Wyoming PATH Program Manual

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Introduction

The Projects for Assistance in Transition from Homelessness (PATH) Program was authorized under the Stewart B. McKinney Homeless Assistance Amendments Act of 1990. PATH is a federal formula grant that the Substance Abuse and Mental Health Services Administration (SAMHSA) administers and distributes annually to each state, the District of Columbia, and five U.S. territories. States and territories determine how to administer PATH funds based on their communities' needs.

PATH funds services for individuals who are experiencing or at risk of homelessness and have a serious mental illness. PATH providers specialize in reaching, engaging, and advocating for those who are most vulnerable, and deliver critical services that mainstream mental health programs may not provide.

PATH Population

While certain federally funded homeless assistance programs serve any individual who is experiencing homelessness, PATH specifically supports those who are experiencing homelessness and have a serious mental illness.

Individuals who are experiencing homelessness and serious mental illness face multiple challenges as they navigate systems that are often complex, confusing, and unable to fully meet their needs. They may lack access to quality and culturally responsive care, insurance, or transportation to services. They may have untreated mental health disorders or negative service system experiences that make them mistrustful of providers. Compounding these challenges is the trauma, marginalization, discrimination, and racial trauma that these individuals faced before they lost their housing and during homeless episodes. The PATH Program seeks to fill the gaps in this population's access to treatment, providing a nontraditional, outreach-based model that meets individuals where they are and provides flexible services to address their needs.

Black, Indigenous, and people of color (BIPOC) experience homelessness at disproportionately high rates, with structural, institutional, and interpersonal racism affecting the safety, economic mobility, and housing stability of these communities. For example, while Black individuals represent 13 percent of the general population in the United States, they represent over 40 percent of those experiencing homelessness (Olivet et al., 2018).

To effectively serve the PATH population, providers must commit to understanding the impact of racism and racial trauma and strive to provide culturally responsive care, recognizing the ways in which various forms of racism contribute to increased rates of homelessness in BIPOC communities. Individuals who feel that they do not receive culturally responsive care are less likely to continue to engage in services (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014), and providing culturally responsive care is therefore a central component of an effective PATH program.

PATH Eligibility and Enrollment

To be eligible to receive PATH services, an individual must meet these conditions:

- be experiencing homelessness or at imminent risk of homelessness; and
- have a serious mental illness, with or without a co-occurring substance use disorder.

Of those who meet the above criteria, PATH providers should prioritize those who are literally and chronically homeless.

Note, individuals who do not have any form of identification are eligible to receive PATH services if they meet the eligibility criteria listed above. Once enrolled in PATH, the PATH provider can and should support the individual in obtaining an ID and other vital documents.

Eligibility is determined by provider agency staff observations and assessments. Wyoming PATH Program's operational definitions related to PATH eligibility are as follows:

Chronically homeless: A residential status for individuals with a substance use disorder, mental health disorder, co-occurring substance use and mental health disorder, physical disability, or developmental disability who have been continuously homeless for a year or more or who have had at least four episodes of homelessness in the past three years.

Co-occurring disorder: An individual who has an identified independent diagnosis of at least one serious mental illness and a substance use disorder.

Deliberate interactive assessment: Includes the formal process and form where the PATH provider works directly with the person experiencing homelessness to evaluate whether the person qualifies for PATH. The provider may conduct the assessment "on the streets" or in an office.

Eligibility: Individuals who receive PATH-funded assistance and services must be adults who are (a) experiencing homelessness or at imminent risk of homelessness, and (b) experiencing a serious mental illness or co-occurring disorder. PATH prioritizes the most

vulnerable individuals who are literally and chronically homeless, including veterans. An *enrolled individual* is a *PATH participant*.

Engagement: Officially begins with the deliberate interactive assessment between the participant and PATH staff to evaluate whether or not the person qualifies for PATH.

Enrollment: An individual who meets the PATH eligibility criteria is enrolled in PATH when the provider agency opens an individual case for that person.

Imminent risk of homelessness: An individual at risk of homelessness may be in the following situation(s) with no future housing arrangements planned: Living with another individual and not listed as a tenant/owner/responsible party member; Living in a condemned building; Received an eviction notice or has not paid rent or utilities which may result in eviction notice; Living in a time limited temporary or transitional facility; or Discharged from a healthcare or criminal justice institution.

Individual experiencing homelessness: An individual whose primary residence during the night may not be suited for human habitation; a temporary living accommodation including public and private facilities (i.e. emergency homeless and domestic violence shelters); or transitional housing.

Serious mental illness (SMI): Adults with SMI refers to persons age 18 and over; who (1) currently meet or at any time during the past year has met criteria for a mental disorder – including within developmental and cultural contexts – as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.), and (2) display functional impairment, as determined by a standardized measure that impedes progress towards recovery and substantially interferes with or limits the person's role or functioning in family, school, employment, relationships, or community activities.

Substance use disorder: Occurs when the recurrent use of alcohol, drugs, or both causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Since clinicians typically diagnose serious mental illness in those 18 years of age and older, PATH programs should primarily serve adults. Transition-age youth (16 – 18 years old) who meet PATH eligibility requirements may receive PATH services where appropriate.

The process of enrolling an individual in PATH services includes the following steps:

- Provider completes eligibility screening
- Provider determines that the individual is eligible for PATH services

- Individual expresses interest in receiving PATH services
- Provider starts a PATH record for the individual

Outreach and Engagement

One of the most important services offered by PATH grantees is outreach to people experiencing homelessness. *Outreach* is the process of *actively seeking out and engaging with* individuals who are potentially PATH eligible. Those who are eligible for PATH services may not independently seek services, which makes the process of active outreach and engagement crucial. As a result, PATH emphasizes *active outreach* by seeking those who may need services rather than waiting for individuals to request services. The Wyoming PATH Program defines outreach as follows:

> *Outreach includes face-to-face interaction with individuals who are experiencing homelessness and SMI. Outreach is conducted in places where people experiencing homelessness sleep or frequent. Outreach requires regular and multiple contacts to build a trusting relationship and engage people eligible for PATH services.*

During outreach, providers will inevitably meet individuals experiencing homelessness who don't have a serious mental illness and therefore are ineligible to receive PATH services. Providers should be familiar with other community programs and resources, provide information on these alternatives, and make referrals as appropriate.

Throughout the process of outreach and engagement, providers should assess individuals for PATH eligibility and explain the program's services. Once enrolled, individuals are eligible to receive comprehensive PATH services.

Principles of Effective Outreach and Engagement

The following principles should guide outreach and engagement efforts (McMurray-Avila, 1997; U.S. Interagency Council on Homelessness, 2019):

- Friendly, nonthreatening approach

- Provider brings services, resources, and supports to individuals rather than waiting for individuals to seek out services
- Provider makes repeated contact over time to gradually build trust and rapport
- Engagement of those who are reluctant to accept or suspicious of help
- Prompt response to individual's basic survival needs
- Provider assesses individual's overall needs and tailors services to meet those unique needs
- Provider offers tools and resources to reduce harmful behaviors
- Patience in motivating individuals to engage in services
- Variable times for outreach, including nonscheduled contacts
- Team approach to outreach
- Respectful and responsive to the beliefs and practices, sexual orientations, disability statuses, age, gender identities, cultural preferences, and linguistic needs of all individuals
- Includes staff who are racially and ethnically representative of the population served
- Includes staff with lived experience of homelessness and recovery
- Ongoing training for all staff in topics of equity, cultural competency, and cultural humility
- Regular data analysis to identify inequities across race, ethnicity, gender, and sexual orientation
- Data inform changes to outreach and engagement efforts to achieve equitable outcomes

Tailoring Outreach to Rural Areas

Conducting outreach to those who are experiencing homelessness in rural areas can be particularly challenging due to the geographic isolation and the general lack of resources such as soup kitchens, day shelters, and libraries that are more common in urban areas. The following list provides strategies for conducting outreach in rural areas.

- Ensure all team members understand the needs of the target populations.

- Identify at least one person who has the trust and respect of the target community to foster relationships with them (for example, a peer who has experienced homelessness).
- Provide essential survival resources as part of outreach efforts (for example, sleeping bags, camping gear, and food).
- Develop relationships and partner with agencies that engage and work with those who are experiencing homelessness or who are at risk of homelessness (for example, the park service, police department, sheriff, libraries, transportation authorities, hospitals, criminal justice institutions, community action programs, and fast-food outlets).
- Make connections with staff members at local convenience, hardware, liquor, and grocery stores and laundromats, and routinely check in with them as part of a regular outreach route.
- Identify faith-based efforts to assist those experiencing and at risk of homelessness and check in regularly with them (for example, food pantries, meal programs, and clothing resources).
- Leave your business card with all contacts so they can easily connect with you.
- Distribute information about PATH to potential participants during the annual Point-in-Time count.

Outreach Safety Guidelines

The following list provides general safety guidelines for conducting outreach (Kraybill, 2002a). The guidelines apply across outreach services that take place in various locations—shelters or drop-in centers, parks, camps, vehicles, city streets, or public spaces such as libraries and bus or train stations. It's important to discuss any additional guidelines or policies with your supervisor and team. As you review and consider these guidelines, it's also important to remember that our implicit biases can impact whether we view situations as safe or unsafe.

- Let your supervisor know where you will be.
- Always carry business cards and identification with you.
- Inform collaborating agencies of your presence.
- Introduce yourself and inform people of what you are doing and why.

- Avoid exacerbating conflict when engaging with someone who doesn't agree with what you are doing.
- Conduct outreach in teams of two. Do not conduct outreach activities alone unless your supervisor provides prior approval.
- Do not approach those who are giving signals that they do not want to interact.
- Avoid criticizing your partner in public while conducting outreach. Always present yourselves as a team.
- Wear casual, comfortable clothing and shoes.
- Avoid carrying valuables.
- If you notice illicit activity taking place, leave the area without drawing attention to yourself or others.
- Maintain confidentiality with every individual you meet.
- Do not accept gifts from individuals.
- Do not give or lend money to individuals.
- Do not accept or hold any type of controlled substance.
- Avoid entering individuals' cars, homes, or any enclosed area.
- Tell individuals approximately when you will be back and where they can reach you.
- Give individuals your business card.
- Develop a contingency plan with your partner and supervisor for worst-case scenarios or dangerous situations.
- Inform your supervisor of any unusual developments.
- In case of an emergency, call or have another individual call 911. Do not separate from your partner unless you feel that staying will increase your danger.

