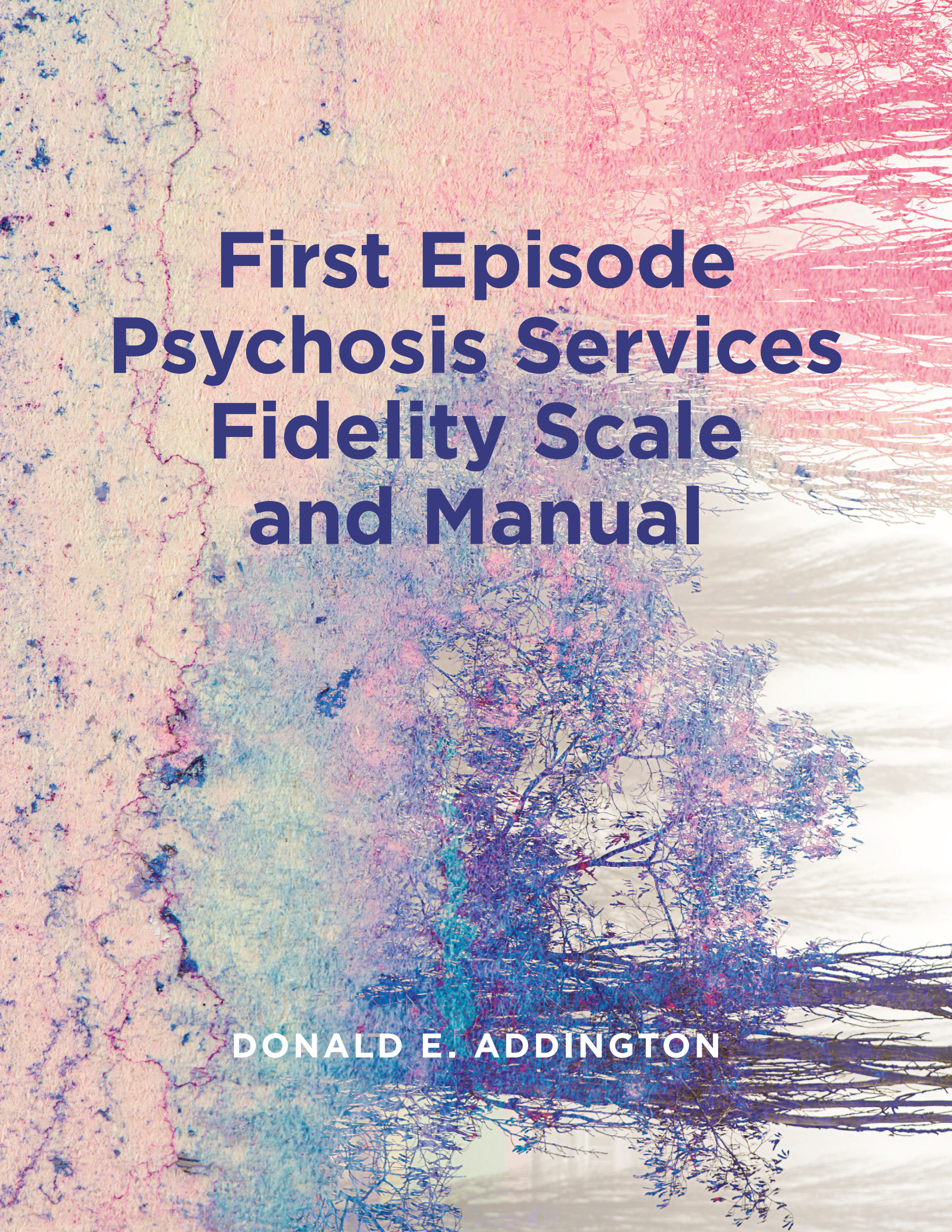

First Episode Psychosis Services Fidelity Scale and Manual

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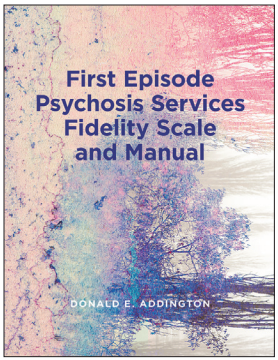

FIRST EPISODE PSYCHOSIS SERVICES FIDELITY SCALE AND MANUAL

by Donald E. Addington

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GENERAL GUIDELINES

Background

The First Episode Psychosis Services Fidelity Scale (FEPS-FS-1.0) is used to assess the degree to which mental health teams deliver specialized care comprised of a range of evidence-based practices to people experiencing a first episode psychosis and their families. Program fidelity refers to the extent to which delivery of an intervention adheres to the protocol of an evidence-based program model. Fidelity scales provide a list of objective criteria by which a program is judged to adhere to a reference standard for the intervention. The scale can be conceptualized as an outcome measure for implementation research or as a quality measure for assessing structure and process indicators in health care (Donabedian, 1966).

The First Episode Psychosis Services Fidelity Scale (FEPS-FS-1.0)

The FEPS-FS was developed using a standardized methodology for developing fidelity scales (Bond et al., 2000). The first stage involved three steps: (1) a systematic review of randomized controlled trials of first episode psychosis teams to identify the components of successful programs, (2) an assessment of the level of evidence supporting those components, and (3) a Delphi consensus process using international experts to identify the essential components (Addington, Mckenzie, Norman, Wang, & Bond, 2013). The second stage included three steps: (1) Developing descriptions of the core components, (2) defining behaviorally anchored criteria for ratings on a 5-point continuum for each component, and (3) development of a rating manual that described detailed procedures for data collection and scoring. The scale was tested for face validity, interrater reliability, and feasibility on programs in Canada and the United States . Results of the testing showed good interrater reliability and face validity. Compared with three other scales published (the Early Assessment and Support Alliance (EASA) scale, the RAISE Connection fidelity tool, and the EDEN scale, developed for Evaluating the Development and Impact of Early Intervention Services in England), the FEPS-FS has fewer components but the highest proportion of components common to all these scales (D. E. Addington et al., 2016). The design of the scale and the evidence base upon which it was developed permits assessment of programs that are based on different models and operating in different health systems.

The FEPS-FS-1.0 is a modified version of the original scale. Modifications were made in the course of and following two multi-center fidelity studies. The first, conducted in Canada, was a study of 9 programs in Ontario using an onsite review by trained clinicians, actively involved in health care delivery and health care evaluators (Durbin et al., 2019). The second study was a representative longitudinal cohort study of 36 US programs using a central remote assessment team and phone interview. The reliability of 33 items of the revised scale were shown to be good to excellent (Addington, Noel, Landers, & Bond, 2020). After the studies were completed, minor editorial changes were made to improve the wording of components and rating

criteria. Two new components reflecting components missed in the original scale were added to form the 35 components of the FEPS-FS 1.0. The two additional items included item 10, The age range served by the program, and item 35, Attention to fidelity. These are clear and concrete items that do not affect the reliability of the FEPS-FS 1.0 compared with the FEPS-FS revised version.

The scale is available in two forms: a 35-item Team scale and a 20-item individual patient scale.

1. The team scale can be rated in one of three ways:
    1.1. Site visit when expert reviewers visit a site.
    1.2. Remote assessment. Data is collected at the site from health record review and administrative data and interviews are conducted from a central site.
    1.3. Self Report. The site collects the data, interviews staff, and reports the results.
2. The individual scale is focused on the services offered to an individual patient. The scale assesses the service components received by the patient (Appendix G). This version of the scale was developed to assess and quantify the quality of the care received by individual patients who did not receive care from a team-based service. It was originally designed for use in a randomized controlled study comparing services offered in standard care versus specialized team care. This version of the scale has not been tested in research studies.

The scale was used as a self-report measure in a national study in Italy (Addington et al., 2020). Instructions on how to use the FEPS-FS 1.0 as a self-report measure are included in Appendix H. The self-report version does not differ from the observer-assessed version of the scale. The reliability of using the measure as a self-report measure has not been tested. Training in use of the scale is recommended for using the scale as a self-report measure just as it is for use by an external assessor.

The terminology used in mental health services varies across countries, service delivery organizations, and the professional groups delivering the services. The purpose of the scale is to assess the quality of services received, not to focus on terminology. For example, the scale and the manual refer consistently to patients, but not clients. Fidelity raters should use the terminology of the programs and services that they are evaluating. Thus, if the program or service uses the term clients rather than patients, the rater should use the term clients. Professionals delivering the services are also described using different terms. The term case manager means different things in different programs. In one program, the case manager does outreach and connects the patient to community services. In another program the case manager is the person primarily involved in coordinating the care within the team and perhaps for delivering a specific component of the services. It is a task of the fidelity rater to identify the services delivered by the different professional groups within their program and to use the program's own terminology to identify the various staff.

Different programs serve different patient diagnostic groups. This is a challenge for the fidelity rater, the fidelity sponsor, and the program. The research on team-based care for people with a first episode psychosis has focused on those with a first episode of a schizophrenia spectrum disorder. However, some programs also serve those with an attenuated psychosis syndrome (also known as the clinical high risk or ultra high risk groups), bipolar disorder, and/or a major depressive disorder with psychotic features. These different groups require different treatments, and the fidelity scale can be used in a way that adjusts for these different patient groups. These adjustments are defined as general principles and specific components for specific

disorders. It is up to the funders of specific fidelity reviews to determine the goals and objectives of the review. The most common focus for the fidelity reviews is for patients with a first episode of a schizophrenia spectrum disorder not including the attenuated risk syndrome. If that is the situation, the health records should be selected to reflect this population.

General Principles:

- Reliable initial diagnosis.
- Record numbers in groups.
- Review health records for population of interest.
- Exclude patients not in population of interest.
- Examine each group with sufficient numbers independently.

If there is a reason to assess fidelity for other groups, it is important to establish that there are sufficient numbers in those groups. To establish fidelity for these groups some components need to be dropped, as shown in the following table.

PATIENT GROUP	ITEMS TO OMIT
Recent Onset (0–5) years Schizophrenia Spectrum disorders	None
Bipolar	19 Initial antipsychotic 20 Antipsychotic dosing 21 Clozapine
Attenuated Psychosis Syndrome	13 Early Intervention 19 Initial antipsychotic 20 Antipsychotic dosing 21 Clozapine

The FEPS-FS is not designed to be a substitute for more detailed operating guidelines including country-specific or health-system-specific guidelines, such as provincial or state guidelines. The scale has been designed to focus on evidence-based services that are specific to or adapted to individuals with a first episode psychosis. Therefore, important general health system policies such as those addressing cultural adaptation, legal requirements for privacy, notification of dangerousness, or requirements for involuntary treatment are not addressed.

FEPS-FS-1.0 Manual

The *First Episode Psychosis Services Fidelity Scale Manual* provides a guide for scoring the FEPS-FS-1.0 and is designed to increase the reliability (consistency) of ratings across different sites and assessors.

The Manual provides the following:

- A definition and rationale for each component in the Fidelity Scale.
- A list of data sources to inform the ratings for each component.
- Decision rules to help score each component correctly.
- Site interview data-collecting tools: interview guides, health record abstraction guide.
- Site fidelity assessment preparation guide.

Overview of the Scale

The FEPS-FS 1.0 (see Appendix F) contains 35 program-specific components. Each component on the scale is rated on a 5-point scale ranging from 1 to 5. In the language of implementation this ranges from 1, "Not implemented" to 5, "Fully implemented". In the language of quality this ranges from 1, "Poor Quality" to 5, "Excellent Quality". In both languages, a 4 means good or satisfactory. The standards used to establish the anchors for the "fully implemented" ratings were determined through a variety of expert sources. The scale assesses the services received by program patients, the training received by the care providers, and how the team works together to engage and retain patients and deliver coordinated and evidence-based care.

Services Delivered and Staff Roles

Staffing patterns, professional designations, and individual roles vary significantly from one organization to another, and across health care jurisdictions and countries. To address this, the FEPS-FS-1.0 ratings focus on assessing the services received by the patients, rather than professional designation of the person who delivers the service. In practice, assessors need to adapt questions to fit with the staffing pattern of the program being reviewed. For example, Cognitive Behavioral Therapy (CBT) might be delivered by a psychologist or by a trained counsellor who is a social worker by profession. Case management may be provided by a mental health professional who is called a case manager or care coordinator, or by someone called a counsellor or recovery coach who may have additional roles such as CBT or individual resiliency training. The scale also assesses the professional training of the staff and the specific training received in order to fulfil their role on the team and deliver the services provided to patients.

Training Fidelity Assessors

Trained assessors should conduct the fidelity assessments. Training varies depending on the experience and knowledge of the fidelity rater. It usually involves a two-day training program followed by two teleconferences with the trainer to discuss consensus ratings of real programs. The training can be delivered in-person or remotely.

The first day of training addresses the following:

- The scale development process
- Review of individual components
- Review of the Manual
- Review of the process used for a fidelity assessment
- Review of best practices for implementing fidelity measures and other health care quality indicators

The second day's training involves case-based training.

After conducting their first few fidelity assessments, raters should have the opportunity to review the process and the ratings with the trainer.

Fidelity Assessment Process

The scale can be used for onsite fidelity reviews, remote fidelity assessment, and self-assessment. The scale was originally designed and first evaluated using an expert in-person site interview method. It has since been adapted and tested for remote assessments including both remote data collection and staff interviews. The fidelity scale has also been used as a self-report measure. The scale and the recommended sources of data are the same in each data collection method.

Preparing for a Site Fidelity Assessment

Fidelity assessments require advanced preparation by all participants to ensure that assessors have time to speak with different program stakeholders and receive the information necessary to make the ratings.

Assessor Role:

- Review the fidelity Manual, scale, and data collection tools in advance of the site assessment.
- Review any documents sent by the site in advance (see data source #1 in Data Collection and Data Sources section below for more detail).
- Complete any required training on ethical evaluation practices and health information privacy regulations.
- Communicate with the central coordinating unit to schedule the assessment date and organize the phone-in schedule.
- Ensure all necessary paperwork related to privacy/confidentiality is completed. (Requirements will vary from program to program.)
- Note: The assessors should meet in advance of the site assessment by teleconference to introduce themselves, discuss initial impressions from advanced materials, and confirm roles/approach for interviews. This can be conducted by phone.
- Arrange a specific time to train the team leader and the health record abstractor.

- Interviews for a single program should be scheduled for one day and should start with the interview with the program manager.

Program Role:

- Identify the lead contact with the fidelity review team.
- Create a schedule for site interview, line up staff interviews, pull active patient health records, and send assessors any important documents/reports. (For full instructions refer to Appendix A: Preparing for a Fidelity Assessment.)
- Ensure all necessary internal approvals (i.e., administrative, ethics) are in place and required paperwork has been completed by the assessors.
- Identify the person responsible for health record abstraction.
- Communicate with the central team to schedule the assessment date.

Central Team Role:

- Liaise with the site and assessors to organize and schedule the site visits.
- Support ethics and privacy processes.

The most successful fidelity assessments are those in which there is a shared goal among the assessors and the program site to understand how the program is progressing and delivering evidence-based practices.

Data Collection and Data Sources

A detailed guide for programs undergoing a fidelity review can be found in: Appendix A: Preparing for a Fidelity Assessment.
The assessor team will need to review three data sources: existing documents and administrative data sent in advance, data abstracted from the health records of active patients, and interviews with staff and patients. A schedule for the interviews or site visit will be prepared in advance by the site to ensure the evaluation runs smoothly

1. Existing documents and administrative data

Documents including policies, practices, detailed program description (including all program components), education materials, and routine reports/admin data (e.g., staff FTEs, admission and discharge statistics, etc.) should be provided by the program in advance. The full list of documents to include can be found in **Appendix A: Preparing for a Fidelity Assessment**. These documents need to be reviewed before the site assessment.

NOTE: *Only aggregate, de-identified data should be shared in advance.*

2. Data abstraction from active health records

a. **Ten active, randomly selected health records of patients who have spent one year in the program.** The health record data abstraction will require approximately 4 hours. The central team will work with each site to develop a randomization process. The records should be selected from patients who have been receiving services for at least one year to ensure patients

have had adequate time to receive the services. Where programs are new or so small that they do not have 10 patients who have received services for a year, the assessment of the health records needs to be reconsidered in light of the purpose of the fidelity review. If the purpose of the study is to strictly compare programs against a standard which requires a size of service that has a meaningful impact on community services, the small program can be rated according to the proportion of 10 records that meet fidelity criteria. If the purpose of the fidelity review is to check on the processes of care as a new program is being established, the rating can be calculated based on the proportion of health records of patients who have received care for one year. The health record review can be undertaken by a local abstractor who will require brief training from the team responsible for the fidelity review and an orientation to the health record by a clinical team member of the first episode psychosis service. More detail on selecting patient health records can be found in **Appendix A: Preparing for a Fidelity Assessment**.

b. **Health records of the last five patients who have had a hospital admission after joining the program.** The focus of this health record abstraction is to identify the data required to rate Component 31, *Communication Between FEPS and Inpatient Service,* and Component 32, *Timely Contact after Hospital Discharge*. Where programs are new or so small that they do not have five patients who have been hospitalized, the assessment of the health records needs to be reconsidered in light of the purpose of the fidelity review.

Any program requirements to support privacy or access from both an ethical and logistical perspective should also be confirmed ahead of time. The **Health Record Review Checklist** (Appendix B) can be used to extract the relevant data from the health records. It is designed to be completed without the use of any information that could be used for personal identification.

3. Interviews with staff

A range of program staff should be interviewed during the fidelity assessment. At all programs it is important to interview the program manager/team leader, one case manager/care coordinator, the psychiatrist or other prescriber, and the supported employment specialist. These interviews will be organized in advance by the program, and interviews are conducted individually. The specific configuration of interviews with staff will depend on the team composition and functions. The assessor should interview all staff needed to obtain the necessary data to complete fidelity ratings.

See Appendix C for the **Fidelity Interview Guide**. It is helpful to review the interview schedule with the site lead at the beginning of the first day of the site visit to clarify the roles of each staff member who will be interviewed.

It is the responsibility of the assessors to ensure that, when required, informed consent is received at the beginning of each interview and to make clear that participation is voluntary and that a decision to not participate will not affect staff member's employment in the program. Site-specific consent forms will be provided to each assessor team, and the signed consent forms will remain onsite and stored by the program. Detailed notes should be kept during the interviews to support the final fidelity ratings.

NOTE: *No identifying information (e.g., names of staff, patients, or families) should be included in assessor notes. Notes also should not include any comments on individual work performance.*

Confidentiality and Data Storage

It is important to ensure that proper confidentiality protocols are in place for each site interview and that any data collected is stored in an appropriate manner. Prior to or at the beginning of the site review, all assessors must sign the necessary confidentiality forms. These vary depending on the data collected during the site review and may include notes from the patient, family and staff interviews, notes from the staff meeting, and the completed Health Record Review Checklist (Appendix B), as well as any documents or reports shared by the site. The information collected should not include any names or references to individual patients, family members, or staff or personal health information. No health records or identifiable information should leave the site.

The information will be kept in a secure location by the assessor (if paper-based, in a locked cabinet/office, and if electronic, in a password-protected file) until the final fidelity report has been produced. At that point, the assessors will send the files to an appropriate site storage depending on the purpose and regulations governing that purpose. If the assessment is part of a research project, the storage follows research requirements. If it is a quality improvement project, then local storage requirements should be in alignment with local procedures. Before sending the documents, assessors should complete a final review of the documents to ensure no individuals are identified.

How to Rate Components and Triangulate Across Data Sources

It is the task of the assessors to review and synthesize all data collected to determine the score for each component on the scale and to complete the final report.

How to rate components:

- Ratings should be made based on the scale as it is written. Any concern that the rating does not accurately reflect program practice should be captured in the comments section of the final report.
- The scale ratings are based on current behavior and activities, not planned or intended behavior.
- For multi-site programs, if service delivery differs across program sites, consider rating the sites separately or rate according to the higher performing program and describe the discrepancy in the comments section.
- If a period of time is not specified, then the rating can be based on service delivered at any point during the period of care.

