



# Mental Health Transformation

An Edited Transcript of the PATH National Teleconference

Sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA)

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## Welcome and Introduction

### *Lynn Aronson*

Hello, everybody, and welcome to our first PATH teleconference of the year. Our topic today is “Mental Health Transformation.” My name is Lynn Aronson. I’m from Advocates for Human Potential (AHP), in Delmar, New York. Along with our colleagues at Policy Research Associates (PRA), we provide technical assistance for the PATH program. I am really glad to be on with all of my friends and peers across the country. I’ll be the moderator for today’s presentation.

We’re delighted to have with us A. Kathryn Power, the director of the Center for Mental Health Services (CMHS); and Dr. Fran Randolph, the director of the Division of Services and Systems Improvement [at CMHS]. We welcome you both.

In addition, we have people on this call from all over the country, including the staff from the PATH-funded service provider agencies and representatives of State and Federal government. Many are listening to the presentation over the telephone, while others are listening via the Internet. Our technology is wonderful. Welcome to all of you and thank you in advance for your very active participation in the call.

The PowerPoint presentations that accompany today’s teleconference may be accessed from the PATH Web site, [www.pathprogram.samhsa.gov](http://www.pathprogram.samhsa.gov). Also, an evaluation form for today’s call was sent with your registration. It is also available on the PATH Web site with other teleconference information. Your feedback is very important to us. It’s used to help us plan future technical assistance and training calls. So, please take a moment after the teleconference to complete it and return it to us. We truly do read them and take them seriously.

At this time I’d like to introduce Dr. Michael Hutner of the Homeless Programs Branch at the Center for Mental Health Services. Dr. Hutner, as you know, is our PATH project officer, and works tirelessly to promote the PATH program within CMHS, as well as to develop more effective ways of delivering training

and technical assistance to our PATH program. Michael, it’s my great pleasure to turn it over to you.

### *Michael Hutner*

Thank you so much, Lynn. It’s a real pleasure to welcome you to this call. This call, I think, is unique in two respects: First, it’s the call specifically for those of us in the PATH audience — that is, State PATH contacts and local PATH-funded providers. So it’s a pleasure to talk to the PATH community, which has a history and long tradition.

Secondly, it’s a great pleasure that Kathryn Power is at this particular conference. It’s the first time in my recollection that we’ve had a center director talking to the PATH audience on a teleconference like this. As Lynn mentioned, the format of this call is, therefore, different. It will be more directive.

Lynn, let me turn it back over to you, and say that I also am looking forward to hearing this presentation. Thank you.

### *Lynn Aronson*

Thank you, Michael. As Michael said, we are extremely fortunate to have both of our presenters on the phone today to give us what I think is obviously the cutting edge in moving mental health forward in this administration. I want to give you a quick introduction of our featured experts. Welcome, again, to our presenters. We thank them so much for taking the time to be with us this afternoon.

The first presenter is A. Kathryn Power, director of the Center for Mental Health Services of SAMHSA. As you know, CMHS provides national leadership in improving mental health systems for all Americans. Among her many other duties at CMHS, Kathryn is responsible for facilitating the transformation of the mental health delivery system called for in the president’s New Freedom Commission on Mental Health, which she will discuss.

Prior to coming to CMHS, Kathryn served for over 10 years as director of the Rhode Island Department of Mental Health, Retardation and Hospitals, a cabinet-level position that reports to the governor. In the mid

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1980s and 90s, she served as executive director of the Rhode Island Council of Community Mental Health Centers. She's been a teacher at both the elementary and secondary levels, and she's been president of the National Association of State Mental Health Program Directors, or NASMHPD, as many of us know it, and has been recognized nationally and locally for her advocacy on behalf of people with disabilities. She has a master's degree in education and counseling and is a graduate of the Toll Fellowship Program of the Council of State Governments (CSG). She is also a captain currently serving in the U.S. Navy Reserve. We welcome her very wholeheartedly to this PATH teleconference.

## PATH: Achieving Its Goals

### *Kathryn Power*

Good afternoon to everyone. I want to thank you very much for inviting me to be a part of this teleconference. I very much appreciate the opportunity to talk with people across the nation involved in our PATH program.

I have two specific goals for my remarks today: The first is to communicate to you my heartfelt admiration for the work that you are doing with persons who have a serious mental illness and who are experiencing homelessness. The second is to help you achieve the potential of the PATH program to transform mental health care for all persons with mental illnesses. I'm going to follow along on the PowerPoint presentation. Now we're going to slide 2.

Homelessness of persons with mental illnesses is a national tragedy. Each night as many as 200,000 persons with a mental illness sleep on the streets or are in shelters. I just came back from the storm in Rhode Island, and one of the things that was the story on the front page of the paper was how many people needed shelter during the blizzard. It was an amazing story that everyone opened their shelters to make sure that no one person was out on the streets in a blizzard.

These individuals represent the most difficult group to reach, the most complex group to treat, and the most in need of renewed hope in recovery. The

PATH program, your program, our program, gives them hope, as well as homes. Research and our own professional experience demonstrate that having a stable home can be a person's critical first step, and, I might add, most critical in terms of their entire life, in accepting and benefiting from treatment. Through your personal efforts, thousands of individuals now are receiving the services they need to regain a life in the community. I believe that you are absolutely wonderful, compassionate, and effective advocates for persons with mental illnesses who experience homelessness. You, as well as the services they receive through PATH, are the basis and the hope of recovery.

Now I'm going to slide 3. On this slide you can see that your success means that we together will have an opportunity to reach out to even more individuals during the upcoming fiscal year. The PATH program is achieving its objective measures of performance, and as a result our program budget has been increased once again. Congratulations.

This year's appropriation includes an additional \$5 million for the program. We can accomplish a great deal with that funding. Why? Because the PATH program recognizes recovery as *the* possibility for persons with serious mental illness. With housing and appropriate support, persons with chronic and serious mental illnesses and co-occurring disorders can leave the streets and can, in fact, lead stable, fulfilling lives. This is the ultimate vision driving all of our efforts at the Substance Abuse and Mental Health Services Administration; a life in the community for everyone.

Slide 4 refers to our famous SAMHSA Matrix. What does a life in the community mean for the people who experience homelessness? This slide shows the SAMHSA Program and Principles Matrix. Charles Curie, the administrator of SAMHSA, says that our matrix is built on the principle that all persons should have the opportunity for a fulfilling life that includes a home, a job, and meaningful relationships with family and friends. These are the ingredients of a life in the community, beginning with a home.

How can we collectively achieve this life for persons who experience homelessness? Look at the box in

the very center of the blue “Programs and Issues” column. You will see the words “Mental Health System Transformation.” This is my job; this is our job here at CMHS. This is the job of the PATH program staff. Transforming our national mental health system for the good of all Americans is one of what we call SAMHSA’s four “redwood” programs. A redwood is a priority program for the investment of our efforts and our resources. Charles Curie coined this term to emphasize a new program philosophy and direction for SAMHSA. Rather than having 1,000 short-lived flowers bloom, he prefers that all three centers within SAMHSA focus on developing a few rich, major, long-lived initiatives with a lasting impact.

Our goal for mental health transformation is to create a system that is truly consumer driven, focused on recovery, and builds a person’s resilience [in order] to face life’s challenges. I believe that the PATH program and each of you involved in the program is absolutely essential to transformation.

