AN
Assessment of Mental Health Needs Among Homeless People in Central Los Angeles
About the USC Division of Community Health

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NEGLECT ON THE STREETS — PART II

AN
Assessment of Mental Health Needs Among Homeless People
IN CENTRAL LOS ANGELES

University of Southern California
Keck School of Medicine
Department of Family Medicine
Division of Community Health

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1. Introduction

In the past 20 years, numerous scientific inquiries have examined the dynamics of homelessness, one of the nation’s most intractable social problems. A consistent finding in many of these studies is the disproportionately high rate of mental illness among homeless people (NCH Fact Sheet #5, 1999; SAMSA, 2004; Burt et al., 2001; Federal Task Force on Homelessness and Severe Mental Illness, 1992). In 2003, the University of Southern California (USC) Division of Community Health issued a report assessing health issues and problems related to access to care for health services among homeless adults and children in central Los Angeles. Due to the high prevalence of mental illness in the homeless population, we are releasing a second report focusing on mental health. This report provides a more in-depth view of the mental health needs of the homeless in central Los Angeles and the system that is designed to provide for their care. As in the previous report, we describe the need for mental health services, assess the capacity in central Los Angeles for providing mental health services to the homeless, identify barriers to mental health care that currently exist both for patients and providers, and offer recommendations to better meet the needs of homeless and mentally ill clients.
2. Approach to Data Collection

This assessment report is based on information collected from conducting a literature review, administering key informant interviews, and reviewing funded programs for the homeless mentally ill in Los Angeles County and elsewhere. The literature review included published articles, reports, manuscripts, and web pages on mental health issues and homelessness dating back to 1988. We conducted in-depth interviews with key informants to obtain detailed qualitative data about the mental health care needs and resources to assist the homeless population. We asked open-ended questions about mental health needs, services, and barriers as well as ideas for system improvement. Interviews lasted approximately 45 minutes and were administered by USC faculty, staff, and graduate students. All interviews were conducted confidentially with informed consent language approved by the USC IRB. During the study period, 31 people were contacted about the interview and 27 interviews were completed. Respondents included executive directors of shelters, missions, and nonprofit mental health clinics, mental health advocates, and staff from the Los Angeles County Department of Mental Health (DMH).

Finally, we gathered data and reports from the Los Angeles County Department of Mental Health (DMH) and from the Department of Health Services (DHS) related to mental health services and facilities, costs, and budget, and the types and number of programs, services, and funding sources for the homeless, mentally ill population in Los Angeles County. These reports were generated by the Department of Mental Health and covered the last two fiscal year periods. As in the previous study of status and access to care for homeless adults and children, this review focuses on central Los Angeles, also known as Skid Row, Central City East, and the Toy District. This area is comprised of three census tracks (2062, 2063, and 2073), and extends from 3rd Street in the north, to Main Street in the west, 7th Street in the south, and Alameda in the east. When possible, this report provides data for the central Los Angeles area. When data are not available for this area, we report data from the Los Angeles County Department of Health Services Central Health District, or the Los Angeles County Metro Service Planning Area or SPA 4, both of which cover a wider geographic area.
3. Mental Illness and the Homeless

The Context for Understanding Mental Illness among Homeless People

Drawing any conclusion about unmet needs for mental health care among the homeless requires some understanding of the context in which homelessness exists in general and in the central Los Angeles area. This means clearly understanding the size of the population at risk and in need of care, standards of care and service (such as utilization rates) that can be applied to the population and the community to create benchmarks from which to assess need. There are many obstacles to clearly understanding the contextual framework. Foremost is the lack of reliable estimates of the overall size of the homeless population. In Los Angeles, several reports have placed the number of homeless on any given night at around 80,000, with about half residing in central Los Angeles or Skid Row (Institute for the Study of Homelessness and Poverty, 2004). Others place the numbers at much lower levels with the difference attributed to different definitions and methods of enumeration. While the overall size of the homeless population is unclear, we have a better picture of the proportion with chronic or serious mental illnesses. Nationally, mental illness is found at disproportionately high rates among the homeless (SAMSHA, 2004; O’Toole, et al, 2003; Kuno, 2000). The same is true in Los Angeles, where 25-33% of the adult homeless population has a mental health-related disability, compared to between two and four percent of the overall adult population. (Los Angeles DMH Planning and Program Support Bureau, 2003; Koegel, 1996). More recently, a study of winter shelter residents in the Los Angeles area showed that about 11% of those using the County’s winter shelter program came directly from a psychiatric facility (Burns, et al., 2003). With estimates of the number of homeless people in central Los Angeles and the prevalence of mental illness among those homeless, it is estimated that 3,000 to 15,000 people are homeless and mentally ill living on the streets, in shelters and the hotel rooms of central Los Angeles. While determining the actual number of homeless people remains uncertain, few dispute that the number is unacceptably high, and growing (US Conference of Mayors, 2003).

Types of Mental Illness. Homeless people suffer from major depressive and bipolar disorders, psychosis, schizophrenia and anxiety disorders.1 This is based on the most

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1 as defined by the DSM-IV.
prevailent diagnoses made for clients served at the Downtown Mental Health Center (DMHC), a Department of Mental Health clinic that serves many homeless clients. Homeless people also have a high prevalence of acute mental health problems, including depression and anxiety, and are often treated for these conditions by physicians at the primary care sites.

Substance Abuse. Addiction to drugs and alcohol is a serious and unsolved problem among homeless individuals living in central Los Angeles. Some studies report half of homeless populations as having a substance abuse disorder (Robertson et al, 1997). Analyses of data from providers show similar results. DMH reports that 47% of clients served by DMHC has a co-occurring disorders of mental illness and substance abuse (DMHC, 2002). The JWCH/Weingart Medical Clinic recently estimated that 80% of their patients have substance abuse disorders. A previously reported study in downtown Los Angeles has shown that nearly 35% of homeless women living downtown are in recovery or abusing substances in the prior year (Dennison et al, 2001). Over 40% of the nearly 16,000 participants in County-funded residential treatment programs were homeless in 2001 (LA County Alcohol and Drug Program Administration, 2001). Between December 2001 and November 2002, both Clinica Monsignor Oscar A. Romero and the Homeless Health Care Clinic treated over 2,500 patients for substance abuse problems. The extent of substance abuse in this population is also evident from a review of mortality in Los Angeles County in 1999. Overall, the rate of drug-related deaths in SPA 4 (Metro) was 9.9—about 10% higher than the overall County rate of 8.4%. Health profiles from health providers also showed serious substance abuse problems among the homeless. (See Division of Community Health, Neglect on the Streets Part I, 2003).

