File No. 260448 **Committee Item No.** 14
Board Item No. 20

COMMITTEE/BOARD OF SUPERVISORS

AGENDA PACKET CONTENTS LIST

Committee: Budget and Finance Committee **Date** May 27, 2026
Board of Supervisors Meeting **Date** June 2, 2026

Cmte Board

Cmte	Board	
☐	☐	**Motion**
☒	☒	**Resolution**
☐	☐	**Ordinance**
☐	☐	**Legislative Digest**
☐	☐	**Budget and Legislative Analyst Report**
☐	☐	**Youth Commission Report**
☐	☐	**Introduction Form**
☒	☒	**Department/Agency Cover Letter and/or Report**
☐	☐	**MOU**
☐	☐	**Grant Information Form**
☐	☐	**Grant Budget**
☐	☐	**Subcontract Budget**
☐	☐	**Contract/Agreement**
☐	☐	**Form 126 – Ethics Commission**
☐	☐	**Notice of Award/Award Letter**
☐	☐	**Application**
☒	☒	**Public Correspondence**

OTHER **(Use back side if additional space is needed)**

☒	☒	SFBHSA Integrated Plan FYs 2026-2029 4/2026
☒	☒	CA Welfare and Institutions Code, Section 5847
☒	☒	Presidential Action Memo – Transfer PSNS-BFC 5/14/2026
☒	☒	DPH Presentation 5/27/2026
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	

Completed by: Brent Jalipa **Date** May 21, 2026
Completed by: Brent Jalipa **Date** May 28, 2026

[San Francisco Behavioral Health Services Act Three-Year Integrated Plan - FY2026-2029]

Resolution authorizing adoption of the San Francisco Behavioral Health Services Act Three-Year Integrated Plan for Fiscal Years (FY) 2026-2029.

WHEREAS, The Behavioral Health Services Act (BHSA) was passed through a ballot initiative (Proposition 1) in 2024 and provides funding to support county behavioral health programs; and

WHEREAS, The BHSA specifies three major program components (Full Service Partnerships, Behavioral Health Services and Supports, and Housing Interventions) for which funds may be used and the percentage of funds to be devoted to each component; and

WHEREAS, In order to access BHSA funding from the State, counties are required to 1) develop a Three-Year Program and Expenditure Plan (Integrated Plan), and Annual Updates, in collaboration with stakeholders; 2) post each plan for a 30-day public comment period; and 3) hold a public hearing on the plan with the County Behavioral Health Commission; and

WHEREAS, The San Francisco Department of Public Health has submitted and received approval for a three-year program and expenditure plan (integrated plan) for FY2023-2026 on file with the Clerk of the Board of Supervisors in File No. 240355; and

WHEREAS, The San Francisco BHSA Annual Update FY2026-2029, a copy of which is on file with the Clerk of the Board of Supervisors in File No. 260448, which is hereby declared to be a part of this Resolution as if set forth fully herein, complies with the BHSA requirements above, and provides an overview of a three-year plan, various components, and an expenditure plan for San Francisco for FYs 2026-2029; and

WHEREAS, Welfare and Institutions Code, Section 5847 requires that BHSA Three-Year Integrated Plans, and Annual Updates, be adopted by County Boards of Supervisors prior to submission to the State; now, therefore, be it

RESOLVED, That the San Francsico BHSA Annual Update for FYs 2026-2029 is adopted by the Board of Supervisors.

Behavioral Health Services Act Three Year Integrated Plan FY26-29

Jessica Brown, MPH
Director, Office of Justice, Equity, Diversity, and Inclusion / Behavioral Health Services Act
Behavioral Health Services
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Agenda

- Behavioral Health Services Act Overview and Integrated Plan Requirements
- Three-Year Integrated Plan Budget FY26-29 and BHSA Programming Changes
- Feedback Received

Behavioral Health Services Act Overview and Integrated Plan Requirements

CA Behavioral Health Services Act: Mental Health Services Act Reform

- Mental Health Services Act (MHSA), approved by voters in 2004, established 1% tax on personal income above $1 million for mental services.
- The first major reform of MHSA, the **Behavioral Health Services Act (BHSA)**, was approved by CA voters under Proposition 1 in 2024.
- BHSA goes into effect July 1, 2026.
- BHSA expands target population to include individuals with substance use disorder; continues to prioritize services for children and youth; people who are chronically homeless, veterans.
- BHSA reform impacts on San Francisco:
  - **New state-directed and required funding allocations**, reduce San Francisco ability to allocate to prevention and non-specified behavioral health services.
  - **New county planning and reporting requirements**; must report all sources of revenue and expenditures to state.

