The Illinois DHS Division of Mental Health
and the
Illinois Mental Health Collaborative for Access and Choice

LOCUS TRAINING

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equivocal

1. (Literally, called equally one thing or the other; hence:) Having two significations equally applicable; capable of double interpretation; of doubtful meaning; ambiguous; uncertain; as, equivocal words; an equivocal sentence. "For the beauties of Shakespeare are not of so dim or equivocal a nature as to be visible only to learned eyes." (Jeffrey)

2. Capable of being ascribed to different motives, or of signifying opposite feelings, purposes, or characters; deserving to be suspected; as, his actions are equivocal. "Equivocal repentances."

3. Uncertain, as an indication or sign; doubtful. "How equivocal a test." Equivocal chord, a chord which can be resolved into several distinct keys; one whose intervals, being all minor thirds, do not clearly indicate its fundamental tone or root; the chord of the diminished triad, and the diminished seventh.

Synonym: Ambiguous, doubtful, uncertain, indeterminate.

Equivocal, Ambiguous. We call an expression ambiguous when it has one general meaning, and yet contains certain words which may be taken in two different senses; or certain clauses which can be so connected with other clauses as to divide the mind between different views of part of the meaning intended. We call an expression equivocal when, taken as a whole, it conveys a given thought with perfect clearness and propriety, and also another thought with equal propriety and clearness. Such were the responses often given by the Delphic oracle; as that to Crsus when consulting about a war with Persia: "If you cross the Halys, you will destroy a great empire." This he applied to the Persian empire, which lay beyond that river, and, having crossed, destroyed his own, empire in the conflict. What is ambiguous is a mere blunder of language; what is equivocal is usually intended to deceive, though it may occur at times from mere inadvertence. Equivocation is applied only to cases where there is a design to deceive.

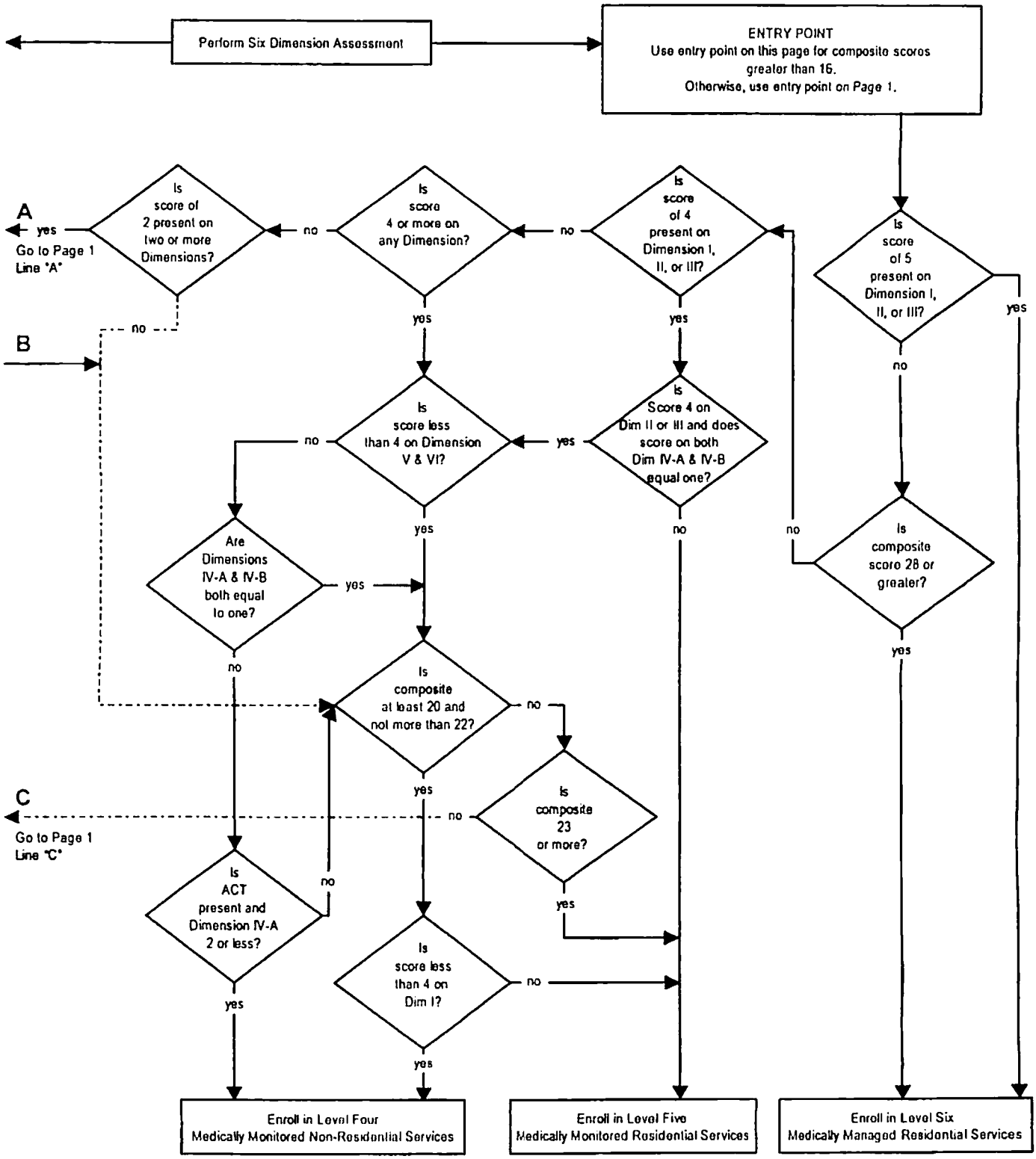
Origin: L. Aequivocus: aequus equal + vox, vocis, word. See Equal, and Voice, and cf. Equivoque.

