OcYP
NEEDS ASSESSMENT

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EXECUTIVE SUMMARY

The O.U.T.Cast Youth Project (OcYP) will develop, implement, and evaluate an HIV, Viral Hepatitis (VH), and substance abuse (SA) intervention for young adults ages 18-24 living in four neighborhoods in San Francisco, California. In January 2019, in line with the SAMHSA Strategic Prevention Framework, a comprehensive needs assessment was conducted to assess the epidemiology of HIV, VH, and SA in the target population, to identify key needs and assets, to provide insight on the level of community readiness, to engage perspectives of the target population and their service providers, and to inform a subsequent strategic plan for the intervention. This report summarizes the findings of the needs assessment process. The major recommendations resulting from this process are summarized below.

Key recommendations:

1. **Align capacity expansion efforts with level of community readiness**
   Given the community's relatively high readiness to act and the availability of resources and partnerships to support the project, capacity expansion efforts should be focused on providing and evaluating evidence-based prevention services in high-risk populations (see #2).

2. **Target intervention efforts to high priority population subgroups**
   The most at-risk young adults in the target population include LGBTQ individuals (especially MSM and people who are transgender), individuals of color, PWID, and those experiencing homelessness. Recruitment of these individuals to participate in intervention activities—particularly those individuals belonging to multiple at-risk groups—should be prioritized.

3. **Place emphasis on Hepatitis C in the intervention's VH efforts**
   VH efforts should address both Hepatitis B and C; however, given the more recent emergence of HCV and the need for greater community awareness, greater focus should be placed on the dissemination of information and resources related to HCV prevention, testing, and treatment.

4. **Conduct additional focus groups and/or interviews with the target population and providers**
   The exploratory focus groups conducted in this needs assessment shed light on informative community resources and barriers to HIV, VH, and SA prevention. Further community assessment and engagement should take place early in the implementation phase to ensure that the intervention complements community needs and assets.

5. **Address both direct and indirect risk factors and gaps in services**
   Direct risk factors (such as knowledge of and attitudes toward safe sexual and injection practices), as well as more indirect risk factors, (such as the need for non-substance-related social connection, recreation, and skill-building opportunities), should be considered as targets of the intervention.

6. **Support ongoing coordination and capacity of service provider network**
   In addition to considering how SFCHC's intervention activities might fill service gaps directly—such as through expanded HIV/VH testing or educational opportunities for the target population—efforts should be made to coordinate and maintain an ongoing network of service providers for young adults. Such a network can lead to sharing of ideas among providers and may yield innovative and collaborative ideas for filling service gaps.

INTRODUCTION

The Outcast Youth Project (OcYP) is a five-year program led by the San Francisco Community Health Center (SFCHC) and funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) Minority AIDS Initiative. The program aims to **O**vercome barriers, **U**nify youth, and **T**each substance abuse (SA), HIV, and viral hepatitis (VH) prevention to young adults. The program will target at-risk young adults ages 18-24 who live in the Castro, South of Market (SOMA), Western Addition, and Tenderloin/Civic Center neighborhoods (see Figure 1).

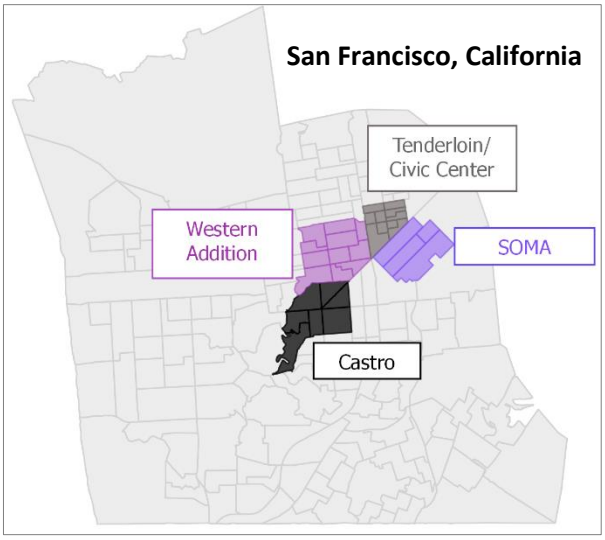


Figure 1. The four catchment area neighborhoods and San Francisco's census tract boundaries.

In line with the SAMHSA Strategic Prevention Framework, an initial needs assessment was conducted to identify and understand the needs and assets of the target population, as well as to assess community readiness to act. This report details the findings that emerged from the assessment process. These findings will inform the project's strategic plan as well as priorities for subsequent intervention development, implementation, evaluation, and continuous quality improvement efforts.

METHODS

To conduct this needs assessment, three main methods were employed:

(1) First, an epidemiological assessment (the primary method) was conducted to assess the extent of HIV, VH, and SA in the target population, as well as San Francisco more broadly. Data sources included the most up-to-date surveillance data and community health assessments from local epidemiological groups working on HIV, Viral Hepatitis (VH), and substance abuse (SA), including the San Francisco Department of Public Health (SFDPH) Population Health Division and the End Hep C SF Research and Surveillance Workgroup. When data were not available, epidemiological details were drawn from the recent peer-reviewed scientific literature.

(2) Second, an exploratory focus group with youth in the target population was conducted to learn about their perspectives on HIV, VH, and SA. The target population was also asked about the availability of existing community resources and their readiness to act.

(3) Third, feedback was solicited from service providers with expertise in providing health and supportive services to young adults from the target population. Service providers were asked for their perspectives on HIV, VH, and SA in the target population. They were also asked about community assets and their readiness to act.

HIV, VH AND SUBSTANCE USE IN THE TARGET POPULATION

1. Epidemiological Findings: HIV [i]

In 2017, San Francisco witnessed 244 deaths related to HIV and 221 new HIV diagnoses.[1] Although the number of new HIV diagnoses in San Francisco has more than halved since 2010, HIV remains an important problem. As of December 2018, there were 15,982 people (approximately 1.8% of the local population) living with HIV (PLWH) in San Francisco. HIV infections in San Francisco constitute a disproportionate amount of the HIV burden statewide and nationally, making up approximately 12% of all California cases and about 2% of PLWH in the United States.

