LOCUS Annual User's Bulletin

2023

American Association for
Community Psychiatry

Introduction

Welcome to the inaugural issue of the annual **LOCUS User's Bulletin**.

This Bulletin is developed by the American Association for Community Psychiatry (AACP) and provides updated information for LOCUS users on LOCUS scoring, usage, and training.

This issue of the bulletin contains the following key topics:

LOCUS Annual Review

Each year, AACP conducts an annual review of LOCUS, incorporating input, questions, and concerns from LOCUS users that are received throughout the year. The purpose of the annual review is to identify issues that require clarification in the User's Bulletin, as well as issues that may need to be addressed in future revisions of the LOCUS.

LOCUS 20 will continue to be the approved version of LOCUS during 2023. However, during 2023, a small group of experienced users will convene to consider revisions needed for the next version of LOCUS, and a new version is anticipated for release in 2024.

LOCUS users will be given ample notice and support to implement the updated version. It is not expected that the update will result in substantive changes to how the tool is scored.

LOCUS Usage and Training Updates:

Expanded Usage due to legislative mandates: Usage of LOCUS has continued to expand in 2022, primarily among payer organizations. This is due in large part to the Wit v. United Behavioral Health decision of the 9th Circuit Court in California in 2019. In that decision, the LOCUS family of tools were recognized as professional standards for medical necessity decision making. Although this decision has been appealed, it has spawned legislation in several states, including California and Oregon, mandating the use of these instruments by payers.

AACP recommends that systems implementing LOCUS provide support for dissemination and training on the tool for population managers, payers, providers, and people receiving services together. For this reason, the AACP is focusing on increasing LOCUS uptake among service providers, particularly in those markets in which payers have adopted the instrument.

AACP Online LOCUS Training and Certification: In response to increased demand, a new online standardized LOCUS training that can be viewed at trainees' convenience is in development by AACP and will be ready for launch in the first half of 2023. AACP recommends that LOCUS users receive this standardized training to ensure consistency of use, which is becoming increasingly more important as LOCUS continues to be recognized as a national standard. The training will incorporate vignette-based scoring exercises and multiple opportunities for trainees to check their learning, including a basic certification test. Certification will confirm the completion of training and indicate basic competency in using the LOCUS instrument.

Designation of LOCUS Leaders: AACP recognizes that an initial one-time training is not sufficient to sustain continued competency among users. For this reason, AACP recommends that organizations using the LOCUS identify "LOCUS Leaders" who can provide coaching, supervision on scoring and use of the tool, and act as a conduit for communication with AACP trainers. AACP plans to offer periodic live consultations with AACP experts, as well as resources to support LOCUS Leaders.

LOCUS Instruction Clarifications:

As part of the 2022 LOCUS annual review process, several key LOCUS scoring issues were identified. A description of these issues, along with clarification for LOCUS users on how to address them, is listed below:

1. **What kinds of behaviors should be considered when rating Dimension I (Risk of Harm)?**

   Current Dimension I (Risk of Harm) language largely emphasizes risk related to suicidal and homicidal ideation in anchors **a** and **b**. However, risk of harm also includes risk of severe self-injury or significant violence to others that may not be accompanied by lethal intent but warrants the highest levels of intervention to promote safety. Further clarification of this issue will be addressed in the next version of LOCUS, but current users should incorporate the following into their training and supervision:

   - Behaviors which place self or others in "imminent danger" or at risk of serious injury such as extreme self-harm or extreme interpersonal violence, even without lethal intent, should be rated on this dimension.

- Distortions in perceptions of reality that may result in dangerous, life-threatening behaviors, such as body image distortions that may lead to extreme food withholding, or impaired thinking which results in extreme threats to physical safety to self or others, should be considered.
- Poorly controlled high-risk behaviors related to active substance use disorder (see Dimension I 4d and I 5c) should be considered.

Note that persistent, non-serious self-harming behaviors (e.g., minor cutting behaviors for relief) or persistent angry outbursts that are not associated with significant risk or threat of injury to self or others should be rated, as before, on Dimension II (Functional Impairment).

2. How is LOCUS applied to populations with diagnoses that have unique presentations and treatment needs, such as people with eating disorders or dementia?

