CapMetro

Community Intervention: Year 2 Report

Year 2: October 14, 2022 – October 13, 2023

On October 13, 2022 the Community Intervention Program concluded its second year of operations. Created as part of CapMetro's new, three-team approach to public safety, the Community Intervention Program is a street outreach effort designed to address quality of life issues on the transit system related to homelessness, substance abuse and mental illness. Community Intervention Specialists (CIS) employ the program by engaging vulnerable populations on the transit system, building a relationship with them, and navigating them to the appropriate resources. The following report will discuss the program metrics, operations and accomplishments for the second full year of operation.

In program year two (October 14, 2022, to October 13, 2023), the Community Intervention team solidified operations, expanded with an additional team member, formed new partnerships and had many housing, shelter and benefits successes with individuals. The program developments, successes, metrics and impacts are discussed below.

Before diving into the numbers, it is important to highlight the CIS team's commitment to the quality of work with individuals rather than strictly focusing on quantity. This focus allows CIS staff to develop lasting relationships with individuals that are needed to help navigate them through a complicated, under-resourced and time-consuming homeless response system. The numbers discussed below reflect the time-intensive efforts CIS staff took with each individual to help them achieve their goals and address quality of life and house rule violations on the transit system for the long-term.

Program Metrics

The CIS team uses 7 indicators, defined below, to track efforts and progress made in the program. In the year 1 report, the CIS team shared the totals from indicators 1-4. For program year 2, we began tracking housing & shelter efforts and success, which are covered by indicators 5-7. Additionally, we included housing & shelter numbers for program year 1 in this report as these numbers were not available at the time of publishing last year.

1. **Engagements** – An individual that is identified for outreach (either through a referral or self-initiated by CIS) is located and engaged in either relationship building or service navigation.
2. **Refusals** – An individual is located by CIS and an attempt is made to engage in services, establish relationship, or provide resources. The individual declines to engage or offer for services.
3. **Unable to locate** – Attempted engagement; an individual is not able to be located. No communication was established.
4. **Referrals** –CIS staff make a referral to a social service agency or other identified resource during engagement with an individual. Examples include referrals for cold weather shelters, housing organizations, and healthcare providers.
5. **Coordinated Assessments** – This is a housing assessment that is overseen by ECHO (the lead agency for homelessness in Austin/ Travis County). It is considered the entry point for several types of housing assistance for people experiencing homelessness. It is time-intensive (it takes on average 1 hour to complete with each person) and requires special training and database access.
6. **Housing Placements** – Number of individuals who moved into stable housing after either working directly with the CIS team, or after the CIS team made a referral to the housing agency.
7. **Shelter Placements** – Number of individuals who were placed in temporary shelter.

CIS Program Metrics

Key Performance Indicator	Year 1 Total	Year 2 Total
Engaged	712	1213
Refused	40	41
UTL	196	650
Referrals	246	276
Coordinated Assessments	100	73
Housing Placements	3	11
Shelter Placements	1	5

