

LOCUS

Training Manual

Level of Care Utilization System
for Psychiatric and Addiction Services
Adult Version 2000

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INTRODUCTION

This manual was designed to provide you with a guide to the use and understanding of the Level of Care Utilization System (LOCUS) instrument. The first part of this manual will introduce you to LOCUS, focusing on the historical context in which it was developed. The second section will focus on the rationale and principles used to define the level of care determinations. The third section will address the dimensional rating system and the evaluation parameters. The fourth section will describe the service areas which comprise each level of care. The fifth section will describe the placement recommendation methodology. Sections six and seven consist of the instrument itself: the evaluation parameters and the level of care definitions. Section eight contains case studies to assess your understanding of the material presented. The final section is a post test and answers to the questions making up the test. An appendix containing a guided interview for collecting information relevant to making a LOCUS level of care recommendation and a worksheet is also provided.

PART I

HISTORICAL PERSPECTIVE

The LOCUS instrument was developed for a variety of reasons. It is important to understand the history of level of care determinations in mental health treatment systems to appreciate some of them. It is no secret that over the past several years the cost of health care has risen dramatically. This has been true of mental health services, as well as other types of health related services. This rise was particularly dramatic during the 1980's and early 1990's. Part of the problem was that resources were poorly distributed and treatment decisions were often made in an idiosyncratic manner. Historically, most resources were used for the most intensive types of care, particularly hospital-based care, and fewer resources were directed toward providing care in the community.

From the 1960's through the 1990's, deinstitutionalization progressed, but in many cases few services were available for the people released from hospitals to help them survive and thrive in the community. Many of the services that were available were fragmented and usually did not constitute a full continuum of care. People would leave the hospital without an adequate transition to independent living, leading to frequent readmissions. Decisions made regarding clients' needs were inconsistent and, in most cases, physicians held much of the power over where and how people should receive care. We ended up with a system of treatment in which the costs were high, and the standard of care was variable, often dependent upon the resources of the patient. Patients were often treated in very restrictive settings that inhibited their freedom and their ability to develop independence.

Dramatic changes in the health care delivery system began in the early 1990's. Because of the high cost of health care, various programs were introduced to change the nature of health care financing. Many of the initiatives took the form of a national health care insurance plan. The Clinton Administration put forth one such plan, but it did not accomplish its goal for a variety of reasons. The Federal Government was not inclined at that time to become involved in the provision or regulation of health care policy. The result was not only the failure of a nationalized health program, but also an abdication of government responsibility for its regulation of health care financing and standards. A policy that depended on market forces to determine the care people received and to control cost was developed. With the advent of resource management companies or "managed care," profit became a major incentive of care managers, and profits could be realized by limiting the amount of care that was provided. This was quite distinct from the earlier situation, where just the opposite was the case. With this development, we had a situation where new problems were replacing old problems, and a restoration of balance was needed. It was in this context that the importance of a standardized instrument for the evaluation of client needs was considered.

Over the last several years we have heard a lot about managed care. It has become a bit of a “dirty” word. However, when we are talking about managed care, we are actually talking about the management of resources. This is nothing new; in the past it was just organized differently. We have now arrived at a time where management of resources needs to make more sense. We need a system that achieves consensus about how to manage services in an efficient manner and one which can provide the best care possible to the largest number of people.

With this in mind, the AACP began its development of an instrument which could represent a broad consensus of both clinicians and resource managers and which could help guide level of care decisions or resource utilization decisions.

PART II

FOUNDATION AND PRINCIPLES

In the past, there have been several attempts to use clinical assessments to determine level of care needs, although there was no clear method for linking the assessment to the need for treatment. These instruments gave us some idea of the client's clinical status with regard to thought process or mood or various other areas of relevance, but they didn't have any direct connection with the client's treatment needs.

Another approach to patient placement focused on the development of criteria which were specific to a given program. For example, a day hospital might have a set of criteria which would describe the type of patient that was appropriate for that program. An evolution of this idea was the concept of "level of care," which tried to group services of similar intensity together. Along with defining the levels of care, standardized and specific criteria were also developed. Rather than focusing on criteria which were specific to a program, criteria specific to a level of care evolved.

Finally, the combination of these two concepts resulted in the development of dimensional assessments for level of care determinations. This process combines the assessment related to a client's clinical needs or functional status with a set of defined levels of care and develops a methodology for matching needs to treatment resources. This became the basic foundation of LOCUS.

As a starting point in the development of LOCUS, we wanted to define a set of dimensions for assessment that were limited in number, but relevant to the type of services that a client needed. Our intent was that the ratings would be simple, yet specific in their content, so there would not be a great deal of complexity or confusion in making decisions. They would also be quantifiable, to convey information easily, and provide a spectrum along which a client might lie on any given dimension. These quantifiable ratings would allow a composite rating score to be obtained that would be the result of the interaction of each of the individual dimensional scores.

An additional principle that we wanted to incorporate into this instrument was the ability to measure both psychiatric and addiction problems. Since most existing instruments focused primarily on either psychiatric or addiction variables, this integration would eliminate the need for different instruments to measure the two different types of disorders. This would allow clients to be assessed without regard to diagnosis and regardless of their presenting problems, thus making this a particularly advantageous tool for use with the co-occurring disorders.

In order to develop a tool applicable to a wide variety of treatment environments and patient needs, it was important to also develop a set of definitions for levels of care that described the various resource elements of specific levels of care. These definitions would need to be flexible and adaptable, in order to be broadly applicable to the wide variety of situations in which care is given. This approach would allow providers to ensure that adequate services and quality care would be provided in an economic fashion.

Application or ease of use of the instrument was also important. Ease of use, time, and universal adaptability were critical factors in establishing broad acceptability which could lead to the establishment of a single standard agreed upon by insurers, providers, and consumers.

Finally, the instrument would be able to be used reliably and have valid results and recommendations. The recommendations it produced should correspond with those made by persons considered to be experts in the field of psychiatry and addiction given the same clinical information. Ultimately we would want to be able to demonstrate that the recommended course of treatment would be a better predictor of success than any other course of treatment that could be chosen.

These expectations and principles resulted in the identification of six defined dimensions: 1) Risk of Harm, 2) Functional Status, 3) Medical, Addictive and Psychiatric Co-Morbidity, 4) Recovery Environment, 5) Treatment and Recovery History, and 6) Engagement. Each of these dimensions has a specific set of criteria based on a five point rating scale that can be quantified. This interaction is the “essence” of the LOCUS assessment system, which allows various assessment factors to influence each other. The rating system also allows a dynamic assessment model, creating a moving picture of the client and how the client is functioning over time.

Recognizing that client needs can vary widely, the LOCUS instrument also defined six service levels of care: 1) Recovery Maintenance and 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, and an additional set of services called “Basic Services,” which define resources available to the general community. Each level of care is defined using four variables that broadly describe the array of services, service intensity, and program characteristic according to: 1) Care Environment, 2) Clinical Services, 3) Supportive Services, and 4) Crisis Resolution and Prevention Services.

The scoring methodology found in LOCUS translates the assessment results from a set of ratings to a placement recommendation. Patient movement and placement recommendations can be determined using the AACCP Level of Care Determination Grid, the AACCP Level of Care Determination Decision Tree or the computerized version of the AACCP Level of Care Determination Decision Tree developed by Deerfield Behavioral Health, Inc. for the AACCP.

The construction of LOCUS is easy to understand, and it is quick and easy to use once basic familiarization has been achieved. It employs multi-disciplinary perspectives and can be used by a variety of mental health professionals. Although it is used for initial placement decisions, it has multiple functions. An important aspect of LOCUS is its use for utilization management. Many instruments in the past developed separate criteria for admissions, continuing stay, and discharge. With LOCUS, it is not necessary to use different criteria because of the dynamic nature of the quantifiable dimensional ratings. The structure of LOCUS may also be applied to activities such as treatment planning, outcomes monitoring, and program development.

There are some things LOCUS will not do. It will not prescribe program design. In other words, it does not tell us exactly what kind of program we need, but rather the type and intensity of resources that need to be available in that program. It does not specify treatment interventions, nor negate the importance of clinical judgement. Nor does it limit our creativity in developing specific programs that meet the needs of special populations or localities. That will continue to be the role of the professional.

The following sections of this manual will provide you with more detail regarding the LOCUS instrument and its appropriate use.

PART III

DIMENSIONAL RATING SYSTEM

LOCUS Instrument

This section will describe the Dimensional Rating System, how it works, and the unique aspects of its application.

The Dimensional Rating System is an assessment that determines the level of severity of a client's needs. It operationalizes many of the factors clinicians would consider in trying to determine the most appropriate services for a client who presents for care.

In the Dimensional Rating System, there are six evaluation parameters (dimensions):

1. Risk of Harm
2. Functional Status
3. Medical, Addictive and Psychiatric Co-Morbidity
4. Recovery Environment:
 - Sub-Scale: A-Stressors
 - B-Supports
5. Treatment and Recovery History
6. Engagement

Each dimension has a five-point rating scale. For each of the five possible ratings within each scale, a set of criteria is clearly defined. Only one criterion needs to be met for the rating to be selected in each scale. The highest rating in which at least one of the criteria is met is the rating that is assigned for the patient. Not only is there a score for each of the dimensions, but a composite score is also calculated. This allows interaction and gives us an overall indicator of the level of need for a given client. For the most part, the use of the rating scale is quite self-explanatory. Each dimension has a paragraph describing its use and what it is designed to measure. Even people who have had no training with LOCUS can do a fairly good job of figuring out how to use it after an initial reading.

In order to understand what each parameter is measuring, it is important to review the introductory paragraphs individually. *Remember, you want to select the highest rating in each dimension where at least one of the criteria is met.* In some cases there may be some ambiguity, in other words, the clinical picture of a real life case may not fit any of the criteria on the rating scales exactly. In that situation you should pick the closest fit, or choose the criterion which most closely approximates the actual condition of the client they are considering.

When there is some confusion about which rating should be assigned, and you are not certain which is the closest fit, you should choose the higher rating. *If there is uncertainty, it makes sense to make decisions on the side of caution.* No instrument can anticipate every circumstance, or be so general that it can be applied to every situation, so a great deal of clinical judgement will be needed. Although the instrument does supply some guidelines, you will be required to make a determination based upon the interview with the client and your intuition about where the most

appropriate assignment or rating level falls within a dimension. This may be based in part on a mental status examination or a family member's observations. Not all of the information you gather must come directly from the client. This is where your clinical judgement is particularly important.

DIMENSIONS

Risk of Harm

The first dimension is Risk of Harm. We are looking at the degree to which a client may have suicidal or homicidal behaviors, either ideation or intentions. We are also looking at other behaviors that might place somebody in danger. For example, a client's judgement or ability to be aware of the environment may be impaired to the extent that they may be in danger.

Before we move on however, there are a couple of things worth emphasizing here. One of the terms used in describing someone's risk for engaging in these kinds of behavior is level of distress. We use terms such as significant distress and extreme distress. These are obviously relative terms, and ones that can't be precisely defined for any particular client. It will be largely up to you, the clinician, to use your discretion to assess and assign a relative level of distress, particularly in terms of putting someone at risk for harmful behaviors. You also need to be aware that there are some cases where you are going to have clients who engage in dangerous behaviors on a chronic basis. We know that very restrictive environments may in some ways delay the expression of these behaviors, but by no means are they a solution. So, for those persons who do suffer from this form of mental illness, we do not rate them in the same way as we do persons who have acute episodes of self destructive or dangerous behaviors. Unless you are seeing a departure from the client's baseline behavior, a lower rating of risk of harm is assigned to these clients than would be assigned if they were part of an acute condition. One other thing to note here is that transient risk of harm may result from intoxication. If you are seeing clients during a period of intoxication and they are aggressive or threatening, you need to rate them, at least in that moment, according to their behavior. However, you also need to recognize that the rating may change very rapidly as they achieve sobriety. This is one example of the dynamic nature of the rating system and how ratings will change as the client's condition changes.

Functional Status

The second dimension is Functional Status. There are four major factors in this dimension: 1) the client's ability to fulfill their obligations or maintain their normal level of functioning; 2) their ability to interact with others; 3) their vegetative status (disruptions in their physical functioning as a result of their illness); and 4) the client's ability to care for themselves. (When we think about functional status, we are looking at a comparison against a baseline or an ideal level of functioning.) In most cases, ratings will be based on recent changes in functional status, rather than functioning relative to others. It is important to note that there is a distinction from the concept of self-care in "Dimension 1 — Risk of Harm," which only considers functioning which may place clients in harm's way. When we are looking at self-care in the functional status category, we are looking at it more in terms of acute changes in one's ability to care for him or herself. So persons who have chronic characterological or functional disturbances will not be rated as highly as somebody who has had an acute change in their ability to function. As a final note,

you should not rate disabilities that are not related to mental illness. Although physical disabilities may have an adverse effect on functioning, if they are not part of the mental illness, you do not include them in this rating of functional status.

