the REDCap system.

The New Journeys team member then needs to log into REDCap for the first time at https://redcap.spo.aws.wsu.edu/ and let the WSU coordinator know when they have done so. At this point the WSU coordinator will establish REDCap access for the New Journeys team member and coordinate a training for the newly added individual.

REDCap Trainings

Once access to REDCap is established, a training will be scheduled with WSU to learn the REDCap system. One-hour trainings are provided via Zoom on a 1:1 or group setting for teams and new hires. During this training the New Journeys team member will learn the following:

1. How to access REDCap
2. How to review the dashboard of all current service users
3. How to add and rename new service users
4. How to input measures
5. Orientation to the Measurement Battery (including what the measures are, why they are delivered, and the frequency of completion with service users)
6. How to track measures with the calendaring system

A second training will be scheduled no later than one week following the first so that they may have time to access REDCap in their own time, practice entering measures or service users into the system, and then ask additional questions they may have.

REDCap Mobile Trainings

Once a "Memorandum of understanding" form has been signed and returned to WSU, New Journeys teams are provided with an iPad which allows the team to deliver measures while in the field, in the lobby, or in any area where they may lack internet access. The "REDCap Mobile" app should be downloaded onto the iPad for this purpose. Teams and individuals will participate in a one-hour training lead by the WSU coordinator on how to navigate REDCap Mobile, including:

1. How to get access to the New Journeys project on the app
2. How to download data from the REDCap server
3. How to enter measures
4. How to upload data from the app back to the REDCap server

Refreshers on both REDCap and REDCap mobile can be provided to any New Journeys team member upon request. Should the measurement completion rate be consistently low (≤70%), the WSU coordinator may request that the team to be retrained, during which there will be a discussion about barriers to measurement completion and potential solutions to these barriers.

The REDCap manuals and Measurement Battery are provided to each team prior to training. They can also be requested or downloaded at any time from each team's Project Dashboard under the File Repository (See Figure 8).

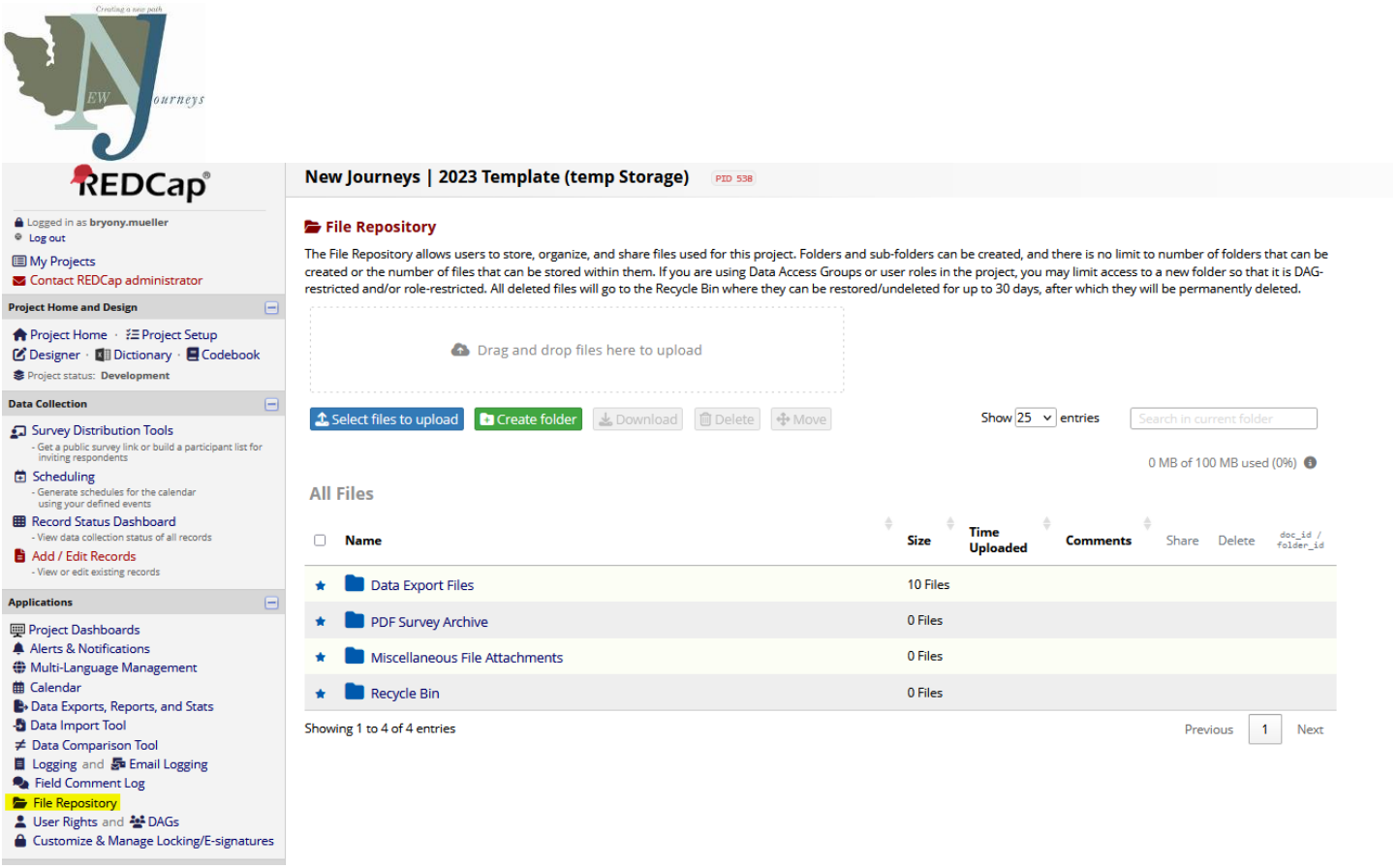


Figure 8: Image of where to access most up to date copies of the REDCap Manuals and Measurement Battery (highlight in yellow)

Any questions about trainings, measures, REDCap, or REDCap Mobile should be directed to your WSU Coordinator and Dr. Oluwoye.

CHAPTER 12: REFERRAL, SCREENING, & ADMISSION

New Journeys teams may receive requests for consultation or other initial contacts that vary considerably, ranging from someone experiencing a crisis, to simple questions about FEP. Due to the nature of FEP work, rapid response to referrals and development relationships in the community are key to overall program success. Response to inquiries require prompt response by the Program Director (usually within 72 hours).

Those referred to New Journeys will pass through up to six initial phases: 1) Request for Consultation, 2) Referral, 3) Prescreening, 4) New Journeys Screening, 5) Agency intake, and 6) and Admission to New Journeys and/or referral to appropriate services. Additional phases (including maintenance and discharge) will be discussed in the following chapters of this manual.

Some agencies have found it helpful to combine stages 1-3 (Consultation, referral, and pre-screening) for ease of access. These phases have corresponding statuses describing an individual's pathway through New Journeys and are tracked in the New Journeys data platform's individual status form (See Table 4). Please refer to the New Journeys REDCap dashboard for a full list of the most up-to-date status options.

Outside of what is included in the New Journeys measurement delivery and data platform, each agency can establish its own protocols for how consultation is conducted and documented based on the needs of their region and requirements of their agency. New Program Directors can reach out to other Program Directors for more information about how they have managed these requests for consultation.

Table 7. REDCap Status Options

Status	Description
Consult Only	A consult was given to another clinician or an individual's natural supports, during which a member of the New Journeys team discussed whether this program was appropriate, but no referral was made, and it was determined that the person in question was not appropriate for services
Unable to Contact	A referral was received, but the clinician was unable to contact the person in question to conduct a screening and determine eligibility.
Pending	A referral has been received, but the referral/screening has not taken place yet OR the eligibility of the individual has yet to be determined as they have current circumstances which prevent them from engaging with the program. *No more than 1 month in this status.*
Not Eligible	The referral and screening indicated that the individual does not meet eligibility criteria for the program
Opted Out	The individual *was* determined eligible for the program; however, they chose not to participate before receiving any services.
Active	The individual is currently enrolled in New Journeys and engaging in services by attending sessions and participating in measurement-based care.
Provisional Admission	This status indicated that an individual has been enrolled with New Journeys with the mutual understanding that ongoing differential diagnosis is needed to determine eligibility. *No longer than 6 months in this status.*
Paused	This individual is currently in a situation where they are unable to receive New Journeys services (e.g., currently hospitalized, in jail, etc.). Their services were paused so as not to exceed the 24 months of allowed services they can receive from the program.
No Show	This individual has given no communication to the New Journeys team about why they are not participating in the program. There is no known reason why they are not able to engage. *No more than 3 consecutive months in this status*.

Referred to another service	While the individual was initially deemed eligible for the program, it was later determined that this program was not the most appropriate for their needs. Clinicians coordinated with other programs/agencies to get them the best care possible.
Referred to another New Journeys program	The individual has relocated in Washington State and been transferred to another New Journeys program.
Disengaged	Best attempts have been made to reengage the individual in the program, but they have not shown up to appointments OR they requested to no longer receive services from this program.
Maintenance	This individual's next goal is graduation. The New Journeys team has lessened services and is providing follow-up care to monitor the individual's transition process. The individual has met the threshold for entering this phase. *No more than 3 months at in this status, at which time the individual either moves back to Active or to Graduated.*
Graduated	The individual has significant improvement from their baseline appointment as indicated by their overall wellbeing and measurement-informed care. The individual has engaged in meaningful activities, such as school or employment, has increased socialization, and has improved symptoms of psychosis and coping skills.

Request for Consultation

In order to ensure a successful referral system, a "no wrong door" approach is best. This means that referrals may be received in several ways (e.g., phone, email, fax, submission of an agency's referral form, and walk-ins). New Journeys Program Directors may spend time in consultation with providers inside and outside of the direct agency, which may or may not result in a formal referral to the program. These informal conversations provide opportunities for ongoing education to providers, community members, and other referral sources in the region, and they may in turn help facilitate appropriate referrals to the team.

Referral

During the startup phase of launching a team, a referral workflow (example in Appendix C) is created as a part of the agency's program development. This process will be refined as the team begins accepting referrals. Referrals can be made in multiple ways. The New Journeys website offers a referral form which can be used to contact New Journeys teams across the state. Most agencies also have their own referral forms (a fillable referral form that can be adapted to each agency is in Appendix E), which should be easily accessible on the Internet. The Program Director is the central point person who manages and oversees all referral activities and finesses the initial contact with referral sources. Referrals should also be tracked in the New Journeys measurement delivery and data platform.

A Note on Maintaining a Referral Network

Once established, the referral network needs ongoing management and support (e.g., contact referral sources regularly, update contact information). Even well-established teams will continue to have opportunities for community education and refinement of referral protocols.

Decreased outreach and engagement in a region is associated with increased DUP (Weiss et al., 2022). This highlights the importance of forming and maintaining an Advisory Committee. An Advisory Committee is comprised of cross-agency partners who serve as liaisons to their larger agency and serve to direct FEP referrals to the New Journeys team. Members may include representatives from various systems in the region, including but not limited to the regional BH-ASO, MCOs, WISe Coordinator(s), allied system/agency partners (schools, youth programming, etc.), individuals with lived experience, and/or natural supports. An Advisory Committee can enhance cross-system collaboration and improve outcomes for youth and young adults through ongoing community education, early identification, and access to early intervention programs. The idea is that someone experiencing FEP should be seen by the team of specialists (e.g., New Journeys) regardless of which agency in a community the person experiencing symptoms seeks services. This may be a different way of thinking and managing referrals than they are accustomed to. Quarterly Advisory Committee meetings

are an excellent opportunity to begin to change the narrative through educational opportunities with those external agencies. Alternatively, some Program Directors have chosen to participate in existing community meetings/advisory boards in their region to serve this function, rather than creating a separate advisory committee.

