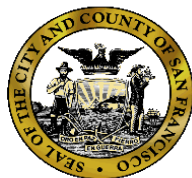# The Mental Health of Children and Their Families Living in HOPE SF Communities

An assessment to inform the development of new strategies and support current programs and activities.

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ACKNOWLEDGEMENTS

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PARTNERS

HOPE SF
HOPE SF is the nation's first large-scale public housing revitalization project to invest in high-quality, sustainable housing and broad scale community development *without* displacing current residents. HOPE SF plans to transform eight highly distressed public housing sites in San Francisco into vibrant neighborhoods with over 6,000 new public, affordable and market-rate homes. There are four active HOPE SF sites – **Alice Griffith, Hunters View, Potrero Terrace & Annex and Sunnydale**. HOPE SF is led by the San Francisco Mayor's Office of Housing with dozens of public and private sector partners. Enterprise Community Partners, The San Francisco Foundation and the Mayor's Office launched the **Campaign for HOPE** with the goal to raise $25 million for a major HOPE SF evaluation as well as to support programs and services over the next five years.

San Francisco Department of Public Health
The mission of the San Francisco Department of Public Health (SFDPH) is to protect and promote the health of all San Franciscans**.** SFDPH realizes its mission through the provision and funding of medical services, Community Health Programs and through the oversight and implementation of Population Health and Prevention activities and programs.

Health Equity Institute, San Francisco State University
The Health Equity Institute (HEI) is a trans-disciplinary research institute at San Francisco State University that links science to community practice in the pursuit of health equity and justice. HEI is a multi-disciplinary team pursuing original research on emerging health equity issues and partnering with communities to understand and address critical health equity issues.

Department of Health Education, San Francisco State University
Housed in the College of Health & Social Sciences, the Department of Health Education currently offers a BS degree in health education with emphases in community-based health, holistic health, and school health. At the graduate level, the Department offers a Master's of Public Health (MPH) degree in community health education.

BACKGROUND

In November 2011, HOPE SF and the Campaign for HOPE, the San Francisco Department of Public Health, and San Francisco State University's Department of Health Education and Health Equity Institute came together in a collaboration to further the development of strategies to address health issues facing HOPE SF communities.

From its inception, this partnership has been guided by recommendations developed by the HOPE SF Health Taskforce and has a focus on gathering additional information and best-practice examples for effective implementation of the Taskforce's recommendations. The collaboration builds on the many community efforts already underway to improve the health of San Francisco communities, including HOPE SF sites, as well as the significant research endeavors that have already and continue to take place with HOPE SF communities.

Current HOPE SF Communities

Alice Griffith   Potrero Terrace and Annex
Hunter's View   Sunnydale

Goals

The partnership's work seeks to illuminate how the City of San Francisco, the Campaign for HOPE and other stakeholders can best support the development and implementation of health strategies at all of the HOPE SF sites in a manner that honors the uniqueness of each community and recognizes commonalities to ensure a coordinated and thoughtful approach.

Commitment to Health Equity & Meeting Immediate Urgent Health Needs

This collaboration and the related projects stem from a commitment to health equity and the urgent need to address the health issues facing the HOPE SF communities today. Actions at all levels – the individual, interpersonal, community and societal levels – are needed to address health inequities in the HOPE SF communities. This work seeks to balance a commitment to both long term changes in social determinants and the more immediate individual, interpersonal and community changes that have an impact on health.

Projects

1. **Peer Health Leadership in HOPE SF Communities**
   Assessment (completed): In 2012, the partnership conducted an assessment of the opportunities and barriers to supporting peer health leadership strategies in HOPE SF communities. The project examined what is needed to build on resources within the community and foster health promoting activities led by residents themselves that draw from their strengths and interests while fostering social connections and

community leadership. The assessment included a comprehensive review of the literature and 50 interviews with community residents, program staff, stakeholders and national experts.

Expanding Support for Peer Leadership (underway): The assessment has led to the development of a funding strategy through the Campaign for HOPE, that supports the enhancement and development of peer leadership activities at all of the HOPE SF sites.

2. Children and Families Affected by Mental Health Issues

Assessment (completed): In January 2013, the partnership launched this effort to examine and address the critical issue of mental health of children and their families in HOPE SF communities. The assessment included a comprehensive review of the literature and over 80 interviews with community residents, program staff, stakeholders.

Strategies to Address the Mental Health of HOPE SF Families (underway): The partnership is building on this assessment and other work that has been done to examine mental health in these communities and is moving forward a strategy to strengthen the investment in addressing this pressing health issue.

Key Project Components

Resident and Community Guidance

Residents and community representatives of HOPE SF sites play a critical role in partnership activities. Resident leaders and site based HOPE SF staff and community organizations provide guidance for assessment activities (including development of data collection tools, outreach, and data collection), and participate in the design and lead implementation of new service and community-building strategies.

Assessment Advisory Groups

For both the peer health leadership and mental health assessments Advisory Groups of scientific experts, City stakeholders and practitioners were convened to provide input into the development of the purpose, data collection tools and analysis.

MPH Students

A key aspect of this work is that it is designed to result in meaningful products for the community and City partners as well as serve as a practice-based learning opportunity for San Francisco State University (SFSU) MPH Students. Students and faculty conduct the assessment activities as part of the Community Assessment for Change and Professional Public Health practice courses in the SFSU MPH program, which take place over a six-month period.

ASSESSMENT PURPOSE AND KEY QUESTIONS

Purpose

To explore opportunities and barriers to supporting the mental health and well-being of children and their families living in the HOPE SF communities.

Key Assessment Questions

Mental Health in HOPE SF Communities

- How are mental health issues of children and families expressed in HOPE SF sites?
- What resources, skills and coping mechanisms are used by HOPE SF children and families to deal with ongoing stressors?
- Who do residents trust and go to for assistance with mental health issues?

Services

- What are weaknesses/challenges of current mental health services in HOPE SF sites?
- What are strengths/effective approaches of current mental health services?
- How can mental health services be embedded and integrated into other activities and services for HOPE SF children and families?
- How can mental health services effectively serve HOPE SF families?

Family Relationships

- What strategies, services and activities exist or could be put in place to foster nurturing family relationships in HOPE SF communities?

Place-Based Approaches and Social Cohesion

- What community-wide strategies exist or could be put in place to promote social cohesion and mental health of children and families in HOPE SF communities?

Sustainability

- What is needed to ensure sustainability of mental health strategies for children and families in HOPE SF communities?

Definition of Mental Health

This assessment focused on mental health issues that are widespread in HOPE SF communities and manifest largely as conditions such as depression, anxiety, stress, fear and other reactions to living in impoverished, isolated and at times violent communities. This assessment did not examine issues related to severe mental health illnesses that are important but less pervasive in HOPE SF communities.

ASSESSMENT STRUCTURE

Assessment Team

SF State MPH students conducted this assessment as part of their work in the Health Education class entitled Community Assessment for Change and the related practicum – HED 820/821/822. The course instructors provided ongoing support and guidance to the students. The following students participated in this assessment under the guidance of the Instructor, Jessica Wolin, MPH, MCRP and Project Coordinator, Sarah Wongking, MPH.

Jacqueline Beck	Corrine Frohlich	JoAnn Irons	Rebecca Randel
Rebecca Chigas	Jesus Gaeta	Christina Ivazes	Jessica Tokunaga
Ashley Desilva	Felicity Harris	Stephanie Jim	Matthew Woodin
Maiya Evans	James Henderson	Fumika Matsubara	
Jessica Franks	Kelly Hill	Temitope Pedro	

Site Leadership

Site leadership of the 4 participating HOPE SF sites played a critical role in the assessment and collaborative tasks. Resident leaders and site based HOPE SF staff and community organizations provided guidance for many of the assessment activities including the development of the purpose, key questions, protocol and interview recruitment.

Name	Organization
Gina Fromer	Executive Director, YMCA SF Bayview Hunters Point
Kathy Perry	Program Manager, YMCA SF Bayview Hunters Point
Isaac Dozier	Senior Project Manager, Urban Strategies
Alissa Nelson	Service Connector, Urban Strategies
Emily Weinstein	Director of Community Development, Rebuild Potrero, Bridge Housing
Uzuri Pease-Green	Community Builder, Rebuild Potrero Bridge Housing
David Fernandez	Sunnydale Transformation Project Director, Mercy Housing
Larry Jones	Community Liaison, Mercy Housing

Advisory Group

The Advisory Group helped shape the scope and focus of this assessment. Academics, practitioners and other stakeholders provided key input into the direction of the literature review as well as the key questions that guided the assessment. Several Advisory Group members identified program staff and key stakeholders for interviews.