1A. Magnitude of HIV in the geographic catchment area

The impact of HIV varies spatially across San Francisco. Notably, the catchment area neighborhoods for this intervention—Castro, Western Addition, Tenderloin, and South of Market (SOMA)—are among the areas most impacted by HIV city-wide. As shown in Figure 2 (see dark blue shaded areas), HIV prevalence in 2017 was highest in these four neighborhoods. More specifically, prevalence in the Castro was the highest city-wide (8,468 per 100,000), followed by the Tenderloin (4,160 per 100,000), SOMA (3,730 per 100,000) and Western Addition (3,384 per 100,000).

Map 19.2 HIV prevalence per 100,000 population by neighborhood, 2017, San Francisco

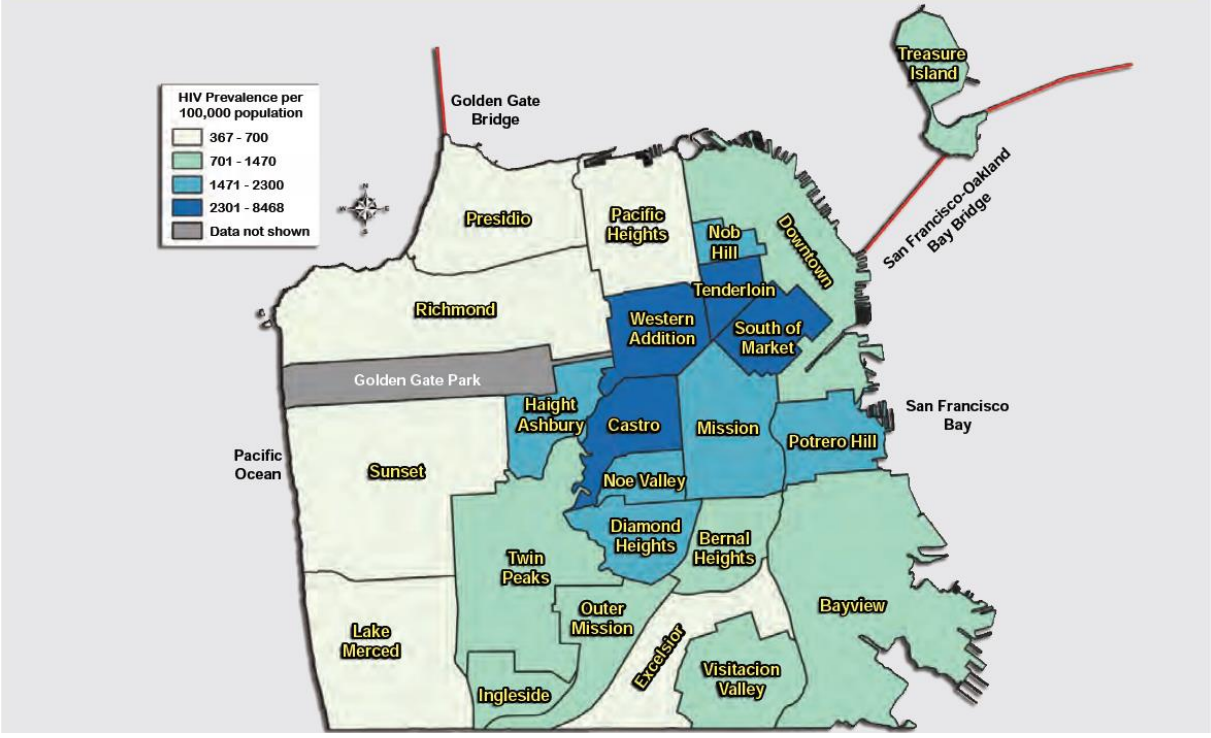


Figure 2 from the San Francisco Department of Public Health 2017 HIV Epidemiology Annual Report.[1] Individuals experiencing homelessness and individuals with unknown or invalid addresses are not represented.

[i] Unless otherwise cited, HIV epidemiological data in this section came from the San Francisco Department of Public Health's (SFDPH) 2017 HIV Epidemiology Surveillance Report (citation 1); see References for more information.

Interestingly, although the Castro had the highest prevalence of HIV in 2017, mortality was higher in the Tenderloin and SOMA neighborhoods than in the Castro. This disparity may be explained by lower rates of viral suppression as well as lower rates of linkage to care in the Tenderloin and SOMA.

With regards to HIV incidence, three of the four catchment area neighborhoods were in the highest quartile of HIV incidence from 2016- 2017. The Castro had the highest rate of new diagnoses city-wide (181 per 100,000), followed by the Tenderloin (171 per 100,000) and SOMA (136 per 100,000).

The disproportionate impact of the HIV epidemic in the catchment area—both in terms of its magnitude (i.e. prevalence) and risk (i.e. incidence) on neighborhoods—reinforces the importance of effective, evidence-based local HIV prevention efforts in this SAMHSA intervention.

1B. Magnitude of HIV in target population

In 2017, adolescent and young adults aged 13-24 years made up only a small proportion (approximately 1%, n=101) of all HIV cases in San Francisco. However, this age group made up 10% (n=23) of all new San Francisco HIV diagnoses that year (Figure 3). These data suggest that HIV prevention efforts may be particularly important among this age group, especially given that young people under 24 are the age group least likely to be virally suppressed throughout the state.

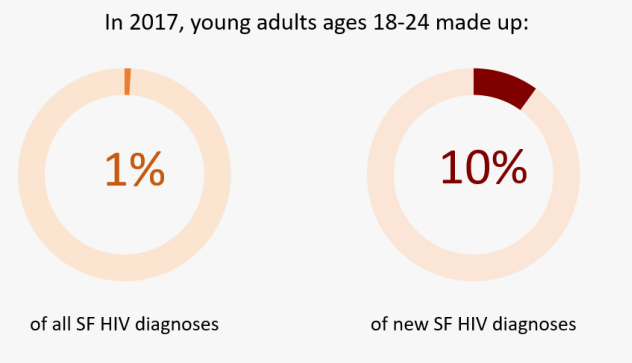


Figure 3. percent of prevalent vs. incident cases constituted by San Franciscans ages 13-24 in 2017, based on data from the SFDPH.[1]

1C. Risk factors for HIV in target population

As shown in Figure 4, of the 101 young adults aged 18-24 years living with HIV in San Francisco in 2017, a large majority (79%) are men, and the primary category of transmission (69%) is sexual transmission among men who have sex with men (MSM). In contrast, heterosexual transmission contributed to 8% of all cases. Together, MSM-PWID (people who inject drugs) and PWID made up 10% of transmissions, suggesting the role of injection drug use in spreading HIV locally.

