BETHESDA HOUSE OF SCHENECTADY, INC.

ANNUAL REPORT

2016-2017

From Top to Bottom:

(L-R) Crystal T, Asst. Director of Residential Services & Mattie, Resident, April Open House

(L-R) Day Guest, Louie, & Day Program Supervisor, Melissa Z., Annual Bowling Event

Bethesda House is an interfaith ministry to the homeless, disabled, and economically disadvantaged citizens of Schenectady County, building a just, hospitable and inclusive community one person at a time by affirming the dignity and addressing the needs of each guest entering this

House of Mercy.

834 State Street, Schenectady, NY 12307, (518) 374-7873

www.bethesdahouseschenectady.org

"There is a lot that happens around the world we cannot control. We cannot stop earthquakes, we cannot prevent droughts, and we cannot prevent all conflict, but when we know where the hungry, the homeless and the sick exist, then we can help."

-Jan Schakowsky
U.S Congresswoman

Table of Contents

Bethesda House at a Glance……………………………………………………………page 4

Introduction……………………………………………………………………………..page 7

Program Department…………………………………………………………………...page 10

Case Management Department………...………………………………………………page 15

Residential Services……………………………………………………………………..page 26

Looking Back……………………………………………………………………………..page 33

Financial Summary……………………………………………………………………..page 35

Ideas Into Action………………………………………………………………..…...page 36

Special Thanks

The administration of Bethesda House of Schenectady, Inc. gratefully acknowledges the work of its Directors and staff responsible for providing and gathering data and information necessary to compile this annual report.

The support that Bethesda House receives from the interfaith community through generous contributions, in-kind items, and volunteer hours is immeasurable. The concept of Bethesda House was born out of the interfaith community's recognition of the tremendous needs of the homeless and disadvantaged population of our Schenectady community. Over the years, as the agency has grown and our needs have increased, we have never been left to stand alone. Bethesda House is deeply grateful for the on-going support and continued commitment to our shared vision of ending homelessness.

Bethesda House at a Glance

"The purpose of human life is to serve,
and to show compassion and the will to help others."

~ Albert Schweitzer

Consumers Served

The numbers cited in the table below only begin to tell the story. These figures represent thousands of hours of case management, social work- behavioral health, emergency services, life skills, and residential services.

Guests Served	Total	% increase/(decrease) change from previous year
Guests	53,225	2.8%
Unduplicated Guests Receiving Services	6,386	27.9%
First Time Guests	2,872	18.5%
Homeless Guests	2,993	1.6%

Program Department Services	Total
Consumer Choice Food Pantry – Meals Served	26,130
P.G. Wright Food Pantry – Meals Served	20,052
Clothing Room	2,900
Showers	305
Telephone	4,293
Hygiene Kits	703
Mailboxes [1]	43,390
Daily Meal	40,272
Laundry	393
Lockers	842

The numbers reflect cumulative totals of services provided.

Case Management Services	Total
Housing, Permanent, and Emergency	2,173
Representative Payee	3,129
Case Management Services	1,896
Emergency Services	316
Referred for Income	701
Secured Income	233
Social Work	2,225
DSRIP 2 ED Triage	81
DSRIP 3 Primary Care/Behavioral Health Integration	109
CASAC- DSS	667
*Continuum of Care (COC) Coordinated Entry Referrals	224
*Continuum of Care (COC) Coordinated Entry Housed	156

The numbers reflect cumulative totals of scheduled appointments.

Home Connections	Total
Schenectady County DSS Referrals for Service	379
Individuals Stably Housed	84
Number of males referred for housing	163
Number of females referred for housing	216

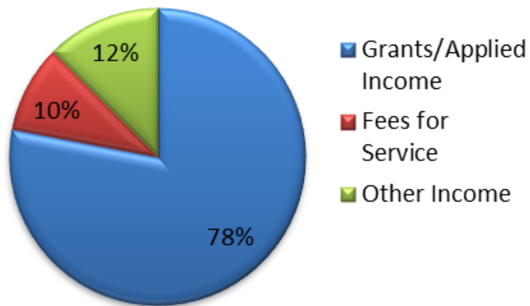
Residential Services	Total
Lighthouse total served including Veterans	23
Liberty Apartments total served	18

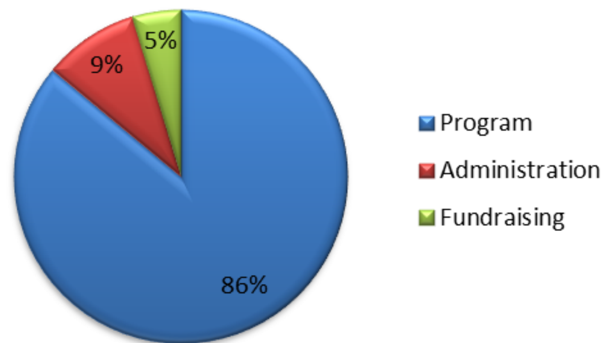
- *CoC is community-wide, includes ___ area providers.
- Consumers were referred to the agency from **16** area providers. Three thousand three hundred and ninety-eight (**3,398**) referrals were made for the following services: **312** Case Management, **379** Home Connections, **402** Emergency Services, **2,225** Social Work- Mental Health, and **80** Residential Services
- Case Management and Program staff referred **248** consumers to area providers to best meet the needs of the individuals.

[1] **Mailbox calculation: 85 (3+82) mailboxes, 3 general, 95 individual; 95 individuals use the general mailboxes; 82 individuals have their own mailbox, available to users 249 days a year; 96% utilization rate**

Revenue & Expenses

Revenue	Amount		Expense	Amount
Grants/Applied Income for Operations	1,305,843		Program	1,545,541
Fees for Service	159,588		Administration	167,717
Other Income	208,980		Fundraising	83,677
Total Revenues	**1,674,411**		**Total Expense**	**1,796,935**





In-Kind & Volunteers

Volunteer Hours	16,692
Value of Volunteer Hours	$422,755
Value of Donated Items	$219,636

Introduction

The administration and staff of Bethesda House of Schenectady, Inc. are pleased to present to you, our Board of Directors, referring agencies, consumers, regulatory and policy making agencies, and friends, this Annual Program Report for fiscal year July 1, 2016 to June 30, 2017. Accountability to both the consumers we serve and the community that supports our mission is important to Bethesda House of Schenectady, Inc. Fundamental to the principles and values of the interfaith communities, the staff of Bethesda House views our agency as a living body, which is always growing and learning. This report reflects some of the agency's experiences of 2016-2017. We are confident, as we reflect on this year, that we are better positioned to serve those who will come to us in the future because we are learning from our past.

During the 2016-17 funding year, the total number of guests that were served increased 2.8% over the previous year. This increase is due to the new initiatives: Code Blue-Emergency Shelter, P.G. Wright Food Pantry, Delivery System Reform Incentive Payment (DSRIP), Certified Alcohol Substance Abuse Counselor (CASAC), and Coordinated Entry that became available during this funding year. The 27.9% increase in our *Unduplicated Guests Receiving Services* supports that we are seeing new people in need of services. We continue to meet with individuals who, for the first time in their lives, need assistance; people who are aging, that have lived their lives on the streets and can no longer tolerate the cold, people with medical and mental health issues that have become such that not addressing them is not an option, and people who want services such as mental health, but are unable to make the necessary connections in order to get the help they need.

As we compiled the data for this report, we are mindful that we are presenting consumer related data and demographic information; we are providing the reader with outcome material that may or may not reflect the policy objectives of those who set policy. As an agency whose mission is "an interfaith ministry to the homeless, disabled, and economically disadvantaged citizens of Schenectady County, building a just, hospitable, and inclusive community one person at a time by affirming the dignity and addressing the needs of each guest entering this "*House of Mercy"*, success takes on a much more subjective and individualized dimension than mere conformity to given policy objectives. If our consumers report that they are feeling more hopeful about the future, more prepared to deal with life's adversities, and more able to care for themselves and their families because of Bethesda House, we consider such an outcome a success. It is this success that drives the actions of our staff and inspires us to keep working on behalf of our consumers.

This Annual Program Report covers five service dimensions of the agency: Program Department: Day Program Drop-in Center/Essential & Emergency Services, Case Management, Social Work – Behavioral Health, Residential Services, and Certified Alcohol and Substance Abuse Counseling (CASAC).

- Bethesda House's Program Department is comprised of a variety of individual services that meet the needs of Schenectady City's and County's homeless and working poor population. Those services include the Day Drop-in Center/Essential & Emergency Services. The goal of these combined programs is to provide crisis management, harm reduction, and stabilization in the lives of the individuals who are experiencing the harshness and difficulties of life and are hopeful to find guidance out of their despair.

  In 2016-2017 the Coordinated Entry Program, under the umbrella of the Program Department, began. This program, in partnership with the Legal Aid Society of NYNE, is designed to track the most vulnerable, homeless families and individuals in need of housing from the point of entry into the system to secure housing.

  The Program Department has more than one contract source. The City of Schenectady, NYS Office of Temporary Disability Assistance (OTDA)'s Solutions to End Homelessness Program (STEHP), Department of HUD, Regional Food Bank, Concern for the Hungry, and private foundations and donors support the services offered by this department.

- The Case Management Department provides a variety of services to the homeless and to those who are at risk of becoming homeless. The goal for each homeless individual who walks through our door, is to first manage the crisis and then to proceed toward the overall goal of moving individuals out of the cycle of homelessness and poverty. All Case Managers are available to any guest who is in need of our emergency/essential and housing services. Case Managers complete an initial assessment to determine the needs of our guests and to offer the appropriate services including, but not limited to: counseling, guidance, assistance with basic needs through our Day Program/Essential & Emergency Services Department, housing and income stability, referrals to other agencies for drug and alcohol addiction treatment, referrals for mental and medical health treatment, as well as networking with other agencies to provide services that Bethesda House does not provide. Case Managers can also assist a guest with rental and/or utility assistance and employment assistance.

The Case Management Department has more than one contract source. The City of Schenectady, NYS Office of Temporary Disability Assistance (OTDA)'s Solutions to End Homelessness Program (STEHP), NYS OMH through Schenectady County, Schenectady County DSS, and private donors support the services offered by this department.

- Our Social Work Department provides mental health services to the agency's guests and residents, processes intakes, assessments, and referrals to area mental and physical health providers. Long-term counseling and support is available. Bethesda House has implemented two separate programs designed to support the reduction of Emergency Department utilization and Integration of Primary Care and Behavioral Health services.

  Bethesda House has a student internship program; graduate level students from University at Albany, Fordham University, and Simmons College (Boston, MA) as well as undergraduate students from Siena and the College of St. Rose, are supervised by our Licensed Social Workers and benefit from the hands on learning experience working with the community's homeless and impoverished citizens who are mentally ill, substance users and typically self-medicate with illegal drugs, experiencing trauma, and other chronic, crisis driven issues.

  The Social Work Department has more than one contract source. The Schenectady County Office of Community Services, Schenectady County (under the Home Connections program), and Delivery System Reform Incentive Payment (DSRIP) through the Alliance for Better Health Care.

- Bethesda House's Residential Department has made a commitment to honor and uphold the mission of Bethesda House. Staff works diligently with residents to overcome life challenges and to help provide a safe, comfortable, and welcoming home for everyone to enjoy and find solace.

  The agency's Lighthouse Program's seven beds and Liberty Apartment's sixteen beds are permanent supportive housing for chronically homeless adults with a history of untreated, severe, and persistent mental illness and other disabling conditions. Both residences follow the *Housing First* model, which is to provide housing first for the chronically homeless population and then combine that housing with supportive treatment services in the areas of mental and physical health, substance abuse, education, and employment. We provide advocacy, housing, and a safety net for our residents. Staff addresses the needs of the whole person focusing on self-respect, personal growth, and discovery of an individual's gifts.