Life on the Street for the Mentally Ill

The increase in the number of homeless mentally ill in the United States has been associated with the closing of state mental hospitals, a lack of housing, and a dearth of other critical support services for the mentally ill (Kuno, et. al, 2000; O’Hara and Miller, 2000; NCH Fact Sheet #6, 1999). Many mentally ill individuals become homeless due to the inability to comply with confusing or expensive treatment regimens and poor access to adequate support services. Many fear institutions because of previous negative experiences with the mental health system. For example, some patients have been hospitalized involuntarily or given treatment or medications that they did not feel were helpful, or that produced side effects. Many turn to the streets rather than re-engaging the system that they perceive as a threat to their independence and welfare. Some also face losing housing or children as a result of hospitalization or seeking treatment for mental health problems. In addition, many have encountered a
complex social services system which is often unsympathetic and intimidating, and requires people to be compliant with a regimen of medication, counseling and other services. Furthermore, homeless people face the broader stigmas of mental illness in our society made even more explicit by their higher visibility on our streets. Their situation is exacerbated by poverty and other illnesses such as HIV/AIDS, diabetes and heart disease. As a result, many mentally ill people turn to the streets, self-medicate using illegal drugs, and hide in byways or under the bridges of urban centers or seek refuge in the shelter system. The added consequence of life on the street makes the homeless mentally ill among society's most vulnerable groups.

While mental illness leads some into homelessness, homelessness itself may cause or exacerbate mental illness, especially an acute episode of depression or anxiety and possibly even psychosis. One central Los Angeles shelter provider states, “The life stress of homelessness brings out mental health issues. Homeless people experience daily traumas, and destitution leads to depression and anxiety.” Indeed, living today without a job, a place to sleep, food and other basic necessities may lead to depression and anxiety. Whether mental illness is a cause or consequence of homelessness, mental illness makes life on the street more difficult. Studies show that the homeless mentally ill:

- tend to remain homeless for longer periods of time,
- have a more difficult time obtaining basic services such as housing, food, medical care and money,
- have more contact with the legal system and are twice as likely as their non-mentally ill counterparts to be arrested or jailed,
- tend to be in poorer physical health than homeless people who do not suffer from mental illness,
- have a greater likelihood of having alcohol or drug addictions, yet face greater barriers to obtaining mental health and substance abuse services,
- are often not receiving benefits from programs for which they are eligible because of the complexity in the application process, and
- have often lost social contact and support from their family network.

The nexus between homelessness and mental illness has particularly difficult consequences for women, veterans, persons who are in jail or prison, and children.

*Homeless Women.* Women often become homeless after having been victims of domestic violence, physical, sexual, or emotional child abuse, and sexual assault. For some, these experiences have contributed to their mental illness, particularly anxiety, deep depression and personality disorders. Tragically, many women, including those
whose mental illness led to their homelessness, experience abuse while on the streets as well. Studies have demonstrated the negative impact domestic violence has on homelessness and on the mental health of the women (Zorza, 1991; U.S. Conference of Mayors, 1998).

**Veterans.** Homeless veterans represent 23% of all homeless adults in Los Angeles County (Institute for the Study of Homelessness and Poverty, 2000). There are an estimated 23,000 homeless veterans in the greater Los Angeles area (Burnette, et al, 2004). The prevalence of mental health and substance abuse in homeless veterans is substantial, with more than half estimated to have a substance abuse problem, a third (32%) with a psychiatric disorder including post-traumatic stress disorder, and a quarter (23%) having a co-occurring substance abuse problem and mental health problem. Unfortunately, providing mental health services is just one of several unmet needs, according to a recent Veterans Affairs survey of agencies serving the homeless veterans.

**Jail and Prison Inmates.** Mental health practitioners and corrections personnel, health providers, shelter operators and advocates in the Los Angeles County jail and prisons report mental health and substance abuse to be highly prevalent among inmates.

**Children.** There are an estimated 700 homeless children residing in central Los Angeles living in local hotels, emergency shelters, and on the street (Neglect on the Street Part I, 2003). A family history of mental illness, multigenerational poverty, abuse and neglect are all risk factors for children to display symptoms of mental illness and later as adolescents and adults (Smolen, 2003). Several studies demonstrate that the social conditions of homelessness contribute to developmental problems and other mental health concerns among homeless children (Czuchta & Akler, 1993). For example, Zima, et al. (1998) found that 46% of the homeless children in downtown Los Angeles had at least one learning disability requiring special education services while 30% have a social-emotional behavioral disorder. Homeless children are often exposed to the sale and use of drugs, prostitution, theft, and other violent crime. These children face difficulties in learning to trust and in developing a sense of autonomy (Akande, 2001). The exposure to violence and crime is particularly detrimental to child development (Bassuk et al, 1997; Garbarino, 2001), sleeping difficulties, asthma, and learning disorders (Evans & English, 2002). It is not surprising, therefore, that homeless and other low-income children are at high risk for developmental delays (Blair & Scott, 2002), and depression and chronic homelessness as adults (Stein 2002). Unfortunately, homeless children often fail to receive services for these needs (Zima et al., 1994). Almost a quarter (23%) of the children requiring special education services had never received services or screening at their school (Zima et al., 1997).
*Homeless Youth.* Adolescents in foster placement also have higher rates of mental health problems compared to the general population. Adolescents who leave placements with untreated mental health problems are more likely to become homeless as adults, compared to those who have treatment and support.
4. Current Mental Health Service Capacity

Mental Health Service Systems

In this section, we describe the current mental health system for the homeless in central Los Angeles. There is a substantial range in how mental health services are provided to mental health patients, where they occur and who provides them. Middle-income patients with health insurance often have full or partial mental health benefits as part of their health plan, paid for through their employer. The delivery of mental health services is determined by the structure of the benefit which defines who is an approved provider, how many visits a person can make within a given period of time, and what types of approvals are necessary to see a psychiatrist. Private practitioners in their offices provide most services to the middle class while inpatient services are provided through private hospitals. In contrast, those with low and moderate incomes, especially those that are homeless and those without health insurance, receive outpatient mental health services through community mental health centers, and inpatient care through public hospitals. They often have a much less integrated treatment plan, and treatment is predominantly episodic. Often, primary care providers prescribe psychiatric medications for their patients if they are not receiving adequate care for their mental health condition by a psychiatrist. According to local providers, mental health services to the homeless encompass some medication management and case management, but counseling and psychotherapy are less frequent. As one local mental health provider describes, “There exists a two-tier system: those that are insured who experience little restrictions for services and those that are uninsured who experience great barriers to treatment.”