Pre-screening

Once a referral is received, if not already completed as a part of the consultation phase, the New Journeys Program Director will review the referral and make contact with the referral source to complete Prescreening activities. Prescreening activities may include contacting the referral source, making the initial contact with an individual and/or their natural supports, and gathering records from the hospital, behavioral health agency, and/or school.

The primary purpose of the prescreening activities is to be responsive to the person seeking services and the referral source and determine if an individual meets the most basic requirements for New Journeys, including age, duration of psychosis, and whether the referred individual lives in the appropriate geographic area. Prescreening is typically conducted remotely. This process can help with providing more efficient and timely feedback to referrals, as the team can avoid conducting a full screening if the person obviously screens out due to factors such as age or geographical location.

New Journeys Screening

The Program Director determines if a formal screening is required after completing the initial prescreening of the referral (see Table 1 for eligibility criteria).

If screening is indicated, the next step is to arrange an in-person, in-depth evaluation with the individual and their natural supports. During this period, it may be helpful to collect additional health records and related documentation and any other collateral information. Many Program Directors utilize the PQ-B and/or the Structured Clinical Interview for DSM-5 (SCID-5) to assist in identifying if an individual meets New Journeys eligibility criteria. There is also a screening form in the New Journeys data platform which should also be completed at the time of or directly after screening. This form can serve as a checklist to indicate if an individual meets the basic New Journeys eligibility criteria.

Typically, if the diagnosis is unclear during the screening process, the Program Director should complete the SCID-5 and use that information to guide consultation with a subject matter expert on the UW-sponsored Differential Diagnosis Consultation Calls held monthly, or by reaching out directly to the UW training team. If further psychological, neuropsychological, or other more extensive evaluation is indicated, the Program Director may request an evaluation through the UW Central Assessment of Psychosis Service (CAPS; capsreferral@uw.edu).

Intake and Admission

Once it is determined that someone is eligible and interested in enrolling in services with New Journeys, the agency's intake protocol should be followed. Once the agency intake is complete, the participant should begin engaging in services with the various team members. The intake marks an individual's start date in treatment. For attested providers, the intake will also trigger the start date of Medicaid enrollees' TBR reimbursement schedule. At this time, the individual's status in New Journeys data platform should be updated to 'Active' and the team should complete intake measures and begin to administer surveys as scheduled.

If the person does not meet eligibility criteria for New Journeys, or declines services, the Program Director should always ensure a warm hand off to services more suited to the individuals' needs. For many teams, this may mean referring individuals to their agency's outpatient programming, a private therapist in the community, or a more specialized program such as WISe or Healthy Transitions for youth, or the Program of Assertive Community Treatment (PACT) for adults with longer durations of psychosis.

Provisional Admission

It is important to note that for some individuals who present a more complex diagnostic picture and/or need more time to further evaluate their symptom presentation, it may take months to determine eligibility. In these cases, the program should provisionally enroll them in New Journeys, using the 'Provisional Admission' status in the New Journeys data platform, while informing the individual and family/natural supports that their enrollment status may change as their diagnosis becomes clearer over time. Provisional Admission is intended as a short-term status option (up to 6 months) to allow a team to complete ongoing engagement and assessment of an individual's needs. If it is determined that the individual meets the New Journeys eligibility criteria during this period, the status in the New Journeys data platform should be updated to 'Active.' During this period, if an individual is determined not to meet New Journeys criteria and is better suited for another service, the individual should be referred to more appropriate services through the developed referral network. The status in the New Journeys measurement delivery and data platform should be updated to 'Referred to Another Service.'

CHAPTER 13: ACTIVE PHASE: TIMING OF ENGAGEMENT & PROVISION OF NEW JOURNEYS INTERVENTIONS

This section will provide an overview of the engagement process as well as some tips for beginning the various interventions. First, it is important to note that the process of engagement with individuals and their natural supports may vary by team and/or based on individual needs. As specific situations/questions arise, you can always reach out to a member of the UW Implementation team (Appendix G).

Active Phase

Once an individual is enrolled in New Journeys, the Program Director and other team members will begin engaging an individual and their natural supports in the various aspects of the model and begin providing services. This is referred to as the 'Active' phase of New Journeys in the data platform. During this time, team members will engage with an individual and their family to establish rapport, build trust, identify treatment goals, stabilize acute symptoms, and support an individual and their natural supports in making progress toward the individual's/family's identified goals. These services are described in the New Journeys manuals and in the suggested timeline of services (Table 7).

During this phase of treatment, the intensity of services is often higher, and an individual may be engaging with various team members three to five contacts per week. This heightened service intensity is accounted for in the TBR.

Table 8. Standard Timeline of Services*

Timepoint	Family Education Specialist	IRT Therapist	SEE Specialist	Psychiatric Care Provider	Peer Support Specialist
Intake	Intake and Orientation; Meet the team			Intake and initial meeting	Orientation and initial meeting
1st Month	Comprehensive Assessment; Orientation to Family Education	Comprehensive Assessment; Orientation to IRT	Comprehensive Assessment; Orientation to SEE services	Comprehensive Assessment: Orientation to Medication Management	Comprehensive Assessment; Orientation to peer services
	Collaborative person-centered treatment planning meeting	Collaborative person-centered treatment planning meeting	Collaborative person-centered treatment planning meeting	Collaborative treatment plan update; Meet weekly	Collaborative treatment plan update
2nd Month	Continue Family Education Program Modules; Meet weekly or twice a month	Begin Standard IRT Modules; continue to meet approximately weekly	Assessment and Goal Setting- Completion of Career and Education Inventory	Meet weekly	Meet weekly
			Assist participant with work or school goals -School or job search -Help participant with disclosure decisions	Shift to meeting every other week, or continue weekly if not yet stabilized	Meet weekly
3rd Month	Complete Family Education Program; Treatment planning with recommendations			Shift to meeting every other week, or continue weekly if not yet stabilized	Shift to meeting every other week, or continue weekly if not yet stabilized

4th Month	Begin monthly check-ins and family consultation as needed		-Participant applications and interviews -Follow-along support once school/job has been started -Evaluate participant satisfaction and goals; Collaborative treatment plan update	Shift to meeting every other week, or continue weekly when not yet stabilized	Shift to meeting every other week, or continue weekly if not yet stabilized
5th Month	Continue monthly check-ins and family consultation as needed	Complete Standard IRT Modules; continue to meet approximately weekly		Shift to meeting every other week, or continue weekly if not yet stabilized	Shift to meeting every other week, or continue weekly when not yet stabilized
6th Month	Continue monthly check-ins and family consultation as needed; Collaborative treatment plan update	Begin Individualized IRT Modules; Collaborative treatment plan update		6 month follow up assessment and shift to meeting monthly if stabilized and/or no major medication changes; Collaborative treatment plan update	Shift to meeting every other week, or continue weekly if not yet stabilized; Collaborative treatment plan update

*Case management, Peer Support, and Nurse Care Management are offered as needed throughout the participant's time with New Journeys. Please note that timelines can vary based on individual and family needs.

Comprehensive Assessment

The New Journeys Comprehensive Assessment is intended to support the comprehensive, ongoing collection and integration of multiple data points in order to inform effective treatment planning. Many teams are already collecting this information through established assessment processes within their agency. The Comprehensive Assessment can be an additional tool to ensure that information is being shared across the team and used in a way that aids in the overall treatment of an individual.

The New Journeys Comprehensive Assessment has three primary aims:

1. Facilitate engagement of the participant with the New Journeys team while developing a shared understanding of their experience and history.
2. Provide a mechanism for completing team-based, integrated assessment and person-centered treatment planning.
3. Incorporate measurement-based care.

Engagement

It is crucial that team members are sensitive to an individual and their natural supports preferences regarding the extent and intensity of services they want to receive, their needs, and their willingness and motivation to engage with the team. Engagement can vary greatly from one individual to the next. This is expected and is why many teams consider engagement an ongoing process throughout an individual's time with a New Journeys team. It is important to note that while teams remain flexible with what their engagement looks like, many agencies hold some level of expectation regarding engagement for anyone to remain enrolled in outpatient programming within their agency. Program Directors can educate the agency's leadership on the unique engagement needs of those with FEP to ensure equitable access to these services as engagement may take more time than would be expected for other outpatient programs. The Program Director should have a clear understanding of the agency's expectations for engagement and communicate those to the various team members as well as those enrolling in services. Setting initial expectations for engagement can benefit the overarching goal of early intervention, stabilization, and recovery.

It is important to inform a participant and their supports about the 24-month timeline of services early in the treatment process. If periods of disengagement do occur, it is important that each agency follow the processes put in place within their agency to utilize the pause feature of the TBR to preserve the 24-month lifetime benefit of the New Journeys TBR.

During the initial months of engagement, there is alignment in the curriculum taught in family education and the standard modules of IRT. As such, coordination is needed between the Family Education Clinician and the IRT Clinician when individuals are engaged with both.

Engagement of Individuals and Natural Supports in New Journeys

The Program Director lays a foundation for engagement while completing the referral, screening, and admission process outlined in Chapter 12. As they are often the first person on the team to engage individuals and natural supports, the Program Director will continue the engagement process as they facilitate introductions to the various team members and provide an orientation to the model.

For individuals who live with (or have very engaged) natural supports, we recommend the following sequence of engagement:

- Pre-screening/Screening- The Program Director engages with the individual, supports, and/or the referral source to determine if the individual meets the New Journeys admission criteria and is interested in pursuing an assessment. During this contact, the Program Director will provide a brief overview of New Journeys and the supports offered by the team and elicit interest from the individual.
- When it is determined that the individual will enroll in New Journeys, the Program Director may revisit what is provided in the model and review the Orientation to NAVIGATE handouts found in both the Family Education and IRT manuals. We encourage teams to tailor this review to New Journeys and their team specifically.
- The Program Director usually tries to arrange a brief "meet and greet" with each team member. This may occur during the screening or intake appointment as a brief introduction or can be scheduled as the first session after intake.
- At the "meet-and-greet", each team member can set up an initial appointment with the individual to further explain their role and how they might be able to support the individual. These initial appointments may be brief and may occur on the same day. This allows the participant to learn more about each team member, their role on the team, and how the intervention can support them in making progress towards what is most important to them.
- In most cases, it is beneficial for the Family Education Clinician and the IRT Clinician to begin regular meetings with an individual and their natural supports as soon as possible.
    - If the individual agrees to their natural supports' participation with the team, the Family Education Clinician should meet with each of the individual's natural supports separately to get to know them better and assess their needs. These individual meetings can be followed by sessions where the natural supports meet together. The individual is encouraged to attend these sessions.

      AND
    - The IRT Therapist should meet with the individual to begin IRT sessions, and together, they agree on a desired frequency of initial meetings. Typically, IRT sessions occur at least weekly during the initial phases of engagement and may decrease in frequency over time as an individual's symptoms and needs resolve.
- If the individual is highly symptomatic and/or still in the process of having their symptoms stabilize, the Program Director may arrange for the individual to meet briefly with the IRT Therapist, while initiating family education sessions with only the natural supports and postponing the first meeting with the SEE specialist and other supports until a more appropriate time. During symptom stabilization, encouraging meetings with the Peer Specialist can

be beneficial, as the Peer can provide hope and encouragement based on their own lived experience. During this period of stabilization, they may also find it helpful to meet with the case manager, who can assist with locating resources to meet an individual's most basic needs such as housing, transportation, or food as needed.

- Initial engagement can be tailored to an individual's personal goals and preferences and based on their willingness to engage in a particular aspect of the model. For example, an individual may choose to engage with a specific team member they get along with most or who can offer them support in an area they are most willing to engage with. This allows for flexibility in engagement and can help build trust with a team.

Navigating Challenges to Engagement in Family Education

Sometimes individuals will say that they do not want their natural supports to participate in their treatment. This can be for many reasons, such as a desire to be independent of their families (e.g., "I can handle this on my own"), not wanting to "bother" their families ("they are too busy to come to any appointments"), a history of conflict with their families ("they don't want to be involved with me"), or a misunderstanding about what family education sessions will entail ("family meetings would be about people criticizing me and telling me what to do").

