2023
2024

Bethesda House of Schenectady, Inc.

ANNUAL REPORT

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

House of Mercy.

Special Thanks

The administration of Bethesda House of Schenectady, Inc. gratefully acknowledges the work of its Directors and staff, who are responsible for providing and gathering the necessary data and information 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.

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834 State Street, Schenectady, NY 12307
(518) 374-7873
www.bethesdaHS.org

Bethesda House at a Glance

Consumers Served

The numbers cited in the table at right only begin to tell the story of the people we serve and the variety of services we offer. These figures represent thousands of hours of case management, clinical services, emergency services, life skills, and residential services.

Guests Served	Total 2023-2024
Number of Contacts	43,750
Unduplicated Guests Receiving Services	4,320
First Time Guests	1,200
Homeless Guests	2,900

> *I alone cannot change the world, but*
> *I can cast a stone across the waters to create many ripples.*
>
> – Mother Teresa

Program Department Services The numbers reflect cumulative totals of services provided.	Total 2023-2024
Consumer Choice Food Pantry – Meals Served	21,420
*P.G. Wright Food Pantry – Meals Served	4,992
Clothing Room	950
Showers	6,620
Telephone	390
Hygiene Kits	399
*Mailboxes	45,910
Daily Meal	31,201
Laundry	2,965
Lockers	7,023

Case Management Services The numbers reflect cumulative totals of scheduled appointments.	Total 2023-2024
Housing, Permanent and Emergency	4,310
Representative Payee	2,100
Case Management Services	3,750
Emergency Services	2,950
Referred for Income	650
Secured Income	140
Social Work avg monthly caseload / contacts /month	85 / 6,185
Transportation Program	820 / 2,601
Outreach Case Management: individuals / contacts	620 / 3,265
Health Home Care Coordination individuals	260
Psychiatric Nurse Practitioner avg monthly caseload	35
*Continuum of Care (COC) Coordinated Entry # Served	557

- *CoC is community-wide, includes 13 area providers.
- Area providers referred 2,900 individuals to Bethesda House for: Case Management, all programs – 1,120, Emergency Services – 1,200, Social Work and Mental Health stabilization- 960, and 60 Residential Services
- Case Management and Program staff referred 230 consumers to area providers to best meet the needs of the individuals.

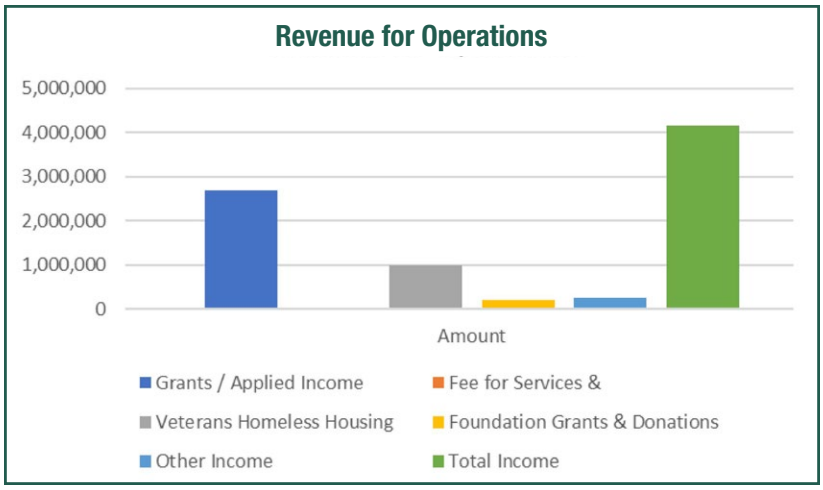
Residential Services	Total Served
Lighthouse: Supportive Housing & Veterans	13
Liberty Apartments	18
Beacon Scattered Sites	10
Cara House	31

Emergency Overnight Shelter	Total
Program Shelter participants (unduplicated)	224
Total utilization of shelter beds	351
Total beds approved for shelter	14
Number of Males	141
Number of Females	83

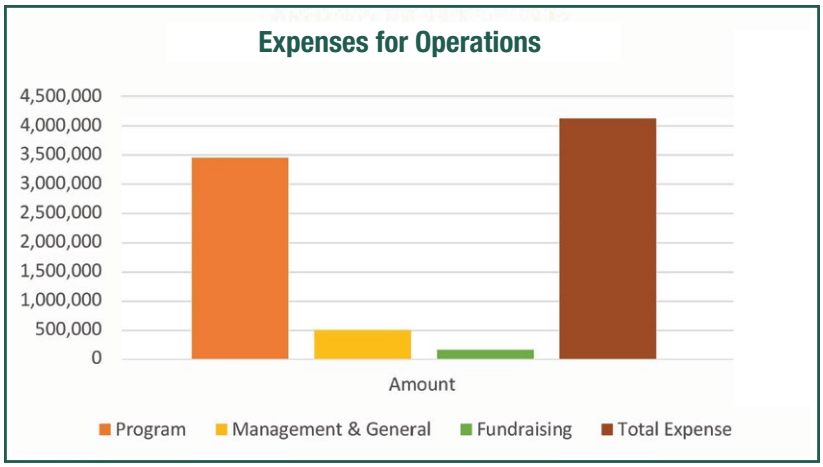
***Mailbox calculation: 85 (3+82) mailboxes, 3 general, 95 individual; 95 individuals use the general mailboxes; 82 individuals have their own mailbox, available to users 249 days a year; 96% utilization rate**

Revenue & Expenses

Revenue	Amount
Grants / Applied Income	2,688,510
Fee for Services & Veterans Homeless Housing	1,006,387
Foundation Grants & Donations	219,757
Other Income	250,065
Total Income	**4,164,719**



Expense	Amount
Program	3,454,150
Management & General	504,336
Fundraising	168,715
Total Expense	**4,127,201**



> *Always remember, you have within you the strength, the patience, and the passion to reach for the stars to change the world.*
>
> – Harriet Tubman

Introduction

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, 2023 to June 30, 2024.

