Albany Project HOPE

Homeless Outreach and Engagement Program

Berkeley Food and Housing Project

April-June 2018

Report to City Council

Activities

Housing Case Management

This quarter has remained consistent with last quarter in managing housed clients at the shared housing unit in Oakland and the senior client housed in Berkeley. Staying consistent has brought Project HOPE's housed clients to a place of self-sufficiency and productivity. Case Manager (CM) has continued to conduct a minimum of 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. It has also brought residents closer together so that they understand the needs of others in the house and can support those needs. Of the five men in the shared housing, three have experienced chronic and long term homelessness in Albany. In the last year, these individuals have shared that they are finally starting to see themselves as individuals living in a state of housing normalcy rather than newly housed or formerly homeless people. This mindset is vital for a positive progression of continued, successful living and significantly reduces the chance of returning to homelessness. This quarter, clients have been more proactive than in the past in utilizing available donation resources, requiring less assistance by the CM. Most clients are either on GA or Social Security so these donations have been essential to make ends meet.

CM has seen a significant increase in sharing of information among residents, requiring less directed intervention by the CM. Clients utilizing services now share the resources and results at house meetings, so that the group is becoming much more self-sufficient. They have shared experiences with employment agencies, Berkeley free clinic, UC Berkeley Minor Hall (vision) and Options Recovery.

Although clients have the option to remain at the shared housing unit, case manager completes an average of two applications per week for permanent supportive housing, senior housing, other affordable housing units and section 8-Property Based units.

This quarter CM has also completed two of the new coordinated entry assessments with clients so that they can be prioritized for county funded services through the North County Hub.

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. At these meeting we reconcile rent balances and address any issues or concerns they may have. In addition to those scheduled meetings, CM met with the landlord four additional times to go over inspection of rooms after a move out, a move-in, to look at various needed repairs and after repair follow-up. The result has been an extremely positive and mutually beneficial housing relationship.

Outreach & Referrals

CM dedicated up to twenty hours a week to outreach, canvassing the main streets of Albany. Literature and contact information was left with various businesses to address the homeless population and avert problematic behavior, offer shelter beds, resources 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. Albany has a group of highly dedicated volunteers who have brought various outreach opportunities to CM's attention. CM provided outreach to thirteen individuals this quarter.

While in outreach, 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.

This quarter brought four more referrals from the Albany Police Dept., identifying possible homeless individuals in Albany. Of those, two have been receptive to active engagement and were given assistance through calling 211.

While outreaching near the railroad tracks, CM came upon a group of three individuals, one young women and two young men. All were asked if they were interested in shelter at the YEAH. All declined however, the young women agreed to meet with CM again. "Andie" met with CM a total of three times. These conversation centered on local services but always seem to return to whether she might return to her family. By the third meeting she decided to go back to her family in the Santa Cruz area and CM gave her a ride to the Greyhound bus terminal in Berkeley that very day.

CM was instrumental in outreaching to a well-known individual who had consistently refused services and missed medical appointments. Due to the tenacious work of volunteers and outreach personnel a successful coordinated effort to get her to the doctor was made to address an ongoing

medical issue. Project HOPE CM outreached alongside her assigned CM to ensure that she made her appointment.

Successes

At the beginning of the quarter Project HOPE was case managing four people in aftercare (housed individuals). Of those participants, one was successfully exited by the end of the quarter and chose to remain in the house. He had been paying his own rent for successfully for over a year and was in case management for application assistance. . Of the remaining three, all are expecteded to be self-sufficient by August 2018.

CM was successful in housing a 71 year old man who was recently homeless in Albany and living in his car after being kicked out of his niece's home and battered by her teen son. He came into the Senior Center two hours before the CM came in. The volunteers were able to share his contact information and CM called him the same day. An appointment to meet was made for the following day when it was discovered that he was literally homeless at that point. He was placed in the shared housing unit immediately which prevented long term consequences of this man having to suffer extended homelessness. He immediately found a part-time job. With that income and his pension, he believes he will need only two months of assistance before he will become self-sufficient.

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. Case manager has found landlords prefer to rent shared housing spaces to UC students. And although shared housing is a solution to the high cost of rent, it opens up a whole set of dynamics. Housemate matching can be challenging as some of our clients have physical and/or mental health that makes co-habituating sometimes difficult. There are few other subsidized housing locations 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.

Outreach has not taken hold for individual known as "Professor". His mental health makes difficult the acquisition of documents such as ID which would allow for further agency assistance. Professor is an example of individuals who have mental health challenges, yet are not to the point where the problem is extreme enough to require more significant intervention.

CM had three separate individuals reach out for services with various levels of case work invested only, to refuse shelter beds. Two of these individuals left the area and the other went to one of the larger local encampments.

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."

CM has found that the homeless population in Albany, although small in numbers, is typically comprised of individuals with a long history of homelessness, who refuse shelter service in any capacity. Having active engagement outreach has been helpful in referring them to services when needed (dental, medical). CM has attempted to use these instances to talk about the possibility of shelter, often to no avail.

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	13	81	
Performed initial intake/enrollment	10	2	16	
Number of housing case plans performed	17	8	38	
New Clients Housed	10	1	3	
Clients maintaining housing for 6 months	10	4	5	
*Clients maintaining housing for a year	3	3	3	
Clients exited from Aftercare program	7	2	5	
Clients receiving prevention	2	0	1	

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

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	16	12	13	10	14	9	147
Discussion about Benefits	17	16	12	10	16	10	12	15	10	11	12	10	141
Discussion about Medical Care	17	16	12	10	16	10	20	14	15	12	14	10	156
Discussion about Homeward Bound	0	0	0	0	0	0	0	0	0	0	0	0	4
Discussion about Employment	14	9	15	10	12	8	4	6	10	4	6	4	99
All other Discussions (document topic in narrative)	21	26	24	22	24	20	18	20	16	20	18	21	231
Assistance with paperwork (specify details)	11	6	9	12	14	10	15	10	4	9	8	14	120
Transporting client to medical appt	2	1	2	2	4	2	6	2	4	2	2	2	37
Transporting client to social services	1	0	2	0	3	3	1	1	1	2	1	4	19
Transporting client to DMV	0	0	0	1	1	0	0	0	1	0	0	0	7
Transporting client to housing viewing	0	0	2	3	1	0	0	1	1	0	0	1	9
Transporting client to employment specialist	1	2	0	0	0	1	2	0	2	0	1	0	9
Transporting client to showers at MASC/Albany	3	1	0	1	1	1	0	1	1	0	0	0	9
All other Transportation (document location in narrative)	2	2	2	1	0	3	4	2	4	4	3	4	27
DMV Voucher provided	6	9	4	2	2	4	2	0	3	2	0	1	34
Bus tickets provided	2	3	2	4	2	4	2	2	2	2	2	2	27
Referrals and linkages to other services	12	16	10	12	16	10	12	14	10	14	15	12	141
Life skills assistance	9	8	12	12	12	12	4	4	4	6	4	8	87
Home visits	6	4	4	12	14	12	8	4	6	5	4	4	79
Con tact with landlords	4	5	4	4	4	4	3	4	2	3	2	4	39
Provided financial assistance for move in	0	0	0	1	0	0	0	0	1	0	0	1	2
Other (Document topic in narrative)													