Barriers to Providing Mental Health Medication to the Homeless Mentally Ill Population

As Required By
The Sunset Advisory Commission
Department of State Health Services Staff Report
with Final Results
New Issue 11

Department of State Health Services
April 2016

- This page is intentionally left blank -

Table of Contents

Executive Summary **1**

Introduction **2**

Prevalence Rates of Mental Illness and Substance Abuse among Homeless Individuals **2**

Barriers to Medical Care among Homeless Individuals **2**

DSHS-Funded Services for Homeless Adults and Youth **3**

Overview of DSHS Service Array 3

Level of Care Service Packages for Adults and Children/Youth 4

Supportive Housing Services 4

Fiscal Year 2015 5

DSHS-Funded Programs for Homeless Adults and Youth **5**

Provider Survey **7**

Survey Development 7

Survey Results 7

Conclusion **8**

Appendix I: FY 2015 Percent of Homeless Youth Receiving Specific Services **9**

Appendix II: FY 2015 Percent of Homeless and Non-Homeless Adults in a Full Level of Care **10**

Appendix III: FY 2015 Percent of Homeless and Non-Homeless Adults Receiving Specific Services **11**

- This page is intentionally left blank -

Executive Summary

New Issue 11 in the 2015 Sunset Advisory Commission *Department of State Health Services Staff Report with Final Decisions* directed the Department of State Health Services (DSHS) to examine current services funded for homeless individuals with mental illness and identify any barriers to providing medication services to these individuals with the goal of avoiding episodes of crisis and criminal justice involvement. In 2015, the Texas Point-In-Time count identified 23,678 homeless individuals.[1] Of these homeless individuals, 4,425 (18.7 percent) self-reported severe mental illness and 3,723 (15.7 percent) self-reported issues with substance abuse.[2]

DSHS contracts with Local Mental Health Authorities (LMHAs) to ensure that behavioral health services are available to individuals with severe and persistent mental illness (SPMI) and individuals with co-occurring psychiatric and substance use disorders (COPSD). In addition to services offered within the levels of care, homeless individuals may receive supportive housing services. There are several DSHS-funded programs specifically designed to increase engagement and access to care for homelessness individuals: the Supported Housing Program, the Projects for Assistance in Transition from Homelessness (PATH) program, and the Healthy Community Collaboratives (HCC) project.

In fiscal year 2015, 184,038 individuals with SPMI received services in a full level of care through LMHAs across the state. Almost six percent of these individuals were literally or marginally homeless (10,489 homeless individuals). Compared with non-homeless individuals, homeless individuals were more likely to receive crisis services and be admitted to a state psychiatric hospital, community hospital, or private purchased bed. During this same time period, compared with non-homeless individuals, homeless individuals were more likely to receive community-based services (meaning they do not have to come to the clinic for many of their services) and DSHS-funded substance use disorder services.

DSHS developed a survey to gather input from statewide homeless service providers on perceived barriers to accessing mental health medication services. For many, this is the first step toward participating in comprehensive care. Several key barriers to accessing psychiatric medication emerged as a result of this survey. Service providers identified issues related to homelessness and poverty, communication and engagement issues with providers, as well as symptoms of mental illness that may be exacerbated by homelessness.

---

[1] Texas is required to provide an annual federal point-in-time count. United States Department of Housing and Urban Development (HUD). 2015 CoC Homeless Populations and Subpopulations Report - Texas. HUD. https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_State_TX_2015.pdf. Published October 29 2015. Accessed December 22 2015.

[2] United States Department of Housing and Urban Development (HUD). 2015 CoC Homeless Populations and Subpopulations Report - Texas. HUD. https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_State_TX_2015.pdf. Published October 29 2015. Accessed December 22 2015.

Introduction

New Issue 11 in the Sunset Advisory Commission *Department of State Health Services Staff Report with Final Decisions* directed DSHS to examine current services funded for homeless individuals with mental illness and identify any barriers to providing medication services to these individuals with the goal of avoiding episodes of crisis and criminal justice involvement.[3] This report includes information on the estimated prevalence rates of homeless individuals with mental illness and barriers to medical care, information on DSHS-funded services and programs for this population, and survey results from providers on perceived barriers to accessing psychiatric medication.

