EPINET
Early Psychosis Intervention Network

Early Psychosis Intervention Network Core Assessment Battery

Follow-Up Assessment

Updated: February 26, 2021

Photo is for illustrative purposes only. Any person depicted in this photo is a model.

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CLINICIAN-COMPLETED

CLIENT SELF-ADMINISTERED OR CLINICIAN-ADMINISTERED

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DEMOGRAPHICS AND BACKGROUND

CLIENT SELF-ADMINISTERED OR CLINICIAN-ADMINISTERED

1. What is your current marital status?

Select one.

- ○ Never married
- ○ Married
- ○ Domestic partnership
- ○ Separated
- ○ Divorced
- ○ Widowed
- ○ Prefer not to say
- ○ Other (Specify: _____)

2. Do you have any children?

Check all that apply.

- ☐ No children
- ☐ Expecting a child
- ☐ Children less than age 18, in my custody
- ☐ Children less than age 18, not in my custody
- ☐ Children 18 or older
- ☐ Prefer not to say
- ☐ Unsure/Don't know

3. **[OPTIONAL] What type of work does your mother currently do or did she do most recently?**

Select one.

- ○ Professional/Technical/Managerial (e.g., doctor, lawyer, accountant, teacher, project manager)
- ○ Office and Administrative Support Occupations and Sales Positions
- ○ Personal Care and Service (e.g., cashier, dog walker, food preparation)
- ○ Construction/Mechanical/Factory Worker/ Maintenance
- ○ Agricultural (e.g., farm, fishery, forest)
- ○ Transportation (e.g., bus, taxi driver)
- ○ Military, emergency services (e.g., police, firefighter), or security
- ○ Domestic/Homemaker
- ○ Unemployed/furloughed
- ○ Other (Specify: _____)
- ○ Unsure/Don't know
- ○ Prefer not to say
- ○ Not applicable

4. **[OPTIONAL] What type of work does your father currently do or did he do most recently?**

Select one.

- ○ Professional/Technical/Managerial (e.g., doctor, lawyer, accountant, teacher, project manager)
- ○ Office and Administrative Support Occupations and Sales Positions
- ○ Personal Care and Service (e.g., cashier, dog walker, food preparation)
- ○ Construction/Mechanical/Factory Worker/ Maintenance
- ○ Agricultural (e.g., farm, fishery, forest)
- ○ Transportation (e.g., bus, taxi driver)
- ○ Military, emergency services (e.g., police, firefighter), or security
- ○ Domestic/Homemaker
- ○ Unemployed/furloughed
- ○ Other (Specify: _____)
- ○ Unsure/Don't know
- ○ Prefer not to say
- ○ Not applicable

5. What is your current housing situation?

Select one.

- ○ Alone or with roommates (unsupervised)
- ○ Living with biological or adoptive family
- ○ Living in foster care
- ○ Supervised apartment (some staff support), supported housing, or dependent living setup, without other individuals
- ○ Group home or residential care with other individuals
- ○ Homeless shelter, or sleeping outdoors
- ○ In temporary housing (e.g., couch surfing, temporarily living with family or friends)
- ○ Other (Specify: _____)
- ○ Prefer not to say
- ○ Unsure/Don't know

6. What type of health insurance do you currently have?

- ○ Commercial insurance
- ○ Medicaid
- ○ No Insurance
- ○ Unsure/Don't know
- ○ Other (Specify: _____)

7. Do you receive financial support from any of the following people?

Check all that apply.

- ☐ Mother
- ☐ Father
- ☐ Guardian
- ☐ Spouse
- ☐ Other (Specify: _____)
- ☐ Unsure/Don't know
- ☐ I do not receive financial support from anyone

8. Do you currently receive Supplemental Security Income (SSI)/ Social Security Disability Insurance (SSDI)?

- ○ Yes
- ○ No, I never received SSI/SSDI → ***Skip to Q10***
- ○ No, I used to receive SSI/SSDI, but I no longer receive it
- ○ Unsure/Don't know → ***Skip to Q10***

9. About how old were you when you began receiving SSI/SSDI?

_____ years

10. Have you applied for SSI/SSDI in the past six months?

○ Yes
○ No

11. Do you currently receive any of the following other monetary supports?

Check all that apply.

☐ Disability benefits other than SSI/SSDI
☐ TANF or other income assistance
☐ Unemployment
☐ Supplemental Nutrition Assistance Program (SNAP)/ Food Stamps
☐ Other (Specify: _____)
☐ Unsure/Don't know
☐ None

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EDUCATION

CLIENT SELF-ADMINISTERED OR CLINICIAN-ADMINISTERED

1. What is the highest grade you have completed?

Select one.

- ○ 8th grade or less
- ○ Some high school
- ○ High school diploma or GED
- ○ Some college, including AA and technical certificates or diploma
- ○ Graduated 4-year college
- ○ Advanced degree (e.g., MA, MD, PhD)
- ○ Unsure/Don't know

2. Are you currently attending school?

Select one.

- ○ Not attending → ***Skip to Q4***
- ○ Attending full-time
- ○ Attending part-time
- ○ Other (Specify: _____)
- ○ Unsure/Don't know → ***Skip to Q4***

3. *If attending full or part-time:* What type of school program are you attending?

Select one.

- ○ Middle school
- ○ High school
- ○ Professional/ vocational certification program
- ○ Two year college
- ○ Four year college
- ○ Graduate program
- ○ Other (Specify: _____)
- ○ Unsure/Don't know

4. **Do you currently receive educational support and accommodation through an Individualized Education Plan (IEP), 504 plan, or from your college disability support office?**
   - ○ Yes
   - ○ No
   - ○ Not applicable
   - ○ Unsure/Don't know

5. **Are you currently working toward a goal related to school at this time, for example, to graduate high school or improve your grades?**
   - ○ Yes
   - ○ No
   - ○ Not applicable
   - ○ Unsure/Don't know

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EMPLOYMENT AND RELATED ACTIVITIES

CLIENT SELF-ADMINISTERED OR CLINICIAN-ADMINISTERED

1. **Are you currently working toward a goal related to employment at this time, for example, to get a job or find a new job?**
   - ○ Yes
   - ○ No
   - ○ Unsure/Don't know

2. **Have you had an internship, apprenticeship, or done volunteer work any time since the last assessment?**
   - ○ Yes
   - ○ No
   - ○ Unsure/Don't know

3. **If yes, was this paid?**
   - ○ Yes
   - ○ No

The next series of questions covers jobs you have had since the last assessment. The first few questions ask about your current or most recent job. Later questions ask about up to two additional jobs you may have had since the last assessment.

4. **Have you had a paid job any time since the last assessment?**
   - ○ Yes
   - ○ No → ***Skip to next section***
   - ○ Unknown → ***Skip to next section***

5. **[OPTIONAL]** ***If yes*****: What is/was your job?**

   _____

6. What type of work is this job?

Select the best option.

- ○ Traineeship
- ○ Professional/ Technical/ Managerial (e.g., doctor, lawyer, accountant, teacher, project manager)
- ○ Office and Administrative Support Occupations and Sales Positions
- ○ Personal Care and Service (e.g., cashier, dog walker, food preparation)
- ○ Construction/ Mechanical/ Factory Worker/ Maintenance
- ○ Agricultural (e.g., farm, fishery, forest)
- ○ Transportation (e.g., bus, taxi driver)
- ○ Military, emergency services (e.g., police, firefighter), or security
- ○ Other (Specify: _____)
- ○ Unknown

7. Is/was this a full-time position (30 hours or more per week) or a part-time position (less than 30 hours per week)?

- ○ Full-time
- ○ Part-time
- ○ Other (Specify: _____)

8. [OPTIONAL] About how much was your take-home pay per week in this position?

