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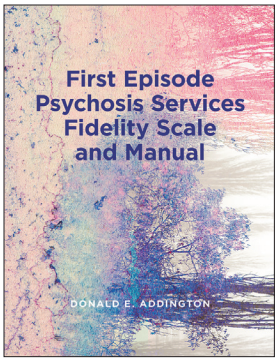

FIRST EPISODE PSYCHOSIS SERVICES FIDELITY SCALE AND MANUAL

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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.

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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.

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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.

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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.

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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'.