Slide 5 is next. What do we mean by transforming our mental health system? The dictionary defines “transformation” as a process, one that changes something in form, in nature, or in function. When applied to a system, transformation implies fundamental change at its very core, not just at the margins. It’s not simply reform or simply change. These major changes will result in new behaviors and in new competencies. Most important, in transformation, new sources of power will emerge. Therefore, in system transformation we look at what we will be able to accomplish now that we were unable to accomplish before.

## A Call to Action: Seeking Roots of Mental Illness

The concept of mental health transformation originated in the report called “Achieving the Promise: Transforming Mental Health Care in America.” If you have not read this report, please request a copy through SAMHSA’s Web site because this report, I believe, is one of the most important documents we have. This report was released in

July 2003. It is a critical assessment of our national mental health system. It describes a system that is fragmented, disconnected, and often inadequate in meeting the mental health needs of Americans.

But most important, “Achieving the Promise” is a national call to action. It looks beyond the flaws of our mental health system to its promise and to its potential for change. It really provides us with the vision of a transformed mental health care system and the guidelines for achieving it.

Slide 6 talks about the six major goals. I’m sure these are all familiar to you, but I want to repeat them just so you have them in front of you as we talk. Americans understand that mental health is essential to overall health. This is a primary goal. There is a reason it is goal 1. This is one that will affect social and cultural change dramatically in America.

Goal 2: Mental health care is consumer and family driven. This one says the individuals we serve should be at the heart of the system, should be at the center of the system, and, in fact, should be making decisions about the services that they receive.

Goal 3: Disparities in mental health care services are eliminated.

Goal 4: Early, appropriate, and relevant mental health screening, assessment, and referral to services are common practice.

Goal 5: Excellent mental health care is delivered and research is accelerated. This goal addresses the gap between current practice and what research tells us is good, evidence-based practice. It takes a very long time to get it into the hands of the practitioners.

Finally, goal 6: Technology is used to access mental health care and information.

The report makes it very clear that addressing the needs of those who are homeless is critical to achieving these goals. The very first goal is that Americans will understand the essential relationship between mental and physical health. We go back to the 16<sup>th</sup> century, when, in fact, the mind and body

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were [perceived as being] disconnected. We have to overcome centuries and centuries and centuries of disconnected thinking. Too many Americans in particular are unaware that mental illnesses are treatable and that recovery is possible. Too many hide their symptoms and deny themselves the treatment that they need. Without appropriate care they can begin a downward spiral of health and well-being. As the report states: “Too many people remain unserved, and the consequences can be shattering. Some people end up addicted to drugs or alcohol, on the streets and homeless, in jail, in prison, or in juvenile detention facilities.” This is the system that we must work together to transform.

Goal 2 of the report is that mental health care will become more consumer and family driven. Under the current system, services often are driven more by bureaucratic regulations than by the needs of people served. The report specifically addresses the plight of persons with mental illnesses who are homeless. They face a host of barriers — that include obtaining stable housing, strong discrimination, weak fair housing enforcement, high costs, and low availability — to achieving the promise emphasized at this point.

On the next slide we quote from the report: “The lack of decent, safe, affordable, and integrated housing is one of the most significant barriers to full participation in community life for individuals with serious mental illnesses.” Today, millions of people with these illnesses lack housing that meets their needs. Why does this tragedy occur when we know that stable housing is critical to recovery? It happens because of the stigma and shame and discrimination against persons with mental illnesses and because the community lacks sufficient understanding and sufficient involvement. It happens because we have a mental health system in desperate need of change.

## Using the Public Health Model

The report “Achieving the Promise” calls for an end to chronic homelessness and recommends that States and communities develop the means to end it. Implicit in this recommendation is that we take a public-health approach to ending homelessness among persons with mental illnesses. Taking a public health approach

is a very different approach, a very great shift, and a change for those of us who have been working in mental health authorities or in mental health service provision.

On slide 8, we talk about the fact that the public health model is a community approach to health. It differs from the traditional medical approach to illness because it does not focus solely on treating sick individuals. Instead, the public health model focuses on protecting the health of individuals by promoting and protecting the health of an entire community. It assumes that the entire community will engage in a continuum of services that can help prevent an illness. This continuum includes promotion of health and prevention of illness. In addition, it includes early intervention, treatment and recovery services, and it also helps reduce or eliminate the spread of illnesses and its consequences. Think about how much homelessness affects public health. When our communities can accept that homelessness is a public health problem, a public health issue, then our communities will understand why we need a public health solution.

On slide 9, we talk about the ripple effects of homelessness. Homelessness affects more than the individual. The consequences of homelessness ripple outward until they affect everyone in the community. As you know, chronically homeless people with mental illnesses are likely to have acute and chronic physical health problems. They are more likely to use alcohol and drugs. They have escalating, ongoing, psychiatric symptoms, and they can, in fact, become victimized and incarcerated with a high degree of frequency. Each of these outcomes places an extremely high burden of cost on a community — and I mean social cost, psychological cost, economic cost, human cost.

Instead of funding better schools, a community can find itself building bigger jails. Its emergency rooms can be overrun with persons needing acute mental health care services, which slows or denies service for others experiencing medical crises. Its parks and its public buildings can become places of refuge for a few rather than [places of] pleasure for many. Thus, a community’s failure to care adequately for the well-

being of its individual members eventually affects everyone.

## Using the Community Model

Now, let's look at the problem from a slightly different perspective: How can we use the public health model to confront homelessness among those with a mental illness? Consider the basic premise of the public health model: It is better to promote health and prevent illness. We already are aware of many factors contributing to mental illnesses, such as physical and sexual abuse or substance abuse. Our community should be using this knowledge to do a better job of eliminating these factors before mental illnesses and their consequences occur.

Families, for example, are the fastest-growing segment among those experiencing homelessness. Children now account for one-fourth of persons without homes. They are extremely vulnerable to the harshest consequences of life on the streets. These children have a much higher risk than housed children of developing physical, cognitive, emotional, and mental problems. They are far more likely to become homeless themselves as adults.

We can decrease homelessness by doing more than helping those who are homeless today. We need to work just as hard at creating community-based programs that can prevent the homelessness of tomorrow by preventing mental illnesses.

The key here is a community approach, which is the keystone of the public health model. Any continuum of service that spans mental health care from mental health promotion through recovery must engage the entire community. It should involve primary health care, education, business, criminal justice, and all of the other organizations that come into contact with persons at risk of developing a mental illness. In other words, it should involve the entire community.

The consequences of mental illnesses, including homelessness, affect everyone in a community. Consequently, preventing these mental illnesses should be a top priority for all community agencies

and not just the mental health system. I'm going to repeat that: Preventing mental illnesses should be a top priority for all community agencies, not just the mental health system. Collaboration among all stakeholders is essential to achieving the promise of a transformed mental health care.

In the report it was stated, "No single goal or recommendation alone can achieve the needed changes. No level or branch of government, no element of the private sector can accomplish the needed change on its own. To transform mental health care as proposed, collaboration between the private and public sectors and among levels of government is crucial."

The Substance Abuse and Mental Health Services Administration, with the Center for Mental Health Services as the lead, has been working intensely over the past year to engage Federal agencies government wide in transformation efforts. This is our community and we are making certain that all agencies with a stake in the mental health of our citizens are involved. We hope that our partnership becomes a model for mental health transformation at the State, regional, and community levels.

## Federal Action Agenda

On slide 11, you will see the Federal partners. Our first priority has been to make a broad-based group of Federal agencies accountable for change. We did this through invitation, through collaboration, through cooperation. An executive team at SAMHSA has been meeting with senior staff members from 20 other Federal organizations to decide how we can respond jointly to the "Achieving the Promise" report. We began with an exhaustive inventory of programs and funding that each agency already had in place. By organizing our inventories around the six goals, we were able to clearly identify ongoing programs that are already supporting transformation. These are the programs that we will maintain and that we will enhance. We also were able to determine where we could collaborate on new initiatives to support transformation.

