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LEVEL OF CARE UTILIZATION SYSTEM
FOR
PSYCHIATRIC AND ADDICTION SERVICES

Adult Version 2010

AMERICAN ASSOCIATION
OF COMMUNITY PSYCHIATRISTS

© 1996-2009 American Association of Community Psychiatrists

LOCUS DEFINED

LOCUS is an acronym for

LEVEL OF CARE UTILIZATION SYSTEM

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History

- Developed by the American Association of Community Psychiatrists (AACMP) in response to the emerging need for a replicable, reliable and standardized level of care determination tool.
- Development began in 1995 through a review of existing patient placement practices and clinical experience.

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LOCUS GOAL

To consistently guide decisions that match clients' needs with the correct level of care or intensity of services available

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LOCUS Principles

LOCUS developed on improving upon medical necessity criteria instruments previously in use

Simple
- easy to Understand

Dimensional
- contains a method for systematic consideration of relevant variables

Concise
- limiting redundancies and irrelevant detail

Quantifiable
- facilitating communication, interactivity, consistency and gives ability to track changes over time

Integrated
- provides a valid recommendation regardless of diagnosis or co-morbidities

Flexible
- adaptable to a variety of service systems and locations

Consumer Centered
- based on defining individual needs

Empowering
- Allows for inclusion of consumer input in level of care decisions

Reliable & Valid
- Proven reliable instrument that is capable of consistent and replicable recommendations

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Inter-rater Reliability

Reliability Testing of LOCUS consisted of ratings of ten 700 to 900 word case vignettes by ten clinician reviewers with varying mental health and training backgrounds.

The interclass correlation coefficient (ICC) for placement recommendations was at the high end of the "good" range at .68

(Sowers, W., et al 2003)

LOCUS in Use

LOCUS has been a well received instrument by clinicians and mental health systems.

Currently LOCUS is in use in Minnesota, Nevada, Illinois, District of Columbia, Connecticut, New Jersey and Maine.

LOCUS is in frequent use for Utilization Review activities, prior authorization and limiting overuse of services in various levels of care

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Context of Use

LOCUS can be used to determine Eligibility, Admission, Continued Stay, Readiness for Discharge and to aid in treatment planning and needs assessment.

LOCUS is an effective managed care instrument that compliments existing utilization review processes and aids in standardizing service payment decisions for both payer organizations and providers.

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LOCUS does not

- Prescribe program design (although LOCUS does specify components of care levels commonly associated with positive clinical outcomes)
- Specify Treatment Interventions (Does suggest intensity and restrictiveness)
- Replace or invalidate clinical judgment (LOCUS in fact augments clinical judgment and prior clinical decisions)
- Limit Creativity

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LOCUS should not be used as a stand alone factor in the determination of service provision

A current, complete and competent assessment or clinician knowledge of documented clinical information is necessary for appropriate completion of LOCUS

LOCUS is best used concurrently with existing and already established level of care determination practices

LOCUS provides a link between clinical staff and payer organizations by providing an evidence based clinical assessment of need

LOCUS can assist clinicians and treatment teams to make informed level of care decisions for their patients

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Once a clinician is experienced in use of LOCUS, LOCUS can be functionally and reliably administered in about 15 minutes

Reliable and functional use is largely dependent upon the quality and content of the most current assessment as well as the clinical and psychosocial knowledge the clinician has about the patient

The ability to adequately interpret the assessment of other clinicians and gather clinical data increases the reliability of LOCUS outcomes

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LOCUS COMPOSITION & STRUCTURE

LOCUS is comprised of six assessment parameters or domains with one domain consisting of two subscales

Each patient assessment requires the completion of seven domains. LOCUS users must complete scoring in all domains to achieve a composite score and level of care recommendation.

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Scoring the LOCUS

Scoring

- The composite Score is comprised of 6 dimensions, 7 scores

- Highest possible score for each dimension is 5
  Must evaluate the client as he or she is now (current state functionality and symptomotology)

- Patient in residential facility? Strip away supports (How would they fare with developed skills related to level of recovery)

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Individual scores in each domain can be used as indicators for intervention and treatment planning without the need to be linked with level of care determinations.

DOMAIN STRUCTURE

Each domain is rated on a scale from 1 to 5 with specific criteria for each increment rating. Sub-criteria consists of between one and seven line items specific to the behaviors, issues or symptoms which exist to validate a score within the domain. Specifity and accuracy is not necessary for clinicians to obtain an correct rating in each domain.

A composite score from 7 to 35 is obtained and weighs predominantly in the determination of level of care recommendations

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SIX DOMAINS

The six domains in LOCUS are

-Risk of Harm-

-Functional Status-

-Medical, Addictive and Psychiatric Co-Morbidity-

-Recovery Environment-

-Treatment and Recovery History-

-Engagement-

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Domain One: RISK OF HARM

- This dimension 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
- For the purposes of evaluation in this parameter, deficits in ability to care for self are considered only in the context of their potential to cause harm.
- Only behaviors associated with substance use are used to rate risk of harm, not the substance use itself.
- Other factors may be considered in determining the likelihood of such behavior such as; past history of dangerous behaviors, ability to contract for safety, and availability of means.
- When considering historical information, recent patterns of behavior should take precedence over patterns reported from the remote past.

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Risk of harm is rated according to the following criteria:

1 - Minimal risk of harm

- a) No indication of suicidal or homicidal thoughts or impulses, and no history of suicidal or homicidal ideation, and no indication of significant distress.
- b) Clear ability to care for self now and in the past.

2 - Low risk of harm

- a) No current suicidal or homicidal ideation, plan, intentions or severe distress, but may have had transient or passive thoughts recently or in the past.
- b) Substance use without significant episodes of potentially harmful behaviors.
- c) Periods in the past of self-neglect without current evidence of such behavior.

3 - Moderate risk of harm

- a) Significant current suicidal or homicidal ideation without intent or conscious plan and without past history
- b) No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists.
- c) History of chronic impulsive suicidal/homicidal behavior or threats and current expressions does not represent significant change from baseline.
- d) Binge or excessive use of substances resulting in potentially harmful behaviors without current involvement in such behavior.
- e) Some evidence of self neglect and/or compromise in ability to care for oneself in current environment.

4 - Serious risk of harm

- a) Current suicidal or homicidal ideation with expressed intentions and/or past history of carrying out such behavior but without means for carrying out the behavior, or with some expressed inability or aversion to doing so, or with ability to contract for safety.
- b) History of chronic impulsive suicidal/homicidal behavior or threats with current expressions or behavior representing a significant elevation from baseline.
- c) Recent pattern of excessive substance use resulting in disinhibition and clearly harmful behaviors with no demonstrated ability to abstain from use.
- e) Clear compromise of ability to care adequately for oneself or to be adequately aware of environment.

5 - Extreme risk of harm

- a) Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior…
  - Without expressed ambivalence or significant barriers to doing so, or
  - With a history of serious past attempts which are not of a chronic, impulsive or consistent nature, or
  - In presence of command hallucinations or delusions which threaten to override usual impulse control.
- b) Repeated episodes of violence toward self or others, or other behaviors resulting in harm while under the influence of intoxicating substances with pattern of nearly continuous and uncontrolled use.
- c) Extreme compromise of ability to care for oneself or to adequately monitor environment with evidence of deterioration in physical condition or injury related to these deficits.

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Domain Two: Functional Status

- This dimension measures the degree to which a consumer is able to fulfill social responsibilities, to interact with others, maintain optimal functioning, as well as a consumer’s capacity for self care.
- This ability should be compared against an ideal level of functioning given an individual’s limitations, or may be compared to a baseline functional level as determined for an adequate period of time prior to onset of this episode of illness.
- Consumers with chronic deficits who do not experience any acute changes in their status are the only exception to this rule and are given a rating of three.
- If such deficits are severe enough that they place a client at risk of harm, they will be considered when rating Dimension I in accord with the criteria elaborated there.
- For the purpose of this document, sources of impairment should be limited to those directly related to psychiatric and/or addiction problems that the individual may be experiencing. While other types of disabilities may play a role in determining what types of support services may be required, they should generally not be considered in determining the placement of a given individual in the behavioral treatment continuum.

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Functional Status is rated according to the following criteria

1 - Minimal Impairment

a) No more than transient impairment in functioning following exposure to an identifiable stressor

2 - Mild Impairment

a) Experiencing some deterioration in interpersonal interactions, with increased incidence of arguments, hostility or conflict, but is able to maintain some meaningful and satisfying relationships.

b) Recent experience of some minor disruptions in aspects of self care or usual activities.

c) Developing minor but consistent difficulties in social role functioning and meeting obligations such as difficulty fulfilling parental responsibilities or performing at expected level in work or school, but maintaining ability to continue in those roles.

e) Demonstrating significant improvement in function following a period of deterioration.

3 - Moderate Impairment

a) Becoming conflicted, withdrawn, alienated or otherwise troubled in most significant relationships, but maintains control of any impulsive or abusive behaviors.

b) Appearance and hygiene may fall below usual standards on a frequent basis.

c) Significant disturbances in vegetative activities such as sleep, eating habits, activity level, or sexual appetite which do not pose a serious threat to health.

d) Significant deterioration in ability to fulfill responsibilities and obligations to job, school, self, or significant others and these may be avoided or neglected on some occasions.

e) Chronic and/or variably severe deficits in interpersonal relationships, ability to engage in socially constructive activities, and ability to maintain responsibilities.

f) Recent gains and or stabilization in function have been achieved while participating in treatment in a structured and /or protected setting.

4 - Serious Impairment

a) Serious deterioration of interpersonal interactions with consistently conflictual or otherwise disrupted relations with others, which may include impulsive or abusive behaviors.

b) Significant withdrawal and avoidance of almost all social interaction.

c) Consistent failure to maintain personal hygiene, appearance, and self care near usual standards.

d) Serious disturbances in vegetative status such as weight change, disrupted sleep, or fatigue that threaten physical well being.

e) Inability to perform close to usual standards in school, work, parenting, or other obligations and these responsibilities may be completely neglected on a frequent basis or for an extended period of time.

5 - Severe Impairment

a) Extreme deterioration in social interactions which may include chaotic communication, threatening behaviors with little or no provocation, or minimal control of impulsive or abusive behavior

b) Development of complete withdrawal from all social interactions.

c) Complete neglect of personal hygiene and appearance and inability to attend to most basic needs such as food intake and personal safety with associated impairment in physical status.

d) Extreme disruptions in vegetative function causing serious harm to health and well being.

e) Complete inability to maintain any aspect of personal responsibility as a citizen, or in occupational, educational, or parental roles.

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Domain Three: Medical, Addictive, and Psychiatric Co-Morbidity

- This dimension measures potential complications in the course of illness related to co-existing medical illness, substance use disorder, or psychiatric disorder in addition to the condition first identified or most readily apparent (here referred to as the presenting disorder).
- Co-existing disorders may prolong the course of illness in some cases, or may necessitate availability of more intensive or more closely monitored services in other cases.
- Unless otherwise indicated, historical existence of potentially interacting disorders should not be considered in this parameter unless current circumstances would make reactivation of those disorders likely.
- For patients who present with substance use disorders, physiologic withdrawal states should be considered to be medical co-morbidity for scoring purposes.

