

### **Client Outcome Assessment Battery (COAB) Paper Forms**

Outcome measures help us ensure that ACT and FACT are improving clients' lives in meaningful ways. Measures can also benefit your team's everyday clinical practice by supporting development of personalized treatment plans and identifying areas where the ACT or FACT service is benefitting or not benefitting the client.

The COAB should be completed with ACT and FACT clients when they enroll with your team, every 6 months thereafter, and when they are discharged from your team.

#### **Measures Inside the COAB:**

1. Demographics (included only for Enrollment and Discharge, NOT 6-Month)
2. Client Status
  - a. Living Arrangements
  - b. Justice System and Legal Involvement
  - c. Work or School Involvement
3. Quality of Life (QOL-1; client self-report)
4. COMPASS-10
5. Illness Management and Recovery Scale (IMR)
6. Daily Living Activities Scale (DLA-20)
7. Service Engagement Scale (SES)
8. Questionnaire About the Process of Recovery (QPR; client self-report)
  - a. *OPTIONAL: This measure provides a rich picture of recovery, but its completion is not required.*

#### **General Guidelines:**

1. Please view [this training](#) on outcome measures before beginning to collect data.
2. Follow your local procedures for safeguarding private patient information during transport and storage. Completed measures include protected health information.

#### **Instructions:**

1. The COAB should be completed within 1-month of each due date (e.g., within 1-month after enrollment, 1-month before or after 6-month reassessment, and 1-month after discharge.)
2. Completion of the COAB can be divided into multiple sessions provided all measures are completed within one week.
3. If the entire COAB cannot be completed within one week, please restart the assessment, with respect to the 1-month window.
4. If unable to complete a new assessment within the due date, please record the partially completed assessment.

**Living Arrangements**

**1. For the below table, please choose the categories that best describe where the client has resided over the past 6 months.**

<b>Residential Type</b>	<b>In the past 6 months, how many days did the client spend living in (must <b>TOTAL 180 days</b>):</b>
<b>1a. Independent Living</b> (e.g., Living alone or with spouse, family, friend or roommate in apartment or house, single room occupancy etc.)	
<b>1b. Minimally Structured</b> (e.g., Board & care, assisted living, adult foster care, supervised individual or congregate placement, etc.)	
<b>1c. Moderately Structured</b> (e.g., Residential treatment program, acute psychiatric facility, mental health rehabilitation center, etc.)	
<b>1d. Extremely Structured</b> (e.g., State psychiatric hospital, institution for mental disease (IMD), skilled nursing facility, jail or prison, long term institutional care, etc.)	
<b>1e. Homeless</b> (e.g., on the street, in a car or abandoned building, or outdoors; in a homeless shelter or emergency shelter, including hotel or motel paid with a shelter voucher; in a transitional or temporary location including couch surfing, hotel or motel, or temporarily living with family or friends; fleeing or attempting to flee domestic violence)	
<b>TOTAL</b>	

Client Code: \_\_\_\_\_

Assessor: \_\_\_\_\_

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**ACT and FACT Client Outcomes**  
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<p><b>2.</b> Is the client <i>currently</i> homeless (e.g., on the street, in a car or abandoned building, or outdoors; in a homeless shelter or emergency shelter, including hotel or motel paid with a shelter voucher; in a transitional or temporary location including couch surfing, hotel or motel, or temporarily living with family or friends; fleeing or attempting to flee domestic violence)?</p>	<p>YES <input type="checkbox"/></p>	<p>NO <input type="checkbox"/></p>	
<p><b>2a. [IF NO]</b> Please indicate the client's <i>current</i> living situation (Select ONE box below).</p>			
<p>Independent Living <input type="checkbox"/></p>	<p>Minimally Structured <input type="checkbox"/></p>	<p>Moderately Structured <input type="checkbox"/></p>	<p>Extremely Structured <input type="checkbox"/></p>
<p><b>3.</b> In your judgment, is the above living situation <i>permanent or non-permanent</i>? (Permanent means the client's housing situation is stable for the foreseeable future)</p>	<p>Permanent <input type="checkbox"/></p>	<p>Non-permanent <input type="checkbox"/></p>	
<p><b>4.</b> Did the client exit an Institution for Mental Disease (IMD) <i>within the past 6 months</i>?</p>	<p>YES <input type="checkbox"/></p>	<p>NO <input type="checkbox"/></p>	

Client Code: \_\_\_\_\_

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**Justice System and Legal Involvement**