Name	Organization
Angela Gallegoes	KDG & Associates
Anne Griffith	Enterprise Community Partners, Inc.
Carlos Reyes	KDG & Associates
Carmen Gomez-Mandic	Edelman Institute, SFSU
Clifton Hicks	Community Behavioral Health Services (CBHS), SFDPH
Cynthia Gomez	Health Equity Institute, SFSU
Ellie Rossiter	Campaign for HOPE, SF Foundation
Helen Hale	HOPE SF, Mayor's Office of Housing
Kanwarpal Dhaliwal	RYSE & Lecturer, SFSU
Ken Epstein	CBHS Children, Youth & Families Systems of Care, SF DPH
Lisa Moore	Health Education Departtment, SFSU
Marcellina Ogbu	Community Programs, SFDPH
Maria X. Martinez	Officeof the Director, SFDPH
Mary Hansell	Maternal and Child Health, SFDPH

Assessment Timeline

- Assessment Planning (December 2012 – January 2013)
- Literature Review (February – March 2013)
- Interviews (April – June 2013)
- Data Analysis (July 2013)
- Presentation of Findings and Recommendations (August 2013)

LITERATURE REVIEW

Methods

An essential element of this assessment is a comprehensive review of the literature regarding the implementation of mental health programs in public housing settings. Prior to making contact with interviewees for the assessment, the class of 18 MPH students read over 200 articles and reports with the purpose of better understanding the causes and impact of stress, trauma and substance abuse on children and families in public housing and strategies for supporting their mental health and well-being. Ultimately, 118 articles were determined to be relevant and were reviewed for lessons learned. In some areas there was a limited amount of literature specific to public housing and articles about communities with similar demographics (e.g. low-income, poverty, impoverished urban communities, minority women and children) were included in this review. However, a full review of this larger body of work was outside the scope of this literature review.

To review the literature of mental health of children and families in public housing settings, the MPH students worked in three teams –Causes (4 students), Impact (4 students) and Solutions (10 students). The Solutions team further divided into sub groups to examine specific aspects of the literature about interventions including community-wide/place based, embedded services, ethnicity-based/culturally centered approaches, and trauma informed care.

Each literature review team used a variety of databases available through the San Francisco State University Library server including: PubMed, ERIC, Web of Science, Academic Search Complete as well as Google Scholar.

Lessons Learned from Literature on Mental Health and Well-being

Causes and Impacts of Mental Health Issues of Children and Families in Public Housing
Learning 1: Trauma and Adverse Childhood Experiences (ACEs) serve as predictors for child health issues and challenges to educational attainment.
Chronic emotional stress and trauma can damage the social and emotional development of children and permanently stifle healthy brain development, often resulting in physical and mental health problems further in life (Health in Public Housing Quarterly Information Bulletin, 2009). Adverse Childhood Experiences (ACEs) are stressful experiences that may include neglect, abuse, and many dimensions of dysfunction in the home such as, being a witness to domestic violence, substance abuse, or parental altercations (Substance Abuse and Mental Health Services Administration, 2013). A child's response to ACEs (exhibiting as Post-Traumatic Stress Disorder (PTSD) symptoms) is a key predictor of their health issues (Graham-Bermann & Seng, 2004). Allostatic load describes physiological "wear and

tear" when normal body functioning is shifted towards abnormal ranges and strain is placed on the various body systems, with the final stage a disease state (Boardman, 2004).

Children's health problems that may arise from stress include allergies, ADHD, developmental delays, and asthma (Graham-Bermann & Seng, 2004). These health issues and exposure to trauma itself all contribute to adverse school behaviors such as inattentiveness and acting out as well as chronic absenteeism (Cunningham & MacDonald, 2012; Lacour & Tissington, 2011; Graham-Bermann & Seng, 2004; Li, Howard, Santon, Rachuba, Cross, 1998). As a result, children living in public housing demonstrate lower educational attainment and graduation rates (Cunningham & MacDonald, 2012; Chapman, Laird, & Kewal Ramani 2010). However the brain is constantly changing and while trauma can lead to changes in brain development it is also important to note the it is possible for the brain to heal.

Learning 2: Chronic stress and poor mental health negatively impact family structure, relationships and child development.

Living in poverty in an urban environment like public housing can undermine family structures and relationships. Many families living in poverty struggle without the tools and supports to create a structured and safe environment for their children. Living in urban poverty may limit the ability of adults to provide parental protection from the physical environment, including violence and crime (Collins et al, 2010; Wethington et al, 2008). Parents' own histories of exposure to trauma, hardship and stress can contribute to intergenerational patterns of excessive discipline, neglectful ad abusive parenting styles impacting child attachment and emotional development (Ackerman, 1999; Ehrle & Moore, n.d.; Dempsey, Overstreet, & Moely, 2000; Newcomb & Locke, 2001). Chronic stress and substance abuse in an urban poverty environment may contribute to family disorder and children may take on parental responsibilities (Kiser, Medoff, & Black, 2009; Lohan & Murphy, 2001).

Exposure to interpersonal trauma, for example, death of someone close, domestic violence, and child abuse, often results in seriously threatening a child's mental health and can hamper a child's emotional development. Exposure to interpersonal trauma has been associated with children exhibiting negative and aggressive behaviors, feelings of abandonment, decreased ability to attach, increased stress, decreased positive coping responses, and PTSD (Collins et.al, 2010; Dalla, 2003; Luthra, 2008; Ackerman, 1999, Ehrle & Moore, n.d.). Furthermore, children who have experienced trauma may be more observant and apprehensive about their environment (hypervigilance) for fear of experiencing a similar traumatic event (Collins et al, 2010; Kiser & Black, 2005). Research shows that over 80% of children living in urban inner city areas have experienced at least one traumatic experience (Collins, et. al, 2010; Luthra, 2008).

Learning 3: Poor mental health negatively impacts the ability of caregivers living in poverty to maintain stable employment.

Low-income women disproportionately experience more mental health issues than women in higher income brackets (Loprest, Zedlewski & Schaner, 2007; Alvaraez, Kimerling, Mack, Baumrind & Smith, 2005; Meisel, Chandler & Rienzi, 2003). There is also an association with poor mental health status of low-income mothers and low educational achievement, thus further hampering their ability to achieve employment (Loprest, Zedlewski & Schaner, 2007). Mental health issues pose as an impediment to successful employment in several ways (Chandler et al., 2005). Because of the cyclical and episodic nature of some mental health conditions, many of these caregivers seek part-time employment, as a way to mediate their mental health needs. Part-time work or no means of employment frequently result in a lack of health insurance or the means to access mental health treatment, leaving caregivers with untreated mental health issues (Loprest, Zedlewski & Schaner, 2007). Mental health conditions such as PTSD serve as a predictor for employment instability (Alvarez, et al., 2005). There is also a well-established body of literature linking unemployment to poor mental health status, thus setting up a cyclical pattern unless interventions interrupt this repetition (McKee-Ryan, Song, Wanberg & Kinicki, 2005).

Learning 4: Violence is a key source of trauma and stress for children and their families living in public housing.

Youth who are victims of violence or witness violence have significantly higher risk for poor mental health including Post-Traumatic Stress Disorder (PTSD), major depressive episodes, substance abuse/dependence and other distress symptoms like emotional numbing, distraction, intrusive thoughts, a sense of not belonging and high vigilance (Howard et. al, 2002; Killpatrick, Ruggiero, Acierno, Saunders, Resnick & Best, 2003; Li et al, 1998). Furthermore, depression and exposure to violence are associated with an increase in an individual's perpetration of violence against others, continuing the cycle (DuRant et al, 2000). Youth living in public housing that are involved in violence perpetration are more likely to have been the victim of violence (Feigelman, Howard, Li & Cross 2000).

