



Level of Intensity Screening Tool (LIST)

Instruction Manual

Sacramento County Department of Health Services

Division of Behavioral Health services

Screening for High Intensity Services

A Level of Intensity Screening Tool (LIST) is completed when clinically indicated to help screen and support intensity of service need recommendations for a new client referred to a Full Service Partnership (FSP) Program in the Sacramento County Mental Health Plan (MHP), or request higher level of care from an existing MHP client.

Full Service Partnership Programs support clients with high intensity mental health needs. The FSP consists of a team of mental health professionals and other service providers. Services may include:

- Individual, group and/or family counseling
- Skill building/social Rehabilitation
- 24/7 Crisis Intervention Support
- Peer support from individuals who have experienced similar issues
- Transportation
- Support with access to physical health care
- Support with access to follow up legal appointments
- Help finding suitable/stable housing and paying rental subsidies when necessary
- Help getting the financial and health insurance benefits to which they are entitled
- Assisting family members as needed
- Assisting with education and/or employment
- Support with probation and other community partners
- Support with linkage to Substance Use Prevention and Treatment (SUPT) services
- Support when discharging from incarceration or hospitals
- Ongoing medication and psychiatric support services

In order to be admitted to an FSP, clients must meet the following criteria:

- Meet Specialty Mental Health Criteria
- Medi-Cal eligible
- Capable of living in the community but whose impairment requires frequent contact and support
- Eligible for high intensity services. Eligibility may include:
 - Recurrent incarcerations
 - Recurrent hospitalizations
 - Homeless or imminently at risk of homelessness
 - History of attempts to succeed in the Mental Health System
 - Other factors that impact mental health
 - Eligibility will be determined on a case-by-case basis, in conjunction with risk factors

Please see the intensity mapping for adult providers and service grid for children, TAY and adult providers.

What is the Level of Intensity Services Screening Tool

The LIST is designed as a dynamic screening tool to support justification of an individual's potential need of high intensity services and linkage to a FSP program. LIST cannot be completed when a client's condition is medically and/or psychiatrically acute or the client has a significant head trauma, or developmental disability. Criteria are endorsed on a here and now basis, representing the clinical picture at the time of completion. In some of the parameters, historical information is considered, but it should not be considered unless it is a clear part of the defined item. Clinical justification/rationale for each risk factor should be documented in the screening tool.

Instruction for Completing the Tool

1. The LIST packet contains: Referral Form, the Screening Tool, Specialty FSPs criteria, Homeless Checklist, Multi-System Team (MST) Release (for Community Justice Support Program (CJSP)) and a general Release of Information (ROI).
2. The Referral Form is designed to gather individual's demographic data, cultural background, current mental health provider, history of co-occurring issues, insurance and benefits and the current place residing.
3. "Primary Diagnosis and Presenting Symptoms" on the Referral Form needs to be filled out.
4. Complete each domain on the screening tool, marking all the criteria that apply. An incomplete screening tool may be returned for additional information. If a question does not apply or is unknown, simply mark N/A or unknown.
5. Each domain is composed of a series of criteria which have three levels of intensity: severe, moderate and mild. Only one intensity score will be given per criteria. E.g. If a criterion is endorsed in both moderate (2) and severe (3), the number associated with the highest intensity will be given. Select "N/A" if the criteria does not apply to the client.
6. Check which Collateral Documents are attached. **Level of Intensity Screening Tools without collateral documents will not be accepted.**
7. Additional information describing all risk factors checked needs to be provided in the designated sections.
8. For specialty Full-Service Partnership programs such as Sierra Elder Wellness Program (SEWP) or Transitional Age Youth Full-Service Partnership (TAY FSP), make sure to check the eligibility section on page 3 of the LIST.

9. If the individual is experiencing homelessness, please complete the Homeless Checklist.
10. For CJSP referrals, in addition to the screening tool, the MST release should be completed.
11. The assigned provider will conduct a comprehensive housing needs assessment to determine most appropriate housing services and supports.

Definitions of the Domains

Clinical Complexity:

This domain recognizes that a person's past experience provides indication of how that person is likely to respond to in future similar circumstances. Past experiences such as responsiveness to treatment exposure, managing recovery via taking psychotropic medications, and frequency of hospitalizations can be predictor of future response to treatment and must be considered in determining service needs and recovery plan.

Psychiatric Hospitalizations:

Number of psychiatric hospitalizations can be an indicator if previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms or no significant success or recovery period has been achieved. Please mark the corresponding frequency of hospitalizations the individual has experienced in the last year. If client is currently in a sub-acute placement, please mark Severe (3).