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 2023-2024. 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.

Bethesda House is an essential agency and as such, we provide in-house and face-to-face services. The Agency's service delivery methods are fluid and constantly evolving to meet the changing needs of the community while maintaining safety and service.

Bethesda House food programs continue to provide pantry food bags for individuals that are unable to physically visit a food pantry. In addition, by way of the Unite Us interagency referral platform, Bethesda House Food and Pantry Programs received community-based referrals for emergency food bags to be delivered to homes of residents that could not easily access food resources.

Bethesda House continued prior years' established practices of visiting homeless encampments to provide basic living services such as food, seasonal clothing, and offer transportation to medical and mental health care. Bethesda House is part of the Schenectady HUB which includes the police department and local nonprofits who make up much of Schenectady's care network. The team meets biweekly to coordinate information and action plans for individuals in need of services. At the end of each meeting, workers are dispatched to various locations around the community, with groups of two or three team members approaching people who are known to be struggling with lack of housing or drug and mental health issues.

The Agency experienced a dramatic increase in medically fragile, severely mentally ill, and developmentally delayed homeless adults in our emergency shelter program last year. Bethesda House staff help individuals who, for the first time in their lives, need assistance; people who are aging, individuals who have lived their lives on the streets and could no longer tolerate the cold, and people with unaddressed, complex medical and mental health needs that require immediate attention.

Due to the comprehensive services offered at Bethesda House, the agency often receives referrals from other community organizations for homeless individuals that require a higher level of support, connection to community services, adherence to medical and mental health treatment, and greater oversight in regards to personal safety.

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.

If our guests and residents report that they are feeling more hopeful about the future, more prepared to deal with life's adversities, and more capable of caring 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 guests and residents.

This Annual Program Report covers eight service dimensions of the agency: Program Department: Day Program Drop-in Center/ Essential Services, Overnight Emergency Shelter, Code Blue Shelter, Coordinated Entry, Case Management, Street Outreach, Clinical Services: Social Work, Medical Care, Psychiatric Nurse Practitioner, and Residential Services.

- Bethesda House's Program Department is comprised of a variety of individual services that meet the needs of Schenectady's homeless and working poor population. The goal of the combined day drop-in and essential services programs is to provide crisis management, harm reduction, and stabilization in the lives of the individuals who are experiencing overwhelming life challenges and who are seeking support and guidance.

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), Regional Food Bank, Concern for the Hungry, and private foundations and donors all support the services offered by this department.

- Overnight Emergency Shelter:

  During the 2023-2024, the Agency offered a 14-bed Overnight Emergency Shelter, at 834 State Street. The Overnight Emergency Shelter at 834 State Street closed operations in April 2024.

  The Agency operates a CODE BLUE Shelter, November 1st – April 30th.

  In January 2024, the Cara House Overnight Emergency Shelter opened offering 16 shelter beds. The shelter is designed to provide a safe and secure environment to homeless single adults in Schenectady County while incorporating higher-level support and case management with Social Workers, Outreach staff and Medical Care Professionals. Hours of operation are from 4:30 pm – 8:00 am, seven days a week.

The Overnight Emergency Shelter is funded through the Schenectady County Department of Social Services.

The Code Blue Shelter is approved by New York State and Schenectady County Department of Social Services, who distributes funding.

- Coordinated Entry is designed to track the most vulnerable homeless families and individuals in need of housing from the point of entry into the Continuum of Care tracking and wait-list system to the moment when they secure housing. Bethesda House is the lead agency; the Agency partners with Legal Aid Society of NENY and CARES of NY.

The Coordinated Entry program is funded by the US Department of HUD.

- The Case Management Department provides a variety of services to all guests experiencing homelessness or who are at risk of becoming homeless. The goal for each homeless individual who walks through our door is to address the immediate critical need, and then to proceed toward the overall goal of moving individuals out of the cycle of homelessness.

The Case Management Department has more than one contract source. The City of Schenectady, Schenectady County DSS, and private donors support the services offered by this department.

- The Street Outreach activities are designed to meet the immediate needs of people experiencing homelessness in unsheltered locations by connecting them with emergency shelter, housing, or critical services, and providing them with urgent, non-facility-based care. Services generally consist of engagement, case management, emergency health and mental health services, and transportation.

The Street Outreach Department is funded by NYS Office of Temporary Disability Assistance (OTDA)'s Solutions to End Homelessness Program (STEHP) and private foundations and donors.

- Our Clinical Department provides Social Work, Medical Care, and mental health services to the agency's guests and residents, completes mental health evaluations, and initiates in-house referrals and referrals to area mental and medical health providers. The walk-in counseling availability and lack of barriers support the reduction of Emergency Department utilization. Under the umbrella of the Clinical Department is the Health Home – Care Management Agency (CMA). NOTE: The Health Home – Care Management Agency closed in November 2024.

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 Ellis Medical Center Nursing Program. Interns are supervised by our

Licensed Social Workers and program Directors. Interns benefit from a hands on learning experience working with our community's homeless and impoverished citizens who are substance users, mentally ill (who typically self-medicate with illegal drugs), who are experiencing trauma, and are struggling with other chronic crisis driven issues.

The Social Work Department has more than one contract source. NYS OMH through the Schenectady County Office of Community Services, Schenectady County (under the Home Connections program), Alliance for Better Health, NYS OTDA Empire State Supportive Housing Initiative (ESSHI), and Department of Health through St. Peters Health Partners Health Home program.

- Bethesda House has operated under the "Housing First" model since 1998. Housing First focuses on providing housing first for the chronically homeless population, and then combining that housing with supportive treatment services in the areas of mental and physical health, substance abuse, education, and employment. In 2002, the Agency opened its first residential program, in 2010 the second residential program, in 2017 the third residential program, and in 2023 the fourth residential program. The "Housing First" model is woven into all services provided by the Agency. Staff work diligently with residents to overcome life challenges and to help provide a safe, comfortable, and welcoming home for everyone to enjoy and find solace.