Prevalence Rates of Mental Illness and Substance Abuse among Homeless Individuals

The United States Department of Housing and Urban Development (HUD) requires annual Point-in-Time (PIT) estimates of states' homeless populations that include both sheltered and unsheltered homeless individuals.[4] These counts are conducted across the nation on a single night in late January each year. In 2015, the Texas PIT count identified 23,678 homeless individuals. Of these homeless individuals, 4,425 (18.7 percent) self-reported severe mental illness and 3,723 (15.7 percent) self-reported issues with substance abuse.[5] These state specific estimates are slightly less than federal estimates of homeless population taken during the same time period, which estimate 25.6 percent self-report a mental illness and 25.5 percent self-reported issues with substance abuse.[6]

Barriers to Medical Care among Homeless Individuals

Individuals who are homeless typically have more chronic physical and mental health problems and substance abuse issues than do the general population. Homeless individuals are also at greater risk for infectious diseases.[7] Additionally, they have high rates of chronic medical conditions such as diabetes and heart disease that are more challenging to care for and manage when living on the streets. Episodes of psychosis or major depression may lead to homelessness

---

[3] Sunset Advisory Commission. Sunset Advisory Commission Staff Report with Final Results: Department of State Health Services. https://www.sunset.texas.gov/public/uploads/DSHS%20Final%20Results.pdf. Published July 2015. Accessed October 9 2015.

[4] United States Department of Housing and Urban Development (HUD). 2015 CoC Homeless Populations and Subpopulations Report - Texas. HUD. https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_State_TX_2015.pdf. Published October 29 2015. Accessed December 22 2015.

[5] United States Department of Housing and Urban Development (HUD). 2015 CoC Homeless Populations and Subpopulations Report - Texas. HUD. https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_State_TX_2015.pdf. Published October 29 2015. Accessed December 22 2015.

[6] United States Department of Housing and Urban Development (HUD). 2015 CoC Homeless Assistance Programs Homeless Populations and Subpopulations. https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_NatlTerrDC_2015.pdf Published October 27 2015. Accessed March 14 2016.

[7] Kidder DP, Wolitski RJ, Campsmith ML, Nakamura GV. Health status, health care use, medication use, and medication adherence among homeless and housed people living with HIV/AIDS. Am J of Publ Health. 2007;97(12):2238–2245. doi:10.2105/AJPH.2006.090209

and homelessness itself can worsen chronic medical conditions. Substance use problems can severely impair a homeless individual's ability to maintain mental and physical health. Treatment and preventive care can be difficult for the homeless to access because they often lack insurance coverage, or they are unable to engage health care providers in the community. Such barriers can result in homeless individuals seeking medical care only once his or her condition has worsened to the point of an emergency room visit.[8]

DSHS-Funded Services for Homeless Adults and Youth

Overview of DSHS Service Array

DSHS contracts with 37 LMHAs and one Local Behavioral Health Authority (LBHA) to ensure that behavioral health services are available to adults with SPMI and/or COPSD as well as children and youth with a diagnosis of mental illness or who exhibit serious emotional, behavioral or mental health disorders.[9,10] Individuals seeking mental health services are initially assessed to identify their needs and strengths and then are authorized into a level of care that meets their needs and preferences. Services are provided in one of several level of care (LOC) service packages and include, but are not limited to: psychiatric diagnosis; pharmacological management, training and support; skills training and education; case management; supported housing and supported employment; peer services (including family partners); crisis intervention; therapy; and rehabilitative services. Individuals assessed as having a substance use disorder may receive COPSD services and are referred to appropriate substance use providers as needed.

The LOC service packages are based on the individual's assessment of strengths and needs. These LOC service packages range from least intensive to most intensive. Individuals authorized into office-based LOCs typically have less intensive service needs and individuals authorized into community-based LOCs typically have more intensive service needs. However, an individual can be served at a less-intensive service package than their assessed need due to client choice (an individual requests a less intensive service package) or resource limitations (the LMHAs capacity to serve the individual is limited because the individual does not have

---

[8] National Alliance to End Homelessness. Health Care. National Alliance to End Homelessness. Http://www.endhomelessness.org/pages/mental_physical_health. Accessed October 9 2015.

