Leveraging Community Partnerships and Harm Reduction Philosophies to Solve Long-Standing Social Issues: The Schenectady Outreach Hub

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Leveraging Community Partnerships to Solve Long-Standing Social Issues

Presenters:
Michelle Cejka
Jennifer Hayden
Ryan Macherone
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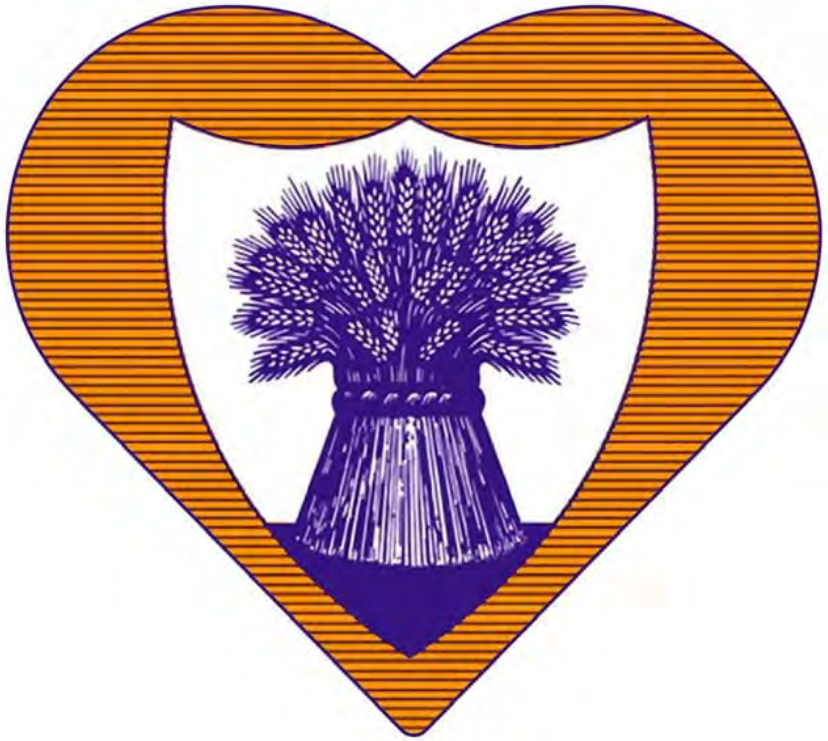
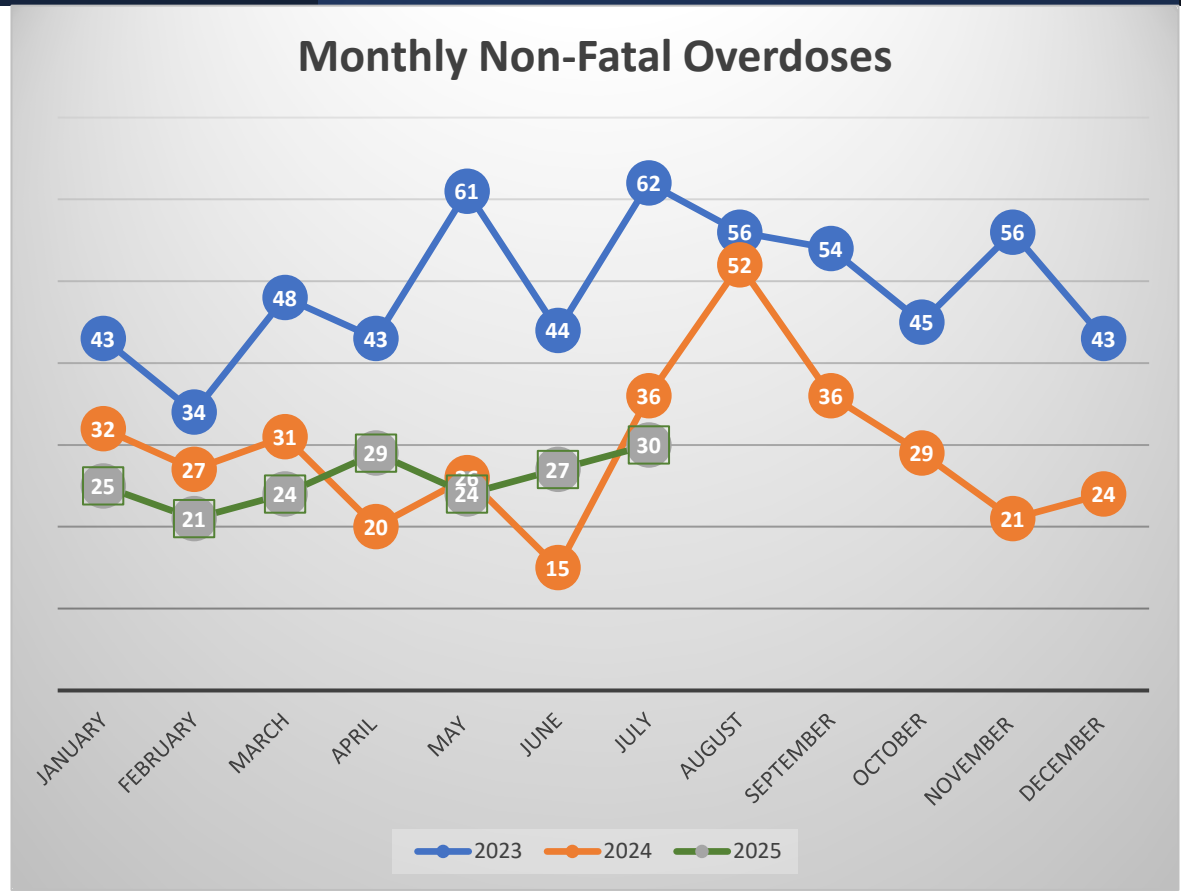
History of Schenectady-Based Programming