Residential programs include the Lighthouse – seven beds, Liberty Apartments – sixteen beds, the Beacon – eight scattered-site apartments, and Cara House – 26 beds. All of the residential programs are permanent supportive housing for chronically homeless adults with a history of untreated, severe, and persistent mental illness and other disabling conditions and single adults recently released from incarceration. We provide advocacy, housing, and a safety net for our residents. Staff address the needs of the whole person focusing on empowerment, personal growth, skill building, and discovery of an individual's strengths.

The Lighthouse Program's additional three beds are transitional housing beds for veterans. Agency staff work 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 Department of HUD, NYS Office of Temporary Disability Assistance (OTDA) NYS Supportive Housing Program (NYSSHP), Veterans Administration, NYS Office of Temporary Disability Assistance (OTDA) ESSHI, and private donors support the services offered by this department.

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 attend meetings with:

Housing and Supportive Services Network
Homeless Veterans
Single Point of Access Committee (SPOA)
Schenectady Homeless Services Planning Board (HSPB)
HSPB – Data Committee
Eviction Task Force
Schenectady Coalition for a Healthy Community
Coordinated Entry
Mental Health Sub-Committee
Concerned for the Hungry
Schenectady County Re-entry Task Force
Adults at Risk – Schenectady County
The Food Pantries of the Capital District

Bethesda House has a variety of linkage agreements throughout the professional community.

Bethesda House's Administration is fully invested in the freedom to be creative, to pioneer useful solutions and implement positive changes within the agency. Agency leadership examines 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 Agency's Board of Directors. The 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.

Program Department Purpose – is to provide a safe, supportive environment for homeless, vulnerable, and/or at- risk individuals to have access to a wide variety of services under one roof. The Program Department's Drop-in Center is the point of entry to all Agency services, which range from basic living needs to intensive case management.

Services That Are Available and Offered:

Drop-In Center – Everyone in need of services is welcome to sit and be in a secure, welcoming environment. It is a place that provides non-judgment, social supports, and sense of belonging. It is known to the community as a safe place and is often the only connection that our population has to services and trusting relationships. Hours of operation are:

Monday through Friday; 9:00 am – 11:30 am;
1:00 pm – 4:30 pm. All services are free.

Food Programs – the Agency has a nutrient dense, nutritional platform in all of the food programs offered. Healthy, low fat and low sodium foods are offered at the daily meal and at our two food pantries.

SNAP benefits are discussed, as well as the importance of budgeting food resources. In addition, other community services and resources are reviewed and explained which also help to stretch a SNAP budget.

Daily Community Meal (Soup Kitchen) – healthy, nutritional meals are prepared by our experienced and talented Chef and his team. The daily meal is served Monday – Friday from 1:30 pm – 3:30 pm. Staff and guests strictly follow recommendations.

Client Choice Food Pantry – The main food pantry at 834 State Street and our satellite food pantry located at the Northside Village apartment complex in the 12308 zip code, offer a variety of food items. The Regional Food Bank's annual award and donated dollars, specifically allocated to the food program, support food item purchases. In the past year, there has been an increase in referrals and requests for food bag deliveries.

Other Pantry Partners – Concerned for the Hungry, Food Pantries of the Capital District, and the Regional Food Bank have food drives and donations to supplement both food pantries.

Day Program guests are offered support from Licensed Clinical and Masters Social Workers, Medical Care staff-RN, and our Psychiatric Nurse Practitioner who are available to explain the direct connection between nutrition and health. Healthy food choices are suggested along with education on the health impact of poor nutrition. We have found that this approach is met with enthusiasm.

Basic Living Needs – Laundry, showers, mailbox (use of Agency address), telephone and fax services are available daily. Program staff are available to assist in these services as needed. The availability of phones has allowed numerous people the opportunity to arrange for job interviews, and connect with critical outside institutions such as the Social Security Administration and Schenectady County Department of Social Services for benefits and monthly cash assistance.

Clothing Room – Donated clean, gently used or new clothing is provided in our easy access clothing room. The clothing room is available on Thursday and available Monday – Friday for emergencies and area provider's referrals.

Critical Services – Bethesda House is known for offering a wide range of critical services to the public. The Agency works with community providers and several outside facilitators to provide on-site education and service connection to those who access the Drop-In Center. Program services such as: Safety Counts, STD testing and education, substance use disorder referrals, and nutritional education, are a part of the Day Program.

Bethesda House partners with local justice officials to provide opportunities for individuals to complete community service hours and to receive on-the-job training.

Schenectady Job Training Agency (SJTA) is active in referring high school students to the Agency for on-the-job training opportunities through the Federal Work Study Program. Each summer the agency is able to work with a maximum of three (3) high school youth on specific job skills through coaching and mentoring. These youths gain a greater understanding of what it means to work for the first time in a professional setting.

A monthly House Meeting is held to address areas of concern with guests and also allows guests a forum to discuss issues or items of interest that need to be brought to the attention of staff.

Administration and Program staff continue to 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.

How the Program Department Works

The department is low-barrier and provides an atmosphere of acceptance where individuals feel that they will be safe as they grow in self-worth, dignity, and self-respect. Individuals meet with staff to obtain one or more services or simply to sit and be safe. Engagement is a critical component to gain trust and begin the process of accepting in-house referrals or referrals to area providers to improve and stabilize individual's lives.

The Future of the Program Department

Agency staff work to demonstrate behavior that is emulated by others. The goal of this department is to be a role model with examples of healthy behavior, appropriate social skills and decision-making skills to promote overall wellness. Staff will work with facilitators to support individual and group sessions on grief and loss, effective communication, and consequential thinking. This in an effort to improve self-awareness and reduce the risk of repeated mistakes or common pitfalls.

Schenectady Coordinated Entry Purpose – The purpose of the program is to provide a uniformed approach in identifying, engaging, and assisting homeless individuals and families effectively, and to ensure that those who request assistance are connected to proper housing programs and services.