Medical, Addictive and Psychiatric Co-Morbidity

The third dimension is Medical, Addictive and Psychiatric Co-morbidity. What we are assessing is the interaction of illnesses when they exist concurrently. Is the client's ability to recover from one condition adversely affected by another? For the sake of clarity, a presenting condition is identified. The presenting condition is the condition identified by the client when they come in. Those conditions identified later are considered to be co-morbid disorders. It does not imply that one disorder may be more important than the other. We need to start with the condition that is most readily apparent and then consider the interaction of one illness with another. Since LOCUS ratings are not diagnostically based, co-morbidity does not include a consideration of symptoms which may represent more than one disorder within a category, such as depression and borderline personality disorder. Only interactions between addiction and psychiatric disorders, psychiatric and medical, or addiction and medical are considered. Also note that for the sake of our assessment with LOCUS, when we consider physiological withdrawal symptoms, we would treat them as a medical co-morbidity. So, if someone has the potential for, or is in the middle of, alcohol withdrawal, we would treat that as a medical condition on the co-morbidity scale. Higher scores on this scale acknowledge that interacting disorders may indeed require more intensive treatments.

Recovery Environment

The fourth dimension is Recovery Environment, and here two sub-scales are defined: first, the level of stress, and second, the level of support. The rating for stress is determined by various sources of stress that may be present, and the level of support is determined by the supportive elements that are available in someone's environment. This can be confusing at times if someone is in a protective environment when they are being assessed. Do we rate on the basis of the protected environment they are in, or do we rate on the basis of the environment they would face if they were not under protection? And do we rate the sources of support that are present at the time of the rating, or those that are likely to be present further down the line? The answer to both questions is the same. We rate on the basis of the conditions which the client will experience if they leave the protected environment. We have to make this clear as we use LOCUS for utilization decisions. There may be some cases where unique sources of stress and/or combinations of supportive services are encountered that are not precisely described in LOCUS. This is an instance where choosing the "best fit" applies. You should attempt to use rating headings along with the criteria that are described at each rating level to guide you to the proper rating in these cases.

Treatment and Recovery History

The fifth dimension is Treatment and Recovery History. This is obviously an important piece of the decision making process. If you know that someone has had a difficult time in treatment in the past, particularly without extensive investment of resources, you may be more inclined to provide more intensive services for this episode of treatment. How they did in their recovery after they completed treatment is also important. One thing to remember when looking at recovery and treatment history is that you place much more weight on recent experiences than you do on experiences that have occurred in the past. Persons who have failed in the intensive services in the

past will continue to merit from greater services to affect change. This does not necessarily imply, however, that they should be the same services that have not been helpful previously.

Engagement

The sixth dimension is Engagement, and four factors need to be considered: 1) understanding and acceptance of illness; 2) one's desire for change; 3) the ability to interact with potential sources of help; and 4) the ability to accept some responsibility for recovery and participation in treatment. This is not intended to be a rating of a client's cooperation and compliance, but rather one's ability and interest in making changes and is derived from recovery models. Clearly, you may want to invest more effort in developing a trusting relationship with someone who has a hard time trusting or who has a hard time engaging in services. So extra efforts may be needed here, particularly for those who have had a hard time either understanding the nature of their problems or getting to a point where they are ready to make an effort to change. This does not imply that the consumer is difficult or otherwise oppositional simply because they do not see their illness in the same way that others do. One thing that we encourage you to do here is to think of this category objectively, and determine how the client's ability to engage may affect his or her capacity for making changes that will enhance well being.

LEVEL OF CARE RECOMMENDATIONS

Having provided you with an overview of the parameters, the rating system should be discussed. Once you have chosen a rating in each dimension, you use the scores to arrive at a placement recommendation. The recommendation describes a level of resource intensity which best suits a given patient according to their needs. It does not mean that the patient needs to comply with the recommendation, nor that these are the only services that can be offered. The client may have an option to choose a lower level of care than that being recommended, unless they are being involuntarily committed for their own safety or the safety of others.

Remember, LOCUS doesn't make judgements about people's attitudes or motivation, it simply suggests what will be most helpful to persons in certain situations.

This has been an overview of the Dimensional Assessment System. There may be some questions that arise, however, as you gain some proficiency in using the rating system. Our hope is that those questions will be few. The criteria described for the dimensional ratings are going to be sufficient in most cases for you to feel confident at arriving at a rating and be able to do that in a relatively rapid fashion.

PART IV

LEVEL OF CARE SERVICES

The Levels of Care in LOCUS are unique and distinct from how levels of care are often defined. In LOCUS, we are really talking about levels of resource intensity. We are using a level of care as a flexible or modular concept. It takes into consideration the expense of treating a client in a given constellation of services. Each Level of Care is defined by a combination of service variables: physical facilities, clinical services, support services, and crisis stabilization and prevention services. Each Level of Care takes into account the availability of resources found in each category. Some Levels of Care may contain the same resources found in other Levels of Care but, by and large, as we go up through the levels of care, the number, types of services available, and the intensity of services that are available will become more and more complex. In most cases, they will be more costly as well.

One way to think about the Levels of Care is analogous to how we think about the differences between a small corner store and a shopping mall. In the simplest case, if a shopper's needs are not great, they can go into the corner store, which may not have a wide selection, but may have enough items to meet the shopper's needs. But, if the shopper has greater and more diverse needs, they might go to the mall where they will have access to a myriad of choices. That is similar to how the Levels of Care work.

In LOCUS there are seven Levels of Care: six are actually service levels. The seventh is a basic service package that is available to everyone in the population being served whether or not they need mental health care at the moment. Basic services focus on prevention and health maintenance issues.

Levels of Care:

Level One	Recovery Maintenance and Health Management
Level Two	Low Intensity Community Based Services
Level Three	High Intensity Community Based Services
Level Four	Medically Monitored Non-Residential Services
Level Five	Medically Monitored Residential Services
Level Six	Medically Managed Residential Services

Each one of these levels is defined by the four variables described earlier: the care environment, the clinical capabilities, the supportive services that are available, and the crisis resolution and prevention services that can be accessed.

The placement criteria are described for each level of care according to scoring on the dimensional assessment. That description provides the basis for the placement methodology. Some resources may be available at more than one level of care. For example, many clients may be in need of residential services, but not all clients will need to have onsite treatment in a residential environment. Supportive housing may be needed for someone who only requires outpatient care or intensive outpatient services. This is recognized by the LOCUS system. All services that do exist are going to fit somewhere in the LOCUS continuum. This means that the continuum defined by

LOCUS is described broadly enough and flexibly enough that it can accommodate all existing services. In most communities there will be gaps in the services that are available in the continuum. In the LOCUS continuum we are looking at a hypothetical or an “ideal” continuum in which there are no gaps, rather than an actual service system.

LEVEL OF CARE DESCRIPTIONS

Basic Services

Basic services are those services that should be available to all members of a community. They are services designed to prevent illness or to limit morbidity. They often have a special focus on children, and are provided primarily in community settings but also in primary care settings. There is clinical capability for emergency care, evaluations, brief interventions, and outreach to various portions of the population. This would include outreach to special populations, victim debriefing, high-risk screening, educational programs, mutual support networks, and day care programs. There are a variety of services available to provide support, address crisis situations and offer prevention services.

Recovery Maintenance and Health Management

Level One, “Recovery Maintenance and Health Management,” is a low-intensity level of care. The clients who participate in this level can live independently in the community, and are usually stepping down from a more intensive treatment level. This level does not require frequent contact with professionals and it is not an entry point into a system. It is for those who have been in treatment and are now ready for assistance in maintaining health and their recovery. These services have minimal requirements, so the care environment can be in a variety of settings. The basic clinical services will be available, and support programs for community living should also be available. Vocational training, rehabilitation, transportation and/or mutual support programs are services that may also be accessible to clients at this level of care.

Low Intensity Community Based Services

Level Two, “Low Intensity Community Based Services,” is more intensive than Level 1. We usually think of them as clinical services that may be provided on a periodic basis, up to once a week. This can be an entry level for clients presenting with minor disturbances. There is no control over access in this setting, and a full menu of supportive services should be available. Not all clients that are assigned to this level of care are going to use all of the services that are available. However, they will have access to them as needed. Rehabilitation, housing support, and living assistance can all be offered at this level of care.

High Intensity Community Based Services

Level Three, “High Intensity Community Based Services,” is the next step. This level is for the client that needs more intensive attention, structure, and contact, usually several days per week, for several hours per day. The requirements for the care environment are not significantly more complex than other outpatient services. However, there will be a greater capacity to provide clinical services, and greater availability of clinicians. Case management is something that is used more extensively at this level of care. Mobile service capability, day care, and rehabilitation services are often part of the treatment plan at this level as well.

Medically Monitored Non-Residential Services

Level Four, “Medically Monitored Non-Residential Services,” is for those who need a great deal of structure, support and monitoring, but not so much that they require an onsite living situation for their treatment. Services at this level of care would be similar to traditional day hospital services, or assertive community treatment. It will have 24-hour availability of clinical support. Clients in this level are followed closely. Daily contact with treatment providers is usually available, and services such as intensive case management, and rehabilitation services are also available. Involvement will vary to some degree depending on the specific circumstances and needs of the client.

Medically Monitored Residential Services

Level Five, “Medically Monitored Residential Services,” is a residential-based service. There is a great deal of structure provided in this setting, and the capability for 24-hour monitoring. There is no capacity for secure care, nor is there the ability to place someone in seclusion or restraints. This may be a level where some chronic custodial care may be provided for those who have little hope of returning to a higher level of functioning. In some cases, it may be similar to a nursing facility; in other cases it may be a subacute or stepdown service. These facilities generally have 24-hour availability of medical personnel, and are capable of providing fairly intensive monitoring. An important aspect of this level of care would be a liaison with community care providers and case management.

Medically Managed Residential Services

Level Six, “Medically Managed Residential Services,” is secure care that has traditionally been provided in a hospital setting, although it does not need to be in a hospital. This is a level of care generally used for the most acute and disturbed persons with mental illness. It provides a secure setting with the availability of seclusion and restraints, where admission and treatment can be voluntary or involuntary, and contact between clients and visitors can be restricted. The clinical attention is generally intense. Medication will be managed and dispensed. A liaison with community care givers is an important component of this treatment modality. Stabilization is the main goal, along with efforts to move clients to less restrictive services as quickly as possible.

PART V

PLACEMENT METHODOLOGY

The LOCUS instrument is designed to assess the service needs of the client. Each Level of Care is associated with a set of criteria, and the criteria are defined using the scores appropriate for that level on each dimension. An initial rating is generally completed following the intake evaluation. Subsequent ratings are conducted throughout the course of treatment and at discharge. A copy of the “Guided Interview” can be found in the appendix (*Attachment A*). This tool is designed to help the clinician gather appropriate clinical information necessary to complete the LOCUS instrument. Each question is associated with one or more of the dimensions found in LOCUS. Although use of the guided interview is not required, it may be a useful aid to structuring the interview.

As noted earlier, each evaluation (dimension) parameter is defined along a scale of one to five. Each score in the scale is defined by one or more criteria which are set apart by lower case letters. Only one of these criteria need be met for a score to be assigned to the subject. The clinician should select the highest rating level in each dimension that most accurately identifies the client’s condition.

Once scores have been assigned in all six evaluation parameters, they should be recorded on the worksheet (*Attachment B*) and totaled to obtain the composite score. Using the LOCUS Level of Care Determination Grid (*Page 42*) will give you a rough estimate of the placement recommendation. In some cases, independent criteria are defined that automatically place a client in a specific level of care. This may be indicated regardless of what their scores in other dimensions are. For example, if someone scores very high in suicidal or dangerous behaviors, and they have no ability to protect their safety outside a protected setting, that score would indicate that, no matter what other circumstances exist, we would place them in a secure setting. These independent criteria are marked in the AACP Level of Care Determination Decision Tree (*Page 40*), and the AACP Level of Care Determination Grid (*Page 42*). For the most accurate recommendation, the LOCUS Decision Tree should be used.

In assigning Levels of Care, there will be some systems that do not have comprehensive services for all populations at every level of the continuum. When this is the case, the Level of Care recommended by LOCUS may not be available, and a choice will need to be made as to whether more intensive services or less intensive services should be provided. In most cases, the higher level of care should be selected, unless there is a clear and compelling rationale to do otherwise. This will again lead us to err on the side of caution and safety rather than risk and instability. The LOCUS Decision Tree is the most accurate way of determining what level of care someone should be offered. Although it may look complicated, it is fairly simple to use once you become familiar with it. When using the LOCUS Decision Tree, always begin at the appropriate “Entry Point” found at the top of the page. Questions pertaining to the score in each of the dimensions help you arrive at a recommended Level of Care. When first using the Decision Tree, it is important to read the questions carefully and pay close attention to the “ands” and “ors” before selecting a yes or no response.