<p><b>1.</b> <i>At any time in the past 6 months</i>, has the client been on an LPS, probate, or temporary conservatorship (T-Con)?</p>	<p>YES <input type="checkbox"/></p>	<p>NO <input type="checkbox"/></p>
<p><b>2.</b> Not counting minor traffic violations, has the client ever been arrested and booked, or convicted, for breaking the law? (Being "booked" means that you were taken into custody and processed by the police or by someone connected with the courts, even if you were then released.)</p>	<p>YES <input type="checkbox"/></p>	<p>NO <input type="checkbox"/></p>
<p><b>2a. [IF Yes]</b> Not counting minor traffic violations, how many times <i>during the past 6 months</i> has the client been arrested and booked, or convicted, for breaking a law?</p>	<p>(# TIMES ARRESTED OR BOOKED)</p>	
<p><b>2b. [IF Yes]</b> <i>In the past 6 months</i>, how many nights total did the client spend incarcerated in jail, prison, or juvenile detention center?</p>	<p>(TOTAL # NIGHTS INCARCERATED)</p>	
<p><b>3.</b> Was the client on probation at any time <i>during the past 6 months</i>?</p>	<p>YES <input type="checkbox"/></p>	<p>NO <input type="checkbox"/></p>
<p><b>4.</b> Was the client on parole, supervised release, or other conditional release (including diversion programs) from jail or prison at any time <i>during the past 6 months</i>?</p>	<p>YES <input type="checkbox"/></p>	<p>NO <input type="checkbox"/></p>

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**Work or School Involvement**

In the past 6 months, did the client engage in any of the following at any time:		
<b>1.</b> Have a paid, competitive job earning at least minimal wage?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>1a. [IF Yes]</b> Estimate the average number of hours spent on this activity <i>in a typical week in the past 6 months:</i>	(AVG HOURS/WEEK)	
<b>2.</b> Attending school or classes, either full- or part-time, for enrichment, for credit, or to lead to a certificate or diploma?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>2a. [IF Yes]</b> Estimate the average number of hours spent on this activity <i>in a typical week in the past 6 months:</i>	(AVG HOURS/WEEK)	

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**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)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**COMPASS-10**

Please complete this measure based on the client’s clinical presentation and experiences over the last week. We recommend having a face-to-face conversation with the client to inform your ratings.

**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).*

Rating	0 =	<b>Not present</b>	<input type="checkbox"/>
	1 =	<b>Very Mild:</b> occasionally feels sad or “down”; of questionable clinical significance	<input type="checkbox"/>
	2 =	<b>Mild:</b> occasionally feels moderately depressed or often feels sad or “down”	<input type="checkbox"/>
	3 =	<b>Moderate:</b> occasionally feels very depressed or often feels moderately depressed	<input type="checkbox"/>
	4 =	<b>Moderately Severe:</b> often feels very depressed	<input type="checkbox"/>
	5 =	<b>Severe:</b> feels very depressed most of the time	<input type="checkbox"/>
	6 =	<b>Very Severe:</b> constant extremely painful feelings of depression	<input type="checkbox"/>
		Unable to assess (e.g. subject uncooperative or incoherent)	<input type="checkbox"/>

**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).*

Rating	0 =	<b>Not present</b>	<input type="checkbox"/>
	1 =	<b>Very Mild:</b> occasionally feels a little anxious; of questionable clinical significance	<input type="checkbox"/>
	2 =	<b>Mild:</b> occasionally feels moderately anxious or often feels a little anxious or worried	<input type="checkbox"/>
	3 =	<b>Moderate:</b> occasionally feels very anxious or often feels moderately anxious	<input type="checkbox"/>
	4 =	<b>Moderately Severe:</b> often feels very anxious or worried	<input type="checkbox"/>
	5 =	<b>Severe:</b> feels very anxious or worried most of the time	<input type="checkbox"/>
	6 =	<b>Very Severe:</b> patient is continually preoccupied with severe anxiety	<input type="checkbox"/>
		Unable to assess (e.g. subject uncooperative or incoherent)	<input type="checkbox"/>