How Coordinated Entry Works

Coordinated Entry uses a standardized assessment tool and incorporates a system- wide housing first, client choice approach, prioritizing housing for those with the highest service needs.

Coordinated Entry is a HUD funded program that is facilitated by Bethesda House, the Legal Aid Society, and CARES of NY. The partnering agencies are New Choices Recovery Center, SCAP, YMCA, YWCA, Mohawk Opportunities, Schenectady Municipal Housing, SAFE Inc., Soldier On, VCHC, the Alliance for Positive Health, and the Re-entry Task Force. Individuals are able to access this program through multiple agencies and will receive the same consideration

Overnight Emergency Shelter – The Agency offered a 14-bed Overnight Emergency Shelter at 834 State Street, which operated 365 days of the year. The 834 State Street, 14-bed emergency shelter closed operations in April 2024.

In January 2024, the Cara House Overnight Emergency Shelter opened, offering 16 shelter beds.

The State mandated, Code Blue shelter operates, November 1st – April 30th, each year.

The shelter is designed to provide a safe and secure environment to homeless single adults in Schenectady County while incorporating higher-level support and case management with Social Workers, Medical Care staff-RN, Outreach staff and Mental Health Professionals. Hours of operation are from 4:30 pm – 8:00 am, seven days a week.

<u>Services Offered During Shelter Hours:</u>

- Shelter bed – A clean space, bed, and blanket in a secure setting monitored by Shelter Aides and Agency Front Desk/Security.
- Food – a light meal is prepared by Agency Chef and offered for breakfast and dinner.
- Clothing – access to the clothing room is available and staff encourage use of weather appropriate attire.
- Shower – personal hygiene is encouraged and showers are available up to 9 pm.
- Laundry – services are available upon request.
- Storage Lockers – Shelter offers locked and monitored lockers to keep personal belongings.
- Medication Storage – Shelter offers a locked medication storage system and staff assists shelter guests with prompts and reminders.
- Intake and Assessment – is processed by Agency Shelter Aides and Case Management. In-house referrals are completed for housing, medical, mental health, and substance use engagement and connection.
- Social Work Services – Licensed Social Workers meet with individuals to complete a psych-social assessment and work to connect each individual to appropriate services.

Case Management is a collaborative process involving the individuals we serve, outside agencies and community service providers. The process encompasses assessment, planning, facilitation, care management, evaluation and advocacy for options and services to meet an individual's crisis and housing placement needs.

Services Offered:

Initial Intake and Assessment – Case Management is available through Schenectady County Department of Social Services referrals, in-house referrals, and for those walking in for services and reporting a need. Case Managers will triage and assess the immediate needs, eligibility for entitlement programs, and review both in-house services and/or area providers for possible service referrals.

Financial Case Management/Representative Payee Program: Proper financial management has been shown to be a pivotal component to stabilization in the community.

Bethesda House is able to act as a Representative Payee for those who are unable to manage or direct the use of his or her SSI/SSD benefits. Staff meet with program participants regularly and as needed to create a budget to pay bills, address wellness needs, and review personal essentials so that all aspects of their lives are being appropriately addressed.

The program is extremely successful in reaching the goals of continued housing and income stabilization. Program participants benefit from on-going encouragement and education. Staff provide counseling, crisis management, and consequential thinking to participants, and as individual lives change, so will their budget.

In addition to Financial Management, staff establish proactive relationships with landlords to ensure a stable housing situation. Staff will work in collaboration with clients to address any issues regarding Independent Living Skills, rental agreements, and safety in order to advocate for them to prevent risk of eviction.

Case Managers will also identify individuals who may be eligible for SSI benefits and will assist in the completion of SSI/SSD Outreach, Access, and Recovery (SOAR) application, which expedites the process. The SOAR application is at no cost to the person.

Shelter/Housing – The Housing First model, which is employed by all departments within the agency, continues to be our guiding principle as we search to find permanent housing options for the most vulnerable.

Case Managers connect and engage with single adults utilizing the Agency's emergency shelter, community emergency shelters, walk-ins, and community referrals. Staff have a strong partnership with Schenectady County DSS, which aids with the transitions from emergency shelter to permanent housing in the community.

Case Managers prioritize serving the entirety of the individual and focus on wrapping comprehensive services before, during and after housing is secured. Contact with individuals following placement in permanent housing is maintained for twelve months and longer if needed. Connection to in-house services and to area providers is initiated immediately in order to encourage engagement in stabilizing treatment. The Social Work and Case Management teams successfully collaborate in order to address the totality of need and provide intensive support in order to have a positive impact.

Case Management staff work with a landlord database and are continually looking to improve and expand such relationships. The Agency has observed the effectiveness of maintaining strong, sustaining relationships with landlords in their efforts to house the chronically homeless. The primary responsibilities of the Case Managers are homeless prevention, transitioning emergency shelter guests to permanent housing, rapid re-housing placement, and providing stabilizing aftercare.

Street Outreach – The Street Outreach Case Management program was implemented in 2018. Street Outreach activities are designed to meet the immediate needs of people experiencing homelessness in unsheltered locations by connecting them with emergency shelter, housing, or critical services, and providing them with urgent, non-facility-based care.

Street outreach programs provide services directly or by collaborating with other agencies. The Outreach staff primarily work in the community providing food, clothing, and connection to area providers. The Outreach Case Manager works to establish a strong relationship and line of communication to provide basic living needs, but with the intention to address the factors contributing to homelessness. The Outreach Case Manager introduces support, information sharing, crisis management, advocacy, and education on pertinent services. As appropriate, Outreach staff will bring a person or persons to the Agency to meet with Case Management or Social Work staff.

Street outreach services include:

- Street-based education and outreach
- Access to emergency shelter
- Survival aid
- Individual assessments
- Trauma-informed treatment and counseling
- Information and referrals
- Crisis intervention
- Follow-up support

Home Connections – Is a unique housing program in Schenectady. This program is designed to significantly reduce the length of time homeless individuals stay in emergency shelters.

