



PATH Program Manual

North Dakota PATH Program



August 2021

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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 outreaching to, engaging, and advocating for those who are most vulnerable and provide critical services that mainstream mental health programs may not support.



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, and discrimination that these individuals have faced prior to becoming homeless 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 impacting 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 support the PATH population, providers must recognize and understand that various forms of racism have a powerful impact and contribute to increased rates of homelessness in BIPOC communities.



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.

Definitions related to PATH eligibility are as follows:

Experiencing homelessness: An individual who lacks housing, including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations, and an individual who is a resident in transitional housing (Public Health Service Act, 2018).

Imminent risk of homelessness: One or more of the following criteria commonly applies to a person facing imminent homelessness:

- Doubled-up living arrangements where the individual's name is not on a lease
- Living in a condemned building without a place to move
- Having arrears in rent or utility payments
- Receiving an eviction notice without having a place to move
- Living in temporary or transitional housing that carries time limits
- Discharge from a healthcare or criminal justice institution with no place to live

Serious mental illness: A diagnosable mental or emotional disorder of such severity and duration as to result in functional impairment that substantially interferes with or limits one or more major life activities (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020).

For information about which mental health diagnoses your agency considers a serious mental illness, contact your supervisor.

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

- Be experiencing homelessness or at imminent risk of homelessness
- Have a serious mental illness, with or without a co-occurring substance use disorder

Substance use disorder: The recurrent use of alcohol or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home (SAMHSA, 2020).

Co-occurring disorder: Having at least one serious mental illness and one substance use disorder that a practitioner can diagnose independently of each other.

Since serious mental illness is typically diagnosed in those age 18 years and older, PATH is intended to 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:

- Complete 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 out services, which makes the process of active outreach and engagement crucial. As a result, PATH emphasizes **active outreach** by seeking out those who may need services rather than waiting for individuals to request 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 aware of and familiar with other programs and resources in the community, and provide information on these alternatives.

Throughout the process of outreach and engagement, providers should assess individuals for PATH eligibility and explain the program services. Individuals must enroll in the program to begin receiving PATH services.

Outreach is the process of **actively seeking out and engaging with** individuals who are potentially PATH eligible.

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 client's basic survival needs
- Provider assesses client's overall needs and tailors services to meet those unique needs
- Provider offers tools and resources to reduce harmful behaviors
- Patience in motivating clients to engage in services
- Variable times for client contact, 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 that is racially and ethnically representative of the population served
- Includes staff with lived experience of homelessness and recovery
- Ongoing training for all staff in issues of equity, cultural competency, and cultural humility
- Regular analysis of data to identify inequities across race, ethnicity, gender, and sexual orientation
- Data informs changes to outreach and engagement efforts to achieve equitable outcomes

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 different locations—in shelters or drop-in centers, parks, camps, vehicles, city streets, or other public spaces such as libraries or bus or train stations. It is important to discuss any additional guidelines or policies with your supervisor and team.

- 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 “signs” 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 clothes 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 client you meet.
- Do not accept gifts from clients.
- Do not give or lend money to clients.
- Do not accept or hold any type of controlled substance.
- Avoid entering clients' cars, homes, or any enclosed area.
- Tell clients approximately when you will be back and where they can reach you.

- Give clients 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 would 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 stability in the community. 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 is 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.

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 some 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.

Mutuality: Supporting Wellness and Stability

In the mutuality phase, we recognize one another as fellow citizens and community members. The worker continues to encourage the client 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. Many PATH providers offer the full menu of PATH services, while others provide just one or two. North Dakota PATH providers, for example, focus their PATH services on providing reengagement, screening, case management, and financial assistance for short-term housing (security deposits and one-time rent).

North Dakota's PATH program also trains PATH providers in the SAMHSA SSI/SSDI Outreach, Access, and Recovery (SOAR) model. 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. If you haven't yet received SOAR training, please contact the [State PATH Contact](#) to request training.

Here is a list of allowable PATH services and their definitions (SAMHSA's Homeless and Housing Resource Network [HHRN], n.d.):

Reengagement: The process of reestablishing interaction with PATH-enrolled individuals disconnected from PATH services to reconnect the client to services based on the previously developed case management or goal plan. Reengagement must occur after enrollment and prior to 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 client's psychosocial needs and concerns.

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

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: A collaboration between a PATH-enrolled service recipient and provider who use advocacy, communication, and resource management to design and implement a wellness plan specific to a PATH-enrolled individual's recovery needs.