When a participant expresses reluctance to have their natural supports involved, it is important to be curious about their point of view and concerns, to talk about what family education session are and are not, and to help the individual consider the possible advantages of their supports being involved. For example, the supports might understand better what the individual has been going through, meeting together might help reduce conflict, or coming to family meetings might help everyone get on the same page and support each other.

On the flip side, sometimes an individual's natural supports will say that they do not want to be involved in family education sessions. Like the suggestions above, it is important to be curious about their point of view and their concerns, to dispel any misunderstandings about family education sessions, and to help them consider the possible advantages of joining family sessions as well as their role in their loved one's recovery process.

When participants and/or supports have not agreed to participate in family education sessions, it is important to re-visit this topic during team meetings so the team can help problem-solve how to involve an individual's natural supports. For example, a participant who is reluctant to have their natural supports involved might be meeting regularly with the IRT clinician. The IRT clinician could suggest that the family clinician join them briefly during an IRT session to talk about the family education sessions and answer any questions the individual may have. As another example, a natural support who is reluctant to be involved in family education might regularly accompany the individual to medication appointments. The prescriber might broach the subject with the natural supports and even suggest that the family clinician join them for a few minutes to answer any questions or address any concerns the support person might have.

Individuals may agree to have their supports attend family sessions but vary in terms of how much they choose to be involved in the sessions themselves. There are three broad categories of involvement:

- The individual may be involved in all or nearly all family education sessions
- The individual may participate in only some family education sessions or may join only part of the session (e.g., either the first or last 20-30 minutes of the session)
- The individual may participate in no family education sessions

While it is the individuals and support person(s) choice to participate in family education sessions, the Program Director and the rest of the team should encourage them to participate for several reasons:

1. Educating an individual's supports about their psychiatric disorder is often more effective when the individual is present since they can provide personal examples of their experiences and the effects of their symptoms on their life. This may serve as a "rallying point" around which the individuals natural supports can work together.

2. Teaching the principles of treatment to the individual and natural supports together is more effective because it involves helping the family work together to address important issues, such as taking medications as prescribed and developing a relapse prevention plan.
3. Working with the individual and the natural supports together can alert the Family Clinician to strengths within the family/support system that they otherwise would not have been aware of, or it can alert the Family Clinician to the presence of problems in communication and problem-solving that would otherwise be impossible to observe.
4. If participants and supports learn about psychosis together and become comfortable talking about it together, this will help them continue to communicate about it in their home environment. For example, if the individual and supports develop skills to talk about the symptom of hearing voices, if the individual begins to have auditory hallucinations, the individual is more likely to share that information with their natural supports and the supports are more likely to have a calm and sympathetic response. Together they may be able to reach out more effectively to the treatment team.

Overlapping Content between Family Education and Individual Resiliency Training (IRT)

As noted above, some individuals attend family sessions along with their natural support(s) and others do not. When the individual is actively involved in family education and attends some or all of the family sessions, IRT sessions can be adapted to avoid overlap of educational information. As noted earlier, the educational material covered in family manual addresses similar topics as the material in the standard modules of IRT.

Adaptations to the provision of IRT for individuals who are actively engaged in Family Education involve using IRT sessions to briefly review any educational material covered in Family Education and to fill in any additional information on the topics that is provided in IRT modules. Or, if the IRT sessions are covering a topic before it is covered in the Family Education sessions, the Family sessions can briefly review the educational material covered in IRT and fill in any additional information on the topic that is provided in the Family Education module.

CHAPTER 14: MAINTENANCE AND DISCHARGE PHASES OF TREATMENT

Maintenance Phase

As an individual's symptoms stabilize and they begin to make progress towards their unique recovery goals, they may require fewer services over time. As such, it may be appropriate to consider discussing moving into the "maintenance phase." During this phase, the team conducts a trial run of decreased supports over a period of at least three months. If this trial goes well and the person still feels ready to graduate from New Journeys, everyone will work together to implement the discharge plan which has been created throughout the individuals time in services.

Indicators of readiness for a maintenance phase:

- The participant indicates that they feel ready to decrease their number of appointments
- Consistent scoring (3 months or more) of 1.46 or below on the CAPE-P15 (See page 60)
- The participant made progress towards some of the goals they set for themselves

In some cases, individuals may try the maintenance phase and then require an increase in services. In this case, the team should move their status in the New Journeys data platform back to 'Active' while providing increased services to meet the individual's needs.

Discharge

New Journeys provides intensive, time limited services to help an individual experiencing FEP to achieve a reduction in symptoms and/or have developed skills to manage persistent symptoms, identify a path forward, and develop resiliency to promote relapse prevention into the future. Since teams can only serve up to 30 individuals at any given time, transitioning participants who have engaged with the treatment model is essential to ensure timely access for other individuals experiencing FEP who need to access services.

It is important to inform a participant and their supports about the 24-month timeline of services early in the treatment process. This introduces the narrative that experiencing psychosis does not equate to a lifetime of clinical services. As an individual approaches 24 months in services, everyone (e.g., the New Journeys team, the individual, and their supports) works together to decide on the next best steps to provide an individualized discharge plan. Discharge needs can vary from person to person. Some people may transition into outpatient services offered within the agency, while others may only need support for ongoing medication management. Many clinicians find it helpful to discuss discharge planning with an individual throughout their course of engagement with the team. This ensures that an individual does not feel blindsided by a transition as they approach 24 months of service. It also allows for ample opportunities to identify supports that an individual will need after completing their time with New Journeys.

Reasons for Discharge

Eligibility Criteria is Not Met

One of the most common reasons for discharge is that the model is no longer considered to be the most appropriate service for the participant's needs. This may occur if it is discovered that an individual's presentation of psychosis is not caused by a schizophrenia spectrum disorder or may be complicated by ongoing substance use and the individual's needs would be better served by primary substance use services. In these scenarios, clinicians coordinate referrals with other programs/agencies to get them the best care possible.

Disengagement or Drop-Out/Request to Discontinue Services
Other times, discharge occurs due to a team's inability to contact a participant, known as 'Disengagement'. In these cases, the team has made their best attempts to contact and reengage the individual in the model. Importantly, many New Journeys team members have communicated the need keep their cases open within the agency for longer durations of no contact than may be typical in an agency's outpatient programming. This need for increased flexibility is due to increased engagement and outreach attempts, including calling the individual and natural support, visiting the individual's home, and sending multiple attempts to contact an individual by mail. In the data platform, the individual's status would be "no-show." This status can last for up to 3 months. An individual is only discharged due to disengagement if they have not responded to these outreach attempts, have not shown up to appointments, and/or they requested to no longer receive services from the team.

Some individuals may ask to discontinue services or drop out. This may be because they are not ready to receive the high level of care provided by New Journeys teams among various other reasons. The TBR accounts for this through a "pause" feature, which acts to preserve the 24-month lifetime benefit of New Journeys and allows someone to disengage and then return to services at a later time if needed.

Graduation
The ideal reason for discharge is graduation! When someone is eligible to graduate from New Journeys, the individual has made significant functional improvement since enrolling with the team (indicated through engagement in meaningful activities, improved symptoms of psychosis, and coping skills). Often these improvements are indicated by observations of their overall wellbeing and self-report measures in the New Journeys data platform.

When someone is ready to graduate from the New Journeys team, it is important to not only make a plan for ongoing step-down care (which may include ongoing medication management, enrollment in other services that meet an individual's ongoing level of care needs, engagement in self-help/peer groups, etc.) but also to consider celebrating the accomplishment! Many teams do this through hosting small celebrations or "graduations" for the participants.

A Note on Referring to PACT/ACT Teams
When New Journeys participants are transitioning out of New Journeys services, team members often ask, "Where does PACT (Program of Assertive Community Treatment) fit in the continuum of care for New Journeys participants?" The goal of New Journeys is to fundamentally change the trajectory and prognosis of individuals with schizophrenia-spectrum disorders through coordinated and systematic treatment in the earliest stages of the illness. New Journeys offers early intervention of someone's illness in order to prevent or limit the lifetime of disability that can be seen in more chronic presentations of psychosis. This fundamental goal targets graduation into less intensive services. PACT, however, is a higher level of service than New Journeys and may counteract the intention of early intervention if not referred to appropriately.

While PACT may be a clinically appropriate transition for some participants, providers should work to ensure that they only transition New Journeys participants into PACT if it is a clinically appropriate referral and that the team is not over-referring New Journeys participants to PACT because it is seen as an easy transition, especially if both programs are offered within the same agency.

As fidelity for New Journeys is developed, clinical appropriateness of individuals transitioning from New Journeys to PACT will be assessed to ensure that when transitions do occur, they are timely, clinically appropriate, and meet the level of care an individual continues to need after graduation from New Journeys.

REFERENCES

Adams, N., & Grieder, D. M. (2005). *Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery*. Burlington, MA: Elsevier Inc.

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*, 1123.

Becker, D. R., & Drake, R. E. (2003). *A Working Life for People with Severe Mental Illness*. New York: Oxford University Press.

Bellack, A. S., Mueser, K. T., Gingerich, S., & Agresta, J. (2004). *Social Skills Training for Schizophrenia: A Step-by-Step Guide* (Second ed.). New York: Guilford Press.

Birchwood, M., Todd, P., & Jackson, C. (1998). Early intervention in psychosis: The critical period hypothesis. *British Journal of Psychiatry, 172 (Supplement 33)*, 5359.

Bond, G. R., Campbell, K., Evans, L. J., Gervey, R., Pascaris, A., Tice, S., Del Bene, D., & Revell, G. (2002). A scale to measure quality of supported employment for persons with severe mental illness. *Journal of Vocational Rehabilitation, 17*, 239250.

Bond, G. R., Drake, R. E., & Becker, D. R. (2008). An update on randomized controlled trials of evidence-based supported employment. *Psychiatric Rehabilitation Journal, 31*, 280-290.

Compton, M. T., & Broussard, B. (2009). *The First Episode of Psychosis: A Guide for Patients and Their Families*. New York: Oxford University Press.

Corrigan, P. W. (2004). Don't call me nuts: An international perspective on the stigma of mental illness. *Acta Psychiatrica Scandinavica, 109*, 403-404.

Corrigan, P. W. (Ed.). (2005). *On the Stigma of Mental Illness: Practical Strategies for Research and Social Change*. Washington, DC: American Psychological Association.

Corrigan, P. W., & Holmes, E. P. (1994). Patient identification of "Street Skills" for a psychosocial training module. *Hospital and Community Psychiatry, 45*, 273-276.

de Leon, J., & Diaz, F. J. (2005). A meta-analysis of worldwide studies demonstrates an association between schizophrenia and tobacco smoking behaviors. *Schizophrenia Research, 76*, 135-157.

Deegan, P. E., Rapp, C. A., Holter, M., & Riefer, M. (2008). Best practices: a program to support shared decision making in an outpatient psychiatric medication clinic. *Psychiatric Services, 59*, 603-605.

Elson S. Floyd College of Medicine- Washington State University. (2022). 2022 Evaluation Report

Falloon, I. R. H., Coverdale, J. H., Laidlaw, T. M., Merry, S., Kydd, R. R., & Morosini, P. (1998). Early intervention for schizophrenic disorders: Implementing optimal treatment strategies in routine clinical services. *British Journal of Psychiatry, 172*(Suppl. 33), 33-38.

Fenton, W. S. (2003). Shared decision making: A model for the physician-patient relationship in the 21st century? *Acta Psychiatrica Scandinavica, 107*, 401-402.

Gingerich, S., & Mueser, K. T. (2005). Illness management and recovery. In R. E. Drake & M. R. Merrens & D. W. Lynde (Eds.), *Evidence-Based Mental Health Practice: A Textbook* (pp. 395-424). New York: Norton.

Gingerich, S. & Mueser, K.T. (2011). *Illness Management and Recovery: Personalized Skills and Strategies for Those with Mental Illness.* Hazelden Publications.

