Department of Mental Health

TRANSMITTAL LETTER

SUBJECT **Level of Care Utilization System (LOCUS/CALOCUS) Evaluations**		
POLICY NUMBER **DMH Policy 300.1D**	DATE FEB 27 2012	TL# 161

Purpose. To set forth the procedures to ensure that the level of care (LOC) for all consumers who are enrolled in a core services agency (CSA) are appropriately determined and guidelines for the type of interventions are identified. Changes to the current policy was made to sync with DMH Policy 200.2A Continuity of Care Guidelines for Adults, and DMH Policy 200.5A Continuity of Care Guidelines for Children and Youth. Revisions are all found in Section 6.

Applicability. Applies to all active consumers, Department of Mental Health (DMH) - certified CSAs, Mental Health Rehabilitation Services (MHRS) providers, their sub-providers and specialty providers, Saint Elizabeths Hospital (SEH), and the Mental Health Authority (MHA). See Section 6 below for instances where consumers are admitted for inpatient treatment at locations other than Saint Elizabeths Hospital.

Policy Clearance. This policy was cleared through the Chief Clinical Officer.

Implementation Plans. A plan of action to implement or adhere to a policy must be developed by designated responsible staff. If materials and/or training are required to implement the policy, these requirements must be part of the action plan. Specific staff should be designated to carry out the implementation and program managers are responsible to follow through to ensure compliance. Action plans and completion dates should be sent to the appropriate authority. Contracting Officer Technical Representatives (COTRs) must also ensure that contractors are informed of this policy if it is applicable or pertinent to their scope of work. Implementation of all DMH policies shall begin as soon as possible. Full implementation of this policy shall be completed within sixty (60) days after the date of this policy.

Policy Dissemination and Filing Instructions. Managers/supervisors of DMH and DMH contractors must ensure that staff is informed of this policy. Each staff person who maintains policy manuals must promptly file this policy in Volume I of the **DMH** Policy and Procedures Manual and contractors must ensure that this policy is maintained in accordance with their internal procedures.

*If any DMH policies are referenced in this policy, copies may be obtained via DMH Intranet on the DMH web or the District Internet at www.dmh.dc.gov Hard copies of DMH policies may be obtained from DMH Policy Support Division by calling (202) 671-4070.

ACTION

REMOVE AND DESTROY	INSERT
DMH Policy 300.1C Level of Care Utilization System (LOCUS/CALOCUS) Evaluations	**DMH Policy 300.1D** Level of Care Utilization System (LOCUS/CALOCUS) Evaluations

2/27/12

Stephen T. Baron — Date
Director, DMH

GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF MENTAL HEALTH	Policy No. 300.1D	Date FEB 27 2012	Page 1
	Supersedes DMH Policy 300.1C, same subject, dated Dec. 10, 2010		

Subject: Level of Care Utilization System (LOCUS/CALOCUS) Evaluations

1. **Purpose**. To set forth the procedures in utilizing LOCUS and CALOCUS effectively to ensure that the level of care for all consumers who are enrolled in a core services agency (CSA) are appropriately determined with the intensity and type of interventions.

2. **Applicability**. Applies to all active consumers, Department of Mental Health (DMH) certified core service agencies (CSAs), their sub-providers and specialty providers, Saint Elizabeths Hospital (SEH), and the Mental Health Authority (MHA).

3. **Authority**. Department of Mental Health Establishment Amendment Act of 2001 and Mental Health Rehabilitation Services (MHRS) Provider Certification Standards (Section 3404.4).

4. **Definitions**.

4a. Active Consumer. A consumer who is enrolled with a CSA who is receiving treatment and services in accordance with his/her agreed upon treatment plan as identified in that active Individual Recovery Plan (IRP) for adults or Individual Plan of Care (IPC) for children/youth.

4b. Assertive Community Treatment (ACT). An intensive, integrated, rehabilitative, crisis, treatment, and mental health rehabilitative community support service provided by an interdisciplinary team to adults with a serious mental illness with dedicated staff time and specific staff to consumer ratios.

4c. Community-Based Intervention (CBI). Services that is time-limited, intensive mental health services delivered to children and youth and their family and intended to prevent the utilization of an out-of-home therapeutic resource by the consumer.

4d. DMH Guidelines in Identifying Possible Service Settings from LOCUS/CALOCUS Rating (see Exhibit 1). Provide guidance in matching LOCUS/CALOCUS composite rating, in combination with clinical judgment, to determine the possible service settings for the consumer. This is a dynamic document that is expected to evolve over time (see Section 8 regarding information on updates).

4e. Level of Care (LOC). Refers to intensity of services with required features (e.g., MHRS type of service – as applicable, location and housing recommendation). Level of Care (LOC) definitions for children and adolescents (see Exhibit 2) and adults (see Exhibit 3) are provided in this policy.

4f. Level Of Care Utilization System (LOCUS) and Child and Adolescent Level Of Care Utilization System (CALOCUS). Refer to clinical evaluations tools that are utilized to determine level of care (LOC) and medical necessity for adults and children and youth respectively.

4g. Mental Health Community Residential Facility (MHCRF). Publicly or privately owned residence that houses individuals, eighteen (18) or older, with a principal diagnosis of mental illness and who require twenty four (24) hour on-site supervision, personal assistance, lodging, and meals and who are not in the custody of the DC Department of Corrections.

5. **Policy**. All consumers enrolled in a CSA and engaged in active treatment shall have their level of functioning and service intensity needs assessed initially, at specified routine intervals, and at other times when in crisis and/or a level of care change. This is required to ensure services delivered are individualized, clinically appropriate, and least restrictive.

5a. LOCUS/CALOCUS evaluations shall be are utilized as part of the treatment planning process to assist in determining the appropriate level of care for the consumer. Treatment interventions shall be determined based on individualized clinical assessment.

5b. The use of the DMH web-based LOCUS/CALOCUS **is mandatory in all circumstances** as specified in this policy (e. g., initially, during the development of a treatment plan, at specified routine intervals, and at other times when in crisis and/or a level of care change is required) to ensure services delivered are individualized, clinically appropriate, and least restrictive for the consumer.

5c. In most cases, CALOCUS may be utilized with children ages 6 through 18 years. Since the service needs of infants and toddlers are fundamentally different than those of older children, services for infants and toddlers are excluded from the CALOCUS. These children should not be assessed with this instrument.

5d. No age cut-off is provided for using the adult versus child/adolescent versions of LOCUS or CALOCUS, since either instrument may be the most appropriate for a given individual, depending on his or her developmental level.

5e. A printed copy of the LOCUS/CALOCUS results shall be part of the consumer's clinical record to make it more accessible in treatment planning.

5f. LOCUS/CALOCUS results shall not be used to force treatment or services or deter consumer choice.

5g. The DMH Guidelines in Identifying Possible Service Settings from LOCUS/CALOCUS Ratings (see Exhibit 1) shall be used to guide intensity of services rather than a strict formula for assigning interventions. A consumer may or may not receive services designated in the level of care depending on the assessed circumstances. DMH authorization is required for some services prior to delivery.

5h. The consumer-level of functioning data gathered from the web-based Level of Care Utilization System (LOCUS/CALOCUS) application will be utilized for system monitoring, quality improvement and performance evaluation activities as outlined in the LOCUS/CALOCUS Data Reporting and Quality Improvement Plan maintained by the DMH Office of Accountability.

6. **Procedures**. A LOCUS adult evaluation or a CALOCUS child/youth evaluation shall be completed by the following given the conditions and frequencies:

6a. Core Services Agency (CSA). The CSA shall perform a LOCUS/CALOCUS in the following circumstances:

(1) At intake. Consumers presenting for intake at a CSA shall have a LOCUS or CALOCUS evaluation completed by the CSA, with collateral information obtained, whenever possible, from persons/entities that have had contact with the individual within, at least, the last thirty (30) days.

(2) Continuing treatment. Consumers in continuing treatment at a CSA shall have a LOCUS or CALOCUS evaluation completed by the CSA at a minimum of every 180 (every 6 months) in concert with the IRP/IPC planning process and update of level of functioning.

(3) Residential transfers. The CSA shall complete a LOCUS evaluation whenever a consumer is recommended for transfer to a Mental Health Community Residential Facility (MHCRF) and every 180 days thereafter.

(4) Consumers at Saint Elizabeths Hospital. The CSA shall complete LOCUS evaluation with input from the hospital's treatment planning team prior to and as part of the discharge planning to determine acuity and level of care for adult consumers receiving continuing treatment at Saint Elizabeths Hospital in civil and forensic programs.

(5) Consumers who are incarcerated. The CSA Provider, with input from the mental health staff at Central Detention Facility (CDF/DC Jail), shall complete a LOCUS evaluation upon initial assessment of the consumer, and prior to release if notified.

(6) As clinically indicated. The CSA shall complete a LOCUS or CALOCUS any time any consumer experiences significant events affecting his/her functioning that would impact service intensity (e.g., visit to crisis emergency provider or hospitalization).

6b. Sub provider/Specialty Providers. For consumers enrolled in a CSA and referred to a sub provider or specialty provider (e.g., CBI or ACT), the sub-provider or specialty provider shall submit the completed LOCUS or CALOCUS Worksheets (Exhibits 4 or 5) via fax or email, etc. to the CSA for input in the web-based evaluation.

(1) Wraparound Providers. In the case of children and youth and their families involved in high fidelity wraparound process, the Wraparound Care Coordinator completes the initial CALOCUS within thirty (30) days of receiving a referral from DMH, and upon discharge from wraparound services.

(2) Assertive Community Treatment (ACT). The CSA conducts the LOCUS evaluation for referral to the ACT. Then, the ACT provider shall complete the LOCUS evaluation every 180 days thereafter or, as clinically indicated.

(3) Community-Based Intervention (CBI). CBI 1, II, and IV are re-authorized every 180 Days. CBI Level III is renewed every ninety (90) days (for CALOCUS submission, see Section 6b above).

(4) Psychiatric Residential Treatment Facilities (PRTFs). For DMH child/youth consumers receiving continuing treatment at a PRTF: The RTC Reinvestment Program staff, **with input** from the child/youth treatment team (e.g., PRTF clinical staff, parent, guardian, placing agency representative, etc.), shall complete a CALOCUS evaluation (or LOCUS evaluation if applicable) during their RTC regularly scheduled site visits, and prior to discharge from the PRTF as part of discharge planning.

(5) Crisis Bed Provider. A consumer, natural support, CSA/ACT Provider, community acute care facility or a crisis emergency provider may refer a consumer to a crisis bed. If the crisis is not resolved within 48 hours, the crisis bed provider staff shall provide a completed LOCUS worksheet to Access Helpline (AHL), along with a psychiatric evaluation and a clinical presentation for initial authorization of the stay."

7. **MHA Responsibilities**.

7a. The MHA, Office of Programs shall:

(1) **Provide** the LOCUS or CALOCUS tool and training on the completion of the web-based assessment tools.

a. After an individual is trained, an account request form must be completed and sent to the DMH Division of Provider Relations in order to establish his/her access to the web-based LOCUS-CALOCUS tools. The Division of Provider Relations will confirm the accuracy of information and level of web access designation, and forward the request to the Division of Information Services to create the user account.

b. Authorized users may access the web-based LOCUS/CALOCUS evaluation tool as follows:

- DMH internal (Intranet) users: http://locus.dmh.dc.gov.
- External providers: https://locus.dmh.dc.gov.

(2) **Analyze, produce, and provide** scheduled data reports as determined by the Mental Health Authority (MHA) leadership using LOCUS/CALOCUS data and assist in the development and implementation of quality improvement activities and system-level change strategies.

7b. The MHA, Office of Accountability (OA) shall:

(1) **Monitor** the evaluation process to ensure the evaluations are accurately completed on a timely basis in compliance with this policy.

(2) **Conduct** quality reviews and develop agency and system-level quality monitoring and improvement activities.

(3) **Develop** quality improvement initiatives or corrective action plans as necessary to improve the quality of the evaluations or compliance with this policy.

8. **Updates** shall be through Provider Bulletins on the DMH website: http://newsroom.dc.gov/list.aspx/agency/dmh/section/25.

9. **Inquiries.** Contact the office of the Director, Division of Provider Relations or Programs and Policy Division.

10. **Related References**.

