Program Name:
Name of individual completing survey:
    Phone number:
    Email:
    Role:

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. However, such research 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.

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. 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) **with separate funding streams, please complete separate surveys for each program** so we can capture the nuances correctly.

However, if you serve **both populations in comparable ways** (e.g. similar entry criteria, funding sources, assessment methods, treatment), **please put all information in one survey.**

1) **What is the status of your early psychosis program?**
    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 (describe)**

For selections of b-f → SKIP TO "PROGRAMS IN DEVELOPMENT" survey

For selection a → Continue below

Section 1: Program Description
1) Does your program serve first-episode psychosis (FEP) clients, clinical-high-risk clients, or both? *[FEPS Domain 30] [single answer checkbox]*
    a) FEP clients only (experience recent onset of <u>psychotic-level</u> 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) Clinical high risk or prodromal clients only (experience attenuated/subthreshold hallucinations, delusions, disorganized speech; meet criteria for a clinical high risk diagnosis according to the SIPS or CAARMS)

c) Both FEP and clinical high-risk/prodromal clients

d) Other (please describe) *[text box]*

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

1-2) *[If 1a or 1c is selected]* How does your program determine the date of psychosis onset (e.g. month and year when symptoms reached threshold psychosis level)? *[text box]*

1-3) *[If 1b or 1c is selected]* Please clarify what types of clinical high risk 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; e.g. BIPS 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 (GRDS on the SIPS)
   d) Other (please describe) *[text box]*

1-4) *[If 1b is selected]* What duration of full psychosis do you serve (in days)? *[text box]*

2) What DSM-IV diagnoses does your program 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. Psychosis NOS, Brief Psychotic Disorder, Delusional Disorder
   c) Mood Disorders <u>with</u> Psychotic features – e.g. Major Depressive Disorder, Bipolar Disorder
   d) Mood Disorders <u>without</u> Psychotic features – e.g. Major Depressive Disorder, Bipolar Disorder
   e) Other (please describe) *[text box]*

3) What age range does your program serve? *[FEPS Domain 30]*
   a) Lowest age accepted: *[text box]*
   b) Highest age accepted: *[text box]*
   c) All ages served *[single answer checkbox]*

4) What are the exclusion criteria 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)
   g) No specific exclusion criteria (we serve everyone)
   h) Other (please describe) *[text box]*

5) On average, how many clients are <u>evaluated for eligibility</u> (e.g. intake evaluations) by your program each month? *[text box]*

6) On average, how many clients are <u>engaged in ongoing treatment</u> (e.g. therapy, groups, med management) with your program each month (i.e. monthly "census" of clients active in treatment? *[text box]*

7) On average, what is the <u>target</u> amount of time your program serves each client? *[FEPS Domain 26]* *[single answer checkbox]*
   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]*

8) Do you serve the following types of clients? Please check all that apply. *[multi-answer checkboxes]*
   a) Uninsured clients
   b) Undocumented clients

9) Does your program use a particular treatment model? *[single answer checkbox]*
   a) PREP
   b) PIER
   c) EDAPT
   d) EASA
   e) RAISE
   f) Other (please describe) *[text box]*
   g) Uncertain

10) What types of support staff and direct clinical service providers does your program employ? Please indicate <u>all</u> roles available, whether or not the position is currently filled. *[multi-answer checkboxes]*
   a) Program Director
   b) Program Manager
   c) Physician/Psychiatrist
   d) Nurse practitioners
   e) Clinical Supervisor
   f) Licensed clinicians (e.g., LCSW, LMFT, psychologist)
   g) Masters-level professionals (e.g., MFT, MSW)
   h) Supported Education/Employment Specialist
   i) Community Support Specialist
   j) Consumer/Peer Advocate
   k) Family Advocate
   l) Case managers (e.g. no clinical training or degree required, provide support for linkage, daily skills, etc.)
   m) Clerical support/Clinic Coordinator
   n) Other (please describe) *[text box]*

11) When did you begin to <u>serve</u> clients in your community (i.e. actively enroll and provide treatment)? (month, year) *[text box]*

12) Since starting your program, approximately how many clients have you served (enrolled in treatment services) through <u>FY 2015-2016</u> (June 30, 2016)? *[text box]*