González-Pardo, H., & Pérez Álvarez, M. (2013). Epigenetics and its implications for Psychology. Psicothema, 25(1), 3–12. https://doi.org/10.7334/psicothema2012.327

Green, M. F. (1996). What are the functional consequences of neurocognitive deficits in schizophrenia? *American Journal of Psychiatry, 153*, 321-330.

Häfner, H., & an der Heiden, W. (2008). Course and outcome. In K. T. Mueser & D. V. Jeste (Eds.), *Clinical Handbook of Schizophrenia* (pp. 100-113). New York: Guilford Press.

Häfner, H., Löffler, W., Maurer, K., Hambrecht, M., & an der Heiden, W. (1999). Depression, negative symptoms, social stagnation and social decline in the early course of schizophrenia. *Acta Psychiatrica Scandinavica, 100*, 105-118.

Häfner, H., Maurer, K., Löffler, W., an der Heiden, W., Hambrecht, M., & SchultzeLutter, F. (2003). Modeling the early course of schizophrenia. *Schizophrenia Bulletin, 29*, 325-340.

Heinssen, R. K., Goldstein, A. B., & Azrin, S. T. (2014). Evidence-based treatments for first episode psychosis: Components of coordinated specialty care. Retrieved from https://www.nimh.nih.gov/health/topics/schizophrenia/raise/evidence-based-treatments-for-first-episode-psychosis-components-of-coordinated-specialty-care.shtml

Herrmann-Doig, T., Maude, D., & Edwards, J. (1993). *Systematic Treatment of Persistent Psychosis: A Psychological Approach to Facilitating Recovery in Young People with First-Episode Psychosis*. London: Martin Dunitz.

Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*(3), 353–366. https://doi.org/10.1037/a0032595

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*, 223-233.

Hunt, G. E., Large, M. M., Cleary, M., Lai, H. M. X., & Saunders, J. B. (2018). Prevalence of comorbid substance use in schizophrenia spectrum disorders in community and clinical settings, 1990-2017: Systematic review and meta-analysis. Drug and alcohol dependence, 191, 234–258. https://doi.org/10.1016/j.drugalcdep.2018.07.011

Jackson, C., Trower, P., Reid, I., Smith, J., Hall, M., Townend, M., Barton, K., Jones, J., Ross, K., Russell, R., Newton, E., Dunn, G., & Birchwood, M. (2009). Improving psychological adjustment following a first episode of psychosis: A randomised controlled trial of cognitive therapy to reduce post psychotic trauma symptoms. *Behaviour and Research Therapy, 47*, 454-462.

Judge, A., Perkins, D. O., Nieri, J., & Penn, D. L. (2005). Pathways to care in first episode psychosis: A pilot study on help-seeking precipitants and barriers to care. *Journal of Mental Health, 14*, 465-469.

Kane, J. M., Robinson, D. E., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., Addington, J., Brunette, M. F., Correll, C. U., Estroff, S. E., Marcy, P., Robinson, J., Lynde, D. W., Meyer-Kalos, P. S., Gottlieb, J. D., Glynn, S. M., Pipes, R., Kurian, B. T., Miller, A. L., Azrin, S. T., Goldstein, A. B., Severe, J. B., Lin, H., Majnu, J., & Heinssen, R. K. (2016). Comprehensive versus usual care for first episode psychosis: Two-year outcomes from the NIMH RAISE Early Treatment Program. *American Journal of Psychiatry, 173*, 362-72

Killackey, E., Jackson, H. J., & McGorry, P. D. (2008). Vocational intervention in first episode psychosis: A randomised controlled trial of individual placement and support versus treatment as usual. *British Journal of Psychiatry, 193*, 114-120.

Kingdon, D. G., & Turkington, D. (2004). *Cognitive Therapy of Schizophrenia*. New York: Guilford Press.

Kurtz, M. M., & Mueser, K. T. (2008). A meta-analysis of controlled research on social skills training for schizophrenia. *Journal of Consulting and Clinical Psychology, 76*, 491-504.

Lambert, M. J., Whipple, J. L., Vermeersch, D. A., Smart, D. W., Hawkins, E. J., Nielsen, S. L., & Goates, M. (2002). Enhancing psychotherapy outcomes via providing feedback on client progress: A replication. *Clinical Psychology & Psychotherapy*, *9*(2), 91-103.

Lambert, M. J., Whipple, J. L., Hawkins, E. J., Vermeersch, D. A., Nielsen, S. L., & Smart, D. W. (2003). Is it time for clinicians to routinely track patient outcome? A meta-analysis. *Clinical Psychology: Science and Practice*, *10*(3), 288-301.

Lewine, R. R. J. (2005). Social class of origin, lost potential, and hopelessness in schizophrenia. *Schizophrenia Research, 76*, 329-335.

Lewis, C. C., Puspitasari, A., Boyd, M. R., Scott, K., Marriott, B. R., Hoffman, M., Navarro, E., & Kassab, H. (2018). Implementing measurement based care in community mental health: A description of tailored and standardized methods. *BMC Research Notes, 11*(1), 76. doi:10.1186/s13104-018-3193-0.

Liberman, R. P., Mueser, K. T., Wallace, C. J., Jacobs, H. E., Eckman, T., & Massel, H. K. (1986). Training skills in the psychiatrically disabled: Learning coping and competence. *Schizophrenia Bulletin, 12*, 631-647.

Mark, T., Coffey, R., Vandivort-Warren, R., Harwood, H., & King, E. (2005). U.S. Spending for Mental Health and Substance Abuse Treatment, 1991-2001. *Health Affairs, Jan-Jun Suppl Web Exclusives*, W5-133-W135-142.

McGurk, S. R., & Mueser, K. T. (2004). Cognitive functioning, symptoms, and work in supported employment: A review and heuristic model. *Schizophrenia Research, 70*, 147-174.

Mihalopoulos, C., Harris, M., Henry, L., Harrigan, S., & McGorry, P. (2009). Is early intervention in psychosis cost-effective over the long term? *Schizophrenia Bulletin, 35*, 909-918.
Miller, W. R., & Rollnick, S. (Eds.). (2012). *Motivational Interviewing: Helping People Change* (3rd ed.). New York: Guilford Press.
Mueser, K. T., & Gingerich, S. (2006). *The Complete Family Guide to Schizophrenia: Helping Your Loved One Get the Most Out of Life*. New York: Guilford Press.
Mueser, K. T., Lu, W., Rosenberg, S. D., & Wolfe, R. (2010). The trauma of psychosis: Posttraumatic stress disorder and recent onset psychosis. *Schizophrenia Research, 116*, 217-227.
Mueser, K. T., Noordsy, D. L., Drake, R. E., & Fox, L. (2003). *Integrated Treatment for Dual Disorders: A Guide to Effective Practice*. New York: Guilford Press.
Murray, C. J. L., & Lopez, A. D. (Eds.). (1996). *The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries, and Risk Factors in 1990 and Projected to 2020*. Cambridge, MA: Harvard University Press.
National Institute of Mental Health. (2022, October). Recovery after an initial schizophrenia episode (RAISE). https://www.nimh.nih.gov/research/research-funded-by-nimh/research-initiatives/recovery-after-an-initial-schizophrenia-episode-raise
Neenan, M. (2009). *Developing Resilience: A Cognitive-Behavioural Approach*. London: Routledge.
Nuechterlein, K. H., & Dawson, M. E. (1984). A heuristic vulnerability/stress model of schizophrenic episodes. *Schizophrenia Bulletin, 10*, 300-312.
Nuechterlein, K. H., Subotnik, K. L., Turner, L. R., Ventura, J., Becker, D. R., & Drake, R. E. (2008). Individual placement and support for individuals with recent-onset schizophrenia: Integrating supported education and supported employment. *Psychiatric Rehabilitation Journal, 31*, 340-349.
Office of Disease Prevention and Health Promotion (2020). *Social Determinants of Health.* Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health#two
Oluwoye, O., Reneau, H., Stokes, B., Daughtry, R., Venuto, E., Sunbury, T., Hong, G., Lucenko, B., Stiles, B., McPherson, S.M. and Kopelovich, S., Monroe-DeVita, M., & McDonell, M. G. (2020). Preliminary evaluation of Washington state's early intervention program for first-episode psychosis. *Psychiatric Services, 71*(3), 228-235.
Penn, D. L., Waldheter, E. J., Mueser, K. T., Perkins, D. O., & Lieberman, J. A. (2005). Psychosocial treatment for first episode psychosis: A research update. *American Journal of Psychiatry, 162*, 2220-2232.
Perkins, D. O., Gu, H., Boteva, K., & Lieberman, J. A. (2005). Relationship between duration of untreated psychosis and outcome in first-episode schizophrenia: A critical review and meta-analysis. *American Journal of Psychiatry, 162*, 17851804.
Perry, B. M., Taylor, D., & Shaw, S. K. (2007). "You've got to have a positive state of mind": An interpretative phenomenological analysis of hope and first episode psychosis. *Journal of Mental Health, 16*, 781-793.
Petersen, L., Jeppesen, P., Thorup, A., Abel, M. B., Ohlenschlager, J., Christensen, T. O., Krarup, G., Jorgensen, P., & Nordentoft, M. (2005). A randomized, multicenter trial of integrated versus standard treatment for patients with a first episode of psychotic illness. *British Medical Journal, 331*, 602-609.
Power, P. (2004). Suicide prevention in early psychosis. In J. Gleeson & P. D. McGorry (Eds.), *Psychological Interventions in Early Psychosis: A Treatment Handbook* (pp. 175-190). Chichester, England: John Wiley & Sons.
President's New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America: Final Report* (DHHS Pub. No. SMA-03-3832). Rockville, MD: Substance Abuse and Mental Health Services Administration.
Rapp, C. A., & Goscha, R. J. (2006). *The Strengths Model: Case Management with People with Psychiatric Disabilities* (Second ed.). New York: Oxford University Press.
Robinson, D., Woerner, M. G., Alvir, J. M., Bilder, R., Goldman, R., Geisler, S., Koreen, A., Sheitman, B., Chakos, M., Mayerhoff, D., & Lieberman, J. A. (1999). Predictors of relapse following response from a first episode of schizophrenia or schizoaffective disorder. *Archives of General Psychiatry, 56*, 241-247.
Ryff, C. D., & Singer, B. (1998). The contours of positive human health. *Psychological Inquiry, 9*, 1-28.

Samnaliev, M., & Clark, R. E. (2008). The economics of schizophrenia. In K. T. Mueser & D. V. Jeste (Eds.), *Clinical Handbook of Schizophrenia* (pp. 507-515). New York: Guilford Press.

Teplin, L. A. (1994). Psychiatric and substance abuse disorders among male urban jail detainees. *American Journal of Public Health, 84*, 290-293.

Teplin, L. A., Abram, K. M., & McClelland, G. M. (1996). Prevalence of psychiatric disorders among incarcerated women. I. Pretrial jail detainees. *Archives of General Psychiatry, 53*, 505-512.

Towle, A., & Godolphin, W. (1999). Framework for teaching and learning informed shared decision making. *British Medical Journal, 319*, 766-771.

Uzenoff, S. R., Perkins, D. O., Hamer, R. M., Wiesen, C. A., & Penn, D. L. (2008). A preliminary trial of adherence-coping-education (ACE) therapy for early psychosis. *Journal of Nervous and Mental Disease, 196*, 572-575.

Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer, W., Read, J., van Os, J., & Bentall, R. P. (2012). Childhood adversities increase the risk of psychosis: a meta-analysis of patient-control, prospective- and cross-sectional cohort studies. Schizophrenia bulletin, 38(4), 661–671. https://doi.org/10.1093/schbul/sbs050

Weiss, A., Steadman, S., Mercier, H.D, Hansel, T.C., Chaudhry, S., & Clark, I. Pathways to Care: How Help-Seeking Behaviors Relate to Duration of Untreated Psychosis and Treatment Engagement. Psychiatric Quarterly, 93, 473–482 (2022). https://doi.org/10.1007/s11126-021-09960-5

Williams-Keeler, L., Milliken, H., & Jones, B. (1994). Psychosis as precipitating trauma for PTSD: A treatment strategy. *American Journal of Orthopsychiatry, 64*, 493498.

