PROGRAM INFORMATION:

Program Title:	Projects for Assistance in Transition from Homelessness (PATH) Program--Kings View PATH Services	**Provider:**	Kings View Behavioral Health Services Inc.
Program Description:	Click here to enter text.The PATH Program delivers services to adult consumers with serious mental illness (SMI) and/or co-occurring substance use disorders who are homeless or at imminent risk of becoming homeless. The program serves as a front door for clients into continuum of care services and mainstream mental health, primary health care, permanent supportive housing, social services, and the substance use disorder services system. Click here to enter text.	**MHP Work Plan:**	2-Wellness, recovery, and resiliency support 1–Behavioral Health Integrated Access Choose an item.
Age Group Served 1:	ADULT	**Dates Of Operation:**	August 26, 2008 - Current
Age Group Served 2:	Choose an item.	**Reporting Period:**	July 1, 2018 – June 30, 2019
Funding Source 1:	Com Services & Supports (MHSA)	**Funding Source 3:**	Other, please specify below
Funding Source 2:	Medical FFP	**Other Funding:**	SAMHSA PATH Grant, Client Reimbursement

FISCAL INFORMATION:

Program Budget Amount:	$410,777.00	**Program Actual Amount:**	$ 368,669.32
Number of Unique Clients Served During Time Period:	304		
Number of Services Rendered During Time Period:	374		
Actual Cost Per Client:	$1212.72		

CONTRACT INFORMATION:

Program Type:		**Type of Program:**	
Contract Term:	July 1, 2015-June 30, 2020 (three-year base contract and two optional one year extensions)	**For Other:**	Outreach Component – Outreach, Engagement, Linkage, Case Management and Housing-Related Services; Mental Health Component - Specialty

Mental Health Treatment and Supportive Housing Service

Renewal Date: July 1, 2020

Level of Care Information Age 18 & Over: Enhanced Outpatient Treatment (caseload 1:40)

Level of Care Information Age 0- 17: Choose an item.

TARGET POPULATION INFORMATION:

Target Population: Seriously Mentally Ill who are at imminent risk of homelessness or currently homeless

CORE CONCEPTS:

• **Community collaboration:** individuals, families, agencies, and businesses work together to accomplish a shared vision.
• **Cultural competence:** adopting behaviors, attitudes and policies that enable providers to work effectively in cross-cultural situations.
• **Individual/Family-Driven, Wellness/Recovery/Resiliency-Focused Services**: adult clients and families of children and youth identify needs and preferences that result in the most effective services and supports.
• **Access to underserved communities:** Historically unserved and underserved communities are those groups that either have documented low levels of access and/or use of mental health services, face barriers to participation in the policy making process in public mental health, have low rates of insurance coverage for mental health care, and/or have been identified as priorities for mental health services.
•**Integrated service experiences:** services for clients and families are seamless. Clients and families do not have to negotiate with multiple agencies and funding sources to meet their needs.

Please select core concepts embedded in services/ program:
(May select more than one)

Individual/Family-Driven, Wellness/Recovery/Resiliency-Focused Services

Community collaboration

Cultural Competency

Access to underserved communities

Please describe how the selected concept (s) embedded :

Individual/Family-Driven, Wellness/Recovery/Resiliency-Focused Services --- The at imminent risk of homelessness or actual homeless community member/family is asked if we can be of any assistance to them. We are striving to work in collaboration with them so their definition of a happy, meaningful and productive life is supported and achieved If they describe a service or resource that we can provide or provide linkage to, then we advise them that we can assist them if they would like. If the community member/family invites us to participate in their efforts to achieve their happy,

meaningful and productive life, we do so in ways that build on what is already working for them. We are looking for and expecting to find the resiliency/wellness that is innate in everyone. We strive to amplify these characteristics or traits that occur in them.

Community collaboration --- Continuing from above, we will either provide these services directly or link them to other persons or agencies that provide the support they are asking for. Community member/families are not turned away, rather we consider ourselves the "right door for them to come to" bringing them into Kings view staffed services or linking them to another agency that will assist them in achieving their goals. We also work in collaboration with other agencies to identify and find community member/families in need and to link them to the proper services if they are interested. (i.e. FMCoC Home Team outreach events, Annual County-wide count, Navigator's Meeting).

