Screener Instructions
for
Wisconsin's Functional Eligibility Screen
for
Mental Health and AODA Programs

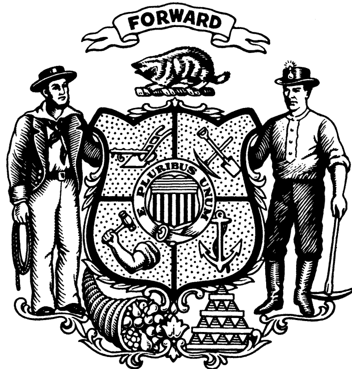

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Table of Contents

MODULE 1: OVERVIEW 5

1.1 Introduction 5
1.2 Factors Influencing the Content of the MH/AODA FS 6
1.3 Screen Development Criteria 6
1.4 Wisconsin's Other Functional Eligibility Screens 7
1.5 A Brief History of the MH/AODA FS 9

MODULE 2: THE SCREENING PROCESS AND QUALITY ASSURANCE 10

2.1 MH/AODA Practitioners Complete the Functional Screen with Consumers 10
2.2 The MH/AODA FS Requires an In-Person Interview 10
2.3 The MH/AODA FS is not an Interview Tool 10
2.4 The MH/AODA FS is a Needs Inventory 10
2.5 The Functional Screen is Voluntary for Consumers 11
2.6 Confidentiality 11
2.7 Requirements for Quality Assurance 12
2.8 Screener Qualifications 12
2.9 Screen Leaders' Role and Responsibility 13
2.10 Quality Assurance and Screening Limitations 13
2.11 Strategies to Reduce Screen Limitations 13
2.12 Ensuring Inter-Rater Reliability 14
2.13 Conflicting Information from Different People 15
2.14 If the Consumer Seems to Overstate Their Needs 15
2.15 If the Consumer Seems to Overstate Their Abilities 16
2.16 If AODA is an Issue 16
2.17 Frequency of Need for Assistance 16
2.18 Ranking Fluctuating Needs 17
2.19 Impending Discharge 18

MODULE 3: BASIC INFORMATION AND DEMOGRAPHICS 19

3.1 Introduction 19
Basic Information 19
3.2 Screening Agency 19
3.3 Referral Date 19
3.4 Screen Type 19
3.5 Applicant Age for MH/AODA Screen 19
3.6 Name 20
3.7 Social Security Number 20
3.8 Date of Birth 20
3.9 County of Residence and County/Tribe of Responsibility 20
3.10 Transfer Information 20
3.11 Applicant's Street Address/City/State/Zip/Phone Number 20
3.12 Directions 20
3.13 Referral Source 21
3.14 Primary Source for Screen Information 21
3.15 Where Screen Interview Was Conducted 21

Demographics 21
3.16 Medical Insurance *21*
3.17 Ethnicity *22*
3.18 Race *22*
3.19 Interpreter Is Required *23*
3.20 Is the Person Under Court Orders for Treatment? *23*
Contact Information 23
3.21 Legal Guardian/Parent of a Minor Responsible for Making Decisions about Medical Care *23*
3.22 Parent of a Minor Responsible for Making Decisions about Medical Care *23*
3.23 Activated Power of Attorney for Health Care Responsible for Making Decisions about Medical Care *24*
3.24 Other Relevant Contacts *24*
Living Situation 24
3.25 Current Residence *24*
3.26 Where Applicant Prefers to Live *25*
Vocational Information 25
3.27 Current Work Status *25*
3.28 Vocational/Educational Assistance *26*

MODULE 4: COMMUNITY LIVING SKILLS 27

4.1 “Need for Assistance” Defined 27
4.2 Help Is Needed Due to Mental Illness or Substance Use Disorder 28
4.3 Frequency of Help Needed 28
4.4 Ranking Fluctuating Needs 29
4.5 Discharge Imminent 30
Specific Community Living Skills 30
4.6 Benefits/Resource Management 30
4.7 Basic Safety 30
4.8 Social or Interpersonal Skills 31
4.9 Home Hazards 32
4.10 Money Management 33
4.11 Basic Nutrition 33
4.12 General Health Maintenance 34
4.13 Managing Psychiatric Symptoms 35
4.14 Hygiene and Grooming 36
4.15 Taking Medications 37
4.16 Monitoring Medication Effects 39
4.17 Monitoring Meds and/or Managing Symptoms 40
4.18 Transportation 40
4.19 Physical Assistance 40

MODULE 5: CRISIS AND SITUATIONAL FACTORS 42

5.1 Introduction 42
5.2 Overlap of Events 42
5.3 Use of Emergency Room, Crisis Intervention or Detox Units 42
5.4 Psychiatric Inpatient Stays 43

5.5 Chapter 51 Emergency Detentions 43
5.6 Physical Aggression 43
5.7 Physical aggression has resulted in the injured person being hospitalized 43
5.8 Involvement with the corrections system 44
5.9 Suicide attempts 44

MODULE 6: RISK FACTORS 46

6.1 Self-Injurious Behaviors 46
6.2 Substance Use 46
6.3 Trauma/Abuse Question 51
6.4 Housing Instability 52
6.5 Intensity of Treatment or Functional Severity 52
6.6 Interdivisional Agreement 1.67 53
6.7 Current COP Level 3 Funding 53

MODULE 7: DIAGNOSES 54

7.1 Overview 54
7.2 MH and AODA Diagnoses 54
A Diagnosis is Required for Eligibility 54
Who Can Make MI/AODA Diagnoses 54
Where Screeners Obtain Diagnoses 54
Not all Diagnoses are Included in the MH/AODA FS 55
Multiple Diagnoses Over Time 55
Summary of MH/AODA Diagnoses 56
7.3 Global Assessment of Functioning (GAF) 57
7.4 “Other Diagnoses” Table 57

MODULE 8: COMPLETING THE MH/AODA FS 59

8.1 Screen Completion Date 59
8.2 Face-to-Face Contact with Person 59
8.3 Collateral Contacts 59
8.4 Paper Work 59
8.5 Travel Time 59
8.6 Total Time to Complete Screen 59
8.7 Notes 60
8.8 Calculating Eligibility and Level of Need 60

GLOSSARY OF ACRONYMS 61

Wisconsin's Functional Eligibility Screen
for
Mental Health and AODA Services ("MH/AODA FS")

Module 1: Overview

1.1 Introduction

Wisconsin's Functional Eligibility Screen for Mental Health and AODA Services (MH/AODA FS) has been under development since 2001. The MH/AODA FS is a secure on-line functional needs assessment with programmed logic to determine eligibility for the following programs:

- Community Support Program (CSP) – Wisconsin's CSPs provide community-based interdisciplinary social, psychiatric and employment services to adults with major mental illness.
- Comprehensive Community Services (CCS) – CCS is a new program, currently in development, which will provide integrated mental health and substance abuse services to children and adults. CCS has wider eligibility than CSP, including persons with substance abuse diagnoses only.
- Community Options Program (COP) – The Community Options Program Waiver (COP-W) help people get the long-term support they need to remain in their own homes and communities. Community Options serves people who need long-term support, *regardless of age or type of disability*, who need the same levels of physical or mental health care as nursing home residents do.

The screen will also automatically refer individuals who have co-morbid substance abuse issues to a level one screen for UPC (uniform placement criteria). This UPC tool provides criteria for completing a referral for a complete AODA assessment at an appropriate level of AODA rehabilitation and/or treatment level of care. The MH/AODA FS will also refer individuals with physical health problems and related ADL (activities of daily living) deficits to a long-term care functional screen to determine eligibility for funding through a home and community-based waiver.

The MH/AODA FS determines eligibility for mental health/AODA programs for persons age 18 and over. It can be completed for youth age 16 and over to allow for advanced planning. The MH/AODA FS includes the following:

- **Community Living Skills**: Vocational, benefits/resource management, safety, social, financial, home management, transportation, basic nutrition, general health maintenance, managing symptoms, grooming, and medication management
- **Crises and Symptoms**: Hospitalizations, ER visits, crises interventions, emergency detentions, physical aggression, suicide attempts, involvement with corrections system
- **Risk Factors**: Self-injurious behaviors, history of trauma or abuse, housing instability
- **Alcohol or other drug problems** and treatment
- **Psychiatric diagnoses**
- **Other diagnoses**

1.2 Factors Influencing the Content of the MH/AODA FS

The MH/AODA FS is an eligibility screen. It is not a complete assessment. The content of the MH/AODA FS was determined by several factors. First of all, it needs to include all of the following **eligibility criteria**:

- The 1996 Wisconsin Blue Ribbon Commission's (BRC) descriptions of target groups BRC-1 and BRC-2 (either directly or by "translation" from adjectival language to more objective functional items);
- In 1999, DHS 75 administrative rules for AODA rehabilitation and treatment level of services were promulgated. This rule mandates the use of either the Wisconsin UPC or ASAS at the point of referral to an AODA level of service and through out the treatment continuum in including ongoing treatment planning, change of level of care and discharge.
- Admission criteria from the current Wisconsin CSP rule (DHS 63) (either directly or by "translation" from adjectival language to more objective functional items); and
- Eligibility criteria from the new statute establishing CCS (either directly or by "translation" from adjectival language to more objective functional items).

Second, the MH/AODA FS is needed to gather information on the needs of people with mental illness. One major barrier to improving mental health services and systems is the lack of information on the populations served and their social, psychiatric, and healthcare needs. A good deal of the information gathered in the functional screen is intended to address gaps in services and **to relate individuals' needs to expenditure data**, to allow for systems redesign and new payment methods in the future. MH/AODA FS data will be analyzed to see which factors affect service utilization costs to assist with rate setting in a future managed care system.

Third, functional screens can help with **quality improvement** efforts on several levels.

- MH/AODA FS data will show differences across counties in populations served or in services provided. For instance, a county can learn that it has far higher rates of emergency detentions or rep payeeship than other counties serving people with apparently similar needs.
- MH/AODA FS information can be tracked over time, for each individual and in aggregate, to see improvements on, for instance, reduced symptoms and increased independence and employment over time.
- Some items on the functional screen are there purely for advocacy reasons, i.e., to gather data to promote more help for primary caregivers, people with post-trauma effects, and people with a mix of physical disabilities and mental illness and substance abuse.

1.3 Screen Development Criteria

The following "screen development criteria" were used to guide screen development:

- **Clarity**: Definitions and answer choices must be clear to screeners, the majority of whom are expected to be mental health/AODA case managers.
- **Objectivity and Reliability**: The screen must be as objective as possible to attain highest possible "inter-rater reliability" (the likelihood that two screeners would answer the same

way for a given consumer). Subjectivity must be minimized to ensure fair and proper eligibility determinations. This is particularly challenging in mental health and substance abuse (as opposed to physical disabilities), and will be a primary focus of quality improvement on this initial screen based on screeners' and consumers' feedback and screen testing.

- **Brevity**: The functional screen is only an eligibility screen, not a complete assessment; for efficiency it should be as brief as possible.
- **Inclusiveness**: Every individual can be accurately screened with given choices for each question – regardless of adult age, diagnoses, idiosyncrasies, and co-occurring disorders or other life conditions.
- **Neutrality**: The functional screen should work well regardless of where the person is living (in a facility, in substitute care, transitional housing, or at home).
- **Service Neutrality**: The functional screen should work well regardless of whether the person is currently receiving any mental health services or is waiting for needed services.
- **Cycle Neutrality**: The functional screen should incorporate the often cyclical nature of mental illness, and not make people ineligible if they are currently doing well with supports.

  The functional screen is "cycle neutral" in the following ways:

  1. It is not merely a "snapshot" of the present moment, but an averaging over longer periods, usually several months. (See section "2.18 Ranking Fluctuating Needs," page 17.)
  2. "Help" includes "support" – supervision, monitoring, reminding, talking with.
  3. "Help" includes support and assistance provided by family and friends as well as paid staff.
  4. The frequency that help is needed has only minor effects on eligibility determination.

1.4 Wisconsin's Other Functional Eligibility Screens

The functional screen evolved out of Wisconsin's outstanding success with its long-term care functional screen for frail elders and adults with physical or cognitive disabilities and a children's functional screen. Functional eligibility screens have been essential to improving Wisconsin human service systems. Functional eligibility screens provide all the following:

- Instantaneous (if done on a laptop), accurate, objective eligibility determinations.
- Consistent across all counties, agencies, and individuals determining eligibility.
- Eligibilities for multiple programs done all at once rather than in separate applications.
- Processes for local and state quality oversight and improvement of eligibility processes and decisions for every applicant.
- Understanding people's needs across systems (physical disabilities, mental health, substance use, infirmities of aging, developmental disabilities, health care, social services, residential, transportation, employment needs).
- Confidential data that can be used for:
  - Relating costs to screen information function, including hospitalizations, to develop a managed-care rate-setting methodology based on functional screen data.

- Quality improvement of some outcomes over time, for local and statewide improvement (e.g., people are living where they want to).
- County and agency-level analyses of population served (or on wait lists)
- Prioritizing wait lists.
- Recognizing the extent of unpaid supports.
- Quality improvement across counties.
- Identifying gaps between needs and services.
- Advocacy for better funding and systems improvements.

Mental health status is very different from physical disabilities, infirmities of aging, or developmental disabilities. Mental health factors are far more difficult to measure "objectively." Mental health status varies much more over weeks, days, even hours. Most mental health service needs (thus costs) may relate to intangible factors such as stress, mood, relationships, specific events, more than to "objective" factors like demographics, diagnoses, and current functional status. Most importantly, the functional screen focuses on needs, i.e., deficits, which seems to violate the principles of strengths-based, consumer-focused, recovery-oriented models. For all these reasons, the functional screen has met with less enthusiasm than previous screens. So why a MH/AODA FS? For these reasons:

- Wisconsin's Long-Term Care Functional Screen (LTC FS) has succeeded despite initial doubts and cynicism. National experts told us it was impossible to correlate program costs with functional status; others have tried and failed for decades. Stakeholders (counties, advocates, consumers and families) were skeptical. Through a participatory process of developing and refining the screen over time, stakeholders came to embrace the LTC FS, which now has had success unprecedented in the U.S. 80 percent of rates for the Family Care program are based on functional screen information. Counties and agencies are voluntarily using the LTC FS to decide rates for services such as residential settings and day treatment. The LTC FS can assign specific levels of care and eligibilities more consistently and accurately than individual experts.

- Mental health system redesign, for which thousands of Wisconsin stakeholders have worked for years, cannot move forward without more information on who's being served and what their needs are.