The computer version of LOCUS will automatically compute the composite score and the Level of Care recommendation. One merely indicates the various criteria that are met in each of the dimensions. This information is then recorded and analyzed to determine the Level of Care recommendation. The criteria selected in each of the dimensions also provide a client profile. This profile can be used to explain why you arrived at the decisions you made regarding a particular Level of Care and later to assess clients' status as they participate in treatment.

As a clinician, you do not have to memorize the definition for each Level of Care, nor do you need to know the criteria for placement at that level. However, as you become more familiar with the criteria you will be able to complete your assessments more quickly and easily. You will want to develop a menu of services that are available within your system for each Level of Care in LOCUS. When a Level of Care placement recommendation is given, you will know what services are needed to approach the requirements of that level, and what pieces may need to be appended in order to complete the treatment plan. Services can always be customized according to local or cultural needs.

LOCUS is a system that is not overly prescriptive. It is flexible and adaptable, and describes an array of services and level of service or resource intensity rather than a level of care per se. This quality should allow your system to incorporate LOCUS easily.

PART VI

LEVEL OF CARE UTILIZATION SYSTEM

**(LOCUS)
Version 2000**

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LOCUS Instrument Version 2000

Evaluation Parameters for Assessment of Service Needs Definitions

I. Risk of Harm

This dimension of the assessment 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 oneself are considered only in the context of their potential to cause harm. Likewise, only behaviors associated with substance use are used to rate risk of harm, not the substance use itself. In addition to direct evidence of potentially dangerous behavior from interview and observation, 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. Risk of harm may be 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.
- 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..
 - 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.

II. Functional Status

This dimension of the assessment measures the degree to which a person is able to fulfill social responsibilities, to interact with others, maintain their vegetative status, as well as a person'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. Persons 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.

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

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.

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

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 person'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 persons to maintain health and role functioning in the face of stressful circumstances, such as availability of adequate material resources and relationships with family members. The availability of friends, employers or teachers, clergy and professionals, and other community members, which provide caring attention and emotional comfort, are also sources of support. For persons 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.

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

This dimension of the assessment 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 person 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.

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

This dimension of the assessment considers the client'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 client's ability to be successful at a given level of care.

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.

LEVELS OF CARE

Definitions

BASIC SERVICES - Prevention and Health Maintenance

Definition:

Basic services 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 with special focus on children.

- 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.

I. LEVEL ONE - Recovery Maintenance and Health Management

Definition:

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 31) will be accessible.

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** - 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.

II. LEVEL TWO - Low Intensity Community Based Services

Definition:

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, but could be provided in community locations. These programs should 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 three hours per week, but usually not less than one hour every two weeks. Psychiatric or physician review and/or contact should take place about once every eight weeks. 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, child care 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 31) will be accessible.

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** - 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.

III. LEVEL THREE - High Intensity Community Based Services

Definition:

This level of care provides treatment to clients who need intensive support and treatment, but who are living either independently or with support in the community. Service needs do not necessarily require daily supervision, but contact is required several times per week. Programs of this type have traditionally been clinic-based programs, but they could be provided in the community as well. These programs should 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 these services may be provided in community settings or in the place of residence.
2. **Clinical Services** - Treatment programming (including group, individual and family therapy) will be available at least three days per week and about two or three hours per day. Psychiatric/medical review and/or contact should take place about every two weeks, and be available more frequently if required. 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.
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, child care 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 31) will also be available.

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** - 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.

IV. 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 delivering services to the client, in which case, capability for staff transportation would be required.
2. **Clinical Services** - Clinical services should be available to clients through most of the day on a daily basis. Psychiatric services would be available on a daily basis and contact would be required at appropriate intervals. Psychiatric services would also be available by remote communication on a 24-hour basis. Nursing services should be available than about 40 hours/wk. 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/wk and include individual, group, and family therapy depending on client needs. Rehabilitative services should be an integral aspect of the treatment program when indicated. 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, child care 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.

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** - 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).
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.)

V. LEVEL FIVE - Medically Monitored Residential Services

Definition:

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 contacts should occur at least weekly, but may occur as often as daily. Emergency medical care services should be easily and rapidly accessible. On site nursing care should be available about 40 hours/wk if medications are being administered on a frequent basis. On site treatment should be available seven days /wk including individual, group and family therapy. In addition, rehabilitation and educational services should 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.

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** - 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.

VI. LEVEL SIX - Medically Managed Residential Services

Definition:

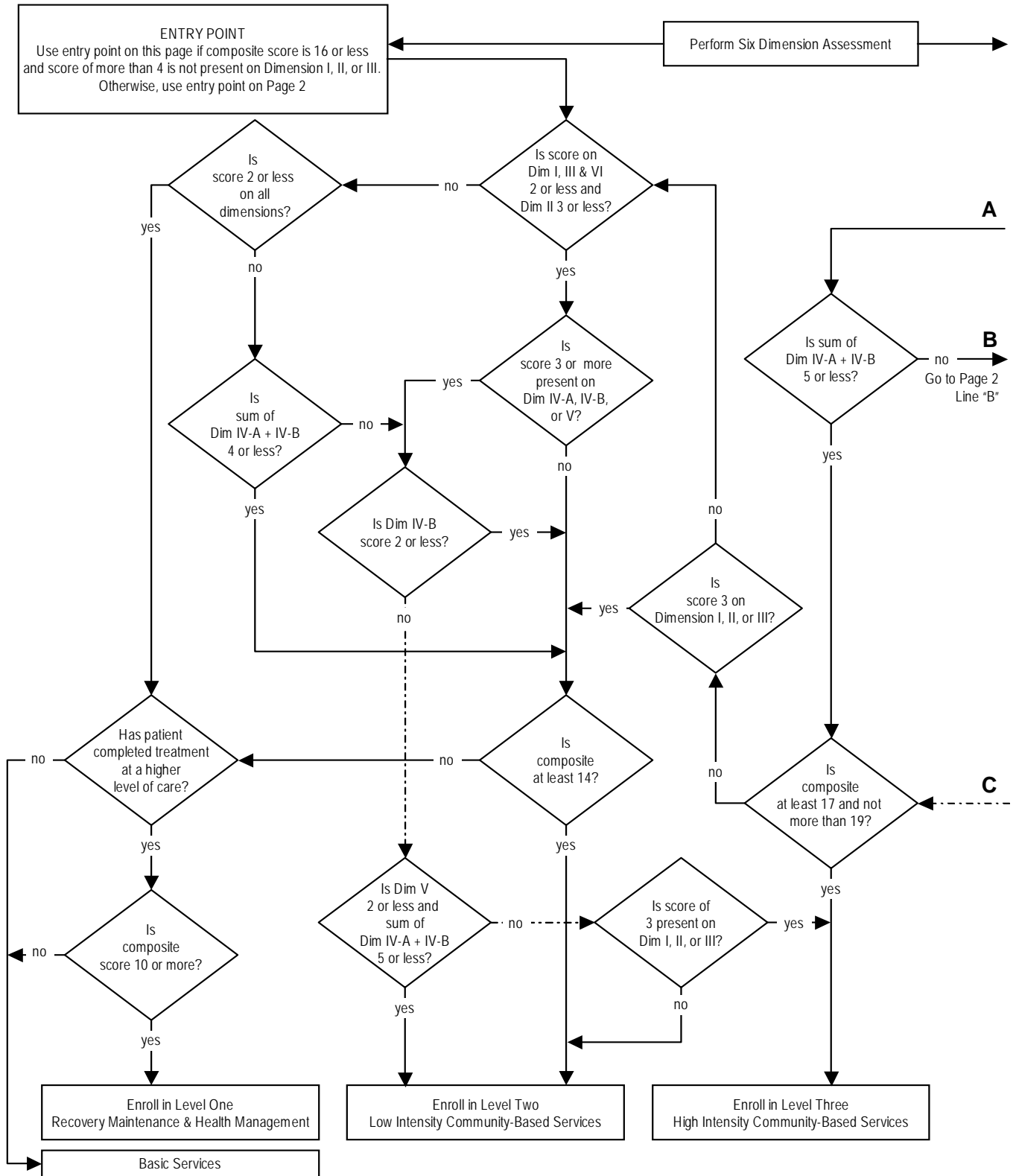
This is the most intense level of care in the continuum. Level six services have traditionally been provided in hospital settings, but could, in some cases, be provided in freestanding non-hospital settings. Whatever the case may be, such settings must be able to provide the following:

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.

Placement Criteria:

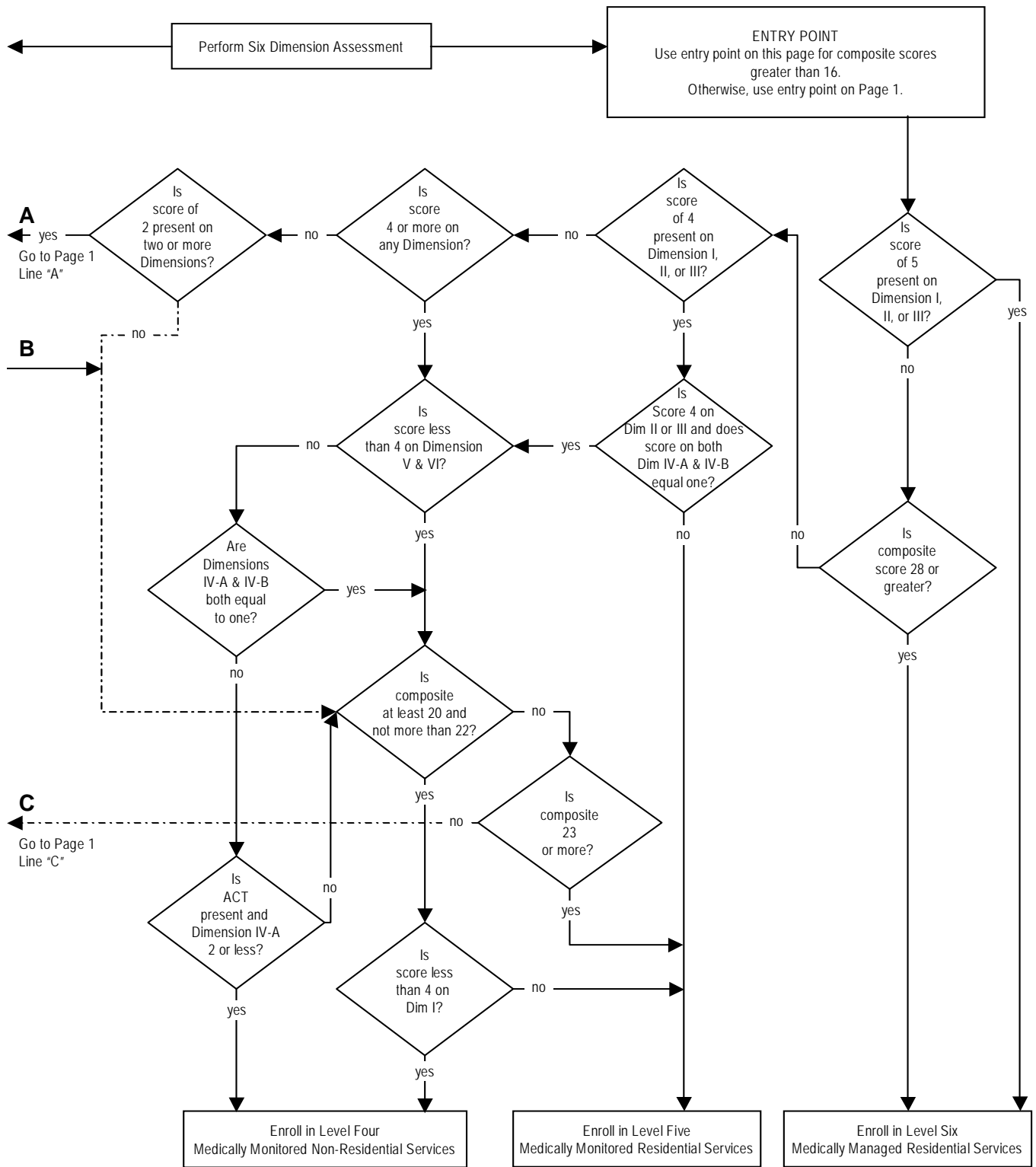
1. **Risk of Harm** - a rating of five qualifies an admission independently of other parameters.
2. **Functional Status** - a rating of five qualifies placement independently of other variables.
3. **Medical, Addictive and Psychiatric Co-Morbidity** - a rating of five qualifies placement independently 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** - 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.