Zubin, J., & Spring, B. (1977). Vulnerability: A new view of schizophrenia. *Journal of Abnormal Psychology, 86*, 103-126.

GLOSSARY OF TERMS

Attestation – An attested provider refers to a team that has completed the start-up phase and is recognized by the New Journeys network as having completed the necessary training to provide New Journeys services. Attested teams are also ready to accept referrals. New Journeys teams typically become attested at the end of the first year of startup and case building. An attestation form is completed and submitted to HCA documenting that basic training, staffing and fidelity requirements have been met.

Case Building – The process of completing intake for 2-3 participants per month, working towards a case load of 30 enrollees over time. Developing a caseload in this way accounts for the additional time needed for staff training and a higher level of service intensity during the initial months of an individual's participation in New Journeys.

Case Building Funds – Per the fidelity model, new NJ teams are required to "ramp up" their caseloads incrementally over time, as required by legislation and guidelines. A full team takes between 15 and 24 months to reach full capacity. "Case building funds" are included in the provider or BH-ASO contracts with DBHR to supplement the New Journeys teams while they are working toward a full caseload.

Coordinated Specialty Care (CSC) – A recovery-oriented, team approach to treating early psychosis that promotes easy access to care and shared decision-making among specialists, the person experiencing psychosis, and family members. Specifically, coordinated specialty care involves multiple components: Individual or group psychotherapy, family support and education, medication management, supported employment and education,
and case management.

Community Launch – An agency's readiness to begin accepting referrals for the New Journeys team from outside of the agency. These referrals will be generated through the marketing, education, and outreach efforts to provide education to the community about the availability of New Journeys services in the area.

Division of Behavioral Health and Recovery (DBHR) – The HCA-designated state mental health authority that is tasked with administering the state- and Medicaid-funded mental health programs authorized by the Revised Code of Washington chapters 71.05, 71.24, and 71.34.

Duration of Untreated Psychosis (DUP) – The time between the onset of psychotic symptoms and the initiation of treatment.

Family Education Provider – A master's level team member who helps an individual's natural supports learn about psychosis and its treatment while developing strategies for coping with stress and communicating effectively. This team member is sometimes also referred to as a Family Education Provider, Family Education Specialist, or simply Family Educator and is often a shared role with the Program Director.

Fidelity Monitoring – The system of measuring and evaluating the degree to which the model is implemented as intended. Fidelity to the New Journeys model is measured through annual site visits with DBHR during the startup and case building phase, and/or through the University of Washington (UW) Fidelity Review Process beginning in year 2 of implementation. Fidelity to the data-driven and measurement elements and use of the data delivery platform are continuously monitored for fidelity by the Washington State University (WSU) Measurement and Evaluation team.

First Episode Psychosis (FEP) – The time period when a person first shows signs of perceptual changes and loss of contact with reality (typically within one week to two years from the onset of changes). The longer symptoms of psychosis go untreated, the more severe and chronic symptoms become, resulting in decreased functioning and other

negative outcomes over the course of their lifetime. The goal of addressing FEP within the first two years of onset is to improve outcomes throughout an individual's lifetime.

Implementation Team – The University of Washington Training and Consultation Team

Individual Resiliency Training Therapist – The team's master's level therapist who provides Cognitive Behavioral Therapy for psychosis (CBTp). This team member provides culturally competent, trauma-informed, strengths-based, and measurement-based care for participants enrolled on the New Journeys team. The team member is sometimes referred to as the IRT Therapist, IRT Clinician, IRT Specialist, or simply IRT.

Natural Supports – A source of support that comes directly from people and communities rather than through paid forms of support. These may include family, chosen family, friends, school classmates, work colleagues, or other community supports.

New Journeys Measurement Battery- a set of standardized assessment tools or instruments used to evaluate various aspects of an individual's mental health and functioning when receiving comprehensive and evidence-based early intervention and treatment for individuals experiencing their first episode of psychosis. This tool collects information about the key domains of early psychosis symptoms, recovery, and treatment to facilitate measurement-based early psychosis care and research.

New Journeys or the New Journeys Model – An evidenced-informed, CSC treatment model for older youth and young adults who are experiencing FEP. New Journeys is more intensive than regular outpatient services and is curated specifically to meet the needs of those in the early stages of psychosis. Treatment goals focus on functional recovery and are defined by what is meaningful to the youth and their family. Routine outcome monitoring or measurement-based care is utilized by teams throughout care to inform youth and families of progress, improve outcomes, and to drive practice improvements.

New Journey's Manual – Document that provides guidelines to ensure consistency in the goals, principles, and delivery of New Journeys services across Washington State.

New Journeys Team – The professional team providing New Journeys services. This team is expected to be comprised of a Program Director/Family Education Specialist (1.0 FTE), a Psychiatrist or Advanced Registered Nurse Practitioner (ARNP) (0.25 FTE), an Individual Resiliency Therapist (1.0 FTE), a Supported Employment and Education Specialist (1.0 FTE), a Case Manager (0.5 FTE), and a Peer Specialist (0.5 FTE) with total FTE count of 4.25. Teams may choose to substitute a Nurse Care Manager (~0.2 FTE) for all or part of the case manager FTE count. Exceptions to this team staffing composition must be approved in writing by DBHR. A full fidelity team serves up to 30 individuals with FEP who meet eligibility criteria for New Journeys. Team members are expected to engage in ongoing training/consultation with UW and WSU. A fully functioning New Journeys team has submitted a New Journeys Attestation which has been approved by DBHR.

Measurement and Evaluation Team – The network supports at Washington State University who implement the New Journeys data platform.

Measurement-Informed Care – The use of standardized measures to guide treatment practice or treatment planning.

Nurse Care Manager – A registered nurse who has dedicated time within an agency to support New Journeys participants. This team member focuses on supporting healthy behaviors, wellness, and care coordination. This team member is often referred to as the nurse or RN.

Mental Health Block Grant (MHBG) – The funds granted to states by the Secretary of the DHHS through the Center for Mental Health Services (CMHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to establish or expand an organized community-based system for providing mental health services for adults with SMI and children with Severe Emotional Disturbance (SED). States must submit an application in accordance with the law for applicable fiscal years for which they seek MHBG funds. Awarded MHBG funds must be used to: a) carry out the State plan contained within the application, b) evaluate programs and services set in place under the plan, and c) conduct planning, administration, and educational activities related to the provision of services under the plan.

Peer Reviewers – Describes New Journeys Team Members who have been trained in/participate in the fidelity review process as co-reviewers with UW.

Peer Support Specialist – A member of the team who has lived experience with mental health challenges and has completed training in the Washington State Certified Peer Counselor Training Program. This team member assists with engagement of individuals experiencing psychosis in services throughout treatment to ensure that they have the information and resources they need to direct their treatment and to use an empowered voice in the treatment planning process. This team member is often referred to as the Peer Specialist or simply the Peer.

Program – Refers to implementation of the New Journeys Model

Program Director – A master's level clinician who serves as the New Journeys clinical team lead. This team member monitors and oversees all team operations, leads regular team clinical meetings, supervises the other team clinicians, is responsible for outreach and community education (community relations), develops a strong referral network within the agency and region, and leads the screening process for referrals. This is often a shared role with the Family Education Provider.

Psychiatric Care Provider – A Psychiatrist or a Psychiatric Advanced Registered Nurse Practitioner (ARNP) who is responsible for psychiatric diagnosis, medication management for psychiatric and substance use disorders, acute management of suicidality and safety concerns, and physical health care needs in coordination with the team nurse and primary care provider.

REDCap – The database currently in place as the New Journeys measurement-based care delivery and data platform.

SAMHSA – The U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration.

Severe Emotional Disturbance/Severe Mental Illness or SED/SMI – Children from birth to age 18 (SED) and adults age 18 and over (SMI): (1) who currently meet or at any time during the past year has met criteria for a mental disorder – including within developmental and cultural contexts – as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.), and (2) who displays functional impairment, as determined by a standardized measure, which impedes progress towards recovery and substantially interferes with or limits the person's role or functioning in family, school, employment, relationships, or community activities.

Soft Launch – Describes an agencies readiness to begin accepting referrals for the New Journeys team from withing the agency. These referrals have been identified as potential candidates for the New Journeys team through the education and training provided by the Program Director within the agency.

Startup Funds – Funding for newly established New Journeys teams provided through contracts with DBHR before the team provides any services. This may include capital and training expenditure funds.

Supported Education and Employment Specialist – An experienced bachelor's or master's level clinician who works from a recovery orientation and focuses on assisting individuals experiencing psychosis to achieve recovery goals related to education and employment. This team member is often referred to as the SEE or SEE Specialist.

Team Based Rate (TBR) – The two-tiered Medicaid service-based enhancement financial model developed though an actuarial process. The tiers reflect a higher level of service intensity during the first six months of treatment. The service-based enhancement is paid to the Managed Care Organizations as a Per User Per Month (PUPM) payment. The fiscal assumptions supporting the PUPM amount fully supports the costs of the NJ teams to provide this service to Medicaid enrollees. Enrollees will be eligible for the New Journeys Team Based Rate for a duration of up to 24 months of treatment. The New Journeys contractor will serve individuals with Medicaid coverage as well as facilitate 2 non-Medicaid slots funded through the regions BH-ASO.

APPENDIX A: EXAMPLE JOB DESCRIPTIONS

Program Director and Family Education Provider

TITLE: New Journeys Program Director and Family Education Provider

GENERAL FUNCTION:
The ideal candidate for the program director/family education specialist is a licensed clinician with experience in diagnostic screening and assessment of psychotic disorders, expertise working with individuals with schizophrenia-spectrum disorders and their families utilizing evidence-based practices such as multi-family groups, and experience connecting families with an array of self-help tools and resources.

The program director monitors and oversees all team operations, leads regular team clinical meetings, and supervises the other team clinicians. The program director is responsible for outreach and recruitment in the community, develops strong referral sources, and leads the screening process for referrals. They are the primary contact person for clients and families, and spearhead efforts to engage clients in treatment. They work with individuals and their families, providing education about psychosis and how to manage it, improving communication and problem-solving skills, and encouraging a strengths-based, recovery-oriented approach to psychosis. The program director works with participants and families using a shared decision-making process.

RESPONSIBLE TO: Director of Outpatient Programming

QUALIFICATIONS:

- Master's degree in Psychology, Social Work or closely related field with accepted licensure and preferred experience as a Clinical Supervisor.
- Experience providing mental health services to individuals experiencing SED/SMI
- Knowledge of and experience with developmental and treatment strategies towards current DSM covered diagnoses.
- Knowledge of and experience with the community support model.
- Previous experience working as a member of a multidisciplinary treatment team and experience working collaboratively with other service providers.
- Relevant therapeutic skills.
- Strong interpersonal skills.
- Strong organizational skills including the use of electronic medical record software or equivalent for scheduling, time management and all clinical documentation.
- Must pass a criminal background and Inspector General check.

DUTIES AND RESPONSIBILITIES:
Direct the day-to-day clinical operations of the care team, and provide administrative coordination as needed with referral sources.

- Assure that the quality of care provided meets fidelity standards provided for the statewide network of New Journeys care teams.
- Participate in the comprehensive assessment of client needs to assure person-centered treatment planning.
- Work with clients and their families, providing education about psychosis and how to manage it, improving communication and problem-solving skills.

- Oversee data collection through clinical tools and protocols designed to measure key indicators of progress in treatment for this population.
- Assist clinicians with the performance of their duties by overseeing and participating in clinical coordination/problem solving between clients and clinicians and other agency programs and community resources. Coordinate crisis intervention with the Crisis Response team, Crisis Triage Center, and other providers as clinically necessary.
- Participate in monthly training provided by Washington Health Care Authority First Episode Psychosis Program, Washington State University, and the University of Washington. Consult with their program director trainer and receive support for program development as your team starts serving clients.
- Maintain a trauma-informed work environment with a focus on the utilization of Recovery-Based Language in both written and verbal communications.