Client Code: \_\_\_\_\_ Assessor: \_\_\_\_\_ Date: \_\_\_\_\_

**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).*

Rating	0 =	<b>Not present</b>	<input type="checkbox"/>
	1 =	<b>Very Mild:</b> occasional thoughts of dying, "I'd be better off dead" or "I wish I were dead"	<input type="checkbox"/>
	2 =	<b>Mild:</b> frequent thoughts of dying or occasional thoughts of killing self, without a plan or method	<input type="checkbox"/>
	3 =	<b>Moderate:</b> often thinks of suicide or has thought of a specific method	<input type="checkbox"/>
	4 =	<b>Moderately Severe:</b> 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)	<input type="checkbox"/>
	5 =	<b>Severe:</b> has made preparations for a potentially lethal suicide attempt (e.g. acquires a gun and bullets for an attempt)	<input type="checkbox"/>
	6 =	<b>Very Severe:</b> has made a suicide attempt with definite intent to die	<input type="checkbox"/>
		Unable to assess (e.g. subject uncooperative or incoherent)	<input type="checkbox"/>

**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.*

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

Client Code: \_\_\_\_\_ Assessor: \_\_\_\_\_ Date: \_\_\_\_\_

**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.*

Rating	0 =	<b>Not present</b>	<input type="checkbox"/>
	1 =	<b>Very Mild:</b> Seems on guard. Reluctant to respond to some “personal” questions. Reports being overly self-conscious in public	<input type="checkbox"/>
	2 =	<b>Mild:</b> 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.	<input type="checkbox"/>
	3 =	<b>Moderate:</b> 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.	<input type="checkbox"/>
	4 =	<b>Moderately Severe:</b> 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).	<input type="checkbox"/>
	5 =	<b>Severe:</b> Delusional -- speaks of Mafia plots, the FBI, or others poisoning his/her food, persecution by supernatural forces.	<input type="checkbox"/>
	6 =	<b>Extremely Severe:</b> Same symptoms as severe (level 5) above, but the beliefs are bizarre or more preoccupying. Patient tends to disclose or act on persecutory delusions.	<input type="checkbox"/>
		Unable to assess (e.g. subject uncooperative or incoherent)	<input type="checkbox"/>

**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.*

Rating	0 =	<b>Not present</b>	<input type="checkbox"/>
	1 =	<b>Very Mild:</b> 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.	<input type="checkbox"/>
	2 =	<b>Mild:</b> 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.	<input type="checkbox"/>
	3 =	<b>Moderate:</b> Delusion present but no preoccupation or functional impairment. May be an encapsulated delusion or a firmly endorsed absurd belief about past delusional circumstances.	<input type="checkbox"/>
	4 =	<b>Moderately Severe:</b> Full delusion(s) present with some preoccupation OR some areas of functioning disrupted by delusional thinking.	<input type="checkbox"/>
	5 =	<b>Severe:</b> Full delusion(s) present with much preoccupation OR many areas of functioning are disrupted by delusional thinking.	<input type="checkbox"/>
	6 =	<b>Extremely Severe:</b> Full delusions present with almost total preoccupation OR most areas of functioning are disrupted by delusional thinking	<input type="checkbox"/>
		Unable to assess (e.g. subject uncooperative or incoherent)	<input type="checkbox"/>

Client Code: \_\_\_\_\_

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**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.*

Rating	0 =	<b>Not present</b>	<input type="checkbox"/>
	1 =	<b>Very Mild:</b> 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	<input type="checkbox"/>
	2 =	<b>Mild:</b> 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.	<input type="checkbox"/>
	3 =	<b>Moderate:</b> 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.	<input type="checkbox"/>
	4 =	<b>Moderately Severe:</b> Experiences daily hallucinations OR some areas of functioning are disrupted by hallucinations.	<input type="checkbox"/>
	5 =	<b>Severe:</b> Experiences verbal or visual hallucinations several times a day OR many areas of functioning are disrupted by these hallucinations.	<input type="checkbox"/>
	6 =	<b>Extremely Severe:</b> Persistent verbal or visual hallucinations throughout the day OR most areas of functioning are disrupted by these hallucinations.	<input type="checkbox"/>
		Unable to assess (e.g. subject uncooperative or incoherent)	<input type="checkbox"/>

Client Code: \_\_\_\_\_

Assessor: \_\_\_\_\_

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**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.*

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

**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)*

Rating	0 =	<b>Not present</b>	<input type="checkbox"/>
	1 =	<b>Very Mild:</b> questionable decrease in time spent in goal-directed activities.	<input type="checkbox"/>
	2 =	<b>Mild:</b> spends less time in goal-directed activities than is appropriate for situation and age	<input type="checkbox"/>
	3 =	<b>Moderate:</b> initiates activities at times but does not follow through	<input type="checkbox"/>
	4 =	<b>Moderately Severe:</b> rarely initiates activity but will passively engage with encouragement	<input type="checkbox"/>
	5 =	<b>Severe:</b> almost never initiates activities; requires assistance to accomplish basic activities	<input type="checkbox"/>
	6 =	<b>Very Severe:</b> does not initiate or persist in any goal-directed activity even with outside assistance	<input type="checkbox"/>
		Unable to assess (e.g. subject uncooperative or incoherent)	<input type="checkbox"/>