LOCUS/CALOCUS Data Reporting and Quality Improvement Plan, Office of Accountability, DMH, 2011.
DMH Policy 200.2A Continuity of Care Guidelines for Adults, 01/17/2012

DMH Policy 200.5A Continuity of Care Guidelines for Children and Youth, 01/27/2012
DMH Policy 340.6A Provision of Assertive Community Treatment (ACT), 12/09/2009
DMH Policy 340.9 Community Based Intervention (CBI) Services for Children and Youth 01/10/2011
DMH Policy 340.10 High Fidelity Wrap Around Care Planning Process, 08/01/2011

12. **Exhibits.**

1 DMH Guidelines in Identifying Possible Service Settings from LOCUS/CALOCUS Rating – Section 4d
2 Levels of Care Definitions (CALOCUS) – Section 4e
3 Levels of Care Definitions (LOCUS) – Section 4e
4 CALOCUS Worksheet – Section 6b
5 LOCUS Worksheet – Section 6b

Approved by:

Stephen T. Baron
Director, DMH

2/27/12

(Signature) **(Date)**

DEPARTMENT OF MENTAL HEALTH

Washington, DC 20002

Applied Research and Evaluation Unit
Division of Organizational Development
Office of Programs and Policy

DMH GUIDELINES IN IDENTIFYING POSSIBLE SERVICE SETTINGS FROM LOCUS/CALOCUS RATINGS

Purpose: This material serves as a guideline in identifying possible service settings for DMH consumers.
Note: DMH authorization is required for some services prior to delivery.

How to Use: LOCUS/CALOCUS assesses consumer needs based on level of functioning, rather than from diagnosis and psychiatric risks alone. DMH utilizes the LOCUS/CALOCUS composite score ranges common to the level of care from the six (6) evaluation dimensions to guide the level of intensity of the consumer service setting.

"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" (CALOCUS Version 1.5, American Academy of Child and Adolescent Psychiatry, AACP, Deerfield Behavioral Health, Inc. and LOCUS Adult Version 2010, AACP, Deerfield Behavioral Health, Inc., March 20, 2009).

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LEVEL	CALOCUS (See Level of Care Definitions. Exhibit 2, Policy 300.1D)	LOCUS (See Level of Care Definitions. Exhibit 3, Policy 300.1D)	Traditional Service Setting	MHRS Service Types - C/Y & Adult	Location of Service	Housing Recommendation	Examples of Service Intensity
0	Basic Services. This is a basic package of prevention and health maintenance services that are available to everyone in the population being served, whether or not they need active mental health care.	Prevention and Health Maintenance. 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.	Package of prevention and health maintenance services assumed to be available to the community.	-24-hour Crisis Services -Prevention Services -Diagnostic/ Assessment -Counseling -Early Childhood Mental Health	-Home (family of origin, kinship foster care, foster care, therapeutic foster care, therapeutic group home) - School -Church -Medical and recreational facilities -Traditional Mental Health Settings (office or clinic) -Other Community settings	Independent Living	As needed unless otherwise specified. Examples may include: Screening for health, behavioral health and developmental disorders, day care and recreational services, publicized and accessible emergency medical and crisis intervention services.

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1	**Composite score ranges common to this level of care:10-13** Recovery Maintenance and Health Management. Usually reserved for those stepping down from higher levels of care that need minimal system involvement to maintain their current level of function or need brief intervention to return to their previous level of functioning. Examples of this level of service are children or adolescents who only need ongoing medication services for a chronic condition or brief crisis counseling.	**Composite score ranges common to this level of care:10-13** Recovery Maintenance and Health Management. 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.	Maintenance services after more intensive services (e.g., crisis counseling, community support services, medication maintenance).	-24-hour Crisis Services -Community Support -Diagnostic/ Assessment -Counseling -Medication/ Somatic Treatment Specialty Services: - Trauma-Focused - CBT Other Services: Housing Assistance; Supported Employment	-Home (family of origin, kinship foster care, foster care, therapeutic foster care, therapeutic group home) -Traditional mental health setting (office or clinic) -Free-standing clinic option for children -Other Community settings	Independent Living	-Community Support = 2x/Month -Diagnostic assessment = 1x/Year -Counseling = 1-2x/Month -Med/Som = 1x/Month Trauma Focused Cognitive Behavior Therapy (CBT) = As prescribed in Evidenced Based Practice (EBP) guidelines

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LEVEL	CALOCUS (See Level of Care Definitions. Exhibit 2, Policy 300.1D)	LOCUS ((See Level of Care Definitions. Exhibit 3, Policy 300.1D)	Traditional Service Setting	MHRS Service Types - C/Y & Adult	Location of Service	Housing Recommendation	Examples of Service Intensity
2	**Composite score ranges common to this level of care: 14-16** Outpatient Services. This level of care most closely resembles traditional office based practice and requires limited use of community-based services.	**Composite score ranges common to this level of care: 14-16** Low Intensity Community Based-Services. This level of care provides treatment to clients who need ongoing treatment, but who are living either independently or with minimal support in the community. Treatment and service needs do not require intense supervision or very frequent contact. Programs of this type have traditionally been clinic-based programs.	Traditional outpatient treatment once/week visits	-24-hour Crisis Services -Community Support -Day Services -Diagnostic/ Assessment -Counseling (individ/group on site) -Medication/Somatic Treatment -Care Coordination Specialty Services: Trauma-Focused CBT Other Services: Housing Assistance; Supported Employment	-Home (family of origin, kinship foster care, foster care, therapeutic foster care, therapeutic group home) -Traditional mental health setting (office or clinic) -Free-standing clinic option for children -Other Community settings	Independent Living	-Community Support = 1x/Week -Day Services -Diagnostic Assessment = 1-2x/Year -Counseling = 1-2x/ Week -Med/Som = 1x/Month

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LEVEL	CALOCUS (See Level of Care Definitions. Exhibit 2, Policy 300.1D)	LOCUS (See Level of Care Definitions. Exhibit 3, Policy 300.1D)	Traditional Service Setting	MHRS Service Types - C/Y & Adult	Location of Service	Housing Recommendation	Examples of Service Intensity
3	**Composite score ranges common to this level of care: 17-19** Intensive Outpatient Services (IOP). It is at this level that services begin to become more complex and more coordinated. The use of case management begins at this level. The use of child and family teams to develop Individualized Service (Wraparound) Plans also begins, using mostly informal community supports such as church or self-help groups and "Big Brothers/Big Sisters." This level requires more frequent contact between providers of care and the youth and his family as the severity of disturbance increases.	**Composite score ranges common to this level of care: 17-19** High Intensity Community Based Services. This level of care provides treatment to clients who need intensive support and treatment, but who are living either independently or with minimal support in the community. Service needs do not require daily supervision, but treatment needs require contact several times per week. Programs of this type have traditionally been clinic based programs.	Intensive Outpatient Services from 2 visits/week up to few hours for 3 days per week; includes multiple services (e.g., church services, mental health services) necessitating coordination (case management).	- 24-hour Crisis Services -Community Support -Day Services -Diagnostic/ Assessment -Intensive Day Treatment -Counseling (individ/group on site) -Counseling (individ/group off-site) -Medication/Somatic Treatment -Crisis/Emergency *Pre-Authorized Services:* -Community-Based Intervention (I -IV)* *Specialty Services: SOC Care Coordination/ Wraparound, Trauma-Focused CBT, and Brief Intervention Treatment* Other Services: Housing Assistance; Supported Employment	- Home (family of origin, kinship foster care, foster care, therapeutic foster care, therapeutic group home) -Traditional mental health setting (office or clinic) -Free-standing clinic option for children	-Independent Living -Supported Independent Living (SIL) - Residential Facility	-Community Support = 2x/Week -Day Services -Diagnostic assessment = 2x/Year -Intensive Day Services -Counseling = 1-2x/Week (on/off site) -Med/Som = 1-2x/Month -CBI (I-IV)* -System of Care / Wraparound (with informal supports) as needed -Trauma Focused Cognitive Behavior Therapy as prescribed in EBP practice guidelines

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LEVEL	CALOCUS (See Level of Care Definitions. Exhibit 2, Policy 300.1D)	LOCUS (See Level of Care Definitions. Exhibit 3, Policy 300.1D)	Traditional Service Setting	MHRS Service Types - C/Y & Adult	Location of Service	Housing Recommendation	Examples of Service Intensity
4	**Composite score ranges common to this level of care: 20-22** Intensive Integrated Service Without 24-Hour Psychiatric Monitoring. Intensive Integrated Service Without 24-Hour Medical Monitoring of care best describes the increased intensity of services necessary for the "multisystem, multi-problem" child or adolescent requiring more extensive collaboration between the increased number of providers and agencies. A more elaborate Wraparound plan is also required, using an increased number of formal supports. Additional supports may include respite, homemaking services or paid mentors. In more traditional systems, this level of service is often provided in a day treatment or a partial hospitalization setting. Active case management is essential at this level of care.	**Composite score ranges common to this level of care: 20-22** 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.	Wraparound plan required, increased formal supports (respite, can include day treatment or partial hospitalization; active case management is essential, ACT	-Community Support -Day Services -Diagnostic/Assessment -Intensive Day Treatment -Counseling (individual/group on site) -Counseling (individual/group on-site and off-site) -Medication/Somatic Treatment -Crisis/Emergency *Pre-Authorized Services:* -Community-Based Intervention (I -IV)* -Assertive Community Treatment *Specialty Services: SOC Care Coordination/ Wraparound, Trauma-Focused CBT, and Brief Intervention Treatment* Other Services: Housing Assistance; Supported Employment	-Home (family of origin, kinship foster care, foster care, therapeutic foster care, therapeutic group home) -Traditional mental health setting (office or clinic) -Free-standing clinic option for children	-Ind. Living -Supported Independent Living (SIL) -Residential Facility	-Community Support = 2x/Week -Day Services -Diagnostic Assessment= 2x/Year -Intensive Day Services -Counseling = 2x/Week (on/off site) -Med/Som = 2x/Month -Community Based Intervention (CBI)(I-IV)* -ACT -System of Care (SOC) / Wraparound as needed -Trauma Focused Cognitive Behavior Therapy = As prescribed in EBP practice guidelines

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LEVEL	CALOCUS (See Level of Care Definitions. Exhibit 2, Policy 300.1D)	LOCUS (See Level of Care Definitions. Exhibit 3, Policy 300.1D)	Traditional Service Setting	MHRS Service Types - C/Y & Adult	Location of Service	Housing Recommendation	Examples of Service Intensity
5	**Composite score ranges common to this level of care: 23-27** Non-Secure, 24-Hour, Services with Psychiatric Monitoring. Traditionally, this level of care is provided in group homes or other unlocked residential facilities, but may be provided in foster care and even family homes if the level of Wraparound services in the community is extraordinarily high. In either case, a complex array of services should be in place around the child and a higher level of care coordination is needed in order to manage the child's multiple needs.	**Composite score ranges common to this level of care: 23-27** Medically Monitored Residential Services. This level of care refers to residential treatment provided in a community setting. This level of care has traditionally been provided in non-hospital, free standing residential facilities based in the community. In some cases, longer-term care for persons with chronic, non-recoverable disability, which has traditionally been provided in nursing homes or similar facilities, may be included at this level.	Group home, foster care or a residential facility, can also be provided by tightly knit wraparound services, Community-based residential services [nursing home, RTC]	-Community Support -Day Services -Diagnostic/Assessment -Intensive Day Treatment -Counseling (individual/group on site) -Counseling (individual/group on-site and off-site) -Medication/Somatic Treatment -Crisis/Emergency *Pre-Authorized Services:* • Community-Based Intervention (I -IV)* • Assertive Community Treatment *Specialty Services: SOC Care Coordination/ Wraparound, Trauma-Focused CBT, and Brief Intervention Treatment* Other Services: Housing Assistance; Supported Employment	***Group Home or other Unlocked Residential Facility*** A complex array of services including medication management and monitoring with 24-hour care available. Services can be provided in the following treatment settings: -Supported Independent Living (SIL) -Community Residential Facility -Residential Treatment Center (RTC) -Psychiatric Residential Treatment Facility (PRTF) **Other Services:** It is possible to provide Level 5 intensive community-based services at the time of transition or discharge. Examples include System of Care/ Wraparound services, ACT and CBI.	**Contract Community Residential Facility for Adults** DMH has designated this level of care as Contract CRF level of care. This is not necessarily a location of service. Community support and other MHRS services may be delivered here and consumers may receive all of the MHRS service types while receiving medically monitored residential services.	- Community Support = 2x/Week -Day Services -Diagnostic Assessment 2x/Year -Counseling = 2x/Week (on/off site) -Med/Som = 2x/Month -CBI (I-IV)* -ACT -System of Care / Wraparound as needed -TF-CBT as prescribed in EBP practice guidelines