Agency Case Managers go into the community to engage homeless individuals in local shelters and motels in efforts to transition them to permanent housing and connect them to appropriate services. Home Connections also promotes connection to medical and mental health care by working with the Social Work Department. Goals include evaluating eligibility for Social Security benefits and/or encouraging and directing individuals to job search and employment resources.

Rental Supplement Program (RSP) Case Management and Subsidy – this program was established to provide vital rental assistance to individuals and families, regardless of immigration status, who are experiencing homelessness or are facing an imminent loss of housing. The RSP is available to eligible individuals and families both with and without children.

How Case Management Works

Under the premise that no two people experience homelessness or manage crisis in the same way, Case Managers approach their work with sensitivity and respect for each person's individuality. They work to build trust and understanding of a mutual goal, while obtaining critical information to begin the case management process.

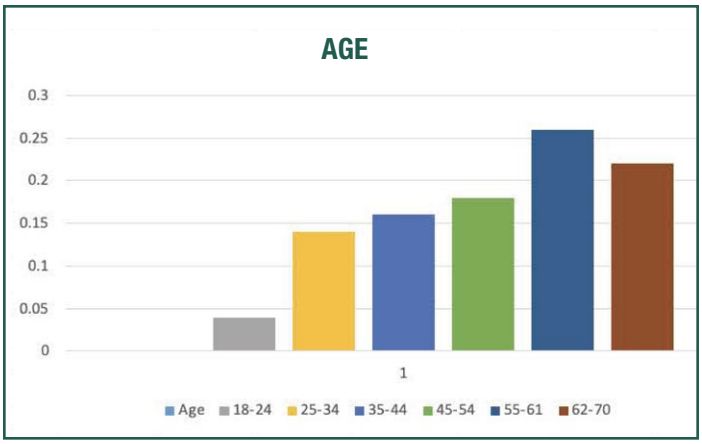
An in-depth assessment is processed and a service plan with individualized goals and follow up is developed. The plan offers enrollment in the Representative Payee program for financial management, engagement with the in-house Social Work, Medical Care Program, and if appropriate enrollment in the Health Home program. This team wrap-around approach has proven to provide greater stability for the individual and increases their chances of successfully integrating into the community.

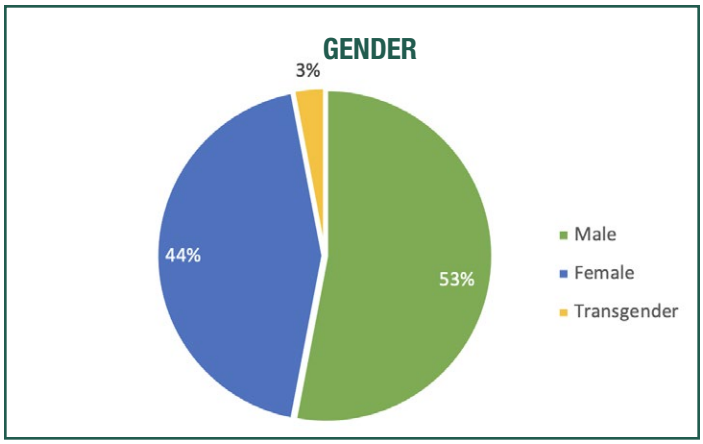
BH's strong partnership with DSS has allowed for greater insight into the deficiencies of the service delivery system and has paved the way for improved relationships with other area agencies in the community. Barriers have been identified allowing greater communication to address the growing needs of the homeless population.

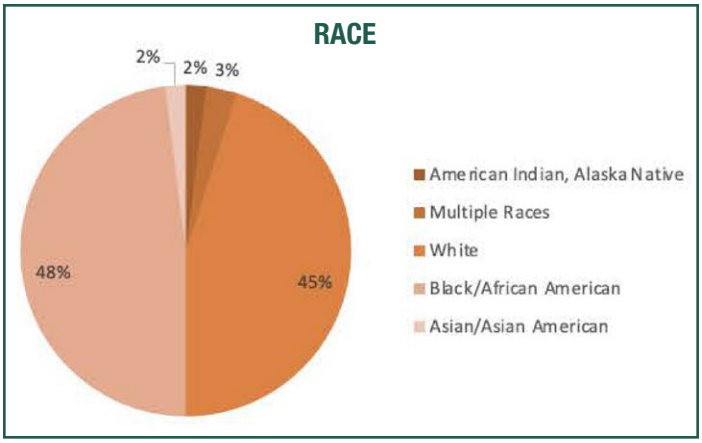
The Future of Case Management at Bethesda House

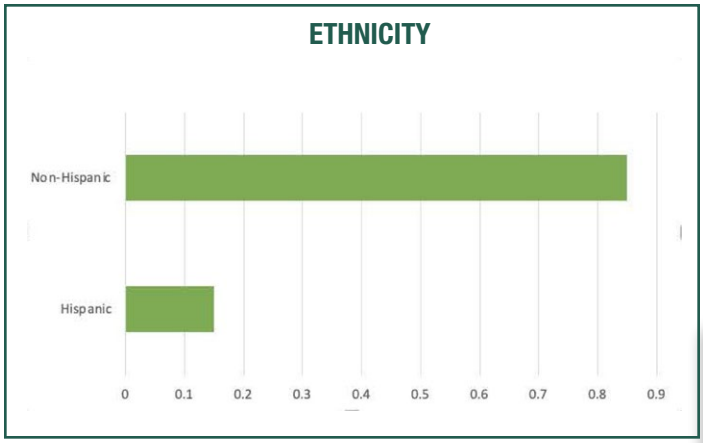
Effective case management positively impacts the healthcare system, especially in aligning with the goals of improving health outcomes of individuals/populations, enhancing the experience of care, and reducing the costs of care. Bethesda House has a comprehensive Case Management team who will enhance the level of services and client interaction to facilitate the achievement of client wellness and autonomy through advocacy, assessment, planning, communication, education, and resource management..