- Many mental health consumers and their families have reported to the Department that eligibility decisions can vary across counties, agencies, and individuals. This is a serious problem that must be corrected, as it is fundamentally unfair to consumers and families. The MH/AODA FS provides a structured way to look at information to reduce, as much as possible, variation among screeners. The programmed eligibility logic represents experts' thinking and yields consistent results.

- Most mental health consumers who participated in initial testing of the MH/AODA FS are positive about it, despite the fact that it is "deficit-based." (One is eligible for services only if one has a *need* for those services; hence, functional eligibility screens are needs-based.)

For these reasons, development of the MH/AODA FS is continuing. Only time, and everyone's participation, will prove success. The MH/AODA FS remains a work in progress and users' participation as co-developers is absolutely critical to that progress.

1.5 A Brief History of the MH/AODA FS

The MH/AODA FS has been developed by several workgroups since 2001.

- Winter 2001/02 – A small group of DHS staff (social workers and nurses) developed a preliminary draft screen and eligibility logic based on BRC criteria.
- Spring '02 – MH Redesign Stakeholders' Screen Workgroup revised initial draft.
- Summer '02 – Initial screener trainings were done and the screen was released for the first phase of testing in the four demonstration counties.
- Summer '03 – Inter-rater reliability tests were done.
- Winter '03 – Screen and logics were revised based on above testing and programmed into an on-line application with entry-level edits and "instant" eligibility determinations.
- Spring '04 – New screen release, screener trainings, and second phase of testing.

NOTE: The MH/AODA FS is still being developed! Screen implementation is an iterative process in which the screen and instructions are improved over time based on feedback from screeners, consumers, and other interested parties. On-going quality assurance and quality improvement processes will need to be established so that the MH/AODA FS works well for every individual needing services.

Module 2: The Screening Process and Quality Assurance

2.1 MH/AODA Practitioners Complete the Functional Screen with Consumers

Screens may only be done with consumers by a mental health/AODA practitioner who has met DHS qualifications and training requirements. Screeners must be direct or contracted **employees** of county agencies specified by DHS as screening pilot agencies.

The MH/AODA FS needs to be completed by MH/AODA practitioners, not consumers themselves, in order to obtain federal approval of its use. We agree that this is not as consumer-focused as we'd like, and in fact adds a significant risk of practitioners' subjectivity to the screen. Instructions, trainings and quality assurance processes (including close communication between screeners and state staff) will reduce subjectivity enough to ensure reliable and valid results.

2.2 The MH/AODA FS Requires an In-Person Interview

The screening process requires face-to-face contact with the individual being screened. No screen should be completed without a meeting with the consumer, even if they have communication difficulties.

The face-to-face interview can take place in any setting (e.g., the applicant's residence, a group home, day services center, a hospital or a restaurant). It may take more than one contact with the consumer to complete the screen.

2.3 The MH/AODA FS is not an Interview Tool

The MH/AODA FS is NOT an interview tool; do not just go through it like a checklist with someone. The screen can be done in any order. More importantly, it should be done within a larger conversation about the whole person, not just their needs.

Screeners should use their best interviewing skills to gather information in a way that is appropriate for a given consumer. The screener should ask questions in a variety of ways, and use collateral informants as necessary. Collateral informants include family, significant others, formal or informal caregivers, health care providers, and agencies serving the consumer. A release of information must be signed by the consumer to access collateral information (either written or verbal). The screener must always have a face-to-face contact with the consumer, even if other informants are used.

2.4 The MH/AODA FS is a Needs Inventory

The MH/AODA FS is based on the person's diagnoses, symptoms, and need for help from others (i.e., functional impairments). Such a deficits-based approach to mental health service delivery and practice is fundamentally contrary to recovery-oriented practice. That said, program eligibilities (particularly under federal Medicaid guidelines) are based on the **need** for program services. A functional eligibility screen by definition must focus on functional impairments, i.e.,

needs for assistance. This means two things concerning the functional screen process and content:

- **Screeners must complete the functional screen within a more holistic dialogue**. Most people would find it insulting, upsetting, and discouraging if MH/AODA practitioners just read off the screen items like a checklist. Instead, screeners should use recovery-based best practices, including learning what the person needs help with within a larger, recovery-focused dialogue that includes the person's strengths, values, goals and perspectives.

- **The screen content will be revised based on screeners' and consumers' feedback**. We will work together to revise the screen (and instructions) based on your experience with it. Revisions will focus on making the screen process acceptable to consumers and screeners, and on making the screen work well, with accurate and reliable data.

2.5 The Functional Screen is Voluntary for Consumers

The person being screened should consent to completion of the functional screen and its submission to DHS for screen development and aggregate data research. No screen should be completed without the person's signed informed consent. However, where the screen is the tool for determining need for services, the consumer needs to know that refusal to participate in the screening process could affect their eligibility for services. All information will be confidential within the Department and the screening agency.

The Department has chosen to make this screen the approved screen for CCS admissions for adults (the new children's screen will be used to determine CCS for children). It will also be the approved screen for COP eligibility for COP level 3 individuals with serious and persistent mental illness. For CCS, it is an annual requirement. It will remain voluntary for CSP at this time, however many counties may want to begin using the screen for CSP as it will give each program access to valuable data on the CSP population locally. For the first time, local agencies will have a mechanism to be able to sort caseloads by living situation, diagnosis, risk factors and ADL functional levels.

2.6 Confidentiality

Any information collected for the screen or during the screening process is confidential. It is to be treated with the same requirements for confidentiality as other long-standing screens and assessments. Screeners and screening agencies shall comply with confidentiality rules and requirements and shall obtain a signed release of information from the person or the person's guardian or power of attorney, where applicable, for the use of medical records, educational records and other records as appropriate before conducting the MH/AODA FS. Signed releases of information shall be included in the person's records as appropriate.

All aspects of the functional screen must comply with HIPAA (the Federal Health Insurance Portability and Accountability Act). The functional screen is a secure on-line computer application, with access limited to Department-assigned users verified by passwords.

Screeners should inform consumers of this, and of the following: A completed functional screen can be seen only by screeners of the screening agency. If MH/AODA screeners elsewhere in the state were to key in the individuals' name or Social Security Number, the program would inform them that a functional screen had been completed for that individual and would show the screening agency and date. That is all that can be seen; the content of the individual's functional screen cannot be seen by anyone except screeners of the screening agency (including the county agency if subcontracting).

Later, when the MH/AODA FS is fully implemented, it will form the basis of a comprehensive assessment by a MH/AODA provider. The provider will ask the consumer to sign a release of information, which allows the original screener to electronically "transfer" permission to see the completed functional screen content. If consumer chooses to sign the release, then the new case manager will read the functional screen to avoid asking all the same questions again. The new case manager will do a complete assessment building from the information shown in the MH/AODA FS.

2.7 Requirements for Quality Assurance

Because the MH/AODA FS will (after testing) determine program eligibility, special requirements for quality assurance and screener qualifications are necessary.

Each pilot county will assign a "**Screen Leader**" who will be responsible for facilitating screen testing, gathering screeners' questions and feedback, and passing them on to designated state staff as soon as possible.

Every screener should test the MH/AODA FS thoughtfully – do not simply fill screens out, but really critique it. Test it on people with high needs, low needs, different sorts of needs, people now eligible for CSP (or BRC target groups 1 or 2) and those who are not.

Never guess or extrapolate on anything. When you encounter something not covered in these instructions – and you will – leave it blank and discuss it with your Screen Leader. The Screen Leader will call or e-mail designated state staff, who will answer the question and the update instructions as necessary. **No one should make interpretations**; instead, pass your questions on to state staff (usually through your Screen Leader). Questions can be answered locally only if they are found in these instructions. This will be most helpful to this project as we test the screen and the instructions for clarity.

2.8 Screener Qualifications

All persons administering the functional screen must meet the following conditions:

1. Meet the following **minimum criteria for education and experience**:
   - Nursing license or a BA or BS, preferably in a health or human services related field, and at least one year of experience working with at least one of the target populations, or

   - Prior approval from the Department based on a combination of post-secondary education and experience or on a written plan for formal and on-the-job training to develop the required expertise; and

2. Meet all **training requirements** as specified by the Department. Currently that means:
   - Completing the online course, or
   - Attending an in-person training by Department staff (or watching video of same), **and**
   - Reading and following screen instructions.

2.9 Screen Leaders' Role and Responsibility

Among the Screen Lead's roles is to oversee quality assurance. As the MH/AODA FS becomes more fully implemented, each agency will have on-going quality assurance methods, such as:

- Training, mentoring, and monitoring new screeners
- Providing on-going feedback and questions to state staff
- Random sampling for accuracy and consistency
- Inter-rate reliability testing.

2.10 Quality Assurance and Screening Limitations

It is recognized (and shown in research) that all functional assessments or screens are imperfect. In particular, screeners should be aware of the following limitations found in national studies to be characteristic of all functional screens:

- Health care and institutional providers tend to overrate the consumer's dependency on others.
- Guardians, spouses, and family members often tend to overrate the consumer's dependency on others.
- Consumers may be unable to provide accurate information or may exaggerate their abilities or their need for assistance.
- Consumers' status and abilities fluctuate, making it difficult to choose the most accurate frequency at which help is needed.
- Consumers can provide conflicting information at different times or to different screeners.
- Screen answers vary somewhat depending on whether the screener knows the consumer well or not.
- Screen answers vary somewhat depending on the profession of the screener.
- Particularly in the field of mental health, some subjectivity remains in some questions.

2.11 Strategies to Reduce Screen Limitations

The MH/AODA FS will be repeatedly revised based on feedback and testing until it has acceptable levels of validity and reliability. However, it is generally recognized that any objective rating of consumers' functioning, cognition, behavior and symptoms can be difficult. This challenge calls for extra vigilance to ensure the greatest possible accuracy in the functional

screen. This is why screeners must be trained and experienced with the population, and why DHS and counties using the screen must have ongoing quality assurance processes.

Screeners should adhere to the following guidelines:

- Read and follow screen definitions and instructions closely.
- Go slowly and carefully enough to be accurate even with someone you know well.
- Do not “inflate” any answers because you think a consumer has special costs not “visible” through the screen. Instead, you should always select the answer that most accurately describes the applicant’s functional status

All screening agencies should have designated “Screen Leaders” to assist you with questions. Refer all questions to your Screen Leader, who will in turn refer questions to designated staff at the WI Bureau of Mental Health and Substance Abuse Services. (You can also contact designated State staff directly.) In this way, interpretations will be kept consistent and communicated to all screeners, and revisions can be made to the screen and instructions as necessary. It is absolutely critical that all screeners participate in this process.

2.12 Ensuring Inter-Rater Reliability

For many items in the functional screen, functional status is ranked by the frequency at which the person needs help from other people. If someone is marked as needing help from others, then it is expected that either the person is getting the help (i.e., it would be in a individualized recovery plan) OR they are suffering negative outcomes or risk thereof from not getting the help.

The goal is the most accurate possible description of the person’s abilities.
Neither consumers’ opinions nor screeners’ opinions alone would generate accurate screens.

Listen carefully, try to understand the consumer’s perspective, ask details, and observe.
Find out what is considered acceptable within the person’s culture.

Gather information from the consumer and others who know them.
Then, weigh ALL of this information in completing the MH/AODA FS.

Ask two questions:
“Would these details lead other trained screeners* to the same answer?”

“Does this answer reflect what might be in an initial care plan for this person?”

* Consider screeners of a different gender, culture, class, agency, etc. from you.

Screeners should always think about inter-rater reliability before selecting answers on the MH/AODA FS. Do not mark your impression without first considering whether you have **objective** information that indicates that answer such that **most other screeners would select it**. Follow these important steps before selecting answers on the functional screen:

- **Follow the precise definitions on the MH/AODA FS**.
  These were written precisely to reduce subjectivity and enhance inter-rater reliability. It is imperative that all screeners read the instructions and follow up with their Screen Leaders as needed.

- **Ask yourself "What objective information do I have, and what would a different screener mark based on that info?"** This means the following:

  A. Gather objective information; do not merely mark your opinion.
  B. Consider what other screeners—including those of a different gender, class, age, etc. from you—would mark based on the objective information.
  C. Consider what is considered typical for members of the person's culture.
  D. If you are unsure regarding A, B, or C, contact your Screen Leader or designated State staff to discuss the situation.

Screen Leaders should facilitate regular times for screeners to discuss screen questions, especially concerning cultural competence and inter-rater reliability. Screen Leaders can then share this feedback with Department staff for improving the screen and instructions.

2.13 Conflicting Information from Different People

Sometimes screeners will get different information from different sources. Consumers may function less independently in day care facilities or institutions than they do at home, and staff at such facilities may tend to perceive more dependency than family or peers in the community might perceive. Screeners are to use their best professional judgment to describe the person's functional abilities as accurately as possible given all the information from multiple sources.

2.14 If the Consumer Seems to Overstate Their Needs

Remember that the goal is to be as objective as possible, to have high "inter-rater reliability," meaning that other screeners would choose the same answer you did. That is why your professional judgment must be based on as much objective information as possible.

Objective information can be obtained by skilled interviewing and observation. If the proper answer is still not clear, discuss it with your Screen Leader, who can then, if necessary, ask DHS for guidance. If the consumer appears to be overstating their needs, ask:

- Have they in fact been doing the task adequately and without significant hardship?
- Does someone in fact help them with it now?
- What has consumer done (or what would they do) if assistance were not available?
- What would the consequence be if assistance were not available?

If no hardship results from a lack of assistance, it implies that the person is in fact able to do the task himself or herself. This, of course, is the familiar "needs versus wants" distinction, but with the thought process clearly spelled out. Doing so shares the power with consumers, improves inter-rater reliability, and reduces at least some errors from assumptions or biases.

2.15 If the Consumer Seems to Overstate Their Abilities
Sometimes MH/AODA practitioners recognize a need for help that the consumer does not recognize. Recovery principles reject the old "professional knows best" model and require that the consumer's perspective be central. Yet MH/AODA practitioners, particularly professionals, are responsible for noticing things that consumers might not notice, and for following up as much as the consumer allows. Example:

- Joe has decided he doesn't need his Lithium anymore, and hasn't taken it for four days, and threw his remaining pills away. He says he'll be fine and you don't need to be coming around to see him. In the past, Joe's had big problems when he's gone off his medication. You negotiate with him to at least accept your visits. You'll be talking with his psychiatrist, getting the prescription refilled, negotiating every day with Joe to try to get him to take it and to see his psychiatrist. On the functional screen, you check "More than weekly" for both "Taking Meds" and "Managing Psychiatric Symptoms" for Joe.