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LEVEL	CALOCUS (See Level of Care Definitions. Exhibit 2, Policy 300.1D)	LOCUS (See Level of Care Definitions. Exhibit 3, Policy 300.1D)	Traditional Service Setting	MHRS Service Types - C/Y & Adult	Location of Service	Housing Recommendation	Examples of Service Intensity
6	**Composite score ranges common to this level of care: 28 +** Secure, 24-Hour, Services With Psychiatric Management. Most commonly, these services are provided in inpatient psychiatric settings or highly programmed residential facilities. If security needs could be met through the Wrap Around process, then this level of intensity of service could also be provided in a community setting. Case management remains essential to make sure that the time each child spends at this level of care is held to the minimum required for optimal care and that the transition to lower levels of care are smooth.	**Composite score ranges common to this level of care: 28 +** Medically Managed Residential Services. This is the most intense level of care in the continuum. Level six services have traditionally been provided in hospital settings, but could, in some cases, be provided in freestanding non-hospital settings.	Inpatient psychiatric settings or highly programmed residential facilities; if security needs can be met through the wrap-around process, could also be provided in a community setting. Case management essential. Time at this level of care held to minimum for optimal care and transition to lower levels of care.	-Community Support -Day Services -Diagnostic/Assessment -Intensive Day Treatment -Counseling (individual/group on site) -Counseling (individual/group on-site and off-site) -Medication/Somatic Treatment -Crisis/Emergency *-Pre-Authorized Services:* -Community-Based Intervention (I -IV)* -Assertive Community Treatment *Specialty **Services:** SOC Care Coordination/ Wraparound, Trauma-Focused CBT, and Brief Intervention Treatment* **Other Services:** Housing Assistance; Supported Employment	**Inpatient Psychiatric Hospital or Secured Residential Facility** A complex array of services including medication management and monitoring with 24-hour care and security available. Services are typically provided in the following treatment settings: -Hospital -Residential Treatment Center (RTC) -Psychiatric Residential Treatment Facility (PRTF) **Other Services:** It is possible to provide Level 6 intensive community-based services at the time of transition or discharge if security measures are met. Examples include System of Care/ Wraparound services, ACT and CBI.	**Contract Community Residential Facility for Adults** DMH has designated this level of care as Contract CRF level of care. This is not necessarily a location of service. All DMH services may deliver either in the home (CRF) or in a traditional mental health setting.	*Inpatient Psychiatric Hospital or Secured Residential Facility* -Hospital -Residential Treatment Center (RTC) -PRTF = -ACT -CBI I -III

**** Functional Family Therapy (FFT) is reimbursable through MHRS as CBI Level IV***

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LEVELS OF CARE DEFINITIONS (CALOCUS)

(An Excerpt from the CALOCUS , Version 1.5, American Academy of Child and Adolescent Psychiatry, AACP, Deerfield Behavioral Health, Inc.).

LEVEL 0. BASIC SERVICES FOR PREVENTION AND MAINTENANCE

Basic Services are designed to prevent the onset of illness and/or to limit the magnitude of morbidity associated with individual family or social risk factors, developmental delays, and existing emotional disorders in various stages of improvement or remission. Services may be developed for individual or community application and are generally offered in a variety of community settings. Prevention and community support may be provided through traditional means, as well as through print and broadcast media (e.g., public service announcements and/or targeted mailings).

1. CLINICAL SERVICES. It is imperative that Basic Services in all settings provide screening for mental health and developmental disorders. Comprehensive, multidisciplinary assessments for children and adolescents who, after initial screening, emerge with multi-faceted problems should be readily available. Expert evaluations should be readily available. Linkage with mental health and substance abuse services (e.g., scheduling intakes) should be provided to families identified in screening assessment. Consultative services by mental health clinicians should be effectively integrated into all prevention and support functions. Medical care from either a pediatrician or family physician should be available in the community.

2. SUPPORT SERVICES. Basic Services should be available to children, adolescents, and families through active collaboration with religious and culturally distinct community groups, and in a variety of community settings, including schools and adult education centers, day care and recreational/social facilities, vocational and social services agencies, and medical facilities. Community volunteers and agency staff should be trained to provide prevention services.

3. CRISIS STABILIZATION AND PREVENTION SERVICES. 24-hour crisis services should be publicized, accessible, and fully integrated into Basic Services in all community settings. Crisis services should include emergency evaluation, brief intervention, and disposition. Child and adolescent psychiatrists and/or psychosocial nurses should be available for direct contact and consultation on a 24-hour basis. Additional crisis intervention and stabilization efforts should include outreach to vulnerable populations, such as homeless families, as well as intervention with victims of trauma and disaster.

4. CARE ENVIRONMENT. Prevention and community support activities may occur in many settings, from a child or adolescent's home, to schools, churches, medical and recreational facilities, or traditional mental health settings. Facilities should address ease of access (e.g., proximity to public transportation, schools, social services agencies); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); cultural competence (e.g., ambiance that is welcoming to families of multiple ethnic and socio-economic groups) and specific service needs (e.g., supervised day care so that parents can participate, staff or consultants for non-English speaking and/or hearing-impaired attendees).

Placement Criteria
All children, adolescents, and families should receive Basic Services.

LEVEL ONE. RECOVERY MAINTENANCE AND HEALTH MANAGEMENT

Level One services typically provide follow-up care to mobilize family strengths and reinforce linkages to natural supports. Those appropriate for Level One services either may be substantially recovered from an emotional disorder or other problem, or, their problems are sufficiently manageable within their families, such that the problems are no longer threatening to expected growth and development.

1. CLINICAL SERVICES. While clinical services at Level One may be non-intensive and/or episodic, they should be readily accessible so that families may use services to avert the need for higher levels of care. Clinical consultation and assessment should be culturally competent and should consider the extent to

LEVELS OF CARE DEFINITIONS (CALOCUS)
(An Excerpt from the CALOCUS , Version 1.5, American Academy of Child and Adolescent Psychiatry, AACP, Deerfield Behavioral Health, Inc.).

which families can mobilize natural supports in the community. Time-limited professional interventions, as well as ongoing case management and follow-up medication services may be provided as part of Level One clinical services. Medical care from either a pediatrician or family physician should be available in the community.

2. SUPPORT SERVICES. Level One support services consist mainly of natural supports in the community, including extended family, family friends, and neighbors; church and recreational programs; 12-step and other self-help programs; school-sponsored programs; and employment. Families appropriate to this level of care have the capacity to access these community resources as needed without professional intervention.

3. CRISIS STABILIZATION AND PREVENTION SERVICES. 24-hour crisis services should be available to children, adolescents, and families at this level of care. Crisis intervention staff should consult with primary clinicians. Crises services should include emergency evaluation, brief intervention, and outreach services. Direct services and/or consultation from child and adolescent psychiatrists and/or psychosocial nurses should be available in each community on a 24-hour basis.

4. CARE ENVIRONMENT. Recovery maintenance and health management services may be provided in a traditional mental health setting (e.g., office or clinic), or in facilities of other components in the system of care. Facilities should address ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired attendees, etc.). For adolescents, facilities should facilitate a mix of adult supervision with privacy for peer group activities. The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.

Placement Criteria

Children and adolescents with composite scores in the range of 10-13 generally may be stepped down to or receive Level One services. Placement at Level One usually indicates that the child or adolescent has successfully completed treatment at a more intensive level of care and primarily needs assistance in maintaining gains realized in the past, or does not need services that are more intensive or restrictive than those offered at Level One. Placement determinations should be made by culturally competent staff or with consultation by culturally competent clinical specialists.
COMPOSITE SCORE (Level 1) 10 - 13

LEVEL TWO. OUTPATIENT SERVICES

This level of care includes mental health services for children, adolescents, and families living in the community. Level Two services frequently are provided in mental health clinics or clinicians_ offices. Services also may be provided within a juvenile justice facility, school, social service agency, or other community setting. Children and adolescents appropriate for Level Two services generally do not require the extensive systems coordination and case management of the higher levels of care, since their families are able to use community supports with minimal assistance. The degree of individualization of services at Level Two also may not be as extensive as at higher levels of care, but continuity of at least one treatment relationship often is essential to maintenance at optimal levels of functioning. Clinicians offering follow-up at Level Two must provide continuing individual and family assessment with the capacity to add needed services as necessary.

1. CLINICAL SERVICES. Clinical services for outpatient care consist primarily of individual, group, and family therapies with active family participation in treatment planning and implementation. Treatment intensity ranges from one hour every other week, to two hours per week, unless the primary service consists of monthly medication management. Psychiatric and cultural competency consultation to the

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treatment team should occur regularly. Medication, evaluation and management may be an essential element. Child and adolescent psychiatrists and psycho-social nurses should be part of the primary treatment team for medication services and 24-hour back-up. Selected adjunct interventions (e.g., occupational, recreational, vocational, and/or expressive therapies) should be made available as indicated. Medical care from either a pediatrician or family physician should be available in the community.

2. SUPPORT SERVICES. Support services for children, adolescents, and families are most often natural supports within the community, including extended family, friends, and neighbors; church and recreational programs; 12-step and other self-help groups; school-sponsored programs; and employment. These families should have the capacity to access other elements of the system of care without substantial professional help, but may need referral and minimal case management. Families also may need support for financial, housing, or child-care problems, or for accessing vocational and education services. These should be included as part of the child or adolescent's individualized service plan.

3. CRISIS STABILIZATION AND PREVENTION SERVICES. 24-hour crisis services should be accessible to children, adolescents, and families at this level of care. Furthermore, crisis services should be provided in collaboration with the family's other service providers. Crisis services should include emergency evaluation, brief intervention, and outreach services. Direct services and/or consultation from child and adolescent psychiatrists and psychosocial nurses should be available on a 24-hour basis.

4. CARE ENVIRONMENT. Outpatient services may be provided in a traditional mental health setting (e.g., office or clinic), in facilities of other components of the service system, or in other community settings. Facilities used for treatment should address ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired attendees, etc.). For adolescents, facilities should facilitate a mix of adult supervision with privacy for peer group activities. The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.

Placement Criteria
Children and adolescents with a composite score in the range of 14-16 generally may begin treatment at, or be stepped down to, Level Two services. Placement at Level Two indicates that the child or adolescent does not need services that are more intensive/restrictive than those offered at Level Two, or has successfully completed treatment at a more intensive level of care and primarily needs assistance in maintaining gains realized in the past. Placement determinations should be made by culturally competent staff or with consultation by culturally competent specialists.
COMPOSITE SCORE (Level 2) 14 - 16

LEVEL THREE. INTENSIVE OUTPATIENT SERVICES

This level of care generally is appropriate for children and adolescents who need more intensive outpatient treatment and who are living either in their families with support, or in alternative families or group facilities in the community. The family's strengths allow many, but not all, of the child's needs to be met through natural supports. Treatment may be needed several times per week, with daily supervision provided by the family or facility staff. Services may be provided in a mental health clinic or clinician's office, but often are provided in other components of the system of care with mental health consultation. Service coordination is essential for maintaining the child or adolescent in the community at Level Three. Medical care from either a pediatrician or family physician should be available in the community.

1. CLINICAL SERVICES. Level Three services incorporate individual, group, and family therapy. Level Three services increasingly depend on the use of "child and family" teams as service coordination becomes more complex. Service intensity averages approximately three days per week. Psychiatric

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consultation to the treatment or "child and family" team should occur regularly. Medication management may be an essential part of treatment. Child and adolescent psychiatrists and psychosocial nurses are part of the treatment team providing medication services and 24-hour back-up. Selected adjunct interventions (e.g., occupational, recreational, vocational, and/or expressive therapies) may be used as indicated. In addition, referrals for clinical services for other family members may be needed. Transition planning for discharge to a lower level of care should be part of the services plan. Medical care from either a pediatrician or family physician should be available in the community.

2. SUPPORT SERVICES. Level Three support services include case management by a culturally competent primary clinician or case manager, or with cultural competency consultation as needed. Support services for these children, adolescents, and families should emphasize natural and culturally congruent supports within the community, such as extended family, neighborhood, church groups, self-help groups and community employers. Families may have difficulty accessing elements of the system of care without professional help due to the complexity of their child or adolescent's problems. In addition, families may need support for financial, housing, child-care, vocational, or education services. These should be included as part of the child or adolescent's individualized service plan.

3. CRISIS STABILIZATION AND PREVENTION SERVICES. 24-hour crisis services, including child and adolescent psychiatric and nursing consultation and/or direct contact, should be available at this level of care. Crisis services should be accessible and, when provided, crisis team personnel should contact the family's primary service providers. Crisis services should include emergency evaluation, brief intervention, and outreach.

4. CARE ENVIRONMENT. Intensive outpatient services may be provided in a traditional mental health setting (e.g., office or clinic), in facilities of other components of the service system, or in other community settings. The site should have the capacity for short-term management of aggressive or other endangering behavior. Facilities should address ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired attendees, etc.). For adolescents, facilities should facilitate a mix of adult supervision with privacy for peer group activities. The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.