Which data source to use:
The next section of this Manual lists all relevant data sources for each component. All the listed data sources for each component can be used to complete the comments section of the report, but we have included instructions on *which data source is the suggested primary source to identify the rating for that component*.

- **Wherever possible, program administrative data or health records should be used to determine the final component rating.**

- In general, if care related to a component is typically documented in the health record and is provided to all patients, then the health record is used as the data source. In this case, if the component is not documented in an individual health record, we assume it did not happen. It is of course possible that it did occur and simply was not documented. This possibility can be discussed in the comments but should not impact the rating.
- However, if a component is **not** routinely documented in the health record, or is provided only to a minority of patients, an alternative data source (e.g., staff interviews) can be used to support the rating. If this is a possibility, interviews will be listed as the appropriate data source for that component. For example, if cognitive behavioral therapy is not documented in the health record, the record cannot be used as a data source.
- **All** data sources may provide important contextual information that should be included in the comments section of the final report (though it may not necessarily impact the rating). For example, if the rating for a component is low and the policy review indicates that no procedures are in place to support the component, this may be a practice improvement area to flag. On the other hand, if the rating is low and the processes seem appropriate, it may be a documentation issue, and this may be flagged.

After Your Fidelity Review

If possible, time should be set aside after the interviews and after the review of the documentation to review data to explore discrepancies. Queries can be addressed with a follow-up email or call to the site. It is critical that the interview rating and documentation be reviewed while the information is still fresh.

After the site interview *a consensus rating meeting* may be scheduled with the assessors and a fidelity expert if available. The assessors present their ratings and rationale, obtain feedback from the expert, discuss differences, and agree on a final consensus rating. The fidelity expert will ensure scoring decisions are in-line with the intended use of the scale.

The assessors can prepare the fidelity ratings and/or report and send to the program or research team within an agreed upon period. Two weeks after the consensus rating meeting is a reasonable time frame. A **Feedback Report Template** can be found in Appendix H. The report can include:

- A high-level overview of findings, highlighting program strengths and opportunities for improvement
- Component fidelity scores
- Data sources used to determine each score
- Any contradictions between data sources
- Any additional relevant contextual information that might explain the score (e.g., problems with outreach in remote regions)
- Specific additional information requested per component (clearly specified in template)
- Additional assessor comments (e.g., Was this component difficult to rate? Do you feel the rating is valuable/ reflects program practice?)

COMPONENT CRITERIA AND RATINGS

1. Practicing Team Leader

Definition: Program staff receive both administrative leadership and clinical supervision. These roles may be held by the same individual (likely a manager or team leader) or by two different individuals. To get the highest rating, the individual who provides clinical supervision should also provide some direct clinical services in the first episode psychosis program. It is *not* required that these individuals have a master's-level education, but in some services, this is a requirement for this role.

Rationale: Longitudinal studies of implementing best practices show a significant correlation between the presence of a practicing team leader and program fidelity.

Component Scoring:

- *Data source to use for rating*: Interviews
- *Component response rating*: If the team leader (or other individual) provides administrative direction and clinical supervision to all staff *as well as* providing some direct clinical service, code the component as '5'.
- *Direct clinical service*: The supervisor is providing a service and not just observing another clinician as part of supervision. It does not have to be functioning as a care coordinator or case manager with a caseload. It can be completing the intakes or family psychoeducation or offering individual therapy.

Comments:

- *Additional data sources to support comments*:
  - Interviews with the team leader and clinicians.
- *Specific information to include*:
  - Does the team leader hold multiple positions (i.e., Team Leader role for other programs or formal role as intake person for the first episode psychosis program)?

2. Patient-to-Provider Ratio

Definition: There is a target ratio of patients to Full Time Equivalent (FTE) clinical staff.

Rationale: Optimal ratios have been reported in the range of 15-20 cases per FTE.

Component Scoring:

- *Data source to use for rating:* Interviews
- *Component response coding:* If interviews indicate that the caseload ratio is 20:1 or less, rate the component as '5'.

To calculate: Divide the total number of currently registered patients by the total number of clinical FTEs. A Full Time Equivalent (FTE) is a unit that indicates the workload of an employed person in a way that makes workloads comparable across various contexts. FTE is often used to measure a worker's involvement in a program. The calculation of full-time equivalent (FTE) is an employee's scheduled hours divided by the employer's hours for a full-time workweek. When an employer has a 40-hour workweek, employees who are scheduled to work 40 hours per week are 1.0 FTEs. Employees scheduled to work 20 hours per week are 0.5 FTEs, and 0.1 FTE represents one half-day of work. In the FEPS-FS, FTEs include all direct clinical care staff. Direct care staff include family support worker, peer support worker, nurse, employment specialist, addiction specialist, psychologist, therapist, and case manager. Do not include residents/interns even if they have their own caseload. Do not include any staff members who have no clinical role. These may include administrators, data managers, managers, and researchers. Do not include prescribers. If the team leader has both an administrative role and a caseload, in the calculation only include the percentage of time the team leader dedicates to clinical services.

Comments:

- *Additional data sources to support comments*:
  - Interviews with team leader, clinicians, and Supported Employment specialist
  - Document review
  - Policy and practice documents

3. Services Delivered by Team

Definition: Includes qualified professionals to provide both case management and specific service components including:

i. Case management/care coordination
2. Health services (registering with primary care, weight and metabolic monitoring)
3. Psychotherapies including Cognitive Behavioral Therapy (CBT) and Motivational Enhancement (ME) (aka Motivational Interviewing)
4. Substance use management
5. Supported employment/Supported education

6. Family education and support
7. Patient psychoeducation
8. Pharmacotherapy

The focus for rating this component is the services received by the patients rather than the professions of the providers. Some of these components may be delivered by a staff member paid by another program but can still be included if that staff member is an active participant in the patient's multidisciplinary team. More than one function may be provided by the same individual. Rating the service as present is separate from the rating of the quality of the service, which is covered by the assessment of each component. A minimum rating of '2' on the specific component score should be required to define the service as present.

Rationale: Patients and families benefit from a range of services which need to be coordinated to deliver consistent care.

Component Scoring:

- *Data source to use for rating:* Interviews and document review.
- Most services are defined under the rating for that component.
- *Component response coding:* If team members provide all the listed services, code the component as '5'.

Comments:

- *Additional data sources to support comments*:
  - Interviews with team leader and clinicians.
  - Document review (program staff role descriptions)

4. Assigned Case Manager/Care Coordinator

Definition: Patient has an assigned case manager/care coordinator (individual may have a different title at different programs) who is a professional qualified clinician in nursing, psychology, social work, or occupational therapy.

Case managers (or "care managers/coordinators") are staff members on coordinated specialty care teams who assess and address the individual and unique needs of each patient, providing direct services or making referrals with follow-up ensuring that individualized needs are addressed. Case managers are part of the team, attend team meetings and coordinate care for patients. Case management responsibilities may include mental health counseling, skills training, financial counseling, housing assistance, substance abuse counseling and treatment, and family counseling.

Rationale: Case management is a component of all treatment guidelines.

Component Scoring:

- *Data source to use for rating:* Health record review or administrative data
- *Component response coding:* If 80% or more patients have been assigned a case manager, code the component as '5'.

Comments:

- *Additional data sources to support comments*:
  - Interviews with team leader and clinicians

5. Psychiatrist Caseload

Definition: Access to psychiatry is an important component of the first episode psychosis treatment model, and each patient should be seen up to once a week by a psychiatrist if necessary. It is important that psychiatrists maintain low caseloads to facilitate this frequency. Other appropriately trained prescribers can take responsibility for pharmacotherapy. Appropriately trained means that the licensed prescriber can evaluate symptoms and functioning, is aware of the available antipsychotics, their risks and benefits, as well as the indications for other psychopharmacological interventions in psychosis. Moreover, they should be able to monitor and manage the side-effects.

Rationale: Implementation guidelines specify the need for psychiatrists or other appropriately trained providers to be part of the team.

Component Scoring:

- *Data source to use for rating:* Interviews with team leader and prescriber, and program documents
- *Component response coding:* If interviews indicate that psychiatrist works with ≤29 patients per 0.2 FTE, code the component as '5'.

To calculate:

1. Add up the total psychiatry FTEs available to the program per week.
2. Divide the total number of enrolled patients by the total psychiatry FTEs.
3. Multiply that number by 0.2.

For example, if you have 30 currently registered patients and a 0.1 psychiatrist FTE, your caseload is 60 per 0.2 psychiatry FTE.

Use the prescriber with the highest ratio who serves at least 30% of the full caseload to code the component. If the caseload is divided more or less equally across multiple prescribers who have equivalent time allocations but variable caseloads, calculate the patient-to-prescriber FTE ratio for each prescriber.

For example, a program has 43 active patients and 3 prescribers. Prescriber 1 is 0.1 FTE and has a caseload of 16, Prescriber 2 is 0.2 FTE and has a caseload of 25, and Prescriber 3 is 0.1 FTE and has a caseload of 20. Converting their caseload ratios to a 0.2 FTE:
Prescriber 1 – 0.2: 16
Prescriber 2 – 0.2: 25
Prescriber 3 – 0.1: 20
Combined (FTE 0.5): 65
Prescriber caseload 25/ 0.2 FTE score 5

Comments:

- *Additional data sources to support comments*:
  - Staff FTE documents
- *Specific information to include*:
  - How many FTEs of psychiatry do you have available?
  - If a patient needs to be seen every two weeks by a psychiatrist, is that possible?

6. Psychiatrist Role on Team

Definition: Psychiatrists/licensed prescribers are team members who provide direct clinical services to individual patients and their families. They share an integrated health record with other team members. In addition, as team members they attend team meetings, may see patients with other clinicians and are accessible for consultation by team during the work week.

Rationale: Program guidelines specify the need to have a psychiatrist/prescriber as part of the team.

Component Scoring:

- *Data source to use for rating:* Interviews with the team leader and psychiatrist/prescriber
- *Component response coding:* If interviews indicate that the psychiatrist/prescriber attends team meetings, sees patients with other clinicians, shares the team health record, and is available for consultations with staff during the work week, code the component as '5'.
- The psychiatrist/prescriber participation must be consistent. Appropriate and accountable funding for these activities reinforces this pattern of practice and strengthens the evidence for the rating.
- The psychiatrist must attend three or more team meetings per month to meet the criterion of attendance at team meetings.
- Some programs may use outside prescribers who are not involved as team members or who do not share the same health record for certain patients. If this affects ≤20% of the current caseload, this should be noted as deficiency in any written review. If it affects >20% of the current caseload the team should not receive the point for sharing the health record with other team members.

NOTE: *If there are multiple psychiatrists/prescribers who work with the program and who have different practices regarding their participation on the team, the rating should be made based on the main psychiatrist/prescriber (the one with the most patients) and discrepancies can be discussed in the comments.*

7. Weekly Multi-Disciplinary Team Meetings

Definition: Multi-disciplinary team meetings are conducted weekly to discuss the following:

1. Case review (new admissions and caseloads)
2. Assessment and treatment planning
3. Complex cases
4. Termination of services

Rationale: Regular team meetings are conducted to review the status of first episode psychosis patients and foster staff communication.

Component Scoring:

- *Data source to use for rating:* Team Leader Interview
- *All team members must be present.*
- *If the psychiatrist is absent* this still counts as a team meeting, but the absence is rated under the psychiatrist role. To be present the psychiatrist must attend three or more of the team meetings in a month.
- *Component response coding*: If the team meetings are conducted weekly, and involve discussion of all four issues, code the component as '5'.
- *Admissions and caseload* refer to discussion of new cases and to maintaining an adequate number of cases or reviewing premature discharges.
- *Termination of services* refers to the clinical detail involved in transition in care after the end of the program.

Comments:

- *Additional data sources to support comments*:
  - Interview with case manager

8. Explicit Diagnostic Admission Criteria

Definition: The FEP program has a clearly identified mandate to serve specific diagnostic groups with a psychosis and uses measurable and operationally defined criteria to select appropriate referrals. There exists a consistent process for screening and documenting uncertain cases and those with co-morbid substance use. The exact diagnostic criteria admitted vary according to the program. Typically, all include those with a schizophrenia spectrum disorder, and some include those with a bipolar disorder or major depressive disorder with psychotic features. Some also serve those with a DSM-5 Attenuated Psychosis Syndrome,

also known as those at Clinical High Risk. It is necessary to know the proportions of these groups in the program, since this affects the components that assess pharmacotherapy.

Rationale: The program needs explicit criteria to conduct effective evaluations and make comparisons with similar programs.

Component Scoring:

- *Data sources to use for rating*:
  - Interview with team leader and document review
  - Policy document
- S*pecific information to include*:
  - Describe the program inclusion and exclusion criteria for admission.
  - Provide the number of people enrolled in the program by diagnostic group.
- *Component response coding:* If over 90% of the patients served meet admission criteria, code the component as '5'.
- *Patients with ambiguous diagnoses:* Count patients with ambiguous diagnoses who later meet criteria for a non-included diagnosis as meeting criteria for program entry.

9. Population Served

Definition: This component evaluates the extent to which first episode psychosis programs are meeting population need. In other words, are they serving the number of new patients expected, based on the incidence of new cases expected from the population in the catchment area? Catchment area may be defined by city, county, or state or region. For guidance, we have included recommended incidence rates based upon data from a systematic review of the literature. If there is data available that describes the precise incidence of new cases in your service area, this should be used.

Rationale: Programs should enroll patients with a schizophrenia spectrum disorder at the annual incidence rate of 16:100,000 people (McGrath, Saha, Chant, & Welham, 2008). Use local data on incidence if available; for example, in England a data base provides specific incidence data for each region (Kirkbride et al., 2013).

Component response coding: If the program serves ≥80% of incident cases expected within the region served by the program, score '5'.

If the program or the service provider organization does not compare the admission rate to the expected incidence rate, rate the component as '1'.

Comments:

- *Data sources to support comments*:
  - Interviews with the team leader
  - Program administrative data on new admissions
  - Publicly available population statistics*

- *Specific information to include*:
    - Number of *new* patients admitted in the past 12 months per 100,000 population

**Use a government-based census source (e.g., www.census.gov) to find the population of catchment area.*
NOTE: *Calculation should be based on the typical number of unique patients admitted in the past 12-month period and the population of the program's catchment area. Information on new patients and estimated boundaries of the program catchment area can be obtained from the program.*

To calculate:

1. Gather necessary numbers:
    a. Identify the number of new patients admitted to the program in the past 12 months.
    b. Identify program catchment area boundaries.

2. To calculate the proportion of total potential patients served:
    a. Look up catchment area population size.
    b. Divide the number of new patients by the total catchment area population.
    c. Multiply this number by 100,000.
    d. The result is the number new cases per 100,000 population.

10. Age Range Served

Definition: The age range accepted by the program.

Rationale: The epidemiology of schizophrenia indicates that the age range of onset covers the age range from early teens to 65. Programs that restrict the age range exclude older patients who are more often female and more likely to be married.

- *Data Source:* Program policies, team leader interview

11. Duration of First Episode Psychosis (FEP) Program

Definition: The mandate of the program is to serve patients for a specified period.

Rationale: Due to the nature of the early course of illness, patients and families often benefit from receiving first episode psychosis services for at least three years. The level of services required varies between individual patients and their families and over time.

Component Scoring:

- *Data source to use for rating:* Interviews and program policies review
- *Component response coding:* If the intended duration of the service is more than three years, code the component as '5'. For this component, duration is based on the program policy and stated mandate (though length of time in program for individual patients may vary).

Comments:

- *Additional data sources to support comments*:
  - Interview with team leader and clinicians
  - Program policy documentation review

12. Targeted Education to Health/Social Service/Community Groups

Definition: Provision of information to first-contact professionals, including family physicians, school and post-secondary counseling services, youth social service agencies, community mental health services, police services, hospital emergency rooms, and other community organizations. Public education may be provided by any source within the program or network.

Rationale: Early identification approaches that involve proactively seeking out patients with early psychosis reduce the duration of untreated psychosis. Enhancing the education, communication, and liaison with health and service providers who may identify or treat patients with early psychosis will reduce the duration of untreated psychosis.

Component Scoring:

- *Data source to use for rating:* Interviews and document review
- *Component response coding:* If community education is provided to service providers more than 12 times in previous 12 months, code the component as '5'.
- *Hospital liaison* is rated under component 33. It does not get rated under this component unless it is for emergency room contacts.
- *Repeated visits to one site:* It is reasonable to visit a site more than once given staff turnover leads to loss of information. Ongoing contact with a site around clinical cases does not count.
- *Within-agency education:* Do not count in-house agency education sessions.
- *Do not count inpatient unit education since this is part of component 33, Communication between FEP and inpatient services. Furthermore, it does not promote community awareness.*

NOTE: *This should be based on face-to-face education. Although potentially useful, activities such as poster campaigns, mass mail outs, phone calls, faxing, or emailing should not be counted towards this component.*

Comments:

- *Additional data sources to support comments*:
  - Interviews with team leader, clinician, and outreach coordinator
  - Public education materials (e.g., slides, handouts, speaking schedule, etc.)
  - Program policy

13. Early Intervention

Definition: The proportion of first episode psychosis patients who have been hospitalized prior to FEPS program admission.

Rationale: The proportion of first episode psychosis patients who have been hospitalized prior to admission to the FEP services reflects success in early intervention.

Component Scoring: If *no more than* 19% of the current caseload were hospitalized in an inpatient psychiatric unit prior to enrollment, code the component as '5'. The numerator for this measure is the number of patients admitted in the last year.

NOTE: *Do not include patients categorized as "clinical high risk" in calculating the proportion.*

Comments:

- *Data sources to support comments*:
  - Interviews with the team leader
  - Program administrative data

14. Timely Contact with Referred Individual

Definition: Patients should receive an in-person appointment within two weeks of referral (10 business days) to the program. The time starts on the date that the referral from the original referral source is received at the program and ends when the patient has an in-person appointment. To meet criteria, appointments must be face-to-face and must include the opportunity to start some element of treatment. Treatment can include any activities that begin with the engagement of the patient and the process of recovery. This can include the first intake appointment where initial assessment, education, and the engagement process begin. The rating is based on appointments attended, not appointments scheduled or offered.

Rationale: Patients who experience a first episode of psychosis require urgent or emergent care. Treatment should be initiated within two weeks of referral. Clear intake and admissions procedures support receipt of a timely initial assessment and treatment.

Component Scoring:

- *Data source to use for rating:* Health record review or administrative data (If program can pull all initial appointment data, the full dataset rather than the health record review can be used to assign the rating.)
- *Component response coding:* If 80% or more patients receive a face-to-face appointment within two weeks, code the component as '5'.
- *Hospitalized patients:* Some patients are first seen by FEPS staff in hospital. This would count as their initial assessment and there would be zero time between referral and assessment.

NOTE: *If a patient is hospitalized after referral but before their first appointment, thereby preventing them from attending a first appointment within 2 weeks, they should be excluded from this calculation. If the patient is referred again to the program, the time is then calculated from the time of hospital discharge.*

Comments:

- *Additional data sources to support comments*:
  - Interviews with program manager, case manager, or intake coordinator
  - Documented program policy and procedure

15. Family Involvement in Assessments

Definition: Service engages family in initial patient assessment to improve the quality of the assessment, and to engage both in the treatment program. Occasionally the patient is first seen alone. In these cases, if the family is seen within a month of the initial individual meeting, this can be counted as part of the initial assessment.

Rationale: The engagement of individuals and families or other carers as partners in the assessment process and care improves the overall reliability of the assessment and may foster therapeutic alliance (e.g., helping choose targets for intervention).

Component Scoring:

- *Data source to use for rating:* Health record review or administrative data
- *Component response coding:* If 80% or more of families are seen during initial assessment or within a month of that meeting, code the component as '5'.

Comments:

- *Additional data sources to support comments*:
  - Interviews with program manager, case manager, or clinicians responsible for initial assessments
  - Program policies and procedures for intake/assessment

16. Comprehensive Clinical Assessment

Definition: Each patient should have a comprehensive clinical assessment as part of their initial assessment. It should include the following:

1. Time course of symptoms, change in functioning, and substance abuse (assessing whether there was change in functioning correlated with substance use changes or other changes)
2. Recent changes in behavior
3. Risk assessment of harm to self/others
4. Mental status exam
5. Psychiatric history

6. Premorbid functioning
7. Comorbid medical illness
8. Comorbid substance use
9. Family History

Rationale: Comprehensive assessments provide essential information for diagnosis, treatment decisions, and care planning.