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.

Housing minor renovation: Services, resources, or small repairs that ensure a housing unit is physically accessible and any health or safety hazards have been mitigated or eliminated.

Housing moving assistance: Monies and other resources provided on behalf of a PATH-enrolled individual to help establish that individual's household. Note that this assistance *excludes* security deposits and one-time rental payments, which have specific definitions.

Housing eligibility determination: Determining whether an individual meets financial and other requirements to enter public or subsidized housing.

Security deposits: Funds provided on behalf of a PATH-enrolled individual to pay up to 2 months' rent or other security deposits to secure housing.

One-time rent for eviction prevention: One-time payment on behalf of PATH-enrolled individuals who are at risk of eviction without financial assistance.

Case management is one of the most common PATH services and covers an array of important activities including helping clients access mainstream benefits such as the Supplemental Nutrition Assistance Program or other cash assistance. Case management also includes helping clients to obtain identification documents, such as a birth certificate, state ID card, or driver's license.



PATH Referrals

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

SAMHSA uses the following terms and definitions to describe PATH referrals (SAMHSA's HHRN, n.d.):

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/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 client's situation. A referral is attained when the client begins receiving services because of PATH assistance. The following checklist can assist in ensuring that referrals are as successful as possible.

Checklist for Making Successful Referrals

- I have an adequate understanding of the client's situation and perceived needs.
- The client and I have talked about how to prioritize these needs and what options exist to help address them.
- The client is willing and ready to accept a referral.
- The client 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 client, 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 client.
- I have a working relationship with at least one staff member at the agency who can provide useful information and help advocate for the client.
- I have considered whether to accompany the client to the appointment based on the client's
 - ability to negotiate complex social situations
 - ability to provide and receive information
 - ability to tolerate waiting
 - degree of ambivalence about seeking help
- If the client is going alone, I have coached them and provided sufficient information to help make the referral successful.
- I have a plan to follow up with the client to see how things went and determine next steps.
- I have a backup plan if this referral is unsuccessful.

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. North Dakota has one Continuum of Care and the North Dakota Housing Finance Agency acts as the CoC's Collaborative Applicant. PATH providers are an integral part of CoC services and should play an active role in CoC decisions about priorities for housing and design of the homeless response system. More information about the [North Dakota CoC](https://ndcontinuumofcare.org) is available online at <https://ndcontinuumofcare.org>.

PATH providers can increase their reach and effectiveness by building strong partnerships with community service providers and sharing their expertise in working with individuals who are experiencing homelessness and serious mental illness. Here are examples of community partnerships:

- Local police departments, which can help minimize the effects of over-policing in BIPOC communities
- 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. PATH providers should also ensure that they connect to and understand the 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. CARES—Coordinated Access, Referral, Entry and Stabilization System—is the regional coordinated entry system serving North Dakota and West Central Minnesota. You can learn more about [CARES](https://www.careslink.org) by visiting the website at <https://www.careslink.org>.

The coordinated entry system may be difficult or complicated for PATH clients to navigate. When possible, PATH providers should explain the process to clients in advance and, if needed, accompany clients to assessments and follow up on their behalf to request updates on housing. A coordinated entry assessment may also ask for information related to disability, income, and identity, and PATH providers can support clients in gathering the necessary information and documentation.