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The outcome of our efforts is a Federal Action Agenda. Our agenda describes how SAMHSA and its partners will respond to each of the goals and recommendations in the report. It identifies specific steps that we can take during the next year to motivate, facilitate, and compel change at the State, community, and individual levels. We will develop new agendas addressing new issues as we make progress, and we're already beginning to take a look at next year's Federal Action Agenda.

The current Federal Action Agenda is a working document within SAMHSA, which has been approved by the secretary of the HHS [Health and Human Services]. Several activities specifically relate to improving mental health care for those who are homeless. For example, SAMHSA is partnering with HRSA, the Health Resources and Services Administration. We are partnering with the U.S. Department of Housing and Urban Development [HUD]. We're partnering with the Department of Veteran's Affairs [VA]. We're partnering with the Interagency Council on Homelessness [ICH]. Together, we are funding a \$35 million initiative to end chronic homelessness among people with mental and substance use disorders.

In addition, we have also joined with HRSA to fund and evaluate a dozen different service delivery grants designed to improve access to both behavioral and primary care services for those individuals who are chronically homeless. The evaluation will examine how well each delivery system performs in improving health outcomes for consumers. One of our overarching goals, as well as the goal of the report, is that we accelerate this research to promote recovery.

We also are taking actions that address mental health care less directly for persons who are homeless. As an example, we are working diligently to promote the use of evidence-based practices. These are interventions known to produce positive results for consumers, and they should be known to and adopted by you and by all of the communities with whom you interact, by practitioners, by everyone in the system, and others serving consumers who are homeless.

On slide 12, we talk about our implementation tool kits. A few months ago, we made six evidence-based practice implementation kits available through our Web site. These are the practices that are listed. More widespread use of these practices, such as integrated treatment of co-occurring disorders, can help to decrease or prevent homelessness. Up to one-half of those with a mental illness who are also homeless will have a substance use disorder. Integrated treatment offers them their greatest hope of recovery and for leaving their life on the streets. These are just a few of the actions the Federal community is taking to confront homelessness among those who have mental illnesses.

## Some Recommendations

Now, I'd like to discuss how the PATH program fits within transformation. As I mentioned earlier, the PATH program and each of you involved with it, I believe, is essential to transformation. The PATH program is a superb means to achieving transformation. Its mandate, its characteristics, and its culture embody the most fundamental characteristics of transformation. What are those characteristics? They are (1) a community-wide approach to mental health, (2) a continuum of coordinated services, and (3) [an approach that is] consumer driven and focused on recovery. You are the perfect example of what can happen in a coordinated system in achieving transformation.

As PATH program members, your mandate is to build bridges between persons who are homeless or at risk of becoming homeless and the services and supports they need for a life in the community. These services include primary and mental health care, housing, supported employment, and transportation. When these services are woven together, they become a lifeline for individuals who find themselves adrift. Supports include access to basic subsistence and necessities, particularly SSI and Medicaid benefits by eligible individuals.

The PATH program is uniquely structured to promote mental health transformation because it brings a community together to provide a continuum

of services. Under your mandate you can build collaborations among any number of agencies providing essential services. As you go about your work, please reach out to even more community groups to help sustain your activities. Go beyond seeking support from direct service providers. Become transformation agents in talking about what mental health transformation means.

As we all know, preventing or ending homelessness among those with mental illnesses should be everyone's concern. We can help others realize this by pointing out how their involvement supports their own self-interest. Hospitals have a stake in ending homelessness because it will reduce the demand on emergency and acute medical care. Criminal justice has a stake in ending homelessness because it will reduce the number of persons who cycle in and out of jails and prisons. Just as homelessness creates negative ripple effects on a community, preventing or ending homelessness among persons with mental illnesses creates positive ripple effects.

Most important, I believe the PATH program is incredibly essential to transformation because it is focused on recovery. I can't tell you how important it is that recovery becomes the focus of transformation. It has not yet taken hold in many jurisdictions across America. You become the agents of transformation because, in fact, you understand that a system needs to be focused on recovery. A recovery-focused system sees each individual as a unique human being, and not just a person with a categorical disability. It focuses on a person's overall health and works to provide the comprehensive services that each person needs to promote recovery. It accepts that recovery, and not disability, should be the expectation of services. This emphasis on recovery is the very foundation of transformation. Why is that? Because when recovery is the common, recognized outcome of mental health services, the stigma surrounding mental illness will be reduced. Therefore, we will reinforce the hope of recovery for every individual with a mental illness.

On slide 13, we talk about the fact that research and practice demonstrate that the individuals we serve can be engaged in services, can accept and benefit

from treatment, and can remain in stable housing with appropriate supports. The fact that they have learned to survive on the streets with very little food and under extreme living conditions speaks to their strength and their resilience. There is enormous power in these traits that we can harness to help them find hope in their own recovery.

I hope that you will use the PATH program to be leaders in transformation, to advocate for greater community involvement, to build more bridges between and among community groups, and to spread the message of hope and recovery. Don't just share this message with persons who are homeless. Share it with all of those who could contribute to their recovery. I will be personally following your efforts and looking forward to your continued successes.

One of the greatest achievements that I believe I had as a mental health commissioner was overseeing the PATH program because the program focused on those individuals who are most vulnerable. I am honored to be a part of CMHS, which now has responsibility for the PATH program, and I really want to thank you for all of your inspirational work, for your tremendous commitment, and for your leadership in serving those with mental illnesses who experience homelessness.

On behalf of all of them I continue to support the tremendous amount of work that you're doing, and I really offer my best wishes and congratulations for continued success in this program. Now I'd like to be able to entertain any questions.

## Questions and Answers

### *Lynn Aronson*

Thank you very much, Kathryn. Our first question comes from Cynthia Adams.

### *Cindy Adams*

It's Cindy Adams, from Willimantic, Connecticut. My question has to do with the goals for the transformational model, the system. The word "prevention" is not articulated in those goals, but it certainly is implied. When we're looking at early

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mental health screening, assessment, and referral, I'm wondering to what extent the courts or the judiciary can be a partner also in what we're doing. We find that a number of the homeless have been through the court system, have slipped through the cracks somewhere, are repeat offenders, or left to their own devices.

### **Kathryn Power**

I'm going to answer your very cogent question on a number of levels if I could. The first is you're correct in that the issue of prevention, though it was not highlighted, could certainly be understood as a part of each of the six goals. We've actually spent some time thinking about that, because, as you know, the Center for Mental Health Services is not just involved in looking at treatment, but also looking at prevention. So what will be coming out in the early spring will be mental health State incentive grants for transformation. States will be able to apply for infrastructure grants. We, in fact, have included in that description our belief that mental health promotion should be looked at by the States in terms of a transformation agenda. So we are certainly taking the commission report to another level.

We at SAMHSA are promoting the notion that if we truly care about individuals who have a mental illness or who may become mentally ill, we have got to be talking about prevention. In addition to that, we have a stake in what is known as the strategic prevention framework. That is another grant program States can compete for that focuses on building information on risk factors and protective factors. We're going to give more credit to those States that have some connection between their mental health transformation efforts and their strategic prevention framework efforts, and we're trying to make sure that States know that prevention includes not just substance abuse prevention, but mental health promotion and mental illness prevention. So those are some of the ways on the Federal level we're trying to get at this.