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Medical, Addictive, and Psychiatric Co-Morbidity is rated according to the following criteria

1 - No Co-morbidity

a) No evidence of medical illness, substance use disorders, or psychiatric disturbances apart from the presenting disorder

b) Any illnesses that may have occurred in the past are now stable and pose no threat to the stability of the current condition.

2 - Minor Co-morbidity

a) Existence of medical problems which are not themselves immediately threatening or debilitating and which have no impact on the course of the presenting disorder

b) Occasional episodes of substance misuse, but any recent episodes are self limited, show no pattern of escalation, and there is no indication that they adversely affect the course of any co-existing psychiatric disorder.

c) May occasionally experience psychiatric symptoms which are related to stress, medical illness, or substance use, but which are transient and have no discernable impact on the co-existing substance use disorder.

3 - Significant Co-morbidity

a) Medical conditions exist, or have potential to develop (such as diabetes or a mild physiologic withdrawal syndrome), which may require significant medical monitoring.

b) Medical conditions exist which may be adversely affected by the existence of the presenting disorder.

c) Medical conditions exist which may adversely affect the course of the presenting disorder.

d) Ongoing or episodic substance use occurring despite adverse consequences with significant or potentially significant negative impact on the course of any co-existing psychiatric disorder.

e) Recent substance use which has had clearly detrimental effects on the presenting disorder but which has been temporarily arrested through use of a highly structured or protected setting or through other external means.

f) Significant psychiatric symptoms and signs are present which are themselves somewhat debilitating, and which interact with and have an adverse affect on the course and severity of any co-existing substance use disorder.

4 - Major Co-morbidity

a) Medical conditions exist, or have a very high likelihood of developing (such as a moderate, but uncomplicated, alcohol, sedative, or opiate withdrawal syndrome, mild pneumonia, or uncontrolled hypertension), which may require intensive, although not constant, medical monitoring.

b) Medical conditions exist which are clearly exacerbated by the existence of the presenting disorder.

c) Medical conditions exist which are clearly detrimental to the course and outcome of the presenting disorder.

d) Uncontrolled substance use occurs at a level, which poses a serious threat to health if unabated, and/or which poses a serious barrier to recovery from any co-existing psychiatric disorder.

e) Psychiatric symptoms exist which are clearly debilitating and which interact with and seriously impair ability to recover from any co-existing substance use disorder.

5 - Severe Co-morbidity

a) Significant medical conditions exist which may be poorly controlled and/or potentially life threatening in the absence of close medical management (e.g., severe or complicated alcohol withdrawal, uncontrolled diabetes mellitus, complicated pregnancy, severe liver disease, debilitating cardiovascular disease).

b) Presence and lack of control of presenting disorder places client in imminent danger from complications of existing medical problems.

c) Uncontrolled medical condition severely exacerbates the presenting disorder, dramatically prolonging the course of illness and seriously impeding the ability to recover from it.

d) Severe substance dependence with inability to control use under any circumstance with intense withdrawal symptoms and /or continuing use despite clear exacerbation of any co-existing psychiatric disorder and other aspects of well being.

e) Acute or severe psychiatric symptoms are present which seriously impair client’s ability to function and prevent recovery from any co-existing substance use disorder, or seriously exacerbate it.

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Domain Four: Recovery Environment

- This dimension considers factors in the environment that may contribute to the onset or maintenance of addiction or mental illness, and factors that may support a consumer's efforts to achieve or maintain mental health and/or abstinence.
- Stressful circumstances may originate from multiple sources and include interpersonal conflict or torment, life transitions, losses, worries relating to health and safety, and ability to maintain role responsibilities.
- Supportive elements in the environment are resources which enable consumers 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, which provide caring attention and emotional comfort, are also sources of support.
- For consumers being treated in residential settings, ratings should be based on the conditions which would be encountered upon transitioning to a new or returning to the usual environment, whichever is most appropriate to the circumstances.

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Recovery Environment is rated according to the following criteria

A) Level of Stress

1 - Low Stress Environment

a) Essentially no significant or enduring difficulties in interpersonal interactions and significant life circumstances are stable.
b) No recent transitions of consequence.
c) No major losses of interpersonal relationships or material status have been experienced recently.
d) Material needs are met without significant cause for concern that they may diminish in the near future, and no significant threats to health or safety are apparent.
e) Living environment poses no significant threats or risk.
f) No pressure to perform beyond capacity in social role.

2 - Mildly Stressful Environment

a) Presence of some ongoing or intermittent interpersonal conflict, alienation, or other difficulties.
b) A transition that requires adjustment such as change in household members or a new job or school.
c) Circumstances causing some distress such as a close friend leaving town, conflict in or near current habitation, or concern about maintaining material well being.
d) A recent onset of a transient but temporarily disabling or debilitating illness or injury.
e) Potential for exposure to alcohol and/or drug use exists.
f) Performance pressure (perceived or actual) in school or employment situations creating discomfort.

3 - Moderately Stressful Environment

a) Significant discord or difficulties in family or other important relationships or alienation from social interaction.
b) Significant transition causing disruption in life circumstances such as job loss, legal difficulties or change of residence.
c) Recent important loss or deterioration of interpersonal or material circumstances.
e) Concern related to sustained decline in health status.
f) Danger in or near habitat.
g) Easy exposure and access to alcohol and drug use.
h) Perception that pressure to perform surpasses ability to meet obligations in a timely or adequate manner.

4 - Highly Stressful Environment

a) Serious disruption of family or social milieu which may be due to illness, death, divorce or separation of parent and child, severe conflict, torment and/or physical or sexual mistreatment.
b) Severe disruption in life circumstances such as imminent incarceration, lack of permanent residence, or immersion in an alien culture.
c) Inability to meet needs for physical and/or material well being.
d) Recent onset of severely disabling or life threatening illness.
e) Difficulty avoiding exposure to active users and other pressures to partake in alcohol or drug use.
f) Episodes of victimization or direct threats of violence near current home.
g) Overwhelming demands to meet immediate obligations are perceived.

5 - Extremely Stressful Environment

a) An acutely traumatic level of stress or enduring and highly disturbing circumstances disrupting ability to cope with even minimal demands in social spheres such as:
- ongoing injurious and abusive behaviors from family member(s) or significant other.
- witnessing or being victim of extremely violent incidents perpetrated by human malice or natural disaster.
- persecution by a dominant social group.
- sudden or unexpected death of loved one.

b) Unavoidable exposure to drug use and active encouragement to participate in use.
c) Incarceration or lack of adequate shelter.
d) Severe pain and/or imminent threat of loss of life due to illness or injury
e) Sustained inability to meet basic needs for physical and material well being;
f) Chaotic and constantly threatening environment.

Domain Five: Treatment & Recovery History

- This dimension recognizes that a client's historical experience provides some indication of how that client is likely to respond to similar circumstances in the future.
- While it is not possible to codify or predict how an individual consumer may respond to any given situation, this scale uses past trends in responsiveness to treatment exposure and past experience in managing recovery as its primary indicators.
- Although the recovery process is a complex concept, for the purposes of rating in this parameter, recovery is defined as a period of stability and good control of symptoms.
- While it is important to recognize that some clients will respond well to some treatment situations and poorly to others, and that this may in some cases be unrelated to level of intensity, but rather to the characteristics and attractiveness of the treatment provided, the usefulness of past experience as one predictor of future response to treatment must be taken into account in determining service needs.
- Most recent experiences in treatment and recovery should take precedence over more remote experiences in determining the proper rating.

Treatment & Recovery History is rated according to the following criteria

1 - Fully Responsive to Treatment and Recovery Management

a)There has been no prior experience with treatment or recovery.

b) Prior experience indicates that efforts in all treatments that have been attempted have been helpful in controlling the presenting problem.

c) There has been successful management of extended recovery with few and limited periods of relapse even in unstructured environments or without frequent treatment.

2 - Significant Response to Treatment and Recovery Management

a) Previous or current experience in treatment has been successful in controlling most symptoms but intensive or repeated exposures may have been required.

b) Recovery has been managed for moderate periods of time with limited support or structure.

3 - Moderate or Equivocal Response to Treatment and Recovery Management

a) Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms.

b) Previous treatment exposures have been marked by minimal effort or motivation and no significant success or recovery period was achieved.

c) Equivocal response to treatment and ability to maintain a significant recovery.

d) At least partial recovery has been maintained for moderate periods of time, but only with strong professional or peer support or in structured settings.

4 - Poor Response to Treatment and Recovery Management

a) Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms even with intensive and/or repeated exposure.

b) Attempts to maintain whatever gains that can be attained in intensive treatment have limited success, even for limited time periods or in structured settings.

5 - Negligible Response to Treatment

a) Past or current response to treatment has been quite minimal, even with intensive medically managed exposure in highly structured settings for extended periods of time.

b) Symptoms are persistent and functional ability shows no significant improvement despite this treatment exposure.

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Domain Six: Engagement

- This dimension considers the individual's understanding of illness and treatment and ability or willingness to engage in the treatment and recovery process.
- Factors such as acceptance of illness, motivation for change, ability to trust others, interaction with treatment opportunities, and ability to take responsibility for recovery should be considered in defining the measures for this dimension.
- These factors will likewise impact a consumer's ability to be successful at a given level of care.

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Engagement is rated according to the following criteria

1 - Optimal Engagement

a) Complete understanding and acceptance of illness and its affect on function.
b) Shows strong desire to change.
c) Is enthusiastic about treatment, is trusting, and shows strong ability to utilize available resources.
e) Understands recovery process and personal role in a successful recovery plan.

2 - Positive Engagement

a) Significant understanding and acceptance of illness and attempts to understand its affect on function.
b) Willingness to change.
c) Engages in treatment in a positive manner, capable of developing trusting relationships, and will use available resources independently when necessary.
e) Shows some recognition of personal role in recovery and accepts some responsibility for it.

3 - Limited Engagement

a) Some variability or equivocation in acceptance or understanding of illness and disability.
b) Has limited desire or commitment to change.
c) Relates to treatment with some difficulty and establishes few, if any, trusting relationships.
d) Does not use available resources independently or only in cases of extreme need.
e) Has limited ability to accept responsibility for recovery.

4 - Minimal Engagement

a) Rarely, if ever, able to accept reality of illness or any disability which accompanies it.
b) Has no desire to adjust behavior.
c) Relates poorly to treatment and treatment providers and ability to trust is extremely narrow.
d) Avoids contact with and use of treatment resources if left to own devices.
e) Does not accept any responsibility for recovery.

5 - Unengaged

a) No awareness or understanding of illness and disability.
b) Inability to understand recovery concept or contributions of personal behavior to disease process.
c) Unable to actively engage in treatment and has no current capacity to relate to another or develop trust.
d) Extremely avoidant, frightened, or guarded.

