Behavioral Health Services for People Experiencing Homelessness

San Francisco Health Commission Community and Public Health Committee, April 16, 2019

San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Patient Story

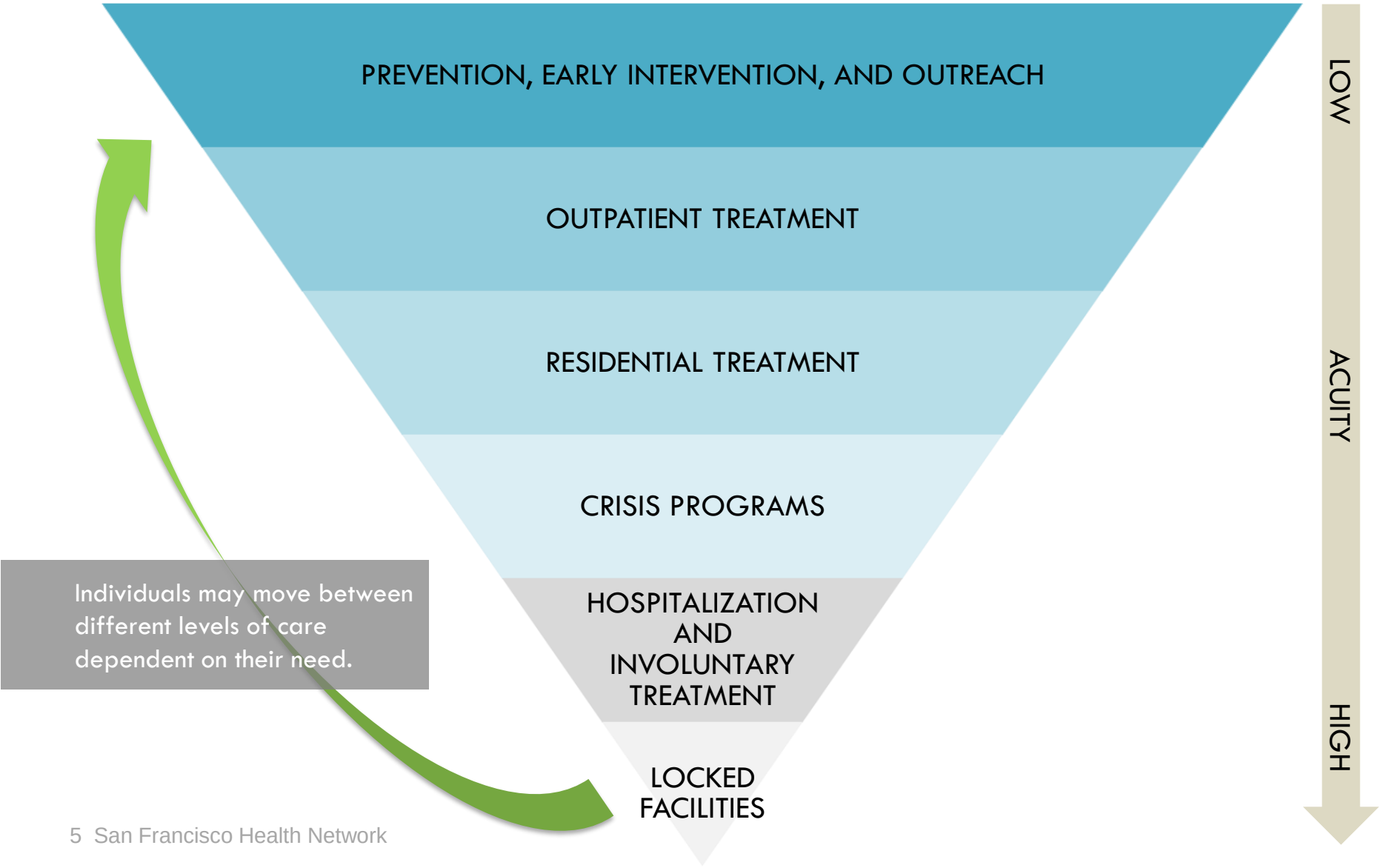
Overview

- Over 13,000 individuals experiencing homelessness served in Fiscal Year 17/18
- "No wrong door"
  - Clients are seen when and where they access services
  - Referrals and connections to behavioral health services, housing, and benefits as appropriate
- "Meet people where they are"
  - DPH: Street Medicine, Engagement Specialists, Mobile Crisis
  - HSH: SF Homeless Outreach Team, Encampment Response Team, Larkin and HYA (Youth), Mobile Access, Family Access Points, Adult Access Points
  - HSA: benefits screening and enrollment at Navigation Centers, shelters, Access Points
  - HSOC: interagency approach for outreach and response