### **Cindy Adams**

Wonderful.

### **Kathryn Power**

But your question relative to engaging the judiciary is, I think, extraordinarily important. One of the things that I find on a regional level, on a local level, and on a State level is that if you can find an individual within the judiciary — a particular judge, a particular advocate, and the attorney general — they have tremendous influence with each other. We found, as I know you know, in Rhode Island, one local judge who became the champion of understanding the issues related to mental health and then understanding the issues as they related to homeless persons. He became the advocate with his peers because influencing the judiciary, I think, means you have to have someone who understands how the judiciary learns and how they gain new knowledge and the way in which they apply it then in their behavior in the courtroom or throughout the criminal justice system.

I would certainly encourage that in terms of a connection for those of you involved with the PATH program. Go and talk to someone and say 'Would you become engaged with us in that discussion?' because I think that's one of the ways in which we can influence the judiciary in particular, but any other component parts of the criminal justice system the same way.

### **Lynn Aronson**

I have an Internet question. "Kathryn, can you tell us more about the specifics of the Federal Action Agenda and how that might benefit people who are homeless and have serious mental illness? What does that mean for the individual States and communities?"

### **Kathryn Power**

That's a great question, and I'm really sorry that I don't have a copy of the Federal Action Agenda to hand to you. It's going to be coming out very shortly. It will really be some very specific steps across agencies that will delineate what we are currently working on. It's actually a very living document. We have a list of activities that each of the 21 agencies has agreed to and we're working that list. Even as we speak, I have another meeting set up with the Federal partners later this week to talk about their

achievements, their sets of activities towards the goals.

I'll just give you a good specific that's in the Action Agenda: One of the things that we agreed to work on across the Federal agencies was the relinquishment of children into State custody in order to receive mental health services. Everyone across all of the Federal agencies agreed that that was a very serious issue and we needed to look across all of the agencies at any policy barriers we had, and then how we would influence our State counterparts in terms of trying to help parents not have to give up custody in order to have access to mental health services. That's an example of what you might see in the Action Agenda.

One of the things that I think would specifically benefit people who experience homelessness is that around goal 3 we have some specific activities in eliminating disparities of care. We know that one of the tragic facts, frankly, of homelessness is that people of color make up a majority of this population. We have been working with our Federal partners to make sure that we get the right kinds of diagnoses and they receive effective treatments and state-of-the-art treatments when individuals are seeking that particular treatment and that the intervention is appropriate for them.

We found there is a gap between the individuals presenting for care and those individuals providing the care. That gap is often based on cultural competence or, frankly, cultural incompetence if I can use that word. But there is a huge gap between what individuals need and the kinds of practices and the kinds of people that are able to deliver them.

We are working on developing a national strategic workforce development plan that we believe will provide States and communities with the methods and standards and benchmarks and performance measures for what we hope will be a group of culturally competent services, including those that would be available for serving persons who experience homelessness. We're going to be sharing that information with academic institutions and behavioral health accrediting bodies. Of course, what we want to do is create a mental health workforce that is capable

of delivering culturally competent services and, hopefully, as I said before, goes beyond the mental health workforce, but have those practices embedded in other social service agencies and other agencies that provide services to people with mental illnesses.

One of the other areas that we're doing some work on in the action plan, and CMHS is taking the lead on this, is to develop individualized plans of care. We think that that's an appropriate way to focus on the consumer as the center and the controller of their own care and making sure that this is a consumer-driven system. I think that's particularly helpful and hopeful for individuals who have homelessness in their history. We're giving back to those individuals the power to articulate their dreams, their hopes, their aspirations, and work on a plan that will help support those dreams and hopes and aspirations, which, of course, would include housing, as well as other services. Those are just two of the examples of what we're working on in the Action Agenda.

### **Robert Snarr**

This is Robert Snarr, with the Division of Mental Health in Utah. I was wondering if there were any plans from CMHS or SAMHSA to help motivate agencies to work together in helping to end chronic homelessness. Any funding alternatives or any other issues that may be available for the States?

### **Kathryn Power**

Obviously, you know that we're going to be able to increase the number of PATH grants over the next year because we have some additional money in 2005. I think that's because of the great work that you all are doing. Congress pays attention to what you're doing, I might add, and I think that's why we have an increase in the amount of Federal dollars. Specifically, I mentioned those mental health State Incentive Grants as an opportunity for States to sit down and make sure that the PATH folks are at the table when, in fact, mental health transformation is going to be.

Hopefully, the States are going to apply for mental health transformation grants, and in that way it helps to get the homeless as a priority population within mental health transformation. So, I am encouraging

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States, particularly you at your level, to get to your State mental health director and prevention director to say if you're going to apply for mental health State Incentive Grants for transformation and for State prevention grants. You will be assured that you can say to the Federal authorities that are responsible for homelessness that there is an expectation that services to homeless individuals will be a part of transformation. If it's coming from you at the community end, hopefully, there will be an opportunity then to look at recombining some of the Federal grants that are available.

We really have just, I think, touched the tip of the iceberg across our Federal partners in the kinds of resources that we're discovering are available. The VA is a perfect example. The Veteran's Administration has made a commitment to transforming all of their mental health services. That means for the 30 percent or so of individuals who are homeless in any one night that are veterans, the Veteran's Administration is now becoming much more outreach focused, evidence-based practice focused, and wants to be partners at the table with those who are serving individuals who are homeless. So your VA regionally is a very important partner.

We're just beginning to discover what might be available on a Federal level, and hopefully we're going to encourage that you have that same level of discovery as you get together with State and community and local folks about what kinds of resources are available.

Finally, once and for all, we're not hiding from the fact that individuals with psychiatric disorders and mental illnesses should only be cared for by the mental health system. Those days are over. Now, it has to be a collaborative, collective effort. We are going to continue to award specialized grants for services for individuals with substance abuse disorders and who are homeless, so there will be some grant opportunities coming up in the future for those particular populations, and we're going to be continuing our work with HUD, of course. They are a major partner at the Federal partner level on the chronic homelessness initiative.

So I would look for those grant opportunities, which, by the way, are now going to be totally Web-based. They're not going to be in the Federal Register anymore. It's going to be [www.grants.gov](http://www.grants.gov) where you can get this information at your fingertips.

### *Lynn Aronson*

I have an Internet question. This comes from Marie DiBianco. Kathryn, she wants to know "Is there work going on in presumptive eligibility for persons who are homeless at the national level?" She knows that there are some demonstrations that have been going on, and she wanted to know the status.

### *Kathryn Power*

Well, I think I have the expert sitting right next to me.

### *Michael Hutner*

There are things going on at the national level. One of those, and I think, Marie, what you were referring to, probably were the HOPE grants. These are grants that the Social Security Administration has been funding to promote outreach. It's primarily outreach to people who have serious mental illnesses. We at the CMHS level have a long-standing commitment to address that absolutely grievous issue of people who are currently disabled and who would be, therefore, eligible for SSI benefits, but are not currently getting them. Our approach generally has been, again, as Kathryn has mentioned, that even though it's disability at the moment, it's recovery in the future, with recovery and employment as the goal. We see those twin concepts not as separate, but as very much together. Even though the framework of eligibility is disability, our goal and emphasis is recovery.

Secondly, we have had a number of superb products, which will soon be coming to your attention. First is a manual for case managers. We expect that to be out within the next two months. And when that happens, like before, we'll be certainly alerting you. That explains for the case manager what the best ways are to assist applicants who are homeless and have serious mental illnesses. We're putting a lot of emphasis on training. You will be hearing soon about the possibilities of our providing that training.