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Hints

Can’t decide between two scores, go with the higher score, erring on the side of clinical caution

Always make scoring decisions on most recent information, events, data or outcomes. Be fair to the patient, give credit for progress and don’t play the “what if” game

You will have better level of care recommendation outcomes using a primary presenting issue to complete the evaluation: e.g. Dually Diagnosed – choose one

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Score Sheet

Client Name:	Date:

Scores					
Dimension I	1☐	2☐	3☐	4☐	5☐
Dimension II	1☐	2☐	3☐	4☐	5☐
Dimension III	1☐	2☐	3☐	4☐	5☐
Dimension IV	1☐	2☐	3☐	4☐	5☐
Dimension IVB	1☐	2☐	3☐	4☐	5☐
Dimension V	1☐	2☐	3☐	4☐	5☐
Dimension VI	1☐	2☐	3☐	4☐	5☐
COMPOSITE SCORE					

Placement Grid Level of Care(LOC)	1☐ 2☐ 3☐ 4☐ 5☐ 6☐
Clinician Recommended (LOC)	1☐ 2☐ 3☐ 4☐ 5☐ 6☐

Signature and Credentials of Assessor ______________________________

LEVEL OF CARE DETERMINATION GRID

Dimensions \ Level of Care	Recovery Maintenance Health Management Level 1	Low Intensity Community Based Services Level 2	High Intensity Community Based Services Level 3	Medically Monitored Non-Residential Services Level 4	Medically Monitored Residential Services Level 5	Medically Managed Residential Services Level 6
I. Risk of Harm	2 or less	2 or less	3 or less	3 or less	④ 3	⑤ 4
II. Functional Status	2 or less	2 or less	3 or less	3 or less	④* 3	⑤ 4
III. Co-Morbidity	2 or less	2 or less	3 or less	3 or less	④* 3	⑤ 4
IV A. Recovery Environment "Stress"	Sum of IV A + IV B is 4 or less	Sum of IV A + IV B is 5 or less	Sum of IV A + IV B is 5 or less	3 or 4	4 or more	4 or more
IV B. Recovery Environment "Support"				3 or less	4 or more	4 or more
V. Treatment & Recovery History	2 or less	2 or less	3 or less	3 or 4	3 or more	4 or more
VI. Engagement	2 or less	2 or less	3 or less	3 or 4	3 or more	4 or more
Composite Rating	10 to 13	14 to 16	17 to 19	20 to 22	23 to 27	28 or more

○ indicates independent criteria - requires admission to this level regardless of composite score

* Unless sum of IV A and IV B equals 2

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On the determination grid, the LOCUS presents outcome recommendations based on the composite rating with justification in each rating for level of care decisions based on the score in each domain

An accurate level of care determination should not be made based on the outcome score in only one domain.

Composite ratings are the most accurate measure of level of care determination

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Composite Score and Corresponding Level of Care Recommendations

Level 1 – Composite Score of 10-13

Level 2 – Composite Score of 14-16

Level 3 – Composite Score of 17-19

Level 4 – Composite Score of 20-22

Level 5 – Composite Score of 23-27

Level 6 – Composite Score of 28-35

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The term “level” is used for simplicity and describes a flexible or variable combination of specific service types and might more accurately be said to describe levels of resource intensity.

The particulars of program development are left to providers to determine based the availability and array of services in a given geographic area.

The LOCUS does make recommendations regarding the components each level of care should include for achieving best outcome. LOCUS makes these recommendations based on three areas of service

1) Care Environment – The requirements of a physical facility most associated with positive treatment outcomes such as layout of office, location to consumers, access, staffing and hours of operation.
2) Clinical Services- The clinical services offered most associated with positive clinical outcomes.
3) Support Services – The ability of a service to link with other services, provide community and home based support, access collateral contacts and provide flexible arrays of service frequency, intensity and duration.
4) Crisis Stabilization and Prevention Services – Crisis and prevention services in varying intensities and forms most associated with positive clinical outcomes

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LOCUS LEVELS OF CARE

1) Recovery Maintenance Health Management
2) Low Intensity Community Based Services
3) High Intensity Community Based Services
4) Medically Monitored Non-Residential Services
5) Medically Monitored Residential Services
6) Medically Managed Residential Services

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Meaning in Levels of Care

Does LOCUS determine need for hospitalization?

Does LOCUS recommend length of stay?

A LOCUS level of care recommendation is often dependent upon the array of services and options available in the area of use.

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BASIC SERVICES - Prevention and Health Maintenance

LOCUS makes accommodation for cases in which those assessed by LOCUS may not be recommended for a level of care associated with the services provided in their area. LOCUS establishes a recommendation of basic services that should exist which are designed to prevent the onset of illness or to limit the magnitude of morbidity associated with already established disease processes. These services may be developed for individual or community application, and are generally carried out in a variety of community settings. These services will be available to all members of the community. LOCUS should not be used to determine eligibility etc. for these types of services.

Basic services should include these components in each of the service areas

1. Care Environment - An easily accessible office and communications equipment. Adequate space for any services provided on-site must be available. Central offices are likely to be most conveniently located in or near a community health center. Most services will be provided in the community, however, in schools, places of employment, community centers, libraries, churches, etc., and transportation capabilities must be available.

2. Clinical Services - Twenty-four hour physician and nursing capabilities will be provided for emergency evaluation, brief intervention, and outreach services.

3. Support Services - As needed for crisis stabilization, having the capability to mobilize community resources and facilitate linkage to more intense levels of care if needed.

4. Crisis Stabilization and Prevention Services - In addition to crisis services already described, prevention programs would be available and promoted for all covered members. These programs would include: 1) Community outreach to special populations such as the homeless, elderly, children, pregnant woman, disrupted or violent families and criminal offenders; 2) Debriefing for victims of trauma or disaster; 3) Frequent opportunities to screen for high risk members in the community; 4) Health maintenance education (e.g., coping skills, stress management, recreation); 5) Violence prevention education and community organization; 6) Consultation to primary care providers and community groups; 7) Facilitation of mutual support networks and empowerment programs; 8) Environmental evaluation programs identifying mental health toxins; and 9) Support of day care and child enrichment programs.

Placement Criteria:

These Basic Services should be available to all members of the community regardless of their status in the dimensional rating scale.

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LEVEL ONE - Recovery Maintenance and Health Management

This level of care provides treatment to clients who are living either independently or with minimal support in the community, and who have achieved significant recovery from past episodes of illness. Treatment and service needs do not require supervision or frequent contact. Recovery Maintenance programs must provide the following:

1. **Care Environment** - Adequate space should be available to carry out activities required for treatment. Space should be easily accessible, well ventilated and lighted. Access to the facility can be monitored and controlled, but egress can not be restricted. In some cases, services may be provided in community locations or in the place of residence.

2. **Clinical Services** - Treatment programming will be available up to two hours per month, and usually not less than one hour every three months. Psychiatric or physician review and/or contact should take place about once every three to four months. Medication use can be monitored and managed in this setting. Capabilities to provide individual or group supportive therapy should be available in at this level.

3. **Supportive Services** - Assistance with arranging financial support, supportive housing, systems management, and transportation may be necessary. Facilitation in linkage with mutual support networks, individual advocacy groups, and with educational or vocational programming will also be available according to client needs.

4. **Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Educational and employment opportunities, and empowerment programs will be available, and access to these services will be facilitated. In addition, all Basic Services (see page 17) will be accessible.

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Level 1 Placement Criteria

1. **Risk of Harm** - clients with a rating of two or less may step down to this level of care.

2. **Functional Status** - clients should demonstrate ability to maintain a rating of two or less to be eligible for this level of care.

3. **Co-morbidity** - a rating of two or less is generally required for this level of care.

4. **Recovery Environment** - a combined rating of no more than four on Scale "A" and "B" should be required for treatment at this level.

5. **Treatment and Recovery History** - a rating of two or less should be required for treatment at this level.

6. **Engagement and Recovery Status** - a rating of two or less should be obtained in this dimension for placement at this level of care.

7. **Composite Rating** - placement at this level of care implies that the client has successfully completed treatment at a more intensive level of care and primarily needs assistance in maintaining gains realized in the past. A composite rating of more than 10 but less than 14 should generally be obtained for eligibility for this service.

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LEVEL TWO - Low Intensity Community Based Services

This level of care provides treatment to clients who need ongoing treatment, but who are living either independently or with minimal support in the community. Treatment and service needs do not require intense supervision or very frequent contact. Programs of this type have traditionally been clinic-based programs. These programs must provide the following:

1. **Care Environment** - Adequate space should be available to carry out activities required for treatment. Space should be easily accessible, well ventilated and lighted. Access to the facility can be monitored and controlled, but the way out cannot be restricted. In some cases services may be provided in community locations or in the place of residence.

2. **Clinical Services** - Treatment programming will be available up to three hours per week, but usually not less than one hour every two weeks. Psychiatric or physician review and/or contact should be available according to need as indicated by initial and ongoing assessment. Medication use can be monitored and managed in this setting. Capabilities to provide individual, group, and family therapies should be available in these settings.

3. **Supportive Services** - Case management services will generally not be required at this level of care, but assistance with arranging financial support, supportive housing, systems management, and transportation may be necessary. Liaison with mutual support networks and individual advocacy groups, and coordination with educational or vocational programming will also be available according to client needs.

4. **Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Educational and employment opportunities, and empowerment programs will be available, and access to these services will be facilitated. In addition, all other Basic Services (see page 17) will be accessible.

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Level 2 Placement Criteria

1. **Risk of Harm** - a rating of two or less would be most appropriate for this level of care. In some cases, a rating of three could be accommodated if the composite rating falls within guidelines.

2. **Functional Status** - ratings of three or less could be managed at this level.

3. **Co-Morbidity** - a rating of two or less is required for placement at this level.

4. **Recovery Environment** - a rating of three or less on each scale and a combined score of no more than five on the “A” and “B” scales is required for treatment at this level.

5. **Treatment and Recovery History** - a rating of two or less is generally most appropriate for this level of care. In some cases, a rating of three could be attempted at this level if stepping down from a more intensive level of care and a rating of two or less is obtained on scale “B” of dimension four.

6. **Engagement and Recovery Status** - a rating of two or less is generally most appropriate for this level of care. In some cases, a rating of three may be placed at this level if unwilling to participate in treatment at a more intensive level.

7. **Composite Rating** - placement at this level of care will generally be determined by the interaction of a variety of factors, but will be excluded by a score of four or more on any dimension. A composite score of at least 14 but no more than 16 is required for treatment at this level.

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LEVEL THREE - High Intensity Community Based Services

This level of care provides treatment to clients who need intensive support and treatment, but who are living either independently or with minimal support in the community. Service needs do not require daily supervision, but treatment needs require contact several times per week. Programs of this type have traditionally been clinic based programs. These programs must provide the following:

1. **Care Environment** - Adequate space should be available to carry out activities required for treatment. Space should be easily accessible, well ventilated and lighted. Access to the facility can be monitored and controlled, but egress can not be restricted. These services may be provided in community locations in some cases, including the place of residence.

2. **Clinical Services** - Treatment programming (including group, individual and family therapy) will be available about three days per week and about two or three hours per day. Psychiatric/medical staffing should be adequate to provide review and/or contact as needed according to initial and ongoing assessment. On call psychiatric/medical services will generally not be available on a 24-hour basis. Skilled nursing care is usually not required at this level of care, and medication use can be monitored but not administered. Capabilities to provide individual, group, family and rehabilitative therapies should be available in these settings.

