San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Innovations Learning Project Proposal: Wellness in the Streets (WITS)

San Francisco Mental Health Services Act

2018

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Wellness in the Streets (WITS) Innovations Proposal

Local Review

The recent San Francisco Community Planning Process (CPP) involved various opportunities for community members and stakeholders to share input in the development of our Wellness in the Streets (WITS) Innovations Project. Please see the CPP meetings section below for details.

In fulfillment of the provisions of the Welfare and Institutions (W&I) Code Section 5848, a 30-day public review and comment of the Wellness in the Streets Innovations Project was posted on the San Francisco Mental Health Services Act (SF-MHSA) website at www.sfdph.org/dph and www.sfmhsa.org. This **plan was posted for a period of 30 days from 7/2/18 to 8/1/2018** as an appendix to the FY18/19 Annual Update. Members of the public were requested to submit their comments either by email or by regular mail. We received no comments regarding this project.

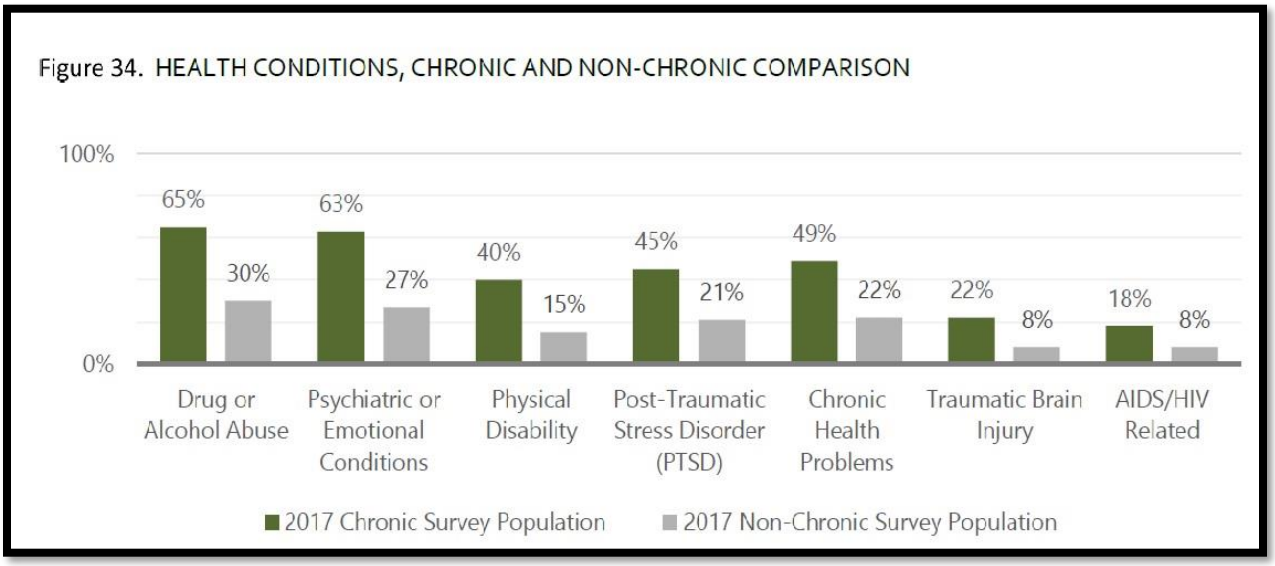
Following the 30-day public comment and review period, **a public hearing was conducted by the Mental Health Board of San Francisco on 8/1/18**. We anticipate that this Innovations project plan and Annual Update will be adopted by the San Francisco Board of Supervisors in October 2018.

Project Background

San Francisco is part of the 9-county Northern Californian Bay Area, containing four of the ten most expensive counties in the United States. With a population exceeding 7 million, the San Francisco Bay Area has an increasingly expensive housing market that is difficult for many to afford. In addition, it has been a destination for individuals who are homeless. As many as 39% of those surveyed have reported they first became homeless in a city outside of San Francisco *(San Francisco's Ten Year Plan to End Chronic Homelessness: Anniversary Report Covering 2004 to 2014)*. According to the last homeless count conducted by the City and County of San Francisco, the city has 7,499 homeless individuals with a large percentage living with severe mental illness or at risk of experiencing mental health issues.

The homeless population is an especially vulnerable population, particularly those who are chronically homeless, which includes those who have been homeless over a year or homeless four times in the last three years, and have a condition keeping them from work or housing. *San Francisco's Ten Year Plan to End Chronic Homelessness: Anniversary Report Covering 2004 to 2014* reports that the chronically homeless population has "high rates of behavioral health needs, including severe mental illness and substance abuse disorders, conditions often exacerbated by physical illness, injury or trauma."

According to the San Francisco 2017 Homeless Count and Survey, **sixty-three percent (63%) of chronically homeless survey respondents reported a psychiatric or emotional condition. Forty-five percent (45%) reported Post Traumatic Stress Disorder (PTSD). Sixty-five percent (65%) reported alcohol or substance use.**



Community Planning Process

The San Francisco Department of Public Health (SF-DPH) has strengthened its Mental Health Service Act program planning by collaborating with mental and behavioral health consumers, their families, peers, and service providers to identify the most pressing mental and behavioral health-related needs of the community and develop strategies to meet these needs. In late 2017 and early 2018, San Francisco Mental Health Services Act (SF-MHSA) hosted eighteen (18) community engagement meetings inviting participants from all over the city to collect community member feedback to better understand the needs of the community. Attendees included mental health and other service providers, consumers of mental health services and their families, representatives from local public agencies, community and faith-based organizations, residents of San Francisco, and other community stakeholders.

All meetings were advertised on the SF-DPH website and via word-of-mouth and email notifications to service providers. Printed and electronic materials were translated into Spanish, Mandarin, and other languages, and interpretation was provided at all public community meetings, as needed. A brief training was provided to the Community Program Planning participants regarding the specific purposes of gathering input and MHSA requirements for Innovations Projects. The community input gathered from these meetings helped to shape the Innovations Proposal for this project.

