Mental Health Services Act

Evaluation of Outcomes and Associated Costs for Early Psychosis Programs: UC Davis Pilot & Statewide Method Development

Deliverable 5:

Summary Report of Descriptive Assessment of Early Psychosis Program Statewide

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Executive Summary

BACKGROUND: California's Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funds provide a unique opportunity for California counties to initiate programs that strive to intervene early in the course of mental health difficulties, thereby preventing serious mental disorders from becoming severe and disabling. Of the 58 California counties, 14 reported using MHSA funding to establish early psychosis (EP) programs to work towards PEI goals. Based on the scientific literature, EP programs have been associated with improvement in clinical and functional outcomes and lower care-related costs. A comprehensive evaluation of California EP programs could determine potential impacts of these programs on the individuals served, the counties where they are implemented, and the state as a whole as well as provide an evidence base for the development of future programs.

PURPOSE OF CURRENT EVALUATION: This report provides a comprehensive descriptive summary of EP programs statewide — including active programs and programs being planned or implemented — that are funded through public entities (e.g., MHSA, other county funds, federal funds). Information gathered from counties that do not currently have an EP program is also summarized to understand the potential barriers to EP program development in California. This report describes how data (e.g. program costs, program outcomes, client and service characteristics, and potential treatment model fidelity) are being collected by EP programs, a historical timeline for when programs were implemented and started data collection, as well as how data collection systems (e.g. electronic health records, EHRs) are used in each program. The information gathered will be used to 1) develop a method of analysis of program costs, outcomes, and costs associated with those outcomes based on data that could be made available for a future statewide evaluation and 2) propose criteria for EP programs that could be included in a statewide analysis.

METHODS: These data were collected through direct contact with counties to determine program status, the distribution of online assessment tools to determine types of data that have been (or will be) collected, and qualitative interviews with county representatives. California counties identified as having an active EP program completed the California Early Psychosis Assessment Survey (CEPAS), while counties developing programs completed the California Early Psychosis Assessment Survey – Development (CEPAS-D). The CEPAS and CEPAS-D obtain self-report information on established or planned EP program components and potential adherence to the First Episode Psychosis Services Fidelity Scale (FEPS-FS 1.0). Data on the CEPAS and CEPAS-D were collected via the web-based Qualtrics data system. MHSA Coordinators for the counties that do not have EP programs participated in a brief telephone interview. Stakeholders provided input on the methodology, results of the analysis, and potential directions for a statewide evaluation.

RESULTS: The response rate to the CEPAS and CEPAS-D was exceptional, with 97% of active EP programs and 92% of in development programs reporting some data. The majority of programs (96%) reported serving individuals with First Episode Psychosis (FEP) who fall within the "transition age youth" (TAY) age range of 14-25 years, with 82% of programs reporting the potential for moderate to good fidelity to evidence-based practices. Programs reported that an estimated 4769 individuals have been served up to June 2016, with additional individuals assessed and served over subsequent months. Further, 65% of sites reported collecting client-level data on 5 or more relevant outcome domains, yet the comparability of outcomes data elements across sites has yet to be determined. Only 5 counties reported collecting data on the Child and Adolescent Needs and Strengths (CANS) Assessment and/or the Adult Needs and Strengths Assessment (ANSA), as well as the Adult or Child versions of the California Department of Health Care Services' (DHCS) Consumer Survey. Stakeholders highlighted challenges of retrospective design with support for prospective design.

CONCLUSIONS: This descriptive assessment provides essential data on the current landscape of EP programming in California, including information on programs in development. While many counties have collected data on EP programs, retrospective analysis could be hindered by lack of comparability of outcomes measures used by each program, missing data, and lack of follow up data. Stakeholders felt that a prospective approach that gathers data on core data elements could create a learning healthcare network from which all providers could benefit.

NEXT STEPS: Based upon the results of the pilot evaluation, various approaches for a statewide evaluation of EP programs should be considered. To guide the development of a statewide evaluation proposal, subsequent Deliverables will provide additional information on measures used to collect outcomes data by each program, methods for identifying and motivating comparator programs, and methods for supporting participation by EP and comparator programs across the state.

Introduction

Innovative county mental health programs for children and young adults are one of the new service areas implemented after Proposition 63 was passed in California in 2004 and the Mental Health Services Act (MHSA) was established. MHSA funds provide a unique opportunity to improve upon traditional mental health services, which often treat chronic, established disorders and impairment, by supporting Prevention and Early Intervention (PEI) services. PEI programs are intended to reduce negative outcomes that may occur as a result of untreated mental illness, including (1) suicide, (2) incarcerations, (3) school failure or dropout, (4) unemployment, (5) prolonged suffering, (6) homelessness, and (7) removal of children from their homes [1]. Thus, the severe and disabling effects of untreated mental health problems may be prevented.

Early intervention in psychosis (EP) is one type of PEI program that has been implemented across multiple counties in California. A preliminary evaluation conducted by University of California, Los Angeles (UCLA) in 2014 identified 20 out of 58 total counties using MHSA funding to implement EP programs [2]. Though results indicated that EP programs were correlated with improvement in several key outcomes, including school participation and employment, these findings were based on only 8 programs that met the full inclusion criteria for the evaluation. Many programs had been operating for less than two years and often did not have comprehensive data collection procedures in place, limiting the data available for tracking longitudinal outcomes over time. These limitations precluded the evaluators' ability to draw strong conclusions regarding the clinical or fiscal impact of EP programs.

Now that several additional years have passed, there is a new opportunity to evaluate EP programs in California. Previously established programs have matured, while additional counties are considering developing EP programs, supported in part by new Mental Health Block Grant funds from the Substance Abuse and Mental Health Services Administration (SAMHSA)[3], and MHSA funding. The current evaluation seeks to identify and describe the current landscape of EP programming in California and determine their potential impact on the individuals served, the counties where they are implemented, and the state as a whole. The University of California, Davis (UCD) has been commissioned by the California Mental Health Services Oversight and Accountability Commission (MHSOAC) to propose a method for a statewide evaluation to examine program costs (i.e. costs expended to implement the program), outcomes (e.g. decreased hospital visits), and costs associated with those outcomes (e.g. costs associated with hospitalization) related to EP programs in California.

To date, the UC Davis research team has submitted the *Summary Report of Descriptive Assessment of SacEDAPT Early Psychosis Program* (Deliverable 1); *Proposed Methodology for Analysis of Program Costs, Outcomes, and Costs Associated with those Outcomes in the SacEDAPT/Sacramento County Pilot* (Deliverable 2); and the *Report of Research Findings for SacEDAPT/Sacramento County Pilot: Implementation of Proposed Analysis of Program Costs, Outcomes, and Costs Associated with those Outcomes* (Deliverable 3) and *Proposed Plan to Complete the Descriptive Assessment of Early Psychosis Programs Statewide* (Deliverable 4). The current report summarizes the findings of a descriptive evaluation of all EP programs currently active or in development in California, focusing on those that are funded through public entities. The summary describes data across several domains related to program characteristics and components, types of data collected, and funding sources. Collection of this descriptive information will facilitate the development of a methodology to identify program costs, outcomes, and costs associated with those outcomes at a statewide level in future deliverables.

Review of the Literature: Early Psychosis Program Models, Fidelity and Associated Outcomes

In order to accurately evaluate EP programs in California, it is necessary to first define what constitutes an EP program and then identify programs that meet the EP definition. This includes establishing the required components that comprise the EP treatment model and subsequently assessing each program's level of fidelity to that model. Once a program reaches a level of fidelity to the EP model, it is appropriate to consider the costs and outcomes associated with that program as part of a larger statewide evaluation.

Early Psychosis Treatment Model

Several countries have adopted EP programs to serve individuals experiencing the early onset of a psychotic illness, including the United States, Canada, Australia, and European countries. The size and structure of these programs often varies to accommodate the unique needs of each local population [4]. While some countries have reached consensus on the specific state or national standards by which EP programs must perform [5-8], EP programs within other countries–including the United States—typically follow guidelines for suggested practices that are targeted at ameliorating impairments that are core to EP [9-15]. While there might be slight variations, all of these EP models have core components, considered to be "best practices" for U.S. programs [11], which will be discussed here.

EP best practices include 1) outreach, 2) assessment, and 3) team-based treatment. Outreach and education is provided to local communities to decrease stigma, improve awareness of the early signs of psychosis, and facilitate rapid referral to treatment. Proactive outreach targets consumers, families, existing treatment programs, related systems, and first responders who may be in a position to identify and refer potential clients. A comprehensive, interview-based assessment is conducted to determine whether individuals meet specific EP program eligibility criteria. Assessment results are then used to inform appropriate treatment plans. Once accepted into an EP treatment program, consumers are offered targeted evidenced-based treatment from an interdisciplinary team, which is referred to as "coordinated specialty care" (CSC) [11]. Components of CSC include case management and coordination; ongoing psychiatric and/or medical assessments and treatment; client and family education, support, and therapy; crisis intervention, and relapse prevention. In-home visits and outreach to families are utilized in order to keep clients engaged in treatment. Psychotherapy components can be provided in individual, group, or family modalities. Clients are also provided direct support to maintain academic and/or vocational functioning provided by staff who focus on supported education and employment services. Family education helps family members and other support persons to understand and cope with the client's illness and maintain their natural support system, minimizing disruption in the client's life and contributing to the recovery process. In addition to these direct services, EP programs should include data collection procedures to measure impact of treatment and long-term health outcomes. Finally, EP teams work under the leadership of administrative and supervisory staff, who help to ensure that EP program components are being delivered accurately and in a timely fashion.

By providing this combination of treatment components, EP programs aim to 1) reduce the duration of untreated psychosis (DUP) to reduce the severity of subsequent illness, 2) minimize the disruption in an individual's life, and 3) reduce reliance on other mental health or social services.

Early Psychosis Treatment Model Fidelity

Studies in several countries have examined the cost effectiveness of EP treatment programs compared to standard care [16-20]. While a majority of these studies found positive client-level outcomes associated with EP programs, many highlight both a lack of consistency between EP programs in the exact treatment components delivered as well as difficulty measuring adherence to the EP treatment model. These discrepancies may have hindered effective evaluation of the true impact of these programs [21]. The premise

of this argument is that if EP programs are providing different types of treatment and care is provided in an inconsistent fashion, the effect of the treatment will be difficult to detect in the data. Consequently, several fidelity assessment tools have been developed to assess adherence to the EP treatment model both in terms of the presence of all requisite treatment components as well as the degree of fidelity within each component.

In the United States, the Oregon Early Assessment and Support Alliance (EASA) developed a fidelity assessment tool using a panel of experts to assist in program implementation and quality control [9]. Similarly, in the United Kingdom, the National EDEN study relied on an expert committee to develop a fidelity assessment tool [22]. The Recovery After an Initial Schizophrenia Episode Connection Program (RAISE,[15]), in the United States, utilized clinical data collected within the program to create a fidelity assessment tool [23]. While these tools are valuable for their respective programs, they were not developed using a systematic review of the literature, evidence rating, or an international expert panel that would allow standardized fidelity assessments across health systems [24]. To address these issues, The First Episode Psychosis Services Fidelity Scale (FEPS-FS 1.0) [9] was developed using an international expert consensus method, focused on six domains: (1) population-level interventions and access, (2) comprehensive assessment and care plan, (3) individual-level intervention, (4) group-level interventions, (5) service system and models of intervention, and (6) evaluation and quality improvement. This scale was tested for reliability in six EP programs in the United States and Canada and an accompanying FEPS-FS 1.0 Fidelity Review Manual was developed for future program reviews [21, 25]. The FEPS-FS represents one standardized method for assessing EP program fidelity in the US and was used as a foundational component of this descriptive assessment of California's EP programs.

Early Psychosis Program Outcomes and Costs

Previous studies indicate that EP programs are associated with some improvement in clinical and functional outcomes as well as lower care-related costs for individuals experiencing psychosis. However, as the majority of cost effectiveness studies of EP programs report findings in countries other than the United States, additional research is needed to determine if EP programs in the United States demonstrate comparable outcomes and associated costs savings.

Outcome studies of EP programs have demonstrated significant improvements in symptoms, functioning, and quality of life compared to standard care (SC). Consumers who received up to 24 months of EP services showed improvement in symptoms and quality of life in a large U.S. cluster randomized controlled trial of 35 sites [26]. A combined measure of symptoms and global functioning showed significant improvement in a Dutch study after a similar period of treatment in EP programs compared to SC [18]. A Swedish study revealed improvement in positive and negative symptoms in an EP group treated for 36 months compared to SC, but the difference was not statistically significant [16] . A smaller more recent study in the United States showed significant improvement in vocational engagement and reduced hospitalizations in the EP program compared to SC [27].

By improving clinical and functional outcomes, EP programs also seek to reduce the costs associated with care. A reduction in symptom severity is expected to lower the use of inpatient services, emergency department treatment, and non-health community services use such as supportive housing services and criminal justice involvement. Several EP studies outside the United States have found that EP treatment programs cost comparably less than SC programs, demonstrating that the difference in total cost, or *cost difference,* favor EP programs due to the comparative cost savings when examining total average annual costs of treatment [13, 17, 19, 20]. A single U.S. study found that EP treatment was associated with increased costs in comparison to SC treatment [21]. However, the authors conclude that the increased expenses associated with EP treatment can be justified, as the benefits of EP treatment outweigh the costs due to the increased level of functioning exhibited in the EP individuals.

Review of the Literature: Conclusion

Developing a methodology for a statewide evaluation of program outcomes and costs for EP programming first requires a description of the EP programs within California, including active programs and programs in development. To do this in a systematic fashion, we conducted a preliminary assessment of program components based upon established EP best practice guidelines [11]. Further, we conducted a preliminary evaluation of program fidelity focused on identifying the potential presence or absence of components set forth by the FEPS-FS 1.0 scale. This descriptive assessment of EP programs in California will provide the foundation for the proposal of a statewide evaluation method.

Review of Previous Deliverables on this Project:

Review of Deliverable 1

The overarching goal of this project is to develop a method for evaluating EP programs across California. Deliverables 1 through 3 utilized data from Sacramento County and the UC Davis (UCD) SacEDAPT Clinic - a California MHSA-funded EP program - for a demonstration project and pilot evaluation that served to support the feasibility of the proposed statewide analysis. In Deliverable 1, we conducted a preliminary examination of potential outcomes and costs associated with participation in an EP program and identified multiple variables for consideration as part of the evaluation. We identified costs associated with EP program implementation as well as sources of funding for the program, including funding from the county, state, or federal government. We identified a preliminary list of eight outcome variables that would be associated with or impacted by participation in the program: (1) healthcare utilization, (2) justice involvement, (3) homelessness, (4) education, (5) income and employment, (6) social and family relationships, (7) clinical disability, and (8) suicide. Finally, we identified potential mediating variables that may affect the costs associated with program implementation as well as the outcomes that are achieved by program participation.

Review of Deliverable 2

In Deliverable 2, we proposed a methodology and data sources for the pilot evaluation of the UCD SacEDAPT Clinic, which would serve as the basis for the development of the analytic approach for the statewide evaluation. Through collaboration with Sacramento County Department of Health and Human Services (Behavioral Health Services), we identified a comparable community-based organization that is contracted by Sacramento County to provide outpatient mental health services for children (up to 21 years of age) and adults with serious mental health issues to serve as a comparator group for the proposed pilot analysis. Through a stakeholder engagement process, we revised our list of potential outcomes as well as our data sources to identify all possible ways in which outcomes of interest could be measured within Sacramento County. The list of outcomes and measures proposed in Deliverable 2 were selected based on the availability of the same electronic data for individuals who received services within UCD SacEDAPT or the comparator outpatient clinic. We proposed that Sacramento County would provide the research team with de-identified data from the UCD SacEDAPT Clinic and the comparator clinic for this analysis. This de-identified data set would include 1) individuals who were treated by UCD SacEDAPT and 2) a comparable sample of individuals who were treated by the comparator outpatient clinic. Additionally, we identified individual- and program-level variables that may affect program outcomes or the costs associated with program implementation or outcomes observed. Methods were proposed for the outcomes and costs analysis.

Review of Deliverable 3

In Deliverable 3, we presented the results of our pilot evaluation examining the outcomes and costs associated with individuals treated in the Sacramento County EP program (UC Davis SacEDAPT) compared with individuals receiving mental health care services from clinics providing “standard care” (SC). The project's primary goal was to demonstrate the feasibility of using existing data to conduct a statewide evaluation of costs

and outcomes of people enrolled in EP programs versus SC programs, in which the SC programs served as the comparator group (CG). Sacramento County provided a de-identified, retrospective dataset representing individuals served by both programs (EP and CG) from for a concurrent time frame in the same community. Analyses examined outcomes related to healthcare utilization, physical health, justice involvement, homelessness, education, employment, peer and family relationships, clinical disability, substance use, and suicidality. Associated cost analyses examined costs related to inpatient psychiatric hospitalization, crisis stabilization, and outpatient service utilization. Stakeholders from an array of relevant areas provided input on the methodology and the results of the pilot analysis. Although various factors limited our ability to draw strong conclusions about the impact of the EP program on costs and outcomes, this pilot project demonstrated the feasibility of evaluating EP programs and highlighted the potential outcomes that could be evaluated using existing and accessible data. Further, the demonstration of the proposed evaluation methodology identified several issues that we are considering as we develop a methodology for a statewide evaluation.

Review of Deliverable 4

To guide the development of a statewide evaluation proposal, Deliverable 4 proposes a method for a descriptive assessment of California EP programs based on a survey that evaluates populations served, program components and potential fidelity, funding sources, and availability of outcomes data. We proposed to examine currently operational EP programs, as well as programs that are in development, to understand the full landscape of EP programming available in California. We also proposed a brief evaluation of counties that do NOT currently have an EP program to understand the potential barriers to EP program development in California. This information will serve as the foundation for the development of the statewide evaluation proposal, including potential criteria for EP programs that could be included in a statewide analysis. Stakeholder engagement was essential to understand how best to gather this information from EP programs, as well as support participation in a larger statewide evaluation.

Deliverable 5: Summary Report of Descriptive Assessment of Early Psychosis Programs Statewide

This report provides a summary of the descriptive assessment of EP programs statewide, including both established programs and programs currently being planned in California. While we identified all available programs to understand the current status of EP programming in California, the descriptive summary will focus on programs that are funded through public entities (e.g. MHSA, other county funds, federal funds). We also summarize information gathered from counties that do not currently have an EP program to understand the potential barriers to EP program development in California. This report describes how data (e.g. program costs, program outcomes, client and service characteristics, and potential treatment model fidelity) are being collected, a historical timeline for when programs were implemented and started data collection, as well as how data collection systems (e.g. electronic health records, EHRs) are used in each program. The information gathered will be used to 1) develop a method of analysis of program outcomes and costs associated with those outcomes based on data that could be made available for a future statewide evaluation and 2) propose inclusion criteria for EP programs that could be included in a statewide analysis.

Approach to Identifying and Describing State Early Psychosis Programs

The goal of this deliverable is to implement the methodology described in *Proposed Plan to Complete the Descriptive Assessment of Early Psychosis Programs Statewide* (Deliverable 4). Within this deliverable, we:

1. Provide a summary of the descriptive assessment of EP programs statewide, including, but not limited to, identifying and describing all EP programs currently being planned or implemented in California funded through public entities (e.g., MHSA, other county funds, federal funds) and the types of data (e.g., program costs, program outcomes, client and service characteristics, fidelity) and data collection systems (e.g.,

EHRs) used by each program.

2. Identify and describe existing data or data that is intended to be collected that will be relevant toward development of a proposal of a statewide evaluation of EP programs. Information to be collected shall include, but not be limited to, the following:
    a. Information on time-related parameters regarding program implementation, program-level data, and data collection systems that may impact the proposed future statewide evaluation (e.g., When are planned programs scheduled to be implemented? Is the data that is being collected now likely to be collected in the same manner in the future? What data has been collected prior to program implementation? Is the county/program planning or considering any changes to data collection methods? Is the county/program in the process of implementing an EHR, or are they currently using one?).
    b. Information that will enable selection of programs for inclusion in a future statewide evaluation to be used within the Development of the Statewide Evaluation Plan.
3. Identify and develop a list of relevant county/provider staff (and their contact information) who can assist with this project and the future statewide evaluation (e.g., staff who can provide access to data/information; staff who can serve as subject matter experts).
4. Collect information on strategies to support counties/providers in their participation of a future statewide evaluation (i.e., the Contractor shall generate ideas based on feedback from counties/providers for successful ease of participation in the future statewide evaluation by all selected counties).

Research Questions for Deliverable 5

This phase of the project will address the following research questions:

1. What descriptive information and data elements are currently being collected from counties that would facilitate the ability to develop and implement a method to identify and describe all early psychosis programs currently being planned or implemented in California funded through public entities?
2. Within the context of all publicly funded EP programs across the State, what methods are available to identify, describe, and analyze the costs incurred by providing an EP program, the resultant outcomes, and costs associated with those outcomes when providing the program?
3. What methods could be used to encourage successful provider/county participation in the statewide evaluation?

Methods

This report is a descriptive assessment of EP programs statewide. This includes the identification of all EP programs in each California county, the type of data collected, the type of data collection tools used, and the program's funding stream (e.g. MHSA, other county funds, federal funds). These data were collected through direct contact with counties, the distribution of assessment tools to determine types of data that have been (or will be) collected, and qualitative interviews with county representatives.

California County Early Psychosis Program List (EP Program List)

The EP Program List (See Appendix A) was created to establish which California counties have established an EP program (e.g., currently active and enrolling clients), or are in the process of developing an EP program. The list was vetted through a multiphase process which included review of county and stakeholder group (e.g. NAMI) websites, review of MHSA plans, review of the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant applications, and gathering feedback from stakeholders. Additionally, each county was contacted to verify the accuracy of the data collected. As of February 16th, 2017, it was determined that 24 counties have at least one active EP program, 12 counties are in the process of developing an EP program, and 22 do not have, nor are planning to implement, an EP program. A county or

EP program representative was established as a point of contact for each county EP program. This point of contact was then provided the opportunity to complete a corresponding assessment tool and follow-up interview.

California Early Psychosis Assessment Survey (CEPAS)

California counties identified as having an active EP program were asked to complete the California Early Psychosis Assessment Survey (CEPAS). The CEPAS is an online assessment that asks respondents to report on a program's EP components and potential adherence to First Episode Psychosis Services Fidelity Scale (FEPS-FS 1.0) – a standardized measure of fidelity to EP program best practices [20, 24]. The FEPS-FS identifies 31 essential components of EP programs categorized into six domains: (1) population-level interventions and access, (2) comprehensive assessment and care plan, (3) individual-level intervention, (4) group-level interventions, (5) service system and models of intervention, and (6) evaluation and quality improvement (See Appendices C for FEPS-FS 1.0 & Appendix D for CEPAS tool). Data on the CEPAS was collected via the web-based Qualtrics data system. The online assessment includes multiple choice and open-ended questions that focus on ten domains, including:

- Age range of clients, types of DSM diagnoses served, and if programs serve first-episode psychosis (FEP) clients and/or clinical high-risk (CHR) clients.
- Methods of data collection related to relevant client outcomes, including presence of electronic records and the assessment tools used by each program to track client symptoms and treatment.
- Funding sources to support the EP program (e.g. MHSA funding, other state or federal funding) and processes for reimbursement for services they provide within the county.
- Program outreach methods and family involvement in EP treatment.
- Treatment methods offered by each program such as individualized treatment plans, psychotherapy, and/or the development of multi-disciplinary care teams.
- Type of pharmacotherapy the program offers.
- Administrative components of the EP program including ratio of Full Time Employees (FTE) to clients, types of licensed clinicians on the program's treatment team, and types of supervision and management provided.
- Use of measurements considered for inclusion in the PhenX (consensus measures of Phenotypes and Exposures) toolkit, a catalog of recommended, standard measures of phenotypes and environmental exposures for use in biomedical research [28].
- A single open-ended question regarding any challenges or barriers in implementing the EP program.
- Program representatives' opinions on how important different components of evidence-based practice according to the FEPS-FS [21, 25] are in the treatment of FEP in California.