[9] Texas prioritizes services to adults with diagnoses such as schizophrenia, bipolar disorder, major depression, post-traumatic stress disorder, schizoaffective disorder, obsessive-compulsive disorder, anxiety disorder, attention deficit disorder, delusional disorder, and eating disorders who are experiencing significant functional impairment due to a mental health disorder that requires crisis resolution or ongoing, long-term support and treatment. Texas prioritizes services to children ages 3 through 17 with serious emotional disturbance (excluding a single diagnosis or substance use disorder, intellectual or developmental disability, or autism spectrum disorder) who have a serious functional impairment or who: 1) are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms, or 2) are enrolled in special education because of serious emotional disturbance. Source: Texas Health and Safety Code, Section 533.0354.

[10] "The term co-occurring disorder describes the coexistence of two independent but intertwined disorders and includes a wide range of mental health and substance use disorders. Co-occurring disorders are the combination of mental health disorders such as schizophrenia and other psychotic disorders, major affective disorders, and personality disorders with substance use disorders related to the ingestion of alcohol and other drugs. The term implies the need for an integrated response to two or more disorders. It does not assume the primacy of one disorder over the other." Source: Winarski JT. Implementing Interventions for Homeless Individuals with Co-Occurring Mental Health and Substance Use Disorders: A PATH Technical Assistance Package. SAMHSA. http://homeless.samhsa.gov/ResourceFiles/tf3cd5hc.pdf. Published March 1998. Accessed October 28 2015.

Medicaid). Therefore, LMHAs have the ability to structure these levels of care based on individual and community needs. Eligible individuals in a full LOC (FLOC) are admitted to ongoing services for an indefinite period of time. These include:

Level of Care Service Packages for Adults and Children/Youth

- *LOC 1M / LOC 1* – Minimal service coordination and medication services.
  - Adults: This office based service is for adults who could transition out of the public mental health system if appropriate community resources were available.
  - Children/Youth: Those served in this LOC may have an occasional need for routine case management services but do not have ongoing treatment needs outside of medication related services.
- *LOC 1S* – Low-intensity office based services for adults comprised primarily of medication, service coordination, and skills training.
- *LOC 2* – Targeted service package delivered in the office or in the community
  - Adults: Those served are diagnosed with major depression and receive office-based services, include medication, service coordination, and Cognitive Behavioral Therapy (counseling).
  - Children/Youth: Those served have identified emotional or behavioral treatment needs. Services include either counseling or individual skill training. Services are provided in the most convenient location for the child/youth and caregiver, including the office setting, school, home, or other community location.
- *LOC 3* – Intensive community-based services
  - Adults: Services include medication, case management, and rehabilitative services.
  - Children/Youth: Some children/youth assigned to this level of care may experience a higher degree of functional impairment. Services include counseling and individual skill training
- *LOC 4* – 24-hour, community-based services
  - Adults: Assertive Community Treatment (ACT) – 24-hour, community-based services for adults with multiple or lengthy psychiatric hospital stays delivered by a multi-disciplinary team.
  - Children/Youth: Intensive Family Services – 24-hour, community-based services for children/youth with significant involvement with multiple child serving systems (ie, juvenile justice involvement, expulsion from school, displacement from home, hospitalization, residential treatment, and/or serious injury to self or others).

Supportive Housing Services

In addition to services offered within the LOCs, homeless adults may be offered supportive housing services. These services include assisting individuals in looking for an apartment, applying for benefits and housing subsidies, budgeting training, and skills training relating to fair housing rights, communicating with landlords and maintaining housing. LMHAs who are most successful in providing supportive housing services often have good working relationships with their local public housing authority and actively seek out opportunities to facilitate access to permanent housing subsidies (rental assistance) for this population. These LMHAs are also adept at establishing and maintaining collaborative relationships with housing providers in their communities in order to decrease barriers to securing housing for those with subsidies.