PATH Data Collection

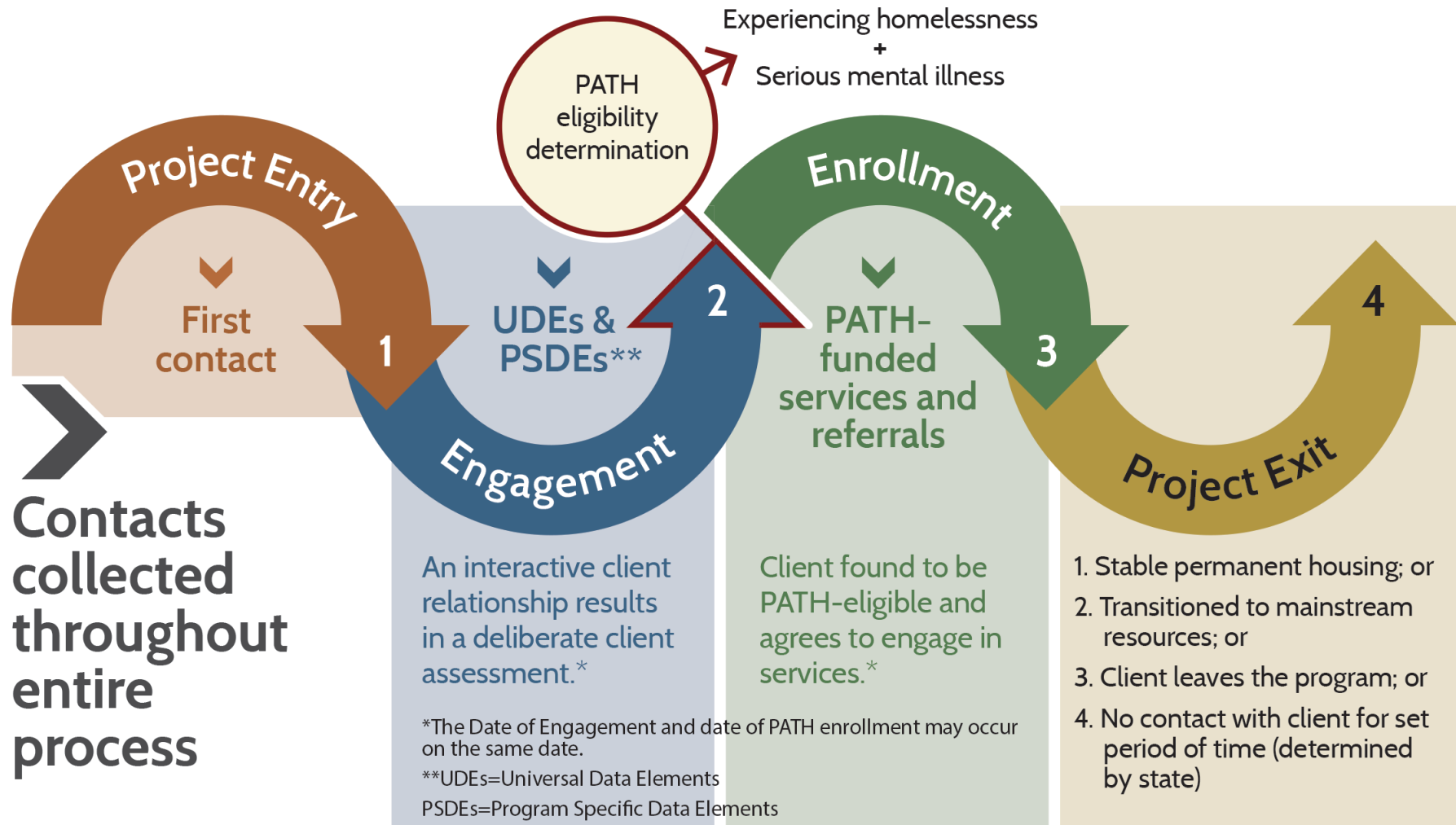
PATH data collection is important not only for meeting federal and state reporting requirements, but also for helping PATH providers and their communities better understand the needs of the homeless population, gaps in services, and ways to improve and sustain services. Having meaningful and useful data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

PATH providers input data into the **Homeless Management Information System (HMIS)**, a locally administered electronic data collection system that stores client-level data about individuals experiencing or at risk of homelessness and the services they access. HMIS administrators and PATH staff members then aggregate client-level data to produce provider-level data about the number, characteristics, and needs of clients who received services. PATH administrators enter provider-level data into the **PATH Data Exchange (PDX)**, an online data collection tool that stores provider- and state-level data. SAMHSA uses PDX to describe and report PATH Program outcomes. The [PATH Annual Report Manual](https://pathpdx.samhsa.gov/UserFiles/Attachment%20A-AnnualReportManual%2004.01.19.pdf) (https://pathpdx.samhsa.gov/UserFiles/Attachment%20A-AnnualReportManual%2004.01.19.pdf) is the best source that you can use to guide you through PATH's reporting process and requirements.

The Institute for Community Alliances (ICA) administers North Dakota's HMIS. You can find more information about your local HMIS on the [North Dakota Continuum of Care website](https://ndcontinuumofcare.org/index.php/homeless-management-information-system) (https://ndcontinuumofcare.org/index.php/homeless-management-information-system) and [ICA's North Dakota HMIS website](https://icalliances.org/north-dakota) (https://icalliances.org/north-dakota). If you are new to the PATH Program, contact your [State PATH Contact](#) to be set up in HMIS and receive data entry training.