The eighteen (18) community engagement meetings are listed in the following table:

Community Program Planning (CPP) Meetings	
Date	**CPP Location**
November 8, 2017	The Village Visitacion Valley Service Providers 1099 Sunnydale Avenue San Francisco, CA 94134
November 28, 2017	Sunset Mental Health Center Service Providers & Community Advisory Board Members 1990 41st Avenue, Suite 207 San Francisco, CA 94116
January 24, 2018	Excelsior Family Connections: Chinese families & Excelsior Family Connections staff 60 Ocean Avenue San Francisco, CA 94112
January 29, 2018	SF LGBT Center Population Focused Engagement 1800 Market Street San Francisco, CA 94102
February 5, 2018	Curry Senior Center MHSA Advisory Committee meeting 315 Turk Street – John Stanley Room San Francisco, CA 94102
February 7, 2018	TAY Full Service Partnership Meeting 755 South Van Ness San Francisco, CA 94110
February 15, 2018	Richmond District Neighborhood Center Service Providers Meeting 4301 Geary Boulevard San Francisco, CA 94118
February 26, 2018	Department of Rehabilitation (DOR-BHS) Co-op Administration Meeting (Vocational Programs) 455 Golden Gate Avenue, #7727 San Francisco, CA 94102
February 28, 2018	San Francisco Veterans Town Hall Meeting Veterans & Service Providers Meeting 401 Van Ness Avenue San Francisco, CA 94102
March 2, 2018	Excelsior Family Connections Spanish Speaking Families & Staff Meeting 60 Ocean Avenue San Francisco, CA 94112
March 2, 2018	SFDPH BHS Adult/Older Adult Service Providers Meeting 1 South Van Ness San Francisco, CA 94103

Community Program Planning (CPP) Meetings	
Date	**CPP Location**
March 9, 2018	API Wellness Center Transgender Program Community Members & Service Providers 730 Polk Street San Francisco, CA 94109
March 13, 2018	Rafiki Coalition Black/African American Community 601 Cesar Chavez Street San Francisco, CA 94124
March 14, 2018	Huckleberry Youth Programs TAY Service Providers Meeting 555 Cole Street San Francisco, CA 94117
March 14, 2018	Crisis Intervention Training Meeting Workgroup – Law Enforcement, Peers & Service Providers 870 Market Street #785 San Francisco, CA 94102
April 18, 2018	SF Behavioral Health Services MHSA Advisory Committee Meeting 1380 Howard Street San Francisco, CA 94103
June 13, 2018	San Francisco Public Library Combined MHSA Provider and Advisory Committee Meeting 100 Larkin Street San Francisco, CA 94102
June 13, 2018	City College of San Francisco - Health Education Dept. Workforce Development Networking Session 50 Phelan Avenue San Francisco, CA 94112

Stakeholders from the Community Program Planning efforts requested more peer-to-peer services, additional programming for the homeless populations and more programs that increase access to clients currently not being served.

Community Needs Assessment

As a result of the feedback we received from our Community Program Planning (CPP) efforts regarding the need to provide support to unhoused individuals who are experiencing difficulty accessing services, we decided to conduct a more thorough and specific Community Needs Assessment targeting this population.

From April 1- July 14 2017, a diverse group of peers from various SF-DPH/BHS programs began the collection of information from homeless and marginally housed individuals. These information collection sessions occurred in multiple San Francisco neighborhoods including: *South of Market, Castro, Bayview/Hunters Point, Tenderloin, Mid-Market, Mission, and the*

Haight Ashbury District. The information collection efforts were conducted in both English and Spanish. Peer specialists were selected to support this needs assessment based on personal lived experience with homelessness, previous history in the BHS Peer Certificate program or previous experience working with the San Francisco homeless population.

Peer Specialists who conducted the Community Assessment

Peer counselors traveled in teams or pairs to various areas of the city with high concentration of unhoused individuals with the goal of engaging them in conversations related to mental health services in San Francisco. The peers provided outreach bags containing socks, snacks, and toiletries as an engagement strategy. The overarching goal was to collect statements related to both engagement and retention in services provided at BHS clinics. Conversations could be as brief as a few sentences or as long as the interaction felt comfortable to gain some insight into the needs of the population. Counselors were advised to create an open ended dialogue as opposed to any promises of services. After the encounters, summary notes were developed to capture the main points of the conversations and the primary needs of this specific population.

Primary Problem and Community Needs

The re-occurring themes to arise from the Community Planning Process and the Community Needs Assessment were feelings of isolation and disconnectedness for the City's homeless population. Homeless participants described **very little contact with social services**. A few respondents had the experience of **falling out of services because of their inability to keep track of appointments within their current living situation**.

The overarching theme was the need to **have contact with someone willing to connect with individuals at their current location**. "No one talks to us…" was repeated frequently during the Needs Assessment as well as, **"you are the only people that have come to speak with us."** In addition, surveyed individuals were confused as to where to obtain mental health services. In two cases, **respondents were within two blocks of identified service providers but were unsure where to go for support.** Calling to ask information for services with no live receptionist to answer questions was also identified as a barrier.

In a Wellness and Recovery-oriented system, a grounding principle is that recovery is a "possible and expected outcome of treatment, and that the full range of comprehensive services and supports that an individual needs to meet his or her recovery goals be **accessible, flexible, individualized, and coordinated**." (Felton et al, 2010, p. 441)

As a result of the Community Program Planning input and the Community Needs Assessment**, a recommendation was formulated to create a peer-based mental health team that would work directly with unhoused individuals on the streets, in their environment, in order for the individual to be successful in their personal recovery.**

"The community is asking for this project!"