Table 11.1 Young adults living with HIV by transmission category, gender[1], and race/ethnicity, December 2017, San Francisco

	18 - 24 Years Old	
	Number	(%)
Total	**101**	**(100)**
Transmission Category		
MSM	69	(68)
PWID	3	(3)
MSM-PWID	7	(7)
Heterosexual	8	(8)
Perinatal	11	(11)
Other/Unidentified	3	(3)
Gender[1]		
Men	79	(78)
Women	20	(20)
Race/Ethnicity		
White	26	(26)
African American	23	(23)
Latino	33	(33)
Asian/Pacific Islander	11	(11)
Multi-race	8	(8)

1 Data on trans women and trans men are not released separately due to small numbers. See

Figure 4 from SFDPH.[1] Characteristics of young adults living with HIV in 2017.

In terms of demographic variability among young adults with HIV, a disproportionate number were young adults of color—particularly Black and Hispanic or Latino young adults. For example, while only 6% of San Francisco residents were Black, Black individuals made up 23% of young adults living with HIV. Similarly, while Hispanic or Latino individuals constituted 15% of the San Francisco

population, 33% of young adults living with HIV were of Latino ethnicity. The racial/ethnic distribution of HIV among young adults may reflect broader HIV epidemic trends in San Francisco, in which decreases in the number of new diagnoses have occurred more rapidly in White individuals than in Black and Latino individuals since 2012.

Besides race and sexual identity, belonging to other marginalized groups may increase risk of HIV among young adults. For example, although transgender women only make up 0.1% of the population of SF,[2] transgender women made up 3% of all San Francisco residents diagnosed with HIV between 2006 and 2017 in SF. When compared to all PLWH in San Francisco, transgender women were more likely to be non-white, PWID, and younger, with 43% of newly diagnosed transgender women 18-29 years old.

Housing stability may also influence HIV risk among young adults. In 2017, 14% (n=31) of new HIV diagnoses in San Francisco were among people experiencing homelessness. People experiencing homelessness at the time of HIV diagnosis were more likely to be women, trans women, African American, PWID, and MSM-PWID. In addition, young adults aged 18-24 made up a relatively high proportion of all homeless diagnosed persons when compared to the proportion of all San Francisco young adults living with HIV. Housing stability may interact with the use of injection drugs (a risk factor for HIV), as chronically homeless individuals are at disproportionate risk for substance abuse. [3] Moreover, homeless individuals are less likely to be virally suppressed and to have a longer time from diagnosis to suppression.

2. Epidemiological Findings: Viral Hepatitis

2A. The magnitude of Hepatitis C (HCV) in San Francisco

Although its epidemiology in SF has not been as well-studied as HIV, hepatitis C (HCV) has recently garnered attention due to increasing prevalence attributed to the opioid epidemic. As a result, many groups are attempting to better quantify HCV's prevalence and incidence. A recent study conducted by members of San Francisco's End Hep C SF Research and Surveillance Work Group estimated the seroprevalence of HCV to be 2.5% (credible range: 1.2%-4.9%), which is higher than the national percentage (1.7%). Of the seropositive individuals in San Francisco, 16,408 individuals (approximately 2%) are expected to have viremic (i.e. untreated and transmissible) infection.[4]

2B. HCV risk factors in target population

As shown in Table 1, men make up more than two thirds of San Francisco's HCV seropositive population, and approximately 38% of seropositive individuals are Baby Boomers (aged 50-69 in 2015). Notably, although the absolute number of transgender women in San Francisco is small (0.1%),[2] seropositivity in this group is high, with approximately one fifth of women having seropositivity.[4]

Table 1, adapted from Facente et al. 2018.[4] HCV in San Francisco subgroups (point estimates only; see article for more detail).

Population subgroup	# HCV seropositive	% HCV seropositive	% of HCV seropositives
PWID	14,441	59.0%	66.4%
MSM	3,057	4.4%	14.0%
TW (low SES)	211	22.1%	1.0%
Baby Boomers[A]	8,305	4.4%	38.2%
Men	15,745	3.8%	72.4%
Women	5,803	1.5%	26.7%

A. Ages 50-69 in 2015.

MSM also had higher than average seropositivity of 4.4%, making up 14% of the HCV seropositive population.[4] However, the San Francisco subgroup at highest risk for HCV is the population of people who inject drugs (PWID), with more than half of PWID seropositive for HCV. As shown in Figure 5, PWID make up two thirds of all individuals seropositive for HCV despite the fact that they constitute less than 3% of the total SF population.[5] Geographically, PWID are concentrated in the catchment area of this project; in 2015, nearly a third (31%) of PWID resided in the Tenderloin, and nearly a quarter (24%) in SOMA.[6]

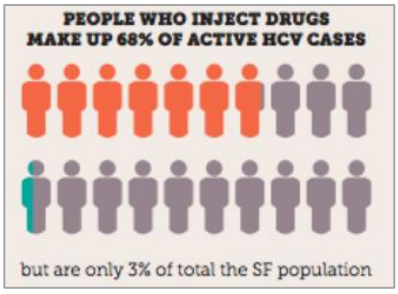


Figure 5, adapted from EndHepCSF.[5]

Although limited data exist on HCV infection in San Francisco's general population of young adults, HCV infection in young adult PWID < age 30 has been studied extensively by the San Francisco UFO Study, a nearly two decades-long community-based epidemiologic study of HCV infection in more than 1500 young adult PWID. In 2013, the study estimated overall incident HCV to occur in approximately 31% of young adult PWID. Among young adult PWID, the risk of HCV infection was significantly higher in those injecting heroin/heroin mixed vs. speed/cocaine/crack in the past month, in those who injected daily vs less than daily, and in those who shared needles and injecting equipment in the last 3 months.[7]