2.16 If AODA is an Issue
Individuals' responsibility and choice-making capacities are less clear when alcohol or drug addiction is involved. If a person's purchase and/or use of drugs or alcohol interferes with their ability to meet **basic** needs (food, clothing, and shelter) the screener will probably indicate some need for assistance with some tasks. The things to remember are:

- Gather details from consumer and others (as permitted by consumer);
- Consider what other trained screeners would select given the same details; and
- Consider what frequency of assistance would seem appropriate in a MH service/treatment plan for this person.

2.17 Frequency of Need for Assistance
Check a given frequency on the functional screen if it reflects **actual** needs as closely as possible; not merely what the person says they need or don't need, and not merely what the screener thinks, but something in between. It is what **most** screeners would agree **should** be in a **service/treatment plan** for that individual. Check a given frequency:

- No matter who's providing it – family or providers.
  - Example: If the family provides med reminders every day, that's the frequency of help needed from others.

- Even if the individual verbally denies the need but accepts the help, including visits to monitor, cue, negotiate.
  - Example: Joe decided he doesn't need his Lithium anymore, and hasn't taken it for four days, and threw his remaining pills away. He says he'll be fine and you don't need to be coming around to see him. In the past, Joe's had big problems when he's gone off his med. You negotiate with him to at least accept your visits. You'll be talking with his psychiatrist, getting the prescription refilled, negotiating every day with Joe to try to get him to take it and to see his psychiatrist. On the functional screen, you check "More than weekly" for both "Taking Meds" and "Managing Psychiatric Symptoms" for Joe.

- Even if the individual currently refuses any help or discussion of the topic.
  - The functional screen is intended to indicate what the person needs, even if they refuse the help. An individualized service plan is negotiated with the consumer, but the functional screen looks only for needs.

- Even if it exceeds a provider's capacity to provide help at that frequency.
  - The functional screen seeks statewide consistency in indicating mental health service needs. Counties vary in how they distribute scarce services. Screeners need to think beyond their own agency to ask what other screeners in any county would indicate for an individual's needs. These instructions are intended to help you do that.

So, frequencies selected on the functional screen will usually match frequencies of MH/AODA case manager contacts with the individual. In this way, completing the functional screen is similar to developing an individualized service plan with someone. There are three exceptions:

- If the consumer declines the services, you still mark them on the functional screen.
- Your agency does not or cannot provide the high frequency needed.
- The functional screen looks for help needed from anyone, not just MH/AODA practitioners.

2.18 Ranking Fluctuating Needs

Mental illnesses are often cyclical, with varying levels of symptoms and functioning. The MH/AODA FS is a mix of a "snapshot" view – the person's current status now and over the past few weeks – and an historical (or "movie") view looking over the past few months up to the past year or two. Every day MH/AODA practitioners (and consumers) make judgments based on this mix of snapshot and historical views, to determine the frequency of contacts and of help needed now and for the next few weeks or months. Of course people's needs will change, and of course predictions are only approximate, but they reflect expert judgment (and sometimes research data) of the frequency of interventions needed to promote recovery and prevent crises.

The MH/AODA FS is similar. For some "Community Living Skills," you are asked to indicate the approximate frequency at which help is needed. To make it easier to select answers, the answer choices have been reduced to "Independent," "Less than monthly," "1 to 4 times a month," "More than one time a week."

Less than monthly

Check this for applicant who, for example:

- Sees their case manager only every few months and is otherwise independent.
- Has had two or three episodes over the past year, requiring interventions for 1 or 2 weeks each episode – such that it **averages** out to less than monthly; and the episodes are unpredictable such that regular and more frequent assistance would not prevent the episodes.
- Recently became independent with a skill, but still needs some follow up and back up.

1 to 4 times a month

Check this for applicant who, for example:

- Needs help with budgeting and finances just 1 to 4 times a month.

- Needs help every other week, for instance, with housekeeping or grocery shopping.
- Needs med boxes filled every two weeks (filling two weekly med boxes at once).
- Is still developing skills they learn during visits with their case manager every two weeks.
- Has crises if they don't get regular emotional support and reinforcement 2 or 3 times a month.
- Does pretty well most of the time, but sometimes calls their case manager for support; this happens irregularly, but on **average** over the past six months or so, it's about 1 to 4 times a month.
- Does not recognize when symptoms escalate, and they do so within 2 or 3 weeks; person needs someone every two weeks to monitor symptoms and prevent crises. For example, Stu has had crises from manic episodes 2 to 3 times a year. His mania progresses rapidly, within 2 or 3 weeks, and he doesn't see it starting. He needs someone to check in with him every two weeks to monitor for mania and help him prevent its escalation.

More than one time per week
Check this for applicant who, for example:

- Needs someone to give them their meds (psych and others) every day or more often.
- Forgets to take their meds unless the person's daughter calls to remind them every day to take them.
- Needs intensive case management and/or psych nursing visits 3 to 5 times a week.
- Comes in to the clinic every morning for meds and money.
- Does not recognize when symptoms escalate, and they do so within a day or two; person needs someone every two days to monitor symptoms and prevent crises. For example, Marilyn has schizophrenia and lives alone. Her MH case manager continues to see her three times a week to help her cope with her symptoms. With this support, Marilyn has only been hospitalized twice in the past three years.

2.19 Impending Discharge

When completing the functional screen with someone preparing for discharge from a mental health facility within the next few days, complete the screen based on how the person is expected to function at home when they go home. This looking ahead is a normal part of discharge planning. So, if, for example, although the facility administers medications now, mark on the screen if the person will need help with medication administration after they go home. It will take additional time and talking with the individual, facility staff, family, etc. to get the most accurate picture of the person's needs at home after discharge.

The screener must be able to envision the person at home. This is why screeners must have experience in community-based mental health/AODA services.

MODULE 3: Basic Information and Demographics

3.1 Introduction

Demographic information collected for the functional screen does not determine eligibility for mental health services. After the initial screen testing, some demographic info may be used for resource and budget planning for state and county budgets.

"**Other**" boxes are available as answer choices to allow screeners to fill in answers that may not be provided in the initial functional screen. These will be used in screen revisions.

Basic Information

3.2 Screening Agency

This is a read-only field that the application will fill in automatically. To transfer a screen to another agency because of enrollment, referral, or applicant's move to another county, the Transfer utility should be used.

3.3 Referral Date

Enter the date someone requested that a functional screen be done. If no one requested the functional screen or the original referral was made years ago, enter the date you start it.

3.4 Screen Type

Select one option from the drop down box. There are three screen type options:

- **Screen type 01, Initial Screen** – The first Mental Health/AODA Functional Screen completed for the applicant. If the consumer has been enrolled in CSP for years but this is their first MH/AODA FS, check Initial Screen for the Screen Type.
- **Screen type 02, Annual Screen** – After full implementation, annual recertification screens may be required to continue in MH/AODA programs, such as CCS.
- **Screen type 03, Change of Condition** – At any time when a applicant's physical, emotional or living condition changes significantly they may request and/or receive additional screenings. For the MH/AODA FS, a change in condition screen should be completed if a significant change occurs that is likely to last 6 months or more. For example, a 19 year old applicant with a current diagnosis of depression who begins to have hallucinations and the psychiatrist changes the diagnosis.

3.5 Applicant Age for MH/AODA Screen

"Applicant" is the consumer you are screening.

The minimum age for programs connected to the MH/AODA FS is **18** years of age. However, to allow for advance planning for youth entering adult mental health services, the MH/AODA FS can be completed for individuals as young as **16**. Otherwise, teens and children's eligibility for Comprehensive Community Supports (CCS) will be determined through the Children's Long-Term Support Functional Screen.

3.6 Name

- Middle name is optional; middle initial is sufficient.
- Last Name: If the applicant has a title such as "Jr." or "IV," list this in the Last Name box, following the last name.

3.7 Social Security Number

- Key in the 9 numbers with dashes (###-##-####). This is a required field.

3.8 Date of Birth

Enter the applicant's date of birth in **MM/DD/YYYY**, as in 01/01/2002. The "/" must be entered between the field elements. Functional screen programming will not allow dates to be entered that make the applicant more than 150 or less than 16 years old. The date of birth must be earlier than the screen begin date.

3.9 County of Residence and County/Tribe of Responsibility

In most cases these will be the same. In a few instances, persons may live in one county but another county/tribe is responsible for services, costs, and/or protective services. For the purposes of screening, residency is physical presence or the intent to reside. The functional screen program will automatically enter ("default") county of responsibility to be the same as county of residence. This can be overridden if different counties are involved.

3.10 Transfer Information

The functional screen is a secure database, and only a few individuals have access to screen information. This section is a "transfer utility" that transfers access to an individual's MH/AODA FS content from the original screening agency to another agency of the applicant's choice (for example, a provider agency, or a new county if the applicant moves).

3.11 Applicant's Street Address/City/State/Zip/Phone Number

Include street number, street name, apartment number, city, and zip. Include telephone number if available. If there is a street address and a PO Box, enter street address and apartment information on line 1, PO Box on line 2, and use the PO Box ZIP Code.

For transient persons, enter the address they lived at the most in the last six months. If the person is homeless, write "homeless."

If the person is now in a hospital or other facility (nursing home, CBRF), that may or may not be their "permanent residence." If a person is now in a facility, but maintains their apartment in the community with the intention of returning to home in the next few weeks, the apartment (not the facility) would be the permanent residence.

The phone number fields are optional; you can leave them blank.

3.12 Directions

This is provided as an optional space for you to enter directions to the applicant's home.

3.13 Referral Source

- Check one box to indicate who referred the applicant to you for assistance.
- Leave blank if it does not apply, such as when you are testing the MH/AODA FS.

3.14 Primary Source for Screen Information

This question is meant as a quality assurance reminder that screeners must not take shortcuts and complete a screen by only talking with caregivers, staff, etc. If the applicant could participate in the screen, the applicant should participate in the screen interview. If the person is not the primary source of information, it is expected that in most cases other parts of the screen will indicate significant cognitive limitations. It will also be used in research to explore differences in MH/AODA FS depending on who provides the information.

"Primary" means the majority, over 50 percent. Please select the one source that most accurately reflect the primary source for screen info. In most cases, the primary source for screen information should be the consumer. Often, screeners will also need to have "collateral" (i.e., additional) contacts with family, residential staff, health care providers; but those are only additional, not "primary," contacts.

If an interpreter is used, the consumer (not the interpreter) is still the primary source of information.

3.15 Where Screen Interview Was Conducted

- Check only one box. Select the place where the screen was conducted from the drop-down box.
- If you select "Other" please write a description, such as "school."

"Person's current residence" includes private homes, residential facilities, or nursing homes.

"Nursing home" includes ICFs-IID and FDDs. Select "nursing home" if the nursing home is not the applicant's primary residence (i.e. they have a permanent residence elsewhere).

"Temporary residence (non-institutional)" is intended for instances when a consumer is staying with family or friends temporarily, for instance to recuperate from an illness or surgery. It also includes temporary stays in residential facilities, such as respite in a CBRF. Do not select this if the person is in an institution such as hospital, IMD, or nursing home.

Demographics

3.16 Medical Insurance
Check ALL that apply.

If Medicare is checked, enter the person's Medicare number, and check box to indicate Part A or B or Medicare Managed Care as applicable. (Note: Medicare Managed Care is a new form of voluntary HMO Medicare called "Medicare Plus Choice." You may see it written as "M + C.")

Private insurance includes employer-sponsored insurances (e.g., an HMO) available as a job benefit. BadgerCare and MAPP (Medical Assistance Purchase Plan, Wisconsin's Medicaid Buy-in) are forms of Medicaid. If the person is on BadgerCare or MAPP, enter this information under Medicaid with the number, and put a comment about this information in the Notes section.

3.17 Ethnicity

Hispanic or Latino ethnicity is included in Wisconsin's functional screens to provide data for federal reporting, quality improvement and advocacy efforts. This is not a required field; however, we expect this field will be completed unless the individual objects. The content of this section follows federal standards.

Hispanic or Latino: A person of Mexican, Puerto Rican, Cuban, Central, South American, or other Spanish culture or origin, regardless of race.

3.18 Race

Race is included in Wisconsin's functional screens to provide data for federal reporting, quality improvement and advocacy efforts. This is **not** a required field; however we expect this field to be completed unless the individual object. The content of this section follows federal standards.

For persons with mixed heritage please check all that apply.

Following are federal definitions:

American Indian or Alaska Native: "American Indian and Alaska Native" refers to people having origins in any of the original people of North and South America (including Central America), and who maintain tribal affiliation or community attachment. It includes people who indicate their race or races as Rosebud Sioux, Chippewa, or Navajo.

Asian or Pacific Islander: Refers to people having origins in any of the original peoples of the Far East, Southeast Asian, or the Indian subcontinent. It includes people who indicate their race or races as "Asian Indian," "Chinese," "Filipino," "Korean," "Japanese," "Vietnamese," or "Other Asian," or as Burmese, Hmong, Pakistani, or Thai.

Black or African American: "Black or African American" refers to people having origins in any of the Black racial groups of Africa. It includes people who indicate their race as "Black," African American, Afro American, Nigerian, or Haitian.

White: "White" refers to people having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicate their race as "White" or as Irish, German, Italian, Lebanese, Near Easterner, Arab, or Polish.

Native Hawaiian or other Pacific Islander: "Native Hawaiian or other Pacific Islander" refers to people having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. It includes people who indicate their race or races as "Native Hawaiian," "Guamanian or Chamorro," "Samoan," or "Other Pacific Islander," or as Tahitian, Mariana Islander, or Chuukese.

3.19 Interpreter Is Required

Human service and health care providers are required by law to provide interpreters for individuals needing them. This information on the MH/AODA FS will help the state, counties, and stakeholders see the extent of such needs, and will also help programs better serve non-English speaking consumers and families.

- Leave this table blank if no interpreter is needed.
- Select the appropriate language if an interpreter is needed. If “Other,” please write in the language needed.

3.20 Is the Person Under Court Orders for Treatment?

Court orders are those issued by a judge. Police do an “emergency detention” and a 72-hour hold. This is followed by a “probable cause hearing” in which a judge can issue “court orders” for involuntary commitment to a psychiatric institution or for community-based treatment. The latter constitutes court-ordered treatment for the purposes of the MH/AODA FS.