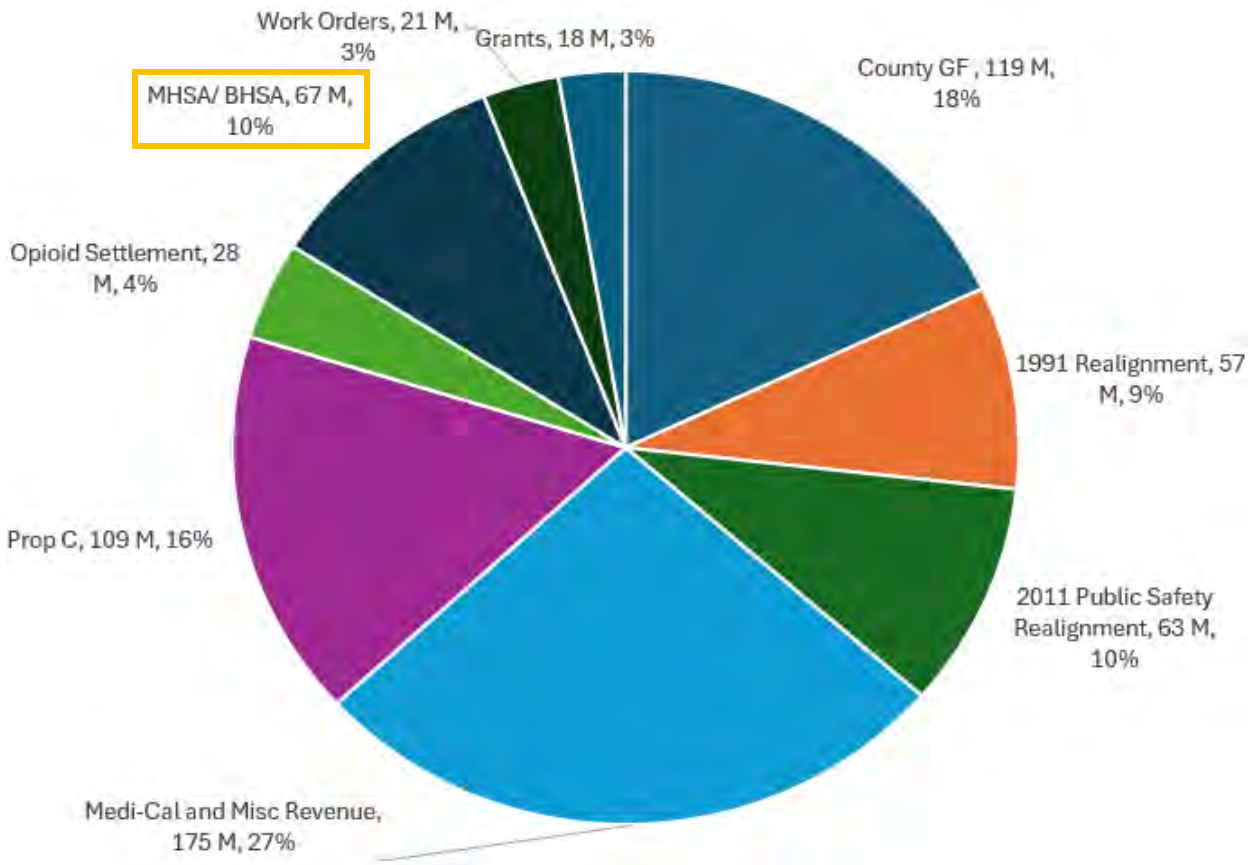
BHSA Three-Year Integrated Plan Requirements

- **BHSA Three-Year Integrated Plan must:**
  - Describe how the County will deliver high quality, culturally responsive, and timely access to services.
  - Include all local, state, and federal behavioral health funding and services.
  - Collaborate with local health jurisdiction and Medi-Cal Managed Care Plans
  - Align with the Community Health Assessment and Community Health Improvement Plan.
  - Be informed by community stakeholders, with extensive engagement requirements.
  - Address statewide priority goals (e.g. access to care, homelessness) and county-selected goal (overdose).
    - In 2026, DHCS will develop **performance accountability measures**.
- Counties must engage with 26 stakeholder groups in a **Community Program Planning (CPP)** process.
  - SFDPH held 15 CPP meetings, conducted targeted stakeholder outreach, administered a community survey (~1,200 responses), and leveraged the 2024 Community Health Assessment.
- Under State requirements, the draft Plan was:
  - **Submitted to CA Department of Health Care Services** (DHCS) with approval from **Behavioral Health Director** and **Mayor** by March 31, 2026
  - Posted for a 30-day **Public Comment** Period
  - Reviewed by the **Behavioral Health Commission**
- **Final plan** must be submitted to DHCS **with approval from Board of Supervisors** by June 30, 2026.

BHSA Three-Year Integrated Plan Budget FY26-29 and BHSA Programming Changes

FY25-26 Total Behavioral Health Services Sources of Revenue

$656M
Total Behavioral Health Services Sources of Revenue



Revenues (FY25-26)

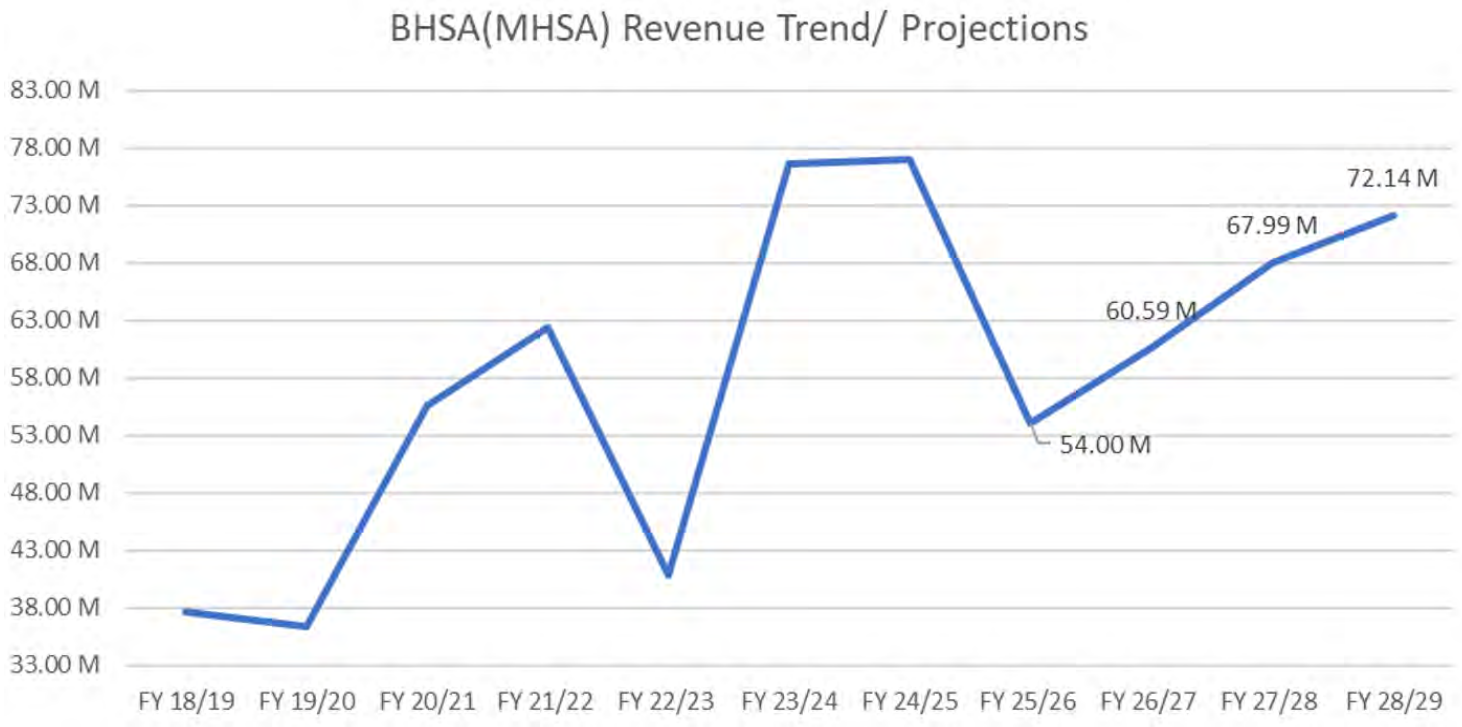
How SFDPH Developed the Proposed BHSA Budget