$_____ (round to dollars, no cents)

JOB #2

9. **Have you had any other job since the last assessment?**
   - ○ Yes
   - ○ No → *Skip to next section*

10. **[OPTIONAL] What is/was your job?**

    _____

11. **What type of work is this job?**
    - ○ Traineeship
    - ○ Professional/ Technical/ Managerial (e.g., doctor, lawyer, accountant, teacher, project manager)
    - ○ Office and Administrative Support Occupations and Sales Positions
    - ○ Personal Care and Service (e.g., cashier, dog walker, food preparation)
    - ○ Construction/ Mechanical/ Factory Worker/ Maintenance
    - ○ Agricultural (e.g., farm, fishery, forest)
    - ○ Transportation (e.g., bus, taxi driver)
    - ○ Military, emergency services (e.g., police, firefighter), or security
    - ○ Other (Specify: _____)
    - ○ Unknown

12. **Is/was this a full-time position (30 hours or more per week) or a part-time position (less than 30 hours per week)?**
    - ○ Full-time
    - ○ Part-time
    - ○ Other (Specify: _____)

13. **[OPTIONAL] About how much was your take-home pay per week in this position?**
    $_____ (round to dollars, no cents)

JOB #3

14. **Have you had a third job during the <u>past 6 months</u>?**
    - ○ Yes
    - ○ No → ***Skip to next section***

15. **[OPTIONAL] What is/was your other job?**

    _____

16. **What type of work is this job?**
    - ○ Traineeship
    - ○ Professional/ Technical/ Managerial (e.g., doctor, lawyer, accountant, teacher, project manager)
    - ○ Office and Administrative Support Occupations and Sales Positions
    - ○ Personal Care and Service (e.g., cashier, dog walker, food preparation)
    - ○ Construction/ Mechanical/ Factory Worker/ Maintenance
    - ○ Agricultural (e.g., farm, fishery, forest)
    - ○ Transportation (e.g., bus, taxi driver)
    - ○ Military, emergency services (e.g., police, firefighter), or security
    - ○ Other (Specify: _____)
    - ○ Unknown

17. **Is/was this a full-time position (30 hours or more per week) or a part-time position (less than 30 hours per week)?**
    - ○ Full-time
    - ○ Part-time
    - ○ Other (Specify: _____)

18. **[OPTIONAL] About how much was your take-home pay per week in this position?**
    $_____ (round to dollars, no cents)

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LEGAL INVOLVEMENT AND RELATED

CLIENT SELF-ADMINISTERED OR CLINICIAN-ADMINISTERED

1. Since the last assessment, have you had legal issues, probation, or parole?

- ○ Yes
- ○ No
- ○ Unknown

2. Since the last assessment, have you spent any nights in jail/prison?

- ○ Yes
- ○ No → *Skip to Q4*
- ○ Unknown → *Skip to Q4*

3. If yes, number of nights?

_____

4. Since the last assessment, have you had court-ordered treatment?

- ○ Yes
- ○ No
- ○ Unknown

5. Since the last assessment, have you had violent or aggressive thoughts?

- ○ Yes
- ○ No
- ○ Unknown

6. Since the last assessment, have you had violent or aggressive behavior?

- ○ Yes
- ○ No
- ○ Unknown

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SUBSTANCE USE

CLIENT SELF-ADMINISTERED

1. **In the past 30 days, have you used nicotine, e-cigarettes, or vaped?**
   - ○ Yes
   - ○ No → ***Skip to Q3***
   - ○ Prefer not to say → ***Skip to Q3***
   - ○ Don't know → ***Skip to Q3***

2. **In the past 30 days, about how often have you used nicotine, e-cigarettes, or vaped?**
   - ○ Daily
   - ○ Weekly
   - ○ Monthly
   - ○ Less than once a month

3. **In the past 30 days, have you used alcohol?**
   - ○ Yes
   - ○ No → ***Skip to Q5***
   - ○ Prefer not to say → ***Skip to Q5***
   - ○ Don't know → ***Skip to Q5***

4. **In the past 30 days, how often have you used alcohol?**
   - ○ Daily
   - ○ Weekly
   - ○ Monthly
   - ○ Less than once a month

5. **In the past 30 days, have you used marijuana? (This refers to THC, not CBD alone)**
   - ○ Yes
   - ○ No → ***Skip to Q8***
   - ○ Prefer not to say → ***Skip to Q8***
   - ○ Don't know → ***Skip to Q8***

6. **In the past 30 days, how frequently have you used marijuana?**
   - ○ Daily
   - ○ Weekly
   - ○ Monthly
   - ○ Less than once a month

7. **Was the marijuana prescribed by a doctor or other healthcare professional?**
   - ○ Yes
   - ○ No
   - ○ Prefer not to say
   - ○ Don't know

8. **In the past 30 days, have you used opioids? Opioids may include drugs such as Vicodin, Oxycontin, Hydrocodone, Percocet, and Methadone.**
   - ○ Yes
   - ○ No → ***Skip to Q11***
   - ○ Prefer not to say → ***Skip to Q11***
   - ○ Don't know → ***Skip to Q11***

9. **In the past 30 days, how frequently have you used opioids?**
   - ○ Daily
   - ○ Weekly
   - ○ Monthly
   - ○ Less than once a month

10. **Were the opioids prescribed?**
    - ○ Yes
    - ○ No
    - ○ Prefer not to say
    - ○ Don't know

11. **In the past 30 days, have you used non-prescribed stimulants** (e.g., methamphetamine, cocaine, Adderall)?
    - ○ Yes
    - ○ No → ***Skip to next section***
    - ○ Prefer not to say → ***Skip to next section***
    - ○ Don't know → ***Skip to next section***

12. **In the past 30 days, how frequently have you used non-prescribed stimulants** (e.g., methamphetamine, cocaine, Adderall)**?**
    - ○ Daily
    - ○ Weekly
    - ○ Monthly
    - ○ Less than once a month

Client ID # _____ Date of Administration: _____

MEDICATION SIDE EFFECTS AND TREATMENT ADHERENCE

CLIENT SELF-ADMINISTERED OR CLINICIAN-ADMINISTERED

1. Do you currently take any prescription medications?

- ○ Yes
- ○ No → ***Skip Q2***
- ○ Unsure/Don't know → ***Skip Q2***

2. What side effects do you currently experience from your medication?

Check all that apply.

- ☐ Daytime sedation/ drowsiness/ sleeping too much
- ☐ Problems with memory or concentration
- ☐ Changes in appetite or weight
- ☐ Muscles being too tense or still, or muscles trembling or shaking
- ☐ Feeling restless, jittery, or the need to move around and pace
- ☐ Blurry vision, dry mouth, constipation, or urinary retention or hesitancy
- ☐ Changes in sexual functioning
- ☐ Problems with menstruation or breast problems (women only)
- ☐ Feeling unlike usual self
- ☐ Other (Specify: _____)
- ☐ None

CLIENT SELF-ADMINISTERED OR CLINICIAN-ADMINISTERED

Intent to Attend and Complete Treatment Scale

1. How likely is it that you will attend the next appointment?

Not at all		Slightly		Moderately		Markedly		Extremely	
0	1	2	3	4	5	6	7	8	9

2. How likely is it that you will complete the program?

Not at all		Slightly		Moderately		Markedly		Extremely	
0	1	2	3	4	5	6	7	8	9

CLINICIAN-ADMINISTERED

Brief Adherence Rating Scale (BARS)