Fiscal Year 2015 Services

In fiscal year 2015, 184,038 adults and 51,788 youth received services in a FLOC through LMHAs across the state.[11] Almost 6 percent of adults and 0.2 percent of youth were literally or marginally homeless at intake (10,489 homeless adults and 105 homeless youth – see Appendix I for details specific to youth homeless service utilization).[12, 13] These individuals are typically living on the streets, in homeless shelters or are at risk of losing their primary nighttime residence within a short amount of time and generally need very high levels of support. The number of homeless adults and persons at risk of imminent homelessness with a COPSD diagnosis was higher than non-homeless individuals in service (44.8 percent; compared to 31.7 percent of non-homeless individuals). These individuals were also more likely to receive crisis services from an LMHA (30.5 percent; compared to 16.8 percent non-homeless individuals) and more likely to be admitted to a state psychiatric hospital, community hospital, or private purchase bed (9.3 percent; compared to 3.7 percent of non-homeless individuals).[14]

Homeless adults and persons at risk of imminent homelessness are more likely to need substance abuse treatment and crisis services, compared to non-homeless populations. These individuals were also more likely to receive intensive community-based services and less likely to receive office-based services (42.4%, compared to 14.6%; see Appendix II for details).[15] Additionally, when compared with non-homeless adults in each of the FLOCs, homeless individuals and persons at risk of imminent homelessness received slightly less pharmacological management, training and support and more psychosocial rehabilitation and supported housing services (see Appendix III for details). The number of unduplicated homeless adults in a full LOC receiving DSHS funded substance use disorder services (13 percent, compared to only 7.5 percent of the non-homeless).[16]

DSHS-Funded Programs for Homeless Adults and Youth

There are three DSHS funded programs specifically designed to increase access to care and improve engagement in services for homeless individuals with mental illness. These programs include the Supportive Housing Program , Projects for Assistance in Transition from Homelessness program, and the Healthy Community Collaboratives project. An overview of each program is below.

---

[11] Department of State Health Services, Division of Mental Health and Substance Abuse Services, Office of Decision Support (October 12, 2015).

[12] Department of State Health Services, Division of Mental Health and Substance Abuse Services, Office of Decision Support (October 12, 2015).

[13] Under the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, literally and marginally homelessness is, in part, defined as "individuals and families who lack a fixed, regular, and adequate nighttime residence" and "individuals and families who will imminently lose their primary nighttime residence" 24 CFR Parts 91, 582, and 583

[14] Department of State Health Services, Division of Mental Health and Substance Abuse Services, Office of Decision Support (October 12, 2015).

[15] Department of State Health Services, Division of Mental Health and Substance Abuse Services, Office of Decision Support (October 12, 2015).

[16] Department of State Health Services, Division of Mental Health and Substance Abuse Services, Office of Decision Support (October 12, 2015).

Supportive Housing Program: While all LMHAs may choose to use general revenue funds to provide brief rent and utility assistance, the Supportive Housing Program is specifically designed to enhance some LMHAs' ability to provide supportive housing services by providing additional funds for short term (up to 6-months) and long term (up to 12 months) rental assistance to this population.[17] In fiscal year 2015, 20 LMHAs received $6.2 million in state general revenue. With these funds, 2,928 homeless individuals with a mental illness received rental assistance and 680 of these individuals transitioned to permanent supportive housing or affordable housing not funded by DSHS.[18, 19]

Projects for Assistance in Transition from Homelessness (PATH): In fiscal year 2015, $5 million in federal and state general revenue funds went to 16 PATH providers.[20, 21] In fiscal year 2015, 12,722 homeless individuals received street outreach, case management, housing services, habilitation and rehabilitation services, alcohol and drug treatment services, and linkages to mainstream resources including assistance obtaining permanent supportive housing.[22]

Healthy Community Collaboratives (HCC) project: The HCC project is designed to improve the service delivery system in the five most populated municipalities in the state. All five sites have successfully implemented a coordinated assessment process and improved communication and collaboration between community providers and stakeholders.[23] At the end of fiscal year 2015, HCC project sites completed 17,087 coordinated assessments, enrolled 5,805 individuals

[17] In fiscal year 2015, the 20 Supported Housing Program providers were: Austin Travis County Integral Care, Center for Health Care Services, Emergence Health Network, MHMR Authority of Harris County, Permian Basin Community Center, Spindletop Center, Tropical Texas Behavioral Health, MHMR of Tarrant County, Andrews Center Behavioral Healthcare System, Texas Panhandle Centers, Community HealthCore, Bluebonnet Trails Community Services, Border Region Behavioral Health Center, Tri-County Services, MHMR Authority of Brazos Valley, Nueces County Center, Betty Hardwick Center, West Texas Centers, and Hill Country MHMR Developmental Disabilities. In fiscal year 2016, Emergence Health Network and Border Region Behavioral Health Center will not be providers.