Individual Resiliency Training Therapist (IRT)

TITLE: New Journeys Individual Resiliency Training (IRT) Clinician

GENERAL FUNCTION:
New Journeys is a coordinated specialty care team that uses evidence-based treatment to provide intensive services to up to 30 individuals aged 15-40 experiencing their first episode of psychosis.

The New Journeys Program Individual Resiliency Trainer (IRT) clinician is a recovery-oriented, experienced master's level clinician who provides evidence-based therapeutic services in a managed care environment to transitional age youth or adults and their families. They assist clients to identify and developing recovery goals, learn about psychosis and skills for managing it, develop coping skills for stressful situations and persistent symptoms, and address challenges related to achieving their recovery goals. It is desirable (but not required) that the IRT clinician have a background in Cognitive Behavioral Therapy (CBT) skills, such as social skills training, cognitive restructuring, behavioral activation, coping skills training, relaxation training, and psychoeducation. Experience with adolescents and young adults is an advantage, but not required.

An IRT clinician must have the ability to meet with individuals outside of typical 8am-5pm work hours and have the capacity to make home and community visits.

RESPONSIBLE TO: New Journeys Program Director

QUALIFICATIONS:

- Master's degree in Psychology, Social Work or closely related field with accepted licensure or eligible for supervision towards agency accepted licensure.
- Experience in providing mental health services to severely emotionally disturbed children, adolescents, and families.
- Knowledge and experience with developmental and treatment strategies towards current DSM covered diagnosis.
- Demonstrated ability to provide culturally competent treatment services to diverse client populations and maintain a cooperative working relationship with others in a culturally diverse environment
- Must have a strong commitment to the right and the ability of each person with a severe mental illness to live in normal community residences; work in market jobs; and have access to helpful, adequate, competent, and continuous supports and services.
- Knowledge of and experience with the community support model.
- Previous experience working as a member of a multidisciplinary treatment team and working collaboratively with other service providers.
- Relevant therapeutic skills.
- Strong interpersonal skills.
- Strong organizational skills including the use of electronic medical record software or equivalent for scheduling, time management and all clinical documentation.
- Must pass a criminal background and Inspector General check.

TYPICAL DUTIES & RESPONSIBILITIES:

- Work in collaboration with referral sources, community service providers, and adjunctive service providers to assess, develop and facilitate individualized treatment services and ensure continuity of care.
- Provide a broad range of medically necessary therapeutic services, including intakes within the framework of a community support model. Services may be provided in agency sites, school, homes and other appropriately deemed community settings.

- Work collaboratively with multi-disciplinary team. Manage individual and shared client caseloads per agency guidelines, develop services appropriate to a community-based service model, and participate in the management of program resources within a managed care framework. Emphasis of caseload will be on youth presenting with early episode psychosis issues and treatment thereof.
- Work in collaboration with other clinicians, leadership, and referral sources to assess, develop, and facilitate individual client treatment services and ensure consistency of care with other involved providers.
- Develop 24-hour crisis plans for assigned youth and utilize the High Risk Protocol as appropriate.
- Maintain client's chart in accordance with WAC and agency standards. Adhere to agency policy pertaining to documentation and chart maintenance.
- Participate in clinical supervision and psychiatric consultation on a regular and scheduled basis.
- Attend mandatory meetings as assigned.
- Adhere to agency Performance Standard Expectations.
- Maintain contact with utilization review team regarding authorizations and funding for services.
- Practice successful client engagement skills and strategically address clients with a frequent and predictable no-show pattern. Close clients when appropriate.
- Maintain regular attendance in order to ensure continuity of quality client care.
- Other duties as needed to fulfill the goals of the New Journeys program including blended roles while building toward capacity.
- Maintain the New Journeys evidence/research-based fidelity model while delivering services.

Supported Education and Employment Specialist

TITLE: New Journeys Supported Education and Employment (SEE) Specialist

GENERAL FUNCTION:
The New Journeys Supported Education and Employment (SEE) Specialist provides a range of community-based vocational and educational support services.

New Journeys is a coordinated specialty care team that uses evidence-based treatment to provide intensive services to up to 30 individuals aged 15-40 experiencing their first episode of psychosis. A potential candidate for this position should have prior experience as a supported education specialist, supported employment specialist, vocational specialist, and/or an intensive case manager. Because of the nature of this job, SEE Specialists need to work directly in the community with employers, potential employers, educational personnel, and families. They connect with community partners and families and spend the majority of their time out of the office providing direct services to clients.

PURPOSE: Assesses participants for employment and/or education goals/capabilities/needs, provides training assistance, and offers continuing support. Assists clients in targeting potential jobs and/or education, exploring job and/or education possibilities in the community, and making job and/or education placements. They work with participants and families using a shared decision-making process. Adjunctive services may include issue-specific and psycho-educational groups, in-home behavioral skills enhancement, and coordination of systems of care. A vital part of this position is community education with employers and community providers about the agency's New Journeys Program and how they operate as a successful community support model for employing people with behavioral health challenges. This includes encouraging them to recognize individuals' abilities to be productive and successful. Services are offered in a community, school, and home-based settings.

RESPONSIBLE TO: New Journeys Program Director

QUALIFICATIONS:

- Bachelor's degree in Psychology, Social Work or closely related field with agency accepted licensure or eligible for supervision towards BHR accepted licensure.
- Experience developing community-based employment and/or education opportunities
- Must have at least one year of documented experience working with individuals with disabilities or one year of human service-related experience addressing issues such as economic disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing
- Must have a strong commitment to the right and the ability of each person with a severe mental illness to live in normal community residences; work in market jobs; and have access to helpful, adequate, competent, and continuous supports and services.
- Bilingual (Spanish/English) fluency skills preferred but not required
- Previous experience working as a member of a multi-disciplinary team
- Knowledge of and experience with the community support model
- Demonstrated ability to provide culturally competent treatment services to diverse client populations and maintain a cooperative working relationship with others in a culturally diverse environment
- Ability to provide employment and/or education services and compliance with confidentiality in accordance with federal, state, and/or funding source requirements
- Knowledge of community resources to enable appropriate referrals for specific client needs
- Proficient in Microsoft Outlook, Excel, and Word; ability to master proprietary software including electronic health record system required

- Access to a car, a valid driver's license, proof of current automobile insurance coverage, and ability to meet the agency's driving requirements
- Must pass a criminal background and Inspector General check

TYPICAL DUTIES & RESPONSIBILITIES:

- Interviews individuals and, if applicable, family members or team members in the client support system to complete the strengths-based vocational/educational assessment to identify clients' skills and strengths, interests, goals, dreams, aspirations, and resources available to reach their goals.
- Provides counseling to individuals to help them understand and overcome personal, social, or behavioral problems affecting their vocational/educational situations.
- Develops an employment and/or education focused service plans based on clients' interests, abilities, strengths and needs; service plans will be client driven and follow-ups will be completed on time, assessing the quantity and quality of services provided.
- Researches possible job and/or education openings and opportunities for clients by contacting employment/school services, newspaper want ads, previous contacts, cold calling, and any other means of reaching potential employers and/or schools.
- Performs job analyses, matching potential openings with clients' needs, skills, and logistics of getting to the job site.
- Establishes and maintains connections with businesses offering employment opportunities.
- Sets up interviews for clients, assists clients with applications, resume preparation, and interviewing skills.
- Locates barriers to client employment and/or educational goals, such as inaccessible sites, inflexible schedules, finances, and transportation problems, and works with clients to develop strategies for overcoming these barriers.
- Maintains close contact with clients during job and educational placements to resolve problems and evaluate placement adequacy.
- Performs interventions as needed with assigned clients previously placed who may be at risk of losing their jobs and/or education.
- Coordinates and consults with other team members to keep the team informed of issues and progress
- Provides counseling to individuals, groups, families, or communities regarding vocational and educational rehabilitation issues.
- Participates in clinical supervision, team consultation, and psychiatric consultation on a weekly basis.
- Participates in monthly consultation calls with the UW New Journeys training team.
- Attends all team meetings including business meetings and case reviews; attend individual service team meetings as negotiated with treatment team.
- Maintains clients' charts in accordance with WAC and agency standards; adhere to agency policy pertaining to documentation, chart maintenance, and other required paperwork.
- Works collaboratively with agency and New Journeys multi-disciplinary teams; manage individual and shared client caseloads per agency guidelines, develop services appropriate to a community-based service model, and participate in the management of program resources within a managed care framework.
- Transports clients in a personal vehicle.
- Other duties as needed to fulfill the goals of the New Journeys Program.

PHYSICAL REQUIREMENTS:

- Ability to perform essential duties of the position
- Ability to travel to other sites is required
- Ability to look at and use a computer for extended periods of time
- Work is performed in an office and in the community; sufficient mobility to meet with other employees and attend meetings at various locations is required
- Requires periods of intense concentration over extended period of time, and is subject to frequent interruption

- Ability to access locations that are not ADA accessible
- Ability to work with individuals in a variety of locations to include office, schools, homes, and community
- Possess a current WA state driver's license and reliable transportation

Peer Support Specialist

TITLE: New Journeys Peer Support Specialist

GENERAL FUNCTION:
This member of the team has experience as a recipient of mental health services for severe and persistent mental illness and is willing to share his or her personal, practical experience, knowledge, and first-hand insight to benefit the team and its clients. The Peer Support Specialist provides expertise about the recovery process, symptom management, and the persistence required to encourage clients to reach their goals. They collaborate to promote a team culture that recognizes, understands, and respects each client's point of view, experiences, and preferences. They are responsible for maximizing client choice, self-determination and decision making in the planning, delivery and evaluation of treatment, rehabilitation, and support services. They provide peer counseling for New Journeys first episode psychosis clients. This includes carrying out rehabilitation and support functions and assisting in treatment, education, and crisis intervention under the clinical supervision of staff with professional degrees.

RESPONSIBLE TO: New Journeys Program Director

QUALIFICATIONS:

- A high school diploma is required and two years of paid or volunteer work experience with youth and/or adults with mental illness is highly desired.
- Completed Peer Certification Training with proof of completion is required.
- Must have good oral and written communication skills.
- The Peer Support Specialist, who is or has been a recipient of mental health services for severe and persistent mental illness or severe emotional disturbance, should have the self-knowledge needed to manage their mental illness and be well along in their recovery.
- Must have a strong commitment to the right and the ability of each person with a severe mental illness to live in normal community residences; work in market jobs; and have access to helpful, adequate, competent, and continuous supports and services.
- Demonstrated ability to provide culturally competent treatment services to diverse client populations and maintain a cooperative working relationship with others in a culturally diverse environment
- It is essential the Peer Support Specialist has skills and competence to establish supportive trusting relationships with youth and young adults with SMI/SED and respect for clients' rights and personal preferences in treatment is essential.
- Able to demonstrate initiative and success in providing client-centered interaction, solution-based approaches to learning, motivation techniques and positive reinforcement skills.
- Able to demonstrate patience, creative thinking, good decision-making skills, and a willingness to assist clients with achieving treatment plan goals.
- Able to demonstrate the ability to maintain appropriate professional boundaries while teaching necessary living skills to clients.
- Demonstrates ability to be organized and keep accurate and timely records.
- Demonstrates an ability to work independently and as a positive team player.
- Demonstrates good time management skills.
- Requires a valid WA State driver's license and use of own vehicle with BHR approved insurance.

TYPICAL DUTIES &
RESPONSIBILITIES:

- Meets regularly as scheduled with New Journeys team to receive work assignments.

