

# LOCUS Training

LOCUS: Level of Care  
Utilization System

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Provided by:  
**Illinois Department of Human  
Services/Division of Mental Health**

Facilitated by the Illinois Mental Health Collaborative for Access and  
Choice

Trainer:

Mary Thornton  
*Mary Thornton & Associates, Inc.*

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**Acknowledgement:** Most of the  
Materials Used in Developing this Training  
come from the LOCUS Manual a publication  
by the AACP and Deerfield Behavioral  
Health. Deerfield has also provided answers  
to our many questions on the LOCUS and  
how to score it properly.

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### For Trainers:

- Manual is excellent guide – should be read through at least once by all trainers
- These slides are available and built: *(Background is light blue)*
  - To be used by trainers for internal staff trainings
  - To be used in conjunction with the tool
  - Change them to reflect your own agency, agency jargon, and to simplify (may be too much info on history for example)
- Training is usually 1 day – ½ day is too short and does not allow for practice
- Can use actual cases rather than Client examples in manual – trainer should pre-score these cases

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### For Trainers:

- May want to mix up cases and use in training both low and high need cases – depends on what levels of care LOCUS will be used for internally
- Look at Hints in **Red** – these are critical scoring issues that if not followed can result in artificially high or low scores.
- This is not a tool to be used by inexperienced case managers – clinical judgment is critical and may need to be defended.
  - However, with experience this is an excellent tool to be used by residential, ACT, and other program staff to look at health outcomes and needs over time.
  - You can choose to use this in all your programs

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### For trainers:

- Scoring Strategy:
  - You have options which we will go over later and you need to choose among them.
  - State will require certain data elements and you will want to make sure you capture them.
  - Ability for agency to look at trended scoring and elements of the scoring are critical for UR – you may want to capture more data than state wants – think about this throughout training today
    - Is there supposed to be progress in health outcomes?
    - If progress, where and how is that being built on?
    - If no progress, why and has strategy been changed?

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**For trainers:**

- Inter-rater reliability:
  - Will go over in end of training some basic strategies –easier to visualize when you understand tool
  - Inter-rater reliability is critical long term, not just short term pilot
  - Annual training and couple of cases scored in groups? *(would need to modify slides)*

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**For trainers:**

- This tool measures needs at a particular point in time – there are no standards for:
  - *Expectations of Improvement – e.g going from a 3 to a 2 in 3 months is acceptable expectation of improvement*
  - *Diagnostic resolution –e.g. movement is expected faster in some diagnostic categories than others*
  - *Internal measures of movement along the dimensions is encouraged but not with expectation of linear movement in all or even in most cases – e.g. medical chronic disease model is more appropriate*

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**What is the LOCUS?**

- LOCUS = Level Of Care Utization System
- Created by the American Association of Community Psychiatrists
- Created in order to provide a tool to:
  - guide assessment: asking and evaluating relevant data
  - level of care placement decisions,
    - Attempt to actually link assessment to need for and focus of treatment
  - continued stay criteria: envisioned as continuing need for service over time
  - clinical outcomes: impact of treatment

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## History of LOCUS

- Developed to combat problems of poor distribution of treatment resources and idiosyncratic treatment decisions.
- Wanted consistency in the management of scarce health care resources and ability to utilize efficiently all levels of care

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## History of LOCUS

- Principles:
  - Simple
  - Not uni-dimensional – mimics at least to some extent the decision-making process that takes place at assessment – but can develop as with GAF a composite score for placement decisions
  - Able to be completed after or during assessment – remove redundancy
  - Measures both psychiatric and addiction problems and their impact on client together – can be used for dually diagnosed
  - Levels of care are flexible – describes resources and intensity not programs – adaptable to any continuum of care
  - Dynamic model – measures client needs over time – eliminates need for separate admission, discharge and continuing stay criteria when using this instrument

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## What is the LOCUS?

- There are three basic building blocks of the LOCUS:
  - A system for evaluating the current status of clients and their needs based on six evaluation parameters.
    - 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.
    - In each client needs are evaluated using a 5 point scale, with #4 having two subscales.