Relational Stages of Outreach and Engagement

Outreach and engagement are the process of coming alongside someone who is experiencing homelessness and related health and social concerns, and sharing the journey in a way that leads to healing, wholeness, and community stability. The

following phases of *relationship* provide a framework for conducting outreach and engagement activities (Rennebohm, n.d.).

Approach: Making a Connection

The approach phase involves observation and introduction. It's helpful to spend time discreetly watching how a person acts, how they relate to others, what kind of space they need, and how they seem to be experiencing their environment and responding to the world. Careful observation helps shape an introduction. One might pass by with a nod or greeting or introduce oneself in some manner. The key is to begin as someone who cares, and define your role more specifically as the relationship develops and trust grows. It's also important to recognize the impact of your implicit biases and remember the importance of cultural humility as you strive to make a connection.

Companionship: Developing the Relationship

At its simplest, companionship means sharing a little of the journey with another—standing, sitting, or walking with them, or listening to them and hearing their story. Companionship may include suggesting possible ways to assist them, going with them to a destination, or arranging for another individual to accompany and help them.

Partnership: Enhancing Motivation and Linking

The partnership phase of outreach and engagement involves providing information, enhancing motivation, and introducing the individual to others who can help or assist. In partnering with others such as peer support specialists, medical providers, social service programs, and family members, a widening circle of care develops that the individual can rely on for support and care. Effective community engagement includes ensuring that partners and programs reflect and respect the community to which the individual belongs and with which they identify.

Mutuality: Supporting Wellness and Stability

In the mutuality phase, we recognize each other as fellow citizens and community members. The worker continues to encourage the participant to make use of appropriate resources and supports them in becoming a stable part of the community. In time, the relationship comes to fruition and reaches closure.

PATH Services

Providers can use PATH funds to provide an array of services, and should prioritize adults who are literally and chronically homeless for these services. Here is a list of allowable PATH services and their definitions, according to SAMHSA and the Wyoming PATH program.

Reengagement: The process of reestablishing interaction with PATH-enrolled individuals disconnected from PATH services to reconnect the participant to services based on the previously developed case management or goal plan. Reengagement must occur after enrollment and before project exit.

Screening: An in-person process where the provider makes a preliminary evaluation to determine a person's needs and how PATH services can address them.

Clinical assessment: A clinical determination of the participant's psychosocial needs and concerns.

Habilitation or rehabilitation: Services that help a PATH participant learn or improve skills needed to function in a variety of daily living activities.

Community mental health: A range of mental health or co-occurring services and activities provided in noninstitutional settings to facilitate an individual's recovery. Note that this category does *not* include case management, substance use treatment, habilitation, or rehabilitation, as they have their own specific definitions.

Substance use treatment: Preventive, diagnostic, and other services and supports provided for people who have a psychological or physical dependence on one or more substances.

Case management: Customized to the needs and wishes of each individual participant, case management generally takes place face-to-face. PATH case management assists participants, as appropriate, to plan and obtain the following:

- Housing in the community, community mental health and substance use treatment, primary health care, recovery services, and other resources.

- Services relating to obtaining and maintaining housing including daily living activities, peer support, personal financial planning, obtaining identification and other vital documents, transportation, habilitation and rehabilitation, prevocational and vocational training, and housing.
- Income support services and income support such as housing assistance, food stamps, supplemental security income benefits, payee services, and other services and resources as appropriate.
- The Wyoming PATH program expects PATH case management to include no less than one hour each week of interactive activity with each person enrolled in PATH. Individuals needing significant face-to-face interaction receive intensive case management, often daily and generally no less often than weekly, for one or more months until the individual is well-established in housing.

Residential supportive services: Services that help PATH-enrolled individuals acquire and practice the skills necessary to live in and maintain residence in the least restrictive community-based setting possible.

PATH-allowed housing expenditures: SAMHSA limits PATH housing expenditures to **20 percent** of total federal PATH expenditures, and limits PATH housing-related expenditures to the following categories:

- **Housing moving assistance:** Matching PATH participants with appropriate housing situations. Expenditures made on behalf of PATH participants to meet the cost of establishing a household. These may include costs such as rental application fees, furniture, furnishings, and moving expenses, as well as small, reasonable expenditures to satisfy outstanding participant debts identified in rental application credit checks that would otherwise preclude successfully securing immediately available housing. Rarely, programs use these funds as a small portion of rent to leverage other resources.
- **Housing minor renovation:** Services or resources provided to make essential repairs to a housing unit to provide or improve access to the unit and eliminate health or safety hazards. Providers should use these funds with discretion.
- **One-time rent for eviction prevention:** One-time rental payments made for PATH participants who are at imminent risk of eviction without assistance and who qualify for this service based on income or need. An individual or family may only receive this assistance one time and may not receive this assistance if the provider has previously paid their rent through any source of funds. Providers should use these funds with discretion.

- **Security deposits:** Providing funds to PATH participants who are in the process of acquiring rental housing but lack assets to pay the first and last month's rent or other security deposits required to move into housing.
- **Housing eligibility determination:** Determining whether an individual meets financial and other requirements to enter public or subsidized housing.

SOAR

SAMHSA's SSI/SSDI Outreach, Access, and Recovery program (https://soarworks.samhsa.gov), commonly known as SOAR, assists children and adults with applying for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits. To receive SOAR assistance, individuals must be experiencing or at risk of homelessness and have a serious mental illness or medical condition, with or without a co-occurring substance use disorder. Navigating the application process for SSI and SSDI can be challenging. Having a SOAR case manager increases access to these important benefits to support recovery.

The Wyoming PATH program requires providers to have at least one PATH-funded staff member trained in the SOAR process and providing SOAR services. PATH providers should offer SOAR services to any PATH participant who does not receive SSI or SSDI or does not have a reliable source of income. New PATH providers who need to complete SOAR training can register for online courses (https://soarworks.samhsa.gov/online-courses). PATH staff members should complete SOAR training within two months of starting their position.

PATH providers must report all SOAR information in the SOAR Online Application Tracking system (https://soartrack.samhsa.gov/login.php).

SAMHSA's SOAR Works website provides more information about the SOAR model. For information about SOAR in Wyoming, contact Wyoming's SOAR State Team Lead (https://soarworks.samhsa.gov/states/wyoming). The State Team Lead can answer questions, help PATH staff complete SOAR training, and connect interested staff members with a cohort with whom to complete SOAR training.

PATH Referrals

Since PATH providers cannot deliver the full scope of services needed by those experiencing homelessness and serious mental illness, it is critical to connect with other agencies and programs in the community and make effective referrals. A *referral* occurs when a PATH provider helps a participant get services from another provider that doesn't receive PATH funding. Referrals may also occur internally within the PATH provider's agency. If PATH doesn't fully or partially fund the staff member providing the service, then SAMHSA considers the service a referral.

SAMHSA (2021) uses the following terms and definitions to describe PATH referrals:

Community mental health referral: Active and direct PATH staff support on behalf of or in conjunction with a PATH-enrolled individual to connect to an appropriate agency, organization, or service that stabilizes, supports, or treats people for mental health disorders or co-occurring mental health and substance use disorders.

Substance use treatment referral: Active and direct PATH staff support on behalf of or in conjunction with a PATH-enrolled individual to connect to an appropriate agency, organization, or service that offers preventive, diagnostic, and other services and supports for individuals who have psychological or physical problems with use of one or more substances.

Primary health or dental care referral: Active and direct PATH staff support on behalf of or in conjunction with a PATH-enrolled individual to connect to an appropriate agency, organization, or service that offers physical or dental healthcare services.

Job training referral: Active and direct PATH staff support on behalf of or in conjunction with a PATH-enrolled individual to connect to an appropriate agency, organization, or service that helps prepare an individual to gain and maintain the skills necessary for paid or volunteer work.

Employment assistance referral: Active and direct PATH staff support on behalf of or in conjunction with a PATH-enrolled individual to connect to an appropriate agency, organization, or service that leads to compensated work.

Educational services referral: Active and direct PATH staff support on behalf of or in conjunction with a PATH-enrolled individual to connect to an appropriate agency, organization, or service that offers academic instruction and training.

Income assistance referral: Active and direct PATH staff support on behalf of or in conjunction with a PATH-enrolled individual to connect to an appropriate agency, organization, or service that offers benefits that provide financial support.

Medical insurance referral: Active and direct PATH staff support on behalf of or in conjunction with a PATH-enrolled individual to connect to an appropriate agency, organization, or service that offers coverage that provides payment for wellness or other services needed because of sickness, injury, or disability.

Housing services referral: Active and direct PATH staff support on behalf of or in conjunction with a PATH-enrolled individual to connect to an appropriate agency, organization, or service that helps attain and sustain living accommodations.

Temporary housing referral: Active and direct PATH staff support on behalf of or in conjunction with a PATH-enrolled individual to connect to an appropriate agency, organization, or service that offers shelter in a time-limited setting.

Permanent housing referral: Active and direct PATH staff support on behalf of or in conjunction with a PATH-enrolled individual to connect to an appropriate agency, organization, or service that offers residence in a stable setting where length of stay is determined by the individual or family without time limitations, if they meet the basic requirements of tenancy.

Making a successful referral involves more than just providing a phone number or program address. PATH providers should be actively involved in supporting attainment of the outside service to the degree necessary based on each participant's situation. A *referral* is attained when the participant begins receiving services because of PATH assistance. The following checklist can help ensure that referrals are as successful as possible.

Checklist for Making Successful Referrals

- ❑ I have an adequate understanding of the participant's situation and perceived needs.
- ❑ The participant and I have talked about how to prioritize these needs and what options exist to help address them.
- ❑ The participant is willing and ready to receive a referral.
- ❑ The participant and I have discussed what issues might make it difficult for them to follow through with the referral.
- ❑ I am familiar with the agency to which I am referring the individual, including its eligibility requirements and services.
- ❑ The agency has the capacity and willingness to serve people experiencing homelessness in a knowledgeable and respectful manner.
- ❑ The agency can be culturally and linguistically responsive to the needs of the participant.
- ❑ The agency can make appropriate accommodations for those with disabilities.
- ❑ I have a working relationship with at least one staff person at the agency who can provide useful information and help advocate for the participant.
- ❑ I have considered whether or not to accompany the participant to the appointment based on the individual's:
    - Ability to negotiate complex social situations
    - Ability to provide and receive information
    - Ability to tolerate waiting
    - Level of ambivalence about seeking help
- ❑ If the person is going alone, I have provided sufficient information and coaching to help make the referral successful.
- ❑ I have a plan to follow up with the participant to see how things went and to determine next steps.
- ❑ I have a backup plan if this referral fails to work out for any reason.