AACP LEVEL OF CARE DETERMINATION DECISION TREE



Decision Tree, Page 1

AACP LEVEL OF CARE DETERMINATION DECISION TREE



Decision Tree, Page 2

LEVEL OF CARE DETERMINATION GRID

Level of Care	Recovery Maintenance Health Maintenance	Low Intensity Community Based Services	High Intensity Community Based Services	Medically Monitored Non-Residential Services	Medically Monitored Residential Services	Medically Managed Residential Services
Dimensions	Level 1	Level 2	Level 3	Level 4	Level 5	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"	2 or less	2 or less	3 or less	3 or less	3 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

* Unless sum of IV A and IV B equals 2

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

PART VIII

CASE STUDIES

In this section you will have an opportunity to use the information that was presented in this manual. Eleven case studies have been created for you to review and score. After reading the case study, select the highest rating in each parameter. Record the scores using the LOCUS worksheet and calculate the composite score. Then, using the LOCUS Decision Tree and the Level of Care Determination Grid, determine the recommended level of care. The dimensional scores and level of care recommendations, determined by an expert panel, for each case study can be found starting on page 62 of this manual. These scores are provided in the form of the “LOCUS Evaluation Report” produced by the software version of LOCUS developed by Deerfield Behavioral Health, Inc. For the purpose of this exercise, all cases are given the same diagnosis, Adjustment Disorder-Unspecified. This does not imply that it is a correct diagnosis. “Program referred to” is an item that will be of local significance only and programs designated in these reports are fictitious.

CASE I

HISTORY OF PRESENT ILLNESS: Harold arrives reporting, "I'm almost out of medication." He brings his pill bottles and identifies the contents which include Depakote, Haldol, Cogentin, and Lithium. He also presents his discharge papers indicating a week long hospitalization about four weeks ago, subsequent to the police being called for loud and threatening behavior towards a neighbor. Harold states that he has been in the hospital several times, but has not been involved with the legal system other than "giving me a ride to the hospital." He denies suicidal or homicidal ideation, indicates he does not need medication, but knows if he doesn't take it, he will need to go back to the hospital.

PSYCHIATRIC HISTORY: Harold has had several psychiatric hospitalizations, starting when he was in his twenties. He has been on various psychotropic medications between hospitalizations. He has not been attending his clinic frequently in recent months, and has taken his medication sporadically. He admits that although he does not like to take his medication, things usually go badly when he does not. He denies past suicidal or homicidal behaviors.

MEDICAL HISTORY: Harold states he has no allergies, and is in relatively good health. "I broke my arm when I was eight because I fell off the porch." He would like to see a dentist "because my teeth hurt."

SUBSTANCE USE HISTORY: Client admits to an occasional beer "for relaxation," but denies other drug use. Hospital records that he brings indicate a drug screen was positive for marijuana at the time of his previous admission for aggressive behavior. He has never had treatment for substance use problems, and does not feel that he has a problem at this time.

SOCIAL HISTORY: Harold is a high school graduate. He had several unskilled jobs in his twenties, when he was first hospitalized and has not worked since. "Nobody will hire me," he reports. Harold's mother died in 1985, his father and two brothers are alive and well, "but I don't see them much. They say I bother them." Currently Harold lives with his girlfriend which is a frequently conflictual arrangement because "she gets mad when I smoke cigarettes and says she's going to have me committed, so then I get mad and stay away for a couple of days." She has threatened to leave him on several occasions. He spends his days watching television, riding his bike, or "sometimes I see some friends, but Karen (his girlfriend) doesn't like them because she thinks all they do is smoke pot." He denies any other distressing circumstances or worries about his situation at the present time.

MENTAL STATUS EXAMINATION: Harold is a Caucasian male, appearing his stated age of 38 years. His eyes stare intensely as he speaks in a pressured, loud, but not aggressive tone. He is casually but neatly dressed. He is oriented x3, but quickly makes references to particular dates such as, "Did you know today in 1985 at 4:00 p.m., Mt. St. Helens set off another cloud?" He continues naming various dates and facts, thereby requiring frequent redirection which he accepts for short periods of time.

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.

CASE III

HISTORY OF PRESENT ILLNESS: George arrived stating that he is concerned about the way he has been feeling the last several months. He reports that he has been feeling down, isolating himself at work and at social functions. He also complained of having crying spells, waking up many times during the night and finding it more difficult each morning to face the stress at work. He reports that he doesn't feel he can handle the responsibilities of his job and worries all of the time. He stated that his relationship with his wife is strained. They argue a lot and rarely go out as a couple. His wife encouraged him to come in for help. He denied any suicidal intentions.

PSYCHIATRIC HISTORY: George reports that he was sent to a counselor when he was thirteen years old because he wouldn't go to school. His father had passed away at Christmas time and he reports this was a very difficult time for him. He claims the counselor wanted to put him into the local psychiatric hospital but his mother refused to follow the recommendation. He claims the counseling was not helpful.

MEDICAL HISTORY: George stated that his last physical was approximately one year ago and that he was given a clean bill of health. He reported that he had the typical childhood illnesses and had his tonsils removed when he was seven years old. At this time, he is not on any medication.

SUBSTANCE USE HISTORY: George states that if he drinks, it is usually beer. His last drink was on Saturday and he claimed he only had two or three glasses. He doesn't smoke cigarettes and denies any past or present drug use. He denies any family history of substance abuse. He did however report to drinking about 10 cans of Mountain Dew every day and only eating one meal a day.

SOCIAL HISTORY: George is a high school graduate. He has been working for company X since graduation. He started as a laborer and is now in charge of the shipping and receiving department. Following the death of his father, his mother raised him and his three brothers. He stated that financially it was difficult for his mother but she was a hard worker and he would help out by working after school. He married at age nineteen and has two children a son 11 years old and daughter 15 years old. He reports that his marriage has been strained due to his moodiness and behavior towards his wife.

MENTAL STATUS EXAMINATION: George is a large white male, appearing his stated age of 36. He was dressed in work cloths. His eye contact was poor and at times he became teary eyed. He appeared nervous and would rub his hands together or scratch his index finger. When unable to answer a question, he would sigh and turn away.

CASE IV

HISTORY OF THE PRESENT ILLNESS: The client is an 85 year-old married mother of a son and a daughter, referred by Greenwood Nursing Home, with chief complaints of “depression...feeling anxious all the time...wondering if I'm doing right...confusion...wondering about my bowels being bound up.” Her family reports that she has confusion, with good and bad days; she especially has confusion during the night. She reports a nine-month history of depression, with difficulty falling asleep, mid-cycle awakening, decreased appetite, interest, energy, concentration, and memory, anhedonia, feelings of helplessness, and passive suicidal ideation. She denies having any crying spells, saying that she is a “trooper and a fighter.” She denies any irritability or guilt. She has been on Xanax 0.25 mg qid and 0.25 mg bid prn. She has also been on Mellaril 37.5 mg qhs. Her primary care physician prescribed these medications, but she feels that they have not helped much.

PAST PSYCHIATRIC HISTORY: Entirely negative. Her primary care physician, Dr. Batell, notes that she has a diagnosis of dementia over the past year or so.

MEDICAL HISTORY: The client has hypothyroidism, treated with Synthroid 0.05 mg qd; history of anemia; says that she required surgery twice, post delivery of her two children. She is allergic to penicillin. She denies any history of head trauma, loss of consciousness, or seizures. She does complain of nausea, and stiffness.

SUBSTANCE USE HISTORY: As a middle aged adult she developed a significant problem with alcohol and she was detoxed several times in the past. She attended AA for many years and has now been abstinent for nearly 30 years.

SOCIAL HISTORY: The client reports that she is the 10th of 11 children. She says that she had a “beautiful mother.” Her father was an alcoholic. She denies any history of physical or sexual abuse. She has been a member of the Unitarian Church. She denies any history of legal problems. She graduated from high school, but went right to work; this was in the Depression. She had been an honor student in high school. She has worked as a switchboard and teletype operator. She has been married for 62 years and describes her relationship as “excellent.” Her husband is still active and healthy and she has five children in the area, all of whom are very helpful and caring. She denies any significant worries at this time.

MENTAL STATUS EXAM: The client was alert and cooperative, but appearing very stiff and somewhat sedated. Speech was soft and slowed. Affect was depressed. Thought process was coherent. Thought content was remarkable for feelings of helplessness and suicidal ideation, she denied having any homicidal ideation. She denied having any auditory or visual hallucinations, or delusions. Insight and judgement were good. On cognitive exam, she was oriented to person and place, and partially to time, knowing that it was July 25th, but she thought it was “19 seventy-something.” She scored 16/30 on a Mini-Mental State Exam.

CASE V

HISTORY OF PRESENT ILLNESS: Jacob arrived stating “I feel like I am going crazy. I don’t know what is wrong with me. I can’t fall asleep and when I do, I wake up within an hour or two.” He reported that this has been a problem for more than three years but the last month has been the worst. He also stated that his relationship with his girlfriend is over because she wasn’t able to handle his mood swings. Also, when they went out together they would end up arguing and fighting. He stated that he thinks it may be due to his drinking although he denied drinking every day. He also reported the day after he drinks he feels great. He kept repeating “tell me what’s wrong.” He denied suicidal intent.

PSYCHIATRIC HISTORY: Jacob reported the he has been in and out of counseling a number of times. He stated that he would seek help when a relationship was falling apart or when he felt like his life was out of control. He stated that at times his family doctor prescribed anti-depressants for him, Zoloft and Prozac, to help with anxiety and depression. But stated that he would stop using the medication after he began to feel better. He expressed that he didn’t like taking medication, and felt he should be able to handle these problems on his own. He also reported being involved in counseling 2 or 3 times. He denies any medication use at this time. He also reported that there were no suicidal attempts in the past.

MEDICAL HISTORY: Jacob’s medical history indicates the routine childhood illnesses, other wise unremarkable.

SUBSTANCE USE HISTORY: Jacob reported that he had smoked marijuana in the past but stopped. He claims it made him feel paranoid. He also used cocaine in his early thirties but stopped. He recognized that he “liked it too much” and “it was interfering with my work.” He reports that he prefers to drink wine and may drink a bottle in an evening. He denied drinking in the morning, during work, or on weekends when he has his children with him. He has had many episodes of sobriety for two to three months at a time. However, he refuses to go to AA, because of confidentiality, and thus, has no supportive resources to help him with recovery issues. He reports that for the past month he has not been able to go more than three days without drinking. He states the he becomes so uncomfortable that he has to have some wine to feel better. He states that his last drink was two days ago, a half bottle of wine (a gallon bottle), and “I feel real good today but I am concerned about tomorrow.”

SOCIAL HISTORY: Jacob is a college graduate and operates his own business. He has been married two times. His first marriage lasted 5 years. His second marriage lasted 3 years and produced two children, ages 5 and 9. He has custody of the children every other weekend. He reports that he dates but has been unable to establish a meaningful relationship. Jacob reports that he has few social outlets or hobbies that he participates in, and that he has very few close friends. He reports that he is worried about his business and financial well being to the point that he will be unable to meet his obligations.

MENTAL STATUS EXAMINATION: Jacob is a 43 year old male who appears older than his stated age. Although he reported that he felt good in the session, he appeared anxious and expressed much concern about remaining sober the next day, since he hadn't been able to go more than three days. He was oriented to person, place, and time. He denied any suicidal plans at this time. However, he reported that when he felt uncomfortable he would think about killing himself, but denies he would ever do it. He has no history of suicide attempts.

CASE VI

HISTORY OF PRESENT ILLNESS: P.L. is a 34-year-old white woman who presented requesting alcohol detoxification. She has been attending AA meetings but continues to drink daily. Consumption is up to 15 beers or a fifth of vodka and a six-pack daily. Last night she drank 15 beers. P.L. reports blacking out when she is drinking and not being able to remember anything that happens. She denied any experience of significant withdrawal symptoms other than “shakiness and nausea,” but has had no real periods of abstinence over the past year. She has had fleeting thoughts of suicide but no plan or attempt. She reports that she has been feeling depressed for the past few months with some sleep and appetite disturbance. She cannot say if she has lost any weight. She denies other mental health problems at present.

PSYCHIATRIC HISTORY: Client reported no history of psychiatric treatment, but states that she has had periods of depression and moodiness throughout the time she has used alcohol.

MEDICAL HISTORY: P.L.'s medical history is unremarkable. She has had three normal pregnancies, during which she stopped drinking, and a tubal ligation in 1992. She was noted to have several facial lacerations and a swollen lip, which she stated were inflicted by her husband, although she cannot remember the specific circumstances because she was drinking.

