The Mission District of San Francisco is a diverse neighborhood with substantial populations of immigrant families from Mexico and Central America; artists, activists, and other people living alternative lifestyles; young dot-com professionals; and a high concentration of homeless people (Little & Murray, 2005). The community has a similarly diverse population of poor and socially vulnerable individuals, including homeless people, people with a mental illness, drug users, undocumented immigrants, and sex workers. Historically, there has been a severe shortage of publicly funded social, mental health, and medical services in the Mission District. In 1999 a group of community nonprofit service providers, advocacy groups, and concerned neighbors called for a drop-in center to serve the Mission District's poor and vulnerable population. With such diverse populations coexisting in one neighborhood, the best approach to starting a resource center was a coalition of agencies representing the needs and concerns of various constituencies. Such a coalition was formed in 1999, consisting of representatives from community-based organizations, including Mission Mental Health, Mission Council for Outpatient Substance Abuse, Mission Neighborhood Health Center, Mission Housing Development Corporation, Mission Agenda, the Mayor's Office on Homelessness, the Department of Human Services, and the Department of Public Health.

GENESIS OF THE MISSION NEIGHBORHOOD RESOURCE CENTER

There were many hurdles to overcome before the opening of the Mission Neighborhood Resource Center (MNRC), including start-up funding, developing a model that could be sustained over time, finding a mutually agreeable location, and meeting the concerns of the diverse neighborhood. At the time, Mayor Willie Brown's office was supportive of creating drop-in centers for homeless individuals throughout San Francisco and committed a grant of $711,000 (renewed every three years), administered by the San Francisco Human Services Agency (SFHSA), to pay for the core drop-in services. Furthermore, the San Francisco Community Clinics Consortium Health Care for the Homeless Program committed $280,000 a year to support medical and dental services at the MNRC. Given ever-changing budgetary priorities in San Francisco, coalition members felt it was important to establish a service model that could weather potential budget cuts. The result was that existing service agencies, with their own funding, agreed to provide services on-site at the MNRC. This gave agencies easy access to a client base and made multiple services available at MNRC, without necessitating a separate funding stream. Nearly a half-million dollars worth of in-kind social services are provided at MNRC each year. Given the difficulty of coordinating services in a population with multiple needs, this was a beneficial model for the MNRC, the participating service agencies, and the homeless population (see Table 1 for a complete list of collaborators and services provided).

Securing Space

Once a plan to create the MNRC coalesced and funding was secured, finding an appropriate location for the MNRC was a challenge. The coalition went through a three-year process of negotiation with concerned neighbors, parent groups, and a local school around each potential site. The primary concern of individuals and business owners was that the neighborhood homeless population would increase as a direct result of the establishment of the resource center. The coalition worked tirelessly, reaching out
Table 1: Services Provided by Collaborating Agencies

<table>
<thead>
<tr>
<th>Collaborating Agency</th>
<th>Services Provided (Funding Source)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>Confidential HIV counseling and testing (in-kind)</td>
</tr>
<tr>
<td>La Clínica Esperanza of the Mission Neighborhood Health Center</td>
<td>Technical assistance and support for the health clinic and a part-time nurse practitioner (in-kind)</td>
</tr>
<tr>
<td>Housing and Urban Health Section, San Francisco Department of Public Health</td>
<td>Drop-in dental care (SFHSA and in-kind)</td>
</tr>
<tr>
<td>Native American Health Center</td>
<td>Acupuncture and other wellness services (SFHSA and in-kind)</td>
</tr>
<tr>
<td>Quan Yin Healing Arts Center</td>
<td></td>
</tr>
<tr>
<td>Mental health</td>
<td></td>
</tr>
<tr>
<td>Mission Council on Alcohol Abuse for the Spanish Speaking, Inc.</td>
<td>One full-time case manager/substance use specialist (SFHSA)</td>
</tr>
<tr>
<td>Mission Mental Health Services, SFDPH, Community Mental Health Services</td>
<td>Clinical supervision and training to the case manager/mental health specialist and technical assistance and training on mental health issues (in-kind)</td>
</tr>
<tr>
<td>Psychiatric Foundation of Northern California</td>
<td>Two full-time therapists, one half-time psychiatric nurse practitioner, and a psychiatrist four hours a week (began in-kind, now California endowment)</td>
</tr>
<tr>
<td>Harm Reduction Therapy Center</td>
<td>Clinical supervision for therapists (California endowment)</td>
</tr>
<tr>
<td>Women’s support services (Ladies’ Night)</td>
<td>Hygiene supplies (in-kind)</td>
</tr>
<tr>
<td>Women’s Community Clinic</td>
<td>Syringe exchange services (in-kind)</td>
</tr>
<tr>
<td>San Francisco Needle Exchange</td>
<td>Chair massage (in-kind)</td>
</tr>
<tr>
<td>Care Through Touch</td>
<td>Hot meals (in-kind)</td>
</tr>
<tr>
<td>Metropolitan Community Church</td>
<td>Technical assistance and training on leadership development and SRO-related issues and opportunities for community building and organizing (SFHSA)</td>
</tr>
<tr>
<td>Staff training</td>
<td></td>
</tr>
<tr>
<td>Mission SRO Collaborative</td>
<td></td>
</tr>
</tbody>
</table>