LOCUS: LEVEL OF CARE CHARACTERISTICS

LOC Characteristics	I. Recovery Maintenance and Health Mainten. *(Usually a step down LOC)*	II. Low Intensity Community Based Services	III. High Intensity Community Based Services	IV. Medically Monitored Non-Residential Services	V. Medically Monitored Residential Services	VI. Medically Managed Residential Services
Client Living situation	Independent with minimal support	Independent with minimal support	Independent OR with support	Independent or with support	Residential setting, community-based. Some Board and Care and LT Resi also.	Traditionally hospital but could be in free-standing facilities.
Recovery History	Achieved significant recovery from past episodes	Clients generally need on-going support.	Intensive support and treatment needed.	Intensive support and treatment needed.	Acute and chronic situations depending on client.	Acute situations primarily.
Supervision and Contact Needed	Minimal for both	Do not require intensive management	Daily not required but usually several times per week	At least several times per week by a multi-disciplinary team.	24 supervision	24 hour monitoring and supervision.
Other	Some community or home-based services.	Traditionally clinic but can do community – based.	Traditionally clinic but can do community – based.	Facility or community: services are partial hospital or ACT	In some cases, intensive supportive housing may meet criteria	
I. Care Environment	Access can be monitored; egress not controlled.	Access can be monitored; egress not controlled.	Access can be monitored; egress not controlled.	Services may need to be mobile depending on client needs.	Adequate and safe living space. Usually no seclusion/ restraint but may manage egress. Food services/food prep avail.	Secure care; locked environment avail.; seclusion/restraint avail; Can do involuntary care.
II. Clinical Services	Up to 2 hrs/mo and not < 1 hr/3 months Med manage at least q 1-4 months Med use can be managed Ind or Grp supportive therapy	Up to 3 hours/wk and not < 1 hr q 2 wks Med manage about 1 x q 8 weeks Med use can be managed Ind, grp and family (I,G,F) therapies.	Tx (I,G, F)available at least 3 days/wk and 2-3 hrs/day. Med manage about q 2 wks Med use monitored/not administered. No skilled nursing needed. I,G, F and rehabilitative services and therapies	Services available most of day, 7 days/wk. Med manage avail. daily/ contacts usually at designated intervals. 24 hr by remote. Nursing available > 40hr/wk. Physical assess avail and accessed. Intensive Tx (I,G,F) 5 days/wk. Rehab services integrated. Meds monitored usually not administered.	Access to care: psych = 24 hours/day; psych contacts daily avail but s/be wkly; on-site nursing if doing med administration; on-site Tx (I,G, F) plus rehab and educational services either on or off-site.	Treatment available 24/7 on site or in close proximity. Psychiatric or medical contact daily. TX daily and pharmacological management.
III. Supportive Services	Yes	CM not usually required, may need help accessing certain services. Assist w/ coordination with support services.	CM and outreach available and integrated. Assist w/ coordination with supports. Ed and voc coordination. Facilitation of social, recreational.	CM integrated with mobile or on-site teams. ADL maintenance along with other coordination and supports, transport, systems management. Ed and voc coordination. Facilitation of social, recreational.	Supervision of ADL or may be custodial care. Staff facilitate social and recreational; staff coordinate interface w/ rehab and educational services if provided off-site	Total care available; client encouraged to do what they can.
IV. Crisis Stabilization and Prevention*	Basic see *	Basic see *	Mobile services, day care and child enrichment programs added to basic.	Mobile services, day care and child enrichment programs added to basic.	Services s/be directed to return to lower LOC in community. Develop transition plan, coord. w/ community resources and family.	Designed to reduce stress related to resuming normal community place. Develop transition plan