SUBSTANCE USE HISTORY: P.L. reports a 17-year history of alcohol abuse, with on and off periods of sobriety. The longest sober periods were during her pregnancies, the last being 5 years ago. She has been hospitalized twice (1994 and early 1997) for detox and rehab. She has also used crack cocaine sporadically but has not used it in the last year. Client reports having seizures in the past and other severe withdrawal symptoms when attempting detoxification. On one occasion, she was sent to the ICU after being delirious. She has been in outpatient treatment twice in the past but felt that it was not helpful to her.

SOCIAL HISTORY: Client lives with her three children, ages 11, 7, and 5. Her husband is in and out of the home and there is a long history of domestic violence. CYS has been involved with the family for several months after the client's sister reported her because of her blackouts and her feeling that the children were often neglected. CYS has encouraged her to get more intensive treatment for her drinking and has threatened to remove the children temporarily. She states she would like to have her children taken from her temporarily so that she can get her life together. She has no close relationships at present, and is angry with her sister, her only family member. She reports a limited and uncertain income from her husband.

MENTAL STATUS EXAMINATION: P.L. was somewhat disheveled and teary-eyed during the interview as she talked about her life. She was cooperative, speech was clear and thoughts well organized, although judgment and insight were poor.

CASE VII

HISTORY OF PRESENT ILLNESS: R.B. is a 45 year old Caucasian male calling the crisis service, seemingly distressed, but refusing to come in. He reports feeling “closed in” and progressively upset for two days, sleeping only 2-3 hours a night, not eating, and overtaking Klonopin (6 mg yesterday, “but it still wasn't enough to calm me down.”) He reports irritability, shouting a visitor out of his house because he stayed too long. He mentions guns several times, saying, “When I aim I don't miss,” and “It's all I can do to keep my guns put up.” He states, “I'm very angry. I'm ready to battle anyone. I feel like I'm capable of anything.” He is eventually able to give assurances that he will not do anything violent, avoid confrontations, and to take medications as prescribed. His wife is called and assures staff that no guns are accessible, but that the client has indeed “crashed” again, and is threatening and suspicious, but not currently violent. She was unable to identify any circumstance that may have precipitated the current episode.

PSYCHIATRIC HISTORY: R.B. has a 10-year history of treatment for Bipolar Disorder. After stopping drinking 6 years ago, there emerged a strong history of rapid cycling with full manic episodes lasting 3 days to 1 month, followed immediately by a depressive episode. Since starting treatment with mood stabilizers (Lithium, Depakote and Tegretol), he has continued to have mood swings, but at a lower frequency and intensity. Medications: Tegretol 400 mg q am and 800 q hs; Zyprexa 10 mg q hs; Klonopin 1 mg bid and 2 mg q hs; Benadryl 25 mg 2-4 hs.

He is well known to the crisis service and has called when in a similar state in the past. He has an ambivalent, but stable relationship with that program, but has generally refused hospitalization. The most recent similar crisis phone call (7 months ago) included suicidal threats, veiled threats against others, reports of rage, discontrol, preoccupation with guns, and paradoxical requests for assistance and treatment coupled with refusals of various treatment strategies. Although he has often mentioned firearms, there have been no guns in his home since the onset of his illness, and he has never followed through on any threats of violence or self harm in the past.

MEDICAL HISTORY: Recurrent prostatitis, chronic back pain and history of Vitamin B12 deficiency. No current treatment.

SUBSTANCE USE HISTORY: 24 year history (15-39 years of age) of alcohol and cannabis dependence, but reports abstinent for 6 years. He has had positive history for driving while intoxicated and one arrest for selling marijuana (age 18, served 18 months in Federal prison). No history of alcohol or drug treatment or rehabilitation. Client and wife deny current use of drugs or alcohol.

SOCIAL HISTORY: R.B. is an accomplished musician, but without steady work for nine years. “Kicked out” of military school (attended 11-15 years old) for destruction of property. High School education and 2 years of “vocational training.” Attended college for one year, then worked off and on as a musician, in music stores, and selling electronic equipment. He has had no significant employment for the past four years, but he and his wife have recently made promotional tapes to restart a music career. He lives with his wife of three years, in a very supportive relationship. They report an adequate income, and could identify no recent sources for worry.

MENTAL STATUS EXAMINATION: Telephone screening of well known client. Wife reports adequate hygiene, grooming and attire. Manner is irritable, demanding, threatening, calming with active listening, ventilation and unhurried support. Speech is loud but not rapid or incessant. Describes mood as angry, frustrated, changing to rage without provocation. Affect is estimated to be labile, angry, intense. Thought processes are coherent, logical, and goal directed. Thought content significant for complaints of irritable response, fear of rage discontrol, suspiciousness, feeling “closed in,” urges to protect self and fend off others with guns. No overt psychotic symptoms, suicidal ideation, directed homicidal ideation, or confusion noted. Oriented, alert and aware; high intelligence.

CASE VIII

HISTORY OF PRESENT ILLNESS: S.S. is a 49-year-old man who was hospitalized 3 days ago after experiencing extreme depression and making a suicidal attempt following a two week binge of alcohol use, which resulted from a disagreement with his girlfriend and subsequent break up of their relationship. He was brought in by police after being spotted standing on the railing of a bridge. He reports that he had approximately three years of sobriety which was motivated primarily by his girlfriend. Although he remained sober during this period, he reports being unhappy and becoming progressively isolated and apathetic.

He began drinking heavily two weeks ago following the disagreement with his girlfriend, and once he started, he drank continuously using more than two six packs of beer daily along with several shots of hard liquor. He reports that he became progressively more depressed during this period with inability to sleep or eat and letting go of his main activities and becoming completely apathetic and finally suicidal, formulating several plans to end his life, including jumping in front of a car, jumping off a bridge and hanging himself. He reports that he has experienced several of these symptoms in the past without this extreme feeling of despair. These symptoms were originally associated with alcohol use. However, he has had problems with motivation and anhedonia and self esteem over the past three years of his sobriety with lack of interest in activities and social isolation. He denies other significant problems at this time and while he is currently feeling more secure, he is uncertain whether he could guarantee his safety outside the hospital. He has been participating in treatment and hoping to return to his former level of functioning and to move toward reconciliation with his girlfriend. Sleep and appetite have improved slightly, but he remains tearful and anhedonic. His girlfriend has agreed to attend a family meeting.

PAST PSYCHIATRIC HISTORY: Although he reports a long history of dysthymia and unhappiness, he has never had a period of treatment in the past. He has never been in therapy or on medication for any difficulties of this sort.

MEDICAL HISTORY: He denies any significant medical problems in his past. He states that he has not been on any medications nor has he had any prolonged illness. He denies any significant problems on review of systems.

PAST SUBSTANCE USE HISTORY: He has a history of substance use since the age of about 14 with progression from marijuana to other substances culminating in addiction to heroin. He was treated for heroin addiction in 1980 at Phoenix House and Samaritan House in New York City and was able to discontinue his use of illegal substances. However, he continued to use alcohol heavily following that period. He also had begun to have problems with the alcohol, losing jobs and getting a DUI and was finally able to bring this problem under control about three years ago. He has attended AA meetings since that time. He reports that he does have a family history of alcohol use with father, grandfather and uncle all involved with alcohol. He smokes approximately two packs of cigarettes per day and has been unable to control that habit.

SOCIAL HISTORY: He is currently living in a hotel room but hopes to return home to his common law wife and his teenage stepson if he can reconcile this relationship. However, he has not spoken to them in the past two weeks. He reports that he has few other supports in his life. He has been

estranged from his extended family for some time and they are not in the area. He has few friends and has been socially isolated during the past several years. He has worked as a pharmaceutical technician and reports that he enjoys his job and has done well with it. Although he believes that he has a job to return to following his discharge from the hospital, he has missed several weeks and has run out of sick time. He has no current legal difficulties. He reports few recreational interests other than shooting pool and drinking beer and recognizes this is an area he needs to develop. He has no religious beliefs or involvement and reports that he was not extremely unhappy as a child but describes a very unsupportive family and a mother who was physically and mentally abusive to him.

MENTAL STATUS EXAMINATION: This is a thin, somewhat cachectic-looking Caucasian male who is dark complected, not particularly attractive. He was appearing somewhat uncomfortable but was able to sit up. He was cooperative and fairly well related in his interview. He showed no abnormality of speech or movement, thought or perception. His mood was reported as depressed, his affect was dysthymic and somewhat constricted, but with some range at various times during the interview. He denies current suicidal intentions but continues to feel somewhat hopeless. He became tearful at several points during the interview and did not feel safe about guaranteeing safety outside the hospital. On cognitive exam, he was intact to short term and long term memory. Attention and concentration were basically intact, intelligence appeared average and insight and judgment were fair.

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.

CASE X

HISTORY OF PRESENT ILLNESS: P.C. is a 45 year-old single man with long-term schizophrenia who was brought to the medical emergency room by his community residence counselor after reportedly ingesting over 50 over-the-counter cold pills (combination pseudoephedrine and antihistamine). Following gastric lavage and medical clearance, the patient is referred for psychiatric evaluation. The counselor's chief complaint is: "We have to stop this dangerous behavior. We can't manage him." The patient's chief complaint is: "I guess they are pretty upset with me." He denied suicidal ideation recently or in the past.

PSYCHIATRIC HISTORY: P.C. has a 25-year history of schizophrenia, including one episode of state hospitalization many years ago. He was homeless and living in shelters after going off meds for two years prior to current placement. He has had no recent acute hospitalizations. Placement has been in his current residential program (a low-staffed lodge program) for nine years, on a medication regime that includes IM fluphenazine weekly, benztropine 1 mg BID, sertraline 100 mg daily. He takes oral meds under supervision twice daily. His treatment team includes his case manager, an outpatient therapist of two years, a psychiatrist who he sees monthly, and residential staff. He belongs to a clubhouse rehabilitation program, but rarely attends. At baseline, he is a pleasant but quite psychotic man who experiences persistent feelings of "double exposure" (believing he is being controlled and exposed by another "self"), and obsessively creates neologisms on paper about drugs (e.g., "smack a whack warm").

MEDICAL HISTORY: Patient is on medication for hypertension. He is currently medically stable.

SUBSTANCE USE HISTORY: The patient has a long-standing history of substance dependence, most notably marijuana, and was hospitalized three years ago for drug treatment. Following that treatment, the patient substantially reduced marijuana use, though was never able to get involved with a recovery program.

Over the past few years, however, the patient has become increasingly involved instead with abuse of cold pills, mostly for the speedy effect, but also for reported relief of "double exposure." His usage has steadily progressed in frequency and amount, so that currently he takes approximately 50 pills 3x/week or more. Usually, his use is not detected because he stays isolated. On two previous occasions in recent months, however, he was observed to be unsteady and pressured (as he is currently). When asked about his use, he told the truth and was brought to the medical ER. On one previous occasion, he was hospitalized for a few days, but no change ensued. Patient was recently told that his placement is in jeopardy, and a more intensively supervised program is being sought, although this would take months to arrange. In response, his use appears to have escalated, leading to today's incident.

SOCIAL HISTORY: Patient has a sister and father who live about 45 minutes away. He sees them regularly but infrequently, and they are worried about him. They are unable to provide significant assistance or monitoring. He has been rather isolative and has no real friends. He relates well to his treatment team and is generally cooperative with them. He reports no major worries or concerns other than the threat of losing his home.

MENTAL STATUS EXAMINATION: P.C. is oriented x 3, but is disorganized, rambling, and loose, with autistic obsessions about drugs. He reports auditory hallucinations and paranoid ideation, but states these symptoms are the same as they have been for years. He adamantly denies any intent to self-harm, only to get high. He denies that his behavior is risky. He doesn't really want to stop using, but agrees to get help if it will make his counselor happy.

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.

CASE RESULTS

LOCUS Evaluation Report

6/28/00 11:42 am

Patient Name: Case I, Harold

Date of Test: 06/28/00

Time: 11:38 am

Social Security: 111-11-1111

Gender: Male

Patient DOB: 01/01/1962

Diagnosis: Adjustment Disorder: Unspecified

Current Disposition: None

Recommended Disposition: High Intensity Community Based Services

Actual Disposition: High Intensity Community Based Services

Reason For Variance: None

Program/Referred To: IOP

Evaluation Notes:

LOCUS RESULTS

LOCUS Score: 17

Risk of Harm

Dimension Score 2

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

Functional Status

Dimension Score 2

- Demonstrating significant improvement in function following a period of deterioration

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 2

- Presence of some ongoing or intermittent interpersonal conflict, alienation, or other difficulties

Recovery Environment (Level of Support)

Dimension Score 3

- 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

Treatment and Recovery History

Dimension Score 3

- 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 2

- Significant understanding and acceptance of illness and attempts to understand its affect on function
- Shows some recognition of personal role in recovery and accepts some responsibility for it

Case I Discussion

Discussion: The man presents with persistent, but variably severe psychiatric symptoms that may be exacerbated on occasion by substance use. Although he denies any current suicidal/homicidal ideation, he was assigned a two on Dim. I based on past threats. A rating of one may also have been considered. He appears to be functioning once again close to baseline and has shown recent improvement, so a rating of two was given on functional status. Although the extent of his substance use is not clear, there is evidence that his use meets a rating of three on the co-morbidity scale. There do not appear to be significant stressors, but criteria for a rating of two are probably satisfied.