“Negotiated settlements” are alternatives to court-ordered treatment that judges might use if the consumer voluntarily promises to accept treatment. The consumer may, for example, promise to take her psych meds as part of a negotiated settlement. If she refused to promise the judge this, the judge could impose court orders for her to take her meds.

Probation officers might impose conditions of probation, but they cannot issue court orders; only judges can.

Contact Information

For each individual, check the box to indicate if that person is the “Primary contact” for the applicant. In every case, the Middle Name is optional.

3.21 Legal Guardian/Parent of a Minor Responsible for Making Decisions about Medical Care

This table is optional. Leave it blank if the adult applicant does not have a “legal guardian of person.”

If the person does have a **legal guardian of person**, provide the guardian’s name, phone number, and address. This information may be needed to complete the screen, and/or to notify the guardian of the applicant’s eligibility determination. This refers to guardian of person for the applicant (not whether the applicant is a guardian of someone else). This does not include guardians of estate or finances. (The need for help with money management is captured elsewhere on the functional screen.)

3.22 Parent of a Minor Responsible for Making Decisions about Medical Care

If the applicant is a minor, complete this field to indicate a parent’s name and contact information. Enter a parent who has legal responsibilities for the child’s medical decisions (a parent who would receive mail from Medicaid and the county). A second parent can be entered in the “Other relevant contact” field.

3.23 Activated Power of Attorney for Health Care Responsible for Making Decisions about Medical Care

This table is optional. Leave it blank if person does not have an activated Power of Attorney for Health Care (POAHC), also called a "durable power of attorney."

Some people may have a durable power of attorney for health care document drafted by their attorney that they think has been "active" from the time it was initially drawn up. However, such documents do not count as an "Activated POA for health care." Such a POAHC is "in force" when it is first filled out, but the consumer makes all her own decisions until she loses the ability to do so. The POAHC cannot make decisions for the person until **after** they are incapacitated. That is what is meant on the screen by "activated." A POAHC is "activated" only when the consumer has lost their capacity to make their own health care decisions. (Activation usually requires documentation by two physicians.)

3.24 Other Relevant Contacts

This table is optional. Screeners do not have to complete it unless the individual is a "Primary Contact" or an important contact for the screener or future case manager to know. A spouse, family member, or case manager may be an important contact to indicate here, particularly if they participated in the screening interview with the applicant. However, this information is not necessary for others who are not important contacts. You do **not** have to record the name of every applicant's probation officer or ex-spouse, for example. You would only enter it here if they participated in the screen interview or only if the applicant agrees that they are important contacts. Complete this table only with the applicant's permission, and preserve confidentiality.

Living Situation

3.25 Current Residence

Check only one box. If you select "other," type an explanation in the "other" box. Most of the drop-down box menu options are self-explanatory. For further clarification:

- "Transitional housing" – Certified or licensed housing provided by human services agencies or corrections system (e.g., half-way house).
- CBRF = Community-based residential facility, also called "group home."
- RCAC = Residential care apartment complex, also known as "assisted living."
- ICF-IID/ FDD = Intermediate care facility for individuals with intellectual disabilities (formerly known as ICF-MR), facility serving people with developmentally disabilities.
- IMD = Other institute for mental disease.
- Child caring institution = a specially licensed setting for minors with high needs.
- "No permanent residence" includes living on the street or in a shelter, living in a car, or "crashing" at friends' or relatives' houses for short periods (days or weeks).

If applicant lives with parents:

- For youth up to age 19 still living in their parent(s) home, check "Own home or apartment (alone or with someone)."
- For applicants age 19 or over still living in their parent's home, check "Someone else's home or apartment."

3.26 Where Applicant Prefers to Live

Check only one box. If you select "other," type an explanation in the "other" box.

This question asks precisely and only for the consumer's own stated preference. It will be used to see if MH consumers are living where they want to live and to track changes over time. This question is asking the person's informed preference. Record where the applicant would like to live – not where anyone else wants them to live, and not where you or others think is realistic. Screeners must take the time to explain the person's options. People cannot express a preference if the screener has not informed them of their options first.

It is well known that people often acquiesce to whatever they feel limited to or whatever they've been told. For example, people with developmental disabilities who live in institutions often think "group home" is the only option available to them. You must take the time to ask questions to help the person articulate her/his preferences. Some people like to live with others; others highly value having their own space. While the person's preference may be difficult to ascertain, screeners are to use their best interviewing skills to select the most accurate answer.

Screeners should select the answer that most accurately reflects what the person is saying. If a person is telling you that she wants "a place of my own," then you select the most accurate selection of "own home or apartment." Do NOT select "someone else's home or apartment" or an "RCAC" even if that is probably what the person will need. The purpose of this question is to record what the person says, not what the system will provide or what you think the person really needs.

If the applicant's preferred living situation is not listed, select "Other" and please type in what the "Other" is, for possible screen revisions in future.

Vocational Information

Wisconsin is very committed to removing barriers to employment for people with disabilities or mental illness who want to work. This section gathers work-related information that will be helpful on county and statewide bases to help improve employment for people receiving MH services.

3.27 Current Work Status

- Check only one box.
- "Full time" means 32 hours/week or more.
- "Competitive" means a **paid** job that the applicant had to **apply** for. Check this if the applicant went through customary job application processes and is paid minimum wage or more.

Sheltered Employment is non-competitive (i.e., the person does not have to apply for and compete for the job). Human service staff are present to assist participants not able to work at competitive paid jobs.

Retired: Do not check if person stopped work due to disabilities or mental illness, even if applicant prefers to use the term “retire.”

Unemployed: Check this if person is not retired, is of working age, and is currently not working. Do NOT check if person is on medical leave from a job, as they are still “employed.”

Unpaid work: homemaker, caregiver, volunteer, or student. Since only one box can be checked, you’ll check this only if none of the above choices apply. This does no work in eligibility, but was added at stakeholders’ requests to recognize unpaid labor.

Interest in a Job:
- Check only one box.
- Check “Interested in a job or a new job” for someone who is not working currently but wants a job or for a person who has a job but wants a different one.
- Check “Not interested in a job or a new job” for someone who is not interested in having a job or for a person who is employed and does not want to change jobs.
- Check “Wants to work, but is afraid of losing MA and SSA benefits” for someone who wants a paying job but does not have one because they are afraid of losing their benefits due to earning too much money.

Needs Assistance to Find Work:
- Check “NA” if the person does not want a job or if the person is not interested in finding a new job.
- Check “Independent” if the person wants to find a job but does not need assistance to do so.
- Check “Needs Assistance” if the person needs help finding a job, such as looking through the Want Ads, completing an application, developing a resume, etc.

3.28 Vocational/Educational Assistance

- **Needs Assistance to Work**:
  Needs assistance to function at a job (includes showing up on time, dressing appropriately, performing expected tasks, and performing in cooperation with others), or for job related activities. (Does not include transportation, which is covered elsewhere.) “Assistance” includes monitoring supervision, reminding, coaching or direct service.

- **Needs Assistance with Schooling**
  Check this for a person who needs help finding or applying for school or for someone who needs assistance to function at school. This includes registering for school, scheduling classes, showing up on time, performing in cooperation with others, etc. This does not include educational tutoring. For example, do not check this for an applicant who has a learning disability and needs educational support in reading comprehension.

Module 4: Community Living Skills

4.1 "Need for Assistance" Defined

Each skill or activity on the MH/AODA FS was developed from BRC and CSP language. Each skill has its own definition purposefully constructed for the MH/AODA FS. Screeners are to follow the definitions precisely in order to select the most accurate rating for level of help needed.

Eligibility for programs and services is based on an applicant's need for assistance.

"Need for assistance" is broadly defined to include any kind of support from another person (monitoring, supervising, reminders, verbal cueing, or hands-on assistance) needed because of a mental health and/or substance use disorder.

Because it is "**support from another person**," it does not include self-help, medication, money, or equipment.

Do not check assistance needed if the assistance is due only to cultural or language differences.

Do not check help needed for money management and basic nutrition if all the person needs is transportation to the bank or stores. The transportation issue would be captured in the transportation question.

Always select the answer that most closely describes the person's need for help from another person – whether they are actually getting that help or not. Always select ONLY ONE rating of help needed with each activity.

Indicate the amount of help the person needs from another person – no matter who is providing the help, and no matter where. (The only exception to this is that when a person is about to be discharged from a facility within a few days, estimate what they'll need in their new setting.)

In the MH/AODA FS, "basic" means adequate for health and safety. "Needs" and "safety" should not be over-interpreted. The MH/AODA FS is intended to be an objective screen of people's need for assistance. Thus, you should ask yourself, 'Would another screener of another discipline, program, gender, culture, etc., rank the person the same way?" (See "2.12 Ensuring Inter-Rater Reliability," page 14.)

If a person can complete a task independently, but it takes them a very long time, you need to consider if the person needs any help with that task to complete it safely and without negative outcomes. If they are in fact completing tasks safely, it does not matter if it takes two or three times longer than for most people. However, if there were significant hardship or negative outcomes for that consumer doing the task so slowly, than it would be justified to mark the person as needing help.

4.2 Help Is Needed Due to Mental Illness or Substance Use Disorder

If the person needs help due to a **physical impairment** (from a disability or infirmities of aging), do not check Community Living Skills in the MH/AODA FS. Such needs are to be indicated only in the last item in this module, “Physical Assistance.”

When someone has dementia co-occurring with mental illness and/or substance abuse, of course it is difficult if not impossible to separate the reasons for their functional impairments. For such individuals, mark help needed in Community Living Skills on the MH/AODA FS. If the person has mental illness and/or substance abuse as well, they could be eligible for long-term care and MH/AODA programs. If a person has **only** dementia, they should be referred for a LTC FS.

Examples:

- Mick has quadriplegia and major depression. In Community Living Skills in the MH/AODA FS, you only indicate help Mick needs **because of his depression**. Under the last item, “Physical Assistance,” you check tasks Mick needs help with because of his quadriplegia (e.g., bathing, dressing, mobility, transfers, meds, money, and transportation). In fact, Mick doesn’t need much help with any of the Community Living Skills because of his depression. He’s not eligible for MH programs.
- Jose has quadriplegia and schizophreniform disorder. In Community Living Skills in the MH/AODA FS, you only indicate help Jose needs **because of his mental illness**. Under the last item, “Physical Assistance,” you check tasks Jose needs help with because of his quadriplegia (e.g., bathing, dressing, mobility, transfers, meds, money, and transportation). In Community Living Skills Jose does need help with “Social/Interpersonal Skills” and “Managing Psychiatric Symptoms” due to his mental illness. He’d need this support even if he didn’t also have a physical disability.
- Martha is a frail 67-year-old with residual schizophrenia, dementia, history of alcohol abuse, congestive heart failure and history of a stroke. She likes to keep herself very clean, and needs physical help getting in and out of the bathtub. You’d mark her Independent in “Hygiene and Grooming” (because her schizophrenia does not make her need help with this), and you’d check “Bathing” under the “Physical Assistance” item.
- George is a 62-year-old long-time alcoholic diagnosed with schizotypal personality disorder, organic brain syndrome and “alcoholic dementia.” His cognition, self-care, and functioning are poor. It’s not clear (even to his psychiatrist) whether his impairments are due to dementia, organic brain disease, or mental illness. It doesn’t matter: You check all the Community Living Skills with which he needs help.

4.3 Frequency of Help Needed

The frequencies for help needed should provide **general** indications of high frequency versus low frequency. Most screen items have frequency choices, for example, of “Independent,” “Less than monthly,” “1 to 4 times a month,” and “More than one time per week.”

We know that selecting a frequency is difficult because:

- You might not know in advance what an applicant will actually need, especially if you just met them, and

- People’s needs often vary, especially due to the cyclical nature of mental illness.

On the other hand, you have always estimated the frequency of help needed, to decide your initial service plan and when to revisit the person. The MH/AODA FS just asks for that same professional judgment.

4.4 Ranking Fluctuating Needs

This section purposefully repeats Section 2.18.

Mental illnesses are often cyclical, with varying levels of symptoms and functioning. The MH/AODA FS is a mix of a “snapshot” view – the person’s current status now and over the past few weeks – and an historical (or “movie”) view looking over the past few months up to the past year or two. Every day MH/AODA practitioners (and consumers) make judgments based on this mix of snapshot and historical views, to determine the frequency of contacts and of help needed now and for the next few weeks or months. Of course people’s needs will change, and of course predictions are only approximate, but they reflect expert judgment (and sometimes research data) of the frequency of interventions needed to promote recovery and prevent crises.

The MH/AODA FS is similar. For some “Community Living Skills,” you are asked to indicate the approximate frequency at which help is needed. To make it easier to select answers, the answer choices have been reduced to “Independent,” “Less than monthly,” “1 to 4 times a month,” “More than one time a week.”

Less than monthly
Check this for applicant who, for example:

- Sees their case manager only every few months and is otherwise independent.
- Has had two or three episodes over the past year, requiring interventions for 1 or 2 weeks each episode – such that it **averages** out to less than monthly; and the episodes are unpredictable such that regular and more frequent assistance would not prevent the episodes.
- Recently became independent with a skill, but still needs some follow up and back up.

1 to 4 times a month
Check this for applicant who, for example:

- Needs help with budgeting and finances just 1 to 4 times a month.
- Needs help every other week, for instance, with housekeeping or grocery shopping.
- Needs med boxes filled every two weeks (filling two weekly med boxes at once).
- Is still developing skills they learn during visits with their case manager every two weeks.
- Has crises if they don’t get regular emotional support and reinforcement 2 or 3 times a month.
- Does pretty well most of the time, but sometimes calls their case manager for support; this happens irregularly, but on **average** over the past six months or so, it’s about 1 to 4 times a month.
- Does not recognize when symptoms escalate, and they do so within 2 or 3 weeks; person needs someone every two weeks to monitor symptoms and prevent crises. For example, Stu has had crises from manic episodes 2 to 3 times a year. His mania progresses rapidly,

within 2 or 3 weeks, and he doesn't see it starting. He needs someone to check in with him every two weeks to monitor for mania and help him prevent its escalation.

More than one time per week
Check this for applicant who, for example:
- Needs someone to give them their meds (psych and others) every day or more often.
- Forgets to take their meds unless the person's daughter calls to remind them every day to take them.
- Needs intensive case management and/or psych nursing visits 3 to 5 times a week.
- Comes in to the clinic every morning for meds and money.
- Does not recognize when symptoms escalate, and they do so within a day or two; person needs someone every two days to monitor symptoms and prevent crises. For example, Marilyn has schizophrenia and lives alone. Her MH case manager continues to see her three times a week to help her cope with her symptoms. With this support, Marilyn has only been hospitalized twice in the past three years.