Past exposure to & use of treatment:

Screen for responsiveness to mental health treatment exposure, both inpatient and outpatient services, and its success in managing recovery. For example: if a client is receiving 2 services a week and still struggling to maintain recovery, this might indicate that they may benefit from receiving high intensity services.

- Do not consider treatment and recovery within a narrow frame, such as whether an individual is "medication adherent" only or whether an individual attends groups. Discuss how the individual defines recovery and consider all aspects.
- Be cautious about stating "denies mental illness" as an indicator for a high score. Ask an individual why s/he is receiving SSI; ask about medications and symptoms and how that relates to daily life; if there is a perceived stigma, isolation, humiliation for a diagnosis.
- For a chronic condition, there may never be a remission of symptoms. However, consider how the individual has progressed in their recovery in terms of coping or thriving despite the symptoms.

Level of Engagement:

Engagement pertains to a person's understanding of and willingness to engage in mental health treatment. Also, factors such as identification and acceptance of needs, stage in the change process, ability to trust others and accept assistance, interaction with treatment opportunities, and ability to take responsibility for recovery should be considered in this domain. If client has never received services prior to this referral, please mark N/A.

Risk Factors:

This section of the tool considers a person's potential to cause significant harm to self or others. While this may most frequently be due to suicidal or homicidal thoughts or intentions, in many cases unintentional harm may result from misinterpretations of reality, from inability to adequately care for oneself, or from altered states of consciousness due to use of intoxicating substances in an uncontrolled manner.

Deficits in ability to care for oneself are considered only in the context of their potential to cause harm.

Likewise, only behaviors associated with substance use are used to rate risk of harm, not the substance use itself.

For this domain, we are requesting a written description in the "Describe all risk factors checked (needs to be filled out)" box. This box should include information about the of the behaviors related to the endorsed severity of the risk factors. Additional collateral documentation (progress notes, assessments, etc.) should include information about the risk factors as well.

Suicidal/Homicidal Ideation:

Screen for recent or current active suicidal/homicidal ideation, intent, or plan. Please note that client needs to be assessed for 5150 criteria if currently endorsing suicidal ideation with plan and means.

Danger to Self or Others:

In this section we look at a person's potential to cause significant harm to self or others. Consider lethality associated with behavior. Questions to ask: What is the risk of harm related to suicidal and/or homicidal behavior? Is there a plan? Is he/she able to contract for safety? If there is a history of suicidal or homicidal threats or attempts that occurred more than one month ago, please mark mild (1). If no history of suicidal or homicidal threats or attempts, please mark N/A.

Self-neglect:

In this section, we have to consider if the self-neglect is necessitating urgent medical or psychiatric intervention. Self-care under Risk Factors domain should be tied to lethality and have evidence to support. Impairments and/or behaviors such as poor hygiene, medication non-adherence, and/or not keeping appointments do not necessitate a high score for harmful behavior in and of itself.

History of Incarceration/ Criminal justice involvement:

Inability to maintain community functioning and mental health recovery due to incarceration is another indicator that client might benefit from receiving high intensity services. Criminal justice involvement includes incarcerations in addition to being on parole or probation, having a 290 status, etc.

High Risk behavior/ Impulsivity

Degree to which the client's perceptions, judgment and/or impulse control is impaired, creating danger for them or others. High-risk behaviors are defined as acts that increase the risk of disease or injury, which can subsequently lead to disability, death, or social problems. Some examples of high-risk behaviors include physical self-harm, violence, risky sexual behaviors, and fire setting. High-risk behaviors include, impulsive, and reckless behaviors. Physical self-harm can be cutting, pulling out hair, burning, scratching, or any other bodily harm.

Life Circumstances:

This domain focuses on the degree to which a person is able to fulfill social responsibilities, interact with others, maintain their physical functioning (such as sleep, appetite, energy, etc.), as well as a person's capacity for self-care. If such deficits are severe enough that they place the client at risk of harm, they will be considered when rating Risk of Harm. This domain additionally focuses on supports available for clients to access including resources in the community, family and natural supports. Persons being treated in locked or otherwise protected residential settings should be rated based on the conditions they would encounter outside that setting prior to a transition to a new or pre-existing living situation. This will ensure that adequate support and personal resources are in place to protect against more stressful environments prior to the transition.