This man meets criteria for intensive outpatient treatment, but it is not clear that he would accept or use these more intensive resources since he has not been taking advantage of current outpatient opportunities. Nevertheless, if he were willing to use them, a brief period of treatment at this level would probably be beneficial allowing his score to drop. He could subsequently maintain his recovery at a lower level of care.

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

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.

LOCUS Evaluation Report

6/29/00 11:22 am

Patient Name: Case III, George**Date of Test:** 06/29/00**Time:** 11:22 am**Social Security:** 333-33-3333**Gender:** Male**Patient DOB:** 01/03/1964**Diagnosis:** Adjustment Disorder: Unspecified**Current Disposition:** None**Recommended Disposition:** Basic Services**Actual Disposition:** Basic Services**Reason For Variance:** None**Program/Referred To:** Crisis Intervention**Evaluation Notes:**

LOCUS RESULTS

LOCUS Score: 12**Risk of Harm****Dimension Score** 1

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

Functional Status**Dimension Score** 2

- 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

Medical, Addictive and Psychiatric Co-Morbidity**Dimension Score** 1

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

Recovery Environment (Level of Stress)**Dimension Score** 3

- Significant discord or difficulties in family or other important relationships or alienation from social interaction

Recovery Environment (Level of Support)**Dimension Score** 2

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

Treatment and Recovery History**Dimension Score** 1

- There has been no prior experience with treatment or recovery

Engagement**Dimension Score** 2

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

Case III Discussion

Discussion: This man is beginning to experience some difficulties emotionally and in several aspects of his life, yet he has not displayed any significant deterioration in function. Although he was given a two for support, a three might be considered if his wife is significantly alienated. Treatment history was rated one since his only experience was as a child and not relevant to current circumstances. Since he was not previously in treatment, a referral to basic services and possible brief crisis intervention (2-5 sessions) will be a good starting point. Failure to improve there would probably indicate a referral to Level Two services.

LOCUS Evaluation Report

6/29/00 10:23 am

Patient Name: Case IV, The Client**Date of Test:** 06/29/00**Time:** 10:18 am**Social Security:** 444-44-4444**Gender:** Female**Patient DOB:** 01/04/1915**Diagnosis:** Adjustment Disorder: Unspecified**Current Disposition:** None**Recommended Disposition:** Low Intensity Community Based Services**Actual Disposition:** Low Intensity Community Based Services**Reason For Variance:** None**Program/Referred To:** Outpatient Clinic**Evaluation Notes:**

LOCUS RESULTS

LOCUS Score: 15**Risk of Harm****Dimension Score** 2

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

Functional Status**Dimension Score** 3

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

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

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

Recovery Environment (Level of Stress)**Dimension Score** 1

- Essentially no significant or enduring difficulties in interpersonal interactions and significant life circumstances are stable

Recovery Environment (Level of Support)**Dimension Score** 1

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

Treatment and Recovery History**Dimension Score** 3

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

Engagement**Dimension Score** 2

- Engages in treatment in a positive manner, capable of developing trusting relationships, and will use available resources independently when necessary

Case IV Discussion

Discussion: The presence of passive wishes for death require a rating of two and she has shown some deterioration in her function recently. Her hypothyroidism may be contributing to her current condition, so a rating of three is chosen in Dimension III. Her response to medication has been minimal, corresponding to a rating of three on Dimension V. Although her understanding of her predicament may be limited, she appears willing to make a strong effort to improve. Outpatient treatment should be sufficient at this time.

LOCUS Evaluation Report

6/29/00 11:09 am

Patient Name: Case V, Jacob**Date of Test:** 06/29/00**Time:** 11:09 am**Social Security:** 555-55-5555**Gender:** Male**Patient DOB:** 01/05/1957**Diagnosis:** Adjustment Disorder: Unspecified**Current Disposition:** None**Recommended Disposition:** Medically Monitored Non-Residential Services**Actual Disposition:** Medically Monitored Non-Residential Services**Reason For Variance:** None**Program/Referred To:** Partial Hospital**Evaluation Notes:**

LOCUS RESULTS

LOCUS Score: 20**Risk of Harm****Dimension Score** 2

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

Functional Status**Dimension Score** 3

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

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

- Perception that pressure to perform surpasses ability to meet obligations in a timely or adequate manner

Recovery Environment (Level of Support)**Dimension Score** 4

- Very few actual or potential sources of support are available

Treatment and Recovery History**Dimension Score** 3

- Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms
- Previous treatment exposures have been marked by minimal effort or motivation and no significant success or recovery period was achieved

Engagement**Dimension Score** 2

- Significant understanding and acceptance of illness and attempts to understand its affect on function

Case V Discussion

Discussion: This man experiences moderate distress, but no suicidal ideation. There is indication of moderate deterioration in function and enough substance use recently to have a significant impact on his condition. He feels overwhelmed and unable to meet obligations indicating a rating of three on stress, and his lack of support is consistent with a rating of four on Dimension IV-B. Although he seeks help when distressed, his recovery skills are minimal. Even though a three was chosen on Dimension V, a two might have been considered if additional information were available. In either case, the recommended level of care for this man is Level Four: Medically Monitored Non-Residential Services, which is justified based on his functional impairment, co-morbidity, poor recovery environment, and treatment history.

LOCUS Evaluation Report

6/29/00 11:15 am

Patient Name: Case VI, P.L.**Date of Test:** 06/29/00**Time:** 11:14 am**Social Security:** 666-66-6666**Gender:** Female**Patient DOB:** 01/06/1966**Diagnosis:** Adjustment Disorder: Unspecified**Current Disposition:** None**Recommended Disposition:** Medically Managed Residential Services**Actual Disposition:** Medically Managed Residential Services**Reason For Variance:** None**Program/Referred To:** Hospital Detoxification Program**Evaluation Notes:**

LOCUS RESULTS

LOCUS Score: 24**Risk of Harm****Dimension Score** 2

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

Functional Status**Dimension Score** 4

- 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** 5

- 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, etc.)

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
- Overwhelming demands to meet immediate obligations are perceived

Recovery Environment (Level of Support)**Dimension Score** 4

- Very few actual or potential sources of support are available
- Client may be alienated and unwilling to use supports available in a constructive manner

Treatment and Recovery History**Dimension Score** 3

- Previous treatment exposures have been marked by minimal effort or motivation and no significant success or recovery period was achieved
- Equivocal response to treatment and ability to maintain a significant recovery

Engagement**Dimension Score** 2

- Significant understanding and acceptance of illness and attempts to understand its affect on function
- Shows some recognition of personal role in recovery and accepts some responsibility for it

Case VI Discussion

Discussion: Alcohol has caused impairment in function and a severe threat to her health, particularly during periods of withdrawal. In addition to stress related to her children and involvement with youth services, she has been mistreated by her husband. She is currently angry with her sister who is perhaps her only source of support. Although she is given a three on Dimension V, a rating of four might also be considered since her successes are relatively remote. A medically managed setting is required to manage a potentially complicated withdrawal, which is consistent with the Level Six recommendation.

LOCUS Evaluation Report

6/29/00 10:10 am

Patient Name: Case VII, R.B.**Date of Test:** 06/29/00**Time:** 10:08 am**Social Security:** 777-77-7777**Gender:** Male**Patient DOB:** 01/07/1955**Diagnosis:** Adjustment Disorder: Unspecified**Current Disposition:** High Intensity Community Based Service**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: 18**Risk of Harm****Dimension Score** 4

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

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** 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** 1

- Essentially no significant or enduring difficulties in interpersonal interactions and significant life circumstances are stable
- No pressure to perform beyond capacity in social role

Recovery Environment (Level of Support)**Dimension Score** 2

- Supportive resources are not abundant, but are capable of and willing to provide significant aid in times of need
- Professional supports are available and effectively engaged (i.e. ICM)

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 acceptance or understanding of illness and disability
- Has limited ability to accept responsibility for recovery

Case VII Discussion

Previous Level of Care Rating:

Dimension I	3c
Dimension II	3d
Dimension III	2a
Dimension IV-A	1a-f
Dimension IV-B	2a,c
Dimension V	3a,d
Dimension VI	3a,e

Total 17

Previous LOC Rec. 3 (High Intensity Community Based Services)

Discussion: This man presents with significant homicidal ideation and a plan, but tempered somewhat by lack of availability of means and negative past history of follow through on these threats. It would be difficult to justify a rating lower than four, however. Functioning is somewhat impaired but it represents an episodic pattern, rather than an isolated deterioration, giving a rating of three. It does appear that he has had some positive response in treatment and has had extended periods of stability. Although he is able to use resources when he is having difficulty, judgement and understanding are marginal at this time, making a rating of three appear most appropriate. The composite score would not indicate the need for non-secure residential. However, the independent criteria on Dimension I would indicate that residential treatment should at least be offered in this case, despite his prior refusal of that level of intensity. The alternative of intensive supervision and monitoring in his home environment would probably be acceptable in this case since he has done well in the past under those circumstances.

LOCUS Evaluation Report

6/28/00 11:42 am

Patient Name: Case VIII, S.S.**Date of Test:** 06/28/00**Time:** 11:38 am**Social Security:** 888-88-8888**Gender:** Male**Patient DOB:** 01/08/1951**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: 23**Risk of Harm****Dimension Score** 4

- 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.

Functional Status**Dimension Score** 4

- 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** 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.
- Overwhelming demands to meet immediate obligations are perceived.

Recovery Environment (Level of Support)**Dimension Score** 3

- 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.

Treatment and Recovery History**Dimension Score** 3

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

Engagement**Dimension Score** 2

- Significant understanding and acceptance of illness and attempts to understand its affect on function
- Willingness to change.
- Shows some recognition of personal role in recovery and accepts some responsibility for it.

Case VIII Discussion

Previous Level of Care Rating:

Dimension I	5a
Dimension II	4e,a
Dimension III	4d
Dimension IV-A	4a,g
Dimension IV-B	4b
Dimension V	3c,d
Dimension VI	2a,b,c

Total 25

Previous LOC Rec. 6 (Medically Managed Residential Services)

Discussion: This man was admitted to the hospital due to suicidal intentions and an apparent plan to follow through with them. He qualified for a rating of five at that time, but after three days of hospitalization his intentions have changed, even though he does not feel confident of maintaining that change outside a structured setting. His rating is now reduced to a four. His functioning continues to be significantly impaired and basically unchanged from admission. His substance use has been arrested since his hospitalization allowing a reduction in his co-morbidity score to three. Although there does not appear to be any change in the factors that were causing him stress, there does seem to be some indication that there is greater potential for receiving needed support from his family, allowing reduction in the Support score to three. He has had only partial success with past treatment experiences, and current treatment has not achieved full remission or control of symptoms. He has a positive attitude toward treatment and recovery. While this man no longer requires inpatient treatment, his composite score of 23 and scores of four in Dimensions I and II indicate the need for residential level (Level 5) services.

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.

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.

LOCUS Evaluation Report

6/28/00 11:42 am

Patient Name: Case X, P.C.**Date of Test:** 06/28/00**Time:** 11:38 am**Social Security:** 101-10-1010**Gender:** Male**Patient DOB:** 01/10/1955**Diagnosis:** Delusional Disorder, NOS**Current Disposition:** High Intensity Community Based 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: 21**Risk of Harm****Dimension Score** 4

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

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** 2

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

Treatment and Recovery History**Dimension Score** 3

- 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.

Case X Discussion

Previous Level of Care Rating:

Dimension I	3e
Dimension II	3e
Dimension III	3d
Dimension IV-A	2e
Dimension IV-B	2c
Dimension V	3d
Dimension VI	3a,b

Total 19

Previous LOC Rec. 3 (High Intensity Community Based Services)

Discussion: This man has been treated in a community setting with supported housing and involvement with an outpatient treatment team and rehabilitative services, although he has not used available resources consistently. While there have been ongoing concerns about his safety due to poor judgment and delusional beliefs, they are escalated by this most recent overdose and his inability to control this behavior. His level of function has not changed significantly, and his substance use continues to adversely affect his psychiatric status. There is some new stress related to the threatened loss of his placement, although he maintains involvement with professional sources of support. His response to treatment and ability to engage remain somewhat limited. An increase in the intensity of services is recommended at this time to address the risk associated with his misuse of substances and to bolster his ability to continue to live in the community with existing support. Although the composite score is relatively low for this level of care, he meets independent criteria for Level 5 on Dimension I.