If a county has more than one program, or is in the process of planning an additional EP program, the representative was asked to complete separate surveys to capture the nuances between programs. Each program or county representative was provided two weeks to complete the CEPAS (and CEPAS-D if also planning an additional program, see description below). If the representative failed to respond to the email, up to three courtesy calls were administered and additional reminder emails (including the county's MHSA representative) were sent to encourage assessment completion. Once the surveys were received, county representatives were then contacted to clarify any unclear responses, discrepancies in in the data, or resubmit any missing data, where necessary.

California Early Psychosis Assessment Survey – Development (CEPAS-D)

California counties that have an EP program in development were provided the opportunity to complete the California Early Psychosis Assessment Survey – Development (CEPAS-D). Counties are considered to have a

program in development if: 1) the EP program is staffed but has not started enrolling clients, 2) is funded but is still in the process of developing the program, 3) lacks funding but is in the planning and preparation phase, or 4) the county is interested in developing a program but has yet to begin planning a program (e.g. identified as a priority in the MHSA planning process).

The CEPAS-D is similar to the CEPAS as it examines program components that counties are *expecting* to include in EP programs. Like the CEPAS, the CEPAS-D includes multiple choice and open-ended questions. The CEPAS-D asks respondents to report on 27 of the 31 criteria included the FEPS-FS 1.0 assessments and is distinguishable from the CEPAS in that it does not have four FEPS-FS questions related to the content of individualized care plans, coordination between the EP program and inpatient services, or the PhenX Toolkit. These items were not included because they represent detailed component characteristics that programs may not be considering while in the development process. In addition, the section of FEPS-FS 1.0 which sought opinions on the importance of different components of evidence-based practice in FEP treatment was excluded, given the absence of an active program meant that any opinions on component importance or effectiveness to this site would be theoretical, rather than based on first-hand experiences. Data on the CEPAS-D was collected via the web-based Qualtrics data system (see Appendix E).

If a county was planning to implement more than one program, the county representative was asked to complete a CEPAS-D for each one to capture the nuances between programs. Each county representative was provided two weeks to complete the CEPAS-D. If the representative failed to respond to the email, up to three courtesy calls were administered and additional reminder emails (including the county's MHSA representative) were sent to encourage assessment completion. Once the surveys were received, county representatives were then contacted to clarify any unclear responses, discrepancies in in the data, or resubmit any missing data, where necessary.

County MHSA Program Coordinator Interview

Counties that were identified as not having an EP program, either active or the development stage, were also contacted to collect data regarding the barriers and challenges that may be preventing the statewide implementation of EP programs.

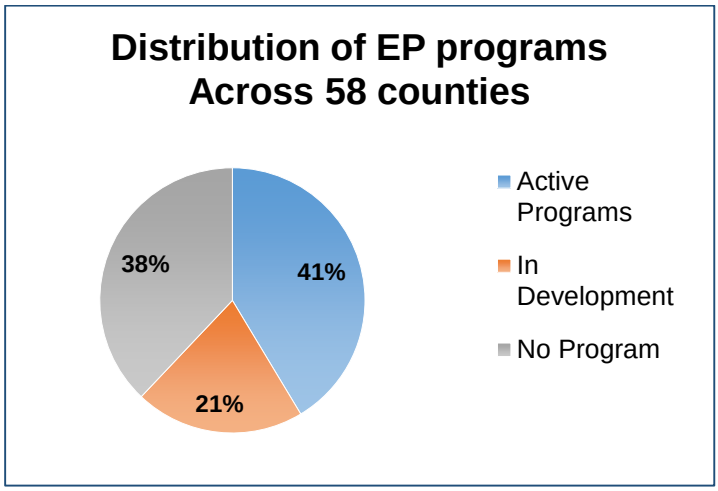
Based on the EP Program List, the MHSA Coordinators for the 22 counties that do not have EP programs (either active or in development) were asked to participate in the County MHSA Program Coordinator Interview. If the coordinator could not participate or was unable to provide the feedback, the interview was referred to the Behavioral/Mental Health Director, or a Behavioral/Mental Health Analyst, depending on county structure and staff availability. The interview consists of open ended questions to determine whether an EP program has been identified as a priority by relevant county stakeholders; if any barriers to implementing an EP program exist; details on the current structure of existing mental health services in the county; whether staff had received training on EP program delivery; and whether any additional support would be required in order implement an EP program in the future (see Appendix F).

Each county representative was contacted via phone or email to schedule an interview. When contact could not be established with a county up to three courtesy calls were administered and additional reminder emails (including to the county's MHSA representative) were sent to encourage participation.

Results

The proportion of counties in California that have an active EP program, are currently in the process of developing an EP program, or do not currently have an EP program is presented in Figure 1. Twenty-four counties (41%) reported having at least one active program, 12 (21%) reported having programs currently in development, while 22 counties (38%) reported having no EP program, either active or in development.

Figure 1. Distribution of EP programs across 58 counties



Counties with Active EP Programs

Across the 58 counties in California, 30 active EP programs were identified, with 24 counties reporting to have at least one active EP program. Four counties have two active programs (Sacramento, San Diego, San Francisco, Santa Clara), and one county (Los Angeles) has three active programs. Twenty-eight of the 30 programs provided complete data on the CEPAS (93%), and one county (San Joaquin) provided partial data.

In the five counties (Los Angeles, Sacramento, San Diego, San Francisco, and Santa Clara) where multiple EP programs were identified, these additional programs did not report receiving public funding (e.g., MHSA funding, Medi-Cal, or the SAMSA Mental Health Block Grant). As a result, these EP programs were excluded from all subsequent analysis. A list of all 30 the programs identified, including the six programs that have been excluded from the analysis and the two programs that only provided partial data, are presented in Table 1.

Table 1. Counties with Active EP Programs

County	Program Name
Alameda	Prevention and Recovery in Early Psychosis (PREP) Alameda
Contra Costa	First Hope
El Dorado	First Episode Psychosis (FEP)
Fresno	First Onset Team
Imperial	MHSA-Transitional Engagement Supportive Services - PIER Model
Los Angeles	Early Psychosis Intervention
Los Angeles †	UCLA Aftercare Research Program
Los Angeles †	UCLA CAPPS Program
Madera	First Episode Psychosis Peer Support
Merced	First Episode Psychosis Program
Monterey	Prevention and Recovery in Early Psychosis (PREP) Monterey
Napa	Napa Supportive Outreach & Access to Resources (SOAR)
Orange	Orange County Center for Resiliency, Education, and Wellness (OC CREW)
Sacramento	UC Davis SacEDAPT Clinic
Sacramento †	UC Davis EDAPT Clinic

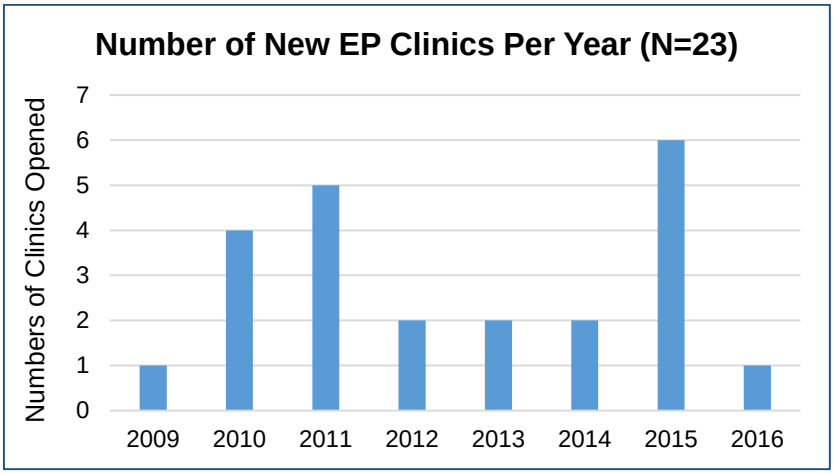
San Diego	Pathways – Kickstart
San Diego †	Cognitive Assessment and Risk Evaluation (CARE) Early Psychosis
San Francisco	Prevention and Recovery in Early Psychosis (PREP) San Francisco
San Francisco †	UCSF Early Psychosis Clinic
San Joaquin ‡	Telecare Early Intervention Recovery Services
San Luis Obispo	Campus Residential Crisis Program (CRCP)
San Mateo	Prevention and Recovery in Early Psychosis (PREP)/BEAM San Mateo
Santa Barbara	Behavioral Wellness Transition Age Youth Program
Santa Clara†	Inspire Clinic – Stanford University
Santa Clara	Raising Awareness and Creating Early Hope (REACH) Program
Shasta	MHSA PEI Early Onset of Psychosis
Solano	Solano Supportive Outreach & Access to Resources (SOAR)
Stanislaus	LIFE Path
Ventura	Ventura Early Intervention Prevention Services (VIPS)
Lake*	First Episode Psychosis

** Counties that did not respond to the survey and were excluded from the analysis.*
† Excluded programs due to funding sources (not publicly funded).
‡ Only partial data received.

Timeline of Program Implementation

As shown below in Figure 2, 23 publicly funded EP programs have been implemented in California since 2009. San Francisco was the first county to open a publicly funded EP Program in 2009, followed by four more programs in 2010 (in Alameda, Fresno, San Diego and Santa Barbara Counties) and an additional five in 2011 (Orange County, Sacramento, Santa Clara, Stanislaus and Ventura County). The most programs to be opened in any one year was in 2015, with six clinics opened during that year (Imperial, Madera, Merced, San Joaquin, San Luis Obispo and Solano County).

Figure 2. Number of publicly funded EP programs implemented by fiscal year



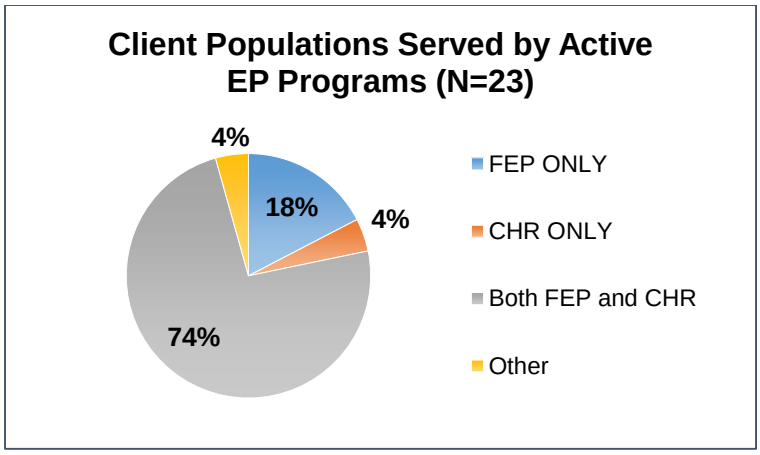
Characteristics of Client Population

Provision of services to FEP/CHR clients: On the CEPAS, programs were asked to indicate the groups of individuals served by their program, including:

- Individuals with first-episode psychosis (FEP) - experience recent onset of psychotic-level hallucinations, delusions, disorganized speech/behavior; meet criteria for DSM Schizophrenia Spectrum Disorders or another DSM disorder with psychotic features; experience positive symptoms at a score of 6 on the SIPS
- Clinical high risk (CHR) or prodromal clients only - experience attenuated/subthreshold hallucinations, delusions, disorganized speech; meet criteria for a clinical high risk diagnosis according to a standardized assessment measure (i.e. SIPS or CAARMS)
- Both FEP and clinical high-risk/prodromal clients

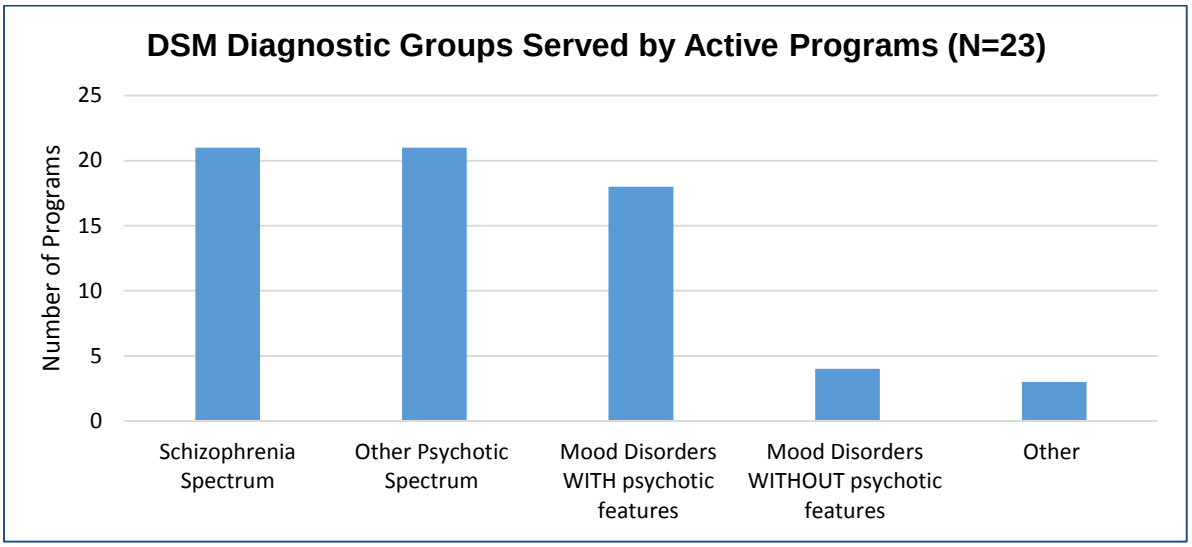
Of the 23 eligible programs that completed the CEPAS, 21 (96%) reported that they provided services FEP clients. Four programs (Alameda, El Dorado, Monterey, and Orange County) reported that their EP program services were only available to FEP clients. Seventy-four percent of programs (N=17) reported that they provide services to both FEP and CHR clients. Noted as "Other" in Figure 3, the Madera program reported that they serve FEP clients, but also serve CHR individuals who are identified by clinician judgment alone (without using a standard assessment measure). Only one program (Contra Costa) reported that at present their program only provides services to CHR clients, with includes individuals with brief but recent onset full threshold psychosis; however, they reported a plan to expand their service provision to include a broader range of FEP clients in the near future.

Figure 3. Client populations served by active EP programs



Diagnoses Served: Figure 4 below represents the breakdown of diagnoses served by 23 the active EP programs. Of the 23 programs, 21 (91%) report that they currently provide services to clients with a diagnosis of a Schizophrenia Spectrum Disorder (e.g. Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder). Twenty-one programs (91%) also reported that they provide services to clients diagnosed with any Psychotic Spectrum Disorder (e.g. Psychotic Disorder Not Otherwise Specified (NOS), Brief Psychotic Disorder, Delusional Disorder), while one program (San Francisco) reported providing services for Psychotic Disorder NOS only. Eighteen EP programs (78%) reportedly serve clients diagnosed with Mood Disorders (e.g. Major Depressive Disorder, Bipolar Disorder) with psychotic features, and four programs (17%) serve clients with a diagnosis of Mood disorders without psychotic features. One EP program (San Mateo) reported that they only provide services to clients diagnosed with Mood Disorders if they meet criteria for Bipolar Disorder I, either with or without psychotic features. Regarding any other diagnoses, one program (San Diego) reported providing services to clients diagnosed with Anxiety Disorders.

Figure 4. Number of programs which provide services to different types of DSM diagnostic groups



Exclusion Criteria: The exclusion criteria adopted by each program are presented in Table 2. The most commonly reported reason for exclusion from EP services was not being a county resident (78% of programs), followed by intellectual disability (74% of programs). Regarding substance abuse, 15 programs (65%) reported excluding potential clients from receiving services due to a diagnosis of substance-induced psychotic disorder, and nine programs (39%) reported excluding individuals due to substance dependence

Table 2. Exclusion criteria adopted by active programs.

Exclusion Criteria:	TOTAL	%
Axis II diagnosis (e.g. personality disorders)	0	0%
Intellectual disability (i.e. IQ under 70)	17	74%
Substance use disorder (of any kind)	0	0%
Substance dependence only	9	39%
Substance-induced psychotic disorder	15	65%
Not county resident (where program is located)	18	78%
No specific exclusion criteria (we serve everyone)	0	0%
Other	6	26%

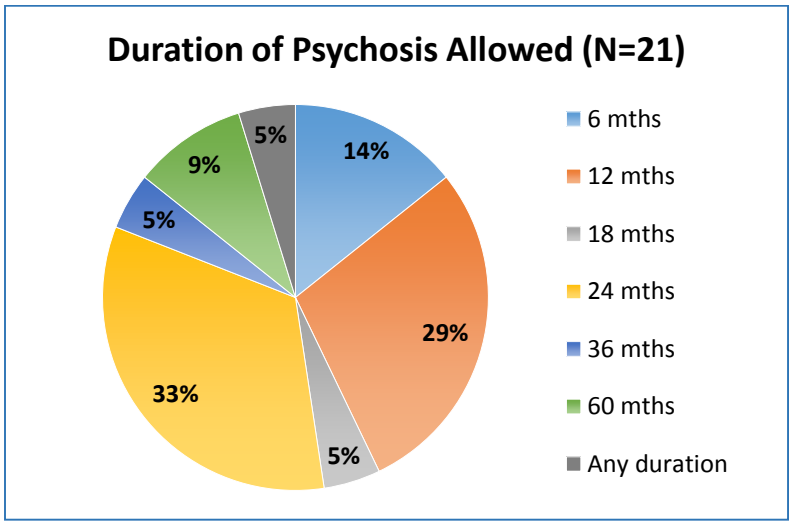
Twenty-three programs reported information regarding additional exclusion criteria based on insurance or undocumented resident status (Table 3). Almost all programs reported that they provided services to uninsured clients (87%), and/or undocumented clients (83%). Sixteen programs currently report providing services to privately insured clients (70%), while only two programs reported that they do not serve any of these types of clients (9%).

Table 3. Insurance and documentation status as criteria for eligibility

Eligibility for Certain Client Populations	TOTAL	%
Uninsured clients	20	87%
Undocumented clients	19	83%
Private insurance clients	16	70%
We do not serve any of these types of clients	2	9%

Duration of Psychotic Symptoms: In total, 21 of 23 programs provided information on the maximum duration of psychotic symptoms that they would assess for and use to determine eligibility for program services (Figure 5). The most frequently adopted maximum duration of illness was 24 months, which was reported by 7 programs (Alameda, Fresno, Napa, Orange, Sacramento, San Mateo, Solano). In six programs, a shorter maximum duration of 12 months was reported (Imperial, Los Angeles, San Joaquin, Santa Barbara, Santa Clara, Stanislaus), and three programs reported using 6 months (El Dorado, Merced, San Diego). At the longer end of the spectrum, one program reported 18 months (Ventura), one program reported 36 months (San Luis Obispo), and 2 programs reported 60 months (Monterey, San Francisco).One program stated they typically seeing clients within the first 12 months of illness, but reported no explicit maximum duration of psychotic symptoms as an exclusion criterion (Shasta). Two programs did not respond to this item (Contra Costa, Madera). Excluding the programs with no specified duration of illness criteria, the reported range of psychotic symptom duration was 6 to 60 months, with an average of 21 months.

Figure 5. Duration of psychotic symptoms used to determine eligibility for EP program services



Ages Served: In all 23 county programs that completed the CEPAS, a minimum and maximum age was reported as part of the inclusion criteria. The most frequent minimum age for inclusion was 14 years, reported by 6 programs (El Dorado, Los Angeles, Monterey, San Mateo, Solano, Stanislaus). Over the different programs, the minimum age inclusion criteria ranged from 8 to 18 years, with an average of 13.8 years. The most frequently adopted maximum age limit to be eligible for services was 25 years, reported by 14 programs (Contra Costa, El Dorado, Imperial, Los Angeles, Orange, San Diego, San Joaquin, San Luis Obispo, Santa Barbara, Santa Clara, Shasta, Solano, Stanislaus, Ventura). The maximum age inclusion criteria ranged from 24 to 35 years, with an average of 27.3 years.

Characteristics of Program Services & Potential Fidelity to CSC Model.

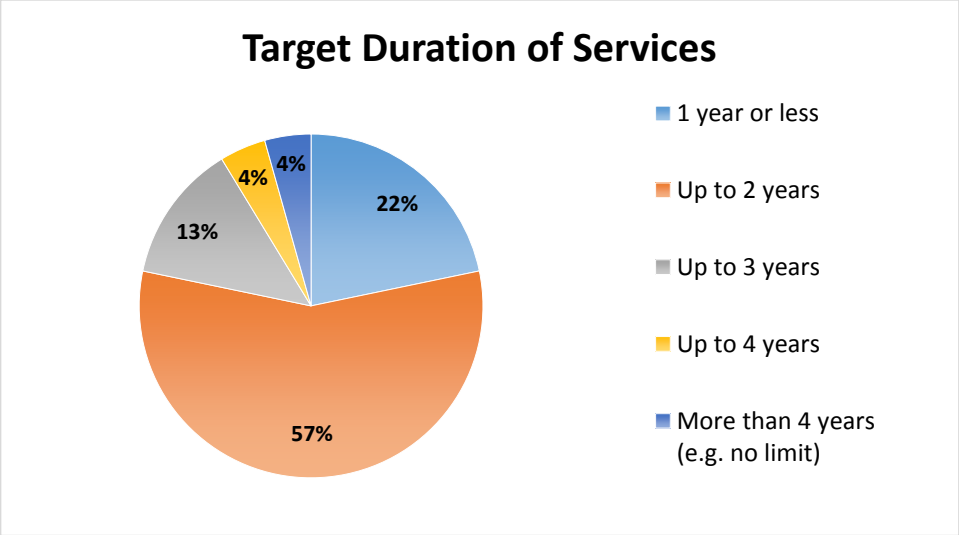
Location of EP Program: Out of 23 programs that responded, 12 EP programs (57%) reported were a stand-alone/independent program (e.g. own site) associated with an established program/agency that provides oversight and support. Six programs (26%) reported that they were integrated within another program (e.g. shared space, staff, and management). Two programs (10%) reported they were a stand-alone/independent program with their own site, staff, management, oversight. Santa Clara reported that their program is located in a "shared site," but with own staff and management within an established agency."