Partnering with the Continuum of Care

The U.S. Department of Housing and Urban Development (HUD) designed the Continuum of Care (CoC) Homeless Assistance Program to promote a community-wide commitment to ending homelessness. The CoC Program provides funding for nonprofit providers as well as state and local governments to assist individuals experiencing homelessness with obtaining stable, permanent housing and accessing mainstream programs.

PATH providers can increase their reach and effectiveness by ensuring that they're involved in their local CoC. CoC partnership should include coordination of street outreach efforts to leverage organizations' resources and ensure that efforts aren't duplicative. It's also essential for PATH providers to build strong partnerships with community service providers, ensure that their local community is aware of the PATH program and the services it provides, and share their expertise in working with individuals who are experiencing homelessness and serious mental illness. Here are a few examples of community partnerships:

- Local police departments, which can help minimize the effects of over-policing in BIPOC communities, which are the most over-policed communities
    - Encourage community service providers to contact PATH for support before contacting the police, when appropriate
    - Encourage the police department to include the PATH team during crisis intervention where feasible and appropriate
- Faith-based organizations and houses of worship, which can help build community for people experiencing homelessness and be a resource for meeting basic needs
- Local clinics, hospitals, and Federally Qualified Health Centers

These partnerships can help to coordinate services for individuals discharged from services without stable housing and can allow for the development of multidisciplinary teams to support street outreach efforts.

Accessing Housing

As a first step in supporting participants to obtain permanent, stable housing, PATH providers should connect to and understand their CoC's **coordinated entry system**. HUD requires each CoC to maintain a coordinated entry system that assesses those who are experiencing or at risk of homelessness in a standardized way and prioritizes

individuals for housing based on their needs and vulnerability. In Wyoming, the coordinated entry system covers the entire state. Every youth, adult, and family who are experiencing homelessness in Wyoming should be entered into the coordinated entry system. This includes all clients in street outreach, emergency shelter, and rapid rehousing programs, as well as federal partner programs such as PATH, Supportive Services for Veteran Families (SSVF), and the Runaway and Homeless Youth Program (RHY).

All participants entered into the coordinated entry system receive a common assessment to determine their level of vulnerability and need. PATH participants are often the most vulnerable among those experiencing homelessness and, as a result, the coordinated entry system prioritizes them for housing.

PATH providers should support participants through the coordinated entry process as a first step in accessing housing and should recognize that the coordinated entry system may be difficult or complicated for PATH participants to navigate. The coordinated entry system may also be triggering for clients who have experienced racial trauma and other forms of trauma and have had negative interactions with service systems in the past. When possible, PATH providers should explain the process to participants in advance and, if needed, accompany participants to assessments and follow up on their behalf to request updates on housing. PATH providers can support participants in gathering the necessary information and documentation to support the coordinated entry assessment. Participants will remain in the coordinated entry system until they obtain permanent housing and can re-enter the system as many times as necessary if additional housing crises occur.

If housing isn't readily available through the coordinated entry system, PATH providers can support participants in exploring other options such as:

- Applying for a subsidized apartment
  - Some apartment buildings offer reduced rents for low-income individuals and families. Providers and participants can search for subsidized apartments in their area using the HUD Resource Locator (https://resources.hud.gov). Participants—with support, if needed—can contact apartment management offices to ask about the application process.
- Applying for public housing or a housing choice voucher (Section 8)
  - The local Public Housing Authority (PHA) can provide information about applying for a housing choice voucher and local public housing developments.

        - Using a housing choice voucher, participants find their own suitable housing unit and the local PHA pays a subsidy directly to the property owner.
        - A list of PHAs in Wyoming is available on HUD's website (https://www.hud.gov/sites/dfiles/PIH/documents/PHA_Contact_Report_WY.pdf). HUD also provides [links to Wyoming PHA websites](https://www.hud.gov/states/wyoming/renting/hawebsites) (https://www.hud.gov/states/wyoming/renting/hawebsites).

- Locating affordable housing through the private housing market. Here are strategies for increasing success in securing affordable housing through the private market:
    - Invest time on a regular basis to search for housing units in local papers, listings from rental agencies, and online housing resources.
    - Develop relationships with private property owners.
        - Understand that property owners' priorities are identifying tenants who will:
            - Pay rent on time and in full
            - Take good care of the unit and have minimal maintenance needs
            - Not be disruptive to others
    - Recognize that property owners may be reluctant to engage with your program; avoid minimizing any real or perceived fears that they have about renting to PATH participants.
    - Make property owners aware of your program and the types of support that you provide as well as the limits of your role.
    - Consider ways that you can use participants' stories to market your program to property owners.
- Understand any housing barriers that a participant may have and work with the participant and property owner (with the participant's permission and a signed release) to identify ways to address them.
- Attend the initial meeting with the property owner and participant to provide a warm referral and introduction.
- Work proactively to maintain relationships with property owners. Communicate with them often, validate their concerns and take their concerns seriously, follow

through on anything they are expecting from you, and consider ways to recognize property owners who are supportive of the PATH program.

Homeless Service System Diversion

Diversion is a service intervention that may be appropriate for PATH participants depending on their circumstances. *Diversion* is the idea that the PATH case manager and participant discuss a temporary or permanent housing solution where the participant avoids having to reside on the streets or in emergency shelter. One example of diversion is *mediation*, where the PATH case manager and participant call a family member or friend to find out how they can support the participant and whether the participant can stay with them. The PATH worker may offer funds for transportation (for example, a bus ticket) if the participant can show that they have someone with whom they can stay but lack the means to get there. Additional information and resources related to diversion and homelessness prevention are available on the National Alliance to End Homelessness's website (https://endhomelessness.org/resource/diversion explainer).

PATH Data Collection

PATH data collection is important not only for meeting federal and state reporting requirements, but also for helping PATH providers and their communities better understand the needs of the homeless population, gaps in services, and ways to improve and sustain services. Having meaningful and useful data requires that providers collect and input accurate data.

The Wyoming PATH program requires providers to input data into the Wyoming Homeless Management Information System (HMIS), a locally administered electronic data collection system that stores participant-level data about individuals experiencing or at risk of homelessness and the services they access. PATH team members can run the PATH Annual Report in HMIS which aggregates participant-level data to produce provider-level data about the number, characteristics, and needs of participants who received services. PATH team leads must then upload provider-level data into the PATH Data Exchange (PDX), an online data collection tool that stores provider- and state-level data (https://pathpdx.samhsa.gov).

The Wyoming PATH program requires providers to submit the following reports:

- Monthly PATH HMIS report with the provider's invoice
- Biannual progress reports in PDX
- PATH Annual Report in PDX

SAMHSA uses PDX to describe and report PATH Program outcomes. The *PATH Annual Report Manual* is the best source to guide PATH providers through PATH's reporting process and requirements.

The Government Performance and Results Act (GPRA) requires federal agencies to set specific performance goals, commonly called *GPRA measures*, for grant programs. SAMHSA reports these PATH GPRA measures annually to Congress:

- Number of homeless persons contacted
- Number of PATH providers trained in SOAR

- Percentage of enrolled PATH participants who receive community mental health services
- Percentage of eligible PATH participants who become enrolled in PATH

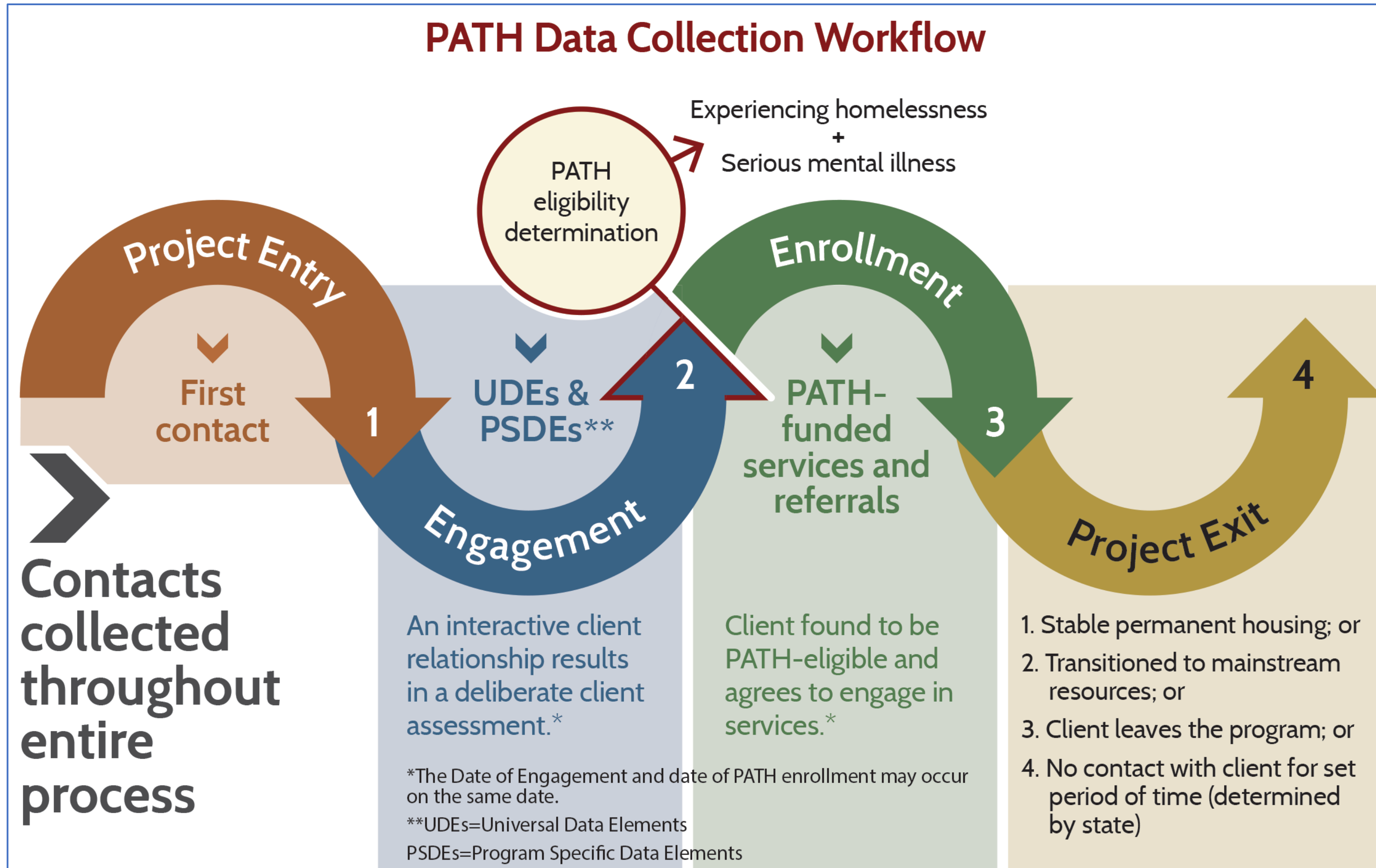
SAMHSA also asks states to report these outcome measures:

- Number of PATH participants who are referred to and attain housing
- Number of PATH participants who are referred to and attain mental health services
- Number of PATH participants who are referred to and attain substance use disorder services

PATH providers collect data from the point of initial contact until program discharge. The types of data vary based on the engagement phase. The Wyoming PATH program requires providers to enter PATH data into HMIS **within three days** of the encounter with the participant. Figure 1 illustrates the data collection process for PATH (U.S. Department of Housing and Urban Development [HUD], 2021).

Figure 1

PATH Data Collection Workflow



Note. From U.S. Department of Housing and Urban Development, 2021, page 16

Data collection begins with the first contact with a potential PATH participant. This data point is known as *Project Entry*. From this point forward, PATH providers record each interaction with the participant in HMIS as a *contact* using the **4.12 Current Living Situation** data element.

Contact: A *contact* is an interaction between a PATH-funded worker(s) and an individual who is potentially PATH eligible or already enrolled in PATH. Contacts may range from a brief conversation between the PATH-funded worker and the participant about the participant's well-being or needs, to a referral to service. A contact must always include the presence of the participant; the facilitation of a referral between a PATH-funded worker and another case manager or service provider without the participant's involvement *does not count* as a contact. A contact may occur in a street outreach setting or in a service setting such as an emergency shelter or drop-in center (HUD, 2021, p. 5).

At the point of *engagement*, PATH providers should collect the required HMIS Universal Data Elements (UDEs) and Program-Specific Data Elements (PSDEs).

Date of engagement: The *PATH Annual Report Manual* (SAMHSA, 2021) defines *date of engagement* as the date when an interactive participant relationship results in a deliberate participant assessment or the beginning of a case plan. For PATH providers, the date of engagement must occur on or before the date of enrollment.

After the point of engagement, the PATH provider determines whether the individual is eligible for PATH services (meaning they are experiencing or at risk of homelessness and have a serious mental illness). If found to be eligible for PATH and the individual agrees to engage in services, the provider then enrolls the individual. After enrolling the participant, the provider can enter data in HMIS documenting the participant's services and referrals.

PATH enrolled: A PATH-eligible individual and a PATH provider have mutually and formally agreed to engage in services, and the provider has initiated an individual file or record for that individual.

PATH exits (disenrollment): A provider *disenrolls*, or exits, a PATH participant from the program when:

- they have permanent, stable housing or
- they have transitioned to mainstream resources or
- the participant leaves the program or
- there has been no contact with the participant for 60 days

If a provider reconnects with the participant after 60 days, they can re-enroll them in PATH if they are still eligible.

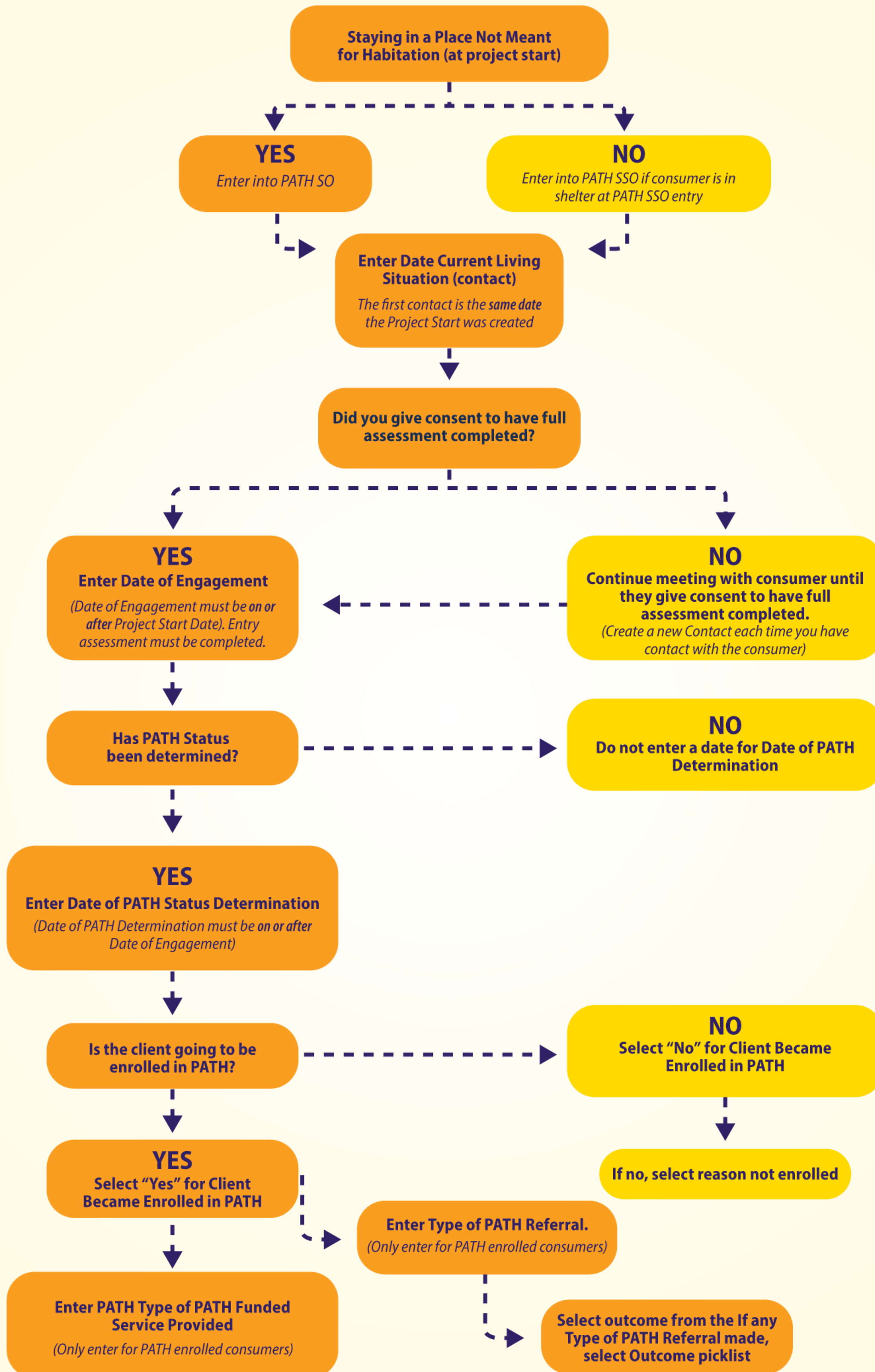
HUD's *PATH Program HMIS Manual* (https://files.hudexchange.info/resources/documents/PATH-Program-HMIS-Manual.pdf) summarizes the PATH data collection workflow and data collection requirements as follows (HUD, 2021, p. 16):

> *PATH data collection workflow supports the interactions and development of relationships with clients over time. As such, HMIS data quality does not begin until the date of engagement, or the point at which an interactive client relationship results in a deliberate client assessment. The date of enrollment may be on or after the project start date and on or after the date of engagement.*
>
> *It is possible that project start, engagement, enrollment, and project exit may all occur during a single contact at a single point in time. It is much more likely, however, that there will be multiple contacts before the date of engagement. The data collection workflow chart (Figure 1) illustrates the necessary sequence of data collection, which may happen in a day, or over several days, weeks, or even months, depending on the client's willingness to engage with the PATH project, eligibility for PATH-funded services and referrals, and continued connection to the project.*
>
> *These are the data that you must capture before the Date of Engagement:*
>
> - *Project Start Date*
> - *Current Living Situation (for all contacts from Project Start to Date of Engagement)*
> - *A name or alias that allows the street outreach worker to identify the client in HMIS*
>
> *Any data collection beyond that—whether it be data not collected, refused, or a default category indicating that the provider hasn't collected the data—is a local community decision and not a HUD requirement.*

Note that it often takes time to gather participant information as the provider works to build trust with the participant. HMIS will generate report errors when there is missing information in a participant's record. To minimize report errors, it's important to navigate to the *Entry/Exit tab* in HMIS and complete an *Interim Update* to fill in missing information as the participant provides it.

The PATH workflow decision tree (Figure 2) developed by the Wyoming HMIS Lead, Institute for Community Alliances, provides guidance for starting PATH records in HMIS.

Figure 2: PATH Workflow Decision Tree



Note. SO = Street Outreach; SSO = Supportive Services Only. From Institute for Community Alliances.

Tables 1–3 outline the HMIS data elements required by the PATH Program (HUD, 2021).