When children are exposed to interpersonal violence they have higher rates of aggression and risk for perpetuating violence (Graham-Bermann & Seng, 2004). In addition, trauma, depression and depressive symptoms are associated with risky behaviors including: increased tobacco use, substance abuse, self-injury, and unprotected sexual activity (Foster & Brooks-Gunn, 2009; Kiser & Black, 2005; Yu et al, 2012). These behaviors negatively impact physical health and put the individual at risk for further victimization (Foster & Brooks-Gunn, 2009). Perpetuating violence and experiencing violence remain locked in a repetitious pattern. Though intimate partner violence is a problem facing women in public housing, there is a gap in research about the mental health impacts of intimate partner

violence in public housing (Raphael, 2001; Collins, et. al, 2010). Furthermore, women living in public housing involved in domestic violence relationships may have "off-lease" partners living in their apartments, and they do not seek out help for fear of jeopardizing their housing (Raphael, 2001; Davis, 2006).

Learning 5: The degraded housing and built environment negatively impacts the mental health of children and their families living in public housing.

Studies show that run down housing produces unhealthy and unsafe environments which greatly impact mental health (Roman & Knight, 2010; Ross, 2000). Adults and children living in substandard housing and unhealthy environments have high levels of depression and other mental health conditions (Gallagher & Bajaj, 2007; Roman & Knight, 2010; Ross, 2000). Urban environments with an increased amount of indoor and outdoor pollutants (lead, solvents, and pesticides) can have adverse effects on physical and mental health. Stress is exacerbated by poor environmental quality in public housing. The knowledge that one has been exposed to toxins creates fear for families and contributes to feelings of lack of control of their environment (Krieger, 2002). Furthermore, poor quality housing is most likely to be located in areas with more urban and environmental decay. Stressful environmental conditions may also influence parenting behavior and neighborhoods with poor-quality housing, few resources, and unsafe conditions impose stresses which can lead to depression (Ceballo & McLoyd, 2002; Cutrona, Wallace & Wesner, 2006; Evans et al., 2000). In areas with a lack of exposure to sunlight (prevalent in many public housing projects) sadness, fatigue and clinical depression can also occur. The spatial layout of public housing neighborhoods can also lead to fear and anxiety as residents are unable to monitor their safety due to a poorly constructed physical environment (Evans, 2003).

Learning 6: Institutionalized racism and an array of past and current policies contribute to mental health issues experienced by children and their families living in public housing.

The mental health issues facing children and families in public housing are rooted in past and current policies and systems. The literature shows clear connections between systematic racial segregation resulting from social, economic and housing policies of the past (Redlining, White Flight and Urban Renewal), persistent multi-generational poverty and concentrated unmet mental health needs in urban areas of public housing today (Williams, D. & Collins, 2001; Welch & Kneipp, 2005; Williams, R. 2004; Kusmer, 1991; Williams, D. & Mohammed, 2009). Public housing communities are plagued by the mental health effects of institutionalized racism, chronic stress and economic/social disadvantage (Williams, Mohammed, 2009; Krieger & Williams, 2008). A history of continual re-development and social resource cuts in public housing has intensified the needs of an already under resourced population (Kotlowitz, 1991).

Delayed and ill-enforced environmental protection policies in low-income urban communities, such as the Lead-Based Poisoning Prevention Act (1971), Safe Drinking Water Act (1974), the Toxic Substance Control Act (1976) and the Federal Insecticide, Fungicide and Rodenticide Act (1996) contribute to long-term exposure to toxins that has been shown to increase physical and mental health challenges for public housing residents living in buildings with maintenance issues (Jacobs, Kelly, Sobolewski, 2007; Jacobs, 2006; Krieger & Higgins, 2002). In addition, zoning policies have historically allowed easy permits for tobacco, alcohol and firearms in low-income neighborhoods increasing mental and physical risks to children and families (AAP, 2012; Perdue, Stone & Gostin, 2003; Ashe, Jernigan, Kline & Galaz, 2003; SF Gate, March 7, 2013).

Literature illustrates how families living in poverty experience chronic stress from numerous social policies that contribute to increased family separations, parental and spousal loss (Smith & Young, 2003; Moynihan & Smeeding, 2006; Alio, et al. 2011; Joint Center for Political and Economic Studies, 2010). Family separation and loss have been shown to increase psychosocial symptoms of trauma including anxiety, depressive symptoms, conduct problems, domestic violence and substance abuse (Walter & Swisher, 2006; Davis, 2006; Moynihan & Smeeding, 2006; Hagen & Dinovitzer, 1999). Of particular note are current policies that prevent former drug offenders from qualifying for public housing further exacerbating social and family mental health issues and contributing to the phenomenon of "off-lease" residents (McCarty, Falk, Aussenberg & Carpenter, 2012; Brewer & Heitzeg, 2008 and Smith & Hattery, 2010).

Finally, studies show the policy of heavy policing and the occurrences of perceived abuses of police power in urban, distressed neighborhoods are a large contributor to the climate of fear and frustration and overall stressful environment among African-American youth in these communities. Examples of overt discrimination and racial profiling are shown to create a sense of mistrust towards police, among people living in a public housing community (Brunson, 2007).

Strategies to Address Mental Health Issues of Public Housing Children and Families

Supporting Families and Fostering Community Connections
Learning 7: Social cohesion, community building and community leadership in service strategies are critical to community-wide mental health and well-being.
Social cohesion is the perceived supportive relationships by residents in a community, and the perception of how individual community members relate to each other (Nebbitt, Lombe, Yu, Vaughn & Stokes, 2012). Social disorder has been shown to contribute to mental health issues and literature describes that building social cohesion is a strategy that

can mitigate these outcomes (Ross, 2000; Roman & Knight, 2009). For adolescents residing in public housing, social cohesion can act as a protective factor for mental health. Adolescents are less likely to internalize stressors when living in a socially cohesive community (Nebbitt & Lambert, 2009; Nebbitt, Lombe, Yu, Vaughn & Stokes, 2012). Additionally, addressing hopelessness at a community level for youth living in low income neighborhoods may increase collective efficacy for community residents (Stoddard, Henly, Sieving & Bolland, 2011). Another study points out that social cohesion may enhance maternal behavior by protecting against depression and fostering positive parent-child relations (Ceballo & McLoyd, 2002).

Fostering community relationships impacts mental health (Bazargan, 2005) and strategies that build social cohesion have been shown to promote mental health by bringing people together in shared, positive experiences and developing community leadership and community driven mental health programs. Community building in public housing is recognized as a critical strategy for cutting through the isolation that is often experienced by residents and for countering damaging factors such as crime and run-down physical environments that contribute to poor mental health (Naparstek, Dooley & Smith, 1997). Public housing residents who participated in Seattle, Washington's High Point Walking Club reported an improvement in overall health including their mental health (Krieger, Rabkin, Sharify & Song, 2009). Wolff, et al. illustrate an approach to building social cohesion with a community advocate program that provided a leadership training program allowing tenants to develop programs addressing mental health in addition to other issues. In addition, community involvement in developing and coordinating social services for public housing residents is an important part of community building and ensuring the success of services and programs in these communities (Naparstek, Dooley & Smith, 1997).

Learning 8: Supporting families is essential to promoting and protecting mental health of children dealing with trauma and community violence in public housing.
Developing positive parenting skills, increasing parental involvement in children's lives, and fostering a healthy parent/child relationship have been shown to help children and adolescents avoid or minimize negative mental health outcomes when they have experienced trauma (Black & Krishnakumar, 1998; Evans, Wells, & Moch, 2003; Hunt, Martens, & Belcher, 2011; Kiser, Nurse, Lucksted, & Collins, 2008; Silverman, Ortiz, Viswesvaran, Burns, Kolko, Putnam, Amaya-Jackson, 2008). Because family violence is a risk factor for traumatic stress symptoms and childhood physical abuse nearly triples the likelihood of developing PTSD symptoms (Hunt, Martens, Belcher, 2011), providing parents with healthy parenting skills has the potential to reduce family violence and childhood physical abuse (Kiser, Nurse, Lucksted, & Collins, 2008). Encouraging supportive, caring, and healthy parent/child relationships have been shown to serve as a protective factor and mitigate the effects of children experiencing neighborhood violence and other traumatic

events (Black & Krishnakumar, 1998; Evans, Wells, & Moch, 2003; Hunt, Martens, & Belcher; Silverman et al., 2008).