*** Includes at least access to 24/7 availability of crisis evals, brief interventions, and respite; vocational and educational and empowerment services. And, all basic services must be available as well: prevention programs that are population based and crisis management and evaluation services.**

AACP LEVEL OF CARE DETERMINATION DECISION TREE



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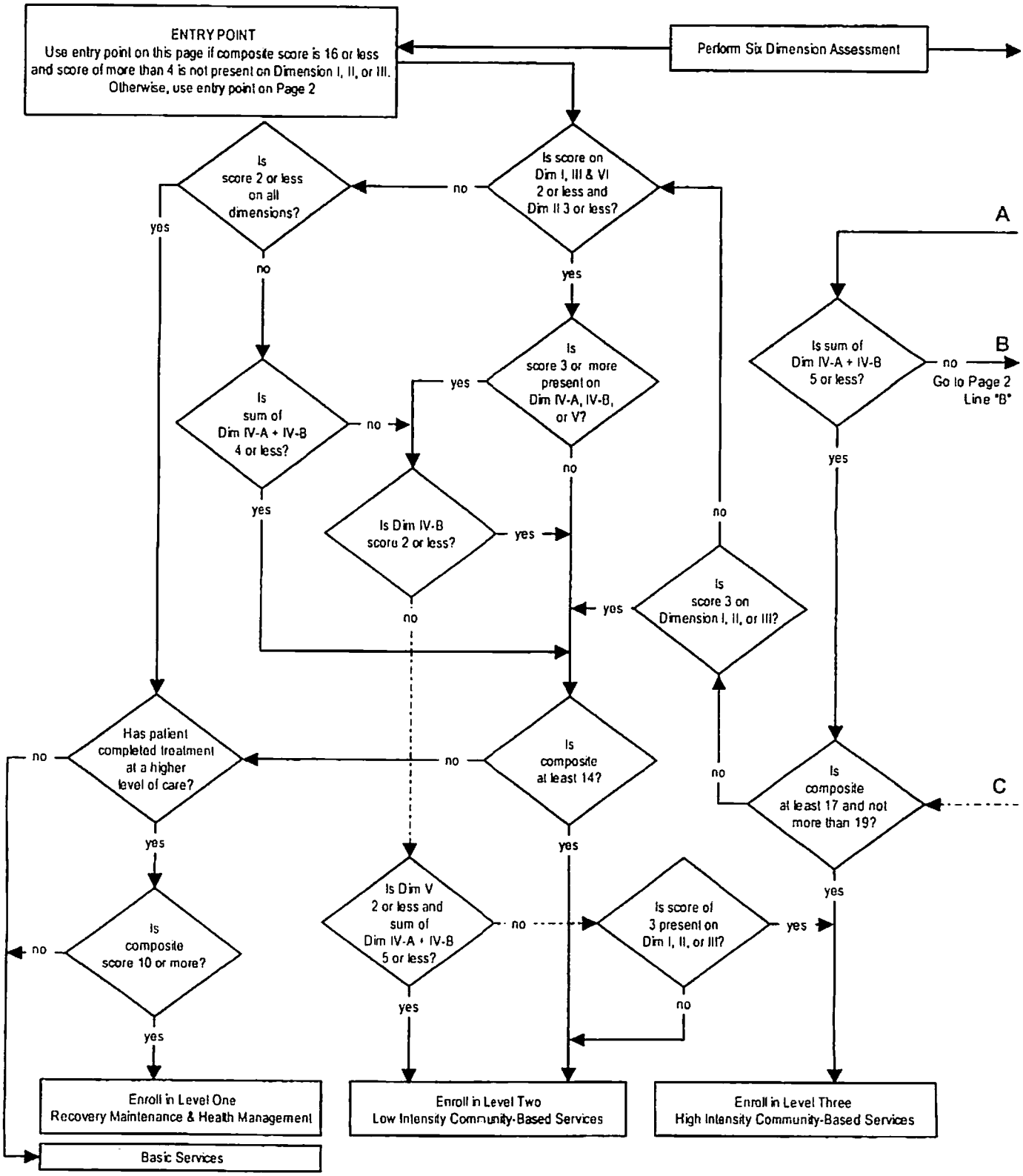
AACP LEVEL OF CARE DETERMINATION DECISION TREE