2C. The magnitude of and risk factors for Hepatitis B (HBV) in San Francisco

A recent epidemiological study conducted in the San Francisco Bay Area found that, among 12 Bay Area counties, San Francisco had the highest prevalence of HBV infection, making up more than 14% of Bay Area infections with more than 15,000 people (nearly 2% of the San Francisco population) infected.[8] Individuals under the age of 29 made up approximately 13% of the burden in the San Francisco Bay Area, and the Asian and Pacific Islander community experienced HBV at a disproportionate rate that was 3% higher than the national average.[8] The San Francisco Department of Public Health has noted that MSM and PWID are at high-risk and has prioritized vaccination efforts among these groups.[9]

2D. The magnitude of and risk factors for Hepatitis A in San Francisco

Hepatitis A has garnered less attention than HCV and HBV in San Francisco, due to its non-chronic nature, distinct mechanisms of transmission, and relatively rare occurrence. However, in 2017, the city turned attention to Hepatitis A prevention efforts amidst California outbreaks of Hepatitis A and the subsequent state of emergency declared by the California governor.[10] San Francisco launched a Hepatitis A vaccination campaign to target the groups most at-risk, with an emphasis on the homeless and drug using communities.[11]

3. Epidemiological Findings: Substance Use

2A. Trends in substance use and its consequences among San Francisco residents[12]

In 2015, the most common drugs seized by the San Francisco Police Department were cannabis (15%), heroin (12%), methamphetamine (11%), cocaine (6%), and morphine (5%). When considering the 10,191 substance-related treatment admissions in San Francisco in 2015 (Figure 6), heroin was the most common primary substance of abuse, making up 41% of treatment admissions. Alcohol was the next most common substance of abuse, making up of 22% of treatment admissions. Methamphetamine was the third most common substance of abuse, making up 14% of treatment admissions. Cocaine, marijuana, and prescription opioids were responsible for a smaller number of treatment admissions.

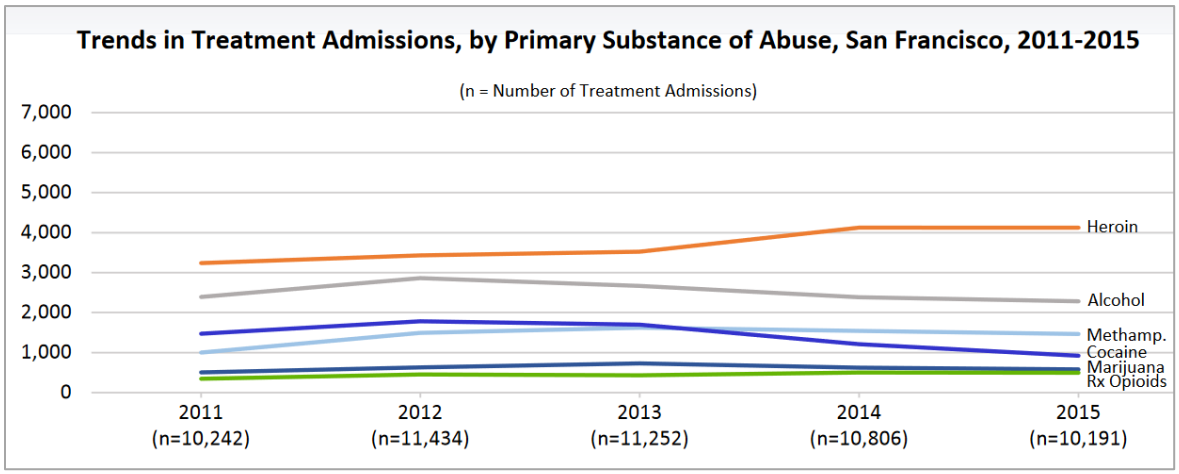


Figure 6, from National Drug Early Warning System (NDEWS), 2016.[12]

When considering trends in drug use over time (also shown in Figure 6), the use of alcohol, marijuana, cocaine, and benzodiazepine in San Francisco were relatively stable in 2015 in comparison to previous years. In contrast, the use of methamphetamines and opioids were rising. With respect to methamphetamines, substance use disorder treatment admissions, hospitalizations, and deaths have increased. Use of methamphetamine is common among homeless and marginally housed individuals, and it is estimated to be used by a third (34%) of the 22,500 PWID in San Francisco. With regards to opioids, heroin use appears to be increasing, making up a high proportion (41%) of all substance use disorder treatment admissions, compared to just 30% in 2012. In 2015, heroin was estimated to be used by 50% of San Francisco's PWID. In contrast, the use of prescription opioids and associated overdoses appear to be decreasing. In addition to the substances described above, tobacco is smoked by approximately 11% of San Franciscans. [3]

2B. Substance use and demographic characteristics

Demographic characteristics of substance-related treatment admissions in 2015 are shown in Figure 7 below. Overall trends show a higher proportion of males than females admitted for substance abuse related treatment. Young adults under age 26 make up relatively small proportions of admissions for all substance use categories except marijuana. Compared to the general population of San Francisco, those admitted for substance use treatment are more likely to be African American/Black and Hispanic.[12]

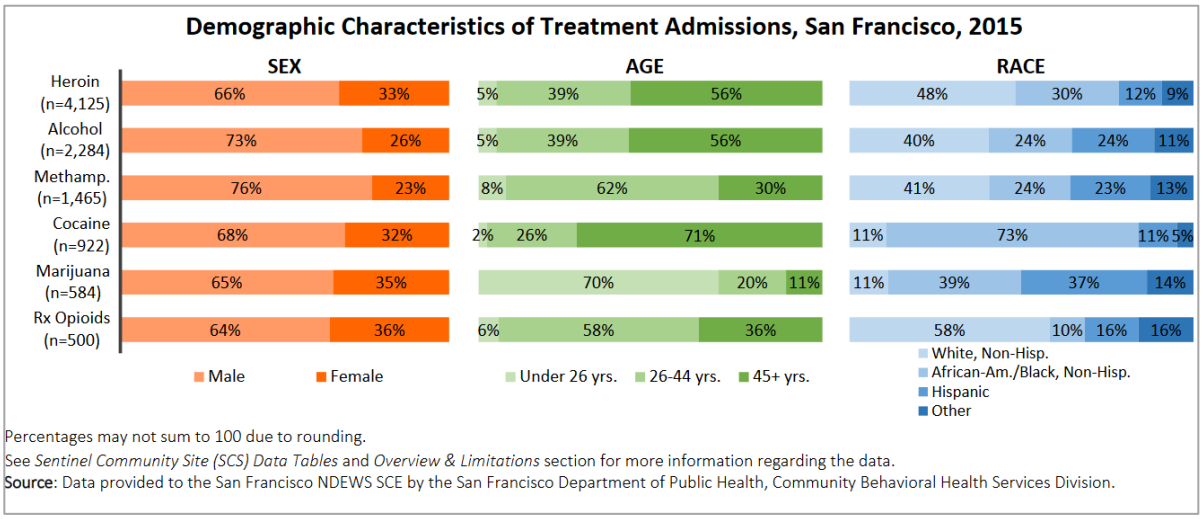


Figure 7, from National Drug Early Warning System (NDEWS), 2016.[12]