Approximate number of clients served: Programs were asked to report 1) the approximate number of clients evaluated for eligibility (e.g. intake evaluations) per month and 2) the approximate number of clients engaged in ongoing treatment (e.g. therapy, groups, med management) each month (i.e. monthly census of clients

active in treatment). Across the 23 programs that provided data, a median of 6 individuals would receive eligibility evaluations per program per month (mean = 13; IQR = 3 - 19), which yields approximately 72clients per program per year. Further, each program reported that 33 individuals (median) would receive services per month (23 programs reporting; mean = 44, IQR = 13 - 45), which would yield approximately 396 clients per program per year. Programs also were asked to report the total number of clients they served between their start date (which varied across programs) and June 2016. Responses from 23 programs indicate that approximately 4769 clients have been served by EP programs prior to June 2016 (median per program = 98; mean = 217; IQR = 39 - 242).

Duration of Services provided: Over 23 programs, the target length of service delivery reported by each EP program is presented in Figure 6. In the majority of programs (57%), the target duration of services was reported to be up to two years. Five programs (22%) reported a target of less than 1 year, three programs (13%) reported a target of three years (4%), and one program reported a target of up to four years (4%). In one program (Shasta), it was reported they do not have a target duration of services, with treatment available indefinitely based on need.

Figure 6. Target duration of services for eligible clients



Implementation of Established CSC Models: Over the past decade, variations on the Coordinated Specialty Care model have developed in California and other states. These models tend to include the core components of CSC care with individual variations depending on the setting. Over the 23 different programs, a number of different CSC models were found to be implemented (see Table 4 below). The most frequently adopted model was reported to be the Maine PIER model (26%), followed by the Felton Institute PREP model (4 programs, 17%). The UC Davis EDAPT model has been adopted in four programs. The RAISE model is being implemented in three programs, while the Oregon-based EASA model has been adopted in two programs. Two programs reported using “Other” models; Los Angeles reported to be using the UCLA CAPPS model, and Madera reported that they were using a “peer supportive service” within a full-service partnership to support linkage to medications and therapy.

Table 4. Established CSC models used by active EP programs

CSC Model Implemented	TOTAL	%
PREP	4	17%
PIER	6	26%

EDAPT	4	17%
EASA	2	9%
RAISE	3	13%
Other	2	9%
Uncertain	2	9

Potential Fidelity to CSC Approach: The FEPS-FS 1.0 was incorporated into the CEPAS because it represents a standardized measure of fidelity to EP program best practices. However, where the FEPS-FS 1.0 explicitly seeks to determine the level of adherence to the model for each component (e.g. what percentage of clients receive a particular model component, such as individual psychotherapy), the CEPAS simply asks respondents to report potential presence or absence of FEPS-FS components to provide an initial overview of each EP program. Relevant portions were adapted from the FEPS-FS 1.0 to permit a preliminary assessment of which programs have the potential for reasonable fidelity so that fidelity can be fully assessed as part of the statewide evaluation. The FEPS-FS 1.0 evaluates 31 components of EP programs categorized into six domains: (1) population-level interventions and access, (2) comprehensive assessment and care plan, (3) individual-level intervention, (4) group-level interventions, (5) service system and models of intervention, and (6) evaluation and quality improvement. Therefore, the preliminary FEPS-FS score reported here is based on 31 items.

As shown in Table 5 below, 22 programs provided sufficient data to calculate a preliminary FEPS-FS score. Eighty-six percent of active EP programs reported that they have at least 15 of the 31 components in their program.

Table 5. Preliminary FEPS-FS Components by program

County	Preliminary FEPS-FS Total per program
San Diego	28
Napa	26
Sacramento	26
Santa Clara	25
Fresno	24
Orange	24
Alameda	23
Imperial	23
Santa Barbara	23
El Dorado	22
Merced	22
San Mateo	22
Solano	23
Ventura	22
Monterey	21
San Francisco	20
Stanislaus	19
Los Angeles	17
Shasta	14
San Luis Obispo	13
Contra Costa	11

Madera	6
San Joaquin ‡	NR

‡ Only partial data received- FEPS-FS score not calculated

Training Support: Out of 22 programs, 13 (59%) reported that they receive ongoing training, technical assistance, and/or support from external organizations, and four (18%) reported that they have received support in the past. This support focuses primarily assistance in the implementation of a CSC model, training in evidence-based treatments such as CBT for psychosis, and training to deliver structured clinical assessments such as the SIPS. This support was provided by a range of leading universities and research institutes, including Yale University, UC Davis, UCSF, the PIER Training Institute and the Felton Institute.

One county (5%) reported that they have not received any external support but would like to receive some in the future, while four programs (18%) reported that they do not receive external support, nor are planning to.

Funding sources used to Support Program Implementation.

The different funding sources used to support active EP programs are presented in Table 6 below. Of the 21 programs who reported funding data, the majority (15 programs, 68%) reportedly receive MHSA funding. Eleven programs (50%) reported receiving funding via Medi-Cal/EPSDT, eleven (50%) reported receiving money via the SAMSHA Mental Health Block Grant, three (14%) reported receiving at least some funds via self-pay, and two (9 %) reported receiving funds via private insurance. One program (Napa) reported receiving funding via donors, one program (San Mateo) reported receiving money via a county-specific fund designated for early Bipolar Disorder treatment, and one reported receiving money via a research grant. Eighteen programs provided data on the breakdown of funding sources within their annual budget; five programs (Napa, San Joaquin, Santa Clara, Shasta, Stainslaus) did not report this data.

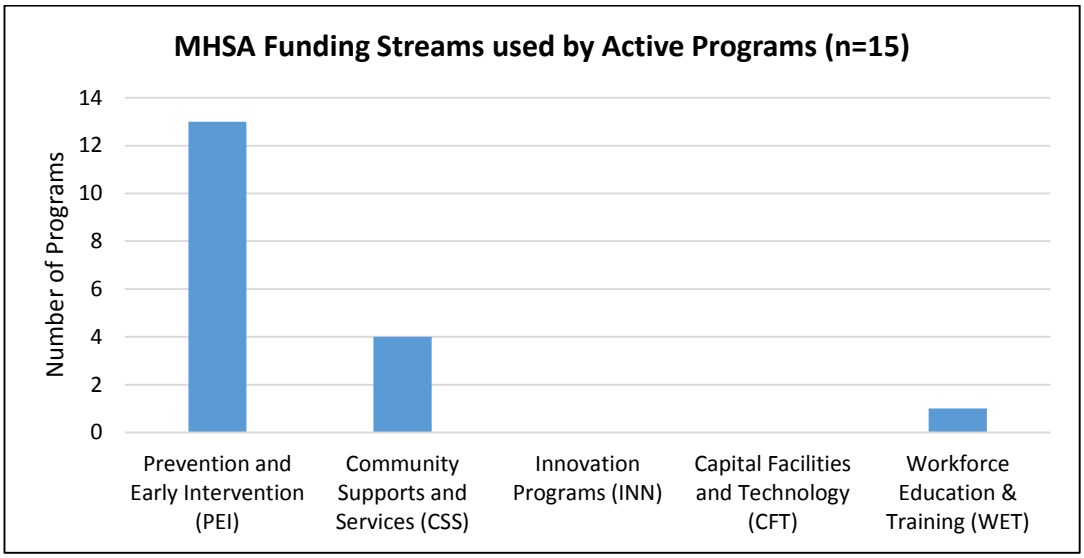
Table 6. Sources of funding for Active EP programs

Funding Sources	Number of Programs	% of Total	Avg % of budget	Min	Max
MHSA	15	68%	76%	50%	100%
Medi-Cal/EPSDT	11	50%	46%	10%	95%
SAMHSA MHBG	11	50%	54%	5%	100%
26.5	0	0%	-	-	-
Private insurance (including Kaiser)	2	9%	5%	5%	5%
Self-pay or sliding scale	3	14%	3.5%	2%	5%
Research grants	1	5%	NR		
Donors	1	5%	NR		
Other	5	23 %	-	-	-

NR = No Response provided

Figure 7 delineates the specific MHSA funding streams utilized by the programs that reported receiving funding from MHSA. Thirteen programs (87%) reportedly accessed MHSA funding through Prevention and Early Intervention (PEI) stream, four programs (27 %) reported receiving funding via Community Supports and Services (CSS) stream, (and one program reported receiving funds from the Workforce Education and Training (WET) stream. No programs reported using Innovation Programs (INN) or Capital Facilities and Technology (CFT).

Figure 7. MHSA funding streams used to support active EP programs



Financial Model for Service Reimbursement.

Programs were asked to report the method by which they are reimbursed for providing EP services in their county. For Medi-Cal/EPSDT programs, services are typically reimbursed by the unit of service provided, with the unit rate for each service established within the contract (e.g. $1.21 for unit/minute of case management). In contrast, other funding sources like MHSA and SAMSHA allow services to be reimbursed via different methods. For example, services can be "bundled" and a provider could be paid a flat rate for each client they served (e.g. $1000 per client served per year). For providers that bill private insurance, such services are often reimbursed at an hourly rate according to the service provided (e.g. $60 per 50-minute therapy session).

Based on responses from 22 programs, 14 programs (64%) reported that they are reimbursed per unit of service, four programs reported that they were reimbursed as part of the SAMHSA Mental Health Block grant, one program (5%) reported they were reimbursed monthly as a 1/12 payment contract, and one program (Orange) reported the financial model was unknown.

Outcomes Data Collection Methods.

Based on previous deliverables and stakeholder input, programs were asked to provide information on what client-level data they collected, both at intake and over time, which could potentially be used as part of the EP program evaluation process. Relevant domains included client characteristics (e.g. sex, gender, age, race/ethnicity, zip code, etc.), clinical diagnosis according to DSM-IV or DSM-V, symptom severity, physical health parameters, family history of mental health conditions, cognitive functioning (e.g. IQ scores), psychosocial functioning, medication usage and side effects, substance use, hospitalizations, ER or crisis utilization, legal involvement, risk assessment (e.g. danger to self/others), self-report of the impact of the care received, and treatment satisfaction.

Counties were asked to report the types of information they collect on these domains as part of a standard assessment battery. They were asked to indicate if the data was collected at intake, and collected again at regular intervals as part of a standardized reassessment or outcomes assessment. Counties could indicate if the re-assessment in each domain occurred at each visit, monthly, every 3 months, every 6 months, every 12 months, PRN (as needed), or other. If a county reported that they collect outcomes data at a standard interval (i.e. at each visit, monthly, every 3 months, every 6 months, or every 12 months), they were included in the "Collected Regularly at Follow Up" column.

All counties reported collecting data on client characteristics at the intake stage (n=22). As shown in Table 7, the most commonly reported types of information collected both at intake and follow-up were psychosocial data (15 counties, 71%), substance use information (14 counties, 67%), risk assessment data (14, counties, 67%), hospitalization data (13 counties, 62%), diagnostic data (13 counties, 62%), symptom severity scores (12 counties, 57%), and ER or crisis services utilization (12 counties, 57%).

Table 7. Types of data currently collected by the active EP programs.

Assessment Domains of Interest	Collected at Intake	Collected Regularly at Follow up	Collected at Intake & Follow up
Client characteristics	21	8	**8**
Diagnosis	20	14	**13**
Symptom Severity Scores	15	14	**12**
Physical Health	18	6	**5**
Metabolic Parameters	10	12	**8**
Vitals	10	13	**8**
Family History	21	5	**5**
Cognitive Measures	10	3	**3**
Psychosocial Data	21	15	**15**
Premorbid Functioning	13	3	**3**
Medication Data	19	13	**12**
Medication Side Effects	13	9	**6**
Substance Use	21	14	**14**
Hospitalizations	0	0	**13**
ER or Crisis Utilization	19	13	**12**
Legal Involvement	21	12	**11**
Risk Assessment	21	11	**14**
Impact of Care (Self-report)	21	14	**5**
Treatment Satisfaction	7	15	**2**
Other	0	0	**0**

Table 8 below shows the number of domains in which programs have reportedly collected data at intake and a regular follow up *by county/program*, which would allow within-person longitudinal analysis of outcomes.

Table 8. Longitudinal outcome data potentially available by program

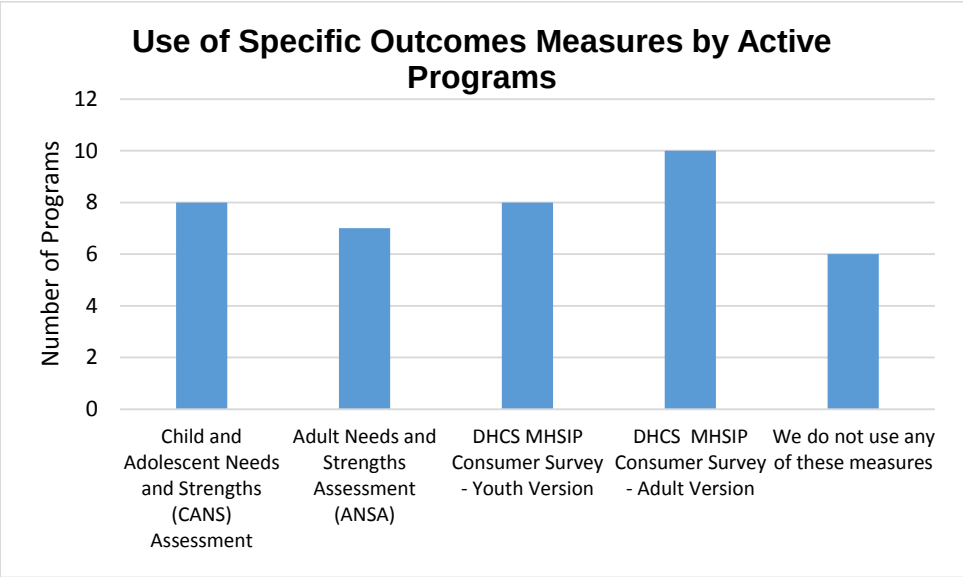
County	Outcome Domains Assessed at Intake & Follow up
Alameda	10
Contra Costa	12
El Dorado	15
Fresno	6
Imperial	2
Los Angeles	1

Madera	0
Merced	14
Monterey	10
Napa	5
Orange , CA	15
Sacramento	14
San Diego	9
San Francisco	10
San Joaquin	NR
San Luis Obispo	0
San Mateo	4
Santa Barbara	8
Santa Clara	11
Shasta	1
Solano	9
Stanislaus	4
Ventura	10

Use of Specific Outcomes Measures: In an effort to identify common data elements, programs were also asked if they use the California Department of Health Care Services' (DHCS) Consumer Survey – Adult and Child versions, the Child and Adolescent Needs and Strengths (CANS) Assessment, and/or the Adult Needs and Strengths Assessment (ANSA) as part of their standard assessment or outcomes procedures. These measures were identified previously (Deliverable #1) as being commonly used across outpatient provides in California to measure the domains of interest. The CANS and DHCS MHSIP Consumer Survey - Youth Version were also used as part of the Sacramento County Pilot Evaluation (Deliverable #3). Therefore, it was important to determine if other programs were planning to use these measures in order to provide information relevant to the development of a statewide evaluation.

The number of programs which reported using the CANS, the ANSA, the DHCS MHSIP Consumer Survey – Youth Version and the DHCS MHSIP Consumer Survey – Adult Version is presented in Figure 8. Out of 21 programs, 8 programs (35%) reported using the CANS, 7 the ANSA (30%), 8 the DHCS – Youth survey (35%), and 10 the DHCS - Adult survey (43 %). Six programs reported not using any of these measures (26 % of the total sample).

Figure 8. Specific outcome measures currently in use by active EP programs



Individual program responses to this item are reported below in Table 9. Eleven programs (49%) reported using either the CANS and/or ANSA as part of their current data collection methods. Five programs (22%) use some combination of the CANS/ANSA and the DHCS MHSIP Consumer Survey. This data is important for understanding the potential utility of the evaluation method that was developed and piloted as part of Deliverables #3 and #4, if it was expanded to a statewide evaluation.

Table 9. Use of CANS, ANSA and DHCS MHSIP Consumer Survey by active EP programs

County	Measures Used
Alameda	Child and Adolescent Needs and Strengths (CANS) Assessment Adult Needs and Strengths Assessment (ANSA)
Contra Costa	DHCS MHSIP Consumer Survey - Youth Version DHCS MHSIP Consumer Survey - Adult Version
El Dorado	Child and Adolescent Needs and Strengths (CANS) Assessment Adult Needs and Strengths Assessment (ANSA)
Fresno	We do not collect any of these measures
Imperial	We do not collect any of these measures
Los Angeles	DHCS MHSIP Consumer Survey - Youth Version DHCS MHSIP Consumer Survey - Adult Version
Madera	Child and Adolescent Needs and Strengths (CANS) Assessment Adult Needs and Strengths Assessment (ANSA)
Merced	We do not collect any of these measures
Monterey	DHCS MHSIP Consumer Survey - Youth Version DHCS MHSIP Consumer Survey - Adult Version Adult Needs and Strengths Assessment (ANSA)
Napa	We do not collect any of these measures
Orange	We do not collect any of these measures
Sacramento	DHCS MHSIP Consumer Survey - Youth Version DHCS MHSIP Consumer Survey - Adult Version
San Diego	DHCS MHSIP Consumer Survey - Adult Version

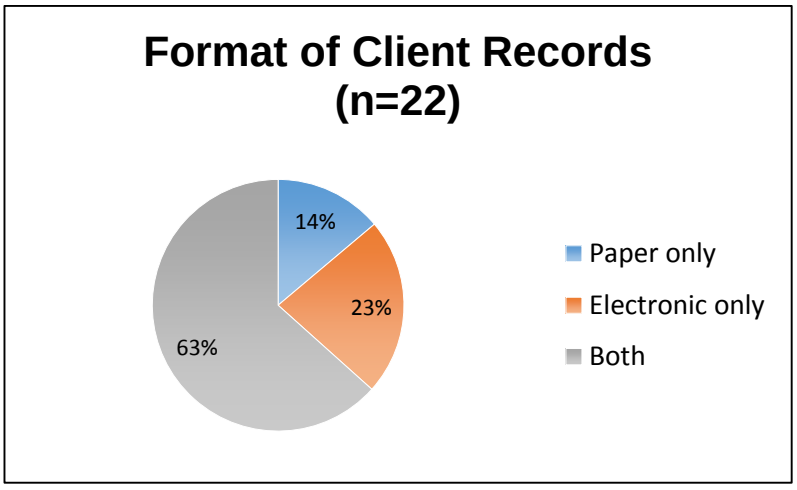
San Francisco	Adult Needs and Strengths Assessment (ANSA) DHCS MHSIP Consumer Survey - Adult Version
San Joaquin ǂ	No response
San Luis Obispo	We do not collect any of these measures
San Mateo	Adult Needs and Strengths Assessment (ANSA) DHCS MHSIP Consumer Survey - Youth Version DHCS MHSIP Consumer Survey - Adult Version
Santa Barbara	Child and Adolescent Needs and Strengths (CANS) Assessment
Santa Clara	Child and Adolescent Needs and Strengths (CANS) Assessment DHCS MHSIP Consumer Survey - Youth Version DHCS MHSIP Consumer Survey - Adult Version
Shasta ǂ	Child and Adolescent Needs and Strengths (CANS) Assessment
Solano	Child and Adolescent Needs and Strengths (CANS) Assessment Adult Needs and Strengths Assessment (ANSA)
Stanislaus	Child and Adolescent Needs and Strengths (CANS) Assessment DHCS MHSIP Consumer Survey - Youth Version DHCS MHSIP Consumer Survey - Adult Version
Ventura	DHCS MHSIP Consumer Survey - Youth Version DHCS MHSIP Consumer Survey - Adult Version

ǂ Only partial data received

Data Collection Systems.

Format of client records: Of the 22 programs that reported on the format of their medical records, 134(64%) programs reported that they are currently storing a mix of paper and electronic records, three programs (14%) are currently using a paper-only system, and five programs (23%) currently use an electronic-only system (See Figure 9).

Figure 9. Current format of client records in active EP programs



Implementation of Electronic Medical Record: The year in which the 17 programs implemented their electronic medical records (EMR) is presented in Table 10. The first EMRs were reportedly implemented in 2009 by two programs (Santa Barbara and San Francisco), and over half (56%) were reportedly implemented by 2013. The most recent EMR to be implemented was in 2016 by the Napa program. For those programs who reportedly started prior to the implementation of their EMR, Table 10 also shows the number of years where program medical records, and associated outcome data, may be found in paper records and therefore would require considerable additional support to convert to electronic format.

Table 10. Timeline for program and EMR implementation by program

County	FY EP Program started	FY EMR was Implemented	Years with Paper-Only Charts
Orange	2011	2015	**4**
Napa	2014	2016	**2**
Sacramento	2011	2013	**2**
San Diego	2010	2012	**2**
Stanislaus	2011	2013	**2**
Alameda	2010	2010	0
El Dorado	2016	2014	0
Fresno	2010	2010	0
Los Angeles	2014	2013	0
Merced	2015	2012	0
Monterey	2013	2013	0
San Francisco	2009	2009	0
San Mateo	2012	2012	0
Santa Barbara	2010	2009	0
Santa Clara	2011	2010	0
Solano	2015	2015	0
Ventura	2011	2011	0
Contra Costa	2013	N/A	N/A
Imperial	2015	N/A	N/A
Madera	2015	2015	0
San Luis Obispo	2015	N/A	N/A
San Joaquin	2015	NR	NR
Shasta	2012	2012	0

FY = Fiscal Year; N/A = No EMR available; NR = No response

Of the 19 programs that reported storing at least some of their medical records electronically, nine (47%) have reportedly adopted a County-based system, nine (47%) reported using an internal system, and one program (5%) was uncertain. Thirteen programs (68%) reported that they are currently able to extract data from their EMR, while three programs (16%) reported that they collect data within an accessible database or spreadsheet. Of the 13 programs that reported that they can extract data from their electronic medical record, in the majority of cases reports can be generated both by county and clinic staff (9 programs, 69%), while in 3 cases (23%) only county staff can generate reports, but clinic staff can request special reports.

With regards to data cleaning, it was reported that regular checking occurs in most programs in order to address missing data (16 programs, 84%). In two programs (11%), it was reported that checking for completeness did occur, however this was only irregularly, and one program (6%) was uncertain of current data-checking practices.

Pending changes to data collection: In addition to asking questions regarding their current data recording practices, the programs were also asked if they were planning to make and changes to their data collection methods in the following 12 months. Almost half of the programs (10/22, 46%) reported that they have no plans to change current data collection methods. Five programs (24%) reported that they were planning to change

the measures that they currently use. One program reported that they are planning to add the CANS and the "COR" at post-discharge to their assessment battery (Santa Clara).

Counties that are Developing EP Programs

Of the 58 counties in California, 12 were identified as being in the process of developing or implementing EP programs (see Table 11). Of the 12 counties contacted, 11 counties responded (92%) and 10 counties (83%) provided complete data on the CEPAS-D as part of this evaluation. One county (Santa Cruz) provided partial data.