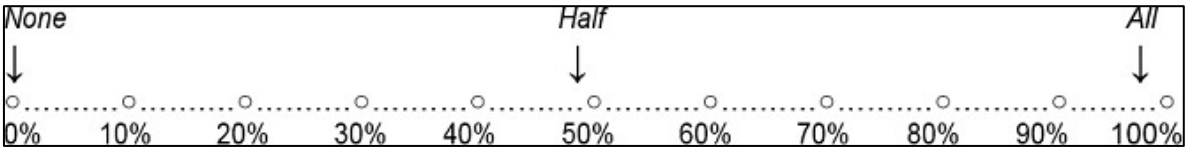
1. **[OPTIONAL] How many pills of *[name of antipsychotic]* did the doctor tell you to take each day?**

   _____

2. **[OPTIONAL] Over the month, since your last visit with me, on how many days did you NOT TAKE your *[name of antipsychotic]*?**
   - ○ Few, if any (<7)
   - ○ 7-13
   - ○ 14-20
   - ○ Most (>20)

3. **Over the month, since your last visit with me, how many days did you TAKE LESS THAN the prescribed number of pills of your *[name of antipsychotic]*?**
   - ○ Always/almost always = 1 ___ (76%-100% of the time)
   - ○ Usually = 2 ___ (51%-75% of the time)
   - ○ Sometimes = 3 ___ (26%-50% of the time)
   - ○ Never/almost never = 4 ___ (0%-25% of the time)

4. **[OPTIONAL] Please place a single vertical line on the dotted line below that you believe best describes, out of the prescribed antipsychotic medication doses, the proportion of doses taken by the client in the past month.**



CLIENT SELF-ADMINISTERED

Adherence Estimator®

For each question, please select the response that best describes how you feel about the medicine you are currently taking.

1. I am convinced of the importance of my prescription medicine.

- ○ Agree completely
- ○ Agree mostly
- ○ Agree somewhat
- ○ Disagree somewhat
- ○ Disagree mostly
- ○ Disagree completely

2. I worry that my prescription medicine will do more harm than good to me.

- ○ Agree completely
- ○ Agree mostly
- ○ Agree somewhat
- ○ Disagree somewhat
- ○ Disagree mostly
- ○ Disagree completely

3. I feel financially burdened by my out-of-pocket expenses for my prescription medicine.

- ○ Agree completely
- ○ Agree mostly
- ○ Agree somewhat
- ○ Disagree somewhat
- ○ Disagree mostly
- ○ Disagree completely

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SYMPTOMS

CLIENT SELF-ADMINISTERED

Modified Colorado Symptom Index

Below is a list of problems that people sometimes have. Please think about how often you experienced certain problems and how much they bothered or distressed you during the past month. For each problem, please pick one answer choice that best describes how often you have had the problem in the past 30 days.

How often have you experienced the problem in the past 30 days?	Not at all	Once during the month	Several times during the month	Several times a week	At least every day	NR	DK
1. How often have you felt nervous, tense, worried, frustrated, or afraid?	0	1	2	3	4		
2. How often have you felt depressed?	0	1	2	3	4		
3. How often have you felt lonely?	0	1	2	3	4		
4. How often have others told you that you acted “paranoid” or “suspicious”?	0	1	2	3	4		
5. How often did you hear voices, or hear and see things that other people didn’t think were there?	0	1	2	3	4		
6. How often did you have trouble making up your mind about something, like deciding where you wanted to go or what you were going to do, or how to solve a problem?	0	1	2	3	4		

How often have you experienced the problem in the past 30 days?	Not at all	Once during the month	Several times during the month	Several times a week	At least every day	NR	DK
7. How often did you have trouble thinking straight or concentrating on something you needed to do (like worrying so much or thinking about problems so much that you can't remember or focus on other things)?	0	1	2	3	4		
8. How often did you feel that your behavior or actions were strange or different from that of other people?	0	1	2	3	4		
9. How often did you feel out of place or like you did not fit in?	0	1	2	3	4		
10. How often did you forget important things?	0	1	2	3	4		
11. How often did you have problems with thinking too fast (thoughts racing)?	0	1	2	3	4		
12. How often did you feel suspicious or paranoid?	0	1	2	3	4		
13. How often did you feel like hurting yourself or killing yourself?	0	1	2	3	4		
14. How often have you felt like seriously hurting someone else?	0	1	2	3	4		

Client ID # _____ Date of Administration: _____

RECOVERY

CLIENT SELF-ADMINISTERED

Quality of Life

Thinking about your own life and personal circumstances, how satisfied are you with your life as a whole?

- ○ 0 – No satisfaction at all
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10 – Completely satisfied

Staying Well (Questionnaire about the Process of Recovery (QPR))

In each row, mark one box that best describes your experience over the last 7 days.

Your experience over the last 7 days	Disagree strongly	Disagree	Neither agree nor disagree	Agree	Agree strongly
1. I feel better about myself					
2. I feel able to take chances in life					
3. I am able to develop positive relationships with other people					
4. I feel part of society rather than isolated					
5. I am able to assert myself					
6. I feel that my life has a purpose					
7. My experiences have changed me for the better					
8. I have been able to come to terms with things that have happened to me in the past and move on with my life					
9. I am basically strongly motivated to get better					
10. I can recognize the positive things I have done					
11. I am able to understand myself better					
12. I can take charge of my life					
13. I can actively engage with life					
14. I can take control of aspects of my life					
15. I can find the time to do the things I enjoy					

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HOSPITALIZATIONS

CLINICIAN-ADMINISTERED AND RECORD REVIEW

1. **Since the last assessment, did you spend the night in a hospital for a mental health reason?**
   - ○ Yes
   - ○ No → *Skip to Q3*

2. **Since the last assessment, how many times did you spend the night in a hospital for a mental health reason?**

   _____

3. **Since the last assessment, what was the total number of nights you spent in any hospital?**

   _____

4. **Since the last assessment, did you go to the emergency room for a mental health or substance use reason but did not stay overnight at the hospital?**
   - ○ Yes
   - ○ No → *Skip to Q6*

5. **Since the last assessment, how many times did you go to an emergency room for a mental health or substance use reason without staying overnight?**

   _____

6. **Since the last assessment, did you spend the night in a hospital, detox facility or a residential treatment facility for substance use?**
   - ○ Yes
   - ○ No → *Skip to Q9*

7. **Since the last assessment, how many times were you admitted to a hospital, detox facility or a residential treatment facility for substance use?**

   _____

8. **Since the last assessment, what was the total number of nights you spent in that setting?**

_____

9. **Since the last assessment, apart from mental health or substance use treatment, did you spend the night in a hospital for a medical condition?**
   - ○ Yes
   - ○ No → ***Skip to Q12***

10. **Since the last assessment, how many times were you admitted to a hospital for a medical condition?**

_____

11. **Since the last assessment, what was the total number of nights you spent in a hospital for a medical condition?**

_____

12. **Since the last assessment, did you go to the emergency room for a medical reason?**
   - ○ Yes
   - ○ No → ***Skip to Q14***

13. **Since the last assessment, how many times did you go to the emergency room for a medical reason?**

_____

14. **Since the last assessment, did you spend the night in a crisis stabilization unit for a mental health or substance use reason?**
   - ○ Yes
   - ○ No → ***Skip to next section***

15. **Since the last assessment, how many times were you admitted to a crisis stabilization unit for a mental health or substance use reason?**

_____

16. **Since the last assessment, what was the total number of nights you spent in a crisis stabilization unit?**

_____

Client ID # _____ Date of Administration: _____

SHARED DECISION MAKING

CLIENT SELF-ADMINISTERED

CollaboRATE [OPTIONAL]

Think about your experience in this program. Select one response for each question.