Component Scoring:

- *Data source to use for rating:* Health record review, clinician interview.
- *Component response coding:* If 8 of the 9 items above are assessed at enrollment for 80% or more of patients, code the component as '5'.
- The comprehensive assessment may be completed over time, for example, as a combination of assessments from the screening interview to the initial assessment by the psychiatrist and other clinicians. The initial assessment must be completed within one month of enrollment.

Comments:

- *Additional data sources to support comments*:
  - Interview with the team leader
  - Policy and procedure manuals, assessment templates (if available)

17. Comprehensive Psychosocial Needs Assessment

Definition: Each patient should have an assessment of their psychosocial needs. The assessment should include the following:

1. Housing
2. Employment
3. Education
4. Social support
5. Financial support
6. Primary care access
7. Family support
8. Past trauma
9. Legal

Rationale: Comprehensive psychosocial needs assessment provides essential information to support patient-centered care planning to support recovery in the community.

Component Scoring:

- *Data source to use for rating:* Health record review or clinician interview.
- *Component response coding:* If eight or more psychosocial needs of patients are included in 80% of needs assessments, code the component as '5'.

Comments:

- *Additional data sources to support comments*:
  - Relevant policy or protocol
  - Interview with the team leader
- This component assesses the thoroughness of the assessment process. It is not meant to suggest that all these items should be included in a treatment plan. The treatment plan will reflect the needs identified and the preferences of the patient.

18. Clinical Treatment Plan/Care Plan after Initial Assessment

Definition: It is important that treatment plans/care plans reflect patient and family preference as well as clinical and psychosocial needs. Evidence that patient and staff collaborate to develop a treatment plan include:

a. Patient's signature on the plan

Rationale: The clinical presentation and impact of psychosis is variable, and it is important that treatment is individualized.

Component Scoring:

- *Data source to use for rating:* Health record review, Clinician Interview
- *Component response coding:* If 80% or more patients have an individualized treatment plan that reflects patient preference, code the component as '5'.

Comments:

- *Additional data sources to support comments*:
  - Interviews with team leader
  - Program policy/procedures

19. Antipsychotic Medication Prescription

Definition: After assessment confirms a diagnosis of a psychosis and the need for pharmacotherapy, antipsychotic medication is prescribed with consideration given to patient preference.

Rationale: Antipsychotic medication is an evidence-based core intervention to treat symptoms of psychosis and reduce relapse rates for patients with a first episode of a schizophrenia spectrum disorder.

Component Scoring:

- *Data source to use for rating:* Health record review or administrative data
- *Component response coding:* If 80% or more patients with a schizophrenia spectrum disorder receive a prescription for antipsychotic medication or enter the program already on an antipsychotic, code the component as '5'.
- Do not count patients with a clinical high risk for developing a schizophrenia spectrum disorder (DSM-5 Specified Schizophrenia Spectrum Disorder Attenuated Psychosis Syndrome) or those with bipolar disorder. These patients do not contribute to the denominator.
- This component refers to a prescription in the first month of starting the program. The dose may not be initiated at the full treatment dose.

Comments:

- *Additional data sources to support comments*:
  - Interviews with team leader, clinician, and prescriber
  - Program policy

20. Antipsychotic Dosing within Recommendations for Individuals with Psychosis

Definition: Antipsychotic medication dosing is within government-approved guidelines for second-generation antipsychotics and between 200 and 800 Chlorpromazine Equivalents for first-generation antipsychotic medications at six months (See Appendix J for **Medication Dosing Guidelines**).

Rationale: First episode psychosis patients tend to respond to lower doses of antipsychotic medications and are more sensitive to side-effects than multi-episode patients. At the same time, a proportion do not respond to medication at all, which means that in practice the full range of doses should be used.

Component Scoring:

- *Data source to use for rating:* Health record review or administrative data
- *Component response coding:* If by six months of starting the program, 80% or more of patients are on a dose within the target range, code the component as '5'.
- *Multiple antipsychotics:* If the patient is prescribed more than one antipsychotic, take the current dosage of each and divide them each by their maximum dosage. Add the fractions. If the total is >1, then the patient is not receiving antipsychotic dosing within guidelines.
  - *Example 1:* Patient is prescribed 15 mg aripiprazole and 4mg risperidone. Divide aripiprazole dosage by the maximum aripiprazole dose (15mg/30mg = 0.5) and divide risperidone dosage by the maximum risperidone dosage (4mg/16.0mg = 0.25). Add the two fractions (0.5 + 0.25 = 0.75). Total value (0.75) is < 1. Therefore, the prescribed dosage is within dosage guidelines.

- *Example 2:* Patient is prescribed 5 mg aripiprazole and 20mg olanzapine. Divide aripiprazole dosage by the maximum aripiprazole dose (5mg/30mg = 0.17) and divide olanzapine dosage by the maximum olanzapine dosage (20mg/20mg = 1.0). Add the two fractions (0.17 + 1.0 = 1.17). Total value (1.17) is >1. Therefore, the prescribed dosage is not within dosage guidelines.

Comments:

- *Additional data sources to support comments*:
  - Interview with prescriber
  - Program policy

21. Clozapine for Medication-Resistant Symptoms

Definition: Use of clozapine if patient does not respond adequately after two trials of antipsychotics (medication resistance occurs in approximately 20% of cases with schizophrenia spectrum disorders).

Treatment equivalent to 10 mg haloperidol, and over 3-month period.

Rationale: Clozapine is indicated for the treatment of inadequate or non-response to first-line antipsychotics.

Component Scoring:

- *Data source to use for rating:* Clozapine monitoring enrollment records, administrative data or interviews (depending on what is available)
- *Component response coding:* If more than 4% of caseload of patients with schizophrenia spectrum disorder are on clozapine, code the component as '5'.

To calculate:
Divide the total number of program patients with a schizophrenia spectrum disorder who are on clozapine by the total number of currently enrolled patients diagnosed with a schizophrenia spectrum disorder.
NOTE: *For programs that serve multiple groups of patients (i.e., schizophrenia spectrum disor*ders, bipolar disorder, depression, and clinical high risk or attenuated psychosis syndrome) the numerator and denominator are exclusively patients with a schizophrenia spectrum disorder.

Comments:

- *Additional data sources to support comments*:
  - Interviews with prescriber
  - If there is a discrepancy between the prescriber and documents prepared and submitted by the team leader, it is likely that the prescriber is more aware of the numbers due to the practical impact of having patients on clozapine. If the numbers are discrepant, provide the prescriber with the number provided by the team leader for clarification. Use the prescriber's final determination as the count for the number of patients on clozapine.
  - Program policy

22. Patient Psychoeducation

Definition: Provision of at least 12 episodes of patient psychoeducation in the first year. Psychoeducation refers to the provision of support, information, and management strategies related to familial, social, biological, and pharmacological perspectives on illness. (See below for a detailed list of topics that may be addressed through psychoeducation.) An episode or session is usually 45-60 minutes covering a specific topic and its relevance to a patient.

The person delivering the psychoeducation must have received formal training in patient psychoeducation as well as supervision. The training may have been part of their formal professional training or as continuing professional development (CPD). For both professional training and CPD, the training should comprise both learning and supervision. Attending courses without supervision is not evidence of effective training.

Psychoeducation can be delivered individually or in a group and may be delivered by any member of the care team with formal training including peer support workers. A structured psychoeducation manual may be used, or psychoeducation may be delivered more informally, embedded as a component of case management. The RAISE research Individual Resiliency Manual sessions 1-3 and 7 are considered to cover psychoeducation, as are modules 12 and 13 on health.

Rationale: Psychoeducation is a way of providing information to patients to both engage them and support autonomy and recovery.

Component Scoring:

- *Data source to use for rating:* Health record review or administrative data (e.g., group attendance)
    - May be captured in structured documentation or in topics listed in progress notes, including:
        - developing coping and self-help strategies
        - developing resiliency
        - dealing with the symptoms of psychosis
        - activities of daily living
        - educational/academic supports
        - vocational/employment supports
        - housing supports
        - substance abuse supports
        - support in establishing social relationships or connections
        - peer support
        - income support, when necessary (i.e., benefits planning)
        - recreational supports

- *Component response coding:* If 80% or more patients participate in the equivalent of 12 episodes of psychoeducation, code the component as '5'.
- *Ideally the sessions are provided during the first year.* That is one of the reasons for selecting health records of patients who have been in the program for at least one year. If the total of twelve sessions is only achieved in the second year this should be counted towards the rating.

Comments:

- *Additional data sources to support comments*:
  - Interviews with team leader and clinician
  - Psychoeducation manual or handouts
- *Specific information to include*:
  - Are patients offered group or individual psychoeducation?
  - Is there a formal manual or curriculum that is followed?

23. Family Education and Support

Definition: Families should receive at least eight episodes of psychoeducation in the first year. Family psychoeducation typically offers information on a range of topics including:

- Information about psychosis
- Information about medications
- Information about coping with stress
- Recognition and prevention of relapse
- Collaboration with clinicians
- Effective communication
- Supporting recovery

An episode or session is usually a 45-minute to one-hour session covering a specific topic and its relevance to a family. It can be delivered individually or in a group and may be delivered by the case manager or by a dedicated family worker. Evidence-based one-day training workshops can be part of a family education program. These typically last for four to six hours and can count for between 4 and 6 sessions, depending upon the schedule of the day.

The person delivering the therapy must have received formal training in family psychoeducation and supervision. The training may have been part of their formal professional training or as continuing professional development (CPD). For both professional training and CPD, the training should comprise both learning and supervision. Attending courses without supervision is not evidence of effective training. The Multifamily Group Treatment (MFGT) model is an evidence-based approach that offers a specific training course. The use of a research-supported manualized program such as the RAISE Navigate Family Education Program Manual or the On Track New York Family Resource and Treatment Manual increases the confidence of a rating.

Rationale: Family psychoeducation is a robust contributor to lower relapse rates.

Component Scoring:

- *Data source to use for rating:* Health record review, interviews or administrative data (e.g., group attendance)
- *Component response coding:* If 80% or more families receive at least eight sessions of family psychoeducation sessions from staff formally trained in family psychoeducation, code the component as '5'.
- *Ideally the sessions are provided during the first year.* That is one of the reasons for selecting health records of patients who have been in the program for at least one year. If the total of eight sessions is only achieved in the second year this should be counted towards the rating.

Comments:

- *Additional data sources to support comments*:
  - Interviews with team leader, clinicians
  - Family psychoeducation manual, curriculum, or handouts
- *Specific information to include*:
  - Are families offered group or individual psychoeducation? If they are not offered groups, are families connected to other families in any other way? Explain.
  - Is there a formal manual or curriculum that is followed?

24. Cognitive Behavioral Therapy (CBT)

Definition: Individual or group cognitive Behavioral therapy (CBT) delivered to individuals where indicated in the first year. CBT is an evidence-based treatment that is indicated for several clinical problems not limited to medication-resistant positive symptoms, anxiety, or depression. An appropriately trained professional should deliver CBT.

The training may have been part of formal professional training or as continuing professional development (CPD). For both professional training and CPD the training should comprise both learning and supervision. Attending courses without supervision is not evidence of effective training.

If provided as part of CPD training, the training should be from an established, authorized provider of CBT training (general CBT training as well as CBT for psychosis (CBT-P) are both acceptable). Recovery-oriented cognitive therapy (CT-R) for individuals with persistent schizophrenia is another validated CBT model. A formal certificate of competence provides confirmation of CPD training or training followed by supervision.

Another way that CBT training and supervision can be confirmed is if the clinician has specific training in the use of a formal manual such as the RAISE Individual Resiliency Training (IRT) Manual. The IRT Manual provides a guide for CBT when the following modules have been delivered: Modules 5 (processing the psychotic episode), 6 and 14 (resiliencies), 8 (dealing with negative feelings), and 9 (coping with

symptoms). To meet criteria for this component, formal CBT should be provided for at least 10 sessions. Providing CBT informed-care or incorporating CBT principles into general case management is valuable (and could be acknowledged in the comments) but does not qualify for this component. Group formats for CBT have also been validated and can count towards this component.

Rationale: CBT has been widely investigated and has been shown to be effective for symptom management and many other aspects of recovery.

Component Scoring:

- *Data source to use for rating:* Team leader and clinician interviews
- *Component response coding:* If 60% or more of patients receive at least 10 sessions of CBT delivered by an appropriately trained professional, code the component as '5'.
- *Ideally the sessions are provided during the first year.* That is one of the reasons for selecting health records of patients who have been in the program for at least one year. If the total of ten sessions is only achieved in the second year this should be counted towards the rating.

Comments:

- *Additional data sources to support comments*:
  - CBT curriculum/manual and materials
- *Specific information to include*:
  - Where was CBT training received? Training can be received during professional training. It can also be obtained during continuing professional development. This is best confirmed by receipt of a diploma or professional recognition by a licensing authority which may be required for billing purposes.
  - Were any staff specifically trained in CBT for psychosis?

25. Supporting Health

Definition: Program takes steps to support patient health, including:

1. Refer to and engage with primary care
2. Measure and record weight at least quarterly in the first year
3. Provide feedback on weight gain and general advice on diet and exercise
4. Monitor and document extrapyramidal side-effects
5. Monitor glucose and or Haemoglobin 1a and triglycerides annually
6. Monitor and document cigarette smoking habits annually
7. Prescribe pharmacological supports to smokers wishing to quit
   a. Nicotine Replacement Therapy
   b. Varenicline
   c. Buproprion

These steps must be taken with all patients unless otherwise specified.

Rationale: Individuals with severe and persistent mental disorders such as schizophrenia have their lifespan shortened by at least a decade in part due to increased mortality from a range of physical illnesses. Early during illness, they have increased rates of smoking and weight gain, have poor exercise habits, and do not access primary health care. In addition, the determinants of health such as income, housing, and social support put them at increased risk of poor health outcomes. Connecting individuals to primary care, monitoring health indicators, and promoting smoking cessation can all impact health status.

Component Scoring:

- *Data source to use for rating*: Team leader, clinician, and prescriber interviews
- Referral and engagement in primary care is rated as present if a team member records the details of the primary care provider in the health record or encourages and supports the patient to register with a primary health care provider.
- *Component response coding:* If all seven items are present, code the component as '5'.

Comments:

- *Additional data sources to support comments*:
  - Interviews with team leader and clinicians

26. Annual Comprehensive Assessment

Definition: All patients should receive an annual or ongoing comprehensive assessment, including:

1. Educational involvement
2. Occupational involvement
3. Social functioning
4. Symptoms
5. Psychosocial needs
6. Risk assessment of harm to self or others
7. Substance use

Rationale: Individual patient circumstances change with time, and several diagnoses are time-dependent. Annual or ongoing assessments are considered a good clinical practice and provide the opportunity for updating treatment plans, communication with primary care providers, and ongoing planning.

Component Scoring:

- *Data source to use for rating:* Health record review
- *Component response coding:* If 80% or more patients undergo annual or ongoing assessments that include at least six items above, code the component as '5'.

- The elements of this assessment may be found in different areas of the health record. For example, weight/BMI and laboratory assessment are often found in the prescriber's component of the health record.

Comments:

- *Additional data sources to support comments*:
  - Interviews with team leader and clinicians

27. Services for Patients with Substance Use Disorders

Definition: The FEP program offers the following:

1. Assessment of substance use for all patients at intake and at annual review
2. Addresses substance use in patient psychoeducation
3. Addresses substance use in family psychoeducation
4. Provides brief evidence-based psychotherapies such as motivational enhancement/ interviewing (ME/MI) or CBT for patients with substance use problems. Staff who provide these services must have had formal training and supervision in these therapies either during training or as Continuing Professional Development (CPD). This may include training on the specific modules used in the RAISE Individual Resilience Training. These are a few of several techniques that have been described as part of ME/MI:
   - Designate a change goal (i.e., substance use)
   - Ask related questions: What? How much? Benefits? Impact? Negatives?
   - Provide simple reflections
   - Provide complex reflections
   - Affirm
   - Summarize
   - Elicit/reinforce change talk
   - Collaborate with patient
   - Support self-efficacy
   - Roll with resistance
   - Address ambivalence
5. Maintains continuity of care and patient engagement if patient is referred to specialized substance use services (e.g., detox, residential treatment).
6. These criteria for FEPS substance use services meet criteria described as Dual Disorders Capability (Gotham, Brown, Comaty, McGovern, & Claus, 2013).
7. Specialized services refer to addiction services such as detoxification, opiate treatment services such as outpatient maintenance programs, and residential addiction programs.

Alcoholics Anonymous or an outpatient addictions group do not count as a specialized service.

Rationale: There is a high prevalence of substance use disorders in those with a first episode psychosis. The program should have staff trained to recognize and provide first-line interventions such as motivational enhancement. The training may have been part of their formal professional training or as continuing professional development (CPD). For both professional training and CPD, the training should comprise both learning and supervision. Attending courses without supervision is not evidence of effective training.

Component Scoring:

- *Data source to use for rating:* Interviews
- *Component response coding:* If the first five items listed above under definition are present, code the component as '5'.

Comments:

- Additional data sources to support comments:
  - Interviews with the team leader, clinicians, and addiction/CBT specialist (if relevant)
  - Program policy and procedures, SUD program manual/materials

28. Supported Employment (SE)

Definition: Supported Employment (SE) or Individual Placement and Support (IPS) is provided to patients interested in gaining competitive employment. In contrast with mainstream employment services, SE is an evidence-based intervention targeted at individuals with mental illness and includes additional supports such as rapid job search, on the job support, negotiating workplace accommodations, and an emphasis on patient choice. The elements of SE include:

1. Supported employment specialist is formally trained and has at least six months of experience as a supported employment specialist.
2. Supported employment specialist is a member of the FEP team and attends team meetings.
3. Supported employment specialist receives supervision at least two times per month from a trained supervisor.
4. Ratio of caseload is 1:20 or less.
5. Completes at least six employer contacts per week.
6. Uses the career profile or an equivalent form.
7. Tracks in-person employer contacts in a format that can be organized and searched. (Hand recorded in a personal notebook does not meet this criterion.)

Rationale: Supported employment is an evidence-based program which increases employment rates.

Component Scoring:

- *Data source to use for rating:* Interviews
- This component assesses the individual components of IPS and rates the program on the number of elements provided to patients
- *Component response coding:* If seven of more of the items listed above are present, code the component as '5'

NOTE: *Identify percentage of time devoted to case management activities. If greater than 10%, remove that time from the supported employment specialist's FTE in determining the 1:20 ratio. For example, the supported employment specialist is a full-time staff member. In the interview the supported employment specialist tells you they do case management activities 30% of the time. Because 30% is greater than the maximum allowable 10%, reduce the employment specialist FTE from 1.0 to 0.7 when calculating the 1:20 ratio.*

Comments:

- *Additional data sources to support comments*:
  - Interviews with the team manager and SE specialist
  - SE program description or materials

29. Supported Education (SEd)

Definition: Supported Education (SEd) is provided to patients who are interested in participating in education. The SEd provider should be integrated into the treatment team, assess educational potential, recommend education that supports the goals of the individual, and link to appropriate local education and accommodation services. Evidence of supported education services include:

1. FEPS program has a designated SEd specialist.
2. SEd specialist is a FEPS team member and attends team meetings.
3. SEd specialist has a caseload of at least three patients with education goals.
4. SEd specialist uses a standardized form to document patient education goals.
5. SEd specialist provides ongoing support including:
   a. Identification of educational programs
   b. Identification of sources of financial aid
   c. Completion of applications and enrollment
   d. Management of coursework
   e. Acting as liaison between high school patient and high school teachers/counselors to develop disability/special education supports and transition plans

Rationale: Supported education is a program which increases participation in education.

