Albany Project HOPE

Homeless Outreach and Engagement Program

Berkeley Food and Housing Project Narrative

Oct-Dec 2017

Report to City Council

Activities to Date

The Albany Homeless Outreach and Engagement Program, with its full time Case Manager and part-time Housing Navigator, has continued to work closely with housed clients and other residents to provide various levels of case management and outreach informational services.

CM has dedicated up to 20 hours of outreach and referral services. All attempts are made to keep the days of outreach regular (Mondays, Wednesdays and Friday's) to maintain a regular point of contact with those living outside. With the opening of the Albany Resource Center the opportunity to reach those unnoticed in housing crises has increased. Individuals living in their cars or out of the way /hidden locations are able to access Project HOPE by coming into the center. CM has dedicated every Wednesday and some Fridays between the hours of 10 am and 1pm to be at the center to maximize effective case management and program services.

Case manager continues outreach in other areas of the city where encampments are known to exist. During these days, CM provides a wide array of referrals and services which may include discussions on improving quality of life, pet care, legal resources (HAC), dentistry (suitcase clinic), food services (hot meals), AOD (Alcohol and Other Drug), personal safety (domestic violence, homeless camps precautions), GED locations/services, area maps, AC transit schedules and where to get them (library), library resources/locations, donations sites (Freecycle, Rooster) for coats-blankets, etc., podiatry services, acupuncture, Mental Health Service Agencies, YMCA memberships (for showers and holistic pain relief alternatives). CM attempts to carry essential supplies such as water, handi- wipes, socks and food. It has led to positive conversations and further meetings.

Not every person living on the streets is interested in housing assistance. These reasons vary from acute Mental Health problems, substance abuse issues or simply not wanting a "structured" lifestyle. Case Manager has learned not to "push" individuals but rather meet them where they are, stay consistent and continue to reach out to them periodically to "check-in" and see if they are ready for longer term help. Every effort to follow up with contacts is made; however, in many cases the individuals have moved on into surrounding areas.

There was only been one referral from the Albany Police Department this quarter. Case Manager will continue to be a resource for the Department, and follow up leads they provide.

Case Manager has spent considerable time canvassing the main streets of Albany and leaving contact information and business card information with various businesses as a proactive measure to address the homeless population and avert problematic behavior. This quarter CM has had four calls from those local businesses, resulting in one full program intake. That individual accepted help and went into one of our shelters. He has part-time employment that he was about to lose due not being able to access basic living needs (showers, clean clothes). We were able to get him into shelter and get him housing ready.

CM spends on average 10 hours per week keeping client files updated with accurate and detailed notes/information. While in outreach, CM will research individual's needs such as bus routes, food pantries, clothing donation sites, libraries. For housed clients, CM keeps relevant information at the housing site for other needs such as free computers for housing research and referral agencies.

CM assisted a housed client in building a resume in order to enhance his employment opportunities. He was able to secure a job and enough hours where he can fully take on the responsibility for his rent beginning Feb. 2018.

CM and Housing Navigator continue to provide assistance to clients in permanent housing search, including those in shared housing. This assistance consists of filling out applications and getting clients on all housing lists.

CM continues to make one to two home visits weekly (one to two hours each) to ensure good housekeeping and offer any assistance in reaching program goals, managing disputes, ensuring timely rent payments and confirming that all housing needs are met. Case Manager performs weekly "check-ins" with landlords with positive results. Case Manager continues to ensure rents are paid on time and other landlord requirements are met.

CM continues to make the program van available to clients on an as needed basis. In this quarter, CM has used the van 8 times (approx. 20 hrs.) to bring clients to appointments and to assist in one move-in. CM has also provided transportation to the DMV, food pantries and Social Service Agency. CM has gathered essential donations for those clients in need and has gradually taught individuals where and how to request items for themselves. Items include such basic needs as blankets, toiletries, and food. Most clients are either on General Assistance or Social Security so these donations have been essential in order to make ends meet.

Case Manager has monitored the Benevolent Program referral for a client request for a monetary donation to buy a laptop to go back to school. Benevolent is a charitable donation site for those citizens wishing to donate for a specific need in a more personalized way. Any person wishing to donate simply accesses the Benevolent website, reads a little about the person and their need, then has the opportunity to donate some or all of the requested amount. Our client's request was not fully funded so we resubmitted his request and will continue to monitor.

Other beneficial programs utilized this quarter have been the CARE program (discounted PG&E), low-cost (or no cost) cell phones, referrals to employment agencies and assisted web searches. With this assistance, of our housed clients was given the opportunity to find employment. Our

newly housed senior will especially benefit from this program. This client did not have a phone for the first two months in housing. This meant that Case Manager had to work as a "go-between" for PG&E appointments and apartment repairs. This was accomplished by leaving notes on client's door and information in her mail box. We finally agreed that this was part of her self-sufficiency plan and CM helped with the paperwork for the client to secure a free phone.

