Outreach Services:
Concepts and Approaches

An Edited Transcript of the
PATH National Teleconference Call
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Outreach Services: Concepts and Approaches

I. Welcome and Introductory Remarks

Pam Rainer: Welcome, everyone, to our national teleconference on Outreach Services: Concepts and Approaches. My name is Pam Rainer and I work for Advocates for Human Potential, the technical assistance contractor for the PATH program. I'll be serving as your moderator. We have approximately 300 people participating, and we are pleased that you have all joined us for today's call.

I'll begin by asking Mike English, Director of the Division of Knowledge Development and Systems Change, and Dr. Michael Hutner, Director of the PATH program, both of the Center for Mental Health Services, to say a few words of introduction. I'll then introduce our featured presenters. We've allotted approximately 15 minutes for each presentation, and the remaining time will be for questions and comments from the audience.

A. Comments from Michael English

I want to welcome you to this teleconference on the topic of outreach to people who are homeless and have mental illness. This is an exciting opportunity for all of us, including myself. My job is to help bridge the gap between what we know and what we do. This teleconference is a wonderful example of how we can take advantage of the technology that's available to us so we can share our knowledge with those closest to the work. For those of you who are in the trenches doing the job, I especially welcome you.

With respect to the topic, we just completed a multi-year, multi-site study on serving persons who are homeless and have mental illness, called the ACCESS program. What we learned through this program is that one should not assume that people who are homeless are not willing to engage in treatment or move towards recovery, permanent housing, or productivity in their communities. We can't assume treatment-resistance or that people don't want to be touched by the services we offer. This program will give us much more information about how to do that effectively, and I really look forward to that. I encourage you all to participate in the interactive question and answer format at the end of the program, and make sure you get clarification on the issues that are important to you.

Finally, I want to thank Mike Hutner. In my division, Mike is the person most avid about taking advantage of technology and integrating the PATH program into our many other programs. I'd also like to thank AHP for all the work they've done to make these teleconferences possible.

B. Comments from Michael Hutner

I am absolutely delighted, of course, about the topic of outreach. It is at the core of the PATH program. And I'm also delighted that there are so many people, particularly so many new people, who have joined the call, and I want to say welcome to you. Thanks so much to Michael Malden at the CMHS Office of External Liaison, and Paolo DelVecchio, Director of that office, for arranging our first Internet broadcast of this call. Thanks to Dick Phillips of Social and Health Services, who has been great with the technical arrangements. And I want to, again, extend a special welcome to those people connected by the Internet.

Mike mentioned my special interest in technology, and that's because we're finding that you need to be getting the most up-to-date information, and that you need to be connected with others doing the same very difficult job that you're doing. So often, we're working in isolation, and technology, such as what we're doing here with the Internet, can be an effective tool in getting and keeping us better connected.

II. Panelist Presentations

A. Introductions

Pam Rainer: Our first featured presenter, **Mr. Ken Kraybill**, is a Clinician Specialist for the National Health Care for the Homeless Council. He was also a founding member of the National Health Care for the Homeless Clinicians Network, which began in 1996. The Network provides support and advocacy on behalf of the 135 Health Care for the Homeless programs, nationwide. Ken has 18 years' experience with outreach, engagement, and long-term clinical case management in downtown Seattle, with people experiencing homelessness and those with mental illness and/or chemical dependency. He has also worked as teacher, supervisor, and consultant.

Our second presenter is **Ms. Susan Watlov Philips**. Sue is a licensed psychologist with a private practice in Minnesota. She has worked for 26 years with people experiencing, or at risk of experiencing, homelessness. She is the Founder and Executive Director of Elim Transitional Housing, the first transitional housing program in Minnesota—one that was used as a model for state legislation and the McKinney Act. She was a founding Board member of the Minnesota Coalition for the Homeless, and has served as the Coalition's President and Legislative Chair. Sue is also a Board member and Executive Committee member, and recently served as Acting Executive Director of the National Coalition for the Homeless.

Our third and last presenter is **Dr. Sam Tsemberis**. Sam is the founder and Executive Director of Pathways to Housing, Inc., which provides assistance to persons with disabilities and substance addiction. Dr. Tsemberis is Assistant Clinical Professor of Psychiatry at the New York University Medical Center, and serves as principal investigator for several federally funded studies of homelessness, mental illness, and substance abuse. He has published several articles on these topics, most recently in the April 2000 issue of *Psychiatric Services*.

B. <u>Ken Kraybill—National Health Care for the Homeless Council</u>

My presentation will be a cursory overview of three conceptual frameworks *(Stages of Change Theory, Motivational Interviewing, and Harm Reduction*), which I have found very useful in my outreach work with the Health Care for the Homeless program over the years. Because this will be such a cursory overview, I will ask that you consider reading and exploring more about these concepts.

I'd like to begin with a story. It's actually an outreach allegory that provides two distinct approaches to outreach, and illustrates the value of starting where a person is, and moving ahead with him/her at a deliberate pace towards that person's own goals. The story is called "The Land of Fools," and it goes like this:

"Once, a man strayed into a world known as the Land of Fools, where he saw a number of people fleeing in terror from a field where they had been trying to harvest wheat. There was a monster in that field, they told him. Upon close examination, the man saw that it was a watermelon. The stranger offered to kill the monster for them. He walked into the field, cut the melon from its stalk, took a slice, and began to eat it. Now the people were more terrified of *him* than they had been of the melon. They drove him away with pitchforks, crying, 'He will kill us next unless we get rid of him.'

Years later, a second man strayed into the Land of Fools, and the same thing happened to him. But instead of offering to help them with the monster, he agreed with them that it must be dangerous, and by tiptoeing away from it with them, he gained their confidence. He spent a long time with them in their houses until he could teach them, little by little, the basic facts, which would enable them not only to lose their fear of melons, but even to cultivate them."

In this story, we see that the second man who came into this land was the one trained in *Motivational Interviewing*. Motivational Interviewing is essentially a counseling or intervention technique that integrates good old social work principles about starting where the client is, as well as some cognitive and behavioral therapy approaches. *Stages of Change* is fundamental to the notion of Motivational Interviewing, and is essentially a paradigm shift in how we think about change. *Harm Reduction*, which I'll discuss later, is a mix of several things; it's a philosophy, a set of public health interventions, and a grassroots advocacy effort that incorporates the Stages of Change Theory and Motivational Interviewing techniques. In the outreach work I've done, and in the teams I've worked with, these concepts have been perhaps the most instructive of any in helping to guide our work.