Current Housing Status:

This section defines the client's category of homelessness based on the Department of Housing and Urban Development (HUD) guidelines. Below are the three categories of homelessness:

Chronic Homelessness: Individual or family who is currently sleeping in an emergency shelter, hotel/motel paid by the County or social services Contractor, or location not meant for human habitation and meets the 4 requirements for chronic homeless status. Chronic homeless status requires that the client lacks a regular fixed nighttime residence and has continuously lived in a place not meant for human habitation, including emergency homeless shelters, for at least 12 months consecutively or at least on 4 separate occasions adding up to 12 months in the last 3 years. For example: Client may be living in an unconverted garage or trailer, without connection to water or electricity and meets the duration requirements for chronic homeless status.

Literal homelessness: Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

1. Has a primary nighttime residence that is a public or private place not meant for human habitation; **or**
2. Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); **or**
3. Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Please note that if client's housing being paid fully by a MH provider or other agencies, the client is considered homeless.

Imminent Risk of Homelessness: An individual or family who without intervention or change in circumstances, will likely lose housing in the next 14 days and homeless prevention services are required to preserve current housing or obtain alternative permanent housing. Client may be living in their own home, living with family/friends or "couch surfing" with a required move-out date within the next 14 days such as an unresolved formal eviction notice. Interventions are permissible prior to receiving a required move out date if it is clear that the intervention will prevent an official notice to move and there are no other resources available.

Relationships/Supports:

We need to determine if the individual relies on behavioral health system for resources and support. Supportive elements in the environment are resources which enable persons to maintain health and role functioning in the face of stressful circumstances, such as availability of adequate material resources and relationships with family members. The availability of friends, employers or teachers, clergy and

professionals, and other community members that provide caring attention and emotional comfort, are also sources of support. Questions to ask: Are supports available & are they willing/able to participate? What is the ability of the individual to engage or use supports?

Level of support with case management needs:

Consider an individual's ability to fulfill obligations at work, school, home, etc. Also, individual's ability to interact with others. Compare current behavior to a baseline behavior and functioning level. Is there an acute change in their status? Is presentation chronic? Also, focus on psychiatric or addictive causes for functional deficits not physical disabilities. Questions to ask: How well is the individual sleeping, eating, and maintaining his/her physical health? How is this individual able to maintain responsibilities such as interacting with peers and/or family or other support systems? If the individual able to perform close to usual standards in school, work, parenting, or other obligations? Is the individual neglecting these responsibilities completely on a frequent basis or for an extended period of time?

Co-morbidity:

This domain screens for potential complications in recovery due to level of acuity or disability related to co-occurring medical illness, substance use disorder, and/or psychiatric disorder in addition to the primary psychiatric diagnosis identified. The presence of co-occurring conditions, when sufficiently unstable or severe, may prolong the course of illness in some cases, or may necessitate more intensive or more closely monitored services in other cases. Consult with medical team to support in rating this domain.

Medical Conditions:

Co-morbid medical concerns must be considered in the context of how the medical diagnosis impacts the psychiatric condition/treatment of an individual. Do not make assumptions such as, "If they do not take their high blood pressure medication, they could have a heart attack or a stroke." These are currently co-existing illnesses – do not consider history unless current situation makes reactivation likely.

Substance Use

When evaluating substance use, it is the current presentation of an individual at the time of assessment not what is "predicted to happen if...". Consider how the co-morbid addictive behaviors impact the psychiatric disorder. Please note that physical withdrawal is considered to be a medical co-morbidity.

Additional information/ Level of Care Recommendation (needs to be filled):

Please include additional information that may have not been previously discovered or anything that can be helpful with determining client's needs. For the level of care recommendation, the rationale should express specifically why a level of care intensity is being recommended. Please include how this level of care recommendation will assist this individual's recovery in reducing, stabilizing, and improving behaviors that were addressed in the preceding domains.

Scoring

Please note that score is just one indication of level of need. Level of care will be determined by county based on collateral information, client's risk factors, level of need and functioning and LIST final score.

If score indicates that client meets the criteria for linking to Managed Care Plans, follow the steps outlined in COUNTY P&P ([Transition of Care Tool for Medi-Cal Mental Health Services](#)) if applicable.

Instructions for Submitting the Tool

Referrals will be processed through Sacramento County Intensive Placement Team (IPT).

1. Please complete the LIST (paper or electronic version) and fax or e-fax the tool and collateral documents to IPT at (916) 854-8824 or DHS-Fax-MH-IPT@SacCounty.gov.
2. The FSP contract monitors will determine appropriateness based on the completed LIST, review of collateral documents attached, consultation with referring provider staff, as needed, and client interview, as needed. Client will be linked to the appropriate mental health provider based off intensity of needs identified in the LIST.
3. IPT will complete inquiry in SmartCare and refer the client to the approved program, as determined by the FSP contract monitors.