[18] The United States Department of Health and Human Services Department, Substance Abuse and Mental Health Services Administration, defines Permanent Supportive Housing programs that provide permanent housing with supportive services. The DSHS-funded Supportive Housing Program is similar to other permanent supportive housing programs as it provides both rental assistance and supportive services, however it differs in the length of time financial assistance is made available to participants. More information can be found by accessing: SAMHSA. Permanent Supportive Housing: Building Your Program Tool Kit. http://store.samhsa.gov/shin/content//SMA10-4510/SMA10-4510-06-BuildingYourProgram-PSH.pdf. Published: July 2010. Accessed: April 27 2016.

[19] Department of State Health Services, Division of Mental Health and Substance Abuse Services, Office of Decision Support (October 12, 2015).

[20] PATH requires $1 of state funds for each $3 of federal funding (75% federal / 25% state funding).

[21] In fiscal year 2015, the 16 PATH providers were: Aliviane, Austin Travis County Integral Care, Border Region MHMR Community Center, Metrocare, Heart of Texas Region MHMR Center, Lubbock Regional MHMR Center, MHMR Authority of Harris County, MHMR Center of Nueces County, SEARCH, Spindletop Center, MHMR of Tarrant County, Texas Panhandle Centers, Center for Health Care Services, Gulf Coast Center, Tri-County Services, and Tropical Texas Behavioral Health.

[22] Substance Abuse Mental Health Service Administration (SAMHSA). 2015 Annual PATH report. PATH Data Exchange (PDX) system. http://www.pathpdx.org/. Accessed September 24 2015.

[23] In fiscal year 2015, the 5 HCC providers were: Austin Travis County Integral Care, Tarrant County MHMR, Houston Coalition for the Homeless, Haven for Hope and the City of Dallas.

into the program, and placed 374 in permanent supportive and affordable housing.[24] Additionally, at the end of fiscal year 2015, 1,536 unduplicated individuals received one or more pharmacological management, training, and support service at the various HCC project sites.[25]

Provider Survey

Survey Development

DSHS developed a survey to gather input from LMHAs providing DSHS-funded homeless services on perceived barriers to accessing medication services and/or adhering to psychiatric medication regimes. The survey consisted of 16 items that included possible clinical, social, environmental, and financial barriers identified through literature review.[26] Through "Yes," "Periodically," or "No" responses, respondents were asked to identify which of the items presented a barrier.[27] Anonymous survey responses were collected from 93 outreach workers, supportive housing specialists, and other staff from PATH, HCC, and the Supported Housing Programs.

Survey Results

The following three issues were identified as not being a barrier for homeless individuals:

- Having a wrong diagnosis
- Not being able to complete lab procedures required for their prescription
- Adhering to the storage requirements for some mental health medications

The following issues were identified as barriers to homeless individuals receiving psychiatric medication:

- Having their psychiatric medication stolen (89 percent)
- Lacking education about their mental illness (89 percent)
- Changing psychiatric medications when clinically stable (82 percent)
- Not participating/engaging in case management services (80 percent)
- Experiencing symptoms associated with mental illness which lead to not taking medications, missing appointments, or refilling prescriptions (76 percent)
- Experiencing negative side effects caused by psychiatric medications (79 percent)
- Choosing not to take psychiatric medications due to social stigma (78 percent)
- Lacking family or social support (77 percent)

---

[24] Bellinger CJ, Stevens-Manser, S. Healthy Community Collaborative Year-End Report October 31, 2015. Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at Austin. http://sites.utexas.edu/mental-health-institute/homeless-populations/. Accessed July 1 2015.

[25] Department of State Health Services, Division of Mental Health and Substance Abuse Services, Office of Decision Support (February 1, 2016).