With regards to tobacco use, Groups that were disproportionately impacted by tobacco included young adults aged 18-24.[3] For example, 16% of young adults smoke, compared to 10% of adults 25 years and older. E-cigarettes are also popular among youth, with more than a quarter of San Francisco high school students having tried e-cigarettes in 2017.[13] Other groups more likely to use tobacco included people of color (specifically black women), low income earners, and LGBTQ community members.[3]

2C. Substance use and homelessness

San Francisco has more than 7,500 homeless residents;[3] approximately 1,170 are young adults ages 18-24.[14] Individuals experiencing homelessness are at higher risk for substance abuse; 18% of homeless persons in SF report drug and alcohol abuse as the primary cause of their homelessness, and more than half (62%) of chronically homeless individuals have a drug or alcohol abuse condition.[3] People experiencing homelessness are also at high risk for mental health issues, including psychiatric illness.[15]

Homelessness and its associated challenges may deter individuals from seeking help for a substance use disorder when they have one.[12] In addition, many groups at higher risk for HIV and VH are also at higher risk for homelessness; in 2017, homeless individuals in San Francisco were more likely to be members of the LGBTQ community and to be people of color (Black, multiracial, or Hispanic/Latino).[14]

2D. Substance use among youth in SF

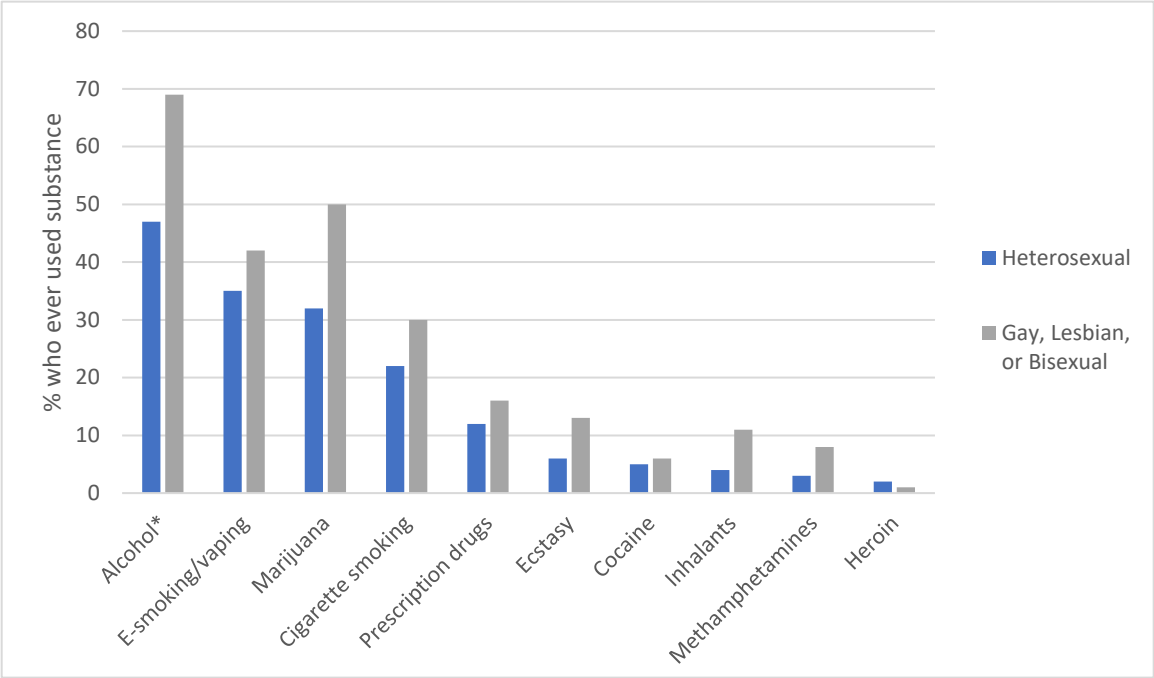
Data from the 2017 Youth Behavioral Risk Surveillance System (YBRSS) survey for high school students demonstrate that youth are at high risk for substance use.[13] As shown in table 2, among high school seniors (the lower age limit of the target population of interest), nearly a quarter (23%) reported ever smoking cigarettes, with 7% reporting current smoking. More than a third (35%) had used an electronic vaping product, with 10% reporting current use of such products. Nearly half (48%) reported ever having drank alcohol, with about a quarter (23%) reporting current drinking and 9% reporting current binge drinking. A third (33%) reported having used marijuana, with 21% current users. 12% reported taking prescription pain medicine in a way not prescribed by a doctor. Less commonly substances that had ever been used included cocaine (5.4%), inhalants (4.8%), heroin (1.8%), methamphetamines (3.6%), and ecstasy (6.9%).

Type and frequency of substance use	% of high school seniors reporting use
Ever drank alcohol	48
Currently drank alcohol	23
Reported current binge drinking	9
Ever used an electronic vaping product	35
Ever used marijuana	33
Currently used marijuana	21
Ever tried cigarette smoking	23
Currently smoked cigarettes	7
Ever took prescription pain medicine in way not prescribed	12
Currently used an electronic vapor product	10
Ever used ecstasy	6.9
Ever used cocaine	5.4
Ever used inhalants	4.8
Ever used methamphetamines	3.6
Ever used heroin	1.8

Table 2. Self-reported substance use among 12th grade students in San Francisco High schools, based on data from the 2017 Youth Risk Behavioral Surveillance System.[13]

When comparing self-reported substance use among heterosexual vs. lesbian, gay, or bisexual (LGB) high school seniors, LGB seniors reported ever having used substances more frequently than their heterosexual counterparts (see Figure 8). However, alcohol use was the only substance for which differences were statistically significant between groups.