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### What is the LOCUS?

- There are three basic building blocks of the LOCUS:
  - An assignment to one of seven levels of care that are defined by descriptions of the:
    - 1) Care Environment, 2) Clinical Services, 3) Support Services, and 4) Crisis Resolution and Prevention Services at each level.

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### What is the LOCUS?

- There are three basic building blocks of the LOCUS:
  - A methodology for quantifying the assessment of service needs in order to reliably place a client into the service continuum.

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### What is the LOCUS?

- The profiler usually first completes the diagnostic assessment of needs and then moves on to assignment to level of care.
  - Should not need a separate assessment just to complete the LOCUS

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## LOCUS: Using the Tool

- Not diagnostically driven – do not need diagnosis to complete
  - Looks at needs now – recognizes that some individuals need similar treatment models even with disparate diagnoses
  - Prioritizes needs: current needs
  - Snapshot only: things change – in some cases quite rapidly
- Adaptable - allows for a changing continuum
- Reliable – used across the country; multiple locations, programs, etc.

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## LOCUS: Using the Tool

- Score is based on an evaluation of 6 dimensions.
  - Driven by highest level of need in each dimension.
- **Hint: Must use a primary presenting issue to complete the evaluation: e.g. dually diagnosed – choose one.**
  - The other becomes a co-morbidity. This and other co-morbidities are evaluated in another dimension.
  - Think of the condition most readily apparent or the primary reason why someone came into care or is still in care.

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## LOCUS: Using the Tool

- Must evaluate the client as he or she is now - e.g. under functionality
  - Client in a residential facility has people telling her when to take pills, when to get up, shower, transports her to medical appts. Etc. What is her functionality? Strip away support. What is her functionality?
  - In another dimension the impact of other environmental supports are measured

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## LOCUS: Using the Tool

- Must evaluate the client as he or she is now - e.g. under risk of harm
  - Client in a residential facility has 24 hour staff, no access unless supervised to the community, etc. What is his risk of harm? Strip away the residence. What is the client's risk of harm?
  - Scoring the client low here because of the structured environment may result in lower score and lower level of care than is necessary.
  - Don't on the other hand assume that the residential supports are necessary for the client (and therefore their level of risk high) if they are just a part of your routine for everyone.
    - Evaluate the individual

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## LOCUS: Using the Tool

- Score is converted to a placement recommendation:
  - Can use placement grid
  - Can use Decision Tree – most accurate
  - Can use software – scores, recommends level of care, produces client profile

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## LOCUS: Using the Tool *(Trainer may want to do crosswalk to agency continuum)*

- Levels of Care
  - Recovery maintenance and health management
  - Low Intensity Community-Based
  - High Intensity Community-Based
  - Medically monitored non-residential
  - Medically monitored residential
  - Medically managed residential

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## LOCUS: Using the Tool

- Placement Criteria - not simple score to LOC – use the LOCUS decision tools
  - Composite score, as modified by:
    - independent placement criteria
    - separate advice on dimensional scores and recommended placement

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## LOCUS: Using the Tool

- LOCUS does not:
  - Tell you how to design your programs.
  - Specify treatment interventions- does not treatment plan for you – but can act as a guide
  - Negate clinical judgment – if you and the score don't agree, then rely on your own judgment.
  - Limit creativity: although it describes levels of care, there is nothing that requires you limit your interventions, the focus of services, or the design of a program for unique client needs.

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## LOCUS Dimensions: Using the Tool

- Evaluation Dimensions
  - Simple but specific
  - Each describe minimal to extreme needs
    - Evaluate where each client falls along this continuum in each dimension
  - Quantifiable so that a composite score can be developed
    - 5 point scale
    - Scores for each dimension can be added together for a level of care assignment.