Cultural Competency --- is translated at KV into a spirit of Cultural Humility. Given the complexity of multiculturalism and its real presence in Fresno County's at imminent risk of or homeless population, it is beneficial to understand cultural competency as a process rather than an end- product. Understanding culture as an intellectual and academic construct does not necessarily equip Behavioral Health staff to serve others effectively.
From this perspective, competency involves more than gaining factual knowledge — it also includes our ongoing attitudes toward both the community members/families that we engage with and *as **well as ourselves***.
As noted above… we must be conscious of and **humble about** our knowledge and understanding (or lack of knowledge and understanding) as we enter and perhaps are invited to further participate in their world.
Competency applied is not just knowing about, it is rather knowing and "being with" the community member/families that we serve. Since the 1990's many researchers and behavioral health staff have called this Cultural

Humility. Cultural Humility is one construct for understanding and developing a *process-oriented approach* to competency. Many experts conceptualize cultural humility as: The ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to that community member/family.

This interpersonal stance incorporates a lifelong commitment to:

- *self-evaluation and self-critique* (we are never finished — we never arrive at a point where we are done learning),
- *redressing the power imbalances in the community member/family-helper dynamic* (The community member/family is the expert on his or her own life, symptoms and strengths. The helper holds a body of knowledge. One holds power in scientific knowledge, the other holds power in personal history and preferences. They are equal partners with different knowledge to share),
- *developing mutually beneficial* (All must collaborate and learn from each other for the best outcomes),
- *non-paternalistic/hierarchical clinical and advocacy partnerships* (**develop partnerships of equal partners with those we serve and people and groups who advocate for others)**

Summarizing: It is Self-evaluation and Self-critique, Redressing the power imbalances in the client/helper dynamic, developing mutually beneficial non-paternalistic/hierarchical clinical and advocacy partnerships with all communities, but specifically Rural Communities on behalf of the community members/families of defined populations that live there.

Access to Underserved Communities--The socio-economic group called the homeless or those at imminent risk of being homeless have only existed since the early 1970's. Since then, they have been historically unserved and underserved with documented low levels of access and/or use of behavioral

health services, facing barriers to participation in the policy making process in public behavioral health, with no or low rates of insurance coverage for behavioral health care, and/or have not been identified as priorities for mental health services. This has led to service delivery that has been coercive, traumatizing, demanding that these community member/families become asymptomatic of their SUD challenges before they can receive services or housing, removing them from their housing for having symptoms of their SUD and/or COD issues, and Knowing this, Kings View PATH staff work to introduce, engage and to build on-going participation of the homeless or at risk of being homeless community member/families in Fresno County in their own social/culturally based wellness and recovery process and perspective. This occurs over time, it is episodic-long-term and person centered. The dignity and respect of the community member/family is valued, upheld and affirmed by the field staff and those doing work at the program office site when they visit. We use recovery oriented COD services that recognize functioning with symptoms is what everyone does and that is want we expect them to do also. Housing is dependent on their functioning and not on their symptoms. The Client will continue to evolve a tell us what they need and want in managing all their challenges.

PROGRAM OUTCOME & GOALS

- Must include each of these areas/domains: (1) Effectiveness, **(2)** Efficiency, **(3)** Access, **(4)** Satisfaction & Feedback Of Persons Served & Stakeholder

- Include the following components for documenting each goal: (1) Indicator, **(2)** Who Applied, **(3)** Time of Measure, **(4)** Data Source, **(5)** Target Goal Expectancy

1. Reduce incidents of incarceration for consumers on probation.
2. Reduce incidents of inpatient hospitalizations for consumers enrolled in the program.
3. PATH will outreach to 350 homeless mentally ill consumers
4. Reduce incidents of homelessness for consumers in the program.
5. PATH will enroll 200 consumers in the Outreach Component and enter them into the HMIS system. The Mental Health Component will be provided up to 30 consumers at a given time.
6. Successful program completion at 65% in compliance with the state average.
7. 80% of Consumers will report satisfaction (Positive Score) with Agency Services
8. 80% of Consumers will report satisfaction (Positive Score) with Accessibility of Services
9. 80% of Consumers will report satisfaction (Positive Score) with Life Functioning as an Indicator of Effectiveness

The Fiscal Year 18-19 Quality Workplan Summary was developed to track and report progress towards goals met and to assess performance for the identified indicators. Please see QWP Below.