Notes: SFHSA = San Francisco Human Services Agency. SFDPH = San Francisco Department of Public Health. SRO = single room occupancy.

to neighbors who opposed the project. Community events, at which there were opportunities for questions to be answered and concerns to be addressed, were critical in leveraging support and addressing fears of those opposed to the center. In early 2001 the city of San Francisco acquired a 10-year lease on what was previously a two-story sewing shop, and construction began.

Funds from the SFHSA grant paid to completely gut and renovate the building according to the vision of the program. All drop-in services are located on the first floor, which facilitates ease of access; the medical clinic and administrative offices are located on the second floor. Key to the neighborhood acceptance of the facility was the creation of an open-air smoking area on the second floor of the building, which addressed neighbor’s concerns about loitering on the street in front of the building.

PROGRAM DESCRIPTION

Mission and Values
The mission of the drop-in center is to provide a safe, clean space; support; and services for homeless communities in the Mission District. The MNRC seeks to meet the needs of program participants by building trust, facilitating the reduction of harms, and encouraging individual- and community-level change. The primary goals of the MNRC are to advocate for housing and shelter and to enhance the physical, social, emotional, and economic health of program participants and the neighborhood. The MNRC is committed to community participation and community organizing throughout all levels of the organization and is dedicated to treating each individual with dignity and respect.

The MNRC is a multicultural, bilingual center that provides services within a harm reduction framework (Des Jarlais, 1995). It is a “low-threshold” program with minimum requirements for participation. For example, clients are not required to be sober to enter the facility. They may spend time in the center without formally engaging in any services. Providers have a pragmatic attitude toward sex and drug use, acknowledging that not all individuals who engage in high-risk behaviors are interested in, willing to, or able to abstain
completely from risks. The goal is to reduce health, social, and economic harms associated with substance use and other high-risk behaviors, however possible. Program participants are encouraged to participate not only in individual change, but also in community and social change as well. Within this model, the multidisciplinary staff provides survival, health, support services, and a structure for community organizing.

**Client Population and Staff at MNRC**
The MNRC opened its doors in July 2002, with the expectation that the program would serve 75 people per day. Currently, 250 people use the program per day, exceeding everyone's expectations. Although the Mission District has been historically a Latino neighborhood, the homeless and marginally housed population living in the neighborhood is diverse. Many African American, Latino, and white men and women use the MNRC. A substantial transgender population also uses the MNRC. Staffing the MNRC with bilingual personnel who have had experience working across races and gender identities and with heavy alcohol users and drug users has been essential. Ongoing staff trainings (provided in-kind and as part of a grant from the California endowment) regarding overdose prevention, violence prevention and de-escalation, safety, and other issues affecting homeless individuals has helped staff members increase their skills to work safely and effectively with the diverse client population.

The MNRC emphasizes the importance of peer advocacy and staffs the drop-in area of the center with peer advocates, who have life experiences similar to the clients who use the program. Peer advocates bring a special understanding of client issues to service delivery. The shared experiences of the client and the peer often help to establish positive relationships, thus facilitating the success of the program.

**Program Components**
MNRC program components include survival and basic needs services, medical clinic, peer-support services, mental health services, and a variety of community building and community organizing programs. All services are free. When clients have Medi-Cal (California’s Medicaid program) or Medicare, health and mental health care services are billed when appropriate.

Survival services, funded by the SFHSA grant, are available in the drop-in area. Peer advocates ensure a welcoming environment, develop relationships with program participants, make shelter reservations, make sure the showers and laundry are used in an organized fashion, and provide referrals to in-house and citywide services. Basic needs services, including bathrooms, lockers, hygiene supplies, and telephones, are also available in the drop-in area. These services are the most heavily used.