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CASE II

HISTORY OF PRESENT ILLNESS: Mr. S is a 49-year-old divorced man who is self-referred. He is currently living in a cheap downtown hotel and is very distressed to find himself in this situation. He reports that his mother and his sister "conspired" to have him evicted from his apartment about four months ago. "My world is falling apart. I feel like I'm at the end of my rope. I need help sleeping and I need a decent place to live."

He lost his job about six months ago and is involved in a complicated workman's compensation claim. He is currently receiving food stamps and living off savings. Since losing his job, Mr. S. reports an increase in emotional and physical fatigue, very low mood, 10 pound weight loss and disrupted sleep. Believes he is only sleeping 2-4 hours a night and feels "worn out." Although he denies suicidal ideation, he does report a history of suicide ideation and reports that once as a teenager he took "a handful of Tylenol" but "nothing happened." Describes a very negative outlook and states that just when things are looking up he gets "knocked down" again.

PSYCHIATRIC HISTORY: Mr. S reports that he has struggled with depression for 15 years. States he can not remember a single day in the last 15 years when he was free from low mood. He reports a seasonal component to his depression. There are also some symptoms suggesting manic episodes (feeling high, inability to sleep) but nothing more definite. He has never been hospitalized for psychiatric reasons but has received outpatient treatment in numerous settings. He expresses considerable dissatisfaction with the treatment he has received in the mental health system and complains that no one has been able to explain to him what was wrong or treat him successfully. He has been tried on a variety of medications, most of them mood stabilizers, with no apparent benefit. He does not currently take any medication for any physical or emotional condition.

MEDICAL HISTORY: Mr. S reports a history of head injuries as a result of a variety of accidents. He states that he has experienced momentary loss of consciousness as a result of some of these blows to the head. He also has a history of enuresis, which persisted until late adolescence. He reportedly sustained an injury in the Air Force which resulted in partial deafness. He does not receive any military pension or disability.

SUBSTANCE USE HISTORY: Mr. S denies any problem with drugs or alcohol. He reports that he drinks "seldom and socially." He does admit to smoking marijuana on a fairly regular basis until the break up of the relationship. He has used marijuana only rarely since then. He denies any present or previous legal problems.