Placement Criteria
Children and adolescents with scores in the range of 17-19 generally may begin treatment at, or be stepped down to, Level Three services. Placement at Level Three generally is excluded by a score of 4 or higher on any dimension. Placement at Level Three indicates that the child or adolescent either does not need more intensive or restrictive services, or has successfully completed treatment at a higher level of care and needs assistance in maintaining gains. Consideration for this level of care should include the age, size, and manageability of the child or adolescent, and the family and community resources available. Placement determinations should be made by culturally competent staff or in consultation with cultural competency specialists.
COMPOSITE SCORE (Level 3) 17 - 19

LEVEL FOUR. INTENSIVE INTEGRATED SERVICES WITHOUT 24-HOUR PSYCHIATRIC MONITORING
This level of care refers to services provided to children and adolescents capable of living in the community with support, either in their family, or in placements such as group homes, foster care, homeless or domestic violence shelters, or transitional housing. To be eligible for Level Four services, a child or adolescent's service needs must require the involvement of multiple components within the system of care. For example, an adolescent may require the services of a probation officer, a mental health clinician, a child and adolescent psychiatrist, and a special education teacher to be maintained in the community. These children and adolescents, therefore, need intensive, clinically informed case

management to coordinate multi-system and multidisciplinary interventions. Optimally, an individualized service plan is developed by a "child and family" team. Services are delivered more frequently and for more extended periods than at lower levels of care. Services in this level of care include partial hospitalization, intensive day treatment, and home-based wraparound care. Level Four services also may be provided in schools, substance abuse programs, juvenile justice facilities, social services group care facilities, mental health facilities, or in the child or adolescent's home.

1. CLINICAL SERVICES. Clinical services at Level Four should be available at times that meet the needs of the family, including non-traditional periods (e.g., evenings and weekends). The frequency of direct contact and/or consultation by child and adolescent psychiatrists and psychosocial nurses should be determined in consultation with the primary clinician and the child and family team. Primary medical care should be accessible as an integrated part of the comprehensive array of services. Interventions may include individual, group, and family therapy, and may be organized into protocols such as occur in day treatment, or offered as part of a comprehensive wraparound plan. Services may be offered within any of the components of the system of care. Services should be designed for flexibility, as part of an Individualized Service Plan, and with emphasis on building on the strengths of the child or adolescent and family. Medical care from either a pediatrician or family physician should be available in the community.

2. SUPPORT SERVICES. Level Four case management services are provided to coordinate the multi-faceted service needs of the children and adolescents and their families at this level of care. Recreational activities, after-school employment, church programs, and other community activities may be integrated into the Individualized Service Plan to form a graded continuum of natural, clinical, and culturally congruent supports, with emphasis on natural supports when available. Families are likely to need support for financial, housing, child-care, vocational, and/or education services. These should be included as part of the child or adolescent's Individualized Service Plan. Services should be family-centered, with the goals of either maintaining or reintegrating the child or adolescent in to the home and community.

3. CRISIS STABILIZATION AND PREVENTION SERVICES. At Level Four, children, adolescents, and families must have access to 24-hour emergency evaluation and brief intervention services that include direct contact and/or consultation by a child and adolescent psychiatrist or psychosocial nurse. Crisis services must be mobile and integrated into the care plan. Crisis services may be offered by a number of components in the system of care, although care should be taken to avoid service duplication. The goal of crisis services is to foster family strengths and prevent the need for admission to higher levels of care.
At Level Four, respite care may be offered to families to provide relief from the demands of caring for the child or adolescent and as a "cooling off" mechanism during crises and while treatment plans are implemented.

A Wraparound team's capacity for managing a child or adolescent at Level Four is partially determined by their age, size, and developmental level, as well as the strengths and size of the team. An inability to manage risk of harm may be reflected in a higher composite score on CALOCUS, and justifies transfer to a more restrictive setting or intensification of the wraparound program to offer active medical monitoring or management.

4. CARE ENVIRONMENT. Level Four services may be provided in an outpatient clinic or hospital (e.g., partial or intensive day treatment), any component in the service system (e.g. public or private day school, juvenile detention center, group home), or in the home (e.g., home-based services). The facility must have the capacity for short-term management of aggressive or other endangering behavior. Transportation needs should be accommodated, both for staff to serve children and adolescents in community settings and to help children, adolescents, and families access services. When home-based treatment is provided, staff transportation needs should be addressed. To optimize family participation, Level Four facilities should be located as near as possible to the child or adolescent's home. Facilities should incorporate ease of access (e.g., proximity to public transportation, schools, social services agencies); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can

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participate, resources for non-English speaking and/or hearing-impaired people). For adolescents, facilities should allow for a mix of adult supervision and privacy for peer group activities. The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.

Placement Criteria
Children and adolescents with scores in the range of 20-22 generally may begin treatment at, or be stepped down to, Level Four services. Placement at Level Four indicates that the child or adolescent either does not need more intensive services, or has successfully completed treatment at a more intensive level and primarily needs assistance in maintaining gains. Consideration for this level of care should include the age, size, and manageability of the child or adolescent, and the family and community resources available. Placement determinations should be made by culturally competent staff or with consultation by culturally competent specialists.
COMPOSITE SCORE (Level 4) 20 - 22

LEVEL FIVE. NON-SECURE, 24-HOUR SERVICES WITH PSYCHIATRIC MONITORING

This level of care refers to treatment in which the essential element is the maintenance of a milieu in which the therapeutic needs of the child or adolescent and family can be addressed intensively. This level of care traditionally has been provided in non-hospital settings such as residential treatment facilities or therapeutic foster homes. Equivalent services have been provided in juvenile justice facilities and specialized residential schools, and could be provided in homeless and/or domestic violence shelters or other community settings. It also is possible to provide Level Five services in a child or adolescent's home, if wraparound planning and resources can provide the needed service intensity in the less restrictive environment. Level Five services include development of a Wraparound program, initiated by the "child and family team" preparing them for the child or adolescent's re-integration into their family and community and/or treatment in lower levels of care. Ideally, the step-down plan represents a modification of the comprehensive Level Five service plan, providing continuity of care and integrating the child or adolescent's treatment experiences into the return to the community setting.

1. CLINICAL SERVICES. Programs for children or adolescents in residential settings, or with wraparound plans offering Level Five services in the community, comprise the core treatment at this level of care. The primary clinician should review the child or adolescent's progress daily and debrief back-up staff as needed. Child and adolescent psychiatrists are integral members of the treatment team and, if not the primary mental health clinician, serve an important consultative or supervisory function, maintaining daily contact with the team and providing 24-hour psychiatric consultation. Medication management should be available. Treatment modalities may include individual, group, and family therapy, with substance abuse services, either as the primary treatment or as an element of a comprehensive program, available as indicated. Primary medical care should be an accessible integrated part of the comprehensive array of services. Non-credentialed child care staff who work in residential programs and who participate as part of intensive Wraparound programs should be considered part of the clinical team, participate in treatment planning, be actively supervised and trained, and follow the treatment plan. Staff and programs should be culturally competent, with access to cultural competency consultation as needed. Treatment should be family-centered. The goal of treatment for children or adolescents in out-of-home placements should be a timely return to the family and community. Thus, transition planning should be considered in daily clinical review. Medical care from either a pediatrician or family physician should be available in the community.

2. SUPPORT SERVICES. Active case management is integral to care at Level Five regardless of which component of the system of care is the lead service provider. Children and adolescents in Level Five programs should receive adequate supervision for activities of daily living. Supervised off-campus passes or excursions into the community from a home-based wraparound program should be provided. Facility or program staff, supportive family members, and/or family friends identified by the "child and family" team may provide basic support services, including recreational, social, or educational activities, and, as needed, escort to substance abuse or self-help groups. Families may need help for problems with

housing, child care, finances, and job or school problems. These services should be integrated into the child or adolescent's individual service plan.

3. CRISIS STABILIZATION AND PREVENTION SERVICES. Children and adolescents at Level Five may require higher levels of care for brief periods to manage crises. Services may include seclusion and/or restraint interventions, as well as crisis medication, with supervision by a child and adolescent psychiatrist or other senior clinician within their scope of practice. The treatment team should address with the family the conditions under which seclusion and restraint or other behavioral interventions are initiated and terminated. These interventions should be used in accordance with the legal requirements of the jurisdiction and ethical professional practices.

More restrictive care may be needed temporarily because the team cannot safely manage acute exacerbations in the child or adolescent's risk of harm status or sudden deteriorations in functioning. Reevaluation using the dimension scales of CALOCUS may yield a composite score supporting admission level six. When more restrictive or intensive services are provided outside of the residential unit or wraparound plan, the staff of all involved service components should collaborate with the family to plan a timely return to lower levels of care. In addition, the treatment plan should be reviewed for adequacy in meeting the child or adolescent's fluctuating needs.

4. CARE ENVIRONMENT. When care at level five is provided institutionally, living space must be provided that offers reasonable protection and safety given the developmental status of the child or adolescent. Physical barriers preventing easy egress from or entry to the facility may be used, but doors at Level Five facilities are not regularly locked. Staffing and engagement are the primary methods of providing security both in facilities and in Wraparound plans. Staffing patterns should be adequate to accommodate episodes of aggressive and/or endangering behavior of moderate duration (e.g., sufficient staff should be available to both monitor a safe room for unlocked seclusion and maintain supervision of the other children or adolescents). Capacity for transporting residents off-campus for educational or recreational activities is a critical element of Level Five services.
Level Five facilities should be located as near as possible to the child or adolescent's home. In addition, facilities for Level Five activities should incorporate ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired people, etc.). Facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as for their families.

Placement Criteria

Children and adolescents with scores in the range of 23-27 generally may begin treatment at, or may be transitioned into, Level Five services. Placement at Level Five indicates that the child or adolescent either does not need more intensive services, or has successfully completed treatment at a more intensive level and primarily needs assistance in maintaining gains. Consideration for Level Five services should include the age, size, and manageability of the child or adolescent, and the family and community resources available. Placement determinations should be made by culturally competent staff or with consultation by culturally competent specialists.

COMPOSITE SCORE (Level 5) 23 – 27

LEVEL SIX. SECURE, 24-HOUR SERVICES WITH PSYCHIATRIC MANAGEMENT

Level Six services are the most restrictive and often, but not necessarily, the most intensive in the level of care continuum. Traditionally, Level Six services have been provided in a secure facility such as a hospital or locked residential program. This level of care also may be provided through intensive application of mental health and medical services in a juvenile detention and/or educational facility, provided that these facilities are able to adhere to medical and psychiatric care standards needed at Level Six. Level Six services also may be provided in community settings, including a child or adolescent's home, if mental health and medical services are organized at the required intensity and security measures are adequate. Although high levels of restrictiveness are typically required for effective

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intervention at Level Six, every effort to reduce, as feasible, the duration and pervasiveness of restrictiveness is desirable to minimize its negative effects.

1. CLINICAL SERVICES. Every child or adolescent requiring Level Six services can be presumed to be in a crisis or near crisis state, and therefore, clinical services should reflect the highest level of service intensity and restrictiveness for the protection of the child or adolescent, the family, and the community. Clinical services must be comprehensive and relevant to the emergent and safety issues at hand. Children and adolescents at Level Six require monitoring and observation on a 24-hour basis. Treatment modalities may include individual, group and, intensive family therapy as well as medication management, and are aimed at managing the crisis, restoring previous levels of functioning, and decreasing risk of harm. Substance abuse treatment at Level Six may include social or medical detoxification. Occupational and recreational therapy may be helpful as indicated. The treatment plan must be family-centered and must address management of aggressive and/or suicidal or self-endangering behavior. Access to pediatric or family physician should be available in the community.
Treatment at Level Six may be organized by a child and adolescent psychiatrist supervising the care provided by the multi- disciplinary treatment team. Child and adolescent psychiatric and nursing services should be available on a 24-hour basis. A member of the treatment team leadership (e.g., a child and adolescent psychiatrist, psychosocial nurse, or other senior clinician) should have daily contact with the child or adolescent. The child and adolescent psychiatrist should consult regularly with the family and the "child and family" team to assure integration of Level Six services with the care provided at previous levels of care. Review of the child or adolescent's status by the treatment team should occur daily, with the goal of transition planning for a rapid return to lower levels of care. Uncomplicated or specialized transition plans may be necessary, depending on the child or adolescent's or family's needs during step-down. All children and adolescents leaving Level Six services must have a well-defined crisis plan that anticipates and accommodates complications during transition to lower levels of care. Medical care from either a pediatrician or family physician should be available in the community.

2. SUPPORT SERVICES. All necessities of living and well-being must be provided for children and adolescents treated at Level Six. The children's legal, educational, recreational, vocational, and spiritual needs should be assessed according to individual needs and culture. Social and cultural factors must be considered in discharge planning. A "child and family" team should be created, if not already in place, mobilizing the strengths of the child or adolescent and family to provide support during the crisis and in aftercare. When capable, children and adolescents should be encouraged to participate in treatment planning, and should maintain activities of daily living, such as hygiene, grooming, and maintenance of their immediate environment. Families are likely to need support for financial, housing, child-care, vocational, and/or educational services. Case management for coordination of services provided after transition to lower care levels should begin while the child or adolescent receives Level Six services. Discharge planning should include integration of the child or adolescent into the home and community, and linkage with social services, education, juvenile justice, and recreational resources as needed. All support services should be described in the Individualized Service Plan.