We also, by the way, are producing another superb product, a curriculum for trainers that trainers in turn can use in training case managers.

There's a third opportunity. As you consider the use of your PATH funds for this next time, it ought to be consistent, very much, as Kathryn has mentioned, with transformation, about thinking about the possibilities of using PATH resources to assist applicants. As Kathryn has mentioned: collaboration. I would hope that any approach to assisting people with serious mental illnesses who would be eligible would be in collaboration with such agencies as Health Care for the Homeless and hospitals and jails who have a stake in reducing that cycling and the reappearance of the people we're assisting, and, for that reason, it is in their self-interest also to provide resources to assist in getting people eligible.

### **Jerome Roberts**

Kathryn, this was a pleasant conference to attend. It's always great to hear that the Federal government has recognized the work that individual nonprofits or CBOs [community-based organizations] are doing in an effort to dwarf this onslaught of issues that confront us every day. I'm calling from Shelter for the Homeless in Stamford, Connecticut. This is a local shelter, which serves about 600 different people every year. It was interesting to hear that there are going to be a number of grants that are coming forward. What I wanted to know, though, is there going to be an increase in funding to [current] participants in the PATH program? Also, will there be money to assist these programs in receiving other services from programs such as Social Security for consultative examinations or areas like that to access mainstream resources?

### **Kathryn Power**

Jerome, I want to thank you for your work and thank you for your comments. I appreciate you paying attention to my comments. Are you asking whether or not the current grantees will have an increase in the amount of money that comes to them? Was that your question?

### **Jerome Roberts**

Yes.

### **Kathryn Power**

I believe that there is no plan for an increase in the current grantees because the distribution is done through a formula that is based on the amount of the nation's population that lives in urbanized areas. The share that each State gets is based on an application of that formula. So whatever amount you get, every State gets at least the baseline and then you get an increase above the baseline based on the State demographic, etc.

### **Michael Hutner**

This year, as you mentioned before, Kathryn, we're fortunate because, thanks to the good work of everyone on this phone call, the appropriation for States has increased.

### **Kathryn Power**

What about Connecticut?

### **Michael Hutner**

Connecticut will receive more than \$700,000, nearly a 10 percent increase over last year. Of course, the State then decides how those funds will be distributed.

### **Kathryn Power**

Connecticut will receive over \$700,000 and then the State will decide how it's distributed, but that's actually good news in terms of an increase for Connecticut. I think the second question you had was would there be opportunities to have some additional resources or some training in terms of making sure that there's connectivity across some of the other Federal agencies. We're closely looking at that in terms of opportunities for getting information out to you from the Federal Action Agenda as we learn more about consultations with agencies like SSI, looking at those eligibility criteria, putting those on the table with our other Federal partners, and trying to figure out a way that we can get a great impact for individuals with mental illnesses and a greater impact

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for individuals who are homeless. So I hope that when you get a copy of the Federal Action Agenda you will read it and then let us know from a local perspective what are some of those barriers, what are some of those policy issues, and what are some of those practices that we might discuss at the Federal level that we could hopefully change that would be helpful to you.

### **Lynn Aronson**

Thank you very much, Kathryn. We actually have time for just one more question. It's an Internet question, from Jean Robinson in King County Mental Health: "How is SAMHSA working with CMS [Centers for Medicare and Medicaid Services] to move Federal regulations to be more consistent with SAMHSA transformation goals? For example, recent rulings from CMS no longer allow for Medicaid savings to be used for non-Medicaid persons or services. Many of the innovative services required to address the needs of homeless, mentally ill persons are not Medicaid modalities and most homeless persons are not on Medicaid."

### **Kathryn Power**

That's a very powerful question and a very important question. Our working relationship with CMS is extraordinarily important to both agencies, particularly important to CMHS, particularly important to SAMHSA. We have a lot of work that we are doing. We have a lot more work to do with CMS. They are a major partner in terms of being a payer for Medicaid and Medicare services. I know that there are some significant barriers and there have been some significant changes in the application of some of the CMS rules, etc. I think that we have a working agenda with CMS relative to making sure that individuals with serious mental illness are not left out in the cold, and we continue to work those through a variety of programs. We're talking about that in terms of Medicare Part B. We're talking about that in terms of individuals with substance abuse and mental health disorders. I mean we have a whole series of topics that we put on our list of items to discuss with CMS.

So I'm very aware that it is a tremendous concern. We want to be advocates for this population, and we

will continue to be advocates for this population in terms of services. They are a very large agency. I'm a very small agency. We do what we can do in terms of raising the issues with them, working to some conclusion on those issues, and we will continue that. I will pledge to you that those issues that we have within our control, those issues that are most significant in terms of policies and grant programs and funding mechanisms and eligibility criteria, those are all extremely important. Trying to walk through them and decipher them and work through a very clear, collaborative agenda with CMS is high on my priority list. So I will take specifically the issue that you've raised and put it on my list.

I know that eligibility is a huge issue, and I know that Medicaid is under its own constraints about not wanting to expand its program, and so we have to kind of balance the needs of individuals who should be funded under Medicaid and CMS constraints relative to the growth of their program. So we'll continue to walk with them, and I hope that every PATH program has a relationship with their state Medicaid agency because Medicaid is a player at the State level. We can do certain things at the Federal level, but Medicaid is a player at the State level, and the Medicaid plan for support of services is really decided by your state Medicaid authority with, of course, guidance and input from the Federal authorities, so I think we can help each other and work with each other across both the local and State and Federal lines.

### **Lynn Aronson**

Kathryn, thank you very, very much. On behalf of all of my peers in the PATH program I really want to take this opportunity to thank you for spending the time with us and for a wonderful presentation and for answering the questions that my colleagues presented to you. I'm sure that each one of them was thrilled to be able to have this time with you.

### **Kathryn Power**

I'm very appreciative of the time with you, Lynn, and with everyone in the network. I continue to consider the PATH program to be a star, and you are all out there as stars and compassionate individuals and

advocates. Frankly, we couldn't do our work without you, and so thank you very, very much. I look for the opportunity to do this again in the near future.

## Keeping PATH on the Cutting Edge

### Lynn Aronson

Thank you very much. I'd now like to introduce our second presenter, Fran Randolph, director of the Division of Services and Systems Improvement at CMHS. In this capacity, Fran oversees the Community Support Programs Branch; the Children, Adolescence, and Families Branch; and the Homeless Programs Branch. Prior to becoming division director, Fran was the chief of the Homeless Programs Branch, and we all knew her very well in that capacity.

Previous to her Federal career, Dr. Randolph also worked at the National Association for State Mental Health Program Directors, providing technical assistance on co-occurring disorders to State mental health authorities. She has conducted research on housing and residential services needs for persons with mental illness, on the community-based service needs of elderly persons with mental illness, and on outcome measures in services research. In addition, Dr. Randolph has been an evaluation consultant and has conducted evaluation seminars for the International Association for Psychosocial Rehabilitation Services, and for the Federal government. We certainly all know her for her work on the Access Program. She has numerous publications. Dr. Randolph received her master's and doctorate from the School of Public Health at the University of California in Berkeley. It is my great pleasure to now open the presentation up to Dr. Fran Randolph.

### Fran Randolph

Thank you very much, Lynn, for that nice introduction. Kathryn Power gave us a very nice overview of mental health transformation and how the PATH program is playing a very central and crucial role in that transformation. The purpose of my presentation to you today is to talk about ways in

which you, as PATH-funded providers, can continue to support mental health transformation in your States.