4.5 Discharge Imminent

If the person is now in a hospital or nursing home, and will go home in the next few days, **record the help they'd need at home**. Talk to the discharge planner, family, person, PT, OT, etc., to get the most accurate possible picture.

Specific Community Living Skills

Each community living skill or activity has its own definition, which serves as the primary guide for screeners. The following section adds some additional instructions and some examples of when the definition does or does not apply. These examples are not exhaustive or all-inclusive; they only supplement the definitions.

4.6 Benefits/Resource Management

Needs assistance to plan for, access, and navigate benefits (e.g., Section 8, SSI, SSDI, Medicaid, Medicare, insurance, etc.). Does NOT include money management, which is captured elsewhere.

This is included because it is often an important part of what MH/AODA practitioners provide.

4.7 Basic Safety

Needs help from others because is unable to recognize immediately dangerous situations or to respond in an emergency. Does not include high-risk behaviors commonly engaged in by the public (such as unsafe sex, drinking and driving, poor health habits).

Assessments of safety can be very subjective and vary among individual screeners. Yet sometimes it is quite clear that safety is a problem, and this item is included on the MH/AODA FS to allow you to indicate those instances. As always, ask yourself, "Would other screeners, given the same observations and information, check this box?"

"Needs help from others" means that if the applicant does not get such help, bad things have happened or are very likely to happen. If the person has in fact been doing something completely independently without any risk or harm, then it would not appear that they need help from others.

This item was intended to focus narrowly on applicants who **need help from others** due to **cognitive impairments** caused by mental illness or substance abuse. It was not intended to include every risky or unhealthy **choice** people make. Especially when AODA is involved, our society is profoundly ambiguous about "choice" versus "disease." For the MH/AODA FS, consider the person's cognitive functioning when not drunk or on drugs. So, for instance, if someone drives drunk, they may suffer from the disease of alcoholism and need treatment (help from others), but they could have made advance arrangements (before getting drunk) to prevent themselves from driving drunk. In this way, the specific behavior of drunk driving is an informed choice and you would not mark this safety item for that individual. You would indicate substance abuse items elsewhere in the MH/AODA FS.

Check this for an applicant who, for example:

- Has no awareness of safety (e.g., wanders into traffic, wanders naked in winter).
- Is cognitively unable to respond to a crisis, for example, by calling 911 or running to neighbor's.
- Is unable to recognize and get out of threatening situations

Do NOT check this for applicant who:

- Understands safety issues and knows how to call for help, but chooses to engage in risky behaviors (e.g., unsafe sex, drunk driving).
- Lives in a crime-ridden neighborhood, but understands risks and how to get help.
- Has a "Lifeline" (personal emergency response button) and knows when and how to use it.
- Might cause some safety concerns for other adults, for instance, by distracting drivers with bizarre behaviors on the sidewalk.
- Who is doing something that *might* cause safety concerns, but no more than normal life risks (e.g., the risk of getting in a car accident on the way to work). (In other words, don't exaggerate "what ifs" that aren't really likely to occur, and remember to consider inter-rater reliability based on facts.)

4.8 Social or Interpersonal Skills

Needs assistance to effectively interact with others to have adult social relationships, or to plan for and carry out adult social or recreational activities according to personal preferences.

This is obviously more of a judgment question than many other items on the MH/AODA FS. But it's an important issue to include. In the majority of cases, most screeners would agree on whether this is an issue for someone.

Check this for applicant who, for example:

- Has become isolated and never leaves his or her apartment.

- Needs someone to accompany them in public and help interact with others.
- Has no friends, no hobbies, and will not leave their bedroom.
- Has agoraphobia and needs assistance to recover and make some trips out.

Do NOT check this for applicant who:

- Enjoys a lot of time alone, but does have a few supportive friends and can interact in public.
- Suffers some social prejudices (e.g., reactions to unusual appearance or mannerisms) but is able to interact effectively with strangers.
- Just needs transportation to get out more, but can interact and socialize.

4.9 Home Hazards

Needs assistance to maintain basic living environment to avoid disease hazards, fire hazards (e.g. hoarding), and/or odors noticeable from outside.

This item is basically looking for housekeeping adequate to avoid disease or danger. Even if the person's housekeeping has declined, say due to depression, do not check this item unless it has declined to the point of creating immediate dangers or health hazards.

Check this for applicant whose:

- Apartment has garbage strewn throughout, with mice feces on many surfaces.
- Home has feces or urine throughout the rooms.
- Home is piled high with boxes, newspapers, magazines, with only narrow pathways through the rooms (i.e., "hoarding").
- Person is at risk of hypothermia because home or heating is inadequate.
- Building is structurally unsound, with high likelihood of collapsing.
- House has immediate fire hazards, e.g., loose or burned electrical wires, gas leaks, etc.

Do NOT check this for applicant whose:

- Home is messy (like a teen's bedroom, a bachelor's pad, a messy co-worker's place) but there are no immediate risks of disease.
- House has some mice, but no mouse feces or odor in living areas.
- Dishes are often left unwashed for several days at a time.
- Toilet bowl is brown inside but toilet functions.
- Home is heated with a wood stove and has an outhouse and has no running water.
- Cat litter stinks, but there is no feces or urine outside the box.
- Housekeeping has deteriorated due to mental illness, but is good enough to avoid dangers or health hazards.

Note: Many times if these problems are present, neighbors may complain and/or landlords may threaten eviction. However, since behaviors of neighbors and landlords can be arbitrary, the definition is based on condition of the home, not the presence of complaints or eviction threats.

Also consider inter-rater reliability (page 14). Housekeeping standards vary widely among individuals, including screeners. So even though a screener finds a household far below what

they consider acceptable standards, the screener should apply the criteria listed above and mark the person independent if none apply.

MH/AODA screeners may be mandatory reporters for child abuse and neglect. If you see poor housekeeping creating risk factors to young children, such as access to garbage, you should respond appropriately. This item looks for immediate dangers and health hazards which exist for the applicant (and would thus exist for any children in the home as well). The functional screen does not, however, look for lax parenting or risks resulting from young children's inability to recognize dangers present in the home.

4.10 Money Management

Needs assistance to manage finances for basic necessities (food, clothing, shelter). **Includes needing assistance to handle money, pay bills, and to budget**.

Do not check this if the limitation is due to **cultural** issues (e.g., recent immigrant who has not learned U.S. currency and/or English language). If a person's inability to manage money is due solely to a language barrier and not due to a cognitive or physical disability or mental illness, the person should be considered independent for purposes of the MH/AODA FS.

Check this for applicant who:

- Has a rep payee because applicant is not able to manage own finances at this time.
- Has cognitive impairments making them unable to do cash transactions and/or to pay bills or budget.
- Does not recognize manic episodes, and spends exorbitantly during them.
- Spends all money on addictions and unable to pay rent, groceries, etc.

Do NOT check this for applicant who:

- Is actually able to manage money, but has a rep payee due to local policy or court order, or for convenience (e.g., to avoid costs of money orders).
- Needs AODA treatment but is able to manage money enough to meet basic needs of food, shelter, and clothing.
- Recently came to U.S. and has not yet learned U.S. currency and English language, so requires help with finances due to that.
- Is able to manage own money, pay bills, and budget finances, but needs help with transportation to the bank and to the mailbox. (The person would be marked independent with money management, and the transportation item would be checked.)
- Is 17 years old, is able to use cash, has cognitive/emotional ability to start managing money, but has not yet had a checking account or a need to budget or pay bills. (This should not count toward eligibility for MH programs.)

4.11 Basic Nutrition

Needs assistance to maintain eating schedule, obtain groceries, and/or to prepare or obtain "routine" meals (and avoid spoiled foods). Does NOT include transportation, which is captured elsewhere.

Note: "Routine" in this definition was intended to mean "average," not regularly scheduled. The functional screen will be revised to change "routine" to "simple," because the person does not need to be able to bake a full-course meal; they only need to be able to make simple meals such as a sandwich, cereal, and something heated on stovetop or in microwave.

Check this for applicant who:

- Receives "meals on wheels" because they otherwise would not get adequate nutrition.
- Due to cognitive/emotional issues, needs someone to help with grocery shopping every week or so (not just transportation).
- Seems unable to distinguish spoiled from fresh foods and has spoiled food in kitchen; case manager has to come clean it out or person will eat it and get sick.
- Has diagnosis of anorexia or bulimia and currently requires interventions from family and/or providers to ensure basic nutrition.
- Has mental illness and/or substance use disorder severe enough to be compromising the person's basic nutrition, i.e., causing malnutrition.
- Due to MH/AODA conditions and/or cognitive impairments, is not able to make informed choices about food enough to have basic nutrition.

Do NOT check this for applicant who:

- Makes informed choices to eat mostly junk food, but does understand and is capable of getting adequate nutrition.
  - **Note**: Case managers differ in the judgment of when a consumer **needs** them to grocery shop to avoid junk food. This will need to be clarified as the MH/AODA FS is further developed.
- Doesn't cook much, but can prepare cold meals (cereal, sandwiches) and can use microwave.
- Eats meals at unusual times.
- Can cook and select groceries but needs rides to the grocery store.
- Is not following a recommended diet, including diabetes diet, weight-loss diet, low cholesterol, low salt, etc. (Instead, check "general health maintenance" if, e.g., diabetes is out of control. This question is basic nutrition only.)
- Has spoiled food in 'fridge and kitchen, but does not eat it.
- Needs transportation to and from the grocery store, but can shop.
- Has agoraphobia and orders groceries on-line for home delivery.
- Needs help due to a physical disability, not MH/AODA (See Instructions 4.2, page 28).

4.12 General Health Maintenance

Needs assistance to care for own health and to recognize symptoms. Includes managing health conditions (e.g., diabetes, hypertension) and making and keeping medical appointments. Does NOT include medication management, which is captured elsewhere. Also does not include transportation, if person arranges it herself.

The person needs help from others because they are unable to self-manage current health conditions or health risks. "Unable to self-manage" means the person:

- Is unable to recognize problems;
- Is unable to respond to problems;
- Does not know contributing factors and corrective actions; OR
- Has a history of failure to self-manage health resulting in multiple ER visits or hospitalizations (inpatient or out-patient).

Check this for applicant who:

- Is unable to make and/or keep healthcare appointments (because of cognitive/emotional impairments including AODA).
- Is not able to notice health problems and/or to respond to them appropriately, e.g., by calling her nurse or doctor.
- Needs family or staff to monitor health symptoms, as applicant is unable to do so.
- Because of schizophrenia, is unable to manage diabetes.
- Has been in the ER and hospital several times from health crises caused by failing to manage health problems. Examples: diabetic coma, or GI bleed (gastrointestinal bleed) in alcoholic. (Does not include health problems **without** related ER or hospitalizations, such as chronic liver disease in person who keeps drinking.)

Do NOT check this for applicant who:

- Is physically healthy and knows how to access health care when it's needed.
- Is physically healthy and not likely to need any health care in the next year or two.
- Has health problems but understands them and knows how to access healthcare when it is needed.
- Has diabetes (or other health problems) but can recognize and report problems to MD.
- Has been in ER and hospital, but not due to failure to self-manage health problems.
- Has health conditions resulting from poor self-care (e.g., GI bleed from alcohol and keeps drinking) but understands disease process and has not had ER or hospitalizations for those conditions.
- Needs transportation to appointments, but can make appointments and self-manages health.
- Has missed a few appointments for specific reasons, but is generally able to keep them.
- Has seizures during which loses consciousness, but who otherwise understands their condition and how to manage it.
- Is seen by a nurse out of agency or nurse habit, e.g., doing monthly visits to check on the person. Functional screen should be based on what the person needs, not what the nurse is doing as part of agency routine.
- Receiving medical or skilled nursing services in a primary care setting.

4.13 Managing Psychiatric Symptoms

Needs assistance (by a person other than a physician) to manage mental health symptoms (e.g., hallucinations, delusions, mania, depression, anxiety, etc.).

The person needs help from others because they are unable to self-manage mental illness symptoms. "Unable to self-manage" means the person:

- Is unable to recognize symptoms when they're starting;
- Is unable to respond when symptoms start;
- Does not understand contributing factors and corrective actions.

This item looks for help needed to recognize and respond to symptoms of mental illness – beyond the typical emotional support we all get from friends and loved ones (or, for some, clergy). If such informal supports are going beyond this to monitor for signs of serious mental illness and help the individual respond to those symptoms, then that more advanced assistance counts for this item.

This item is limited to psychiatric symptoms; substance use problems are addressed separately in the Risk section of the MH/AODA FS. Although MH and AODA problems can be inextricably enmeshed in real life, providers still distinguish MH from AODA treatment.

Check this for applicant who:

- Has schizophrenia and needs parents to monitor symptoms and call the psychiatrist or MH staff with problems, as applicant is unable to do so.
- Has bi-polar disorder and does not yet recognize when symptoms are getting worse.
- Becomes depressed and stops going to work; needs assistance to recognize and cope with depression and to avoid losing job.
- Can not recognize when mania is starting, so has set up intervention plans and contracts with family and friends to monitor for it and help respond.
- Is learning coping skills, but still needs regular mental health support from case manager.
- Has severe bulimia and must be monitored every day for that; her parents do this but if they couldn't, paid supports would be needed.

Do NOT check this for applicant who:

- Can recognize and self-manage symptoms.
- Calls psychiatrist whenever he or she has problems or concerns.
- Independently accesses community resources (such as peer support groups, or a spiritual advisor or therapist) as part of self-care.
- Has chronic "voices" (auditory hallucinations) but can cope with them, and calls psychiatrist when they get worse.
- Processes emotions with friends, but friends don't need to help monitor symptoms.

4.14 Hygiene and Grooming

Needs assistance to maintain basic hygiene and grooming.

Screeners must consider this item in the context of the applicant's culture, not the screener's own culture or values. In some cultures, some amount of body odor, hair grease, or dirty nails or clothes is acceptable. The MH/AODA FS looks for problems, help needed, for the applicant to succeed in their own culture.

Check this for applicant who:

- Will not bathe without someone (either family or MH practitioners) coaxing them into it every week or so.
- Has strong body odor and is clearly in need of hygiene (by standards of applicant's culture, not the screener's culture).

Do NOT check this for applicant who:

- Has very casual or unusual clothes and hairstyle, but is clean and without body odor.
- Has some odor, grease, or dirt, but within acceptable levels for own culture.
- Has lice. (Lice can appear even in well-groomed people, so having lice does not mean the person needs help from others with hygiene.)