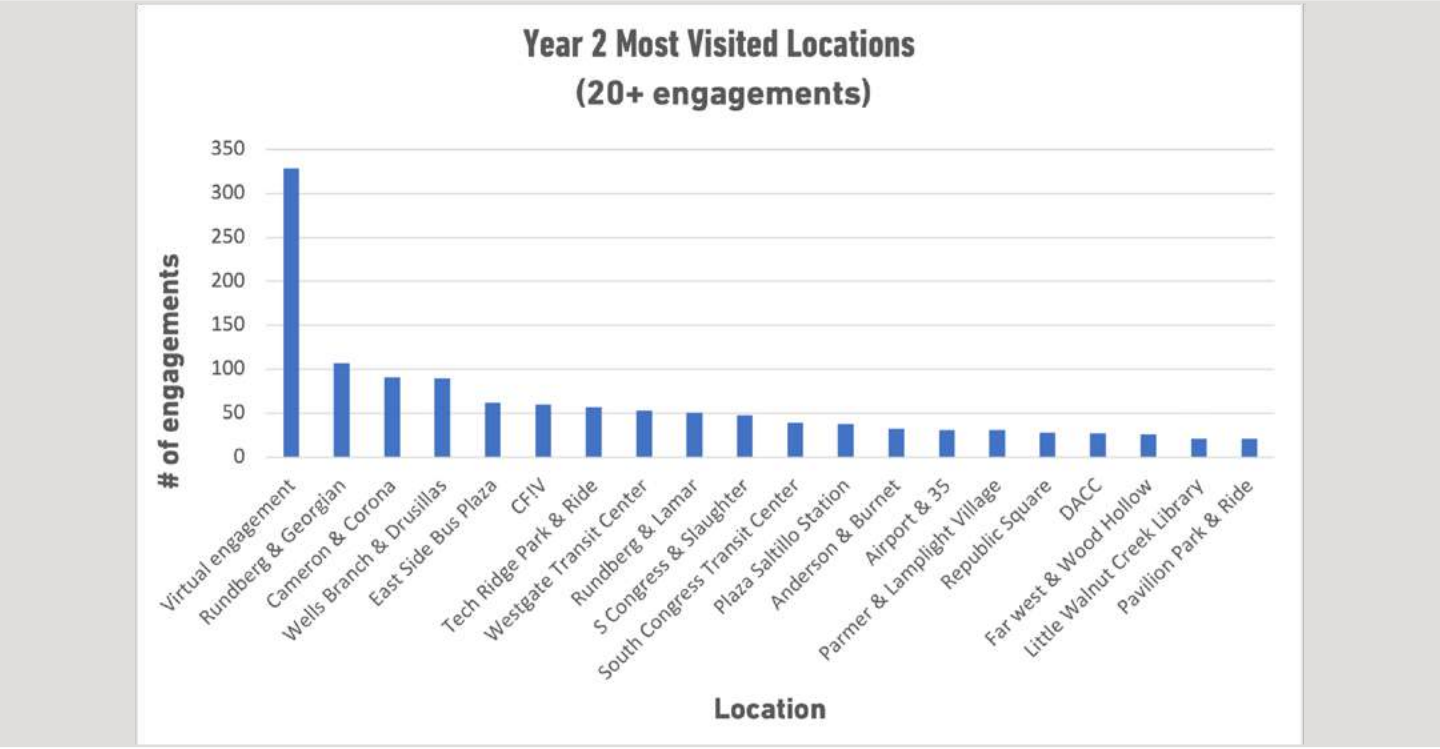
In program year 2, the CIS team engaged with 336 unique individuals. Out of those 336 people, almost half (166) were engaged at least two times, and 59 individuals were engaged five or more times. Usually when the CIS team engages an individual five or more times, it means this person is likely remaining on our system (sleeping at or very near a bus stop, transit center or rail line) and is being actively case managed by the team to help them access very needed mental health, medical, basic needs, and housing resources. Case management done by the CIS team is intensive and productive, as shown by our number of resource referrals, coordinated assessments, housing placements, and shelter placements. There are many tasks and steps taken when we are case managing an individual, and we pride ourselves in our commitment to breaking down barriers for individuals and walking side-by-side with the individual to navigate frustrating, time-consuming, and hard to access resources.

Although the number of coordinated assessments for housing are less in program year 2 than year 1, housing placements and shelter are up in year 2. This is likely due to the long process of on boarding our third team member and getting them trained in the coordinated assessment, as well as the time intensive and complex nature of getting individuals into permanent housing.

Other insights in our program metrics from year 1 to year 2 include a significant increase in engagements (both realized and attempted) while refusals were nearly the same. There are likely several reasons for this. One, referrals increased as a third Public Safety Ambassador class became fully functional and our program and services became more known to customers, CapMetro staff and the public. An increase in referrals resulted in many more one-off engagements with individuals that we either never found again or quickly reconnected to a service provider (a success still!). Additionally, this added to our "unable to locate" (UTL) metric since we look for individuals at least 3 times before closing it out. The second reason for increased engagements while refusals stayed the same is likely our improved approach to working with individuals who are initially hesitant to engage with us. We noticed when we began engaging those individuals slowly but consistently, we were able to develop a good relationship built on trust and mutual respect. Ultimately, this allows us to navigate them to resources and housing, leading to a situation where individuals are no longer causing issues on our system and have been able to access resources to improve their lives and ability to function in society.