Volatile Revenue Source
BHSA funding fluctuates; depends on a 1% tax on personal income over $1M; shifts significantly during economic ups and downs.

Conservative Planning
SFDPH planned conservatively to avoid overcomitting revenue. Revenues came in higher than projected, can result in unspent balances.

Rollover Funds
State permits counties to carry forward unspent funds.

Proposed BHSA Budget of $92M is based on projected revenues, unspent fund balances, and increased Medi-Cal revenue.



*Summary includes State distributions only, excluding interest and reallocations of reverted funding from other counties

Required BHSA Funding Allocations

Housing Interventions: 30%

- 50%+ dedicated to chronically homeless
- ≤ 25% capital development
- ≤ 7% outreach and engagement

Full-Service Partnership: 35%

- Assertive Community Treatment (ACT)/Forensic ACT (FACT)
- Intensive Case Management (ICM)
- Individual Placement and Supported Employment (IPS)
- High Fidelity Wrap (HFW)

Behavioral Health Services and Supports: 35%

- At least 51% dedicated to early intervention (EI) programs
- Of EI, at least 51% for individuals 25 years or younger
  - Required Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)
- Remaining funding can include
  - Other behavioral health services
  - Outreach and Engagement
  - Workforce Education and Training (WET)
  - Capital facilities and technological needs

These allocations apply only to BHSA-funded programming and do not reflect all Behavioral Health Services programming and investments.

BHSA funding categories changed under Proposition 1, but overall BHSA funding did not increase.

MHSA v. BHSA Funding Allocations & Budgets

FY25-26 SF MHSA Budget

	Total $ (M) *Programs + staff*	% allocation**
Community Services & Supports (CSS)	$34.7	76%
Innovation (INN)	$1.1	5%
Prevention & Early Intervention (PEI)	$17.6	19%
Workforce Education & Training (WET)	$11	***
Capital Facilities (CF) / Technology Needs (TN)	$2.4	***
Total	**$66.8**	**100%**

Proposed FY26-27 SF BHSA Budget

	Total $ (M) *Programs + staff*	% allocation**
Housing	$30.8	34%
Full-Service Partnership (FSP)	$28.8	31%
Behavioral Health Services & Supports (BHSS)	$32.3	35%
Total	**$92.0***	**100%**

BHSA adds new funding categories and reduces county allocations, requiring PEI and non-Full-Service Partnership reductions and shifts to other services. The State anticipated that these shifts would require counties to reduce and rebalance contracts.

*Estimate, based on state revenues. Subject to changes based on tax revenue, finalized in March/April. **Funding transfers allowed up to 7% for in any 1 group, no more than 14% across total budget.
***While not part of the 76/19/5 allocation formula, per MHSA, counties may transfer up to 20% of their CSS funds to WET or CFTN to support staff development, recruitment, and infrastructure.

Our Approach for Programmatic Changes

Policy

- Implemented BHSA requirements to allocate and potentially modify existing MHSA programs and services

Budget

- Developed a spending plan based on historic MHSA funding allocation and projected state revenues to develop a BHSA budget FY26-29. These are subject to change.

Programming

- Evaluated MHSA program and staff expenditures against BHSA program requirements and funding allocations.
- Identified other DPH-funded programs that qualified for BHSA funding priorities
- Engaged various community stakeholders and receive their input throughout the process.
- Reviewed areas where program shifts were needed to meet new BHSA requirements, including difficult decisions to reduce and eliminate programs, particularly primary prevention.

BHSA Program Impacts for FY26-27 and FY27-28

After reviewing all BHSA-funded programs, DPH determined fit for new categories and reduced programs in areas that were oversubscribed or did not meet BHSA priorities.