[26] Glazier R, Whitney N. Factors affecting medication adherence among the homeless. Univ Toronto Med J. 2004;82(1):1-9. http://www.researchgate.net/publication/50854785_Factors_Affecting_Medication_Adherence_among_the_Homeless_A_Qualitative_Study_of_Patients'_Perspectivess. Accessed October 9 2015.

[27] The sum of the values of each item was calculated and the highest percentage for each item is reported. "Yes" was defined as always, "No" was defined as never, and "Periodically" was defined as less than always, but more than never.

The following three issues were identified as periodic barriers for homeless individuals:

- Inability to afford copays (23 percent)
- Inability to schedule an appointment with a psychiatrist (20 percent)
- Lack of transportation (30 percent)

Conclusion

Several barriers to accessing medication services and/or adhering to psychiatric medication regimes emerged as a result of this survey. Service providers identified issues that include an inability to safely store psychiatric medications, requiring assistance when symptoms lead to missing appointments, and not refilling medications. Also, the inability to afford copays, and a lack of transportation to participate in medical and social service appointments are periodic barriers that can lead to a disruption in medications. Barriers related to the service delivery system include communication issues (homeless individuals not being educated about their mental illness and having their psychiatric medications changed by providers when clinically stable) and engagement issues with providers (homeless individuals not participating in services and/or there is a lack of psychiatric service availability). The results of this are instructive, and point to a need for DSHS to continue to work with local providers regarding barriers to effectively serving homeless individuals and their families. DSHS will continue to examine data regarding criminal justice utilization. In addition, DSHS will work collaboratively with HHSC to explore opportunities for additional data related to general hospital, emergency room, and psychiatric hospital utilization for this population.

Access to psychiatric and substance abuse services improves a homeless individual's ability to avoid incarceration and crisis episodes.[28] DSHS data on homeless persons served indicates that compared to non-homeless populations, homeless individuals are more likely to be served in more intensive LOCs. In addition, as seen with some LMHAs, improving collaboration and coordination between LMHAs and local public housing authorities can increase access to subsidized housing for this vulnerable population. Access to stable housing regardless of a person's level of recovery is likely to increase participation in treatment and address many barriers identified in this report. DSHS will continue to work with state and community partners to identify opportunities to improve engagement with and services to the homeless.

[28] United States Interagency Council on Homelessness. Opening doors: Federal strategic plan to prevent and end homelessness. http://dev2.usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf. Published 2010. Amended June 2015. Accessed February 26 2016.

Appendix I: FY 2015 Percent of Homeless Youth Receiving Specific Services

Full Level of Care	Substance Abuse Services	Case Management and Skills Training	Family Partner (Peer Services)	Medication Services	Crisis Services
1	0.0%	85.7%	28.6%	100%	0.0%
2	2.0%	80.4%	29.4%	60.8%	5.9%
3	4.9%	78.0%	26.8%	63.4%	14.6%
4	0.0%	100%	100%	100%	0.0%
Average	**2.9%**	**81.0%**	**32.4%**	**66.7%**	**8.6%**

Notes: LOC 1 - 4 are the service packages youth were authorized and receiving services in fiscal year 2015. The most recent assessment and corresponding authorized LOC was used to identify this unduplicated count; if only one assessment was available, the intake assessment was used. Homeless youths are defined during initial intake assessment as those who were literally or marginally homeless. The number of homeless youth served in fiscal year 2015 was substantially smaller than the number of non-homeless youth and comparisons could not be made to the same extent as with the homeless and non-homeless adult data comparisons.
Source: Department of State Health Services, Division of Mental Health and Substance Abuse Services, Office of Decision Support (February 17, 2016).

Appendix II: FY 2015 Percent of Homeless and Non-Homeless Adults in a Full Level of Care

Full Level of Care	Homeless	Non-Homeless
1M	<.01%	0.1%
1S	54.0%	80.0%
2	3.7%	5.3%
3	39.3%	13.0%
4	3.1%	1.6%
Total	**100%**	**100%**

Notes: LOC 1M - 4 are the service packages individuals were authorized and receiving services in fiscal year 2015. The most recent assessment and corresponding authorized LOC was used to identify this unduplicated count; if only one assessment was available, the intake assessment was used. There was only one homeless individual who received LOC 1M services (medication monitoring only). Homeless individuals are defined during initial intake assessment as those who were literally or marginally homeless. Non-homeless individuals are defined as living in any situation except literally or marginally homeless (which includes nursing homes, incarceration, group home/assisted living/treatment-training-rehab center). Services in a FLOC are typically provided in either an office-based setting (LOC 1 and LOC 2) or a community-based setting (LOC 3 and LOC4).
Source: Department of State Health Services, Division of Mental Health and Substance Abuse Services, Office of Decision Support (October 12, 2015).

