

Projects for Assistance in Transition from
Homelessness (PATH)

California PATH Site Visit
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**Substance Abuse and Mental Health Services Administration
Center for Mental Health Services**

Introduction

The Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) has contracted with Advocates for Human Potential, Inc. (AHP) to conduct site visits to States to monitor the administration and operation of the Projects for Assistance in Transition from Homelessness (PATH) program. The purpose of the PATH site visit is to assess the State's performance in general administration of the program and to assess performance on each of the five voluntary performance goals (VPGs):

Goal 1: State focuses provider operation on serving literally homeless individuals.

Goal 2: Active State management and oversight of the PATH program.

Goal 3: State provides specific guidance and oversight to providers regarding reporting and definitions.

Goal 4: State leadership fosters the use of exemplary practices at provider sites.

Goal 5: State leadership actively supports transition to mainstream services activities.

The California site visit was conducted February 23-25, 2010 by Ilze Ruditis, Homeless Programs Branch, CMHS/SAMHSA; and, Lynn Aronson Napolitano, AHP. The site visit focused on three Counties (Sacramento, Marin, and Alameda) and the State Department of Mental health

This report describes the State's performance in administering the PATH program. Observations from the site visit were collected and organized using the five VPGs listed above. This methodology allows site visit teams to examine the performance of the State and its contracted providers in a comprehensive and standardized way and offers the opportunity to discuss best practices within PATH. This report uses these goals as the basis for summarizing communication with consumers and staff and the meetings and observations made at each of the PATH provider organizations. All formal recommendations are directed towards the State rather than to providers.

Description of State

The State of California has 58 counties, covering 155,959 square miles. According to 2008 estimates from the U.S. Census Bureau, California has a population of 36,756,666, 12.4 percent of whom are living below the Federal Poverty Level.

The California Department of Mental Health (DMH), located in Sacramento, has oversight of a public mental health budget of more than \$4 billion, including local assistance funding. Under a 1991 California law, the mental health treatment system is the joint responsibility of the State DMH and the counties.

While the DMH operates the State's hospital system, the 58 county mental health departments directly administer all other mental health services such as outpatient care, day treatment, crisis intervention, short-term inpatient care, case management, outreach, and long-term placement. The State operates five mental hospitals (Atascadero, Metropolitan, Napa, Coalinga, and Patton State Hospitals) and three acute care facilities within the Department of Corrections and Rehabilitation.

Role of PATH:

In California, PATH funds are distributed to the county mental health departments. See http://www.dmh.ca.gov/services_and_programs/adults/PATH.asp

The PATH grant funds community based outreach, mental health and substance abuse referral/treatment, case management, and other support services, as well as a limited set of housing services for the people who are homeless and have mental illnesses. During SFY 2003-04, a total of 37 counties elected to participate in the PATH program. While local programs serve thousands of homeless persons with realignment funds and other local revenues, the PATH grant augments these programs by providing services to approximately 8,300 additional persons annually. Each county determines the use of PATH funds based on local priorities and needs. These targeted funds provide much needed services to an extremely vulnerable population throughout California.

In accordance with Federal procedures, the DMH's PATH and housing staff have developed guidelines that define the counties' responsibilities to clients who are homeless and have mental illnesses. Counties receiving PATH funds must develop a service plan and budget annually for utilization of the funds. The service plan must describe each program setting and the services and activities to be provided. The estimated number of persons to be served must also be included in the plan.

It is estimated that approximately 13,846 individuals in California will be served with the PATH funds in FFY 2009.

Homelessness in California

According to a study released in 2007, by The National Alliance to End Homelessness, the estimated number of homeless people living in California was 159,732--26 percent of whom were members of a family, 27 percent of whom were chronically homeless, and 18 percent of whom were veterans. Between 2005 and 2007, homelessness among California residents decreased 6 percent. The State's Health and Human Services Agency and the Business, Transportation, and Housing Agency are responsible for the overall coordination of homeless activities in State government. The roles of these agencies include, among other things, coordination among State departments that implement homeless programs.

Housing

The Mental Health Services Act (MHSA) Housing Program is designed to increase the number of available permanent supportive housing units across the State for individuals and families receiving services under MHSA. The program is a partnership between DMH and California Housing Finance Agency (CalHFA) to provide both capital funding and project-based capitalized operating subsidies. Permanent supportive housing blends affordable housing with needed services and supports to ensure the housing stability and recovery of tenants.

