First-Episode Psychosis Services Fidelity Scale (FEPS-FS 1.0) Components and Rating Criteria

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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, 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. Do not count team leader's administrative time or psychiatrist/prescriber (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

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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 four or fewer of listed items	Team delivers five items including case management/ care coordination	Team delivers six items including case management/ care coordination	Team delivers seven 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 assigned case manager	20-39% patients have assigned case manager	40-59% patients have assigned case manager	60-79% patients have assigned case manager	≥ 80% patients have assigned case manager

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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
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; and, 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	Psychiatrists 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 listed items covered	Weekly team meetings with all listed items covered

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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)	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)

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10. **Age Range Served** Program serves the entire age spectrum from ages 14 - 65 (Data source: program policies, team leader interview)	Program serves ages 14- ≤25	Program serves ages 14 - ≤35	Program serves ages 14 - ≤45	Program serves ages 14 - ≤55	Program serves ages 14 - ≤65
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

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12. **Targeted Education to Health/Education/Social Service/Community groups** Provision of information 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 10-12 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% patients	In-person appointment target met for 20-39% patients	In-person appointment target met for 40-59% patients	In-person appointment target met for 60-79% patients	In-person appointment target met for ≥80% 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

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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
18. **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

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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% patients receive prescription for antipsychotic medication	20-39% patients receive prescription for antipsychotic medication	40-59% patients receive prescription for antipsychotic medication	60-79% patients receive prescription for antipsychotic medication	≥ 80% 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% patients with psychosis receive antipsychotic dosing within guidelines	20-39% patients with psychosis receive antipsychotic dosing within guidelines	40-59% patients with psychosis receive antipsychotic dosing within guidelines	60-79% patients with psychosis receive antipsychotic dosing within guidelines	≥ 80% 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 on clozapine	1-2% of caseload of SSD patients on clozapine	2-3% of caseload of SSD patients on clozapine	3-4% of caseload of SSD patients on clozapine	≥ 4% of caseload of SSD patients on clozapine

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22. **Patient Psychoeducation** Provision of 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% patients participate in 12 sessions of psycho-education.	20-39% patients participate in 12 sessions of psycho-education	40-59% patients participate in 12 sessions of psycho-education	60-79% patients participate in 12 sessions of psycho-education	≥80 % patients participate in 12 sessions of psycho-education
23. **Family Education and Support** In the first year of participation in the program, a trained clinician delivers at least 8 sessions of evidence-based individual or group family education and support that covers curriculum. (Data source: Health Record Review, Administrative data)	0-29% families participate in an evidence-based family education and support program	30-49% families participate in an evidence-based family education and support program	50-69% families participate in an evidence-based family education and support program	70-79% families participate in an evidence-based family education and support program	≥ 80% families participate in an evidence-based family education and support program
24. **Cognitive Behavioural Therapy (CBT)** Provision of 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 % patients received at least 10 sessions of CBT	30-39% patients received at least 10 sessions of CBT	40-49% patients received at least 10 sessions of CBT	50-59% patients received at least 10 sessions of CBT	≥ 60% patients received at least 10 sessions of CBT

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25. **Supporting Health Management** Program takes steps to support patient health through the following: 1. Measurement and recording of weight at least quarterly in first year of program; 2. Provision of feedback on weight gain and general advice on diet and exercise; 3. Monitoring and documenting of extrapyramidal side effects; 4. Staff referring to and engaging with primary care; 5. Annual monitoring of glucose and triglycerides; 6. Annual monitoring and documenting of cigarette smoking habits; 7 Prescribing pharmacological supports to smokers wishing to quit. (Data source: Team Leader; psychiatrist / case manager/; nurse practitioner)	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
26. **Annual Formal 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 found in 0-19% of annual assessments	At least 6 items found in 20-39% of annual assessments	At least 6 items found in 40-59% of annual assessments	At least 6 items found in 60-79% of annual assessments	At least 6 items found in ≥ 80% of annual assessments

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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 item present	2 items present	3 items present	4 items present	All items present

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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 case load 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 items present	4 items present	5 items present	6 items present	All items present

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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 part of FEPS team; 3. SEd case load of at least 3 patients with education goals; 4. SEd specialist completes and documents educational goals. Specialist supports patients: a. explore education programs; b. secure sources of financial aid; c. complete applications and enrolment; 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, and 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

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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

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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

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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 present in ≥ 80% of health record of admitted patients	3 items present in ≥ 80% of health record of admitted patients	4 items present in ≥ 80% of health record of admitted patients	5 items present in ≥ 80% of health record of admitted patients	All items 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

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35. **Quality of Care**: Program monitors quality using a validated fidelity scale or quality indicators linked to standards for program treatment components such as pharmacological and psychosocial treatments. (data source: Administrative data demonstrating; 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 monitor quality indicators linked to standards.	Program has standards and monitors ≥ four quality indicators linked to standards	Program monitors ≥ eight quality indicators linked to standards or uses a valid internally rated fidelity scale	Program uses a valid externally rated fidelity measure or monitors ≥ 11 quality indicators linked to standards