The programs impacted were the following:

Programs ending June 30, 2026:

- **$3.9M** - Workforce Education & Training* (14 programs)
- **$1.3M** - Early Childhood Prevention (1 program)
- **$978K** – Socially Isolated Adults (3 programs)

Programs ending June 30, 2027:

- **$1.1M** - Workforce Education & Training (4 programs)
- **$973K** - School-based Wellness (4 programs)
- **$750K** - Innovation Program (1 program)
- **$500K** - Prevention Program (1 program)

*Inclusive of previously announced $17M DPH CBO reductions

Feedback Received

Integrated Plan Feedback

SFDPH has received feedback on the Integrated Plan through public comment and a hearing at the Behavioral Health Commission, which **will be reflected in the final Plan**.

Public Commenters:

- Called out veterans and immigrant populations as priority populations for services
- Advocated for sustained funding for peer-led and family support services
- Advocated for early intervention services for children

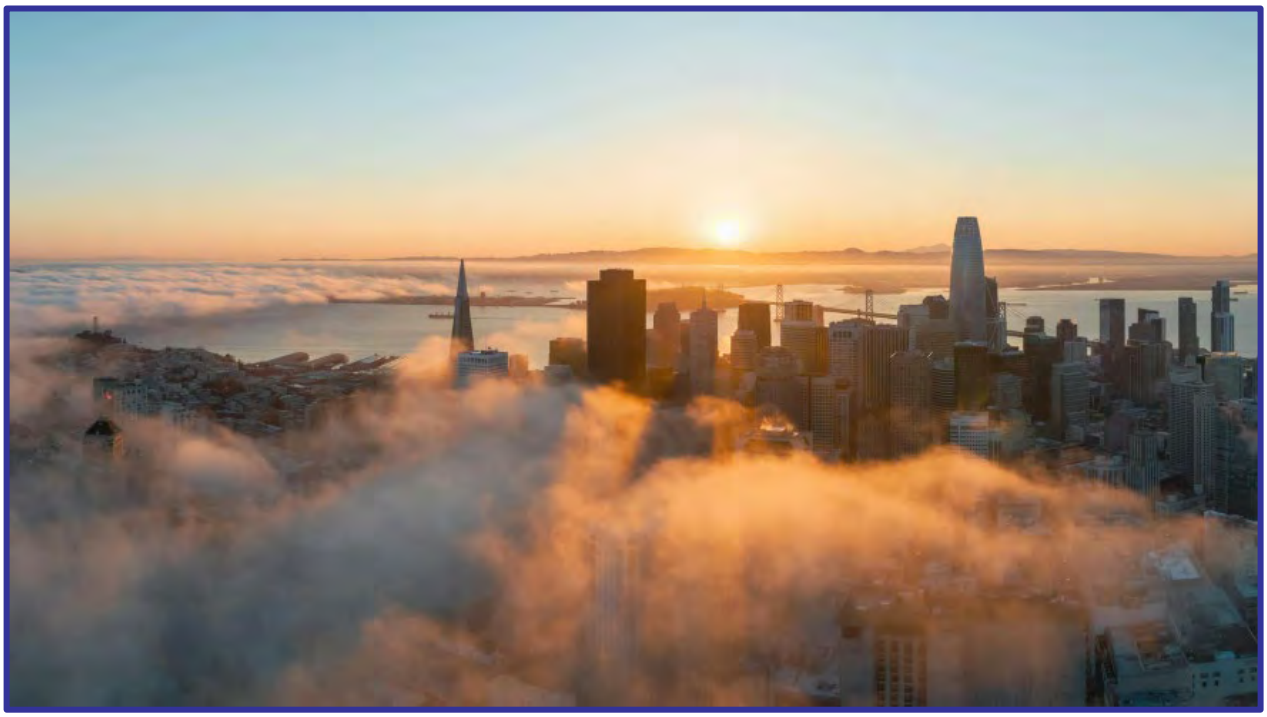
Behavioral Health Commissioners:

- Highlighted the importance of housing investments and sought more detail on DPH's overall housing portfolio
- Called out justice-involved adults as a priority population for services
- Sought more information on administrative costs
- Sought more information on performance measures for County Behavioral Health
- Clarified the reach of the Community Planning Process
- Sought more information on prevention funding, including future use of State Prevention Set-Aside

SFDPH is revising the plan to call out these needs and investments more prominently. **No funding or programming changes are necessary to respond to this feedback.**

Thank you

San Francisco
Department of Public Health



San Francisco Department of Public Health,
Behavioral Health Services

Behavioral Health Services Act Three-Year Integrated Plan, FY2026-2029

DRAFT FOR PUBLIC COMMENT
April 2026

2026 - 2029 Integrated Plan

San Francisco County

The Behavioral Health Services Act (BHSA) requires counties to submit three-year Integrated Plans (IPs) for Behavioral Health Services and Outcomes. For related policy information, refer to 3.A. Purpose of the Integrated Plan .

General Information

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 3.A. General Information .

General Information

County, City, Joint Powers, or Joint Submission
County

Entity Name
San Francisco County

Behavioral Health Agency Name
San Francisco Department of Public Health, Behavioral Health Services

Behavioral Health Agency Mailing Address
1380 Howard Street, San Francisco, CA 94103

Primary Mental Health Contact

Name
Hillary Kunins

Email
hillary.kunins@sfdph.org

Phone
6287549527

Secondary Mental Health Contact

Name
Maximilian Rocha

Email
maximilian.rocha@sfdph.org

Phone
6287549549

Primary Substance Use Disorder Contact

Name
Kellee Hom

Email
kellee.hom@sfdph.org

Phone
4152553425

Secondary Substance Use Disorder Contact

Name
Christine Soran

Email
christine.soran@sfdph.org

Phone
6287543239

Primary Housing Interventions Contact

Name
Jessica Brown

Email
jessica.n.brown@sfdph.org

Phone
6287549535

Compliance Officer for Specialty Mental Health Services (SMHS)

Name
Joe Turner

Email
joe.turner@sfdph.org

Compliance Officer for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services