1. **How much effort was made to help you understand your mental health concerns?**
   - ○ No effort was made
   - ○ A little effort was made
   - ○ Some effort was made
   - ○ A lot of effort was made
   - ○ Every effort was made

2. **How much effort was made to listen to the things that matter most to you about your mental health concerns?**
   - ○ No effort was made
   - ○ A little effort was made
   - ○ Some effort was made
   - ○ A lot of effort was made
   - ○ Every effort was made

3. **How much effort was made to include what matters most to you in choosing what to do next?**
   - ○ No effort was made
   - ○ A little effort was made
   - ○ Some effort was made
   - ○ A lot of effort was made
   - ○ Every effort was made

Client ID # _____ Date of Administration: _____

STRESS, TRAUMA, AND ADVERSE CHILDHOOD EXPERIENCES

CLIENT SELF-ADMINISTERED

Life Events Checklist (LEC-5) [OPTIONAL]

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it *happened to you* personally, (b) you *witnessed it* happen to someone else, (c) you *learned about it* happening to someone close to you, (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder), (e) you're *not sure* if it fits, or (f) it *doesn't apply* to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Does not apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)						
2. Fire or explosion						
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)						
4. Serious accident at work, home, or during recreational activity						
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)						

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Does not apply
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)						
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)						
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)						
9. Other unwanted or uncomfortable sexual experience						
10. Combat or exposure to a war-zone (in the military or as a civilian)						
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)						
12. Life-threatening illness or injury						
13. Severe human suffering						
14. Sudden, violent death (for example, homicide, suicide)						
15. Sudden, unexpected death of someone close to you						
16. Serious injury, harm, or death you caused to someone else						
17. Any other very stressful event or experience						

Client ID # _____ Date of Administration: _____

Post Traumatic Stress Disorder Checklist for DSM-5 (PCL-5) [OPTIONAL]

Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being “super-alert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Client ID # _____ Date of Administration: _____

Child and Adolescent Trauma Screen (CATS) – Youth Report (Age 7-17)

[OPTIONAL]

Stressful or scary events happen to many people. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to you. Mark No if it didn't happen to you.

Event	No	Yes
1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire.		
2. Serious accident or injury like a car/bike crash, dog bite, or sports injury.		
3. Threatened, hit or hurt badly within the family.		
4. Threatened, hit or hurt badly in school or the community.		
5. Attacked, stabbed, shot at or robbed by threat.		
6. Seeing someone in the family threatened, hit or hurt badly.		
7. Seeing someone in school or the community threatened, hit or hurt badly.		
8. Someone doing sexual things to you or making you do sexual things to them when you couldn't say no. Or when you were forced or pressured.		
9. Online or in social media, someone asking or pressuring you to do something sexual. Like take or send pictures.		
10. Someone bullying you in person. Saying very mean things that scare you.		
11. Someone bullying you online. Saying very mean things that scare you.		
12. Someone close to you dying suddenly or violently.		
13. Stressful or scary medical procedure.		
14. Being around war.		
15. Other stressful or scary event?		
Describe: _____		

Mark 0, 1, 2 or 3 for how often the following things have bothered you in the last two weeks:

In the last two weeks, how often were you bothered by:	Never	Once in a while	Half the time	Almost always
1. Upsetting thoughts or pictures about what happened that pop into your head.	0	1	2	3
2. Bad dreams reminding you of what happened.	0	1	2	3
3. Feeling as if what happened is happening all over again.	0	1	2	3
4. Feeling very upset when you are reminded of what happened.	0	1	2	3
5. Strong feelings in your body when you are reminded of what happened (sweating, heart beating fast, upset stomach).	0	1	2	3
6. Trying not to think about or talk about what happened. Or to not have feelings about it.	0	1	2	3
7. Staying away from people, places, things, or situations that remind you of what happened.	0	1	2	3
8. Not being able to remember part of what happened.	0	1	2	3
9. Negative thoughts about yourself or others. Thoughts like I won't have a good life, no one can be trusted, the whole world is unsafe.	0	1	2	3
10. Blaming yourself for what happened, or blaming someone else when it isn't their fault.	0	1	2	3
11. Bad feelings (afraid, angry, guilty, ashamed) a lot of the time.	0	1	2	3
12. Not wanting to do things you used to do.	0	1	2	3
13. Not feeling close to people.	0	1	2	3
14. Not being able to have good or happy feelings.	0	1	2	3
15. Feeling mad. Having fits of anger and taking it out on others.	0	1	2	3
16. Doing unsafe things.	0	1	2	3
17. Being overly careful or on guard (checking to see who is around you).	0	1	2	3
18. Being jumpy.	0	1	2	3
19. Problems paying attention.	0	1	2	3
20. Trouble falling or staying asleep.	0	1	2	3

Please mark "YES" or "NO" if the problems you marked interfered with:

Do the problems described in the previous questions interfere with these aspects of your life?	Yes	No
1. Getting along with others	○	○
2. Hobbies/Fun	○	○
3. School or work	○	○
4. Family relationships	○	○
5. General happiness	○	○

CLINICIAN-COMPLETED

Client ID # _____ Date of Administration: _____

DURATION OF UNTREATED PSYCHOSIS (DUP) AND PATHWAY TO CARE

CLINICIAN-COMPLETED AND RECORD REVIEW

1. **Using all available information, please provide a best estimate of when frank (not prodromal) psychotic symptoms (e.g., delusions, hallucinations, or disorganized speech/behavior) began.**
   ___ ___ (Month) ___ ___ ___ ___ (Year)

2. **Does this date differ from the date entered at the last assessment period?**
   - ○ Yes, differs
   - ○ No, the same
   - ○ Unsure

3. **[OPTIONAL] How was this information obtained?**
   Check all that apply.
   - ☐ Client self-report
   - ☐ Family report
   - ☐ Administrative record
   - ☐ Other (Specify: _____)

Client ID # _____ Date of Administration: _____

DIAGNOSIS

CLINICIAN-COMPLETED

1. Current primary diagnosis

Select one.

- ○ Schizophrenia
- ○ Schizophreniform disorder
- ○ Schizoaffective disorder
- ○ Other non-affective psychoses
- ○ Major depression with psychotic features
- ○ Bipolar disorder with psychotic features
- ○ Substance induced psychotic disorder
- ○ Other (Specify: _____)

2. Was a structured, standardized tool (e.g., the MINI, SCID) used to make this diagnosis?

- ○ Yes
- ○ No

3. Does the client meet criteria for Clinical High Risk?

- ○ Yes
- ○ No → ***Skip to next section***
- ○ Does not apply → ***Skip to next section***

4. Clinical High Risk: Inclusion Criteria

- ☐ Attenuated Psychotic Symptoms (APS)
- ☐ Genetic Risk and Deterioration Syndrome (GRD)
- ☐ Brief Intermittent Psychotic Symptoms (BIPS)

5. Clinical High Risk: Status Specifiers

Select one.

- ○ Progression
- ○ Persistence
- ○ Partial Remission
- ○ Full Remission

Client ID # _____ Date of Administration: _____

FAMILY INVOLVEMENT

CLINICIAN-COMPLETED

1. **Since the last assessment, how frequently was the client in contact with family?**
   Select one.
   - ○ About daily
   - ○ About weekly
   - ○ About monthly
   - ○ Less than monthly
   - ○ Never
   - ○ Unknown

2. **Since the last assessment, what has been the client's preference for family involvement?**
   Select one.
   - ○ Prefers no involvement
   - ○ Prefers family involvement with some restrictions
   - ○ Prefers family involvement with no restrictions
   - ○ Preferences were not assessed

3. **During this assessment period, did any family member receive any treatment services provided by the clinical staff (e.g., family therapy, individual sessions with the client, etc.)?**
   - ○ Yes
   - ○ No
   - ○ Does not apply

4. **During this assessment period, did the family refuse to participate in treatment?**
   - ○ Yes
   - ○ No
   - ○ Does not apply