3. CRISIS STABILIZATION AND PREVENTION SERVICES. At Level Six, crisis services involve rapid response to fluctuations in psychiatric and/or medical status. Crisis stabilization may include seclusion and/or restraint interventions as well as crisis medication, under the supervision of a child and adolescent psychiatrist or other professional within their scope of practice. The treatment team should address with the family the conditions under which seclusion and restraint interventions are initiated and terminated, and these interventions should be in accordance with legal requirements and ethical professional practices. Emergency medical services should be available on-site or in close proximity and all staff should have training in emergency protocols.

4. CARE ENVIRONMENT. In most cases, Level Six care is provided in a closed and locked facility. Alternative settings must have an equivalent capacity for providing a secure environment. Facilities should have space that is quiet and free of potentially harmful items, with adequate staffing to monitor child or adolescent using such a space (e.g., seclusion, restraint, and/or holding). Facilities and staff also

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should provide protection from potential abuse from others. Level Six facilities should be capable of providing involuntary care.

Level Six facilities, or their alternatives, should be located as near as possible to the child or adolescent's home. In addition, these facilities should incorporate ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired people, etc.). The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as for their families.

Placement Criteria

Children and adolescents with scores of 28 or higher are appropriate for treatment at Level Six. Consideration for this level of care should include the age, size, and manageability of the child or adolescent, and the family and community resources available. Placement determinations should be made by culturally competent staff and/or with consultation by cultural competency specialists.

COMPOSITE SCORE (Level 6) 28 or higher

LEVELS OF CARE DEFINITIONS (LOCUS)

(An Excerpt from the LOCUS Adult Version 2010, AACP, Deerfield Behavioral Health, Inc. , March 20, 2009).

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:

LEVELS OF CARE DEFINITIONS (LOCUS)

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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 cannot be restricted. In some cases, services may be provided in community locations or in the place of residence.

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

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

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

Placement Criteria:

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

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

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

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

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

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

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

LEVELS OF CARE DEFINITIONS (LOCUS)
(An Excerpt from the LOCUS Adult Version 2010, AACP, Deerfield Behavioral Health, Inc. , March 20, 2009).

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. These programs must provide the following:

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

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

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

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

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.

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(An Excerpt from the LOCUS Adult Version 2010, AACP, Deerfield Behavioral Health, Inc. , March 20, 2009).

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

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

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

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 minimal support in the community. Service needs do not require daily supervision, but treatment needs require contact several times per week. Programs of this type have traditionally been clinic based programs. These programs must provide the following:

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

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

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

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(An Excerpt from the LOCUS Adult Version 2010, AACP, Deerfield Behavioral Health, Inc. , March 20, 2009).

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

Placement Criteria:

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

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

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

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

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

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

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

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 wrapping services around the client in the community (i.e. ACT team).

2. Clinical Services - Clinical services should be available to clients throughout most of the day on a daily basis. Psychiatric services would be accessible on a daily basis and contact would occur as required by initial and ongoing assessment. Psychiatric services would also be available by remote communication on a 24-hour basis. Nursing services should be available than about 40 hours per week. Physical assessment should be provided on-site if possible and access to ongoing primary medical care should be available. Intensive treatment should be provided at least five days per week and include individual, group, and family therapy depending

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on client needs. Rehabilitative services will be an integral aspect of the treatment program. Medication can be carefully monitored, but in most cases will be self-administered.

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

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

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).

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

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

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

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

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

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

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

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

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

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

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

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

CALOCUS ABBREVIATED MANUAL & SCORING PROTOCOL

(For use when a computer is not available. Transfer scores from this sheet to the web-based system)

Consumer Name: _____ **eCura ID** [ ]

Date of Evaluation: _____ **Name of Clinician/Worker:** _____

A.	**Previous** Level of Care Recommendation (1, 2, 3, 4, 5 or 6)	[ ]
B.	**Previous** Composite LOCUS Score (6 to 28+)	[ ]

Child & Adolescent Level of Care Utilization System (CALOCUS)

Dimension	Rating	Criteria Selected (Write in "a, b, c, d and/or e")
1. Risk of Harm	1 2 3 **4*** **5**	[ ] [ ] [ ] [ ] [ ]
2. Functional Status	1 2 3 **4*** **5**	[ ] [ ] [ ] [ ] [ ]
3. Co-Morbidity	1 2 3 **4*** **5**	[ ] [ ] [ ] [ ] [ ]
4. Recovery Environment		
4a. Stress	1 2 3 4 5	[ ] [ ] [ ] [ ] [ ]
4b. Support	1 2 3 4 5	[ ] [ ] [ ] [ ] [ ]
5. Resiliency & Treatment History	1 2 3 4 5	[ ] [ ] [ ] [ ] [ ]
6. Acceptance & Engagement	1 2 3 4 5	[ ] [ ] [ ] [ ] [ ]

*(Note: **Bold** indicates independent criteria domains. A score of 4 results in placement at level 5 and a score of 5 results in placement at level six regardless of combined score.). * = independent criteria that may be waived if sum of 4a and 4b scores equal 2 (Low Stress Environment).*
(Note: For question 4, please record the higher of the two scores)

C. COMPOSITE CALOCUS SCORE (Use web-based system to score accurately) [ ]

D. CALOCUS Derived Level of Care Recommendation (Use web-based system to score accurately) [ ]

E. Actual Level of Care (if different from recommended Level of Care) [ ]

Reason for Variance from CALOCUS Derived Level of Care Recommendation:

_____

_____

_____

_____

_____

(Adapted from the American Academy of Child and Adolescent Psychiatry American Association of Community Psychiatrists CALOCUS – Level Of Care System Manual Version 1.5)

DIMENSION I. RISK OF HARM

This dimension considers a child or adolescent's potential to be harmed by others or cause significant harm to self or others. Each category contains items that assess a child or adolescent's risk of harming him/herself and of harming others. While Risk of Harm most frequently is manifested by suicidal or homicidal behavior, it also may embody unintentional harm from misinterpretations of reality; inability to adequately care for oneself or temper impulses with judgment; or intoxication. Furthermore, Risk of Harm may be manifested by a child or adolescent's inability to perceive threats to safety and to take appropriate action to be safe. In this regard, younger children and children with developmental or other disabilities, unless protected, are more vulnerable. It also is true that children of any age who have experienced severe and/or repeated abuse in a hostile environment may be unable to perceive threat or take adequate measures to increase their safety.

In addition to direct evidence of potentially dangerous behavior or vulnerability from interview and observation, other factors should be considered in determining the likelihood of such behavior, such as past history of dangerous behavior and/or abuse and/or neglect, ability to contract for safety, and ability to use available supports. It also is important to be alert to racial or ethnic biases that may lead clinicians to misinterpret behaviors as threatening or dangerous.

☐ **LOW RISK OF HARM**

- ☐ No indication of current suicidal or homicidal thoughts or impulses, with no significant distress, and no history of suicidal or homicidal ideation.
- ☐ No indication or report of physically or sexually aggressive impulses.
- ☐ Developmentally appropriate ability to maintain physical safety and/or use environment for safety.
- ☐ Low risk for victimization, abuse, or neglect.

☐ **SOME RISK OF HARM**

- ☐ Past history of fleeting suicidal or homicidal thoughts with no current ideation, plan, or intention and no significant distress.
- ☐ Mild suicidal ideation with no intent or conscious plan and with no past history.
- ☐ Indication or report of occasional impulsivity, and/or some physically or sexually aggressive impulses with minimal consequences for self or others.
- ☐ Substance use without significant endangerment of self or others.
- ☐ Infrequent, brief lapses in the ability to care for self and/or use environment for safety.
- ☐ Some risk for victimization, abuse, or neglect.

☐ **SIGNIFICANT RISK OF HARM**

- ☐ Significant current suicidal or homicidal ideation with some intent and plan, with the ability of the child or adolescent and his/her family to contract for safety and carry out a safety plan. Child or adolescent expresses some aversion to carrying out such behavior.
- ☐ No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior.
- ☐ Indication or report of episodic impulsivity, or physically or sexually aggressive impulses that are moderately endangering to self or others (e.g. status offenses, impulsive acts while intoxicated; self-mutilation; running away from home or facility with voluntary return; fire-setting; violence toward animals; affiliation with dangerous peer group.)
- ☐ Binge or excessive use of alcohol and other drugs resulting in potentially harmful behaviors.

- ☐ Episodic inability to care for self and/or maintain physical safety in developmentally appropriate ways.
- ☐ Serious or extreme risk for victimization, abuse or neglect.

☐ **SERIOUS RISK OF HARM**

- ☐ Current suicidal or homicidal ideation with either clear, expressed intentions and/or past history of carrying out such behavior. Child or adolescent has expressed ambivalence about carrying out the safety plan and/or his/her family's ability to carry out the safety plan is compromised.
- ☐ Indication or report of significant impulsivity and/or physical or sexual aggression, with poor judgment and insight, and that is/are significantly endangering to self or others (property destruction; repetitive fire setting or violence toward animals.)
- ☐ Indication of consistent deficits in ability to care for self and/or use environment for safety.
- ☐ Recent pattern of excessive substance use resulting in clearly harmful behaviors with no demonstrated ability of child/adolescent or family to restrict use.
- ☐ Clear and persistent inability, given developmental abilities, to maintain physical safety and/or use environment for safety.

Note: A rating of serious risk of harm requires care at level 5 (non-secure, 24-hour services with psychiatric monitoring), independent of other dimensions.

☐ **EXTREME RISK OF HARM**

- ☐ 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 that are not of a chronic, impulsive, or consistent nature, or
  - In presence of command hallucinations or delusions that threaten to override usual impulse control.
- ☐ Indication or report of repeated behavior, including physical or sexual aggression, that is clearly injurious to self or others (e.g., fire setting with intent of serious property destruction or harm to others or self, planned violence and/or group violence with other perpetrators) with history, plan, or intent, and no insight and judgment (forcible and violent, repetitive sexual acts against others).
- ☐ Relentlessly engaging in acutely self endangering behaviors.
- ☐ A pattern of nearly constant and uncontrolled use of alcohol or other drugs, resulting in behavior that is clearly endangering.

Note: A rating of extreme risk of harm requires care at level 6 (secure, 24-hour services with psychiatric management), independent of other dimensions.

DIMENSION II. FUNCTIONAL STATUS

This dimension measures changes in the degree to which a child or adolescent is able to fulfill responsibilities and to interact with others, changes in vegetative status, (such as sleeping, eating habits activity level, or sexual interest), and capacity for self-care. Functioning may be compared against what would be expected for a given child or adolescent at a given developmental level, or may be compared to a baseline functional level for that individual. For the purposes of this dimension, only sources of impairment directly related to developmental, psychiatric, and/or substance use problems should be considered. While other types of disabilities may play a role in determining the support services required, they generally will not be considered in determining level of care placement in the

behavioral treatment continuum. Functional deficits that are ongoing and may place a child or adolescent at risk of harm are rated on Dimension I. An example would be the failure of an autistic child to understand the risk of safety when crossing a busy intersection. Clinicians also need to be aware that psychosocial functioning may be under-estimated in the context of low socioeconomic status or different expectations about functioning for children and adolescents of culturally distinct backgrounds.

☐ **MINIMAL FUNCTIONAL IMPAIRMENT**

- ☐ Consistent functioning appropriate to age and developmental level in school behavior and/or academic achievement, relationships with peers, adults, and family, and self-care/hygiene/control of bodily functions.
- ☐ No more than transient impairment in functioning following exposure to an identifiable stressor with consistent and normative vegetative status.

☐ **MILD FUNCTIONAL IMPAIRMENT**

- ☐ Evidence of minor deterioration, or episodic failure to achieve expected levels of functioning, in relationships with peers, adults, and/or family (e.g., defiance, provocative behavior, lying/cheating/not sharing, or avoidance/lack of follow through); school behavior and/or academic achievement (difficulty turning in homework, occasional attendance problems), or biologic functions (feeding or elimination problems) but with adequate functioning in at least some areas and/or ability to respond to redirection/intervention.
- ☐ Sporadic episodes during which some aspects of self-care/hygiene/control of bodily functions are compromised.
- ☐ Demonstrates significant improvement in function following a period of deterioration.

☐ **MODERATE FUNCTIONAL IMPAIRMENT**

- ☐ Conflicted, withdrawn, or otherwise troubled in relationships with peers, adults, and/or family, but without episodes of physical aggression.
- ☐ Self-care/hygiene deteriorates below usual or expected standards on a frequent basis.
- ☐ Significant disturbances in vegetative activities, (such as sleeping, eating habits, activity level, or sexual interest), that do not pose a serious threat to health.
- ☐ School behavior has deteriorated to the point that in-school suspension has occurred and the child is at risk for placement in an alternative school or expulsion due to their disruptive behavior. Absenteeism may be frequent. The child is at risk for repeating their grade.
- ☐ Chronic and/or variably severe deficits in interpersonal relationships, ability to engage in socially constructive activities, and ability to maintain responsibilities.
- ☐ Recent gains and/or stabilization in functioning have been achieved while participating in treatment in a structured, protected, and/or enriched setting.