As we all know, people we work with live in extreme poverty and harmful conditions. They face many structural barriers, including a lack of livable wages or income, inadequate housing, mental health care and social supports. And of course, we all know that they encounter many personal vulnerabilities, including physical health, mental health, substance abuse disorders, and history of abuse. I think we've all probably observed that one of the hallmark characteristics of people who are chronically homeless is that they so often have suffered from chronic trauma, often relating back to early childhood. Some writers commonly see this as a

complex Post Traumatic Stress Disorder (PTSD). Domestic violence, of course, is part of that picture as well.

And when it's all said and done, in addition to all these barriers and vulnerabilities, so many of the people we encounter have developed a very low sense of self-efficacy—that is, an ability to effect change in their lives—as well as a sense of profound hopelessness.

When we look at this picture, which is not a pretty one, we have to ask ourselves: "As workers, how is it that we can possibly attempt to promote change in individuals with whom we work?" I think we all know that embracing change, even in the best of circumstances, even when it's in our best interests, and we are supported in it, doesn't come easy. And the familiar is often more comfortable, even if it hurts. John Galbraith has said that, "Given a choice between changing, and proving that it is not necessary, most people get busy with the proof." That is to say, we tend to dig in our heels, rather than pick up our feet and move on.

Stages of Change Theory

So let's move on and look further at the model of change. This model was developed by Prochosk and Declemente, who say that change doesn't depend on luck or willpower, but instead, occurs in seven rather predictable stages. As workers, we need to try to understand the stage somebody is in, given a particular problem, and then tailor our responses accordingly. For example, if someone doesn't even acknowledge that they have a drinking problem, even if we and the rest of the world know they do, it doesn't really make much sense to tell them they need help for that problem. Rather, it requires that we begin at a different starting point.

The main concept that underscores the stage model of change idea is that change is not a linear process, that it happens, instead, in a very fluid, two-steps forward, one-step backward kind of approach. Perhaps a spiral image is more effective to describe how change occurs for us. It's also something that requires a great deal of self-efficacy. The reality is that we do not change people. What we do is cultivate the possibility for change. But part of that cultivation is to try to instill people with a sense of confidence to make changes in their lives, even if those changes might be very minute ones.

The first stage of change is called **pre-contemplation**. It's a kind of euphemism, I suppose, for saying that a person doesn't have a clue. *It's characterized by unawareness, or a lack of readiness to acknowledge a problem.* Often people will say things like, "Just get off my back," or, "If only other people would leave me alone, I'd be just fine." Sometimes we characterize this as denial, but in this particular paradigm, I think it's more helpful to view it as the person having a lack of information, and/or awareness about the problem. And thus, our task as workers is to help increase that awareness.

The second stage is called **contemplation**. Once a person is able to raise their awareness to the point of acknowledging that there might be a problem—and this can take years—the person then moves into a stage in which *they begin to consider change, but aren't necessarily ready to put it into action*. In this stage, people will say things like, "I want to stop feeling so

stuck, but...," or, "I'd like to stop drinking, but I'm under a lot of stress right now," or "I know I need help for my depression, but it's really not that bad." Or they might say, "It would be nice to have food stamps but, you know, it's such a big hassle to go there." *The principle issue at play in contemplation is ambivalence*. Ambivalence is a normal occurrence, and one to be encouraged. We find that when clients are able to explore, with a counselor or a worker, both sides of the ambivalence, it's the best way to determine the direction they wish to take with a behavior.

Once a person has entered the contemplation stage and acknowledged the problem, they then might come to the point where ambivalence becomes more resolved, and they move into the third stage, known as either the **preparation or commitment stage**. This is the point at which people say, "I'm going to do something about this problem." *Intention takes effect in this stage, and people begin to set achievable goals.* Now people might set very high goals, such as abstinence, but it's also likely that they might set something that's much more achievable, on a continuum that allows them to be more successful. So it might be something even like, "I don't think I'm going to start drinking until 10 a.m., instead of at 8 a.m., like I have been," or "I think I'll go to one AA meeting this month, and see what it's like." We need to recognize that even the very smallest goals can lead towards further change.

Once the goals are set, then the individual hopefully moves into the fourth stage—**action**. This is when the person says, here I go. "I'm going to enter treatment." "I'm going to go ahead and see the psychiatrist." "I'm going to go apply for benefits." *This is the stage in which the most overt behavior —action— takes place*. It's important to note that only a very small percentage of clients we encounter are really ready for an action phase, though virtually all our programs are oriented towards people who are ready to do something about their problems. So there's oftentimes a real dissonance there, between where people are in their readiness to change, and where our programs are. PATH, of course, is a good example of a program that helps people through those initial stages of change to prepare for taking these action steps.

The fifth stage is **relapse**. This is the oops, I did it again phase. *It's technically not a stage of change, but relapse is an integral part of the change process*. It's normal. It happens. And we need to see it as a learning opportunity, where we can go back to the drawing board and help people understand what might have triggered the relapse so it might be prevented in the future.

The sixth stage is **maintenance**. *This is the keep moving forward phase*. It would apply, for instance, to someone coming out of treatment and trying to maintain sobriety. This is probably *the most difficult change phase*, because it requires that people make major adaptations in their lives, in terms of who they hang out with, what behaviors they're involved in, and what they fill their lives with to replace the old behavior. This stage is not to be taken lightly.

I've included **termination** as the seventh stage to remind us that sometimes people get to a point *where the behavior itself is no longer something they have to be preoccupied with*. We celebrate their success, even the small ones, and hopefully help them move towards bigger changes.

Motivational Interviewing

So how does all this all relate to Motivational Interviewing? Motivational Interviewing is *a series of techniques*, and also *a treatment strategy*, that centrally applies these various stages of change. And I might note that a person, given multiple problematic behaviors, might be at a very different level of readiness to do something about it, depending on the behavior. So we can't just say across the board that somebody is at this stage; it has to be specific to a behavior.

Motivational Interviewing assumes that motivation is fluid and can be influenced; in fact, it is the task of the worker to primarily be involved in trying to help influence that. Its main task is to address ambivalence and resistance while recognizing that the relationship is the key determinant of instilling motivation. Furthermore, it seeks to help people change incrementally in the direction of health. So often, we think of these things as all or nothing propositions, that people are either one way or the other, with no in-between. I believe it's important for us to shift our thinking toward recognizing that change is progressive and incremental.