Please refer to slide 2. The fundamental premise behind mental health transformation is that if everyone actively pursued achieving the six goals and the 19 recommendations that are outlined in the commission's report, "Achieving the Promise," we would be successful in creating a world where adults with serious mental illness and children with serious emotional disturbances are able to live, work, learn, and participate fully in their communities. We would also be successful in reducing homelessness for persons with serious mental illnesses.

Slide 3: Let me say at the very beginning of this talk, I strongly believe that a mental health system can be innovative, can be competent in providing effective services, but it is not seriously engaged in mental health transformation if it does not also focus on the needs of homeless persons with serious mental illnesses. To say you're doing mental health transformation and you are not also focusing on homeless people with serious mental illness, I would call into question whether this is truly mental health transformation.

What are we doing at the Federal level? Well, slide 4 summarizes some of that information that Kathryn already talked about in her presentation, but let me just go back and summarize it very, very briefly. This is really just a small level of activities. There is so much more that is going on that we really don't even have time to talk about. You heard Kathryn talk about the Federal Action Agenda. Although it's not yet published, the work on this Action Agenda is continuing. The exciting thing about this agenda is that you've got 21 Federal departments and operating divisions that have committed themselves to making serious changes in their operations in order to support mental health transformation at the Federal, State, and local levels.

You also heard about the Mental Health Transformation State Incentive Grant Program. We can't provide you with too much detail right now. This is an infrastructure program and not a service

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program. The program announcement will appear shortly. It will be on our Web site, but it will be a significant resource to assist your States in developing an infrastructure for mental health transformation.

Kathryn also talked a little bit about some of the technical assistance materials that we are developing, like the standards and protocols for individualized plans of care. We're also developing some guidance materials to help the States in developing their comprehensive plans for mental health transformation. We're also continuing to expand our inventory of tool kits and implementation resource kits. She talked about the six that are available right now on our Web page. We've also started to develop others. We are currently working now on one related to supportive housing and effective practices for people who are mentally ill who are elderly.

Finally, another important thing that we're doing at the Federal level is we're developing, I'd like to call it, a transformational newsletter. But it's more like a briefing. This will be available on a frequent basis from the SAMHSA Web site. It will include very valuable information about what we are doing here at the Federal level around transformational activities, and also we'll talk about what some of the States are doing and what some of the communities are doing around transformation. So it is an opportunity for us to keep the country abreast of some of the really exciting activities that are going on around mental health transformation.

Now, slide 5 speaks to the leadership that we think you have an opportunity to take at the State and local levels as PATH-funded providers. Each of us has a leadership role in transforming the mental health system and on impacting other systems that provide critical services and support to persons who are homeless with serious mental illness. I want to challenge each of you to embrace the New Freedom Commission report, "Achieving the Promise," and use it to leverage the good work and reputation of your PATH program. To start with, there are three things that you can do.

One: Re-examine your PATH-funded program. Really, look at it critically.

Two: Based on your re-examination, refocus your efforts so that the PATH program is at the cutting edge of transformation in your State and community.

Three: Re-energize your State and local commitment to addressing homelessness by linking PATH to mental health transformation.

What does this mean? Let's go to slide 6, "Re-examining Your PATH program." I challenge you to look critically at your PATH program, and ask yourself: Is it viewed by others as a model for mental health transformation? Does it reach and serve those in greatest of need through active outreach engagements? Does it actively involve seeking people on the streets, in shelters, emergency rooms, and in jails? Does your program have a recovery-oriented focus? Does staff still use such terms as "chronic," or do they believe that consumers are resilient and can recover and reflect that language in their discussions? Are your services consumer driven? Does your program hire consumers as service providers? Is the service and treatment planning process driven by what consumers need? Are consumers involved in the planning and evaluation of services? Are clients' preferences and personal goals and aspirations actively honored and promoted? What about cultural competence? Can you say that your program provides services that are culturally competent? Is staff trained to understand and provide for the needs of the consumers in ways that are sensitive to who they are? Does your program implement services and treatments that are considered to be evidence-based or promising practices? For example, does your program provide peer support activities? Do you use the assertive community treatment model for case management? Do you provide integrated substance abuse and mental health services for persons with co-occurring disorders? If you don't provide those, are you at least making referrals to agencies that provide these kinds of services and treatments that are evidence based?

The second thing was to refocus your efforts. You've done a careful review of your PATH program. Now there's an opportunity to refocus your efforts. How do you do this? One way is to start by examining each of the six goals and deciding which of these goals you're

going to implement. You can use the FY 2006 PATH application process as an opportunity to propose new ways to use these funds that will support the implementation of mental health transformation.

The PATH legislation encourages transformation. It allows every State and its local partners to determine how PATH funds will be spent. It provides lots of flexibility in the types of services that can be funded under the legislation. And it also encourages consumers to be active participants in recovery and in planning and in delivery and in the evaluation of services.

So PATH is a wonderful mechanism to use in helping you move your State along in terms of homelessness and mental health transformation, and we are at a time right now, an opportune time because you will be receiving your PATH application information and be going through the PATH application process. So this is a wonderful, wonderful time and opportunity for you to begin to think about what you can do to change.

Slide 8 talks about re-energizing your State and local commitment to addressing homelessness by linking PATH to mental health transformation. PATH can be a key resource as States are redirecting funds for different purposes and, possibly even, to different providers. It is important that those of you who are involved with PATH-funded services help to shape and drive these discussions. For example, new or redirected PATH funds could be used at the State and local levels for testing innovative approaches. By using PATH funds to test innovations and then getting the mainstream mental health system to adopt these innovations, you can see how PATH funds can play a powerful role in helping States and communities in the transformation process.

Slide 9: I don't have a lot of time to talk about how you can use PATH funds to implement all of the six goals and all of the 19 recommendations that are in the commission's report — although I think we need to do that at some point, and I'll talk a little bit later on about an activity that we're going to be doing that will actually produce that kind of information. But right now what I want to do is talk very briefly

about what you can do to implement at least a couple of these goals, just to give you some ideas, some suggestions.

Slide 10 is goal 2: Mental health care is consumer and family driven. This means, as Kathryn mentioned, that what we're talking about here are services driven by the needs of the people, and not by the bureaucracy. The commission recommends that each homeless person with serious mental illness has an individualized plan of care. The purpose of these plans is to give consumers and providers opportunities to create meaningful partnerships that will improve service coordination, make informed choices, and ultimately achieve and sustain recovery. PATH-funded agencies should all have protocols for developing individualized plans of care that are consumer centric and coordinated across different programs and agencies. As PATH-funded providers, you should be offering choice even when resources are scarce. It means that you have to be extraordinarily creative and, all of you — because you operate in environments where resources are very, very scarce — being able to offer a choice. This is precisely the time when innovation and creativity are most needed. So, using small pilot programs can lay the groundwork for expansion and larger changes as transformation moves ahead and new resources become available.

Under goal 2, the commission also recommends that each State create a comprehensive mental health plan to coordinate services. The purpose of these plans is to facilitate partnership among the Federal, State, and local governments in order to improve the use of existing resources. Every State will have a chance to apply for a Mental Health Transformation State Incentive Grant that will support the development of a comprehensive planning process. Now, whether a State is initially successful in obtaining a grant or not doesn't make a difference because we expect that many States will proceed with their own planning process. Because these plans will have a powerful impact on the mental health service system, it is extremely important that each of you look for an opportunity to be a part of that planning process in your State, to make certain that homelessness issues are addressed. It's also important that consumers and

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family members in your State have key roles in the planning and implementation process.