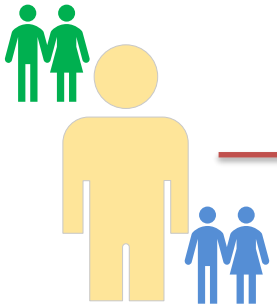
Roles and Collaborations

- **Public Health** – Provide medical and behavioral health services
- **Homelessness and Supportive Housing** – Outreach, shelter, housing, support services
- **Department of Human Services & Department of Aging and Adult Services** – Benefits linkages, case management and conservatorship
- **Police Department** – Outreach, refer to services, or detain
- **Departmental Collaborations**
  - HSOC
  - Whole Person Care
  - Interagency Prioritization Workgroup
  - Coordinated Entry Mobile Access Points

Behavioral Health Spectrum of Care



Substance Use Scenario: John

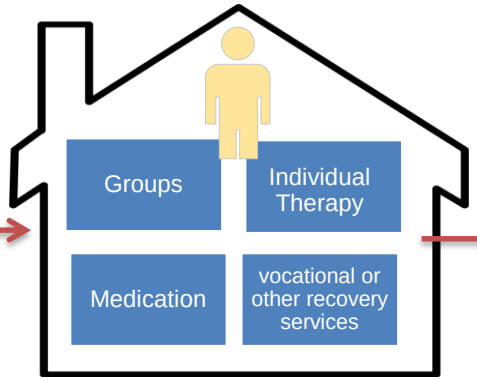


SF HOT engages with John to refer him to Coordinated Entry Access Point.

DPH **engagement specialists also** approach John, who struggles with substance use and lives on the streets of the Tenderloin, for weeks.

John decides after many attempted referrals that he would like treatment and willingly goes to DPH **Treatment Access Program** (TAP)

TAP completes level of care assessment and refers to substance use residential treatment program