In the late 1990's strengthening families was the focus of several public housing sites around the country through HUD supported Family Investment Centers located on site. In other locations family resource centers tied to public housing sites strive to meet the needs of families. This strategy puts families at the center and provides services and case management activities that prioritize family needs including access to mental health services (Naparstek, Dooley & Smith, 1997). Another approach to supporting families that some public housing sites around the country have taken is reuniting men with their families living in public housing and encouraging family unification. In programs in Cleveland, Hartford and Baltimore the Housing Authority has created programs providing men who are fathers with incentives such as employment in site revitalization and freezing rents to support their family involvement. Housing policies that undermine family unification must be waived to support such family restoration efforts (Naparstek, Dooley & Smith, 1997).

Service Strategies
Learning 9: Building on existing relationships and implementing culturally responsive mental health services are key to effectively serving families living in public housing.
Researchers suggest that building on existing family and social bonds can play an important role in promoting mental health as trusted family and informal sources may play a key role for low-income African Americans experiencing emotional or psychological issues (Lindsey, Joe & Nebbitt, 2010). As a result, lay health worker models in which select community members are trained to assist other residents in accessing health care options and other social services available to them has been shown to increase the accessibility of mental health services for populations more receptive to community members of cultural relevance (Brown, 2011).

Furthermore, a significant barrier to mental health treatment is the lack of cultural competence or cultural sensitivity of service providers (Larkin, 2003). The ethnicity, age, and gender of individuals must be considered when creating solutions to mental health issues (Saulsberry, Corden, Taylor-Crawford, Crawford, Johnson, et. al., 2013). Programs that are more culturally relevant to participants will produce higher rates of participation and completion, resulting in successful behavioral change (Larkin, 2003). However, research shows that many African Americans are unlikely to find culturally appropriate services when they seek treatment (Saulsberry, et al., 2013). Many mental health treatment services still use Eurocentric-oriented approaches, based on white, male, middle-class values, which often prevent low-income African Americans from seeking mental health treatment (Jones, 2012).

Utilizing religious or spiritual interventions to address mental health issues present opportunities to practice culturally appropriate care (Caplan, Paris, Whittemore, Desai, Dixon, Alvidrez, & Scahill, 2011). Culturally relevant approaches for public housing residents may incorporate interventions with religious or spiritual components as they are effective tools in alleviating mental health issues in people and communities that suffer trauma (Koening 2009; Wallace 2012; Molock & Barksdale 2013). Religion and spirituality are protective factors for mental health by providing strength, resiliency, and lowering stress (Koening, 2009; Molock, Barksdale 2013; Wallace 2012). It has been documented in the literature that African Americans who utilize religious expression through songs were able to cope, endure, and persevere through stressful life events (Hamilton et al, 2012).

Learning 10: Outreach and identification in medical settings and community programs is necessary to effectively reach many individuals and families who experience chronic stress and trauma.
Successfully identifying and engaging persons who may be suffering but not seeking treatment is necessary in order to deliver mental health interventions appropriately (Bebout, 2001; DeKeseredy, & Schwartz, 2002; Glynn, Asarnow, J., Asarnow, R., Shetty, V., Elliot-Brown, Black, & Berlin, 2003; Kelly, Merrill, Shumway, Alvidrez, & Boccellari, 2010; Parrish, Miller, & Peltekof, 2011). It is commonly suggested that acute medical care settings, primary care clinics, crisis centers, and community health centers are effective and essential places to outreach to victims of trauma and intervene early (DeKeseredy, & Schwartz, 2002; Kelly et al., 2010; Parrish et al., 2011). Minimal training and encouragement is necessary to train healthcare workers in these settings to identify and refer clients to mental health services (Kelly et al., 2010; Parrish et al., 2011). Prior to addressing the complex needs of trauma related symptoms, concentrating on needs surrounding financial, housing, medical, and support dealing with law enforcement help to create a sense of stability in clients' lives as well as builds rapport (Kelly et al, 2010).

Learning 11: Evidenced based approaches exist for addressing trauma experience by children and their families but, few have been tested in public housing settings.
The literature demonstrates that population-based treatment approaches are needed for low-income, urban, children and family members who have trauma histories and/or live with chronic trauma (de Arellano, Ko, Danielson & Sprague, 2008; Silverman, Ortiz, Viswesvaran, Burns, Kolko Putnam & Amaya-Jackson, 2008). Recent literature highlights the importance of choosing treatment plans that acknowledge the socioeconomic and cultural contexts that shape a person's mental health and psychiatric symptoms (Becker, Greenwald & Mitchell, 2011). Evidence-based psychotherapeutic treatment approaches are widely discussed in the literature as recommendations for reducing trauma-related

symptoms among low-income, urban, children and families of various ethnic groups. This literature review does not include a review of specific approaches or methods as it is beyond the scope. There are numerous sources for specific information about trauma services. Choosing appropriate trauma-informed treatments for individuals and groups is key to achieving sustained trauma recovery; the wrong treatment model can actually re-traumatize an individual (Cooper et al., 2007; Ford, Steinberg, Moffitt & Zhang, 2008). Of primary importance is that services are tailored for the specific individual and family so as to ensure effective treatment and sustained benefits. It is of note that there is little literature available that discusses tested and proven interventions for PTSD or trauma-related symptoms specifically for public housing residents.

Learning 12: On-site mental health services within public housing settings can provide access and integration of services but face significant challenges.

Provision of onsite clinical mental health services within public housing resources or offices is viewed as critical by researchers. (Getsinger & Popkin, 2010; Howard-Robinson, 2003; Larkin, 2003; Popkin & Getsinger, 2010). Case management teams in the Chicago Housing Authority find that residents are in need of onsite comprehensive mental health care and that public housing residents benefit from onsite counseling in conjunction with targeted case management resources (Getsinger & Popkin, 2010; Popkin & Getsinger, 2010). One powerful example is the Cleveland Cuyahoga Metropolitan Housing Authority's (CMHA's) Miracle Village which is a residential substance abuse treatment program for mothers located within a public housing site. Miracle Village renovated existing public housing units to create a residential program that links substance abuse treatment for women with critical social and health services including access to health care, education, childcare, and supportive programs that lead toward full-time employment, all within the context of their public housing community (Naparstek, Dooley & Smith, 1997).

However, locating mental health care services in a public housing setting has the potential for challenges. Stigma associated with mental illness makes seeking mental healthcare a sensitive topic. These challenges are found in services offered in schools and churches, but is not well documented for those services offered in public housing sites (Cardemil et al, 2007; Lindsey, Joe & Nebbitt, 2010; Neighbors, Musik & Williams, 1998; Saltzman et al, 2001). On the other hand, programs that incorporate mental health support for children and adolescents located within local schools show positive results in terms of lower levels of symptoms of depression and distress and greater participation in school and community activities (Barnes, 2004; Barnes, 2006; Black & Krishnakumar, 1998; Cardemil et al, 2007; Saltzman et al, 2001).

Examples of embedded services are available in settings outside of public housing. Further exploration is needed to develop embedded mental health services in a public housing

setting. The term "embedded services" is not being used to describe mental health services that are integrated into local community resources or located within an already existing community space. There is no consistent term that encompasses this type of program (Barnes, 2004; Barnes, 2006; Howard-Robinson, 2008; Larkin, 2003; Saltzman, Pynoos, Layne, Steinberg & Aisenberg, 2001). Embedded services have been found, but are available in a limited scope and focus on health services other than mental health (Howard-Robinson, 2003; Larkin, 2003). Most of the services that could be categorized as embedded are located within schools. The primary focus of these services has been social support, including limited mental health services for youth and families (Barnes, 2004; Barnes, 2006; Cardemil, Reivich, Beevers, Seligman & James, 2007; Saltzman et al, 2001). Within public housing sites, there are documented home-based substance abuse treatment services as well as onsite or local primary health care clinics (Howard-Robinson, 2003). There are few documented examples of models of embedded trauma focused mental health services within public housing sites.

Environmental Improvements
Learning 13: Structural revitalization of public housing units improves the mental health status of families.