Case Management









Disability	% of Population
Development Disability	37%
Chronic Health	75%
Substance Use Disorder	65%
Mental Illness	94%
HIV/AIDS	3%
Physical Disability	44%

Number of Conditions	
1 Condition	17.42%
2 Conditions	34.25%
3+ Conditions	48.33%

Services

- Stabilize emergencies
- Reduce obstacles
- Access to community resources
- Referrals to area providers
- Emergency placement
- Permanent / Long-term housing
- Housing Subsidy
- Eviction Prevention
- On-going support
- Wrap around services

Clinical Program Purpose – The program offers Social Work, Medical Care and Mental Health stabilization, supportive counseling, and referral services to the disenfranchised, impoverished and homeless individuals of Schenectady County.

Services Offered:

Walk-in Hospitality Center – There is a dedicated space available daily to the public. Individuals in the community can walk in between the hours of 9:00 – 11:30 and 1:00 - 4:30, Monday through Friday for respite, access to basic needs, and assistance with emergency services. If the individual agrees, they will be connected with in-house or community resources. Social Work services are offered to those walking in and seeking support or advocacy.

Outreach – The Clinical staff work closely with the Outreach staff. This collaboration has been highly successful in meeting street homeless people where they are, providing counseling and medical need services, and advocating and encouraging people to agree to emergency shelter services.

Medical Services – Agency Licensed Clinical Social Workers, Medical Care – RN staff, and Psychiatric Nurse Practitioner triage the need and proceed appropriately. The Ellis Medical Center's Residency Program Doctors are on-site two afternoons a month to work with the clients who were referred for engagement and treatment. This service is offered to Bethesda House Day Program guests, residents, and individuals engaged with services.

Psychiatric Nurse Practitioner – The Bethesda House PNP Program provides Psychiatric stabilization services on-site. Those referred to the PNP Program will also meet with a Social Worker who screens for services and provides a comprehensive treatment plan. The PNP will complete a thorough Psychiatric evaluation and provide treatment as appropriate. Social Work staff work with the PNP to connect individuals to additional services and provide case management and consistent supportive counseling.

Health Home – Bethesda House became a Care Management Agency in 2019. The Program's Care Coordinators provide case management services and work diligently to connect clients to medical and mental health services while addressing Social Determinants of Health.

The Health Home staff work closely with the Case Management and Social Work departments and coordinates closely with community providers. Bethesda House has committed resources such as transportation services in order to maximize the positive impact of the program. NOTE: the Health Home Care Management Agency closed operations November 2024.

Medical/Mental Health/Substance Use Disorder Care – The population accessing services at Bethesda House consistently present issues related to Significant Mental Illness, Substance Use Disorder, Trauma, and untreated Chronic Health Conditions. The Social Work and Case Management Staff are dedicated to engaging individuals in all means of support in order to assess the needs of individuals and provide guidance and information in order to connect to services and community providers. Staff have established strong relationships with community agencies/programs such as Project Safe Point, Ellis Hospital, New Choices, Ellis Mental Health Clinic, and Schenectady DSS in order to best serve the population and have an impact. A main component of the service is that individuals often interact with Social Work staff quite frequently. Shelter guests and Drop-in Center guests are able to see staff on a daily basis. This intense support allows for greater engagement and effectiveness.

How Our Social Work Department Works

We believe that it begins with valuing the individual's experience, choices, and priorities. Meeting the individual 'where they are at' and listening to what is important to them is the process of engagement for us. Being available to address a need or problem in the moment and building trust is a key component to how Social Work staff operate. Staff hold the belief that individuals have a desire to and the ability to change that which is causing them distress. Social Workers further believe that sabotaging incidents and behaviors are a response to a physical and/or psychological pain or condition. Staff foremost offer comfort care and safety, thus cultivating further opportunities for treatment to begin. Staff want clients to experience and remember Bethesda House as a place to return to when in need. Bethesda House finds value in working and collaborating with other human service agencies for the common good and safety of the individual and the greater community.

The Future of Social Work at Bethesda House

Social Work staff will continue to be a bridge and safety net for individuals disconnected from life stabilizing services and supports. The overarching goal is to expand to provide and strengthen existing programs that have proven effective with the population.

The Agency's new facility, Cara House, includes an on-site social work office designed to address the needs of the re-entry residents, working to stabilize each person so that they are able to successfully re-enter society. In addition, we are working to extend clinical services to include evenings and weekends.

Housing First is a homeless assistance approach that prioritizes providing permanent housing to people experiencing homelessness. This model is at the core of all services Bethesda House provides and was directly implemented in 2002 when the Agency's first residential program began operations.

Residential Department Purpose – The Lighthouse, Beacon, and Liberty residential programs are permanent supportive housing programs for chronically homeless single adults. It is a model that combines low-barrier affordable housing, health care, and supportive services to help individuals lead more stable lives.

The Agency's Veterans program offers transitional housing to Veterans who are referred to the program from the Veterans Administration.

The Agency's new facility, Cara House, offers supportive housing to chronically homeless single adults and homeless single adults recently released from incarceration.

Services Offered:

Permanent Supportive Housing – Chronically Homeless, single adults are housed first then work with residential staff to create an Individualized Service Plan (ISP). Continued housing placement is not contingent of following the ISP.

Harm Reduction is a set of practical strategies and ideas aimed at reducing negative consequences and is built on a belief in, and respect for, the rights of people who use drugs. Staff are non-judgmental and will work with individuals providing services and resources in order to assist them in stabilization or on their path to sobriety.

Life Skills – services provide opportunities to develop functional everyday life skills such as self-care, vocational goals, money management, self-advocacy, and independence.

Money Management – Residents who are on SSI/ SSD are encouraged to participate in the Agency's Representative Payee program which is designed to assist in money management.