4.15 Taking Medications

Needs assistance with taking medications.

Competent adults do have the right to refuse medications. See Section 4.12 (page 34) about when the person chooses not to take medications versus when they needs help from others because they are unable to self-manage current health conditions or health risks. "Unable to self-manage" means the person:

- Is unable to recognize problems related to meds;
- Is unable to respond to problems related to meds (such as calling MD);
- Has a history of failure to self-manage health resulting in multiple ER visits or hospitalizations (inpatient or out-patient).

NEEDS SOMEONE TO ADMINISTER REGULAR IM (intramuscular) INJECTIONS

Check this for applicant who:

- Goes to clinic every three weeks to receive IM Prolixin.
- Has her mother inject her IM meds without problems.

Do NOT check this for applicant who:

- Receives subcutaneous (just under the skin) Vitamin B injections from a nurse.
- Needs someone to administer their insulin (that's subcutaneous, not IM).
- Self-administers subcutaneous injections (e.g., insulin).
- Self-administers IM shots.

ASSISTANCE NEEDED WITH TAKING OTHER (non-IM) PRESCRIBED MEDS

This applies to any medications **prescribed** (by an MD or other prescriber, e.g., an advance practice nurse or physician's assistant) for **psychiatric or other medical** conditions. It does not include over-the-counter meds.

"Assistance" includes any of the following:

- **Administering medications**: Actually giving them the meds.
- **Observation of self-administration**: Watching them take the meds to ensure they are taking them.
- **Verbal reminders** to take meds (can include phone reminders).
- **"Setting up"** medications in med boxes, cassette machines, or syringes.

The MH/AODA FS is intended to capture what individuals' needs, not merely what they are receiving because of providers' habits or philosophy. This distinction is particularly challenging with medication administration. Residential or treatment center staff, for example, may dispense medications mostly because of convenience or liability concerns. A particular individual may or may not be able to take their meds without such help. As much as possible, screeners should try to ascertain whether the individual is in fact independent with taking meds, regardless of what a provider does.

A special exception to this is court orders: Screeners can check this item for medication assistance that MH/AODA providers feel is required to provide for consumers under court orders for MH treatment. The frequency marked on the MH/AODA FS should correlate with the frequency you would include in a service/treatment plan for this person.

Check this for applicant who:

- Would not take psych meds without MH staff or family directly cueing and watching him or her take them.
- Only takes their meds if parents call to remind them every day.
- Has major mental illness and is very old and needs someone to hand them their heart and blood pressure pills several times a day.
- Is under court orders and does not take meds consistently unless case manager visits every week to coax him or her into taking them.
- Refuses to take prescribed meds for other (non-psych) health conditions and cannot understand the dangers of not taking them.
- Refuses to take prescribed meds for other (non-psych) health conditions, does understand the risks, and has had ER or hospitalizations as a result.
- Says doesn't need meds, but agrees to someone cueing him or her to take them.
- Does not want meds but is under court orders to take them and agrees to plan to assure he or she takes them.
- Just stopped taking psych meds and needs intensive interventions (negotiations, coaxing, coaching, etc.) to get back on them.

Do NOT check this for applicant who:

- Takes meds regularly without anyone reminding them.
- Is under court orders to take meds, but has been taking them consistently as prescribed without any reminders or help from others.
- Fills own med box every week.
- Receives pills from day center staff when there three times a week, due to provider policy, but is in fact completely independent with meds.

- Misuses over-the-counter meds, but takes prescribed meds as recommended or has no prescribed meds.
- Refuses to take prescribed meds for other (non-psych) health conditions but understands the med, the condition, and the risks, and has not had ER or hospitalizations as a result.
- Is taking a "med holiday."

4.16 Monitoring Medication Effects

Needs assistance monitoring effects and side effects of prescribed medications.

This item applies to any medications prescribed (by an MD or other prescriber, e.g., an advance practice nurse or physician's assistant) for psychiatric or other medical conditions. It does not include over-the-counter meds.

Monitoring medication effects includes all of the following:

1. Recognize effects and noticeable side effects of prescribed medications,
2. Report med effects or new problems to a prescribing professional, and
3. Follow any med or dose changes recommended by the prescriber.

When blood tests must be done, monitoring med effects also includes:

4. Doing self-tests, for example, blood sugar checks; or going to clinic for blood draws.

A person is "independent" in Monitoring Med Effects if they are able to do all 3 (or 4, if applicable) of these steps.

If the person cannot do all 3 or 4 of these steps, they needs assistance from someone else (someone besides the prescriber) to notice problems, report them to the prescriber, and to help the consumer follow through with the prescriber's recommendations. Since prescription meds always involve a prescriber, the prescriber's actions in themselves do not constitute the "assistance" sought for in this item. Thus, visits or contacts with a physician or other prescriber do not count. Instead, this item asks whether the consumer needs a "third party" as intermediary between them and the prescriber.

Check this for applicant who:

- Has schizophrenia and unstable diabetes and needs someone to check their blood sugars and watch for signs of high or low blood sugar and respond accordingly.
- Is unable to notice or report med side effects and needs someone else to do so, as is on prescribed meds with potential side effects.

Do NOT check this for applicant who:

- Is not on any prescribed medications.
- Has diabetes with a history of dangerously low blood sugars, but has learned to recognize when blood sugar level is getting low and has a snack at those times.
- Can check own blood sugar levels, although doesn't always do it.
- Goes to the clinic every three weeks for lab test for medication side effects.
- Can call doctor to report problems, and can follow instructions such as a dosage change.

4.17 Monitoring Meds and/or Managing Symptoms

With prescribed psychiatric medications, there is a significant overlap between this "Monitoring for Medication Effects" question and the "Managing Psychiatric Symptoms" question elsewhere in the MH/AODA FS. When psychiatric meds are being adjusted to reduce psychiatric symptoms, screeners will check **both** "Managing Psychiatric Symptoms" and "Monitoring for Medication Effects." Sometimes only one of the items would be checked, for example:

- Needs help with "Monitoring for Medication Effects" but not with "Managing Psychiatric Symptoms"
  - Joey has none of the symptoms (hallucinations, delusions, mania, depression, anxiety, etc.) listed under "Managing Symptoms," but does need someone to monitor for med side effects and report them to MD.

- Needs help with "Managing Psychiatric Symptoms" but not with "Monitoring for Medication Effects"
  - Shar needs regular support from several people to help her manage her anxiety and depression, but is capable of noticing med effects, reporting them, and making changes as instructed by her psychiatrist.

4.18 Transportation

The ability to drive a regular or adapted vehicle.

- Person drives.
- Person drives but there are serious safety concerns.
- Person can not drive **due to physical, psychiatric, or cognitive impairment**. *Includes no driver's license due to medical problems (e.g., seizures, poor vision).*
- Person does not drive **due to other reasons** *(e.g., lost license, has no car).*

4.19 Physical Assistance

Needs assistance to physically accomplish the following tasks: (Check all that apply)

This item is intended to indicate when help is needed with these tasks due to PHYSICAL LIMITATIONS. These applicants may be eligible for **long-term care services** in addition to mental health services. (These factors will also impact costs in MH services.)

Independent = No PHYSICAL limitations requiring assistance with any of the tasks listed below. (Limitations due to mental illness or cognitive limitations are indicated in the previous Community Living Skills items.)

Bathing
The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate hygiene. This also includes the ability to get in and out of the tub, turn faucets on and off, regulate water temperature, wash and dry fully.

Dressing
The ability to dress and undress as necessary and choose appropriate clothing. Includes the ability to put on prostheses, braces, and/or antiembolism hose (e.g., "TED stockings") with or without assistive devices. Includes fine motor coordination for buttons and zippers. Includes choice of clothing appropriate for the weather. (However, difficulties with a zipper or buttons at the *back* of a dress or blouse do not constitute a functional deficit.)

Toileting
The ability to use the toilet, commode, bedpan, or urinal. This includes transferring on/off the toilet, cleansing of self, changing of pads, managing an ostomy or catheter, and adjusting clothes. Check this box if the applicant needs physical help from another person, **or** if they use a commode, elevated toilet seat, ostomy, urinary catheter, or regular bowel program or is incontinent more than monthly.

Mobility in Home
The ability to move **between locations** in the individual's living environment (defined as kitchen, living room, bathroom, and sleeping area). For purposes of the functional screen, this excludes basements, attics and yards.

Transferring
The physical ability to move **between surfaces**: from bed/chair to wheelchair, walker or standing position. The ability to get in and out of bed or usual sleeping place. The ability to use assistive devices for transfers. Excludes toileting transfers. Check this box if the person needs physical help from another person, **or** if they use a mechanical lift, transfer board, or trapeze.

MODULE 5: Crisis and Situational Factors

5.1 Introduction

Check all that apply or have applied within the specified timeframes.

Most items separate frequency “within the past year” from frequency “13 months to 3 years ago.” This requires screeners to **ask two separate frequency questions** for each item:

- How often in the past year?
  and
- How often 13 months to 3 years ago? or How often in the two years before this past year?

This adds a little extra thought and time to the screening process. The benefits are that it allows greater recognition of serious problems that occurred more than a year ago, as well as frequent problems in the past year. This recognizes the cyclical nature of mental illness and stability resulting from MH supports received, for example, in the past year, since you can indicate the frequency of problems in years **prior** to the past year. Both time frames can be important in determining need for on-going MH supports.

If the events have occurred both in the past year and before then, indicate the frequency of events in both of the time periods.

It might be challenging for some applicants to answer these frequency questions. Screeners may need to consult written records or speak with other people (with the applicant’s permission, of course) in order to determine the frequency of these items. If no such resources are available to you (e.g., with someone who just moved to Wisconsin), complete the functional screen as best as you can with the information you can obtain. In many cases, the applicant might make eligibility even with incomplete information. You can always update the functional screen as new information becomes available. If the applicant does not make eligibility due to insufficient background information, discuss it with your Screen Leader, who will call or e-mail designated state staff.

5.2 Overlap of Events

One event could involve several items in this list. For instance, the person might have been suicidal, gotten drunk, assaulted someone, been arrested for OWI, been injured and treated in the ER, and had an emergency detention all in one evening. Alternatively, these all could have occurred as separate incidents. It doesn’t matter; screeners can check all that apply in each timeframe.

5.3 Use of Emergency Room, Crisis Intervention or Detox Units

- Use of emergency rooms can be for **any** reason, *psychiatric or medical*.

- The “Use of an emergency room” does not include going through the ER due to an emergency detention.
- Crisis intervention does **not** include telephone-only contact. Hospital Diversion should be counted as crisis intervention

5.4 Psychiatric Inpatient Stays

Any stay in a psychiatric hospital or psych unit of a hospital, voluntary or involuntary.

- If person was admitted over one year ago and is still there, check **both** “Within the past year” and “13 months to 3 years ago”.
- If that same admission followed a Chapter 51 Emergency Detention (ED), you would check Chapter 51 ED “13 months to 3 years ago” **and** Psych inpatient stay “Within past year” and “13 months to 3 years ago.”

5.5 Chapter 51 Emergency Detentions

Wisconsin statute 51 allows for involuntary “emergency detention” if an individual presents immediate danger to self or others. Police do an “emergency detention” and 72-hour hold, which is followed by a probable cause hearing with a judge. You will check this box for any ED, regardless of the judges’ decision, including if the judge dismisses it.

An “on-going ED” that’s been extended several times is not really an ED anymore; it is “court orders” which you indicate elsewhere on the functional screen.

We are aware that the use of emergency detentions varies among counties, and may reflect local resources and the philosophies of the police, sheriff, and mental health systems as much as individuals’ needs. The functional screen will provide data that stakeholders can analyze for local and statewide quality improvement in this area.

5.6 Physical Aggression

Note: Verbal aggression is not included here. If verbal aggression is a serious problem, it is likely to show up elsewhere in the MH/AODA FS, for example, in problems with housing, social interactions, or managing symptoms.

Torturing or killing animals can be counted here only if it reflects abnormal psychoses, delusions, rage, or punishment of others (such as killing a child’s pet to punish the child). While some people consider raising and killing farm animals to be “torture” and “abuse,” for the MH/AODA FS screeners should restrict themselves to this more narrow use.

5.7 Physical aggression has resulted in the injured person being hospitalized

Does not include ER visit only. This question reflects the reality that serious harm to others may have occurred several years ago but still be an important consideration for MH program eligibility. Check this box if the injured person was hospitalized or was killed.

5.8 Involvement with the corrections system

This includes OWI/DUI, arrests, jail, prison, probation, parole, conditional release, Huber, bail monitoring, diversion agreement, etc. It does not include other interactions with police. It does not include minor traffic tickets, but does include driving under the influence or operating while intoxicated. The involvement is the applicant's own, not a family member's. If a person is arrested and then jailed for the same incident this should count as one event.

Jail is one continuous event and should just be captured when the event was initiated. For example, if a person was jailed 13 months to 3 years and the person was still in jail during the past year, this is one event and should only be captured in the "13 months to 3 years ago" time period. This is the case for the corrections question only because being jailed is for a relatively fixed period of time and is not reevaluated and extended based on the person's functioning. If the person was jailed two years ago and released and then jailed again in the past year for a separate crime or a parole/probation violation then both separate instances should be counted, one occurred "13 months to 3 years ago" and one occurred "within the past year."

In contrast, you will notice that the instructions state that for a psychiatric inpatient stay if the person was admitted over one year ago and is still there, check **both** "Within the past year" and "13 months to 3 years ago". This is because the continuation of a hospitalization is due to the ongoing severity of functioning of the person not the sentence being served for an original incident.

5.9 Suicide attempts

A suicide attempt is an act with a significant risk of death. The judgment that a suicide attempt was "only a gesture," or was "just for attention" or "just manipulation" is excessively subjective. (It is also dangerous, because many suicides are preceded by multiple suicide attempts.)

Screeners should avoid subjective judgments about the individual's motivation or desired outcomes of the act. Instead, screeners should consider the level of risk of dying. For example, shallow cutting of the skin on the forearms is not a suicide attempt, as no blood vessels are cut to create risk of death. (Such cutting is indicated elsewhere in the MH/AODA FS, in "self-injurious behaviors.") However, large overdoses of pills or other acts with high risk of death are "suicide attempts," no matter how often they have occurred.

Has had a suicidal ideation with a feasible plan within the past two months
This item is intended to indicate people who are currently or recently struggling with suicidality.