Mental Health Services for the Indigent

The Los Angeles County Department of Mental Health (DMH) is at the heart of the mental health system for indigent patients. DMH is a County-operated and governed system that serves over 220,000 individuals per year. According to interviews with DMH officials and Los Angeles County documents, DMH operates with a budget of over $1 Billion, most (90%) of which is derived from State, Federal and other sources, (including over $450 million from Medi-Cal) and 10% directly from local County sources. DMH provides mental health services in county-operated facilities and subcontracted hospitals and private community mental health centers. Approximately
15-20% of DMH’s budget supports hospital care with 70% supporting outpatient services. DMH providers and contractors serve a disproportionately high number of uninsured patients. According to DMH, in 2003, over 70,000 people, were uninsured (LA County 2003), representing about one-third of DMH clients.

The DMH budget is currently at risk for significant reductions. A proposed 48 million dollar reduction will affect primarily the uninsured and the clients who are provided with mental health services as well as clients who have had extensive hospital stays. To reduce costs, DMH proposes to: 1) increase efforts to enroll uninsured clients into Patient Assistance Programs that are available through the pharmaceutical industry which provides clients with free medication, 2) increase the number of uninsured clients who apply for benefits (Medi-Cal, Medicare, etc.) through benefits establishment centers at clinic sites, and 3) replace costlier modalities of service such as day treatment and individual therapy with the less expensive group therapy and case management services as clinically appropriate.

**DMH Support for the Homeless.** The DMH network reported serving over 4,700 homeless people last year; however, this may be a lower estimate of the actual number served because many providers do not consistently record the housing status of their clients. There are some homeless people who are served by the network but may have a residence in a shelter, a rehabilitation center, or a transitional housing program, or have written an address identifying them as living with a friend or family member. Still, based on available data, SPA 4 agencies provide a disproportionately high number of mental health visits for the homeless in Los Angeles County. DMH reports that about 30% of mental health services that were delivered to homeless clients occurred in SPA 4 in 2003 (Exhibit 2). DMH programs for homeless people are augmented with less formal but important shelter-based programs operated by private or university affiliated providers. Some of these have affiliations with DMH providers. Note that while we focus on providers located in central Los Angeles and SPA 4, there exist some providers from other SPAs who serve residents of central Los Angeles.
**Private Support.** Over the years the private philanthropic community has supported mental health services in central Los Angeles. While the list is quite long, current funders include The Weingart Foundation, the Robert Wood Johnson Foundation, the California Community Foundation, and the Hilton Foundation. Other private funders have included the Parsons and Ahmanson foundations. The Hilton Foundation has supported housing initiatives for the mentally ill in other cities and is preparing a significant expansion of housing and supportive services in Los Angeles and other major cities in the United States aimed at the homeless mentally ill. The California Endowment is also supporting a $30 million initiative for improving access to mental health services in California. Projects funded under this initiative will include those targeting uninsured and under insured individuals, ethnic minorities, foster children and those in the juvenile justice system. They will focus on expanding access to a range of mental health services.

**Downtown Mental Health Center.** DMH supports 27 mental health providers in SPA 4, not including those in the Hollywood area. Of the 27 providers, DMH directly operates two. The others are private non-profits operating with DMH contracts. The largest mental health provider in SPA 4 is Downtown Mental Health Center (DMHC) a directly operated DMH facility located in the heart of central Los Angeles and in close proximity to many shelters and other homeless service providers. The DMHC budget is about $4 million with approximately $1.5 million coming from the Medi-Cal program, about $250,000 from public assistance-related programs, and the remaining from the County General Fund within the County’s mental health indigent care budget. DMHC serves as an anchor for the mentally ill community, providing outpatient mental health services to the homeless of central Los Angeles. DMHC reports 5.5 full time equivalent
(FTE) staff psychiatrists and about 20 other clinical staff who provide counseling, case management and related services, and prescribe and monitor medication. In FY 2003-2004, DMHC served over 5,000 unduplicated clients, the majority, if not all, of whom are homeless or formerly homeless.

**DMH Affiliated or Contracted Agencies.** Several non-profit agencies provide mental health services to the homeless in central Los Angeles. They include LAMP, Special Services for Groups (SSG), and Prototypes. LAMP is major non-profit mental health provider in central Los Angeles. It is an innovative housing and services program for the homeless mentally ill. LAMP provides a supportive environment, short-term and long-term housing options, and other support services. LAMP does not directly provide clinical services in the traditional medical model, although a close affiliation with DMHC helps to facilitate access to psychiatric care, medical management and counseling.

In addition to LAMP, DMHC has also established close working relationships with other providers in central Los Angeles that include the Skid Row Housing Trust and SRO Housing Corporation, the Salvation Army, the Weingart Center, the Downtown Women’s Center (DWC), and Para Los Ninos. DMH is exploring new options with the Veterans Administration and Volunteers of America (VOA). These agencies regularly refer clients to DMHC, and County psychiatrists visit select residential hotel sites. DMHC is also part of the Skid Row Collaborative, a three-year federally funded project in which 13 agencies provide a range of services to the homeless mentally ill. DMHC provides psychiatric medication support services to targeted chronically homeless mentally ill persons. DMHC also has emergency shelter bed housing contracts with the Weingart Center, SRO Housing Corporation, and Skid Row Housing Trust.

In addition to the public and County-contracted mental health providers, there are several privately-funded providers in Los Angeles. Some are also affiliated with DMHC. These include the Jerry Butler Mental Health Clinic at the Union Rescue Mission (URM), staffed by six clinical psychology students from Pepperdine University. At this site, there are no psychotropic medications prescribed or dispensed, so clients who require medication are referred to DMHC. The clinic operates two days per week from September to July. During fiscal year 2003-2004, just over 1,000 sessions were conducted. The Weingart Center also offers limited clinical mental health counseling for recently released prison inmates. New sites are being considered for the Midnight Mission, which is currently under construction.