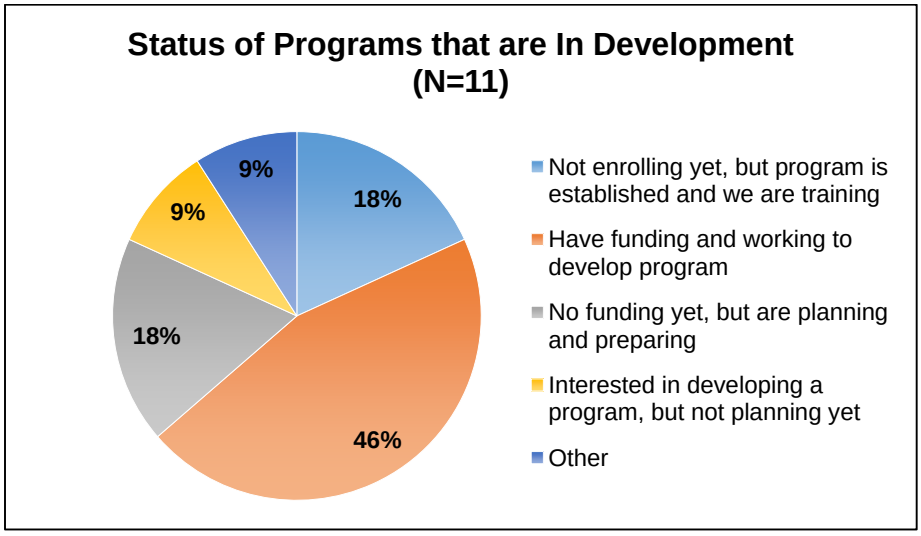
Table 11. Counties with EP Programs In Development

County	Program Name
Sierra	Sierra County Behavioral Health
Sonoma	Transition Age Youth
Yolo	Turning Point Community Programs
Mariposa	Mariposa County Behavioral Health and Recovery Services
Marin	Behavioral Health & Recovery Services (FEP Program Name TBD)
Tehama	Tehama County Health Services Agency - Early Psychosis
Inyo	Progress House FEP
Riverside	TAY Centers
Santa Cruz ‡	Prevention and Early Intervention/TAY
Tuolumne	FEP Services
Trinity	First Episode Psychosis Treatment
Lassen *	FEP Program

** Counties that did not respond to the survey*
‡ Only partial data received

These counties reported that they were in various stages of program development (see Figure 10 below), with the majority of counties having funding and actively working to develop their program components (64%).

Figure 10. Status of EP Programs in Development



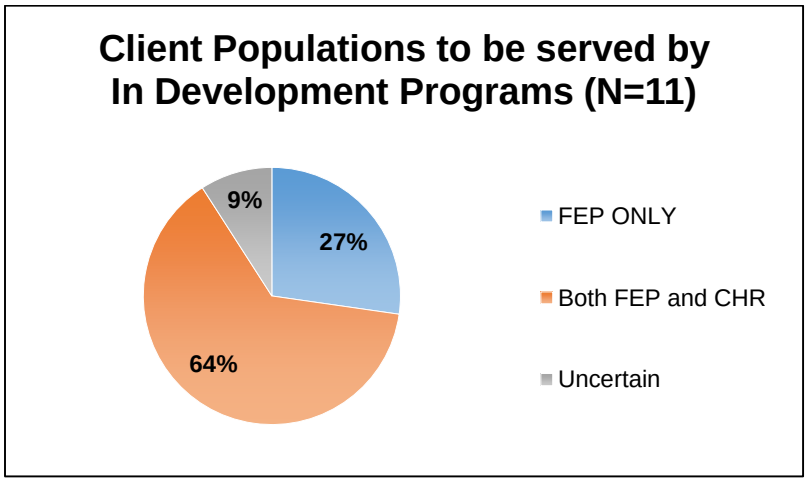
Planned Timeline for Program Implementation

One county (Sierra) reported that they have been seeing clients since 2014, noting that they have been serving EP individuals historically as part a larger established outpatient program; however, it was not clear how their EP program might change during the course of program development. Two programs reported they implemented their program in 2016 (Inyo and Trinity), while eight counties reported a plan to implement their EP program in 2017 (74%).

Characteristics of Client Population to be Served

Counties in the process of developing EP programs reported that they were predominantly focusing on providing services to both FEP and CHR individuals, or FEP individuals only (see Figure 11 below). Of those counties considering serving CHR individuals, 5 counties (71%) reported they were considering serving individuals with "recent onset but brief psychosis" as well as individuals with "attenuated or subthreshold symptoms of psychosis (APS)." One county reported they were as considering serving only CHR individuals with "attenuated or subthreshold symptoms of psychosis (APS)."

Figure 11. Client Populations to be served by EP Programs in Development



Diagnoses Served & Exclusion Criteria: All counties in the process of developing EP programs (100%) reported a plan to serve Schizophrenia Spectrum Diagnoses (e.g. Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder), as well as Other Psychotic Spectrum Disorders (e.g. Psychotic Disorder NOS, Brief Psychotic Disorder, Delusional Disorder). Ten counties reported a plan to serve individuals with Mood Disorders (e.g. Major Depressive Disorder, Bipolar Disorder) WITH psychotic features, with only 6 counties reported a plan to serve individuals diagnosed with Mood Disorders WITHOUT psychotic features. One county also reported a plan to serve individuals with "co-occurring substance use disorders with symptoms of psychosis of unknown origin."

Counties in the process of developing EP programs were also considering a number of criteria that would exclude individuals from their services. As shown in Table 12 below, counties reported they were most often considering Intellectual Disability (45%), Substance dependence (45%), and not being a county resident (55%) as possible reason for exclusion from services. These exclusion criteria are consistent with the majority of Active EP programs in California.

Table 12. Potential exclusion criteria for EP Services

Exclusion Criteria considered:	% of Programs	Count
Axis II diagnosis (e.g. personality disorders)	9%	1
Intellectual disability (i.e. IQ under 70)	45%	5
Substance use disorder (of any kind)	0%	0
Substance dependence only	45%	5
Substance-induced psychotic disorder	18%	2
Not county resident (where program is located)	55%	6
No specific exclusion criteria (we serve everyone)	9%	1
Other	9%	1
Uncertain	18%	2

Eleven counties reported information regarding additional exclusion criteria based on insurance or undocumented resident status (see Table 13). The majority of counties reported they would serve uninsured individuals (82%) and/or undocumented individuals (55%).

Table 13. Additional eligibility criteria under consideration by EP programs In Development

Eligibility for Certain Client Populations	%	Count
Uninsured clients	82%	9
Undocumented clients	55%	6
Private insurance clients	27%	3
We do not plan to serve any of these types of clients	0%	0
Uncertain	18%	2

Duration of Psychotic Symptoms: Nine counties reported on the duration of psychotic symptoms that they would assess for and use to determine eligibility. Three counties (Sierra, Yolo, Trinity) reported they would allow individuals with any duration of psychotic symptoms to be served by their program; however, for Yolo County this would only be for evaluation and linkage to services as part of their current program structure. The permissible range of psychotic symptom duration extended from a minimum of 2 months to a maximum of 60 months (mean = 23 months).

Ages to be Served: Six counties reported that they would provide EP services to individuals regardless of their age. In contrast, four counties reported specific age criteria for their programs, with minimum age of 16 years for three counties and 18 years for one county and maximum age of 25 years for all four counties. These age ranges are consistent with the majority of active EP programs in California.

Characteristics of Program Services & Potential Fidelity to CSC Model

Location of Potential EP Program: The majority of counties reported that their EP program would be integrated within another program (73%, e.g. shared space, staff management). One county reported their EP program will be independent (e.g. own site) but associated with an established program or agency that would provide oversight and support. Yolo county reported that they plan to "educate the community about FEP and provide on-demand screenings, crisis intervention, and linkage for individuals who may be experiencing first episode psychosis," noting that treatment services would be contracted through an established EP program in another county. Tuolumne County reported they were uncertain as to the future location of their EP program.

Approximate number of clients to be served: Counties were asked to report 1) the approximate number of clients that they would evaluate for eligibility (e.g. intake evaluations) per month and 2) the approximate number of clients they hoped to engage in ongoing treatment (e.g. therapy, groups, med management) each month (i.e. monthly census of clients active in treatment). Across the eight counties that reported data, approximately 4 individuals would receive eligibility evaluations per county per month (minimum = 2; maximum = 8), which would average approximately 48 clients per county per year. Across all new programs (n=11), this could result in an estimated 528 individuals being evaluated for EP services each year. Further, approximately 12 individuals would receive services per month (7 counties reporting; minimum = 4; maximum = 30), which would average approximately 144 clients per county per year. Across all new programs (n=11), this could result in an estimated 1584 individuals receiving EP services each year.

Some respondents provided other information in this section of the survey. Sierra County reported that their EP program would be integrated within other outpatient programs and were not able to provide an estimated number of eligibility evaluations or ongoing clients, but noted that they serve approximately "160 (unduplicated) clients per annum." Similarly, Mariposa County reported that their integrated EP program would likely complete 2 eligibility evaluations per month, but reported that they serve approximately 300 clients per month. As noted previously, Yolo County reported that their EP services would only "provide screenings but not full evaluations" and eligible individuals would be linked to ongoing treatment through an established EP program in a nearby county. Sonoma County reported that their EP program would be part of their Transition Age Youth (TAY) program and they "hope to evaluate all TAY eligible for specialty mental health services;" in terms of capacity, they noted that they are seeking to expand their TAY program to "serve all those in need," noting that their program currently has "a cap of 40 with approximately 20 on the waitlist."

Duration of Services: Eleven counties provided information on the duration of EP program services that they would provide to eligible individuals (see Table 14). The majority of programs (36%) reported a plan to provide services for more than 4 years or as long as the individual was in need of services. Other counties reported a plan to limit services to two years or less (27%).

Table 14. Potential duration of EP program services for eligible individuals

Duration of Services considered	%	Count
1 year or less	9%	1
Up to 2 years	27%	3
Up to 3 years	0%	0
Up to 4 years	9%	1
More than 4 years (e.g. no limit)	36%	4
Other	9%	1
Uncertain	9%	1

CSC Models under Consideration for Implementation: Of the 11 programs that responded (see Table 15), five reported that they were considering implementing Coordinated Specialty Care models based on established practices in California or other states. Three counties (Santa Cruz, Sonoma, and Trinity, 27%) reported that they were considering the Felton PREP model, one county (Yolo) reported considering a partnership to implement the UC Davis EDAPT model, and one county (Marin) reported considering the RAISE model. Inyo County reported they were considering "a hybrid program that is adapted to a very small population." The majority (45%) of counties reported that they were still uncertain as to which CSC model they might implement.

Table 15. Established CSC Models under consideration by EP programs in development

CSC Model Under Consideration:	%	Count
PREP	27%	3
PIER	0%	0
EDAPT	9%	1
EASA	0%	0
RAISE	9%	1
Other	9%	1
Uncertain	45%	5

Potential Fidelity to CSC Approach: Programs provided information on potential fidelity to the EP treatment model based on the FEPS-FS 1.0. As described previously, the CEPAS-D asks respondents to report on the potential presence or absence of 27 of the 31 criteria included the FEPS-FS 1.0 assessments. As shown in Table 16 below, 10 programs reported sufficient data to calculate a preliminary FEPS-FS score. Fifty-five percent of EP programs in development reported that they were planning to provide at least half of the 27 components in their program.

Table 16. Anticipated FEPS-FS Components by program

County	Preliminary FEPS-FS Total per program
Marin County	24
Sonoma	19
Trinity County	17
Mariposa	16
Inyo	15
Riverside	15
Sierra County	10
Tehama County	9
Tuolumne	7
Yolo	1
Santa Cruz ǂ	N/R

ǂ *Only partial data received*

Training Support: Four counties reported established relationships with training California-based organizations, including the Felton Institute, UC Davis, CBHDA and CIBHS, in addition to trainings from other institutions. Four counties reported they are not currently receiving training, but would like to, and two counties reported they were "uncertain."

Funding sources to be used for Program Implementation

Counties were asked to report the sources of funding they planned to use to implement their EP program (see Table 17 below). Five counties (Inyo, Riverside, Sierra, Sonoma, and Trinity) reported that they were planning to use some combination of MHSA, Medi-Cal/EPSDT and SAMHSA Mental Health block grant dollars. Tuolumne County was planning to use only SAMHSA funding. Sierra County reported that they planned to use all sources of funding listed, but reported a plan to use 50% MHSA and 50% SAMSHA funding. Yolo County reported that the used alternative funding (SB-82) to provide community education, screening and linkage. Inyo County reported that 10% of their funding comes from SSI. Three counties (Marin, Mariposa, and Tehama)

were uncertain about the funding sources at the time of the survey.

Table 17. Potential sources of funding for EP programs In Development

Sources of funding	%	Count	Avg % of budget	Min	Max
MHSA	50%	5	33	10	75
Medi-Cal/EPSDT	50%	5	34	25	60
SAMHSA Mental Health Block Grant (MHBG)	50%	5	38	1	100
26.5 funds	10%	1	-	-	75
Private insurance (including Kaiser)	10%	1	-	-	75
Self-pay or sliding scale	10%	1	-	-	50
Research grants	10%	1	-	-	50
Donors	10%	1	-	-	30
Other (please describe)	30%	3	-	-	-
Uncertain	30%	3	-	-	-

Counties were also asked to report the MHSA funding streams that they were considering using to support their programs (Table 18). Of the 5 programs that reported using MHSA as a funding source, Community Supports and Services (CSS) funding was the most commonly reported (60%) funding stream for supporting these developing programs.

Table 18. Potential sources of MHSA funding for EP programs In Development

Potential MHSA Funding Streams	%	Count
Prevention and Early Intervention (PEI)	40%	2
Community Supports and Services (CSS)	60%	3
Innovation Programs (INN)	40%	2
Capital Facilities and Technology (CFT)	20%	1
Workforce Education & Training (WET)	40%	2
Uncertain	20%	1

Financial Model for Service Reimbursement

Counties were asked to report the method by which a clinical provider would be reimbursed for providing EP services in these new programs. Options included: 1) reimbursement by the unit of service provided, with the unit rate for each service established within the contract; 2) reimbursement via different methods (e.g. “bundled” services with a flat rate for each client they served); or 3) reimbursement at an hourly rate according to the service provided. As shown in Table 19 below, approximately half (50%) of counties reported that they would be reimbursed per unit of service (30%) or via a flat rate per client served (20%). Three programs reported some combination at these options, depending on the client’s eligibility for different funding streams (e.g. Medi-Cal eligible would be billed by unit, while SAMHSA eligible clients might be at a flat rate). Alternatively, some programs reported that different services would be covered by different funding sources (e.g. funding for training under SAMSHA and mental health services under Medi-Cal/EPSDT).

Table 19. Potential reimbursement methods for EP programs in development

Reimbursement Method	%	Count
Rate per unit of service, established by contract	30%	3
Flat rate per client served across all service types, services are “bundled”	20%	2
Hourly rate based on service type provided	0%	0
Other (please describe):	40%	4
Uncertain	10%	1

These different approaches and combinations of funding reflect the flexibility that is afforded to counties as they develop their programs via these funding sources to meet the needs of their community.

Plan for Outcomes Data collection

Based on previous deliverables and stakeholder input, counties were asked to provide information on the data they planned to collect related to client status at initial presentation to the provider and over time as part of ongoing outcomes evaluation to determine the impact of the program. The domains of interest included socio-demographic details, clinical diagnosis and symptom severity, physical health parameters, family history of mental health conditions, cognitive functioning, psychosocial functioning, medication usage and side effects, substance use, hospitalizations, ER or crisis utilization, legal involvement, risk assessment (e.g. danger to self/others), self-report of the impact of the care received, and treatment satisfaction. The number of EP programs that collected at least some form of data relevant to each area is presented in Table 20. Regular data collection was defined as collecting the same data at any standard interval, ranging from “Each visit” to “Every 12 months.”

Table 20. Potential types of data to be collected by EP programs in development

Assessment Domains of Interest	Will Collect at Intake	Will Collect Regularly at Follow up	Will collect at Intake & Follow up
Client characteristics	10	2	**2**
Diagnosis	7	4	**3**
Symptom Severity Scores	5	5	**3**
Physical Health	6	6	**3**
Metabolic Parameters	5	5	**4**
Vitals	3	6	**3**
Family History	9	1	**1**
Cognitive Measures	6	2	**2**
Psychosocial Data	9	6	**5**
Premorbid Functioning	7	1	**1**
Medication Data	7	8	**6**
Medication Side Effects	5	9	**5**
Substance Use	9	7	**6**
Hospitalizations	6	7	**4**
ER or Crisis Utilization	6	7	**4**
Legal Involvement	7	7	**4**
Risk Assessment	9	5	**5**

Impact of Care (Self-report)	1	8	**1**
Treatment Satisfaction	0	5	**0**
Other	2	2	**0**

These data indicate that a majority of programs reported that they are considering collecting outcomes information across a variety of domains of interest, with more than 5 programs indicating that they plan to have intake and outcomes data all domains of interest. However, it is not clear if these domains will be measured in the same manner across sites. Table 21 below shows the number of domains in which programs report they plan to collect data at intake and a regular follow up *by county/program*, which would allow within-person longitudinal analysis of outcomes.

Table 21. Longitudinal outcome data potentially available for EP programs in development

County	Outcome Domains Assessed at Intake & Follow up
Inyo	3
Marin	12
Mariposa	0
Riverside	15
Santa Cruz	0
Sierra	2
Sonoma	14
Tehama	9
Trinity	7
Tuolumne	0
Yolo	0

In an effort to identify common data elements, counties were also asked to report if they planned to use the California Department of Health Care Services' (DHCS) Consumer Survey – Adult and Youth versions, the CANS Assessment, and/or the ANSA as part of their standard assessment or outcomes procedures. These measures were identified previous as being commonly used across outpatient provides in California to measure the domains of interest. The CANS and DHCS MHSIP Consumer Survey - Youth Version were also used as part of the Sacramento County Pilot Evaluation (Deliverable #3). Therefore, it was important to determine if other counties were planning to use these measures in order to provide information relevant to the development of a statewide evaluation.

Table 22. Potential use of standard measures by EP programs in development

Assessment Measure	%	Count
Child and Adolescent Needs and Strengths (CANS) Assessment	30%	3
Adult Needs and Strengths Assessment (ANSA)	20%	2
DHCS MHSIP Consumer Survey - Youth Version	30%	3
DHCS MHSIP Consumer Survey - Adult Version	40%	4
We do not plan to use any of these measures	10%	1
Uncertain	40%	4

As reported above in Table 22, five counties reported they would use at least one of these measures in their developing EP program. Four programs were unsure, if these measures would be implemented and one program had already determined that these measures would not be used.

Plan for Data Collection Systems

To determine the potential accessibility of data for a statewide evaluation, counties were asked to describe their plan to implement a paper-only client record, an electronic medical record, or some combination of the two (see Table 23). Eighty-percent of counties reported a plan to use some combination of paper and electronic records for storing client data. It is unclear which components of the outcomes data elements described above would be available in the electronic record, and whether that data is in a format that could be easily analyzed as part of a larger evaluation.

Table 23. Potential format of client records for EP programs in development

Record Format	%	Count
Paper only	0%	0
Electronic only	20%	2
Both	80%	8
Uncertain	0%	0

Further, as shown in Table 24 below, counties who were considering EMRs were asked if that medical record would be part of a county-wide system or part of a program-specific (internal) EMR system. Sixty percent of counties reported that they were planning to implement the county-wide system. Consequently, access to client-level data may be managed at the level of the county rather than the program and required increase coordination with the county to obtain data for a larger evaluation.

Table 24. County versus internal format for medical records for EP programs in development

EMR County vs Program	%	Count
County system	60%	6
Program (internal) system	30%	3
Uncertain	10%	1

Counties Currently Without a Program

A total of 22 counties were identified as not having an EP program, either active or in development, and are presented in Table 25. These sites typically had a small population (median population size= 65,470, IQR= 27,873 – 150,960) and low population density (median number of people per square mile = 38.5, IQR 15 – 100). The one notable exception was San Bernadino County, with an estimated population of 2.09 million. In all reported cases, the counties endorsed providing telemedicine in at least some capacity in order to aid service provision in medically underserved areas.

Table 25. Counties with no EP program either active or in development

Alpine	Kern *	San Benito
Amador	Kings *	San Bernadino
Butte *	Mendocino	Siskiyou

Calaveras	Modoc *	Sutter
Colusa *	Mono	Tulare *
Del Norte *	Nevada *	Yuba
Glenn *	Placer	
Humboldt *	Plumas *	

** Counties that did not respond to the survey*

Of these 22 counties that were found not to have an EP program either active or in development, 11 completed a program coordinator interview, yielding a response rate of 50%. Of the 11 that responded, all of the sites reported that they had no plans to implement an EP program in the immediate future. The most commonly cited reason for not developing an EP program was that it was not identified as a priority by relevant county stakeholders (Calaveras, Mendocino, San Benito, San Bernadino, Siskiyou). In one case (Mendocino), it was determined that there was a community desire for broad-based programs, rather than specialist services, which supported the decision not to develop a specialist EP program. In 4 counties, the decision was made to not develop an EP program due to a perceived lack of need (Alpine, Amador, Calaveras, and Placer Counties), with 3 of the 4 counties with a population lower than 50,000. In 3 counties (Calaveras, Mendocino, Mono), it was reported that a low population density and the large distances between towns meant that implementing specialist EP programs was not feasible due to accessibility. Finally, in 2 counties (Sutter and Yuba Counties) no reasons were given as to why there are currently no plans to develop a program.

Of the 11 counties that responded, only 3 reported that current staff had pursued training related to EP program delivery (Calaveras, Placer, San Bernadino). In Calaveras, some unspecified training was received approximately 6 years ago, and in San Bernadino a number of psychiatrists and clinicians received training in 2008/2009. In Placer County, clinicians attended a multi-day course on CBT for psychosis in 2015/2016, and in 2016 hosted three training days from clinicians affiliated with the RAISE program. While the majority of sites reported not pursuing any form of training, almost half said they would welcome additional training presently (Alpine, Calaveras, Mendocino, San Bernadino, Siskiyou), while another (Amador County) suggested they would if a need for such expertise should arise in the future. Regarding any other additional support required, three counties reported that technical assistance would be required in order to implement any EP programming should a need for such a program be determined in the future (Alpine, Amador, Placer), and two sites (San Bernadino, Siskiyou) reported that more financial and human resources would be required to start an EP program.

Stakeholder Engagement

A stakeholder engagement meeting was convened on February 22, 2017 to provide input on the descriptive assessment of statewide EP programs. The stakeholder group was comprised of representatives from state and county agencies (MHSOAC, DHCS); providers from multiple EP programs across California (Sacramento, San Francisco, Alameda, San Joaquin, Salinas/Monterey, San Matteo); evaluation experts from experience in EP programs from the UC Davis and UC San Francisco; and family members with lived experience who have been involved in EP programs.

Stakeholders were provided with a summary of the survey data reviewing the status of all EP programs in California, both active and currently in development, funded through public entities. This information included details on the populations served, funding sources, information regarding the types of data collected, the format and availability of data, and the components of care delivered in each program. The principle aim of the meeting was to collect feedback from stakeholders on the available data to inform the development of a method for analysis to evaluate EP program costs, outcomes, and costs associated with outcomes statewide. A summary of the key points raised by the group are summarized below:

1. Identifying and engaging an appropriate comparator group: Stakeholders stressed the importance of incentivizing engagement of comparator groups, as well as possible barriers to identifying adequate comparator groups in each county (e.g. rural counties may not have multiple clinics). For Deliverable 6, inclusion of comparator group stakeholders to discuss their participation will be prioritized.

2. Protection of PHI and potential HIPPA complications: The pilot study (Deliverable 3) was possible due to the involvement of Sacramento County, which allowed for the protection of PHI when considering sensitive data such as hospitalization records. The feasibility of county level engagement across California would have to be addressed moving forward to allow access to necessary data.