- ***SF-MHSA Peer Specialist***

Review of Existing Practices and Evidenced-Based Models

An extensive literature review of categories including homeless engagement strategies, evidence-based treatment modalities when working with the homeless population, patient navigation, peer programs, and housing reveals the following:

- Street based mental health services are generally conducted as an extension of an Assertive Community Treatment (ACT) program, a street based medical program, or a program that encourages individuals who are homeless to come into a physical program.
- Individuals who are homeless may wait until symptoms become so severe that they need to be treated at psychiatric hospitals or inpatient facilities.
- Teaching about wellness tools and crisis planning can be implemented by peers and is proven to be effective with homeless individuals.
- We could not identify any other counties or states that have extensive research on implementing street-based peer-to-peer interventions for the unhoused community.

Innovative Component

The Wellness in the Streets (WITS) project will implement **changes to existing mental health practices that have not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting and population.** This project is unique to San Francisco since we will utilize peer-to-peer interventions among San Francisco's diverse communities, targeting all San Franciscans who are unhoused.

The California Mental Health Services Act has done incredible work promoting Wellness and Recovery principles among the consumers that have accessed services since the implementation in 2005. The WITS project will be taking a fresh approach to peer support services. As rising housing costs and other exacerbating factors have pushed more and more communities to confront the needs of displaced residents, WITS aims to bring the concepts of Wellness and Recovery to many of San Francisco's most vulnerable residents.

Based on our literature review and extensive research of programming in other counties, the WITS model, which is described in the following section '*Proposed Project*', has not been attempted anywhere else in the State. Outreach and engagement services of unhoused

individuals has been a key aspect of numerous public health programs, yet the WITS model plans to bring something new to the community. Many current programs conduct outreach to unhoused individuals on the streets with the goal of linking to programs at a physical location but many individuals are not able to follow-through to gain access to mental health support, however, this project will bring the peer mental health interventions directly to the clients wherever they may be in the community.

San Francisco's Chinatown District

We feel this project is innovative due to the following:

- Peer-to-Peer Counseling and peer interventions provided to unhoused individuals directly where they are at and directly on the streets have rarely been tested, especially in a support group setting in a local park.
- Interventions directly on the streets have never been tested in San Francisco with San Francisco's unique and diverse communities.
- Peer interventions that include manual-based and evidence-based peer modalities including WRAP, Seeking Safety, crisis planning, wellness planning, coping skills development, etc. have rarely been tested directly on the streets.

Another unique feature of WITS would be the incorporation of real time feedback to evaluate what can be done to improve upon the service. Peers with lived experience with homelessness will be providing participants with a feedback tool at the end of each interaction. Instead of waiting days, weeks or months to gather information regarding what elements of the program are perceived as being valuable, the feedback tool will allow for immediate adaptation according to the needs of the people the program serves. SF-MHSA will also partner with the Quality Management (QM) department to frequently monitor and evaluate the success of our engagement and implementation strategies so we can fine-tune and adjust as needed.

We feel it is important to examine these aspects of the project so we can determine if our approach of providing peer interventions directly on the streets where unhoused individuals are located demonstrates positive health outcomes. We believe it is important to test and determine what specific engagement strategies and what specific peer interventions are most useful for participants on the streets.

Proposed Project / Response to Community Needs

Wellness in the Streets, otherwise known as WITS, will be a five-year peer-run, peer-led project that will test new ways of service delivery and engaging with unhoused San Francisco residents. The SF Bay Area is in the middle of a housing crisis that disproportionately impacts low income

individuals suffering with or at-risk of severe mental illness. With shelters full to capacity every single night, individuals and organizations are facing the reality that services must meet people "where they are at" in new ways. This includes outdoor settings including street corners, encampments, and public parks. Peers would be leading interested individuals in activities such as one-to-one support, crisis planning, and support groups.

"No one ever talks to us!"

-Unhoused San Francisco Resident who expressed the need for support

The ultimate goal of WITS is moving participants along the stages of change until they are able to engage in services. Peers will gage the interactions through short feedback tools that will be filled out on the spot to evaluate what can be changed or added to improve the service quality and delivery.

WITS is a project that is fully invested in the concept that lack of housing should not be a barrier to creating improvements in mental health. While WITS staff will certainly do their best to refer and/or link participants to any and all available housing opportunities, housing linkage is not the main goal. The overarching concept is that the unhoused community should be able to utilize the benefits of peer services where ever they are located in the community.

Program Design

The purpose of this Innovations Learning Project will be to increase access to underserved populations, with **our target population being San Francisco adult and older adult residents who are homeless that do not typically access behavioral health services despite experiencing behavioral health needs.** The proposed project would involve a roving support team of **4.0 Full-Time Equivalent (FTE) formerly homeless peer counselors** that would engage in peer counseling directly on the streets of San Francisco in areas where individuals are unhoused.

Teams of 2-3 peers will go out to the various neighborhoods of San Francisco in search of or to follow-up with unhoused residents who are at-risk or currently in need of peer-based mental health services. The initial meetings with participants will involve building rapport and documenting the general geographic areas where individuals can be found for future encounters. In the pool of the long-term homeless, many have a particular habit of returning to a coffee shop, a street corner, or block where they feel safe while developing relationships with neighborhood regulars. The hours of operations for the WITS project will be more flexible than traditional clinics, with available times earlier in the day and later into the night depending on the weather, the seasons and the needs of the community.

Peer Roles

A peer is defined as an individual with personal lived experience who is a current or former client of behavioral health services, or a family member of a current or former client. Peer-to-Peer services encourage peers to utilize their lived experience, when appropriate and at the discretion of the peer, to benefit the wellness and recovery of the clients being served. Each peer working with this project will be trained as a peer specialist with experience in a mental health work place, personal experience with homelessness and a vast understanding of the mental health system.

The peers will be a vital component to designing the program details, developing the policies, implementing the scope of work, monitoring the progress and evaluating the desired outcomes. The peer specialists will be a driving force through all phases of this project from beginning to end and will act as leaders for the communities being served.