SOCIAL HISTORY: Mr. S has one older sister. His mother and father remained married until his father's death about 20 years ago. He describes a good relationship with his father and a very conflicted relationship with his mother and his sister. He reports that his mother was physically and emotionally abusive. Mr. S considers himself to be of above average intelligence but admits that he always struggled in school. He joined the Air Force immediately upon graduating from high school. He was in the service for eight years and received an honorable discharge. He was married during this time for about a year. He has no children. He was trained on computers in the Air Force and has previously worked, on and off, at a computer repair business. He claims to have

sustained a back injury on the job and this is the basis of his workman's comp claim. The claim has been denied and he is in the process of making an appeal. For the last 19 years he has been living with another man. It is not clear whether or not this was a sexual relationship but it came to end at the time of his eviction and he has had no contact with his ex-partner. There is a positive family history for psychiatric problems. There is a maternal cousin who is institutionalized for some unknown reason and a maternal aunt and two other cousins diagnosed with bipolar disorder. He believes his mother may be alcoholic.

MENTAL STATUS EXAMINATION: This is a slight, somewhat disheveled man who appears cachectic, distressed and anxious. He is restless and speaks somewhat rapidly, but WNL. Thoughts are organized and no perceptual disturbance noted. Mood is upset and affect is dysphoric and constricted. Cognitive exam shows some deficit in concentration.

CASE IX

HISTORY OF PRESENT ILLNESS: D.M. is a 32-year-old Caucasian female who presented to the emergency room due to depression and suicidal ideation. She reported that over the past couple of weeks, she has had increasing problems with depression with occasional episodes of irritability and increasing use of alcohol and cocaine. She reported that her mood had been depressed with troubled sleep, frequent awakenings, fatigued and anhedonia. She was apathetic and unmotivated with poor concentration and low self esteem. Prior to admission she developed suicidal ideation with plan to overdose on her medications and those of her boyfriend. When she became fearful that she would follow through on these plans, she presented to the emergency room and was admitted. She reported that she has been drinking 6-8 drinks daily for the past 1 1/2 years. She also used cocaine intermittently when she has access to it. She has had a number of adverse consequences resulting in her current condition and which are related to her substance use and mental health problems. She has now been hospitalized for 6 days and over the past 2 days suicidal ideation has subsided, sleep has improved, and while she has made efforts to participate in treatment, she remains somewhat unmotivated and apathetic. Withdrawal symptoms have resolved.

PSYCHIATRIC HISTORY: She has had multiple hospital admissions over the last 1 1/2 years, both for substance use rehabilitation and mood disorder. She is taking Depakote 250 mg b.i.d., Risperdal 2 mg q hs.. and Paroxetine 20 mg q a.m., increased to 40 mg, for mood problems. She has been diagnosed with bipolar disorder, but does not describe any frankly manic episodes. She does describe some periods of extreme irritability and hyperactivity and high levels of energy. She states that while she maintains herself on her medications and when not using, that she does fairly well. She denies past suicide attempts with the exception of one attempt during her teen years. Other than some improvement in response to medications, she does not feel that her past treatment experiences have been helpful. She has not been consistent in following treatment recommendations.

MEDICAL HISTORY: She has a history of asthma. She is using an Albuterol inhaler on a p.r.n. basis, maximum 3 times in 24 hours. She also is using Pepcid, 20 mg tablets b.i.d. for gastritis. She also has recently had some problems with bronchitis and urinary tract infections. She is not currently on any antibiotics. Apart from these problems, she denies any other significant medical problems.

SUBSTANCE USE HISTORY: While she has used mainly alcohol and cocaine, she reports that she uses a variety of other substances when they are available. She has used alcohol on a daily basis for a number of years and recently has become involved in both crack cocaine and powder cocaine. She sometimes uses the cocaine in a binge fashion and has runs of several days at a time. She has had previous treatment and previous periods of abstinence, up to 3 years. She designates no particular programs as being most beneficial, but does report that AA has been quite helpful at various times. She reports that she does have several family members who are involved with substances, some of whom are in recovery and some of whom are active. She reports the use of cigarettes, about 2 packs per day, and is not willing to discontinue her use of nicotine at this time.