Table 1

Universal Data Elements

Required PATH HMIS data element	At project start	By date of engagement	At date of enrollment	At project exit
3.01 Name	X			
3.02 Social Security Number		X		
3.03 Date of Birth		X		
3.04 Race		X		
3.05 Ethnicity		X		
3.06 Gender		X		
3.07 Veteran Status		X		
3.08 Disabling Condition		X		
3.10 Project Start Date	X			
3.11 Project Exit Date				X
3.12 Destination				X
3.15 Relationship to Head of Household	X	X	X	X
3.16 Client Location	X	X	X	X
3.917 Living Situation	X	X	X	X

Table 2

Common Program-Specific Data Elements

Required PATH HMIS data element	At project start	By date of engagement	At date of enrollment	At project exit
4.02 Income and Sources		X		
4.03 Non-Cash Benefits		X		
4.04 Health Insurance		X		
4.05 Physical Disability		X		
4.06 Developmental Disability		X		
4.07 Chronic Health Condition		X		
4.08 HIV/AIDS		X		
4.09 Mental Health Problem		X		
4.10 Substance Abuse		X		
4.11 Domestic Violence		X		
4.12 Current Living Situation	X	X	X	X
4.13 Date of Engagement		X		

Table 3

Federal Partner Program Data Elements

Required PATH HMIS data element	At project start	By date of engagement	At date of enrollment	At project exit
P1 Services Provided – PATH Funded			X	X
P2 Referrals Provided – PATH			X	X
P3 PATH Status			X	
P4 Connection with SOAR	X	X	X	X

Providers should run the *PATH Current Living Situation (CLS), Services, and Referrals by Client* report in HMIS on a regular basis to check their program's data quality. Appendix A provides a sample report and explains the components of the report and how to review the information to identify data collection issues.

Institute for Community Alliances (ICA) serves as the lead administrator for Wyoming's HMIS (https://icalliances.org/wyoming). For questions related to HMIS training, data entry, running reports, and other guidance, Wyoming PATH providers can contact wyhmis@icalliances.org. Providers can access additional information and resources about using Wyoming's HMIS in the ICA Wyoming Knowledgebase (https://icawyoming.helpscoutdocs.com/).

PATH Program Compliance

PATH program leads can use the following checklist to ensure that their program complies with Wyoming's PATH program standards. The term "our program" refers to the program lead's organization.

- ❑ Our program meets the established monthly goals:
  - Provide direct contact to PATH participants through outreach and case management.
  - Outreach potentially eligible individuals each month.
  - Screen potentially eligible individuals each month.
  - Provide case management and intensive case management to PATH participants each month.
  - House participants monthly and within 30 days of enrolling (requirement beginning in October 2022).
  - Provide required documentation for staff travel, training and fees, operational expenses, housing, and outreach or health services.
- ❑ Our program meets the established annual goals:
  - Enroll 30 or more eligible individuals into PATH case management.
  - House 10 or more formerly homeless new PATH participants in permanent housing for at least 30 days.
  - House nine or more formerly homeless PATH participants for at least six months.
  - Transition 10 or more PATH participants into mainstream services, assist in finding other ways to pay for their housing, assist in finding wellness and well-being services, and transition out of PATH services.
  - Enter all required data into HMIS and provide data related to PATH GPRA measures.

- [ ] Our program provides housing support by:
    - Creating and sustaining partnerships to maximize services and resources leveraged for the benefit of PATH participants.
    - Assisting and guiding PATH participants in ways that increase helpful monetary and nonmonetary supports and relationships.
- [ ] Our program trains all PATH team members in relevant best practices.
- [ ] PATH team members attend PATH meetings (held in conjunction with Wyoming Homeless Collaborative meetings).
- [ ] Our program participates in the planning and implementation of the local Point-in-Time count.
- [ ] On an ongoing basis, PATH team members collaborate with local agencies, including local housing authorities, Emergency Solution Grant recipients, homeless shelters, transitional housing agencies, local police departments, county sheriff offices, community mental health and substance use treatment centers, health agencies assisting low-income individuals, and agencies working with veterans.
- [ ] PATH staff educate other agencies about strategies for reducing discrimination and preventing homelessness, and for increasing the ability of these agencies to quickly house individuals with serious mental illness or co-occurring disorders.
- [ ] Our program complies with funding requirements and limitations:
    - Match $1.00 for every $3.00 of federal PATH funds received with nonfederal cash or in-kind contributions.
    - Maintain a list of all match funds expended by date and transaction.
    - Only use match funds for allowable PATH expenses.
    - Submit a monthly report that summarizes actual expenditures by line item (personnel, fringe benefits, travel, supplies, housing, other, and indirect costs).
    - Submit a hard copy of the independent financial and compliance audits for the State Fiscal Year performed by an independent certified public accountant.
    - Administrative expenses do not exceed 4 percent of federal PATH funds received.
    - Funds expended for eligible housing services do not exceed 20 percent of federal PATH funds received.
- [ ] Our program participates in and provides the requested information for the annual state monitoring visit (on-site or virtual).

- [ ] Our program met its established objective to increase our use of the National Standards for Culturally and Linguistically Appropriate Services standards.
- [ ] Our program met its objective to increase our inclusion of individuals who have experienced homelessness in the management or implementation of the PATH program.
- [ ] Our program met its objective to advance community, regional, or statewide efforts to coordinate entry into publicly funded programs and increase prioritization of PATH-eligible individuals.
- [ ] Our program reviews disaster preparedness plans on an annual basis with a local disaster preparedness or emergency planning group to provide input on plans for individuals who are experiencing homelessness.

Best Practices in PATH Programs

Incorporating best practices into the services delivered by PATH providers sets up participants for success and sustains PATH providers in their challenging, yet rewarding work.

Mind-Set and Heart-Set

It is well known that the manner or spirit in which we provide care has a significant influence on people's receptivity to accepting the help we offer. This mind-set and heart-set must be genuine and sincere and we cannot fabricate it. We express our true manner and spirit through our body language, nonverbal facial expressions, tone of voice, attitudes, intentions, and use of language.

The elements of the mind-set and heart-set of best practices, drawn from the core elements of Motivational Interviewing, are below (Miller & Rollnick, 2013). Additional information about these core elements is available on the Motivational Interviewing Network of Trainers website (https://motivationalinterviewing.org).

Partnership: Forming a collaborative working relationship with someone; letting go of the need to be the expert; showing genuine respect for another's life experience, hopes, and strengths; assuming you both have valuable expertise and ideas; and "dancing" rather than "wrestling" with the participant

Acceptance: Meeting someone "where they are" without judgment; believing in the individual's inherent worth and potential; conveying empathy by seeking to understand where they're coming from; shining a light on the good things you see in them instead of focusing on what you perceive to be wrong with them

Compassion: Coming alongside people in their suffering (for example, homelessness, trauma, mental illness, addiction, grief, stigmatization, racial injustice, denial of rights); offering the gift of a safe, listening presence; being in solidarity with; acting for and with people

Evocation: Inviting or "calling forth" from people what they already possess: their hopes, values, desires, and aspirations; learning what people are passionate about, what

they already know and can do, what they want to learn, and what's important to them; discovering how they'd like their lives to be different and what changes they're willing to consider making.

Cultural Humility and Culturally Responsive Services

Effective support of the PATH population requires a commitment to *cultural competency*, *cultural humility,* and *racial equity*.

> *Cultural competence* refers to the "ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services" (SAMHSA, 2014, p. 296).
>
> *Cultural humility* is "a lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but one starts with an examination of their own beliefs and cultural identifies" (Yeager & Bauer-Wu, 2013, p. 2).
>
> *Racial equity* is "a process of eliminating racial disparities and improving outcomes for everyone. It is the intentional and continual practice of changing policies, practices, systems, and structures by prioritizing measurable change in the lives of people of color" (Race Forward, n.d.).

These principles form the foundation of effective PATH providers and services. As a result, providers must commit to ongoing training and demonstrating a willingness to engage in self-reflection, recognizing their own biases, and actively working to address power imbalances. In providing culturally responsive services, providers must ensure that relevant cultural factors are recognized and taken into consideration while avoiding assumptions or stereotypes based on a client's appearance or identity (SAMHSA, 2014).

Project READY is an online professional development curriculum dedicated to increasing knowledge about racism and racial equity with the goal of improving services and resources for youth of color. Per the Project READY curriculum (n.d.), culturally competent PATH providers do the following:

- Understand and honor the histories, cultures, and traditions of diverse communities
- Respect differences in cultures

- Build on the different ways of knowing and expertise found in various cultures and communities
- Understand that a strong sense of cultural identity and belonging is central to developing positive self-esteem
- Work to identify and challenge their own cultural assumptions, values, and beliefs
- Commit to developing their own cultural humility on an ongoing basis

Cultural humility takes the concepts of cultural competency a step further and requires an understanding of and desire to address power imbalances as well as an ongoing commitment to self-reflection and self-critique. PATH providers can take the following steps to integrate principles of cultural humility into their work and programs (Project READY, n.d.):

- Study the history of race and racism in the United States and understand the ways it disproportionately affects BIPOC individuals
- Complete racial equity training; these organizations provide racial equity training specific to homeless service providers:
  - C4 Innovations (https://c4innovates.com/our-expertise/equity/equity-and-homelessness) and Racial Equity Partners (https://www.racialequitypartners.com) provide racial equity training specific to homeless service providers

PATH providers can work to advance racial equity by analyzing data on an ongoing basis to identify inequities, and developing and implementing plans to address these inequities. Providers can also review program policies for bias and revise them to reflect the PATH population's varying needs.

Additional information about racial equity and strategies for developing racially equitable homeless service systems is available through C4 Innovations (https://c4innovates.com/bringing-racial-equity-to-homeless-response-systems).

Working with Native Communities

The following information was with collaboration from tribal members. In hopes that individuals may have many occasions to visit nearby Tribal communities and work with the Native families and individuals of the community, the following information is in hopes to help enrich their communities through prevention, education, and continuum of care while honoring culture and traditions. American Indians and Alaska Natives (AI/AN) in the United States have unique health patterns due to their history and culture, geographical

region of residence, and health care disparities to name a few. Rural and Urban American Indians and Alaska Natives have more poverty, lower levels of education, and poorer housing conditions than the general U.S. population.

There is much that Native families need and want to know about in order to know how to support their family members with their healthcare, their housing, and the resources available to them. Along with how to team with the healthcare system and programs with respect to their cultural traditions.

There are two federally recognized tribes in Wyoming, the Newe' (Eastern Shoshone) and the Hinono'ei (Northern Arapaho), though thirteen tribes have been recorded as having resided within the present state of Wyoming. There is great diversity among tribal communities in their languages, histories, cultures, and belief systems. Further, each Native person experiences their cultural connection in a unique way, and there is wide variation in how traditional and cultural practices are integrated into individual identities.