Client ID # _____ Date of Administration: _____

SUICIDALITY

CLINICIAN-COMPLETED

1. Since the last assessment period, has the client had suicidal ideation?

- ○ Yes
- ○ No
- ○ Unknown

2. Since the last assessment period, has the client had any suicide attempts?

- ○ Yes
- ○ No
- ○ Unknown

3. If yes, how many times?

_____

4. Since the last assessment period, has the client had non-suicidal self-injurious behavior?

- ○ Yes
- ○ No
- ○ Unknown

Client ID # _____ Date of Administration: _____

HEALTH

CLINICIAN-COMPLETED AND RECORD REVIEW

1. **Client's height:** _____ ft _____ in
   ☐ Not collected

2. **Client's weight:** _____ lbs _____oz
   ☐ Not collected

3. **Client's BP:** Systolic (upper number): _____ Diastolic (lower number): _____
   ☐ Not collected

4. **[OPTIONAL] Client's Total Cholesterol (mg/dl):** _____
   ☐ Not collected

5. **[OPTIONAL] Client's LDL cholesterol (mg/dl):** _____
   ☐ Not collected

6. **[OPTIONAL] Client's HDL cholesterol (mg/dl):** _____
   ☐ Not collected

7. **[OPTIONAL] Client's Triglycerides (mg/dl):** _____
   ☐ Not collected

8. **[OPTIONAL] Client's fasting glucose (mg/dl):** _____
   ○ Client did not fast
   ○ Not collected

9. **[OPTIONAL] Client's fasting insulin (uU/ml):** _____
   ○ Client did not fast
   ○ Not collected

10. **[OPTIONAL] Client's hemoglobin A_{1c} (HbA_{1c}):** _____
    ☐ Not collected

Client ID # _____ Date of Administration: _____

MEDICATIONS

CLINICIAN-COMPLETED

1. Is the client currently prescribed an oral antipsychotic medication?

- ○ Yes
- ○ No → *Skip to Q4*
- ○ Don't know → *Skip to Q4*

2. In the following table, find the name of the medication prescribed and check the range that indicates the <u>total mgs prescribed per day</u>. If the prescription includes multiple doses per day, add the different doses to obtain a daily total.

Medication	Range 1	Range 2	Range 3	Dosage not known
a. Aripiprazole (Abilify)	○ <5 mg/day	○ 5-15 mg/day	○ >15 mg/day	○
b. Asenapine (Saphris)	○ <10 mg/day	○ 10 mg/day	○ >10 mg/day	○
c. Brexpiprazole (Rexulti)	○ <2 mg/day	○ 2-4 mg/day	○ >4 mg/day	○
d. Chlorpromazine (Largactil, Thorazine)	○ <400 mg/day	○ 400-600 mg/day	○ >600 mg/day	○
e. Clozapine (Clozaril)	○ <200 mg/day	○ 200–600 mg/day	○ >600 mg/day	○
f. Fluphenazine (Prolixin)	○ <2.5 mg/day	○ 2.5-5.0 mg/day	○ >5.0 mg/day	○
g. Haloperidol (Haldol)	○ <2 mg/day	○ 2–6 mg/day	○ >6 mg/day	○
h. Loxapine (Loxitane)	○ <10 mg/day	○ 10–25 mg/day	○ >25 mg/day	○
i. Lurasidone (Latuda)	○ <40 mg/day	○ 40–80 mg/day	○ >80 mg/day	○
j. Olanzapine (Zyprexa, Ozace)	○ <5 mg/day	○ 5-15 mg/day	○ >15 mg/day	○
k. Paliperidone (Invega)	○ <3 mg/day	○ 3-6 mg/day	○ >6 mg/day	○
l. Perphenazine (Trilafon)	○ <4 mg/day	○ 4-12 mg/day	○ >12 mg/day	○
m. Quetiapine (Seroquel)	○ <300 mg/day	○ 300–600 mg/day	○ >600 mg/day	○
n. Risperidone (Risperdal, Zepidone)	○ <2 mg/day	○ 2–4 mg/day	○ >4 mg/day	○
o. Ziprasidone (Geodon, Zeldox)	○ <40 mg/day	○ 40-160 mg/day	○ >160 mg/day	○

3. **If the client is prescribed an oral antipsychotic not listed above, indicate the name and daily dose.**
   Name: _____
   Dosage: _____

4. **Is the client currently prescribed a Long-Acting Injectable (LAI)?**
   ○ Yes
   ○ No → *Skip to Q7*
   ○ Don't Know → *Skip to Q7*

5. **In the following table, find the name of the medication prescribed and check the correct dosage.**

Medication	Dosage			Dosage not known
a. Aripiprazole (Abilify Maintena)	○ 300mg ○ 400mg	○ other:_____		○
b. Aripiprazole (Aristada Lauroxil)	○ 441mg ○ 662mg	○ 882mg ○ 1064mg		○
c. Fluphenazine (Prolixin Decanoate)	○ 25mg ○ 37.5mg	○ 50mg ○ 75mg	○ 100mg	○
d. Haloperidol (Haldol Decanoate)	○ 50mg ○ 100mg	○ 150mg ○ 200mg		○
e. Olanzapine (Zyprexa Relprevv)	○ 150mg ○ 210mg	○ 300mg ○ 405mg		○
f. Paliperidone (Invega Sustenna)	○ 39mg ○ 78mg	○ 117mg ○ 156mg	○ 234mg	○
g. Paliperidone (Invega Trinza)	○ 273mg ○ 410mg	○ 546mg ○ 819mg		○
h. Risperidone (Risperdal Consta)	○ 12.5mg ○ 25mg	○ 37.5mg ○ 50mg		○
i. Risperidone (Perseris)	○ 90mg ○ 120mg			○

6. **If the client is prescribed an LAI not listed above, indicate the name and dose.**
   Name: _____
   Dosage: _____

7. Is the client currently prescribed any other psychotropic medications?

○ Yes
○ No → ***Skip to next section***

8. Indicate all psychotropic medications prescribed.

Check all that apply.

Antidepressants

☐ Bupropion Hcl (Wellbutrin)
☐ Citalopram Hydrobromide (Celexa)
☐ Duloxetine Hcl (Cymbalta)
☐ Desvenlafazine (Pristiq)
☐ Escitalopram Oxalate (Lexapro)
☐ Fluoxetine Hcl (Prozac)
☐ Mirtazapine (Remeron)
☐ Paroxetine Hcl (Paxil)
☐ Sertraline Hcl (Zoloft)
☐ Venlafaxine Hcl (Effexor XR)
☐ Vilazodone (Viibryd)
☐ Vortioxetine (Brintellix)
☐ Other (Specify: _____)

Benzodiazepines

☐ Lorazepam (Ativan)
  ○ Daily
  ○ PRN
☐ Clonazepam (Klonopin)
  ○ Daily
  ○ PRN

Sedative/hypnotics

☐ Zolpidem (Ambien)

Mood Stabilizers

☐ Carbamazepine (Tegretol)
☐ Divalproex/ Valproic acid (Depakote)
☐ Lamotrigine (Lamictal)
☐ Lithium Citrate (Lithium)
☐ Lithium Carbonate (Eskalith)
☐ Oxcarbazepine (Trileptal)
☐ Topiramate (Topamax)

ADHD medications

☐ Amphetamine (Adderall, Vyvanse)
☐ Methylphenidate (Ritalin, Concerta)
☐ Guanfacine (Intuniv)
☐ Atomoxetine (Strattera)

Anxiolytic

☐ Buspirone (Buspar)

Smoking Cessation

☐ Bupropion Hcl (Zyban)
☐ Varenacline (Chantix)

Other

☐ Gabapentin (Gralise)
☐ Trazodone Hcl (Desyrell)
☐ Other (Specify: _____)