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### LOCUS Dimensions: Using the Tool

- Interactions among the dimensions can be seen – juxtaposition of them with one another is apparent in the scoring.
- Done at intervals it shows a sort of moving picture of client needs over time. *(Trainer may want to speak about internal agency use of LOCUS, UR and other reporting activities)*

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### LOCUS: Using the Tool

- Dimensional rating system:
  - Each dimension has a 5 point scale.
  - Each point has one or more descriptors
  - Choose/circle the descriptors that apply to the client
  - The points are assigned by:
    - Choosing the highest point number where at least one of the criteria is circled.
  - Disregard lower scores even though there may be more of them.
  - Do not add lower scores together to get higher scores.

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### LOCUS: Using the Tool

Dimension 1:  
Level 1:  
 a.  
 b.  
 c.  
 Level 2:  
 a.  
 b.

Choose Level 2

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## LOCUS: Using the Tool

- Always stand back and regard the point chosen – does it make sense for the client?
- Err on the side of caution, but do not choose a level of need that exaggerates the client's situation in your opinion. Think of the client, by themselves – their capabilities, their needs.
- Use all the incoming data including the interview, most recent MSE, intuition, data from client, family, others, and history.
- Remember you are concentrating on now and the current needs, although in both history and risk of harm information about past history is important.

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## Dimension 1: Risk of Harm

- Measures two different things:
  - Degree of suicidal/homicidal ideation, behavior and/or intentions
  - Degree to which the client's perceptions/ judgment/or impulse control is impaired creating danger for them or others

**REMEMBER:** "Why" is not important.  
Measuring the extent of the risk is important

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## Dimension 1: Risk of Harm

- Think about the following:
  - What is client's baseline? Where are they now in relationship to their baseline?
  - Differentiate between chronic and acute risk of harm
    - Chronic issues usually fall in the 1,2,3 scores
    - Acute issues in the 3,4,5 scores
  - What is the client's current level of distress? Are they wringing hands, unable to answer, incoherent, not answering, tearing up, fidgeting, saying things that indicate a level of distress?

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## Dimension 1: Risk of Harm

- Think about the following:
  - Remember looking at two issues:
    - Expressed thoughts: what level of distress is associated with these thoughts – expressed or visible?
    - To what degree is judgment impaired; in what areas; with what potential impact?
    - Each of these is independently evaluated.
  - Is intoxication a factor? May be transient risk of harm that will have to be considered

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## Dimension 1: Risk of Harm

- BIG HINT ON SCORING ALL DIMENSIONS
  - Look at operative words: and, or, with, but, without
    - **Hint: highlight these words in your LOCUS tool and use them to fine tune your scoring**
  - Many statements build on one another as they move up in scoring.
    - Suicidal thoughts – no plan, no past attempts
    - Suicidal thoughts – no plan, some minor past attempts
    - Suicidal thoughts – with plan, no past attempts
    - Suicidal thoughts – with plan, with past attempts

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## Dimension 1: Risk of Harm

- Moderate Risk of Harm
  - Significant current suicidal or homicidal ideation, WITHOUT:
    - Intent OR
    - conscious plan OR
    - history
  - No active ideation, BUT:
    - Extreme distress
    - History

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**Dimension 1: Risk of Harm**

- Moderate Risk of Harm
  - History of chronic impulsive behavior or threats (baseline) AND,
    - Current expressions are close to baseline
  - Binge or excessive use of substances, WITHOUT
    - Current involvement in such behavior
  - Some evidence of self neglect and/or compromise in self-care

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**Dimension 1: Risk of Harm**

- Process of elimination:
  - Difficulty is trying to differentiate between 2,3,4 – the 1's and 5's are easy to spot.
  - Has the client had suicidal/homicidal ideas before?
    - Yes: is it a 2 or 3?
  - Has the client tried before?
    - Yes: is it a 3, 4, or 5?
- **Hint: Independent placement criteria: if client has a 4 or 5**

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**Dimension 1: Risk of Harm**

- Remember - some clients may have a chronic history of engagement in dangerous behavior
  - Usually scored lower unless:
    - There is a departure from baseline
  - Clinical judgment critical

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## Dimension 2: Functional Status

- Four factors:
  - Ability to fulfill obligations at work, school, home, etc.
    - These are role obligations they have –not ones they would like to have.
    - Usual activities
  - Ability to interact with others
    - Absolutely not treatment providers – their ability to engage with you or the treatment team is not being measured.
    - Look at relationships they have and that have acutely changed.