In terms of tracking topic discussions this quarter, Case Manager has taken an "all subject" approach. This means that other than those conversations which are clearly tailored, Case Manager will make a point of discussing Housing, Benefits and Health Care with every outreach individual(s). With those housed, these topics have been discussed at every check in and house meeting.

This quarter CM has provided outreach to sixteen potential participants. Many were not interested in further housing discussions. It is not uncommon for CM to find individuals or groups in outreach who do not identify with Albany. Of those sixteen, six appeared genuinely interested in further housing discussions. By the end of December, those six clients were given intakes and officially put in Outreach Case Management. Two of these individuals were "high needs" and housing services/search began, with one getting housed. The other high needs client was not housing ready with many mental health barriers. Of the remaining four, one is considered to be in "Prevention "housing services. That client is an elderly man in housing crises with his benefactor having to pull out of his rental assistance commitment. It was a struggle to get the necessary documents to move forward with payment assistance; however, Case Manager was finally able to make contact with the apartment manager to acquire documents and information. Two months of assistance was provided to get him caught up on his rent.

Of the remaining three individuals, two are in shelter with one of them "housing ready." This means he has an income and only needs initial housing financial assistance. The remaining intake was with a man who rejected a shelter bed and is sleeping outdoors at this time. Case Manager is actively engaged with him, setting up medical and dental assistance.

PLEASE NOTE: Case Manager still finds that some outreach contacts are with people who wouldn't identify as homeless either in Berkeley or Albany. Some have said they reside in Albany and have been located in Albany one week and Berkeley the next. In most of these cases, they are more interested in donated items and services than in housing assistance.

The housing specialist created and maintains folders containing all documentation and case notes on clients. HS spends ten to twelve hours a week searching various sites for housing opportunities. Four to six hours a week are used for the viewing of rental properties. Two to four hours are utilized to assist clients in completing rental applications, face sheets and maintaining their folders.

The specialist completed several applications for housings for one client. These applications include properties where rent is based on income. Two housing opportunities were offered to that client; however, they did not meet all his particular requirements. The specialist has bi-

weekly check-ins with three other clients regarding housing opportunities. One additional client was moved into permanent housing.

Successes this Quarter

Initial face sheets where completed on sixteen new individuals. Of those sixteen, program assessments were completed on six. Of those six, one was housed, one was placed "homeless prevention" status, one has been building trust, two went into shelters and one is in the beginning stages of referrals and assistance.

Project HOPE has successfully moved two individuals from housing subsidy to full self-sufficiency where they are paying their own rent. A third client will be "softly handed" to BACS Case Management where he will get the mental health services needed. Of the new assessment given, two were senior women both of whom were living in vehicles (one in a van, the other with a non-client individual in small car) Of the two, M.H. (65 yrs old) was housing ready with a fixed income and emotionally ready. We were able to officially house her in October, 2017. Although the rent is high, we were able negotiate with the landlord to reduce it to below market value. We are currently working on senior living applications and brainstorming on how we can make her current unit work. With Case Manager's assistance, client was able to obtain a new set of furniture through Seasons of Sharing. Season of Sharing (SOS) is a private fund providing one-time crisis-based assistance for housing and critical family needs to Alameda County residents. The program aims to help eligible households regain stability after experiencing an unforeseen emergency situation beyond their control such as homelessness.

The other new client, although initially expressing a desire for housing assistance, found multiple reason to reject potential housing plans. It appeared to CM she was self-sabotaging housing assistance. However, in the three months of working with her, she has come a very long way in developing trust and realistic expectations. She has recently resumed communication after a brief hiatus. Case Manager will closely follow up.

In all cases when the intakes were completed, so, too, was paperwork for "Homestretch". Homestretch is a permanent supportive housing program for high needs homeless individuals.

There had been multiple complaints with regards to one particular resident. His inability to live in shared housing dictated a higher level of Case Management need. Case manager has connected the client to HAC (Homeless Action Center) in an attempt to acquire mental health services. This was finally achieved and CM had multiple meetings with client's assigned BACS Case Manager to work on placing him in a shared living environment conducive in meeting his mental health needs.

