Albany Project HOPE

Homeless Outreach and Engagement Program

Berkeley Food and Housing Project

Jan-March 2018

Report to City Council

Activities

Housing Case Management

The Albany Homeless Outreach and Engagement Program with its full time Case Manager (CM) has continued to work closely with housed clients in a shared housing unit in Oakland and Berkeley to provide various levels of case management. CM conducts four to six house meetings a month and averages one to two visits weekly with individual clients to address their personal needs. These visits help to ensure good housekeeping and offer any assistance in reaching program goals, manage disputes, ensure timely rent payments and confirm that all housing needs are met. CM has gathered essential donations for clients in need and has gradually taught individuals where and how to request items for themselves. Items include blankets, toiletries, and food. Most clients are either on GA or Social Security so these donations have been essential to make ends meet. CM has also completed five of the new coordinated entry assessments with clients so that they can be prioritized for county funded services through the North County Hub.

Although these activities can be time consuming for CM at the "front end" of housing case management, they have proven to be essential in showing clients how to get items that they thought they could never afford and in attaining self-sufficiency by learning how to meet their own needs. Other beneficial programs utilized this quarter have been low-cost (or no cost) cell phones, referrals to employment agencies, Berkeley free clinic, UC Berkeley Minor Hall (vision) and Options Recovery.

Although each client has the option to stay at the shared housing unit at 1647 14th Street, CM continues to provide assistance to clients in other permanent housing searches, filling out applications and getting on all housing lists such as Senior Housing and Project-based Section 8 for permanent housing subsidies/discounts.

Landlord Liaison

Case Manager meets with the landlord of the shared housing unit once a month to ensure there are no problems with rents, building maintenance or repairs. In addition to those scheduled meetings, CM met with Landlord six additional times to go over inspection of rooms after move outs (2), move-ins (1), to look at various needed repairs (twice), and after repair follow-up. It is this type of consistency and Landlord contact that maintains an extremely positive and mutual beneficial housing relationship.

Outreach & Referrals

CM dedicated up to 20 hours a week to outreach, canvassing the main streets of Albany and leaving contact information with various businesses to address the homeless population and avert problematic behavior, offer shelter beds, resource services and referral services. All attempts are made to keep outreach days consistent (Wednesdays and Fridays) to maintain a regular point of contact with those living outside. This allows CM to make repeated contact with individuals to build rapport and consistency. When the Albany Community Resource Center opened, people who were previously hidden from outreach in their vehicles and other hidden sites became contactable. CM has provided outreach to 14 individuals this quarter.

CM provides a wide array of referrals and services which 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 (DV, 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. These referrals have led to positive conversations and further meetings.

Successes

At the beginning of the quarter Project HOPE was case managing six people in aftercare (housed individuals). Of those participants, two were successfully exited by the end of the quarter with one going to the military and the other to their own apartment. Both of these individuals were in Project HOPE program for less than 8 months. The remaining four are in various stages of case management from one needing no financial assistance, two requiring partial subsidies and one in need of her full rent paid due to medical issues.

This quarter Project HOPE was able to assist a man who had been sleeping in his car move into shared housing.

Challenges

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. 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 that makes co- habituating sometimes difficulty. There are few other subsidy options that are accepting new clients. We continue to help clients to get on senior wait lists, and complete applications for Senior Living, section 8 property based housing and ultimately Homestretch to try to obtain permanent supportive housing. However that can be a long process and may not address our client immediate needs.

The fact that our clients come in after many years of living outside presents a long list of initial challenges. The first 90 days is spent in adjusting to indoor living. Simple things for the average person such as sleeping on a bed can really challenge a chronic homeless person's psyche. Calming the hypervigilance needed to survive homelessness is often a struggle and may present itself as aggression, hoarding, and paranoia. Although in shared housing it is more understood, as all program participants tend to go through it to some degree, it nevertheless poses a problem if not cautiously and thoroughly managed from the onset.

Case Manager must be able to drop everything to problem solve issues quickly for clients. This often interferes with outreach schedules and/or appointments which may need to be rescheduled. Case managing requires thinking "outside the box."

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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	16	12	13				
Discussion about Benefits	17	16	12	10	16	10	12	15	10				
Discussion about Medical Care	17	16	12	10	16	10	20	14	15				
Discussion about Homeward Bound	0	0	0	0	0	0	0	0	0				
Discussion about Employment	14	9	15	10	12	8	4	6	10				
All other Discussions (document topic)	21	26	24	22	24	20	18	20	16				
Assistance with paperwork (specify details)	11	6	9	12	14	10	15	10	4				
Transporting client to medical appt	2	1	2	2	4	2	6	2	4				
Transporting client to social services	1	0	2	0	3	3	1	1	1				
Transporting client to DMV	0	0	0	1	1	0	0	0	1				
Transporting client to housing viewing	0	0	2	3	1	0	0	1	1				
Transporting client to employment specialist	1	2	0	0	0	1	2	0	2				
Transporting client to showers at MASC/Albany	3	1	0	1	1	1	0	1	1				
All other Transportation (document location)	2	2	2	1	0	3	4	2	4				
DMV Voucher provided	6	9	4	2	2	4	2	0	3				
Bus tickets provided	2	3	2	4	2	4	2	2	2				
Referrals and linkages to other services	12	16	10	12	16	10	12	14	10				
Life skills assistance	9	8	12	12	12	12	4	4	4				
Home visits	6	4	4	12	14	12	8	4	6				
Con tact with landlords	4	5	4	4	4	4	3	4	2				
Provided financial assistance for move in	0	0	0	1	0	0	0	0	1				
Other (Document topic)													

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BFHP Albany PROJECT HOPE 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	14	68	
Performed initial intake/enrollment	10	2	14	
Number of housing case plans performed	17	9	30	
New Clients Housed	10	1	2	
Clients maintaining housing for 6 months	10	3	3	
*Clients maintaining housing for a year	13	1	1	
Clients exited from Aftercare program	7	2	3	
Clients receiving prevention	2	0	1	

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