Client ID # _____ Date of Administration: _____

SERVICE USE

CLINICIAN-COMPLETED

1. **Since the last assessment, has a child protective services (or equivalent state agency) report been initiated on behalf of the client?**
   - ○ Yes
   - ○ No
   - ○ Don't Know

2. **Has the client received psychiatric medication management through your program since the last assessment?**
   - ○ Yes
   - ○ No
   - ○ Program does not provide this service
   - ○ Don’t Know

3. **Has the client received psychotherapy (individual or group) through your program since the last assessment?**
   - ○ Yes
   - ○ No
   - ○ Program does not provide this service
   - ○ Don’t Know

4. **Has the client received supported education assistance through your program since the last assessment?**
   - ○ Yes
   - ○ No
   - ○ Program does not provide this service
   - ○ Don’t Know

5. **Has the client received supported employment assistance through your program since the last assessment?**
   - ○ Yes
   - ○ No
   - ○ Program does not provide this service
   - ○ Don't Know

6. **Has the client received case management through your program since the last assessment?**
   - ○ Yes
   - ○ No
   - ○ Program does not provide this service
   - ○ Don't Know

7. **Has the client received peer support through your program since the last assessment?**
   - ○ Yes
   - ○ No
   - ○ Program does not provide this service
   - ○ Don't Know

8. **Have the client's legal guardians or supportive others received family treatment/support through your program since the last assessment?**
   - ○ Yes
   - ○ No
   - ○ Program does not provide this service
   - ○ Don't Know

9. **Did any visit with the client through your program take place in the community since the last assessment?**
   - ○ Yes
   - ○ No
   - ○ Program does not provide this service
   - ○ Don't Know

FUNCTIONING

CLINICIAN-COMPLETED

CLINICS CAN ADMINISTER EITHER THE GLOBAL FUNCTIONING SOCIAL SCALE AND ROLE SCALE OR THE MIRECC-GAF SOCIAL FUNCTIONING AND OCCUPATIONAL FUNCTIONING SCALE.

Client ID # _____ Date of Administration: _____

Global Functioning: Social Scale

Please rate the client's most impaired level of functioning in occupational, educational, and/or homemaker roles, as appropriate, in the past month. Rate actual functioning regardless of etiology of occupational/educational problems.

1. Rating (1-10): _____

Client ID # _____ Date of Administration: _____

Global Functioning: Role Scale

Please rate the client's most impaired level of functioning in occupational, educational, and/or homemaker roles, as appropriate, in the past month. Rate actual functioning regardless of etiology of occupational/educational problems.

2. Rating (1-10): _____

Client ID # _____ Date of Administration: _____

MIRECC-GAF Social Functioning

1. Rating (0-100) : _____

Client ID # _____ Date of Administration: _____

MIRECC-GAF Occupational Functioning

2. Rating (0-100) : _____

Client ID # _____ Date of Administration: _____

SYMPTOMS

CLINICIAN-COMPLETED

CLINICS CAN ADMINISTER THE COMPASS-10 SCALE, THE BRIEF PSYCHIATRIC RATING SCALE (BPRS), OR THE POSITIVE AND NEGATIVE SYMPTOMS OF SCHIZOPHRENIA SCALE (PANSS-6)

COMPASS-10 Scale

The Compass-10 scale consists of 10 items selected from the COMPASS Clinician Rating Form developed for the RAISE-ETP study. Each item includes a description of the symptom being assessed that immediately follows the name of the symptom. Following the description are suggested probe questions (in italics) to obtain information about the symptom. Assessors should ask additional questions if the probe questions do not provide enough information to make a rating for symptom severity.

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1. DEPRESSED MOOD

Sadness, grief, or discouragement (do not rate emotional indifference or empty mood here - only mood which is associated with a painful, sorrowful feeling).

Have you been feeling depressed, sad, or down?

a. ***If yes:*** *Tell me about what you have been experiencing. How often did it happen? Does it come and go? How long does it last? How bad is the feeling? (Can you stand it?)*

b. ***If no:*** *Any problems not being interested in things you usually enjoy?*

   i. *If decreased interest is present, probe further for the presence of depressed mood.*

Rating	**0 = Not present**
	1 = Very Mild: Occasionally feels sad or "down"; of questionable clinical significance.
	2 = Mild: Occasionally feels moderately depressed or often feels sad or "down".
	3 = Moderate: Occasionally feels very depressed or often feels moderately depressed.
	4 = Moderately Severe: Often feels very depressed.
	5 = Severe: Feels very depressed most of the time.
	6 = Very Severe: Constant extremely painful feelings of depression.
	☐ Unable to assess (e.g., subject uncooperative or incoherent).

2. ANXIETY/WORRY

Subjective experience of worry, apprehension; over-concern for present or future. Anxiety/fear from a psychotic symptom should be rated (e.g., the subject feels anxious because of a belief that he/she is about to be killed).

Have you been feeling anxious, worried or nervous?

a. ***If yes:*** *Tell me about what you have been experiencing. What are some things you worry about or that make your nervous? How often did it happen? Does it come and go? How bad is the feeling?*

b. ***If no:*** *Would you say that you have usually been feeling calm and relaxed recently?*

Rating	**0 = Not present**
	1 = Very Mild: Occasionally feels a little anxious; of questionable clinical significance.
	2 = Mild: Occasionally feels moderately anxious or often feels a little anxious or worried.
	3 = Moderate: Occasionally feels very anxious or often feels moderately anxious.
	4 = Moderately Severe: Often feels very anxious or worried.
	5 = Severe: Feels very anxious or worried most of the time.
	6 = Very Severe: Patient is continually preoccupied with severe anxiety.
	☐ Unable to assess (e.g., subject uncooperative or incoherent).

3. SUICIDAL IDEATION/BEHAVIOR

The individual reports a passive death wish, thoughts of suicide, or engages in suicidal behavior (do not include self-injurious behavior without suicidal intent).

Have you had any thoughts recently about death or that you would be better off dead?

a. ***If yes:*** *Tell me about what you have been thinking. How often do you think about death? Have you thought about hurting yourself?*

   i. *If suicidal ideation is present, further suggested questions are:*

      1) *Have you thought of any ways to hurt yourself?*

      2) *Do these thoughts upset you?*

      3) *Any times when you have tried to hurt yourself since our last visit?*

Rating	**0 = Not present**
	1 = Very Mild: Occasional thoughts of dying, "I'd be better off dead" or "I wish I were dead".
	2 = Mild: Frequent thoughts of dying or occasional thoughts of killing self, without a plan or method.
	3 = Moderate: Often thinks of suicide or has thought of a specific method.
	4 = Moderately Severe: Has mentally rehearsed a specific method of suicide or has made a suicide attempt with questionable intent to die (e.g., takes aspirins and then tells family).
	5 = Severe: Has made preparations for a potentially lethal suicide attempt (e.g., acquires a gun and bullets for an attempt).
	6 = Very Severe: Has made a suicide attempt with definite intent to die.
	☐ Unable to assess (e.g., subject uncooperative or incoherent).

4. HOSTILITY/ANGER/IRRITABILITY/AGGRESSIVENESS

Anger, verbal and non-verbal expressions of anger and resentment including a belligerent attitude, sarcasm, abusive language, and assaultive or threatening behavior.

Have you been feeling anxious, worried or nervous?

a. ***If yes:*** *Tell me how you have been feeling. Have other people done things to make you mad?*

   i. *If applicable, other suggested questions include:*

      1) *Could other people tell that you were angry?*

      2) *Have you done anything about your anger [for example, shout at people])?*

b. ***If no:*** *Have other people done things that could have make you mad?*

Rating	**0 = Not present**
	1 = Very Mild: Occasional irritability of doubtful clinical significance.
	2 = Mild: Occasionally feels angry or mild or indirect expressions of anger, e.g., sarcasm, disrespect or hostile gestures.
	3 = Moderate: Frequently feels angry, frequent irritability or occasional direct expression of anger, e.g., yelling at others.
	4 = Moderately Severe: Often feels very angry, often yells at others or occasionally threatens to harm others.
	5 = Severe: Has acted on his anger by becoming physically abusive on one or two occasions or makes frequent threats to harm others or is very angry most of the time.
	6 = Very Severe: Has been physically aggressive and/or required intervention to prevent assaultiveness on several occasions; or any serious assaultive act.
	☐ Unable to assess (e.g., subject uncooperative or incoherent).