- Writes and submits progress notes for each client seen on each day of service. Progress notes must meet the standards of content and legibility set for the program.
- Organizes and schedules work time in order to complete assignments and all related paperwork in a timely manner and according to program standards.
- Attends required program and agency trainings.
- Attends ongoing briefing and debriefing consultations as are relevant to the program.
- Meets with Supervisor on a regular basis as scheduled. Accepts direction and carries out self-care methods to stay healthy.
- Acts as an interpreter to help non-mental health consumer team members better understand and empathize with each client's unique and subjective experience and perceptions.
- Provides expertise and consultation from a mental health consumer perspective to the entire team concerning client's experiences on symptoms of mental illness, the effects and side effects of medications, clients' responses to opinions of treatment and clients' experience of recovery.
- Collaborates with the team to promote a team culture in which each client's point of view, experiences, and preferences are recognized, understood, and respected, and in which client self-determination and decision making in treatment planning are maximized and supported.
- Helps clients identify, understand and combat stigma and discrimination associated with mental illness and develop strategies to reduce self-stigma.
- Helps other team members identify and understand culture-wide stigma and discrimination against people with mental illness and develop strategies to eliminate stigma within the team.
- Helps clients develop interests and personal identity outside of the mental health system.
- Other duties as assigned to meet necessary goals of the position.

PHYSICAL REQUIREMENTS:

- Must be able to drive and to transport clients as needed.
- Ability to work in office, home, school, and community-based settings.

APPENDIX B: RECURRING TRAINING AND CONSULTATION HOURS FOR NEW JOURNEYS TEAM MEMBERS

Trainings	Program Director/ Family Ed. Specialist	Family Ed. Specialist (only)	IRT Clinician	SEE Specialist	Peer	Psychiatric Care Provider	Nurse Care Manager
Consultation Calls	36 Hours *(Prog Dir = 12 hrs Family Ed = 12 hrs Diff Dx = 12 hrs)*	12 Hours	12 – 24 Hours *(IRT = 12 hrs *Diff Dx = 12 hrs)*	12 Hours	12 Hours	12 Hours	12 Hours
ECHO	18 Hours *(12 clinics x 90 min)*	18 Hours *(12 clinics x 90 min)*	18 Hours *(12 clinics x 90 min)*	18 Hours *(12 clinics x 90 min)*	18 Hours *(12 clinics x 90 min)*	18 Hours *(12 clinics x 90 min)*	18 Hours *(12 clinics x 90 min)*
Start-Up	16 Hours *(8 hrs x 2 days)*	16 Hours *(8 hrs x 2 days)*	16 Hours *(8 hrs x 2 days)*	16 Hours *(8 hrs x 2 days)*	16 Hours *(8 hrs x 2 days)*	8 Hours *(8 hrs x 1 day)*	8 Hours *(8 hrs x 1 day)*
One specialty topic	8 Hours *(8 hrs x 1 days)*	8 Hours *(8 hrs x 1 days)*	8 Hours *(8 hrs x 1 days)*	8 Hours *(8 hrs x 1 days)*	8 Hours *(8 hrs x 1 days)*	8 Hours *(8 hrs x 1 days)*	8 Hours *(8 hrs x 1 days)*
Fidelity review preparation and participation	18 Hours	N/A	N/A	N/A	N/A	N/A	N/A
REDCap training	6 Hours *(4 hrs x 1 day + 1 hr x 2 days)*	6 Hours *(4 hrs x 1 day + 1 hr x 2 days)*	6 Hours *(4 hrs x 1 day + 1 hr x 2 days)*	6 Hours *(4 hrs x 1 day + 1 hr x 2 days)*	6 Hours *(4 hrs x 1 day + 1 hr x 2 days)*	6 Hours *(4 hrs x 1 day + 1 hr x 2 days)*	6 Hours *(4 hrs x 1 day + 1 hr x 2 days)*
Total Annual Training Hours	**102 Hours**	**60 Hours**	**60-72 Hours**	**60 Hours**	**60 Hours**	**52 Hours**	**52 Hours**

APPENDIX C: EXAMPLE OF AGENCY LEVEL NEW JOURNEY'S FLOW SHEET

Purpose

This purpose of this protocol is to clearly define the process for accepting new clients into the New Journey's program within an agency. Any specific questions related to New Journey's clients and the admission process should be directed to the appropriate New Journey's supervisor.

Protocol

External Referrals

I. New Journeys staff receive a request for information or referral for an individual **not currently** enrolled in services at the agency.

II. New Journeys staff will request Office Support (OS) open a chart for potential client in the Electronic Health Record under the New Journeys-Request for Services (NJ-RFS) program.

III. OS staff will open the RFS episode by completing the following:
- A. Checking Provider One for Medicaid coverage
- B. Consumer First Contact Service form
- C. Admission form
- D. **Please note**: OS will enter an Admission Diagnosis of R69 for the same date and time Episode was opened (Type of Diagnosis = Admission, Assessment Type = Admission).

IV. New Journeys staff will obtain funding information for the potential client
- A. New Journeys staff will ask client/guardian if client has additional funding/insurance coverage
  1. If client has private insurance, staff will make a copy of front and back of insurance card and submit for scanning
- B. New Journey's staff will email all funding information to the agency Financial Department

V. New Journeys staff will bill to, and document contact with, client and collaterals in the Electronic Health Record in the NJ-RFS Episode, using the allowable codes:
- A. SAC (H0023HW) "Engagement + Outreach" for face-to-face service
- B. SAC (H0023HWGQ) "Engagement + Outreach –Phone" for phone service
- C. Specify in each note that you are working on assessment and engagement
- D. For related travel, staff will use SAC (735) "Travel"

VI. If New Journeys staff decides client is **not** appropriate for New Journeys during the engagement/screening process:
- A. New Journey's staff will complete Discharge Summary form
- B. After finalizing Discharge Summary form, New Journey's supervisor will complete Discharge form – Type of Discharge is "OP – Terminated by Facility," Note is "Not appropriate for New Journeys – Referred to "
- C. Clients with Medicaid coverage or those who wish to pay out of pocket should be referred to the agency for walk-in intake assessment, or other appropriate community partner (ex. WISe).
- D. Clients with private insurance should be referred to provider who accepts client's funding source

VII. If New Journeys staff decides client might be appropriate for New Journeys during the engagement/screening process, and the client agrees to complete Intake:
   A. New Journeys staff will provide OS with information about when the Intake Assessment can be completed.
   B. OS will make an appointment in the Electronic Health Record Scheduling Calendar.

VIII. If the client does show up for their scheduled intake:
   A. New Journeys staff will enter a Program Transfer from NJ-RFS to the New Journeys program.
   B. New Journeys staff will complete agency paperwork, Agency Intake Assessment including Diagnosis (Type of Diagnosis = Update, Assessment Type = At Admission), and New Journeys specific assessments with client. The Intake should be billed to and documented in the New Journeys episode using the following codes:
      1. Full/completed intake: SAC (90791) "Diagnostic Evaluation-No Medical"
      2. Unfinished intake (part 1) SAC (9079153) "Diag Eval-Not Completed"
      3. Unfinished intake (part 2): SAC (9079152) "Diag Eval –Abrv, Partl or Update"
   C. New Journeys staff will complete the agency Authorization form.
      1. For clients who will be admitted to New Journeys, Authorization Type is New Journeys.
   D. New Journeys staff will submit all agency paperwork to OS for processing
   E. Once all documentation, including intake, is submitted for clients who will be served in New Journeys, New Journeys staff can begin using all approved Service Activity Codes.
   F. All services for admitted New Journeys clients should be billed to and documented in the New Journeys episode.

IX. If the client does **not** show up for their intake appointment:
   A. New Journeys staff will call client or hospital and explain they missed their scheduled appointment and **either** inform the client of agency's walk-in intake hours **or** attempt to schedule a new intake.
      1. Bill phone service as SAC (H0023HWGQ) "Engagement + Outreach –Phone"
   B. New Journeys staff will complete Discharge Summary form
   C. After finalizing Discharge Summary form, New Journey's supervisor will complete Discharge form – Type of Discharge is "OP – Terminated by Facility," Note is "Client did not show for Intake"

Internal Referrals

X. The New Journeys Supervisor will consult with the agency staff requesting admission into New Journeys to confirm that the client meets eligibility for screening.

XI. If it is agreed that the client meets eligibility criteria, and the client is agreeable to completing a screening, New Journeys staff will open a NJ-RFS episode in the Electronic Health Record.

XII. **Please Note**: If a client is being referred from intake and has **not** yet started services with New Journeys and is eligible for New Journeys, a NJ-RFS does **not** need to be opened and screening will be completed under the OP episode. Each potential New Journeys client that is being referred internally should be individually evaluated as to whether or not a NJ-RFS episode should be opened. As a general rule of thumb: If the client clearly meets criteria for New Journeys, and is agreeable to participate in the program, the client can be immediately enrolled in the New Journeys program – thus bypassing the NJ-RFS episode.

XIII. If more time is needed to determine client eligibility, and for client engagement and outreach, a NJ-RFS episode should be opened. If this is done, a new Consumer First Contact Service form must also be created.

XIV. If New Journeys staff meets with client and/or collaterals **without** the regular Attending Practitioner, bill to and document under the new NJ-RFS episode.

XV. If New Journeys staff meets with client and/or collaterals **with** Attending Practitioner, bill to and document in the new NJ-RFS episode using the following code:

A. SAC (22) "Secondary Practitioner"

XVI. If client is **not** appropriate for New Journeys, this should be documented in client chart under the new NJ-RFS episode. Once documented, and all parties notified, the NJ-RFS episode may be closed.

XVII. If the New Journeys staff decides client will be appropriate for New Journeys during the engagement/screening process, and the client agrees to engage in the New Journeys program:

A. New Journeys Supervisor will enter a Program Transfer to New Journeys program.
B. New Journeys Supervisor will ensure that a new agency Authorization form is completed that states the new program for the client. Authorization Type is "New Journeys".

XVIII. Once all documentation is submitted for clients who will be served in New Journeys, New Journeys staff can begin using all approved Service Activity Codes.

XIX. All services for admitted New Journeys clients should be billed to and documented in the New Journeys episode.

XX. **Please Note:** For internal clients moving into the New Journeys program, the New Journeys Supervisor must evaluate the current intake assessment to determine if new intake assessment is required. As a general rule, intake assessments are valid for one (1) for program transfers. If the intake assessment is older than one (1) year, it is generally best practice to complete a new intake assessment. The New Journeys Program Supervisor will be responsible to evaluating the intake assessment and making this determination.

APPENDIX D: EXAMPLE COMMUNITY PRESENTATION

A PowerPoint version of this document, with talking points, is available for team use and can be requested from the UW Program Director Trainer.

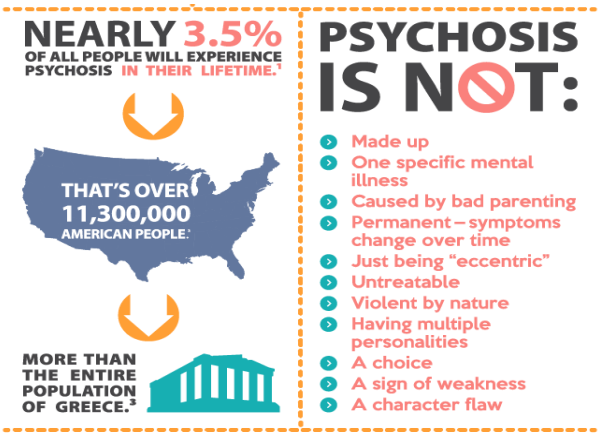
Space for agency logo

New Journeys- {Insert regions served}
{Insert name of agency}

Symptoms Associated with Psychosis

- Hallucinations
- Delusions/Ideas of Reference
- Confused Thinking and Other Cognitive Deficits
- Decline in Social Functioning
- Disorganized Behavior and/or speech
- Negative Symptoms (lack of energy, motivation, expressiveness)
- Depression
- Anxiety

WHAT IS FIRST-EPISODE PSYCHOSIS (FEP)?