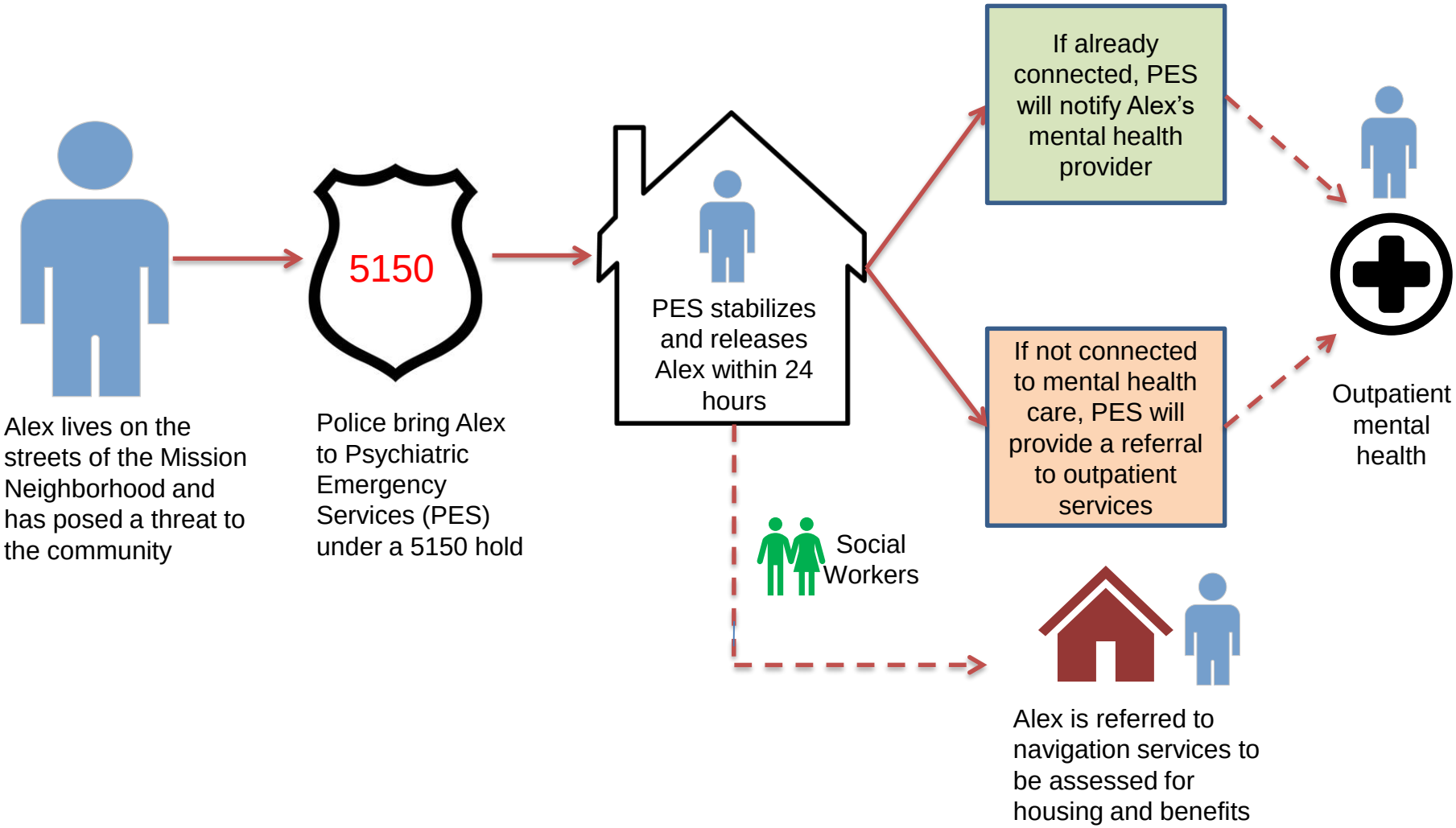


Residential Treatment Program

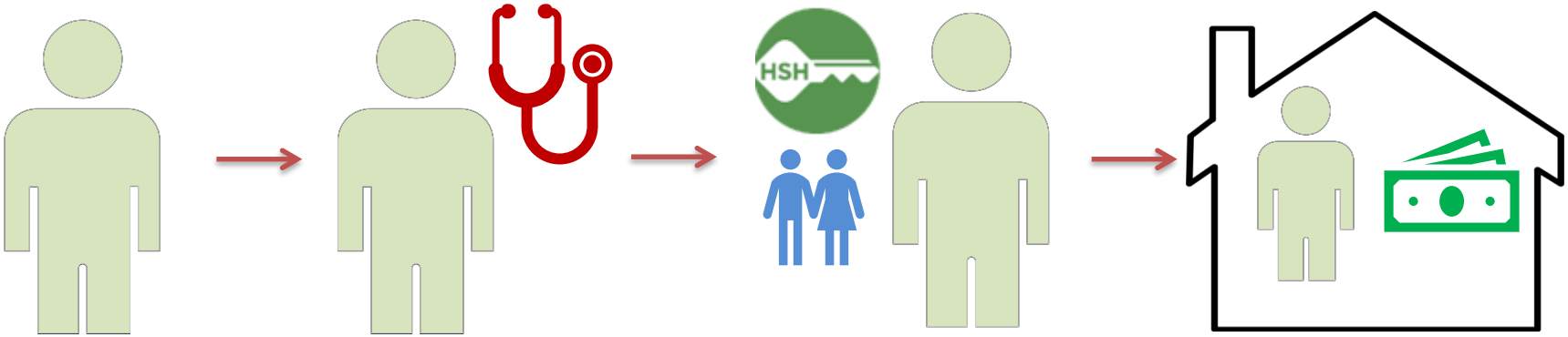
John is placed in Recovery Residences for temporary housing to aid his recovery

Outpatient Behavioral Health

Crisis Scenario: Alex



Physical Health Scenario: Maria



Maria is living on the streets of SOMA and has open sores on her legs.