SOCIAL HISTORY: She has been living currently with a somewhat abusive boyfriend who is also a problem alcohol user. She states that he does well when he is not using but has been physically abusive and cruel to her when he is intoxicated. She is uncertain about her ability to dissociate from the relationship with her partner. She has left him several times but always returns after he promises to change. She has no relationship with her parents, who recently moved to Florida, and has no other current friends. She reports that she recently lost her job. She worked as a mental health therapist but lost her job due to substance abuse and frequent call offs. She also has several legal charges which are pending including theft and possession. On the advice of her public defender, she is seeking treatment, in part, because it will "look good to the judge." She reports that she has few recreational interests and she has personal religious beliefs but no religious involvement. She reports a history of unhappiness dating back to the time of her childhood when she felt neglected by an alcoholic mother. She also was sexually abused by a 17-year-old stepbrother at the age of 8 and has continued to be involved in abusive relationships as an adult.

MENTAL STATUS EXAMINATION: This is a tall, blonde haired, Caucasian female who was somewhat lethargic at the time of interview but was able to brighten and cooperate with the exam. She was dressed in street clothes, casual but clean. She also was able to engage in the interview process and was reasonably well related. She showed no abnormality of speech or movement. Thoughts were well associated and there were no perceptual disturbances reported. She does report, however, that thoughts occasionally become paranoid when off her medication. She reports her mood is depressed but somewhat better than yesterday. Her affect was dysthymic but showed fairly good range and appropriate reactivity. She denied current suicidal ideation. On cognitive exam, she was intact to short term and long term memory, attention and concentration. Her intelligence was average. Her insight and judgment were fair.

CASE XI

HISTORY OF PRESENT ILLNESS: Ms. C. is a 35-year-old Vietnamese-born, divorced woman who is currently a patient at a state hospital. She is being evaluated today by a treatment team to consider a possible change in level of care.

She has been stable. Ms. C. has been on Clozaril 200mg BID for the past seven months. She reports that this medication has been the most useful to her in decreasing auditory hallucinations. She describes these voices as command hallucinations about activities of daily living like "write to your sister" or "brush your teeth." She denies presence of command hallucinations to harm herself or others. She reports she has had hallucinations since her illness began at age 19. She denies any suicidal or homicidal thoughts at the present time and indicates no significant distress at the present time.

PSYCHIATRIC HISTORY: Ms. C. was admitted to the state hospital four years ago and was transferred to an on-site residential program one year ago. She has been in inpatient care since her admission with the exception of one trial visit with a county community residence. This visit one year after her admission was not successful. Ms. C. reports that she became lost one night and was not able to return to her assigned residence. Hospital records report that there were several incidents and she was described as "non-compliant with the rules of the program."

She re-entered the state hospital after several short-term acute hospitalizations. Past medication trials have included Prolixin Decanoate, Haldol and Trilafon. She has required treatment with anti-Parkinsonian agents, Benadryl and Cogentin.

Records indicated that Ms. C's most significant impairment has been confused, irresponsible, and undirected behaviors. She has a history of leaving her family home or residence and wandering in the neighborhood. During one episode, she was sexually assaulted by several men. She has had periods of hypersexuality while hospitalized. She has been unable to live independently and manage her finances since her illness began sixteen years ago. Ms. C. has two reported suicide attempts by overdose of sleeping pills and aspirin. Today, she is unclear whether she intended to die when these occurred.

MEDICAL HISTORY: Only admission was for childbirth six years ago. No current medications for medical problems. Records indicate history of vaginal infections and abnormal PAP smears. Follow-up for this problem is unclear. Most recent lab work was positive for HIV infection.

SUBSTANCE USE HISTORY: Ms. C. denies use of alcohol or other substances, but toxicology tests on several previous admissions were positive for cocaine and cannabis.

SOCIAL HISTORY: Ms. C. was born in Vietnam and immigrated when she was a teenager. She was raised by her mother and father with her one sister. Two stepsisters were left behind in Vietnam. She was married briefly and divorced by her husband during her current admission. Her daughter is being raised by her mother. Records indicate that she lost custody of her daughter after an alleged incident of feeding her daughter poison. Ms. C. reports that she graduated from high

school and wanted to go to community college prior to her illness and wonders whether this would still be possible. She describes her other interests as music, cooking and walking outside.