When professionals and social program staff visit a Tribal community, they may find it helpful to know a bit about Tribal etiquette and culture. While etiquette will vary from Tribal community to Tribal community, there are commonalities as well. This informational material provides cultural consideration to observe while enhancing communication with Native families and your connectedness with the Tribal community.

In order to partner with a tribal community to offer outreach services, an invitation must first be made by a tribal community or member. If you accept the invitation, it is important to remember to step back and *listen*. It is essential you do not center yourself, your ideas, or the services you offer. Rather than showing up in the community implying "Here I am!" and assuming that everyone will be grateful for your presence and help, arrive humbly, be gracious, and center the tribe and their experiences – "Thank you. There you are." Based on what you hear in listening to tribal members, if you feel you have something to offer that may be helpful, you may offer it, and the community will decide whether or not to accept.

It is best practices to approach the Tribal program closely related to the services you are seeking to provide. If there are no similar programs or you are unaware of where to turn, it is best practices to approach the Tribal Business Council you are seeking to work with; they then can provide you guidance and direction. It is important to be honorable and respectful. In order to approach the Business Councils, it is best to contact their offices where the receptionist and secretaries may provide you with the process for meeting with the Council or provide direction to an appropriate office, program, or organization.

Housing First

The National Alliance to End Homelessness defines *Housing First* as a homeless assistance approach that prioritizes providing permanent housing, which then serves as a platform from which the individual can pursue their personal goals and improve their quality of life (McDonald, 2019).

The Downtown Emergency Service Center (DESC), located in Seattle, Washington, defines its Housing First principles as follows:

- Housing is a basic human right, not a reward for clinical success.
- Once the chaos of homelessness is eliminated from an individual's life, clinical and social stabilization occur faster and are more enduring.

DESC (Downtown Emergency Service Center, n.d.) created the following Housing First principles to guide best practices:

- Do not require preconditions (such as treatment acceptance or compliance) for individuals to obtain permanent housing.
- Offer comprehensive support services to assist individuals in sustaining permanent housing.
- Offer services, but do not require individuals to participate to keep their housing.
- Prioritize those who are most vulnerable for housing units.
- Take a harm reduction approach when working with individuals with substance use disorders, and don't require abstinence from substances to maintain housing. Providers should offer appropriate services to support an individual's commitment to recovery.
- Residents must have leases and tenant protections that follow local and federal laws.
- A Housing First approach works for both project-based and scattered-site models.

Trauma-Informed Care

Trauma-informed care is "a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma that emphasizes physical, psychological, and emotional safety for both providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper et

al., 2010). Trauma-informed best practices include understanding trauma and its effects, creating safe physical and emotional spaces, supporting control and choice, and integrating trauma-informed care across service systems.

Among individuals and families experiencing homelessness, the rates of exposure to traumatic events are extremely high. Many have experienced ongoing trauma throughout their lives. These experiences affect the way individuals think, relate to others, and cope with challenges. Individuals have often learned ways of adapting to survive in a world that can feel confusing and unpredictable. Survival strategies, such as substance use, withdrawal, and aggression, can be confusing to others. A provider's initial reaction may be to view these behaviors as "manipulative," "oppositional," or "unmotivated," when in fact the behaviors are ways the individual has learned to cope with traumatic stress and manage overwhelming feelings and difficult situations. Using a trauma-informed lens to deliver services ensures that providers recognize the prevalence of trauma in participants' lives and address trauma survivors' unique needs.

Adverse Childhood Experiences (ACEs)

The term *Adverse Childhood Experiences (ACEs)* originated from a landmark study published in 1998 (Felitti et al., 1998). Researchers found that those exposed to traumatic experiences in childhood—such as emotional or physical abuse, neglect, or household dysfunction—have an increased risk of poor health outcomes in adulthood. The ACEs study highlights the lifelong impact of traumatic stress and the toll it can take on one's physical and emotional health. Additional information about ACEs is available on the Centers for Disease Control and Prevention website (https://www.cdc.gov/violence prevention/aces/index.html).

What makes an experience traumatic?

Traumatic events have the following characteristics (Guarino, 2009):

- The experience is overwhelming.
- It involves a threat to an individual's physical or emotional well-being.
- It results in feeling vulnerable and having a lack of control.
- It leaves an individual feeling helpless and fearful.
- It changes the way an individual understands the world, and it interferes with their relationships.

Racial trauma

Racial trauma refers to the negative and ongoing effect that race-related stress, racial harassment, race-based violence (including witnessing violence), and racial discrimination has on an individual's physical and mental health. BIPOC communities experience not only single events of overt racism, but ongoing exposure to race-based stress resulting from racial discrimination and oppression. Responses to racial trauma are often like responses to other significant traumas, including physical reactions, such as difficulty sleeping, fatigue, and changes in appetite, as well as emotional reactions, such as irritability, anger, anxiety, and difficulty concentrating (Counseling and Psychological Services, n.d.). These are understandable responses given the ongoing impact of racial trauma. It's important to note, however, that BIPOC individuals respond differently to trauma and not everyone will have the responses listed here. Trauma-informed PATH providers must recognize the specific effect of racial trauma and work to increase their cultural competence and cultural humility.

Promoting physical and emotional safety

Ensuring physical environments are inviting and offer a sense of physical and emotional safety is an important concrete step that providers can take in implementing trauma-informed care. Kathleen Guarino (2009) offers these suggestions for developing safe physical environments:

- Ensure spaces are well-lit
- Use security systems and ensure participants can lock doors and windows
- Post participant rights and other important information in easily visible areas
- Make child-friendly spaces available that include objects for self-soothing

The following practices help create a safe emotional environment:

- Providing consistent, respectful responses to individuals across the agency
- Asking participants what does and does not work for them
- Being clear about how the provider uses personal information
- Allowing participants to engage in their own cultural and spiritual rituals
- Providing group activities that promote agency and community (such as movement, exercise, yoga, music, dancing, writing, and visual arts)

Supporting control and choice

Interactions with the service system may cause a participant to feel helpless or without control, resulting in re-traumatization. Here are ways to help individuals regain a sense of control over their daily lives:

- Teach emotional self-regulation skills such as breathing techniques
- Ensure individuals are equal partners in the development and implementation of wellness plans and goals
- Request participant input on program design and policies
- Give participants control over their own spaces and physical belongings
- Maintain an overall awareness of and respect for basic human rights and freedoms (Guarino, 2009)

Integrating care and advocating for change

PATH providers can leverage their roles as connectors and advocates in the community to ensure there is effective partnership, coordination, and communication across the service system. This can help to decrease participants' frustration with the complexities of the service system.

PATH providers can also educate other service providers and programs about the effects of trauma and advocate for changes in traditional service models. Table 4 gives examples of practice changes that can occur when providers implement programs using a trauma-informed lens.

Table 4

Differences in Approaches Comparing Traditional Care to Trauma-Informed Care

Traditional service model	Trauma-informed care
Hierarchical (service providers have the power)	Provider finds ways to share power (for example, requesting participant input on program design, encouraging participants to make their own choices)
Provider defines the goals and focuses on reducing negative behaviors	Participant defines their goals with support from the provider
Is reactive and crisis-driven	Takes proactive steps to prevent future crises
Views participants as broken and needing protection from themselves	Focuses on participant strengths, control, and choice

Trauma-informed care shifts providers' perspective from focusing on "What's wrong with you?" to asking "What happened to you?" (Harris & Fallot, 2001). This is a powerful shift that can affect all aspects of a program and ensure participants receive quality services that address their needs.

Motivational Interviewing

Motivational Interviewing is a counseling approach that is "a collaborative conversation style for strengthening a person's own motivation and commitment to change" (Miller & Rollnick, 2013).

In *Motivational Interviewing*, clinical psychologists William R. Miller and Stephen Rollnick (2013) note that the following principles, processes, and skills are essential for success in motivational conversations:

The spirit (mind-set and heart-set) of motivational conversations

- **P**artnership: Collaborating with the participant's own expertise
- **A**cceptance: Communicating absolute worth, accurate empathy, affirmation, and autonomy support

- **C**ompassion: Promoting the participant's welfare, giving priority to the participant's needs
- **E**vocation: Eliciting the participant's own perspectives and motivation

Four processes that guide motivational conversations

- **E**ngaging: Establishing the relational foundation
- **F**ocusing: Clarifying a particular goal or direction for change
- **E**voking: Eliciting the individual's own motivation for a particular change
- **P**lanning: Developing a specific change plan that the participant is willing to implement

Four conversational skills

- **O**pen questions: Offers participant broad latitude and choice in how to respond
- **A**ffirmation: Statement valuing a positive participant attribute or behaviors
- **R**eflections: Statements intended to mirror meaning (explicit or implicit) of preceding participant speech
- **S**ummaries: Reflections that draw together content from two or more earlier participant statements

Sample questions to explore ambivalence and strengthen motivation

- Tell me more about this issue, concern, or dilemma. What's okay about how things are? What's not okay?
- If you decide not to change anything, what would be at stake?
- If you were to make a change, what would be the benefits of (or your reasons for) doing so? What is the most important benefit or reason?
- If you were to decide to change, how would you go about it to be successful? What do you think would work for you?
- Looking at your life currently, how important or urgent is it for you to make this change? For example, on a scale of 0 to 10 where *0* is *not at all important* and *10* is *extremely important*, where would you place yourself? What makes it already a ___ and not a ___ (several numbers lower)? What would it take to move from a ___ to a ___ (next highest number)?
- How confident are you that you could be successful in changing? (Asking scaling questions works well here, too.)

- How can I or others be helpful to you in supporting this change?
- What do you think you might do as a very next step to move toward this change?

Elicit–Provide–Elicit Method

Elicit

- Ask what the person already knows
- Ask what the person would like to know
- Ask permission to provide information and advice

Provide

- Prioritize what the person most wants to know
- Be clear; use everyday language
- Offer small amounts of information with time to reflect
- Acknowledge freedom to disagree or ignore

Elicit

- Ask for the person's response, interpretation, and understanding

The Stages of Change

One of the best-known approaches to changing behavior is known as the Transtheoretical Model, or the Stages of Change. The *transtheoretical model* asserts that individuals move through seven stages of change when attempting health behavior change: precontemplation, contemplation, preparation, action, maintenance, relapse, and termination. The description and framing of the Stages of Change in this section is based on information from *Motivational Interviewing: Preparing People for Change* (Miller & Rollnick, 2013), though we have made revisions to reflect more recent developments of the model.