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## Dimension 2: Functional Status

- Four factors:
  - Vegetative Status:
    - Eating, sleeping, activity level, sexual appetite
  - Ability to care for self
    - Decision making
    - Appearance, hygiene
    - Environment
  - Comparison is to client's baseline or to ideal level for them in past – this is usually not measured against an ideal "other"
    - Prior to mental illness
    - Highest previous level
  - Rating is based on recent changes/current status in one or more of these areas that are causing problems for the client.

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## Dimension 2: Functional Status

- Again differentiate between acute and chronic issues – as with risk of harm
  - **Hint: Persons with chronic deficits with no acute changes in status are given a 3 – do not compare them to a baseline or ideal.**
  - Don't confuse this with risk of harm. This is not a measurement of risk of harm but rather changes in status. Dimension 1 looks at functioning only where it puts the individual in harm's way.
- Focus is on psychiatric or addictive causes for functional deficits – not physical disabilities
  - **Hint: Independent placement criteria for a 4 or 5**

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### Dimension 3: Medical, Addictive, Psychiatric Co-morbidity

- Remember you have picked the most readily apparent illness already – this is the everything else dimension
  - Does not imply the importance of one over the other
  - Start with most readily apparent and move on
- Looking at the interactions of co-existing illnesses – no psych on psych
  - Primary issue and comorbidity:
    - Psych with Medical
    - Psych with substance abuse
    - Substance abuse with psych
    - Substance abuse with medical
  - Triple diagnoses use same model: pick primary and then both secondaries become co-morbidities
- These are currently co-existing illnesses – do not consider history unless current situation makes reactivation likely
- For substance abusers – physical withdrawal is considered to be a medical co-morbidity

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### Dimension 3: Medical, Addictive, Psychiatric Co-morbidity

- To score:
  - Think of the presenting problem and put it aside in your mind – evaluate this dimension based on everything else.
    - Co-morbidities sometimes prolong the presenting problem, may require more intensive placements, may require an order to placement – but they don't have to – this is what you are looking at.
  - **Hint: There are independent placement criteria for a 4 or 5 score.**

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### Dimension 4: Recovery Environment

- Focus here again on the primary or presenting concern
- Environmental factors that contribute to onset or the continuation of addiction or mental illness
- Two scores:
  - Level of stress:
    - What in the client's life is impeding progress towards recovery or treatment? Looking at specific stressors and their level:
      - » Transitional adjustments
      - » Exposure to drugs and alcohol
      - » Performance pressures in life roles/new roles
      - » Disruptions in family other relationships
    - How does client perceive these pressures? Low/high/overwhelming levels of demand or perceived pressure to perform.

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## Dimension 4: Recovery Environment

- Two scores:
  - Level of support:
    - What in the client's life is assisting/supporting treatment or recovery?
    - What helps the client maintain their mental health/recovery in the face of stressful circumstances?
    - Will supports be available and able to participate?
    - Low to high levels of support may be available, but also looking at ability of client to engage or use supports.
    - **HINT: if client is able to engage in treatment = 3. No higher level can be scored.**
    - **HINT: If client in ACT – scored as a 1 in all cases**
    - **HINT: If client residing in nursing home (not temporary) – scored same as ACT**

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## Dimension 4: Recovery Environment

- **Hint: Client's in a residential setting (protected environment) should be evaluated the following way:**
  - "Rate them based on the conditions (support) the client will experience if they leave the protected environment."
  - The residential setting should hopefully = good supports and reduce stress level =1 or 2.
    - Results in inappropriately low composite score.
  - Supports may be available later are not considered if not available now.