5. SUSPICIOUSNESS

Expressed or apparent belief that other persons have acted maliciously or with discriminatory intent. Include persecution by supernatural or other nonhuman agencies (e.g., the devil).
Note: Ratings of "2" (mild) or above should also be rated under Unusual Thought Content.

Do you ever feel uncomfortable in public? Does it seem as though others are watching you? Are you concerned about anyone's intentions toward you?

Is anyone going out of their way to give you a hard time, or trying to hurt you? Do you feel in any danger?

a. *If an individual reports any persecutory ideas/delusions, ask the following:*
   i. *How often have you been concerned that [use individual's description]?*
   ii. *Have you told anyone about these experiences?*

Rating	**0 = Not present**
	1 = Very Mild: Seems on guard. Reluctant to respond to some "personal" questions. Reports being overly self-conscious in public.
	2 = Mild: Describes incidents in which others have harmed or wanted to harm him/her that sound plausible. Patient feels as if others are watching, laughing, or criticizing him/her in public, but this occurs only occasionally or rarely. Little or no preoccupation.
	3 = Moderate: Says others are talking about him/her maliciously, have negative intentions, or may harm him/her. Beyond the likelihood of plausibility, but not delusional. Incidents of suspected persecution occur occasionally (less than once per week) with some preoccupation.
	4 = Moderately Severe: Same symptoms as moderate (level 3) above, but incidents occur frequently such as more than once a week. Patient is moderately preoccupied with ideas of persecution OR patient reports persecutory delusions expressed with much doubt (e.g., partial delusion).
	5 = Severe: Delusional -- speaks of Mafia plots, the FBI, or others poisoning his/her food, persecution by supernatural forces.
	6 = Extremely Severe: Same symptoms as severe (level 5) above, but the beliefs are bizarre or more preoccupying. Patient tends to disclose or act on persecutory delusions.
	☐ Unable to assess (e.g., subject uncooperative or incoherent).

6. UNUSUAL THOUGHT CONTENT

Unusual, odd, strange or bizarre thought content. Rate the degree of unusualness, not the degree of disorganization of speech. Delusions are patently absurd, clearly false or bizarre ideas that are expressed with full conviction. Consider the patient to have full conviction if he/she has acted as though the delusional belief were true. Ideas of reference/persecution can be differentiated from delusions in that ideas are expressed with much doubt and contain more elements of reality. Include thought insertion, withdrawal and broadcast. Include grandiose, somatic and persecutory delusions even if rated elsewhere. **Note:** If Suspiciousness is rated "5" (severe) or "6" (extremely severe) due to delusions, then Unusual Thought Content must be rated a "3" (moderate) or above.

Have you been receiving any special messages from people or from the way things are arranged around you? Have you seen any references to yourself on TV or in the newspapers? Can anyone read your mind? Do you have a special relationship with God? Is anything like electricity, X-rays, or radio waves affecting you? Are thoughts put into your head that are not your own? Have you felt that you were under the control of another person or force?

a. *If an individual reports any odd ideas/delusions, ask the following:*

   i. *How often do you think about [use individual's description]?*

   ii. *Have you told anyone about these experiences?*

   iii. *How do you explain the things that have been happening [specify]?*

Rating	**0 = Not present**
	1 = Very Mild: Ideas of reference (people may stare or may laugh at him), ideas of persecution (people may mistreat him). Unusual beliefs in psychic powers, spirits, UFOs, or unrealistic beliefs in one's own abilities. Not strongly held. Some doubt.
	2 = Mild: Same symptoms as very mild (level 1) above, but degree of reality distortion is more severe as indicated by highly unusual ideas or greater conviction. Content may be typical of delusions (even bizarre), but without full conviction. The delusion does not seem to have fully formed, but is considered as one possible explanation for an unusual experience.
	3 = Moderate: Delusion present but no preoccupation or functional impairment. May be an encapsulated delusion or a firmly endorsed absurd belief about past delusional circumstances.
	4 = Moderately Severe: Full delusion(s) present with some preoccupation OR some areas of functioning disrupted by delusional thinking.
	5 = Severe: Full delusion(s) present with much preoccupation OR many areas of functioning are disrupted by delusional thinking.
	6 = Extremely Severe: Full delusions present with almost total preoccupation OR most areas of functioning are disrupted by delusional thinking.
	☐ Unable to assess (e.g., subject uncooperative or incoherent).

7. HALLUCINATIONS

Reports of perceptual experiences in the absence of relevant external stimuli. When rating degree to which functioning is disrupted by hallucinations, include preoccupation with the content and experience of the hallucinations, as well as functioning disrupted by acting out on the hallucinatory content (e.g., engaging in deviant behavior due to command hallucinations). Include "thoughts aloud" ("gedankenlautwerden") or pseudohallucinations (e.g., hears a voice inside head) if a voice quality is present.

Do you ever seem to hear your name being called? Have you heard any sounds or people talking to you or about you when there has been nobody around?

a. *If hears voices: What does the voice/voices say? Did it have a voice quality?*

Do you ever have visions or see things that others do not see?

What about smell — odors that others do not smell?

a. *If the individual reports hallucinations, ask the following:*
b. *Have these experiences interfered with your ability to perform your usual activities/work?*
c. *How do you explain them?*
d. *How often do they occur?*

Rating	**0 = Not present**
	1 = Very Mild: While resting or going to sleep, sees visions, smells odors, or hears voices, sounds or whispers in the absence of external stimulation, but no impairment in functioning.
	2 = Mild: While in a clear state of consciousness, hears a voice calling the subject's name, experiences non-verbal auditory hallucinations (e.g., sounds or whispers), formless visual hallucinations, or has sensory experiences in the presence of a modality-relevant stimulus (e.g., visual illusions) infrequently (e.g., 1-2 times per week) and with no functional impairment.
	3 = Moderate: Occasional verbal, visual, gustatory, olfactory, or tactile hallucinations with no functional impairment OR non-verbal auditory hallucinations/visual illusions more than infrequently or with impairment.
	4 = Moderately Severe: Experiences daily hallucinations OR some areas of functioning are disrupted by hallucinations.
	5 = Severe: Experiences verbal or visual hallucinations several times a day OR many areas of functioning are disrupted by these hallucinations.
	6 = Extremely Severe: Persistent verbal or visual hallucinations throughout the day OR most areas of functioning are disrupted by these hallucinations.
	☐ Unable to assess (e.g., subject uncooperative or incoherent).

8. CONCEPTUAL DISORGANIZATION

Degree to which speech is confused, disconnected, vague or disorganized. Rate tangentiality, circumstantiality, sudden topic shifts, incoherence, derailment, blocking, neologisms, and other speech disorders. Do not rate content of speech.

This item does not have specific probe questions as it is based upon speech obtained in response to questions about other COMPASS-10 items.

Rating	**0 = Not present**
	1 = Very Mild: Peculiar use of words or rambling but speech is comprehensible.
	2 = Mild: Speech a bit hard to understand or make sense of due to tangentiality, circumstantiality, or sudden topic shifts.
	3 = Moderate: Speech difficult to understand due to tangentiality, circumstantiality, idiosyncratic speech, or topic shifts on many occasions OR 1-2 instances of incoherent phrases.
	4 = Moderately Severe: Speech difficult to understand due to circumstantiality, tangentiality, neologisms, blocking, or topic shifts most of the time OR 3-5 instances of incoherent phrases.
	5 = Severe: Speech is incomprehensible due to severe impairments most of the time. Many symptom items cannot be rated by self-report alone.
	6 = Extremely Severe: Speech is incomprehensible throughout interview.
	☐ Unable to assess (e.g., subject uncooperative or incoherent).