PATH providers collect data from the point of initial contact until program discharge. The types of data vary based on the engagement phase. The following PATH Data Collection Workflow graphic (U.S. Department of Housing and Urban Development [HUD], 2020) summarizes the data collection process.

PATH Data Collection Workflow



Source: [PATH Program HMIS Manual](#) (2020)

Data collection begins with the first contact with a potential PATH client. This data point is known as Project Entry. From this point forward, PATH providers record each interaction with the client in HMIS as a **contact**.

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 client about the client's well-being or needs, to a referral to service. A contact must always include the presence of the client; the facilitation of a referral between a PATH-funded worker and another case manager or service provider without the client'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, 2020, p. 5).

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

Date of engagement: The *PATH Annual Report Manual* (SAMHSA's HHRN, n.d.) defines *date of engagement* as the date when an interactive client relationship results in a deliberate client assessment or 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 (that is, if 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 client, the provider can enter data documenting the client's services and referrals in HMIS.

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.

A provider discharges, or exits, a PATH client from the program when:

- they have permanent, stable housing *or*
- they have transitioned to mainstream resources *or*
- the client leaves the program *or*
- there has been no contact with the client for 90 days

HUD's [PATH Program HMIS Manual](#) summarizes the PATH data collection workflow and data collection requirements as follows (HUD, 2020, 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 prior to the date of engagement. The data collection workflow chart 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.

Tables 1–3 outline the HMIS data elements (HUD, 2020) required by the PATH Program.

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



Best Practices for PATH Providers

Incorporating best practices into the services delivered by PATH providers sets up clients 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 impact on people's receptivity to accepting the help offered. This mind-set and heart-set must be genuine and sincere and cannot be fabricated. 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 are described below (Miller & Rollnick, 2013):

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 that you both have important expertise and ideas; and "dancing rather than wrestling"

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; what's important to them; 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 and cultural humility. These principles form the foundation of effective PATH providers and

services. As a result, providers must commit to ongoing training and demonstrate a willingness to engage in self-reflection, recognize their own biases, and actively work to address power imbalances.

Culturally competent PATH providers do the following (Project READY, n.d.):

- 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 different 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 competence 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. 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 in which it disproportionately impacts BIPOC
- Complete racial equity training
- Provide culturally relevant services and resources
- Analyze data on an ongoing basis to identify inequities and develop and implement plans to address them
- Analyze program policies for bias and revise them to reflect the PATH population's varying needs

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:

1. Do not require preconditions (such as treatment acceptance or compliance) for individuals to obtain permanent housing.
2. Offer comprehensive support services to assist individuals in sustaining permanent housing.
3. Offer services but do not require individuals to participate to keep their housing.
4. Prioritize those who are most vulnerable for housing units.
5. Take a harm reduction approach when working with individuals with substance use disorders and do not require abstinence from substances to maintain housing. Providers should also offer appropriate services to support an individual's commitment to recovery.
6. Residents must have leases and tenant protections that follow local and federal laws.
7. 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 that 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, and 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 clients' lives and address trauma survivors' unique needs.

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 interferes with their relationships.

Racial trauma

Racial trauma refers to the negative impact that race-related stress, racial harassment, race-based violence (including witnessing violence), and racial discrimination has on an individual's health 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, changes in appetite) as well as emotional reactions (such as irritability, anger, anxiety, difficulty concentrating) (Counseling and Psychological Services, n.d.). Trauma-informed PATH providers must recognize the specific impact of racial trauma and work to increase their cultural competence and cultural humility.

Promoting physical and emotional safety

Ensuring that 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 the following suggestions for developing safe physical environments:

- Ensure spaces are well-lit
- Use security systems and ensure clients can lock doors and windows
- Visibly post client rights and other important information
- Use culturally familiar signs and decorations
- 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 clients what does and does not work for them
- Being clear about how the provider uses personal information
- Allowing clients 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, visual arts)

Supporting control and choice

Interactions with the service system that cause a client to feel helpless or without control can result in the client feeling re-traumatized. Here are some ways to help individuals regain a sense of control over their daily lives:

- Teach emotional self-regulation skills such as breathing techniques
- Ensure that individuals are equal partners in the development and implementation of wellness plans and goals
- Request client input on program design and policies
- Give clients 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 that there is effective partnership, coordination, and communication across the service system. This can help to decrease clients' 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)	Find ways to share power (for example, requesting client input on program design, encouraging clients to make their own choices)
Provider defines the goals and focuses on reducing negative behaviors	Client defines their goals with support from the provider
Reactive and crisis-driven	Proactive steps taken to prevent future crises
Views clients as broken and needing protection from themselves	Focuses on client 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 & Falot, 2001). This is a powerful shift that can impact all aspects of a program and ensure that clients receive quality services that address their needs.