Component Scoring:

- *Data source to use for rating:* Interviews
- *Component response coding:* If SEd does not have a caseload of at least three patients, code component as '1'. If FEPS team meets items 1-4 above and at least four support sub items from item 5 ongoing support, code the component as '5'.

Comments:

- *Additional data sources to support comments*:
  - Interviews with the team leader and SEd specialist
  - SE program description or materials.

30. Active Engagement and Retention

Definition: Use of proactive outreach services (i.e., patient visits in the community) by clinicians to reduce missed appointments, engage patients with a first episode psychosis, and minimize drop-outs.

Rationale: Active outreach promotes engagement and reduces drop-outs.

Component Scoring:

- *Data source to use for rating:* Team leader and clinician interviews
- *Component response coding:* In the calculation only include percentage of out-in-the-community time by case managers/care coordinators. Average across case managers, but weight by their caseload. If more than 40% of all patient and family visits are out-of-office, code the component as '5'.

Comments:

- *Additional data sources to support comments*:
  - Program policies/procedures. For example, are they set up to do community visits? Policies that support outreach include financial support for transportation, insurance, and staff safety protocols.

31. Patient Retention

Definition: The dropout index is the ratio of the number of early dropouts (stayed in program <1 year) in the last 12 months to the total current caseload. This is a measure of all-cause discontinuation or the degree to which the program keeps individuals engaged in the program.

Rationale: Patient and family engagement can be indirectly assessed through patient retention, as reflected in the numbers retained in the first year.

Component Scoring:

- *Data source to use for rating:* Administrative data
- *Component response coding:* The denominator is the number of FEPS patients in the program. The numerator is the number of patients who left the program in the last year before completing one year in the program.

32. Crisis Intervention Services

Definition: First Episode Psychosis program delivers crisis services or has links to crisis response services including crisis lines, mobile response teams, urgent care center, or hospital emergency rooms

Rationale: Crises are a common occurrence in this population, and both organizational linkages and individual patients/patients care plans must reflect crisis plans.

Component Scoring:

- *Data source to use for rating:* Interviews
- *Component response coding:* If the first episode psychosis team provides five-day a week, eight-hour per day drop-in services plus 24-hour phone crisis services, code the component as '5'.

Comments:

- *Additional data sources to support comments*:
  - Interviews with the program manager and case manager
  - Review of policy documents

33. Communication between FEP and Inpatient Services

Definition: If there is a hospitalization of a patient, the staff contacts the inpatient staff to be involved in treatment and discharge planning. Communication includes:

1. Contact inpatient unit to establish communication plan.
2. Visit with patient on inpatient unit.
3. Communicate with family about admission.
4. Involvement in discharge planning process.
5. Receive/obtain hospital discharge summary.
6. Schedule outpatient appointment prior to discharge.

Rationale: Close coordination between the treatment team and hospital staff is a hallmark of the assertive community treatment model, which has a strong evidence base demonstrating effectiveness in reducing hospital admissions.

Component Scoring:

- *Data source to use for rating:* Health record review, Interviews
- *Component response coding:* Health record review of the most recent five patients who have been admitted to hospital after starting the First Episode Psychosis program and discharged back to the care of the team. If the team performs all six communication activities when a patient is hospitalized, code the component as '5'. If the team has not had five admissions in the last year, records from earlier years could be used. If the number is still less than five, the evaluation could be made on three records. If there are fewer than three, the component cannot be rated.

Comments:

- *Additional data sources to support comments*:
  - Interviews with program manager and case manager
  - Program policy documentation review
- *Specific information to include*:
  - What is the typical communication between first episode psychosis service staff and inpatient staff during hospitalization?
  - Are first episode psychosis staff typically involved in discharge planning?

34. Timely Contact After Discharge from Hospital

Definition: Patient in FEP service has face-to-face contact with FEP service provider within two weeks of discharge from hospital.

Rationale: Post-discharge follow-up has been shown to reduce re-hospitalization.

Component Scoring:

- *Data source to use for rating:* Health record; Program documents.
- If the patient is referred to another clinical service after discharge from hospital, this is rated as a discharge and is not rated under this component.
- *Component response coding:* If 80% or more of first episode psychosis patients admitted to hospital are seen at the first episode psychosis service for an outpatient appointment within 14 days of hospital discharge, code the component as '5'.

Comments:

- *Additional data sources to support comments*:
  - Interviews with program manager and case manager
  - Program policy documentation review
- *Specific information to include*:
  - What is the typical communication between first episode psychosis service staff and inpatient staff during hospitalization?

35. Assuring Fidelity

Definition: Program monitors quality using a fidelity scale or quality indicators linked to standards for program treatment components such as pharmacological and psychosocial treatments.

Rationale: Adherence to the components identified in research as effective increases the chances of successful implementation. In general, higher fidelity is associated with improved outcomes, although this has yet to be demonstrated for the FEPS-FS 1.0.

Component Scoring:

- *Data source to use for rating:* Administrative Data; Interview with Team Leader.
- The fidelity scale must have been published and previously used in fidelity assessments.
- The quality indicators must be linked to discreet service components. For example, the proportion of new referrals receiving a telephone response within three working days and the proportion of new referrals being seen for an assessment within two weeks cannot be counted as two indicators.
- Acceptable indicators include the following:
  - Percentage of referrals seen within two weeks
  - Percentage receiving Cognitive Behavioral Therapy
  - Percentage receiving Family Psychoeducation
  - Percentage receiving clozapine
  - Percentage receiving Supported Employment
  - Percentage receiving annual physical assessment
  - Percentage receiving motivational enhancement for substance use disorder
  - Any other indicators
- *Component response coding:* If the program fidelity is assessed using a published fidelity scale by an external assessor, or if 11 or more discreet quality indicators are used to assess quality every two years, code the component as '5'.

Comments:

- *Additional data sources to support comments*:
  - Interviews with program manager. If the results of quality indicators or of a fidelity assessment are not part of the administrative data supplied by the program, ask the program manager. Ask about the measures used and ask for a copy of the most recent assessment.
- *Specific information to include*:
  - The fidelity scale used or the quality indicators used and the method of collecting data for the quality indicators.
  - Health record review is the most reliable source of quality indicators.

APPENDIX A: PREPARING FOR A FIDELITY ASSESSMENT

This document is a guide for site leaders at sites participating in the evaluation, outlining the steps required to prepare and complete the fidelity assessments. Please review carefully and keep in mind that preparations will need to begin several weeks in advance of the assessment date.

The fidelity team will seek to schedule assessments at times convenient for the sites. It is important that the program information be provided in advance of interviews and that interviews occur over one or two days. The steps in the process are similar whether the assessment is onsite by the assessors or conducted remotely.

1. The Fidelity Team Will Work with You

Most of your contacts will be with the fidelity rater and the scheduler. These two roles may be filled by one person, but they will be the people who will work with you every step of the way to explain the process.

2. Determine Primary Contact Person and Other Key Personnel

The site leader should identify a **primary contact person** for the fidelity assessment (usually the site leader) to help organize and prepare for the fidelity assessment. The site leader should also assign a **program document coordinator** to assemble documents to upload to the data portal ahead of time and identify a **health record abstractor** who will be abstracting information from the health records. The health record abstractor should be an agency staff person who is not involved in clinical services (e.g., a quality assurance manager).

The fidelity assessment will include interviews with at least four First Episode Psychosis (FEP) program staff: the team leader, the psychiatrist/prescriber, the supported employment/education specialist, and one case manager/therapist. The site leader will need to identify these four staff members for the interviews. Onsite fidelity assessments provide more flexibility to meet staff and patients.

3. Establish Process and Obtain Approvals for Ethics/Privacy Oversight

It is important that the fidelity reviews are conducted in an ethical manner that respects and protects the privacy of all patients, families, and staff. The fidelity assessor and site leader determine what processes and approvals are needed at your site. The process varies with the purpose of the fidelity assessment, specifically whether it is for research or quality assurance. The fidelity assessor will share with the site materials such as consent form templates/samples, confidentiality agreements (if your organization does not have its own form), and data collection tools. Please note that, depending on the required process at your program, this component may take up to several months to put in place. Once the required approvals have been obtained, please send a copy of the approval letter or email.

4. Schedule the Fidelity Assessment Dates

The fidelity assessment includes interviews which require advance preparation by all participants to ensure they run smoothly. When scheduling your site interviews, it is important to consider the following factors:

- The team leader should be interviewed first, with the remainder of the interviews scheduled over one or two days.
- Schedule the assessment for days of the week when most or many of the program staff will be onsite (including the psychiatrist/prescriber).
- Establish a timeline for expected ethics approval (if approvals have not yet been received).

The fidelity assessment team will work with the primary site contact person and the fidelity rater to find a date that works for everyone.

5. Prepare Materials for the Assessment

As part of the assessment, the fidelity rater will review program materials and administrative data reports. The program document coordinator needs to prepare these materials in advance and provide them through the pre-planned mechanism *at least one week prior* to the assessment.

NOTE: *Only aggregate, de-identified data should be shared in advance*.
Do not include any documents containing personal health information. In the United States, review the following website for a list of what is considered personal health information: https://www.hipaa.com/hipaa-protected-health-information-what-does-phi-include. Canada's federal law, the Personal Information Protection and Electronic Documents Act (PIPEDA) can be found at https://www.priv.gc.ca/en/privacy-topics/privacy-laws-in-canada/the-personal-information-protection-and-electronic-documents-act-pipeda/.

The program document coordinator will capture components 9 and 10 in the table below by completing the **Fidelity Program Data Table**. No other information is required from the program document coordinator to capture this information.

Please provide the following:

	Document	Description
1.	Program Brochure	Includes description of services offered and patients served
2.	FTEs and Staff Roles	List of the full-time equivalents for all prescribers and team members in the FEP program
3.	Program Admission Criteria	Eligibility criteria for receiving FEP services
4.	Service Catchment Area	Geographical area that the program services. If available, include estimated average travel time to the facility and specific geographic boundaries or populations within area.
5.	Patient Caseload Info	Number of participants currently enrolled Numbers with diagnoses of: Schizophrenia spectrum disorder Major Depressive Disorder with psychotic features Bipolar Disorder with psychosis Attenuated Psychosis Syndrome or (Clinical High Risk) Non-Psychotic Disorders
6.	Assessment Templates	Clinical and vocational assessment tools For example, include initial comprehensive assessment templates in the electronic health record.
7.	Psychoeducational Materials	Manuals, curriculums, lesson plans, etc., used with patients/families for psychoeducation
8.	Hospital Discharge Info	Number of days between hospital discharge and being seen in person by a member of the FEP team for each patient who has been hospitalized in the past 12 months
9.	Targeted education to health/social services/community groups	Number of information sessions delivered in the last 12 months to first-contact people in health, education, community organizations, etc. The goal is to educate people to recognize signs of early psychosis and make them aware of the program.
10.	Clozapine Enrollment Information	Number of patients with schizophrenia spectrum disorders who have been prescribed clozapine
11.	Patient Retention	Number of first episode psychosis patients discharged in the last year who were in their first year in the program as a proportion of the total caseload of first episode psychosis patients
12.	Early Intervention	Number of patients admitted to hospital prior to program entry in the last year as a proportion of the total number of patients admitted
13.	Results of most recent fidelity assessment or quality indicator assessment	

6. Prepare Health Record Review Checklists

As part of the fidelity review, the site will ensure that the fidelity rater receives a completed **Health Record Review Checklist**. This checklist is based on the health records of 10 patients who have been in the program for at least one year. The procedures are as follows:

- The primary contact will identify and assign a number to the health records of active patients who have been in the program for at least one year. The primary contact will provide the fidelity assessment team with the total number of these health records. Using the total number of health records, the fidelity assessment team will provide the site with 10 random numbers. They will then use these numbers to identify the health records.
    - For example, a site has 30 patients meeting the criteria. The site tells the assessment team that they have 30 health records. The research assistant identifies 10 randomly selected numbers. The research assistant tells the primary contact to use, hypothetically, the 2nd, 7th, 8th, 10th, 11th, 15th, 19th, 22nd, 27th, and 30th health record for the review.
- The site will be responsible for cross-referencing these numbers to numbers assigned to the actual health record of patients.
- Do not send health record IDs as this will violate privacy regulations.
- In the case of a small program, it may be necessary to make accommodations in procedures. The assessment team will work with the primary contact person to identify the records to be reviewed.

Logistics and privacy requirements for sharing health records should be determined during your ethics review/process. Things to think about include:

- Will the health record abstractor need access to computers?
- Will the abstractor need to be assigned a temporary password?
- Will paper health records need to be requested?
- Will a room need to be booked to review the health records?

The health record abstractor will not record any identifying/personal health information in any notes that they take.

7. Plan Interview Schedule

The interviews should be scheduled as close together as possible, preferably over one to two days. During the call, the fidelity rater will interview the following staff members:

- The program manager/team leader (~1 hour 45 minutes)
- A psychiatrist/prescriber (~1 hour)
- A case manager (~1 hour 30 minutes)
- A supported employment specialist (~30 minutes)
- Other staff as required to collect adequate data for rating fidelity

8. Confidentiality Forms and Other Permissions

The fidelity rater may be required to sign a confidentiality form before starting the assessment. If this document needs to be signed in advance, please ensure it is sent to the fidelity rater to complete well in advance.

APPENDIX B: HEALTH RECORD REVIEW

Health Record Abstractor: _____

Program: _____

Date(s) of Health Record Review: _____

Instructions: The health record review should be completed before the staff interviews. The abstractor should return the completed checklist to the Fidelity Rater.

Health record selection. Two samples of health records should be selected.

The first sample is selected according to the following criteria:

1. 10 randomly chosen health records of
2. patients with a Schizophrenia Spectrum Disorder
3. who have attended the program for at least one year

The second sample is selected according to the following criteria:

1. Patients enrolled in program
2. Last five who were admitted to hospital

The health record review will require four hours or less for abstractors who are familiar with the record organization. The FEP program team leader should ensure the abstractor is familiar with the record organization (e.g., through a meeting of the abstractor with a staff member who is familiar with the records and can orient the abstractor).

The fidelity team will hold a one-hour training session with the site's health record abstractor prior to the review and a one-hour debriefing after the completion of the review.

The review of the first one or two health records may take longer to complete. After completing the review on two health records, the target time to complete each health record is expected to be no more than 15 minutes. If the abstractor cannot locate the information for a component within five minutes, record that component as missing and give no credit.
Components should not be rated according to a practitioner discipline; for example, the psychoeducation component includes all sessions or meetings regardless of which team member provides the psychoeducation.

The fidelity assessment team will determine the scoring of some of the components, such as determining whether medication doses are in the acceptable range. The health record abstractor's responsibility is to record health record information.

To share comments about the rating of individual components or how to improve the manual, please write in the comments section at the bottom.

Health Record Review Checklist

FEPS-FS-1.0 components	Response format	Possible evidence	Health Record #									
			1	2	3	4	5	6	7	8	9	10
4. Assigned Case Manager/Care Coordinator	Yes No	Health Record initial assessment										
14. Timely Contact with Referred Individual	Number of days from date of referral to 1st appointment	Health Record										
15. Family Involvement in Assessment	Yes No	Assessment or notes										
16. Comprehensive Clinical Assessment – All 9 components included in assessment[i]	Check which of 9 components completed	Assessment or progress notes or structured assessment	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9
17. Comprehensive Psychosocial Needs Assessment – 8 or more components included in needs assessment[ii]	Check which of 9 items completed	Assessment or progress notes or structured assessment	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9
18. Clinical Treatment Plan/Care Plan After Initial Assessment: addresses clinical and psychosocial needs. If treatment/care plan present, mark 1 at right. If patient signs off on plan, mark 2 at right.	Yes No	1: Plan present 2: Patient signs off on plan	___1 ___2	___1 ___2	___1 ___2	___1 ___2	___1 ___2	___1 ___2	___1 ___2	___1 ___2	___1 ___2	___1 ___2

FEPS-FS-1.0 components	Response format	Possible evidence	Health Record #									
			1	2	3	4	5	6	7	8	9	10
19. Antipsychotic Medication Prescription	Yes No	Indicated in psychiatrist note or copy of prescription										
20. Antipsychotic Dosing within Guidelines for Individuals with Psychosis – at 6 months	Yes No	Medication										
		Daily dose										
20. Second antipsychotic medication prescribed at 6 months	Yes No	Medication										
		Daily dose										
22. Patient Psychoeducation: received 12 episodes by trained clinician (individual or group)	Yes No	Patient notes or group attendance										
23. Family Education and Support: received 8 sessions by trained clinician (individual or group format)	Yes No											
26. Annual Comprehensive Assessment: addresses 7 areas of functioning[iii]	Yes No	Annual assessments on file OR clear descriptions of review of 1-7 components in progress notes	___1 ___2 ___3 ___4 ___5 ___6 ___7	___1 ___2 ___3 ___4 ___5 ___6 ___7	___1 ___2 ___3 ___4 ___5 ___6 ___7	___1 ___2 ___3 ___4 ___5 ___6 ___7	___1 ___2 ___3 ___4 ___5 ___6 ___7	___1 ___2 ___3 ___4 ___5 ___6 ___7	___1 ___2 ___3 ___4 ___5 ___6 ___7	___1 ___2 ___3 ___4 ___5 ___6 ___7	___1 ___2 ___3 ___4 ___5 ___6 ___7	___1 ___2 ___3 ___4 ___5 ___6 ___7
NB: **Components 33 and 34** are rated on the basis of data abstracted from health records of last five patients admitted to hospital after joining the program.												
33. Communication between FEP and Inpatient Services	Yes No	Documentation supports each of the 6 items	___1 ___2 ___3 ___4 ___5 ___6	___1 ___2 ___3 ___4 ___5 ___6	___1 ___2 ___3 ___4 ___5 ___6	___1 ___2 ___3 ___4 ___5 ___6	___1 ___2 ___3 ___4 ___5 ___6					_

FEPS-FS-1.0 components	Response format	Possible evidence	Health Record #									
			1	2	3	4	5	6	7	8	9	10
34. Timely Contact after Discharge from Hospital: patient in FEP service seen for face-to-face contact with FEP service provider within two weeks of discharge from hospital	Yes No		___1	___1	___1	___1	___1					

i. **Component 16** should include at least 8 of 9 items: (1) Time course of symptoms, change in functioning, and substance abuse (assessing whether there was change in functioning correlated with substance use changes or other changes); (2) Recent changes in behavior; (3) Risk assessment/harm to self or others; (4) Mental status exam; (5) Psychiatric history; (6) Premorbid functioning; (7) Co-morbid medical illness; (8) Co-morbid substance use; (9) Family history.

ii. **Component 17** should include all 9 items: (1) Housing; (2) Employment; (3) Education; (4) Social support; (5) Financial support; (6) Primary care access; (7) Family Support; (8) Past trauma; (9) Legal.

iii. **Component 26** should include all 7 areas: (1) Educational; (2) Occupational functioning; (3) Social function; (4) Symptoms; (5) Psychosocial needs; (6) Risk assessment of harm to self or others; (7) Substance use.

iv. **Component 33** should include all 6 items: (1) Contact inpatient unit to establish communication plan; (2) Visit with patient on inpatient unit; (3). Communicate with family about admission; (4) Involved in discharge planning process; (5) Receive/obtain a hospital discharge summary; and, (6) Schedule outpatient appointment prior to discharge.