9. AVOLITION/APATHY

Avolition manifests itself as a characteristic lack of energy, drive, and interest. Consider degree of passivity in pursuing goal-directed activities. Factor in the range of activities available to the subject (e.g., inpatient hospitalization often substantially limits the range of activities available to patients).

During the past week, how have you been spending your time?

Rating	**0 = Not present**
	1 = Very Mild: Questionable decrease in time spent in goal-directed activities.
	2 = Mild: Spends less time in goal-directed activities than is appropriate for situation and age.
	3 = Moderate: Initiates activities at times but does not follow through.
	4 = Moderately Severe: Rarely initiates activity but will passively engage with encouragement.
	5 = Severe: Almost never initiates activities; requires assistance to accomplish basic activities.
	6 = Very Severe: Does not initiate or persist in any goal-directed activity even with outside assistance.
	☐ Unable to assess (e.g., subject uncooperative or incoherent).

10. ASOCIALITY/LOW SOCIAL DRIVE

The subject pursues little or no social interaction, and tends to spend much of the time alone or non-interactively.

Some people are very outgoing and like to always be around people; they are "the life of the party". Other people are very reserved and like to have a lot of time alone. What type of person are you? *(if extra prompt needed: Are you more reserved or more outgoing?)*

What types of things have you done with people during the past week?

Tell me about your friends?

Have you had a chance to see or speak with them lately?

a. *If an inpatient: How about people on the ward?*

What types of things do you do with them?

Rating	**0 = Not present**
	1 = Very Mild: Questionable.
	2 = Mild: Slow to initiate social interactions but usually responds to overtures by others.
	3 = Moderate: Rarely initiates social interactions; sometimes responds to overtures by others.
	4 = Moderately Severe: Does not initiate but sometimes responds to overtures by others; little social interaction outside close family members.
	5 = Severe: Never initiates and rarely encourages conversations or activities; avoids being with others unless prodded, may have contacts with family.
	6 = Very Severe: Avoids being with others (even family members) whenever possible, extreme social isolation.
	☐ Unable to assess (e.g., subject uncooperative or incoherent).

Client ID # _____ Date of Administration: _____

Brief Psychiatric Rating Scale (BPRS)

Please enter the score for the term that best describes the patient's condition.
0 = Not present, 1 = Very mild, 2 = Mild, 3 = Moderate, 4 = Moderately severe, 5 = Severe,
6 = Extremely severe

Item	Score
1. **Somatic Concern** Preoccupation with physical health, fear of physical illness, hypochondriasis.	
2. **Anxiety** Worry, fear, over-concern for present or future, uneasiness.	
3. **Emotional Withdrawal** Lack of spontaneous interaction, isolation deficiency in relating to others.	
4. **Conceptual Disorganization** Thought processes confused, disconnected, disorganized, disrupted.	
5. **Guilt Feelings** Self-blame, shame, remorse for past behavior.	
6. **Tension** Physical and motor manifestations of nervousness, over-activation.	
7. **Mannerisms and Posturing** Peculiar, bizarre, unnatural motor behavior (not including tic).	
8. **Grandiosity** Exaggerated self-opinion, arrogance, conviction of unusual power or abilities.	
9. **Depressive Mood** Sorrow, sadness, despondency, pessimism.	
10. **Hostility** Animosity, contempt, belligerence, disdain for others.	
11. **Suspiciousness** Mistrust, belief others harbor malicious or discriminatory intent.	
12. **Hallucinatory Behavior** Perceptions without normal external stimulus correspondence.	
13. **Motor Retardation** Slowed, weakened movements or speech, reduced body tone.	
14. **Uncooperativeness** Resistance, guardedness, rejection of authority.	
15. **Unusual Thought Content** Unusual, odd, strange, bizarre thought content.	

Item	Score
16. **Blunted Affect** Reduced emotional tone, reduction in formal intensity of feelings, flatness.	
17. **Excitement** Heightened emotional tone, agitation, increased reactivity.	
18. **Disorientation** Confusion or lack of proper association for person, place or time.	

Client ID # _____ Date of Administration: _____

Positive and Negative Symptoms of Schizophrenia Scale (PANSS-6)

Test	Client score
a. Delusions	
b. Conceptual disorganization	
c. Hallucinatory behavior	
d. Blunted affect	
e. Passive/apathetic social withdrawal	
f. Lack of spontaneity and flow of conversation	

COGNITION

CLINICIAN-COMPLETED

1. **During this assessment period, was the client's cognition assessed with a validated tool ?**
   - ○ Yes
   - ○ No
   - ○ Unsure

2. **During this assessment period, was the client's cognition used for treatment planning?**
   - ○ Yes
   - ○ No
   - ○ Unsure

CLINICS SHOULD ADMINISTER EITHER THE PENN CNB OR THE BAC-APP V2.1.0

Client ID # _____ Date of Administration: _____

Pennsylvania Computerized Neurocognitive Battery (Penn CNB)

Test	Client score
a. Penn Digit Symbol Substitution Test (DSST)	
b. Penn Word Memory Test (PWMT)	
c. Penn Matrix Reasoning Test (PMAT)	
d. Emotion Recognition Test (ER-40)	

Client ID # _____ Date of Administration: _____

Brief Assessment of Cognition (BAC-APP v2.1.0)

Test	Client score
a. Token Motor	
b. Symbol Coding	
c. Semantic and Letter Fluency	
d. Digit Sequencing	
e. Verbal Memory	
f. Tower of London	

Client ID # _____ Date of Administration: _____

DISCHARGE PLANNING AND DISPOSITION

CLINICIAN-COMPLETED

1. Date of discharge ***[Entered only at discharge]***

___ ___ (Month) ___ ___ ___ ___ (Year)

2. What is the primary reason for discharge? ***[Entered only at discharge]***

Select *primary* reason

- ○ Terminated, refused or declined services
- ○ Completed program, graduated, or services no longer indicated due to client improvement
- ○ Client does not display signs and symptoms that lead to the inclusion of a covered diagnosis and/or an established level of impairment
- ○ Has reached limit for length of allowable stay
- ○ Pursuing a positive opportunity elsewhere (e.g., school, employment, training)
- ○ Admitted to state hospital
- ○ Admitted to a residential program
- ○ Transferred services to provider outside CSC program (other than state hospital or residential program)
- ○ Incarcerated
- ○ Moved out of service area because of reasons other than options noted above
- ○ Deceased (by suicide)
- ○ Deceased (by other means)
- ○ Whereabouts unknown, team unable to contact client
- ○ Other (Specify: _____)

3. Did team refer for further services? ***[Entered only at discharge]***

- ○ Yes
- ○ No
- ○ Unknown

4. Indicate any referrals made for services that were *within* your agency. ***[Entered only at discharge]***

Check all that apply.

- ☐ Medication only
- ☐ Psychotherapy only or some mix of psychosocial treatments, medication, supportive services, etc.
- ☐ Higher level of service
- ☐ Other (Specify: _____)
- ☐ None
- ☐ Does not apply

5. Indicate any referrals made for services that were *outside* your agency. ***[Entered only at discharge]***

- ☐ Medication only
- ☐ Psychotherapy only or some mix of psychosocial treatments, medication, supportive services, etc.
- ☐ Higher level of service
- ☐ Other (Specify: _____)
- ☐ None
- ☐ Does not apply