3. Reducing the burden on providers: Stakeholders emphasized that the burden of providing outcomes data be shifted away from providers. Certain outcomes data, such as vocational and academic functioning, could be provided by consumers and families in a simple, easily administered paper or online questionnaires.

4. Re-evaluating inclusion criteria: Programs accepting individuals with a longer duration of untreated psychosis (DUP) should be evaluated separately given research clarifying the relationship between longer DUP and potential benefit from an EP program. In the recent RAISE study (Kane et al., 2015), treatment outcomes were significantly better in patients with a duration of untreated psychosis shorter than 74 weeks. As a result, it is possible that inclusion of sites which treat individuals who have been psychotic for longer may dilute the impact of treatment on outcomes and thereby significantly affect outcome analyses. The suggestion was that in any statewide evaluation a sub-group analysis of clients with a DUP of <74 weeks should be completed in addition to the main analysis.

5. Highlighting outcomes that are relevant and motivating for consumers: Stakeholders identified a number of issues regarding current outcome assessment practice. It was noted that the domains are disproportionately deficit-orientated, with insufficient coverage of more recovery-orientated outcomes. Feedback from stakeholders with lived experience suggested that focusing on elements of recovery that are relevant to consumers and families (psychosocial functioning, preparedness for future mental health complications and relapse, risk assessment, substance use, role functioning) could encourage engagement and participation in long term outcomes evaluation.

6. Heterogeneity of outcomes measured by programs: Stakeholders noted the significant heterogeneity in the types of data collected, and the manner of collection between programs, which may act as significant impediment to a *retrospective* statewide evaluation of programs using existing data. Stakeholders also noted that the CANS is intended to be a measure of treatment progress and therefore may not be an appropriate treatment outcome measure for any future statewide evaluation of outcome.

Overall, stakeholders felt that the results of the descriptive assessment supported the development of a *prospective* statewide evaluation proposal. Stakeholders favored the concept of building a learning healthcare network for gathering prospective data for the purpose of improving program efficacy and quality of treatment. Several program leaders not only supported, but suggested harmonizing ongoing outcomes assessment practices across programs. This would provide an incentivizing structure to engage programs and streamline the implementation of measures for a prospective study.

Summary of Findings

This report provides a comprehensive descriptive summary of early psychosis programs statewide, including programs currently being planned or implemented in California funded through public entities (e.g., MHSA, other county funds, federal funds) and the types of data (e.g., program costs, program outcomes, client and service characteristics, potential fidelity) and data collection systems (e.g., EHRs) used by each program. We

also provide information regarding counties that have not implemented EP programs and the potential barriers to implementation. The response rate by EP programs to our online survey was exceptional, with 97% of active EP programs and 92% of in development programs providing some data.

Results of this descriptive assessment provided essential details on the current and future landscape of EP programming in California. Of the 30 active EP programs, we identified 23 that are receiving public funding to provide services. An additional six EP programs also provide care, but receive other forms of funding (e.g. research grants, donor support) that precluded their inclusion in this analysis. Of the 22 programs that provided sufficient data, 82% reported that they are providing at least half of the components of evidence-based EP care according to the FEPS-FS 1.0. In terms of client populations served, 74% of programs are providing care for both individuals that have experienced their first episode of psychosis (FEP) and individuals at clinical-high-risk (CHR), while an additional five programs are serving just FEP. The majority of clinics serve individuals between the ages of 14 and 25 years, include individuals who have experienced psychosis up to 24 months, and provide services for up to 2 years. Further, 15 programs are collecting data on five or more relevant outcome domains at intake and follow up. Eleven programs (48%) reported using either the CANS and/or ANSA as part of their current data collection methods. Eighty-six percent of programs have EMRs, or some combination of paper and electronic records, which contain information relevant to client-level outcomes. These key data elements are summarized in Table 26 below.

Table 26. Summary of Active Program Data Elements, ranked by preliminary FEPS-FS score

County	Preliminary FEPS-FS Total	Outcome Domains Assessed at Intake & Follow up	Use CANS/ANSA (and DCHS survey)	Fiscal Year Program Started	Fiscal Year EMR Started	# Clients Served to 6/2016	Min age	Max age	Max DUP
San Diego	28	9	DHCS only	2010	2012	600	10	25	6
Sacramento	25	14	DHCS only	2011	2013	217	12	30	24
Santa Clara	25	11	CANS, DHCS	2011	2010	89	10	25	12
Fresno	24	6	None	2010	2010	1598	18	28	24
Napa	24	5	None	2014	2016	29	8	30	24
Orange	24	15	None	2011	2015	115	12	25	24
Alameda	23	10	CANS/ANSA	2010	2010	384	16	24	24
Imperial	23	2	None	2015	N/A	46	12	25	12
Santa Barbara	23	8	CANS	2010	2009	500	16	25	12
Solano	23	12	CANS/ANSA	2015	2015	37	14	25	24
El Dorado	22	15	CANS/ANSA	2016	2014	3	14	25	6
Merced	22	14	None	2015	2012	14	15	30	6
San Mateo	22	4	ANSA, DHCS	2012	2012	127	14	35	24
Ventura	22	10	DHCS only	2011	2011	106	16	25	18
Monterey	21	10	ANSA, DHCS	2013	2013	73	14	35	60
San Francisco	20	10	ANSA, DCHS	2009	2009	250	12	35	60
Stanislaus	19	4	CANS, DCHS	2011	2013	NR	14	25	12
Los Angeles	17	1	DCHS only	2014	2013	320	14	25	12
Shasta	14	1	CANS	2012	2012	55	15	25	Any
San Luis Obispo	13	0	None	2015	N/A	46	17	25	36
Contra Costa	11	12	DHCS only	2013	N/A	106	12	25	NR
Madera	6	0	CANS/ANSA	2015	2015	35	16	30	NR
San Joaquin ǂ	NR	NR	NR	2015	N/A	19	16	25	12

ǂ Only partial data received; NR – No response; N/A – Not applicable

Overall, these data allow us to understand who is being served by 23 publicly funded EP programs in California, how those services are being provided, funding sources used, and how data is collected. The information gathered via this descriptive assessment will be used to guide the development of a statewide evaluation plan for publicly funded EP programs.

Discussion

This report provides a summary of the descriptive assessment of EP programs in California, including all EP programs currently being planned or implemented in California. Through direct contact with counties and EP programs via online survey assessment tools and interviews, we identified potential data sources for outcomes and costs related to program participation, acquired data to inform inclusion criteria for EP programs, and established relationships with county and EP program leadership to support the development of a methodology for a future statewide evaluation.

Insight into the Landscape of California EP Programs

The survey instruments (CEPAS and CEPAS-D) and County MHSA Program Coordinator Interview generated rich and detailed data on currently active EP programs in California counties, as well as the plans for programs currently in development. As each county is autonomous, it has discretion in how it chooses to develop EP programming, leading to county-by-county variation in program components, populations served, and data collection methods. This descriptive assessment provided insight into the similarities and differences in EP programs and types of data being collected throughout the state.

Overall, the findings of this descriptive summary shed new light on the status of EP programming in California. The majority of programs (96%) reported serving individuals with First Episode Psychosis (FEP) who fall within the “transition age youth” (TAY) age range of 14-25 years, with 82% of programs reporting the potential for moderate to good fidelity to evidence-based practices. Programs reported that an estimated 4769 individuals have been served up to June 2016, with additional individuals assessed and served over subsequent months. Further, 65% of sites reported collecting client-level data on 5 or more relevant outcome domains. Only 11 counties reported collecting data on the Child and Adolescent Needs and Strengths (CANS) Assessment and/or the Adult Needs and Strengths Assessment (ANSA), with only 5 counties collecting these measures in combination with the California Department of Health Care Services’ (DHCS) Consumer Survey – Adult and Child versions. However, the comparability of this data across sites – and its availability in an electronic format for use in analyses of outcomes and costs – has yet to be fully determined. This information critical to shape the development of methods for a statewide evaluation of EP programs, as the availability of compatible data and comparable components across programs determines the feasibility of a retrospective versus prospective approach for statewide evaluation.

Determining Inclusion Criteria for a Statewide Evaluation

A statewide evaluation will likely be limited to a selected number of EP programs throughout the state. The criteria for selecting EP programs to include in a statewide analysis is dependent on the elements offered by the program, types of data collected by counties, clients served, and ability to coordinate with the research team. Program responses to the CEPAS allowed preliminary identification of counties with EP programs that are providing some core components of the EP treatment model and could be included in a statewide analysis. As described in the Summary of Findings section above, key data elements related to each program (e.g. preliminary FEPS-FS 1.0 score, number of outcome domains assessed at intake and follow up, etc.) can be used to identify a sample of diverse EP programs, thereby allowing an investigation of the outcomes and costs

associated with California EP programs at a representative and generalizable level.

Further, the approach used in the statewide analysis may also determine which EP programs are included. One method is the *retrospective comparison* based on existing data, which was used for the UC Davis pilot analysis of outcomes and costs in Sacramento County. For this method, programs could be selected for inclusion based on their fidelity as well as the amount, quality, and electronic format of historical data that is already available. This approach is limited by the availability of comparable existing data across programs, and time and financial support is often required to harmonize data across sites to permit appropriate statistical analysis. In contrast, a prospective design would require included programs to collect data on core data elements for an agreed upon period. For this approach, program selection may be based upon a program's fidelity and their ability and willingness to collect compatible data going forward and avoid missing data. A prospective approach is the most rigorous approach and ideal for ensuring that the same outcomes are being analyzed; however, this approach is also expensive and time-consuming.

Stakeholder input also identified other potential issues that must be considered. For example, duration of psychotic illness allowed as part of program inclusion criteria could affect the outcomes observed. The most frequently adopted maximum duration of illness for active EP programs was 24 months, which was reported by 7 programs. Three programs treat individuals with duration of psychosis over this threshold, with one program limiting duration to 36 months and two programs limiting duration to 60 months. Recent evaluations of EP programs in the United States have shown that duration of psychosis in excess of 74 weeks is associated with lack of response to coordinated specialty care above that seen with standard care [29]. Therefore, the duration of psychosis allowed by programs must be considered as part of 1) inclusion criteria for the statewide evaluation and/or 2) analysis approaches where by subgroups of individuals with shorter duration of illness are compared to individuals who have been ill for longer.

Further, in the case of a retrospective analysis, additional information is needed from active EP programs to determine 1) the comparability of outcomes measured and 2) the availability of outcomes data in an electronic format. While the CEPAS provided preliminary information on the outcome domains and format of data, detailed information on the exact measures used by each program was not obtained. The CEPAS and CEPAS-D were designed to provide an overview of program components and to be completed quickly, in approximately 15-25 minutes to encourage participation by programs. Follow up interviews of program leadership will obtain additional information on these two essential areas to further guide program inclusion decisions.

Identification of Potential Comparator Programs

Over the course of this project, we have proposed that any evaluation of EP programs must also include an appropriate comparison group if we are to determine the impact of EP programs on outcomes and costs. If we want to determine if EP programs yield "better outcomes" or "lower costs," then the analysis must ask "better or less costly than what alternative?" Otherwise, there is no way to know if the outcomes reported by EP programs differ in any meaningful way from other programs that serve similar clients in the community. For example, with data from given EP Program A, you could conduct a "within program analyses" and ask the question: "Do Program A participants' severity of psychosis symptoms decline over time?" This is the typical approach for internal quality improvement projects and can allow you to see trends related to individuals' participation in Program A; however, they do not allow you to understand how participation in Program A leads to better or worse outcomes for its participants in comparison to similar Programs B or C. Further, in an examination of costs, a within-program analysis does not allow you to say that Program A is more or less expensive than comparable programs.

Therefore, to compare the outcomes and costs of the EP programs to what they would be without the programs, an appropriate comparison group representing "standard care" (SC) is an essential component of

this evaluation. The comparison group for each county would be comprised of individuals receiving SC that were enrolled in treatment during the same timeframe, with the same characteristics (e.g. diagnosis, age, sex) in the same community. Through the implementation of the current deliverable, it was recognized that EP programs might not know the best comparator for their clinic in their community. Therefore, we decided to proceed with the descriptive assessment of EP programs and to gather additional information about potential comparator groups as part of follow up interviews, which will be reported in Deliverable #7 (*Proposed Statewide Evaluation Plan)*. We also recognized that further engagement at the county and state level would be required to provide support for comparator site participation, due to the fact that outcome or cost data may be held at the county rather than program level. Engagement of potential comparator sites via stakeholder meetings would also be helpful to identify their motivation related to participating in the evaluation. These next steps will be essential components of developing the proposal for statewide evaluation.

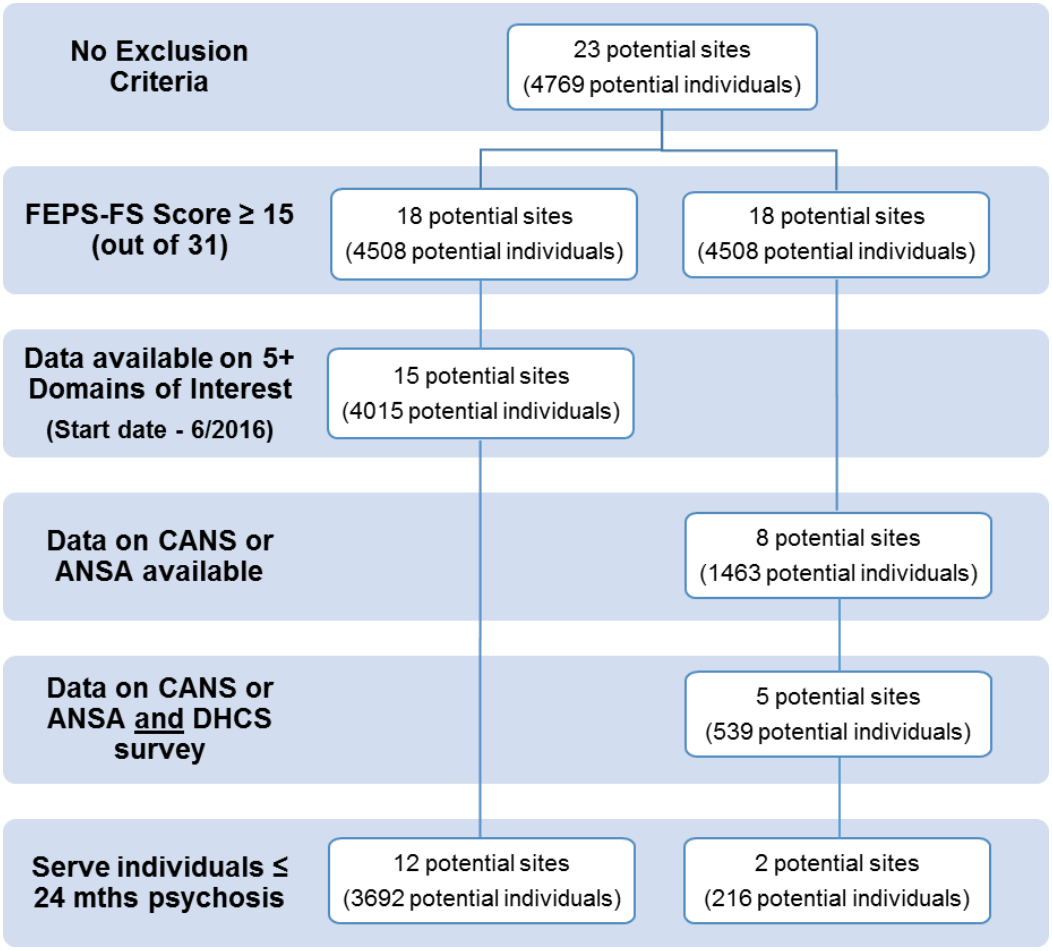
Considerations for Future Statewide Study Design

In Deliverable 4, we described potential methods for examining the impact of a program on outcomes and costs. In *retrospective* approach, the analysis of outcomes and costs relies on historical data collected as part of regular operations for the EP and comparison programs during the same timeframe. Based on the information summarized above in Table 26, one can see options for how programs may be chosen for inclusion in a retrospective statewide evaluation. For example, if we were to limit inclusion to only those programs who reported a potential minimum fidelity to the EP coordinated specialty care model on the FEPS-FS 1.0 greater than or equal to 15 (out of 31), that would yield 18 sites for potential inclusion. Based upon the numbers of clients that have been reportedly treated by those programs since their inception up to June 2016, this could yield data on approximately 4508 individuals. Similarly, if we were to limit inclusion to sites with FEPS-FS 1.0 scores greater than or equal to 15 (out of 31) and potential outcomes data on five or more relevant domains, that would yield 15 potential sites with data on approximately 4015 individuals. If we also required that programs serve individuals with less than 24 months of psychotic illness, the number of potential sites would reduce to 12 with approximately 3692 individuals.

In contrast, if we were to include sites with FEPS-FS 1.0 scores greater than or equal to 15 (out of 31) and CANS/ANSA data, that would yield 8 potential sites with data on approximately 1463 individuals. Finally, consistent with the Sacramento County pilot described in Deliverable 3, if we were to include sites with FEPS-FS 1.0 scores greater than or equal to 15 (out of 31), CANS/ANSA data, as well as data on the DHCS Consumer Survey, it would yield 5 potential sites with approximately 539individuals. If we also required that programs serve individuals with less than 24 months of psychotic illness, the number of potential sites would reduce to 2 with approximately 216 individuals.

The impact of this approach on the number of potential individuals who could be included in a retrospective analysis is illustrated in Figure 12 below, which shows the decreasing number of potential individuals by program with each additional inclusion criteria that is added.

Figure 12. Impact of inclusion criterion on number of sites/individuals for potential retrospective analysis



However, the comparability of outcomes data across sites and availability of outcomes data on all reported individuals is not clear; therefore these numbers represent the *maximum* sample size that could be expected, which actual numbers likely being well below expectations. This was illustrated in the UC Davis pilot analysis, where data on some variables (i.e. diagnosis) were available for the EP and comparator sites on 100% of individuals, while data on key outcomes (e.g. employment, school participation, social relationships) were only available on 23-51% of individuals for the EP program at 12 month follow up. Consequently, at best, we may be able to obtain comparable retrospective data on approximate half of the estimated numbers reported in Figure 12 above, with smaller sample sizes on most data elements of interest. Available data was even more limited for the comparator programs, with data available on only 42% of comparator individuals at baseline and further reduced to 20% of comparator individuals by 12 months. These issues were related to missing data at follow up, as well as site-specific delays in implementing outcome measures, and therefore hindered the ability to draw strong conclusions about the pilot analysis results. These challenges will likely exist in other counties and therefore complicate the ability to find complete data on comparable measures of outcomes and costs for both EP and comparator programs.

Further, stakeholders expressed concerns about using the CANS and ANSA as measures of outcomes across counties when the measures are not designed for this purpose, and each measure is used with specific age ranges (e.g. CANS used up to age 21) and cannot be combined. Therefore, in addition to being limited to fewer programs serving fewer clients, retrospective analyses based on these measures will be impacted by the same issues related to missing data, implementation timelines, and limited samples due to age range. While a retrospective approach may seem like the least costly method, it will require significant investment to support both EP and comparator programs to identify data, check it for errors, and make it available for analysis. Furthermore, results will be applicable only to a limited set of EP programs.

In contrast, these data also illustrate potential options for program inclusion in a *prospective* evaluation. In this approach, we could choose to include all programs who reported a potential minimum fidelity to the EP coordinated specialty care model on the FEPS-FS 1.0 greater than or equal to 15 (out of 31), yielding 18 sites for potential inclusion. If these sites continue to serve FEP individuals at their historical rate, that could yield comparable data for approximately 4500 individuals. Although not yet operational, six programs that are in development reported aspirations to meet this FEPS-FS 1.0 criteria, which could represent additional sites for inclusion in a prospective design. This approach would require investment to develop core data elements, which are considered appropriate and useful by both EP and comparator programs, and determine appropriate methods for data collection. Further, recovery-oriented data elements could also be included to understand program impact across additional domains that are important to stakeholders and may not be reflected in more traditional outcome measures. As noted in the stakeholder meeting, clients and families could directly provide data via questionnaires, which would reduce burden on clinic staff, and such data could be collected electronically on tablets to minimize data loss. If data elements are seen as useful metrics of program goals, the collection of outcomes data in this method could increase motivation for participation by EP and county programs. Many of the stakeholders noted a desire to have more outcomes information to show the impact of their program and desire to participate in a learning healthcare network.

Increasing County Collaboration

A stated goal of this deliverable is identifying methods to encourage successful provider and county participation in a statewide evaluation. Over the course of the project, we have sought multiple opportunities to engage with counties and other relevant stakeholder groups. The Mental Health Services Oversight and Accountability Commission webinar as part of Deliverable 4 allowed us to inform counties about the goals of the project and encourage participation. During Deliverables 4 and 5, we had direct contact with all California counties by phone call and emails, allowing us to develop effective lines of communication with county staff and EP program directors and managers. We have developed a relationship with the Community Behavioral Health Directors Association (CBHDA), which has helped us disseminate information and request support from county and program leadership. Finally, our stakeholder group helps to connect us with other important constituents, disseminate information, and gather support for the project.

Stakeholders outlined potential motivating factors for participation in statewide evaluation, for both EP and comparator programs. Stakeholders felt that the opportunity to gain valuable information about program impact – perhaps through a learning healthcare network – would be a valuable motivator for participation. Compensation for participation in surveys or interviews was also suggested, noting that many program staff and leadership are busy and may complete project tasks outside of work hours. Sufficient staffing of the statewide evaluation was also stressed in order to provide on-site support for data identification, cleaning, and entry or training of staff in administering outcomes evaluation. Stakeholders noted that many programs are understaffed and would need direct support to enable participation in an evaluation.

Over the course of the coming months, interviews with EP program staff will help to clarify the unique areas where programs would need support to participate in an evaluation. Further, county-level meetings will enable understanding of potential barriers to collecting data from the counties. As each county is unique, there may be a need to develop Memorandums of Understanding (MOU) with counties or to complete local Institutional Review Board (IRB) applications to gain access to the needed data. By discussing these barriers with the counties, the research team can account for potential challenges the project timeline for the proposed statewide evaluation in order to complete the research in a timely manner. As we engage with EP programs and counties to understand the support needed for participation in the statewide evaluation, we will also be able to gather information regarding options for “standard” care comparator clinics in the community and the availability of outcomes and costs data for those programs. Stakeholder meetings with potential comparator sites will identify factors that can enhance their motivation to participate as well as address any potential barriers or concerns.

Limitations

This descriptive assessment was based upon survey and interview data reported by staff associated with EP programs and counties. As a result, the findings reported here are contingent upon the accuracy of the information that was reported.

Although we adapted the FEPS-FS 1.0 to obtain potential fidelity via self-report, fidelity was not formally assessed. Importantly, survey and interview data only assessed for the potential presence of FEPS-FS 1.0 components and did not investigate the exact level of fidelity within each component. This limitation would be addressed through a formal fidelity evaluation as part of a statewide evaluation proposal.

When unusual or inconsistent information was found in the survey, we contacted the program or county respondent to clarify and adjusted the data accordingly. However, not all counties responded to our follow up contacts. Further, two counties did not provide complete data; therefore, we were not able to include them in some analyses. We will continue to work with programs and counties to ensure that all counties are engaged and our data is accurate in support of the proposal for a statewide evaluation.