## Considering the Cultural Factors

Another goal that offers opportunity for you as PATH providers is goal 3, and Kathryn talked a little bit about this too: Disparities in mental health services are eliminated. This means that everyone, regardless of race or ethnicity or geography, gets access to services. People who are homeless with serious mental illness, as you all know, are also disproportionately African American, and we're also seeing that there's a growing number of Hispanics that are a part of the homeless population, and, certainly, there are other areas of the country where Native Americans are a large part of the homeless population.

One aspect to addressing disparity is providing culturally competent services. As PATH providers, you should be embracing cultural competence at all levels of an organization, from administrative all of the way down to front-line staff. You should make certain that your agencies provide training on cultural competence. You also need to build in accountability at all levels, implementing measures of success and time into success of the consumers. You should provide incentives when good outcomes are achieved and require those who did not demonstrate cultural competence to make those improvements.

Sustainable change could be supported through system-level mandates that require agencies to meet performance standards in order to be funded. At a provider level, cultural competence should be considered in the hiring process. Training should begin at staff orientation and be reinforced with ongoing training and supervision. Yes, there is no one way or one correct way to achieve cultural competence, but the will to learn and engage all members of the community is an important start.

## Tracking Your Progress

Slide 12 talks about goal 5, which is [that] excellent mental health care is delivered, and research is

accelerated. This means that you are implementing services that are deemed effective, that have a strong knowledge base that supports their effectiveness. There has been a significant amount of research and evaluations that have been conducted since the late 1980s. We now know a lot more about how to provide effective services than we have ever in the past. A good reference source is the *Blueprint for Change*, which came out about a year ago, which I'm certain you all have, but if you don't, remember, it is available by contacting Policy Research Associates.

In terms of effective practices, we already know a lot about how to provide successful outreach and engagement. We know about how to create housing with wraparound services, supported housing so that we can be successful in keeping people in their housing. We know about effective case management models, like the assertive community treatment. We know that there are good ways to organize the way we provide case management. We know how to provide effective prevention services and self-help and peer support programs. We know about the need to integrate mental health treatment in primary care settings, in jails. We know about the importance of trauma-informed, trauma-sensitive services. Effective strategies for getting consumers on SSI and SSDI was this last point that Mike talked about. There are some manuals that are going to be coming out that have been demonstrated to be very effective in getting clients on SSI and SSDI. As PATH-funded providers, you really have an obligation to figure out how you can get your program to adopt these effective practices.

On slide 13 you've got a list of the current implementation resource tool kits available on the Web site. They're going to be published. There are 1,000 copies of each of the tool kits that are going to be available to people. Then they're going through another revision. They're going to be translated into DVDs and CDs, and so on, so that they'll become extremely useful and accessible to all of you and an important resource. So I urge you to take advantage of these resources.

I want to end this presentation by telling you of a few things that we are doing at CMHS to help the

PATH community transform the mental health system for people who are homeless with serious mental illnesses. If you turn to slide 14, first of all, we're organizing a PATH Transformation Workgroup. This is a work group of people from the State PATH contacts, from PATH-funded providers, and others, who are going to come together. I have committed resources in my division to support these meetings, where we bring people together to critically look at how PATH can be even more successfully involved in mental health transformation.

The second is that we are committing resources from the Homeless Programs Branch to develop some guidelines that State PATH contacts and PATH providers can use to help support and enhance you all in doing mental health transformation. Obviously, a lot of the work from the Transformation Workgroup will feed into these guidelines. This report will be disseminated broadly to all of you.

### Help in the Field

Another thing is that technical assistance is being made available from the PATH TA Center, and from PATH project officers. We are offering technical assistance consultants who will provide TA to you over the phone. The consultants will be available to talk with you about your ideas for transformation. There are also some additional, but modest, resources available for implementing some of these ideas. So we're trying to create a forum for you so that you can talk to people at the Federal and national levels and to folks who've been spending all of their time and energy on mental health transformation. In this way we could begin to explore some of your ideas and you could get some information from them that would help to advance your thinking and, hopefully, to advance the work that you're doing around mental health transformation in the PATH program.

Last, we have, too, the PATH Web site, which has a lot of information and will continue to have more and more information about mental health transformation.

Finally, I offer you my own e-mail address, [fran.randolph@samhsa.hhs.gov](mailto:fran.randolph@samhsa.hhs.gov), and invite you to e-mail me if you have some other ideas and suggestions

about what we can be doing at the Federal level to help you at the State and local levels be more effective around mental health transformation.

In my final slide, I want to close by saying thank you on behalf of Kathryn and myself for giving us this opportunity to talk to you about mental health transformation. I know that you are already doing many of the things that we talked about today; however, I know, as you do, that as long as there are unmet needs and areas that impede care for homeless people with mental illness, we are not doing enough to achieve the promise. The only way we will be successful in making mental health transformation happen is if we all work together and with a common vision. If we do this, we can achieve the goal of mental health transformation, which is this: a future when everyone who is homeless with a mental illness will recover. A future when homelessness and mental illnesses are detected early. A future when everyone who is homeless with a mental illness at any stage of life has access to effective treatment and support, essentials for living, working, learning, and participating fully in the community.

Thank you very much for this opportunity to talk to you this afternoon. Now, Lynn, I will entertain questions.

### Questions and Answers

#### *Lynn Aronson*

Thank you so very much for a wonderful talk. I'll take this opportunity to do an Internet question, from Dave Schultz in Minnesota. He's asking, "Can PATH funding be used to hire staff on an ACT Team if the person sees more than homeless persons, but the whole team sees many more homeless persons?"

#### *Fran Randolph*

David, I'm going to actually turn this question over to Mike Hutner, who I'm quite certain has been asked that question multiple and multiple times.

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## **Michael Hutner**

The principle behind the use of PATH funds is that it be proportionate, that the amount of funding should be proportionate to the persons who are PATH eligible who are served. So, yes, you can use PATH funding to pay part of the salary, X percent, of one or more individuals who, from other funding sources, will be supported for serving people who are not PATH eligible.

## **Lynn Aronson**

I have an Internet question: “My State isn’t getting an increase this year. Are you suggesting that we redirect PATH funds toward larger mental health transformation goals? Are you suggesting that our commissioner is going to be encouraged to ask us to do this? What would happen to the outreach and other services that my PATH providers are now delivering?”

## **Fran Randolph**

That’s an excellent question. Let me just say one thing. First of all, PATH legislation, which is very, very broad, pretty much defines what the PATH funds can be used for. When we talked about thinking about how you can use your PATH resources, even if you’re not getting an increase, what we’re saying is ‘Look at what you’re currently doing right now.’ If you are funding services, the same services that you’ve been funding for the last 20 years, I don’t even know if PATH goes back that far, but say the last 20 years, look very critically at what you’re doing. Is this what you want to be funding? Does it meet your standards and our standards for something that’s considered to be transformational, that is effective, that is really meeting the needs of the population?

We’re basically saying ‘See this as an opportunity.’ Transformation is really an opportunity to move your State and your community through a process of positive change. So we don’t want people to be threatened and to see this as being something that’s negative, but to really see this as being a really important opportunity to improve the way we work with people who are homeless with serious mental

illness so that we can have a huge impact on this problem.

## **Lynn Aronson**

Thank you, Fran. Let me take the question from the Internet. This is again from Marie DiBianco. It says, “Hello, Fran, I do like the slides in your presentation; however, for about half of the States, PATH has been stagnant and represents less of the service budget. Could some strategies be focused on this issue?”