**Programs for Homeless Women.** An important program for the homeless mentally ill is the Downtown Women’s Center (DWC). The DWC operates a day center and a residence for 47 single women. The day center offers refuge during the day for women living on the streets. Women can obtain meals and case-management services as well as participate in craft activities and exercise classes. DWC serves approximately 130 women
per day through the day center. DWC has an important affiliation with Downtown Mental Health (DMHC) where many of the women receive clinical psychiatric care for their mental health problems. With social work interns and the DMHC affiliation, DWC is able to help facilitate access to mental health care for women who come off the street and need care as well as for existing clients who have problems with their medication, need refill adjustments or have other problems. In addition, DMHC refers patients to the DWC for shelter and case management services. In 2002, DWC reported serving 237 case-management clients, and this increased to 455 in 2003. This year, DWC is projected to serve 655 clients. Special programs for women are also available at the Union Rescue Mission (URM) and the Weingart Center.

**Programs for Children and Families.** In 2002, DMHC, along with the Los Angeles County DPSS CalWORKs and Los Angeles Homeless Services Authority (LAHSA), piloted the Homeless Families Project targeting mentally ill adults with minor children. The mission was to assist families to move from the streets or sub-standard living situations into safe and permanent housing. According to DMHC, in the first year, 30 adults and 60 children were assisted with case management and referrals for permanent housing. More than 90% of the parents assisted were female. However, according to one advocate, it is unclear how many of these families actually received permanent housing. Para Los Ninos is a social service and child-care agency located in central Los Angeles. It currently has a contract with DMH for providing mental health and support services for children. At the present time, they serve 27 families, including mental health and psychiatric services provided to children and their families. Many of the families served by the program are those living in the surrounding hotels and apartments of downtown Los Angeles.

**Programs for Those Who are Incarcerated.** Some mental health services are available in the county jail. Those who are incarcerated within the Los Angeles County Sheriff’s Department Jail (Twin Towers) are assisted by the DMH health jail program or the LA County Sheriff’s Community Transition Unit (CTU) located in the Inmate Reception Center. Within Twin Towers are separate mental health housing areas for women and men. DMH employees working in the jail develop treatment plans for mentally ill inmates. They also attempt to implement a discharge plan prior to the time an inmate is released from jail, which includes securing access to housing, jobs and mental health services.

Twin Tower’s CTU was developed to enhance inmate participation in educational, vocational and other life skills training, and to provide linkages between inmates and vital resources needed to give the inmates of sense of direction, thereby empowering them as they reintegrate into society. This was achieved by establishing partnerships with more than 100 community/government agencies, including DMH, to assist inmates in making the difficult transition into the community. CTU employs 25 people to serve the needs of more than 17,000 inmates. A total of 641 referrals were made by
the CTU to outside agencies, mostly to shelters and job placement centers. CTU attempts to follow up with the former inmates in specified time intervals but often loses direct contact with the client after a few weeks. The VOA works in the jail with the CTU program through their Grace Project. This service provides assistance to those inmates about to be released who have chronic health or mental health problems and adds additional assistance to these individuals as they transition from the jails to the community.

**Programs for Homeless Veterans.** Services for veterans are provided or coordinated through the Veterans Administration of Greater Los Angeles Healthcare System (GLAHS). Prior to 1992, the focus of the VA treatment programs for homeless had been within the walls of the VA Medical Center in West Los Angeles (McGuire, et al, 2001). In 1992, GLAHS developed a continuum of services for homeless veterans through partnerships with community-based, non-profit agencies. The following programs are located outside of central Los Angeles, although they are available to homeless veterans living anywhere in the greater Los Angeles area. In 1996, a 60-bed onsite residential substance abuse program was created through a partnership with the Salvation Army. Also in partnership with the Salvation Army, in 2002, a 90-bed onsite program for veterans with serious mental illness and a 30-bed program for extended post-inpatient psychiatry discharge planning were established. In 1997, a 156-bed onsite long-term substance abuse rehabilitation program was established through a partnership with the non-profit organization for veterans called New Directions, and an onsite dual diagnosis residential program was established in 2002 (McGuire, et al, 2001).

Although these programs are located elsewhere, GLAHS now deploys VA staff to community agencies serving homeless veterans throughout the County, some in central Los Angeles. With each of these partnerships, the strengths and assets of each partner are identified and used to develop the most effective program or project. Funding for these projects is leveraged and diversified. Through this network of partnerships and relationships, a comprehensive infrastructure exists that allows for a full continuum of care.

With about 7,500 veterans passing through the Los Angeles County Jail system each year, GLAHS has developed a program to link veterans leaving jail to VA medical, psychiatric and substance abuse services (McGuire, 2002). Transportation is provided to veterans to the Medical Center in West Los Angeles.

**Emergency Services**

*Hospital Emergency Departments.* Unfortunately, many homeless people rely on the emergency room for mental health services. The hospital ERs that are frequently used by homeless people in central Los Angeles include the Los Angeles County University
of Southern California Medical Center (LAC-USC) and the California Medical Center. Currently the ER at California Medical Center is at risk for closure, which would significantly affect access to a broad range of services for the homeless (LA Times August 26, 2004). The LAC-USC psychiatric emergency room is available to individuals presenting with a psychiatric emergency. Individuals with general health problems who have a secondary mental health problem, however, are seen at the regular ER. Although data systems are unable to track homeless individuals, interviews with ER staff suggest that many ER patients at LAC-USC are or have been homeless. Patients with mental health and substance abuse problems create a significant burden on the ER. Data from the Los Angeles County Department of Health Services Planning Department shows that during the 2002-2003 fiscal year, the LAC-USC ER treated 13,219 unique patients with a primary or secondary psychiatric diagnosis.2 These patients made 17,786 ER visits related to their psychiatric issue, which represents about 11% of the ER’s total volume. Again, while not all of these patients are homeless, physicians routinely send homeless patients to the ER and the ER staff report a large number of homeless patients. While the majority of the 13,219 ER users with mental health problems sought services at the ER only once, 20% made between 2 and 20 visits suggesting that intervention with these frequent users might redirect these patients to more appropriate community based care and away from the more expensive and over crowded emergency services.