Our peer staff will also help provide outreach and education about this program to San Francisco residents among various community settings including the San Francisco Library system, wellness centers, homeless shelters and behavioral health programs to promote WITS. Peer staff will provide education about San Francisco mental health resources and linkage to services. As participants utilize the support of WITS, they will be offered alternative and appropriate services within Behavioral Health Services, as needed.

One of the peers will be assigned as a peer supervisor leading the peer team. This peer supervisor will be a key individual on the team designing and driving the peer engagement/intervention efforts and providing feedback. This peer supervisor will help us determine how to best train our system of peers for outreach, engagement, and supporting the use of these street-based peer interventions. We plan to hire this position as soon as we are approved by the MHSOAC since this is such a vital role.

Training and Supervision for Peer Specialists

Peer specialists will be trained using the current 12-week BHS Peer Specialist Mental Health Certificate Program, the Advanced Peer Certificate Program and the Leadership Academy monthly training seminars for peers. Additional training will be offered including, but not limited to:

- Wellness Recovery Action Plan (WRAP)
- Harm Reduction
- Psycho-education on mental health, coping skills and socialization skills
- De-escalation strategies
- CPR/First Aid
- Personal safety training
- Seeking Safety
- Motivational Interviewing

Peer Program Team Huddle

A SF-DPH Manager will be available to supervise the project and peers. There will also be clinical supervision available on an as needed basis and quarterly debriefings with the clinical supervisor to provide clinical support.

Assessment and Engagement Strategies

WITS will seek to build rapport with unhoused individuals over time through a process of mapping out “hang-out spots” and resources that have value to potential program participants. A brief community assessment and research will be conducted to determine what areas of San Francisco have the greatest number of unhoused individuals and the greatest level of need. These areas will then be prioritized and targeted.

Engagement will be made based on building a relationship between the peer and the participant, verses a traditional quick triage of what a caseworker perceives the needs of the person in front of them to be. A diverse team of peer counselors will go out in the community in pairs to engage unhoused San Francisco residents in meaningful connections, based on the needs of the residents. Peer workers will distinguish themselves by wearing a sweatshirt or other garment with a visible project logo.

The first 3 months of the implementation stage of this project will be primarily focused on engaging and building a relationship with unhoused community members Small items will be used as engagement tools such as coffee, snacks, clothing, blankets and other items. Peer counselors will engage unhoused individuals by explaining their role and asking initial questions such as, “how are you doing today?” and, “are you interested in talking?”. Most of this stage will be focused on listening to community members tell their story and relationship building. **We will also use this engagement period to better assess their needs and gather information about what unhoused individuals think we should do to best provide support.** It is important to develop a process of best practice to determine what will best motivate unhoused individuals to move through the stages of change. We believe that this population should lead the interventions, not the project staff.

After the first 3 months, it is believed that a trusting relationship should be developed with several community members at which point more concrete peer interventions will be offered. These interventions will be introduced based on the feedback we received and based on what individuals told us they would prefer. These may include evidenced-based peer interventions that can take place in a park, on a sidewalk or in a nearby coffee shop.

Peer Interventions

Peer counselors will spend time listening to personal stories, discussing wellness and recovery, and modeling hope. Peers will provide **brief peer counseling activities** including behavioral health education activities, wellness planning, crisis planning and other activities. Peer counselors will also distribute a one-page resource sheet to educate unhoused individuals regarding behavioral health services, housing resources and alternate peer counselling programs. Education regarding the array of behavioral health services that San Francisco has to offer will be provided.

Longer-term interventions will be provided including weekly support groups in a park or café based on the preferences of the participants. These interventions may include, but not limited to:

- Wellness planning group – help individuals develop a wellness toolbox directly on the street that can be used on a daily basis to promote recovery
- Motivational Interviewing - meet up with unhoused individuals at coffee shops for one-on-one social connection while using motivational interviewing and other evidenced-based peer interventions for support
- Crisis planning group – help create a self-developed crisis plan to provide participants coping tools and a concrete plan to follow when feeling distressed or in crisis
- Support system development – develop a list of support people when needs arise and help create a plan to stay organized

- Mental health psycho-education groups - teach early warning signs of mental health problems, teach what to do when problems arise and provide education on resources
- Seeking safety support groups – teach coping skills and healthy strategies regarding trauma and substance use
- Socialization skills development – teach conflict resolution and communication skills that are specific to the individuals' needs
- Harm reduction skills training – teach safe and alternative practices to reduce harm
- Coping skills development – teach healthy new ways to deal with stressors
- Support managing appointments & medications – teach organizational strategies and provide organizational tools
- Reconnection with friends or family members support – provide emotional support and help individuals access their support system
- Stages of Change Model and education – teach the stages of change model and help the individual strategize ways to reach their goal

Participants will be able to set up appointments to meet with a peer. In addition, a 4-hour block of time will be available for community meet-ups with the peers. Programming will be entirely street-based and peer specialists will be setting up activities on street corners, in coffee shops or cafes based on the preferences of the participants.


SF-MHSA Peer Specialists

Peer counselors will provide linkage to services as needed and assist with escorting individuals to such programs. For example, if an unhoused individual is found to be in need of medical care, they will be supported and escorted to the SF Hot Street Medicine team to address their needs in an appropriate setting.

Estimate of Clients Served

According to the last homeless count conducted by the City and County of San Francisco, the city has 7,499 homeless individuals with a large percentage with high-risk situations or at-risk of experiencing mental health issues. This data demonstrates a high need for this population.

We conducted research on various low-threshold, outreach and peer-to-peer programs that are similar in nature to analyze the number of clients being served. We determined that this program should invest about $600-$900 per client per year, and on average we should invest $750 per client per year. With our requested annual budget of $350,000, we should serve about 465 clients per year. Of these clients being served, 50 of them will receive longer term interventions.