FEPS-FS-1.0 components abstracted from Health Record	Abstractor's comments
FEPS-FS-1.0 components	
4. Assigned Case Manager/Care Coordinator	
14. Timely Contact with Referred Individual	
15. Family Involvement in Assessment	
16. Comprehensive Clinical Assessment – All 9 items included in assessment	
17. Comprehensive Psychosocial Needs Assessment – All 9 items included in care plan	
18. Clinical Treatment Plan/Care Plan After Initial Assessment that addresses clinical and psychosocial needs.	
19. Antipsychotic Medication Prescription	
20. Antipsychotic Dosing within Recommendations for Individuals with Psychosis at 6 months	
22. Patient Psychoeducation	
23. Family Education and Support	
24. Cognitive Behavior Therapy	
26. Annual Comprehensive Assessment	
33. Communication between FEP and Inpatient Services	
34. Timely Contact after Discharge from Hospital	

APPENDIX C: FIDELITY INTERVIEW GUIDE

The First Episode Psychosis Services Fidelity Scale interview is a structured interview. The purpose of using a structured interview is to ensure that each interviewee is presented with the same questions in the same order. This ensures that the answers can be reliably aggregated and that programs can be compared with confidence. The interview guide is designed to be used in conjunction with the *First Episode Psychosis Fidelity Scale* (*FEPS-FS-1.0*) and the *FEPS-FS 1.0 Manual*. The interview is the primary source of information for the service components that describe clinician's practice and team functioning. It is a secondary source of information for other services and is used to validate data obtained from health record review and administrative data. Once the required questions are asked, supplementary questions can be asked to clarify inconsistencies.

The suggested questions are designed to cover all aspects of the fidelity assessment but should be supplemented by any questions the rater may have based on the information submitted before the interview. All the questions should be asked to the team leader or other person taking the lead for the fidelity review. This person should be prepared to answer all the questions and be knowledgeable about all the information submitted prior to the fidelity interview. It is useful to provide team leader with the questions in advance.

Who is interviewed?

- The assessment team leader completes the whole interview.
- The same questions can be used for the start of the more targeted interviews with other individuals, but more probing questions need to be asked to explore their perspective and role.
- The focus of the scale is services received by patients, and there is significant variability in the titles and professions titles of the person who delivers the specific service. The interviewer can identify the key providers during the orientation with the team leader.
- The individual responsible for assessment, care-coordination, and therapy is interviewed on components 4, 15, 16, 17, 18, 22, 24, 26 27, 30, and 33.
- The supported employment specialist is interviewed on components 28 and 29.
- The psychiatrist/prescriber is interviewed on components 5, 6, 8, 15, 16, 18, 19, 20, 21, and 25.

Assessor Instructions:

This interview guide is intended to be used with the team leader or program manager. Relevant questions may also be used with other staff (e.g., case managers/care coordinators, nurse, employment specialist, CBT specialist, peer support worker, etc.) as appropriate. If you know you will be interviewing other specialty roles, it is helpful to note in advance which questions are relevant. If you are using this interview guide with multiple individuals, you do not necessarily have to ask a question again once you are confident that you have made an accurate rating.

Most fidelity raters prefer to use a separate interview sheet for each interview. If you are doing multiple assessments in which the staff titles and roles are the same, you can tailor the interview sheet to fit the circumstances.

If more than one person is completing the in-person interviews, the assessors should identify one team member to ask questions and another to take notes. The assessor leading the interview should view these questions as a guide and use their judgement as to which questions are appropriate to ask individual staff.

Questions may be rephrased, omitted/added, or reordered as appropriate to gather the information needed to complete the ratings.

Notes should not include any individual names or personal health information. Notes should pertain to program performance. Please avoid comments about performance of individual staff.

Sample Introduction/consent:

"Thank you for agreeing to be interviewed as part of the fidelity review. Before we begin, please review the consent form. I am happy to answer any questions. If you feel comfortable proceeding, please sign the bottom. Remember that you can always choose not to answer specific questions or stop the interview entirely." (*Give time for staff to review consent form and answer any questions.*)

Background:

"Could you tell us about your role in the program, your professional background, and how long you have been involved in the program?" (*This question can be used to help gauge which questions will be appropriate for this individual.)*

Sample Questions:

QUESTIONS	RESPONSES
Component 1: Practicing Team Leader	
• What are your academic and professional credentials? • Do you (the team leader) provide clinical services to patients? • How much time do you spend providing direct supervision and/or clinical services? • Do you carry a caseload? Do you provide counseling or other direct services? • What Full Time Equivalent (FTE) do you devote to the FEP service?	
Component 2: Patient-to-Provider Ratio	
• What is the total FTE of all clinical staff assigned to the program, excluding the psychiatrist/prescriber? • How many patients are currently enrolled in the program?	
Component 3: Services Delivered by Team	
• What services are provided to the patients enrolled in your program? □ Case Management Services including care coordination □ Health Services (i.e., registering with primary care, measuring weight and metabolic monitoring, supporting smoking cessation) □ Evidence-based psychotherapies such as CBT and ME/MI □ Substance use management including, assessment, assessing readiness to change and ME/MI or CBT for addictions □ Employment services such as Supported Employment or Supported Education □ Family Education and Support □ Patient Psychoeducation □ Pharmacotherapy	
Component 4: Assigned Case Manager/Care Coordinator	
• What proportion of your patients get assigned a clinician who is responsible for delivering case management services or care coordinator upon enrollment in the FEP service? • Who provides the care coordination?	

Component 5: Psychiatrist Caseload

• Are patients assigned a psychiatrist/qualified prescriber (excluding family doctor) upon enrollment into the program? • How frequently can patients be seen by the psychiatrist/qualified prescriber (excluding family doctor) for urgent problems or to adjust medications early in treatment? • What is the caseload of the psychiatrist/qualified prescriber (excluding family doctor)? • How much FTE of psychiatrist/qualified prescriber time is available for that caseload?	

Component 6: Psychiatrist Role on Team

• What is the role of the psychiatrist on the team? □ Attend team meetings □ See patients with another clinician □ Accessible for consultation by team during the work week □ Record medication, symptoms, side-effects, etc., in the same health record as the rest of the team □ Registering with a primary care provider for those not already enrolled in primary care	

Component 7: Weekly Multi-Disciplinary Team Meetings

• Does your program have clinical team meetings? • How often are team meetings held? • What issues are discussed during team meetings? □ Case review, admissions, and discharges □ Assessment and treatment planning and coordination □ Discussion of complex cases • Who attends those meetings?	

Component 8: Explicit Diagnostic Admission Criteria

• Does your program have explicit admission diagnostic criteria that are listed in a document? • If yes, what are your admission criteria? (Ask for a blank copy if you don't have one already.) • How do you determine if a patient meets criteria? • Do you sometimes have exceptions? What the reasons for making an exception? • What percentage of your patients meet the program criteria after you have established a firm diagnosis ?	

Component 9: Population Served

• Does your program serve a designated catchment area? • How do you determine the size of the population that you serve? • Does the program compare the expected incidence of first episode psychosis in the population with the annual admission rate to the program? • What is the ratio of annual admission rate to the expected incidence?	

Component 10: Age Range Served

• What is the age range served by your program?	

Component 11: Duration of First Episode Psychosis (FEP) Program

• Is there a time limit on the length of time a person can receive services in your program? What is it?	

Component 12: Targeted Education to Health/Education/Social Service/Community Groups

• Do you provide education about psychosis and first episode psychosis services to first-contact professionals such as community mental health teams, school and college counsellors, social services agencies, family physicians, or emergency rooms? • How many such presentations did you provide in the last year? • Were any to services within your own agency? • How often, where, and to whom? □ family physicians □ school and post-secondary counseling services □ police service □ hospital emergency rooms □ youth social services agencies □ community mental health services	

Component 13: Early Intervention

• How many patients do you have on your caseload with a first episode psychosis, not including any patients at clinical high risk? • What proportion of these patients with a first episode psychosis received inpatient psychiatric care prior to starting or being admitted to first episode psychosis services?	

Component 14: Timely Contact with Referred Individual	
• Do you have a time limit in which to respond to referrals? • What proportion of referrals are seen within two weeks at a face-to-face interview with a FEPS team clinician who can start treatment?	

Component 15: Family Involvement in Assessments	
• Do you have a policy of family involvement in the initial assessment? If yes, what is it? • Where is this policy document? Is it written or assumed? (Ask for a copy if you don't have one already.) • How do you communicate the need and benefit of family involvement in the initial assessment prior to the first meeting?	

Component 16: Comprehensive Clinical Assessment at Enrollment (all 9 components completed)	
• Please outline what information is collected at the initial assessment upon enrollment into the FEP Service: □ Change in functioning from stable baseline □ Time of onset of substance use and frequency of use □ Recent changes in behavior □ Risk assessment/harm to self or others □ Mental status exam □ Psychiatric history □ Premorbid functioning □ Co-morbid medical illness and substance use □ Family history of mental disorder • Who reviews the initial assessment after completion? • Where would we find it in the health record? (Ask for a blank copy if you don't have one already.)	

Component 17: Comprehensive Psychosocial Needs Assessment	
• Do you assess the psychosocial needs of your patients? • Which of the following areas are assessed? □ Housing □ Employment □ Education □ Social support □ Past trauma □ Family physician □ Legal □ Financial support □ Family support	
Component 18: Clinical Treatment/Care Plan after Initial Assessment	
• Do your patients have clinical treatment plans? • How do you engage patients in developing the plans? • How do you document patient involvement in developing the plans? □ Do the patients sign off on the plan? • What is addressed in the clinical treatment plan? □ Needs □ Goals □ Preferences □ Pharmacotherapy □ Psychotherapy □ Substance Use □ Mood problems □ Suicide prevention □ Weight management	
Component 19: Antipsychotic Medication Prescription	
• What percentage of patients with a confirmed first episode schizophrenia spectrum disorder are offered antipsychotic medications?	
Component 20: Antipsychotic Dosing within Recommendations for Individuals with Psychosis	
• What is your policy regarding antipsychotic dosing? • What proportion of antipsychotic prescriptions are within the recommended government approved dose range (at 6 months)? • What percentage of patients are on dosages below the guidelines at 6 months?	

Component 21: Clozapine for Medication-Resistant Symptoms	
• Does the program use clozapine when indicated? • How many patients with schizophrenia spectrum diagnosis do you have in the program? • How many of your patients with a schizophrenia spectrum diagnosis are on clozapine?	

Component 22: Patient Psychoeducation	
• Are patients provided with information about the schizophrenia spectrum disorders? If yes, how? • What languages do you provide written materials in? • Do you have a structured psychoeducational curriculum (e.g., Illness Management and Recovery curriculum, Wellness, Recovery Action Plan (WRAP) training)? If yes, what is it? (Ask for a copy if you don't have one already.) • Who delivers the curriculum? • Do the staff who deliver Psychoeducation (PE) have formal training in PE? If yes, what is it? □ A formal part of their professional training including: □ Training □ Supervision □ Continuing professional development including: □ Training □ Supervision • How is this curriculum delivered? Are patients engaged in formal group or individual psychoeducational sessions? What are the topics of discussion? □ Developing coping and self-help strategies □ Developing resiliency □ Dealing with the symptoms of psychosis □ Activities of daily living □ Educational/academic supports □ Vocational/employment supports □ Housing supports □ Substance use □ Establishing social relationships or connections □ Peer support □ Income support • Do you document whether a patient receives this curriculum? If yes, how do you document this?	

Component 23: Family Education and Support	

• How do you deliver information about psychosis to family and caregivers?
• Do you provide written materials in various languages?
• Are families engaged in individual or group sessions?
• Do you document family and caregiver participation in your sessions?
• Who delivers the Family Psychoeducation?
• Do the staff who deliver Family Psychoeducation have formal training in Family Education and Support? If yes, what is it?
  □ A formal part of their professional training including
  □ Training
  □ Supervision
  □ Continuing professional development including
  □ Training
  □ Supervision
• Do the staff who deliver Family Psychoeducation receive supervision? Describe the frequency and intensity of the supervision.
• Which of the following topics are addressed?
  □ Information about psychosis
  □ Information about medications
  □ Information about coping with stress
  □ Recognition and prevention of relapse
  □ Collaboration with clinicians
  □ Effective communication
  □ Supporting recovery	

Component 24: Cognitive Behavioral Therapy (CBT)

• Does the program offer Cognitive Behaviour Therapy (CBT) for patients?
• Who delivers CBT?
• Do the staff who deliver CBT have formal training in CBT? If yes, what is it?
  □ A formal part of their professional training including:
  □ Training
  □ Supervision
  □ Continuing professional development including:
  □ Training
  □ Supervision
• What are the indications for which CBT is provided?
  □ Anxiety or depression
  □ Residual or medication-resistant positive symptoms
  □ Substance Use Disorders
• How many sessions are typically given to an individual patient?
• What proportion of patients receive at least 10 sessions of CBT in their first year in the program?
• Where is CBT documented?
• Do you offer CBT in individual or group formats or both?	

Component 25: Supporting Health

• Primary care linkage:
  ○ Do you record whether your patients have a primary medical care provider?
  ○ Do you refer patients or support patient application to a primary care provider?
  ○ Where do you document support for primary care engagement?
• Non-pharmacological weight management:
  ○ Do you routinely monitor weight?
  ○ How often do you monitor weight?
  ○ Where is this documented?
  ○ Does someone on the team provide feedback to patients on their weight?
  ○ Does someone on the team provide advice and suggestions about diet and exercise?
• Monitor glucose and triglycerides annually:
  ○ Do you routinely assess blood glucose and or haemoglobin A1C?
  ○ Do you routinely assess triglycerides?
  ○ Who on the team is responsible for ensuring that these are done?
  ○ Where is this recorded?
• Smoking reduction:
  ○ Do you routinely assess patients' smoking habits?
  ○ Who is responsible for assessing and recording this?
  ○ Do you prescribe pharmacological aids to smoking cessation?
  □ Nicotine Replacement Therapy
  □ Varenicline
  □ Bupropion
  ○ Where is this recorded?	

Component 26. Annual Comprehensive Assessment (all 7 components)

• Do you conduct an annual comprehensive assessment?
• Please outline what information is collected at the annual assessment:
  □ Educational functioning
  □ Occupational functioning
  □ Social Functioning
  □ Symptoms
  □ Psychosocial needs
  □ Risk assessment of harm to self/others
  □ Substance use
• Where would we find it in the health record? (Ask for a blank copy if you don't have one already.)	

Component 27: Services for Patients with Substance Use Disorders

- Does the service exclude patients with a substance use disorders?
- If patients with substance use disorders are accepted, how do you assess for the presence of substance use?
- Do you address substance use in patient psychoeducation?
- Do you address substance use in family education?
- Does the program provide brief interventions such as motivational enhancement/motivational interviewing of CBT for substance use problems?
- Does the program refer patients with moderate to severe (i.e., DSM-5 moderate 4-5 symptoms, severe 6 or more symptoms) substance use disorders to specialized addictions services ranging from detoxification to residential treatment? If the patient is attending specialized services does the service maintain them in the FEP program? Liaise with the addiction service and maintain contact with the patient?
- Who delivers the Motivational Enhancement (ME) or Motivational Interviewing (MI)?
- Do the staff who deliver ME/MI have formal training in ME/MI? If yes, what is it?
    - □ A formal part of their professional training including:
        - □ Training
        - □ Supervision
    - □ Continuing professional development including:
        - □ Training
        - □ Supervision
- How many sessions are typically given to an individual patient?

Evidence suggests that only training and supervision ensure that clinicians use correct ME/MI strategies in practice. If there is uncertainty about the MI/ME delivered ask an open question about which techniques are used. If the respondent does not understand the question, use one or two of the following as an example:

- What techniques or skills do you use in motivational interviewing? Can you give examples from a recent case?
- These are a few of several techniques that have been described as part of MI:
    - Designate a change goal (i.e. reduce substance use)
    - Ask related questions, including: What? How much? Benefits? Impact? Negatives?
    - Provide simple reflections
    - Provide complex reflections
    - Affirm
    - Summarize
    - Elicit/reinforce change talk
    - Collaborate with patient
    - Support Self-Efficacy
    - Roll with resistance
    - Address ambivalence
- Do the staff who deliver ME/MI or CBT for psychosis have formal training in those modalities? If yes, what is it?
    - □ A formal part of their professional training
    - □ Continuing professional development with a formal confirmation of proficiency
    - □ Continuing professional development without confirmation of proficiency
- What other services are offered to address co-occurring substance use disorders?

Component 28: Supported Employment (SE)	
• Do you have a separate role on your team for SE specialist (or is this part of the job responsibilities for a care manager)? • What training has your SE specialist received? (Prompts: IPS Employment Center online course, IPS practice manual, SAMHSA toolkit, RAISE toolkit, On Track) • What supported employment model do you follow? (Prompts: IPS, SAMHSA toolkit, RAISE NAVIGATE model, On Track) • How much experience does your SE specialist have? Is it >6 months? • Is SE specialist a team member who attends team meetings? Is it at least twice monthly? • Does your SE specialist receive supervision from an experienced SE supervisor? (What frequency?) • How many patients are on each SE specialist's caseload? • How many employer contacts doe your SE have? Is it tracked on a specific form? Does SE have ≥6 employer contacts per week? • Does your SE specialist use a Career Profile or equivalent? • Does your SE specialist track in-person employer contacts?	

Component 29: Supported Education (SEd)	
• Do you offer supported education services to all patients interested in education? • Who provides supported education services? • What training has your SEd specialist received? (Prompts: IPS, SAMHSA toolkit, RAISE model, On Track) • Is your SEd specialist a member of FEPS team? • Do you offer SEd services to all patients interested in education? • Who provides SEd services? • What training has your SEd specialist received? (Prompts: IPS, SAMHSA toolkit, RAISE model, On Track) • Is your SEd specialist a member of FEPS team? • What is your SEd's caseload of patients with education goals? • Does your SEd specialist complete and documents educational goals? What forms do they use for documenting goals? • Does your SEd specialist explore education programs with interested patients? • Does your SEd support educational financial planning (e.g., loan forgiveness, financial aid, loan repayment, scholarship application)? • Does your SEd specialist support patients in applying to programs? • Does your SEd specialist help students manage course work? • Does your SEd specialist identify legislated support for high school students?	

Component 30: Active Engagement and Retention

• Do you have a policy about where case managers/care coordinators meet their patients and families? If yes, what is it? • Where is this policy documented? Is it written or assumed? • What proportion of case managers/care coordinator visits are out of the clinic and in the community?	

Component 31: Patient Retention

For this component we are considering "all causes discontinuation" as the measure of retention. This means all patients who leave the program before the end of their first year in the program. Questions: • What is the total caseload of patients with a first episode psychosis in your program at this time? • How many patients were terminated/discharged from your program in the last 12 months? • Of those who were terminated/discharged, how many were active patients for less than 12 months? • Count the number of early terminators and divide by caseload size.	

Component 32: Crisis Intervention Services

• How does your program manage patient-related crises during and after hours? □ Formal linkages to out-of-hours services □ Respond to crisis calls during office hours □ Drop-in crisis visits during office hours □ 24-hour phone and in-person crisis services	

Component 33: Communication Between FEP and Inpatient Services

• How many patients on the caseload were admitted to an inpatient psychiatric unit in the last year? • What arrangements do you have in place to ensure communication with inpatients and continuity of care during and after hospitalization? • Which of the following roles are part of FEPS staffs' standard communication protocol for patients admitted to hospital? □ Contact inpatient unit to establish communication plan □ Visit with patient on inpatient unit □ Communicate with family about admission □ Involvement in discharge planning process □ Schedule outpatient appointment prior to discharge □ Obtain a hospital discharge summary	

Component 34: Timely Contact after Discharge from Hospital	
• Do you have a target for how soon patients who have been admitted to hospital should be seen after discharge? • How soon were each of the last five patients admitted to hospital seen after discharge?	