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## Dimension 5: Treatment and Recovery History

- Looks at historical information
- Assumes history may give some indication of how client will react currently.
  - Past exposure to and use of treatment
  - Past history of managing a recovery once out of treatment or at basic levels of care
  - Durability of recovery
- If someone has had a difficult time being able to manage a recovery in past with treatment – always want to consider the value of more intensive services
  - Clinical judgment: what types of more intensive services – you do not need to repeat past mistakes - use flexibility of LOCUS
- What is recovery?
  - A period of stability with good control of symptoms

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### Dimension 5: Treatment and Recovery History

- More weight should be placed on more recent experiences
- **Hint: zero history should – a 1.**
- History must be relevant to be scored.
  - E.g. someone in for marital therapy with history of ADHD. Someone in for acute schizophrenia with history of treatment for a mild adjustment disorder when a child.

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### Dimension 5: Treatment and Recovery History

- Moderate or Equivocal Response
  - Past treatment has not achieved:
    - Complete remission **or** optimal control of symptoms
  - Previous treatment marked by minimal effort **or** motivation **and** no significant success **or** recovery period.
  - Equivocal response to treatment **and** ability to maintain recovery.
  - Partial recovery achieved for moderate periods, **but** only with strong professional or peer support **in** structured settings.

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### Dimension 6: Engagement

- 2 factors:
  - Client’s understanding of illness and treatment
  - Client’s willingness to engage in treatment and recovery
- Consider
  - Acceptance of illness
  - Desire for change
  - Ability to trust others
  - Ability to interact with sources of help
  - Ability to accept responsibility for recovery

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## Dimension 6: Engagement

- Basic insight: should lead to lower scores
- Help seeking behaviors: can they use treatment resources independently? Is the individual interested in treatment? Willing to participate?
  - Not rote cooperation and compliance but ability and interest.
- Ability to seek and use help should lower scores

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## More Hints

- Use complete data: history, family, friends, client, prior evaluations, etc.
- The tool does not need to be used in a linear fashion – especially once you know the tool well
- Acute vs. chronic: former = 3,4,5's; latter =1,2,3's.
  - Start where you think the client is – don't just confirm your prior assumptions however – see if the score fits the client and then scan above and below
- Don't load stress onto all dimensions – need to put it aside except for dimension that measures stress.

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## More Hints

- Can't decided between 2 scores, go with higher.
- Remember 3 = a moderate issue, not nothing.
- Choose a primary problem or reason for treatment – remind yourself of this as you approach scoring each dimension.

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### LOCUS Level of Care Placements

- LOCUS describes levels of resource intensity using four variables that describe services, intensity, and service or program characteristics:
  - Care environment (physical facilities)
  - Clinical services
  - Supportive services
  - Crisis resolution and preventative services

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### LOCUS Level of Care Placements

- Some levels have same services as others, but in general service array, intensity and complexity increases with levels
  - More expensive also
- Actually seven levels of care –but only six are service levels
  - All levels include availability of some services

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### LOCUS Level of Care Placements

- Basic Services
  - Should be available to all community including to clients at all levels of care
  - Prevention of illness, limiting morbidity
  - Emergency care/Crisis services
    - Evaluations
    - Brief interventions
    - Outreach in some cases to specialty populations – e.g. homeless, victims of violence

Other prevention services – educational, high risk screening, day care, support networks

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### LOCUS Level of Care Placements

- **LOCUS Level 1: Recovery Maintenance and Health Management**
  - Low intensity
  - Clients can live independently and are usually stepping down – ready now for support and maintenance
  - Minimal requirements – multiple settings
  - Basic clinical service available
  - Support programs for community living: case management usually no, but other linkages and programs yes
    - Rehabilitation, voc training, transportation, mutual support
    - Housing, benefits, systems support, child care linkages

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### LOCUS Level of Care Placements

- **LOCUS Level II: Low Intensity Community-Based**
  - Low intensity but more than level 1
  - Clients can live independently and with periodic support, e.g. therapy weekly
  - May be entry level for minor disturbances
  - No controls on access
  - Clients may choose from menu of services but may not use all
  - Usually facility but some community based services maybe
  - Basic clinical service available
  - Support programs for community living: full array should be available including rehab, housing support, living assistance

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### LOCUS Level of Care Placements

- **LOCUS Level III: High Intensity Community-Based**
  - Clients can live independently but with more intensive contacts and structure – possibly several days per week for several hours
  - Controls maybe on access, not egress
  - Facility plus mobile capacity needed
  - More intensive clinical services available
  - Case management often needed here
  - Support programs for community living: full array should be available including rehab, housing support, living assistance