Renovations to housing units and maintenance of facilities are fundamental in improving the mental health status of residents living in public housing communities (Evans, Wells, & Moch, 2003). Improving the quality of the housing is associated with a reduction in psychological distress. One study found that, under controlled income levels, an increase in the quality of housing resulted in a decrease in symptoms of psychological distress among low-income African American and Caucasian women residing in urban areas (Evans et al., 2000). Mental health conditions including behavioral problems and depression have shown to decrease in youth and adults after moving into improved living environments (Cove, Eiseman, & Popkin, 2005; Katz, Kling, & Liebman, 2000). Furthermore, improvements to individual family units have been shown to reduce crime and increase safety which has a positive impact on the mental health status of residents in public housing communities (Evans et al, 2003).

ASSESSMENT METHODS

18 MPH students conducted a total of **81 interviews** over the course of three months. Potential interviewees were identified by site leadership and the assessment Advisory Group and through snowball sampling methods. All interviews were recorded and hand written notes were taken as well. Data analysis took place over the course of a month and was done by coding all interview data and identifying key themes which were developed into findings and recommendations.

Resident Interviews

30 interviews with residents from four of the HOPE SF sites – Sunnydale (5), Alice Griffith (5), Potrero (14) and Hunter's View (6) were conducted. 44 % of those interviewed were African American while other participants identified themselves as Latino, Samoan, White & Bi-racial. The ages of interviewees ranged from 23-70 years old and 7 self-identified as males while 23 self-identified as female. Residents were identified by site leadership who made initial contact. Students in teams of two conducted interviews and gave all resident interviewees a gift bag that included snacks and school/art supplies for children.

Program Staff Interviews

23 interviews with mental health program staff who work with residents of HOPE SF communities were conducted. Due to the small number of programs focused exclusively on these communities many interviewees were program staff from organizations that implement mental health programs that include public housing residents along with other community members. Program staff also had varying levels of interaction with residents ranging from front line programmatic work and mixed responsibilities to program leadership and supervision. Program staff were identified by Advisory Group members and were contacted and interviewed by students in teams of two. All interviewees were provided a $5 gift card to Starbucks. Interviews were done with representatives from the following organizations,

Bayview Hunter's Point Behavioral Health Program	Bayview TLC Family Resource Center	Bayview YMCA- Family Resource Center
Black Infant Health Improvement Project	Bride Housing- Potrero Terrace & Annex	CBHS Comprehensive Crisis Services
Children's System of Care	Comprehensive Child Crisis Services	Edgewood Center
Family Mosaic Project	Jelani House	Maternal and Child Health SFDPH
Potrero Hill Family Support Center	Seneca Center	SF HSA & CPS
SF Department of Public Health	S.E. Child/Family Therapy Center	Sunnydale YMCA
Urban Strategies		

Key Stakeholder Interviews

28 interviews with key stakeholders including individuals in leadership roles in organizations that are involved in HOPE SF were conducted. Advisory Group members identified key stakeholders to be interviewed. Interviews were done by students in teams of two and included representatives from the following organizations,

APA Family Support Services	Bayview Hunter Point Foundation for Community Improvement	Bridge Housing
First 5 San Francisco	Mercy Housing	San Francisco Adult Probation
San Francisco Department of Childrem, Youth and Families	San Francisco, Department of Public Health	San Francisco Housing Authority
San Francisco Human Services Agency	San Francisco Juvenile Probation	San Francisco Police Department
San Francisco Programs Seneca Center	San Francisco Mayor's Office	San Francisco Office of Economic and Workforce Development
YMCA	Young Community Developers	

INTERVIEW FINDINGS

The following findings were developed by the MPH students who conducted the in-depth and key stakeholder interviews and transcribed, coded and analyzed the interviews in collaboration with the course instructor who guided the data analysis process. The findings reflect themes that were found in the interviews with residents, key stakeholders, and program managers and highlight those areas of agreement across these groups. In addition, specific important issues raised by interviewees from only one group of interviews are presented.

Mental Health Issues in HOPE SF Communities

Finding #1: Violence and lack of safety are a cause of tremendous ongoing stress and trauma for children and families in HOPE SF communities that results in widespread mental health issues for residents.
Residents of HOPE SF communities endure daily stressors including significant community violence. Many residents and program staff commented that this violence has been "normalized" and is an accepted reality as part of living in these communities. One resident described how even the youngest residents are asked to incorporate dealing with violence in their daily lives, " *It's sad, 'cause at the daycare here, the kids have a song – 'Gunshots, go inside. Gunshots, go inside.' [sung like a children's lullaby melody]. It's not a song that you really want kids to have to learn. But hey, that's something that they have to learn in order to keep them safe."*

However, many interviewees acknowledged that the lack of safety experienced by residents' has a tremendous deleterious affect on their mental wellbeing and that of their children. Residents report that the stress and fear associated with feeling unsafe, coupled with other daily challenges, leads to significant mental health issues including feelings of ongoing sadness, isolation, depression, anxiety, and other severely negative emotions. Residents described the toll this fear and stress takes on young children as they are exposed to episodes of community violence. "*One little girl just started throwing up and was shaking.*"

Children and Families Coping with Mental Health Issues
Finding #2: In reaction to ongoing fear and stress many residents are forced to remain indoors, restrict children's play outside, turn inward and become isolated. As a result, community connections suffer and mistrust between residents is fostered.
Residents, key stakeholders and program staff all point out that in reaction to ongoing community violence, HOPE SF residents often forced stay indoors and isolate themselves and their families in their own homes. Many parents and caregivers are fearful for their

children's safety and may not permit them to play anywhere except at home under close supervision or send their children out of town or to summer programs to provide a safer and healthier environment.

One key stakeholder described, *"If you have 187 people living in Hunters Point and every week two or three people get murdered, would you want to go outside? Would you send your kids outside? Everything shifts...Fear and violence isolate people."* This isolation takes a toll on individual residents and their families as it only compounds their fear and stress, as one resident explains, *"If you take the outside world and put it on a parent who has those stress levels and she shut into her house and she builds up her own stress by being shut in because she can't deal with her own factors. If she goes outside she will be robbed, if she goes outside she can be shot. If her kids go outside they can be shot. So you have this shut in factor."*

Violence acts as a damper to the community, forcing families and children inside and fostering distrust among residents. Residents describe that community members maintain a constant sense of guardedness which poses significant barriers to social connection and community building. Interviewees discuss that gun and gang violence in particular inflame the fear that exists in Hope SF neighborhoods. Furthermore, residents perceive that the reputation that HOPE SF neighborhoods are unsafe and violent places exacerbates their isolation as services and businesses avoid their communities. A resident describes a common occurrence, *"Taxi drivers are scared to come into this area...They practically want to leave me at the hill and not bring me into Hunter's Point."*

Finding #3: Violence is perceived to be, at times, a reaction to stress and "acting out" is a visible negative reaction of some young people in HOPE SF communities. Distrust of police may prevent residents from calling upon them for assistance.
Community members perceive that violence itself has become a frequent outlet for managing stress for some residents. One resident expressed, *"Around here, the way people deal with stress is they create more stress for other people. I'm stressed out so I'm going to go shoot somebody today or I'm stressed out so I'm going to rob somebody today."* Some residents feel that if there were readily available alternatives to dealing with violence, reactionary violence would not be expressed, *"People are angry and violent. They look like they are trying to find something to get into. If they had something to do, they wouldn't get into trouble."*

The negative ways in which youth express stress was described in similar ways by residents of all four HOPE SF communities and residents identify these expressions as frequent and visible to the whole community. Some youth show their stress through fighting, bad language, arguing, vandalism, robberies, physical illness, and isolation. A long-

time resident of Hunter's View shared that, "*once a young man got upset about something and he started kicking people's cars, jumping on them and yelling and screaming.*"

Furthermore, some residents acknowledge the reluctance of their neighbors to reach out to the police in times of need. Residents observe that some community members are hesitant to contact police and that there is a strong sense of mistrust of law enforcement within HOPE SF communities. Resident concerns about abuse of police power, "snitching" and a general feeling that policing is ineffective all contribute to this lack of trust. A resident voiced her concern about contacting the police, "*It's kind of hard to believe in a system when you don't see it working here. It's hard to know who to trust. Even with the police. "*