☐ **SERIOUS FUNCTIONAL IMPAIRMENT**

- ☐ Serious deterioration of interpersonal interactions with consistently conflicting or otherwise disrupted relations with others, which may include impulsive or abusive behaviors.
- ☐ Significant withdrawal and avoidance of almost all social interaction.

(Adapted from the American Academy of Child and Adolescent Psychiatry American Association of Community Psychiatrists CALOCUS – Level Of Care System Manual Version 1.5)

- ☐ Consistent failure to achieve self-care/hygiene at levels appropriate to age and/or developmental level.
- ☐ Serious disturbances in vegetative status, such as weight change, disrupted sleep or fatigue, and feeding or elimination, which threaten physical functioning.
- ☐ Inability to perform adequately even in a specialized school setting due to disruptive or aggressive behavior. School attendance may be sporadic. The child or adolescent has multiple academic failures.

Note: A rating of serious functional impairment requires care at level 5 (non-secure, 24-hour services with psychiatric monitoring), independent of other dimensions.

☐ **SEVERE FUNCTIONAL IMPAIRMENT**

- ☐ Extreme deterioration in interactions with peers, adults, and/or family that may include chaotic communication or assaultive behaviors with little or no provocation, minimal control over impulses that may result in abusive behaviors.
- ☐ Complete withdrawal from all social interactions.
- ☐ Complete neglect of and inability to attend to self-care/hygiene/control of biological functions with associated impairment in physical status.
- ☐ Extreme disruption in vegetative function causing serious comprise of health and well being.
- ☐ Nearly complete inability to maintain any appropriate school behavior and/or academic achievement given age and developmental level.

Note: A rating of severe functional impairment requires care at level 6 (secure, 24-hour services with psychiatric management), independent of other dimensions. The only exception to this is if the sum of IVA & IV B = 2, indicating both a minimally stressful and a highly supportive recovering environment.

DIMENSION III. CO-MORBIDITY: DEVELOPMENTAL, MEDICAL, SUBSTANCE USE, AND PSYCHIATRIC

This dimension measures the coexistence of disorders across four domains (developmental medical, substance use, and psychiatric); but does not consider co-occurring disturbances within each domain. Coexisting disorders across domains may prolong the course of illness, or necessitate the use of more intensive or restrictive, or additional, services. Physiologic withdrawal states related to substance use should be considered medical co-morbidity for scoring purposes. Clinicians must be alert to the under-recognition of co-morbidity in children from lower socioeconomic backgrounds and culturally distinct backgrounds that are underserved.

NOTE: If a child or adolescent has more than one disorder in the same domain (e.g., two medical, developmental, substance use, or psychiatric disorders), the second does not count as "co-morbidity" for purposes of scoring on CALOCUS. For example, two medical disorders, such as diabetes and asthma or two psychiatric disorders, such as attention deficit hyperactivity disorder and major depressive disorder, are not counted as additional co-morbidity for the purposes of scoring CALOCUS.

☐ **NO CO-MORBIDITY**

- ☐ No evidence of medical illness, substance abuse, developmental disability, or psychiatric disturbances apart from the presenting problem.
- ☐ Past medical, substance use, developmental, or psychiatric conditions are stable and pose no threat to the child or adolescent's current functioning or presenting problem.

☐ **MINOR CO-MORBIDITY**

- ☐ Minimal developmental delay or disorder is present that has no impact on the presenting problem and for which the child or adolescent has achieved satisfactory adaptation and/or compensation.
- ☐ Self-limited medical problems are present that are not immediately threatening or debilitating and that have no impact on the presenting problem and are not affected by it.
- ☐ Occasional, self-limited episodes of substance use are present that show no pattern of escalation, with no indication of adverse effect on functioning or the presenting problem.
- ☐ Transient, occasional, stress-related psychiatric symptoms are present that have no discernable impact on the presenting problem.

☐ **SIGNIFICANT CO-MORBIDITY**

- ☐ Developmental disability is present that may adversely affect the presenting problem, and/or may require significant augmentation or alteration of treatment for the presenting problem or co-morbid condition, or adversely affects the presenting problem.
- ☐ Medical conditions are present requiring significant medical monitoring (e.g., diabetes or asthma).
- ☐ Medical conditions are present that may adversely affect, or be adversely affected by, the presenting problem.
- ☐ Substance abuse is present, with significant adverse effect on functioning and the presenting problem.
- ☐ Recent substance use that has significant impact on the presenting problem and that has been arrested due to use of a highly structured or protected setting or through other external means.
- ☐ Psychiatric signs and symptoms are present and persist in the absence of stress, are moderately debilitating, and adversely affect the presenting problem.

☐ **MAJOR CO-MORBIDITY**

- ☐ Medical conditions are present or have a high likelihood of developing that may require intensive, although not constant, medical monitoring (e.g., insulin-dependent diabetes, hemophilia).
- ☐ Medical conditions are present that will adversely affect, or be affected by, the presenting disorder.
- ☐ Uncontrolled substance use is present that poses a serious threat to health if unabated and impedes recovery from the presenting problem.
- ☐ Developmental delay or disorder is present that will adversely affect the course, treatment, or outcome of the presenting disorder.
- ☐ Psychiatric symptoms are present that clearly impair functioning, persist in the absence of stressors, and seriously impair recovery from the presenting problem.

Note: A rating of major co-morbidity requires care at a level of 5 (non-secure, 24-hours services with psychiatric monitoring), independent of other dimensions. The only exception to this is if the sum of IVA & IV B = 2, indicating both a minimally stressful and a highly supportive recovering environment.

☐ **SEVERE CO-MORBIDITY**

- ☐ Significant medical condition is present that is poorly controlled and/or potentially life threatening in the absence of close medical management (e.g., severe alcohol withdrawal, uncontrolled diabetes mellitus, complicated pregnancy, severe liver disease, debilitating cardiovascular disease).
- ☐ Medical condition acutely or chronically worsens or is worsened by the presenting problem.
- ☐ Substance dependence is present, with inability to control use, intense withdrawal symptoms and extreme negative impact on the presenting disorder.
- ☐ Developmental disorder is present that seriously complicates, or is seriously compromised by, the presenting disorder.
- ☐ Acute or severe psychiatric symptoms are present that seriously impair functioning, and/or prevent voluntary participation in treatment for the presenting problem, or otherwise prevent recovery from the presenting problem.

Note: A rating of severe co-morbidity requires care at level 6 (secure, 24-hour services with psychiatric management), independent of other dimensions.

DIMENSION IV. RECOVERY ENVIRONMENT

This dimension considers factors in the environment that may contribute to the onset or maintenance of the primary disorder, and factors that may support a child or adolescent's efforts to achieve or maintain recovery. Supportive elements in the environment include, first and foremost, the presence of stable, supportive, and ongoing relationships with family (biological or adoptive) members. Other important supportive factors include the availability of adequate housing and material resources, stable and supportive relationships with friends, employers or teachers, clergy, professionals, and other community members. Clinicians must be alert to underestimation of family, cultural, and community strengths, where such strengths/resources may not be evident or may not be readily mobilized. Stressful circumstances may include interpersonal conflict or trauma, life transitions, losses, worries relating to health and safety, and difficulty in maintaining role responsibilities.

Because children and adolescents are more dependent on, and exert less control over, their environment than adults, in the CALOCUS, the recovery environment encompasses the family milieu, as well as the school, medical, social services, juvenile justice, and other components in which the child or adolescent may receive services or be involved on an ongoing basis. Two sub-scales are used to measure this dimension: Environmental Stress and Environmental Support. These two sub-scales are designed to balance the relative contributions of these factors.

Environmental Stress:

☐ **MINIMALLY STRESSFUL ENVIRONMENT**

- ☐ Absence of significant or enduring difficulties in environment and life circumstances are stable.
- ☐ Absence of recent transitions or losses of consequence (e.g., no change in school, residence, or marital status of parents, or no birth/death of family member).
- ☐ Material needs are met without significant cause for concern that they may diminish in the near future, with no significant threats to safety or health.
- ☐ Living environment is conducive to normative growth, development, and recovery.
- ☐ Role expectations are normative and congruent with child or adolescent's age, capacities and/or developmental level.

☐ **MILDLY STRESSFUL ENVIRONMENT**

- ☐ Significant normative transition requiring adjustment, such as change in household members, or new school or teacher.

- ☐ Minor interpersonal loss or conflict, such as peer relationship ending due to change in residence or school, or illness or death of distant extended family member that has moderate effect on child and family.
- ☐ Transient but significant illness or injury (e.g., pneumonia, broken bone).
- ☐ Somewhat inadequate material resources or threat of loss of resources due to parental underemployment, separation, or other factor.
- ☐ Expectations for performance at home or school that create discomfort.
- ☐ Potential for exposure to substance use exists.

☐ **MODERATELY STRESSFUL ENVIRONMENT**

- ☐ Disruption of family/social milieu (e.g., move to significantly different living situation, absence or addition of parent or other primary care taker, serious legal or school difficulties, serious drop in capacity of parent or usual primary care taker due to physical, psychiatric, substance abuse, or other problem with expectation of return to previous functioning).
- ☐ Interpersonal or material loss that has significant impact on child and family.
- ☐ Serious illness or injury for prolonged period, unremitting pain, or other disabling condition.
- ☐ Danger or threat in neighborhood or community, or sustained harassment by peers or others.
- ☐ Exposure to substance abuse and its effects.
- ☐ Role expectations that exceed child or adolescent's capacity, given his/her age, status, and developmental level.

☐ **HIGHLY STRESSFUL ENVIRONMENT**

- ☐ Serious disruption of family or social milieu due to illness, death, divorce, or separation of parent and child or adolescent; severe conflict; torment and/or physical/sexual abuse or maltreatment.
- ☐ Threat of severe disruption in life circumstances, including threat of imminent incarceration, lack of permanent residence, or immersion in alien and hostile culture.
- ☐ Inability to meet needs for physical and/or material well-being.
- ☐ Exposure to endangering, criminal activities in family and/or neighborhood.
- ☐ Difficulty avoiding substance use and its effects.

☐ **EXTREMELY STRESSFUL ENVIRONMENT**

- ☐ Traumatic or enduring and highly disturbing circumstances, such as 1) violence, sexual abuse or illegal activity in the home or community, 2) the child or adolescent is witness to or a victim of a natural disaster, 3) the sudden or unexpected death of a loved one, 4) unexpected or unwanted pregnancy.
- ☐ Political or racial persecution, immigration, social isolation, language barriers, and/or illegal alien status.
- ☐ Incarceration, foster home placement or re-placement, inadequate residence, and/or extreme poverty or constant threat of such.
- ☐ Severe pain, injury, or disability, or imminent threat of death due to severe illness or injury.

Environmental Support:

☐ **HIGHLY SUPPORTIVE ENVIRONMENT**

- ☐ Family and ordinary community resources are adequate to address child's developmental and material needs.
- ☐ Continuity of active, engaged primary care takers, with a warm, caring relationship with at least one primary care taker.

☐ **SUPPORTIVE ENVIRONMENT**

- ☐ Continuity of family or primary care takers is only occasionally disrupted, and/or relationships with family or primary care takers are only occasionally inconsistent.
- ☐ Family/primary care-takers are willing and able to participate in treatment if requested to do so and have capacity to effect needed changes.
- ☐ Special needs are addressed through successful involvement in systems of care (e.g., low level special education, tutoring, speech therapy.)
- ☐ Community resources are sufficient to address child's developmental and material needs.

☐ **LIMITED SUPPORT IN ENVIRONMENT**

- ☐ Family has limited ability to respond appropriately to child's developmental needs and/or problems, or is ambivalent toward meeting these needs or addressing these problems.
- ☐ Community resources only partially compensate for unmet material and emotional needs and/or child or adolescent has limited or inconsistent access to network.
- ☐ Family or primary care-takers demonstrate only partial ability to make necessary changes during treatment.

☐ **MINIMALLY SUPPORTIVE ENVIRONMENT**

- ☐ Family or primary care taker is seriously limited in ability to provide for the child's developmental, material, and emotional needs.
- ☐ Few community supports and/or serious limitations in access to sources of support so that material, health, and/or emotional needs are mostly unmet.
- ☐ Family and other primary care takers display limited ability to participate in treatment and/or service plan (e.g., unwilling, inaccessible, cultural dissonance).

☐ **NO SUPPORT IN THE ENVIRONMENT**

- ☐ Family and/or other primary care takers are completely unable to meet the child's developmental, material, and/or emotional needs.
- ☐ Community has deteriorated so that it is unsafe and/or hostile to the needs of children and adolescents for education, recreation, constructive peer relations, and mentoring from unrelated adults.
- ☐ Lack of liaison and cooperation between child-servicing agencies.
- ☐ Inability of family or other primary care takers to make changes or participate in treatment.
- ☐ Lack of even minimal attachment to benevolent other, or multiple attachments to abusive, violent, and/or threatening others.