As noted previously, we did not obtain detailed information on the assessment measures used by each program to examine the relevant outcome domains, or the availability of each measure in an electronic format. In our follow up interviews with EP programs, we will obtain detailed information on these items to guide the development of the statewide proposal.

Next Steps

To support the development of a statewide evaluation of EP programs, we will gather more specific information about the availability of outcomes data, develop methods for identifying and recruiting comparator programs, and identify additional methods for increasing feasibility of program implementation.

To date, we have identified which EP programs have the most available data and the outcome domains that are typically collected as part of EP care across active programs. Additional information is needed about the measures used to collect this information to determine how much additional effort is needed to harmonize the data across sites. For example, some sites may be collecting quantifiable data related to school performance (i.e. a numeric score on a measure of school functioning) while other sites may only qualitatively describe the individual's functioning in a paragraph of a report. Research staff would then have to determine how to create a "common score" across these two types of information. If many sites provide only qualitative descriptions of core outcomes, research staff would then have to code that data for analysis. This information will be gathered as part of follow up interviews with program staff as part of developing the statewide evaluation proposal.

To determine methods for identifying and encouraging comparator site participation, we will conduct stakeholder meetings with potential comparator sites to understand what barriers may hinder their participation and what might motivate them to participate in a statewide evaluation. This feedback, along with continued input from EP program staff, will help to shape the method that is proposed for the statewide evaluation.

Appendix A. California EP Program Contact List

County	Program / Project Name	Contact	Status
Alameda	Prevention & Recovery in Early Psychosis (PREP)	Adriana Furuzawa, MFTI, CPRP Division Director, PREP 415-474-7310 ext. 314 afuruzawa@felton.org	Active
Alpine		Alissa Nourse, Ed.M Director, Behavioral Health Department 530-694-1321 anourse@alpinecountyca.gov	No program
Amador		Melissa Cranfill, LCSW Director, Behavioral Health Department 209-223-6335 mcranfill@amadorgov.org	No program
Butte	Mobile TAY Project	Jeremy Wilson MHSA Program Director 530-891-2850 jwilson@buttecounty.net	Active
Calaveras		Joni Romeo, LMFT Clinic Supervisor, Behavioral Health Services 209-754-6532 jromeo@co.calaveras.ca.us	No program
Colusa	FEP Program	Deana Fleming, LCSW Deputy Director, Adult Services 530-458-0799 dfleming@countyofcolusa.com	In development
Contra Costa	First Hope	Nancy Ebbert, MD Lead Psychiatrist, First Hope nancy.ebbert@hsd.cccounty.us Phyllis Mace, LMFT Acting Program Supervisor, First Hope 925-681-4450 phyllis.mace@hsd.cccounty.us	Active
Del Norte		Jack Breazeal Clinical Services Manager, Department of Health & Human Services jbreazeal@co.del-norte.ca.us	No program
El Dorado	Transitional Age Youth Engagement, Wellness and Recovery Services: First Episode of Psychosis	Lesly VanSloten, LMFT Program Coordinator 530- 621-6133 Lesly.VanSloten@edcgov.us Sabrina Owen Program Manager, South Lake Tahoe Mental Health 530- 573-7956 sabrina.owen@edcgov.us	In development
Fresno	First Onset Team (FOT)	Jeffrey Avery, LMFT Clinical Supervisor 559-600-4681 javery@co.fresno.ca.us Karen Markland (MHSA Coordinator) 559-600-9055 KMarkland@co.fresno.ca.us	Active

		On emails, cc Stacy Vanbruggen and Paula Roberts svanbruggen@co.fresno.ca.us proberts@co.fresno.ca.us	
Glenn			No response
Humboldt		Jaclyn Culleton (MHSA Coordinator) 707-268-2923 jculleton@co.humboldt.ca.us	No program
Imperial		Sarah Moore sarahmoore@co.imperial.ca.us	Active
Inyo	FEP Program	Gail Zwier, PhD (MHSA Coordinator) 760-873-6533 gzwier@inyocounty.us	In development
Kern		Brad Cloud (Dep. Director Clinical Services) BCloud@co.kern.ca.us Steve Devore, LMFT sdevore@co.kern.ca.us	No program
Kings		Katie Arnst, MA (Program Manager) (559) 852-2317 katie.arnst@co.kings.ca.us	No program
Lake	FEP Program	Christina Drukala, LMFT Christina.Drukala@lakecountyca.gov	Active
Lassen	FEP Program	Scott Nordstrom, LCSW (Clinical Supervisor) 530-251-8108 snordstrom@co.lassen.ca.us Pamela Grosso (Director) (530) 251-8131 pgrosso@co.lassen.ca.us	In development
Los Angeles	Aftercare Research Program	Luana Turner, PsyD (Training Coordinator) 310.794.7340 (office) luana@ucla.edu	Active
Los Angeles	Center for the Assessment & Prevention of Prodromal States (CAPPS)	Dr. Carrie Bearden (Site Director) 310-206-3466 cbearden@mednet.ucla.edu Jamie Zinberg (Admin Director) JZinberg@mednet.ucla.edu	Active
Madera	Community Intervention Services (CIS)	Annette Presley (Division Manager) annette.presley@co.madera.ca.gov	Active
Marin	FEP Program	Laura Sciacca LSciacca@marincounty.org Kristen Gardner (MHSA Coordinator) 415-420-5911 kgardner@co.marin.ca.us	In development
Mariposa	Mariposa County First Episode Psychosis program (Mariposa FEP)	Todd Davidson, LMFT tdavidson@mariposahsc.org Barbara Gatlin (Deputy Director) bgatlin@mariposahsc.org	In development

Mendocino	Children and Family Services Program & TAY	Karen Lovato lovatok@co.mendocino.ca.us 707-472-2342 Robin Meloche melocher@co.mendocino.ca.us 707-472-2332 Jenine Miller millerje@co.mendocino.ca.us	Active
Merced	FEP Program	Betty Hoskins, LCSW CSOC Program Coordinator (209) 381-6800 Ext. 3277 bhoskins@co.merced.ca.us	In development
Modoc		Tara Shepherd tarashepherd@co.modoc.ca.us	No program
Mono		Robin Roberts (Director) 760-924-1740 rroberts@mono.ca.gov	No program
Monterey	Prevention & Recovery in Early Psychosis (PREP)	Adriana Furuzawa, MFTI, CPRP Division Director 415.474.7310 ext. 314 afuruzawa@felton.org	Active
Napa	Supportive Outreach & Access to Resources (SOAR)	Julianna Huijon, BSW (Bilingual Intake Coordinator) 707-253-0123, ext. 652 jhuijon@aldeainc.org	Active
Nevada		Michele Violett (MHSA Coordinator) 530-265-1790 michele.violett@co.nevada.ca.us	No program
Orange	Orange County Center for Resiliency Education & Wellness (OCCREW)	LEFT Skarlet Bui (Service Chief) 714-480-5115 sbui@ochca.com	Active
Placer	FEP Program - Turning Point Community Programs	Kathie Denton 530-886-2974 kdenton@placer.ca.gov	No program
Plumas		Bob Brunson, LMFT (Director) (530) 283-6307 EXT. 1006 bbrunson@pchb.services	No program
Riverside	FEP Program	John Schwarzlose JTSchwarzlose@rcmhd.org Paul Thompson PThompson@rcmhd.org	In development
Sacramento	EDAPT/SacEDAPT Clinic	Tara Niendam, PhD (Director of Operations) 916-734-3090 tniendam@ucdavis.edu	Active
San Benito		Alan Yamamoto (Director) (831) 636-4020 alan@sbcmh.org	No program
San Bernadino		Vernoica Kelley, LCSW (Asst. Director) 909-388-0808 vkelley@dbh.sbcounty.gov	No program

San Diego	Cognitive Assessment & Risk Evaluation (CARE) Program	Kristin Cadenhead, MD Tel: (619) 543-7745 Fax: (619) 543-7315 kcadenhead@ucsd.edu	Active
San Diego	Kickstart	Hope Graven (Clinical Director) 619-481-3790 hgraven@provcorp.com	Active
San Francisco	UCSF Path Program	Demian Rose, MD, Ph.D. (Clinic Director) 415-476-7843 demianr@lppi.ucsf.edu Gabriella Moreno Gabriella.Moreno@ucsf.edu	Active
San Francisco	Prevention & Recovery in Early Psychosis (PREP)	Adriana Furuzawa, MFTI, CPRP Division Director 415.474.7310 ext. 314 afuruzawa@felton.org	Active
San Joaquin	Telecare Early Intervention and Recovery (TEIR) Program	Melissa Planas (Clinical Director) 209-955-1139 mplanas@telecarecorp.com	Active
San Luis Obispo	Early Psychosis Program	Frank Warren (MHSA County Coordinator) 805.788.2055 fwarren@co.slo.ca.us	Active
San Mateo	Prevention & Recovery in Early Psychosis (PREP)	Adriana Furuzawa, MFTI, CPRP Division Director 415.474.7310 ext. 314 afuruzawa@felton.org	Active
Santa Barbara	FEP Program	Suzanne Grimmesey (Chief Quality Care and Service Officer) 805-681-5289 suzkirk@co.santa-barbara.ca.us Refuijo “Cuco” Rodriquez-Rodriquez (MHSA Coordinator) 805.681.4505 CucoRodriquez@co.santa-barbara.ca.us	Active
Santa Clara	INSPIRE Clinic	Jacob Ballon (Director) 650-723-3305 jballon@stanford.edu	Active
Santa Clara	Raising Awareness and Creating Early Hope (REACH) Program	Michelle Burlyga (Program Manager) 408-207-0070x5301 mburlyga@momentumMH.org Yea-Ching (Sunny) Wang 408-207-0070 x2115 ywang@momentumMH.org	Active
Santa Cruz	Early Intervention Program for Transition Age Youth & Adults	Steve Ruzicka (Supervisor) Steve.Ruzicka@santacruzcounty.us Jasmine Najera (Program Manager) Jasmine.Najera@santacruzcounty.us	Active
Shasta		Doug Shelton (Division Chief) 530-229-8423 Dshelton@co.shasta.ca.us	Active

Sierra	FEP Program	Kathryn Hill, LMFT (Asst. Director) khill@sierracounty.ca.gov 530-993-6746 Lea Salas (Asst. Director) lsalas@sierracounty.ca.gov	Active
Siskiyou		Camy Rightmier (MHSA Coordinator) 530-841-4281 crightmier@co.siskiyou.ca.us	No program
Solano	Supportive Outreach & Access to Resources (SOAR)	Julie Falicki, Program Director (707) 425-9670, ext. 218 jfalicki@aldeainc.org	Active
Sonoma	Crisis Assessment, Prevention, & Education (CAPE) Team	Susan Castillo, MSW (MHSA Program Manager) 707.565.5005 susan.castillo@sonoma-county.org	Active
Stanislaus	LIFE Path	Diane Rose, MFT (Program Supervisor) 209.312.9580 drose@sierravistacares.org	Active
Sutter		Patrick Larrigan plarrigan@co.sutter.ca.us	No program
Tehama	FEP Program	Elizabeth Gowan, LMFT 530-527-8491 x3026 betsy.gowan@tchsa.net	Active
Trinity	FEP Program	Julie Ashton-Boyd (Clinical Deputy Director) 530-623-1362 jashton-boyd@kingsview.org	In development
Tulare		Katrina Carmichael 559-624-7384 kvcarmichael@tularehhsa.org	No program
Tuolumne	FEP Program	Rita Austin laustin@co.tuolumne.ca.us	In development
Ventura	Ventura Early Intervention Prevention Services (VIPS)*	Barry Boatman, Psy.D. (Program Director) 805-642-7033 bboatman@telecarecorp.com	Active
Yolo	FEP Program - Turning Point Community Programs	Diana White (Turning Point Contractor) DianaWhite@tpcp.org Karen Larsen 530-666-8651 karen.larsen@yolocounty.org	Active
Yuba		Patrick Larrigan plarrigan@co.sutter.ca.us	No program

Appendix B. Stakeholder List

Stakeholder Name/ Affiliated County	Stakeholder Group(s)	Relevant Status
Rachel Loewy, Ph.D. *San Francisco*	Evaluation expert Early psychosis program provider	Professor *UC San Francisco* Researcher in Early Psychosis Developed 5 Prevention & Recovery in Early Psychosis (PREP) programs in Bay Area
Julie Godzikovskaya, M.A. *San Francisco*	Early psychosis program provider	Research & Evaluation Analyst *PREP Early Psychosis Program*
Bonita Hotz *Sacramento*	Family Advocate	Parent of EP service consumer Family Advocate *UC Davis SacEDAPT Clinic*
Mark Savill, Ph.D. *San Francisco*	Mental Health Services Researcher	Postdoctoral Fellow *UC San Francisco*
Debbie Innes-Gomberg, Ph.D. *Los Angeles*	Other community provider	Deputy Director *Adult System of Care & MHSA* Co-Chair *California Behavioral Health Directors Association (CBHDA)*
Sermed Alkass, Psy.D. *Los Angeles*	Other community provider	Managing Psychologist *Los Angeles County Department of Mental Health*
Jane Ann LeBlanc *Sacramento*	County Representative	MHSA Program Manager *Sacramento County Behavioral Health Services*
Brandon Staglin *Napa*	Consumer Advocate	Communications Director *International Mental Health Research Organization (IMHRO)/One Mind Institute*

Appendix C. FEPS-FS 1.0

Individual evidence-based practices	1	2	3	4	5
1. Timely contact with referred individual: patient is seen within two weeks of service receiving referral	Target met in-person appointment for 0-19% patients	Target met for in-person appointment for 20-39% patients	Target met for in-person appointment for 40-59% patients	Target met for in-person appointment for 60-79% patients	Target met for 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 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
3. Comprehensive clinical assessment. Initial assessment includes: 1. Time course of symptoms, change in functioning and substance use; 2. Recent changes in behaviour; 3. Risk assessment 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	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

Individual evidence-based practices	1	2	3	4	5
4. Psychosocial needs assessed for care plan: assess patient and family preference 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% of patients receive explicit individualized clinical treatment plan	20-39% of patients receive explicit individualized clinical treatment plan	40-59% of patients receive explicit individualized clinical treatment plan	60-79% of patients receive explicit individualized clinical treatment plan	80+% of patients receive explicit individualized clinical treatment plan
6. Antipsychotic medication prescription: after diagnostic assessment confirms psychosis and need for pharmacotherapy, antipsychotic medication is prescribed after taking into consideration 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

Individual evidence-based practices	1	2	3	4	5
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% 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% eligible patients receive guided reduction of antipsychotic medication	80+% eligible patients receive guided reduction of antipsychotic medication
8. Guided antipsychotic dose 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 monitored reduction of antipsychotic medication, some may discontinue medication. 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 % eligible patients receive guided reduction of antipsychotic medication	80+ % eligible patients receive guided reduction of antipsychotic medication
9. 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

Individual evidence-based practices	1	2	3	4	5
10. Patient psychoeducation: provision of at least 12 episodes of 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 episodes of psycho-education	20-39% patients receive at least 12 episodes of psycho-education	40-59% patients receive at least 12 episodes of psycho-education	60-79% patients receive at least 12 episodes of psycho-education	80+% patients receive at least 12 episodes of psycho-education
11. Family education and support: Provision of individual or group family education and support covering curriculum. At least 8 episodes delivered by appropriately trained clinician	0-19% families receive at least 8 episodes of family education & support	20-39% families receive at least 8 episodes of family education & support	40-59% families receive at least 8 episodes of family education & support	60-79% families receive at least 8 episodes of family education & support	80+% families receive at least 8 episodes of family education & support
12. Individual or group cognitive behaviour therapy (CBT), delivered by an appropriately trained professional, for treatment resistant positive symptoms, residual anxiety or depression: CBT is an evidence-based treatment that is indicated for treatment resistant positive symptoms, 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

Individual evidence-based practices	1	2	3	4	5
13. Individual and / or group interventions to prevent weight gain: at least 10 sessions to deliver evidence-based programs: nutritional counselling, cognitive behavioural therapy and exercise and medication options.	All patients have weight recorded. Feedback and weight management advice not pattern of practice	All patients have weight recorded. Feedback and weight 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
14. 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 0 – 19 % of annual assessments	7 assessment items found in 20 -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
15. Assigned psychiatrist: each patient has an assigned psychiatrist who sees 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

Individual evidence-based practices	1	2	3	4	5
16. 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
17. Motivational enhancement or cognitive behavioural 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
18. Supported employment (SE): SE is provided to patients interested in participating in competitive paid employment by 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 SE specialist who is part of FEP team and provides high fidelity SE services

Individual evidence-based practices	1	2	3	4	5
19. Active engagement and retention: use of 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
20. Community living skills: program works in the community, in addition to the office, to develop community living skills (i.e. Social activities, using transportation, renting, banking, budgeting, meal planning)	0-19% of patients receive community living skills training delivered in community setting	20-39 % of patients receive community living skills training delivered in community setting	40-59 % of patients receive community living skills training delivered in community setting	60-79 % of patients receive community living skills training delivered in community setting	>90 % of patients receive community living skills training delivered in community setting

Individual evidence-based practices	1	2	3	4	5
21. 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 members. No out of hours services or formal linkages to out of hours services	Team provides telephone crisis support up to 8 hrs per day 5 days per week but no linkage to out of hours crisis services	Team provides telephone crisis support 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 in person crisis service 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 in-person crisis support services 24 hrs per day, 7 days per week

Evidence-based team practices	1	2	3	4	5
22. 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
23. Practicing team leader: masters level team leader has administrative, supervisory responsibilities and has practical experience in delivering or still 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 in addition to providing some direct clinical service

Evidence-based team practices	1	2	3	4	5
24. 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. Not available for consult	Psychiatrist attends team meetings, does not see patients with other clinicians. Shares team health record. Is not available for consultations with staff	Psychiatrist attends team meetings, sees patients with other clinicians. Shares team health record. Is not available for consultations with staff	Psychiatrist attends team meetings, sees patients with other clinicians, shares team health record and available for consultations with staff.
25. Multidisciplinary team: qualified professionals to provide both case management and specific service elements including: 1. Nursing services; 2. Evidence-based psychotherapy; 3. Addictions services; 4. SE; 5. Family education/ support; 6. Social/community living skills; 7. Case management	Team delivers 3 or fewer of listed elements	Team delivers 4 of listed elements	Team delivers 5 of listed elements	Team delivers 6 of listed elements	Team delivers 7 of listed elements
26. Duration of FEP program: mandate of FEP program is to provide service to patients for specified period of time.	FEP program serves patients for 1 year or less	FEP program serves patients for 1 to 2 years	FEP program serves patients for 2 to 3 years	FEP program serves patients for 3 to 4 years	FEP program serves patients for 4+ years

27. 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	Bi-weekly team meetings	Weekly team meetings with less than all items covered	Weekly team meetings with all items covered
28. Targeted health / social service/ community group: provision of information to first-contact individuals, in health, education social agencies and community organizations.	No targeted education	First contact community education is occurring less than 6 times a year	First contact community education is occurring 6 to 9 times a year	First contact community education is occurring 9-12 times per year	First contact community education which is occurring > 12 times a year
29. 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 admitted to hospital are seen at FEP Service within 15 days of hospital discharge	20-39% of FEP patients admitted to hospital are seen at FEP Service within 15 days of hospital discharge	40-59% of FEP patients admitted to hospital are seen at FEP Service within 15 days of hospital discharge	60-79% of FEP patients admitted to hospital are seen at FEP Service within 15 days of hospital discharge	80+% of FEP patients admitted to hospital are seen at FEP Service within 15 days of hospital discharge
30. 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 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
31. 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

Appendix D. CEPAS

Although untreated mental illness can be devastating, an individual typically does not qualify for treatment until their symptoms are severe enough to adversely impact their life. In California, funding from the Mental Health Services Act (MHSA) provides a unique opportunity for counties to initiate programs to intervene early in the course of mental health difficulties, thereby preventing symptoms from becoming severe and disabling. Numerous California counties have elected to use MHSA funding to establish specialized early psychosis (EP) programs to attempt to reduce the negative outcomes related to mental illness, such as suicide, incarceration, school failure or dropout, unemployment, and homelessness. Research has found that EP programs are associated with improvements in such outcomes, as well as lower care-related costs. EP programs can target individuals with the recent onset of psychotic illness (e.g. first episode), individuals at high clinical risk (e.g. prodromal), or both. However, research related to the impact of EP programs is not specific to California, and does not take into account potential impacts on the counties where the programs are implemented, or the state overall.

Purpose of Survey: To guide the development of a proposal for a statewide evaluation of EP programs, this survey will ask you about various aspects of your program, such as populations served, program components, funding sources, and types of outcomes data collected. If you are currently planning or starting a program, it will ask you about what you are planning to do. This survey has been reviewed and approved by the UC Davis Institutional Review Board (IRB). With this information, California will be another step closer to understanding the contribution of EP programs to the lives of children and young adults living with serious mental illness.

Please note, if your agency has more than one program providing care for individuals in the early stages of psychosis (e.g. one program for first episode and another program for clinical high-risk; one program is currently active and another is in development; programs have different inclusion criteria; or programs have separate or different funding streams) **please complete separate surveys for each program.** This will allow us to capture the nuances of each program correctly.

Please remember:

- The survey will **auto-save your progress if you exit** (close your browser/tab) **without completing the full survey**. Therefore, **if you need to save and continue later**, close the survey as needed and click the link again.
- **For individuals filling out multiple surveys, please note that the link included in the email is reusable.** Upon completing the survey for one program, click the link again to reopen a new survey, and then enter the data for your second program.

