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

March 05, 2015

Fidelity Assessor: _____ Program: _____ Date of Fidelity Assessment: _____

Ratings/Anchor Points

Individual Evidence Based Practices	**1**	**2**	**3**	**4**	**5**
1. Timely Contact with Referred Individual: Patient with FEP is offered an in-person appointment within two weeks of service receiving referral.	Target met for in-person appointment for 0-19% patients	Target met for in-person appointment for 20-39% patients	Target met for appointment for 40-59% patients	Target met for appointment for 60-79% patients	Target met in-person appointment for 80+% patients
2. Patient and Family Involvement in Assessments: Service engages patient and family in initial assessment to improve quality of assessment and engagement	0-19% of families seen during initial assessment	20-39% of families seen during initial assessment	40-59% of families seen during initial assessment	60-79% of families seen during initial assessment	80+% of families seen during initial assessment
3. Comprehensive Clinical Assessment: Initial assessment includes: 1. Time course of symptoms, change in functioning and substance use 2. Recent changes in behavior 3. Risk assessment risk to self/others 5. Mental status exam; 6. Psychiatric history; 7. Premorbid functioning; 8. Co-morbid medical illness; 9. Co-morbid substance use; 10. Family history	All assessment items found in 0 – 19 % of patients	All assessment items found in 20-39% of patients	All assessment items found in 40-59% of patients	All assessment items found in 60-79% of patients	All assessment items found in 80+% of patients

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4. Psychosocial Needs Assessed for Care Plan: Assess and incorporate into Care Plan needs related to: 1. Housing; 2. Employment; 3. Education; 4. Social support; 5. Finances; 6. Basic living skills; 7. Primary care access; 8. Social skills; 9. Family Support; 10. Past trauma; 11. Legal	All items addressed in 0-19% of Care Plans	All items addressed in 20-39% of Care Plans	All items addressed in 40-59% of Care Plans	All items addressed in 60-79 % of Care Plans	All items addressed in 80 +% of Care Plans
5. Individualized Clinical Treatment Plan After initial assessment: Patients, Family and Staff develop individualized treatment plan using evidence-supported treatments addressing patient needs, goals and preferences (i.e. pharmacotherapy, psychotherapy, addictions, mood problems, suicide prevention, weight management)	0-19% patients receive explicit individualized clinical treatment plan	20-39% patients receive explicit individualized clinical treatment plan	40-59% patients receive explicit individualized clinical treatment plan	60-79% patients receive explicit individualized clinical treatment plan	80+% patients receive explicit individualized clinical treatment plan
6. Antipsychotic Medication Prescription: After diagnostic assessment confirms psychosis and the need for pharmacotherapy, antipsychotic medication is prescribed according to patient preference.	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

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7. Antipsychotic Dosing Within Recommendations: 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	0-19% patients receive doses within recommendations	20-39 % patients receive dosing within recommendations	40-59% patients receive dosing within recommendations	60-79% patients receive dosing within recommendations	80+% patients receive dosing within recommendations
8. Antipsychotic Selection based on low EPS and low weight gain potential. * Includes: Aripiprazole, Ziprasidone, Lurasidone	0-19% patients receive antipsychotic with low EPS and low weight gain potential	20-39 % patients receive antipsychotic with low EPS and low weight gain potential s	40-59% patients receive antipsychotic with low EPS and low weight gain potential	60-79% patients receive antipsychotic with low EPS and low weight gain potential	80+% patients receive antipsychotic with low EPS and low weight gain potential
9. Guided Antipsychotic Reduction: Patients who have had positive symptoms for more than one month and have achieved remission for at least one year are offered guided and carefully monitored reduction of antipsychotic medication possibly to the point of discontinuation. Ideally family or significant others are aware.	0-19% eligible patients receive guided reduction of antipsychotic medication.	20-39 % eligible patients receive guided reduction of antipsychotic medication.	40-59% eligible patients receive guided reduction of antipsychotic medication.	60-79% of eligible patients receive guided reduction of antipsychotic medication.	80+% of eligible patients receive guided reduction of antipsychotic medication.

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10. Clozapine for Medication Resistant Symptoms: Use of Clozapine if individual does not respond adequately after two trials of antipsychotics (equivalent to 10 mg Haloperidol, and over 3 month period), one of which is a second generation antipsychotic	< 1 % patients on Clozapine at 2 years	1-3% patients on Clozapine at 2 years	3-5% patients on Clozapine at 2 years	6-8% patients on Clozapine at 2 years	> 8% patients on Clozapine at 2 years
11. Patient Psychoeducation: Provision of at least 12 sessions of semi structured patient psychoeducation / illness management training delivered by appropriately trained clinicians, either to individuals or in group psychoeducation sessions.	0-19% patients receive at least 12 sessions of psychoeducation	20-39% patients receive at least 12 sessions of psychoeducation	40-59% patients receive at least 12 sessions of psychoeducation	60-79% patients receive at least 12 sessions of psychoeducation	80+% patients receive at least 12 episodes of psychoeducation
12. Family Education and Support Provision of individual or group family education and support covering a structured curriculum. At least 8 sessions delivered by an appropriately trained clinician	0-19% families receive at least 8 sessions of family education & support over 1 year	20-39% families receive at least 8 sessions of family education & support over 1 year	40-59% families receive at least 8 sessions of family education & support over 1 year	60-79% families receive at least 8 sessions o family education & support over 1 year	80+% families receive at least 8 sessions of family education & support over 1 year