The General System Development service category allows counties to augment the available housing stock by purchasing or master leasing housing units and establishing needed project-based subsidies pursuant to local stakeholder planning. This service category permits counties to tailor the housing expenditures to meet the needs of the community, whether it is safe havens, emergency housing, respite housing, transition housing, or any other type of housing needed at the local level.

The mission of the Department of Housing and Community Development (HCD) is to provide leadership, policies and programs to preserve and expand safe and affordable housing opportunities and promote strong communities for all Californians. As stated in the Department's 2007-2010 strategic plan, "The overriding challenge to housing affordability in California continues to be the lack of supply. California's population continues to grow, and its housing supply must grow with its population in order to increase affordability."

http://www.hcd.ca.gov/strategic_plan_docs/HCDStrategicPlan2007-2010.doc

Gaps in Services

Current gaps in services continue to include the lack of affordable housing, high cost of rental housing, and shortage of shelter beds.

Co-Occurring Disorders

The Governor's Budget Act of 1995-96 mandated that the Departments of Alcohol and Drug Programs (ADP) and Mental Health (DMH) actively seek methods to eliminate barriers between the substance abuse and mental health treatment systems at both the State and local levels on behalf of persons with dual diagnoses of serious mental illness and substance use disorders. In 2003, the two departments established a Co-Occurring Disorders (COD) Workgroup to

recommend strategies to improve treatment outcomes for persons with co-occurring disorders. The COD workgroup has been incorporated into the Co-Occurring Disorders Joint Action Council (COJAC) which has representatives from governmental agencies and non-profit provider groups. The COJAC is a volunteer body that advises ADP and DMH.

The Mental Health Services Act (MHSA)

In 2004, California voters passed MHSA as Proposition 63. Two key tenets of MHSA are that effective services for people with serious mental illness must include “whatever it takes” for recovery and that those services must be integrated. “Whatever it takes” refers to funding for a wide array of clinical and supportive services beyond mental health care, notably including such things as housing and treatment for COD. ‘Integrated’ refers to services that are concurrently delivered by a coordinated team of caregivers, often sharing single sites. Among the most important services to integrate are mental health and treatment for alcohol and other chemical dependency.

In 2005, DMH provided MHSA funding to ADP for the expansion of the COD Unit. The COD Unit is a collaborative effort between the two departments and works to accomplish the goals of the MHSA.

Voluntary Performance Goals (VPGs)

The discussion of State performance on the five VPGs is based on the State’s FFY09 PATH Application; PATH Annual Report data 2007 – 2008; observations and conversations on site; written answers to the site visit question guide provided by State staff, county staff, and providers; and independent research conducted by AHP staff.

Voluntary Performance Goal 1: Services Are Targeted to Literally Homeless People

The most recent data on homelessness in California come from the Statewide Housing Plan (2005-2007) prepared by DMH and Housing and Community Development (HCD). HCD estimates that on any given day there are 361,000 people homeless in California, or about 1.1 percent of the State’s total population. Of this number, two-thirds are single adults while the remaining one-third are members of homeless families. Approximately 30 percent of California’s homeless population, or 108,000 individuals, are classified chronically homeless.

Counties do not have a standardized methodology for gathering these data, and the information was derived from a variety of sources, including agency counts, community counts, census information, and estimates.

PATH data show that programs in Sacramento overwhelmingly serve literally homeless persons (State average of 82 percent, across providers, 2006 through 2008). Marin County does not report this data in their Annual Report, but based on information gathered from the local

provider, it too serves a literally homeless population. Alameda's numbers do not seem to support the literally homeless population in their data, but when interviewed it was clear that that is the population the Mobile Crisis Team (MCT) were serving.

Outreach is provided by two of the three PATH programs we visited, and members of the site visit (SV) team accompanied PATH staff to observe sites where homeless persons in the streets were contacted. These observations confirm the data that programs focus on serving literally homeless persons. Examples of particularly effective approaches to outreach and engagement include:

- The Marin County PATH CARE Team is a completely consumer-run and staffed program. The Outreach workers have had personal experience with homelessness and many years experience working with the target population. This approach can be a non-threatening engagement strategy for homeless individuals with behavioral health disorders. The workers are able to develop relationships and encourage people to enroll in PATH for services and mental health treatment.
- Alameda County has created a mental health clinic in the community designated specifically to serve individuals who are homeless. An adjunct program funded by PATH, the Mobile Crisis Team (MCT), provides outreach services to the target population. The MCT staff attends the clinic's team meetings to ensure successful transition and engagement in services. This clinic offers multiple strategies to engage individuals experiencing homelessness and serious mental illnesses. While the clinic itself is *not* PATH-funded, it is an important and engaging link to mainstream services for the Alameda MCT PATH team.