Client Code: \_\_\_\_\_ Assessor: \_\_\_\_\_ Date: \_\_\_\_\_

**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.*

Rating	0 =	<b>Not present</b>	<input type="checkbox"/>
	1 =	<b>Very Mild:</b> questionable	<input type="checkbox"/>
	2 =	<b>Mild:</b> slow to initiate social interactions but usually responds to overtures by others	<input type="checkbox"/>
	3 =	<b>Moderate:</b> rarely initiates social interactions; sometimes responds to overtures by others.	<input type="checkbox"/>
	4 =	<b>Moderately Severe:</b> does not initiate but sometimes responds to overtures by others; little social interaction outside close family members.	<input type="checkbox"/>
	5 =	<b>Severe:</b> never initiates and rarely encourages conversations or activities; avoids being with others unless prodded, may have contacts with family.	<input type="checkbox"/>
	6 =	<b>Very Severe:</b> avoids being with others (even family members) whenever possible, extreme social isolation.	<input type="checkbox"/>
		Unable to assess (e.g. subject uncooperative or incoherent)	<input type="checkbox"/>

Client Code: \_\_\_\_\_

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**Illness Management and Recovery Scale: Clinician Version**

Please complete the following items based on recent information from the client, as well as information gathered at team meetings and from collateral contacts. Please base your ratings on the client's current functioning unless an item specifies another time frame.

1. *Progress toward goals:* In the past 3 months, s/he has come up with...

No personal goals	A personal goal, but has <i>not done anything</i> to finish the goal	A personal goal and made it a <i>little way</i> toward finishing it	A personal goal and has gotten <i>pretty far</i> in finishing the goal	A personal goal and has <i>finished it</i>
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

2. *Knowledge:* How much do you feel your client knows about symptoms, treatment, coping strategies (coping methods), and medication?

Not very much	A little	Some	Quite a bit	A great deal
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

3. *Involvement of family and friends in his/her mental health treatment:* How much are people like family, friends, boyfriends/girlfriends, and other people who are important to your client (outside the mental health agency) involved in his/her treatment?

Not at all	Only when there is a serious problem	Sometimes, like when things are starting to go badly	Much of the time	A lot of the time <i>and</i> they really help with his/her mental health
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

4. *Contact with people outside of the family:* In a normal week, how many times does s/he talk to someone outside of her/his family and outside of treatment providers (like a friend, co-worker, classmate, roommate, etc.)?

0 times/week	1-2 times/week	3-4 times/week	6-7 times/week	8 or more times/week
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Client Code: \_\_\_\_\_ Assessor: \_\_\_\_\_ Date: \_\_\_\_\_

**ACT and FACT Client Outcomes**  
**6-Month Assessment**

5. *Time in Structured Roles:* How much time does s/he spend working, volunteering, being a student, being a parent, taking care of someone else or someone else's house or apartment? That is, how much time does s/he spend in doing activities for or with another person that are expected of him/her? (This would not include self-care or personal home maintenance.)

2 hours or less/week	3-5 hours/week	6 to 15 hours/week	16-30 hours/week	More than 30 hours/week
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

6. *Symptom distress:* How much do symptoms bother him/her?

Symptoms <i>really</i> bother him/her a lot	Symptoms bother him/her <i>quite a bit</i>	Symptoms bother him/her <i>somewhat</i>	Symptoms bother him/her <i>very little</i>	Symptoms don't bother him/her <i>at all</i>
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

7. *Impairment of functioning:* How much do symptoms get in the way of him/her doing things that s/he would like to do or needs to do?

Symptoms <i>really</i> get in her/his way a lot	Symptoms get in his/her way <i>quite a bit</i>	Symptoms get in his/her way <i>somewhat</i>	Symptoms get in his/her way <i>very little</i>	Symptoms don't get in his/her way <i>at all</i>
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

8. *Relapse Prevention Planning:* Which of the following would best describe what s/he knows and has done in order not to have a relapse?