Component 35: Assuring Fidelity	

• Does the program use a set of quality standards?
• Who set or published these standards?
• Do you assess program quality with a Fidelity Scale?
  □ Which fidelity scale do you use?
  □ Has the fidelity scale been published?
  □ Is the fidelity assessment done by an independent rater?
• Do you measure quality indicators for
  □ Percentage of referrals seen within 2 weeks
  □ Percentage receiving Cognitive Behavioral Therapy
  □ Percentage receiving Family Psychoeducation
  □ Percentage receiving clozapine
  □ Percentage receiving Supported Employment
  □ Percentage receiving annual physical assessment
  □ Percentage receiving motivational enhancement for substance use disorder
  □ Any other indicators	

APPENDIX D: SCORING SHEET

Study Name: _____ Today's date: _____

Site name: _____ Fidelity interview dates: _____

Fidelity Round: Year 1 Year 2

	Item	Score
1	Practicing team leader:	
2	Participant/provider ratio:	
3	Services provided by team:	
4	Assignment of case manager/care coordinator:	
5	Psychiatrist caseload:	
6	Psychiatrist role on team:	
7	Weekly multi-disciplinary team meetings:	
8	Explicit diagnostic admission criteria:	
9	Population served:	
10	Age range served:	
11	Duration of FEP program:	
12	Targeted Education to health/social service/community groups:	
13	Early Intervention:	
14	Timely contact with referred individual:	
15	Family involvement in assessments:	
16	Comprehensive clinical assessment:	
17	Comprehensive psychosocial needs assessment:	
18	Treatment/Care Plan after initial assessment:	
19	Antipsychotic medication prescription:	
20	Antipsychotic dosing within recommendations:	
21	Clozapine for medication-resistant symptoms:	
22	Patient psychoeducation:	
23	Family education and support:	
24	Cognitive behavioral therapy (CBT):	
25	Supporting Health:	
26	Annual comprehensive assessment:	
27	Services for patients with Substance Use Disorders:	
28	Supported employment (SE):	
29	Supported education (SEd):	
30	Active engagement and retention:	
31	Patient Retention:	
32	Crisis intervention services:	
33	Communication between FEP and inpatient services:	
34	Timely contact after discharge from hospital:	
35	Assuring fidelity:	
	Total Score:	

APPENDIX E: FEEDBACK REPORT TEMPLATE

Program Name: _____
Program location: _____
Date(s) of fidelity review: _____
Assessment type – Remote/Site Visit: _____
Assessor(s): _____

Date of Report: XX-XX-XXXX

Introduction

This report includes the findings from fidelity assessment using the First Episode Psychosis Fidelity Scale at XXX program. Measuring fidelity, or adherence to the model, is important to ensure that the services delivered are consistent and are of high quality. This fidelity assessment was conducted using the First-Episode Psychosis Services Fidelity Scale (FEPS-FS-1.0).

The purpose of fidelity assessments is to better understand the services delivered in First Episode Psychosis Services programs. It is expected that ratings will vary widely depending on available resources. A rating in the range of 1 to 3 indicates a need for improvement. A score of 4 is considered good and 5 exemplary. The nature and detail of the report will vary depending on whether there has been a site visit or a remote assessment. It will also vary according to the purpose of the fidelity assessment and the nature of the relationship between the assessor and the program.

A fidelity assessment in which the primary purpose is for quality improvement should be more detailed and specific to the challenges faced by a program. Whatever the purpose of the assessment this report is an opportunity to reflect and identify areas of strength as well as opportunities for quality improvement. This template gives some examples based on composite anonymized reviews.

Summary

Program XXX XXXX located in XXX XXXX, serves the people of YYY region. Clinical team members include X team leaders, N care coordinators/case managers, N therapists, N supported employment specialists, and N psychiatrists (Other team members should be included, such as nurses, peer support workers, etc.). The team currently serves N patients with a diagnosis of a schizophrenia spectrum disorder. The team follows the XXX XXXX model and XXX model or manual for delivering patient and family psychoeducation. The team delivers Cognitive Behaviour Therapy using XX model and uses motivational interviewing for patients who abuse substances.

On dates XXXX and XXXX we conducted a remote/on site fidelity review which consisted of interviews with the (Titles). The assessor reviewed the health record checklist—review of 10 patient records who had been in the program at least one year and 5 who had had an admission to hospital in the last year, both prepared by a non-clinical staff member at the site, and program documents.

The program achieved either good or high fidelity (a score of '4' and '5', respectively) across the majority (XX %) of components on the FEPS-FS-1.0 scale. The program reports that their clinicians have received formal training and supervision in CBT (Name model), Patient Psychoeducation (Name model), Family Education (Name model) and Motivational Interviewing, Supported Employment (Name model) and Supported Education (Name model). The program provides (list services delivered or not delivered) Pharmacotherapy, CBT, Patient and Family Psychoeducation, Supported Employment and Supported Education services to support health and deal with Substance Use Disorders. We applaud the team for (Name a special achievement of the program if appropriate). Suggest a quality improvement initiative that is supported by the review. For example, "The program has a high patient-to-staff ratio, which offers the team the opportunity to provide services to more patients."

Fidelity components and service delivery areas that the agency may wish to prioritize for improvement include: (Focus on the components that score 3 or less.)

Component XX: YYY YYY

Component XX: YYY YYY

Component XX: YYY YYY

For a step-by-step guide on how to improve in these areas, see ratings and suggestions below.

Ratings per component

The following section provides the score for each of the 35 fidelity components from the First-Episode Psychosis Services Fidelity Scale (FEPS-FS-1.0).

The following information will be provided per component:

Score
Each component will receive a score between 1 (indicating a low level of fidelity) to 5 (indicating a high level of fidelity). A rating of 4 is considered good fidelity to the model.

Data source used for rating
Specification of the data source that the assessor used to determine the rating for that component. Additional data sources helped to inform the narrative feedback, but this section identifies the data sources used for the rating.

Program practice and strengths
How the program delivers/adheres to this component.

Quality improvement opportunities
May include suggestions for quality improvement opportunities related to this component.

Additional comments
Additional comments the assessor may wish to include (e.g., relevant contextual/scoring information).

Example of Completed Feedback Form

RATING	COMMENTS
1. Practicing Team Leader	
Score	Data source used for rating: Team leader interview
5	Program practice and strengths: Team leader carries administrative, clinical, and supervision duties. Quality improvement opportunities: No comment
2. Patient-to-Provider Ratio	
Score	Data source used for rating: Team leader interview and program documents
5	Program practice and strengths: Ratio = 4.2 patients per 1 staff FTE
	Quality improvement opportunities: No comment
3. Services Delivered by Team	
Score	Data source used for rating: All team member interviews
4	Program practice and strengths: Team provides: 1. Case management/care coordination; 2. Psychotherapy; 3. Substance use management; 4. Supported employment; 5. Family education/support; 6. Patient psychoeducation; 7. Pharmacotherapy
	Quality improvement opportunities: Missing provision of health services. Consider including a nursing staff as a member of the FEP team. We recommend patients are routinely weighed at each visit with the psychiatrist and have their smoking habits monitored annually. Nursing staff can deliver these services, which will also reduce burden on other staff members.
4. Assigned Case Manager/Care Coordinator	
Score	Data source used for rating: Health record review
5	Program practice and strengths: 100% of patients are assigned a case manager or receive care coordination services when they enroll.
	Quality improvement opportunities: No comment

RATING	COMMENTS
5. Psychiatrist Caseload	
Score	Data source used for rating: Psychiatrist interview and program documents
5	Program practice and strengths: Ratio = 10 patients per 0.2 psychiatrist FTE
	Quality improvement opportunities: No comment
6. Psychiatrist Role on Team	
Score	Data source used for rating: Team leader and psychiatrist interview
4	Program practice and strengths: Psychiatrist attends only half the team meetings, sees patients with another clinician, is accessible by the team during the work week for consultation, and shares health record with other team members.
	Quality improvement opportunities: No comment
7. Weekly Multi-Disciplinary Team Meetings	
Score	Data source used for rating: Team leader interview
5	Program practice and strengths: All team members attend weekly team meetings.
	Quality improvement opportunities: No comment
8. Explicit Diagnostic Admission Criteria	
Score	Data source used for rating: Team leader interview and program documents
5	Program practice and strengths: All patients meet program's eligibility guidelines.
	Quality improvement opportunities: No comment
9. Population Served	
Score	Data source used for rating: Team leader interview, program documents, census.gov
1	Program practice and strengths: Over the last 12 months, the program enrolled 7% (N = 13) of the expected incidence of first episode psychosis in region (N = 184).
	Quality improvement opportunities: Change in the number of patients served by the program is an administrative and funding issue rather than a clinical practice issue under the control of clinicians.

RATING	COMMENTS
10. Age Range Served	
Score	Data source used for rating: Score Team leader interview, program documents
1	Program practices and strengths; The program offers services to patients in age range of 18 to 30. This represents 25% of the age range of onset of 14 – 65.
	Quality improvement opportunities: Change in the program age range mandate is an administrative and funding issue rather than a clinical practice issue under the control of clinicians.
11. Duration of First Episode Psychosis (FEP) Program	
Score	Data source used for rating: Team leader interview
3	Program practice and strengths: The mandated length of the program is two years.
	Quality improvement opportunities: It is important for a program to have a clear duration to ensure appropriate access and for new patients. The risk of relapse is highest in the first years. Some studies have found better outcomes for those patients who are provided first episode psychosis services for at least 3 years.
12. Targeted Education to Health/Education/Social Service/Community groups	
Score	Data source used for rating: Team leader interview and health record review
4	Program practice and strengths: Over the past 12 months, the program delivered 10 face-to face-information sessions to first-contact professionals including schools, mental health community providers, and a physician.
	Quality improvement opportunities: Aim for at least 12 in-person information sessions per year. Additional comments: Though podcasts do not meet criteria for this component, we applaud the team using podcast technology, which has the potential to deliver information to a wide audience.
13. Early Intervention	
Score	Data source used for rating: Program documents and an email
1	Program practice and strengths: Of those currently enrolled in the program (N = 25), 88% (n = 22) were hospitalized prior to enrollment.
	Quality improvement opportunities: The following strategies have been found to be helpful for earlier intervention. Outreach to local community first contacts, services adequate to meet the expected incidence.

RATING	COMMENTS
14. Timely Contact with Referred Individual	
Score	Data source used for rating: Health record review
5	Program practice and strengths: Patients were seen in person within 14 days after referral in 9 out of 10 patient records reviewed.
	Quality improvement opportunities: No comment
15. Family Involvement in Assessments	
Score	Data source used for rating: Health record review
5	Program practice and strengths: 9 families of the 10 patient records reviewed were involved in the initial assessment or seen within the first month of the patient's initial assessment.
	Quality improvement opportunities: No comment
16. Comprehensive Clinical Assessment	
Score	Data source used for rating: Health record review and interviews
5	Program practice and strengths: Program consistently assesses all 9 key clinical areas during enrollment.
	Quality improvement opportunities: No comment
17. Comprehensive Psychosocial Needs Assessment	
Score	Data source used for rating: Health record review and interviews
5	Program practice and strengths: Program consistently assesses 8 of 9 psychosocial areas during enrollment in the 10 patient records reviewed.
	Quality improvement opportunities: Ensure to document the patient's financial situation (e.g., receiving benefits or disability).
18. Clinical Treatment Plan/Care Plan after Initial Assessment	
Score	Data source used for rating: Health record review
5	Program practice and strengths: Treatment plan found for 8 of 10 patients.
	Quality improvement opportunities: Ensure that all patients have a treatment/care plan and that all patients sign the plan as a form of documentation that they agree to the plan.

RATING	COMMENTS
19. Antipsychotic Medication Prescription	
Score	Data source used for rating: Health record review
5	Program practice and strengths: 9 out of 10 patients reviewed were prescribed an antipsychotic medication upon confirmation of diagnosis.
	Quality improvement opportunities: No comment
20. Antipsychotic Dosing within Recommendations for Individuals with FEP	
Score	Data source used for rating: Health record review
4	Program practice and strengths: 6 out of 10 patients reviewed received medication dosages in line with US Federal Drug Administration approved dose ranges for antipsychotic medications for schizophrenia spectrum disorders.
	Quality improvement opportunities: Aim for doses in the range shown to be effective. Research shows that higher than recommended doses or multiple antipsychotics cause more side-effects with no incremental benefit. Clozapine is an option for treatment resistant positive symptoms.
21. Clozapine for Medication-Resistant Symptoms	
Score	Data source used for rating: Psychiatrist interview and program documents
5	Program practice and strengths: 12% (n = 3) of patients are prescribed clozapine.
	Quality improvement opportunities: No comment
22. Patient Psychoeducation	
Score	Data source used for rating: Health record review
5	Program practice and strengths: Program delivers patient psychoeducation to all patients by trained clinicians.
	Quality improvement opportunities: No comment
23. Family Education and Support	
Score	Data source used for rating: Health record review
2	Program practice and strengths: Families from 4 out of 10 patients received 8 sessions of family psychoeducation.
	Quality improvement opportunities: Continue efforts to engage families in the patient's treatment. Family psychoeducation can be delivered in-person, by telephone, or by video-conference.

RATING	COMMENTS
24. Cognitive Behavioral Therapy (CBT)	
Score	Data source used for rating: Primary clinician interview
1	Program practice and strengths: Clinicians are trained in CBT but only 20% of patients have received 10 sessions of CBT.
	Quality improvement opportunities: Continue to engage patients and provide psychoeducation on the benefits of CBT for specific problems. Look at program flexibility to deliver services for patients at times and places that work for patients.
25. Supporting Health	
Score	Data source used for rating: Team leader and Psychiatrist interview
1	Program practice and strengths: Program performs these functions: 1. Provides feedback on weight gain and general advice on diet and exercise; 2. Monitors and documents extrapyramidal side-effects; 3. Refers/engages with primary care.
	Quality improvement opportunities: Weigh patients at least quarterly in the first year after enrollment. Monitor all patients' glucose levels, triglycerides, and smoking habits at least annually. For those who smoke tobacco and are interested in quitting, offer pharmacological interventions to support this goal. Clarify process and accountability for delivery of these services.
26. Annual Comprehensive Assessment	
Score	Data source used for rating: Health record review
5	Program practice and strengths: Program routinely assessed 6 of 7 key clinical and psychosocial areas at least annually.
	Quality improvement opportunities: Include an assessment of metabolic parameters in the assessment.
27. Services for Patients with Substance Use Disorders	
Score	Data source used for rating: Primary clinician interview
5	Program practice and strengths: Team maintains high level of engagement with patients receiving specialized substance use services.
	Quality improvement opportunities: No comment

RATING	COMMENTS
28. Supported Employment (SE)	
Score	Data source used for rating: Supported employment specialist and team leader interviews
3	Program practice and strengths: SE specialist is well trained.
	Quality improvement opportunities: SE should aim for at least 6 employer contacts per week for patients looking for employment and track these contacts in a format that can be easily searched and organized (e.g., on a spreadsheet). The fewer contacts made were likely due to only two patients searching for employment.
29. Supported Education (SEd)	
Score	Data source used for rating: Supported employment specialist interview
5	Program practice, strengths, and challenges: Supports patients looking for college programs (connects with university program coordinators, attends school tours, and supports application completion) and those still in high school (attends IEP meetings and ensures accommodations are met).
	Quality improvement opportunities: No comment
30. Active Engagement and Retention	
Score	Data source used for rating: Team leader and clinician interview
2	Program practice and strengths: Clinicians spend on average 14.75% out in the community.
	Quality improvement opportunities: Increasing time in the community will improve patient engagement in the program. Aim for an average of at least 40% of time out in the community for those clinicians providing case management and care coordination services.
31. Patient Retention	
Score	Data source used for rating: Program documents
4	Program practice and strengths: Dropout index = 0.20
	Quality improvement opportunities: Spending more time in outreach may reduce early dropout rate.

RATING	COMMENTS
32. Crisis Intervention Services	
Score	Data source used for rating: Team leader and primary clinician interviews
4	Program practice and strengths: Program is very accessible to patients in crisis both via phone and in-person
	Quality improvement opportunities: None
33. Communication Between FEP and Inpatient Services	
Score	Data source used for rating: Health record review
5	Program practice and strengths: Program maintains excellent communication with inpatient staff, patients, and families, and is actively involved in discharge planning and follow-up.
	Quality improvement opportunities: No comment
34. Timely Contact after Discharge from Hospital	
Score	Data source used for rating: Health record review
5	Program practice and strengths: Team members consistently see patients within 14 days of hospital discharge.
	Quality improvement opportunities: No comment
35. Assuring Fidelity	
Score	
2	The program has standards defined by the funder, but does not use either validated quality indicators or a fidelity scale to assure fidelity to those standards.
	Quality improvement opportunities: Work with funder to identify a valid fidelity scale or a set of quality indicators that they would accept.

APPENDIX F: FIRST EPISODE PSYCHOSIS SERVICES FIDELITY SCALE (FEPS-FS 1.0)

Component	Rating				
	1	2	3	4	5
1. Practicing Team Leader Team leader has administrative and supervisory responsibilities and also provides direct clinical services. Administrative and supervisory roles may be divided between two people. (Data source: team leader interview)	Team leader provides only administrative supervision.	Team leader provides administrative supervision. Ensures clinical supervision by others.	Team leader provides administrative supervision and clinical supervision to some staff.	Team leader provides administrative supervision and clinical supervision to all staff.	Team leader provides administrative supervision and clinical supervision to all staff and direct clinical service.
2. Patient-to-Provider Ratio Target ratio of active patient to provider (i.e., team members) is 20:1. Staff time counted in Full Time Equivalents (FTE). Do not count team leader's administrative time or psychiatrist/prescriber time. (Data source: team leader interview, program documents)	51+ patients per provider FTE	41-50 patients per provider FTE	31-40 patients per provider FTE	21-30 patients per provider FTE	20 or fewer patients per provider FTE
3. Services Delivered by Team Qualified professionals deliver services that include the following: 1. Case management/care coordination; 2. Health services; 3. Psychotherapy; 4. Substance use management; 5. Supported employment; 6. Family education/support; 7. Patient psychoeducation; 8. Pharmacotherapy (Data source: Team Leader, all interviews)	Team delivers 4 or fewer of listed items.	Team delivers 5 items including case management/ care coordination.	Team delivers 6 items including case management/ care coordination.	Team delivers 7 items including case management/ care coordination.	Team delivers all items.
4. Assigned Case Manager/Care Coordinator Patient has an assigned clinician who is identified as the person who delivers case management services/ care coordination. (Data source: Health Record Review)	0-19% patients have an assigned case manager.	20-39% patients have an assigned case manager.	40-59% patients have an assigned case manager.	60-79% patients have an assigned case manager.	≥80% patients have an assigned case manager.
5. Psychiatrist Caseload Each patient has an assigned psychiatrist who has a caseload that allows for patients to be seen for medication reviews or other clinical indications. (Data source: Team leader, prescriber interviews, program documents)	Psychiatrist caseload is >60 patients per 0.2 FTE.	Psychiatrist caseload is >50 - ≤60 patients per 0.2 FTE.	Psychiatrist caseload is >40 - ≤50 patients per 0.2 FTE.	Psychiatrist caseload is >30- ≤40 patients per 0.2 FTE.	Psychiatrist caseload is ≤30 patients per 0.2 FTE.

Component	Rating				
	1	2	3	4	5
6. Psychiatrist Role on Team Psychiatrists are team members who: 1. Attend team meetings; 2. See patients with other clinicians; 3. Are accessible for consultation by team during the work week; 4. Share health record with other team members. (Data source: team leader, prescriber interviews)	Psychiatrist is not a member of the team and practices separately.	Psychiatrist meets 1 out of the 4 listed criteria.	Psychiatrist meets 2 out of the 4 listed criteria.	Psychiatrist meets 3 out of the 4 listed criteria.	Psychiatrist meets all listed criteria.
7. Weekly Multi-disciplinary Team Meetings Team members attend weekly meetings that focus on 1. Case review (admissions and caseloads); 2. Assessment and treatment planning; 3. Discussion of complex cases; 4. Termination of services. (Data source: Team leader interview)	No team meetings held	Monthly team meetings	Bi-weekly team meetings	Weekly team meetings with less than all 4 listed items covered	Weekly team meetings with all listed items covered
8. Explicit Diagnostic Admission Criteria Program has clearly identified mandate to serve specific diagnostic groups with a psychosis and uses measurable and operationally defined criteria to select patients. This includes a consistent process for including and documenting uncertain cases and those with co-morbid substance use. (Data source: Team leader interview, program documents)	< 60% population served meet admission criteria.	60-69% population served meet admission criteria.	70-79% population served meet admission criteria.	80-89% population served meet admission criteria.	≥90% population served meet admission criteria.
9. Population Served Program has a clearly identified mandate to serve a specific geographic population and uses a comparison of annual incidence to accepted cases of people with schizophrenia spectrum disorder to assess success in admitting all incident cases. (Data source: Team leader interview, program documents, Census data)	0-19% of incident cases are admitted to FEP service (based on annual incidence of 16 per 100,000 population), or program has no population mandate.	20-39% of incident cases are admitted to FEP service (based on annual incidence of 16 per 100,000 population).	40-59% of incident cases are admitted to FEP service (based on annual incidence of 16 per 100,000 population).	60-79% of incident cases are admitted to FEP service (based on annual incidence of 16 per 100,000 population).	≥80% of incident cases are admitted to FEP service (based on annual incidence of 16 per 100,000 population).
10. Age Range Served Program serves the entire age spectrum from ages 14 – 65. (Data source: Program administrative data, team leader interview)	Program serves < 60% age range.	Program serves 60-69% age range.	Program serves 70-79% age range.	Program serves 80-89% age range.	Program serves ≥90% age range.
11. Duration of FEP Program Formal funding mandate and policy of FEP program is to provide service to all patients for a specified period measured in years. (Data source: Team leader interview)	FEP program has no mandate or policy on duration of program.	FEP program serves patients for ≤1 year.	FEP program serves patients for ≤2 years.	FEP program serves patients for ≤3 years.	FEP program serves patients for >3 years.