  The Lighthouse Program's additional three beds are transitional housing beds for veterans. Agency staff works closely with Albany Veterans Administration staff, providing a safe and stable setting while the veterans begin treatment and work on financial stability; long-term services are secured after completion of our program.

  The Residential Services Department has more than one contract source. The US Department of Housing and Urban Development (HUD), NYS Office of Temporary Disability Assistance (OTDA) NYSSHP, Veterans Administration, and private donors support the services offered by this department.

- Our Certified Alcohol and Substance Abuse Counseling program performs drug and alcohol assessments and re-assessments and/or drug screens as referred by Schenectady County Department of Social Services (SC DSS).

  The CASAC program has one contract with Schenectady County.

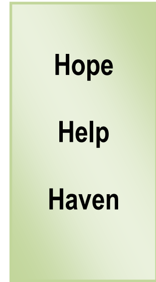
Bethesda House ministers to a vulnerable, diverse, and challenging population. Therefore, it is important to recognize that the agency would not be successful without the incredible, selfless support from our volunteers.

Agency staff regularly attends meetings with:

Housing and Supportive Services Network
Single Point of Access Committee
Evictions Task Force
Dual Recovery Task Force
Coordinated Community Response to Domestic Violence
Schenectady County Re-entry Task Force
Schenectady Food Providers
Homeless Veterans
Homeless Services Planning Board
Schenectady Coalition for a Healthy Community
Population Health Improvement Program Advisory
Coordinated Entry
Diabetes and Obesity Workshop
Mental Health Sub-committee

Bethesda House has a variety of linkage agreements and Memorandums of Understanding (MOU) throughout the professional community.

Linkage Agreements:
The Alliance for Positive Health
The Center for Community Justice
Catholic Charities AIDS Services
Healthy Schenectady Families
Legal Aid Society of NENY
New Choices Recovery
Center Office of Fair Housing
SAFE Inc. of Schenectady
Schenectady County DSS
Schenectady Community Action Program (SCAP)
Schenectady Home Town Health Center Schenectady
Municipal Housing Authority (SMHA) Sexual Assault
Support Services of PPMH
The YMCA of Schenectady



Memorandums of Understanding (MOU):
Ellis Hospital Department of Psychiatry
Ellis Hospital: Care Central
The YWCA of Schenectady
Schenectady County Re-entry Task Force
Cornell University Cooperative Extension
The City Mission
Peter Young: Housing, Industry & Treatment

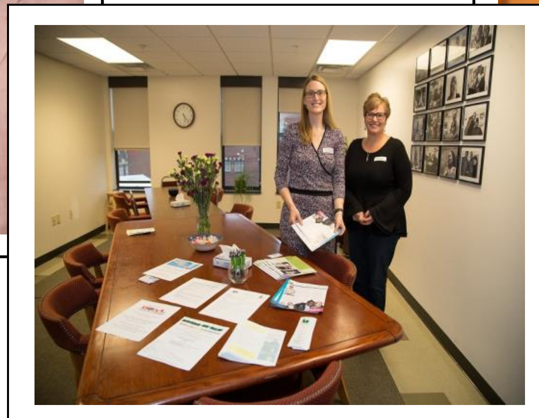
The Management Team is fully invested in the freedom to be creative in pioneering useful solutions to implement positive changes within the agency. In addition, the team is examining how effectively the agency works with area service providers, as it is essential that duplication of services is avoided and working collaboratively is in the best interest of the population we serve.

Worker safety is the common thread running through all of our departments and remains a priority.

The staff and administration of the agency wish to express our gratitude to the Board of Directors of Bethesda House. The Board's support and commitment to the agency are salient reminders to all of us of the importance of our work. We are partners in ending homelessness and providing hope in the lives of Schenectady County's most vulnerable population. ***Thank you!***

(L-R) Former Board President, Sharran C., and Volunteer Bob C. at our Annual Fall Event

(L-R) Cathy T, Vice President, & Louise O, Secretary, at our April Open House



Rick M, Board President speaks at our Annual Fall Fundraiser

Program Department

The Program Department's Day Program Drop-In Center is well-known on the streets as a safe place and is often the first and, many times, the only connection that chronically homeless persons have to any system of care; it opens the door to forging trust and building relationships with the most challenging members in our community. The Day Program provides much the same function as a street outreach team. This program is the primary point of referral and entry into Bethesda House's twenty-three units of permanent supportive housing and three units of transitional housing for veterans.

The Day Program Drop-in Center serves the most vulnerable and homeless population including individuals with challenging behaviors who have been barred from other agencies due to substance abuse, noncompliance: unwillingness to enter or continue with treatment programs, issues with mental health, anger management, or other emotional and mental health concerns, which resulted in an unfavorable status within the community.

The Day Program provides a unique entryway into the Continuum of Care where a wide range of services can be accessed. Services include: Drop-In for the homeless and working poor, a safe haven social setting for adults with a disabling condition, daily community meal (Soup Kitchen), referrals to other community agencies, storage lockers, mailboxes, laundry, shower, telephone, fax, hygiene kits, clothing room, and client choice food pantry. Several outside facilitators have been recruited to provide on-site expertise in a variety of programs. Bethesda House staff also run programs and workshops along with outside facilitators such as: Landlord/Tenant Training, Women's/Men's Support Groups, Safety Counts, HIV testing and education, Schenectady DOH Flu Vaccine clinics and PPD testing, blood pressure clinics, and nutrition outreach and education.

This department is led by the Program Director who works closely with the Program, Case Management, Social Work, Residential, and the Property and Facility Operations staff. This approach maximizes efficiency as staff members navigate their way through daily interactions with our consumers.

The Agency's ***Food Program*** has grown to include a second food pantry site and additional health services. In August 2016, Bethesda House was approved by the *Schenectady County Strategic Alliance for Health Coalition* to open a satellite food pantry. On October 6, 2016, Bethesda House, in partnership with *Schenectady Municipal Housing Authority and Schenectady County Public Health Services* opened the ***PG Wright Food Pantry*** in North Schenectady, at Yates Village.

This new site is a client-choice food pantry that is open to residents of the 12308 area; each qualifying household can use the pantry once per month. The pantry is a cornucopia of fresh meats, vegetables, whole-grain breads, and foods that are low in sugar, sodium, trans fats, and artificial sweeteners. We are grateful that the Schenectady County Strategic Alliance for Health Coalition provided funding during the pantry's first year and equally grateful that on-going support will be with the Regional Food Bank's Hunger Prevention and Nutrition Assistance Program (HPNAP) and through the generosity of our donors.

Since opening the doors of *PG Wright*, we have expanded our services not only to include access to healthy non-perishable items, but also a self-serve produce room and baby care items, such as formula, baby food, pedialyte (restores mineral loss due to illness), and diapers. We provide on-site nutrition education through our partnership with Cornell Cooperative Extension, and access to referral services such as health insurance assistance from CDPHP and Fidelis. In addition, program participants have access to services offered through Schenectady County Healthy Neighborhoods Program, EFNP, and Food Stamp Assistance through our county's Nutrition Outreach and Education Program NOEP or Center for Independent Living.

Our **State Street food pantry** is open two days a month and for emergency referrals. Our partnership with Cornell Cooperative Extension (CCE) has grown and the services and classes CCE offers has increased while continuing to provide ongoing nutrition education program, which delivers direction and support by teaching our guests how to stretch their SNAPS (food stamps) and how to supplement with local food pantries. We have revamped our food program to be in line with the goals of reducing diabetes and obesity in the county. Case Managers offer one-on-one education to individuals that come in with emergency referrals for the pantry. Case Managers and Day Program staff meet with each individual and assess their food stamp allotment and buying habits that have led to the early depletion of their resources.

Staff is finding that people continue to shop in corner stores, which are far more expensive than regular grocery stores, due to convenience and lack of transportation. BH staff offer alternatives to the corner stores and work with the individual on meal planning and stretching the food stamp dollars. We have found that this approach, along with collaboration with Cornell Cooperative Extension who provides educational workshops and classes, is met with enthusiasm; however, it has not produced the participation that we anticipated, more needs to be done. BH implemented a transportation program designed to take groups grocery shopping at the beginning of each month. This transportation model was not highly utilized during 2016-2017 and the Agency continues to market this program to increase participation. The Program Department continues to work in close collaboration with Concern for the Hungry and the Regional Food Bank to address the number of families and individuals suffering from food insecurity and scarcity.

During the 2016-2017 fiscal year, Bethesda House expanded existing services and added four new programs. The additional Case Management and Social Work staff and associated programs resulted in an increase in the agency's daily attendance. Agency staff and volunteers worked together to ensure safety and smooth operations, it was an energy packed year!

Bethesda House partners with local justice officials to provide opportunities for those convicted of a crime to complete community service hours and to receive on-the-job training. In addition to obtaining job skills, the participants are educated in social responsibility and offered assistance in career path planning. Bethesda House increased its presence and expanded services within the Schenectady County justice system. In 2016-17, we saw an increase of former inmates released from prison who were homeless and in need of physical and mental health intervention. The justice system recognizes this underserved population and is working with Bethesda House to provide wrap around services that will ensure a smooth transition back into their community and to help reduce recidivism.

The Program Department holds staff meetings monthly to review issues that impact programming and staffing. A *House Meeting* held once a month includes guests, residents, and staff. During these meetings a variety of topics are covered: non-violence within the agency and in the community, guest issues, respect for others and the building, self-respect, community presentation, and the agency policies that directly impact those we serve. Potential changes for the Agency are discussed at House Meetings. Guests and residents are encouraged to engage with staff on the changes that they would like to see and for those who prefer, we have a Suggestion Box for the guests, located in the Hospitality Room for easy access.

The availability of phones has allowed numerous people the opportunity to arrange for job interviews and follow up on phone calls to the Social Security Administration and Schenectady County Department of Social Services for benefits and monthly cash assistance. Bus passes are available to assist individuals with transportation for job interviews and medical appointments. Having these emergency services available is a significant component in our effort to prevent homelessness for families and single individuals.

Bethesda House continues to improve our methods of data collection in order to create systems that capture accurate statistical information helping to identify areas of need not being addressed and to identify where there is a need to increase specific services.

Administration and Program staff continues to work with area congregations to increase our volunteer pool and promote community involvement. We actively reach out to local colleges and high schools, offering opportunities for internships and community service hours. We would not be able to offer the variety of services we do without the generosity of the community. When there is a need, the community responds.

Bethesda House remains committed to education. Clarkson University Education graduate students will be providing on-going literacy education to our guests. This partnership will begin in September 2017. The students will be utilizing the education software and laptops that we received from GE Elfund. They will use their educational experience and creativity to craft person centered education plans to ensure continued growth and success with our program participants. The students will be able to offer 26 hours of literacy education each semester.

During 2016-17 Community Partnerships included developing existing relationships and establishing new services. The enhancements and new programs resulted in added services to the population we serve. They are the following:

- CDPHP Community Outreach ~ CDPHP comes into Bethesda House to connect their clients to services and benefits they may not be aware of or utilizing.
- Schenectady County Healthy Neighborhoods ~ This program comes to both our main and satellite food pantries to enroll participants in a program providing cleaning supplies, assistance with child proofing, lead testing, and other valuable services. This program is well received by our clients.
- Ellis School of Nursing ~ nurses come to our agency and will shadow our Social Workers as part of their MH education.
- Alliance for Positive Health ~ mentors come to our agency to distribute safe sex information and provide testing for HIV/STI's.
- St. Mary's Cancer Peer Education Program ~ provides information to our guests on breast cancer and prostate cancer screenings.
- Tobacco Free Coalition~ Bethesda House has a Tobacco Free Policy for staff, the coalition created and donated signs for campus wide *smoke free signage*. Bethesda House continues to engage with this community partner who will train staff to be a smoking cessation educator for the clients and residents we serve.
- Literacy Program ~ a graduate student worked with staff to create the base for our Literacy program. We are fortunate that GE Elfund program donated the computers, software, and other tech equipment. Beginning September 2017, Ms. Patricia Rand, NBCT English and Literacy, Department of Education, Clarkson University, discussed and put in place a partnership with Clarkson University grad students to teach classes.