THE TERM "PSYCHOSIS" DESCRIBES CONDITIONS THAT AFFECT THE MIND, CAUSING A **LOSS OF CONTACT WITH REALITY** OR TROUBLE DECIDING ON WHAT IS REAL AND WHAT IS NOT REAL.

(PSYCHOSIS IS A CLUSTER OF SYMPTOMS NOT A DIAGNOSIS.)

THE FACTS

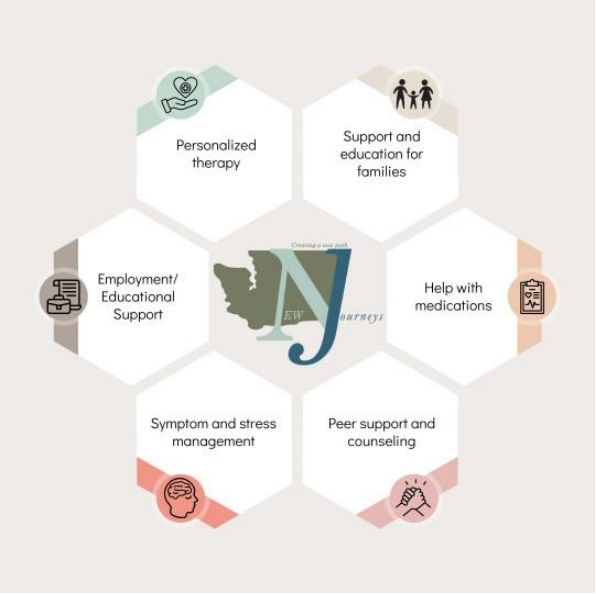
3 OUT OF EVERY 100 YOUNG PEOPLE WILL EXPERIENCE AN EPISODE OF PSYCHOSIS IN THEIR LIFETIME, MAKING IT **THE 3RD MOST DISABLING CONDITION IN THE WORLD**

THE AVERAGE DURATION OF UNTREATED PSYCHOSIS IN THE U.S. IS MORE THAN 2 YEARS.

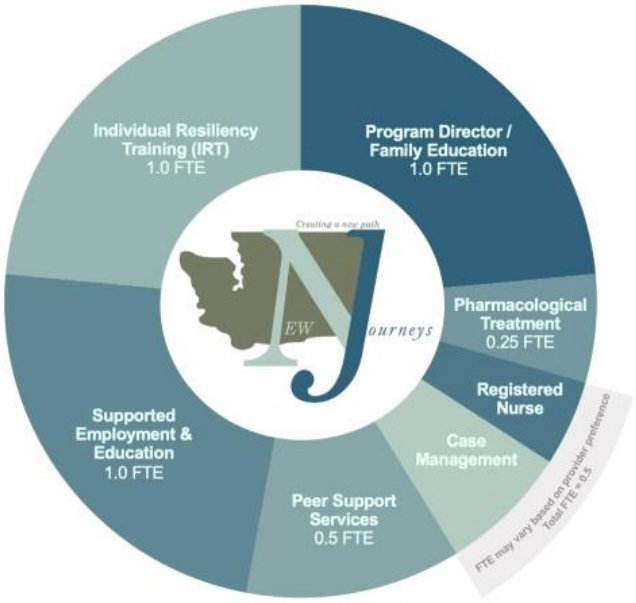
UNTREATED PSYCHOSIS CAN LEAD TO:

- INCREASED SUBSTANCE USE
- MORE HOSPITAL VISITS
- LEGAL TROUBLE
- RISK OF HOMELESSNESS
- PREMATURE DEATH

NEW JOURNEYS MODEL



NEW TEAM MEMBERS



FAMILY EDUCATION

- Teaching families about psychosis and its treatment
- Help the family process the episode of psychosis
- Reducing relapses by encouraging medication adherence and monitoring early warning signs of relapse
- Supporting the client's work towards personal recovery goals
- Reducing family stress through improved communication and problem solving skills

INDIVIDUAL RESILIENCY TRAINING

- Processing the experience of psychosis and teaching coping skills
- Teaching social and resiliency skills
- Helping clients achieve personal goals by teaching them about their disorder and its treatment
- Reducing self-stigmatizing beliefs

SUPPORTED EDUCATION AND EMPLOYMENT

- Help clients to develop and achieve educational and employment goals related to their career interests
- Weigh the pros/cons of social security benefits
- Developing independent living skills
- Reinforce skills learned in sessions

MEDICATION MANAGEMENT

- Education and assistance in choosing the right medication for symptom management
- Guidance in managing side effects of management
- Delivery of injectable medications

CASE MANAGEMENT

- Access and navigate systems in the community (i.e. food benefits, insurance, social security)
- Developing independent living skills
- Reinforce skills learned in sessions
- Assistance with transportation
- Connection to resources as needed

PEER SUPPORT

- Learn about the individual and understand the individual's treatment goals
- Disclose personal experiences as appropriate to assist an individual in their own recovery process.
- Spend time the community to build confidence in abilities and practice skills alongside participants
- Learn together and from each-others experiences and progress

Admission Criteria

1. AGE: 15-40
2. RESIDENT OF: {INSERT COUNTIES SERVED)
3. PSYCHOTIC SYMPTOMS HAVE BEEN PRESENT BETWEEN 1 WEEK AND 2 YEARS
4. PRIMARY DX OF ONE OF THE FOLLOWING:
   - SCHIZOPHRENIA
   - SCHIZOAFFECTIVE DISORDER
   - SCHIZOPHRENIFORM DISORDER
   - BRIEF PSYCHOTIC DISORDER
   - DELUSIONAL DISORDER
   - OTHER SPECIFIED PSYCHOTIC DISORDER

PSYCHOSIS IS NOT KNOWN TO BE CAUSED BY ONE OF THE FOLLOWING:

- A CURRENT DX OF:
  - MOOD DISORDER
  - PERVASIVE DEVELOPMENTAL DISORDER
  - AUTISM SPECTRUM DISORDER
  - DOCUMENTED IQ LESS THAN 70
- SUBSTANCE INTOXICATION AND/OR WITHDRAWAL
- A MEDICAL CONDITION

All insurances are accepted as well as unfunded

ACCESS TO SERVICES

THERE'S NO WRONG DOOR

REQUEST INFORMATION
CONSULTATION ON A CASE
MAKE A REFERRAL

CONTACT: PROGRAM DIRECTOR NAME
NEW JOURNEYS CLINICAL SUPERVISOR

CALL:
FAX:
EMAIL:

QUESTIONS?

THANK YOU!

Contact:

Name, Credentials

New Journeys Program Supervisor

Insert agency logo

Contact information

APPENDIX E: NEW JOURNEYS REFERRAL FORM

New Journeys Referral Form

Referral Date: Click or tap to enter a date.	Is the individual aware of the referral? ☐Yes ☐ No
Referred by: Click or tap here to enter text. Agency/Relationship to individual being referred: Click or tap here to enter text.	Referent Phone #: Click or tap here to enter text.
What kind of insurance does the youth/young adult have: ☐Medicaid ☐ Private Insurance Click here to enter text. ☐ No Insurance	
Name of referred individual: Click or tap here to enter text. DOB Click or tap here to enter text. Identified Gender: Click or tap here to enter text. Preferred Pronouns: Click or tap here to enter text. Resident of ☐ {Team inserts county/regions served}	Address: Click or tap here to enter text. Phone: Click or tap here to enter text.
Name/phone # of parent/primary care giver if applicable: Click or tap here to enter text.	
Race/ethnicity: Click or tap here to enter text. Hispanic origin? ☐ Yes ☐ No	Highest grade level completed: Click or tap here to enter text. School: Click or tap here to enter text.
Does the referred individual have an existing mental health diagnosis? ☐ Yes ☐ No Please list any known diagnoses: Click or tap here to enter text.	
Is the individual already receiving services for mental health? ☐ Yes ☐ No If yes, where? Click or tap here to enter text.	
Reason for Referral: Click or tap here to enter text.	
Please review the following items and check all that apply: ☐ The individual's speech doesn't make sense ☐ The individual has behaviors, speech, or beliefs are uncharacteristic and/or bizarre ☐ The individual reports hearing voices or sounds that others do not ☐ The individual feels that other people are putting thoughts in their head, stealing their thoughts ☐ The individual believes others can read their mind (or vice versa) ☐ The individual believes that they do not exist or that their surroundings are not real	

☐ The individual has experienced a significant decline overall functioning
☐ The individual has experienced significant changes in sleep (sleeping less or sleeping too much)
☐ The individual has been experiencing increased fear or anxiety for no apparent reason
☐ There is a family history of major psychotic disorder
☐ The individual has an existing diagnosis of autism spectrum disorder
☐ The individual has a history of Drug/marijuana/alcohol use (list substances used below):
Click or tap here to enter text.

Is the individual experiencing any other symptoms not listed? ☐ Yes ☐ No

Please explain: Click or tap here to enter text.

When did you first notice these changes in the individual being referred? Click or tap here to enter text.

Safety Concerns? Click or tap here to enter text.

Has the individual ever been prescribed antipsychotic medication? ☐ Yes ☐ No

What medications are currently being prescribed? Click or tap here to enter text.

Who is prescribing the medications? Click or tap here to enter text.

Submit form to: {Insert name of Program Director}, New Journeys Program Director
Fax: {Insert Fax #}
Email: {Insert Phone #}

Questions? Call {Insert name of PD and phone #}

APPENDIX F: WEEKLY TEAM MEETING PARTICIPANT TRACKING SHEET

Participant	Goals	Psychiatric Care Provider notes	IRT Specialist notes	Family Education Specialist notes	SEE Specialist notes	Peer Specialist notes
Andy	(1) paid employment; (2) improved connection with others, including two new friends; and (3) improve health by decreasing BMI to <30	Past week: He is currently on risperidone but continues to be bothered by weight gain and is sedated; On propranolol and takes Melatonin PRN for sleep. Plan: Start to cross-taper to Abilify.	Past week: Working on Having Fun & Developing Good Relationships module. Plan: Continue with Nutrition & Exercise module. Work with Peer to walk around Green Lake and make eye contact with three people. Will discuss possible family meeting.	Past week: Contacted mom to resume weekly sessions. Plan: Will connect with local support groups and resources. Will initiate family meeting after IRT discusses with Andy.	Past week: No contact with Andy over the past week, per his request. Plan: Will re-approach likes and dislikes related to recent job loss, pros and cons of disclosure at the workplace, availability of supports to better assure satisfaction and success in employment	Past week: Has not engaged with Peer so far. Plan: Will use strategies for engagement, including motivational interviewing and sharing aspects of lived experiences. Will engage with walks around Green Lake and discuss bus routes. Will also talk about pros and cons of disclosure at work, sharing lived experiences regarding asking for accommodations.

Participant	Goals	Psychiatric Care Provider notes	IRT Specialist notes	Family Education Specialist notes	SEE Specialist notes	Peer Specialist notes
Megan	Return to school	Past week: On discharge meds of risperidone 2 mg. Met with Megan alone and with mother. Hesitant to increase dose. Introduced possibility of LAI. Plan: Continue current dose and have Megan and mother track functioning and side effects. Have them review LAI video before doing decisional balance worksheet.	Past week: No contact yet. Plan: Orient Megan to IRT. Elicit commitment to meeting weekly and establish their preference for meeting place.	Past week: Met with mom and Megan to orient to New Journeys. Plan: Will begin weekly sessions with mom starting with "Just the Facts" modules in the NAVIGATE Family Education Manual.	Past week: Engaged with Megan, shared nature and benefits of SEE services. Early interest appears to be focused on a return to school asap. Agreed to keep talking. Plan: Continue engagement, offer to assist in development of plan to return to school, begin gathering information for the educational profile, open up the topic of disclosure and related accommodations.	Past week: Shared lived experience and explained role. Shared info regarding possible open mic nights in the area. Plan: Scheduled next meeting to check out a comedy open mic at a local community college that they are interested in performing at.

APPENDIX G: NETWORK CONTACTS