3. **Supportive Services** - Case management or outreach services should be available and integrated with treatment teams. Assistance with providing or arranging financial support, supportive housing, systems management and transportation should be available. Liaison with mutual support networks and individual advocacy groups, facilitation of recreational and social activities, and coordination with educational or vocational programming will also be available according to client needs.

4. **Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Mobile service capability, day care and child enrichment programs, education and employment opportunities, and empowerment programs will be available, and access to these services will be facilitated. All other Basic Services (see page 17) will also be available.

Level 3 Placement Criteria

1. **Risk of Harm** - a rating of three or less can be managed at this level.

2. **Functional Status** - a rating of three or less is required for this level of care.

3. **Co-Morbidity** - a rating of three or less can be managed at this level of care.

4. **Recovery Environment** - a rating of three or less on each scale and a combined score of no more than five on the "A" and "B" scales is required for treatment at this level.

5. **Treatment and Recovery History** - a rating of two is most appropriate for management at this level of care, but in many cases a rating of three can be accommodated.

6. **Engagement and Recovery Status** - a rating of three or less is required for this level of care.

7. **Composite Rating** - placement at this level of care will generally be determined by the interaction of a variety of factors, but will be excluded by a score of four or more on any dimension. A composite score of at least 17 and no more than 19 is required for treatment at this level.

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LEVEL FOUR - Medically Monitored Non-Residential Services

This level of care refers to services provided to clients capable of living in the community either in supportive or independent settings, but whose treatment needs require intensive management by a multi disciplinary treatment team. Services, which would be included in this level of care, have traditionally been described as partial hospital programs and as assertive community treatment programs.

1. **Care Environment** - Services may be provided within the confines of a clinic setting providing adequate space for provision of services available at this level, or they may in some cases be provided by wrapping services around the client in the community (i.e. ACT team).

2. **Clinical Services** - Clinical services should be available to clients throughout most of the day on a daily basis. Psychiatric services would be accessible on a daily basis and contact would occur as required by initial and ongoing assessment. Psychiatric services would also be available by remote communication on a 24-hour basis. Nursing services should be available than about 40 hours per week. Physical assessment should be provided on-site if possible and access to ongoing primary medical care should be available. Intensive treatment should be provided at least five days per week and include individual, group, and family therapy depending on client needs. Rehabilitative services will be an integral aspect of the treatment program. Medication can be carefully monitored, but in most cases will be self-administered.

3. **Supportive Services** - Case management services will be integrated with on site treatment teams or mobile treatment teams and will provide assistance with providing or arranging financial support, supportive housing, systems management, transportation and ADL maintenance. Liaison with mutual support networks and individual groups, facilitation of recreational and social activities, and coordination with educational or vocational programming will also be available according to client needs.

4. **Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Mobile service capability, day care and child enrichment programs, education and employment opportunities, and empowerment programs will be available, as will other Basic Services.

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Level 4 Placement Criteria

1. **Risk of Harm** - a rating of three or less is required for placement at this level independent of other variables, and a rating higher than three should not be managed at this level.

2. **Functional Status** - a rating of three is most appropriate for this level of care independent of other variables. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "A" and "B" in dimension four. (Availability of Assertive Community Treatment (ACT) would be equivalent to a rating of one on scale "B". An "A" scale rating of two could generally be managed in conjunction with ACT).

3. **Co-Morbidity** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "A" and "B" in dimension four. (Availability of Assertive Community Treatment would be equivalent to a rating of one on scale "B". An "A" scale rating of two could generally be managed in that circumstance).

4. **Recovery Environment** - an "A" scale rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "B". (Availability of Assertive Community Treatment would merit a rating of one on scale "B"). A "B" scale rating of three or less could otherwise generally be managed at this level.

5. **Treatment and Recovery History** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "A" and "B" in dimension four. (Availability of Assertive Community Treatment would be equivalent to a rating of one on scale "B". An "A" scale rating of two could generally be managed in conjunction with ACT).

6. **Engagement and Recovery Status** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "A" and "B" in dimension four. (Availability of Assertive Community Treatment would equivalent to a rating of one on scale "B". An "A" scale rating of two could generally be managed in conjunction with ACT).

7. **Composite Rating** - in many cases, utilization of this level of care will be determined by the interaction of a variety of factors. A composite rating of 20 requires treatment at this level with or without ACT resources available. (The presence of ACT reduces scores on dimension four enabling these criteria to be met even when scores of four are obtained in other dimensions.)

LEVEL FIVE - Medically Monitored Residential Services

This level of care refers to residential treatment provided in a community setting. This level of care has traditionally been provided in non-hospital, free standing residential facilities based in the community. In some cases, longer-term care for persons with chronic, non-recoverable disability, which has traditionally been provided in nursing homes or similar facilities, may be included at this level. Level five services must be capable of providing the following:

1. **Care Environment** - Facilities will provide adequate living space for all residents and be capable of providing reasonable protection of personal safety and property. Physical barriers preventing egress or access to the community may be used at this level of care but facilities of this type will generally not allow the use of seclusion or restraint. Food services must be available or adequate provisions for residents to purchase and prepare their food must be made.

2. **Clinical Capabilities** - Access to clinical care must be available at all times. Psychiatric care should be available either on site or by remote communication 24 hours daily and psychiatric consultation should be available on site at least weekly, but client contact may be required as often as daily. Emergency medical care services should be easily and rapidly accessible. On site nursing care should be available about 40 hours per week if medications are being administered on a frequent basis. On site treatment should be available seven days a week including individual, group and family therapy. In addition, rehabilitation and educational services must be available either on or off site. Medication is monitored, but does not necessarily need to be administered to residents in this setting.

3. **Supportive Services** - Residents will be provided with supervision of activities of daily living, and custodial care may be provided to designated populations at this level. Staff will facilitate recreational and social activities and coordinate interface with educational and rehabilitative programming provided off site.

4. **Crisis Resolution and Prevention** - Residential treatment programs must provide services facilitating return to community functioning in a less restrictive setting. These services will include coordination with community case managers, family and community resource mobilization, liaison with community based mutual support networks, and development of transition plan to supportive environment.

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Level 5 Placement Criteria

1. **Risk of Harm** - a rating of four requires care at this level independently of other parameters.

2. **Functional Status** - a rating of four requires care at this level independently of other dimensional ratings, with the exception of some clients who are rated at one on dimension four on both scale “A” and “B” (see level three criteria).

3. **Co-Morbidity** - a rating of four requires care at this level independently of other parameters, with the exception of some clients who are rated at one on dimension four on both scale “A” and “B” (see level three criteria).

4. **Recovery Environment** - a rating of four or higher on the “A” and “B” scale and in conjunction with a rating of at least three on one of the first three dimensions requires care at this level.

5. **Treatment and Recovery History** - a rating of three or higher in conjunction with a rating of at least three on one of the first three dimensions requires treatment at this level.

6. **Engagement and Recovery Status** - a rating of three or higher in conjunction with a rating of at least three on one of the first three dimensions requires treatment at this level.

7. **Composite Rating** - while a client may not meet any of the above independent ratings, in some circumstances, a combination of factors may require treatment in a more structured setting. This would generally be the case for clients who have a composite rating of 24 or higher.

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LEVEL SIX - Medically Managed Residential Services

This is the most intense level of care in the continuum. Level six services have traditionally been provided in hospital settings, but could, in some cases, be provided in freestanding non-hospital settings. Whatever the case may be, such settings must be able to provide the following:

1. **Care Environment** - The facility must be capable of providing secure care, usually meaning that clients should be contained within a locked environment (this may not be necessary for services such as detoxification, however) with capabilities for providing seclusion and/or restraint if necessary. It should be capable of providing involuntary care when called upon to do so. Facilities must provide adequate space, light, ventilation, and privacy. Food services and other personal care needs must be adequately provided.

2. **Clinical Services** - Clinical services must be available 24 hours a day, seven days a week. Psychiatric, nursing, and medical services must be available on site, or in close enough proximity to provide a rapid response, at all times. Psychiatric/medical contact will generally be made on a daily basis. Treatment will be provided on a daily basis and would include individual, group and family therapy as well as pharmacologic treatment, depending on the client's needs.

3. **Supportive Services** - All necessities of living and well being must be provided for clients treated in these settings. When capable, clients will be encouraged to participate in and be supported in efforts to carry out activities of daily living such as hygiene, grooming and maintenance of their immediate environment.

4. **Crisis Resolution and Prevention Services** – These residential settings must provide services designed to reduce the stress related to resuming normal activities in the community. Such services might include coordination with community case managers, family and community resource mobilization, environmental evaluation and coordination with residential services, and coordination with and transfer to less intense levels of care.

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Level 6 Placement Criteria

1. **Risk of Harm** - a rating of five qualifies an admission independently of other parameters.

2. **Functional Status** - a rating of five qualifies placement independently of other variables.

3. **Medical and Psychiatric Co-Morbidity** - a rating of five qualifies placement independently of other parameters.

4. **Recovery Environment** - a rating of four or more would be most appropriate for this level, but no rating in this parameter qualifies placement independently at this level, nor would it disqualify placement if otherwise warranted.

5. **Treatment and Recovery History** - a rating of four or more would be most appropriate for this level but, no rating in this dimension qualifies placement independently at this level, nor would it disqualify an otherwise warranted placement.

6. **Engagement and Recovery Status** - a rating of four or more would be most appropriate for this level but no rating in this parameter qualifies or disqualifies placement independently at this level.

7. **Composite Rating** - in some cases, patients not meeting independent criteria in any one category, may still need treatment at this level if ratings in several categories are high, thereby increasing the risk of treatment in a less intensive setting. A composite rating of 28 (an average rating of four or more in each dimension) would indicate the need for treatment at this level.