(Adapted from the American Academy of Child and Adolescent Psychiatry American Association of Community Psychiatrists CALOCUS – Level Of Care System Manual Version 1.5)

DIMENSION V. RESILIENCY AND TREATMENT HISTORY

This dimension records that a child or adolescent's ability to self-correct when there are disruptions in the environment. This includes the ability to use the environment as well as the child/adolescent's own internal resources. This judgment can be made by considering how well the child or adolescent has responded to the treatment in the past, but consideration should also be given to responses to stressor and life changes.
For children/adolescents who have faced major life changes and respond adaptively, the score will be low. For children/adolescents who are sensitive to minor changes such as schedule disruptions, the score will be higher. Most children in the autistic spectrum struggle with particular sensitivities that leave then much less flexible to manage the minor bumps of life.

With regard to treatment, children may respond well to some treatment situations and poorly to others. The treatment response in some cases may not be related to level of intensity, but rather to the characteristics, attractiveness, and/or cultural competency of the treatment provided. However, children and adolescents rarely have long histories of prior treatment upon which to evaluate resiliency, thus responses to stressors and life changes with no professional involvement should be considered as well.

Most recent experiences in treatment or care take precedence over more remote experiences in determining the score. For younger children who may not have extensive involvement in any treatment, responses to developmental challenges without professional involvement may be as indicative of resiliency as treatment history.

Recovery for children and adolescents is defined not only as a period of stability and control of problems, but also as a continuation or resumption of progress toward an expected developmental level for a given child or adolescent.

☐ **FULL RESILIENCY AND/OR RESPONSE TO TREATMENT**

- ☐ Child has demonstrated significant and consistent capacity to maintain development in the face of normal challenges, or to readily resume normal development following extraordinary challenges.
- ☐ Prior experience indicates that efforts in most types of treatment have been helpful in controlling the presenting problem in a relatively short period of time.
- ☐ There has been successful management of extended recovery with few and limited periods of relapse even in unstructured environments or without frequent treatment.
- ☐ Able to transition successfully and accept changes in routing without support; optimal flexibility.

☐ **SIGNIFICANT RESILIENCY AND/OR RESPONSE TO TREATMENT**

- ☐ Child demonstrated average ability to deal with stressors and maintain developmental progress.
- ☐ Previous experience in treatment has been successful in controlling symptoms but more lengthy treatment is required.
- ☐ Significant ability to manage recovery has been demonstrated for extended periods, but has required structured settings or ongoing care and/or peer support.
- ☐ Recovery has been managed for short periods of time with limited support or structure.
- ☐ Able to transition successfully and accept changes in routine with minimal support.

☐ **MODERATE OR EQUIVOCAL RESILIENCY AND/OR RESPONSE TO TREATMENT**

- ☐ Child has demonstrated an inconsistent or equivocal capacity to deal with stressors and maintain normal development.

- ☐ Previous experience in treatment at low level of intensity has not been successful in relief of symptoms or optimal control of symptoms.
- ☐ Recovery has been maintained for moderate periods of time, but only with strong professional or peer support or in structured settings.
- ☐ Has demonstrated limited ability to follow through with treatment recommendations.
- ☐ Developmental pressures and life changes have created temporary stress.
- ☐ Able to transition successfully and accept change in routine most of the time with a moderate intensity of support.

☐ **POOR RESILIENCY AND/OR RESPONSE TO TREATMENT**

- ☐ Child has demonstrated frequent evidence of innate vulnerability under stress and difficulty resuming progress toward expected developmental level.
- ☐ Previous treatment has not achieved complete remission of symptoms or optimal control of symptoms even with intensive and/or repeated exposure to treatment
- ☐ Attempts to maintain whatever gains that can be attained in intensive treatment have limited success, even for limited time periods or in structured settings.
- ☐ Developmental pressures and life changes have created episodes of turmoil or sustained distress.
- ☐ Transitions with changes in routine are difficult even with a high degree of support.

☐ **NEGLIGIBLE RESILIENCY AND/OR RESPONSE TO TREATMENT**

- ☐ Child has demonstrated significant and consistent evidence of innate vulnerability under stress, with lack of any resumption of progress toward expected developmental level.
- ☐ Past response to treatment has been quite minimal, even when treated at high levels of care for extended periods of time.
- ☐ Symptoms are persistent and functional ability shows no significant improvement despite this treatment exposure.
- ☐ Developmental pressures and life changes have created sustained turmoil and/or developmental regression.
- ☐ Unable to transition or accept changes in routine successfully despite intensive support.

DIMENSION VI. TREATMENT ACCEPTANCE AND ENGAGEMENT

The Acceptance and Engagement dimension measures both the child or adolescent's, as well as the parent and/or primary care taker's, acceptance of and engagement in treatment. For the purpose of this document, treatment includes an array of therapeutic interventions to address the child's, adolescent's, and parent and/or primary care taker's needs. The sub-scales reflect the importance of the parent and/or primary care taker's willingness and ability to participate pro-actively in the intake, planning, implementation, and maintenance phases of treatment. It also is critical to note that a parent or primary care taker's cultural background influences understanding and acceptance of a problem, as well as choice of care options for solving it. Care should be taken to note barriers to proper assessment and treatment based on cultural differences between the youth and parent and/or primary care taker and the clinician. If needed, consultation with or addition of culturally congruent staff may eliminate cultural barriers to effective assessment and treatment.

Only the highest of the two sub-scale scores (child or adolescent vs. parent and/or primary care taker) is added into the composite score. In addition, if a child or adolescent is emancipated, the parent and/or primary care taker sub-scale is not scored.

Child or adolescent acceptance and engagement

The child or adolescent sub-scale measures the ability of the child or adolescent, within developmental constraints, to form a positive therapeutic relationship with people in components of the system providing treatment, to define the presenting problems, to accept his or her role in the development and perpetuation of the primary problem, and to accept his or her role in the treatment planning and treatment process, and to actively cooperate in treatment.

☐ **OPTIMAL**

- ☐ Quickly forms a trusting and respectful positive therapeutic relationship with clinicians and other care providers.
- ☐ Able to define problem(s) and accepts others' definition of the problem(s), and consequences.
- ☐ Accepts age-appropriate responsibility for behavior that causes and/or exacerbates primary problem.
- ☐ Actively participates in treatment planning and cooperates with treatment.

☐ **CONSTRUCTIVE**

- ☐ Able to develop a trusting, positive relationship with clinicians and other care providers.
- ☐ Unable to define the problem, but accepts others' definition of the problem and its consequences.
- ☐ Accepts limited age-appropriate responsibility for behavior.
- ☐ Passively cooperates in treatment planning and treatment.

☐ **OBSTRUCTIVE**

- ☐ Ambivalent, avoidant, or distrustful relationship with clinicians and other care providers.
- ☐ Acknowledges existence of problem, but resists accepting even limited age-appropriate responsibility for development, perpetuation, or consequences of the problem.
- ☐ Minimizes or rationalizes problem behaviors and consequences.
- ☐ Unable to accept others' definition of the problem and its consequences.
- ☐ Frequently misses or is late for treatment appointments and/or is noncompliant with treatment, including medication and homework assignments.

☐ **ADVERSARIAL**

- ☐ Actively hostile relationship with clinicians and other care providers.
- ☐ Accepts no age-appropriate responsibility role in development, perpetuation, or consequences of the problem.
- ☐ Actively, frequently disrupts assessment and treatment.

☐ **INACCESSIBLE**

- ☐ Unable to form therapeutic working relationship with clinicians or other care providers due to severe withdrawal, psychosis, or other profound disturbance in relatedness.
- ☐ Unaware of problem or its consequences.
- ☐ Unable to communicate with clinician due to severe cognitive delay or speech/language impairment.

(Adapted from the American Academy of Child and Adolescent Psychiatry American Association of Community Psychiatrists CALOCUS – Level Of Care System Manual Version 1.5)

Parent and/or primary care taker acceptance and engagement

The parent and/or primary care taker sub-scale measures the ability of the parents or other primary care taker to form a positive therapeutic relationship, to engage with the clinician in defining the presenting problem, to explore their role as it impacts on the primary problem, and to take an active role in the treatment planning process.

☐ **OPTIMAL**

- ☐ Quickly and actively engages in a trusting and positive relationship with clinician and other service providers.
- ☐ Sensitive and aware of the child or adolescent's needs and strengths as they pertain to the presenting problem.
- ☐ Sensitive and aware of the child or adolescent's problems and how they can contribute to their child's recovery.
- ☐ Active and enthusiastic in participating in assessment and treatment.

☐ **CONSTRUCTIVE**

- ☐ Develops positive therapeutic relationship with clinicians and other primary care takers.
- ☐ Explores the problem and accept others' definition of the problem.
- ☐ Works collaboratively with clinicians and other primary care takers in development of treatment plan.
- ☐ Cooperates with treatment plan, with behavior change and good follow-through on interventions, including medications and homework assignments.

☐ **OBSTRUCTIVE**

- ☐ Inconsistent and/or avoidant relationship with clinicians and other care providers.
- ☐ Defines problem, but has difficulty creating a shared definition of development, perpetuation, or consequences of the problem.
- ☐ Unable to collaborate in development of treatment plan.
- ☐ Unable to participate consistently in treatment, with inconsistent follow-through.

☐ **ADVERSARIAL**

- ☐ Contentious and/or hostile relationship with clinician and other care providers.
- ☐ Unable to reach shared definition of the development, perpetuation, or consequences of problem.
- ☐ Able to accept child or adolescent's need to change, but unable or unwilling to consider the need for any change in other family members.
- ☐ Engages in behaviors that are inconsistent with the treatment plan.

☐ **INACCESSIBLE**

- ☐ No awareness of problem.
- ☐ Not physically available.
- ☐ Refuses to accept child or adolescent, or other family members' need to change.
- ☐ Unable to form relationship with clinician or other care provider due to significant cognitive difficulties, psychosis, intoxication, or major mental illness or impairment.

LOCUS ABBREVIATED MANUAL & SCORING PROTOCOL

(For use when a computer is not available. Transfer scores from this sheet to the web-based system)

Consumer Name: _____ **eCura ID** [ ]

Date of Evaluation: _____ **Name of Clinician/Worker:** _____

A.	**Previous** Level of Care Recommendation (1, 2, 3, 4, 5 or 6)	[ ]
B.	**Previous** Composite LOCUS Score (6 to 28+)	[ ]

Level of Care Utilization System (LOCUS)

Dimension	Rating	Criteria Selected (Write in "a, b, c, d and/or e")
1. Risk of Harm	1 2 3 **4* 5**	[ ] [ ] [ ] [ ] [ ]
2. Functional Status	1 2 3 **4* 5**	[ ] [ ] [ ] [ ] [ ]
3. Co-Morbidity	1 2 3 **4* 5**	[ ] [ ] [ ] [ ] [ ]
4. Recovery Environment		
4a. Level of Stress	1 2 3 4 5	[ ] [ ] [ ] [ ] [ ]
4b. Level of Support	1 2 3 4 5	[ ] [ ] [ ] [ ] [ ]
5. Treatment and Recovery History	1 2 3 4 5	[ ] [ ] [ ] [ ] [ ]
6. Engagement and Recovery Status	1 2 3 4 5	[ ] [ ] [ ] [ ] [ ]

*(Note: **Bold** indicates independent criteria domains. A score of 4 results in placement at level 5 and a score of 5 results in placement at level six regardless of combined score.). * = independent criteria that may be waived if sum of 4a and 4b scores equal 2 (Low Stress Environment).*
(Note: For question 4, please record the higher of the two scores)

C. COMPOSITE LOCUS SCORE (Use web-based system to score accurately)	[ ]
D. LOCUS Derived Level of Care Recommendation (Use web-based system to score accurately)	[ ]
E. Actual Level of Care (if different from recommended Level of Care)	[ ]

Reason for Variance from LOCUS Derived Level of Care Recommendation:

_____

_____

_____

_____

_____

(Adapted from the American Association of Community Psychiatrists LOCUS – Level of Care Utilization System for Psychiatric and Addiction Services Manual, Adult Version 2010)

DIMENSION 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 one's self, 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 one's self 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, inability to contract for safety (while contracting for safety does not guarantee it, the inability to do so increases concern), 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:

☐ **MINIMAL RISK OF HARM**

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

☐ **LOW RISK OF HARM**

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

☐ **MODERATE RISK OF HARM**

- ☐ Significant current suicidal or homicidal ideation without intent or conscious plan and without past history.
- ☐ No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists.
- ☐ History of chronic impulsive suicidal/homicidal behavior or threats, but current expressions do not represent significant change from usual behavior.
- ☐ Binge or excessive use of substances resulted in potentially harmful behaviors in the past, but there have been no recent episodes.
- ☐ Some evidence of self-neglect and/or decrease in ability to care for one's self in current environment.

☐ **SERIOUS RISK OF HARM**

- ☐ 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 usual behavior.
- ☐ Recent pattern of excessive substance use resulting in loss of self-control and clearly harmful behaviors with no demonstrated ability to abstain from use.
- ☐ Clear compromise of ability to care adequately for one's self or to be adequately aware of environment.