Bethesda House continues to partner with Schenectady Job Training Agency (SJTA) in providing on the job training opportunities for high school students through the Federal Work Study Program. This program functions much like our Community Service program, where high school students are provided meaningful summer work opportunities and, through coaching and mentoring, youth gain an understanding about the workplace and appropriate employment skills necessary to succeed.

Schenectady County Coordinated Entry

Schenectady County Continuum of Care Coordinated Entry (COCCE) process is designed to identify, engage, and assist homeless individuals and families and to ensure those who request or are in need of assistance are connected to proper housing and services. Coordinated Entry uses a standardized assessment tool and incorporates a system-wide housing first approach, client choice and prioritizes housing for those with the most vulnerable service needs.

This HUD funded program that began in September 2016, is facilitated by Bethesda House and Legal Aid Society. The partnering agencies that sit at the table include: New Choices Recovery Center, SCAP, YMCA, YWCA, Mohawk Opportunities, Schenectady Municipal Housing, SAFE Inc., Solider On, and Vet Help (SSVF).

The four core elements of Coordinated Entry are access, assessment, prioritization, and referral. It is these four principles that guide the team to effectively house the most vulnerable homeless individuals and families in Schenectady County using HUD funded beds. Through the no wrong door approach, a standardized system wide assessment tool is used and prioritization is based on vulnerability and a smooth interagency referral process. To date 156 Singles and Families have been housed in either community based housing or in HUD funded beds.

Bethesda House is fortunate to be located in a County were providers work together and when a community crisis rears its dreadful compromising and challenging head, we come together to provide assistance and resolution. In 2011, when Schoharie was devastated and in 2013 when Fort Plain suffered horrific storms we transported staff, guests, residents and volunteers to help residents clean-up and to offer encouragement and hope. In March 2015, when the Jay Street fire displaced nearly one-hundred (100) people, BH was a leader in rapidly re-housing individuals, replacing possessions, and giving comfort to the inconsolable. Bethesda House is proud of its staff, day program guests, residents and volunteers. When disaster hit our immediate and surrounding communities, Bethesda House acted.

Bethesda House has always been available as an emergency overnight shelter especially during inclement weather. During the winter of 2016/2017, with Governor Andrew Cuomo's continuing mandate that all homeless people in NY were required to be off the streets in weather 32 degrees and below, Schenectady County DSS acted in support of the Governor's mandate and, Bethesda House immediately responded to be an overnight shelter. Each night, our Hospitality Center was open to individuals referred to us through Schenectady County DSS. The Program /Case Management/Social Work team created a plan to interact with individuals in the overnight shelter to assist with emergency and/ or permanent housing placement and to engage with each person in an effort to assist with other areas of need, such as mental and physical health, and/or substance use. With the overnight shelter, BH was open around the clock to the homeless of Schenectady and all staff were willing and able to come in at a moment's notice should the need arise. Each day at the close of business, BH staff prepared the Hospitality Center by setting up bedding, towels, and a light meal.

Day Drop-in Center/Essential Services Stories

"For I was hungry, and you gave me something to eat; I was thirsty, and you gave me drink; I was a stranger and you invited me in; naked and you clothed me." (Matt. 25: 35-36)

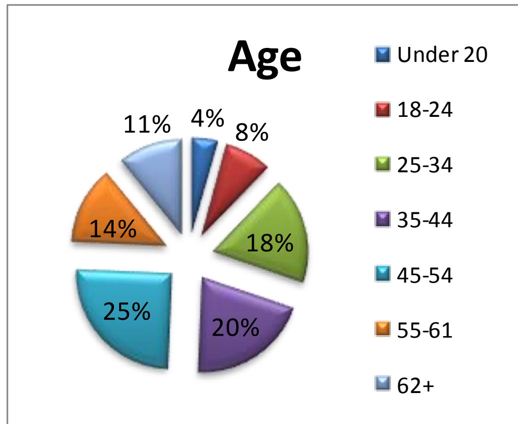
Hospitality takes many forms and means many things to many different people, but at its root being hospitable requires us to be inviting and willing, joyful and humble. The most vulnerable and disheartened individuals of our community walk through the doors and into our Hospitality Center. It is through this room, where all are greeted warmly and with a smile, where a person's past is not judged and all are equal. Our Staff and Volunteers work diligently to respect and serve even our most difficult of clients, creating a warm and inviting environment that many of our guests have never experienced.

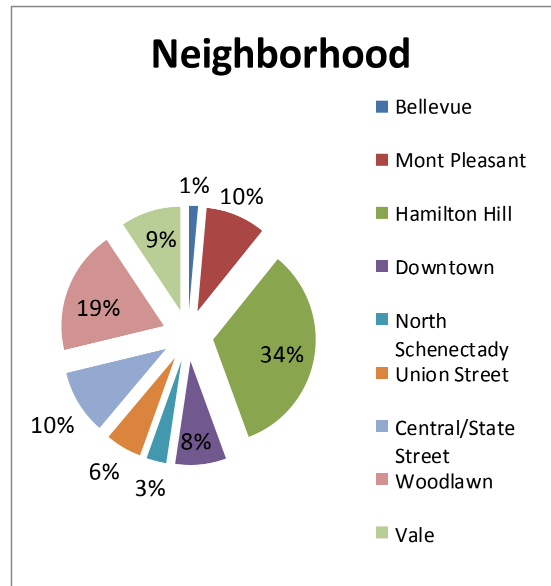
It is through this room were the needs of client M.G were met. M.G. is a thirty five year old black man who was recently released from a four year incarceration, hardened from a life filled with poverty and disappointment M.G. was not the kindest to staff and volunteers when he first entered our doors. The more challenging he became, the harder staff worked to figure out his needs and to teach him how to appropriately engage with peers and staff. Through staff's willingness to serve, M.G was provided with a supply of food, clothing, hygiene products and a referral to housing. Now when he enters our doors, M.G engages staff in polite conversation, he is warm toward his peers; he is on the road to employment. He continues to utilize many of the agency's emergency services to keep himself afloat, while he regains his life.

(L-R) Resident & Volunteer Mary Ellen and Day Program Supervisor, Melissa Z.

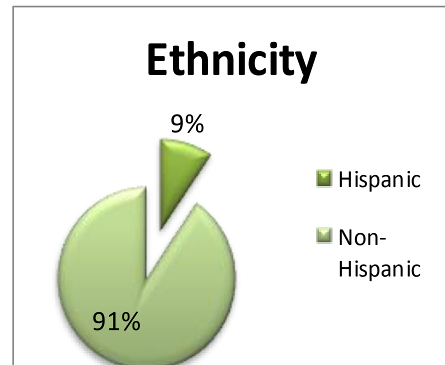
(L-R) Resident & Volunteer Paul & Volunteer Mr. Oliver

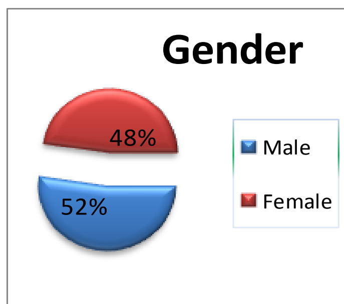
Program Department Demographics

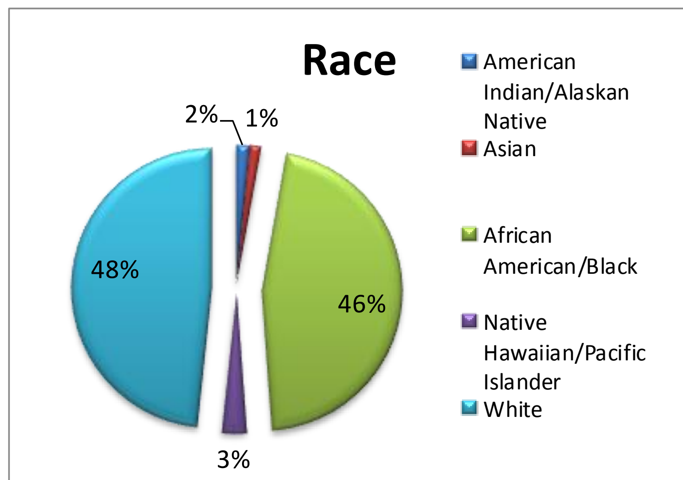




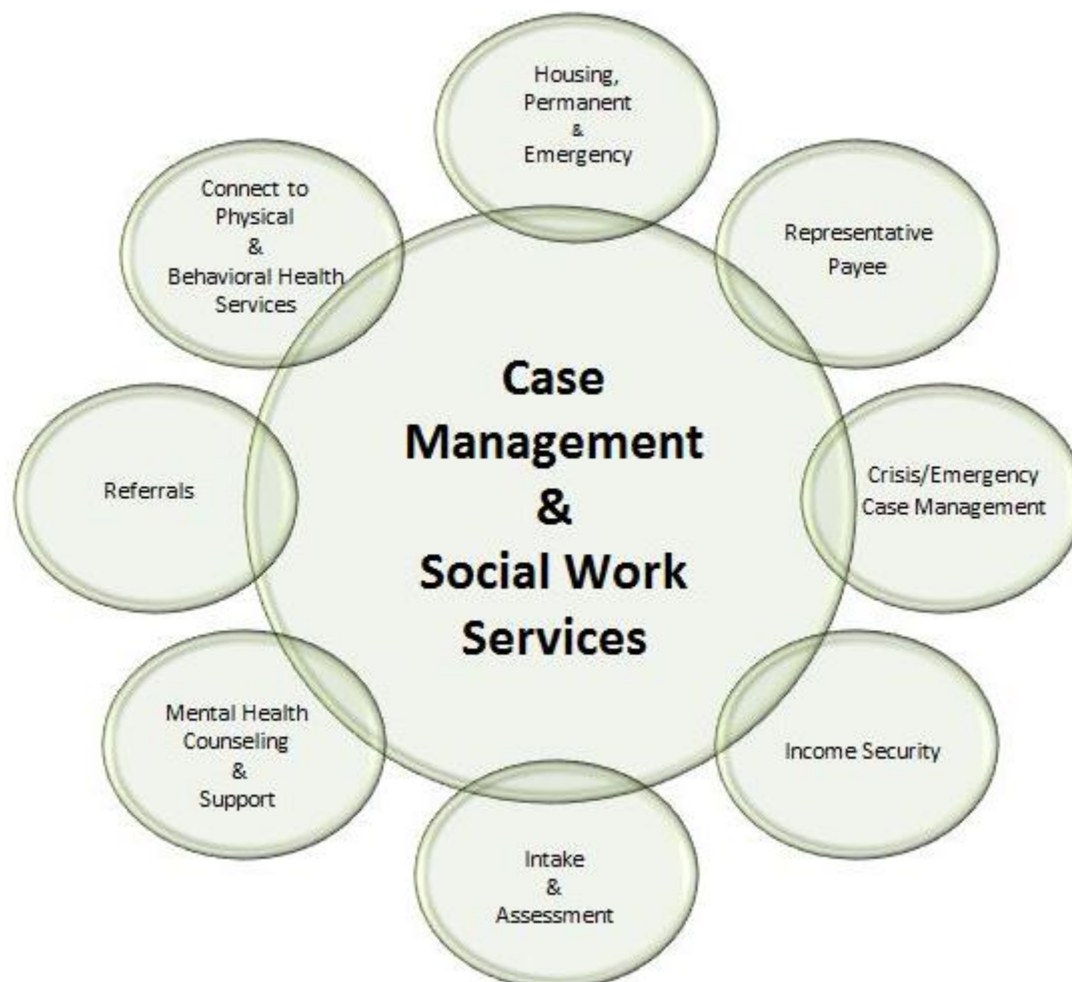
Volunteer, Colleen







Case Management & Social Work Services



The Case Management and Social Work Department is led by the Program Director who coordinates the team approach with the Day Program Supervisor, the Case Management and the Social Work staff. This team also works closely with the Residential Department to address the needs of our guests and residents.