LOCUS is a multi-dimensional assessment of service **intensity** needs, independent of diagnosis. The LOCUS assesses service intensity needs by applying the six dimensional categories contained in the instrument to the person being assessed.

In the case of **eating disorders**, for example, any eating disordered behaviors that are life threatening or risk substantial harm to the individual if not addressed are rated on Dimension I (Risk of Harm).

Similarly, in the case of **dementia**, if an individual's lack of awareness or judgement results in behaviors that could cause imminent harm to themselves or others, a corresponding high rating could be made on Dimension I (Risk of Harm).

The effect of the eating disorder or dementia on functioning (e.g., weight loss, loss of energy, inability to fulfill roles and responsibilities, etc.) is rated on Dimension II (Functional Status).

Medical comorbidities related to eating disordered behavior or dementia (e.g., electrolyte imbalances, hormonal disruptions, immunologic responses, pneumonia, etc.) that impact the psychiatric presentation would be rated on Dimension III (Medical, Addictive, and Psychiatric Co-Morbidity), along with any possible substance use disorder comorbidity.

The same approach applies to evaluating the other dimensions, which address the person's environmental stress and support, engagement in treatment, and treatment and recovery history.

LOCUS only provides recommendations for service intensity. It does not provide direction on the specific kinds of treatments that should be employed. Treatment interventions for specific diagnoses are addressed via the treatment planning process. LOCUS users are encouraged to use the LOCUS service intensity score along with their own agency / entity- specific treatment guidelines when considering specialized treatment options for specific diagnoses.

3. How is LOCUS assessment sensitive to the needs of populations that have typically encountered inequity or discrimination?

Racial, linguistic and cultural minority populations (including LGBTQIA+ and immigrant populations) often experience barriers when accessing behavioral health or substance use services that may prevent them (or have prevented them in the past) from benefiting from or engaging in treatment.

These challenges and barriers are real and may substantially impact the recommended service intensity for these individuals. Additional clarifying language will be included in the next edition of the instrument to further address these challenges related to LOCUS scoring.

Past or present experiences with treatment access barriers or inequity should be considered in ratings on Dimensions IV, Dimension V, and Dimension VI (Recovery Environment, Treatment and Recovery History and Engagement and Recovery Status respectively). These ratings indicate how a person may have been impacted by discriminatory treatment.

4. How should raters make decisions regarding the timing of ratings related to baseline behaviors and changes occurring recently in response to treatment?

Unless otherwise specified in dimensional instructions, LOCUS prompts raters to focus on the "here and now" behaviors and conditions for the person being rated. The following points are intended to provide further clarification on timing considerations for specific dimensional ratings:

- On **Dimension I (Risk of Harm),** if behaviors are arrested due to treatment in a secure setting, a rating of 3b usually applies.
- On **Dimension II (Functional Status),** current functional status is rated relative to baseline function. Questions may arise about what constitutes the baseline. Someone with significant and chronic impairments over the course of years may establish a new baseline because of treatment or otherwise changed conditions.

Behaviors / conditions should be stable for at least a 3-month period in order for them to quality as the new baseline.

- On **Dimension IV (Recovery Environment)**, at times of transition, ratings are based on conditions a person is expected to encounter in the environment into which they are being transitioned. This will often be based on their proposed transition plan.
- On **Dimension V (Treatment and Recovery History),** questions may arise about what constitutes a "current" treatment response and when it may supersede past treatment experiences. A history of poor responses to treatment may conflict with current, short-term positive responses to treatment occurring in highly structured settings. This dimension rates *past* experiences, which take precedence over short term responses *except* in cases where the individual has had no previous treatment or treatment has only occurred in the distant past or was directed at a different condition.
- On **Dimension VI (Engagement and Recovery Status)**, engagement may be temporarily disrupted due to fluctuations in the intensity of the person's illness, or as part of a response to significant stress. Unless there is reason to believe that these changes in engagement may be enduring or permanently disrupted, ratings should reflect the individual's *baseline engagement* as a predictor of their ability to participate in treatment and recovery.

5. What is the significance of the presenting condition on Dimension III (Medical, Addictive, and Psychiatric Co-Morbidity) scale and how should that be determined?