- Recognized the rise in overdoses, and the limited/detrimental effects of traditional law enforcement methods in addressing them.
- 2019 Schenectady Police partners with the Schenectady County Office of Community Services, PAARI, New Choices Recovery Center, Catholic Charities, Team Schenectady, University at Albany School of Public Health & Chatham Police.
- July of 2019 – The Schenectady Cares Program officially launches.
- Opens the doors of the police department to anyone looking to connect to services without fear of arrest.



History of Schenectady-Based Programming

- Schenectady Cares quickly evolves from supporting in-patient focused treatment to supporting a broad spectrum of harm reduction programming.
- September, 2021- Schenectady Cares expands to overdose tracking, surveillance, and supporting post-overdose outreach through partnerships with New Choices and Catholic Charities.
- Works with Schenectady County Office of Community Services/Public Health on community messaging following spikes in overdoses.
- To date, over 1,700 referrals have been made and in 2024 Schenectady saw a near 40% reduction in overdoses.



Evolution of Programming

- Addressing much more than overdoses.
- 2020- Groups of providers got together to collaboratively assist with a homeless encampment in Vale Cemetery. Teams consisting of Sergeant Nick Mannix, Michelle Cejka, Lauren Pierce (Mohawk Opportunities), New Choices and Catholic Charities worked together to help multiple people living in a tent community.
- Paved the way to evolving past only focusing on overdoses.
- 2022- Michelle Cejka, Jennifer Hayden, Nick Mannix and Ryan Macherone attend the PAARI Conference at Boston University School of Public Health to learn more about Outreach Hub Model.
- 2023- Schenectady Police hire Behavioral Health Navigator Lauren Pierce.

SPD Behavioral Health Navigator

Assist Schenectady County HUB with case management for individuals, Schenectady CARES data collection and outreach.

Assist SPD with High Volume Calls from locations, households and or individuals that may not always be related to law enforcement response/assistance. Such as mental health, substance use disorder, interfamily dynamics, homelessness, ongoing medical concerns and other areas.

In person and or over the phone outreach to identify if individuals are open to discussing areas of concern further and how I may be able to support/assist.

Ongoing support/outreach by informing/ connecting individuals of the community resources and supports that can help address their current obstacles and needs.

Ability to assist officers in real time when they respond to calls where individuals may be looking for help with current obstacles/needs and are not aware of how to receive support.

Schenectady HUB Outreach Truck & Supplies

The Schenectady Outreach Hub

A multidisciplinary team made up of invested community stakeholders. The model is harm-reduction centered with the overall goals of reducing levels of harm and victimization for individuals being served and helping them to re-establish their autonomy in the community.