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### LOCUS Level of Care Placements

- LOCUS Level IV: Medically Monitored Non-Residential
  - Clients can live independently but with very intensive supports and structures –e.g. partial hospital, ACT
  - Controls maybe on access, not egress
  - Mobile capacity needed, plus facility based
  - 24 hour clinical supports available
  - Daily contacts must be possible
  - Intensive case management often needed here
  - Rehabilitative services also

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### LOCUS Level of Care Placements

- LOCUS Level V: Medically Monitored Residential
  - Clients cannot live independently
  - No secure care or restraints or seclusion possible
  - May be some custodial care for individuals with little recovery potential
  - Controls maybe on access, not egress
  - 24 hour clinical supports available
  - 24 hour medical on-call
  - Liaison with community providers for transition back to the community.

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### LOCUS Level of Care Placements

- LOCUS Level VI: Medically Managed Residential
  - Secure care: traditionally a hospital but not necessary
  - Usually for most acute and disturbed
  - Admission can be voluntary or involuntary
  - Can restrict outside contacts, use restraints and seclusion
  - Clinical attention and supports intense
  - Medication managed and dispensed
  - Liaison with community providers for transition back to community
  - Want stabilization and move to lower level of care

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## LOCUS Levels to IL Levels<sup>\*(trainer add their own continuum)</sup>

<u>LOCUS</u>	<u>Levels</u>
■ Level I	■ Community OP
■ Level II	
■ Level III	
■ Level IV	■ ACT/Supported Housing/CST
■ Level V	■ Nursing Homes/Crisis Residential/24 Hr Supervised
■ Level VI	■ Crisis Residential/Hospital

\*Pilot levels for data collection only. Each level assumes full array of Rule 132 services except where prohibited by definition/rule/regulation.

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## Scoring and Placement

### Choices

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## Training: Practice Cases

- Use at least two cases
- Score one in group
- Score second individually
- Discuss scoring differences: individual dimensional as well as composite scores
- Look at the amount of time it takes

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### Scoring Choices

- Manual: composite and individual score sheet – see handout
- Electronic: software available; watch for copyright issues

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### Placement Choices

- Grid: LOCUS developed – see handouts – not recommended by LOCUS but may be easier to use for some
- Decision Tree: LOCUS recommended but can be difficult to use first couple of times

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### Placement Choices

- Level of Care Characteristics: see handout – remember this is not supposed to be prescriptive – LOCUS is intended to reflect the continuum of care available and not an ideal continuum.

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## Training Exercises

- Do one case using Grid
- Do second case using Decision Tree
- Now go back and use the opposite tool for each case
- See which individual scorer like better
- Determine if there are any differences in placement decisions

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## Inter-Rater Reliability

- Each agency will need to design a system that they believe best produces consistent results for clients with like level of needs
  - Concern 1: LOCUS allows for significant amount of clinical judgment
  - Concern 2: LOCUS instructions suggest always choosing high if in doubt
  - Important that differences of concern result in a different level of care – high or low

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## Inter-Rater Reliability

- Some possible actions:
  - **At beginning for any LOCUS Profiler:**
    - Post -sampling by independent rater: progressive reviews based on small samples
      - E.g 3 second looks – disagreement on > 1, then look at 3 more – disagreement on >1 – retrain and re-look
    - Concurrent profiles until % agreement is reached
      - Review 5 together –if agreement is greater than \_\_\_\_% then move forward independently
  - **On-going:** Second independent review of any profile that results in recommendation for change in level of care either up or down

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## Inter-Rater Reliability

- On-going: training of all scorers with practice cases, annually
- On-going: publication of de-identified data on placement, UR, health outcomes
- On-going: updating the training slides to reflect trainee input, evaluations

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## Training Materials Handouts

All handouts including LOCUS tool and original PowerPoint slides can be found at:

[illinoismentalhealthcollaborative.com](http://illinoismentalhealthcollaborative.com)

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