Stage 1: Precontemplation. The individual may be experiencing negative issues associated with their behavior; however, they do not perceive these issues as serious enough to motivate them to consider changing their behavior. The individual does not intend to take action in the near future (defined as within the next six months).

Stage 2: Contemplation. The individual recognizes that their behavior is harming them, but they are ambivalent about making changes. The person may have a desire to change and may even have considered changing their behavior but has not yet invested effort into changing their behavior.

Stage 3: Preparation. The individual has made a commitment to changing their behavior. Most individuals in this stage weigh the positive and negative impacts of their behavior and have concluded that the negative aspects outweigh any benefits it may bring them.

Stage 4: Action. The individual is actively involved in changing their behavior. Most individuals in this stage understand that they are responsible for changing their behavior, and they often require some form of outside assistance to help them reach their goal.

Stage 5: Maintenance. The individual has sustained their behavior change for a significant period (defined as more than 6 months) and intends to maintain the behavior change going forward. The individual may still be working on change, but they have made and sustained their behavior change.

Stage 6: Relapse. The individual experiences a setback in their attempt to change or modify their behavior. The Stages of Change model recognizes that change and recovery is nonlinear and relapse is a normal part of the process.

Stage 7: Termination. In this stage, the person has been able to make positive changes, maintain new habits, and continues to improve. Even though the title of this stage implies the process is over, many individuals do not actually terminate their participation in their program of change as in many cases, change is an ongoing process.

Harm Reduction

Harm reduction is a set of strategies and tactics that encourages individuals to reduce the risk of harm associated with their activities. The goal of harm reduction is to facilitate change by helping individuals become more conscious of the risks of activities related to substance use and providing them with the tools and resources with which they can reduce their risk. Harm reduction takes a humanistic, participant-centered approach where providers meet people "where they are," supporting individuals through incremental behavior change and viewing any positive change as significant.

The National Harm Reduction Coalition (2020) defined these principles of harm reduction:

- Acknowledge that substance use is a part of our world, and recognize that it is more effective to work to minimize its harmful effects rather than to ignore them
- Understand that substance use involves a continuum of behaviors ranging from abstinence to severe use, and recognize that some ways of using drugs are safer than others
- Consider program interventions and policies to be successful based on the quality of an individual's life rather than abstinence from all substance use
- Offer program services in a nonjudgmental, noncoercive manner
- Ensure those with lived experience of substance use have a voice in the development of substance use treatment programs and policies
- Assert that those who use substances are in control of reducing the harms related to substance use, and seek to empower them in exchanging information and supporting one another
- Recognize the effects of poverty, class, racism, social isolation, past trauma, discrimination, and other social inequalities and the ways they affect people's abilities to address the harms associated with substance use
- Do not attempt to minimize or ignore the harms associated with substance use

Recovery-Oriented Practices

What is recovery?

Recovery is a process of growth and change through which people improve their health and wellness, live a self-directed life, and strive to reach their full potential. People in recovery say that the process of recovery is about finding new meaning, purpose, and possibility in life. For many people, recovery means the following:

- No longer feeling defined by the experience of mental illness
- Identifying with valued roles in the community (for example, worker, student, friend, neighbor)
- Being in control of making one's own decisions
- Developing a network of reliable and fulfilling social supports
- Being proud of the strength, knowledge, and experience gained from one's experience with recovery

- Feeling hopeful for the future (Tondora et al., 2014)

Person-Centered Recovery Planning

Person-Centered Recovery Planning (PCRP) is a useful approach and framework PATH providers can use when developing wellness plans. PCRP focuses on giving participants choices in the services they use and developing wellness plans in close collaboration with participants, ensuring they are active partners in identifying the services they need and who should be involved in their support team (for example, family members, employers, neighbors). The PCRP process can begin by asking participants to identify their goals. Providers can then work with participants to determine how PATH services can best support participants in achieving those goals and whether referrals to community partners would be helpful. Participants may have nontraditional goals, such as making friends, learning a new skill, or developing a hobby, and PATH providers can think creatively about how to support participants in meeting these goals (Tondora et al., 2014).

How is a person-centered care plan developed and evaluated?

Tondora and others (2014) recommend the following steps for creating a person-centered care plan in collaboration with participants:

- Conduct a strengths-based assessment
- Formulate an integrated understanding of the individual
- Prioritize areas that the care plan will address
- Set recovery goals and a vision for the future
- Identify barriers to address as well as strengths to draw upon
- Create short-term objectives that help overcome barriers
- Describe interventions or activities reflecting a range of evidence-based and emerging practices
- Work with the participant to identify action steps that they can take with the support of their recovery network
- Evaluate progress and outcomes, including evaluating discharge and transition criteria

Peer Support Services

Peer support services is an evidence-based practice where people with personal experience of recovery from mental health conditions, substance use, homelessness, and other traumatic stressors receive specialized training and supervision to guide and support others in their own recovery journey. There are many different peer support titles and roles, such as peer support specialist, peer advocate, peer counselor, peer coach, peer mentor, peer educator, recovery coach, and recovery support specialist, among others (interNational Association of Peer Supporters [iNAPS], n.d.).

Peer support providers have made a personal commitment to their own recovery, maintained their recovery for a period, have completed peer support training, and are willing to share what they have learned about recovery in a practical, concrete way. Peer support providers' lived experience often fosters the ability to develop trust and rapport more easily with participants while offering a unique perspective to support a participant's recovery (iNAPS, n.d.).

Peer support providers promote the following values (iNAPS, n.d.):

- Recovery is a choice
- Recovery is unique to the individual
- Recovery is a journey, not a destination
- Self-directed recovery is possible for everyone—with or without professional help

The SAMHSA–HRSA Center for Integrated Health Solutions (2014) identifies the following strengths that peer support providers bring to the workplace:

- Personal experience with whole health recovery that includes addressing wellness of both mind and body
- Insight into the experience of internalized stigma and how to combat it
- Compassion and commitment to supporting others, rooted in a sense of gratitude
- Experience of moving from hopelessness to hope
- A unique position from which to build a trusting relationship, which is especially helpful in working with people in trauma recovery
- Honed skills in monitoring their own recovery and self-managing their lives holistically

Self-Care

This section is adapted from an article appearing in *Healing Hands*, a publication of the Health Care for the Homeless Clinicians' Network (Kraybill, 2002b).

Providing care to people who have experienced homelessness and high levels of traumatic stress and marginalization may involve working in challenging circumstances. PATH providers bear witness to tremendous human suffering and daily wrestle with thorny interpersonal and systemic issues. At the same time, PATH providers have the privilege of becoming partners in extraordinary relationships, marveling at the resiliency of the human spirit, and laying claim to important and often significant steps forward. Such is the nature of this work that it can both drain and inspire us.

Despite the rewards inherent in the work, it inevitably exacts a personal toll. By listening to others' stories and providing a sense of deep caring, we walk a difficult path. Yet, we do so willingly, knowing that first we must "enter into" another's suffering before we can offer hope and healing. As the spiritual thinker and writer Henri Nouwen notes, it is interesting that the word *care* finds its roots in the Gothic *kara* which means "lament, mourning, to express sorrow."

Caring can become burdensome, causing us to experience signs and symptoms of what the literature variously calls *compassion fatigue*, *secondary traumatic stress*, or *vicarious traumatization*. The frustrations of providing support in the face of multiple barriers, such as inadequate resources and structural supports, compounds the impact. To feel weighed down by these circumstances is not unusual or pathological. It is, in fact, a quite normal response.

In part, the treatment of choice for diminishing the negative effects of this stress is to seek resiliency and renewal through the practice of healthy self-care. Self-care is most effective when approached with forethought, not as afterthought. In the same manner that we provide care for others, we must care for ourselves by first acknowledging and assessing the realities of our condition, creating a realistic plan of care, and acting upon it. Though many providers practice self-care in creative and effective ways, we all sometimes lose our sense of balance and fail to provide the necessary care for ourselves with the same resoluteness that we offer care to others.

To help us better understand what self-care is, here are three things that it is *not*:

- **Self-care is *not* an emergency response plan to activate when stress becomes overwhelming.** Instead, healthy self-care is an intentional way of living where we integrate our values, attitudes, and actions into our day-to-day routines. The need for "emergency care" should be an exception to usual practice.

- **Self-care is *not* about acting selfishly.** Instead, healthy self-care is about being a worthy steward of *self*—body, mind, and spirit. We cannot provide good support for others without providing proper nurture and sustenance for ourselves.
- **Self-care is *not* about doing more or adding more tasks to an already lengthy to-do list.** Instead, healthy self-care is as much about letting go as it is about taking action. It has to do with taking time to be a human *being* as well as a human *doing*. It is about letting go of frenzied schedules, meaningless activities, unhealthy behaviors, and detrimental attitudes such as worry, guilt, or being judgmental or unforgiving.

The following A, B, Cs of self-care provide a useful guide in reflecting upon the status of your own practices and attitudes.

Awareness: Self-care begins in stillness. By quieting our busy lives and entering a space of solitude, we can develop an awareness of our own true needs, and then act accordingly. This is the contemplative way of the desert, rather than the constant activity of the city. The theologian Thomas Merton suggests that the busyness of our lives can be a form of "violence" that robs us of inner wisdom. Too often, we act first without true understanding and then wonder why we feel more burdened and not relieved. In *Let Your Life Speak*, the writer, teacher, and activist Parker J. Palmer suggests that we reflect on the following question: "Is the life I am living the same as the life that wants to live in me?"

Balance: Self-care is a balancing act. It includes balancing action and mindfulness. Balance guides decisions about embracing or relinquishing certain activities, behaviors, or attitudes. It also shapes the degree to which we give attention to the physical, emotional, psychological, spiritual, and social aspects of our being, in other words, how much time we spend working, playing, and resting.