Let me review briefly the five general principles of Motivational Interviewing. The first is to express **empathy**, which comes from the Greek word "empathia," meaning passion. Essentially, it means *to walk in another's shoes, to have a deep understanding of the feelings, thoughts, and motives of another person*. For empathy to occur, *a relationship must first exist.* Empathy can be expressed verbally, though that's just one means, and I think it's critical to recognize that it's not just about words. More than likely, our empathy is conveyed in *nonverbal* ways, such as through careful listening, attentiveness, reflection, respect and tolerance, and through our behaviors and actions. It's really our whole being that's essential to conveying this sense of identification with an individual.

The second principle of Motivational Interviewing is to help those in the pre-contemplative stages explore their **ambivalence** and come to some *recognition that there's an inconsistency between what it is that they say they want, and what they're doing*. We don't need to beat them over the head with it; rather, we need to be a catalyst for helping them see that inconsistency, and helping them reconcile the discrepancy.

A third principle is that we **avoid argumentation** with people. I think in our own personal experiences, as well as in our work with clients, we recognize that often when we put ourselves in an argumentative position, our own egos are getting in the way, and what we're really doing is causing people to defend their behavior even more so, which leads away from change, rather than toward it. What we can do is help people discover and become aware of their situation and options. We can be what I call confrontative with care, that is to say, we can help elicit the truth and reality of their situation. Sometimes I call it uncovering that which is hidden, and the hidden is sometimes that which is in plain sight, but the person just can't quite see it.

A fourth principle is the notion of rolling with our clients' **resistance**. Resistance is actually a human strength, and if we think about it, it's really quite self-protective. It can keep us out of trouble, and it's often something we do to stand up for what's right and just. We need to

see that our clients' so-called resistance can really be a sign of health and a normal part of the change process. In moving towards a commitment to change, it is necessary that almost all people go through periods of resistance in which they test their resolve.

The fifth principle is that of supporting **self-efficacy**. And as I mentioned earlier, we as workers are not the changers; we are the catalysts for change. For lasting change to occur, we need to support self-esteem and self-confidence, both of which are essential to self-efficacy.

Harm Reduction

So how does the notion of Harm Reduction fit into all this? Harm Reduction is a somewhat confusing concept, and in many respects, represents three different ideas. First, it's a set of **public health interventions** that have been around forever. Literally since the beginning of humankind, people have been involved in reducing harm. Let me illustrate: When we brush our teeth, when we give our children vaccinations, build sewage disposal plants, or put on seatbelts, we are engaging in Harm Reduction. Harm Reduction is a grassroots advocacy effort, one that tends to be more focused on targeting drug users and those involved in unsafe sex. In a more narrow definition, Harm Reduction is a set of strategies and tactics that encourage individuals to reduce harm done to themselves and their communities by their licit and elicit behaviors. In that sense, the goal is to educate the individual about becoming more conscious of the risks of their behavior, and to provide them with the tools, ability, and support to reduce those risks.

Second, Harm Reduction is a **philosophy** espousing that all people be treated without discriminatory attitudes and practices, and that we begin with all people where they are, rather than where we think they should be. Typically, the first priority of Harm Reduction is to decrease the negative consequences of a behavior, rather than focus on reducing its actual prevalence. This is a fairly major shift in the way we often think.

Third, Harm Reduction is a **humanistic, individualistic approach** that accepts risk as a natural part of life. It also puts risky behavior on a continuum where some behaviors are more dangerous than others. It takes a client-centered approach and looks at the relationship to their behavior as defined by themselves, not by society or by the worker. Harm Reduction accepts that change is often incremental, and that any positive change is significant. Interventions are not rigid, but innovative and tailored to the individual.

Closing Remarks

In closing, I want to spend a few moments on how we outreach workers are involved in helping people affect change in their lives. At the National Health Care for the Homeless Council, we encounter people on the streets through our Street Corner Assessment Program, where we make small talk and build trust. These are all things that bring people into a tentative—but nonetheless—a relationship, which has the potential to help them reduce harm in their lives. Obviously, when we offer food, blankets, clothing, hygiene, and supplies, we are also helping people find some self-protection from the elements and effects of being on the streets. Money management, case management, advising, counseling, and crisis intervention are also ways we intervene to reduce harm in people's lives. A very good example of a harm reduction

approach is the Safe Haven Model, which says you don't have to be compliant or adherent to psychiatric treatment, that you don't have to be drug/alcohol free, to receive shelter. It says, you are welcome here, and in the course of your being here, we'll accept small, incremental changes along the way.

When we talk about psychiatric interventions – and this might be a little more controversial – but in my own experience, I've learned that when psychiatrists or nurse practitioners who can prescribe drugs, spend more time with patients, they help bridge the gap between patient and provider, and lead to a client's acceptance of services. Regarding medications, sometimes starting with an extremely low dose that's not necessarily going to be biologically therapeutic, but might be therapeutic in terms of allowing the person to get used to the idea of taking meds, is one idea we might take on. Maybe we'll say to people: "Why don't you just try this on a time-limited basis and see how that goes?" Or we permit them to take meds on a PRN basis, give them IM meds, or monitor their meds. These are all, in my estimation, ways of decreasing harm and helping people increase health in their lives. For those using substances, instead of saying, "You have to be sober and drug/alcohol free in order for me to work with you," we might take the approach of helping them decrease their frequency or amount of use, or even alter the time of day or week that they use. Obviously, other harm reduction models out there such as methadone maintenance and needle exchange, are examples of programmatic responses.

As outreach workers, we can never just be involved in the care of individuals, so I think it behooves us, given our experience and our standing, to also be involved in advocating— which literally means giving voice— to the systems that be, to help them improve care for our homeless clientele. I would assert that when we become involved in systems advocacy, in whatever form that might take, we are involved in a systems-level harm reduction application on behalf of our clients.

C. <u>Susan Watlov Philips – Elim Transitional Housing</u>

As Pam mentioned, Elim began in the early '80s as an outgrowth of a church-based shelter. Our agency development, and the development of all the services we provide, is based on what people tell us. So a lot of what you'll hear from me today is that it's very important that we listen to what people say their needs are, what their dreams are, and what they want their lives to be like.