Over the 5-year project, we will need approximately 3 months to ramp up the project and 3 months to tapper down the project. Therefore we will be serving participants over the span of 4.5 years. If we **serve 465 clients per year,** and serve these clients for 4.5 years, then we will **serve an estimated total of 2,090 participants over the entire 5 year project.**

Safety

Safety is critical for both the participant and the WITS team. In the program development stage, the peer staff will receive training on Harm Reduction, De-escalation, Overdose Prevention, and other safety and risk related training seminars. The peers will spend weeks shadowing existing Health Department staff who currently are working in the field to get a baseline understanding on how to conduct operations in a safe fashion. In addition, the peers will carry Narcan; a non-prescription nasal spray that can be administered in case of an overdose.

SF-MHSA CPP Meeting

Self-Care

There will be a heavy emphasis on self-care and wellness for the WITS staff and preserving the wellness of the WITS team of peers will be critical to the functions of the project. There is a core understanding that working with humans in such substandard environments can be taxing on the mental health of community outreach specialists.

Regular supervision and team stress reduction activities will be provided for all peer staff members. Accommodations will also be provided for those in need of additional breaks or increased wellness/support activities in order to prevent burn-out. Lastly, the pay-rate for the WITS peers will be a starting salary comparable to the City and County of San Francisco's civil service Health Workers to demonstrate that this team is valued.

San Francisco Partnerships

SF-MHSA will partner with several local and county programs to best implement this project. We envision collaborating with the following organizations/programs:

- The Peer Wellness Center
- Mental Health Association San Francisco
- The Peer Employment Program
- Central City Hospitability House
- Transgender Pilot Project
- The Department of Homelessness and Supported Housing
- Law Enforcement Assisted Diversion (LEAD) Program
- San Francisco Homeless Outreach Team (HOT Team)
- Multiple other behavioral health and community programs

Language Capacity and Cultural Considerations

The City and County of San Francisco has five threshold languages that include Spanish, Vietnamese, Cantonese, Russian and Tagalog. SF-MHSA will work in collaboration with the San Francisco Department of Public Health's Cultural Competency department to implement these services in the threshold languages and engage these specific populations.

In addition, we will aim to hire a peer who identifies as lesbian, gay, bi-sexual, transgender, queer, questioning and/or intersex (LGBTQQI+) and a Spanish speaking peer to assist with reaching these communities.

Confidentiality

All elements of this project will adhere to HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, and we will only implement HIPAA compliant protocol with a high concern to safe-guarding participant confidentiality.

The process of informed consent will lie with the peer specialists and verbal consent will be required before working with the peer team. This will serve as the informed consent outlining the nature of the relationship, parameters of this project, confidentiality, data collection, etc.

Contribution to Learning

This project will center on the development of a highly skilled peer specialist team to help support San Francisco homeless residents advance in their wellness and recovery using a peer-to-peer counseling approach directly on the streets. The primary goals of the project would be to increase social connectedness of homeless individuals; increase awareness of mental health resources; and increase feelings of wellness and the overall quality of life of individuals who are homeless by using peer-to-peer interventions on the street. These goals will be achieved by taking a unique approach of learning from unhoused residents in the moment regarding their presenting needs and then strategize as an interdisciplinary team (including peers and consumers) on how to best work together to meet those needs.

Key Learning Questions

1. Do street-based mental health peer-to-peer activities that address the immediate needs and wants of unhoused individuals help to increase their personal wellness (i.e. social connectedness, better quality of life, etc.)?

2. What components of the peer-based interventions and tools are most positively received by San Francisco residents who are homeless?

3. What engagement strategies work best to facilitate collaboration and communication between mental health peer specialists and homeless residents living on the street?

Evaluation / Learning Plan

SF-MHSA will work in close partnership with SF-DPH Quality Management (QM) to implement a comprehensive evaluation plan with tools to measure immediate outcomes and longer term impact of the project. The evaluation plan includes a logic model to guide the design and implementation of the Innovations Learning Project. An ethnically diverse group of consumers and community members will be involved in the design of the evaluation tools, particularly people with lived experience with homelessness. The use of surveys and key informant interviews will be used. The number and quality of the peer staff interactions with homeless residents will be measured by survey questions, with some questions to measure the satisfaction of the interaction and some to identify what community members suggest for near future efforts and activities. SF-MHSA and QM will compile evaluation reports summarizing the program design, results, outcomes, lessons learned, and ways to continuously improve program services based on stakeholder feedback.

Based on evidence available in the existing literature for effective interventions with homeless individuals (Altena, Brilleslijper-Kater, & Wolf, 2010; Karabanow & Clement, 2004), it is better for rapport development to begin with asking what the unhoused residents needs and wants are in the moment, rather than approaching this community with the assumption that we know what works best already. We anticipate that this approach will be more effective for rapport development as a first step towards increasing knowledge and willingness to engage with the larger, institutional, behavioral health system of care.

In addition, the peer staff will begin by engaging unhoused residents with evidence-based intervention strategies, such as developing trust, facilitating positive interpersonal relationships, and increasing access to information and community-based social services. While doing so, we will gather real-time information from the unhoused residents about what intervention strategies may be more effective in achieving one or more of our program goals such as increasing knowledge of community resources, and increasing both motivation and willingness to engage in the available community-based social services. As the new intervention strategies are developed based on the input from the unhoused residents, the peer staff will begin to implement these new strategies and get new ratings of efficacy on these new strategies. The evaluation staff may then recommend implementation or ongoing use of the intervention strategies that have higher positive ratings.

Based on the lessons learned from the above activities, best practice protocols will be developed for both engagement and intervention activities when working with unhoused residents in San Francisco. The expectation is to expand the existing knowledge base of known effective intervention strategies.