Connection: Healthy self-care cannot take place solely within oneself. It involves connecting in meaningful ways with others and something larger. We are decidedly interdependent and social beings. We grow and thrive through connections to friends, family, social groups, nature, recreational activities, spiritual practices, and therapy, among others. Often, we can find our most renewing connections right in our midst—in the workplace and with coworkers and those for whom we provide care.

There is no one formula for self-care. Our self-care plans will be unique and change over time. We must listen well to our own bodies, hearts, and minds, as well as to the counsel of trusted friends, as we seek resiliency and renewal in our lives and work.

Additional Resources

These websites provide additional information and resources for providers who are working with individuals experiencing homelessness.

National Alliance to End Homelessness
https://endhomelessness.org

National Health Care for the Homeless Council
https://nhchc.org

Homeless and Housing Resource Center
https://hhrctraining.org

HUD's Wyoming State Information website
https://www.hud.gov/states/wyoming

PATH Annual Report Manual
https://pathpdx.samhsa.gov/UserFiles/PATH%202021%20Annual%20Report%20Manual%20Review%208.17.2021%20(003).pdf

SAMHSA's Homelessness Programs and Resources website
https://www.samhsa.gov/homelessness-programs-resources

website Wyoming Department of Health, Behavioral Health Division, Mental Health and Substance Abuse Section website
https://health.wyo.gov/behavioralhealth/mhsa/

This work...

exhilarating
and exhausting

drives me up a wall
and opens doors I never imagined

lays bare a wide range of emotions
yet leaves me feeling numb beyond belief

provides tremendous satisfaction
and leaves me feeling profoundly helpless

evokes genuine empathy
and provokes a fearsome intolerance within me

puts me in touch with deep suffering
and points me toward greater wholeness

brings me face to face with many poverties
and enriches me encounter by encounter

renews my hope
and leaves me grasping for faith

enables me to envision a future
but with no ability to control it

breaks me apart emotionally
and breaks me open spiritually

leaves me wounded
and heals me

—Ken Kraybill

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Appendix A: Sample HMIS Report

Wyoming's PATH program and HMIS lead administrator encourage PATH providers to run the PATH *Current Living Situation (CLS), Services, and Referrals by Client* report on a regular basis (ideally at least monthly) to check for data quality. ICA provided the sample report below along with summary information to guide providers in using the report to identify issues. The ICA Wyoming Knowledgebase (https://icawyoming.helpscoutdocs.com/) provides additional information about where the report is located and how to run the report.

The report has three tabs—Summary, Client Detail, and Additional Information.

The **Summary tab** provides overview information about how many clients the provider served during the report date range.

- Report Summary information
  - Number of Clients: Clients with a PATH Entry
  - Number of Clients who are Engaged: Clients who have an Engagement Date entered
  - Number of Clients who are PATH Enrolled: Clients who have a PATH Status Determination Date entered
  - Number of Current Living Situations Recorded: Clients who have at least one contact entered
  - Number of Services Provided: Number of clients with a PATH Service Type entered
  - Number of Referrals Provided: Number of clients with a PATH Referral Type Entered
- Prompt Summary information
  - EDA (Enter Data As) Provider: One of the providers included in the report
  - Enter Effective Date: The last date to pull information
  - Selected Provider(s): Providers chosen to be included in the report
  - Enter Start Date: First date for data to be pulled
  - Enter End Date PLUS 1 Day: Same as Effective Date

PATH CLS, Services & Referrals by Client (v1.1)

Summary

Reporting Period: 1/1/2022 - 6/23/2022

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This report is designed to be utililzed by PATH Providers to identify current living situations (CLS), services, and referrals documented for each client in their PATH project during the report period. Please take note of the following:

1) The report will show only those clients with an entry during the report period selected in the prompts.
2) Only current living situations, services, and referrals will appear that occurred within the report period.
3) The entry/exit provider, current living situation provider, service provider, and referral provider should be the same provider within each client's record.
4) Services and referrals are only reported in the official PATH report if they take place on or after the Date of PATH Status Determination and the client did enroll in PATH.

Reminder: Since this report contains identifying information (client names), it cannot be emailed unless encrypted.

Report Summary	
Number of Clients	100
Number of Clients who are Engaged	24
Number of Clients who are PATH Enrolled	24
Number of Current Living Situations Recorded	86
Number of Services Provided	98
Number of Referrals Provided	12

Prompt Summary	
EDA Provider	- PATH - Street Outreach -
Enter effective date	6/24/2022
Selected Provider(s):	- PATH - Street Outreach - - PATH - Supportive Services Only -
Enter Start Date:	1/1/2022
Enter End Date PLUS 1 Day:	6/24/2022

Summary | Client Detail | Additional Information

The **Client Detail tab** shows client names and information entered about the client including:

- Engagement Date
- PATH Determination, Date Client Enrolled
- Services
- Referrals

Providers can use this tab to check their data quality.

- Fields that are missing will appear in red.
- Confirm that the Engagement Date is the same as or after the Start Date but before the Exit Date.
- Confirm that the PATH Date of Status Determination is the same as or after the Engagement Date but before the Exit Date.

- Services and Referrals must include the **PATH Service Type** and **PATH Referral Type** for the client to be included on the PATH Report.

Here is an example of a completed client record:

Client Name (SP Number)

Entry/Exit Provider	Entry Date	Exit Date	Engagement Date	PATH Status Determination Date	Client Enrolled?
PATH - Supportive Services Only	1/16/2018	5/3/2022	1/16/2018	1/16/2018	Yes

Info Date	Current Living Situation	Current Living Situation Provider
1/4/2022	Permanent housing (other than RRH) for formerly homeless persons (HUD)	PATH - Supportive Services Only
1/11/2022	Permanent housing (other than RRH) for formerly homeless persons (HUD)	PATH - Supportive Services Only
1/25/2022	Permanent housing (other than RRH) for formerly homeless persons (HUD)	PATH - Supportive Services Only
2/2/2022	Permanent housing (other than RRH) for formerly homeless persons (HUD)	PATH - Supportive Services Only
2/15/2022	Permanent housing (other than RRH) for formerly homeless persons (HUD)	PATH - Supportive Services Only
2/22/2022	Permanent housing (other than RRH) for formerly homeless persons (HUD)	PATH - Supportive Services Only
3/1/2022	Permanent housing (other than RRH) for formerly homeless persons (HUD)	PATH - Supportive Services Only
3/15/2022	Permanent housing (other than RRH) for formerly homeless persons (HUD)	PATH - Supportive Services Only
3/22/2022	Permanent housing (other than RRH) for formerly homeless persons (HUD)	PATH - Supportive Services Only
4/5/2022	Permanent housing (other than RRH) for formerly homeless persons (HUD)	PATH - Supportive Services Only
4/12/2022	Permanent housing (other than RRH) for formerly homeless persons (HUD)	PATH - Supportive Services Only
4/19/2022	Permanent housing (other than RRH) for formerly homeless persons (HUD)	PATH - Supportive Services Only

Service Date	Service Type	PATH Service Type	Service Provider
1/12/2022	Benefits Assistance	Case management	PATH - Supportive Services Only
2/2/2022	Benefits Assistance	Case management	PATH - Supportive Services Only
3/1/2022	Benefits Assistance	Case management	PATH - Supportive Services Only
4/13/2022	Benefits Assistance	Case management	PATH - Supportive Services Only

Referral Date	Referral Type	PATH Referral Type	PATH Referral Outcome	Referral Provider	Refer-To Provider

Here is an example of client information that is missing information:

Client Name (SP Number)

Entry/Exit Provider	Entry Date	Exit Date	Engagement Date	PATH Status Determination Date	Client Enrolled?
PATH - Street Outreach	4/27/2022				

This information has not been entered.

Info Date	Current Living Situation	Current Living Situation Provider
4/27/2022	Emergency shelter, incl. hotel/motel paid for w/ ES voucher, or RHY-funded Host Home shelter (HUD)	PATH - Street Outreach

Service Date	Service Type	PATH Service Type	Service Provider
4/27/2022	Material Goods	Screening	PATH - Street Outreach

Referral Date	Referral Type	PATH Referral Type	PATH Referral Outcome	Referral Provider	Refer-To Provider
4/27/2022	Street Outreach Programs	Missing	Missing	PATH - Street Outreach	Housing First - NA - Permanent Supportive Housing

The **Additional Information tab** provides report details and summarizes provider reporting information.

- Report Information and Values

- Report Name: The name of the report
- Report Path: Where to find the report in the BusinessObjects reporting tool
- Report Run Date/Time: The date and time of the report prompts
- User Running Report: Username of the user who ran the report
- Report User Guide: Contact HelpDesk for Support
- Get Support: wyhmis@icalliances.org

- User Prompt Field and Value(s) Selected
    - Select Provider(s): The project(s) selected in the report prompts
    - EDA (Enter Data As) Provider: The same provider selected in "Select Provider(s)" or one of the providers if more than one provider selected
    - Enter Effective Date: The last date for information to pull
    - Enter Start Date: The first date for information to pull
    - Enter End Date PLUS 1 day: Same as the Effective Date
- Provider Reporting Information
    - For each provider selected in the prompts, this section shows:
        - Client Count: The number of clients for each project included in the report
        - Service Count: The number of services entered under each project
        - Referral Count: The number of referrals entered under each project
        - CLS Records: The number of Current Living Situations recorded under each project

PATH CLS, Services & Referrals by Client (v1.1)

Additional Information

Reporting Period: 1/1/2022 - 6/23/2022

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Report Information	Values
Report Name	PATH CLS, Services & Referrals by Client (v1.1, revised 6/16/2022)
Report Path	casperwy_live_folder/PATH/
Report Run Date/Time	6/24/2022 11:48 AM MDT (run time: 1 seconds)
User Running Report	bnielsen
Report User Guide	Contact the Helpdesk for Support
Get Support	wyhmis@icalliances.org

User Prompt Field	Value(s) Selected
Select Provider(s):	PATH - Street Outreach PATH - Supportive Services Only
EDA Provider	PATH - Street Outreach
Enter effective date	6/24/2022 12:00:00 AM
Enter Start Date:	1/1/2022 12:00:00 AM
Enter End Date PLUS 1 Day:	6/24/2022 12:00:00 AM

Provider Reporting Information	Client Count	Service Count	Referral Count	CLS Records
PATH - Street Outreach	66	34	9	31
PATH - Supportive Services Only	36	64	3	55