Support Services – Liberty Apartments, Lighthouse, and Cara House are staffed 24/7. Residents interact with staff on a regular basis; Beacon residents interact with staff at least weekly. One-on-one meetings are designed to focus on each resident, giving them full attention. During scheduled meetings, the discussions between staff and residents focus on progress towards goals, immediate concerns, and any modifications to their existing service plan. All residents have access to the Agency's Social Work, Medical Care, and Psychiatric Nurse Practitioner services. Residents engage and connect with our Health Home Programs' Care Coordinators to ensure their medical and mental health needs are met.

Day Program – Drop-in Center – All residents have access to the Agency's essential and basic living needs services such as daily meal, food pantry, clothing room, hygiene kit program, and facilitators.

How the Residential Department Works

The Agency has five specific residential programs, Liberty Apartments which has 16 PSH beds, the Lighthouse which has 7 PSH beds and 3 transitional beds for Veterans, the Beacon which is made up of 8-scattered site apartments, and Cara House which has 26 PSH beds.

Staff meet monthly to review issues that affect programming and staffing. The Director, Associate, and Assistant Director regularly attend the Single Point of Access (SPOA) meetings which 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 representative 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.

The design of the program allows for greater autonomy, but most residents seek interaction with their resident neighbors, our Day Program population, and general staff members. Ninety-six percent of the residents have developed their goals for their service plans with one of the Residential Program's Leaders.

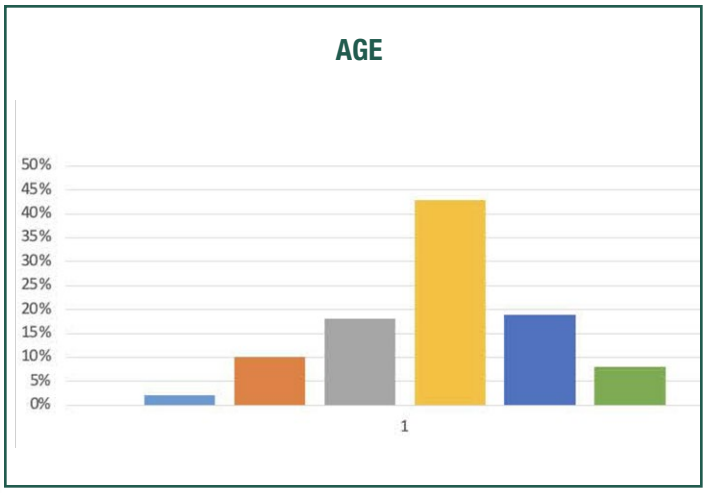
Obtaining secure and stable housing is the first step in alleviating the lifestyle effects and trauma associated with living on the streets. It takes a great deal of time for a homeless person to let go of street life and to trust that they are worthy of their new life. With each step forward, there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

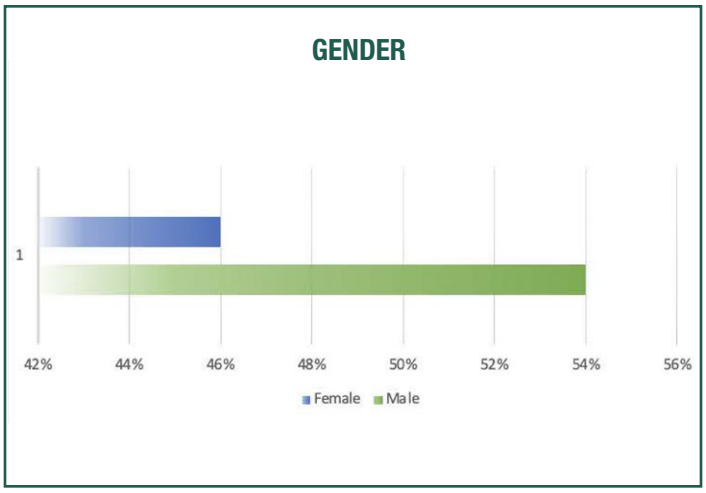
Residents actively participate in social activities and most thoroughly enjoy each other's company. It is refreshing to see over sixty percent of the residents engage in various activities such as movie theater trips, nutrition classes, grocery shopping, community events at local congregations, and on-site events.

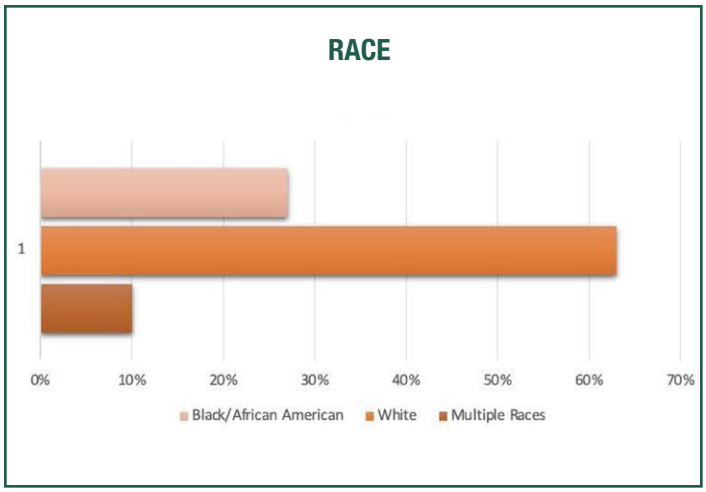
The Future of the Residential Program

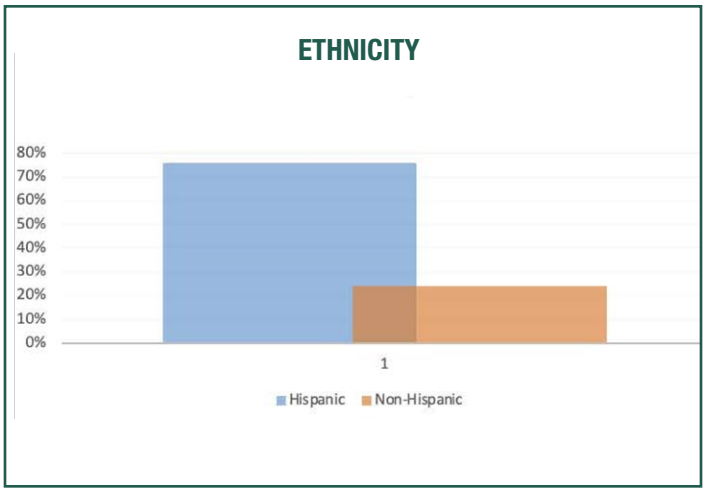
Within our current residential programs, we will expand our current multifaceted activities with the goal of helping and encouraging residents to become independent and comfortable in a community setting as well as having security in navigating community resources. Staff will encourage seasonal activities that will act like springboards to help residents move forward and develop skillful ways to communicate and manage anxiety. The Agency will further develop the resident volunteer program and encourage residents to sign up for volunteer programs in the community.