Name
Joe Turner

Email
joe.turner@sfdph.org

Behavioral Health Services Act (BHSA) Coordinator

Name	Email address
Jessica Brown	jessica.n.brown@sfdph.org
Danyelle Marshall	danyelle.marshall@sfdph.org

Substance Abuse and Mental Health Services Administration (SAMHSA) liaison

Name	Email address
Hillary Kunins	hillary.kunins@sfdph.org
Kellee Hom	kellee.hom@sfdph.org

Quality Assurance or Quality Improvement (QA/QI) lead

Name	Email address
Alecia Martin	alecia.martin@sfdph.org
Linda Wu	linda.h.wu@sfdph.org

Medical Director

Name	**Email address**
Lisa Inman	lisa.inman@sfdph.org
Ana Gonzalez	ana.i.gonzalez@sfdph.org

County Behavioral Health System Overview

Please provide the city/county behavioral health system (inclusive of mental health and substance use disorder) information listed throughout this section. The purpose of this section is to provide a high-level overview of the city/county behavioral health system's populations served, technological infrastructure, and services provided. This information is intended to support city/county planning and transparency for stakeholders. The Department of Health Care Services recognizes that some information provided in this section is subject to change over the course of the Integrated Plan (IP) period. All data should be based on FY preceding the year plan development begins (i.e., for 2026-2029 IP, data from FY 2023-2024 should be used).

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 3.E.2 General Requirements.

Populations Served by County Behavioral Health System

Includes individuals that have been served through the county Medi-Cal Behavioral Health Delivery System and individuals served through other county behavioral health programs. Population-level behavioral health measures, including for untreated behavioral health conditions, are covered in the Statewide Behavioral Health Goals section and County Population-Level Behavioral Health Measure Workbook.For related policy information, refer to 2.B.3 Eligible Populations and 3.A.2 Contents of the Integrated Plan.

Children and Youth

In the table below, please report the number of children and youth (under 21) served by the county behavioral health system who meet the criteria listed in each row.**Counts may be duplicated as individuals may be included in more than one category**.

Criteria	**Number of Children and Youth Under Age 21**
Received Medi-Cal Specialty Mental Health Services (SMHS)	3940
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	941
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	42
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	4036

Criteria	Number of Children and Youth Under Age 21
Accessed the Early Psychosis Intervention Plus Program, pursuant to Welfare and Institutions Code Part 3.4 (commencing with section 5835), Coordinated Specialty Care, or other similar evidence-based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs	29
Were chronically homeless or experiencing homelessness or at risk of homelessness	193
Were in the juvenile justice system	328
Have reentered the community from a youth correctional facility	222
Were served by the Mental Health Plan and had an open child welfare case	589
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	<11*

Criteria	Number of Children and Youth Under Age 21
Have received acute psychiatric care	140

Adults and Older Adults

In the table below, please report the number of adults and older adults (21 and older) served by the county behavioral health system who meet the criteria listed in each row.**Counts may be duplicated as individuals may be included in more than one category**.

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	3566
Received Medi-Cal SMHS	11394
Received DMC or DMC-ODS services	4943
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	16584
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	5268

Criteria	Number of Adults and Older Adults
Experienced unsheltered homelessness	2487
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	0000
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	0000
Were in the justice system (on parole or probation and not currently incarcerated)	2390
Were incarcerated (including state prison and jail)	2390
Reentered the community from state prison or county jail	1546
Received acute psychiatric services	1021

Input the number of persons in designated and approved facilities who were

Admitted or detained for 72-hour evaluation and treatment rate

3386

Admitted for 14-day and 30-day periods of intensive treatment
1189

Admitted for 180-day post certification intensive treatment
0

Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs
24

Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs)
<11*

Of the data reported in this section, are there any areas where the county would like to provide additional context for DHCS's understanding?
Yes

Please explain
San Francisco Department of Public Health Behavioral Health Services (SFDPH BHS) collects data on individuals served within our behavioral health system; however, BHS does not consistently capture whether those individuals are also part of certain specialized populations. As a result, SF BHS cannot provide consistent precise counts for population groups, such as adults who are experiencing unsheltered homelessness and transitioning to housing (Adult Criteria 7 & 8), adults who are incarcerated or reentering the community from incarceration (Adult Criteria 10 & 11), adults enrolled in Department of State Hospital Lanterman-Petris-Short Act programs (Adult Criteria 14), and youth who are reentering the community from correctional facilities (Youth Criteria 8). To complete the Populations Served table, SF BHS requested supplemental data from partner agencies, including the SF Department of Homelessness and Supportive Housing and the SF Public Conservator's Office. Data on reentry populations remains limited. SF BHS is working to enhance our Electronic Health Record system to better capture these data across programs, particularly our Locked Residential Treatment, Low-Threshold Services, Emergency Stabilization Units, Therapeutic Residential, and Residential Care Facilities.

Note on Methodology: SF BHS Medi-Cal client counts rely on including any client served at any provider that is Medi-Cal certified. This approach counts individuals regardless of the specific service rendered or the client's individual Medi-Cal status, and the data is subsequently unduplicated to produce the final reported figures.

Please describe the local data used during the planning process

SFDPH BHS evaluated local data from various sources to inform the BHSA IP planning process. This included data analysis and reflection on:

(1) The statewide behavioral health (six priority and one additional) goals and (37) measures, as described under the BHSA Goals and Measures section of this plan. We convened subject matter experts from BHS, as well as Population Health, Emergency Medical Services, SF Department of Homelessness and Supportive Housing, and the SF Department of Youth Probation, and others to review specific measure data and inform systems planning to align service delivery and/or share programmatic and client outcome data.