The lens of the program is trauma-informed. Each participant is treated as a unique individual with the dignity and respect they deserve.

Community members who may benefit from Hub services can include individuals experiencing the following:

- An emergency shelter need
- Food insecurities
- Mental health and substance use-related challenges
- Other related behavioral health disparities that cause significant distress and functional impairment

Hub History

First official Hub meeting with stakeholders was held in December, 2022

“Boots on the Ground” outreach work began in January 2023 – Release of Information, Policy & Procedures developed in spring 2023

Biweekly meetings: Cases reviewed and active plans made for enrolled individuals. Teams then disperse to various locations to do field work.

Community Collaboration

Harm Reduction Based Outreach

“Meeting people where they are at”

New Member Orientation &
Quarterly Stakeholder Meetings

Lunch & Learn Opportunities

Topics include grief & loss and substance use trends

Qualitative Data: Case Study 1

CN: 2024- 63 yr old male, struggling with ongoing alcohol abuse, homeless for 2 years, no income , no benefits and not connected to services.

Previously: This individual had several EMS calls due to intoxication where he would need to be transported to Ellis Hospital for further Evaluation but would often leave AMA and or would not be open to talking about his alcohol use. Multiple calls with police contact due to open container, intoxication , bench warrants for not appearing at court and or concerns regarding homelessness.

What did the HUB Do? – Encountered individual on **10/13/24**- Was open to talking about supportive services but not open to moving forward yet as he felt many judged him on his alcohol use alone and only wanted to get him into treatment. Wanted to get to know the program better. Met with him and built a rapport. **1/2/25** Agreed to Emergency Housing through DSS and applied for TA, SNAP , and Medicaid. Same day placement at a shelter. **1/5/25** Referred to ongoing case management services with Mohawk Opportunities, **1/8/25** completed a COC for safe and affordable housing options. While staying at the shelter we were able to assist him with his SSI Denial Appeal. Which he later won . **2/1 C**onnected to Harm Reduction Supports to see if he could reduce his alcohol intake. **2/20/25** Completed an intake with The YMCA at 845 Broadway- **3/4/2025** Successfully moved into 845 Broadway.

Since working with the Hub: had **0** contact with SPD, **1** contact with EMS, has reduced his alcohol intake and has created a support network with other residents at 845 Commons.

Qualitative Data: Case Study 2

CN: 16 – Homeless, not connected to any services.

Previously: This individual has had a total of 115 visits at the ED which resulted in 1,637 hours of hospital staffing time. Average cost per hospital visit is $2006.00. Since 2020, has cost the hospital system approximately $230,690.00. He has had 78 contacts with the Fire Department, 8 contacts with PD and 3 arrests.

What did the HUB Do? – Encountered individual on 2/22- Was connected to Care Management on 2/28. Care management able to provide individual with clothing, backpack (hat ,scarf, gloves, toiletries, blankets, socks, personal needs) Housing applications submitted, connected with substance use disorder treatment and HOUSED on 4/3.

Since working with the Hub: had **0** contact with SPD, **1** contact with EMS and **4** hours at the hospital.

Qualitative Data: Case Study 3

CN: 1 – Multiple contacts with SPD, EMS, Fire Department, was discharged from multiple programs due to being inappropriate with staff while under the influence and was at risk of losing his apartment due to losing his rental assistance program.

Previously: From 1/1/2025 -3/25/25 Individual had 61 calls into dispatch which would result in EMS/Fire needing to transport individual to various ER's for significant alcohol use with reports of SI -10 of the calls needed an SPD response due to level of intoxication in the community at local businesses. This individual also had several open court matters due to calling dispatch rapidly/continuously while under the influence and tying up the call lines which would decrease the opportunity for others to call in with emergencies and speak with dispatch in a timely manner.

3/18/25 Enrolled in the HUB –**3/19/25-** Connected to Harm Reduction at New Choices. **3/26/25** Outreach completed a home visit after they received a call from individual while he was intoxicated and upset, at this time, he was agreeable to detox. **3/28/25** Went to Pheonix House for Inpatient MH & SUD

Since working with the Hub: Successfully completed 3 months at Pheonix House Inpatient and then transitioned onto the aftercare residential program in NYC. Currently working on employment opportunities , long term housing in NYC, started taking prescribed medication to assist with mental health diagnoses and legal matters were successfully reduced and closed.