Emergency Mental Health Services. DMH’s Emergency Outreach Bureau (EOB) operates the Psychiatric Mobile Response Team (PMRT). For those individuals in mental health crisis, the PMRT is the first to respond. PMRT is called when a situation occurs that poses danger to self, others, or grave disability. The majority of PMRT responses are to indigent or Medi-Cal clients. Upon PMRT’s arrival, all parties are interviewed and the situation is evaluated to determine if the client should be hospitalized. Approximately half of all county PMRT calls result in hospitalization. While the PMRT is a valuable service, it is also expensive. Based on EOB estimates of staff salary, ambulance fees, and other measurements, EOB approximates that $5,000 is spent in response to each PMRT call. Los Angeles County is one of the few remaining counties to offer emergency mental health services in California. In other counties, the police would be called or the person would be taken to a medical emergency room. Although many homeless service agencies report using the PMRT, the PMRT does not record the housing or homelessness status of its patients, therefore we do not precisely know how many PMRT calls are related to homelessness. Still, during January-April,

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2 A psychiatric ER visit is defined by the following list of ICD-9 codes: Alcohol and Drug Psychoses, Schizophrenic Disorders, Affective Disorders, Paranoid States, Other Non-organic Psychoses, Neurotic Disorders, Personality Disorders, Sexual Deviations and Disorders, Alcohol Dependence Syndrome, Drug Dependence Syndrome, Nondependent Abuse of Drugs, Acute Reaction to Stress, Adjustment Reaction, Depressive Disorder, and Disturbance of Conduct.
2004 there were 529 PMRT calls from SPA 4, many of which report coming from central Los Angeles area and homeless service providers.

Substance Abuse Programs

Alcohol and Drug Rehabilitation services are provided throughout central Los Angeles. Some are funded directly from the Los Angeles County Alcohol and Drug Abuse Program Administration and others through private funding, generally affiliated with the Downtown missions. All of the central Los Angeles missions (The Union Rescue Mission, The Los Angeles Mission, and The Midnight Mission) operate recovery programs as part of their overnight and day programs. Many of the programs utilize the 12-step model for substance abuse. A recovery program is also offered by the Volunteers of America (VOA). This includes a 12-bed detoxification center and a 60-day residential substance abuse treatment program. The latter accommodates 55 people and is located in the Weingart Center. The Salvation Army offers several programs like Harbor Lights, which is a six-month residential substance abuse recovery program serving over 200 men. The Salvation Army also runs Safe Harbor, a residential substance abuse program serving 56 women who participate in substance abuse recovery programs, counseling, and life skills and job readiness classes. Outside of Skid Row, the Salvation Army operates the Harmony Hall Center, which provides ongoing support for 60 men and women who have successfully completed the recovery program. Nearby is Homeless Healthcare LA (HHCLA) which operates a one year, non-residential program for homeless people with substance abuse problems. HHCLA’s three-pronged approach includes case management, therapy, and if appropriate psychotropic medication. In the program, participants meet weekly with a case manager and bi-weekly in group or private counseling sessions. Many of their case managers are former homeless clients.

Services for People with Co-Occurring Disorders (COD). Downtown Mental Health Center has operated a COD program for the past 10 years in their day program, and has expanded the program within the past three years with the addition of COD trained clinicians including social workers, nurses and physicians.

Housing and Support Programs for Mentally Ill Homeless

Housing is a critical component of any treatment plan for the mentally ill. Studies of supportive housing in New York City revealed that an investment in service enriched supportive housing for the mentally ill yielded savings of over $13,000 per year per person, with the savings resulting from a reduction in the use of health and mental health services, use of emergency shelters, and other types of assistance (CPS, May 2001).
Both temporary and permanent housing options exist in Los Angeles County, specifically for clients with a psychiatric disability, and include: Section 8 Aftercare Program, Shelter Plus Care Program (S+C) through the City and County Housing Authorities, and the Specialized Shelter Bed Program. Section 8 is a housing voucher program supported by the federal department of Housing and Urban Development. The Section 8 Aftercare Program aims to increase families’ independence and quality of life by providing affordable, safe housing options to qualifying families. DMH has a contract with the Housing Authority of the City of Los Angeles (HACLA) to refer families to the Section 8 Aftercare Program. Approximately 100 DMH clients receive rental assistance through this program. As a part of HUD’s Continuum of Care Homeless Assistance Programs, S+C provides housing and supportive services to homeless and disabled people, including those with serious mental illness and/or chronic drug or alcohol use. DMH has Shelter Plus Care grants from both the City and the County Housing Authorities. Since 1996, DMH has been granted 155 County Shelter Plus Care certificates and 211 City certificates. Clients that participate in the program receive subsidized housing and services for five years, at which time the certificate is renewable. The Specialized Shelter Bed Program was created in 2001 to specifically address the growing numbers of homeless individuals and families who also have mental illness. The Department pays for the cost of approximately 80 beds (including two meals) each day at thirteen DMH contracted shelters that offer temporary, emergency shelter to homeless clients. Without such facilities, many of the clients would revert to hospital emergency rooms, jails, and the streets (Burns, et. al., 2003).

The AB 34/2034 program. AB 34/2034 is a major funding source for services to individuals who are homeless and have a mental illness. This bill was implemented in November 1999 and supports comprehensive services to mentally ill people who are homeless, those who have recently been released from county jail or state prison, and those who, without treatment, are at risk for becoming incarcerated or homeless. The program assists clients to access housing, employment, public benefits, health care and other community resources, in addition to mental health treatment and psychiatric medications. Through the AB 34/2034 programs, clients receive intensive case management services, and combined with outreach services in the jails and on the streets, programs have decreased recidivism, hospitalization, and homelessness. There are 16 DMH contract providers funded through AB 2034, including LAMP and Special Services for Groups (SSG), both of which are located in Skid Row. As of March 2004, there were 1,660 people in Los Angeles County enrolled in an AB 2034 program, including 171 served by LAMP and SSG.
5. Barriers and Gaps in Mental Health Services

In this section, we discuss systemic barriers, programmatic barriers and barriers related to social psychological factors.