Finding #4: Substance use can be a form of coping with the stress experienced in HOPE SF communities. It is also thought to contribute to fear and safety issues and negatively affect the community as a whole.
Many residents, program staff and key stakeholders report that some HOPE SF community members use drugs and alcohol to self-medicate and cope with domestic and community stress. Program staff report that alcohol and marijuana are the most commonly used substances that serve as a type of "self-medication." According to one resident, "*Everybody deals with stress differently. You know, some use, drink; what I mean by use is drug use. Alcohol use, to kill, away from you know, the stress level. That pretty much as a whole is what I see, from my experience; you know, that's what people do.*"

However, easy availability of drugs and alcohol, discarded drug paraphernalia, and abandoned apartments used for drug related activities are all thought to contribute to a climate of fear, stress and lack of safety in HOPE SF communities. One resident observed, "*I think it would save a lot of problems if they have a way to board up the vacant houses so people to use them to drink and do drugs and break in to live in there. There are 50-60 vacates and there are people living in every one of them and the office knows about it. Board them up or put families in them, so they won't have no place to congregate in.*"

Finding #5: Fundamental needs and chronic stress can eclipse some caregivers' capacity to engage in self-care and family building activities. Residents desire accessible safe spaces for families to spend quality time together.
A significant priority for caregivers in HOPE SF communities is meeting the daily needs of their families such as ensuring children have essentials such as clothing and food. For some families, issues such as unemployment, struggles to pay rent and substance use create daily challenges that add to the stress of living in violent communities. Residents who are caregivers describe that taking care of themselves often takes a back seat and that their mental health suffers. Furthermore, for some residents, as they work to meet their family's

needs without being able to address their own emotional issues, time and capacity for positive family building activities is limited. Residents see that some children are forced to seek out food and care from neighbors because their parents lack the capacity to provide that to them. One resident commented, *"There's not enough affection that goes on between the families. So if there was some way to change that way of thinking into being more positive and loving with each other…"*

At the same time, many caregivers in HOPE SF communities are keenly aware of the importance of self-care and participating in family relationship building activities. They express concern about the lack of programs for children and families that provide the opportunity to spend time together. Numerous residents are very clear about wanting services specifically for families that include safe, extra-curricular activities for children as well as mental health support services for caregivers. There is also a desire for programming that targets all age young people because adolescents are frequently overlooked in terms of services specifically designed for that age group. One resident commented, "*Especially 10-16 year olds; it seems like there are no programs for them.*"

Finding #6: Community ties, social connections and community building activities provide support and relief from stress and other mental health issues for members of HOPE SF communities. Residents want more activities and opportunities to build community.
Residents currently use community support as a primary way to cope with the daily and ongoing stress of living in HOPE SF neighborhoods. They describe that both caregivers and youth talk to trusted friends and family members. Community members rely on neighbors for emotional support, childcare, and help with everyday activities, looking out for each other and seeking out resident leaders for support. *"I see a lot of reliance on each other, so really close networks in the community. I see a lot of love being expressed between people when they're in a sort of social environment that makes that possible and they feel safe."*

In addition to seeking out informal support from neighbors, residents describe that to cope with stress and daily mental health issues, community members most often turn to the resources and activities provided by their churches, community and housing partnerships. One resident believes that these activities are well-attended because "*[community members] enjoy being there, they feel like it is a safe and quiet space for them to get away from everything.*" Residents feel that these activities and types of groups help by providing space for people to relax with one another and to take their minds off their stress. Being around fellow residents and staff members that are welcoming and non-judgmental also promotes a sense of community. These activities allow residents to build trust with their community members and confide in them during challenging times.

Specifically, residents in Potrero Terrace and Annex feel their organized community activities such as gardening, Zumba, meditation, and the walking club help community members cope with stress. One resident believes, "*when you are meeting people in our neighborhood, you are not so afraid of other people.*" Residents at Sunnydale, describe how potluck events create connections and healing circles offer support to residents when traumatic incidents occur. Residents feel that the Bayview YMCA is a community resource that fosters connections and have found mental health benefits from having organized community meetings, like those at Alice Griffith. One resident believes that people who attend community meetings, "*come away feeling better*" because, "*they have more knowledge about what is going on in their community.*" Support groups are seen as particularly helpful in facilitating open discussions about community and individual issues that create stress. Residents believe that participants in these groups find that they are able to learn new ways to cope, collectively problem solve and serve as a support for other people in the group and the broader community.

Despite the fact that community connections offer significant support through stress and mental health challenges, residents also describe deep distrust within HOPE SF communities. Residents recognize that engaging in community activities makes them feel more connected, but they feel like many community members do not want to engage in these activities because they are not willing to help themselves and are also apathetic towards working to build a sense community. Even though residents desire and rely on social support within the community to cope with stress and deal with hard times, they perceive that their neighbors do not care about helping each other and that neighborhood support is limited. One resident reports that "*You all know each other; you all talk. We bring each other dishes of food. We share and where we are at is good. I know a lot of people, there is no trust; they just enemies. They call the police on each other. It's just madness. If they could listen to each other. Stop disrespecting each other.*" Residents believe that having more community involvement with one another would improve community trust and safety. "*I wish there was more community and like trust among the neighbors that would be ideal in getting neighbors out more.*"

Finding #7: Opportunities to engage in activities outside of HOPE SF communities provide a respite from isolation, community violence and stress.
In addition to wanting more community connections within HOPE SF neighborhoods, residents feel that they need to spend time outside of their neighborhoods. At times, residents feel stuck in their own community and isolated from the rest of San Francisco. Many residents do not have space for respite from the daily problems that they face in their community. Residents explained that leaving their communities would assist in subduing feelings of isolation, give community members an opportunity to explore other neighborhoods and connect with people outside their community. Residents believe that

getting a break to spend the day going to a museum, sightseeing, or participating in activities like camping and fishing would give families the ability to cope by relaxing and forgetting about the daily stressors. Caregivers feel that experiences outside the community would also give their children and teens different perspectives and create learning opportunities beyond what their community offers.

Access to Services

Finding #8: Some residents may only seek out mental health services when they are in crisis due to access barriers and because other mechanisms for coping have been exhausted. There is substantial need for care for many children and families who do not currently use mental health services.

In HOPE SF communities there is an ongoing cycle of 'crisis care' that neglects primary and secondary mental health issue prevention and intervention. A mental health program staff commented *"Generally we come in at a point where people are already like in a very, very dark place and they didn't even know of the kind of services they could have been getting this whole time."* Some residents never receive diagnoses of persistent mental health issues. Program staff report that residents do not often directly access mental health services and that identification of an individual or family in need of support is not as simple as responding to a request for help . *"They (residents) never come presenting a problem or saying, 'I'm worried,' or 'this is gonna happen to me,' they don't come in like that. They come in and use the computer. You gotta track people down to offer help. And the only time we find out about something is when there's a major crisis going on; then we find out."*

Multiple barriers contribute to delayed mental health care or intervention only at the point of a severe emotional crisis for many residents of HOPE SF communities. Program staff describe that lack of knowledge or understanding of what services are available and how to access them hinders utilization of less intensive services. They explain that other factors for delaying or avoiding care include lack of awareness of symptoms of mental health problems leading into crisis, lack of trust in the effectiveness or importance of mental health care; stigma or denial. Other barriers are cost, no follow up from services, paperwork and bureaucratic "hoops", and having to go to multiple locations for help. Many caretakers also have limited options for childcare and therefore lack time to access services without having to take their children with them. Those interviewed feel that the combination of fears about using services and logistical access barriers result in avoidance or underutilization of available services. For residents, this lack of engagement with preventive or early intervention services contributes to their view of other community members as apathetic about seeking care.

Finding #9: Effective programs are viewed as ensuring confidentiality and are in tune with HOPE SF community members. However, there is also a lack of relevant and relatable mental health programs that instill confidence and earn the trust of HOPE SF residents.

Current services that are perceived by residents to adequately serve their mental health needs are characterized as relatable, confidential, and easy to access. Residents who use these services feel that the environment is judgment-free and they trust that the staff will maintain confidentiality. Services that are well used have positive reputations in the community and residents learn about these services largely by word-of-mouth. These services use a variety of outreach methods, but having residents give positive recommendations to services is seen as the most effective way to encourage others to use those resources.