(2) Community Program Planning (CPP) data, as described under the CPP section of this plan. SF BHS staff led deep community engagement processes to solicit feedback on community needs and service provision and to inform the planning process. SF BHS held 12 meetings with community groups between June 2025 and October 2025. Community groups included service providers and consumers, the SF BHSA Advisory Committee, the SF Behavioral Health Services Client Council, and the SF Behavioral Health Commission.

(3) SF BHS also administered a community-wide survey as part of our CPP process. The survey reached 1,191 respondents and provided data on community-wide behavioral health needs, health system strengths, and service priorities.

(4) SF BHS staff also partnered with other BHSA stakeholders through data sharing and planning for systems alignment, including the SF Department of Public Health, Population Heath team in the development of their Community Health Improvement Plan and Medi-Cal Managed Care Providers in the development of their Community Reinvestment Plans. BHS consulted other existing local needs assessments to identify other key areas of need, including the SF Community Health Assessment, the SF Controller's Office 2025 Homelessness Needs Assessment, and the SF Department of Children Youth and Families 2022 Community Needs Assessment.

If desired, provide documentation on the local data used during the planning process

County Behavioral Health Technical Infrastructure

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to 6.C.1 Promoting Access to Care Through Efficient Use of State and County Resources Introduction .

Does the county behavioral health system use an Electronic Health Record (EHR)?

Yes

Please select which of the following EHRs the county uses
Epic Systems
Netsmart
Other

Please describe
SF BHS Substance Use Services System of Care will move to Epic Systems by May 2026.

County participates in a Qualified Health Information Organization (QHIO)?
No

Application Programming Interface Information

Counties are required to implement Application Programming Interfaces (API) in accordance with Behavioral Health Information Notice (BHIN) 22-068 and federal law.

Please provide the link to the county's API endpoint on the county behavioral health plan's website
https://api.sfdph.org/bhs/metadata

Does the county wish to disclose any implementation challenges or concerns with these requirements?
Yes

Please describe these challenges and concerns
Patient Access: Currently, Epic Systems is unable to parse out Medi-Cal only data. SFDPH BHS escalated this issue with Epic Systems. Unable to list Total Third-Party Applications (TPAs) Registered.

SF BHS Substance Use Services System of Care will move to Epic Systems by May 2026. Currently, SF BHS is not collecting this data for SUS patient portal.

Counties are required to meet admission, discharge, and transfer data sharing requirements as outlined in the attachments to BHINs 23-056 , 23-057 , and 24-016 . Does the county wish to disclose any implementation challenges or concerns with these requirements?
No

County Behavioral Health System Service Delivery Landscape

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to 6.C.1 Promoting Access to Care Through Efficient Use of State and County Resources Introduction .

Substance Abuse and Mental Health Services Administration (SAMHSA) Projects for Assistance in Transition from Homelessness (PATH) Grant

Will the county participate in SAMHSA's PATH Grant during the Integrated Plan period?
No

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Community Mental Health Services Block Grant (MHBG)

Will the county behavioral health system participate in any MHBG set-asides during the Integrated Plan period?
Yes

Please select all set asides that the county behavioral health system plans to participate in under the MHBG
Children's System of Care Set-Aside
Discretionary/Base Allocation
Dual Diagnosis Set-Aside
First Episode Psychosis Set-Aside
Integrated Services Agency Set-Aside

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)

Will the county behavioral health system participate in any SUBG set asides during the Integrated Plan period?
Yes

Please select all set-asides that the county behavioral health system participates in under SUBG
Adolescent/Youth Set-Aside
Discretionary
Perinatal Set-Aside
Primary Prevention Set-Aside
Syringe Services Program Allowance

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Opioid Settlement Funds (OSF)

Will the county behavioral health system have planned expenditures for OSF during the Integrated Plan period?
Yes

Please check all set asides the county behavioral health system participates in under OSF Exhibit E
Connect People Who Need Help to The Help They Need (Connections to Care)
Leadership, Planning, and Coordination
Prevent Misuse of Opioids
Prevent Overdose Deaths and Other Harms (Harm Reduction)
Research
Support People in Treatment and Recovery

Training
Treat Opioid Use Disorder (OUD)

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Bronzan-McCorquodale Act

The county behavioral health system is mandated to provide the following community mental health services as described in the Bronzan-McCorquodale Act (BMA).
a. Case Management
b. Comprehensive Evaluation and Assessment
c. Group Services
d. Individual Service Plan
e. Medication Education and Management
f. Pre-crisis and Crisis Services
g. Rehabilitation and Support Services
h. Residential Services
i. Services for Homeless Persons
j. Twenty-four-hour Treatment Services
k. Vocational Rehabilitation

In addition, BMA funds may be used for the specific services identified in the list below. Select all services that are funded with BMA funds:
Not Applicable

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Public Safety Realignment (2011 Realignment)

The county behavioral health system is required to provide the following services which may be funded under the Public Safety Realignment (2011 Realignment)

a. Drug Courts
b. Medi-Cal Specialty Mental Health Services, including Early Periodic Screening Diagnostic Treatment (EPSDT)
c. Regular and Perinatal Drug Medi-Cal Services
d. Regular and Perinatal DMC Organized Delivery System Services, including EPSDT
e. Regular and Perinatal Non-Drug Medi-Cal Services

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Medi-Cal Specialty Mental Health Services (SMHS)