The specific outcomes that we may measure include:

1. Qualitative assessment of presenting need(s) of users (e.g., what are your immediate needs? What can I help you with today?)
2. Increased social connectedness for users
3. Decreased social isolation for users
4. Increased quality of life
5. Increased feelings of personal value or self-worth

6. Satisfaction with intervention strategies
7. Satisfaction with outreach/engagement strategies
8. Qualitative assessment of other strategies for outreach, engagement, and intervention (e.g., What are your interests? What do you need information about? What are some things that you want to get help with today?)
9. Increased knowledge of activities and/or resources (including services) available to users
10. Increased motivation to engage in harm reduction and/or social service activities
11. Increased willingness to engage in harm reduction and/or social service activities.

Social connectedness is defined as the measure of how people come together and interact with others such as friends, family and acquaintances, whether one on one or in groups. It can be structured or scheduled activities or unstructured visiting and conversation. It measures a person's comfort and trust with others such that they can ask for help when they need it.

Wellness is defined as the presence of purpose in life, active involvement in satisfying work and/or play, joyful relationships, a healthy body and living environment, and happiness. Wellness is often evident when individuals have "a reason to get out of bed in the morning," something to do, somewhere they want to be, along with the emotional and physical capacity to do it. It is often linked to purpose and optimism.

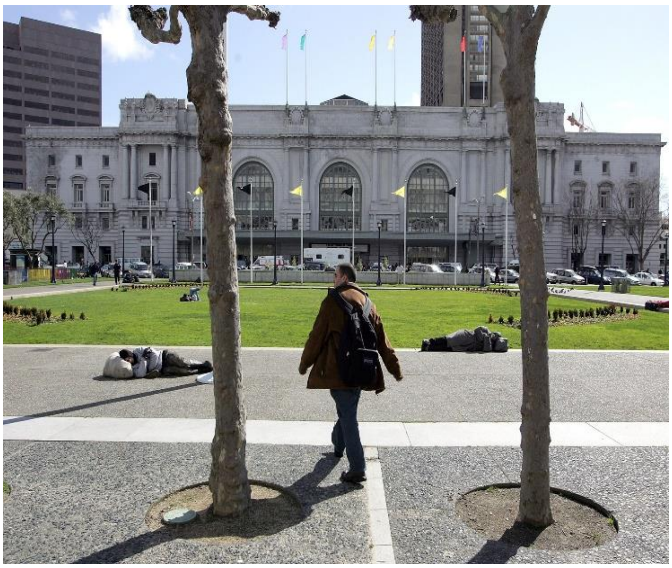
Learning Question	Sources of Data	Data Collection Strategy
1) Do street-based mental health peer-to-peer activities that address the immediate needs and wants of unhoused individuals help to increase their personal wellness (i.e. social connectedness, better quality of life, etc.)?	Peer Staff Unhoused residents	Interviews with Users on the streets Client feedback survey forms Focus groups
2) What components of the peer-based interventions and tools are most positively received by San Francisco residents who are homeless?	Peer Staff Unhoused residents	Interviews with Users on the streets Client feedback survey forms Focus groups
3) What engagement strategies work best to facilitate collaboration and communication between mental health peer specialists and homeless residents living on the street?	Peer Staff Unhoused residents	Interviews with Users on the streets Client feedback survey forms Focus groups

Data collection tools include, but not limited to:

- Brief client feedback survey to be used for the short-term peer interventions to evaluate activities provided in the moment to individuals that are more transient
- Surveys to assess the longer-term peer interventions (i.e. weekly support groups in the park) to evaluate individuals engaged in ongoing activities
- Staff checklists that include a list of evidence-based effective peer interventions that also include blank spaces for new interventions suggested or implemented in real time to track the peer activities being used.

In addition, process measures may be gathered to track the progress of outreach/engagement, rapport development, and the implementation of the peer-based street interventions. For example,

- Number of interactions with unhoused residents on the streets (administrative)
- Number of resources shared with unhoused residents on the streets (administrative)
- Number of peer-led groups hosted for unhoused residents off the streets (administrative)
- Number of repeat interactions



It is proposed as part of this project that we explore and test different strategies for outreach, engagement, and intervention with unhoused residents as a PDSA (Plan-Do-Study-Act) in the early stages of implementation and review its value. The PDSA cycles will focus on community-informed recommendations for improving engagement and intervention strategies. Qualitative information gathered will inform the longer term outcome objectives of forming best-practice models for increasing motivation and willingness to engage with behavioral health and harm reduction social services in San Francisco. Data will be analyzed in aggregate quarterly to identify and improve our engagement and intervention activities. The PDSA cycle is expected to contribute to ongoing improvements, as based on the lessons learned from the activities used most successfully. Best practice protocols will be developed for both engagement and intervention activities when working with unhoused residents in San Francisco. The expectation is to expand the existing knowledge base of known effective intervention strategies.

- Satisfaction with outreach/engagement strategies (quantitative data collection)
- Satisfaction with intervention strategies (quantitative data collection)
- Recommendations for improving engagement strategies (qualitative data collection)
- Recommendations for improving intervention strategies (qualitative data collection)

Please see the below logic model to describe the evaluation efforts and desired outcomes.

San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Identified Concern:	**Contributing Risk Factors:**	**Learning Questions:**
There are 7,000 + unhoused SF residents currently experiencing emotional distress Unhoused residents report feelings of isolation and disconnectedness Limited access to services Limited access to social support	Poverty, personal history of trauma, substance use, low inventory of stable affordable housing, prevalence of street drugs and alcohol, disability, stigma, and open hostility related to those who are unhoused	1) Do street-based mental health peer-to-peer activities that address the immediate needs and wants of unhoused individuals help to increase their personal wellness (i.e. social connectedness, better quality of life, etc.)? 2) What components of the peer-based interventions and tools are most positively received by San Francisco residents who are homeless? **3)** What engagement strategies work best to facilitate collaboration and communication between mental health peer specialists and homeless residents living on the street?