Systemic Barriers

*Insufficient Capacity for Clinical Mental Health Services.* With 5.5 psychiatrists and 20 other full time clinicians, the central Los Angeles area may not have enough clinical staff to meet the mental health needs of those in the community. Figure 2 shows that there are 5.5 full time equivalent psychiatrists serving the three census tracks of central Los Angeles, compared to 1.7 which would be needed based on the number of psychiatrists per 100,000 in the California population. However, the number of child psychiatrists, clinical psychologists and social workers are far lower than what would be expected based on California workforce patterns.

**Figure 2. Psychiatrists Per 1000 Residents.**

<table>
<thead>
<tr>
<th></th>
<th>CALIF. RATE OF PSYCHIATRISTS PER 1000</th>
<th>EXPECTED # IN CENTRAL LA BASED ON CALIF. STANDARDS</th>
<th>OBSERVED IN CENTRAL LA</th>
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</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>.14</td>
<td>1.7</td>
<td>5.5</td>
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<tr>
<td>Child Psychiatrists</td>
<td>1.7</td>
<td>0.2</td>
<td>0</td>
</tr>
<tr>
<td>Psychologists</td>
<td>.28</td>
<td>3.7</td>
<td>?</td>
</tr>
<tr>
<td>Social Workers (licensed)</td>
<td>.22</td>
<td>2.7</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Population numbers are derived from the 2000 census. Psychiatrists are those practicing at DMHC. Scheffler and Kirby, *The Occupational Transformation of the Mental Health System*, Health Affairs, (2003)22 (5) 177.

However, the actual capacity should be much larger than average population estimates because the need for mental health among the homeless is so much greater than it is for the general population. Prevalence of mental illness among the homeless is about
five times greater than among the general population. Some of the need for mental health care is being met by primary care physicians who report treating acute episodes of mental illness such as depression or anxiety. However, these same clinicians express some reluctance in treating more serious disorders and refer their patients to mental health centers, especially DMHC for more serious problems. Many providers and advocates indicate that DMHC could provide more care with its current capacity if it was better organized and integrated within the broader delivery system, and more accessible to those who need the services. Services could also be more decentralized or co-located with primary medical care clinics and health centers.

*Workforce Issues.* Many of the providers mentioned the ongoing problem of recruiting and training mental health professionals and paraprofessionals to work with the homeless, particularly in central Los Angeles. While compensation within the public and private sector is competitive, the pressure of working with high need, vulnerable populations such as the homeless mentally ill in central Los Angeles has made it challenging to identify a full and qualified staff. The need for better training of existing staff within the health and mental health delivery system, and within the support system (shelters and other social services) is high.

*Treatment for Substance Abuse.* The need for additional substance abuse treatment is high, especially residential treatment programs. The need for both inpatient and outpatient substance abuse treatment slots is an on-going problem, especially for those with co-occurring disorders.

*Treatment for Children and Families.* While there are some programs for children in SPA 4, the programs are not adequate to respond to the growing need among children and parents, especially those living in the hotels and who use short-term and emergency shelter programs.

*Lack of Access to Housing and Support Services.* Housing is, overwhelmingly, a formidable problem for the homeless, mentally ill. According to the providers in the metro area, having a safe and reliable living environment is the number one basic need that must be addressed among this population. The homeless mentally ill, especially the dual-diagnosed, face complex barriers to housing. First, some individuals exhibit behaviors that may be perceived as destructive, intimidating and inconsistent with the rules set by the housing operator. Second, providers and others we have spoken with indicate that restrictions imposed by funders and housing program operators often serve as barriers to short and long-term housing. For example, regulations requiring applicants to remain drug and alcohol free to receive housing assistance make it difficult for many to comply with, especially given the barriers people face who want and need substance abuse treatment. Some downtown shelters and missions have rules and requirements that govern the conditions for staying at their facilities. Breaking the
rules often results in having to leave their housing. The cost-benefit of these restrictions should be reviewed in light of the evidence that imposing these restrictions does not lead to a reduction in substance abuse behaviors or improved outcomes (Tsemberis, Gulcer and Nakae, 2004). Providing housing with a wide range of health, mental health and other types of services may be a more prudent approach and reduce the use of emergency shelter beds and services.

**Lack of Financial Access to Services.** Supplemental Security Income (SSI) benefits are a primary source of income for those who are disabled due to mental illness. Yet homeless people and others at risk for homelessness face numerous barriers to gaining access to these benefits. SSI is important because, once approved, the person is automatically enrolled in Medi-Cal. Medi-Cal provides financial access to both public and private resources and allows DMH and its contractors to recover more of their costs for services provided. The greatest barrier to SSI for persons with mental illness is the requirement to demonstrate a history of mental health treatment. In order to receive SSI, the client must prove through medical evidence from health providers (hospitals, private physicians, mental health clinics) that he or she is so disabled that doing even a simple job is precluded, and that the disability is expected to remain at that level of severity for at least the next 12 months. In order to prove disability, there must be a good description of the person’s longitudinal medical history and ability to function over time (frequently over the past 12 months). Those clients whose medical documentation is either nonexistent or insufficient for a decision are referred to a State-contracted psychiatrist for an evaluation. According to Mental Health Advocacy, these appointments rarely last longer than 15 minutes and seldom cover and document severe problems in functioning. Due to the transient nature of homeless mentally ill individuals, it is difficult to connect them with community mental health centers in order to start the documentation process needed to qualify for SSI. Finally, it is very difficult to establish a disability in a client who is dually diagnosed with a substance abuse problem. The federal government has determined that people who are disabled due to substance abuse will not receive SSI; therefore, the client’s documentation must demonstrate through medical records that his/her disability is due to the mental health diagnosis, and not due in any part to the substance abuse.

**Programmatic Barriers**

**Gaining Access to Mental Health Services.** Although services are available, access to community-based mental health care remains limited for many homeless individuals in central Los Angeles. Both providers and clients remark that the restructuring of DMHC in the past few years has enabled the agency to be more responsive, and many providers see the value in decentralizing its services into other agencies. Yet most of the providers in the central Los Angeles area report that the DMHC system remains
difficult for many to access. The waiting time at DMHC can be lengthy and many people leave rather than wait the necessary amount of time. Some providers reported that when they refer individuals to DMHC, many simply do not go because of the anticipated waiting times. DMHC limits medication prescriptions to a 30-day supply, requiring people to return for medication refills every month. This requirement may not in itself be bad practice and indeed, may help patients if it is coupled with counseling, other services, and support. Absent of this more comprehensive approach, many patients simply fail to return for their refill appointments, and without medication their mental health status diminishes.