Motivational Interviewing

Motivational Interviewing is “a collaborative conversation style for strengthening a person’s own motivation and commitment to change” (Miller & Rollnick, 2013).

In *Motivational Interviewing*, Miller and 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

- **Partnership:** Collaborating with the client’s own expertise
- **Acceptance:** Communicating absolute worth, accurate empathy, affirmation, and autonomy support
- **Compassion:** Promoting the client’s welfare, giving priority to the client’s needs
- **Evocation:** Eliciting the client’s own perspectives and motivation

Four processes that guide motivational conversations

- **Engaging:** Establishing the relational foundation
- **Focusing:** Clarifying a particular goal or direction for change
- **Evoking:** Eliciting the individual’s own motivation for a particular change
- **Planning:** Developing a specific change plan that the client is willing to implement

Four conversational skills

- **Open questions:** Offers client broad latitude and choice in how to respond
- **Affirmation:** Statement valuing a positive client attribute or behaviors
- **Reflections:** Statements intended to mirror meaning (explicit or implicit) of preceding client speech
- **Summaries:** Reflections that draw together content from two or more prior client 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?
- 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? (Scaling questions work 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 person’s response, interpretation, and understanding

Harm Reduction

Harm reduction is a set of strategies and tactics that encourage 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, client-centered approach where providers meet people “where they are,” support individuals through incremental behavior change, and view any positive change as significant.

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

- Acknowledges that substance use is a part of our world and recognizes that it is more effective to work to minimize its harmful effects rather than ignore them
- Understands that substance use involves a continuum of behaviors ranging from abstinence to severe use and recognizes that some ways of using drugs are safer than others
- Programs consider interventions and policies to be successful based on the quality of an individual’s and community’s life rather than abstinence from all substance use
- Programs offer services in a nonjudgmental, noncoercive manner
- Ensures that those with lived experience of substance use have a voice in the development of substance use treatment programs and policies
- Asserts that those who use substances are in control of reducing the harms related to substance use and seeks to empower them to share information and support each other

- Recognizes the impact of poverty, class, racism, social isolation, past trauma, discrimination, and other social inequalities and the ways in which they affect people's abilities to address the harms associated with substance use
- Does 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 that PATH providers can use when developing wellness plans. PCRP focuses on giving clients choices in the services that they use and developing wellness plans in close collaboration with clients, ensuring that they are active partners in identifying the services they need and in identifying who should be involved in their support team (for example, family members, employers, neighbors). The PCRP process can begin by asking clients to identify their goals. Providers can then work with clients to determine how PATH services can best support clients in achieving those goals and whether referrals to community partners would be helpful. Clients 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 clients 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 clients:

- 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 on
- Create short-term objectives that help overcome barriers
- Describe interventions or activities reflecting a range of evidence-based and emerging practices
- Work with the client 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 challenges, substance use, homelessness, and other traumatic stressors receive specialized training and supervision to guide and support others in their 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 of time, have completed peer support training, and are willing to share what they have learned about recovery in a practical and concrete way. The lived experience that peer support providers have often allows them to more easily develop trust and rapport with clients and offer a unique perspective to support a client'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) outlines the following strengths that peer support providers add 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
- In a unique position to develop a relationship of trust, which is especially helpful in working with people in trauma recovery
- Developed skills in monitoring their own recovery and self-managing their lives holistically

North Dakota has an official certification process to become a qualified Peer Support Specialist. Additional information about peer support specialists and the certification process is available on the [Behavioral Health Division's website](https://www.behavioralhealth.nd.gov/addiction/peer-support) (https://www.behavioralhealth.nd.gov/addiction/peer-support).

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 wrestle with thorny interpersonal and systemic issues daily. 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 drain and inspire us all at once.

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 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, 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. 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. Parker Palmer in *Let Your Life Speak* suggests reflecting 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 informs the degree to which we give attention to the physical, emotional, psychological, spiritual, and social aspects of our being, or 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, with coworkers, and those for whom we provide care.

There is no 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.

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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