Check this for applicant who:

- Currently feels suicidal and has a plan and the means to carry it out.
- Was close to suicide (with a plan and means) within the past two months, but does not feel that way today.

Do NOT check this for applicant who:*

- Says they are going to drown themselves in the lake, but is unable to walk or wheel outside of the house.
- Says "I just want to die," but does not have a plan and is not actively suicidal.

*Note: For these applicants, you still **care about** what they're saying, and follow up appropriately; you just don't check this box on the functional screen.

MODULE 6: Risk Factors

Check all that apply or have applied.

6.1 Self-Injurious Behaviors

Includes cutting, burning, pica, polydipsia, head-banging. Does not include suicide attempts.

- “Pica” is eating inedible objects such as metal or coins.
- “Polydipsia” is drinking excessive amounts of water, large amounts of which can be fatal.

Check this for applicant who:

- Cuts him or herself.
- Has mental illness and developmental disability and has to be monitored almost constantly to prevent them from drinking huge amounts of water (from which they have almost died in the past).

Do NOT check this for applicant who:

- Engages in prostitution and/or other high-risk activities.
- Has unhealthy habits such as smoking, drinking, or misusing over-the-counter meds.
- Gets many body piercings and/or tattoos.

6.2 Substance Use

NOTE: On the MH/AODA FS, substance use does NOT include tobacco or caffeine.

Outcomes of Substance Use (Part 1)

- No use or low risk use in 12 months
- In past 12 months, substance use has involved risks but it is not clear that negative consequences have occurred.
- In past 12 months, person has experienced negative consequences in legal (including OWI), vocational, financial, relational, or health domains that are linked to substance use.

Most of the FS uses expected frequency of help needed from others. This substance use question instead asks about the outcomes – the consequences – of substance use. With just a few questions it’s quite easy to categorize alcohol use in one of these four categories:

- **“No use or Low Risk” Drinking**
- **“At-risk” or “Hazardous” Drinking**
- **“Harmful” or “Problem” Drinking**
- **Dependency**

(Most AODA professionals consider any illegal drug use to be inherently risky or harmful because of legal risks. Some argue that occasional use of some illegal drugs can be low risk.)

Hazardous or harmful drinking can consider the amount consumed, by these federal guidelines:

Recommended Alcohol Limits
(from US Dept. of Health & Human Services)

Number of Standard Drinks	Under Age 65		Over Age 65		While Pregnant
	Men	Women	Men	Women	
Per Occasion	4	3	2	1	0
Per Week	14	9	9	6	0

Many people do not recognize that their AOD use creates any risks or problems. That's okay. The question asks for "problems linked to substance use"; some links are objectively evident even if the applicant doesn't see the link. To recognize such links is not to blame, judge, or label people; it is to help people. (The first stage of treatment is forming an empathic relationship and helping the person see the links.) In the meantime, for purposes of this FS, consumer advocacy is better served by screeners indicating apparent AOD problems or risks, regardless of whether the consumer recognizes them. This is not just screener opinion, but is based on evidence and expertise. Evidence can include scientifically proven links, for example, between alcohol and depression, insomnia, accidents, falls, stomachaches (gastritis, esophagitis), liver disease, or problems managing diabetes or seizures or other health conditions. Some problems--in relationships, jobs, or finances—may be less clearly linked to AOD use; see examples below.

NO USE OR LOW RISK USE EVIDENT IN PAST 12 MONTHS

Check this box for person who:
- Does not drink alcohol or use recreational drugs, and uses prescription drugs only as prescribed.
- Drinks less than recommended limits and has no health conditions or medications creating risks or problems even with low to moderate alcohol intake
- Has been abstinent for the past 12 months (If any use occurred, check a box below)

IN PAST 12 MONTHS, SUBSTANCE USE HAS INVOLVED RISKS BUT IT IS NOT CLEAR THAT NEGATIVE CONSEQUENCES HAVE OCCURRED

Check this box for person who:
- Drinks more than recommended limits but has not had negative consequences (yet)
- Drinks less than recommended limits but has health conditions or medications indicating that person should not drink at all or as much
- Has driven drunk but hasn't been caught doing so

IN PAST 12 MONTHS, PERSON HAS EXPERIENCED NEGATIVE CONSEQUENCES in legal (including OWI), financial, family, relational, or health domains that are linked to substance use

Check this box for person who:

- Has diagnosis of AOD dependence and continues to use
- Has sign(s) of dependence-- cannot control use, cannot go long without using, has withdrawal symptoms if doesn't use, and/or continues to use despite negative consequences
- Experienced negative outcomes 11 months ago and has been abstinent since has had health problems worsened by alcohol or drug use (or has been advised to
- quit or reduce use and hasn't)
- Has been charged with OUI
- Was arrested, ED'd, or taken to detox or ER after AOD use
- Has had any of the following after AOD use: Violence (victim or perpetrator), abuse (victim or perpetrator), child neglect or abuse, injuries, car accident, fall
- Does not recognize (or denies) link between problems and AOD use, but evidence indicates link is probable.
  Examples:
  - "My wife said she left me because of my drinking, but she's crazy, I don't' drink too much."
  - "My doctor told me to quit because of my liver, but I can handle it."
  - Screener asks, "What did they say about why they fired you?" Reply: "They said I was late to work too many mornings." Screener: "Could that be from all that partying you do during the week?" Absent other reason for tardiness, a link is likely even if person doesn't see it.

Additional Outcomes of Substance Use Questions (part 2)

The following questions have been added as screening items that will identify additional need for further substance use screening, assessment and treatment referral. The five questions have been adapted for the screen from the extensively researched Global Appraisal of Individual Needs (GAIN) Short Screener with permission from Chestnut Health Services.

Please ask the person the questions directly and record their answer. If one of their answers seems to be different from than the collateral information available, please ask additional clarifying questions.

The responses to the questions require that a time frame be chosen. The definitions are as follows:

Past Month: Any one single incident or more in the past 30 days
2-12 Months: Any one single incident or more that occurred 60 days to 12 months ago
1 year or more ago: Any one single incident or more that occurred 12 months or longer ago, even if that incident was 20 years ago.

If there is a response to any question where there is a choice between two or more time frames, record the time frame that is the most recent.

These questions are only screening questions to identify a potential issue and do not represent the information needed in a Substance Use and Addiction assessment.

- More information regarding the complete screen or other assessment tools can be found at www.chestnut.org.
- For current information regarding other co-occurring information, please see www.coce.samhsa.org.
- Further information regarding Wisconsin's Uniform Placement Tool can be found at https://dhs.wisconsin.gov/aoda/index.htm.
- Substance Abuse and Addictions: www.attcnetwork.org.

Used Alcohol and Drugs Weekly:
This question is designed to determine a frequency of substance use, not quantity of weekly use or the seriousness or dangerousness of use.

If the person asks," Does drinking a glass of wine count?" Explain that this is only a frequency question and if they are experiencing no other negative consequences from their usage the question will not by itself forward them to a referral or label them in any way.

Check for applicant who:

- Uses marijuana daily or a shot of whiskey at night before bed (past or present).
- Has a glass of wine with dinner (past or present)
- Drinks or uses only on the weekends (past or present)

DO NOT check this for applicant who:

- Has never or rarely consumes alcohol or drugs
- Uses prescription medication as prescribed
- Rarely consumes alcohol but smokes cigarettes daily

Spent a lot of time either getting alcohol or drugs, using alcohol or drugs or feeling the effects of alcohol or drugs (high or sick).
This question is designed to receive a response that demonstrates the level of preoccupation the person experiences regarding their use of alcohol and drugs.

Check this for applicant who:

- Spends a lot of time thinking about getting alcohol or drugs.
- Uses alcohol or drugs while knowing that using in combination with other health issues will make them sick.
- States that their usage makes the other psychotropic medication work better.
- Uses prescription drugs on a different frequency than prescribed.

DO NOT check this for an applicant who:
- Uses prescription medication as prescribed
- Has one glass of wine with dinner

Kept using alcohol or drugs even though it was causing social problems, leading to fights, or getting into trouble with other people.
This question is designed to measure the negative social and physical aggressive consequences that some people experience when using drugs or alcohol.
- Refer to section 4.9 for a definition of Social or Interpersonal skills
- Refer to section 5.6 for definitions of Physical Aggression
- Refer to section 5.7 for definitions of Physical aggression has resulted in the injured person being hospitalized
- Refer to section 5.8 for definitions regarding Involvement with the Corrections systems

Check this for applicant who:
- Continues to drink even when his wife says she is leaving if he does not stop drinking.
- Has gotten a DWI or OWI or any drug related charges.
- Has gotten into fights while using drugs or alcohol.

DO NOT check this for applicant who:
- Drinks socially and it does not lead to arguments with others, loss of friendships, or legal repercussions.

Use of alcohol or drugs caused applicant to give up, reduce or have problems at important activities at work, school, home or social events.
This question is designed to measure the negative impacts of the person's major life responsibilities solely related to the use of substances.
- Refer to section 4.9 for a definition of social and interpersonal skills
- A comprehensive list of home issues can be found in the definitions from 4.7 to 4.16 under Specific Community living skills

Check this for applicant who:
- Does not have enough money to pay the rent due to the high cost of alcohol and substances.
- Has had negative consequences in the school system for possession or use of substances in school.
- Has experienced decreased capacity to perform job responsibilities, loss of job, demotion or reduction of hours due to substance use.

DO NOT check this for applicant who:
- Drinks on the weekends but always follows through with work or school responsibilities (showing up on time, completing tasks as assigned, etc.).
- Has used marijuana but it has not lead to withdrawal from social situations or apathy at work.

Had withdrawal problems for alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping or used any alcohol or drugs to stop being sick or avoid withdrawal problems
This question is designed to measure the negative physical effects caused by using too much of a substance.

Check this for applicant who:

- Experiences blackouts
- Has been hospitalized due to the use of substances or has had detoxification treatment episodes.
- Has trouble sitting still due to over use of amphetamines.
- Has trouble sleeping due to either the use of alcohol or other sedatives.
- Has to have a drink first thing in the morning (the morning eye opener) or other continued use to avoid withdrawal symptoms.

DO NOT check this for applicant who:

- Uses alcohol or drugs and has never experienced a negative physical response.

If the eligibility results indicate a “Yes” for the GAIN Assessment it is recommended that the applicant receive further AODA assessment by a qualified substance abuse professional.

Substance Use Treatment (not detox)
This means “formal” substance use treatment by professional “AODA” (alcohol or other drug abuse) counselor(s). It can include individual or group therapy.

Substance Use Peer Group Support (e.g., aftercare group, AA, NA)
Includes participation in any peer support groups, including on-line ones. This does not include groups run by professional AODA counselors.

6.3 Trauma/Abuse Question

We know that many people have experienced physical, emotional, or sexual abuse or neglect as an adult or in childhood. Trauma and its aftermath are under-recognized realities in many people’s lives. Wisconsin’s State Trauma Workgroup (2000-2001) suggested more screening to raise awareness and support advocacy efforts.

This question is **optional**; it can be answered Unknown. It is obviously a sensitive topic, and many people will not want to answer it. Be very clear that they do not have to answer it. The question, “Would you say that you have?” is purposefully equivocal so that it can be answered, “No, I have not experienced abuse” **or** “No, I would not say,” i.e., “No, I will not divulge that information for the functional screen.”

Screeners should always preface this question with a statement that the consumer does not have to answer it. You could say something like this:

> “The state and advocates are concerned that trauma and abuse are usually overlooked, so the functional screen includes a question on it. You do not have to answer it.”

6.4 Housing Instability

If "Yes," check all boxes that apply to indicate type of housing instability within the past 12 months:

- Currently homeless (on the street or no permanent address).
  - Includes staying at homeless shelters, living in a car or tent, or "crashing" at friends' or relatives' houses for short periods (days or weeks).
- Homeless less than half the time in the past year.
- Homeless 50 percent of the time or more within the past year.
- Has been evicted two or more times in the past year (by landlords, family, friends, etc.)

6.5 Intensity of Treatment or Functional Severity

The current CSP regulations at DHS 63.08 (1) address criteria for admission to a CSP. The rule indicates that admission to a CSP shall be limited to an individual who has chronic mental illness which by history or prognosis requires repeated acute treatment or prolonged periods of institutional care and who exhibits persistent disability or impairment in major areas of community living as evidenced by either:

(a) Specific diagnoses (e.g., schizophrenia), a significant risk of either continuing in a pattern of institutionalization or living in a severely dysfunctional way if CSP services are not provided, and impairment in one or more of the listed functional areas; or

(b) Another diagnosis listed in the DSM–III–R other than a diagnosis listed in par. (a) that has required consistent and extensive efforts beyond basic outpatient clinical standards of practice to treat the client, such as use of special structured housing or home visiting when the client does not come in for appointments, for a person who exhibits persistent dangerousness to self or others, a significant risk of either continuing in a pattern of institutionalization or living in a severely dysfunctional way if CSP services are not provided, and impairment in one or more areas listed under sub. (2).

If the person has a history of dangerousness to self or others preceding the initiation of the consistent and extensive treatment efforts (within three months), then it may be reasonable to assume that without these treatment efforts that the person may have continued to exhibit behavior that posed a danger to self or others. If there is appropriate documentation, then this item is met.

Example 1. Person A has a diagnosis of schizotypal personality disorder. Twenty years ago, he believed that his parents were spying on him for the FBI and had a plan to kill his parents, but was arrested before he could carry out the plan. He spent five years in a correctional facility and then moved to Wisconsin. He has not seen his family since then. Three years ago, he began to receive consistent and extensive treatment following a referral from public housing officials who were preparing to evict him due to nonpayment of rent and general lack of cleanliness of his apartment. This history does not satisfy the CSP admission criteria, but he may be appropriate for enrollment in a CCS program.

Example 2. Five years prior to the completion of the functional screen, Person B received a diagnosis of borderline personality disorder. After going out on a date, he told his date that he would commit suicide if she did not see him again. When he did not hear from her for one week, he did attempt suicide and was held under an emergency detention. Following the hospitalization, he began to receive consistent and extensive treatment from the county. He continues to have significant problems with interpersonal relationships, although he has not attempted or threatened to commit suicide in the past five years. If he has impairments in one or more of the listed areas, then this history is sufficient to indicate that he meets the CSP admission criteria. He may also meet the enrollment criteria for CCS and, if so, then he should have a choice between CSP and CCS.

6.6 Interdivisional Agreement 1.67

Applies to individuals for whom a DHS/Division of Quality Assurance nursing home surveyor has issued a 1.67 administrative order to refer the individual to the county for nursing home discharge and alternative living arrangement (or other needed services).