Program Contact Information

Program Name:
County where program is located:
Name of individual completing survey:
Role of individual completing survey:
Phone Number:
Email:

Introduction

1) What is the status of your early psychosis program? *[Please select one option below]*

a) We are open and actively enrolling clients
b) We have not started to enroll clients, but our program is established and we are training staff
c) We have funding and are working to develop our program
d) We do not have funding yet, but are in the planning and preparation phase
e) We are interested in developing a program, but haven't started any planning
f) Other (please describe)

For selections of b-d, → Please complete "PROGRAMS IN DEVELOPMENT" survey instead

For selections of e & f → Please complete "MHSA Directors Interview" instead

For selection a → Continue below

Section 1: Program Description

1) When did you begin to serve clients in your community *(i.e. actively enroll and provide treatment)*? **Please indicate the month and year in the following format: mm/dd/yyyy.** P*lease use "01" for "dd" if you are unsure of the exact date*. ____/ ____ / _____

2) Since starting your program, approximately how many clients have you served *(i.e. actively enrolled and provided treatment)* through FY 2015-2016 (June 30, 2016)? _____

3) Is your program a stand-alone program or integrated within other established clinical services? *[Please select one option below]*

a) Stand-alone/independent program *(e.g. own site, staff, management, oversight)*
b) Stand-alone/independent program *(e.g. own site)* associated with established program/agency (e.g. provide oversight, support)
c) Integrated within another program *(e.g. shared space, staff, management)*
d) Other (please describe): _____
e) Uncertain

4) Does your program serve first-episode psychosis (FEP) clients, clinical high-risk (CHR)/prodromal clients, or both? *[Please select one option below]*

a) FEP clients ONLY *(experience recent onset of psychotic-level hallucinations, delusions, disorganized speech/behavior; meet criteria for DSM Schizophrenia Spectrum Disorders or another DSM disorder with psychotic features; experience positive symptoms at a score of 6 on the SIPS)*
b) CHR/prodromal clients ONLY *(experience attenuated/subthreshold hallucinations, delusions, disorganized speech; meet criteria for a CHR diagnosis according to the SIPS or CAARMS)*
c) BOTH FEP and CHR/prodromal clients
d) Other (please describe): _____

4-1) *[If 4a or 4c is selected]* What duration of first-episode psychosis onset do you serve (in months)? _____

4-2) *[If 4a or 4c is selected]* How does your program determine the date of psychosis onset *(e.g. month and year when symptoms reached threshold psychosis level)* for FEP clients?
_____

4-3) *[If 4b or 4c is selected]* Please clarify what types of CHR clients you serve. **Please check all that apply.** *[multi-answer checkboxes]*

a) Recent onset but brief psychosis *(e.g. fully psychotic symptoms of recent onset and brief duration; BIPS or POPS on the SIPS)*
b) Attenuated/subthreshold symptoms of psychosis *(e.g. APS on the SIPS)*
c) Genetic risk (family history and/or schizotypal personality disorder) PLUS deterioration *(e.g. GRDS on the SIPS)*

d) Other (please describe): _____

4-3-1) *[If 4-3a is selected]* For recent onset but brief psychosis *(e.g. BIPS)* CHR cases, how many days maximum of full psychosis do you allow for an individual to still be categorized as CHR? _____

5) What DSM diagnoses does your program serve? **Please check all that apply.**

a) Schizophrenia Spectrum Diagnoses *(e.g. Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder)*
b) Other Psychotic Spectrum Disorders *(e.g. Psychotic Disorder NOS, Brief Psychotic Disorder, Delusional Disorder)*
c) Mood Disorders *(e.g. Major Depressive Disorder, Bipolar Disorder)* WITH Psychotic features
d) Mood Disorders *(e.g. Major Depressive Disorder, Bipolar Disorder)* WITHOUT Psychotic features
e) Other (please describe): _____

6) What age range does your program serve? *[Please select one option below]*

a) Age range accepted: _____
b) All ages served

7) What are the exclusion criteria for your program? **Please check all that apply.**

a) Axis II diagnosis *(e.g. personality disorders)*
b) Intellectual disability *(i.e. IQ under 70)*
c) Substance use disorder (of any kind)
d) Substance dependence only
e) Substance-induced psychotic disorder
f) Not county resident (where program is located)
g) No specific exclusion criteria (we serve everyone)
h) Other (please describe): _____

8) On average, how many new clients are evaluated for eligibility *(e.g. intake evaluations)* by your program each month? _____

9) On average, how many clients are engaged in ongoing treatment *(e.g. therapy, groups, med management)* with your program each month *(i.e. monthly "census" of clients active in treatment)*?

_____

a) On average, what percentage of your program census *(i.e. individuals deemed eligible at intake and then engaged in ongoing treatment)* is FEP versus CHR? **If a percentage of your clients meet criteria under another category, please define it below.**
   (i) % FEP: _____
   (ii) % CHR: _____
   (iii) % other (define): _____

10) On average, what is the target amount of time your program serves each client? *[Please select one option below]*

a) 1 year or less
b) Up to 2 years
c) Up to 3 years
d) Up to 4 years

e) More than 4 years *(e.g. no limit)*
f) Other (please describe): _____

11) Is your program able to offer services to the following types of clients? We will ask you later how services for these clients are covered/funded. **Please check all that apply.**

a) Uninsured clients
b) Undocumented clients
c) Private insurance clients
d) We do not serve any of these types of clients

12) Does your program use a particular treatment model? *[Please select one option below]*

a) PREP
b) PIER
c) EDAPT
d) EASA
e) RAISE
f) Other (please describe): _____
g) Uncertain

Please continue with survey on next page

Section 2: Data Collection & Medical Record System

1. Does your program collect information on the following domains as part of your standard assessment battery? If so, please indicate how often this data is collected *(e.g. intake and every 6 months after)*. For some items, you may assess the domain more often *(e.g. risk for suicide after a hospitalization)*; however we are interested in the data you collect at regular intervals as part of a standardized intake or outcomes assessment. **Please check all that apply.**

	At intake	Each visit	Monthly	Every 3 months	Every 6 months	Every 12 months	PRN (as needed)	Other	Not collected
Client characteristics *(e.g. sex, gender, age, race/ ethnicity, zip code, etc.)*									
Diagnosis *(e.g. via SIPS, SCID, MINI, etc.)*									
Symptom severity scores *(e.g. SANS, SAPS, BPRS, CGI)*									
Physical health *(e.g. comorbid medical diagnosis/Axis III)*									
Metabolic parameters *(e.g. labs with glucose, lipids)*									
Vitals *(e.g. blood pressure, weight, height)*									
Family history of mental health conditions									
Cognitive measures *(e.g. IQ scores)*									
Psychosocial data *(e.g. CANS/ANSA, GAF, Global Functioning Scales: Social and Role)*									
Premorbid functioning *(e.g. PAS)*									
Medication data *(e.g. medications prescribed, dosage, duration of supply)*									
Medication side effects (e.g. AIMS, Barnes)									
Substance use data *(e.g. substances used, frequency, impact)*									
Hospitalizations *(dates, duration, reason)*									
ER or crisis utilization *(dates, duration, reason)*									
Legal involvement *(e.g. arrests, incarcerations)*									
Risk assessment *(e.g. suicidal ideation/attempts, danger to others, etc.)*									
Self-report of impact of care received *(e.g. DHCS MHSIP Consumer Survey, etc.)*									
Satisfaction with treatment *(e.g. CSQ)*									
Other (please describe):									

1) Does your program collect data via any of these specific measures? **Please check all that apply.** *[multi-answer checkboxes]*

a) ANSA
b) CANS
c) DHCS Adult MHSIP Consumer Survey – Adult Version
d) DHCS Adult MHSIP Consumer Survey – Youth Version
e) We do not collect any of these measures

2) Does your program seek involvement from family members or significant collateral informants *(e.g. significant other, extended family, roommates)* during the initial assessment, if the client with FEP consents? *[Please select one option below]*

a) Yes
b) No
c) Uncertain

3) Do you keep paper or electronic client records? *[Please select one option below]*

a) Paper only
b) Electronic only
c) Both

3-1) *[If 4b or 4c is selected]* When did you implement your electronic medical record? **Please indicate the month and year in the following format: mm/dd/yyyy.** P*lease use "01" for "dd" if you are unsure of the exact date*. ____/ ____ / _____

3-2) *[If 4b or 4c is selected]* Is your electronic medical record system part of the county-wide system, or is it a program-specific (internal) system? *[Please select one option below]*

a) County system
b) Program (internal) system
c) Uncertain

3-3) *[If 4b or 4c is selected]* Based on your previous responses regarding information your program collects, which of the following are recorded <u>within your electronic medical record</u> (or other electronic database)? **Please check all that apply.** *[multi-answer checkboxes]*

a) Client characteristics (e.g. sex, gender, age, race/ethnicity, zip code, etc.)
b) Diagnosis (via SIPS, SCID, MINI, etc.)
c) Symptom severity scores (e.g., SANS, SAPS, BPRS, CGI)
d) Physical health (e.g. comorbid medical diagnosis/Axis III)
e) Metabolic parameters (weight, labs with glucose, lipids)
f) Vitals (e.g. blood pressure, weight, height)
g) Family history of mental health conditions
h) Cognitive measures (e.g. IQ scores)
i) Psychosocial data (e.g. CANS/ANSA, GAF, Global Functioning Scales: Social and Role)
j) Premorbid functioning (e.g. PAS)

k) Medication data (e.g. medications prescribed, dosage, duration of supply)
l) Medication side effects (e.g. AIMS, Barnes)
m) Substance use data (e.g. substances used, frequency, impact)
n) Hospitalization (dates, duration, reason)
o) ER or Crisis utilization (dates, duration, reason)
p) Legal involvement (e.g. arrests, incarcerations)
q) Risk assessment (e.g. suicidal ideation/attempts, danger to others, etc.)
r) Self-report of impact of care received (e.g. DHCS Adult MHSIP Consumer Survey – Adult/Youth Version, etc.)
s) Satisfaction with treatment (e.g. CSQ)
t) Other (please describe): _____

3-4) *[If 4b or 4c is selected]* Are you able to generate reports on the data you have collected? *[Please select one option below]*

a) Yes, we can extract data from our electronic medical record
b) Yes, we collect data within a database or other electronic format (e.g. Microsoft Access, Excel)
c) No, we do not systematically collect our data in an electronic format
d) Uncertain

4-4-1) *[If 4-4a is selected]* Who is able to generate summary data reports? *[Please select one option below]*

a) County staff only
a) County staff and clinic staff
a) County staff only, but clinic staff can request special reports

3-5) Does your program regularly check your data (in your EMR or in your database) for completeness? *[Please select one option below]*

a) Yes, regularly
b) Yes, but irregularly
c) No, we have not checked it
d) Uncertain

4) Is your program/county planning or considering any changes to your data collection methods in the next year (e.g. starting or stopping the use of a particular measure, implementing an electronic health record)? *[Please select one option below]*

a) No changes planned currently – we will continue to use our current methods
b) Yes, we are planning changes to our measures (please describe): _____
c) Yes, we are planning changes to our data collection system (please describe): _____
d) Uncertain

Section 3: Funding Sources

1) What percentage of your annual funding comes from the following sources? **Please check all sources that apply and indicate the percentage for each *(e.g. 25% MHSA, 25% Medi-Cal/EPSDT, etc.)*.** *[multi-answer checkboxes with associated text boxes]*

a) MHSA
b) Medi-Cal/EPSDT

c) SAMHSA Mental Health Block Grant (MHBG)
d) 26.5 funds
e) Private insurance, including Kaiser
f) Self-pay or sliding scale
g) Research grants
h) Donors
i) Other (please describe): _____

1-1) *[If 1a is selected]* Which MHSA funding stream(s) is/are used to support your program? **Please check all that apply.** *[multi-answer checkboxes]*
   a) Prevention and Early Intervention (PEI)
   b) Community Supports and Services (CSS)
   c) Innovation Programs (INN)
   d) Capital Facilities and Technology (CFT)
   e) Workforce Education & Training (WET)
   f) Uncertain

2) What percentage of your clients pay for (or have their services covered) by the following sources? **Please check all sources that apply and indicate the percentage for each *(e.g. 25% MHSA, 25% Medi-Cal/EPSDT, etc.)*.** *[multi-answer checkboxes with associated text boxes]*
   a) MHSA only (no other funding)
   b) Medi-Cal/EPSDT
   c) SAMHSA MHBG
   d) 26.5 funds
   e) Private insurance (including Kaiser)
   f) Self-pay or sliding scale
   g) Other (please describe): _____
   h) Uncertain

3) In general, how are you reimbursed for the services you provide as part of your contract? *[Please select one option below]*
   a) Rate per unit of service *(e.g. $1.21 per unit of case management)*, established by contract
   b) Flat rate per client served across all service types *(e.g. $1000 per client served per year – services are "bundled")*
   c) Hourly rate based on service type provided *(e.g. $60 per 50 min therapy session)*
   d) Other (please describe): _____

4) Has your program received training, technical assistance or support from an outside organization(s) or university? *[Please select one option below]*
   a) Yes, we are currently working with an outside organization(s) for training (e.g. regular trainings and/or supervision are provided)
   b) Yes, we have worked with an organization(s) in the past, but are no longer engaged in formal training relationship (e.g. may have brief calls to check in as needed)

c) No, we are not currently collaborating with an outside organization, BUT we would like to in the future
d) No, we are not current collaborating with an outside organization and we do not plan to
e) Uncertain

4-1) *[If 4a or 4b is selected]* What are the name(s) of the organization(s) or university that provided you with training? What type of training did they provide?

_____

4-2) *[If 4c is selected]* What type of training are you interested in?

_____

5) Approximately how many NEW staff have you needed to train each year?

_____

6) Are there any particular staff positions that you consistently have difficulty filling?

_____

7) What percent of your annual budget is allocated to training NEW staff?

_____

Now that we have collected some general data on your program, we would like to ask you some more specific questions about components of your program. **For the following questions, please focus on the services provided by your program to individuals who have experienced the onset of full psychosis (FEP), even if your program also serves CHR clients.**

Section 4: Program Components - Outreach, Referrals & Engagement

1) Does your program provide outreach and information on how to identify psychosis and refer to first-contact individuals in the community? **Please check all that apply.**

a) Yes, to health/medical agencies
b) Yes, to education agencies or schools
c) Yes, to social services agencies
d) Yes, to community mental health organizations
e) Yes, to jails and prisons
f) Yes, to police departments
g) Yes, to other community organizations
h) Yes, via social media
i) No
j) Uncertain

1-1) *[If any of 1a through 1h are selected]* How often is community education/outreach occurring? *[Please select one option below]*

a) Less than 6 times per year
b) 6-9 times per year
c) 9-12 times per year

d) >12 times per year
e) Uncertain

2) After a client with FEP is referred to your clinic and you determine they are eligible for an intake, what is the average timeframe (in weeks) within which you are able to offer them a first face-to-face *(e.g. intake)* appointment? _____

3) Does your program offer proactive outreach and engagement for clients with FEP, such as community based intake appointments or ongoing community-based visits, to reduce missed appointments? *[Please select one option below]*

a) Yes
b) No
c) Uncertain

Section 5: Program Components – Education, Therapy and Services

1) Does your program staff develop an individualized treatment plan with the client and family, addressing their needs, goals, and preferences? *[Please select one option below]*

a) Yes, at the start of treatment
b) Yes, at the start of treatment and annually there after
c) No
d) Other (please describe): _____
e) Uncertain

1-1) What information about the psychosocial needs of the FEP client are incorporated into your treatment plan? **Please check all that apply.** *[multiple answer checkboxes]*

a) Housing
b) Employment
c) Education
d) Social support
e) Finances
f) Basic living skills
g) Registered with a primary care physician
h) Social skills
i) Past trauma
j) Legal
k) Other (please describe): _____

2) What components of multi-disciplinary care does your program team offer as part of the treatment plan? **Please check all that apply** *[multi-answer checkboxes]*

a) Psychiatric services *(e.g. regular appointments for medication support)*
b) Nursing services
c) Individual psychotherapy
d) Case management
e) Client-focused psychoeducation or illness management training (via individual or group setting)

f) Treatment of comorbid substance use
g) Supported employment
h) Supported education
i) Family/caregiver/support person education and support (via individual or group setting)
j) Family therapy
k) Occupational therapy
l) Social and community living skills training *(e.g. social activities, using transportation, renting, banking, budgeting, meal planning)*
m) Multi-Family Groups (MFG)
n) Other (please describe): _____

3) Do you offer clients with FEP sessions of individual or group psychotherapy, delivered by an appropriately trained professional, using any of the following approaches? **Please check all that apply.**

a) Cognitive Behavioral Therapy (CBT) for psychosis symptoms
b) Cognitive Behavioral Therapy (CBT) for OTHER symptoms *(e.g. depression, anxiety)*
c) Cognitive Behavioral Therapy (CBT) or Motivational Enhancement for comorbid substance use
d) Cognitive Behavioral Social Skills Training
e) Dialectical Behavior Therapy (DBT)
f) Multi Family Group (MFG)
g) Family-Focused Therapy (FFT)
h) Trauma informed care *(e.g. TF-CBT)*
i) Individual Placement and Support (IPS)
j) Feedback-Informed Treatment (FIT)
k) Wellness Recovery Action Planning (WRAP)
l) Mindfulness-based treatment
m) Cognitive training/remediation
n) Structured intervention to prevent weight gain
o) Other standardized curricula or evidence-based treatment (please describe):
p) We do not use any of these treatments

4) Does your program deliver crisis intervention services or provide links to crisis response services in the community? **Please check all that apply.**

a) Yes, we deliver crisis intervention services during regular working hours
b) Yes, we deliver crisis intervention services 24 hours per day, 7 days per week
c) Yes, we provide links to crisis lines
d) Yes, we provide links to mobile response teams
e) Yes, we provide links to urgent care centers
f) Yes, we provide links to hospital emergency rooms
g) Other (please describe):
h) No

5) Is there a formal link between your program and psychiatric hospital inpatient units? *[Please select one option below]*

a) Yes
b) No

c) Uncertain

6) Are clients who are admitted to the hospital provided with an appointment to be seen at your program within 15 days of discharge? *[Please select one option below]*
   a) Yes
   b) No
   c) Uncertain

Section 6: Program Components – Medications

1) After a diagnostic assessment confirms psychosis, are your clients with FEP prescribed antipsychotic medication, after taking into consideration client preference? *[Please select one option below]*
   a) Yes
   b) No
   c) Uncertain

2) Do you offer your clients with FEP any of the following options related to their psychiatric care? Please check all that apply. *[multi-answer checkboxes]*
   a) Medication decision based on standardized algorithm (e.g. PORT, RAISE)
   b) Guided antipsychotic dose reduction after at least one year of remission
   c) Clozapine after two unsuccessful trials of antipsychotics
   d) Depot/injection antipsychotic medication option
   e) Other standardized curricula or evidence-based treatment (please describe):
   f) We do not offer any of these options related to psychiatric care

Section 7: Program Components – Providers and Program Administration

1) What types of support staff and direct clinical service providers does your program employ? **Please indicate ALL roles available, whether or not the position is currently filled.**
   a) Program Director *(provides leadership at organizational, county or state level, but not day-to-day oversight)*
   b) Program Manager *(provides day-to-day oversight of activities, manages staff)*
   c) Physician/Psychiatrist *(provides direct service)*
   d) Registered nurse (RN)/Nurse practitioner *(provides direct service)*
   e) Clinical Supervisor *(supervises staff, ensures fidelity to model - may also provide direct service)*
   f) Licensed clinicians *(e.g. LCSW, LMFT, psychologist – provide direct service)*
   g) Masters-level professionals *(e.g. MFT, MSW – provide direct service)*
   h) Supported Employment Specialist *(provides direct support in maintaining or obtaining linkage to services in work setting)*
   i) Supported Education Specialist *(provides direct support in maintaining or obtaining linkage to services in school setting)*
   j) Community Support Specialist *(provides direct service linking or supporting engagement in daily living skills or community activities)*
   k) Occupational Therapist *(provides direct service)*

l) Family Advocate *(has lived experience as caregiver/primary support person for family member with psychosis - provides direct or supporting service)*
m) Consumer/Peer Advocate *(has lived experience with psychosis - provides direct or supporting service)*
n) Case managers *(e.g. no clinical training or degree required, provide support for linkage, daily skills, etc.)*
o) Clerical support/Clinic Coordinator
p) Other (please describe): _____

2) What is the ratio of active FEP clients to case-carrying clinician/case manager ratio in your program? *[Please select one option below]*
a) 51+ clients with FEP per provider FTE
b) 41-50 clients with FEP per provider FTE
c) 31-40 clients with FEP per provider FTE
d) 21-30 clients with FEP per provider FTE
e) 20 or fewer clients with FEP per provider FTE

3) Does your program have a Masters-level (or higher) Team Leader/Supervisor? *[Please select one option below]*
a) Yes, providing only administrative/managerial direction – no responsibility to ensure clinical supervision
b) Yes, providing administrative direction AND ensures clinical supervision by others
c) Yes, providing administrative direction AND supervision to SOME staff
d) Yes, providing administrative direction AND supervision to ALL staff
e) Yes, providing administrative direction AND supervision to ALL staff, in addition to providing some direct clinical services
f) No, our program does not have a Master-level Team Leader

4) Does your program have a psychiatrist who is integrated within your team? *[Please select one option below]*
a) Yes
b) No

4-1) *[If 4a is selected]* What is the role of your psychiatrist? Please check all that apply. *[multi-answer checkboxes]*
a) Attends team meetings
b) Assigned to specific clients
c) Sees clients in the program location
d) Shares team health records
e) Sees clients with other clinicians
f) Available for consultations during the work week
g) Is co-located with other team members
h) Other (please describe)

5) Do your clients with FEP have an assigned case manager or clinician? *[Please select one option below]*
a) Yes

b) No

6) Does your program offer the use of interpreters? *[Please select one option below]*
a) Yes
b) No
c) Uncertain

7) How often does your program hold team meetings? *[Please select one option below]*
a) Monthly team meetings
b) Bi-weekly team meetings
c) Weekly team meetings
d) We do not hold team meetings
e) Uncertain

7-1) *[If 7a, 7b or 7c is selected]* Which of the following items are covered in your team meetings? Please check all that apply.
a) Case review (admissions and discharge)
b) Assessment and treatment planning
c) Discussion of complex cases
d) Termination of services
e) Other (please describe)

FEP vs. CHR Treatment Model

1) You indicated that your program serves both FEP and CHR clients. Based on your responses throughout this survey, do any of the services you provide differ between FEP and CHR clients? **If yes, please describe***:* _____

Section 8: Essential Components of FEP Care

1) For the components of FEP care listed below, please indicate your opinion of how important each component is to provide for individuals with FEP, even if you are not currently able to offer a particular component in your program, on a scale of 1 ("Unimportant") to 5 ("Extremely important").