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.

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.

PART IX

LOCUS POST TRAINING TEST QUESTIONS

- 1) When considering functional status, how should persons with longstanding and ongoing deficits be rated?
- 2) If a client's functional ability stabilizes and apparently improves during the course of treatment in a protected environment, what rating should be chosen for subsequent ratings during that episode of treatment?
- 3) What should be considered in order to determine how to rate someone who has had a twenty pound weight loss?
- 4) When physiologic withdrawal syndromes from substance dependence are present, what type of co-morbidity should they be considered to be?
- 5) If substance use has occurred in an uncontrolled manner, significantly exacerbating a previously existing psychiatric disorder, and is arrested during the course of treatment in a protected setting for a period of time long enough to significantly diminish its impact on psychiatric symptoms, how should the client be rated on the co-morbidity scale?
- 6) What is the meaning of the presenting disorder on the co-morbidity scale?
- 7) What are the three domains of co-morbidity considered on the co-morbidity scale?
- 8) Which three evaluation parameters contain independent criteria which place clients at residential levels of care regardless of ratings in other parameters?
- 9) Which parameter has two subscales? What are they?
- 10) For clients who have been receiving treatment in a protected environment, what circumstances should be considered when making a rating for level of stress?
- 11) When considering level of support, how does the active and effective involvement of a professional person(s) effect the rating?

- 12) How are past experiences with treatment weighted relative to more recent treatment or recovery efforts?
- 13) How is past treatment and recovery history rated if the client has had no previous treatment experiences?
- 14) How are current treatment or recovery experiences relevant to ratings on the Treatment History and Recovery Management scale?
- 15) What factors are assessed by the engagement scale?
- 16) How many rating options are available in each evaluation parameter?
- 17) How many criteria must be met for a particular rating level to be chosen in any dimension?
- 18) Is a composite score alone sufficient to make a level of care determination in all instances?
- 19) What rating should be chosen if circumstances do not match the defined LOCUS criteria exactly?
- 20) When the rater is uncertain about the closest fit between two criteria at different rating levels, which rating should be chosen?
- 21) On which dimension is a client's ability to maintain their safety considered?
- 22) What factors other than homicidality and suicidality should be considered in choosing a rating for risk of harm?
- 23) How often should LOCUS ratings be repeated?
- 24) Should persons with histories of chronically dangerous behaviors be rated in the same way as persons with acute changes?
- 25) Should a history of substance dependence, without current involvement or use be considered when making a rating on the co-morbidity scale?

- 26) How many dimensional scores do you add to obtain a composite score?
- 27) If the level of care recommended isn't available in your community, which level do you recommend?
- 28) What level of care is available to all members of the community?
- 29) Is a client required to participate in the level of care recommended by LOCUS?
- 30) If a client requires supervised housing, what level of care should be recommended?
- 31) What methods in LOCUS are available to determine the recommended level of care for a client?
- 32) What categories or factors are used to define the Levels of Care in LOCUS?
- 33) What is meant by a flexible continuum of care?
- 34) How are the Placement Criteria for each level of care used by the clinician?
- 35) What is the importance of diagnosis in completing the LOCUS assessment?
- 36) How should a person on methadone maintenance be scored on Dim. III?
- 37) How should past traumatic events be considered when scoring the Level of Stress subscale?
- 38) What are some of the uses for LOCUS apart from initial placement decisions?
- 39) Who should complete LOCUS assessments? How much clinical experience is necessary?
- 40) Why are Level One Services unavailable to persons who have not completed treatment at a higher level of care?

- 41) What should be done if the client does not accept the level of care recommended?
- 42) If clients are able to receive many of the same services at different “Levels of Care,” how are the levels distinguished from one another?
- 43) At what Level of Care are case management services available?
- 44) What Level of Care corresponds to Assertive Community Treatment programs?
- 45) A composite score of 19 is most commonly associated with what Level of Care?
- 46) If starting with a composite score of 24, which entry point should be used on the Decision Tree?
- 47) What should the rater do if inadequate information is available to complete a rating on a given dimension?
- 48) What distinguishes Level 4 from Level 5 Services?
- 49) What traditional programming corresponds to Level Four (Intensively Managed Non-Residential)?
- 50) Do clinicians need to know the criteria for each level of care to arrive at accurate placement recommendations?

ANSWERS TO POST TEST

- 1) Persons with long-standing or ongoing functional deficits should be assigned a rating of three according to Dim. II criteria, as long as these deficits do not represent a significant change from baseline. (If deficits are so severe that they place the client at Risk of Harm and require ongoing residential structure and monitoring, they will be addressed by the Dim. I rating).
- 2) A rating of three should be assigned to persons who demonstrate functional stabilization and/or ability to participate in treatment in a protected environment such as an inpatient/hospital program. This will allow the client to progress in the treatment continuum.
- 3) A twenty pound weight loss should be considered in the context of its immediate threat to health and well-being and client's baseline weight. A three will be assigned to persons who are not at risk of current/significant health problem. Ratings of four or five will be assigned, according to respective criteria, for persons whose health status is compromised currently or emergently.
- 4) Physiologic withdrawal symptoms should be regarded as a medical issue and, therefore, medical co-morbidity.
- 5) A client, whose substance use is arrested due to admission to a protected setting so that it is no longer having a direct impact on psychiatric symptomatology, should be assigned a rating of three.
- 6) The presenting disorder is the condition that is most readily apparent, but is not necessarily more significant than other co-occurring conditions that are subsequently discovered.
- 7) Medical, Addictive and Psychiatric are the domains of co-morbidity that are considered on Dim. III. It is important to note that only co-occurring disorders between these domains are considered here, and not co-morbidity within one of these domains, (e.g. two psychiatric disorders).
- 8) Dimensions I (Risk of Harm), II (Function Status) and III (Medical, Addictive and Psychiatric Co-Morbidity).
- 9) Dim. IV (Recovery Environment) has two subscales: 1) Level of Stress, 2) Level of Support.
- 10) Clients who have been treated in a protected setting should have stressors rated according to the conditions they will most likely encounter upon their discharge from that setting.
- 11) Active, effective involvement of professional service providers will increase clients' level of support and will often enable a lower rating on the support scale.

- 12) Past treatment experiences are less important than recent or current experiences in treatment and recovery, and this should be reflected in the rating selected. A treatment episode that occurred during childhood or adolescence may have little relevance for the middle-aged adult. In many cases, deciding the degree of relevance of past treatments will be a matter of clinical judgement.
- 13) A rating of one is given on Dim. V if there have been no previous treatment experiences, or no previous treatment of relevance to the current condition. One is given because in the absence of indications to the contrary, we give the client the benefit of the doubt and assume that they will do well. If this places them at a level of care which is not successful for them, it will be reflected in subsequent evaluations and a higher score in this dimension may lead to referral to more intensive services.
- 14) Current treatment experiences quickly become historical so that if a client responds well during the initial part of the current episode of treatment the score on Dim. V will decrease, even if the client has not had great success in the more distant past.
- 15) Dim. VI (Engagement) assesses clients' ability to recognize that they are having difficulties, the desire to change their circumstances, their acceptance of responsibility for this change, and their ability to engage with persons who can offer assistance.
- 16) There are five rating options available in each evaluation parameter.
- 17) Only one criterion needs to be met for a rating within a dimension to be selected.
- 18) The composite score will generally give a rough estimate of an appropriate placement recommendation, but will not always be accurate. Attention must be paid to independent criteria and other extenuating circumstances to arrive at a correct recommendation. The Decision Tree will be the most accurate way to arrive at the final recommendation.
- 19) When a client's circumstances do not match LOCUS criteria exactly, a rating is chosen which has criteria that are most similar in intensity or consequence to the actual conditions.
- 20) When the clinician cannot decide between two ratings within a dimension due to uncertainty about which rating is the closest match to actual conditions, the higher of the two ratings should generally be chosen.
- 21) Dimension I (Risk of Harm) is where a client's ability to maintain safety is considered.
- 22) A person's ability to be aware of their environment and to adequately care for themselves is also considered on Dim. I.

- 23) LOCUS rating should be repeated at regular intervals depending on the level of care that is being considered. While there are no pre-established recommendations, generally ratings will be repeated more frequently at higher levels of care, and less frequently at lower levels of care.
- 24) Persons who have histories of ongoing suicidal ideation and impulsive self destructive behaviors will be rated as three on dimension I as long as this behavior does not represent a significant change from baseline. Intensive attention may be needed by these clients, but we know that repeated inpatient admissions (as required by ratings of four or five) are not generally helpful and should be avoided.
- 25) A rating of one is given on Dimension III (Co-Morbidity) when there is a past history of substance dependence without any current or recent use. This would indicate that there is no present interactions or complications for the presenting disorder.
- 26) There are seven dimensional scores that are summed to obtain the composite score (five dimensions with one scale each and one dimension with two). The maximum score is therefore 35 and the minimum score is 7.
- 27) If programs are not available that meet the definition for a given level of care in your community, and the LOCUS recommendation would indicate the need for that level of services, the client should be assigned to the next higher level of care. This may result in the client getting services that are more intensive than needed in some cases, but this is preferable to providing services that are inadequate to meet the client's needs.
- 28) Basic Services are available to all members of the community in the LOCUS continuum. These services are not a level of care per se, since many of the elements are preventive rather than reactive. Some aspects of these services do respond to crisis and emergency situations and describe an available group of services in this respect.
- 29) Although the Level of Care recommended by LOCUS may be the most appropriate according to the criteria, other circumstances such as past involvement with a client, lack of service availability, or information from a third party may suggest to the clinician another level of care is more appropriate. LOCUS only makes recommendations.
- 30) Supervised or supported housing may be available to persons at all levels of the outpatient continuum (Level One through Level Four). Level Five services are only necessary for persons who need intensive on-site, medically monitored treatment. This is clearly not necessary for all persons who have needs for supported housing.
- 31) After completing the assessment and scoring of an individual with LOCUS, the level of care recommendation may be obtained in three ways. A rough estimate of the proper level of care can be obtained from the placement grid. Although this method is not completely accurate, it will give the proper placement about 90% of the time. A definitive recommendation will be obtained from the Level of Care Decision Tree. Similarly, the

computerized version will automatically supply the level of care recommendation using the Decision Tree algorithm.

- 32) The categories used to define the levels of care in LOCUS are 1) Physical Facility; 2) Clinical Services; 3) Supportive Services; and 4) Crisis Stabilization and Prevention Services.
- 33) A flexible continuum of care refers to the ability to accommodate service systems of various compositions and which have diverse needs and characteristics. The continuum is not rigidly prescribed, but rather qualitatively described, allowing versatility and creativity in designing service systems. Flexibility also refers to some degree of overlap or a blurring of the boundaries between levels of care. It recognizes that certain elements of the service array must be available at several levels of care to adequately meet the needs of clients.
- 34) The clinician will rarely need to refer to the Placement Criteria in the course of using LOCUS. The Criteria describe scores that are generally most appropriate for a given level of care, but they are not definitive by themselves. They were used to guide the development of the Decision Tree, which will be the most useful tool for the clinician to arrive at a level of care recommendation.
- 35) Diagnosis is not necessary for the completion of a LOCUS assessment. This allows LOCUS to be used whether or not a diagnosis or all diagnoses are known. Diagnosis is not considered useful in determining placement recommendations.
- 36) Although methadone treatment constitutes a physiological dependence, it does not necessarily imply an addiction (if addiction is considered to be uncontrolled, compulsive use of a substance). Rather it is a medicine used to treat an addiction. Unless it is being self administered in an uncontrolled manner, it would not be considered addictive co-morbidity. If maintenance were discontinued and a withdrawal syndrome precipitated, medical co-morbidity would become a factor.
- 37) Past trauma would not be included in the rating of current stressors. Post Traumatic Stress Disorder might cause disability and functional deficits which would be rated on Dim. II, but this would not be considered a current stressor. There may be instances however, when this disorder could cause an individual to perceive stressors more intensely.
- 38) In addition to initial placement decisions, LOCUS can be used for utilization management (continuing stay and discharge decisions), treatment planning, service system planning, progress documentation, monitoring course of illness, and providing organized rationale to MCOs for placement decisions.
- 39) There are no guidelines for who should use LOCUS. It should improve the consistency and reliability of placement decisions for all who use it. Although clinical expertise is not required to employ LOCUS profitably, in general, since it is an instrument that relies on clinical judgement, persons with more clinical expertise would be expected to apply it most accurately. This hypothesis remains to be tested, however.