Case Managers have been cross-trained to assist all people at risk of homelessness and/or in immediate need providing access to the Emergency/Essential Services that Bethesda House offers. The department meets once a month with program and residential staff to review issues that impact programming and staffing.

In keeping with BH's commitment to improve the lives of those we serve, all BH Case Managers and Directors were trained in SSI/SSDI Outreach, Access, and Recovery **(SOAR)** a program designed to increase access to SSI/SSD for eligible adults who are experiencing or are at risk of homelessness and have a mental illness, medical impairment, and/or a co-occurring substance use disorder. The process for applying for SSI/SSD can be a laborious, cumbersome process, which can take many years of denials before being approved for the benefit. Many of those we serve find the process so daunting that they pursue legal assistance to obtain their benefits, which does not necessarily shorten the process.

Individuals that are awarded benefits after many years are given retroactive payment from the time they applied and that can add up to thousands of dollars that could be used for them to stabilize financially and set them up to live more comfortably with their monthly allotment. However, for individuals that obtained legal services, they are required to pay the majority of their back benefits for the legal services rendered, resulting in the individual having a financial deficit. *SOAR* is a no charge service that gets results for the individual in 3-6 months. Case managers obtain releases so that all of the pertinent medical and psychiatric history can be obtained expediently.

Bethesda House Hospitality Center Volunteers.

SOAR provides an easy to understand format in which the case manager compiles the information, giving the Social Security Administration all the necessary information needed to make a determination, the first time a case is presented, that favors the individual.

BH has assisted 6 individuals in obtaining their benefits; each of the individuals moved into nicer, affordable apartments and were able to use their retroactive pay to furnish their new homes according to their likes.

Case Management personnel cover the following needs:

Initial Intake and Assessment: triage and assessment of immediate needs, eligibility for entitlement programs, and the need for immediate referrals to other agencies.

Financial Case Management: managing the SSI/SSD benefits for disabled and identified guests. A budget is established with each person in our Rep Payee Program ensuring rent, utilities, food, medical care, and other essential needs are met and paid for before the guest receives a personal spending allowance.

Case Managers meet these needs through the following programs:

Shelter/Housing

The Case Management team provides emergency services to assist homeless individuals with emergency shelter placement. Guests can continue to work with Case Management to obtain steady income and permanent housing (subsidized or programmatic housing) or to obtain placement in Drug/Alcohol rehabilitation.

Bethesda House's Case Management staff works to increase landlord relationships and to facilitate the placement of homeless people in safe and secure housing. This position's primary responsibilities include homelessness prevention, helping individuals obtain housing and rapid re-housing, and assisting homeless individuals with finding permanent housing. Many strong, on-going working relationships with landlords have been developed and have increased the outreach to house chronically homeless people. The Case Management staff has created an extensive landlord database, which aids in the success of securing affordable housing.

The staff assigned to the Program and Case Management department meets with individuals to assess emergency service needs and assist the same in navigating Bethesda House's intake system in order to obtain the appropriate services. We are seeing a significant need for emergency services by individuals and families that are at risk of homelessness. The number of individuals served by Bethesda House increased during the last fiscal year; this is directly related to the slow growth of the economy. Bethesda House anticipates demand to continue to grow into the 2017-2018 fiscal year.

The Representative Payee program

This program is essential in helping to prevent individuals from becoming homeless (assisting individuals in finding permanent housing) and aiding the financial stability of our consumers. Many individuals who do not participate in this program find themselves being taken advantage of by others and run the risk of losing their minimal income to drugs/alcohol and other addictions, due to their inability to handle and manage their monthly Social Security payment. The self-determination that people gain from living independently is remarkable. The current average income of a participant is $808 a month. Regardless of the amount, individuals are living on their own and not with family, in group homes, or having to share living quarters with someone who could possibly take advantage of them.

During the 2016-17 fiscal year, the number of participants in this program reached 98. The Case Management staff works closely with area providers, particularly with Schenectady County DSS Protective Services for Adults. The Case Manager works with each participant to develop a budget ensuring all bills (rent, utility, phone, medical, etc.) are paid in addition to allowing for "personal needs" money for necessities. During 2017-2018, Case Managers will continue to collaborate with the appropriate staff and local providers to ensure consumers secure housing placement and financial stability.

Consumer feedback gained at House Meetings has provided us with valuable information. In 2017-2018, we are implementing a consumer satisfaction survey to gain more insight on the effectiveness of the services we offer. Our goal is to ensure that consumers meet their milestones and that staff are mindful of the services the individuals are seeking. We will give careful review of the documentation we receive.

Home Connections

Bethesda House received 379 referrals during the 2016-2017 fiscal year and, of those referrals, 84 were placed in permanent housing. Of the remaining 295 individuals that did not go into permanent housing, the reasons are broken down by percentage as follows: 3% were incarcerated, 16% found employment and no longer needed services, 36% never showed up at the shelter location, 2% passed away, 4% left the State or moved to another county, and 39% refused to comply with the goals of their Independent Living Plan (ILP), as dictated by the Schenectady Department of Social Services, thus making them ineligible for Temporary Assistance until such time as they are ready to comply.

Bethesda House's contract with the Schenectady Department of Social Services is designed to significantly reduce the length of time homeless individuals stay in emergency shelters. The Housing First model, which is employed by all departments within the agency, continues to be our guiding principle as we searched to find permanent housing options for the most vulnerable. The vast majority of individuals that end up in shelters are chronically homeless and suffer from severe disabilities, of which 90% suffer from severe, persistent and untreated mental illness.

The challenges we continue to face in this program is locating affordable housing and the ability to obtain mental health services in a reasonable timeframe. Home Connections is unique in that it acknowledges the critical component of aftercare when considering successful integration into one's community.

Once an individual is housed in the community, they become part of Case Management and receive wrap-around services which includes access to an Intensive Case Manager who will complete an in-depth assessment and develop a service plan with individualized goals and follow-up; ensure financial assistance through the Representative Payee CM, Social Work oversight to assist with setting up and keeping mental health/substance abuse appointments/treatments and to provide counselling and support as needed; referrals for services; and crisis/emergency support. This team wrap around approach has proven to provide for greater stability for the individual and increases their chances of successful integration into their community. BH's strong partnership with DSS has allowed for greater insight into the deficiencies of the service delivery system and has paved the way for improved relationships with other area agencies in the community; barriers are identified and plans are implemented to address the growing needs of the homeless population of Schenectady.

Social Work Program

The Social Work Program offers a unique approach to people who have severe, persistent, and untreated mental illness in Schenectady County. Our program uses the Housing First model for our homeless consumers. While in the process of obtaining housing, our social work staff process intakes and assessments and attempt to secure mental health treatment and other services that enable individuals to remain in permanent housing. The Social Work staff works closely with Case Management forming a cohesive team. The team wraps services around the consumer to achieve residential and income stability. Our Social Work staff counsel consumers and work with each to ensure that appropriate mental health services are obtained and regularly attended.

Over the past several years, BH has seen an alarming increase in the number of individuals with severe, persistent, and untreated mental illness. While our Social Work department does an excellent job of providing crisis management and counselling to maintain stability, we are not equipped to handle intensive treatment and medication management for those requiring concentrated intervention. BH Social Worker works diligently to ensure psychiatric intervention when necessary, but the options in Schenectady County are such that the demand outweighs the treatment/service availability. The Psychiatric clinic has a wait list and while the local hospital has opened a new clinic in the neighborhood, it is not yet fully staffed so referrals are slow to process. BH is working closely with the Schenectady County DSS, OMH, and the local hospital to address the mental health crisis in Schenectady; however, in the meantime, there are many people that are in desperate need of immediate intervention.

BH Social Worker continues to meet with the head of Psychiatry at the local hospital one afternoon a week for consultation. While this partnership provides a wonderful avenue of care for those we serve, it has its difficulties. BH SW department has enjoyed great success in part due to its policy of no appointments necessary. Individuals that may come in for other services will check-in with the SW for a short visit. We know from years of serving our population that they don't do well with scheduled appointments and they don't do well sitting and talking for long periods of time. It has been challenging to get individuals to sit long enough to be able to complete the intake paperwork and even more challenging to get them to the actual appointments. BH SW spends much of his time driving around in the community trying to find individuals so he can get them to their appointment. While this may not be a perfect solution to the mental health crisis in Schenectady, it is providing valuable data for the community as we strive to create services that meet the needs of the population we serve.

<u>Delivery System Reform Incentive Payment Program</u>

DSRIP Transportation Program

Ask any medical service provider in the area what is the biggest need of the population we serve and you will most likely hear transportation. So many of those we serve are unable to keep appointments due to the inconsistency of the Medicaid cab system and several medical providers have a "three strikes and you are out" rule, which means that after the third missed appointment the individual must find a new medical provider. Individuals being discharged from the hospital are provided transportation to their homes or back to Bethesda House to obtain shelter if they are homeless, but most lack transportation to pick up medications that were prescribed during their stay at the hospital.

BH Case Manager provides transportation for patients being discharged from the hospital and for individuals traveling to and from medical appointments. At the start of the program Bethesda House's short bus and/or 10 passenger van was utilized in this project; however, it soon became apparent that there were challenges for riders utilizing these vehicles. As such, a minivan was purchased to accommodate all program participants. At the beginning of each scheduled shift the Case Manager collects emergency food bags from the agency food pantry, hygiene products, as well as blankets and linens; these items are available to give to clients when they are returned to their homes.

During pick-up and drop-off a basic needs assessment is offered. The Case Manager, if needed, secures medications and reviews discharge plans for follow up medical appointments. At the point of patient drop-off, the Case Manager also conducts an environmental assessment to assure that the patient is being left in a stable and safe situation. Assessment information and appropriate paperwork is given to the BH Social Worker and follow-up takes place within 24-48 hours to address any additional needs that may have been identified (i.e. no food in house, utilities, unsafe living environment, etc.). The BH Social Worker provides community care coordination to ensure long term services are in place. The Social Worker, either directly or through coordination with the patient's care manager, provides support services to maintain the stability of each patient, assisting with follow up instructions and medical appointment scheduling, and ensuring that these appointments are kept and that prescribed medications are secured.

DSRIP Primary Care / Behavioral Health Integration – Social Work

The initiation of this program has occurred with the philosophy of development through action. Traditionally, providing stable and consistent support services to individuals who are dually diagnosed, homeless, and engaging in maladaptive coping skills has been challenging. Their ability to maintain contact with service providers, follow medical or mental health recommendations, and establish a wellness-based lifestyle is extremely limited. For this reason, Bethesda House is uniquely qualified to engage this population in accessing health services, because it already serves as a resource to address basic living needs. Social Work staff work closely with all departments within the agency to establish a streamlined referral process to individuals needing medical or mental health services and to engage those individuals within the program.

Once identified, there have been challenges and barriers to successful connection between the individual and treatment. Immediately, maintaining consistent contact with participants has proven difficult. Lack of a reliable phone, unavailability for home visits, or simply an unpredictable lifestyle is often present with this population. Additionally, accurate information sharing is an issue due to mental health symptoms, substance abuse, and/or a lack of trust between worker and individual. Often times, a participant will not be in agreement with the need for a particular service or consult. Transitioning participants to a healthier lifestyle and prioritizing their overall wellness is the mission of this program. This involves valuing all aspects of their lives and providing support and education on available services. There are limited mental health resources in the community at this time; therefore, it requires staff and participants to be diligent and persistent. Consistent contact and reinforcement of healthier habits and proactive interventions are incorporated to support participant compliance with treatment recommendations.