In developing the transitional housing program, we spent time listening to people at the shelter about what they saw as the step that would have prevented them from becoming homeless in the first place, or that would assist them now in moving back into the community. What they described was scattered housing throughout the community where staff weren't necessarily on-site, but where folks could come and go, and do the things they needed to do, had a phone, newspaper, and some help getting the types of services they needed within the community. And that's really the design of our transitional housing program. We've helped start over 100 programs in Minnesota, and have done consulting in 35 states.

Elim serves in a three-county metro area, in five Continuums of Care, and six consolidated planning communities, or about a 1,200 square mile area. We work very closely with our PATH and Access providers within those communities. The populations we serve are women, men, children, youth, single and two-parent families, gays, lesbians, people with HIV+ or AIDS, and people with mental illnesses, chemical abuse, dual diagnoses, and multiple diagnoses.

Elim is primarily a scattered site approach, utilizing a variety of rental units and permanent housing. Both our staffing and our Board of Directors reflect people who are experiencing, or have experienced homelessness. In fact, 60% of our Board, including our President, Vice President, and Secretary, and over half our staff, have experienced homelessness at some point in their lives.

We provide prevention services for both mortgage and rental assistance to help people stay in their own housing; we offer an assessment of every family that enters the shelter system in Hedepin County; and we help over 1,200 families per year access community resources. *Rapid Exit Services*, which in some communities is known as *Housing First*, enables us to assist individuals and families in quickly moving out of a shelter into some type of housing. We provide about 70-80 units of transitional housing scattered throughout the three counties, and we have 26 units of permanent supportive housing, 32 that are in-process, and 135 permanent housing rent subsidies. That's just to give you an idea of the 3,500+ people we're working with on an annual basis.

Health Model

I'd like to talk more specifically about how we work with people. Our **Health Model** is neither problem nor illness-based, but rather asks, "what do you want in your life, how can your life be healthier, and what steps will help make that happen"? This is quite a shift from what often happens in social service agencies, which is that you need to do this and that to fix yourself. Instead, the Health Model gives people permission to start thinking about what they want their lives to be like, what their dreams have been, are, or what they may want them to be. Oftentimes, that's a very difficult thing for people living on the streets, in their cars, or in abandoned buildings. But as we interact with folks, spend time getting to know them, and provide them with basic services, they begin to start seeing the possibilities for their lives.

We don't offer case management with folks living on the streets, in shelters, or other settings. We're more interested in crisis intervention and trying to help people meet their basic needs, such as food, clothing, appropriate shelter, and safety. To help people take those steps toward a healthier place in their lives, we believe stable housing, such as transitional, permanent, supportive housing, or rent subsidies is a key component. Prior to getting folks stabilized, much of our work is trying to make that connection so people can sense that we're really on their side, that they can trust that we have their best interests at heart, and that we're interested in helping them develop the healthiest lives they can. Some people—it's a small percentage in our area—are not necessarily interested in coming inside. For them, home is more of an outdoor location. Therefore, it's essential that we create a safe environment where people can at least come and

have their basic needs met.

Part of the work we do in training our staff relates to **Maslow's Hierarchy of Needs**. We think about what we can do to help stabilize people before helping them meet their higher needs and goals. We also discuss the fact that people will tend to sabotage their case management plan if they're not feeling safe and if their basic needs are not being met.

Reality Therapy

We use Reality Therapy as an approach to meeting people where they're at. We also spend time in helping people recognize that change happens only in the here and now. We're not going to change what's happened in any of our pasts, and we're not going to change the future, unless what we do today creates a healthier lifestyle for where we want to go in life. Therefore, we spend very little time dealing with past issues, other than with things that get in the way. We spend a lot of time talking with them about what they want their lives to be like, and what they need to do today to help them move in that direction. We spend time talking about taking responsibility for our lives, and make it clear that as outreach workers, we can't change another person. In fact, it's patronizing to imply such a thing. We encourage them to take responsibility for their decision to change or not, and offer support, such as access to services, that can help them make those changes. We also stress that as members of a community, they are responsible for others around them too. We stress this point because one of the things we often see with people experiencing homelessness is that they've become very isolated and tend to feel disconnected from the community. They may, however, feel connected to others living in the same shelter, or with those whom they share the same campsite on the streets. So we provide an opportunity for people to see that they're not only responsible for themselves, but that they're part of a community, and are welcomed as a member of our community.

We also need to think about how we treat the people we employ, and assure that our employees are paid a living wage within the community, have stable housing, and have their basic needs met. If we're not providing that type of compensation, it's going to be very difficult for folks to model the types of healthy behaviors that will help others take a chance on themselves and move ahead with their lives.

Another crucial aspect of our work is to help people identify behaviors that are keeping them from making positive changes in their lives. We then explore those barriers and strategize how to reduce some of those harmful behaviors and replace them with healthier ones. Again, going back to the Harm Reduction Model, it's certainly a model we utilize a great deal in all aspects of our program. We also utilize a guided discovery approach in helping people realize their options and choices—particularly those resources available in the community—in making the changes they want.

For many of the people we work with, a sobriety model for dealing with chemical issues is not one that's going to work. Usually, they've tried it many times without success. In these instances, a Harm Reduction Model may be much more helpful. Some folks who've been in different types of mental health systems may not see sitting down in a one-on-one therapy situation as the most appropriate way to deal with their mental health issues. Instead, we conduct

peer or group counseling sessions or other forms of work with mental health providers, to help them work through some of the issues and emotional difficulties that keep them from being as healthy as they'd like.

At Elim, we treat the people we work with as fellow human beings on a continuum to health. We realize none of us is all healthy, just as none of us is all "sick." Rather, at various stages of our lives, we are in different places on the road to health.

Working with PATH and Access Providers

I'd now like to go over a few examples of how we're working with some of our PATH and Access providers. In our Rapid Exit Program, we work closely with both individuals and families in helping to establish connections with the shelter system and those living outside. We then work in conjunction with the PATH and Access worker to assist people in identifying the directions in which they want to go. Along with our case manager or advocate, we work to help them obtain those services on an ongoing basis.

One of the newer programs we're being funded for falls under the Permanent Supportive Housing Program. It's very similar to a Safe Haven Model, but with the 30% set-aside for permanent housing, it's much easier to do, while applying a scattered site approach. We are, however, going to use a Safe Haven Model within the Permanent Supportive Housing Model. The Access or PATH worker will continue to be involved with people as they move into one of our housing situations. One of the key things we want to be sure of is that the housing programs we're developing are flexible and tolerant of the variety of issues people are dealing with. Therefore, we'll allow them to move back and forth, if they need to, between the housing and outdoor location, until they're feeling more and more comfortable being inside.