Voluntary Performance Goal 2: Active Management and Oversight of the Program

Allocations

California has a strong County DMH system, and as a result the State DMH views itself as a pass through for PATH funds rather than an active participant in the allocation process: California's PATH funds are allocated to a County DMH in 48 participating counties (out of 58). Through a notification process, the counties are given the opportunity to participate on a yearly non-competitive basis. Those that choose to participate submit an application for funding. Upon approval, each county receives an allocation based on a formula used by DMH to distribute all homeless categorical funds. Based on local needs, each county determines which providers will receive the PATH allocation. Table 1 summarizes these allocations

Table 1: California Allocations by County, FFY2009

ID Number	Agency Name	FY 2009/2010 Allocations
601	Alameda County Department of Behavioral Health Care	\$263,554
603	Butte County Department of Behavioral Health	\$80,055
605	Contra Costa County Department of Mental Health	\$138,666
607	El Dorado County Department of Mental Health	\$32,937
608	Fresno County Department of Adult Services	\$330,156
610	Humboldt County, DHHS	\$43,787
611	Imperial County Behavioral Health Services	\$55,723
612	Kern County Mental Health	\$197,381
613	Kings View Counseling Services for Kings County	\$37,975
616	Los Angeles County Department of Mental Health	\$2,048,866
617	Madera County Mental Health	\$36,103
618	Marin County Mental Health	\$73,755
620	Mendocino County Mental Health	\$18,614
621	Merced County Mental Health Department	\$88,138
622	Monterey County Behavioral Health	\$90,268
623	Napa County Health and Human Services	\$46,547
624	Orange County Mental Health	\$490,922
625	Placer County Mental Health and Services	\$41,338
627	Riverside Adult Systems of Care	\$289,604
628	Sacramento County Dept of HHS/MH Division	\$418,227
629	San Bernardino County Department of Behavioral Health	\$447,122
630	San Diego County Mental Health	\$732,806
631	San Francisco County Mental Health	\$544,847
632	San Joaquin County Mental Health Services	\$222,201
633	San Luis Obispo County Mental Health	\$50,862
634	San Mateo County Mental Health	\$146,530
635	Santa Barbara County Mental Health	\$55,896
636	Santa Clara County Mental Health Department	\$243,481
637	Santa Cruz County Mental Health	\$39,300
638	Shasta County Mental Health	\$60,353
639	Solano County Mental Health	\$62,733
640	Sonoma County Mental Health Services	\$62,749
641	Stanislaus County Behavioral Health & Recovery Services	\$152,171
642	Sutter/Yuba Counties Mental Health Services	\$55,814
644	Tulare County Mental Health	\$159,676
646	Ventura County Behavioral Health Department	\$107,329
647	Yolo County Alcohol, Drug and MH Services	\$30,514

Monitoring and Oversight

In the last year, California has had a large turnover of senior staff, including the State PATH Contact (SPC) position. For the most part this position has been filled on a temporary basis until just recently. This has resulted in a reduction in the monitoring and oversight functions at the State level. Site visits have not occurred and are just now being planned for the upcoming fiscal year. However fiscal oversight has remained steady, and for the most part it does not appear that there has been any disruption to the PATH program at the local level.

The State has a comprehensive contract with each County DMH that includes specific language governing the PATH program (linked to the PATH legislation). The contract specifies additional Special Requirements that counties are obligated to follow. They are:

- Grant funds may be used only to provide services to individuals who are suffering from serious mental illnesses or from co-occurring serious mental illnesses and substance abuse disorders and who are homeless or at imminent risk of becoming homeless.
- Grant funds cannot be used by any entity that has a policy excluding individuals due to the existence of substance abuse or that has a policy of excluding individuals from substance abuse services due to the existence or suspicion of mental illness.
- In selecting contract providers, counties are to give special consideration to entities with a demonstrated effectiveness in serving homeless veterans.

The new SPC has been working with PATH for four months and is planning on conducting 8-12 site visits over the next several months. He is reviewing PATH data submitted for the Annual Report and is hoping to coordinate the data collection process so that it is more consistent across the State.