Appendix III: FY 2015 Percent of Homeless and Non-Homeless Adults Receiving Specific Services

Percent of Homeless and Non-Homeless Adults in each Full Level of Care Receiving Supportive Housing Services

Full Level of Care	Homeless	Non-Homeless
1M	0%	1.7%
1S	13.8%	6.6%
2	13.3%	5.4%
3	20.4%	15.0%
4	44.3%	18.7%
Overall	**17.3%**	**7.8%**

Notes: LOC 1M - 4 are the service packages individuals were authorized and receiving services in fiscal year 2015. The most recent assessment and corresponding authorized level of care was used to identify this unduplicated count; if only one assessment was available, the intake assessment was used. Homeless individuals are defined during initial intake assessment as those who were literally or marginally homeless. Non-homeless individuals are defined as living in any situation except literally or marginally homeless (which includes, nursing homes, incarceration, group home/assisted living/treatment-training-rehab center). Services in a FLOC are typically provided in either an office-based setting (LOC 1 and LOC 2) or a community-based setting (LOC 3 and LOC4).
Source: Department of State Health Services, Division of Mental Health and Substance Abuse Services, Office of Decision Support (October 12, 2015).

Appendix III: FY 2015 Percent of Homeless and Non-Homeless Adults Receiving Specific Services (continued)

Percent of Homeless and Non-Homeless Adults in each Full Level of Care Receiving Pharmacological Management, Training and Support Services

Pharmacological Services	Homeless	Non-Homeless
1M	100%	92.6%
1S	60.6%	66.5%
2	40.9%	51.3%
3	47.4%	56.7%
4	84.2%	67.7%
Overall	**55.4%**	**64.5%**

Notes: LOC 1M - 4 are the service packages individuals were authorized and receiving services in fiscal year 2015. The most recent assessment and corresponding authorized level of care was used to identify this unduplicated count; if only one assessment was available, the intake assessment was used. Homeless individuals are defined during initial intake assessment as those who were literally or marginally homeless. Non-homeless individuals are defined as living in any situation except literally or marginally homeless (which includes, nursing homes, incarceration, group home/assisted living/treatment-training-rehab center). Services in a FLOC are typically provided in either an office-based setting (LOC 1 and LOC 2) or a community-based setting (LOC 3 and LOC4).
Source: Department of State Health Services, Division of Mental Health and Substance Abuse Services, Office of Decision Support (February 17, 2016).

Appendix III: FY 2015 Percent of Homeless and Non-Homeless Adults Receiving Specific Services (continued)

Percent of Homeless and Non-Homeless Adults in each Full Level of Care Receiving Psychosocial Rehabilitation Services

Psychosocial Rehabilitation Services	Homeless	Non-Homeless
1M	0%	0%
1S	9.1%	5.4%
2	6.0%	4.0%
3	46.8%	56.7%
4	87.0%	66.6%
Overall	**26.2%**	**13.0%**

Notes: LOC 1M - 4 are the service packages individuals were authorized and receiving services in fiscal year 2015. The most recent assessment and corresponding authorized level of care was used to identify this unduplicated count; if only one assessment was available, the intake assessment was used. Homeless individuals are defined during initial intake assessment as those who were literally or marginally homeless. Non-homeless individuals are defined as living in any situation except literally or marginally homeless (which includes, nursing homes, incarceration, group home/assisted living/treatment-training-rehab center). Services in a FLOC are typically provided in either an office-based setting (LOC 1 and LOC 2) or a community-based setting (LOC 3 and LOC4).
Source: Department of State Health Services, Division of Mental Health and Substance Abuse Services, Office of Decision Support (October 12, 2015).