Certified Alcohol and Substance Abuse Counselor (CASAC)
Bethesda House has established an excellent working relationship with Schenectady County Department of Social Services (SCDSS). Bethesda House's management of the CASAC program, housed at SCDSS, further strengthens the continuum of care in Schenectady County. The program, which is located in the SCDSS building, works closely with the Department of Temporary Assistance (TA). CASAC staff screen individuals for issues of substance abuse. When an individual applies for TA, they are screened by the TA case worker and any history of drug or alcohol use will result in a referral to BH CASAC. An assessment is completed by BH CASAC and treatment options are examined based on the recommended level of care. BH CASAC acts as a liaison between treatment providers and SCDSS assuring that individuals have several options for treatment and services can be customized to meet the needs of each individual. An added benefit to this new partnership is that during the assessment process, BH CASAC can refer individuals to BH with other needs that have been identified during the assessment process. This added layer of support helps to minimize the likelihood of an individual becoming sanctioned for noncompliance as the BH Case Management/Social Work Team wrap the necessary services around the individual and meets the needs that present barriers to an individual receiving treatment.

BH Treatment Team
BH Treatment team's inception was designed as a way for Home Connections, Housing CM, Rep Payee CM, and the Program Director to meet weekly to ensure that each participant had the services they needed in order to be successful. With the development of the Social Work Program, which includes DSRIP, the Coordinated Entry program and the CASAC program, it quickly became apparent that persons were being served in several different programs and diverse relationships were being established with various staff. These diverse relationships added substance and insight to the discussions on how to best serve each individual, as such, the decision was made to expand the team to include all staff.

The Treatment team meets weekly, individuals from each program are discussed and plans are put in place to best meet the needs of the individual. With limited options and many barriers to success, the team has the daunting task of finding options for individuals that have few alternatives. The team is able to use their collective expertise, to creatively and efficiently meet the needs of these individuals, within a small window of time. BH Treatment team is an added layer of behind the scenes support, which enhances our unique delivery system of services, providing our clients with stability and long term successful outcomes.

Case Management Story

Meet DB
DB is a 21 year old man who found himself in an unfamiliar city. Originally from Tacoma, Washington, DB came here to stay with extended family members after being kicked out of his mother's home. Upon arriving in Schenectady, the family members denied him a place to stay and directed him to the Department of Social Services. Originally he was referred for assistance to find housing, but quickly staff could see how vulnerable this young man was. He struggled to keep appointments with DSS, which would cost him shelter. When staff asked him where he was staying when his shelter ran out he'd say, "Usually I stay out to try to make a friend who will let me sleep on their couch. If I can't find anyone, I'll usually find a bench or sleep in the cemetery". Staff feared for him, knowing how naïve and easily misguided he could be. Case management located DB a room he could call his own. He lived there while staff worked with him on completing a SOAR application for Social Security Disability. In a few short months, he was approved for benefits and for subsidized housing. He is now stably housed, receiving mental health treatment, a participant in the Representative Payee program and is taking GED/ TASC classes at Washington Irving.

DSRIP

Meet HM

A year and a half ago, HM first walked through the doors of Bethesda House. Initially, she was referred for assistance with locating housing; however, case managers could see her needs extended far beyond just housing. HM presented with a host of different issues, she had serious physical health conditions that were visibly taking a toll on her body, a history of trauma and mental health issues that prevented her from maintaining stability, so she was admitted to DSRIP. Throughout her life, HM's mental health was a constant struggle. It kept her fearful, delusional, and paranoid of all those who were trying to help. Case management staff at Bethesda House worked relentlessly to engage HM in services and build a trusting relationship with her. At first, she refused to work with most of the staff, but she did learn to trust a select few and accepted minimal services. Months passed and staff was concerned as she was deteriorating rapidly and refusing to take most of her medications. The stress of HM's situation got the best of her and she was hospitalized at Ellis Hospital's Inpatient Mental Health Unit. She remained there for 3 weeks until she was stabilized medically and mentally. Upon discharge, DSRIP ICM worked closely with HM to make sure she was attending mental health appointments and taking her meds. One of her preferred case managers assisted her with a Social Security Disability application and assisted HM in applying for every supportive housing opportunity for which she was eligible. Flash forward six months, HM is now in the appeal process working with staff to secure her SSI/SSDI, she is actively engaged with Mental Health treatment and is living in Supportive Housing; finally having an apartment all her own.

Home Connections

Meet SH

SH's background is one of chronic homelessness, domestic violence, drug abuse, incarceration and child protective cases. As we look briefly into the circumstances that lead her down the wrong path, the resiliency which she displayed paved the road on which she stands today. SH, through despair and hopelessness, fueled by domestic violence, turned to drugs as an escape from her reality. Her drug abuse would have a profound impact on her life, she was incarcerated for drug related crimes and she ultimately lost custody of her youngest child while continuing to escape the reality of who she had become by using drugs.

When SH first came to Bethesda House success, would not immediately follow. No matter how diligently she tried, setbacks became the norm of her existence. In December of 2016, SH was referred to Home Connections and in February of 2017 she moved into her own apartment. SH was provided Intensive Case Management, as well as all the other support services Bethesda House provides in order to maintain success. SH did not let the setbacks change her course and she is now gainfully employed and she is enrolled in an outpatient treatment facility. With the help of her ICM and the BH team,

SH is in the process of gaining custody of her youngest child.

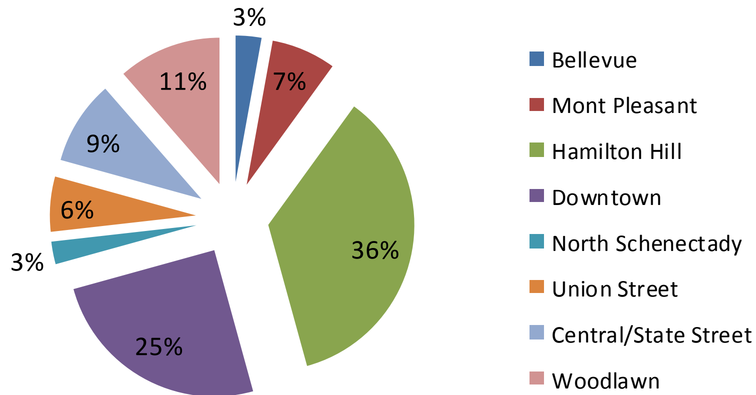
Social Work Story

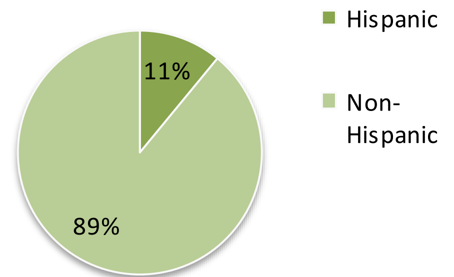
Meet SW

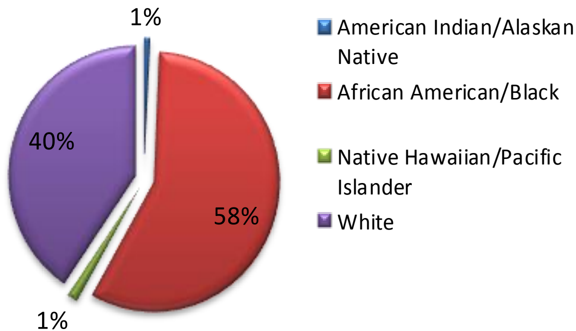
SW is a single mother who had a long history of homelessness caused in part by her mental health and substance abuse diagnoses. At the age of 29, SW began her battle with addiction, using prescription drugs at first then transitioning to Heroin. She would drink and use drugs to avoid having to deal with her life. Several of her children were removed from her custody and she found herself being kicked out of her mom's house and living on the streets. When SW found herself alone and in the cold with no one to support her, she reached her rock bottom. She knew her children deserved a mother and that she had to be determined to stay clean. With the help and guidance of Bethesda House's Social Work department, she found hope and help. She actively engaged in her mental health treatment, attended a drug treatment program and obtained housing. She now has almost one year of clean time and custody of her daughter.

Resident, Kathy

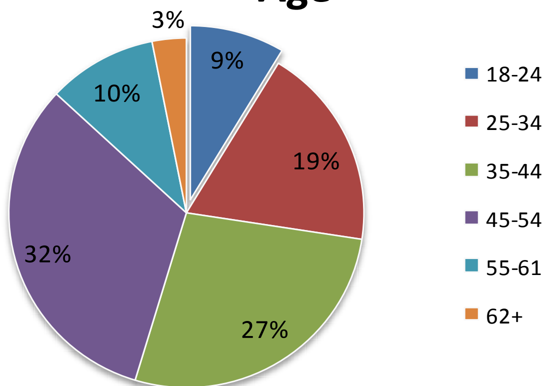
Housing and Crisis Case Management Services







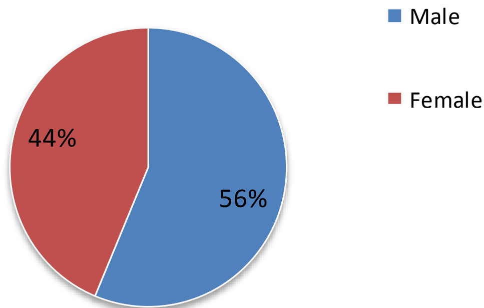
(L-R) Bill, Day Guest with Danny P., Director of Residential Services

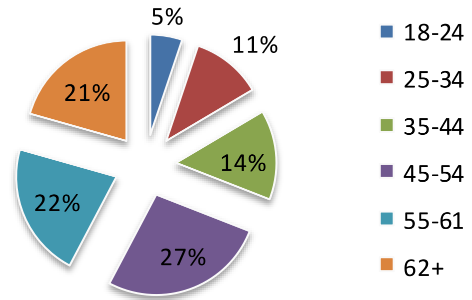


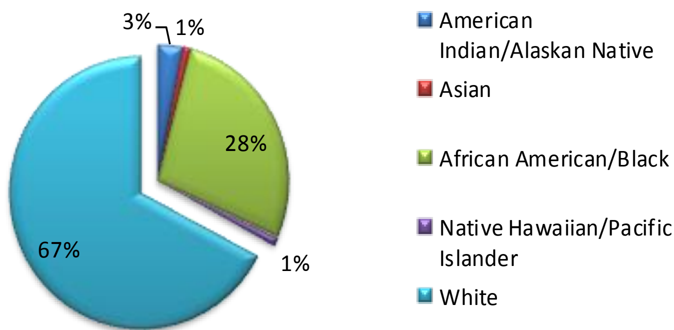
Crisis Case Management ~
- Stabilizing emergencies
- Reducing obstacles
- Obtaining services
- Referrals to area providers

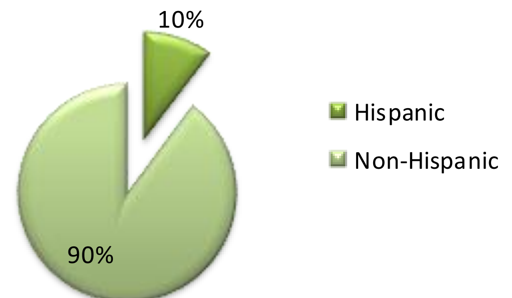
Housing Case Management ~
- Emergency placement
- Permanent housing
- Rapid Re-housing
- On-going support

Case Management Representative Payee Services



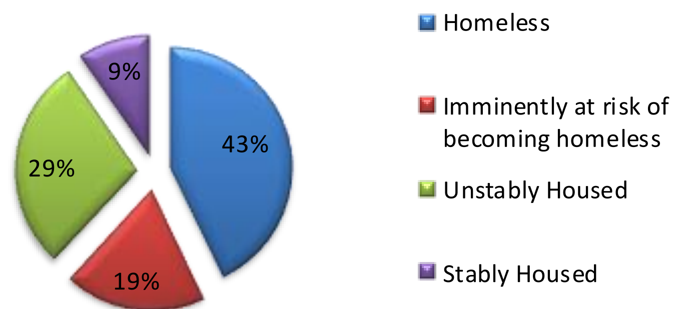






Rep Payee Program:

- ✓ stabilizes housing and income,
- ✓ financial education and budgeting
- ✓ case management provides a path to engage in mental and physical health services



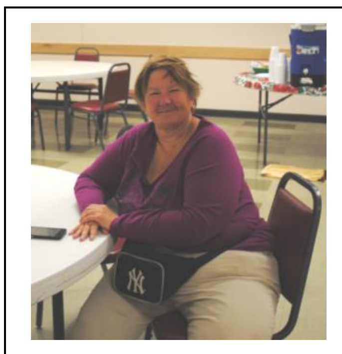
Women's Group

Abuse can be very lonely, but not to the twenty-five women who gather at Bethesda House weekly to share their stories and offer support to one another. Our confidential group meets weekly and addresses a variety of issues related to domestic violence. The group provides a comfortable atmosphere to develop healthy relationships in a nurturing environment. The group is facilitated by professionals from Bethesda House, YWCA, and Sexual Assault Support at Planned Parenthood.