Qualitative Data: Case Study 4

CN: 1 – Multiple contacts with SPD, not linked, numerous calls from Business Owners

Previously: 2022-2023 Schenectady Police Department- 36 interactions & 14 arrests

Collaboration with SPD, OCS, and Hospital staff to ensure individuals needs were prioritized and we continued to work along side of each other throughout hospitalization. Linked to mental health treatment , substance use disorder treatment, care management and housing. From November 2022-December 2022 the hospital cost was $**10,030.00**. Cost for emergency services during the month of Nov-Dec was $**23,400.00.**

Since working with the Hub: **0** interactions with SPD, 0 arrests

Graduated Substance Use Outpatient Program, Applying for Graduate School, Working Full Time.

Schenectady County Outreach Hub

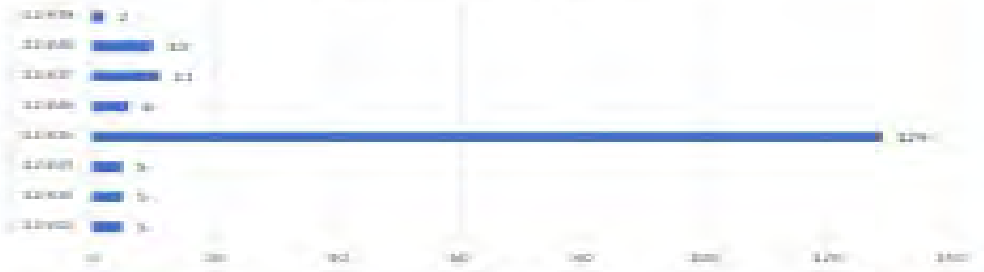
Medical Treatment	Housing Referrals	Case Management	Substance Use Treatment	Mental Health Treatment	TA Benefits	Food Stamps	Peers	Employed	Emergency Housing Services
32	75	119	41	46	52	56	24	5	94

Complete Program
159

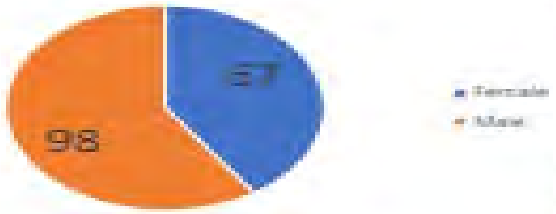
Lost Contact
2

188
Residents reached

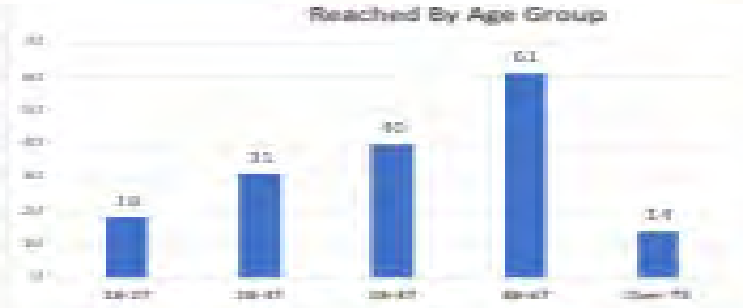
Reached by Zipcodes



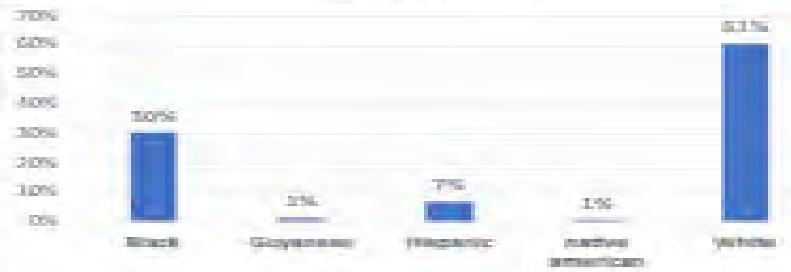
Gender



Reached By Age Group



Race/Ethnicity



Medical Diagnoses

69%
% MH Diagnosis

61%
% SUD Diagnosis

6%
% IDD Diagnosis

Question & Answer

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