## **Fran Randolph**

I’m sorry.

## **Lynn Aronson**

I think the question you’re asking, I may be interpreting Marie’s question wrong, but I think what she’s asking is if some of the new strategy is focused on moving the program to be less stagnant and to become a bigger part of their service budget.

## **Fran Randolph**

I think if I understand the question correctly she’s basically saying she wants to know if she can take PATH resources and use them for mental health transformation.

## **Lynn Aronson**

Right.

## **Fran Randolph**

As long as it honors the legislation. As long as it’s consistent with the legislation I would say yes, absolutely.

## **Lynn Aronson**

I’m just going to let you know that I did get a response back from Dave Schultz, and Michael, this is directed towards you. It says, “Thank you, Michael, for your answer. I’ll follow up with you since I see ACT is a way to transform Minnesota’s mental health system in serving homeless programs.”

**Brad Munger**

I'm calling from Rock County Community Support Program, in Janesville, Wisconsin. We are fortunate to be able to use PATH funds to partly fund our Shelter Plus Care Program. It's enormously helpful, but what we're noticing is that we're getting a lot more medically ill people that are out there on the streets that we're picking up that need additional medical services. Of course, many times, without some presumptive eligibility, we're running into some barriers with getting them treatment for such conditions as chronic asthma or heart disease and that kind of thing, hypertension. I was intrigued by goal 6 of the transform system; using technology to access mental health care and information. But also, I think we need to look at how we could use the technology resources at our disposal for addressing some of these medical problems. I'm wondering if you've run across any innovative, unique uses of technology to address the mental health issues and/or the medical issues?

**Fran Randolph**

Brad, thank you very much for that question. That is a really, really good question. Goal 6, which talks about the creative use of technology, applies very well to homeless people, especially those living in rural settings. We have part of CMHS actually looking very specifically at identifying a variety of different technologies that can be proven to be successful and effective. I don't have any information right now to share with you on that, but it is extraordinarily challenging and we're also curious to find out what the States are going to propose when they submit applications to see how many of them are actually going to propose to even address that particular goal, because I think our technology out there is still somewhat limited.

Although, interestingly enough, I come from a public-health background, and we were looking at the "barefoot doctors" as a technology that was used in the past — where you have people who are not necessarily physicians, but they are trained as medical practitioners who go into underdeveloped countries and provide medical care and so on. So there are

obviously some things that have been done in the past that might also bear some possibilities in the future.

Because you've got a lot of medically sick, physically sick people in addition to their mental illness and substance abuse, one of the things that mental health transformation is all about is partnerships and collaborations. We recognize that we cannot do this alone; that we have to partner with hospitals and primary care settings. We need to develop training among physicians so that they better understand the mental health needs of our population and are willing to collaborate with us in partnership and providing also health care services, so mental health transformation is very much in support of those kinds of activities. I hope that answered your question.

**Brad Munger**

Yes, thank you. It does. I might mention that some of the things, the pretty basic things, that we've been using with some of these folks: just simply having access to, and having staff trained in how to use, a blood pressure cuff, or we've gotten a couple of these pulse oximeters to measure oxygen concentration in people that are having trouble breathing, and some of these things where you just go around and take some vital signs and use that in conjunction with our nursing staff to determine if somebody needs follow-up medical care or perhaps an emergency room or urgent care visit.

**Fran Randolph**

That's a beautiful example of kind of what I was talking about is some of these medical models where people are trained or cross-trained to provide services where there are no professionals available to provide those services. I think what you're doing is really very appropriate.

**Lynn Aronson**

I have one more Internet question: "You mentioned PATH protocols for developing individualized plans of care. Could you tell us where we can find an example of these?"

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## **Fran Randolph**

The individualized plans of care, the model for comprehensive planning, all of these kinds of products are things that are currently under development at CMHS. They're not being done in my division, but they're being done in another division, so I don't know what the timeline is for having them completed. But I do know that they're out there purposely to help the States so that they can implement or work with their communities in implementing individualized plans of care protocols.

I also know that there are others. I know that there are some States out there that are also working on this. It's very interesting. Kathryn goes around the country talking a lot about mental health transformation. She has totally inspired States and communities not to sit and wait for the Federal government to do something. So there's a tremendous amount of creative stuff, and I wouldn't be surprised if somebody out there is also doing some developmental work on this area. If that's the case I'm pretty certain we're going to find out about it, and we'll hopefully become an inventory for all of that interesting technology, and then we'll be able to make it available to all of you.

## **Lynn Aronson**

Thank you. That's terrific, Fran.

## **Coordinator**

We do have another question. Teo Ramirez, you may ask your question.

## **Teo Ramirez**

I work at the King County Jail in Seattle, Washington. One thing that I've come across is that there are a lot of people that are mentally ill but don't fall under "seriously mentally ill," which, without housing and treatment, I know they fall under the non-Medicaid program, but they're taking that off over here as well. Are there any future plans for these people that have mental illness that's not currently active, like bipolar or anxiety, to the point where they can't work?

## **Fran Randolph**

That's a good question. You basically want to know, "Is there anything that we're going to be doing at the Federal level, or have thought about doing at the Federal level, to expand our target population beyond persons with serious mental illness?"

At this point in time I have to say no. It's primarily because of the fact that the people who are with serious mental illness often consume so much more of the available resources. Therefore, traditionally, historically, we really have focused primarily on that population, but if you look at goal 1, mental health transformation focuses on everybody. In fact, we've had a lot of discussion on this because we've wondered whether this changes the mandate of CMHS, and maybe over time it will. Because in order to really address stigma and to change the way people think about mental illness, you really are talking about working with the entire public, the entire country, around that. So at this point in time there's nothing immediately planned, but I would say keep in touch.

## **Lynn Aronson**

I do have a follow-up question here on the Internet. It's again from Dave Schultz, but it's on a different topic. Dave writes, "I'm concerned about the future of HUD and the housing needs of those who are homeless and have a serious mental illness. As you talk about transforming our mental health system, what can be done by SAMHSA to uphold and expand HUD's critical role in assisting with housing our people in need?"

## **Fran Randolph**

We have HUD as a member of the Federal Action Plan. We also are aware of the fact that there has been some pre-release of information around the FY 2006 budget for HUD that doesn't look very good and could potentially have a profound impact on our population. We at SAMHSA recognize that housing plays an essential role in people's recovery from mental illness. I think that Kathryn and I, both of us, are really committed to working with HUD on chronic homelessness issues, as well as other initiatives in 2005 and beyond. We can't really speak to what's

going on in the 2006 budget because it hasn't been published, and that will happen in early February. But when it is published I will tell you, David, that we are going to be looking very carefully at what's going on there and looking at what the potential impact is on our population. It will probably be very much a part of some of the discussion that we are having with the Federal partners on the Action Agenda.

**Lynn Aronson**

This will conclude the formal part of today's program. I'd like to remind everyone to please complete and return their evaluation form. As I said, we take these very seriously. And visit the PATH Web site at [www.pathprogram.samhsa.gov](http://www.pathprogram.samhsa.gov), for other resources. I also want to invite you to join us on Thursday, March 3<sup>rd</sup>, for our next teleconference. The topic for that one will be "Establishing Collaborative Relationships with Jails."

Finally, thank you to our featured presenters, Kathryn Power and Fran Randolph, to Michael Hutner of the Homeless Service Branch, and to Margaret Lassiter and our colleagues at Policy Research Associates, who have helped enormously on the Internet access to this presentation. I thank you all very much. With that, our call is concluded. Thank you all for participating today. □