Section 2: Data Collection & Medical Record System

1) Does your program collect information on the following domains? If so, please indicate how often this data is collected (e.g. intake and every 6 months after). *[FEPS Domain 3 for items noted in intake assessment, FEPS Domain 14 for items completed annually] [multi-answer checkboxes for domains and intake/6 months/annual time points, text boxes for other time points]*

   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) 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 Adult MHSIP Consumer Survey – Adult/Youth Version, etc.)
   s) Satisfaction with treatment (e.g. CSQ)
   t) Other (please describe) *[text box]*

2) 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

3) Do you keep paper or electronic client records? *[single answer checkbox]*

   a) Paper only
   b) Electronic only
   c) Both

   3-1) *[If 15b or 15c is selected]* When did you implement your electronic medical record? (month and year) *[text box]*

   3-2) *[If 15b or 15c is selected]* Is your electronic medical record system part of the county-wide system, or is it a program-specific (internal) system? *[single answer checkbox]*

      a) County system
      b) Program system
      c) Uncertain

3-3) *[If 15b or 15c is selected]* What information is recorded within your electronic medical record (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) *[text box]*

4) Are you able to generate reports on the data you have collected? *[single answer checkbox]*
   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

   4-1) *[If 16a or 16b is selected]* Who is able to generate summary data reports? *[single answer checkbox]*
      a) County staff only
      b) County staff and clinic staff
      c) County staff only, but clinic staff can request special reports

5) Does your program regularly check your data (in your EMR or in your database) for completeness? *[single answer checkbox]*
   a) Yes, regularly
   b) Yes, but irregularly
   c) No, we have not checked it
   d) Uncertain

6) 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)
   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 <u>annual funding</u> comes from the following sources? *[multi-answer checkboxes with associated text boxes]*

    a) MHSA
    b) Medi-Cal/EPSDT
    c) SAMHSA
    d) 26.5 funds
    e) Private insurance, including Kaiser
    f) Self-pay or sliding scale
    g) Research grants
    h) Donors
    i) Other (please describe) *[text box]*

    1-1) *[If 1a is selected]* Which MHSA funding stream(s) is/are used to <u>support</u> 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)

2) What percentage of your <u>clients</u> are covered by the following sources? *[multi-answer checkboxes with associated text boxes]*

    a) MHSA only (no other funding)
    b) Medi-Cal/EPSDT
    c) 26.5 funds
    d) Private insurance, including Kaiser
    e) Self-pay or sliding scale
    f) Uninsured
    g) Other (please describe) *[text box]*

3) In general, how are you reimbursed for the services you provide as part of your contract? *[single answer checkbox]*

    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]*

4) Does your program receive training, technical assistance or support from an outside organization or university? *[single answer checkbox]*

    a) Yes, we are currently working with an outside organization for training
    b) Yes, we plan to work with an outside organization, but are not sure who yet
    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 is selected]* What is the name of the organization or university? What type of training do they provide? *[text box]*

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

5) Approximately how many <u>NEW</u> staff have you needed to train each year? *[text box]*

6) Are there any particular staff positions that you <u>consistently</u> have difficulty filling? *[text box]*

7) What percent of your annual budget is allocated to training <u>NEW</u> staff? *[text box]*

All following sections would only be asked of clinics selecting the following answers re: the populations they serve (Section 1, Question 1):

1a – FEP clients only
1c – both FEP and clinical high-risk
1-2 – recent onset but brief psychosis (BIPS or POPS)

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. <u>For the following questions, please focus on the services provided by your program to individuals who have experienced the onset of full psychosis (i.e. First Episode or FEP), even if your program also serves individuals at clinical-high-risk.</u>

<u>Section 4: Program Components - Outreach, Referrals & Engagement</u>

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. *[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) No
   i) Uncertain

   1-1) *[If 1a through 1g are selected]* How often is community education/outreach occurring? *[single answer checkbox]*
   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) Are clients with FEP offered an in-person appointment within 2 weeks of receiving a referral to your clinic? *[FEPS Domain 1] [single answer checkbox]*
   a) Yes
   b) No
   c) Uncertain

3) Does your program offer proactive outreach and engagement for clients with FEP, such as community visits to reduce missed appointments? *[FEPS Domain 19] [single answer checkbox]*
   a) Yes
   b) No
   c) Uncertain