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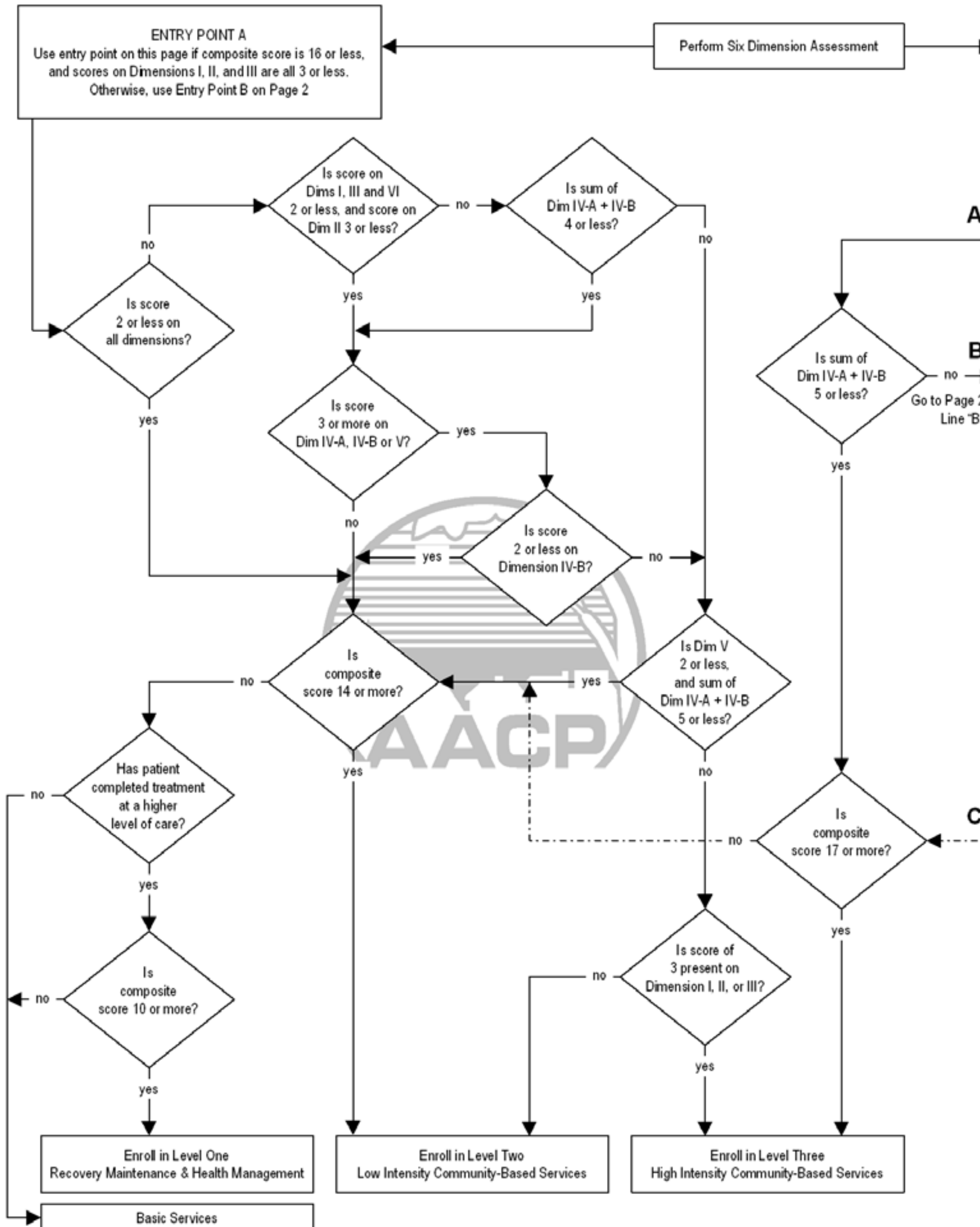
AACP LEVEL OF CARE DETERMINATION DECISION TREE



Decision Tree, Page 1

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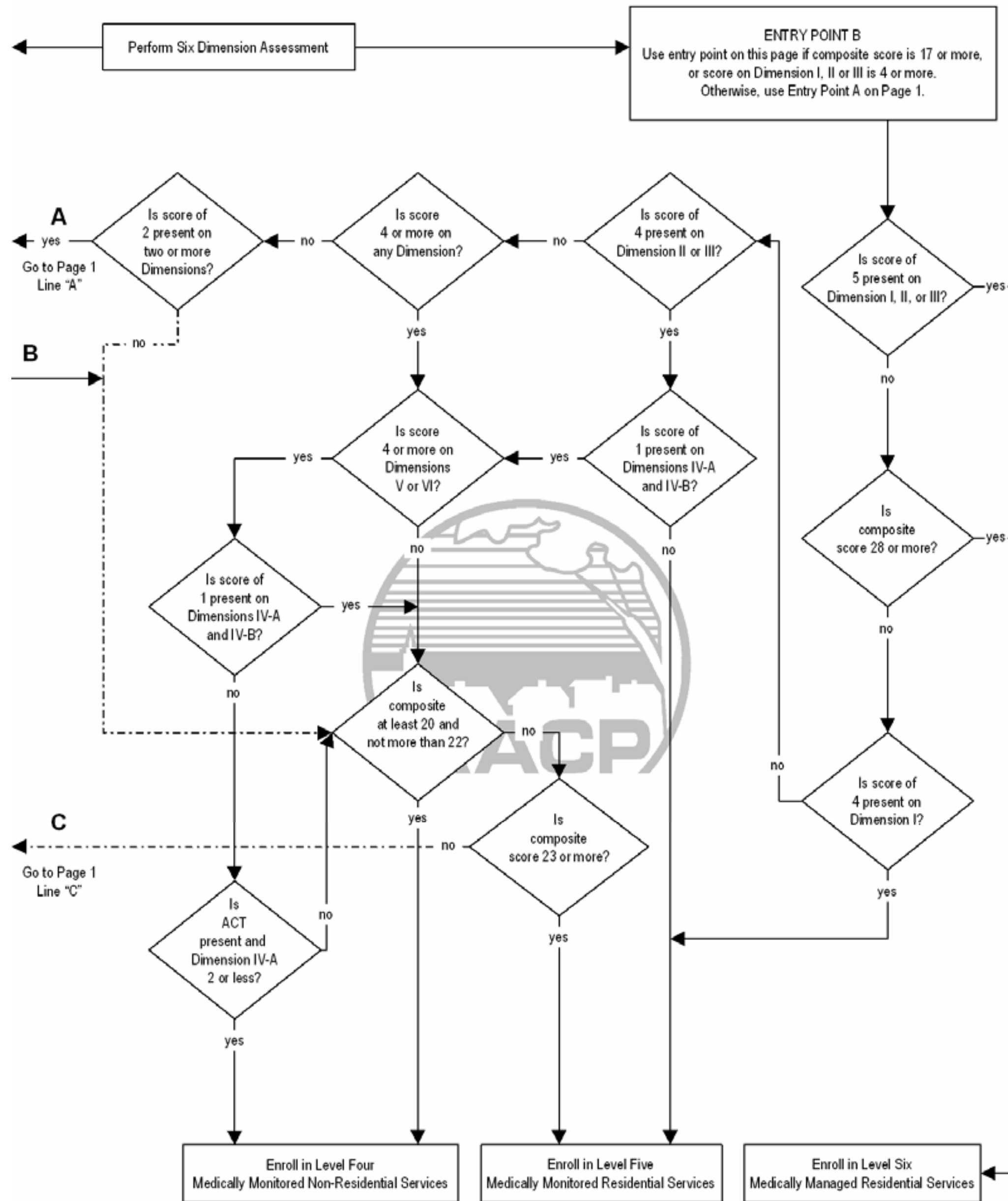
AACP LEVEL OF CARE DETERMINATION DECISION TREE



CASE PRACTICE

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CASE II

HISTORY OF PRESENT ILLNESS: Mr. S is a 49-year-old divorced man who is self-referred. He is currently living in a cheap downtown hotel and is very distressed to find himself in this situation. He reports that his mother and his sister "conspired" to have him evicted from his apartment about four months ago. "My world is falling apart. I feel like I'm at the end of my rope. I need help sleeping and I need a decent place to live."

He lost his job about six months ago and is involved in a complicated workman's compensation claim. He is currently receiving food stamps and living off savings. Since losing his job, Mr. S. reports an increase in emotional and physical fatigue, very low mood, 10 pound weight loss and disrupted sleep. Believes he is only sleeping 2-4 hours a night and feels "worn out." Although he denies suicidal ideation, he does report a history of suicide ideation and reports that once as a teenager he took "a handful of Tylenol" but "nothing happened." Describes a very negative outlook and states that just when things are looking up he gets "knocked down" again.

PSYCHIATRIC HISTORY: Mr. S reports that he has struggled with depression for 15 years. States he can not remember a single day in the last 15 years when he was free from low mood. He reports a seasonal component to his depression. There are also some symptoms suggesting manic episodes (feeling high, inability to sleep) but nothing more definite. He has never been hospitalized for psychiatric reasons but has received outpatient treatment in numerous settings. He expresses considerable dissatisfaction with the treatment he has received in the mental health system and complains that no one has been able to explain to him what was wrong or treat him successfully. He has been tried on a variety of medications, most of them mood stabilizers, with no apparent benefit. He does not currently take any medication for any physical or emotional condition.

MEDICAL HISTORY: Mr. S reports a history of head injuries as a result of a variety of accidents. He states that he has experienced momentary loss of consciousness as a result of some of these blows to the head. He also has a history of enuresis, which persisted until late adolescence. He reportedly sustained an injury in the Air Force which resulted in partial deafness. He does not receive any military pension or disability.

SUBSTANCE USE HISTORY: Mr. S denies any problem with drugs or alcohol. He reports that he drinks "seldom and socially." He does admit to smoking marijuana on a fairly regular basis until the break up of the relationship. He has used marijuana only rarely since then. He denies any present or previous legal problems.

SOCIAL HISTORY: Mr. S has one older sister. His mother and father remained married until his father's death about 20 years ago. He describes a good relationship with his father and a very conflicted relationship with his mother and his sister. He reports that his mother was physically and emotionally abusive. Mr. S considers himself to be of above average intelligence but admits that he always struggled in school. He joined the Air Force immediately upon graduating from high school. He was in the service for eight years and received an honorable discharge. He was married during this time for about a year. He has no children. He was trained on computers in the Air Force and has previously worked, on and off, at a computer repair business. He claims to have sustained a back injury on the job and this is the basis of his workman's comp claim. The claim has been denied and he is in the process of making an appeal. For the last 19 years he has been living with another man. It is not clear whether or not this was a sexual relationship but it came to end at the time of his eviction and he has had no contact with his ex-partner. There is a positive family history for psychiatric problems. There is a maternal cousin who is institutionalized for some unknown reason and a maternal aunt and two other cousins diagnosed with bipolar disorder. He believes his mother may be alcoholic.

MENTAL STATUS EXAMINATION: This is a slight, somewhat disheveled man who appears cachectic, distressed and anxious. He is restless and speaks somewhat rapidly, but WNL. Thoughts are organized and no perceptual disturbance noted. Mood is upset and affect is dysphoric and constricted. Cognitive exam shows some deficit in concentration.

LOCUS© Adult Version 2010 Instrument Score Sheet

Client Name				PRIME #	
Reviewer Name				Date Completed	
Agency			Program		
Prior Composite Score		Prior Placement Grid Level of Care LOC or recommended LOC			
Date of Prior LOCUS			Prior LOCUS completed by		

I. Risk of Harm

1 - Minimal risk of harm

a- ☐ No indication of suicidal or homicidal thoughts or impulses, and no history of suicidal or homicidal ideation, and no indication of significant distress.

b- ☐ Clear ability to care for self now and in the past.

2 - Low risk of harm

a- ☐ No current suicidal or homicidal ideation, plan, intentions or severe distress, but may have had transient or passive thoughts recently or in the past.

b- ☐ Substance use without significant episodes of potentially harmful behaviors.

c- ☐ Periods in the past of self-neglect without current evidence of such behavior.

3 - Moderate risk of harm

a- ☐ Significant current suicidal or homicidal ideation without intent or conscious plan and without past history.

b- ☐ No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists.

c- ☐ History of chronic impulsive suicidal/homicidal behavior or threats and current expressions does not represent significant change from baseline.

d- ☐ Binge or excessive use of substances resulting in potentially harmful behaviors without current involvement in such behavior.

e- ☐ Some evidence of self neglect and/or compromise in ability to care for oneself in current environment

4 - Serious risk of harm

a- ☐ Current suicidal or homicidal ideation with expressed intentions and/or past history of carrying out such behavior but without means for carrying out the behavior, or with some expressed inability or aversion to doing so, or with ability to contract for safety.

b- ☐ History of chronic impulsive suicidal/homicidal behavior or threats with current expressions or behavior representing a significant elevation from baseline.

c- ☐ Recent pattern of excessive substance use resulting in disinhibition and clearly harmful behaviors with no demonstrated ability to abstain from use.

d- ☐ Clear compromise of ability to care adequately for oneself or to be adequately aware of environment.