A related problem pertains to gaining access to appointments. DMHC does not accept appointments and people are seen on a walk-in basis. DMHC staff indicated that the walk-in system was implemented in part as a result of the high volume of no-show appointments. They point out that the walk-in system is a fair, more efficient and effective way of accommodating the area's mental health population, given their limited resources. On the other hand, many shelter and other program operators and primary care physicians are not able to make direct referrals to DMHC and can only secure access for their clients or patients by telling them to go to the facility and wait. As a result, many people, especially those who are distrustful and intimidated by the system, do not get care even if they need treatment. This is especially true for very vulnerable patients who need more support to commence and maintain treatment. It also leads to fragmentation and duplication of services when individuals return to the referring clinic or shelter without receiving the treatment or medication they need. Some end up in the ER, which contributes to the overuse of emergency departments by those whose conditions can be better treated in a community setting.

_Lack of Focus and Access for Immigrants._ Respondents mentioned the growing number of Spanish-speaking individuals and families in central Los Angeles and expressed concern about the lack of resources focused on this population. The need for bilingual and bi-cultural staff and programs in this community appears to be growing, as the overall population of immigrant homeless and near homeless individuals and families increases.

_Fragmentation and Lack of Integration between Health and Mental Health Services._ There is little coordination between physicians and the mental health clinicians at DMHC. Since physicians do not have access to appointment slots, physicians and other providers indicate that they seldom know if the patient ever goes for treatment and if they do, they rarely get any information back from the mental health providers about the outcome of the appointment. Primary care physicians should know the types of medication his or her patient is taking (or should be taking), the scope of treatment and how it integrates with the treatment prescribed
for other conditions the patient may have, such as HIV or diabetes. Options for new models of care by co-locating psychiatric and medical care services and pharmacy services at primary care sites should be considered.

Insufficient levels of coordination exist for discharged jail inmates. While some programs exist in the county jail for inmates leaving the facility, investigators determined that developing a mental health and substance abuse treatment plan and assuring some level of continuity of care is difficult in the county jail, where people stay for short periods of time and loss to follow up is very high. Creating short-term treatment plans for the mentally ill inmates (especially those with substance abuse problems) is a challenge, given the number of people leaving the jail every day. First, discharge planners have a difficult time finding treatment options for those leaving the jail. And if treatment is started in the jail, many do not have access to community providers for continuing that treatment after they leave.

Lack of Access to Co-Occurring Disorders Treatment. While the DMHC does have a co-occurring disorders (dual-diagnosed) protocol, many community providers acknowledge the lack of integrated substance abuse and mental health treatment. DMHC has taken some steps to promote the expansion of treatment for those with co-occurring disorders. All DMHC directly-operated and contract providers are required to assess clients for substance abuse-related issues. In addition, DMHC promotes specific psychotherapy techniques that may ameliorate the substance abuse, such as family therapy and cognitive behavioral therapy. Yet it is unclear the extent to which this protocol is actually practiced in the field. Additionally, providers noted that many clinicians do not have the skills to work with substance abusing clients. Nor do many clinicians treat the substance abuse problem as a serious and treatable condition; they tend to focus on the mental health issues.

Social Psychological Barriers

Social Stigma. Society continues to impose a stigma on those living with mental illnesses (Phelan, et.al., 1997). One local provider states, “We have not yet deinstitutionalized the mentally ill, rather, we have sent them into an open-air institution.” Stereotypes and offensive language about persons with mental illnesses persist and seem pervasive, which may contribute to our failure to adequately find a solution to homelessness. Changing the culture of society to treat people living with mental illness with equal respect and dignity is a great challenge. Such stigmas prevent people with mental illness from obtaining or maintaining employment, housing, social services, and other important resources. (Beatty & Haggard, 1998).
Competition from Other Basic Needs. Homeless people must often balance their need for food and shelter with their need for treatment. When hungry or cold, many people must choose between waiting in line for a bed or a hot meal, or keeping their appointment with their psychiatrist or counselor. Providers must organize care in the context of the social conditions of homelessness. As one provider states: “Mental health needs prevent people from getting their basic needs met which further prevents them from getting mental health services; it is a vicious cycle.” As a result, mental health clinicians must offer services to accommodate other pressing needs such as obtaining food and waiting in line at a local mission for a night’s bed.

Challenges for Providers

In providing services to the homeless mentally ill, clinicians reported numerous challenges:

- Frustration in not being able to provide the high caliber of services they want to for the client
- Burn out from working with seriously ill and needy clients
- Frustration from noncompliance, or when appointments are not kept
- Frustration by the lack of time case managers are allotted to spend with each client
- Prohibitively high case loads
- Pressed by time and thus must focus on crisis management as opposed to treating the root of the mental health disorder
- Need for more clinical support from supervisor to discuss difficulties with clients
- Lack of continuity of care and poor documentation to carry the client on to the next step
6. Conclusions

Without dispute, homeless individuals with mental health disorders are among our most vulnerable populations. They are not, however, a homogeneous group; some require more assistance than others. Unfortunately, many are not receiving the level of support they need to achieve a stable and healthy life, including a safe and protective living environment. In response, this analysis has shown that the mental health system has developed and matured in central Los Angeles. Although it is anchored in a complex and fragmented financing, the mental health system has reached beyond its own doors to other agencies and has taken advantage of other programs and funds necessary to reach vulnerable clients to expand treatment and provide access to a wide range of services. In particular, the AB 2034 program, which has provided a critical resource to those assisting the homeless mentally ill in obtaining treatment and other services; should be protected and, if possible, expanded. Still, no one felt that there were adequate levels of mental health or support services available and accessible to the homeless mentally ill, particularly in the area of housing. Already, homeless people and providers continue to face significant access barriers to mental health services as evidenced in part by the high number of people with mental health problems seeking care at hospital emergency rooms. The anticipated increase in the number of homeless people and the proposed reductions in mental health services as outlined in the Los Angeles County DMH budget will make the system even more fragile and difficult to access. The ten year plan to end homelessness sponsored by the Los Angeles Homeless Services Authority (LAHSA) is one opportunity to address the problems of the mentally ill homeless, yet this plan in its current state inadequately addresses the clinical and treatment barriers faced by homeless people suffering from severe and persistent mental health problems.