Closing Remarks

Let me conclude by saying something similar to what Ken said earlier. One of the key challenges in this decade for us as providers is whether we're going to continue to institutionalize this homeless system we created in the early '80s, which was really an emergency, urgent system designed with the development of the McKinney Act to address the immediate needs of people experiencing homelessness. I think what's happened over the last 16 or 17 years is that we've created this institutionalized homeless provider system, as opposed to really addressing the issues within our mainstream systems that have prevented people from utilizing the system, such as not creating permanent affordable housing options. So I think one of the challenges we have to look at is, are we just providers or are we really about ending homelessness within our community? While recognizing that there are always going to be people who are homeless, and those who move in and out of housing, it's unacceptable for a society as wealthy as ours to have 3.5 million people experiencing homelessness.

It's important that we be more than providers; we must be advocates, as Ken said earlier. As well as maintaining our mainstream programs, we must also continue to work within our communities to make structural changes and promote the creation of permanent housing and permanent supportive housing options. We must also make sure that we are not the voice for those we serve, but rather, that we encourage and provide opportunities for them to use their own

voices, their own power, in advocating for themselves and telling their own stories.

To summarize, if we can utilize more health models, as opposed to problem-based models, we can begin to see possibilities for people's lives, and help them start dreaming about what they want. Dreams are incredible motivators. Sometimes we don't end up having exactly what we dreamt of, but that dream helped us get to where we are now. Hopefully, all of us are still dreaming about where we want to go, and that becomes a motivator for us to develop healthier lives.

I want to thank you all for the incredible work each of you do every day, because it's making a significant difference in your community, and in people's lives. But still, we need to do more. We have to be advocates that call upon our communities and our country to do much better, to be sure that everyone has equal protection of civil rights, a livable income with health services, and most of all, a decent, safe, affordable place to call home.

D. Sam Tsemberis—Pathways to Housing

Thank you Ken and Sue for laying so much groundwork for us today. I'd like to share my experience working with people who are literally street homeless - which has really been the sum total of my contact with people who are homeless - and also to talk about some of the system issues I've encountered in working with this group in New York City. And lastly, I'd like to offer what I've learned from that experience.

Serving People Outside the System

I think the issue of housing is so central to our work that it permeates even our clinical interventions. Let me tell you that the group we've focused on that's chronically homeless, living on the streets, in parks, or in the subway system, represents a small segment of the homeless population, but is also the most difficult to engage, the most vulnerable, and in terms of service, the costliest. We have what Sue described as the national system of care, which is a continuum that begins with outreach workers, and then goes to drop-in centers and transitional residences, as Ken discussed, and then ultimately to permanent housing. It is indeed a homelessness industry that serves a good portion of the population well. But I want to focus on the people that remain outside that system, and discuss some of the issues as to why they continue to remain outside the system, and what we can do about it.

The prevailing program model, or philosophy in the continuum of care in trying to address people who are homeless, mentally ill, and using substances, is to first address the drug problem or the psychiatric problem in an effort to get people housing-ready. And this approach, which is sort of the practiced paradigm, is not working for people who remain on the street. For them, they see the system in a way that's different from the system the provider sees. So, there ends up being a kind of friction between what outreach teams are offering and what people actually want.

Housing First

For those who have been on the street for a long time, when you ask them about their

hierarchy of needs, they will say they want housing first. This idea of getting treatment first is either representative of an early stage of contemplation, or no contemplation at all, whether it's about their substance abuse problem or their mental illness. Many who are severely mentally ill don't acknowledge it at all. Some don't even acknowledge that they're homeless or abusing substances. So the idea of selling somebody treatment as a way to get housing is not a great ticket. The problem we experience as outreach workers is that there are very few programs that will honor a client's request for housing first. Sue mentioned a few in Minnesota, and we operate one in New York City, but that's not really the prevailing model.

We, ourselves, have been raised using a psychiatric rehabilitation approach, which looks to maximize people's functioning, and doesn't use a biological psychiatry approach, but rather assesses people's abilities to function. We use all these fine clinical technologies, such as Motivational Interviewing, Harm Reduction, or health practices. We then work with a goal-setting technology that is assisted by the rehab counselor. And this will work. All of these things will work fine, depending on whom you're working with and what the problem is. And you will get people to the next step. As an outreach worker, if you're on the streets, you'll be able to get a person to come to the drop-in center, or you'll be able to get a person to go to the Safe Haven. And you've spent all this time giving them hope and aspirations, only to sever that relationship the minute they go to the next program step, where you have to then refer the person, and then you leave. And they either make it in that program, or you meet them again when they fail, and they're out of the Safe Haven, or out of the hospital, or out of the prison, and then back on the street at the usual location. And you start all over again.

This kind of *circularity*—in having to go step-by-step through the programs, in having to first prove their ability to be treated for their mental illness and substance abuse, and then subsequently, to be offered increasing levels of permanent or independent housing—is so frustrating for both the worker and the person who's homeless.

Applying a Client-Centered Approach

Now, if you believe what I just said, then I think it requires a shift, in terms of your empathy and in terms of the consumer's point of view of the system. To continue to advocate for going to the drop-in center, or going to the Safe Haven, or going to places where people don't want to go – I'm talking about the sort of entrenched street group – and insisting on selling it as more than it is, will not be helpful. If you can**,** empathize that for this person, this system does not work, that it is, in fact, a terrible thing that you can't refer them to housing. And that it is, in fact, coercive to insist on their taking medication or being clean and sober for a period of time before they can get housing. We need to understand it all from their perspective, and to reflect it back for them is a helpful way of letting that person know you're both working against this difficult melon, if you will, and that together, perhaps, you can work towards the same goal.

A similar approach is helpful in addressing psychiatric hospitalization, and other kinds of unwanted treatments. And it's important to understand how the person you're working with feels about these things, and, again, to reflect that position back to them. The things we need to do are often the things that aren't necessarily expected. If you can, figure out a way, through your own initiatives, or perhaps with the blessing of the program you're in, to go beyond the boundaries of

the existing program and maintain some kind of a relationship with the person through all steps in the continuum. It's not the most widely practiced approach, but I think, informally and formally, that it would not only be possible, but effective to do so. To provide some personal continuity in a program structure that's fraught with discontinuities would be a very, very helpful thing.