5 - Extreme risk of harm

a- ☐ Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior...

- i- ☐ without expressed ambivalence or significant barriers to doing so, or
- ii- ☐ with a history of serious past attempts which are not of a chronic, impulsive or consistent nature, or
- iii- ☐ in presence of command hallucinations or delusions which threaten to override usual impulse control.

b- ☐ Repeated episodes of violence toward self or others, or other behaviors resulting in harm while under the influence of intoxicating substances with pattern of nearly continuous and uncontrolled use.

c- ☐ Extreme compromise of ability to care for oneself or to adequately monitor environment with evidence of deterioration in physical condition or injury related to these deficits

II. Functional Status

1 - Minimal Impairment

a- ☐ No more than transient impairment in functioning following exposure to an identifiable stressor.

2 - Mild Impairment

a- ☐ Experiencing some deterioration in interpersonal interactions, with increased incidence of arguments, hostility or conflict, but is able to maintain some meaningful and satisfying relationships.
b- ☐ Recent experience of some minor disruptions in aspects of self care or usual activities.
c- ☐ Developing minor but consistent difficulties in social role functioning and meeting obligations such as difficulty fulfilling parental responsibilities or performing at expected level in work or school, but maintaining ability to continue in those roles.
d- ☐ Demonstrating significant improvement in function following a period of deterioration.

3 - Moderate Impairment

a- ☐ Becoming conflicted, withdrawn, alienated or otherwise troubled in most significant relationships, but maintains control of any impulsive or abusive behaviors.
b- ☐ Appearance and hygiene may fall below usual standards on a frequent basis.
c- ☐ Significant disturbances in vegetative activities such as sleep, eating habits, activity level, or sexual appetite which do not pose a serious threat to health.
d- ☐ Significant deterioration in ability to fulfill responsibilities and obligations to job, school, self, or significant others and these may be avoided or neglected on some occasions.
e- ☐ Chronic and/or variably severe deficits in interpersonal relationships, ability to engage in socially constructive activities, and ability to maintain responsibilities.
f- ☐ Recent gains and or stabilization in function have been achieved while participating in treatment in a structured and /or protected setting.

4 - Serious Impairment

a- ☐ Serious deterioration of interpersonal interactions with consistently conflictual or otherwise disrupted relations with others, which may include impulsive, or abusive behaviors.
b- ☐ Significant withdrawal and avoidance of almost all social interaction.
c- ☐ Consistent failure to maintain personal hygiene, appearance, and self care near usual standards.
d- ☐ Serious disturbances in vegetative status such as weight change, disrupted sleep, or fatigue that threaten physical well being.
e- ☐ Inability to perform close to usual standards in school, work, parenting, or other obligations and these responsibilities may be completely neglected on a frequent basis or for an extended period of time.

5 - Severe Impairment

a- ☐ Extreme deterioration in social interactions which may include chaotic communication, threatening behaviors with little or no provocation, or minimal control of impulsive or abusive behavior.
b- ☐ Development of complete withdrawal from all social interactions.
c- ☐ Complete neglect of personal hygiene and appearance and inability to attend to most basic needs such as food intake and personal safety with associated impairment in physical status.
d- ☐ Extreme disruptions in vegetative function causing serious harm to health and well being.
e- ☐ Complete inability to maintain any aspect of personal responsibility as a citizen, or in occupational, educational, or parental roles.

III. Medical, Addictive, and Psychiatric Co-Morbidity

1 - No Co-morbidity

a- ☐ No evidence of medical illness, substance use disorders, or psychiatric disturbances apart from the presenting disorder.

b- ☐ Any illnesses that may have occurred in the past are now stable and pose no threat to the stability of the current condition.

2 - Minor Co-morbidity

a- ☐ Existence of medical problems which are not themselves immediately threatening or debilitating and which have no impact on the course of the presenting disorder.

b- ☐ Occasional episodes of substance misuse, but any recent episodes are self limited, show no pattern of escalation, and there is no indication that they adversely affect the course of any co-existing psychiatric disorder.

c- ☐ May occasionally experience psychiatric symptoms which are related to stress, medical illness, or substance use, but which are transient and have no discernable impact on the co-existing substance use disorder.

3 - Significant Co-morbidity

a- ☐ Medical conditions exist, or have potential to develop (such as diabetes or a mild physiologic withdrawal syndrome), which may require significant medical monitoring.

b- ☐ Medical conditions exist which may be adversely affected by the existence of the presenting disorder.

c- ☐ Medical conditions exist which may adversely affect the course of the presenting disorder.

d- ☐ Ongoing or episodic substance use occurring despite adverse consequences with significant or potentially significant negative impact on the course of any co-existing psychiatric disorder.

e- ☐ Recent substance use which has had clearly detrimental effects on the presenting disorder but which has been temporarily arrested through use of a highly structured or protected setting or through other external means.

f- ☐ Significant psychiatric symptoms and signs are present which are themselves somewhat debilitating, and which interact with and have an adverse affect on the course and severity of any co-existing substance use disorder.

4 - Major Co-morbidity

a- ☐ Medical conditions exist, or have a very high likelihood of developing (such as a moderate, but uncomplicated, alcohol, sedative, or opiate withdrawal syndrome, mild pneumonia, or uncontrolled hypertension), which may require intensive, although not constant, medical monitoring.

b- ☐ Medical conditions exist which are clearly exacerbated by the existence of the presenting disorder.

c- Medical conditions exist which are clearly detrimental to the course and outcome of the presenting disorder.

d- ☐ Uncontrolled substance use occurs at a level, which poses a serious threat to health if unabated, and/or which poses a serious barrier to recovery from any co-existing psychiatric disorder.

e- ☐ Psychiatric symptoms exist which are clearly debilitating and which interact with and seriously impair ability to recover from any co-existing substance use disorder.

5 - Severe Co-morbidity

a- ☐ Significant medical conditions exist which may be poorly controlled and/or potentially life threatening in the absence of close medical management (e.g., severe or complicated alcohol withdrawal, uncontrolled diabetes mellitus, complicated pregnancy, severe liver disease, debilitating cardiovascular disease).

b- ☐ Presence and lack of control of presenting disorder places client in imminent danger from complications of existing medical problems.

c- ☐ Uncontrolled medical condition severely exacerbates the presenting disorder, dramatically prolonging the course of illness and seriously impeding the ability to recover from it.

d- ☐ Severe substance dependence with inability to control use under any circumstance with intense withdrawal symptoms and /or continuing use despite clear exacerbation of any co-existing psychiatric disorder and other aspects of well being.

e- ☐ Acute or severe psychiatric symptoms are present which seriously impair client's ability to function and prevent recovery from any co-existing substance use disorder, or seriously exacerbate it.

IV. Recovery Environment

A) Level of Stress

1 - Low Stress Environment

a- ☐ Essentially no significant or enduring difficulties in interpersonal interactions and significant life circumstances are stable.
b- ☐ No recent transitions of consequence.
c- ☐ No major losses of interpersonal relationships or material status have been experienced recently.
d- ☐ Material needs are met without significant cause for concern that they may diminish in the near future, and no significant threats to health or safety are apparent.
e- ☐ Living environment poses no significant threats or risk.
f- ☐ No pressure to perform beyond capacity in social role.

2 - Mildly Stressful Environment

a- ☐ Presence of some ongoing or intermittent interpersonal conflict, alienation, or other difficulties.
b- ☐ A transition that requires adjustment such as change in household members or a new job or school.
c- ☐ Circumstances causing some distress such as a close friend leaving town, conflict in or near current habitation, or concern about maintaining material well being.
d- ☐ A recent onset of a transient but temporarily disabling or debilitating illness or injury.
e- ☐ Potential for exposure to alcohol and/or drug use exists.
f- ☐ Performance pressure (perceived or actual) in school or employment situations creating discomfort.

3 - Moderately Stressful Environment

a- ☐ Significant discord or difficulties in family or other important relationships or alienation from social interaction.
b- ☐ Significant transition causing disruption in life circumstances such as job loss, legal difficulties or change of residence.
c- ☐ Recent important loss or deterioration of interpersonal or material circumstances.
d- ☐ Concern related to sustained decline in health status.
e- ☐ Danger in or near habitat.
f- ☐ Easy exposure and access to alcohol and drug use.
g- ☐ Perception that pressure to perform surpasses ability to meet obligations in a timely or adequate manner.

4 - Highly Stressful Environment

a- ☐ Serious disruption of family or social milieu which may be due to illness, death, divorce or separation of parent and child, severe conflict, torment and/or physical or sexual mistreatment.
b- ☐ Severe disruption in life circumstances such as imminent incarceration, lack of permanent residence, or immersion in an alien culture.
c- ☐ Inability to meet needs for physical and/or material well being.
d- ☐ Recent onset of severely disabling or life threatening illness.
e- ☐ Difficulty avoiding exposure to active users and other pressures to partake in alcohol or drug use.
f- ☐ Episodes of victimization or direct threats of violence near current home.
g- ☐ Overwhelming demands to meet immediate obligations are perceived.

5 - Extremely Stressful Environment

a- ☐ An acutely traumatic level of stress or enduring and highly disturbing circumstances disrupting ability to cope with even minimal demands in social spheres such as:
  - ☐ ongoing injurious and abusive behaviors from family member(s) or significant other.
  - ☐ witnessing or being victim of extremely violent incidents perpetrated by human malice or natural disaster.
  - ☐ persecution by a dominant social group.
  - ☐ sudden or unexpected death of loved one.

b- ☐ Unavoidable exposure to drug use and active encouragement to participate in use.
c- ☐ Incarceration or lack of adequate shelter.
d- ☐ Severe pain and/or imminent threat of loss of life due to illness or injury
e- ☐ Sustained inability to meet basic needs for physical and material well being;
f- ☐ Chaotic and constantly threatening environment.

B) Level of Support

1 - Highly Supportive Environment

a- ☐ Abundant sources of support with ample time and interest to provide for both material and emotional needs in all circumstances.

b- ☐ Effective involvement of Assertive Community Treatment Team (ACT) or other similarly highly supportive resources.

(Selection of this criterion pre-empts higher ratings)

2 - Supportive Environment

a- ☐ Supportive resources are not abundant, but are capable of and willing to provide significant aid in times of need.

b- ☐ Some elements of the support system are willing and able to participate in treatment if requested to do so and have capacity to effect needed changes.

c- ☐ Professional supports are available and effectively engaged (i.e. ICM).

(Selection of this criterion pre-empts higher ratings)

3 - Limited Support in Environment

a- ☐ A few supportive resources exist in current environment and may be capable of providing some help if needed.

b- ☐ Usual sources of support may be somewhat ambivalent, alienated, difficult to access, or have a limited amount of resources they are willing or able to offer when needed.

c- ☐ Persons who have potential to provide support have incomplete ability to participate in treatment and make necessary changes.

d- ☐ Resources may be only partially utilized even when available.

e- ☐ Limited constructive engagement with any professional sources of support which are available.