6.7 Current COP Level 3 Funding

Applies to individuals that are currently receiving COP Level 3 funding for serious and persistent mental illness. This does not apply if the person is receiving COP waiver or regular state COP funding for Level 1 or 2 due to a medical or physical condition. That person should receive a LTC FS.

MODULE 7: Diagnoses

7.1 Overview

There are two diagnoses tables on the MH/AODA FS. The first is for mental illness and substance-related diagnoses, and the second is to indicate other general medical diagnoses. Psychiatric diagnoses are needed for eligibility for MH programs. “Other” or “general” medical diagnoses do not affect eligibility for MH/AODA programs. The “other” diagnoses are included on the MH/AODA FS to improve, at all levels from practitioners’ awareness to county and state systems, the well-being and access to quality health care for people with mental illness and/or substance use problems.

7.2 MH and AODA Diagnoses

The MH/AODA FS reflects current state and federal policies on eligibility for Medicaid-funded MH and AODA programs. As those policies evolve (e.g., with the new CCS program), the functional screen and instructions will be revised as needed.

A Diagnosis is Required for Eligibility

- Specific psychiatric or AODA diagnoses are required for eligibility for most MH or AODA programs (respectively) in Wisconsin.
  - Nicotine addiction is listed but does not count toward eligibility for AODA treatment programs.
- For MH programs, the applicant must have at least one of the specified psychiatric diagnoses listed in this table, including the precise numeric code from the DSM-IV (Diagnostic and Statistical Manual – Version 4).

Who Can Make MI/AODA Diagnoses

- Psychiatric diagnoses must have been made by a **psychiatrist or licensed psychologist**.
- Non-psychiatrist MD’s diagnoses are NOT sufficient for eligibility for MH programs.
- Psychiatric nurse practitioners’ or physician’s assistants’ diagnoses do count **if** made under supervision of a psychiatrist.
- AODA diagnoses checked in the functional screen should reflect diagnoses made by professionals whose scope of practice includes diagnosing substance use disorders (physicians, advanced practice nurses, psychiatrists, and some AODA professionals).

Where Screeners Obtain Diagnoses

Screeners can obtain diagnoses from any of the following:

- Written records from psychiatrist or licensed psychologist.
- Other medical records if the psychiatric diagnosis was made by a psychiatrist or licensed psychologist.
- A healthcare or mental health professional’s verbal report that a qualified professional made a particular diagnosis.

- Documentation from schools or group homes do not count unless they cite a diagnosis made by qualified diagnostician. In other words, school category assignments or diagnoses made by teachers do not count.
- Consumer or family report count if and only if they can state the diagnosis exactly and can name the qualified professional who made the diagnosis and (approximately) when.

Diagnoses obtained in these ways are “verified” diagnoses. In many cases, screeners will need to obtain a signed release of information in order to verify diagnoses. Sometimes you or another helper will need to persuade the consumer and assist them to see a qualified diagnostician to obtain the diagnoses required for entry into MH or AODA treatment programs.

Not all Diagnoses are Included in the MH/AODA FS
Not every diagnosis is considered sufficient grounds for eligibility for MH/AODA programs. The DSM-IV includes some diagnoses that should not count toward eligibility for MH/AODA programs. Examples include intellectual disability, learning disorder, ADHD (attention deficit/hyperactivity disorder), or dementia.

If you encounter someone with a diagnosis not on this table whom you think should be eligible for MH/AODA programs, please contact your Screen Leader immediately, who will contact designated state staff.

Multiple Diagnoses Over Time
The same individual may be given different diagnoses by different psychiatrists at different times. Below are some guidelines to follow. These apply to psychiatric diagnoses made by psychiatrists or licensed psychologists only; diagnoses made by general MDs or others are not included in the MH/AODA Diagnoses table.

1. Diagnoses do not have to be from within the past year if they still seem applicable.
2. In general, use the most recent diagnoses.
3. When the individual received different diagnoses at different times, you have two choices:

   A. Check only the most recent diagnoses if earlier diagnoses seem no longer accurate or applicable.

   Example*: Paula was diagnosed with schizophrenia at age 17, but records indicate that her current psychiatrist considers that a misdiagnosis, and that Paula has PTSD, cyclothymic disorder, and dissociative disorder. You do not check schizophrenia on the MH/AODA FS.*

   B. Check all the diagnoses if you’re not sure which are the most accurate or whether or not they still apply.

   Screeners are not expected to make clinical decisions about whether or not a diagnosis is accurate or still applicable for an applicant. When you are not sure, go ahead and check the diagnosis in the table.

> ***Example**: Tony has a long list of diagnoses from encounters with psych hospitals and psychiatrists in numerous states, including schizophrenia, schizophreniform disorder, schizoid personality disorder, bipolar disorder, anxiety, psychosis NOS (not otherwise specified). You just met Tony, and you have no way of knowing which diagnoses are the most accurate, which do or do not still apply, or whether later diagnoses "override" earlier diagnoses. So you check them all.*

4. Note that "**history of**" or "**status post**" usually means that it is no longer applicable.

   Examples:
   - "History of apparent psychotic disorder 25 years ago, none since"
   - "History of paranoid schizophrenia, current diagnoses residual schizophrenia, alcoholism, and dementia"
   - "History of cocaine dependence 17 years ago, no use since"

Summary of MH/AODA Diagnoses

Check a Diagnosis on the MH/AODA Diagnosis Table When

- The diagnosis was made by a psychiatrist or licensed psychologist (for psychiatric diagnoses).
- You have the precise DSM-IV numeric code listed, or within a range listed, in the table.
- As far as you can tell (based on your professional expertise and/or lack of contrary evidence) the diagnosis still seems applicable.

Do NOT Check a Diagnosis on the MH/AODA Diagnosis Table When

- You have the diagnosis but not the DSM-IV numeric code (You could contact the diagnostician to request the diagnosis code).
- The diagnosis is a psychiatric or AODA diagnoses (even with DSM-IV numeric codes) that is **not** specified on this table.
- It is another mental, emotional, or behavioral diagnoses not specified on this table.
- It is an older MH/AODA diagnosis that no longer applies (especially if listed only as "history of" and not listed in current diagnoses as well).
- It was not made by a psychiatrist or licensed psychologist (for MI diagnoses).

If after review of medical records and contact with health care providers it is determined that a consumer has no diagnosis, the screener should choose the "No Diagnoses" box.

If an applicant refuses to see a health care professional and does not have any medical records that confirm a diagnosis, enter this information in the "Notes" field on the functional screen.

> ***Example**: "Mr. Smith has not been to the doctor in over four years and refuses to be seen by a health care provider."*

You will continue to carry out your normal professional responsibilities to help Mr. Smith get whatever assistance he needs. If he is in immediate danger, you might seek emergency detention for him. If not, you may continue to visit him and establish a relationship with him, such that eventually you can coax him into being seen by a psychiatrist or psychologist. You can then re-

do a MH/AODA FS for him, and he might then be eligible for MH/AODA programs. This process is not unlike what counties have always done in Wisconsin.

7.3 Global Assessment of Functioning (GAF)

The Global Assessment of Functioning is for reporting the clinicians judgment of the consumer's overall level of functioning. The GAF scale is to be rated with respect only to psychological, social, and occupational functioning. Do not include impairment in functioning due to physical or environmental limitations. In most instances, ratings on the GAF scale should be for the current period (i.e. the level of functioning at the time of the evaluation) because ratings of current functioning will generally reflect the need for treatment or care. If you are obtaining this information from a previous evaluation, please note the date of that evaluation in the Notes Section on the MH/AODA Diagnosis page of the screen.

The GAF does not have to be provided by a psychologist or psychiatrist because this does not affect eligibility for MH or AODA programs. This information should be provided by a qualified clinician who is familiar with using this measure, for example a Licensed Social Worker or a Licensed Professional Counselor.

7.4 "Other Diagnoses" Table

The "Other Diagnoses" table does not affect eligibility for MH or AODA programs. It is here to improve, at all levels from practitioners' awareness to county and state systems, the health and access to quality health care for people with mental illness and/or substance use problems. Research shows that the most effective services fully integrate healthcare with mental health and AODA treatment. Functional screen data will help counties and the state move toward more integrated and effective services for all.

Unlike the "Mental Health and AODA Diagnoses" table, the "Other Diagnoses" table is not meant to be all-inclusive; only some of the more common diagnoses are here. For convenience, the diagnoses are grouped by major categories (e.g., Pulmonary, Cardiovascular, Neurological).

If the applicant has no "other" diagnoses, check the "No Diagnoses" box.

Check all that apply, meaning all that are still applicable to the individual. Screeners are not expected to make clinical decisions about whether or not a previous condition still affects an applicant. When you are not sure, go ahead and check the diagnosis in the table. Still, some diagnoses are clearly only in the past and no longer applicable. A few examples include:

- Diagnoses preceded with "history of" or "status post" that are not also listed as current diagnoses.
- A fracture, burn, or wound months or years ago that is now fully healed with no residual impairments.
- A condition that was corrected by surgery or treatment, with no residual impairments.

Again, when in doubt, check the diagnosis on the "Other Diagnoses" table.

Screeners should NOT interpret the applicant’s complaints or symptoms. Instead, only check if you have a “verified diagnosis.”

> ***Example:*** *62-year-old Betty has diabetes and is complaining of increasingly poor vision. You only see a diagnosis of diabetes. You do NOT check "Cataracts/Glaucoma/Diabetic Retinopathy" based on Betty’s complaints, because it hasn’t been diagnosed yet.*

Medical information on a physical diagnosis only is “verified” if it is:

- Stated to screener by an MD, RN, or other health care professional, or
- Copied from recent health care records, or very clearly stated -in exact words--by the person, family, advocate, etc.

There are different requirements for a MH/AODA diagnosis, refer to the previous set of instructions for the complete description of a verifiable MH/AODA diagnosis.

MODULE 8: Completing the MH/AODA FS

8.1 Screen Completion Date

Indicate the date (mm/dd/yyyy) on which all sections of the functional screen were complete. It may take more than one day to complete all sections, especially if a screener must wait for information from health care providers. It is acceptable for one person to enter the demographic information (module 3) and for the certified screener to complete the clinical entries (module 4-7). However, all of the screen entry time should be combined and put under the certified screener's name.

When correcting information on a screen, do not change the "screen completion date." Enter the time it took to correct or update a screen. If you are simply making changes to the demographics (e.g., change of address), then enter "0". You must re-calculate eligibility after making screen corrections as required in section 8.8.

Note: The screen completion date is the date when all sections were completed by the certified screener, not the date information is entered into the computer.

Write all times as hours and minutes rounded to the nearest 15 minutes (00, 15, 30, 45). The functional screen application will sum them up for the total time.

8.2 Face-to-Face Contact with Person

This is the amount of time the screener spent face-to-face meeting with the applicant. Please round time to the nearest 15 minutes (00, 15, 30, 45).

8.3 Collateral Contacts

Either in-person or telephone contact with any other people, including family, advocates, providers, etc.

8.4 Paper Work

Includes review of medical documents, etc. Phone contact with the applicant should be included in this category. Please round time to the nearest 15 minutes (00, 15, 30, 45).

8.5 Travel Time

Time the screener spent traveling to and from appointments associated with the gathering of information necessary to complete the functional screen. Please round time to the nearest 15 minutes (00, 15, 30, 45).

8.6 Total Time to Complete Screen

The computer application will calculate and auto-enter this field based on your above entries.

8.7 Notes

Throughout all sections of the functional screen screeners may click on the “Notes” link on the left bar of the screen to enter notes. Notes should be dated and initialed by the screener

8.8 Calculating Eligibility and Level of Need

The act of calculating eligibility and level of need is the final step that makes a functional screen ‘complete’. This applies to new screens, or updates to existing screens.

When you enter a new screen, that screen will be considered ‘incomplete’ until eligibility is calculated. If there is no red check mark next to eligibility on the left-hand navigation bar, then the screen is currently ‘incomplete’. You must calculate eligibility to make this screen ‘complete’, which will show up as a red check mark next to eligibility on the left-hand navigation bar.

When you are making a change to an existing screen, there are some times when you must re-calculate eligibility, and some times when re-calculating eligibility is not required.

Any time you change any data which may cause a change in eligibility/level of need (i.e., a change to Community Living Skills or Risk Factors, etc.), you must re-calculate eligibility, even though the level of need results may not have changed. In addition, any time you make a change to applicant name, applicant SSN, or applicant birth date, eligibility must be re-calculated, even though these data items won’t have any affect on the level of need.

If you change any of the following information, you will not have to re-calculate eligibility:

- Applicant address
- Applicant phone number
- Applicant gender
- County/tribe of residence
- County of responsibility
- Directions
- Screener’s name
- Referral date
- Medical insurance
- Contact information

How can you tell when you need to re-calculate eligibility? ***Always check for the red check mark next to eligibility on the left-hand navigation bar***. If there is a red check mark, the screen is considered ‘complete’. No red check mark means the screen is considered ‘incomplete’.

Glossary of Acronyms

AA	Alcoholics Anonymous
AODA	Alcohol and Other Drug Abuse
APS	Adult Protective Services
BA	Bachelor of Arts
BS	Bachelor of Science
BRC	Blue Ribbon Commission
CBRF	Community-Based Residential Facility
CCS	Comprehensive Community Supports
CSP	Community Support Program
DD	Developmental Disability
DHS	Department of Health Services
DSM	Diagnostic and Statistical Manual
DUI	Driving Under the Influence
ED	Emergency Detention
ER	Emergency Room
FDD	Facility Serving People with Developmental Disabilities
FS	Functional Screen
GI	Gastrointestinal
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Management Organization
ICF-IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
IM	Intramuscular

IMD	Institution for Mental Disease
LTC	Long-Term Care
LTCFS	Long Term Care Functional Screen
LTS	Long-Term Supports
MAPP	Medicaid Purchase Plan
MD	Medical Doctor
MH	Mental Health
NA	Narcotics Anonymous
NOS	Not Otherwise Specified
OT	Occupational Therapist
OWI	Operating While Intoxicated
POAHC	Power Of Attorney for Health Care
PT	Physical Therapist
PTSD	Post Traumatic Stress Disorder
SSDI	Social Security Disability Income
SSI	Social Security Income
SSN	Social Security Number
TED	Tedgradcoman (anti-embolism)
UPC	Uniform Placement Criteria
VA	Veterans Assistance
W2	Wisconsin Works