County DMH Management and Oversight

County DMHs, by definition, assume provider network development and monitoring functions on behalf of the State. All three counties we visited recruit providers, provide oversight, plan for behavioral health services in their regions, and monitor the performance of the system and providers. For PATH, this means that the County DMH conducts some or all of the following activities:

- Recruit providers
- Work with providers on strategies to mitigate/end homelessness
- Participate in the Continuum of Care planning process
- Hold regular meetings with providers
- Monitor service delivery (including target population, numbers served, services provided, and outcomes)
- Conduct site visits
- Monitor budgets and expenditures

The County DMHs have the authority and the responsibility to replace providers who are not performing well, or to adjust the service mix to meet changing needs of their regions.

Voluntary Performance Goal 3: Clarity Regarding Data and Reporting

This Goal presents the biggest problem for California. There are several issues with data collection in general and in particular the PATH Annual Report data. The site visit team observed that this may be related to how programs collect PATH data.

Firstly, there appears to be little data collection and analysis regarding the PATH population happening at the State DMH level. The only homeless data seems to be coming from the data collected for the HUD Plan to End Homelessness. The data that is collected from the Annual Report does not appear to be used for any future program enhancement.

Second, Marin County does not report any data, as they state they do not “enroll” anyone because they do not want to scare off the target population. However when the SV team met with the local provider, they received a detailed data set that answered all the questions needed to respond to the questions on the Annual Report.

Finally there is much diversity of terms pertaining to outreach and enrollment. The SPC is finding that there is little consistency across the counties making it difficult to come up with relevant data at the State level. The SPC is looking to the Center for Social Innovation for technical assistance in defining these terms with some specificity.

Enrollment

For two of the three PATH programs, the enrollment percentage is below the national average. This data element shows the number of persons enrolled as a percentage of outreach contacts. Using data from the PATH Annual Report for 2006-2008, the actual enrollment is below the national average of 42 percent in both Alameda (29 percent) and Sacramento (35 percent). In the third county visited (Marin), no data is reported.

We recommend that the State review the data collection procedures at each PATH site and compare actual activity with reported activity. The State can use these observations, and, working cooperatively with the County DMHs and the providers, create specific guidance about how to count, track, and report required data.

Voluntary Performance Goal 4: PATH Providers Use Exemplary Practices

At the State level the planning, development, and use of MHSA funding is commendable. MHSA provides counties funds to establish new programs. These programs are designed to reach out to and engage those individuals and families living with untreated mental illnesses that frequently live on the streets. DMH has created service categories under the Community Services and Supports of the MHSA that allow housing expenditures for individuals who meet program eligibility requirements including being un-served, underserved, homeless, or at risk of homelessness. Full Service Partnerships (FSP) are designed as the most intensive service and support category included in MHSA Community Services and Supports. PATH funds in the counties visited are integrated with this funding stream, and PATH clients have direct access to

this level of service. The FSP programs are intended to provide recovery-focused, comprehensive services that will result in the individuals being served becoming integrated into their communities and accomplishing improved life outcomes. These programs promote a “whatever it takes” methodology in delivering a comprehensive array of services. Site visitors meeting with staff in all three counties heard this principle strongly articulated.

The Alameda program is exemplary for its use of an intensive team approach that provides active outreach and engagement as an entry point for the mainstream system. The Crisis Outpatient Clinic and its PATH Mobile Crisis Team work cooperatively with many providers, including health care, police, and emergency shelters. The longevity and experience of the staff, along with the skill, knowledge, expertise, and diversity of the Alameda team is commendable.

In Marin, staff “bend over backwards” to provide what people need. Outreach is done to the literal homeless population and the provision of practical and necessary survival items is an important part of outreach and engagement. The program is attentive to cultural issues and the all consumer-run and staffed program is an example of this. The commitment of the outreach staff was commendable and the “do what it takes” approach was clearly articulated.

At the State level, the responsibility for instilling and strengthening cultural competencies falls under the direction of the DMH Chief of Multicultural Services. Through this leadership along with a mandate from the Director of Mental Health, California has undertaken a massive effort to establish new standards and criteria for the entire County Mental Health System, including Medi-Cal services, MHSA, and Realignment services as part of working toward achieving cultural and linguistic competence. Each county must develop and submit a cultural competence plan consistent with standards and criteria set in California Code of Regulations. This effort is intended to move toward the reduction of mental health service disparities identified in racial, cultural, ethnic, linguistic, and other un-served/underserved populations.

In all three sites visited, providers described strong collaborations established with their local police departments. In Alameda the Mobile Outreach Team carries a police beeper and can call for police back-up whenever they feel they need an officer to go with them. In Sacramento and Marin, providers related the training they had done with their local police departments and the positive impact it has had on the way mental health clients are treated.