4 - Minimal Support in Environment

a- ☐ Very few actual or potential sources of support are available.

b- ☐ Usual supportive resources display little motivation or willingness to offer assistance or they are dysfunctional or hostile toward client.

c- ☐ Existing supports are unable to provide sufficient resources to meet material or emotional needs.

d- ☐ Client may be alienated and unwilling to use supports available in a constructive manner.

5 - No Support in Environment

a- ☐ No sources for assistance are available in environment either emotionally or materially.

V. Treatment and Recovery History

1 - Fully Responsive to Treatment and Recovery Management

a- ☐ There has been no prior experience with treatment or recovery.

b- ☐ Prior experience indicates that efforts in all treatments that have been attempted have been helpful in controlling the presenting problem.

c- ☐ There has been successful management of extended recovery with few and limited periods of relapse even in unstructured environments or without frequent treatment.

2 - Significant Response to Treatment and Recovery Management

a- ☐ Previous or current experience in treatment has been successful in controlling most symptoms but intensive or repeated exposures may have been required.

b- ☐ Recovery has been managed for moderate periods of time with limited support or structure.

3 - Moderate or Equivocal Response to Treatment and Recovery Management

a- ☐ Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms.

b- ☐ Previous treatment exposures have been marked by minimal effort or motivation and no significant success or recovery period was achieved.

c- ☐ Equivocal response to treatment and ability to maintain a significant recovery.

d- ☐ At least partial recovery has been maintained for moderate periods of time, but only with strong professional or peer support or in structured settings.

4 - Poor Response to Treatment and Recovery Management

- a- ☐ Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms even with intensive and/or repeated exposure.
- b- ☐ Attempts to maintain whatever gains that can be attained in intensive treatment have limited success, even for limited time periods or in structured settings.

5 - Negligible Response to Treatment

- a- ☐ Past or current response to treatment has been quite minimal, even with intensive medically managed exposure in highly structured settings for extended periods of time.
- b- ☐ Symptoms are persistent and functional ability shows no significant improvement despite this treatment exposure.

VI. Engagement

1 - Optimal Engagement

- a- ☐ Complete understanding and acceptance of illness and its affect on function.
- b- ☐ Shows strong desire to change.
- c- ☐ Is enthusiastic about treatment, is trusting, and shows strong ability to utilize available resources.
- d- ☐ Understands recovery process and personal role in a successful recovery plan.

2 - Positive Engagement

- a- ☐ Significant understanding and acceptance of illness and attempts to understand its affect on function.
- b- ☐ Willingness to change.
- c- ☐ Engages in treatment in a positive manner, capable of developing trusting relationships, and will use available resources independently when necessary.
- d- ☐ Shows some recognition of personal role in recovery and accepts some responsibility for it.

3 - Limited Engagement

- a- ☐ Some variability or equivocation in acceptance or understanding of illness and disability.
- b- ☐ Has limited desire or commitment to change.
- c- ☐ Relates to treatment with some difficulty and establishes few, if any, trusting relationships.
- d- ☐ Does not use available resources independently or only in cases of extreme need.
- e- ☐ Has limited ability to accept responsibility for recovery.

4 - Minimal Engagement

- a- ☐ Rarely, if ever, able to accept reality of illness or any disability which accompanies it.
- b- ☐ Has no desire to adjust behavior.
- c- ☐ Relates poorly to treatment and treatment providers and ability to trust is extremely narrow.
- d- ☐ Avoids contact with and use of treatment resources if left to own devices.
- e- ☐ Does not accept any responsibility for recovery.

5 - Unengaged

- a- ☐ No awareness or understanding of illness and disability.
- b- ☐ Inability to understand recovery concept or contributions of personal behavior to disease process.
- c- ☐ Unable to actively engage in treatment and has no current capacity to relate to another or develop trust.
- d- ☐ Extremely avoidant, frightened, or guarded.

LOCUS© Adult Version 2010 Instrument
Score Sheet

Client Name:	Date:

Scores					
Dimension I	1☐	2☐	3☐	4☐	5☐
Dimension II	1☐	2☐	3☐	4☐	5☐
Dimension III	1☐	2☐	3☐	4☐	5☐
Dimension IV	1☐	2☐	3☐	4☐	5☐
Dimension IVB	1☐	2☐	3☐	4☐	5☐
Dimension V	1☐	2☐	3☐	4☐	5☐
Dimension VI	1☐	2☐	3☐	4☐	5☐
COMPOSITE SCORE					

Placement Grid Level of Care(LOC)	1☐ 2☐ 3☐ 4☐ 5☐ 6☐
Clinician Recommended (LOC)	1☐ 2☐ 3☐ 4☐ 5☐ 6☐

Signature and Credentials of Assessor ______________________________

LEVEL OF CARE DETERMINATION GRID

<table>
<tr><th>Level of Care / Dimensions</th><th>Recovery Maintenance Health Management
Level 1</th><th>Low Intensity Community Based Services
Level 2</th><th>High Intensity Community Based Services
Level 3</th><th>Medically Monitored Non-Residential Services
Level 4</th><th>Medically Monitored Residential Services
Level 5</th><th>Medically Managed Residential Services
Level 6</th></tr>
<tr><td>I. Risk of Harm</td><td>2 or less</td><td>2 or less</td><td>3 or less</td><td>3 or less</td><td>④
3</td><td>⑤
4</td></tr>
<tr><td>II. Functional Status</td><td>2 or less</td><td>2 or less</td><td>3 or less</td><td>3 or less</td><td>④*
3</td><td>⑤
4</td></tr>
<tr><td>III. Co-Morbidity</td><td>2 or less</td><td>2 or less</td><td>3 or less</td><td>3 or less</td><td>④*
3</td><td>⑤
4</td></tr>
<tr><td>IV A. Recovery Environment “Stress”</td><td rowspan="2">Sum of
IV A + IV B
is 4 or less</td><td rowspan="2">Sum of
IV A + IV B
is 5 or less</td><td rowspan="2">Sum of
IV A + IV B
is 5 or less</td><td>3 or 4</td><td>4 or more</td><td>4 or more</td></tr>
<tr><td>IV B. Recovery Environment “Support”</td><td>3 or less</td><td>4 or more</td><td>4 or more</td></tr>
<tr><td>V. Treatment & Recovery History</td><td>2 or less</td><td>2 or less</td><td>3 or less</td><td>3 or 4</td><td>3 or more</td><td>4 or more</td></tr>
<tr><td>VI. Engagement</td><td>2 or less</td><td>2 or less</td><td>3 or less</td><td>3 or 4</td><td>3 or more</td><td>4 or more</td></tr>
<tr><td>Composite Rating</td><td>10 to 13</td><td>14 to 16</td><td>17 to 19</td><td>20 to 22</td><td>23 to 27</td><td>28 or more</td></tr>
</table>

❍ indicates independent criteria - requires admission to this level regardless of composite score

* Unless sum of IV A and IV B equals 2

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LOCUS Evaluation Report

6/28/00 11:47 am

Patient Name: Case II, Mr. S. **Date of Test:** 06/28/00 **Time:** 11:47 am

Social Security: 222-22-2222 **Gender:** Male **Patient DOB:** 01/02/1951

Diagnosis: Adjustment Disorder: Unspecified

Current Disposition: None

Recommended Disposition: Medically Monitored Residential Services

Actual Disposition: Medically Monitored Residential Services

Reason For Variance: None

Program/Referred To: Treatment House

Evaluation Notes:

LOCUS RESULTS

LOCUS Score: 22

Risk of Harm — Dimension Score 3

- No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists

Functional Status — Dimension Score 4

- Serious disturbances in vegetative status such as weight change, disrupted sleep, or fatigue that threaten physical well being
- Inability to perform close to usual standards in school, work, parenting, or other obligations and these responsibilities may be completely neglected on a frequent basis or for an extended period of time

Medical, Addictive and Psychiatric Co-Morbidity — Dimension Score 2

- Occasional episodes of substance misuse, but any recent episodes are self limited, show no pattern of escalation, and there is no indication that they adversely affect the course of any co-existing psychiatric disorder

Recovery Environment (Level of Stress) — Dimension Score 4

- Severe disruption in life circumstances such as imminent incarceration, lack of permanent residence, or immersion in an alien culture

Recovery Environment (Level of Support) — Dimension Score 4

- Client may be alienated and unwilling to use supports available in a constructive manner

Treatment and Recovery History — Dimension Score 3

- Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms
- Equivocal response to treatment and ability to maintain a significant recovery

Engagement — Dimension Score 2

- Willingness to change

Page 1 of 1

Clinician: Wesley, S

Date Test Performed

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Case II Discussion

Discussion: Although past suicidal behavior was distant, a rating of three is probably justified in the context of his current distress. Vegetative signs are beginning to take their toll, and his ability to function has otherwise deteriorated, indicating the rating of four. It is unclear how much support his mother and sister would be willing to provide but his distrust makes this a somewhat moot point. His treatment history is not clear cut, but it does appear that he has not had great success with past experiences. He was rated as a two in Engagement primarily due to his help seeking behavior, which indicates a desire to change, and some recognition of his problem. Although his composite score is slightly low for a level five, he meets independent criteria for residential treatment, at least temporarily, due to his impaired functioning.

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CASE IX

HISTORY OF PRESENT ILLNESS: D.M. is a 32-year-old Caucasian female who presented to the emergency room due to depression and suicidal ideation. She reported that over the past couple of weeks, she has had increasing problems with depression with occasional episodes of irritability and increasing use of alcohol and cocaine. She reported that her mood had been depressed with troubled sleep, frequent awakenings, fatigued and anhedonia. She was apathetic and unmotivated with poor concentration and low self esteem. Prior to admission she developed suicidal ideation with plan to overdose on her medications and those of her boyfriend. When she became fearful that she would follow through on these plans, she presented to the emergency room and was admitted. She reported that she has been drinking 6-8 drinks daily for the past 1 1/2 years. She also used cocaine intermittently when she has access to it. She has had a number of adverse consequences resulting in her current condition and which are related to her substance use and mental health problems. She has now been hospitalized for 6 days and over the past 2 days suicidal ideation has subsided, sleep has improved, and while she has made efforts to participate in treatment, she remains somewhat unmotivated and apathetic. Withdrawal symptoms have resolved.

PSYCHIATRIC HISTORY: She has had multiple hospital admissions over the last 1 1/2 years, both for substance use rehabilitation and mood disorder. She is taking Depakote 250 mg b.i.d., Risperdal 2 mg q hs.. and Paroxetine 20 mg q a.m., increased to 40 mg, for mood problems. She has been diagnosed with bipolar disorder, but does not describe any frankly manic episodes. She does describe some periods of extreme irritability and hyperactivity and high levels of energy. She states that while she maintains herself on her medications and when not using, that she does fairly well. She denies past suicide attempts with the exception of one attempt during her teen years. Other than some improvement in response to medications, she does not feel that her past treatment experiences have been helpful. She has not been consistent in following treatment recommendations.

MEDICAL HISTORY: She has a history of asthma. She is using an Albuterol inhaler on a p.r.n. basis, maximum 3 times in 24 hours. She also is using Pepcid, 20 mg tablets b.i.d. for gastritis. She also has recently had some problems with bronchitis and urinary tract infections. She is not currently on any antibiotics. Apart from these problems, she denies any other significant medical problems.