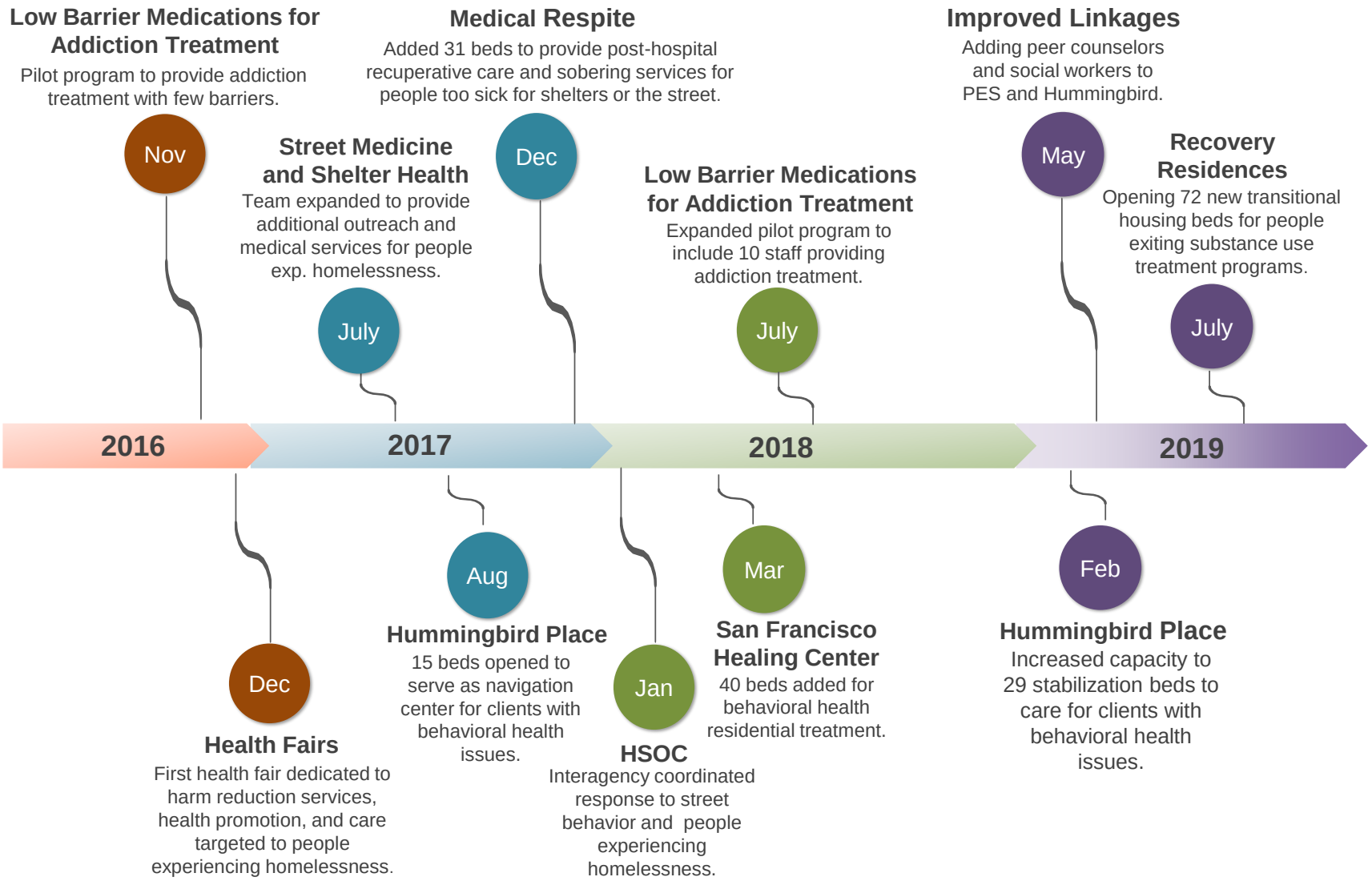
DPH Street Medicine nurses encounter Maria and address her medical needs.

SF HOT, working alongside Street Medicine, refers Maria to a coordinated entry access point.

Maria is assessed by Coordinated Entry and is assigned priority status. Maria is screened for benefits eligibility and assigned a Housing Navigator/ Stabilizer who places her in permanent supportive housing and provides housing stabilization follow up care.

Street Medicine refers Maria for ongoing primary care services.

DPH Investments and Initiatives 2016-2019



Questions

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