Despite the positive reputation of some community mental health services, program staff are often outsiders in the communities that they serve. According to one program staff, *"To be in the community is to be out and engage and see faces and people. I'm not there to be disruptive; I'm here to help you."* Many residents, program staff and key stakeholders commented that residents feel more at ease and willing to participate in services if offered by someone whose personal experiences reflect their own. According to one key stakeholder, *"Get people who were born and raised there, who have a history there who have trust, who left and got their education and came back, who look like them and speak the language and get stuff done."* Another key stakeholder underscores the need for services to be delivered by *"...people in the service delivery system they trust, people that work in the community, and reflect the community they serve. They should have commitment and passion to be culturally responsive...to see it through an equity lens."*

In addition key stakeholders and program staff felt that it is important to expand access to services that are housed in welcoming environments. According to one key stakeholder, *"We really are in these people's homes- in their community. How do we do this in a way that you [staff person] are invited in and feel welcome instead of coming and doing the 'we are here to make your lives better'."* Key stakeholders described that it is crucial to create an environment that puts individuals at ease so that they are more willing to participate. This will promote participant retention in services over time.

Many interviewees explained that residents are particularly wary of program staff because they are known mandated reporters who may pass information about family issues and perceived child maltreatment to Child Protective Services (CPS), possibly resulting in the loss of a child to the foster care system. Social workers, case managers, psychotherapists and other potentially helpful staff are bypassed even when they or their family members need mental health services. One resident stated, *"people really do need help here and people are scared to open up because they're scared that their kids will be taken away."*

Finding #10: Many mental health programs serving HOPE SF communities are perceived to be uncoordinated, only temporarily available and not integral to the community, which undermines trust, rapport and effective service delivery and contributes to lack of utilization.
Interviewees report that residents are frequently re-traumatized by systems and agencies that are insensitive to their trauma histories and those who have had upsetting experiences with agencies are very unlikely to return. Program staff feel that **s**taff turnover, research fatigue, and unsuccessful programs all lead to inconsistent accessibility of services. They explain that the large number of HOPE SF residents living with mental health challenges requires greater numbers of qualified service providers. However, constant "restaffing" leads to less continuity of care and outreach from the providers to the community, negatively affecting the sustainability of these programs and services. The use of interns as a cost-saving measure actually creates discontinuity for families who need long-term therapists with whom they can build a trusting therapeutic relationship. As stated by a program staff, there should not be *"...a lot of interns because it's cheaper, but interns are gone within the year."* An investment in funding licensed therapists will be beneficial in raising the quality and continuity of care.

Residents feel similarly and describe that building rapport and trust between services and the community takes time and many services end before those relationships can form. One resident states that "*The hardest thing in this neighborhood because there is such a high turnover of programs and such a lack of trust.*" Even if services are located within the community, residents may not be aware of them and what help they provide. Residents believe that the type of outreach to the community is important and that in person or "door to door" education about services is effective, especially to those who are most isolated.

Finding #11: The geographic isolation of HOPE SF communities, the distance from mental health services, and transportation challenges impede utilization and delivery of care for many children and families.
Safety concerns, lack of time, the cost, and inadequate public transportation greatly hinder residents' ability to seek out mental health services undermining the ability of mental health providers to serve HOPE SF residents effectively. Distant location and lack of adequate public transit services or access to a car creates a significant barrier for residents to access mental health services. Furthermore, many residents have family and work obligations that do not allow time for lengthy trips, regardless of the need for services. One program staff noted *"A big barrier to services is when you expect clients to come to an office to meet you, as opposed to when you can offer the services right in the building they live in or come to their apartment even. I think that can be a helpful thing that takes away probably the biggest barrier to treatment."* Limited open hours for services and appointment-based

services exacerbate location challenges and are also barriers because many residents may not be available during normal working hours or are in crisis and need help immediately.

Finding #12: Some residents may avoid seeking care because of stigma surrounding mental health, mental health services, public housing and fear of family separation. Some families are deterred from receiving help for fear of being labeled and judged.

Program staff and key stakeholders believe that many HOPE SF residents perceive a great deal of stigma regarding mental health and the seeking and receiving of mental health services, resulting in delays in care. According to a program staff, *"We know also that there's a stigma sometimes for different people to go and get counseling, so our job is to make it a norm…No one is ashamed to go to the doctor. But some people are ashamed to seek out mental health. 'Cause no one wants to be labeled."* Program staff feel that labeling services as "mental health" programs reduces the chances that residents will seek out these services. In addition, program staff report that some HOPE SF residents fear that service providers may judge them because they live in public housing. Residents describe that community members feel that there is much stigma and judgment related to mental health issues and many are worried about community gossip if they are seen seeking help for mental health. Because neighbors may not trust each other, they may not be willing to access on-site mental health services due to concerns about confidentiality.

Finding #13: Concern for personal safety prevents many residents from accessing mental health services and affects staff ability to work within the community, at time hindering service delivery, consistency, and continuity.

For both HOPE SF community residents and mental health program staff violence and safety concerns present a significant barrier to effective service delivery. For residents lack of safety for both themselves and their belongings can prevent caregivers from seeking out care. *"You can't leave your house because somebody is going to break into it. Why would you leave? Why would you go down the street to get medical help [and] when you come home somebody took all of your belongings?"* Even when services are placed within the community, there are environmental and social challenges in using them. Because of gang territories within HOPE SF communities, some residents do not feel they are safe to go to certain areas within their neighborhood.

For mental health program staff, persistent and unpredictable violence takes a toll on their own mental health and can create additional challenges to service delivery. Program staff describe that they can be distracted and concerned by threats to their own health and safety when working in the field. They explain that they will avoid an area after a shooting for a few days or refuse to return, missing opportunities to reach residents in that area. One program staff member stated, "*We're scared to death to go to lunch. Bullets don't have a name*

on them. Things are very random....You have to be on guard and once again it puts a barrier up between yourself and the community." Staff are aware of the risks their job entails, and this makes them feel unsafe and uncomfortable, describing a "you are on your own" mentality. They explain that staff may choose to avoid certain tasks, such as home visits or client follow up, because they fear traveling into a dangerous community. These risks lead to staff burnout, turnover, and vicarious trauma, which affect program success. *"Everyone walks around with vicarious trauma...I didn't get injured, but I'm seeing it everyday."*

Funding

Finding #14: Lack of flexible funding, a short-term view and historic disinvestment in HOPE SF communities are significant system challenges that undermine effective service delivery, relevant programs and ultimately the mental health of residents.

Program staff and key stakeholders both describe how service fragmentation at the City and community levels creates barriers to services. Organizations often receive multiple funding sources with competing requirements and funding cuts at all levels of government result in limited funding and inflexible contracting requirements. As one key stakeholder states, *"Having flexibility with the funding to provide the services is really critical and where you get that [type of] funding is really challenging."* Residents are attracted to non-traditional and non-diagnosis-based wellness programs, such as yoga classes. *"We need to create more flexible and collaborative funding models."*

Furthermore, lack of coordination and responsiveness leads to mistrust between the community and service providers. Because programs and positions are at risk of being cut it can contribute to a "revolving door" of providers. Residents may not see the same faces and do not have the opportunity to develop trusting relationships. According to one key stakeholder, *"Success depends on an integrated courageous collaborative process that asks what the residents need and have and puts decision makers in place where they can integrate and deliver their services. Until that happens... [services], even with best of circumstances, will be delivered in a fragmented way."*

In addition to fragmentation and lack of coordination, there is an inadequate short term view on the deeply rooted community issues that underlie mental health issues. A key stakeholder explains that mental health disparities in HOPE SF communities are the result of historic disinvestment which must be remedied through sustained reinvestment. "*A lot of people feel like it takes too long to see changes but people need to expand their time frames because it takes a long time to make change. Mental health services will always face an uphill battle because of how long it takes to change."* They emphasized the need to strengthen long-term financial and political investment that reflects a "*generational intervention."*

RECOMMENDATIONS

The following recommendations were developed by the MPH students who conducted this assessment. The recommendations reflect specific suggestions and ideas provided by residents, program staff and key stakeholders as well as the ideas of students and faculty.

Big Picture

Recommendation #1: **Prioritize addressing violence in HOPE SF communities and providing support to residents who experience the emotional aftermath of violent events.**
Community and interpersonal violence underpin much of the stress and trauma experienced by HOPE SF residents and creates a barrier to effective service delivery. Without an effective multi-faceted strategy to address violence in HOPE SF communities, mental health services are left to pick up the pieces and focus on supporting residents to effectively cope with living with violence. Reducing violence and less exposure to trauma is the best long-term solution to many of the mental health issues experienced by HOPE SF residents. In the more short term, a coordinated and immediate response to support HOPE SF residents exposed to violent events is critical to help children and families engage in positive coping strategies in the aftermath of these traumatic experiences.