There are several volunteers that come each week to assist with the weekly meal and provide additional support as needed. The group discusses topics such as drug and alcohol addiction, housing crisis issues, abusive relationships, and their children. All participants provide confidential and emotional support to those who attend. The facilitators are available for outside referrals and counseling. Occasionally, guest speakers from the community come to discuss topics of interest to the women. Facilitators plan community outings such as a yearly picnic and a special Mother's Day luncheon; when financial assistance is available, crafts are purchased for attendees to make gifts and holiday projects. The group is served a lunch and, for most, it is the only meal they may eat for the day. The group is free and could be the only source of support and counseling available for those attending.

Men's Group

Bethesda House has tried unsuccessfully several times in the past to start a Men's Group. Three years ago, when Men's Group was started, no one believed it would last, but not only has the group maintained, it has flourished. Men are coming together to share their thoughts and feelings and to work toward breaking down the barriers that confine them. The group has been meeting at the State Street Presbyterian Church, Catherine Street, every Thursday, from 11:30 am – 1:00 pm. Reverend Richard Parsons facilitates group discussions such as health, parenting, community, violence, being role models, and spirituality. Outside facilitators are brought in as guest speakers who lead discussions on more sensitive topics such as, terminal illness, and trauma and loss.



Participant in Women's Group

Facilitators

Bethesda House is fortunate to have dedicated facilitators who are on-site once or twice a week making, themselves available to all guests and residents who are interested in the services they provide.

The facilitators are:

Facilitator	Frequency
Alliance for Positive Health	Once per month
National Grid Advocate	Once per week
Blood Pressure Clinic, run by volunteers	Once per week
Fidelis	Twice per month
Tenant Training in collaboration with SCAP, Legal Aid, & Center of Disability Services	Once per quarter

Women's Group Stories

Meet TS

TS has been coming to Women's group for several years and is a favorite of many in the group. She lives independently in the community, but she has developmental disabilities and is prone to being taken advantage of, so the women look out for her. It is not uncommon for the group to form a protective circle when TS is in crisis and never has that been more apparent than when recently someone broke into her apartment and assaulted her. TS had staff from Bethesda House and an advocate from Planned Parenthood with her immediately following the incident, but it was when word went out to the women of Women's Group and they came to support TS, that she finally felt safe. The women of Women's Group take care of their own emotionally, spiritually, and physically. They surrounded TS and helped her make decisions that had previously paralyzed her and stayed with her as she identified her attacker to the police. There is great healing, strength, determination, and spirit that is born of trauma and TS has found solace and conviction to heal in the presence of women that know her pain all too well.

Meet NP

NP is a kind and warm hearted 51 year old woman who consistently attends Women's Group. NP has struggled in the past with issues of self-confidence and building positive relationships. Through her experiences in Women's Group, she has gained the confidence and strength to make healthy and meaningful friendships. It is through the shared experiences of the other women in the group that NP has been able to grow and blossom into a strong, independent woman.

Nutrition Story

Meet SW

SW is a resident of Bethesda House who is diagnosed with several co-morbidities, as a result of being morbidly obese. Her struggles with her weight have caused issues with ambulation and led to her pre-diabetic condition. Her life long struggle with her weight is a result of a diet high in sugary beverages, saturated fat, refined carbohydrates and sodium. She also lacked the motivation to participate in physical exercise.

Through attending our nutrition classes on a drop in basis and working with her case manager, SW realized it was time for her to take an active role in her health. She eliminated sugary beverages; this was a very difficult lifestyle change as soda comprised a large part of her diet. She began walking laps in our case management suite, and then took to cutting out take-out. Our Nutrition Educator, assisted SW with healthy meal planning and how to replace her favorite unhealthy foods, with more nutrient dense alternatives.

She now swims several times a week at a local community center that staff transport her to. She has a long road ahead of her, but the path to wellness is paved.

P.G. Wright Story

One in Five American Families face food insecurity, or a household-level economic and social condition of limited or uncertain access to adequate food. When you mix an impoverished economic climate with inadequate access to food, the long- term psychological and physiological effects on a community are devastating.

Food Insecurity and limited access to healthy food is directly correlated to health. Residents who identify as food insecure have increased rates of chronic diseases, exacerbations of existing health conditions, poor maternal and infant health, and an increase of Psycho-Social issues.

Meet RF

At P.G. Wright, we serve many adults with chronic and persistent health conditions that are directly derived from poor nutrition. R.F is only 51 and must use a walker; she takes multiple medications to manage her diabetes, high blood pressure, and cholesterol. Her diet, for the majority of her life, consisted of fried food, refined and processed foods, soda, and included no exercise. Her chronic health conditions have made it difficult for R.F to get out of her home and she now struggles with anxiety and depression. R.F. was referred to our Social Work team and now receives appropriate care for her mental health issues. She has increased her produce consumption and no longer eats foods high in sodium.

P.G Wright has the resources to meet all the needs of our clients not just there food insecurity issues. Reframing hunger as a health issue and a social issue is key to understanding and meeting the needs of the community.

Coordinated Entry Story

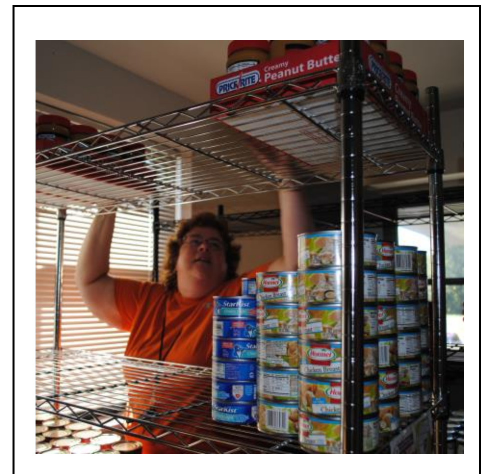
Meet DS

Obtaining affordable housing is a challenging and often daunting task for anyone. When faced with barriers such as previous incarceration, being in treatment for substance abuse, having an open CPS case, and not speaking English, securing housing is almost impossible.

D.S was that person. Per the request of Schenectady County Child Protective Services, Bethesda House's Coordinated Entry Facilitator met D.S at her emergency shelter along with a team of case managers, who had been working diligently, but with no real results, to find her housing. The team met at the Family Life Center and a translation service was utilized so that a Coordinated Assessment could be completed. D.S spoke no English and had visitation right with her children who she was working on regaining custody of. Therefore; she needed housing that could accommodate not only her and support her drug treatment, but house her children as well when the family unit was reestablished.

Through open communication and an effective referral system, D.S was housed within a month, in a program that specializes in substance abuse and that had a Spanish speaking case manager to provide monitoring, as well has having the extra bedrooms for her children's return.

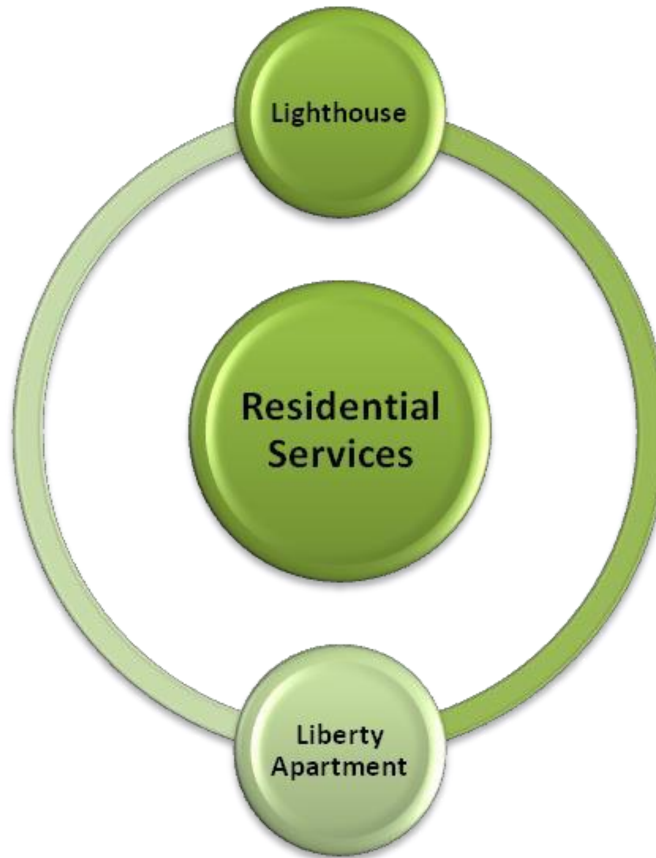
Paul, Resident and Volunteer, State Street Food Pantry



Anne, Program Director, organizing
PG Wright Food Pantry, at Yates Village

CBA Volunteers, setting up and stocking
PG Wright Food Pantry, at Yates Village

Residential Services



Bethesda House's Residential Services Department meets the daily challenges of encouraging and assisting each resident as they work toward the goals of their Individual Service Plans. Staff and volunteers are an essential component of the primary success for each resident.

The department's experienced team, comprised of the Director and Assistant Director of Residential Services and the Life Skills Counselor, works closely with agency Directors, the Social Work and Case Management Team, and the Property and Facility Operations staff. This creates efficiency as staff members navigate their way through the needs of our residents. The Residential Services Department meets bi-monthly with staff to review issues that impact programming and staffing. The Director and Assistant Director regularly attend the Single Point of Access (SPOA) meetings to provide a setting to:

- Identify residents' needs
- Seek community services
- Build accountability to the treatment plan among service providers
- Develop treatment recommendations and review medications
- Develop social/vocational/employment goals
- Address rep payee issues
- Create personal goals and objectives
- Seek input and evaluation on employment and/or vocational options
- Review all mainstream benefits
- Review and discuss options to assist residents in obtaining independence and self-sufficiency.

In our Permanent Supportive Housing Program, the Director and/or Assistant Director of Residential Services with each of the residents bi-weekly, establishing a level of consistency and demonstrating that each resident is important. During the scheduled meeting, discussions center on progress towards goals, immediate concerns, and any modifications to the established service plan. In addition, the Director and/or Assistant Director of Residential Services informally interact with each resident on a daily basis.

Each resident, in collaboration with the Director and/or Assistant Director of Residential Services, designs the most appropriate path to manage mental health issues and addictions. Staff will often attend appointments with the residents and assist with follow-up up and treatment, provide transportation to medical appointments and meetings as needed. Residents are referred to the agency's DSRIP programs and engage with the licensed social work staff as appropriate.

Residents are encouraged to participate in the Representative Payee program. One hundred (100%) percent of the residents receive Social Security benefits; 75% participate in the Representative Payee program. The remaining twenty-five percent (25%) not in the payee program are responsible for addressing their monthly obligations with the assistance of the Director of Residential Services.

During 2016-17, residents continued to participate in the nutritional educational program led by agency staff and staff from the Cornell Cooperative Extension. Staff members work with residents to reinforce healthy menu planning and stretching food stamp dollars.