- 40) Level One is designed specifically for persons who have completed treatment for an episode of illness or dysfunction but who may need occasional check ins or medication management. Persons who score from 10-13 but who have not had previous treatment will generally have their needs met by services available through Basic Services.
- 41) One of the main distinctions between one level of care and another is that service arrays are generally more extensive as one goes from lower levels of care to higher levels. This means that on average, the cost of providing services will be greater at higher levels than at lower levels, although this is not necessarily true in each individual case.
- 42) LOCUS provides guidelines on the level of intensity of services which should be available. There may be cases where clients will be unwilling to use all of those resources. In general, LOCUS ratings will not suggest that a client must accept services offered unless criteria are met for involuntary treatment. In other cases, we should usually try to provide the closest approximation to what we would recommend and offer.
- 43) Case Management services are available at all non-residential levels (One to Four) but will most commonly be used on levels Two, Three and Four.
- 44) Assertive Community Treatment programs will almost always fit into the description of Level Four.
- 45) A composite score of 19 is most commonly associated with a placement recommendation of Level Three.
- 46) A composite score of 24 would enter the Decision Tree on the far right or on page two.
- 47) When inadequate information is available to complete the rating on a dimension, the best thing to do is to get more! If this is impossible, the rater should make the best guess possible based on whatever information is available.
- 48) Level Four is distinguished from Level Five mainly by the level of security it can provide. In general, Level Four is not capable of constant observation or seclusion or restraint.
- 49) The most common traditional programming that falls under the description of Level Four is Day Hospitalization or Partial Hospital.
- 50) Clinicians do not need to know the criteria for each level of care in order to make accurate placement recommendations. LOCUS will guide this decision based on the clinician ratings.

Attachment A

Guided Interview for LOCUS

Most professionals and organizations will utilize their own standardized evaluation or assessment instrument to gather clinical information to use with the LOCUS instrument. However, at times, this may seem cumbersome. In an effort to ease this process and familiarize the user with the LOCUS criteria “The Guided Interview for LOCUS” was developed. This instrument includes the primary assessment categories required by many licensing organizations. The format is easy to follow and can be used to write the psycho-social summary and identify treatment needs of the client. The questions are broken down into five categories: 1) History of Present Illness, 2) Past Psychiatric History, 3) Medical History, 4) Substance Abuse History, and 5) Social History. Each question is designed to help the clinician gather information appropriate to the given category, and relevant to the criteria found in each dimension. The “Code” on the right hand side of the page indicates which dimension or dimensions relate to the question.

Although use of the “Guided Interview for LOCUS” is not required to complete the LOCUS instrument, you may want to consider it as an additional tool of your organizations intake and assessment process.

The Guided Interview for LOCUS

HPI	CODE
1) Why did you come in for help (evaluation) today?	I + VI
2) Has anything happened to cause this problem (to get worse)?	IV-A
3) What kind of distress has this caused you? How much?	I
4) What other problems do you have at this time?	III
5) How do you think that these problems are related to each other?	III, IV
6) Have you had any thoughts of hurting or killing yourself or anyone else recently? <i>If yes, ask 6a</i>	I
6a) Do you have any intentions of following through on those thoughts or have you made any plans to do so? <i>If yes ask 6b</i>	I
6b) What stops you from following through on those plans? <i>If nothing or very little ask 6c</i>	I
6c) Do you think you could stop yourself from trying if people were around to help you? <i>If no, ask 6d</i>	I
6d) What makes you feel that you must do this now?	I
7) Has your present situation caused you to behave in any way that has been dangerous, either for yourself or for someone else? <i>If yes, ask 7a</i>	I
7a) What kind of behavior was it or what did you do?	I
8) Has substance use and intoxication ever caused you to behave in a way that was dangerous or harmful to others or to yourself? <i>If yes, ask 8a</i>	I
8a) What kind of behavior was that?	I
9) Have you experienced any problems in your relationship with others recently as a result of this problem? <i>If yes, ask 9a and 9b</i>	II
9a) What kind of problems have you had?	II
9b) Have you ever become violent or abusive?	I + II

10) Have you been able to take care of yourself recently as well as you have in the past? <i>If yes, ask 10a</i>	II
10a) In what way has it changed?	II
11) Have you been able to take care of your responsibilities as well as usual? <i>If yes, ask 11a</i>	II
11a) What kind of difficulties have you had?	II
12) Have there been any problems with your sleep, appetite, energy level or sexual activity? <i>If yes, ask 12a</i>	II
12a) How severe have these problems been? (weight loss?, sleep pattern?, activity?)	II
13) Do you have any thoughts about what would be most helpful to you right now?	V, VI
Past Psych Hx.	
14) Have you ever had any mental health problems in the past? <i>(may give examples) If yes, ask 14a and 14b</i>	II - III
14a) What kind?	II - III
14b) Did you ever get any treatment for those problems? <i>If yes, ask 14b1 - 14b6</i>	V
14b1) What kind of treatment did you get? <i>(Repeat as needed)</i>	V
14b2) Did you think this treatment was helpful? If yes, why?	V, VI
14b3) Did others feel that the treatment was helpful? Explain.	V, VI
14b4) Did you get along well with your mental health workers?	IV-B, V -VI
14b5) Did you usually follow their instructions/requests pretty closely? <i>If no, ask 14b5a</i>	VI
14b5a) Was there any reason why you didn't?	VI

14b6) Have there been times that you have done well on your own? Explain.	V
14c) What is the longest period of time during which you have been free of these problems?	V
14d) Was there anything that you would say helped you during that period?	IV-B, V
14e) Have you ever thought about, or actually attempted suicide in the past? <i>If yes, ask 14e1 and 14e2</i>	I
14e1) Please explain. Do you think you really wished to die?	I
14e2) How frequently has that been a problem?	I
14f) Have you ever thought about, or actually engaged in violence toward others in the past? <i>If yes, ask 14f1 and 14f2</i>	I
14f1) Please explain. Did you really want to see that person or persons harmed or suffering?	I
14f2) How frequently has that occurred?	I
Medical History	
15) Do you have any current or past medical problems? <i>If yes, ask 15a - 15d</i>	III
15a) What kind?	III
15b) Do you think these problems affect your (primary) disorder? How?	III
15c) Do you think your (primary) disorder affects this problem?	III
15d) Are you receiving any treatment for these problems? <i>If yes, ask 15d1 and 15d2</i>	III, V
15d1) What kind?	III, V
15d2) Are you usually able to follow the suggestions of your doctor?	VI

Substance Use History

- | | |
|--|------------|
| 16) Have you ever had any problems with substance or alcohol use?
<i>If no, ask 16a / If yes, go to 16b</i> | III |
| 16a) Do you use substances at all? If so, how? | III |
| 16b) What substances do you use? | III |
| 16c) How much of these substances do you use? How often? | III |
| 16d) Why do you say that using is a problem for you? | I, II, III |
| 16e) Have you ever been physically dependent on a substance?
<i>If yes, ask 16e1 and 16e2</i> | III |
| 16e1) What kind of symptoms do you have when that substance is
not available? | III |
| 16e2) Have you ever become seriously ill during withdrawal?
Explain. | III |
| 16f) What is the longest period of time during which you have been free
of these problems? | V |
| 16g) Was there anything that you would say helped you during that
period? | IV-B |
| 16h) Have you ever had any treatment for these substance use problems?
<i>If yes, ask 16h1-16h4</i> | V |
| 16h1) What kinds of treatment have you had? | V |
| 16h2) Were any of these treatment experiences helpful? | V, VI |
| 16h3) Did others feel that the treatment helped? Explain. | V, VI |
| 16h4) Have there been times when you have done well on your
own? Explain. | V |
| 16i) Are substances available to you where you are living now? How
easily? | IV-A |

- | | |
|---|----|
| 16j) Do you think that treatment providers are really interested in helping? | VI |
| 16k) Do you think that there are things that you could/should do differently to improve your situation? | VI |
| 16l) Do you call your family or case worker when things are going badly for you? | V |

Social History

- | | |
|--|---------|
| 17) Are there any difficulties in your personal life now which you have not mentioned so far? <i>If yes, ask 17a - 17h</i> | IV-A |
| 17a) What kind of difficulties have you had?
<i>If not mentioned above ask:</i> | IV-A |
| 17b) Do you have any problems with people who are important in your life? Are there persons who are important to you? | IV-B |
| 17c) Have your circumstances changed in any important way recently? | IV-A |
| 17d) Have you lost anyone or anything important to you recently? | IV-A |
| 17e) Have you had any recent, significant concerns about your well being? | IV-A |
| 17f) Do you feel safe where you are living? | IV-A |
| 17g) Do you have enough income to take care of your needs? | IV-A |
| 17h) Do you feel overwhelmed, as if you can't do all you must do? | IV-A |
| 18) Are there persons in your life who help you if you need them to?
<i>If yes, ask 18a</i> | IV-B |
| 18a) Who are they? How much help does each one give? | IV-B |
| 18b) Do you have any caseworkers who you can rely on? | IV-B |
| 18c) Do you actually ask for help when things are not going well? | IV-B, V |

Attachment B

LEVEL OF CARE UTILIZATION SYSTEM VERSION 2000

WORKSHEET

The LOCUS worksheet was originally designed to help the user complete the locus instrument and easily compute a LOCUS score. The worksheet contains each of the dimensions, the five rating levels and a check box for the corresponding rating criteria. Once the composite score is calculated, you can use AACPL Level of Care Determination Grid, or the AACPL Level of Care Determination Decision Tree, if the computer version is not available to obtain a level of care recommendation.

For information regarding the computer software, contact:
Deerfield Behavioral Health at (814) 456-2457, or on the Internet at <http://www.dbhn.com>

LOCUS WORKSHEET VERSION 2000

Rater Name _____ Date _____

Please check the applicable ratings within each dimension and record the score in the lower right hand corner. Total your score and determine the recommended level of care using either the Placement Grid or the Decision Tree.

<p>I. Risk of Harm</p> <p><input type="checkbox"/> 1. Minimal Risk of Harm</p> <p><input type="checkbox"/> 2. Low Risk of Harm</p> <p><input type="checkbox"/> 3. Moderate Risk of Harm</p> <p><input type="checkbox"/> 4. Serious Risk of Harm</p> <p><input type="checkbox"/> 5. Extreme Risk of Harm</p> <p style="text-align: right;">Score _____</p>	<p>IV-B. Recovery Environment - Level of Support</p> <p><input type="checkbox"/> 1. Highly Supportive Environment</p> <p><input type="checkbox"/> 2. Supportive Environment</p> <p><input type="checkbox"/> 3. Limited Support in Environment</p> <p><input type="checkbox"/> 4. Minimal Support in Environment</p> <p><input type="checkbox"/> 5. No Support in Environment</p> <p style="text-align: right;">Score _____</p>
<p>II. Functional Status</p> <p><input type="checkbox"/> 1. Minimal Impairment</p> <p><input type="checkbox"/> 2. Mild Impairment</p> <p><input type="checkbox"/> 3. Moderate Impairment</p> <p><input type="checkbox"/> 4. Serious Impairment</p> <p><input type="checkbox"/> 5. Severe Impairment</p> <p style="text-align: right;">Score _____</p>	<p>V. Treatment and Recovery History</p> <p><input type="checkbox"/> 1. Full Response to Treatment and Recovery Management</p> <p><input type="checkbox"/> 2. Significant Response to Treatment and Recovery Management</p> <p><input type="checkbox"/> 3. Moderate or Equivocal Response to Treatment and Recovery Management</p> <p><input type="checkbox"/> 4. Poor Response to Treatment and Recovery Management</p> <p><input type="checkbox"/> 5. Negligible Response to Treatment</p> <p style="text-align: right;">Score _____</p>
<p>III. Co-Morbidity</p> <p><input type="checkbox"/> 1. No Co-Morbidity</p> <p><input type="checkbox"/> 2. Minor Co-Morbidity</p> <p><input type="checkbox"/> 3. Significant Co-Morbidity</p> <p><input type="checkbox"/> 4. Major Co-Morbidity</p> <p><input type="checkbox"/> 5. Severe Co-Morbidity</p> <p style="text-align: right;">Score _____</p>	<p>VI. Engagement</p> <p><input type="checkbox"/> 1. Optimal Engagement</p> <p><input type="checkbox"/> 2. Positive Engagement</p> <p><input type="checkbox"/> 3. Limited Engagement</p> <p><input type="checkbox"/> 4. Minimal Engagement</p> <p><input type="checkbox"/> 5. Unengaged</p> <p style="text-align: right;">Score _____</p>
<p>IV-A. Recovery Environment - Level of Stress</p> <p><input type="checkbox"/> 1. Low Stress Environment</p> <p><input type="checkbox"/> 2. Mildly Stressful Environment</p> <p><input type="checkbox"/> 3. Moderately Stressful Environment</p> <p><input type="checkbox"/> 4. Highly Stressful Environment</p> <p><input type="checkbox"/> 5. Extremely Stressful Environment</p> <p style="text-align: right;">Score _____</p>	<p>Composite Score </p> <p>Level of Care Recommendation </p>

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