4) 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? *[FEPS Domain 2] [single answer checkbox]*
   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? *[FEPS Domain 5] [single answer checkbox]*
   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 information about the psychosocial needs of the FEP client are incorporated into your treatment plan? Please check all that apply. *[FEPS Domain 4] [multiple answer checkboxes]*
   a) Housing
   b) Employment
   c) Education
   d) Social support
   e) Finances
   f) Basic living skills
   g) Registered with a family physician
   h) Social skills
   i) Past trauma
   j) Legal
   k) Other (please describe) *[text box]*
   l) Our program does not create a care plan

3) What components of multi-disciplinary care does your program team offer as part of the treatment plan? Please check all that apply. *[FEPS Domain 5, 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 *[FEPS Domain 18]*

i) Family/Caregiver/Support person education and support (via individual or group setting) *[FEPS Domain 11]*
j) Occupational Therapy
k) Social and community living skills training (e.g. social activities, using transportation, renting, banking, budgeting, meal planning)? *[FEPS Domain 20]*
l) Other (please describe) *[text box]*

4) 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. *[FEPS Domain 12]* *[multi-answer checkboxes]*
   a) Cognitive Behavioral Therapy (CBT)for psychosis symptoms
   b) Cognitive Behavioral Therapy for OTHER symptoms (e.g. depression, anxiety)
   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 (IPT)
   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) We do not use any of these treatments
   p) Uncertain

5) Does your program utilize any other standardized curricula or evidenced-based treatments for your individual or group approaches? *[single answer checkbox]*
   a) Yes (please describe) *[text box]*
   b) No
   c) Uncertain

6) Does your program deliver crisis intervention services or provide links to crisis response services in the community? *[FEPS Domain 21]* *[single answer checkbox]*
   a) Yes, deliver crisis intervention services
   b) Yes, provide links to crisis lines
   c) Yes, provide links to mobile response teams
   d) Yes, provide links to urgent care centers
   e) Yes, provide links to hospital emergency rooms
   f) No
   g) Uncertain

7) Is there a formal link between your program and psychiatric hospital inpatient units? *[FEPS Domain 29]* *[single answer checkbox]*
   a) Yes
   b) No
   c) Uncertain

8) Are clients who are admitted to the hospital provided with an appointment to be seen at your program within 15 days of discharge? *[single answer checkbox]*
   a) Yes
   b) No
   c) Uncertain

Section 6: Program Components – Medications

1) After a diagnostic assessment confirms psychosis and the need for pharmacotherapy, are your clients with FEP prescribed antipsychotic medication, after taking into consideration client preference? *[FEPS Domain 6] [single answer checkbox]*
   a) Yes
   b) No
   c) Uncertain

2) Do you offer your clients with FEP 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

Section 7: Program Components – Providers and Program Administration

1) What is the active FEP client/provider ratio in your program? *[FEPS Domain 22] [single answer checkbox]*
   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

2) Does your program have a Masters-level (or higher) Team Leader/Supervisor? *[FEPS Domain 23] [single answer checkbox]*
   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 Team Leader
   g) Uncertain

3) Does your program have a psychiatrist <u>who is part of the team</u>? *[FEPS Domain 24] [single answer checkbox]*
   a) Yes
   b) No
   c) Uncertain

3-1) *[If 3a is selected]* What is the role of your psychiatrist? Please check all that apply. *[FEPS Domain 24] [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

4) Do your clients with FEP have an <u>assigned</u> case manager or clinician? *[FEPS Domain 16] [single answer checkbox]*
   a) Yes
   b) No
   c) Uncertain

5) Does your program offer the use of interpreters? *[single answer checkbox]*
   a) Yes
   b) No
   c) Uncertain

6) How often does your program hold team meetings? *[FEPS Domain 27] [single answer checkbox]*
   a) Monthly team meetings
   b) Bi-weekly team meetings
   c) Weekly team meetings
   d) No team meetings
   e) Uncertain

   6-1) *[If 6a, 6b or 6c is selected]* Which of the following items are covered in your team meetings? Please check all that apply. *[FEPS Domain 27] [multi-answer checkboxes]*
      a) Case review (admissions and discharge)
      b) Assessment and treatment planning
      c) Discussion of complex cases
      d) Termination of services

7) Is your program a stand-alone program or integrated within other established clinical services? *[single answer checkbox]*
   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 (describe)
   e) Uncertain

Section 8: PhenX Toolkit Measures
1) Do you collect any of the following measures? Please check all that apply. *[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)

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]*