The presenting condition (PC) is the starting point for making a rating on Dimension III, which is intended to consider the impact of other types of conditions on the individual's service intensity needs.

LOCUS is intended for use primarily in behavior health (BH) settings, so the presenting condition (PC) can only be either psychiatric or addiction. It should be noted that the PC is not necessarily the condition which a care provider deems to be the most 'serious.' Rather, identification of the PC is better determined by the person's chief complaint, their type of service request, their perception of the most important issue for which they want help, or the setting (MH or SUD) in which they are seeking help. Relying on the person's own request or priority is most useful if the person is being evaluated in a non-BH setting, such as a primary care setting or an emergency room.

Note that ratings on Dimension III relate ONLY to "other" types of comorbidities and not to comorbidities that fall in the same category of the PC. For example, if the person being assessed has an identified PC of alcohol use disorder, but they also have a drug

use disorder, the drug use disorder is not considered on Dimension III as it falls within the same category as the PC. Similarly, if a person is presenting for help with psychosis, but is also experiencing mood or anxiety disorders, these would not be rated as Co-Morbidity on Dimension III since they are disorders of the same category.

LOCUS Scoring Reminders:

✓ Maintaining Consistency:

LOCUS users should be aware that the criteria should not be altered. The consistency in the use of the criteria will ensure the integrity and validity of assessments. LOCUS is intended to provide a common language for communication of information. This can only be accomplished when all users are applying the same criteria. Localities can maintain the capacity to customize treatment plans and their menu of service elements at any given level of care while adhering to the common protocol for assessment.

✓ Provider-Client Rating Disparities:

When clients participate in the assessment process, there may be cases in which the opinion of the clinician does not match that of the client. In these instances, client and clinician can agree to disagree and record both scores. After all ratings are completed, the pair could see if the disparity resulted in any difference in the recommended level of care (LOC). If so, the eventual disposition can be negotiated. In most cases, the client's preference will prevail unless there is clear evidence that involuntary treatment is necessary for safety.

✓ Effective Engagement:

On Dimension IVB (Recovery Environment: Level of Support), lower ratings may be appropriate when the client is" effectively" engaged with professional supports. Effective engagement indicates that the client has developed basic trust with professional supports and collaborates with them in a constructive way. This may be difficult to determine at times of transition to a new set of supports, especially when transitioning from residential to community living. In these cases, when a warm hand off is not possible, the client's *potential* to engage with professional supports must be estimated in the selection of the proper rating for the transition.

Summary of Bulletin Key Points

- AACP continues to develop and refine its training products to create a consistent approach to LOCUS user competency.
- On Dimension I (Risk of Harm), in addition to suicidal and homicidal behaviors, LOCUS scoring should consider risk of severe self-injury or significant violence to others that may not be accompanied by lethal intent.
- LOCUS is a multi-dimensional assessment of service **intensity** needs, independent of diagnosis. When making ratings for diagnoses that have unique presentations and treatment needs (e.g., eating disorders, dementia) scorers should apply the six dimensional categories considering the person's symptom presentation, environment and supports much as they would for any other diagnosis.
- LOCUS only provides recommendations for service intensity. It does not provide direction about specific treatment protocols.
- Past or present experiences with treatment access barriers or inequity should be considered in ratings on Dimensions IV, Dimension V, and Dimension VI (Recovery Environment, Treatment and Recovery History and Engagement and Recovery Status respectively).
- Unless otherwise specified in dimensional instructions, LOCUS prompts raters to focus on the "here and now" behaviors and conditions for the person being rated.
- When making ratings on Dimension III (Medical, Addictive, and Psychiatric Co-Morbidity) the person's primary condition can be determined by the person's chief complaint, their type of service request, their perception of the most important issue for which they want help, or the setting (MH or SUD) in which they are seeking help.
- Ratings on Dimension III relate ONLY to "other" types of comorbidities and not to comorbidities that fall in the same category as the PC.

Opportunities for Involvement

Please direct any questions or feedback to Stephanie Smit-Dillard at: Stephanie.Smit-Dillard@communitypsychiatry.org

We welcome your comments and are always looking for volunteers to help with various aspects of LOCUS use, evaluation, and training.