Location Data

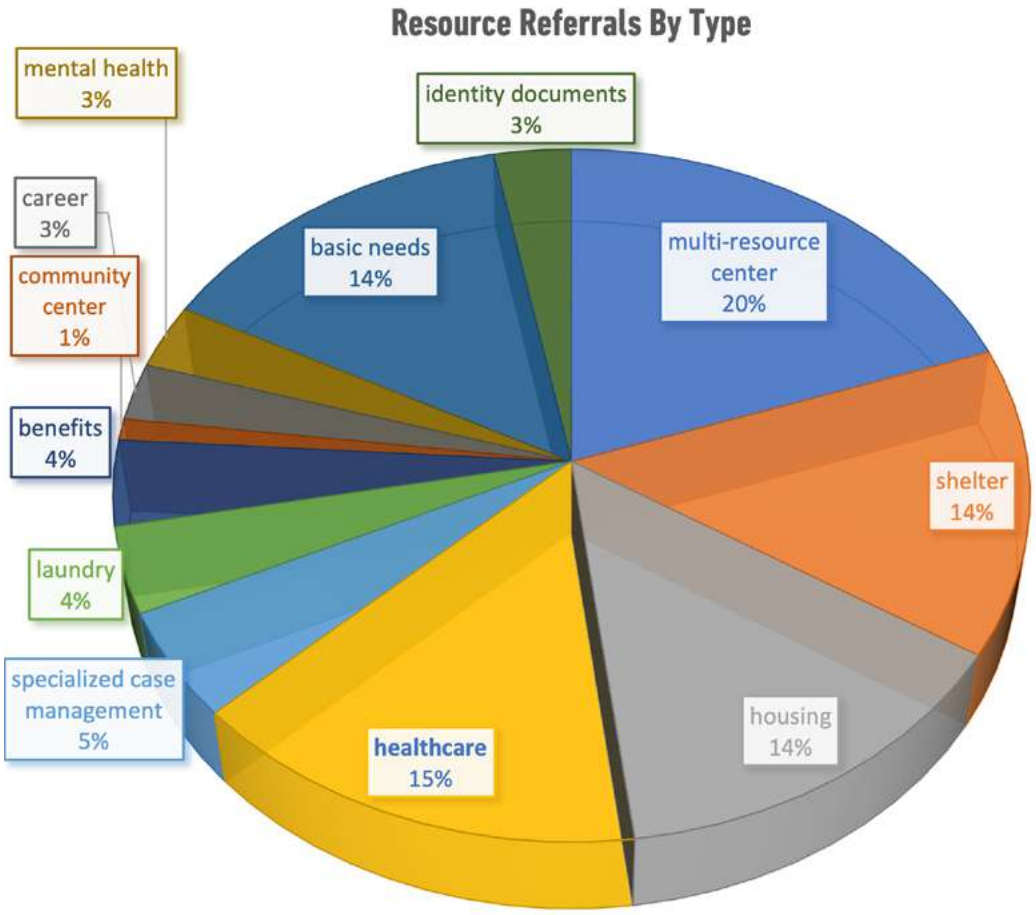
CIS staff engaged with individuals at 197 unique locations across the system, almost double the number of locations from program year 1. Some of the most visited locations for conducting outreach are known 'hotspot' areas on the transit system with high ridership traffic and quality of life issues. The chart below shows the most visited locations with at least 20 engagements with individuals.



Virtual engagements, the most common "location" on the chart above, includes all texts, phone calls, or emails with individuals and online applications the CIS team completed on their behalf. This area has increased significantly in year 2, likely due to increased trust and relationship building the team established with individuals in year 1 and becoming more proficient in navigating services like Social Security, SNAP (food stamp) assistance and health insurance.

Resource Referral Data

The CIS team made 309 referrals for individuals to resources for housing, food, medical care, shelter and many other needs. The most common referral types included basic needs, healthcare, housing, shelter and multi-resource centers. Referrals are the bread and butter of our program. Without knowledge of resources, how to navigate them and partnerships with providers, our program would not work. Referrals are also hard to track! In program year 1, the CIS team realized the need for a more comprehensive case management system to help us better track referrals (how many we make, which ones are successful and how many direct services we do for individuals vs. sending the individual to a resource). In this report, referrals encompass many, but not all the effort we make with and on behalf of individuals to help them access the resources and services they need. With the help of the new case management system, future reports will have more data to illuminate the effort and success of obtaining services and resources for individuals.



More than Just Data: Year 2 Successes

In program year 2, the CIS team found success in both small and large ways with individuals. Some success stories resulted in housing after years of work, while some successes resulted in a simple identifying document or even accomplishing one step in a multi-step process. Everyone we work with has unique circumstances, needs and strengths that we consider when navigating them. Helping someone get an ID again after 20 years without one might seem small to some, but to that individual, it is more than just access to any number of resources or services. We are honored to be present with individuals when they hold their first ID in many years and express "feeling human" again. Additionally, the lack of an ID is often the biggest or only barrier to work, benefits or housing. Between year 1 and 2, the CIS team ordered 69 vital documents (social security cards, state IDs, healthcare cards, birth certificates and voter ID cards) for individuals.

We found great success in year 2 with housing where we directly[1] placed five individuals into housing and assisted[2] with 6 others. Out of the 5 individuals we placed in housing, three are at the tiny home neighborhood called **Community First! Village** and two (a mother and adult daughter) are at an apartment with the Housing Authority of the City of Austin (HACA). Each one of these placements required tremendous effort. For every person we help get housing at Community First! Village, we helped them acquire IDs, benefits, or income via a livening wage job, attended their interviews, and partnered with service providers to cover their move-in costs. We are thrilled to report that everyone we have placed in housing so far have remained steadily housed!