	1	2	3	4	5
13. Individual Cognitive Behaviour Therapy, delivered by an appropriately trained professional, for Treatment Resistant Positive Symptoms or for Residual Anxiety or Depression: CBT is an evidence based treatment that is indicated for treatment resistant positive symptoms or for anxiety or depression after acute treatment of psychosis	0-15 % patients participated in at least 10 sessions of CBT	16-20 % patients participated in at least 10 sessions of CBT	21-25% patients participated in at least 10 sessions of CBT	26-30 % patients participated in at least 10 sessions of CBT	> 30% patients participated in at least 10 sessions of CBT
14. Individual and / or Group Interventions to Prevent Weight Gain: At least 10 sessions to provide following evidence-supported programs: nutritional counseling, cognitive behavioral therapy and exercise and medication options.	All patients have their weight recorded. Feedback and wt. management advices not pattern of practice	All patients have weight recorded. Feedback and wt., management part of routine clinical discussions about health	0-19 % patients participated in at least 10 sessions of structured weight management program	20-29 % patients participated in at least 10 sessions of structured weight management program	>30 % patients participated in at least 10 sessions of structured weight management program
15. Annual Formal Comprehensive Assessment Documented: Includes assessment of: 1. Educational, occupational and social functioning; 2. Symptoms; 3. Psychosocial needs; 4. Risk assessment of harm to self or others; 5. Substance use; 6. Metabolic parameters (weight, glucose and lipids); and, 7. Extrapyramidal Side Effects.	7 assessment items found in 20 – 30% of annual assessments	7 assessment items found in 31-39% of annual assessments	7 assessment items found in 40-59% of annual assessments	7 assessment items found in 60-79% of annual assessments	7 assessment items found in 80+% of annual assessments

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16. Assigned Psychiatrist: Each patient has an assigned psychiatrist who can see patients up to once every two weeks as medications are being adjusted	Psychiatrist works with > 60 patients per 0.2 FTE	Psychiatrist works with 50 - 59 patients per 0.2 FTE	Psychiatrist works with 40 - 49 patients per 0.2FTE	Psychiatrist works with 30 - 39 patients per 0.2 FTE	Psychiatrist works with < 29 patients per 0.2 FTE
17. Assignment of Case Manager : Patient has an assigned professional who is identified as the person who delivers Case Management Services	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
18. Motivational Enhancement or Cognitive Behavioral Therapy for Co-Morbid Substance Use Disorder (SUD): Patient with co-morbid SUD receives 3 or more sessions of Motivational Enhancement (ME) or Cognitive Behaviour Therapy (CBT)	0-19% patients with SUD receive at least three sessions of either ME or CBT	20-39% patients with SUD receive at least three sessions of either ME or CBT	40-59% patients with SUD receive at least three sessions of either ME or CBT	60-79% patients with SUD receive at least three sessions of either ME or CBT	80 + % patients with SUD receive at least three sessions of either ME or CBT
19. Supported Employment (SE): SE is provided to patients interested in participating in competitive paid employment by an Employment Specialist who is part of the FEPS team and works in a high fidelity SE service.	Program staff do not actively assess work interest of patients and do not encourage a return to work	Documented assessment of patient interest in work and encourage patients to apply for jobs	Documented referral to an employment program that does not provide high fidelity SE services	Documented assessment of work interest and referral to supported employment program that provides high fidelity SE services	Documented assessment of work interest engagement by ES who is part of FEP team and provides high fidelity SE services

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20. Active Engagement and Retention: Use of proactive outreach with community visits to reduce missed appointments, engage individuals with FEP.	0- 9% of all patient and family visits are out-of-office visit to facilitate engagement	10-19% of all patient and family visits are out-of-office visit to facilitate engagement	20-29% of all patient and family visits are out-of-office visit to facilitate engagement	30-39% of all patient and family visits are out-of-office visit to facilitate engagement	>40 % of all patient and family visits are out-of-office visit to facilitate engagement
21. Community Living Skills: Program works in the community, in addition to the office, to develop community living skills for those in need (i.e. social activities, using transportation, renting, banking, budgeting, meal planning)	0-19% of all patients receive community living skills training delivered in community setting	20-39 % of all patients receive community living skills training delivered in community setting	40-59 % of all patients receive community living skills training delivered in community setting	60-79 % of all patients receive community living skills training delivered in community setting	>90 % of all patients receive community living skills training delivered in community setting
22. Crisis Intervention Services: FEP Service delivers crisis services or has links to crisis response services including crisis lines, mobile response teams, urgent care centres or hospital emergency rooms	Team provides no crisis services to patient or family. No out of hours services or formal linkages to out of hours services	Team provides telephone crisis advice up to 8 hrs per day 5 days per week but no linkage to out of hours crisis services	Team provides telephone crisis advice up to 8 hrs per day 5 days per week and linkage to out of hours crisis services such as crisis lines and urgent care centres or emergency rooms	Team provides telephone crisis outreach up to 8 hrs per day 5 days per week and linkage to out of hours crisis services such as crisis lines and urgent care centres or emergency rooms	Team provides 24 hr crisis outreach services per day, 7 days per week