Individual Evidence-Based Practices						
Treatment Components	**5 = Extremely important** *Essential, must be given to everyone in FEP care.*	**4 = Important** *Should be offered to everyone in FEP care.*	**3 = Equivocal** *May be useful for a subset of individuals in FEP care.*	**2 = Less Important** *Less important, but nice to have available for individuals who want it.*	**1 = Unimportant** *Not important for FEP care.*
1. Offer the first face-to-face appointment within 2 weeks for eligible clients					
2. Seek involvement from family members or significant collateral informants during the initial					

Individual Evidence-Based Practices					
Treatment Components	**5 = Extremely important** *Essential, must be given to everyone in FEP care.*	**4 = Important** *Should be offered to everyone in FEP care.*	**3 = Equivocal** *May be useful for a subset of individuals in FEP care.*	**2 = Less Important** *Less important, but nice to have available for individuals who want it.*	**1 = Unimportant** *Not important for FEP care.*
assessment (if client consent is obtained)					
3. Comprehensive clinical assessment at intake (including symptoms, functioning, substance use, behavioral changes, risk assessment, mental status exam, etc.)					
4. Create individualized treatment plan with the client and family, addressing their needs, goals, and preferences					
5. Psychosocial needs incorporated into care plan (including housing, employment, education, social support, finances, etc.)					
6. Case manager/clinician assigned to specific clients for ongoing care					
7. Proactive outreach and engagement for clients (e.g. community based intake appointments or ongoing community-based visits) to reduce missed appointments					
8. Psychiatrists assigned to specific clients for ongoing care					
9. After a diagnostic assessment confirms psychosis, clients prescribed antipsychotic medication (with consideration of client preference)					
10. Medication decision based on standardized algorithm (e.g. PORT, RAISE)					
11. Guided antipsychotic dose reduction after at least one year of remission					
12. Clozapine offered after two unsuccessful trials of antipsychotics					
13. Client-focused psychoeducation or illness management training (via individual or group setting)					
14. Family/caregiver/support person education and support (via individual or group setting)					

Individual Evidence-Based Practices					
Treatment Components	**5 = Extremely important** *Essential, must be given to everyone in FEP care.*	**4 = Important** *Should be offered to everyone in FEP care.*	**3 = Equivocal** *May be useful for a subset of individuals in FEP care.*	**2 = Less Important** *Less important, but nice to have available for individuals who want it.*	**1 = Unimportant** *Not important for FEP care.*
15. Cognitive Behavioral Therapy (CBT) for symptoms of psychosis, depression, and anxiety					
16. Structured intervention to prevent weight gain					
17. Formal annual assessment (includes educational, occupational, and social functioning, symptoms, psychosocial needs, risk assessment, etc.)					
18. CBT or Motivational Enhancement for co-morbid substance use					
19. Supported employment (or education) services					
20. Social and community living skills training (e.g. social activities, using transportation, renting, banking, budgeting, meal planning)					
21. Delivering crisis intervention services or providing links to crisis response services in the community					

Evidence-Based Team Practices					
Team Practices	**5 = Extremely important** *Essential, must be a component of a FEP program.*	**4 = Important** *Should be a component of a FEP program.*	**3 = Equivocal** *May be useful to have as a component of FEP program.*	**2 = Less Important** *Less important, but nice to have as a component of a FEP program.*	**1 = Unimportant** *Not important for FEP care.*
22. Target ratio of active FEP clients to case-carrying clinician/case manager is 20:1					
23. Masters-level (or higher) Team Leader/Supervisor					
24. Psychiatrist on the team that attends team meetings, sees clients with other clinicians, and is available for consultation during the work week					
25. Multidisciplinary team of qualified professionals providing case management and direct service (e.g. nursing services, evidence-based psychotherapy, addiction services, supported employment,					

Evidence-Based Team Practices					
Team Practices	**5 = Extremely important** *Essential, must be a component of a FEP program.*	**4 = Important** *Should be a component of a FEP program.*	**3 = Equivocal** *May be useful to have as a component of FEP program.*	**2 = Less Important** *Less important, but nice to have as a component of a FEP program.*	**1 = Unimportant** *Not important for FEP care.*
family education/support, social/ community living skills, etc.)					
26. Mandate to provide service to patients for a specified period of time (e.g. 1 year, 2 years)					
27. Multidisciplinary team meetings to discuss cases (e.g. case review/admissions and discharges, assessment and treatment planning, discussion of complex cases, termination of services, etc.)					
28. Targeted, proactive outreach and education to "first-contact" individuals (e.g. in health, education/social agencies, community organizations, etc.)					
29. Communication between program and psychiatric hospital inpatient units (e.g. appointment with FEP program within 15 days of hospital discharge)					
30. Explicit admission criteria (e.g. specific diagnoses) to select appropriate referrals					
31. Clearly identified population served (e.g. specific geographic population; comparison of annual incidence and accepted cases to assess success in reaching all new incidence cases)					

Section 9: PhenX Toolkit Measures

1) Within the domains below, do you collect any of the following specific measures from your program participants (noted in parentheses)? Please check any domain in which you collect one (or more) of the measures listed. *[multi-answer checkboxes]*

a) Brain imaging measures (including DTI, MRS, fMRI, MP-RAGE)
b) Bloodwork (including CRP in serum, glutathione)
c) Cognitive measures (including CNB, AX-CPT, RiSE, ACPT)
d) Clinical measures (including FIGS, PAS, CSI, BPRS, QPR, GFS/GFR, SOS, NSA-4, SIPS, M.I.N.I, SCID-5-CV)

e) Service use and service satisfaction measures (including MHSPID YSS, SURF-M, NSDUH Questionnaire, CollaboRATE Questionnaire, RSA)
f) Fidelity measures (including FEPS-FS)
g) Quality of life measures (including PWI-A/PWI-SC, IPAQ)
h) Burden and needs measures (including CANSAS/CANSAS-P, BAS)
i) Family functioning measures (including FQ, FAD, SCORE-15 Index of Family Functioning and Change)
j) Medication monitoring measures (including ESRS, GASS, BARS)
k) We do not use any of the noted measures

Section 10: Challenges and Barriers

1) Has your program encountered any challenges or barriers to implementing your EP program (e.g. with funding, staffing, training)? How have you been able to resolve them (or not)?

_____

Section 11: Other

1) Is there anything else about your program that is important for us to know that we have not already covered? Do you collect any other data that we did not ask about here?

_____

Appendix E. CEPAS-D

PROGRAMS IN DEVELOPMENT

You noted that you are in the process of planning or starting your early psychosis program. We would like to ask you some questions about what populations you plan to serve and program components you plan to use.

Section 1: Program Description

1) Will your program be a stand-alone program or integrated within other established clinical services? *[single answer checkboxes]*
   a) Stand-alone/independent program (e.g. own site, staff, management, oversight)
   b) Stand-alone/independent program (e.g. own site) associated with established program/agency (e.g. provide oversight, support)
   c) Integrated within another program (e.g. shared space, staff, management)
   d) Other (please describe) *[text box]*
   e) Uncertain

2) When do you plan to start serving clients in your community *(i.e. actively enroll and provide treatment)*? **Please indicate the month and year in the following format: mm/dd/yyyy.** P*lease use "01" for "dd" if you are unsure of the exact date*. *[text box]*

3) Does your program plan to serve first-episode psychosis (FEP) clients, clinical high-risk (CHR)/prodromal clients, or both? *[single answer checkboxes]*
   a) FEP clients ONLY (experience recent onset of psychotic-level hallucinations, delusions, disorganized speech/behavior; meet criteria for DSM Schizophrenia Spectrum Disorders or another DSM disorder with psychotic features; experience positive symptoms at a score of 6 on the SIPS)
   b) CHR/prodromal ONLY (experience attenuated/subthreshold hallucinations, delusions, disorganized speech; meet criteria for a CHR diagnosis according to the SIPS or CAARMS)
   c) BOTH FEP and CHR/prodromal clients
   d) Other (please describe) *[text box]*
   e) Uncertain

   3-1) *[If 3a or 3c is selected]* What duration of first-episode psychosis onset do you plan to serve (in months)? *[text box]*

   3-2) *[If 3b or 3c is selected]* Please clarify what types of CHR clients you plan to serve. Please check all that apply. *[multi-answer checkboxes]*
      i) Recent onset but brief psychosis *(e.g. fully psychotic symptoms of recent onset and brief duration; BIPS or POPS on the SIPS)*
      j) Attenuated/subthreshold symptoms of psychosis *(e.g. APS on the SIPS)*
      k) Genetic risk (family history and/or schizotypal personality disorder) PLUS deterioration *(e.g. GRDS on the SIPS)*
      l) Other (please describe) *[text box]*
      m) Uncertain

4) What DSM diagnoses does your program plan to serve? Please check all that apply. *[FEPS Domain 30] [multi-answer checkboxes]*
   a) Schizophrenia Spectrum Diagnoses *(e.g. Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder)*
   b) Other Psychotic Spectrum Disorders *(e.g. Psychotic Disorder NOS, Brief Psychotic Disorder, Delusional Disorder)*
   c) Mood Disorders *(e.g. Major Depressive Disorder, Bipolar Disorder)* WITH Psychotic features
   d) Mood Disorders *(e.g. Major Depressive Disorder, Bipolar Disorder)* WITHOUT Psychotic features
   e) Other (please describe) *[text box]*
   f) Uncertain

5) What age range(s) does your program plan to serve?
   a) Age range accepted: *[text box]*
   b) All ages served

6) What exclusion criteria are you considering using for your program? Please check all that apply. *[multi-answer checkboxes]*
   a) Axis II diagnosis *(e.g. personality disorders)*
   b) Intellectual disability *(i.e. IQ under 70)*
   c) Substance use disorder (of any kind)
   d) Substance dependence only
   e) Substance-induced psychotic disorder
   f) Not county resident (where program is located) *[FEPS Domain 31]*
   g) No specific exclusion criteria (we serve everyone)
   h) Other (please describe) *[text box]*
   i) Uncertain

7) On average, how many clients do you hope to evaluate for eligibility (e.g. intake evaluations) by your program per month? *[text box]*

8) On average, how many clients do you hope to engage in ongoing treatment *(e.g. therapy, groups, med management)* with your program each month *(i.e. monthly "census" of clients active in treatment)*? *[text box]*

   8-1) On average, what percentage of your program census *(i.e. individuals deemed eligible at intake and then engaged in ongoing treatment)* will be FEP versus CHR? **If a percentage of your clients will meet criteria under another category, please define it below.**
   a) % FEP *[text box]*
   b) % CHR *[text box]*
   c) % other (define) *[text box]*
   d) Uncertain

9) On average, what is the target amount of time your program plans to serves each client? *[FEPS Domain 26] [single answer checkboxes]*
   a) 1 year or less
   b) Up to 2 years

c) Up to 3 years
d) Up to 4 years
e) More than 4 years *(e.g. no limit)*
f) Other (please describe) *[text box]*
g) Uncertain

10) Will your program be able to offer services to the following types of clients? We will ask you later how services for these clients will be covered/funded. **Please check all that apply.** *[multi-answer checkboxes]*
a) Uninsured clients
b) Undocumented clients
c) Private insurance clients
d) We do not plan to serve any of these types of clients
e) Uncertain

11) Are you considering using a particular early psychosis treatment model? *[single answer checkboxes]*
a) PREP
b) PIER
c) EDAPT
d) EASA
e) RAISE
f) Other (please describe) *[text box]*
g) Uncertain

Section 2: Data Collection & Medical Record System

1) Is your program planning to collect information on the following domains as part of your standard assessment battery? If so, please indicate how often this data will be collected *(e.g. intake and every 6 months after)*. For some items, you may assess the domain more often *(e.g. risk for suicide after a hospitalization)*; however we are interested in the data you will collect at regular intervals as part of a standardized intake or outcomes assessment. **Please check all that apply.** *[FEPS Domain 3 for items noted in intake assessment, FEPS Domain 14 for items completed annually] [matrix table for domains and time points]*
a) Client characteristics *(e.g. sex, gender, age, race/ethnicity, zip code, etc.)*
b) Diagnosis *(e.g. via SIPS, SCID, MINI, etc.)*
c) Symptom severity scores *(e.g. SANS, SAPS, BPRS, CGI)*
d) Physical health *(e.g. comorbid medical diagnosis/Axis III)*
e) Metabolic parameters *(e.g. labs with glucose, lipids)*
f) Vitals *(e.g. blood pressure, weight, height)*
g) Family history of mental health conditions
h) Cognitive measures *(e.g. IQ scores)*
i) Psychosocial data *(e.g. CANS/ANSA, GAF, Global Functioning Scales: Social and Role)*
j) Premorbid functioning *(e.g. PAS)*
k) Medication data *(e.g. medications prescribed, dosage, duration of supply)*
l) Medication side effects *(e.g. AIMS, Barnes)*
m) Substance use data *(e.g. substances used, frequency, impact)*
n) Hospitalizations *(dates, duration, reason)*
o) ER or crisis utilization *(dates, duration, reason)*

p) Legal involvement *(e.g. arrests, incarcerations)*
q) Risk assessment *(e.g. suicidal ideation/attempts, danger to others, etc.)*
r) Self-report of impact of care received *(e.g. DHCS MHSIP Consumer Survey, etc.)*
s) Satisfaction with treatment *(e.g. CSQ)*
t) Other (please describe) *[text box]*
u) Uncertain

2) Will your program be required to use any of these specific data collection measures? **Please check all that apply.** *[multi-answer checkboxes]*
a) ANSA
b) CANS
c) DHCS Adult MHSIP Consumer Survey – Adult Version
d) DHCS Adult MHSIP Consumer Survey – Child Version
e) We do not plan to use any of these measures
f) Uncertain

3) Will your program seek to involve family members or significant collateral informants (e.g., significant other, extended family, roommates) during the initial assessment, if the client with FEP consents? *[FEPS Domain 2] [single answer checkboxes]*
a) Yes
b) No
c) Uncertain

4) Did you collect any data as part of your process of planning and developing your program *(e.g. number of individuals with particular diagnoses receiving services in your county, feedback from stakeholder supporting need for your program, etc.)*? *[single answer checkboxes]*
a) Yes (please describe) *[text box]*
b) No
c) Uncertain

5) Will your program use paper or electronic client records? *[single answer checkboxes]*
a) Paper only
b) Electronic only
c) Both
d) Uncertain

5-1) *[If 5b or 5c is selected]* Will your electronic medical record system part of the county-wide system, or will it be a program-specific system? *[single answer checkboxes]*
a) County system
b) Program (internal) system
c) Uncertain

Section 3: Funding Sources

1) What percentage of your annual funding will come from the following sources? **Please check all sources that apply and indicate the percentage for each *(e.g. 25% MHSA, 25% Medi-Cal/EPSDT, etc.)*.** *[multi-answer checkboxes with associated text boxes]*
a) MHSA
b) Medi-Cal/EPSDT
c) SAMHSA Mental Health Block Grant (MHBG)

d) 26.5 funds
e) Private insurance, including Kaiser
f) Self-pay or sliding scale
g) Research grants
h) Donors
i) Other (please describe)
j) Uncertain

1-1) *[If 1a is selected]* Which MHSA funding stream(s) will be used to support your program? **Please check all that apply.** *[multi-answer checkboxes]*
a) Prevention and Early Intervention (PEI)
b) Community Supports and Services (CSS)
c) Innovation Programs (INN)
d) Capital Facilities and Technology (CFT)
e) Workforce Education & Training (WET)
f) Uncertain

2) In general, how will you be reimbursed for the services you provide as part of your contract? *[single answer checkboxes]*
a) Rate per unit of service *(e.g. $1.21 per unit of case management)*, established by contract
b) Flat rate per client served across all service types *(e.g. $1000 per client served per year – services are "bundled")*
c) Hourly rate based on service type provided *(e.g. $60 per 50 min therapy session)*
d) Other (please describe) *[text box]*
e) Uncertain

3) Does your program currently receive OR plan to receive training, technical assistance or support from an outside organization(s) or university? *[single answer checkboxes]*
a) Yes, we are currently working with an outside organization(s) for training *(e.g. regular trainings and/or supervision are provided)*
b) Yes, we have worked with an organization(s) in the past, but are no longer engaged in formal training relationship *(e.g. may have brief calls to check in as needed)*
c) No, we are not currently collaborating with an outside organization, BUT we would like to in the future
d) No, we are not current collaborating with an outside organization and we do not plan to
e) Uncertain

3-1) *[If 3a or 3b is selected]* What are the name(s) of the organization(s) or university that provided you with training? What type of training did they provide? *[text box]*

3-2) *[If 3c is selected]* What type of training are you interested in? *[text box]*

Section 4: Program Components - Outreach, Referrals & Engagement

1) Does your program plan to provide outreach and information on how to identify psychosis and refer to first-contact individuals in the community? Please check all that apply. *[FEPS Domain 28] [multi-answer checkboxes]*

a) Yes, to health/medical agencies
b) Yes, to education agencies or schools
c) Yes, to social services agencies
d) Yes, to community mental health organizations
e) Yes, to jails and prisons
f) Yes, to police departments
g) Yes, to other community organizations
h) Yes, via social media
i) No
j) Uncertain

1-2) *[If any of 1a through 1h are selected]* How often will community education/outreach occur? *[single answer checkboxes]*
   a) Less than 6 times per year
   b) 6-9 times per year
   c) 9-12 times per year
   d) >12 times per year
   e) Uncertain

2) Does your program plan to offer proactive outreach and engagement for clients with FEP, such as community based intake appointments or ongoing community-based visits, to reduce missed appointments? *[FEPS Domain 19] [single answer checkboxes]*
   a) Yes
   b) No
   c) Uncertain

Section 5: Program Components – Education, Therapy and Services

1) Will your program staff develop an individualized treatment plan with the client and family, addressing their needs, goals and preferences? *[FEPS Domain 5] [single answer checkboxes]*
   a) Yes, at the start of treatment
   b) Yes, at the start of treatment and annually there after
   c) No
   d) Other (please describe) *[text box]*
   e) Uncertain

2) What components of multi-disciplinary care is your program team planning to provide? **Please check all that apply.** *[FEPS Domain 25] [multi-answer checkboxes]*
   a) Psychiatric services *(e.g. regular appointments for medication support)*
   b) Nursing services
   c) Individual Psychotherapy
   d) Case management
   e) Client-focused psychoeducation or illness management training (via individual or group setting) *[FEPS Domain 10]*
   f) Treatment of comorbid substance use
   g) Supported employment *[FEPS Domain 18]*
   h) Supported education
   i) Family/Caregiver/Support person education and support (via individual or group setting) *[FEPS Domain 11]*
   j) Family Therapy

k) Occupational Therapy
l) Social and community living skills training (e.g. social activities, using transportation, renting, banking, budgeting, meal planning)? *[FEPS Domain 20]*
m) Multi-Family Groups
n) Other (please describe) *[text box]*
o) Uncertain

3) Do you plan to offer clients with FEP sessions of individual or group psychotherapy, delivered by an appropriately trained professional, using any of the following approaches? **Please check all that apply.** *[FEPS Domain 12] [multi-answer checkboxes]*
a) Cognitive Behavioral Therapy (CBT) for psychosis symptoms *[FEPS Domain 12]*
b) Cognitive Behavioral Therapy for OTHER symptoms *(e.g. depression, anxiety) [FEPS Domain 12]*
c) Cognitive Behavioral Therapy or Motivational Enhancement for comorbid substance use *[FEPS Domain 17]*
d) Cognitive Behavioral Social Skills Training
e) Dialectical Behavior Therapy (DBT)
f) Multi Family Group (MFG)
g) Family Focused Therapy (FFT)
h) Trauma informed care *(e.g. TF-CBT)*
i) Individual Placement and Support (IPS)
j) Feedback Informed Treatment (FIT)
k) Wellness Recovery Action Planning (WRAP)
l) Mindfulness based treatment
m) Cognitive training/remediation
n) Structured intervention to prevent weight gain *[FEPS Domain 13]*
o) Other standardized curricula or evidence-based treatment (please describe) *[text box]*
p) We do not plan to use any of these treatments
q) Uncertain

4) Does your program plan to deliver crisis intervention services or provide links to crisis response services in the community? **Please check all that apply.** *[FEPS Domain 21] [multi-answer checkboxes]*
a) Yes, deliver crisis intervention services during regular working hours
b) Yes, deliver crisis intervention services 24 hours per day, 7 days per week
c) Yes, provide links to crisis lines
d) Yes, provide links to mobile response teams
e) Yes, provide links to urgent care centers
f) Yes, provide links to hospital emergency rooms
g) Other (please describe) *[text box]*
h) No
i) Uncertain

Section 6: Program Components – Medications

3) After a diagnostic assessment confirms psychosis, will your clients with FEP be prescribed antipsychotic medication, after taking into consideration client preference? *[FEPS Domain 6] [single answer checkboxes]*
a) Yes
b) No

c) Uncertain

4) Do you plan to offer your clients with FEP any of the following options related to their psychiatric care? **Please check all that apply.** *[multi-answer checkboxes]*

a) Medication decision based on standardized algorithm (e.g. PORT, RAISE) *[FEPS Domain 7]*
b) Guided antipsychotic dose reduction after at least one year of remission *[FEPS Domain 8]*
c) Clozapine after two unsuccessful trials of antipsychotics *[FEPS Domain 9]*
d) Depot/injection antipsychotic medication option
e) Other standardized curricula or evidence-based treatment (please describe) *[text box]*
f) We do not plan to offer any of these options related to psychiatric care
g) Uncertain

Section 7: Program Components – Providers and Program Administration

1) What types of support staff and direct clinical service providers and staff do you plan to employ in your program? **Please check all that apply.** *[multi-answer checkboxes]*

a) Program Director *(provides leadership at organizational, county or state level, but not day-to-day oversight)*
b) Program Manager *(provides day-to-day oversight of activities, manages staff)*
c) Physician/Psychiatrist *(provides direct service)*
d) Registered nurse (RN)/Nurse practitioner *(provides direct service)*
e) Clinical Supervisor *(supervises staff, ensures fidelity to model - may also provide direct service)*
f) Licensed clinicians *(e.g. LCSW, LMFT, psychologist – provide direct service)*
g) Masters-level professionals *(e.g. MFT, MSW – provide direct service)*
h) Supported Employment Specialist *(provides direct support in maintaining or obtaining linkage to services in work setting)*
i) Supported Education Specialist *(provides direct support in maintaining or obtaining linkage to services in school setting)*
j) Community Support Specialist *(provides direct service linking or supporting engagement in daily living skills or community activities)*
k) Occupational Therapist *(provides direct service)*
l) Family Advocate *(has lived experience as caregiver/primary support person for family member with psychosis - provides direct or supporting service)*
m) Consumer/Peer Advocate *(has lived experience with psychosis - provides direct or supporting service)*
n) Case managers *(e.g. no clinical training or degree required, provide support for linkage, daily skills, etc.)*
o) Clerical support/Clinic Coordinator
p) Other (please describe) *[text box]*
q) Uncertain

2) What is the target active FEP clients to case-carrying clinician/case manager ratio in your program? *[FEPS Domain 22] [single answer checkboxes]*

a) 51+ clients with FEP per provider FTE
b) 41-50 clients with FEP per provider FTE
c) 31-40 clients with FEP per provider FTE
d) 21-30 clients with FEP per provider FTE

e) 20 or fewer clients with FEP per provider FTE
f) Uncertain

3) Are you planning to have a Masters-level (or higher) Team Leader/Supervisor? *[FEPS Domain 23] [single answer checkboxes]*

a) Yes, providing only administrative/managerial direction – no responsibility to ensure clinical supervision
b) Yes, providing administrative direction AND ensures clinical supervision by others
c) Yes, providing administrative direction AND supervision to SOME staff
d) Yes, providing administrative direction AND supervision to ALL staff
e) Yes, providing administrative direction AND supervision to ALL staff, in addition to providing some direct clinical services
f) No, our program will not have a Masters-level Team Leader
g) Uncertain

4) Are you planning to have a psychiatrist who will be integrated within your team? *[single answer checkboxes]*

a) Yes
b) No
c) Uncertain

4-1) *[If 4a is selected]* What will be the role of your psychiatrist? **Please check all that apply.** *[multi-answer checkboxes]*

f) Attends team meetings *[FEPS Domain 24]*
g) Assigned to specific clients *[FEPS Domain 15]*
h) Sees clients in the program location
i) Shares team health records
j) Sees clients with other clinicians *[FEPS Domain 24]*
k) Available for consultations during the work week *[FEPS Domain 24]*
l) Is co-located with other team members
m) Other (please describe) *[text box]*
n) Uncertain

5) Will your clients with FEP have an assigned case manager or clinician? *[FEPS Domain 16] [single answer checkboxes]*

a) Yes
b) No
c) Uncertain

6) How often does your program plan to hold team meetings? *[FEPS Domain 27] [single answer checkboxes]*

a) Monthly team meetings
b) Bi-weekly team meetings
c) Weekly team meetings
d) We do not plan to hold team meetings
e) Uncertain

7) If your program serves both FEP and CHR, will any of the services you plan to provide (as described above) differ between the two groups? *[text box]*

Section 8: Challenges and Barriers

1) Has your program encountered any challenges or barriers to implementing your EP program (e.g. with funding, staffing, training)? How have you been able to resolve them (or not)? *[text box]*

Section 9: Other

1) Is there anything else about your program that is important for us to know that we have not already covered? *[text box]*

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