The county behavioral health system is mandated to provide the following services under SMHS authority (no action required).
a. Adult Residential Treatment Services
b. Crisis Intervention
c. Crisis Residential Treatment Services
d. Crisis Stabilization
e. Day Rehabilitation
f. Day Treatment Intensive
g. Mental Health Services
h. Medication Support Services
i. Mobile Crisis Services
j. Psychiatric Health Facility Services
k. Psychiatric Inpatient Hospital Services
l. Targeted Case Management
m. Functional Family Therapy for individuals under the age of 21
n. High Fidelity Wraparound for individuals under the age of 21
o. Intensive Care Coordination for individuals under the age of 21
p. Intensive Home-based Services for individuals under the age of 21
q. Multisystemic Therapy for individuals under the age of 21
r. Parent-Child Interaction Therapy for individuals under the age of 21
s. Therapeutic Behavioral Services for individuals under the age of 21
t. Therapeutic Foster Care for individuals under the age of 21
u. All Other Medically Necessary SMHS for individuals under the age of 21

Has the county behavioral health system opted to provide the specific Medi-Cal SMHS identified in the list below as of June 30, 2026?
ACT
FACT
CSC for FEP
Peer Support Services

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Drug Medi-Cal (DMC)/Drug Medi-Cal Organized Delivery System (DMC-ODS)

Select which of the following services the county behavioral health system participates in DMC-ODS Program

Drug Medi-Cal Organized Delivery System (DMC-ODS)
The county behavioral health system is mandated to provide the following services as a part of the DMC-ODS Program (DHCS currently follows the guidance set forth in the American Society of Addiction Medicine (ASAM) Criteria, 3rd Edition). (no action required)
a. Care Coordination Services
b. Clinician Consultation
c. Outpatient Treatment Services (ASAM Level 1)
d. Intensive Outpatient Treatment Services (ASAM Level 2.1)
e. Medications for Addiction Treatment (MAT), Including Narcotics Treatment Program (NTP) Services
f. Mobile Crisis Services
g. Recovery Services
h. Residential Treatment services (ASAM Levels 3.1, 3.3., 3.5)
i. Traditional Healers and Natural Helpers
j. Withdrawal Management Services
k. All Other Medically Necessary Services for individuals under age 21 for individuals under age 21
l. Early Intervention for individuals under age 21

Has the county behavioral health system opted to provide the specific Medi-Cal SUD services identified in the list below as of June 30, 2026?

Peer Support Services
Recovery Incentives Program (Contingency Management)

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Other Programs and Services

Please list any other programs and services the county behavioral health system provides through other federal grants or other county mental health and SUD programs

Program or service
SF BHS provides a range of behavioral health programs and services supported by other local and state funding sources including: - The San Francisco General Fund supports behavioral health services including those not fully reimbursable through Medi-Cal. The general fund invests in core clinical behavioral health services, including crisis services, residential treatment services and beds, outpatient clinics for mental health and substance use treatment services, and safety-net services for uninsured and underinsured individuals.
- Our City, Our Home (Proposition C) – Voter-approved local funding supporting housing stabilization, prevention, and supportive services for individuals experiencing homelessness with behavioral health needs, implemented in coordination with other San Francisco agencies.

- State and federal discretionary grants (non-block grant) provide one-time funding to support SF BHS crisis services, substance use treatment services, law enforcement diversion programs, prevention and early intervention programming, and BHS workforce development and system improvement efforts.

- Interdepartmental funding (work order agreements) with other San Francisco agencies braid funding with BHS to deliver integrated behavioral health services across the health care continuum. For example, this includes mental health and substance use treatment services offered in partnership with the San Francisco Department of Homelessness and Supportive Housing.

Care Transitions

Has the county implemented the state-mandated Transition of Care Tool for Medi-Cal Mental Health Services **(Adult and Youth)?**

Yes

Does the county's Memorandum of Understanding include a description of the system used to transition a member's care between the member's mental health plan and their managed care plan based upon the member's health condition?

Yes

Statewide Behavioral Health Goals

All fields must be completed unless marked as optional. You don't need to finish everything at once-your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to, please see 3.E.6 Statewide behavioral health goals

Population-Level Behavioral Health Measures

The statewide behavioral health goals and associated population-level behavioral health measures must be used in the county Behavioral Health Services Act (BHSA) planning process and should inform resource planning and implementation of targeted interventions to improve outcomes for the fiscal year(s) being addressed in the IP. For more information on the statewide behavioral health goals, please see the Policy Manual Chapter 2, Section C.

Please review your county's status on each population-level behavioral health measure, including the primary measures and supplemental measures for each of the 14 goals. All measures are publicly available, and counties are able to review their status by accessing the measures via DHCS-provided instructions and the County Population-Level Behavioral Health Measure Workbook.

As part of this review, counties are required to evaluate disparities related to the six priority statewide behavioral health goals. Counties are encouraged to use their existing tools, methods, and systems to support this analysis and may also incorporate local data sources to strengthen their evaluation.

Please note that several Phase 1 measures include demographic stratifications – such as race, sex, age, and spoken language – which are included in the prompts below. Counties may also use local data to conduct additional analyses beyond these demographic categories.

For related policy information, refer to E.6.1 Population-level Behavioral Health Measures.

Mark page as complete

Priority statewide behavioral health goals for improvement

Counties are required to address the six priority statewide behavioral health goals in this section. Cities should utilize data that corresponds to the county they are located within. As such, the City of Berkeley should use data from Alameda County and Tri-City should use data from Los Angeles County. For related policy information, refer to E.6.2 Primary and Supplemental Measures.

Access to care: Primary measures

Specialty Mental Health Services (SMHS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2023

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Above

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity

Non-Specialty Mental Health Services (NSMHS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2023

How does your county status compare to the statewide rate?

For adults/older adults
Below

For children/youth
Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Spoken Language

Drug Medi-Cal (DMC) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023

How does your county status compare to the statewide rate?