Component	Rating				
	1	2	3	4	5
12. Targeted Education to Health/ Education/Social Service/Community groups Information is provided to first-contact individuals in health, education, and social agencies, as well as community organizations. (Data source: Team leader interview, program documents)	No targeted education provided	Education to first-contact individuals and groups occurs less than 6 times a year.	Education to first-contact individuals and groups occurs 6 to 9 times a year.	Education to first-contact individuals and groups occurs 10 to 12 times per year.	Education to first-contact individuals and groups occurs >12 times a year.
13. Early Intervention Early intervention is measured by the proportion of people hospitalized prior to FEPS admission. (Data source: Administrative data, team leader interview)	≥80% of FEP patients receive inpatient care prior to FEPS admission.	60-79% of FEP patients receive inpatient care prior to FEPS admission.	40-59% of FEP patients receive inpatient care prior to FEPS admission.	20-39% of patients receive inpatient care prior to FEPS admission.	< 20% of patients receive inpatient care prior to FEPS admission.
14. Timely Contact with Referred Individual Individuals with a first episode of psychosis commence treatment in early first-episode psychosis services, as measured by in-person appointment, within 2 weeks of referral. (Data source: Administrative data, health record review)	In-person appointment target met for 0-19% of patients.	In-person appointment target met for 20-39% of patient.s	In-person appointment target met for 40-59% of patients.	In-person appointment target met for 60-79% of patients.	In-person appointment target met for ≥80% of patients.
15. Family Involvement in Assessments Service engages family in initial assessment to improve quality of assessment and engagement. (Data source: Health record review)	0-19% of families seen during initial patient assessment.	20-39% of families seen during initial patient assessment.	40-59% of families seen during initial patient assessment.	60-79% of families seen during initial patient assessment.	≥80% of families seen during initial patient assessment.
16. Comprehensive Clinical Assessment Initial clinical assessment includes: 1. Time course of symptoms, change in functioning, and substance use; 2. Recent changes in behavior; 3. Assessment of risk to self/ others; 4. Mental status exam; 5. Psychiatric history; 6. Premorbid functioning; 7. Co-morbid medical illness; 8. Co-morbid substance use; 9. Family history. (Data source: Health record review	8 or more assessment items found in 0-19% of recorded clinical assessments.	8 or more assessment items found in 20-39% of recorded clinical assessments.	8 or more assessment items found in 40-59% of recorded clinical assessments.	8 or more assessment items found in 60-79% of recorded clinical assessments.	8 or more assessment items found in ≥80 % of recorded clinical assessments.
17. Comprehensive Psychosocial Needs Assessment Initial psychosocial needs assessment includes: 1. Housing; 2. Employment; 3. Education; 4. Social support; 5. Financial support; 6. Primary care access; 7. Family support; 8. Past trauma; 9. Legal. (Data source: Health record review)	8 or more assessment items in 0-19% of needs assessments.	8 or more assessment items in 20-39% of needs assessments.	8 or more assessment items in 40-59% of needs assessments.	8 or more assessment items in 60-79% of needs assessments.	8 or more assessment items in ≥80% of needs assessments.

Component	Rating				
	1	2	3	4	5
18. Clinical Treatment/Care Plan after Initial Assessment Patients, family, and staff collaborate to develop a treatment/care plan that addresses clinical and psychosocial needs. Patient-provider collaboration is evidenced by the patient's sign-off on plan. (Data source: Health record review)	0-39% of patients have a clinical treatment plan.	40-69% of patients have a clinical treatment plan.	70- 79% of patients have a clinical treatment plan.	≥80% of patients have a clinical treatment plan.	≥80% of patients have a clinical treatment plan and have signed off on the plan.
19. Antipsychotic Medication Prescription After assessment confirms a diagnosis of a psychosis and the need for pharmacotherapy, antipsychotic medication is prescribed with consideration given to patient preference. (Data source: Health record review)	0-19% of patients receive prescription for antipsychotic medication.	20-39% of patients receive prescription for antipsychotic medication.	40-59% of patients receive prescription for antipsychotic medication.	60-79% of patients receive prescription for antipsychotic medication.	≥80% of patients receive prescription for antipsychotic medication.
20. Antipsychotic Dosing within Recommendations for Individuals with Psychosis Antipsychotic dosing is within government-approved guidelines for second-generation antipsychotic medications, and between 300 and 600 chlorpromazine equivalents for first-generation antipsychotics 6 months after starting FEPS. (Data source: Health record review)	0-19% of patients with psychosis receive antipsychotic dosing within guidelines.	20-39% of patients with psychosis receive antipsychotic dosing within guidelines.	40-59% of patients with psychosis receive antipsychotic dosing within guidelines.	60-79% of patients with psychosis receive antipsychotic dosing within guidelines.	≥80% of patients with psychosis receive antipsychotic dosing within guidelines.
21. Clozapine for Medication-Resistant Symptoms Use of clozapine if individual with schizophrenia spectrum disorder (SSD) does not adequately respond to two courses of first-line antipsychotic medication. (Data source: Prescriber interview, program documents)	< 1% patients of caseload of SSD patients are on clozapine.	1-2% of caseload of SSD patients are on clozapine.	2-3% of caseload of SSD patients are on clozapine.	3-4% of caseload of SSD patients are on clozapine.	≥4% of caseload of SSD patients are on clozapine.
22. Patient Psychoeducation Patient receives at least 12 sessions of patient psychoeducation/illness management training in the first year. Delivered by trained clinicians, either to individuals or in group psychoeducation sessions. (Data source: Health record review)	0-19% of patients participate in 12 sessions of psycho-education.	20-39% of patients participate in 12 sessions of psycho-education.	40-59% of patients participate in 12 sessions of psycho-education.	60-79% of patients participate in 12 sessions of psycho-education.	≥80 % of patients participate in 12 sessions of psycho-education.

Component	Rating				
	1	2	3	4	5
23. Family Education and Support Family receives at least 8 sessions of evidence-based individual or group family education and support that covers curriculum in the first year of patient being in the program. Education and support provided by a clinician trained to deliver the program. (Data source: Health record review, administrative data)	0-29% of families participate in an evidence-based family education and support program.	30-49% of families participate in an evidence-based family education and support program.	50-69% of families participate in an evidence-based family education and support program.	70-79% of families participate in an evidence-based family education and support program.	≥80% of families participate in an evidence-based family education and support program.
24. Cognitive Behavioral Therapy (CBT) Patient receives at least 10 sessions of CBT delivered in individual or group format in the first year of program. Delivered by an appropriately trained clinician, for indications such as positive symptoms, anxiety, or depression. (Data source: Health record review, team leader/ interview with clinician who provides CBT)	0-29% of patients received at least 10 sessions of CBT.	30-39% of patients received at least 10 sessions of CBT.	40-49% of patients received at least 10 sessions of CBT.	50-59% of patients received at least 10 sessions of CBT.	≥60% of patients received at least 10 sessions of CBT.
25. Supporting Health Program takes steps to support patient health through the following: 1. Refer and enroll patient in primary care; 2. Measure and record weight at least quarterly in first year of program; 3. Provide feedback on weight gain and advice on diet and exercise; 4. Monitor and document extrapyramidal side-effects; 5. Monitor triglycerides and glucose/Hb A1c annually; 6. Monitor and document cigarette smoking habits; 7. Prescribe pharmacological supports to smokers wishing to quit. (Data source: Team leader, psychiatrist/case manager/nurse practitioner)	3 of the listed items are provided.	4 of the listed items are provided.	5 of the listed items are provided.	6 of the listed items are provided.	All listed items are provided.
26. Annual Comprehensive Assessment Includes documented assessment of: 1. Educational involvement; 2. Occupational functioning; 3. Social functioning; 4. Symptoms; 5. Psychosocial needs; 6. Risk assessment of harm to self or others; 7. Substance use. (Data source: Health record review)	At least 6 items are found in 0-19% of annual assessments.	At least 6 items are found in 20-39% of annual assessments.	At least 6 items are found in 40-59% of annual assessments.	At least 6 items are found in 60-79% of annual assessments.	At least 6 items are found in ≥80% of annual assessments.

Component	Rating				
	1	2	3	4	5
27. Services for Patients with Substance Use Disorders FEP program offers the following: 1. Routine assessment of substance use for all patients at intake and at review; 2. Substance use addressed in patient psychoeducation; 3. Substance use addressed in family psychoeducation; 4. Brief evidence-based psychotherapies including motivational enhancement or CBT for patients with substance use problems; 5. Continuity of care and patient engagement for patients referred to specialized substance use services ranging from detox to residential treatment. (Data source: case manager/therapist/clinician interview)	1 of the listed items are present.	2 of the listed items are present.	3 of the listed items are present.	4 of the listed items are present.	All of the listed items are present.
28. Supported Employment (SE) SE is provided to patients interested in participating in competitive employment. Elements of SE include: 1. Trained SE specialist with at least 6 months experience; 2. SE specialist is a FEPS team member and attends team meetings; 3. SE specialists received at least twice monthly supervision from a qualified supervisor; 4. Ratio of SE specialist caseload is 1:20 or less; 5. SE has ≥6 employer contacts per week; 6 Uses career profile or equivalent; 7. Tracks in-person employer contacts. (Data source: Supported employment specialist, team leader interviews)	≤3 of the listed items are present.	4 of the listed items are present.	5 of the listed items are present.	6 of the listed items are present.	All items are present.

Component	Rating				
	1	2	3	4	5
29. Supported Education (SEd) SEd is provided to patients interested in participating in education as evidenced by: 1. A designated SEd specialist; 2. SEd specialist is part of FEPS team; 3. SEd caseload of at least 3 patients with education goals; 4. SEd specialist completes and documents educational goals. Specialist supports patients to: a. Explore education programs; b. Secure sources of financial aid; c. Complete applications and enrollment; d. Manage course work; e. Identify legislated and other sources of support for high school students (Data source: Supported employment specialist, team leader interviews)	FEPS team meets items 1-2 or has no SEd specialist.	FEPS team meets items 1-3 + at least 1 support item.	FEPS team meets items 1-4 + at least 2 support items.	FEPS team meets items 1-4 + at least 3 support items.	FEPS team meets items 1-4 + at least 4 support items.
30. Active Engagement and Retention Use of proactive outreach by a designated team member, including community visits to engage individuals with FEP and reduce missed appointments. (Data source: Team leader, designated team member delivering the service)	0-9% of time of designated team member is spent out-of-office conducting proactive outreach.	10-19% of time of designated team member is spent out-of-office conducting proactive outreach.	20-29% of time of designated team member is spent out-of-office conducting proactive outreach.	30-39% of time of designated team member is spent out-of-office conducting proactive outreach.	≥40 % of time of designated team member is spent out-of-office conducting proactive outreach.
31. Patient Retention Patient retention can be measured by calculation of the dropout index--the ratio of the number patients who dropped out of program in the last year to the total current caseload (Data source: Program administrative data, team leader interview)	Dropout index = ≥.41	Dropout index = .31 - .40	Dropout index = .21 - .30	Dropout index = .10 - .20	Dropout index = < .10
32. Crisis Intervention Services FEP service providers either deliver crisis services or have formal links to crisis response services that include crisis lines, mobile response teams, urgent care centers, or hospital emergency rooms (Data source: Team leader interview)	Team provides no crisis services to patient or family members and has no out-of-hours services or formal linkages to out-of-hours services.	Team provides crisis support only via a linkage to a 24-hour crisis support such as crisis lines and urgent care centers or emergency rooms.	Team provides telephone crisis support up to 8 hours per day, 5 days per week.	Team provides drop-in crisis support up to 8 hours per day, 5 days per week.	Team provides weekday drop- in crisis support plus a team member provides 24-hour, 7 days a week telephone crisis support.

Component	Rating				
	1	2	3	4	5
33. Communication between FEP and Inpatient Services Upon hospitalization of FEPS patient, FEPS staff: 1. Contact inpatient unit to establish communication plan; 2. Visit with patient on inpatient unit; 3. Communicate with family about admission; 4. Are involved in discharge planning process; 5. Receive/obtain a hospital discharge summary; 6. Schedule an outpatient appointment prior to discharge (Data source: Health record, team leader interview)	2 or fewer items are present in ≥80% of health record of admitted patients.	3 items are present in ≥80% of health record of admitted patients.	4 items are present in ≥80% of health record of admitted patients.	5 items are present in ≥80% of health record of admitted patients.	All items are present in ≥80% of health record of admitted patients.
34. Timely Contact after Discharge from Hospital Patient in FEP service has face-to-face contact with FEP service provider within two weeks of discharge from hospital. (Data source: Health record, team leader interview)	0-19% of FEP patients admitted to hospital are seen at FEP service within 14 days of hospital discharge.	20-39% of FEP patients admitted to hospital are seen at FEP service within 14 days of hospital discharge.	40-59% of FEP patients admitted to hospital are seen at FEP service within 14 days of hospital discharge.	60-79% of FEP patients admitted to hospital are seen at FEP service within 14 days of hospital discharge.	≥80% of FEP patients admitted to hospital are seen at FEP service within 14 days of hospital discharge.
35. Assuring Fidelity: Program monitors quality using a published fidelity scale or quality indicators linked to standards for program treatment components calculated from health record audit or administrative data. □ Percentage of referrals seen within 2 weeks □ Percentage receiving Cognitive Behavioral Therapy □ Percentage receiving Family Psychoeducation □ Percentage receiving clozapine □ Percentage receiving Supported Employment □ Percentage receiving annual metabolic monitoring □ Percentage receiving motivational enhancement for substance use disorder □ Percentage receiving case management or care coordination □ Patient Provider ratio □ Any other indicators? (Data source: Administrative data, team leader interview)	Program does not have approved standards and does not use a fidelity measure or quality indicators.	Program has standards but does not use a fidelity scale or monitor quality indicators linked to standards.	Program has standards but does not use a fidelity scale. Program monitors ≥4 quality indicators linked to standards.	Program has standards. Program monitors ≥8 quality indicators linked to standards for core services or uses a valid internally rated fidelity scale.	Program uses a published externally rated fidelity measure or monitors ≥11 quality indicators linked to standards for core services.

APPENDIX G: INDIVIDUAL PATIENT VERSION

	1	2	3	4	5
1. Timely Contact with Referred Individual Individuals with a first episode of psychosis commence treatment within 2 weeks of referral.	Patient contacted within 15 working days of referral and in-person appointment after more than 10 weeks.	Patient contacted within 10 working days of referral and in-person appointment within 7-9 weeks.	Patient contacted within 5 working days of referral and in-person appointment within 4-6 weeks.	Patient contacted within 72 hrs of referral and in-person appointment within 2-4 weeks.	Patient contacted within 72 hrs of referral and in-person appointment within 2 weeks.
2. Comprehensive Clinical Assessment Initial assessment includes: 1. Time course of symptoms, change in functioning, and substance use; 2. Recent changes in behavior; 3. Assessment of risk to self/ others; 4. Mental status exam; 5. Psychiatric history; 6. Premorbid functioning; 7. Co-morbid medical illness; 8. Co-morbid substance use; 9. Family history.	No more than 2 assessment items found in health record.	3-4 assessment items found in health record.	5-7 assessment items found in health record.	8-9 assessment items found in health record.	All assessment items found in health record.
3. Comprehensive Psychosocial Needs Assessment Initial psychosocial needs assessment includes: 1. Housing; 2. Employment; 3. Education; 4. Social support; 5. Financial support; 6. Primary care access; 7. Family support; 8. Past trauma; 9. Legal.	≤2 assessment items found in health record.	3-4 assessment items found in health record.	5-6 assessment items found in health record.	7-8 assessment items found in health record.	All 9 assessment items found in health record.
4. Family Involvement in Assessments Family is engaged and involved in initial assessment to improve quality of assessment and engagement.	Family is not invited or seen during initial assessment. No information available from family in health record.	Family is invited but not seen during initial assessment. No information from family in health record.	Family is invited but not seen during initial assessment, but information from family is in health record.	Family is invited and seen during initial assessment and information from family is in health record.	Family is invited and seen during initial assessment. Family is involved in follow up care. Information from family is in health record.

	1	2	3	4	5
5. Treatment/Care Plan after Initial Assessment Patients, family, and clinician collaborate to develop a treatment/ care plan that addresses clinical and psychosocial needs. Patient-provider collaboration is evidenced by the patient's sign off on plan.	Patient has a documented treatment plan that only addresses pharmaco-therapy.	Patient has a documented treatment plan that addresses pharmacotherapy and psycho-therapy.	Patient has a documented treatment plan that addresses pharmaco-therapy, psychotherapy, and psycho-social needs.	Patient has a documented treatment plan that addresses pharmacotherapy, psychother-apy, psycho-social needs, and family involvement.	Patient has a documented treatment plan that addresses pharmacotherapy, psychother-apy psycho-social needs. and family involvement. Patient signs plan.
6. Psychiatric Management Patient has an assigned psychiatrist who provides pharmacotherapy.	Patient receives no psychiatric management.	Patient receives psychiatric management for ≤1 year.	Patient receives psychiatric management for ≤2 years.	Patient receives psychiatric management for ≤3 years.	Patient receives psychiatric management for >3 years.
7. Case Management/Care Coordination Patient has an assigned professional who is identified as the person who delivers case management services including care coordination.	Patient receives no case management.	Patient receives case management for ≤1 year.	Patient receives case management for ≤2 years.	Patient receives case management for ≤3 years.	Patient receives case management for >3 years.
8. Antipsychotic Medication Prescription After assessment confirms a diagnosis of a psychosis and the need for pharmacotherapy, antipsychotic medication is prescribed with consideration given to patient preference.	No antipsychotic prescribed in first six months.	Antipsychotic prescribed between 2 and 3 months after initial assessment.	Antipsychotic prescribed between 1 and 2 months after initial assessment.	Antipsychotic prescribed within 1 month of initial assessment.	Antipsychotic prescribed after initial assessment.
9. Antipsychotic Dosing within Recommendations for Individuals with Psychosis Antipsychotic dosing is within government-approved guidelines for second-generation antipsychotic medications and between 300 and 600 chlorpromazine equivalents for first-generation antipsychotics at 6 months.	After starting pharmaco-therapy, dose is at least 20% above or below target range.	After starting pharmaco-therapy, dose is 15%-19% above or below target range.	After starting pharmaco-therapy, dose is 10%-14% above or below target range.	After start-ing pharma-cotherapy, dose is 5% -9% above or below target range.	After starting pharmaco-therapy, dose is in target range.