The Lighthouse Program is a ten-bed facility located in the Mont Pleasant neighborhood of Schenectady. Seven beds are for single adults formerly chronically homeless (defined by HUD); three beds serve as transitional housing for veterans. The goal for all residents living at the Lighthouse is greater independence. The Lighthouse staff work with each individual to take on more responsibility in all areas of daily living.

One resident has lived at the Lighthouse for over 14 years, over thirty-seven percent (37%) of the residents have lived at the Lighthouse for four years or longer, fifty percent (50%) have been in the program for over 2 years. In our Veterans' program, of the fifteen veterans admitted, more than seventy-five percent (75%) had their needs met and were discharged to permanent housing.

The Life Skills Counselor and the Resident Assistants work with the residents, helping them develop basic living skills so that they will be comfortable actively participating in their community. The residents participate in community activities weekly and some volunteer at our main facility's Day Program Drop-in Center. Activities that the residents participate in include trips to area grocery stores, movie theaters, parks, shopping malls, and restaurants. Two of our residents attend church regularly. Most of the residents have established significant relationships with members of the community and look to them to provide support during difficult times.

The residents have taken an interest in keeping up the grounds at the Lighthouse facility by completing yard work and ensuring that the property is clean. There is a garden for the residents to enjoy during the summer months; they are encouraged to participate in its upkeep and staffs use the vegetables in the daily meal.

Many of the residents at the Lighthouse have never known a home of their own. They have lived in areas not fit for human habitation such as wooded areas, under bridges, in attics, or in abandoned buildings; in some cases sleeping on front porches in neighborhoods. All of our residents come in with survival skills engrained in their thinking. They have survived by being on the defensive, accepting to live in filth, eating out of dumpsters, and resting whenever and wherever they can. The skills necessary to survive a life on the street differ greatly from those necessary to keep a house. The average homeless person does not think about sanitation, they think only of survival.

With the assistance of the Director and Assistant Director of Residential Services, Resident Assistants, and the Life Skills Counselor, each resident will continue to have the opportunity to work one-on-one with staff to develop the on-going skills necessary to keep their environment neat and orderly and attend to their personal hygiene. In addition, staff will encourage residents to be more active and regularly participate in the volunteer program.

The **Liberty Apartments** is a fifteen-unit, sixteen-bed facility located on State Street in Schenectady. Residents live privately and independently while having access to supportive staff 24/7. Fourteen units are single room occupancies and one unit has double occupancy; all units have their own bathroom and fully functional kitchenette. Each resident is encouraged to make their home their own, and if necessary, to stay permanently. Fifty percent (50%) of the residents have been in their homes for over four years. Thirty nine percent (39%) of the residents have been in their homes for over one year.

Bethesda House's Day Program Drop-in Center is a primary point of contact/entry into the system of care. The residents living at Liberty House Apartments have access to all of the services provided by Bethesda House. Residents make use of the Hospitality Center, the clothing room, food pantry, and the medical management services offered (blood pressure clinic, aids counseling, etc.). Bethesda House provides outreach through the local business community; residents have access to services through Fidelis and a representative from The Veteran's Administration who visits weekly.

Residents are encouraged to participate in monthly house meetings where they are able to express their concerns. The Property and Facility Operations Manager attends all house meetings in order to answer questions and address concerns. The residents plan social and recreational activities during these meetings. Bethesda House has a van available to transport residents to community activities.

The goal for all of the residents living at the Liberty Apartments is greater independence. The design of the program does allow for greater autonomy; however, the greater percent of residents seek interaction with other residents, our Day Program population, and staff members in general. In addition, ninety-five percent (95%) of the residents have planned their goals for their service plans with minimal assistance from staff.

Residents of both the Lighthouse and Liberty Apartments who require more intensive staff intervention can work one-on-one with the Life Skills Counselor. The Life Skills Counselor works with all residents to provide graduated instruction and remains a presence until they can independently complete the task. For those residents with physical disabilities, the Life Skills Counselor encourages as much independence as possible and assists with tasks that are beyond their physical capabilities. The Life Skills Counselor also assists residents with nutritional counseling, menu planning, food, and personal needs shopping and assists with planning recreational activities.

Obtaining secure and stable housing is the first step in alleviating the inconsistencies and trauma associated with living on the streets. It takes a great deal of time for a homeless person to let go of street living and to trust that they are worthy of this new life. With each step forward, there can be several steps back, but, with patience and persistence, no goal is out of reach.

A year full of activities:

Summer is the time of year to shed winter's hibernation, to move around more, and interact with one another. For some, summer is all about tradition, like attending local eateries that only open seasonally such as **Jumping Jacks**. The agency's Residents are all in agreement when it comes to Jumping Jacks, it is not just a place to indulge in great food, but also a great place to meet for a cheat day if you're watching your diet! For most of the residents, Jumping Jacks is a landmark that holds many memories and they enjoy nothing more than gathering as a group to indulge in a burger and a memory or two about the good old days.

Residents who are from the area reminisce about shared family meals as a child and those who relocated to the area just can't forget their first time indulging in the summer time treat or the music held in the park next door. Giggling can be heard as they stand in line listening to the kitchen team yell back a short order, shouting a hearty thank you, or when Subway is announced for a tip left by a customer. Fond memories are shared as their yummy lunch is consumed and the question of "is there room for ice cream" is pondered!

Late summer brought **NASCAR** to New Hampshire, as well as two residents from Bethesda House. On this particular race day, two residents were anxiously waiting to leave for the get-away that they had been planning for all summer. The day was finally here and full of anticipation. On the ride to the NH Speedway, there was talk of the last time the residents had been to a live race and the amazing experience. There were lulls in conversation as they looked off into the scenery and dozed off during the early morning car ride. Conversations of firsts ensued as they travelled the winding country roads leading toward their destination. They discussed the first time coming to NY, traveling to VT, and first jobs, it was also a first for O.T to have passed a harvested corn field, filled with a gaggle of turkeys. The scene before continued to bring a smile to their faces as we continued to travel down the road. When we finally arrived at the race, there was so much to take in, parking, seating, and the aroma of grandstand food that mixed with the cool air under the late afternoon sun. The two residents took it all in; they spoke amongst our small group guessing who they thought would crash and who would win. They stood to cheer with the crowd in outrageous moments and during unexpected wins. The ride home was a discussion of replays and future planning of other races that they would like to attend. While the two weary travelers were pleased to have gone, they were equally pleased to return to their happy home.

Each year a **Halloween** adventure is planned as the majority of the residents share a common interest in the Spirit of Halloween. Staff and residents alike actively participate in researching the Capital Regions Scariest Haunted House or Hay Ride. The top four were picked, posted and polled; this year's winner was Saratoga Scare Fair. There were screams, surprises, giggles, and residents saying "I can't believe that scarred me." Fun was had by all; the challenge to find the spookiest and scariest of them all still remains.

Union College Students returned for their Annual Fall Cleanup Project, the garden was purged of its remaining plant life for the upcoming winter months, as the ground prepared for its deep freeze. The Lighthouse program has a new Greenhouse and the residents eagerly await the opportunity to begin growing vegetable and flowers for Spring 2018. Many look forward to working on their botany skills.

In December the residents gathered together to attend the tradition of **Festival of Lights** in the City of Albany. The residents enjoyed the cool evening ride through the park, viewing the abstract lights that represent winter and the meaning of holiday cheer.

The residents continue to participate in a bi-weekly shopping trip to a local grocery store. The ride to the grocery store is one of thought as some plan out their purchases and, on other occasions, the ride is filled with positive banter.

Our former Board President, Sharran Coppola, has taken the time out of her busy schedule to prepare a **family style meal** on the first Saturday of the month for our Residents. This has been a rewarding experience for all parties involved. The anticipation that leads up to the meal and the lasting excitement that follows into the next week, has the residents raving about the meal and rehashing the topics they had the opportunity to discuss at the meal.

Resident Stories

Meet BD

Most wouldn't think twice about showering daily and cleaning up after themselves. Not the case for B.D. who has a diagnosed MH disability that at times makes it difficult to differentiate reality from delusions. For B.D., encouragement was required to shower daily and to complete other personal tasks. After several years of work on this goal, B.D. has reached a level where a weekly routine has been established without missing a beat, such as laundry, room cleaning and assisting with small household chores and ensuring personal care and grooming are maintained. B.D. has gained self-confidence and takes pride in personal appearance. So much so that B.D. is working on stepping outside of his comfort zone by assisting with planning this year's 4th of July residential Picnic for B.D and peers. This is a great milestone for B.D.

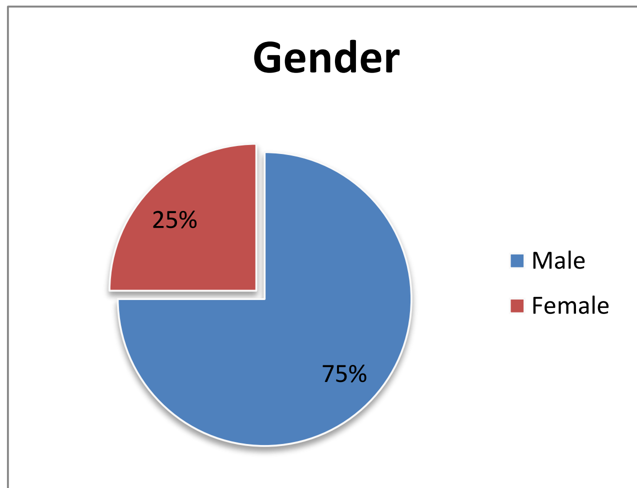
Meet OK

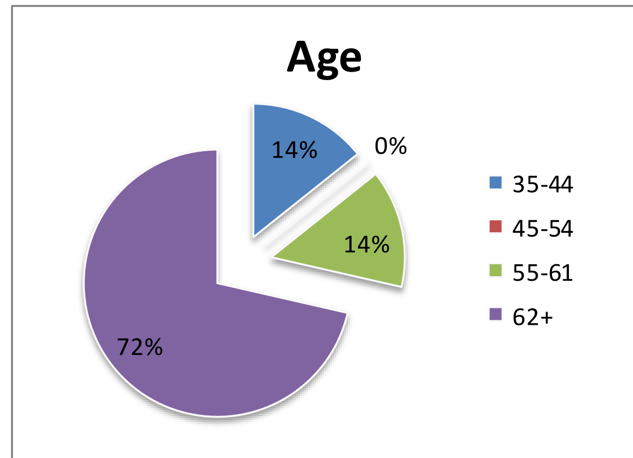
For most, the New Year is a time that we set a resolution to accomplish something for ourselves such as quit smoking, weight loss, change in diet, etc. For most, we can choose to keep going or stop and be okay with the decision. In O.K.'s case, she was faced with a decision to either stop drinking and change those who she socialized with or violate her probation and serve 90 days in jail. This may seem like an easy decision ~ quit and follow the rules. But, take into consideration that there are years of addiction, developmental disability, and learned behavior that has become her daily norm. O.K. fought within herself to quit drinking to the point O.K. would say no more then, days after agreeing, she was cited for open container. O.K.'s team at BH and other community agencies stepped in to provide the support O.K. needed to encourage the positive change in O.K was eventually was able to self-identify how great it felt to change the daily norm. She joined a support group after three months O.K. and she celebrated sobriety and began to become involved in new daily activates allowed O.K to become a new person who is now able to self-identify feelings and emotions that had been suppressed for so long. Three months turned into six months and, now reaching ten months, she graduated from Alternative Court. O.K continues to follow through with sobriety and involvement with daily activities and self-awareness. With a community team behind O.K., O.K. was provided the positive encouragement to succeed.