Resources	**Strategies/ Activities**	**Expected Outcomes**			**Suggested Measurements**
		Short Term	**Intermediate**	**Long Term**	
◊ MHSA funding ◊ Peers with lived experience of homelessness from the community ◊ Peers trained and certified in engagement modalities (stages of change, motivational interviewing, harm reduction, seeking safety, Certified Wellness Recovery Action Plan (WRAP), etc.) ◊ Program Manager ◊ Knowledge of the SF neighborhoods, service provider landscape, and homeless engagement services. ◊ City Partnerships (e.g., coffee shops, SF public library, SF police department) ◊ Materials (e.g., log books, Narcan)	◊ Peer led trainings, outreach, and engagement ◊ Peer-based services ▪ 1:1 counseling ▪ Groups (e.g., seeking safety) ▪ Resource planning ▪ Crisis planning ▪ Social support ▪ Skill building (socialization, harm reduction, coping) ▪ Appointment management ▪ Asset mapping ◊ System navigation or linkage as needed, where appropriate ◊ Interventions occur on location with unhoused residents (not in clinics). ◊ Meetings (staff, stakeholder, supervision, evaluation) ◊ Partnership coordination ◊ Protocol development	◊ Connect unhoused individual with a peer to establish trust & rapport ◊ Identification of presenting needs of unhoused individual ◊ Increase knowledge of peer-led wellness activities available for unhoused residents ◊ Increase knowledge of harm reduction supports for isolated and/or high risk unhoused individuals ◊ Increase participant knowledge of additional available services & mental health and/or wellness resources ◊ Linkage to behavioral health services as needed	◊ Decrease feelings of social isolation among unhoused SF residents ◊ Identify factors that increase motivation to access services ◊ Identify factors that are feasible for serving unhoused residents on the streets ◊ Increase willingness of unhoused residents to engage in peer-led wellness activities ◊ Increase willingness of unhoused residents to engage with harm reduction supports ◊ Increase willingness of unhoused residents to engage with behavioral health and/or wellness resources ◊ Increase knowledge among unhoused residents of a wellness toolbox for support	◊ Develop best practice peer-engagement strategies with unhoused residents. ◊ Develop best practice peer-led interventions that increase motivation to engage with behavioral health services ◊ Increase quality of life among unhoused residents ◊ Increase feelings of personal value among unhoused residents ◊ Better service delivery to unhoused residents in SF that is directly informed by homeless needs ◊ Improve experiences among unhoused residents with behavioral health and/or wellness resources ◊ Improve understanding of behavioral health service needs among unhoused individuals experiencing/at risk for trauma, substance use disorder, mental health conditions	**Outcome indicators**: ◊ Assessment of presenting need ◊ Satisfaction with intervention strategies ◊ Satisfaction with outreach and engagement strategies **Real-time survey that as a direct result of working with the peer staff assesses measures of:** 1. Social connectedness 2. Social isolation 3. Quality of life 4. Self-worth (personal value) 5. Resource knowledge gained 6. Motivation to engage in services 7. Most positively received interventions 8. Engagement strategies that facilitate collaboration 9. Willingness to engage in services 10. Knowledge of mental health services

Project Evaluation, Cultural Competence and Meaningful Stakeholder Involvement

The evaluation of the Wellness in the Streets project will be conducted with sensitivity and awareness of our users' diverse experiences related to age, disabilities, as well as cultural, language, ethnic, sexual and gender identities. We seek to generate relevant and useful evaluation results by consulting with key stakeholders who help us ensure that any data collection reflect the values and diverse experiences of our behavioral health community.

We have already established a group of stakeholders that includes community members, behavioral health leaders and peer advocates. As the Innovations program is established and the Peer Team identified and trained, the stakeholder group will expand to include members of the Peer Team as well as clients/users.

The stakeholder group will be consulted on Innovations project learning goals, data collection tools, methods and language for data collection, and how best to summarize and communicate findings to suit diverse audiences. San Francisco also has an active Mental Health Board that meets monthly and a Behavioral Health Services Client Council, where issues important to client representatives, including Innovations project findings, are presented and discussed. Both the Client Council and the Mental Health Board will be integral partners in designing the evaluation, interpreting and reporting the findings, and making recommendations for client-focused program improvement.

MHSA General Standards

Our Innovations Project reflects and is consistent with all potentially applicable MHSA General Standards set forth in Title 9 California Code of Regulations, Section 3320.

a) Community Collaboration
The project will be a collaboration between peer specialists, Behavioral Health Services, community-based organizations, and San Francisco community members.

b) Cultural Competency
The Peer Specialists will receive cultural humility training and they will reflect the diversity of the community they are serving.

c) Client-Driven/ Family-Driven
This project places peers who have lived experience and who have been involved in the mental health system at the center of programming. The peer specialists will be a highly skilled team who will use their expertise to meet each client where they are at.

d) Wellness, Recovery, and Resilience-Focused
This project design will be consistent with the philosophy, principles, and practices of Wellness and Recovery for mental health consumers. It will promote concepts key to the recovery for mental illness such as: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

e) Integrated Service Experience for Clients and Families
This project focuses on increasing access to mental health resources for underserved communities throughout San Francisco by utilizing the peer interventions integrated throughout the existing San Francisco mental health system and implementing these interventions directly where participants are located.

Plan after the Innovations Learning Project Ends

San Francisco Behavioral Health Services will utilize several strategies to secure continuation funding for the proposed Innovations Learning Project, if the entire project or components of the project are found to be effective in meeting our proposed outcomes.

The team will utilize data reports to identify successful interventions, population needs and opportunities. The Program Manager and Quality Management will analyze project data to determine the efficacious components of this project. These findings will be used to construct a rationale for the ongoing continuation of funding based both on the positive impact of the community being served.