Voluntary Performance Goal 5: Transition to Mainstream Services

The California system has several features that serve to streamline access to publicly funded behavioral health services. The most notable example is the non-silo, integrated approach that California takes with PATH funding. In particular the integration of PATH funding with MHSA funding, the funding stream that has as its basic mandate a “whatever it takes” methodology, gives PATH clients access to all components of the service system developed with this funding, as long as they meet DMH eligibility criteria.

In Alameda a mental health clinic was developed to provide services to individuals who are homeless. This is a “mainstream” service in that it is funded by the MHSA funding stream and is part of the publicly funded behavioral health system in Alameda County. This is a good example of using mainstream mental health services to provide access and ongoing support to persons who are homeless. The partnership between the PATH Mobile Crisis Program and the Homeless Mental Health Clinic is exemplary.

In Sacramento the PATH provider has developed an excellent relationship with the local provider for Shelter Plus Care vouchers. They work together to make the most of the vouchers they have available, and PATH clients move through the application process with as much ease as possible with this type of program.

The State PATH Contact reports that the State under MHSA has made many improvements to the eligibility process for enrollment into the behavioral health system. These changes include reducing barriers for individuals who have a co-occurring disorder by ensuring that they are not being “screened out” of services. In all cases, PATH funds are used for front-end outreach, engagement, and case management efforts to assist individuals to enroll in the system and maintain needed services. The County DMH is participating with PATH contractors to actively ensure that persons who are homeless and have serious mental illnesses are provided with immediate services and support to promote recovery. There seem to be few barriers to mainstream enrollment in behavioral health services for PATH clients who meet DMH criteria.

A number of activities support mainstream housing opportunities:

- State and County DMH use State MHSA funds to leverage HUD funds for housing adults who are homeless through the HUD Continuum of Care Statewide.
- The MHSA Housing Program is jointly administered by DMH and CalHFA. This program blends the mental health services expertise of DMH and the County DMH with the fiscal and housing development expertise of CalHFA to address homelessness for individuals with serious mental illnesses.
- The MHSA Housing Program provides funding for both the capital costs and operating subsidies to develop permanent supportive housing for persons with serious mental illnesses who are homeless or at risk of homelessness, and who are eligible for services under the MHSA.
- The goal of this program is to develop 10,000 units of housing.

Summary and Recommendations

Summary:

1. Mission and Purpose: There is a very close, cooperative, and collaborative working relationship among State, County Mental Health, and PATH program staff. There is a

shared sense of mission and purpose, and creative energy is directed at solving problems for individual clients as well as thoughtful activity at the system level.

2. **PATH Funds:** The State has allocated PATH funds in a formula-driven way to 48 counties. Each county determines the use of PATH funds based on local priorities and needs.
3. **PATH Population:** PATH programs are providing services to literally homeless and at-risk individuals.
4. **Cultural Competency:** The State has put a strong focus on cultural competency and created a statewide training for County and provider staff. The State has mandated the development of a Cultural Competency Plan that meets state requirements. Providers are aware of cultural issues and have developed successful approaches to addressing needs, including providing comprehensive language services and hiring staff with language skills and diverse backgrounds.
5. **Coordination with Continuum of Care Planning:** State and county staff and PATH providers participate in local and State Continuum of Care planning. The PATH program is an integral part of the solution to homelessness in each community visited.
6. **Housing:** The State's commitment to housing for persons with serious mental illnesses, and the strong connections between HUD Continuum of Care systems and PATH helps to ensure that PATH-enrolled clients have access to housing opportunities. The use of the MHSA Housing Program is crucial to the success of these housing efforts.
7. **Mainstream Behavioral Health Services:** Access to mainstream mental health services is ensured in Alameda by the MHSA-funded Homeless Mental Health Clinic. The use of consumer staff in Marin helps to streamline transition from the PATH team to mainstream services.

Recommendations:

1. Compare data reports from the counties and community providers collecting data regarding homelessness. Work to clarify definitions and protocols for counting outreach, enrollment, and transition to mainstream data points; create consistency in reporting methods.
2. Use more frequent site visits and the data collected as an opportunity to make program improvements, which might include clarification of data elements and reporting practices, setting outreach and enrollment targets, etc.
3. Develop a State PATH manual that guides the operation of the program statewide, including policies and procedures, terms, definitions, data, etc.

Recommended TA:

- a. Data collection
- b. Training/ directions regarding terms and definitions used for PATH data collection (State request)
- c. Housing training/subsidies (local level)