*Figure 8. Self-reported substance use among 12th grade heterosexual vs. gay, lesbian, or bisexual students in San Francisco high schools, based on data from the 2017 Youth Risk Behavioral Surveillance System (YRBSS).[13] *Alcohol use differences between groups were statistically significant.*



2E. Substance use in the catchment area

To solicit information about substance use in the target population more directly, members of the target population as well as service providers who work closely with the target population were asked about the types of substances used. Young adults reported that the most popular reported drugs (in no particular order) were cocaine poppers, methamphetamine, marijuana, alcohol, and cough syrup/codeine. Service providers mentioned methamphetamine, heroine, crack, marijuana, and alcohol as substances commonly seen in their young adult client populations. However, providers emphasized that methamphetamine was doing most of the damage to youth, who used it to self-medicate, to stay awake and vigilant in a stressful environment, and to enhance sexual pleasure. Youth also may be pressured to use methamphetamine to make friends or become part of a community.

In terms of rates of substance use in the target population, the catchment area is characterized by a relatively high rate of substance use. A 2016 community health assessment conducted by the San Francisco Department of Public Health found that alcohol-related ER visits were disproportionately high in 3 of 4 of this intervention's target neighborhoods, with the Tenderloin, SOMA, and Western Addition neighborhoods hosting between 26 and 71 alcohol-related ER visits per 10,000 adults.[3] The assessment also noted that these three neighborhoods have a relatively high density of retail outlets with licenses to sell alcohol. Smoking prevalence is also relatively high in the catchment area, with smoking rates in areas near Western Addition, SOMA, and the Tenderloin upward of 12%.[16] Injection drug use is also common in the catchment area, with nearly a third (31%) of PWID residing in the Tenderloin and nearly a quarter (24%) in SOMA in 2015.[6] In addition, homelessness, which is associated with substance use, is particularly high in the Tenderloin and SOMA neighborhoods, which belong to a supervisorial district that made up between 16% and 37% of the city's total street homeless population in 2011.[17]

4. Estimated Population at Risk

When integrating neighborhood-specific epidemiological data from the San Francisco Department of Public Health with neighborhood-specific and city-wide demographic data from the U.S. Census Bureau[18] and the peer-reviewed literature, [2,19] we estimate that approximately 9,711 young adults aged 18-24 at risk for HIV, viral hepatitis, and substance use in the catchment area neighborhoods of Castro, SOMA, Tenderloin, and Western Addition.

Table 3 summarizes the characteristics of the catchment area's estimated population of young adults at risk. Of the 9,711 at-risk young adults, approximately 57% are estimated to be cis-male (n=5,568) and 43% are estimated to be cis-female (n=4,143). Transgender men and transgender women are estimated to make up less than 0.5% of the San Francisco population (0.11% and 0.13%, respectively, totaling 11 and 13 individuals in the catchment area.[2,19] No data were available for other gender identity categories. With regards to sexual identity, San Francisco-specific data could only be found for men who have sex with men, which were estimated to make up 9.25% of the catchment area population (n=1,030).[20]

In terms of race and ethnicity, 54% of young adults in the catchment area are estimated to be White (n=5220), 24% to be Asian (n=2362), 9% to be Black (n=888), 1% to be American Indian, Alaskan Native, or Pacific Islander (n=100), 6% to be another race (n=609), and 5% to be more than one race (n=533). Approximately 13% of young adults (n=1,221) are estimated to be of Hispanic or Latino ethnicity.

Table 3. Estimated number and percent of young adults in catchment area by gender identity, race/ethnicity, and sexual identity.

Characteristic	Category	Number of young adults (% of total[A])
Gender Identity[B]	Cis-male	5,568 (57%)
	Cis-female	4,143 (43%)
	Transgender male	13 (0.13%)
	Transgender female	11 (0.11%)
Sexual Identity[C]	Men who have sex with men	1,030 (9.25%)
Race/ Ethnicity	White	5,220 (54%)
	Asian	2,362 (24%)
	Black	888 (9%)
	American Indian/ Alaskan Native	76 (0.8%)
	Pacific Islander	24 (0.2%)
	Other Race	609 (6%)
	Multiple Races	533 (5%)
	Hispanic or Latino origin	1,221 (13%)

A. Total young adults in catchment area estimated to be 9,711.
B. Data were not available for other gender identities.
C. Data were not available for other sexual identities.

RISK FACTORS & GAPS IN SERVICES AS DESCRIBED BY THE COMMUNITY

To complement epidemiological analyses, qualitative approaches were employed to directly hear the perspectives of the target population and service providers of the target population. These groups were asked about risk factors and needs/gaps in services related to HIV, VH, and SA.

1. Risk factors reported by the target population and service providers

1A. Self-reported risk factors for HIV, VH, and substance use

When discussing HIV risk factors with the target population, participants primarily noted unsafe sex (i.e. sex without condom use and/or with multiple partners) and sharing of needles. With respect to sexual transmission, they noted that among young adults, condoms are not attractive because they make sex less enjoyable. The reality that sex is sometimes not fully under one's control—particularly among those for whom sex is work—was also mentioned. With respect to sharing of needles—a risk factor also discussed in the context of HCV—participants noted the role of the opioid crisis in increasing addiction to street drugs.

Participants also described the broader context and the social determinants that put young adults at risk for HIV, VH, and SA. For example, one participant noted that race/ethnicity influenced the type of drugs that people used, with lower-class and black individuals using crack and higher-class and white individuals using cocaine. Another individual explained that people with low socioeconomic status, especially immigrants, are so busy working to make a living that they don't have time to know their community or learn about health. One emphasized the importance of broken families or relationships in which there was pressure to use substances, engage in risky behaviors, or get trapped in a cycle of addiction or dependence. Participants even went as far to describe the role of the broader cultural messages promoted by society, with one convinced that the messages conveyed in the popular media (e.g. music) and advertising—which emphasized not caring about yourself or your body—were responsible for the "I don't care generation" attitude of young adults.