Closing Remarks

Just to say a thing or two about the program we've been running since '92. After years of frustration, we started a supported apartment program, similar to what Sue was describing in Minneapolis, where we invited people who wanted to be housed, directly into apartments of their own. These were independent apartments with strong clinical support services backed around them offsite, with 24/7 availability on a beeper, and so on. It was a risky time, initially, because having grown up in the Continuum of Care model, we knew we were kind of violating a few assumptions about jumping the gun on treatment and sobriety. But since that time, we have housed more than 400 people in these apartments, and more than 80% just off the streets, remained housed. Over the years, they began to participate in psychiatric treatment, in work, and in reconnecting with families on their own journeys toward recovery.

Back to Maslow's hierarchy about what did the person on the street want first, and what were they ready for? – And who is more ready for housing than the person who is homeless? By meeting that housing need first, by giving them that first essential security of a home, we provided them with an avenue to continue on their path toward recovery.

III. Case Studies

A. Introductions

Pam Rainer: We now have two case studies to be presented by outreach workers who are willing to share a challenging case example for discussion and consultation with our three panelists.

Our first presenter is **Suzanne Grubaugh**, who has more than 27 years experience as a social worker, and is currently the dual diagnosis money manager at St. Joseph's Center, a PATH provider located in Venice, California. She develops programs to assist persons with mental illness who are homeless in obtaining and retaining benefits.

Al Teague will present the second case example. Al has several years experience as a homeless outreach worker at Waccamaw Mental Health Center in South Carolina, where he provides community-based services to people with dual diagnoses who are homeless.

B. Suzanne Grubaugh – St. Joseph's Center, Venice, CA

Thank you to all the presenters. I've truly enjoyed your presentations, and have drawn something from each one. My client is a 54 year-old Caucasian male. He has diagnoses of shared psychotic disorder, mood disorder, cyclodine abuse, and alcohol dependence. I first met him on the street in March 2000. He subsequently entered a closed rehab facility, went through the nine-month program, and approximately two weeks before he was to be released from that program, he went back out on the street, where he is currently. He maintains frequent connection with me, and I see him three times a week. He has access to pieces of other programs, but I am the most stable contact he has at this point.

He's now back in the contemplation phase. He's talking about ambivalence, about the reasons he'd like to get sober again. He refuses rehab because he doesn't want the structures. We're working strictly from a harm reduction model with this person. He's also one of the people who says, "I want housing, and I want it now". And unfortunately, he's not meeting the criteria for the housing we have available. I would really appreciate suggestions on moving with him toward readiness for getting sober, and also suggestions on helping him negotiate the process toward housing.

Susan Watlov Philips: Could you just talk very briefly about the types of housing available in your community?

Suzanne Grubaugh: Primarily they're dry houses, sober living facilities. We have some transitional housing and we also have shelters. But again, a requirement for all these is sobriety. We have a few places that are trying the Safe Haven model, but it's not yet institutionalized. Priority is sometimes given to our clients in our Section 8 programs. We have vouchers through our agency and programs to help them receive those vouchers. But unfortunately, the availability of Section 8, (we are in the Venice, Los Angeles, Santa Monica area) is minimal, even with the vouchers. So basically, what we're looking at is that even to enter a rehab program, which he refuses to do, he must have a minimum of 72 hours sobriety. He's on SSI, and we do have rent subsidy money available through one of the agencies I refer clients to. It's not an ongoing subsidy, but it is a subsidy for first and last month's rent, damage deposit, moving expenses. This would provide him with enough assistance for getting into an SRO. Usually we've had very good luck negotiating with apartment managers, housing managers, etc., through our program.

Susan Watlov Philips: I would try the Housing First model, or the Rapid Exit model that we were talking about earlier. You obviously have a very good connection with him in helping him obtain other types of services. I would continue with the Harm Reduction model, and maybe look at some other possibility of getting him onto a list for Section 8 that could eventually help with the apartment cost. But if he does have a disability, and that can help in paying for a good portion of the rent, I would try that model first. Unfortunately, as was talked about earlier, a lot of providers require that people be sober. I think getting people into a stable housing situation, and then helping them work through their harm reduction, or their chemical health, is very similar to what we do with the rest of our population. We have a very high chemical use in the general population, and we don't require anybody to be sober to get a mortgage, and we don't require most people to be sober to get into any other type of rental

housing. So I think it really is a ridiculous prospect to expect that of people experiencing homelessness.

Sam Tsemberis: I agree with Sue about Housing First. By the way, it's not surprising that he escaped rehab with only two weeks to go. Most people leave long-term treatment programs, or try to escape prison in the last month before their release. There's something about the freedom beckoning that is just intolerable, and that's a very risky time. But if you could get him to this housing, I would also encourage you to keep your relationship with him, which sounds very strong, but add a money management component to it, if you could. Then you would see him on a regular basis around the money management, and could help ensure that his rent is going to be paid. But I would wonder about his other capacities to maintain an apartment, and his vulnerability around other folks, and would take that all into account in the assessment.

Suzanne Grubaugh: He is extremely vulnerable to other people. Peer pressure just wins him over instantly. The request for housing is a new request. He has previously been very happy with his homeless status. And with our weather out here, that isn't usually problematic for people.

Sam Tsemberis: Because it gives him the money to drink. It's a tradeoff to sleep on the beach, but be able to buy alcohol.

Suzanne Grubaugh: Exactly. Given the likelihood that I can't get him into a facility that's using a Safe Haven model, I'm wondering if anyone has suggestions for negotiating with landlords, so they'll be open to working with this client? How can I help educate them about the realities of mental illness and substance abuse without violating my client?

Sam Tsemberis: I think our experience with landlords is that they're more interested in the consistency of the rent payment. And as long as your client isn't disruptive, or in some way violating the lease, it may not be a big issue.

Ken Kraybill: I think we have to not only assess what this man needs, or says he wants, but also what the nature of the SRO housing is. I'm familiar with SRO housing, as we all are, which is probably much worse for the individual than living on the streets, or even in a shelter. And I just throw that out, because if we just seek housing first without taking into account the fact that this may or may not be a safe place for him, then I think we err by not taking a fuller look at things.

Sam Tsemberis: I guess that's a point of difference in geographical areas. Because he's in Venice, there isn't really the risk of the weather, but in another geographic area, such as New York City, the housing we find in affordable neighborhoods is not in great buildings. But still, I think the risks of life on the street, especially with the difference in weather, is a much higher risk. Regarding the landlord issue, letting them know they could reach you would also be a very supportive thing. If they know they're going to have a steady rent stream, and know there's a responsible person to call in the event of any problem, landlords may be more willing to work with you.