As in the previous report, investigators believe that homeless mentally ill individuals could benefit from a more integrated approach to care delivery, one in which health and mental health treatment and supportive services are closely coordinated. This can be done through targeted and coordinated outreach, improved communication among providers, the development of joint management mechanisms, and expanded supportive housing.

Clearly, providers recognize the need to work in a coordinated fashion, since their client maybe another provider’s the next day. Physicians who refer their patients to DMH seldom find out if they ever made it into the center for services. Primary care providers expressed their concern over the lack of funding and resources available for mental health programs; however, many providers believe that more could be
accomplished by working together and being able to track clients to determine what services they are receiving at various locations. Some mental health professionals stated that central Los Angeles should be organized under a community psychiatry model in which services and service providers are placed in the community, especially in shelter and missions where mentally ill people stay.

Previously cited studies from New York demonstrate that service-connected housing will potentially save millions of dollars in Los Angeles County by reducing the use of unnecessary emergency shelter beds, as well as health and mental health services, especially the ER. Many of the successes for the homeless mentally ill in Los Angeles County, as well as in other communities, come from the expansion of supportive housing. Nothing short of a systematic expansion of this model is likely to achieve these outcomes both for families and adults.

More should be done to coordinate efforts with the Los Angeles County jail for the mentally ill who are about to be released. Despite efforts to coordinate follow up mental health services, actual follow-up with clients is difficult and complicated, reducing the effectiveness of these efforts. Some homeless service providers have recommended that judges make follow-up mental health services mandatory as a condition of release, but there are legal limitations to utilizing this mechanism.

The ongoing presence of children who are homeless is an unnecessary social tragedy and a public policy failure. Child homelessness increases the risk of health and mental health problems in the short-term as they grow to adults. Many may become homeless themselves. Preventing homelessness should be a public policy priority that begins with identifying children who are homeless, especially those under the age of five, and securing a stable housing and service program for them.

Investigators recognize that many of the obstacles to achieving programmatic change are at the policy level. Expanded access to health and mental health services could be accomplished by easing many of the restrictions on access to SSI and Medi-Cal. The proposed cuts to DMH and the requirements of moving individuals onto Medi-Cal without commensurate easing of the eligibility rules will further destabilize the mental health system for the indigent, increase the demand for services at hospital ERs, and push more people into homelessness.
7. Recommendations

- The convening of health and mental health providers, advocates and homeless people towards the redesign of mental health services in central Los Angeles. This goal is to determine the optimal deployment of resources to maximize service delivery and improve quality. The focus should be on ways to eliminate programmatic barriers to mental health care for homeless in central Los Angeles through service expansion or redesign.

- Based on the above workgroup, expand mental health capacity by increasing the number of professional and licensed mental health staff working in central Los Angeles.

- Expand and improve training of para-professionals to work as mental health aids or case managers in conjunction with professional staff and other service providers.

- A coordinated long-term intervention aimed at homeless children and their families in central Los Angeles. The intervention should include outreach to shelters and hotels, service referrals, public benefits assistance, health/mental health screening and treatment, and short-term and long term supportive housing in areas safe for children and families. Steps include the following:
  1. Development of a short-term task force on homeless families and children to plan and oversee the intervention. Major social service agencies, advocacy groups and public support programs should participate. The task force should be of limited duration and should generate a report and a plan which should be presented to public and private funders within 12 months.
  2. An expansion of outreach to children, particularly families with children under the age of five, those with mentally ill parents, those living on the street for six months or longer, and those at immediate risk for health and mental health problems.
  3. Development or expansion of short term service options with a strong mental health component. These programs could include indoor playgrounds, adolescent programs and child care that are connected to support services for families living in the hotels and shelters in and adjacent to Skid Row.
  4. Development of permanent supportive housing options for families affected by mental illness.
Co-location of psychiatric and other mental health services in primary medical clinics in central Los Angeles.

Expanded deployment of psychiatric care to other facilities in central Los Angeles based on the community psychiatry and supportive housing options that incorporate outreach, case management, and street and shelter level intervention. Regular deployment of mental health professionals to the streets of central Los Angeles is also recommended.

A systematic integration of treatment and disease management for individuals with co-occurring disorders (health, mental health and substance abuse) involving central Los Angeles health clinics, mental health providers and those providing substance abuse services and case management services. Plans should include outreach and the identification of these individuals, followed by joint management of treatment and support services.

A continued effort to improve and expand the coordination of mental health and health care services for inmates about to be released from the county jail.

An expansion of supportive housing options for the homeless mentally ill, integrating treatment, housing, support services, and leveraging federal and state dollars for support. At least one of these should focus on families with young children.

The immediate expansion of assistance programs that facilitate enrollment of homeless mentally ill people into SSI. The Skid Row Health Collaborative and DMH could provide the mechanism for health assessments necessary for individuals to begin the medical documentation process necessary for showing disability.

Establishment of a pilot project and legislation that would make some homeless mentally ill individuals who are applying for SSI presumptively eligible for Medi-Cal during their pending the SSI applications.
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9. Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>DHS</td>
<td>Los Angeles County Department of Health Services</td>
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<td>DMH</td>
<td>Los Angeles County Department of Mental Health</td>
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<td>DMHC</td>
<td>Downtown Mental Health Center</td>
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<td>GLAHS</td>
<td>Veterans Administration Greater Los Angeles Healthcare System</td>
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<td>HUD</td>
<td>The United States Department of Housing and Urban Development</td>
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<td>Los Angeles Homeless Services Authority</td>
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<td>California Department of Health</td>
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<td>COD</td>
<td>Co-Occurring Disorders, individuals with a mental health and a substance abuse disorder</td>
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<td>Supplemental Security Income</td>
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<td>Medi-Cal</td>
<td>California’s Medicaid health insurance program</td>
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<td>International Classification of Diseases</td>
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<td>Corporation for Supportive Housing</td>
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<td>Emergency Outreach Bureau</td>
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<td>Psychiatric Mobile Response Team</td>
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*Chronically homeless.* Defined as being homeless for more than one year or having had four episodes of homelessness in the past three years as well as having a disabling condition (i.e. mental health, medical, developmental).
For more information about the USC Division of Community Health,
email Michael Cousineau at cousinea@usc.edu