She has limited involvement with her family, and they have visited and taken part in family programming infrequently. She appears indifferent to her relationship with them.

MENTAL STATUS EXAMINATION: Ms. C. is a pleasant, well-dressed woman who speaks with an accent and at times is difficult to understand. Formal thought disorder with occasional loose associations is evident but does not impede the interview. She gives the impression of trying to give an answer to every question even if she isn't sure, in order to be polite. Mood is euthymic and affect is stable and somewhat blunted. She denied current suicidal/homicidal thoughts. Reported occasional mild auditory hallucinations. Cognition was not formally tested, but patient was alert, oriented, with no evidence of major impairment.

LOCUS PLACEMENT CRITERIA TABLE

Level of Care **Dimensions**	**Recovery Maintenance and Health Maintenance** *(Clients usually step down to this level)*	**Low Intensity Community Based Services**	**High Intensity Community Based Services**	**Medically Monitored Non-Residential Services**	**Medically Monitored Residential Services**	**Medically Managed Residential Services**
I. Risk of Harm	2 or less	2 or less (*3 can be accommodated if composite is OK)*	3 or less	3 or less (Do not generally see > 3)	(4) * 3	**(5)** ** 4
II. Functional Status	2 or less *(Clients s/be able to maintain a 2 or less to be eligible)*	3 or less	3 or less	3 or less *(4's maybe if IV A and IV B are both 1. A 2 on IV A maybe is a 1 on IV B which is ACT)*	(4) * 3	**(5)** ** 4
III. Co-Morbidity	2 or less	2 or less	3 or less	3 or less *(4's - See above under II for additional guidance)*	*(4)* * 3	(5) ** 4
IV. A. Recovery Environment "Stress"	Sum of IV A &B Should be 4 or less	Sum no greater than 5 for both and no more than a 3 for either one	Sum no greater than 5 for both and no more than a 3 for either one	3 or less *(4 could be managed if IV B =1, which is ACT)*	4 or higher on each scale *(A rating of 4 or higher on the A or B scale in conjunction with a rating of at least 3 on I, II, or III requires care at this level.)*	4 or more on either scale *(no rating requires independent placement or disqualifies placement)*
IV. A. Recovery Environment "Support"				3 or less *(See also above)*		
V. Treatment & Recovery History	2 or less	2 or less *(3 can be attempted if stepping down and IVB is 2 or less)*	3 or less *(2 is best, but many 3's can be accommodated)*	3 or less *(4's -See above under II for additional guidance)*	3 or higher *(This LOC required if also I, II, or III = 3 or more)*	4 or more *(See also above under Dimension IV)*
V. Engagement	2 or less should be obtained for this level	2 or less *(Can place a 3 here if client will not go higher)*	3 or less	3 or less *(4's -See above under II for additional guidance)*	3 or higher *(This LOC required if also I, II, or III = 3 or more)*	4 or more *(See also above under Dimension IV)*
Composite Rating	**10 -13** *(Clients generally successfully completed higher LOC and primary assistance is to maintain gains)*	**14 -16** *(4 or more on any dimension should exclude treatment at this level of care)*	**17 -19** *(4 or more on any dimension should exclude treatment at this level of care.*	**20 -22** *(A composite of 20 requires Tx at this LOC with or w/out ACT. ACT which is a 1 on IV B may mean some 4's in other dimensions.)*	**23 – 27** *(With 24 or higher may because of # of factors have a client who needs more structured LOC)*	**28 or more** *(This is an average of 4 or more on each dimension. However, even if client does not meet independent criteria in any one category, may still need this LOC.)*

*Indicates that there are independent criteria – requires admission to this level regardless of composite score unless meet criteria under Level IV, Dimension II.
** Indicates that there are independent criteria that requires placement at this level, regardless of other factors.