SUBSTANCE USE HISTORY: While she has used mainly alcohol and cocaine, she reports that she uses a variety of other substances when they are available. She has used alcohol on a daily basis for a number of years and recently has become involved in both crack cocaine and powder cocaine. She sometimes uses the cocaine in a binge fashion and has runs of several days at a time. She has had previous treatment and previous periods of abstinence, up to 3 years. She designates no particular programs as being most beneficial, but does report that AA has been quite helpful at various times. She reports that she does have several family members who are involved with substances, some of whom are in recovery and some of whom are active. She reports the use of cigarettes, about 2 packs per day, and is not willing to discontinue her use of nicotine at this time.

SOCIAL HISTORY: She has been living currently with a somewhat abusive boyfriend who is also a problem alcohol user. She states that he does well when he is not using but has been physically abusive and cruel to her when he is intoxicated. She is uncertain about her ability to dissociate from the relationship with her partner. She has left him several times but always returns after he promises to change. She has no relationship with her parents, who recently moved to Florida, and has no other current friends. She reports that she recently lost her job. She worked as a mental health therapist but lost her job due to substance abuse and frequent call offs. She also has several legal charges which are pending including theft and possession. On the advice of her public defender, she is seeking treatment, in part, because it will "look good to the judge." She reports that she has few recreational interests and she has personal religious beliefs but no religious involvement. She reports a history of unhappiness dating back to the time of her childhood when she felt neglected by an alcoholic mother. She also was sexually abused by a 17-year-old stepbrother at the age of 8 and has continued to be involved in abusive relationships as an adult.

MENTAL STATUS EXAMINATION: This is a tall, blonde haired, Caucasian female who was somewhat lethargic at the time of interview but was able to brighten and cooperate with the exam. She was dressed in street clothes, casual but clean. She also was able to engage in the interview process and was reasonably well related. She showed no abnormality of speech or movement. Thoughts were well associated and there were no perceptual disturbances reported. She does report, however, that thoughts occasionally become paranoid when off her medication. She reports her mood is depressed but somewhat better than yesterday. Her affect was dysthymic but showed fairly good range and appropriate reactivity. She denied current suicidal ideation. On cognitive exam, she was intact to short term and long term memory, attention and concentration. Her intelligence was average. Her insight and judgment were fair.

LOCUS Evaluation Report

6/28/00 11:42 am

Patient Name: Case IX, D.M. **Date of Test:** 06/28/00 **Time:** 11:38 am

Social Security: 999-99-9999 **Gender:** Female **Patient DOB:** 01/09/1968

Diagnosis: Major Depression, recurrent

Current Disposition: Medically Managed Residential Services

Recommended Disposition: Medically Monitored Residential Services

Actual Disposition: Medically Monitored Residential Services

Reason For Variance: None

Program/Referred To:

Evaluation Notes:

LOCUS RESULTS

LOCUS Score: 24

Risk of Harm — **Dimension Score 3**

- No active suicidal/homicidal ideation, extreme distress and/or history of suicidal/homicidal behavior exists.

Functional Status — **Dimension Score 3**

- Recent gains and/or stabilization in function have been achieved while participating in treatment in a structured and/or protected setting.

Medical, Addictive and Psychiatric Co-Morbidity — **Dimension Score 3**

- Recent substance use which has had clearly detrimental effects on the presenting disorder but which has been temporarily arrested through the use of a highly structured or protected setting or through other external means.

Recovery Environment (Level of Stress) — **Dimension Score 4**

- Serious disruption of family or social milieu which may be due to illness, death, divorce or separation of parent and child, severe conflict, torment and/or physical or sexual mistreatment.
- Difficulty avoiding exposure to active users and other pressures to partake in alcohol or drug use.

Recovery Environment (Level of Support) — **Dimension Score 5**

- No sources for assistance are available in environment either emotionally or materially.

Treatment and Recovery History — **Dimension Score 3**

- Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms.
- At least partial recovery has been maintained for moderate periods of time, but only with strong professional or peer support or in structured settings.

Engagement — **Dimension Score 3**

- Some variability or equivocation in accepting or understanding of illness and disability.
- Has limited desire or commitment to change.

Page 1 of 1 **Clinician:** Wesley, S **Date Test Performed**

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Case IX Discussion

Previous Level of Care Rating

Dimension I	4a
Dimension II	4e
Dimension III	4a,d
Dimension IV-A	4a,e
Dimension IV-B	5a
Dimension V	3d
Dimension VI	4d,e
Total	**28**
Previous LOC Rec.	**6 (Medically Managed Residential Services)**

Discussion: This woman no longer experiences suicidal intentions, so now rates a three for Risk of Harm. Her functioning has improved slightly, and her substance use has at least temporarily been arrested and stabilized, allowing a reduction in her score to three in both dimensions. Her recovery environment is unchanged and will be a challenging problem in her continuing treatment plan. She has shown some improvement in response to current treatment and some improvement since admission in the degree to which she has engaged in treatment, although in a very limited way. Her score indicates that while her deficits in multiple categories required hospitalization initially, she now appears ready to move to a protected, but less intensive setting.

CASE XI

HISTORY OF PRESENT ILLNESS: Ms. C. is a 35-year-old Vietnamese-born, divorced woman who is currently a patient at a state hospital. She is being evaluated today by a treatment team to consider a possible change in level of care.

She has been stable. Ms. C. has been on Clozaril 200mg BID for the past seven months. She reports that this medication has been the most useful to her in decreasing auditory hallucinations. She describes these voices as command hallucinations about activities of daily living like "write to your sister" or "brush your teeth." She denies presence of command hallucinations to harm herself or others. She reports she has had hallucinations since her illness began at age 19. She denies any suicidal or homicidal thoughts at the present time and indicates no significant distress at the present time.

PSYCHIATRIC HISTORY: Ms. C. was admitted to the state hospital four years ago and was transferred to an on-site residential program one year ago. She has been in inpatient care since her admission with the exception of one trial visit with a county community residence. This visit one year after her admission was not successful. Ms. C. reports that she became lost one night and was not able to return to her assigned residence. Hospital records report that there were several incidents and she was described as "non-compliant with the rules of the program."

She re-entered the state hospital after several short-term acute hospitalizations. Past medication trials have included Prolixin Decanoate, Haldol and Trilafon. She has required treatment with anti-Parkinsonian agents, Benadryl and Cogentin.

Records indicated that Ms. C's most significant impairment has been confused, irresponsible, and undirected behaviors. She has a history of leaving her family home or residence and wandering in the neighborhood. During one episode, she was sexually assaulted by several men. She has had periods of hypersexuality while hospitalized. She has been unable to live independently and manage her finances since her illness began sixteen years ago. Ms. C. has two reported suicide attempts by overdose of sleeping pills and aspirin. Today, she is unclear whether she intended to die when these occurred.

MEDICAL HISTORY: Only admission was for childbirth six years ago. No current medications for medical problems. Records indicate history of vaginal infections and abnormal PAP smears. Follow-up for this problem is unclear. Most recent lab work was positive for HIV infection.

SUBSTANCE USE HISTORY: Ms. C. denies use of alcohol or other substances, but toxicology tests on several previous admissions were positive for cocaine and cannabis.

SOCIAL HISTORY: Ms. C. was born in Vietnam and immigrated when she was a teenager. She was raised by her mother and father with her one sister. Two stepsisters were left behind in Vietnam. She was married briefly and divorced by her husband during her current admission. Her daughter is being raised by her mother. Records indicate that she lost custody of her daughter after an alleged incident of feeding her daughter poison. Ms. C. reports that she graduated from high school and wanted to go to community college prior to her illness and wonders whether this would still be possible. She describes her other interests as music, cooking and walking outside.

She has limited involvement with her family, and they have visited and taken part in family programming infrequently. She appears indifferent to her relationship with them.

MENTAL STATUS EXAMINATION: Ms. C. is a pleasant, well-dressed woman who speaks with an accent and at times is difficult to understand. Formal thought disorder with occasional loose associations is evident but does not impede the interview. She gives the impression of trying to give an answer to every question even if she isn't sure, in order to be polite. Mood is euthymic and affect is stable and somewhat blunted. She denied current suicidal/homicidal thoughts. Reported occasional mild auditory hallucinations. Cognition was not formally tested, but patient was alert, oriented, with no evidence of major impairment.

LOCUS Evaluation Report

6/28/00 11:42 am

Patient Name: Case XI, Ms. C. **Date of Test:** 06/28/00 **Time:** 11:38 am

Social Security: 111-11-1112 **Gender:** Female **Patient DOB:** 01/11/1965

Diagnosis: Schizoaffective Disorder

Current Disposition: Medically Managed Residential Services

Recommended Disposition: Medically Monitored Residential Services

Actual Disposition: Medically Monitored Residential Services

Reason For Variance: None

Program/Referred To:

Evaluation Notes:

LOCUS RESULTS

LOCUS Score: 24

Risk of Harm — Dimension Score 3
- No active suicidal/homicidal ideation, but extreme distress and/or history of suicidal/homicidal behavior exists.

Functional Status — Dimension Score 3
- Chronic and/or variably severe deficits in interpersonal relationships. ability to engage in socially constructive activities, and ability to maintain responsibilities.

Medical, Addictive and Psychiatric Co-Morbidity — Dimension Score 3
- Ongoing or episodic substance use occurring despite adverse consequences with significant or potentially significant negative impact on the course of any co-existing psychiatric disorder.

Recovery Environment (Level of Stress) — Dimension Score 3
- Significant transition causing disruption in life circumstances such as job loss, legal difficulties or change of residence.

Recovery Environment (Level of Support) — Dimension Score 4
- Existing supports are unable to provide sufficient resources to meet material or emotional needs.

Treatment and Recovery History — Dimension Score 4
- Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms even with intensive and/or repeated exposure.

Engagement — Dimension Score 4
- Rarely, if ever, able to accept reality of illness or any disability which accompanies it.

Page 1 of 1 **Clinician:** Wesley, S **Date Test Performed**

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Case XI Discussion

Previous Level of Care Rating:

Dimension I	3b
Dimension II	5e
Dimension III	3d
Dimension IV-A	3a
Dimension IV-B	4c
Dimension V	4a
Dimension VI	4d,a

Total **26**
Previous LOC Rec. **6 (Medically Managed Residential Services)**

Discussion: This woman, who has failed in past attempts to live in the community, has recently improved and stabilized her functioning with the introduction of a new medication. Her past history of suicide attempts puts her at moderate risk of harm, but functioning has improved and stabilized, although there are some chronic deficits. Substance use has been at least temporarily arrested. The possible change in her living situation may be causing some moderate stress at this time, and she currently has little support available in the community. Her ability to maintain herself in a less structured setting is not established, nor is her ability to engage with treatment resources. The improvement in her function is sufficient to support a recommendation for less intensive management in a community-based residence with the hope of eventually strengthening community supports and graduation to less structured living in the future.

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References

Sowers, W., et al (2003). Level of care decision making in behavioral health services: LOCUS and CALOCUS. Psychiatryonline.org, vol 54, no. 11.

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