Other successes we found in program year 2 include:

1. Formalized a partnership with The Sobering Center, a jail and hospital diversion resource for individuals struggling with substance abuse. The Sobering Center serves as a safe place for intoxicated individuals to sober up and as a connector to longer-term recovery with access to rehab and other substance abuse resources.
2. Developed a relationship with the UT Social Resource Center to help individuals in food and resource deserts get rapid access to fresh food.
3. Collaborated with the City of Austin to rapidly move a family of four living at one of our park and ride centers directly into shelter. The family was evicted from a hotel nearby after a delay in receiving one of their paychecks. The CIS team helped ensure the family remained in shelter after leaving the transit center which ultimately led to them finding their own apartment and becoming officially housed!
4. In one of our fastest resolutions to date, the CIS team helped an individual get back into housing within hours of receiving a referral from the Public Safety Ambassadors. This individual, who struggled with dementia, was found sleeping at one of our transit centers and thought to be experiencing homelessness. The CIS team collaborated with our outreach partners and were able to figure out his housing status and arrange for the organization to pick him up that same day.

The successes described above result in a win-win: Individuals are connected to resources and the impact of homelessness, mental illness and substance abuse on our system is lessened.

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Direct housing help means we walked the individual all the way through the housing process, from application to interview to move-in. This could be for CFV, PSH/RRH, HACA waitlists, etc.

Assist housing help means we completed 1 or 2 steps in the individual's housing process but did not walk them all the way through (for example, we completed their CA and found out later they were housed through the CA system).

These impacts are hard to measure, but we have found that when we are able to help an individual get a need met or greet them with empathy and compassion, they are more likely to follow our rider rules and have fewer escalated interactions when using the transit system. Sometimes the impact is more immediately clear (ex: someone living at our bus stops and leaving belongings or trash there is moved into housing and those stops are now clean and easily used by customers). Other times, the impact is less clear but potentially more impactful (ex: an individual struggling with their mental health is connected to counseling or medication and as a result, has more positive interactions with customers and operators when riding the system). We have found a gesture as small as offering a bottle of water, snack or pair of shoes has de-escalated someone and reduced the need for security or police response.

National & Local Initiatives

The CIS team continued our national work with peer transit agencies in program year 2, formalizing the efforts by establishing the National Transit and Vulnerable Populations Workgroup and co-creating a Steering Committee. CIS team lead Holly Winge sits on the Steering Committee and facilitates the monthly meetings where industry leaders and experts in areas like substance abuse and de-escalation present and peer agencies engage in lively discussion around best practices and universal challenges. Peer agencies like LA Metro, TriMet, RTD-Denver, MARTA, BART, MTA and many other transit agencies regularly join this meeting and share ideas that have directly led to improved practices or the creation of an entirely new program across the country.

Locally, the CIS team continued to develop and deepen internal and external partnerships to increase the effectiveness of the program. We worked in close partnership with other outreach groups, churches, nonprofits, and City of Austin staff, meeting weekly to ensure non-duplication of outreach efforts and coordinate services for individuals. Internally, we continue to implement training on Mental Health First Aid, the Community Intervention Team operations, and the Homeless Response System in Austin with all new Public Safety Ambassadors (PSAs). The two-day training builds skills to help staff de-escalate situations and provides information on facts and resources related to homelessness. These trainings, along with our monthly meeting with all PSAs, help our teams coordinate on referrals for individuals needing CIS services on the system and proactively address challenging areas on the system.

Reflection & Final Thoughts

The CIS team's second year of operations was filled with growth and collaboration. The expansion of our team and our work with internal and external partners has led to many improvements in our program and thus successes with individuals struggling on our transit system. We thank all our community partners, customers and CapMetro as a whole for embracing a compassionate, humane response to the challenges homelessness, substance abuse and mental illness bring to our transit system.

While the numbers and data in this report are important and help us evaluate and communicate our work in a tangible way, we would like to end with a note on the foundation of our program, the art of outreach. Our role encompasses extremely challenging and extremely rewarding work, with a little bit of everything in between. When we step out into a camp or to meet someone at a bus stop, we never know what we are going to be met with or how that interaction is going to go. All we can do is go into it with dignity and respect as one human being to another and see where that takes us:

> *The process of outreach and engagement is an art, best described as a dance. Outreach workers take one step toward a potential client, not knowing what their response will be—will the client join in or walk away? Do they like to lead or follow? Every outreach worker has a different style and is better at some steps than others.* ***To dance with grace, when the stakes are high, is the challenge for all of us****.*[3]

Community Intervention Team

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[3] Practical Lessons: The 1998 National Symposium on Homelessness Research (Arlington, Virginia, October 29-30, 1998).