**Department of Mental Health**

# TRANSMITTAL LETTER

| SUBJECT<br>**Level of Care Utilization System (LOCUS/CALOCUS) Evaluations** | | |
|---|---|---|
| POLICY NUMBER<br>**DMH Policy 300.1C** | DATE<br>DEC 2 1 2010 | TL#<br>147 |

**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 for their needs are provided.

**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 300.1B**<br>Level of Care Utilization System<br>(LOCUS/CALOCUS) Evaluations | **DMH Policy 300.1C**<br>Level of Care Utilization System<br>(LOCUS/CALOCUS) Evaluations |

Stephen T. Baron Date
Director, DMH

| GOVERNMENT OF THE DISTRICT OF COLUMBIA<br>DEPARTMENT OF MENTAL HEALTH | Policy No. 300.1C | Date DEC 21 2010 | Page 1 |
|---|---|---|---|
| | Supersedes<br>DMH Policy 300.1B, same subject, dated Sept. 14, 2010 | | |

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

1. **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.

2. **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, and the Mental Health Authority (MHA).

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

4. **Definitions**.

4a. Active Consumer. A consumer who is enrolled, receiving treatment and services with a CSA, including inpatient or residential treatment, in accordance with his/her agreed upon Individualized Recovery Plan (IRP) or Individualized Plan of Care (IPC).

4b. LOCUS and CALOCUS. The acronyms for Level of Care Utilization System, evaluation tools used to measure and track dimensions of functioning of adult and child/youth consumers respectively.

4c. DMH Guidelines in Identifying Possible Service Settings (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).

4d. 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.

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. DMH shall use the LOCUS/CALOCUS instrument in a computerized environment to perform these evaluations electronically - see Section 7a (1) regarding training and electronic access.

- 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.

- 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.

- LOCUS/CALOCUS evaluations 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.

- 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.

- 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.

- LOCUS/CALOCUS evaluations shall not be used to force treatment or services or deter consumer choice.

- The DMH Guidelines in Identifying Possible Service Settings from LOCUS/CALOCUS Ratings (see Exhibit 1) shall be used to gauge 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.

The consumer-level 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.

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).

(1) Consumers presenting for intake at a CSA shall have a LOCUS or CALOCUS evaluation completed by the CSA.

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

(3) The one hundred eighty (180)-day implementation of CALOCUS/LOCUS does not apply to individuals who are changing a level of care, or who are needing authorization (either new or continuing) for services at a frequency of less than 180 days in one service, such as consumers in community-based intervention (CBI) and wrap-around services.

(4) Consumers in continuing treatment at a CSA shall have a LOCUS or CALOCUS evaluation completed by the CSA to support requests for changes in service that

require service authorization [assertive community treatment (ACT), intensive day treatment (IDT), rehabilitation/day services, and DMH funded residential services].

(5) The CSA shall complete a LOCUS evaluation for consumers whenever a consumer is recommended for transfer from one level of residential care to another level of residential care (for example, transfer from an independent Mental Health Community Residential Facility (MHCRF) to a contract MHCRF, or transfer from a MHCRF to supported independent living or independent living).

(6) The CSA may complete a LOCUS or CALOCUS evaluation at any time as clinically indicated to assess changes in functioning or to assess changes in service needs.

(7) For adult consumers receiving continuing treatment at Saint Elizabeths Hospital in civil and forensic programs, the CSA shall complete LOCUS evaluation **with input** from the hospital's treatment planning team prior to and as part of the discharge planning.

(8) For consumers in other inpatient treatment settings and crisis stabilization programs, the CSA, **with input** from the treatment team of the setting, shall complete a LOCUS or CALOCUS evaluation for consumers within the first five (5) calendar days of admission, and complete a LOCUS or CALOCUS evaluation for consumers prior to discharge from the inpatient treatment setting or crisis stabilization program as part of discharge planning.

(9) For incarcerated adult consumers or adult inmates in need of mental health services at the D.C. Jail, the CSA, upon notification from the DMH Jail Liaison, and **with input** from the D.C. Jail mental health staff, shall complete a LOCUS evaluation upon initial assessment of the inmate, and prior to release if notified.

6b. Sub provider/Specialty Provider. For consumers enrolled in a CSA and referred to a sub provider or specialty provider for specialty services, the CSA shall maintain responsibility for ensuring completion of the LOCUS or CALOCUS evaluations in conjunction with the sub provider or specialty provider.

6c. 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 PRTF treatment team, 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.

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.

- After an individual is trained, an account request form must be completed and sent to the Division of Provider Relations within the Office of Administrative Operations at 64 New York Avenue, NE, Washington, DC 20002 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.

- 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. **Effective date**. The mandatory use of the DMH web-based LOCUS/CALOCUS tool is **April 01, 2011**.