B. Al Teague—Waccamaw Mental Health Center, Waccamaw, SC

Al Teague: I work with a 38-year old white male named Eddie in Myrtle Beach who's been homeless for 35 months, living either in an abandoned shelter or building, or in the woods. As Ken mentioned early on in the call, some of these folks have been traumatized early on. He fits that bill. At age seven, he and his mother moved away from his alcoholic dad, and a year later he was placed in an institution. Over many years, he proceeded to run away from these institutions. He then tried to live with his dad, but received beatings and abuse nearly every day. His dad died in '81. His mother is mentally ill, and there's an extensive history of mental illness in his family. He moved to our area from Connecticut, so we don't have all his information. We know his diagnosis is post-traumatic stress and anxiety disorder. He was on SSI prior to his contacting us, but then he lost it. We've had him in housing for almost a year, but he still hasn't received his SSI benefits. It appears to be a legal problem with the state of Connecticut. And as he's told me, he pleaded guilty to some charge because, he said, the police intimidated him.

Eddie's very isolated and hates being around people. He has a fear of being inside buildings because they smell like the institution he once lived in. He also fears medication. I think now he's more in the contemplative stages. Since he's been in housing, we've had to work towards him maintaining that housing. He's under PATH Shelter Plus Care housing, but he's had to pay his own electricity. We've been able to do that through problem-solving and utilizing community assistance resources. Because of the continuous kind of crisis there, he's now come up with the idea of working at a church where people are kind.

This weekend we had really great weather here in Myrtle Beach, and low humidity, which is rare for this time of year. When I asked him what he did this weekend, he told me he stayed inside all day. He says he's always been a loner. He has a lot of rage and outbursts. Sometimes he'll go out early in the morning looking for cigarettes and change that people leave around. While he's out, he'll yell out vulgarities, but they're usually from a distance. He has no history of violence. He seems to be very honest with me. He's compensated now, but is not sleeping very much. He has a lot of depressive type symptoms, and his biggest fear is that the police will come knocking at his door.

Eddie sometimes presents himself extremely well, and says everything is fine. However, we had a recent incident where his food stamps had to be renewed, and so the psychiatrist had to sign off on his not being able to work. Because of his lack of forthrightness with the psychiatrist, it really created a problem. So he now knows that he's got to tell the psychiatrist what's going on, and he's willing to do that to a degree, although he feels like he may have burned his bridges there. So now he's going to a new psychiatrist.

I've worked with Eddie for over a year, probably once a week or once every two weeks. My time with him involves a lot of problem-solving, and I'm really looking for ideas on how to continue engaging with him.

Ken Kraybill: Unfortunately, I think you present an all too common case, but a very complex one. And I think you describe very accurately someone who is suffering from this complex PTSD, as I think it's most accurately called. Just as an aside, I don't know if you're familiar with a book written by Judith Lewis Herman, out of Harvard, called *Trauma and Recovery*, but in the group I've been doing direct practice with, we found it to be very transforming in how we viewed many of our clients. We began to recognize that so much of the symptomotology we were seeing, which was hard to define categorically, was really a result of this early and ongoing childhood trauma. And I think you're seeing the manifestations of it.

It sounds to me like you have developed a personal relationship with Eddie in which he feels a large measure of safety, and ability to reflect on his situation. And that is always the key starting point, in my mind, that, in order for him to be ready, to interact with the psychiatrist with other systems, it's going to have to still be centered in that recovery relationship he has with you. And that's because he's suffering from a trauma of relationship. So he's rebuilding, or at least experimenting with you, which is probably a new experience for him.

I don't know if you sit in on appointments with Eddie's psychiatrist, or if you've been invited to do that, but the one suggestion I would make is that you do that, if possible. I've often found that when it's a team approach, when we surround people with a circle of care, that's often more helpful. And it also gives an opportunity for you to give voice to some of the things Eddie might have said to you, but is afraid to say to the psychiatrist. That would be just one starting point that I would recommend.

Sam Tsemberis: What do you think about his desire to work?

Al Teague: Well, I see it as progress, because his dream was to be a caretaker in a park, but not have to socialize with anyone. I tried various places and gardens around here, but nothing worked. While I was talking this over with him, he eventually came up with the church idea. I still think he's got a lot of fear about it, though, because he doesn't know how to handle the lunch breaks.

Sam Tsemberis: I think it's a very positive move that he wants to do that. Do you think that you could find a way to help him with coping with that lunch hour? People don't necessarily have to sit and socialize during lunch breaks. They take walks, do chores, or some sort of independent activity.

Al Teague: That's a good idea. We've got to go ahead and firm up job possibilities. It does happen that he has a background in Catholicism and the Catholic church community, so that's where we're trying first.

Sam Tsemberis: Has he had much contact with others? I'm asking because I'm wondering about the possibility of his having a roommate to share the rent.

Al Teague: He hasn't had much contact with others. Although, he recently befriended a man who is alcoholic and homeless. Actually, I've ended up doing a little work with this other

fellow. Eddie's also had one contact with a lady in the library he once visited. But other than that, he's mostly by himself. He's a real meticulous type. If he could room with an animal, he'd definitely consider it, but as for another human, I don't think he'd go for it.

Sam Tsemberis: My feeling is he's lucky to have found you, and you've got a great opportunity for taking this man to the next step, wherever it may be.

Al Teague: What's the likelihood of getting him back on SSI and receiving any benefits? He says when he's totally inebriated he can socialize. His feeling is that he can never get that through any kind of medication.

Sam Tsemberis: Not only are there better options on the psycho-pharmacological side for social phobia, but it's relatively inexpensive. If you can get him on a benefit, he can get it through prescription. You might need a lawyer if there's an outstanding legal issue, and for the SSI, I'd go legal advocacy.

Al Teague: I've done that, and I've tried to engage through our Senator's office here in South Carolina. It turns out that Senator Dodd from Connecticut is on the Human Services Committee, and so we're trying to get a tie-in with him, but I'm getting nowhere. An advocate here is volunteering to help me. The Department of Mental Health has already said they'll do whatever legal work is necessary once we get a door opened up in Connecticut, so we're pursuing that.

Suzanne Grubaugh: With regard to your comment that he'd prefer an animal living with him, there may be therapy animals in your area that he may be able to house and receive some sort of compensation for.