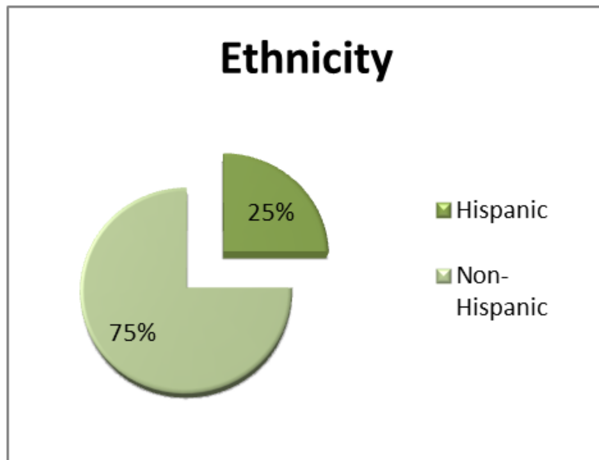
Resident, Richard

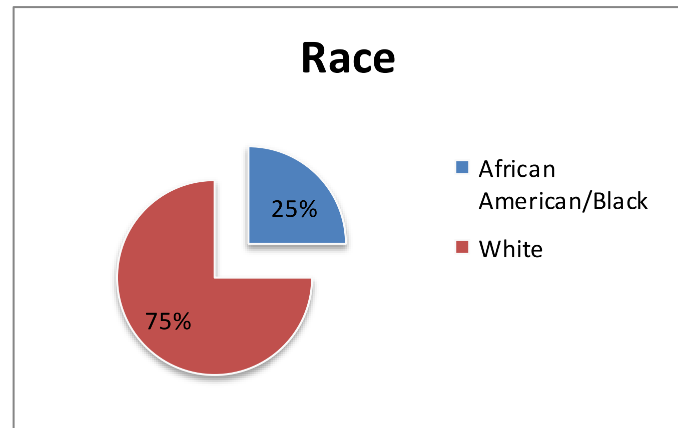
Day Guest, Wendy

Lighthouse Permanent Supportive Housing

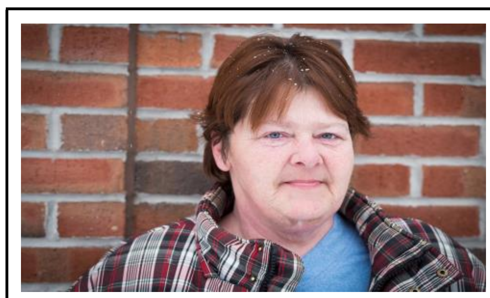








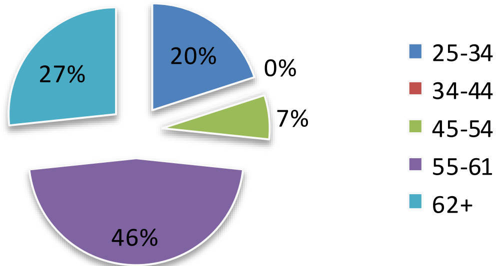
Disability	% of Residents, Number of Residents 8
Development Disability	25%
Chronic Health of Physical Disability	13%
Diagnosable Substance Use Disorder	38%
Mental Illness	63%



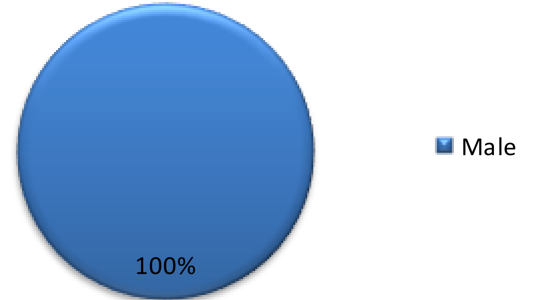
Resident, Tracy

Lighthouse Transitional Housing Veterans

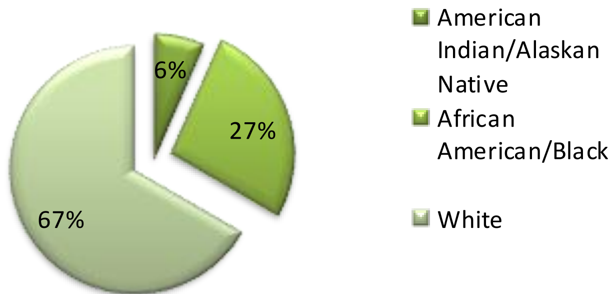
Age



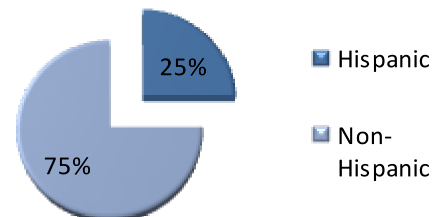
Gender



Race

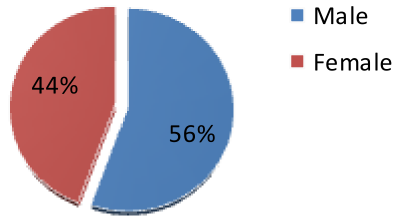


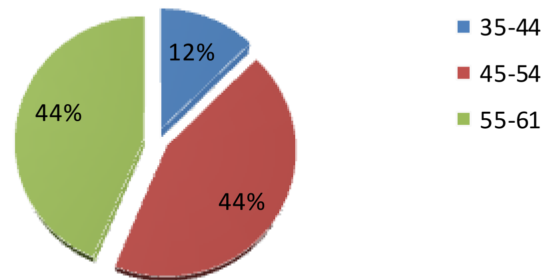
Ethnicity

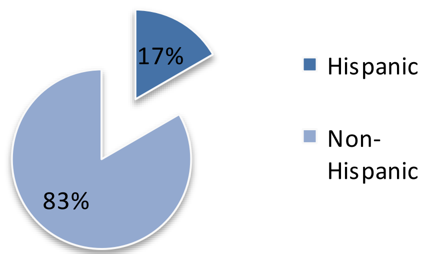


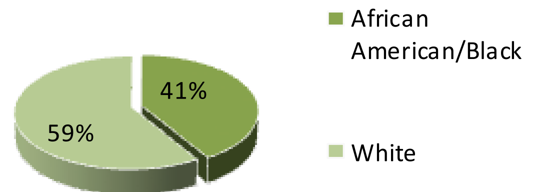
"I alone cannot change the world, but I can cast a stone across the waters to create many ripples."
~Mother Theresa

Liberty Apartments Demographics









Disability	% of Residents, Number of Residents 18
Development Disability	6%
Chronic Health of Physical Disability	67%
Diagnosable Substance Use Disorder	56%
Mental Illness	83%

Looking Back

Volunteers:
Bethesda House is deeply grateful for our wonderful volunteers. We feel their energy and love each day and would not be able to carry out our mission and vision without their gifts of time and compassion.

A special ***Thank you*** to *St. Kateri Takawitha Parish Church, Our Redeemer Evangelical Lutheran Church, St. Josephs of Glenville, Immanuel Lutheran, Our Lady of Fatima, Grace Lutheran Church* for providing delicious sandwiches for our daily meal. The homemade delights are paired with a healthy soup and fruit making an excellent meal for our guests. We greatly appreciate the care that goes into making the sandwiches and ensuring they arrive to Bethesda House.

The Boy Scouts of America's Scouting for Food is a project that has been part of the Boys Scouts for decades. Scouts go out on one weekend in November to place hangers (bags with handles) on the doors of their neighbors. The next week they circle back through those neighborhoods to pick up the food and take it to a local food bank. This year, Bethesda House was the recipient of the Scouts hard work! A very special thank you to Boy Scout Troop 34 of Niskayuna for this large donation that will assist many people right here in our community!! Their hard work and dedication to this project is very much appreciated!! Way to go Troop 34!!

Boy Scouts of America's "Scouting for Food" Project

Union College Volunteers

Melissa Zampino was invited by the Girl Scouts to give an early childhood friendly presentation on hunger and community. She spoke to a group of 15, five and six year old girls at the Rotterdam Senior Center in November 2016. They were taught about what a food pantry is, hunger, how to serve the community and help our neighbors. The girls had great questions, such as, "What does non-perishable mean?" and "How many people do you feed?" The girls then created a food city out of non-perishable food items, creating a cityscape with all the places people in a community can eat. The can goods that were used for this interactive project were then donated to Bethesda House's 834 State Street food pantry.

On November 6th, members from Congregation Gates of Heaven blessed the guests of our community with a beef stew dinner. Many of Bethesda Houses' residents were in attendance and were extremely appreciative to have a hot meal served on a Sunday. The members of this congregation were participating in their annual day of service, known as Mitzvah Day. Each year this dedicated group returns to Bethesda House to offer not only a delicious meal, but to participate in creating a community of acceptance and love.

On Thanksgiving Day, the residents at the Lighthouse received a delicious, homemade meal donated by the Congregation Gates of Heaven. The meal was the talk of the house! We are so very appreciative of the generosity and kindness of these special volunteers.

Each year Bethesda House serves a Thanksgiving meal recognizing the camaraderie between volunteers and staff and the spirit of coming together as a community to give thanks for the many blessings of friendship, support, services, and a safe haven.

LDS Missionaries prepare Thanksgiving feast

Immaculate Conception Church Volunteers

We celebrate the winter holidays acknowledging the traditions of many different religions. We talk about the core beliefs of each religion as well as the common thread that is woven within all faiths. Wonderful meals are served as former Niskayuna High Schools students sing traditional and seasonal songs. We take pause to remember those we have lost, friendships that have developed, and rejoice in the light of peace and love.

Niskayuna High School Graduates, (L-R) Julianna, Nikhil, Katherine, Caroline, Andrew, and Cassandra sing at our Annual Holiday Meal

Congressman Paul Tonko & Volunteers at our Annual Thanksgiving Dinner

Financial Summary

Bethesda House's 2016-2017 fiscal year ended with an operating surplus of $47,659 due to capital improvement grants and an overall agency deficit of $122,524, which includes depreciation for capital item's supported by foundation and government contracts.

The agency's most significant fiscal challenge this year was related to fundraising. In Human Service agencies such as Bethesda House, there is a direct correlation between the country's economic health and the number of people in need of services. During our 2016-17 fiscal year, Bethesda House Administration and Board of Directors took an active approach to fundraising initiatives, securing funds from private foundations, and continuing to cultivate a more extensive donor base. Even with this commitment, our 2016-17 contributions fell short of our 2015-16 contributions by 18%.

Contribution dollars allow our agency to enhance and increase the services we provide to the homeless and impoverished citizens of Schenectady County. We are deeply grateful to have received generous donations from long-term donors and the SEFCU Foundation.

Special ***Thank you*** to the *COINS Foundation* who provided financial support for our Lighthouse renovations which included upgrades to our basement, two new residential bathrooms, and support for our new website.

Bethesda House will continue to explore initiatives to increase our contribution dollars to strengthen our programs and build upon our current success of housing the homeless, feeding the hungry, providing social work services directly related to mental health, and providing crisis and emergency services to those in need.

(L-R)LCSW, Cynthia A, with volunteer Antoinette

(L-R) Barb N., Executive Director, Kimarie S. and Rep Payee, Ryan C., and John S. at our Annual Bowling Event

Ideas Into Action

Bethesda House is underway with a new initiative. New construction for a twenty-six (26) bed facility will provide permanent supportive housing for homeless individuals with one or more disability, and individuals recently released from incarceration. Our highly skilled and trained staff will provide education, crisis management, housing and income stabilization, enrollment in insurance, engagement and connection to physical and behavioral health services, and support to encourage and achieve independence and success in the community. Partnerships include, but not limited to, The Center for Community Justice ~ Re-entry Task Force, Schenectady County Office of Community Services, Schenectady County Department of Social Services, area health providers, and current partnerships with are providers. Contingent on approval, we anticipate new construction to begin mid-2018 with an opening date in the spring of 2019. Below is a rendering from architect, Mr. Michael J. Roth, Stracher-Roth-Gilmore, Architects.

Bethesda House of Schenectady, Inc.

<u>Management Team</u>

Kimarie Sheppard, Executive Director

Anne McGhee, Program Director

Danny Payne, Director of Residential Services

Kevin Fogg, Property and Facility Operations

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