Doesn't know how to prevent relapses	Knows a little, but hasn't made a relapse prevention plan	Knows 1 or 2 things to do, but doesn't have a written plan	Knows several things to do, but doesn't have a written plan	Has a written plan and has shared it with others
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

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9. *Relapse of Symptoms*: When is the last time s/he had a relapse of symptoms (that is, when his/her symptoms have gotten much worse)?

Within the last month	In the past 2 to 3 months	In the past 4 to 6 months	In the past 7 to 12 months	Hasn't had a relapse in the past year
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

10. *Psychiatric Hospitalizations*: When is the last time s/he has been hospitalized for mental health or substance abuse reasons?

Within the last month	In the past 2 to 3 months	In the past 4 to 6 months	In the past 7 to 12 months	No hospitalization in the past year
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

11. *Coping*: How well do you feel your client is coping with her/his mental or emotional illness from day to day?

Not well at all	Not very well	Alright	Well	Very well
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

12. *Involvement with self-help activities*: How involved is s/he in consumer run services, peer support groups, Alcoholics Anonymous, drop-in centers, WRAP (Wellness Recovery Action Plan), or other similar self-help programs?

Doesn't know about any self-help activities	Knows about some self-help activities, but isn't interested	Is interested in self-help activities, but hasn't participated in the past year	Participates in self-help activities occasionally	Participates in self-help activities regularly
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Client Code: \_\_\_\_\_ Assessor: \_\_\_\_\_ Date: \_\_\_\_\_

13. *Using Medication Effectively*: How often does s/he take his/ her medication as prescribed?

Never	Occasionally	About half the time	Most of the time	Every day	Client is <i>not</i> prescribed psychiatric medications
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

14. *Impairment of functioning through alcohol use*: Drinking can interfere with functioning when it contributes to conflict in relationships, or to financial, housing and legal concerns, to difficulty attending appointments or focusing during them, or to increases of symptoms. Over the past 3 months, did alcohol use get in the way of his/her functioning?

Alcohol use <i>really</i> gets in her/his way <i>a lot</i>	Alcohol use gets in his/her way <i>quite a bit</i>	Alcohol use gets in his/her way <i>somewhat</i>	Alcohol use gets in his/her way <i>very little</i>	Alcohol use is <i>not a factor</i> in his/her functioning
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

15. *Impairment of functioning through drug use*: Using street drugs, and misusing prescription or over-the-counter medication can interfere with functioning when it contributes to conflict in relationships, or to financial, housing and legal concerns, to difficulty attending appointments or focusing during them, or to increases of symptoms. Over the past 3 months, did drug use get in the way of his/her functioning?

Drug use <i>really</i> gets in her/his way <i>a lot</i>	Drug use gets in his/her way <i>quite a bit</i>	Drug use gets in his/her way <i>somewhat</i>	Drug use gets in his/her way <i>very little</i>	Drug use is <i>not a factor</i> in his/her functioning
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Client Code: \_\_\_\_\_

Assessor: \_\_\_\_\_

Date: \_\_\_\_\_

**Daily Living Activities-20 (DLA-20)**

Rate how often or how well the client independently performed or managed each of the 20 Activities of Daily Living (ADLs) in the community during the last 30 days. If the client’s level of functioning varied, rate the lower score. Consider impairments in functioning due to physical limitations as well as those due to mental impairments. Do not consider environmental limitations (e.g., “no jobs available”). Strengths scored  $\geq 5$  in an activity indicate functioning “within normal limits” (WNL) for that activity. Enter N/A only if the activity was not assessed & do not exceed 5 N/A DLAs.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5 (WNL)</b>	<b>6 (WNL)</b>	<b>7 (WNL)</b>
None of the time; extremely severe impairment of problems in functioning; pervasive level of continuous paid supports needed	A little of the time; severe impairment or problems in functioning; extensive level of continuous paid supports needed	Occasionally; moderately severe impairment or problems in functioning; moderate level of continuous paid supports needed	Some of the time; moderate impairment or problems in functioning; low level of continuous paid supports needed	A good bit of the time; mild impairment or problems in functioning; moderate level of intermittent paid supports needed	Most of the time; very mild impairment or problems in functioning; low level of intermittent paid supports needed	All of the time; independently managed DLA in community; no impairment or problem in functioning requiring paid supports
<b>Activities</b>		<b>Examples of scoring strengths as WNL behaviors (Scores 5-7)</b>				<b>Score</b>
1. Health Practices		Takes care of health issues, manages moods, infections; takes medication as prescribed; follows up on medical appointments.				
2. Housing Stability, Maintenance		Maintains stable housing; organizes possessions, cleans, abides by rules and contributes to maintenance if living with others				
3. Communication		Listens to people, expresses opinions/feelings; makes wishes known effectively.				
4. Safety		Safely moves about community – adequate vision, hearing, makes safe decisions. Safely uses small appliances, ovens/burners, matches, knives, razors, other tools.				
5. Managing Time		Follows regular schedule for bedtime, wake-up, meal times, rarely tardy or absent for work, day programs, appointments, scheduled activities.				
6. Managing Money		Manages money wisely (independent source of funds); controls spending habits.				
7. Nutrition		Eats at least 2 basically nutritious meals daily.				
8. Problem Solving		Resolves basic problems of daily living, asks questions for clarity and setting expectations.				
9. Family Relationships		Gets along with family, positive relationships as parent, sibling, child, significant other family member.				
10. Alcohol/Drug Use		Avoids abuse or abstains from alcohol/drugs, cigarettes; understands signs and symptoms of abuse or dependency; avoids misuse or combining alcohol, drugs, medication.				