Al Teague: Thank you, those have all been helpful and thoughtful suggestions.

IV. Question and Answer Session

Q: I have two questions. How do I go about promoting the creation of a Safe Haven in New Jersey? And who is eligible for, and how do I get a therapy animal in New Jersey?

Sam Tsemberis: You may want to check out the Supportive Housing Network. It's an advocacy group for permanent housing located in New Jersey.

Suzanne Grubaugh*:* The primary avenue for a therapy animal would be either through the local Humane Society, or through one of the main pet stores. Failing that, you might contact long-term care facilities, because that's the primary place therapy animals are used. They may have a suggestion for you, or they may know somebody who has a therapy animal, and that person could direct you.

Q: I'd like to know if the Harm Reduction Model conflicts with the AA principles?

Ken Kraybill: That's a very good question. Some say they're compatible, and some say they aren't. I think there are some areas of compatibility. There's that step-by-step process in both models. I think the difference is that in AA there's this need to embrace something outside of yourself—a higher power—that you have to admit powerlessness over the behavior you're engaged in. I think the Harm Reduction Model would not embrace that, but rather would say you have the power within yourself to do that, and that it's the motivational factor that helps people find self-efficacy. I will say personally that I think it's possible to hold both as true.

Q: What is your feeling or attitude toward the chronic relapser? The weather conditions here in Florida are conducive to people living outside. And there are some people who have strongly chosen this as a lifestyle; but some of us have a hard time accepting that. We would like them to think otherwise, I guess. And many times, there are people who just say, look, if I can get day labor and buy a little bit of food and whatever else I need, I'm fine. The individual I'm referring to has been to our agency repeatedly and we've tried everything. He needs a place to live, but when I try to connect him with some sort of housing, he'll stay for awhile, then leaves and goes through it all again. He was in a drug program, but continues to go back to the same one. He's tried St. Matthews, or other places, but none of them have worked for him. We've tried housing and homeless outreach, but that's been unsuccessful. Do you think we should be working on another area instead of continuing to try to house him?

Sam Tsemberis: It sounds to me that you're trying to drive the person, in terms of getting him into whatever treatment options are available, and that's not really working. I think the housing approach you mentioned also isn't working. That's different than some of the Housing First approaches we've been talking about, where they try and get the person into some kind of stable housing. I do think you can still take a motivational approach, and recognize that there might be risks this person is living under that could be reduced. To learn what those risks are could only happen through the relationship itself. Of course, I don't know what those risks are, but my sense is that there are probably good reasons why this man does what he does. By continuing to offer a relationship that's more receptive than directive, I think you might discover some nuggets of truth in there.

You have to let the client define what he needs from you, rather than guiding him toward what you think he needs. But you have to have the patience and tolerance to just let him say what it is he wants. In the context of this Housing First idea, we have to remember that it's still based on what the client states they want. And it's not our job to come in with a housing first priority; it's theirs. Oftentimes, this requires months, if not years, of engagement that simply involves listening to the person's story, and reflecting back to them what you're hearing. This is very basic, elemental relationship work. It might be necessary in your case to back away from offering services and, instead, work on developing and nurturing the relationship.

Q: With regard to the Harm Reduction model, what would you recommend, treatment-wise, for a client diagnosed with schizophrenia who has a history of decompensating while in stable housing? I've known the client I'm referring to since December 2000. She doesn't have a substance abuse problem, and she refuses to take any anti-psychotic medication. We haven't

been able to hospitalize her because she hasn't been an immediate harm to herself or others. She has delusions about contamination, poisons in the water, stuff coming from the carpets. And these delusions get so bad that she'll actually get evicted, or she'll just leave the apartment on her own. When she gets into a shelter, she actually improves psychiatrically. She has complaints there as well, but she's not as delusional or psychotic. She says she wants to get into her own apartment again. Yet, once she gets into another apartment, the situation repeats itself. This has been going on for 10-15 years. She'll often stay in one place for just three months, but I think the most she's lived anywhere has been up to two years.

We've received records from the neighboring county where she received psychiatric services for years, and we've also had contact with family members who told us of her eviction history. We got her housed back in April, and she's just now starting to decompensate, talking about poisoning and contamination. This time, it's happening pretty quickly.

Sam Tsemberis: I would say you have two options. If you can reach her, you can talk to her about what's going to happen, which is what's happened many times before. If she's interested in averting that, you can help her. Or if she's beyond that, even though she doesn't present a danger to herself or others in the immediate sense -- and I don't know what your State laws are regarding mental hygiene practice -- I would be inclined to persuade a mobile crisis team to hospitalize her before she's evicted, saying that this is her pattern, her history. She may not be dangerous now, but she's going to end up on the street, and she will be a danger to herself when she's on the street. It might be worth a hospitalization. If she's hospitalized, she can't be evicted, and you can hold on to the apartment. She'll have a short stay in the hospital, she might stabilize on medication, and you may be able to avert the cycle this one time.

Ken Kraybill*:* The State I work in allows for the possibility of getting court-ordered treatment without hospitalization. That also might be worth pursuing. Though people with fixed delusions are generally not prone to responding well to cognitive type approaches, I firmly believe that every person, whatever their level of psychosis, has some grain of recognition of what's going on within them. Trying to appeal to that continues to be something I keep in mind when I'm talking with somebody, so as not to let the delusion be the all-consuming, defining issue.

Sam Tsemberis: I agree with that completely. In fact, even if you're planning to try and get some kind of mental health warrant, I would explain to your client what you know every step of the way, and speak to that rational person, which I also believe is there.

Suzanne Grubaugh: Sometimes we begin to withdraw when a person seems to be stable in housing, and they've had that structure and outreach support. Her delusions and concerns about cleanliness may be her way of gaining some sort of structure for herself. I wonder how closely the letting go, or the withdrawing or pulling back of supports, coincides with her escalation.

V. Closing Remarks

Pam Rainer: I'd like to thank Ken, Sam, and Sue for sharing their insights, talents, and time with us today (Sue had to leave the call early, just prior to Al's case presentation); to both Suzanne and Al for providing us with the opportunity to learn from their challenges, as well as offering their insights; to Mike English and Mike Hutner, for their welcoming words and leadership of the PATH program; to Policy Research Associates for breaking new ground for us, and making the Internet live broadcast possible; to MCI for setting up this call, and keeping us well organized; to Arlington Typing for transcription services; and a special thanks to everyone in the PATH network across the United States for joining us today.