	1	2	3	4	5
10. Clozapine for Medication-Resistant Symptoms * Use of clozapine if individual with schizophrenia spectrum disorder (SSD) does not adequately respond to two courses of first-line antipsychotic medication.	Cannot identify whether patient has adequate response to first-line antipsychotic.	Patient has inadequate response to first-line antipsychotic. No record of second antipsychotic trial.	Patient has inadequate response to two first-line antipsychotics.	Patient has inadequate response to two first-line antipsychotics and is prescribed clozapine.	Patient who has inadequate response to two first-line antipsychotics is prescribed clozapine and remains on clozapine for 6 months.
11. Patient Psychoeducation Patient receives at least 12 sessions of patient psychoeducation/illness management training in the first year, delivered by trained clinicians, either to individuals or in group psychoeducation sessions.	No evidence of patient psychoeducation in health record.	Evidence of sessions of informal patient psychoeducation in health record.	Evidence of 1-3 sessions of formal patient psychoeducation sessions in health record.	Evidence of 4-10 sessions of formal patient psychoeducation in health record.	Evidence of 11 or more sessions of formal patient psychoeducation sessions in health record.
12. Family Education and Support Family receives at least 8 sessions of evidence-based individual or group family education and support that covers curriculum in the first year of treatment provided by a clinician trained to deliver the program.	No evidence of family psychoeducation in health record.	Evidence of 1-2 family psychoeducation sessions in health record.	Evidence of 3-5 family psychoeducation sessions in health record.	Evidence of 6-8 family psychoeducation sessions in health record.	Evidence of >8 family psychoeducation sessions in health record.
13. Cognitive Behavioral Therapy (CBT) Patient receives at least 10 sessions of CBT delivered in individual or group format in the first year of program, delivered by an appropriately trained clinician, for indications such as positive symptoms, anxiety, or depression.	No evidence of CBT in health record.	Evidence of 1-3 sessions of CBT in health record.	Evidence of 4-7 sessions of CBT in health record.	Evidence of 8-10 sessions of CBT in health record.	Evidence of < 10 sessions of CBT in health record.

	1	2	3	4	5
14. Supporting Health Patient receives services that promote health: 1. Refer and enroll patient in primary care; 2. Measure and record weight at least quarterly in first year of program; 3. Provide feedback on weight gain and advice on diet and exercise; 4. Monitor and document extrapyramidal side-effects; 5. Monitor triglycerides and glucose / Hb A1c annually; 6. Monitor and document cigarette smoking habits; 7 Prescribe pharmacological supports to smokers wishing to quit.	3 of the listed items provided.	4 of the listed items provided.	5 of the listed items provided.	6 of the listed items provided.	All listed items provided.
15. Annual Comprehensive Assessment Documented assessment includes: 1. Educational involvement; 2. Occupational functioning; 3. Social functioning; 4. Symptoms; 5. Psychosocial needs; 6. Risk assessment of harm to self or others; 7. Substance use	Assessment of none of the items at one-year review.	Assessment of 1-2 of the items at one-year review.	Assessment of 3-4 of the items at one-year review.	Assessment of 5-6 of the items at one-year review.	Assessment of 7 of the items at one-year review.
16. Services for Patients with Substance Use Disorders * Patient has assessment of substance use at intake and at review. If substance use disorder is present: 1. Substance use addressed in patient psychoeducation; 2. Substance use addressed in family psychoeducation; 3. Brief evidence-based psychotherapies including motivational enhancement or CBT for patients with substance use problems; 4. Continuity of care and patient engagement for patients referred to specialized substance use services ranging from detox to residential treatment.	No assessment of substance use.	Patient assessed for substance use disorder at initial assessment and at one year.	If patient has a substance use disorder, they receive services 1-2.	If patient has a substance use disorder, they receive services 1-3.	If patient has a substance use disorder, they receive services 1-4.

	1	2	3	4	5
17. Supported Employment (SE) SE is provided to patients interested in participating in competitive employment. Elements of SE include: 1. Trained SE specialist with at least 6 months experience; 2. SE specialist is a FEPS team member and attends team meetings; 3. SE specialist received at least twice-monthly supervision from a qualified supervisor; 4. Ratio of SE specialist caseload is 1:20 or less; 5. SE has ≥6 employer contacts per week; 6. Uses career profile or equivalent; 7. Tracks in-person employer contacts.	No evidence that work interest is actively assessed or that work is discussed.	Documented assessment of patient interest in work and referral to SE specialist.	≤3 items present.	≤5 items present.	≤7 items present.
18. Supported Education (SEd) * SEd is provided to patients interested in participating in education as evidenced by: 1. A designated SEd specialist; 2. SEd caseload of at least 3 patients with education goals; 4. SEd specialist completes and documents educational goals. Specialist supports patients: a. Explores education programs; b. Secure sources of financial aid; c. Complete applications and enrollment; d. Manages course work; e. Identifies legislated and other sources of support for high school students.	No evidence that educational interest is actively assessed or that work is discussed.	Documented assessment of patient interest in education, referral to and assessment by an SE specialist.	Patient receives items 1-4 + at least 2 support items.	FEPS team meets items 1-4 + at least 3 support items.	FEPS team meets items 1-4 + at least 4 support items.
19. Active Engagement and Retention Patient receives proactive outreach with community visits to reduce missed appointments and engage individuals with FEP.	0-9% of all patient and family visits are out-of-office to facilitate engagement.	10-19% of all patient and family visits are out-of-office to facilitate engagement.	20-29% of all patient and family visits are out-of-office to facilitate engagement.	30-39% of all patient and family visits are out-of-office to facilitate engagement.	>40% of all patient and family visits are out-of-office to facilitate engagement.

	1	2	3	4	5
20. Crisis Intervention Services Patient has access to: 1. 24-hour crisis line; 2. Crisis telephone support from staff 8 hours per day 5 days per week; 3. Drop-in crisis support by staff up to 8 hours per day 5 days per week; 4. Access to telephone crisis support 24 hour 7 days a week.	Patient has no access to crisis services.	Patient has access to crisis support via a 24-hour crisis line.	Patient has access to services 1 and 2.	Patient has access to services 1 to 3.	Patient has access to services 1 to 4.

* **Components 10, 16, 17 and 18** are not required for all patients. For those who do not require the service, score '5'. For example, a patient who has a good response to first-line antipsychotic medication, score the clozapine as '5'. If the patient has employment and does not need supported employment, score '5'.

APPENDIX H: SELF-ASSESSMENT INSTRUCTIONS

The First Episode Psychosis Services Fidelity Scale 1.0 is a 35-item scale designed to assess the quality of First Episode Psychosis Services. Each item has a clear definition and is rated on a five-point interval scale. Each rating interval is defined with precise boundaries. The self-assessment process requires the same data, obtained from the same sources, as an externally rated fidelity assessment. The data for rating each item comes from one of three sources.

1. Health Record Review

i. 13 Components including:

1. 11 Components from 10 random health records covering

    a. Services provided to all patients

1. 2 Components from the last 5 patients hospitalized covering

    a. Hospital outpatient communication

2. Administrative data

i. 8 Components covering:

1. Staffing
2. Area served
3. Admissions and discharges
4. Templates

3. Interview

i. 14 Components covering:

1. Training
2. Practice patterns
3. Team functioning

Training to understand and use the scale will help you to organize the task and make the ratings more reliable and the results more useful.

1. Components rated from health records

There are 13 components rated from data abstracted from health records. 13 of these components are rated from a sample of 10 randomly selected records of patients who have been in the program for at least one year. The components represent services that all patients should receive. Two components assess communication between inpatient and outpatient services and are rated based on information abstracted from the health records of the last 5 patients who have been hospitalized. The data abstraction can be done by a person who is not a clinician, and the process does not require knowledge of the scale and rating criteria.

Component Number	Component
4	Assigned Case Manager/Care Coordinator
14	Timely Contact with Referred Individual
15	Family Involvement in Assessments
16	Comprehensive Clinical Assessment at Enrollment
17	Comprehensive Psychosocial Needs Assessment
18	Treatment/Care Plan after Initial Assessment
19	Antipsychotic Medication Prescription
20	Antipsychotic Dosing within Recommendations
22	Patient Psychoeducation
23	Family Education and Support
26	Annual Comprehensive Assessment
33	Communication between FEP and Inpatient Services
34	Timely Contact after Discharge from Hospital

There is a template in the First Episode Psychosis Fidelity Scale Manual that can be used to abstract the data from the health record. The data abstraction form is designed to collect data reliably. It is easier if it is abstracted by someone familiar with the health record and where specific information can be found in the health record. If needed a clinician can orient the data abstractor to the health record. There is specific training available for the health record abstractor in the FEPS-FS 1.0 training program. For the person completing the rating, the abstracted data needs some interpretation. For example, the doses of antipsychotic medication prescribed needs to be added up and compared with the approved dose. A list of antipsychotics and their approved doses can be found in the First Episode Psychosis Fidelity Scale Manual. These lists and doses are country specific.

2. Components rated from administrative data

These components describe the structure of the program that is the goal of the program and the resources available to achieve the goal.

Component Number	Component
2	Patient-to-Provider Ratio
8	Explicit Diagnostic Admission Criteria
9	Population Served
10	Age Range Served
11	Duration of FEP Program
12	Targeted Education to Health/Education/Social Service/Community Groups
13	Early Intervention
31	Patient Retention

There is a list of documents that typically have the data required to complete the structural components.

Geographic area served and area population
List of program staff, titles, and full time equivalents that they give to program
Age range served by program
Diagnostic admission criteria
Total number of current patients
Numbers in each diagnostic category
Number of patients who have left program in last year
Number of patients who left the program in their first year

3. Interview

Fourteen components of the First Episode Psychosis Services Fidelity Scale 1.0 are rated from the interview. These questions cover components that assess staff training, practice patterns and team functioning. The full interview is available from the Manual. The team leader should be interviewed about all the components, but staff only need to be interviewed on the specific questions that address their role. When using the interview template it is important to refer to the staff role using the terminology that you use in the program. Also use the terminology of the program when referring to patients/clients. In some programs peer support workers deliver evidence-supported programs such as patient psychoeducation.

Number	Component
1	Practicing Team Leader
3	Services Delivered by Team
5	Psychiatrist Caseload
6	Psychiatrist Role on Team
7.	Weekly Multi-disciplinary Team Meetings
21	Clozapine for Medication-Resistant Symptoms
24	Cognitive Behavioral Therapy (CBT)
25	Supporting Health Management
27	Services for Patients with Substance Use Disorders
28	Supported Employment (SE)
29	Supported Education (SEd)
30	Active Engagement and Retention
32	Crisis Intervention Services
35	Assuring Fidelity

APPENDIX I: QUALITY IMPROVEMENT STEP-BY-STEP GUIDE

The goal of this fidelity report is to support quality improvement (QI), however sometimes this is easier said than done. To help you on your QI journey we have included some tips and links to resources that you may find helpful.

Step-by-Step Guide:

1. Identify a gap

What is the problem?
Based on the fidelity report, select one gap or opportunity to focus on for improvement.
Other important gaps can be identified for future work.

2. Select a change idea

How can this problem be fixed?
Meet as a team and discuss ideas about how the gap can be improved.
Ideas can be big or small.
There are tools available to help narrow down the gap and brainstorm change ideas (e.g., Fishbone diagram, 5 Why's, Process mapping).

3. Select measures

How do you know if the change worked?
Identify some measures that will tell you if the change has worked.
These can be simple.
Example: If you are trying to increase attendance at a family support group, you can compare attendance numbers before and after you made the change.

4. Make the change

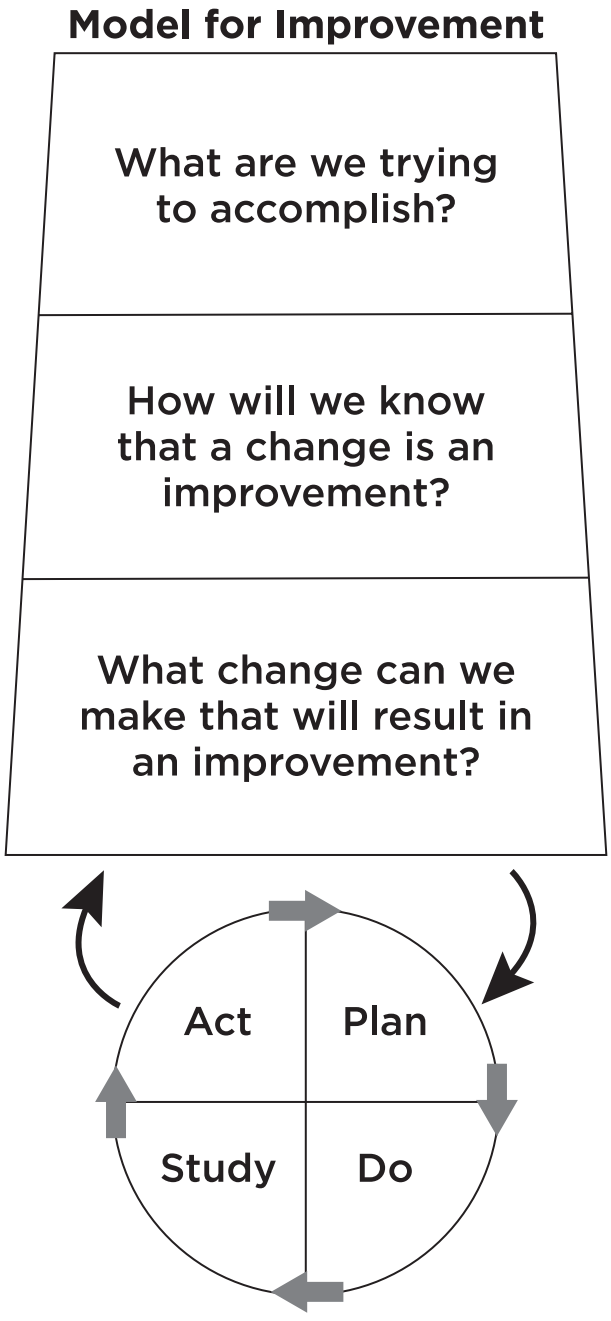
Work with your team members to make the change to your program.

5. Test and refine

Check to see if your change is working and make any refinements needed.
You may do a few testing and refinement cycles—these are also called Plan-Do-Study-Act (PDSA) cycles.

6. Sustainability

Making the change stick.
Think about how you can make sure the new practice will be sustained.
E.g., is ongoing coaching required? Can it be included in training for new staff? Can it be checked with regular audits?


Model for Improvement
What are we trying to accomplish?
How will we know that a change is an improvement?
What change can we make that will result in an improvement?
Act
Plan
Study
Do

APPENDIX J: MEDICATION DOSING GUIDELINES

US Federal Drug Administration approved dose ranges for antipsychotics in the treatment of schizophrenia

March 30, 2020

Generic Name	Proprietary Name	Approved dose range
Aripiprazole Oral	Abilify	10 mg – 30 mg / day
Aripiprazole IM LA	Abilify Maintaina	300 mg – 400 mg / 4 weeks
Asenapine	Saphris	10 mg – 20 mg / day
Brexpiprazole	Rexulti	2 mg – 4 mg /day
Cariprazine	Vraylar	1.5 mg – 6 mg / day
Chlorpromazine	Generic	200 mg – 800 mg / day
Clozapine	Generic	300 mg – 900 mg / day
Fluphenazine	Prolixin	2.5 mg – 20 mg / day
Fluphenzine decanoate IM LA	Modecate	12.5 mg – 50 mg / 2-3 weeks
Haloperidol	Haldol	1.5 – 20 mg / day
Haloperidol decanoate IM LA	Generic	50 mg – 250 mg / 4 weeks
Iloperidone	Fanapt	6 mg – 12 mg / day
Lumateperone	Calypta	42 mg / day
Lurasidone	Latuda	40 to mg – 120 mg / day
Molindone	Moban	20 mg – 200 mg /day
Olanzapine	Zyprexa	10 mg – 20 mg / day
Paliperidone Oral	Invega	3 mg – 12 mg / day
Paliperidone Palmitate IM LA	Invega Sustena	39 mg – 234 mg / 4 weeks
Paliperidone	Invega Trinza	78 mg – 819 mg / 12 weeks
Quetiapine	Seroquel	150 mg – 800 mg / day
Quetiapine XR	Seroquel XR	400 mg – 800 mg / day
Risperidone	Risperdal	2.0 mg – 16.0 mg /day
Risperidone IM LA	Risperidal Consta	25 mg – 50 mg / 4 weeks
Thiothixine	Navane	2 mg – 40 mg / day
Trifluoperazine	Generic	2 mg – 40 mg / day
Ziprasidone	Geodon	40 – 160 mg / day

Health Canada approved dose ranges for antipsychotics for treatment of schizophrenia

April 06, 2020

Generic Name	Proprietary Name	Approved dose range
Aripiprazole Oral	Abilify	10 mg – 30 mg / day
Aripiprazole IM LA	Abilify Maintaina	300 mg – 400 mg / 4 weeks
Asenapine	Saphris	10 mg – 20 mg / day
Brexipiprazole	Rexulti	2 mg -4 mg / day
Chlorpromazine	Generic	200 mg – 1000 mg / day
Clozapine	Generic	300 mg – 900 mg / day
Flupentixol	Fluanxol	9 mg – 24 mg / day
Flupentixol decanoate IM LA	Flavanxol Depot	20 mg – 40 mg / day
Fluphenazine	Generic	2.5 mg – 20 mg / day
Fluphenzine decanoate IM LA	Modecate	12.5 mg – 100 mg / 2- 3 weeks
Haloperidol	Generic	1.5 – 20 mg / day
Haloperidol decanoate IM LA	Generic	50 mg – 300 mg / 4 weeks
Loxapine	Generic	20 mg – 250 mg / day
Lurasidone	Latuda	40 to mg - 160 / day
Methotrimeprazine	Generic	100 mg – 1000 mg / day
Olanzapine	Zyprexa	10 mg – 20 mg / day
Paliperidone Oral	Invega	3 mg – 12 mg / day
Paliperidone Palmitate IM LA	Invega Sustena	25 mg – 150 mg / 4 weeks
Paliperidone	Invega Trinza	175 mg – 525 mg / 12 weeks
Perphenazine	Generic	12 mg – 64 mg /day
Pimozide	Generic	2 mg – 12 mg / day
Pipotiazine Palmitate IM LA	Piportil L4	25 mg – 250 mg / 4 weeks
Quetiapine	Seroquel	300 mg – 800 mg / day
Quetiapine XR	Seroquel XR	400 mg – 800 mg / day
Risperidone	Risperdal	2.0 mg – 6.0 mg /day
Risperidone IM LA	Risperidal Consta	25 mg – 50 mg / 4 weeks
Thiothixine	Navane	15 mg – 60 mg / day
Trifluoperazine	Generic	6 mg – 40 mg / day
Ziprasidone	Zeldox	80 – 160 mg / day
Zuclopenthixol acetate	Clopixol	20 – 100 mg / day
Zuclopenthixol decanoate IM LA	Clopixol Depot	100 mg – 400 mg / 2–4 weeks

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With the First Episode Psychosis Fidelity Scale and Manual*, Don Addington has provided a comprehensive and practical guide to an essential tool for evaluating first episode psychosis services. This state-of-the-art manual will be indispensable; Addington has thought of every detail needed to assess the fidelity of first episode psychosis services.*

—Howard Goldman, Professor of Psychiatry, University of Maryland

This manual is an outstanding volume. It is clear and well written, both practical and conceptual, providing a rationale for the criteria and detailed information about how to measure each item. This will move the field forward and offer a common vocabulary.

—Lisa Dixon, Edna L. Edison Professor of Psychiatry, New York State Psychiatric Institute

One of the tragedies of mental illness is that a wide range of effective treatments have been developed but only a minority of patients truly benefit from their efficient delivery. Early psychosis fidelity tools provide a model for what should be in place in all mental health services, and this volume is a blueprint of how to implement this process.

—Patrick McGorry, Professor of Youth Mental Health, University of Melbourne

The First Episode Psychosis Services Fidelity Scale (FEPS-FS 1.0) is a highly reliable scale that assesses the degree to which mental health teams deliver specialized evidence-based care to people experiencing a first episode psychosis. The scale comprises 35 components each rated on a 1 to 5 scale.

The Manual provides a practical guide for scoring a FEPS program against the criteria set out in the fidelity scale. It is designed to increase the reliability and consistency of ratings across different sites and assessors. It includes a definition and rationale for each component, data sources, decision rules, and practical guides for proper implementation of the Fidelity Scale.

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