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Evidence Based Team Practices	1	2	3	4	5
23. Participant/Provider Ratio Target ratio of active patient /provider i.e. team members 20:1	51+ patients/ provider FTE	41-50 patients/ provider FTE	31-40 patients/ provider FTE	21-30 patients/ provider FTE	20 or fewer patients/ provider FTE
24. Practicing Team Leader: Masters Level Team Leader has administrative, supervisory responsibilities and provides direct clinical services	Team leader provides only administrative managerial direction. No responsibility to ensure clinical supervision	Team leader provides administrative direction and ensures clinical supervision by others	Team leader provides administrative direction and supervision to some staff	Team leader provides administrative direction and supervision to all staff	Team leader provides administrative direction and supervision to all staff and some direct clinical service
25. Psychiatrist Role on Team: Psychiatrists are team members who attend team meetings, see patients with other clinicians and are accessible for consultation by team during the work week.	Psychiatrist does not attend team meetings, sees patients in a separate location and does not share same team health record as FEP clinicians	Psychiatrist does not attend team meetings but sees patients at team location and shares team health records. Does not see patients with other program clinicians. Is not available for consultations	Psychiatrist attends team meetings, does not see patients with other clinicians. Shares team health record but is not available for consultations with staff	Psychiatrist attends team meetings, sees patients with other clinicians, shares same health record but is not available for consultations with staff	Psychiatrist attends team meetings, sees patients with other clinicians, shares same health record and is available for consultations with staff.

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26. Multidisciplinary Team: Includes qualified professionals to provide both case management and specific service elements including: 1. Nursing services; 2. Evidence Based Psychotherapy; 3. Addictions services; 4. Supported Employment; 5. Family Education and Support; 6. Social and community living skills; and 7. Case management.	Team delivers 3 or fewer of listed elements	Team delivers 4 of the listed elements	Team delivers 5 of the listed elements	Team delivers 6 of the listed elements	Team delivers 7 of the listed elements
27. Duration of FEP Program: Mandate of FEP Program is to provides service to patients for specified period	FEP program serves patients for 1 year or less	FEP program serves patients for 1 year to 2 years	FEP program serves patients for 2 years to 3 years	FEP program serves patients for 3 years to 4 years	FEP program serves patients for 4+ years
28. Weekly Multi-Disciplinary Team Meetings: All team members attend weekly meetings with focus on: 1. Case review (admissions & discharges); 2. Assessment and treatment planning; 3. Discussion of complex cases; & 4. Termination of services	No team meetings held	Monthly team meetings	Team meetings held more often than once a month, but less often than every two weeks	Bi-weekly team meetings	Weekly team meetings

29. Targeted Health / Social Service/ Community Group: Provision of information to first-contact individuals, in health, education social agencies and community organizations.	No targeted education	No team members set aside time do first contact community education on a routine basis but some is occurring	One team member sets aside time do first contact community education on a routine basis but is occurring less than 6 times a year	One team member sets aside time do first contact community education on a routine basis which is occurring 6 to 9 times a year	One or more team member sets aside time do first contact community education on a routine basis which is occurring > 9 times a year
30. Communication Between FEP and Inpatient services: If there is hospitalization of individual currently enrolled in FEP Service, FEP Service staff contact inpatient staff to be involved in discharge planning and arranging outpatient follow up	0-19% of FEP patients who are admitted to hospital are seen at FEP Service within 15 days of hospital discharge	20-39% of FEP patients who are admitted to hospital are seen at FEP Service within 15 days of hospital discharge	40-59% of FEP patients who are admitted to hospital are seen at FEP Service within 15 days of hospital discharge	60-79% of FEP patients who are admitted to hospital are seen at FEP Service within 15 days of hospital discharge	80+% of FEP patients who are admitted to hospital are seen at FEP Service within 15 days of hospital discharge
31. Explicit Admission Criteria: Program has clearly identified mission to serve specific diagnostic groups and uses measurable and operationally defined criteria to select appropriate referrals. There exists a consistent process of screening and documenting of uncertain cases and those with co-morbid substance use.	< 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

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32. Population Served: Program has a clearly identified mission to serve a specific geographic population and uses comparison of annual incidence and accepted cases to assess success in reaching all new incidence cases.	0-19% of incident cases are admitted to FEP service based on annual incidence of 20 per 100,000 aged 15 - 45	20-39% of incident cases are admitted to FEP service based on annual incidence of 20 per 100,000 aged 15 - 45	40-59%of incident cases are admitted to FEP service based on annual incidence of 20 per 100,000 aged 15 - 45	60-79% of incident cases are admitted to FEP service based on annual incidence of 20 per 100,000 aged 15 - 45	80+% of incident cases are admitted to FEP service based on annual incidence of 20 per 100,000 aged 15 - 45