CM has been successful in obtaining living essentials for clients such as furniture, bathroom supplies and kitchen needs. All of our clients come with no belongings and making their living space comfortable can be challenging. Project HOPE has successfully made this happen for its housed clients. This quarter Project HOPE has assisted two housed clients with the tools needed

(clothing for interviews and bus passes) for finding employment. Client T.C. has been on medication consistently now for the first time since being diagnosed with a mental health disorder several years ago. This has allowed him to complete the simple task of making his own dinner successfully. These are just two huge life changing examples of the successes this quarter. All of our current housed clients have been working with Homeless Action Center toward continued financial and Social Service assistance.

Challenges this Quarter

Lack of affordable housing in the current market continues to be a problem. Landlords are reluctant to rent to people with subsidies and our client base brings with them questionable credit reports and poor tenant histories. This is further complicated by the landlord's requirements of minimum yearly income for the applicant. Often this income requirement cannot be satisfied by Albany applicants. We continue to search for shared housing opportunities that will fit limited budgets. Although that may make housing affordable, it makes housemate matching challenging as some of our clients have physical and/or mental health issues that make co- habituating a difficult and thoughtful process. Other subsidy options that are "open" can be scarce. Getting them on senior wait lists, filling out senior living applications, Section 8 property based housing and ultimately Homestretch are some of our continued strategies for permanent supportive housing. However, these are lengthy processes and may not address our client immediate needs.

There have been some instances of conflict at the shared housing unit. Case manager has taken several approaches in defusing these conflicts. In the early part of September, case manager tried to let them iron out their own conflicts in an effort to push them to step up and take more responsibility. However the problems continued into this quarter. The conflict centered around one client in particular and although T.C. has stated he continues to take his meds, his functioning has not increased sufficiently for a shared housing environment. CM is working with BACS Case Manager toward finding him higher level of assistance to meet his needs. The situation has been very time consuming for the Case Manager, requiring multiple trips out to the Oakland shared housing unit.

One of our housed clients, when initially housed, was a hard-working, seemingly healthy individual who only needed a "leg up". It was our initial understanding that he needed no more than up to 3 months of subsidy. After going to the hospital, he was diagnosed with colon cancer and had an emergency colectomy. He is undocumented, so finding services has been difficult. He has a son in Albany who thus far has been unwilling to re-unite with him. After many discussions about alternatives, it was discovered that there is a sister as well. She came from Mexico to help him right after the procedure. CM is discussing using other family resources with him.

Another factor that needs consideration is clients' desire to stay within their community. These clients usually have a very strong wish to stay connected to their friends, and known resources. Sometimes they will refuse housing opportunities outside the community for these very reasons.

ATTACHMENT

BFHP Albany PROJECT PERFORMANCE MEASURES

Due on the 15th of each month following the quarter

Project Performance Measures and Targets				
Performance Measure	**Target**	**Progress/Activity this period**	**Year to date statistics**	**Comments**
Outreach contacts (unduplicated contact with a new client)	20	16	54	
Performed initial intake/enrollment	10	6	12	
Number of housing case plans performed	17	11	21	
New Clients Housed	10	1	1	
Clients maintaining housing for 6 months	10	4	6	
*Clients maintaining housing for a year	13	1	2	
Clients exited from Aftercare program	7	1	1	
Clients receiving prevention	2	1	1	

*This measure duplicates clients in the measure above. It includes only non-exited clients.

Commented [LT1]: Update this column after activity this period is entered

Commented [SA2R1]:

ATTACHMENT E

BFHP Albany Services Tracking 2017 to 18

Due on the 5th of each Month

SERVICES	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	YTD
Discussion about Housing	17	16	12	10	16	10							
Discussion about Benefits	17	16	12	10	16	10							
Discussion about Medical Care	17	16	12	10	16	10							
Discussion about Homeward Bound	0	0	0	0	0	0							
Discussion about Employment	14	9	15	10	12	8							
All other Discussions (document topic)	21	26	24	22	24	20							
Assistance with paperwork (specify details)	11	6	9	12	14	10							
Transporting client to medical appt	2	1	2	2	4	2							
Transporting client to social services	1	0	2	0	3	3							
Transporting client to DMV	0	0	0	1	1	0							
Transporting client to housing viewing	0	0	2	3	1	0							
Transporting client to employment specialist	1	2	0	0	0	1							
Transporting client to showers at MASC/Albany	3	1	0	1	1	1							
All other Transportation (document location)	2	2	2	1	0	3							
DMV Voucher provided	6	9	4	2	2	4							
Bus tickets provided	2	3	2	4	2	4							
Referrals and linkages to other services	12	16	10	12	16	10							
Life skills assistance	9	8	12	12	12	12							
Home visits	6	4	4	12	14	12							
Con tact with landlords	4	5	4	4	4	4							
Provided financial assistance for move in	0	0	0	1	0	0							
Other (Document topic)													