(Adapted from the American Association of Community Psychiatrists LOCUS – Level of Care Utilization System for Psychiatric and Addiction Services Manual, Adult Version 2010)

☐ **EXTREME RISK OF HARM**

- ☐ 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.
- ☐ 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.
- ☐ Extreme compromise of ability to care for one's self or to adequately monitor environment with evidence of deterioration in physical condition or injury related to these deficits.

DIMENSION 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 physical functioning (such as sleep, appetite, energy, etc.), 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 ongoing, longstanding 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 the 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.

☐ **MINIMAL IMPAIRMENT**

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

☐ **MILD IMPAIRMENT**

- ☐ Experiencing some problems in interpersonal interactions, with increased irritability, hostility or conflict, but is able to maintain some meaningful and satisfying relationships.
- ☐ Recent experience of some minor disruptions in aspects of self-care or usual activities.
- ☐ 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.
- ☐ Demonstrating significant improvement in function following a period of difficulty.

☐ **MODERATE IMPAIRMENT**

- ☐ Recently conflicted, withdrawn, alienated or otherwise troubled in most significant relationships, but maintains control of any impulsive, aggressive or abusive behaviors.
- ☐ Appearance and hygiene falls below usual standards on a frequent basis.
- ☐ Significant disturbances in physical functioning such as sleep, eating habits, activity level, or sexual appetite, but without a serious threat to health.

(Adapted from the American Association of Community Psychiatrists LOCUS – Level of Care Utilization System for Psychiatric and Addiction Services Manual, Adult Version 2010)

- ☐ 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.
- ☐ Ongoing and/or variably severe deficits in interpersonal relationships, ability to engage in socially constructive activities, and ability to maintain responsibilities.
- ☐ Recent gains and/or stabilization in function have been achieved while participating in treatment in a structured and/or protected setting.

☐ **SERIOUS IMPAIRMENT**

- ☐ Serious decrease in the quality of interpersonal interactions with consistently conflicting or otherwise disrupted relations with others, which may include impulsive, aggressive or abusive behaviors.
- ☐ Significant withdrawal and avoidance of almost all social interaction.
- ☐ Consistent failure to maintain personal hygiene, appearance, and self-care near usual standards.
- ☐ Serious disturbances in physical functioning 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.

☐ **SEVERE IMPAIRMENT**

- ☐ Extreme deterioration in social interactions which may include chaotic communication, threatening behaviors with little or no provocation, or minimal control of impulsive, aggressive or otherwise abusive behavior.
- ☐ Development of complete withdrawal from all social interactions.
- ☐ 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.
- ☐ Extreme disruptions in physical functioning causing serious harm to health and well being.
- ☐ Complete inability to maintain any aspect of personal responsibility as a citizen, or in occupational, educational, or parental roles.

DIMENSION 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.

☐ **NO CO-MORBIDITY**

- ☐ No evidence of medical illness, substance use disorders, or psychiatric disturbances apart from the presenting disorder.
- ☐ Any illnesses that may have occurred in the past are now stable and pose no threat to the stability of the current condition.

(Adapted from the American Association of Community Psychiatrists LOCUS – Level of Care Utilization System for Psychiatric and Addiction Services Manual, Adult Version 2010)

☐ MINOR CO-MORBIDITY

- ☐ Existence of medical problems which are not themselves immediately threatening or debilitating and which have no impact on the course of the presenting disorder.
- ☐ 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 a co-existing psychiatric disorder.
- ☐ May occasionally experience psychiatric symptoms which are related to stress, medical illness, or substance use, but these are transient and have no detectable impact on a co-existing substance use disorder.

☐ SIGNIFICANT CO-MORBIDITY

- ☐ Medical conditions exist, or have potential to develop (such as diabetes or a mild physiologic withdrawal syndrome), which may require significant medical monitoring.
- ☐ Medical conditions exist which may be created or adversely affected by the existence of the presenting disorder.
- ☐ Medical conditions exist which may adversely affect the course of the presenting disorder.
- ☐ Ongoing or episodic substance use occurring despite negative consequences with significant or potentially significant negative impact on the course of any co-existing psychiatric disorder.
- ☐ 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.
- ☐ 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.

☐ MAJOR CO-MORBIDITY

- ☐ 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.
- ☐ Medical conditions exist which are clearly made worse by the existence of the presenting disorder.
- ☐ Medical conditions exist which clearly worsen the course and outcome of the presenting disorder.
- ☐ Uncontrolled substance use occurs at a level, which poses a serious threat to health if unchanged, and/or which poses a serious barrier to recovery from any co-existing psychiatric disorder.
- ☐ Psychiatric symptoms exist which are clearly disabling and which interact with and seriously impair ability to recover from any co-existing substance use disorder.

☐ SEVERE CO-MORBIDITY

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

(Adapted from the American Association of Community Psychiatrists LOCUS – Level of Care Utilization System for Psychiatric and Addiction Services Manual, Adult Version 2010)

- ☐ Uncontrolled medical condition severely worsens the presenting disorder, dramatically prolonging the course of illness and seriously impeding the ability to recover from it.
- ☐ Severe substance dependence with inability to control use under any circumstance and which may include intense withdrawal symptoms or continuing use despite clear worsening of any co-existing psychiatric disorder and other aspects of well being.
- ☐ 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 worsen it.

DIMENSION 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 that provide caring attention and emotional comfort, are also sources of support. For persons being treated in locked or otherwise protected residential settings, ratings should be based on the conditions that would be encountered upon transitioning to a new or returning to the usual environment, whichever is most appropriate to the circumstances.

LEVEL OF STRESS:

☐ LOW STRESS ENVIRONMENT

- ☐ Essentially no significant or enduring difficulties in interpersonal interactions and significant life circumstances are stable.
- ☐ No recent transitions of consequence.
- ☐ No major losses of interpersonal relationships or material status have been experienced recently.
- ☐ 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.
- ☐ Living environment poses no significant threats or risk.
- ☐ No pressure to perform beyond capacity in social role.

☐ MILDLY STRESSFUL ENVIRONMENT

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

☐ MODERATELY STRESSFUL ENVIRONMENT

- ☐ Significant discord or difficulties in family or other important relationships or alienation from social interaction.
- ☐ Significant transition causing disruption in life circumstances such as job loss, legal difficulties or change of residence.

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- ☐ Recent important loss or deterioration of interpersonal or material circumstances.
- ☐ Concern related to sustained decline in health status.
- ☐ Danger in or near habitat.
- ☐ Easy exposure and access to alcohol and drug use. *
- ☐ Perception that pressure to perform surpasses ability to meet obligations in a timely or adequate manner.

☐ **HIGHLY STRESSFUL ENVIRONMENT**

- ☐ 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.
- ☐ Severe disruption in life circumstances such as going to jail, losing housing, or living in an unfamiliar, unfriendly culture.
- ☐ Inability to meet needs for physical and/or material well being.
- ☐ Recent onset of severely disabling or life threatening illness.
- ☐ Difficulty avoiding exposure to active users and other pressures to partake in alcohol or drug use. *
- ☐ Episodes of victimization or direct threats of violence near current home.
- ☐ Overwhelming demands to meet immediate obligations are perceived.

☐ **EXTREMELY STRESSFUL ENVIRONMENT**

- ☐ 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 brought about by human malice or natural disaster.
  - persecution by a dominant social group.
  - sudden or unexpected death of loved one.
- ☐ Unavoidable exposure to drug use and active encouragement to participate in use. *
- ☐ Incarceration or lack of adequate shelter.
- ☐ Severe pain and/or imminent threat of loss of life due to illness or injury.
- ☐ Sustained inability to meet basic needs for physical and material well being.
- ☐ Chaotic and constantly threatening environment.

* These criteria apply to persons with past or present difficulties with substance use.

LEVEL OF SUPPORT:

☐ **HIGHLY SUPPORTIVE ENVIRONMENT**

- ☐ Plentiful sources of support with ample time and interest to provide for both material and emotional needs in most circumstances.
- ☐ Effective involvement of Assertive Community Treatment Team (ACT) or other similarly highly supportive resources. *(Selection of this criterion pre-empts higher ratings)*

☐ **SUPPORTIVE ENVIRONMENT**

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

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- ☐ Professional supports are available and effectively engaged (i.e. ICM). *(Selection of this criterion pre-empts higher ratings)*

☐ **LIMITED SUPPORT IN ENVIRONMENT**

- ☐ A few supportive resources exist in current environment and may be capable of providing some help if needed.
- ☐ 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.
- ☐ Persons who have potential to provide support have incomplete ability to participate in treatment and make necessary changes.
- ☐ Resources may be only partially utilized even when available.
- ☐ Limited constructive involvement with any professional sources of support that are available.

☐ **MINIMALLY SUPPORTIVE ENVIRONMENT**

- ☐ Very few actual or potential sources of support are available.
- ☐ Usual supportive resources display little motivation or willingness to offer assistance, or they are themselves troubled or hostile toward client.
- ☐ Existing supports are unable to provide sufficient resources to meet material or emotional needs.
- ☐ Client may be on bad terms with and unwilling to use supports available in a constructive manner.

☐ **NO SUPPORT IN THE ENVIRONMENT**

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

DIMENSION V. TREATMENT AND RECOVERY HISTORY

This dimension of the assessment recognizes that a person's past experience provides some indication of how that person 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 with 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.

☐ **FULLY RESPONSIVE TO TREATMENT AND RECOVERY MANAGEMENT**

- ☐ There has been no prior experience with treatment or recovery.
- ☐ Prior experience indicates that efforts in all treatments that have been attempted have been helpful in controlling the presenting problem.
- ☐ There has been successful management of extended recovery with few and limited periods of relapse even in unstructured environments or without frequent treatment.

☐ **SIGNIFICANT RESPONSE TO TREATMENT AND RECOVERY MANAGEMENT**

- ☐ Previous or current experience in treatment has been successful in controlling most symptoms but intensive or repeated exposures may have been required.
- ☐ Recovery has been managed for moderate periods of time with limited support or structure.

☐ **MODERATE RESPONSE TO TREATMENT AND RECOVERY MANAGEMENT**

- ☐ 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.
- ☐ Unclear response to treatment and ability to maintain a significant recovery.
- ☐ At least partial recovery has been maintained for moderate periods of time, but only with strong professional or peer support or in structured settings.

☐ **POOR RESPONSE TO TREATMENT AND RECOVERY MANAGEMENT**

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

☐ **NEGLIGIBLE RESPONSE TO TREATMENT**

- ☐ 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.
- ☐ Symptoms are persistent and functional ability shows no significant improvement despite this treatment exposure.

DIMENSION VI. ENGAGEMENT AND RECOVERY STATUS

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

☐ **OPTIMAL ENAGEMENT AND RECOVERY**

- ☐ Has complete understanding and acceptance of illness and its effect on function.
- ☐ Actively maintains changes made in the past (Maintenance Stage).
- ☐ Is enthusiastic about recovery, is trusting, and shows strong ability to utilize available resources and treatment.
- ☐ Understands recovery process and takes on a personal role and responsibility in a recovery plan.

☐ **POSITIVE ENAGEMENT AND RECOVERY**

- ☐ Has significant understanding and acceptance of illness and its effect on function.
- ☐ Willing to change and is actively working toward it (Action Stage).
- ☐ Positive attitude toward recovery and treatment, capable of developing trusting relationships, and uses available resources independently when necessary.
- ☐ Shows recognition of personal role in recovery and accepts significant responsibility for it.

☐ **LIMITED ENAGEMENT AND RECOVERY**

- ☐ Has some variability, hesitation or uncertainty in acceptance or understanding of illness and disability.
- ☐ Has limited desire or lacks confidence to change despite intentions to do so (Preparation Stage).
- ☐ Relates to treatment with some difficulty and establishes few, if any, trusting relationships.
- ☐ Does not use available resources independently or only in cases of extreme need.

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- ☐ Has limited ability to accept responsibility for recovery.

☐ MINIMAL ENAGEMENT AND RECOVERY

- ☐ Rarely, if ever, is able to accept reality of illness or any disability that accompanies it, but may acknowledge some difficulties in living.
- ☐ Has no desire or is afraid to adjust behavior, but may recognize the need to do so (Contemplation Stage).
- ☐ Relates poorly to treatment and treatment providers and ability to trust is extremely narrow.
- ☐ Avoids contact with and use of treatment resources if left to own devices.
- ☐ Does not accept any responsibility for recovery or feels powerless to do so.

☐ DISENGAGED AND STUCK

- ☐ Has no awareness or understanding of illness and disability (Pre-contemplation Stage).
- ☐ Inability to understand recovery concept or contributions of personal behavior to disease process.
- ☐ Unable to actively engage in recovery or treatment and has no current capacity to relate to another or develop trust.
- ☐ Extremely avoidant, frightened, or guarded.

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