1B. Provider-reported risk factors for HIV, VH, and substance use

Like the participating youth, service providers cited sex (and survival sex work) and needle sharing as major risk factors for HIV and VH. They also suggested that the inability to strongly advocate for oneself increased risk among young adults. Similar to the participating youth, service providers also noted the broader context in which risky behaviors take place. For example, providers suggested that a lack of connectedness to a community promotes substance use; for LGBTQ individuals, this lack of connectedness is often linked to the isolation and/or repercussions that result from "coming out" to one's family. Another major contextual factor was the relationship between poverty—especially homelessness—and infection. Providers noted that the lack of a safety net, paired with city "sweeps" to clean up sites occupied by people experiencing homelessness could cause trauma and result in the loss of essential risk reduction supplies such as clean needles and condoms. This repeated process can make getting HCV seem less under one's control, reducing motivation to seek treatment or prevention resources if people will "just get it again."

2. Gaps in services as reported by the target population and service providers

2A. Gaps in services described by target population

Four major categories of needs were expressed by young adults from the target population. First, participants suggested that there is a need for more standard education and knowledge dissemination about HIV and VH in the community. Such education that conveys "the reality of the situation" would encourage people to use condoms, get tested, use pre-exposure prophylaxis (PrEP), disclose their status to their sexual and injecting partners, and to engage in healthy relationships. The second category of needs related to the availability of "positive outlets." Participants explained that more positive outlets were needed to provide spaces and activities for young adults to engage in that were equally appealing alternatives to substance use. Examples of positive outlets described included physical spaces, such as recreational facilities with games or sports, as well as new relationships, such as mentorship opportunities. In addition, better promotion of and linkage to existing positive outlets was needed. Third, existing health, wellness, and social support providers needed to be inclusive, respectful of people's identities and experiences, conveniently located, and "not too chaotic" to be truly accessible to young adults. Multiple participants described experiences in which they had felt unwelcome, misgendered, or traumatized based on the way they were treated by service providers. The final category of needs related to targeted outreach efforts, with participants emphasizing the importance of outreach to impoverished neighborhoods where there may be fewer opportunities for education, positive outlets, and health/social support resources.

2B. Gaps in services described by providers

Providers emphasized the importance of basic needs (such as safe, stable housing), the opportunity to gain skills (critical thinking, advocacy, job-related) and education related to HIV/VH/substance use, and opportunities to connect with a community. They suggested that more drop-in hubs with a range of services (medical, mental health, substance use, food, clothing, showers, community space) were needed to accomplish this. Related to expanded services was the importance of reducing the number of hoops that young adults have to jump through for existing services, such as being referred from place to place to find care or having to belong to a certain identity (e.g. LGBTQ) to access resources. Providers also noted the importance of existing and new services being inclusive and respecting the young person's experience, gender identity, and voice without judgment. Continuous outreach was noted as critical to getting youth participation and peer endorsement was described as another way to spread the word about services and resources.

Like the youth, providers also suggested the need to provide positive outlets for youth that went beyond health or social services. Examples provided included mural-making or other creation spaces, a talent night for staff and youth to celebrate together, and the creation of physical spaces large enough to let people take a break, breathe, support each other, and form community. Lastly, providers emphasized the need for service providers of youth in the catchment area to collaborate more intentionally and regularly. Currently, there is no formal coordination between many providers and organizations, despite similar goals and overlapping clientele.

COMMUNITY CAPACITY: ASSETS, RESOURCES, AND READINESS

1. Community Assets and Resources

The target community for this intervention benefits from a number of local assets, as well as resources across the city of San Francisco. These many assets and resources fall into three major categories related to HIV/VH/substance use: the availability of high-quality data, a history of city-level support and leadership, and the presence of numerous existing experienced service providers.

1A. High-quality data on HIV, VH, and SA

The San Francisco Department of Public Health (SFDPH) collects extensive data related to HIV, VH, and SA, and regularly makes this data available to the public through periodic reports. In addition, SFDPH partners with community-level work groups in coordinated efforts to collect, analyze, and interpret epidemiologic data. Such data make it possible to understand the extent of each public health issue and the population subgroups most affected, allowing resources and intervention activities to be targeted to the people and places who can benefit most. One example of such efforts includes the recent initiative to estimate HCV prevalence in San Francisco in conjunction with the End Hep C SF initiative.[4] Such data were needed to build a foundation for efforts to eliminate the disease city-wide.

1B. History of city-level support of HIV/VH/substance use prevention initiatives

As the U.S. ground zero for the HIV epidemic, San Francisco has a long history of funding and supporting programs and policies that target the prevention of infectious disease and the risk factors that propagate them. Initiatives such as Getting to Zero San Francisco (to reduce HIV infection, death, and stigma),[21] Hep B Free San Francisco Bay Area (to eliminate HBV infection),[22] and End Hep C SF (to eliminate HCV infection)[23] have been prioritized by the city as ways to prevent the spread of infectious disease and reduce stigma. In response to the opioid crisis, SFDPH set up a task force to study various harm reduction approaches that aimed to reduce needle sharing and overdose.[24] Currently, given the recent finding that methamphetamine use is on the rise,[12] the city is starting a task force to study this problem in detail.[25] San Francisco has also proposed innovative policies to reduce the use of tobacco, including raising the smoking age to 21 years in 2016[26] and banning the sale of flavored tobacco in 2018.[27] In sum, the high prioritization of HIV, VH, and SA by the city has led to the availability of related funding, capacity-building support, and other resources.

1C. Numerous existing service providers in the fields of HIV/VH/SA

San Francisco is home to various organizations that provide youth-friendly services related to HIV, VH, and SA (see Figure 9 for examples from the catchment area). These organizations have expertise in serving the LGBTQ community, people of color, people experiencing homelessness, PWID, and others that may be marginalized, stigmatized, or at higher risk for health problems. Many of these organizations are led by individuals who are or have been members of the communities served, allowing them to better understand the needs of their clients and how to relate to them.

Name of Youth Resource	Neighborhood
Strut (wellness center) and its sexual health clinic (Magnet)	Castro
San Francisco LGBT Center	Western Addition
Larkin Street Youth Services	Tenderloin
San Francisco AIDS Foundation	SOMA
San Francisco Community Health Center	Tenderloin
LYRIC (LGBT youth organization)	Castro

Figure 9. Examples of youth-friendly HIV/HCV/ substance use services in the catchment area.