The drop-in medical clinic, funded primarily by the San Francisco Community Clinics Consortium Health Care for the Homeless Program and the San Francisco Department of Public Health, provides one nurse practitioner in-kind. The clinic is staffed by a nurse manager, two nurse-practitioners, and a clinic assistant. It operates three days per week, offering wound and abscess care, tuberculosis screening, vaccinations, flu shots, STD testing, acupuncture, HIV testing, dental referrals, homeopathy, and referrals for medical and methadone detox. Medications to treat foot and skin problems, coughs, headaches, mild pain, and asthma are dispensed at the clinic, and medication management is available for clients who need a safe place to store their medications.

Support services include case management, support groups, psychotherapy, and psychiatric care funded by the SFHSA grant and funding from the California endowment. Case managers help program participants with housing applications and referrals, immigration matters, and compilation of documentation for public benefits eligibility. The Psychiatric Foundation of California staffs the resource center with a mental health team, whose services originally were donated in-kind but evolved into a collaboration with the Harm Reduction Therapy Center funded through the California endowment. The mental health team works with program participants on issues related to drug and alcohol use, anxiety and depression, and other mental health problems. Depending on need, clients can attend a mental health or harm reduction support group or meet with a therapist or a psychiatrist for ongoing care.

Programs that focus on community building and community organizing are a distinctive element of the resource center. For example, every Thursday night is “Ladies’ Night” at MNRC. All Ladies’ Night services and programs are provided in-kind. At this women-only social program, women have an opportunity to eat a nutritious meal, work on art projects, listen to music, or just relax. In addition,
services such as syringe exchange, hygiene supply
distribution, massage, medical clinic, and HIV test-
ing are provided at Ladies' Night. Hosting regular
community education workshops and events that
are fun and informative and address the concerns
of the client community has become fundamental
in strengthening bonds between program partici-
pants and MNRC staff. These events have become
forums in which there is opportunity for clients
and staff to talk about issues and look for alterna-
tive ways to relate to each other. Food and music
are always integrated into these events as a way to
attract participants and to make the occasion more
enjoyable. These events have been funded by small
grants provided by local businesses such as Rainbow
Grocery, an organic and natural food cooperative.
In addition, monthly community meetings are held
as a forum where clients have the chance to express
their needs and ideas regarding the structure of,
and their experiences with, the program. Given
that many community members are monolingual
Spanish speakers and many others have low literacy
levels, community events are an opportunity for
everyone to communicate concerns orally. The
center is committed to responding to concerns in
a timely manner.

MNRC staff and clients also participate in lo-
cal advocacy efforts regarding issues that affect
the MNRC community. Housing and shelters have been
the main focus of advocacy and organizing efforts.
There have also been strong efforts to address safety,
neighborhood relations, criminalization, and civil
rights. MNRC is a member of several progressive
neighborhood and citywide networks promoting
housing and shelters, community services, and harm
reduction policy.

LESSONS LEARNED
During the first year of operation, a multitude of
programmatic possibilities were proposed by clients,
staff, collaborators, and neighbors and program staff
attempted to provide as many services as possible.
Because of limited resources (financial and staffing), it became evident that the program needed to
narrow the focus of service delivery and increase
the focus on growth in a few strategic directions.
Thus, after its first year and a half of operation, the
MNRC management team instituted a formal pro-
gram prioritization process. Each year, the manage-
ment team and staff meet to refresh and affirm the
mission and principles of the MNRC, review the
accomplishments of the previous year, and create a
plan for the upcoming year.

Improving Services for Subpopulations
As a result of information obtained from surveys
filled out by program participants, concerns voiced
at community meetings, and individual requests for
services, it became apparent that addressing the needs
of specific subpopulations who use the MNRC
needed to become a program priority. For example,
the MNRC staff recognized that monolingual Span-
ish-speaking clients who suffer from depression,
anxiety, and other mental health problems experi-
enced difficulty navigating the mental health system
and rarely received the care they need. Subsequently,
the MNRC, in collaboration with the Psychiatric
Foundation of Northern California and the Harm
Reduction Therapy Center, applied for and received
an endowment that supports two full-time therapists,
a psychiatric nurse-practitioner, and clinical supervi-
sion. These funds are used to provide monolingual,
Spanish-speaking homeless clients with culturally
and linguistically competent mental health services
within a harm reduction framework.

Safety
Staff and client safety was not adequately addressed
when the program was first conceived. The drop-in
area of the center was insufficiently staffed, and staff
members were overwhelmed by the sheer volume
of clients and the sometimes hostile behavior they
encountered during their work day. During the
prioritization process, safety emerged as a top con-
cern. Funds to hire an additional staff member were
secured, and intensive trainings around safety issues
were conducted. In addition, community events
were organized to increase clients’ “ownership” of
the program.