Recommendation #2: Long term, sustained investment in comprehensive, coordinated and flexible services are needed. Enact policies that support family well-being and dismantle those that undermine family mental health and further structural inequities.
The goal of HOPE SF is not just to rebuild the communities, but also to revitalize them. After decades of isolation and poverty, long-term commitment and investment is needed to affect change. These communities have a history of projects or services that may be great but are discontinued because of lack of funding. The investment should be long-term, with funding commitments at a minimum of five or ten year to ensure mental health programs and services do not disappear after their first year in operation. Additionally, investments should be data driven and responsive to the needs of the community. According to one key stakeholder, *"Data and outcomes…can help us direct monies properly. Then we can bring it to….funders 'this works, this makes a better community for all of us.'"* At the same time, it is important to note that these communities have been targeted as the subject of many research projects so future assessments and data collection efforts must be tailored to avoid being duplicative. A meaningful commitment to revitalization includes more than just financial investment. Furthermore, addressing policies that undermine mental health and wellbeing of children and families who live in HOPE SF communities is critical. Rigid funding parameters; restrictive rules; and, structures and systems that harm more than they help, need to be addressed. This type of policy reform requires leadership, vision and coordinated action by City departments and agencies.

Community Engagement

Recommendation #3: Engage in community building activities that foster social connections and provide opportunities for mutual support. In particular create safe spaces that support family interaction and also nurture caregivers.

Community building activities at the HOPE SF sites already have demonstrated impact on residents and their role in creating a connected community that supports resident emotional well-being. Activities such as walking clubs, group physical activities, gardening, social events and support groups are all activities which cost little and can make a tremendous difference in the lives of residents. In particular, activities and a space that provide families an opportunity to be together in a fun and supportive environment is greatly needed at all of the HOPE SF sites. As one resident stated, *"No matter how crazy the household may be or how hot it's been as far as violence for the past few weeks that people can go somewhere and know that they're safe, [interact] with each other, [so] parents with other parents, kids with other kids."* Another resident went on to say, *"There should be something like that, that families can come to and just talk to each other and be open and be real. If there was something like that I would definitely take them to that. Where they can be with their kids and be open about what stresses them out and they can relate to other people and give them advice to each other on what could help them not stress too much about their situation."*

These types of activities should be regarded as essential to protecting and promoting the mental health of HOPE SF residents and should be provided the necessary support to be replicated and expanded at all HOPE SF sites. In addition, organized off-site trips can provide a respite from everyday neighborhood stresses for residents. These trips can foster family and community bonding, and provide an opportunity for children to engage in safe and educational activities outside their community. Many residents feel that just "*getting away for a day*" could significantly reduce their stress levels and mitigate their isolation from the rest of San Francisco. Moreover, residents would have a chance to experience an environment different from their own neighborhood, giving them a chance to explore other places. Some of the places mentioned were local destinations such as the San Francisco Exploratorium, Monterey Bay Aquarium, museums and local beaches, as well as farther destinations. These trips should be free and open to everyone in the community.

Recommendation #4: Support relevant and engaging outreach to inform individual residents about available mental health services while working at a community level to de-stigmatize and demystify mental health care.

There is a need for more outreach from service providers to promote available mental health services. Both offsite and onsite services need to increase their community presence and education activities. Outreach is necessary to inform residents of the services offered

and how to access services. Fears about lack of confidentiality must be addressed. Outreach would also help build relationships, trust and rapport with residents in HOPE SF communities. Community-wide strategies to combat stigma should be generated through a collaboration of HOPE SF site staff, resident leaders and local service providers. Efforts to address community norms, provide information and make services relevant and accessible is needed.

Recommendation #5: **Mental Health services must address staffing issues that have a significant impact on resident access and utilization of services including relevance, training and support of staff.**

- **As much as possible**, **mental health programs should hire staff that have direct understanding of community experiences; are relatable to the HOPE SF residents they serve; and, are sensitive to cultural norms.**
  Residents feel that staff that are more relatable or familiar with the issues in their communities would make services more welcoming and trustworthy. One caregiver said that residents "…*just need someone to talk to them…Somebody that they can just open up to. Not feel like they are being judged. Not like a therapist or I don't know what you would consider that, but just somebody they can honestly just talk to and let it all out and be real with.*" Relatable staff are seen as more approachable and comfortable to talk to for residents. Staff who are familiar with the issues that current HOPE SF residents are going through can also feel more equipped and prepared to work with this population because they understand their specific needs.
- **Consistent staffing should be ensured and the use of temporary clinicians and interns should be minimized.**
  As much as possible service providers who work with HOPE SF residents should be long-term staff. Consistency over time is a critical aspect of building trust and rapport. Although training programs provide less expensive and readily available staff, their temporary nature is challenging for residents.
- **All staff should receive support for their own stress and traumatic experiences. In addition, they should participate in training in trauma informed approaches.**
  Program managers should make it a priority to support their staff about their own trauma, whether it is group debriefings, one-on-one supervision, or another method. Trainings should be provided initially when staff members start their job and on a regular basis, with the aim of developing skills to deal with violence and minimize risk. It is not fair to just assume or demand that a front line staff member has "street smarts" or "common sense." These skills should be taught and supported for staff.

Recommendation #6: Support peer-to-peer mental health activities including peer navigation and peer led community building activities.

Resident leaders in HOPE SF communities were found to be the most trusted source of support for residents. By increasing the number of trained leaders in HOPE SF communities, there could be more supportive responses to stress and trauma. Furthermore, peer navigators could act as guides for residents struggling to manage the complicated mental health and social services systems. Residents who have successfully traversed these systems could be hired and trained to serve in this role and be paired with an individual or family who needs assistance. Resident leaders can also serve as organizers and facilitators of community building activities. Finally, engaging resident leaders in modeling mental health and wellness self-care can also aid in de-stigmatizing mental health and promoting self-care care behaviors among residents.

Recommendation #7: **Develop an on-site, inclusive Community Center for the whole family that provides "embedded" mental health services and a variety of wellness resources to promote positive relationships and the well-being of residents.**

HOPE SF residents want a free, on-site, one-stop, all-inclusive center for the whole family. They desire a center that will provide easily accessible resources for residents. Integration of services and recreational activities has been identified as a crucial part of what would make the center work for residents. Programs would include a variety of classes, support groups, therapy, and social activities designed to promote positive relationships and foster well-being. As one resident expressed, "*If there was a place up here we could come to that would be nice...I don't know where to send them for help. I need help myself and I don't know where to go.*" Specifically, this center should have groups and classes for community members of all ages and include staff and resident leaders who reflect the community. In particular there should be more nontraditional types of services and resources with the purpose of decreasing residents' stress and residents should be involved in the selection and planning of these groups.

In addition, to support the mental well-being and stress reduction of residents in the HOPE SF communities, residents need access to an integrated team of mental health service providers that should also be located at and "embedded" at the Community Center and other community programs. One key stakeholder noted "*I think that if services can be co-located with other services, whether it's job training, childcare, anytime a service is located in the path of daily life it becomes easier to access those services.*" Further discussion and examination of best practices is needed as little information is available in the existing literature or was gleaned from these interviews about how to effectively embed services.

Recommendation #8: Provide case management to HOPE SF families to assess their ongoing needs, improve service planning and coordination, and promote sustained mental health and well-being.

A number of key stakeholders identified the need for case management to bridge the gap between mental health services and residents accessing services. San Francisco has many mental health resources, but residents often have difficulty accessing these services. Ideally, there should be a case manager for each home to provide a deeper needs assessment of the household. This assessment will more adequately align HOPE SF residents with services that complement them. One key stakeholder explained, *"Resources aren't always matched with where the needs are. [It is important to] evaluate the needs and particular specialties of the provider so there is a match...."* Being able to improve the link between residents and available services will help to improve ongoing care. Case managers could also bring services to individual family members and in turn, provide support to the family as a whole. Adopting a child-centered approach may encourage parents to engage with service providers.

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