Another approach involves an ongoing process of improving and enhancing citywide collaborations as a way to both expand services reimbursements and identify potential points of interaction or resource sharing that could create opportunities for alternate forms of continuation support.

Continuity of Care for Individuals with Serious Mental Illness

Within the broader system of care, there is a network of peer providers that provide services for clients with severe mental illness. In addition, a segment of peer services exists within a wide variety of MHSA providers. These contractors are funded by MHSA to provide peer services for any BHS clients. The existing menu of services includes support groups; individual and group counseling; wellness activities including outings and family to family classes; linkage; Dual Recovery Anonymous groups, Wellness Recovery Action Plan (WRAP) planning; cultural specific activities; services to those with hoarding and cluttering issues; and support for those interested in vocational activities.

Some of the ongoing goals for the peer specialists involved with this project will be to educate participants about existing resources and link into relevant services in the community, as needed. When the project ends, the participants involved in the project will have received an introduction to these services and be able to access them as part of their care plans.

Communication and Dissemination Plan

Feedback from participants will be shared regarding the successes and lessons learned from this project. The peer specialists will be invited to co-present with other project staff on progress, findings, and their experience of the project to stakeholders.

Project learnings and newly demonstrated successful practices will be shared within our county and to stakeholders. Successful elements of this project can be applied to other areas of the behavioral health system of care. Shared practices could change service delivery and the peer employment infrastructure, possibly expanding the focus areas of future peer programs to involve more street-based interventions.

Successful practices and lessons learned will be shared with the San Francisco Mental Health Board and San Francisco Board of Supervisors, as well as with the BHS Executive Team. SF-MHSA team members will present findings at the MHSA Advisory Committee and MHSA Provider Meetings, which include peer-based organizations and community-based agencies. Project successes and challenges will be presented at the Client Council, a committee of consumers that perform an advisory role on BHS affairs. The findings will be disseminated to stakeholders via the SF-MHSA website, the email distribution system, and through the monthly BHS Director's Newsletter. Lastly, the results will be disseminated on a state-level to the MHSOAC and these findings may provide insight to other counties working on similar projects.

Timeline

The City and County of San Francisco is proposing a five-year timeline that will begin upon MHSOAC approval.

Phase I- Start Up and Planning (11/1/2018-12/31/2019)

Program staff and consumers will spend the first two months of this project selecting community partners that employ peers that can engage and serve San Francisco residents who experience homelessness. The program will also fine-tune the scope of work, hire needed staff, and establish the necessary infrastructure to operate the program.

Phase II- Implementation (1/1/2019-6/30/2023)

In this phase, the project will be fully operational and engaging with San Francisco residents who experience homelessness directly on the streets by considering their social and behavioral health needs, and implementing mutually-agreed upon peer activities. The evaluation plan will be refined and implemented throughout this phase.

Phase III – Reflection, Evaluation, and Dissemination (7/1/2023-10/31/2023)

In this phase, the project will be wrapping up and the implementation phase will be tapering down. The evaluation data gathered in the implementation phase will be analyzed and we will work with stakeholders to determine best practices, lessons learned and the overall impact of the project. We will also assess the success of the community partnerships and the added value of their collaborative efforts. In partnership with consumers and stakeholders, we will determine whether and how to continue the successful components of this project. We will disseminate the results.

Budget Narrative

The total requested budget is $350,000 annually, for a total budget of $1,750,000 over five (5) years. If approved by the MHSOAC, SF-MHSA will utilize FY18/19 Innovations Funding for the first year and will not utilize reversion funds.

The majority of spending for this project will go toward hiring 3.0 FTE County Contracted Peer Counselors at $20/hr to staff the project. There will also be a 1.0 FTE County Contracted Peer Supervisor who identifies as a consumer at $22/hr. The peer counselor rates of pay were determined by using the Behavioral Health Services' Peer Pay Rate Structure based on the specific peer activities being conducted and the skill-level required. All peers that work at least 20 hours per week will be eligible for health insurance, and all peers will be eligible for fringe benefits including workers compensation and access to a health services account. All benefits/fringe is estimated to be at 29.74% of the total salaries budget.

There will be a 0.25 FTE SF-DPH Manager of the overall project who self-identifies as a consumer. This manager will be responsible for implementing the work plan for this project.

We are requesting $18,397 annually for operating expenditures to engage participants and operate the program including food, coffee, clothing materials, blankets, travel, art supplies, office supplies and other items.

Lastly, we will place a strong emphasis on evaluation. Therefore we are requesting an annual budget of $40,000 to implement the evaluation activities. These efforts may be carried out by SF-DPH personnel and/or county contracted professional consultants.

Leveraged Funding

The training for the peer counselors and the peer supervisor will be leveraged through existing funds allocated to the BHS Peer Specialist Mental Health Certificate program, the Advanced

Peer Certificate Program and the Leadership Academy's monthly training seminars for peers. The additional annual training expenditures for this project are estimated at $6,600.

Please refer to the Innovations Project Budget below for more details.

Innovations Budget

WITS BUDGET	Year One	Year Two	Year Three	Year Four	Year Five	Innovations Total
Personnel Expenses						
County Manager	$ 39,133	$ 39,133	$ 39,133	$ 39,133	$ 39,133	$ 195,665
County Contracted Peers	$ 245,870	$ 245,870	$ 245,870	$ 245,870	$ 245,870	$ 1,229,350
Evaluation	$ 40,000	$ 40,000	$ 40,000	$ 40,000	$ 40,000	$ 200,000
Operating Expenses	$ 18,397	$ 18,397	$ 18,397	$ 18,397	$ 18,397	$ 91,985
Training Expenses	$ 6,600	$ 6,600	$ 6,600	$ 6,600	$ 6,600	$ 33,000
TOTAL EXPENSES	**$ 350,000**	**$ 350,000**	**$ 350,000**	**$ 350,000**	**$ 350,000**	**$ 1,750,000**