Residential Programs









Number of Conditions	
1 Condition	19.75%
2 Conditions	29.01%
3+ Conditions	51.24%

Disability	% of Residents, Based on 31 Residents
Development Disability	19.50%
Chronic Health	32.50%
Substance Use Disorder	65.00%
Mental Illness	91.50%
HIV/AIDS	2.00%
Physical Disability	35.59%

Looking Back

In our 2023-2024 year, we had four successful fundraisers:
Cheers! for Bethesda in August, Light Up Bethesda in October, Virtual BINGO in January, z and Bowl for Bethesda in May. Bethesda House raised over $40,000 in special events alone.

On November 30th, 2023 Cara House had its ribbon cutting ceremony. City officials, politicians, donors and Bethesda House supporters gathered to celebrate the grand opening.

Bethesda House would not be the full service agency we are today without the generosity of our in-kind donors. We rely on donations to ensure our kitchen is stocked, our clothing room is functional, our medical care office has the proper supplies and our outreach team is prepared to go out every day. Looking back, we are so grateful to the organizations and congregations that continue to keep Bethesda House top of mind. Thank you for sharing your time and resources in support of our mission!

Thank you to St Joseph's Church and Holy Redeemer Church for the carefully made sandwiches; to AllTown Fresh, City Mission, St Luke's Parish, Lansing's Farm Market and Greenhouses for your fresh, healthy food donations; Sisters & Brothers Church of the Latter-day Saints, Lynnwood Reform Church, Eastern Parkway United Methodist Church, Comfort Inn & Suites Schenectady-Scotia, and St. Gabriel's Church for clothing, linens, and street outreach items; and Rivers Casino and Resort for this year's turkey donations.

Thank you to the groups of volunteers from Anthem Insurance, Elevance Health, NYS DEC, St. Madeleine Sophie Church, Eastern Parkway United Methodist Church, Lynwood Reformed Church, First United Methodist Church, and Hannaford.
We love hosting you and hope you continue to come back!

Thank you to our Volunteer Team of 20 volunteers! Every day, every hour, we feel the gifts of your time, compassion and caring for others.

It is with our deepest gratitude, that through our continued partnership with Concern for The Hungry, The Food Pantries of the Capital District and the Schenectady County Food Providers, we are able to receive non- perishable food and funds for our food programs.

The Agency's holiday meals are always filled with camaraderie and great food! Thank you to our wonderful community supporters who helped to make each holiday meal a success!

Looking Forward…

In 2024-2025, the Agency is looking forward to increasing marketing efforts and enhancing special fundraising events to reach a wider donor base and ensure cost effectiveness. The Agency is also looking to enhance the street outreach program and develop the Education Program at Cara House. The Education program is an integrative, holistic model of education and life skills services for the chronically homeless, impoverished and re-entry populations in Schenectady County. It is a forward-thinking program that will provide tools to address the social determinants of health that keep them from safe, stable housing and living independently. The Education Program will include practical modalities such as basic education, higher education, life skills, and job training in addition to more nuanced approaches such as grief and loss programming and creative outlets in art, music and play. It will address the diverse needs of these populations while promoting a sense of empowerment, self-sufficiency, and a pathway to long-term stability.

Bethesda House of Schenectady, Inc.

Kimarie Sheppard
Executive Director

Megan DeMeo
Deputy Director of Program Operations

Crystal Thatcher
Director of Homeless & Residential Services

Sharon Lotano
Finance Manager

Homelessness Myths

MYTH 1

Staying in a shelter is free

Shelter Allowance for Family of 4 with children: **$351/month**
Shelter Allowance for an Individual: **$195/month**

MYTH 2

Individuals experiencing homelessness don't want help

There is no evidence to support that persons experiencing homelessness are service-resistant. As of September 2024, there are **237 homeless households** on the Coordinated Entry waitlist in Schenectady County. This likely does not represent all individuals in need of services.

MYTH 3

People who are homeless just don't want to work

Nationally, a full-time employee making a minimum wage must work **86 hours** a week to afford a one-bedroom apartment. For every **100** extremely low-income renters nationwide, there are only **37** affordable homes available.

MYTH 4

People choose to be homeless

Homelessness is caused by a variety of factors.
Of the Schenectady County homeless population… **3.5%** are victims of domestic violence, **4.9%** are unaccompanied youth, **17%** are living with a severe mental illness

MYTH 5

Providing services enables people to remain homeless

Support services reduce the numbers of households that are homeless.
Of the Schenectady County homeless population… **29%** exited homeless to permanent destinations, **67%** exited to temporary destinations, The return rate to homelessness in Schenectady is less than **15%**

MYTH 6

All people who experience homelessness are addicts

Only **17.9%** of homeless individuals in Schenectady County experience chronic substance abuse.

MYTH 7

It's easy to access shelter

It's not that individuals don't want services, it's that services are often limited and/or not available for certain populations. **1.6%** of the homeless population in Schenectady is unsheltered, **12.1%** of households experiencing homelessness in Schenectady County include children

MYTH 8

Homelessness will never happen to me

Persons living with homelessness have said they **never expected** to be homeless.

By Caroline Codd
reprinted from Bethesda House's 2024 Fall/Winter newsletter, The Beacon

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