2. Community Readiness

The constructs of the Community Readiness Model were used to assess the readiness of the target community to take action on the issue of HIV, VH, and SA prevention. Community readiness was determined to be at the "confirmation/expansion" (stage 8)[ii] due to the solid foundation of HIV, VH, and SA data, existing programs/resources, and support from local organizations and the City and County of San Francisco. This assessment of readiness was based on the dimensions of community readiness,[28] as assessed during focus groups with the target population and service providers. Findings on these dimensions are summarized below.

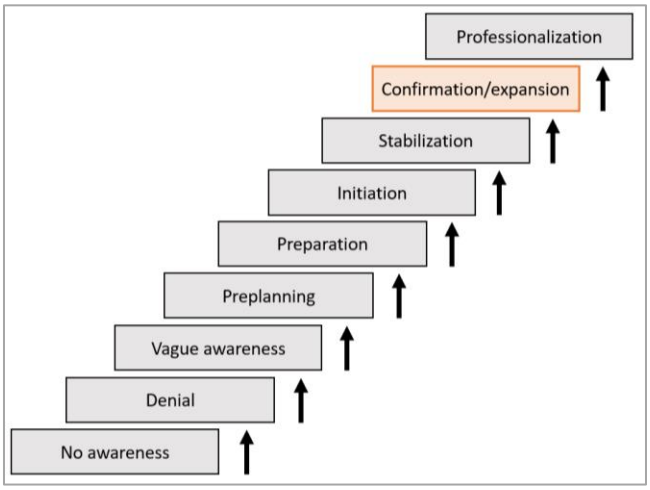


Figure 10. Stages of the Community Readiness Model.[28] For this intervention, the overall readiness level is "Confirmation/expansion."

2A. Community efforts

As noted in the previous section, San Francisco Department of Public Health and the many non-governmental organizations that work on HIV, VH, and SA are leading numerous existing efforts, programs, and policies related to these issues. These include a "Getting to Zero" initiative for HIV, [21] an "End Hep C SF" initiative,[23] and task forces to study opioid and methamphetamine use.[24,25]

2B. Leadership

As described in the previous section, the City and County of San Francisco has been instrumental in supporting the HIV/VH/SA use efforts of the SFDPH, as well as promoting policies that reduce substance use. San Francisco's long history with HIV and its leadership in fighting stigma in the LGBTQ community lend support to initiatives that target the LGBTQ population and other marginalized groups.

2C. Resources

A major resource supporting community readiness is the enthusiasm of service providers who work with young adults to improve HIV, VH, and SA efforts in a coordinated way. Service providers have expressed strong interest in a regular stakeholder meeting to discuss youth-related HIV, VH, and SA issues. Such partnerships will be essential for ensuring that any HIV, VH, and SA initiatives are appropriate and accessible to the target population.

[ii] As described on the SAMHSA website (https://www.samhsa.gov/capt/tools-learning-resources/stages-community-readiness), in the confirmation/expansion stage of community readiness: "Standard programs are viewed as valuable and authorities support expanding or improving programs. New programs are being planned or piloted in order to reach more people. Outreach may be targeted to higher risk populations or different demographic groups. Funds for new programs are being sought or committed. Data are obtained regularly on extent of local problems and efforts are made to assess risk factors and causes of the problem."

2D. Community knowledge

Although data on HIV, VH, and SA in San Francisco are available, representatives from both the target population and service provider organizations noted that important knowledge/educational gaps exist among at-risk young adults. In particular, young adults seemed to know less about HCV risk factors and treatment than HIV, which may be due to the more recent emergence of HCV locally.

2E. Community knowledge of the efforts

Knowledge of HIV/VH/SA efforts is present in the community but appears to be heterogeneously distributed. For example, while young adults from the target population were able to quickly list several youth-focused organizations providing HIV, VH, or SA resources, they also noted the need for more outreach and awareness around these initiatives to help link other young people in their social circles and communities to specific prevention efforts. Service providers also acknowledged a need for enhanced outreach to make services visible and accessible to a larger number of at-risk young adults.

2F. Community Climate

The community climate is somewhat mixed with regards to this health issue. Service providers and youth who participated in our focus groups were enthusiastic about HIV/VH/SA prevention, and both expressed interest in further in shaping the initiative through future participation and collaboration. However, young adults noted that the prevailing culture around substance use and risky behaviors, in tandem with difficult life circumstances, created feelings of dependence or apathy related to these health issues in many of their friends and acquaintances.

RECOMMENDATIONS BASED ON NEEDS, RESOURCES, AND READINESS

Based on the identified needs, resources, and readiness in the target community, the following priorities are recommended for moving forward with the strategic planning of the intervention:

1. *Align capacity expansion efforts with level of community readiness*
   Given the community's relatively high readiness to act and the availability of resources and partnerships to support the project, capacity expansion efforts should be focused on providing and evaluating evidence-based prevention services in high-risk populations (see #2).

2. *Target high priority population subgroups*
   The most at-risk young adults in the target population include LGBTQ individuals (especially MSM and people who are transgender), individuals of color, PWID, and those experiencing homelessness. Recruitment of these individuals to participate in intervention activities—particularly those individuals belonging to multiple at-risk groups—should be prioritized.

3. *Place emphasis on HCV in the intervention*
   VH efforts should address both HBV and HCV; however, given the more recent emergence of HCV and the need for greater community awareness, greater focus should be placed on the dissemination of information and resources related to HCV prevention, testing, and treatment.

4. *Conduct additional focus groups and/or interviews with the target population and providers*
   The exploratory focus groups conducted in this needs assessment shed light on informative community resources and barriers to HIV, VH, and SA prevention. Further community assessment and engagement should take place early in the strategic plan to ensure that the intervention aligns with community needs and assets.

5. *Address both direct and indirect risk factors and gaps in services*
   Direct risk factors (such as knowledge of and attitudes toward safe sexual and injection practices), as well as more indirect risk factors, (such as the need for non-substance-related social connection, recreation, and skill-building opportunities), should both be considered as targets of the intervention.

6. *Support ongoing coordination and capacity of service provider network*
   In addition to considering how SFCHC's intervention activities might fill service gaps directly—such as through expanded HIV/VH testing or educational opportunities for the target population—efforts should be made to coordinate and maintain an ongoing network of service providers for young adults. Such a network can lead to sharing of ideas among providers and may yield innovative and collaborative ideas for filling service gaps.

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