Sustainability
During the resource center’s third year of operation,
budgetary constraints and limited resources forced
the resource center to focus prioritization planning
on sustainability. This plan included limiting services
(number of hours of operation and available time for
use of showers and laundry), fostering positive rela-
tionships with neighbors, enhancing the role of peer
advocates, community organizing, and fundraising.
The biggest lesson and challenge has been to balance
tremendous need with available resources. Originally
designed and funded to serve 75 clients a day, the
MNRC has seen nearly 250 clients a day since the day it opened. Originally the resource center was open Monday thru Saturday from 7 A.M. to 7 P.M., and showers and laundry were available whenever the resource center was open. Saturdays were the most difficult days to staff. Running laundry and bathroom services all day, every day, required much staff time, and the energy bills were unmanageable. To cut costs and free up staff time, the program decided to close on Saturdays and limit the hours for showers and laundry to alternating mornings or afternoons. Consequently, energy bills have decreased and the peer advocate staff now has more time for positive engagement with clients.

**Community Organizing**

Community building and organizing is central to the mission and core values of the MNRC. This component of the program was slow to take hold during the first years, when the focus was on service provision. However, a dramatic shift in city policies regarding poverty and homelessness in 2004 compelled the MNRC staff to make community organizing a priority. One proposed city policy was to close multiple neighborhood homeless shelters. This policy disproportionately affected the large Latino homeless community. The MNRC was the only homeless services organization in San Francisco to have a community organizer on staff, and one of a few homeless services organizations whose mission includes community organizing. Therefore, MNRC, together with social justice groups and several other activist homeless services organizations, played an important role in resisting and reforming the policy. Because of strong community organizing efforts, what started as a proposal to close shelters ended with the city agreeing to reopen shelters, enhance shelter budgets, and create an innovative new immigrant housing initiative. This experience demonstrated to the MNRC the necessity of having a strong community organizing component to protect, enhance, and advocate for the rights and services for homeless communities. As a result, the MNRC continues its organizing efforts and has made fundraising to hire another community organizer a priority.

**Enhancing Peer Advocacy**

The peer advocate role was initially stressful, with advocates spending most of their time policing the bathrooms, handing out scarce resources, monitoring the laundry area, and defusing potentially violent situations. Varying the responsibilities was one change implemented to support the peer advocates in their daily work and to reduce staff turnover. The center established two Spanish-language support groups, cofacilitated by peer advocates and case managers. By facilitating support groups, peer advocates could provide ongoing support to clients rather than police their behaviors. This change in role has further integrated the peer advocates into the MNRC support staff and made the job more satisfying.

**Neighborhood Relations**

One anticipated consequence of the opening of the MNRC was an increase in the number of homeless people congregating in the area where the program is housed. It quickly became clear that a delicate balance needed to be maintained between meeting the needs of homeless clients and property owners in the neighborhood. Staff works diligently to keep the area in front of the MNRC clean and to discourage clients from camping or congregating in front of the building. Clients are encouraged to come into the building, smoke in the designated smoking area, and leave the immediate area when they have finished their business.

The resource center now hosts quarterly neighborhood meetings. These meetings give neighbors a chance to work hand-in-hand with the resource center staff and provide a forum where neighborhood concerns can be identified and actions can be taken to address those concerns. One such concern is the limited street lighting on the block where the resource center is located. To pay for increased lighting, the neighborhood group has written a grant to cover the costs; to ensure sufficient funding, the building owners are going to match any funds raised.

Key to MNRC’s success is the prioritization process developed in the second year of its operation. The process has helped to stabilize the program by reducing program costs, assessing and making community needs a priority, increasing overall safety within the MNRC, and creating a supportive environment for staff. Resulting program stabilization has given the staff an opportunity to refocus on the center’s priorities. For example, the community programs coordinator can now dedicate much of her time to organizing a network of providers and concerned neighbors to protect the program and advocate for services. In addition, the program
director now has time to focus on fundraising and enhancing the program’s sustainability.

CONCLUSION
The MNRC has met its original goals and has been extremely successful in providing comprehensive services to homeless residents of the San Francisco Mission District. The mix of medical, mental health, substance abuse, and survival services, along with efforts to build and sustain community, make the MNRC a unique hub of activity where people are cared for and their ideas are nurtured. Community collaboration has helped with program sustainability and also ensured diversity of service delivery.

Although the program still struggles to subsist within budgetary constraints, it has successfully integrated the demands of running a high-volume, multicultural agency with the center’s core values of client participation, mutual respect, and high-quality services. By implementing a prioritization process, the center has created a system to plan for the future using creative input from staff, community members, and collaborators.

REFERENCES

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