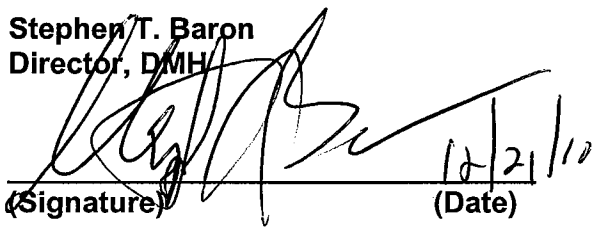
9. **Updates** shall be through Provider Bulletins on the DMH website: http://newsroom.dc.gov/list.aspx/agency/dmh/section/25.

10. **Inquiries.** Contact the Director, Division of Provider Relations at (202) 671-2900 or the Director, Programs and Policy Division, (202) 671-2910.

11. **Related References**. *LOCUS/CALOCUS Data Reporting and Quality Improvement Plan*, Office of Accountability, DMH, 2009.

**Approved by:**

**Stephen T. Baron**
**Director, DMH**



12/21/10

**(Signature)** **(Date)**

DEPARTMENT OF MENTAL HEALTH

64 New York Avenue, NE
Washington, DC 20002

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

DEC 2 1 2010

# 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).

**DEPARTMENT OF MENTAL HEALTH**

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| LEVEL | CALOCUS (See details of Descriptions in Exhibit 2, Policy 300.1B) | LOCUS (See details of Descriptions in Exhibit 3, Policy 300.1B) | 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<br>-Prevention Services<br>-Diagnostic/ Assessment<br>-Counseling<br>-Early Childhood Mental Health | -Home (family of origin, kinship foster care, foster care, therapeutic foster care, therapeutic group home)<br>- School<br>-Church<br>-Medical and recreational facilities<br>-Traditional Mental Health Settings (office or clinic)<br>-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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| LEVEL | CALOCUS (See details of Descriptions in Exhibit 2, Policy 300.1B) | LOCUS (See details of Descriptions in Exhibit 3, Policy 300.1B) | Traditional Service Setting | MHRS Service Types - C/Y & Adult | Location of Service | Housing Recommendation | Examples of Service Intensity |
|---|---|---|---|---|---|---|---|
| 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<br>-Community Support<br>-Diagnostic/ Assessment<br>-Counseling<br>-Medication/ Somatic Treatment<br><br>Specialty Services:<br>- Trauma-Focused<br>- CBT<br><br>Other Services: Housing Assistance; Supported Employment | -Home (family of origin, kinship foster care, foster care, therapeutic foster care, therapeutic group home)<br><br>-Traditional mental health setting (office or clinic)<br><br>-Free-standing clinic option for children<br>-Other Community settings | Independent Living | -Community Support = 2x/Month<br><br>-Diagnostic assessment = 1x/Year<br><br>-Counseling = 1-2x/Month<br><br>-Med/Som = 1x/Month<br><br>Trauma Focused Cognitive Behavior Therapy (CBT) = As prescribed in Evidenced Based Practice (EBP) guidelines |

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|---|---|---|---|---|---|---|---|
| **2** | **Composite score ranges common to this level of care: 14-16**<br>Outpatient Services.<br>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**<br>Low Intensity Community Based-Services.<br>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<br><br>-Community Support<br><br>-Day Services<br><br>-Diagnostic/ Assessment<br><br>-Counseling (individ/group on site)<br>-<br>Medication/Somatic Treatment<br>-Care Coordination<br>Specialty Services: Trauma-Focused CBT<br>Other Services: Housing Assistance; Supported Employment | -Home (family of origin, kinship foster care, foster care, therapeutic foster care, therapeutic group home)<br><br>-Traditional mental health setting (office or clinic)<br><br>-Free-standing clinic option for children<br><br>-Other Community settings | Independent Living | -Community Support = 1x/Week<br><br>-Day Services<br><br>-Diagnostic Assessment = 1-2x/Year<br><br>-Counseling = 1-2x/ Week<br><br>-Med/Som = 1x/Month |

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| LEVEL | CALOCUS (See details of Descriptions in Exhibit 2, Policy 300.1B) | LOCUS (See details of Descriptions in Exhibit 3, Policy 300.1B) | 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<br>-Community Support<br>-Day Services<br>-Diagnostic/ Assessment<br>-Intensive Day Treatment<br>-Counseling (individ/group on site)<br>-Counseling (individ/group off-site)<br>-Medication/Somatic Treatment<br>-Crisis/Emergency<br>*Pre-Authorized Services:*<br>-Community-Based Intervention (I -IV)*<br>*Specialty Services: SOC Care Coordination/ Wraparound, Trauma-Focused CBT, and Brief Intervention Treatment*<br>Other Services: Housing Assistance; Supported Employment | - Home (family of origin, kinship foster care, foster care, therapeutic foster care, therapeutic group home)<br>-Traditional mental health setting (office or clinic)<br>-Free-standing clinic option for children | -Independent Living<br>-Supported Independent Living (SIL)<br>- Residential Facility | -Community Support = 2x/Week<br><br>-Day Services<br><br>-Diagnostic assessment = 2x/Year<br><br>-Intensive Day Services<br><br>-Counseling = 1-2x/Week (on/off site)<br><br>-Med/Som = 1-2x/Month<br><br>-CBI (I-IV)*<br><br>-System of Care / Wraparound (with informal supports) as needed<br>-Trauma Focused Cognitive Behavior Therapy as prescribed in EBP practice guidelines |