Client Code: \_\_\_\_\_

Assessor: \_\_\_\_\_

Date: \_\_\_\_\_

**ACT and FACT Client Outcomes**  
**6-Month Assessment**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5 (WNL)</b>	<b>6 (WNL)</b>	<b>7 (WNL)</b>
None of the time; extremely severe impairment of problems in functioning; pervasive level of continuous paid supports needed	A little of the time; severe impairment or problems in functioning; extensive level of continuous paid supports needed	Occasionally; moderately severe impairment or problems in functioning; moderate level of continuous paid supports needed	Some of the time; moderate impairment or problems in functioning; low level of continuous paid supports needed	A good bit of the time; mild impairment or problems in functioning; moderate level of intermittent paid supports needed	Most of the time; very mild impairment or problems in functioning; low level of intermittent paid supports needed	All of the time; independently managed DLA in community; no impairment or problem in functioning requiring paid supports
<b>Activities</b>	<b>Examples of scoring strengths as WNL behaviors (Scores 5-7)</b>					<b>Score</b>
11. Leisure	Relaxes with a variety of activities; attends/participates in sports or performing arts events; reads newspapers, magazines, books; recreational games with others; involved arts/crafts; goes to movies.					
12. Community Resources	Uses other community services, self-help groups, telephone, public transportation, religious organizations, shopping.					
13. Social Network	Gets along with friends, neighbors, coworkers, other peers.					
14. Sexuality	Appropriate behavior toward others; comfortable with gender, respects privacy and rights of others, practices safe sex or abstains.					
15. Productivity	Independently working, volunteering, homemaking, or learning skills for financial self-support.					
16. Coping Skills	Knows about nature of disability/illness, probable limitations, and symptoms of relapse; behaviors that cause relapse or make situation/condition worse; options for coping, improving, preventing relapse, restoring feelings of self-worth, competence, being in control.					
17. Behavior Norms	Complies with community norms, probation/parole, court requirements, if applicable; controls dangerous, violent, aggressive, bizarre, or nuisance behaviors; respects rights of others.					
18. Personal Hygiene	Cares for personal cleanliness, such as bathing, brushing teeth.					
19. Grooming	Cares for hair, hands, general appearance; shaves.					
20. Dress	Dresses self; wears clean clothes that are appropriate for weather, job, and other activities; clothing is generally neat and intact.					

Client Code: \_\_\_\_\_

Assessor: \_\_\_\_\_

Date: \_\_\_\_\_

**Service Engagement Scale**

Please rate your agreement with each of the following statements by marking whether it's not at all or rarely true, sometimes true, often true, or true most of the time. Please focus on the client's current functioning when rating each item.

	<b>0 (Not at all or rarely)</b>	<b>1 (Sometimes)</b>	<b>2 (Often)</b>	<b>3 (Most of the time)</b>
1. The client seems to make it difficult to arrange appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. When a visit is arranged, the client is available	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The client seems to avoid making appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. If you offer advice, does the client usually resist it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The client takes an active part in the setting of goals or treatment plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The client actively participates in managing his/her illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. The client seeks help when assistance is needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. The client finds it difficult to ask for help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. The client seeks help to prevent a crisis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. The client does not actively seek help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. The client agrees to take prescribed medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. The client is clear about what medications he/she is taking and why	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. The client refuses to cooperate with treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. The client has difficulty in adhering to the prescribed medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Client Code: \_\_\_\_\_

Assessor: \_\_\_\_\_

Date: \_\_\_\_\_