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| LEVEL | CALOCUS (See details of Descriptions in Exhibit 2, Policy 300.1B) | LOCUS (See details of Descriptions in Exhibit 3, Policy 300.1B) | 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**<br>Intensive Integrated Service Without 24-Hour Psychiatric Monitoring.<br>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**<br>Medically Monitored Non-Residential Services.<br>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<br>-Day Services<br>-Diagnostic/Assessment<br>-Intensive Day Treatment<br>-Counseling (individual/group on site)<br>-Counseling (individual/group on-site and off-site)<br>-Medication/Somatic Treatment<br>-Crisis/Emergency<br>*Pre-Authorized Services:*<br>-Community-Based Intervention (I -IV)*<br>-Assertive Community Treatment<br>*Specialty Services: SOC Care Coordination/ Wraparound, Trauma-Focused CBT, and Brief Intervention Treatment*<br><br>Other Services: Housing Assistance; Supported Employment | -Home (family of origin, kinship foster care, foster care, therapeutic foster care, therapeutic group home)<br>-Traditional mental health setting (office or clinic)<br>-Free-standing clinic option for children | -Ind. Living<br>-Supported Independent Living (SIL)<br>-Residential Facility | -Community Support = 2x/Week<br>-Day Services<br>-Diagnostic Assessment= 2x/Year<br>-Intensive Day Services<br>-Counseling = 2x/Week (on/off site)<br>-Med/Som = 2x/Month<br><br>-Community Based Intervention (CBI )(I-IV)*<br>-ACT<br><br>-System of Care (SOC) / Wraparound as needed<br>-Trauma Focused Cognitive Behavior Therapy = As prescribed in EBP practice guidelines |

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| LEVEL | CALOCUS (See details of Descriptions in Exhibit 2, Policy 300.1B) | LOCUS (See details of Descriptions in Exhibit 3, Policy 300.1B) | 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**<br>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**<br>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<br>-Day Services<br>-Diagnostic/Assessment<br>-Intensive Day Treatment<br>-Counseling (individual/group on site)<br>-Counseling (individual/group on-site and off-site)<br>-Medication/Somatic Treatment<br>-Crisis/Emergency<br><br>*Pre-Authorized Services:*<br>• Community-Based Intervention (I -IV)*<br>• Assertive Community Treatment<br>*Specialty Services: SOC Care Coordination/ Wraparound, Trauma-Focused CBT, and Brief Intervention Treatment*<br>Other Services: Housing Assistance; Supported Employment | ***Group Home or other Unlocked Residential Facility***<br><br>A complex array of services including medication management and monitoring with 24-hour care available. Services can be provided in the following treatment settings:<br>-Supported Independent Living (SIL)<br>-Community Residential Facility<br>-Residential Treatment Center (RTC)<br>-Psychiatric Residential Treatment Facility (PRTF)<br><br>**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**<br><br>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<br><br>-Day Services<br>-Diagnostic Assessment 2x/Year<br><br>-Counseling = 2x/Week (on/off site)<br><br>-Med/Som = 2x/Month<br>-CBI (I-IV)*<br>-ACT<br>-System of Care / Wraparound as needed<br>-TF-CBT as prescribed in EBP practice guidelines |

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| LEVEL | CALOCUS (See details of Descriptions in Exhibit 2, Policy 300.1B) | LOCUS (See details of Descriptions in Exhibit 3, Policy 300.1B) | 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<br>-Day Services<br>-Diagnostic/Assessment<br>-Intensive Day Treatment<br>-Counseling (individual/group on site)<br>-Counseling (individual/group on-site and off-site)<br>-Medication/Somatic Treatment<br>-Crisis/Emergency<br>*-Pre-Authorized Services:*<br>-Community-Based Intervention (I -IV)*<br>-Assertive Community Treatment<br><br>*Specialty **Services:** SOC Care Coordination/ Wraparound, Trauma-Focused CBT, and Brief Intervention Treatment*<br><br>**Other Services:** Housing Assistance; Supported Employment | **Inpatient Psychiatric Hospital or Secured Residential Facility**<br>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:<br>-Hospital<br>-Residential Treatment Center (RTC)<br>-Psychiatric Residential Treatment Facility (PRTF)<br><br>**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**<br><br>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*<br><br>-Hospital<br><br>-Residential Treatment Center (RTC)<br><br>-PRTF =<br><br>-ACT<br><br>-CBI I -III |

***Although not currently available, Functional Family Therapy (FFT) will be reimbursable through MHRS as CBI Level IV toward the last quarter of FY2010***

# 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

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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

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

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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

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

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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)

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

**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 His**tory - 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 Se**rvices - 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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**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 Stat**us - 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

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

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 Service**s - 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 Service**s – 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.