For adults/older adults
Not Applicable

For children/youth
Not Applicable

What disparities did you identify across demographic groups or special populations?
None Identified

Drug Medi-Cal Organized Delivery System (DMC-ODS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Same

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity

Access to care: Supplemental Measures

Initiation of Substance Use Disorder Treatment (IET-INI) (DHCS), FY 2023

How does your county status compare to the statewide rate?
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Access to care: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
The San Francisco Department of Public Health Behavioral Health Services (SFDPH BHS) reaches many high-need residents through low-barrier access to specialty care services, with targeted outreach and culturally and linguistically responsive services. San Francisco Specialty Mental Health Services (SMHS) penetration rates for adults and children/youth are above state averages. However, disparities in utilization persist, signaling a continued need to strengthen engagement with specific populations. Hispanic, Asian, and Pacific Islander residents, as well as adults over age 65, use SMHS at rates lower than the county average.

San Francisco Non-Specialty Mental Health Services (NSMHS) penetration rate falls below statewide averages for both adults and youth. These gaps are particularly evident among non-English speakers, Hispanic, Asian, and Pacific Islander residents. This suggests that, while San Francisco's healthcare system succeeds in connecting people with higher acuity needs to SMHS, it is less effective in reaching individuals with lower acuity needs or those requiring preventive and early intervention services.

San Francisco Drug Medi-Cal Organized Delivery System (DMC-ODS) penetration rates for adults are slightly above the state average. Asian, and Pacific Islander youth have the lowest penetration rates. Historically, youth access is limited due to a lack of certified providers. San Francisco's Initiation of Substance Use Disorder Treatment rate is below the state average, which may be reflective of the barriers to timely follow-up and continuity of care for individuals with substance use disorder, particularly those with co-occurring serious mental illness, chronic health conditions, and housing instability.

Overall, the data reveal that San Francisco behavioral health system is reaching many residents, often at rates above the state average. However, inequities in access for communities of color, older adults, and non-English-speaking residents highlight areas where targeted investment and structural improvements remain urgently needed.

Access to care: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may increase your county's level of access to care. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes

SFDPH BHS is taking steps to strengthen our behavioral health system to improve access across the full continuum of care, with a particular focus on populations experiencing disparities. In 2022, BHS opened the Office of Coordinated Care (OCC) to support clients' transition between Specialty Mental Health Services (SMHS), Non Specialty Mental Health Services (NSMHS), Medi-Cal Managed Care Plans, and Primary Care Behavioral Health. The OCC functions as a centralized coordination point that enables health care providers to refer and connect clients across these settings, strengthening system capacity and continuity of care. By implementing standardized screening tools, a centralized referral inbox, and regular cross-system coordination meetings, the OCC helps close gaps in referrals, follow-up, and ongoing engagement.

By May 2026, SFDPH BHS Substance Use Services (SUS) System of Care will migrate to Epic Electronic Health Record system. This transition will expand BHS's closed-loop referral capacity, enabling the OCC to directly schedule SUS appointments for clients. This is expected to improve care coordination, strengthen follow-up, improve timely access to care, and increase NSMHS penetration.

SF BHS is also expanding substance use treatment capacity to serve youth. BHS SUS is contracting with new providers across American Society of Addiction Medicine (ASAM) levels 0.5–3.1. These actions will directly increase DMC-ODS youth penetration and reduce disparities in access for communities of color.

To improve initiation of SUD treatment, SF BHS OCC and SUS are streamlining referral workflows, focusing on residential treatment entry, and developing targeted outreach and navigation supports. SUS' planned transition to Epic Electronic Health Record system will further improve timely access to care.

BHS is also integrating translation tools across services to strengthen language capacity increase access to care for non-English speakers.

File Upload

Please identify the category or categories of funding that the county is using to address the access to care goal
BHSA Behavioral Health Services and Supports (BHSS)
BHSA Full Services Partnership (FSP)
1991 Realignment
2011 Realignment
Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)
Other

Please describe other
San Francisco General Fund

Homelessness: Primary measures

People Experiencing Homelessness Point-in-Time Count (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?
Above

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Gender

Homeless Student Enrollment by Dwelling Type, California Department of Education (CDE), 2023 - 2024

How does your county status compare to the statewide rate?
Above

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Spoken Language

Homelessness: Supplemental Measures

PIT Count Rate of People Experience Homelessness with Severe Mental Illness, (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

PIT Count Rate of People Experience Homelessness with Chronic Substance Abuse, (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

People Experiencing Homelessness Who Accessed Services from a Continuum of Care (CoC) Rate (BCSH), 2023 (This measure will increase as people access services.)

How does your local CoC's rate compare to the average rate across all CoCs?
Above

What disparities did you identify across demographic groups or special populations?
Age
Gender
Race or Ethnicity

Homelessness: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
San Francisco continues to face one of the highest rates of homelessness across all counties in California. The 2024 Point-in-Time Count highlights significant disparities across the homeless population, in age, race, and gender. Adults ages 18–44 and males are overrepresented. Women, particularly those with children, experience unique vulnerabilities. Racial disparities are especially severe: Black, Native American, Pacific Islander, and Latine residents are represented at rates far higher than their share of the general population.

K-12 students who are experiencing homelessness also experience inequities. English learners and students identifying as American Indian, African American, or Pacific Islander are disproportionately represented.

Among all California counties, San Francisco has the highest rate of people experiencing homelessness who access services from the Continuum of Care, which demonstrates systemwide capacity to engage individuals once they are identified. However, older adults are underrepresented in service utilization which may indicate persistent barriers to access.

Data from the UCSF California Statewide Study of People Experiencing Homelessness confirm that SF's unhoused population is aging and many experience chronic illness, mental illness, and substance use disorders.

Overall, these data reflect the magnitude and complexity of homelessness in SF. While SF's health, housing, and human service systems are comparatively effective at connecting people to services, needs and demand continue to far exceed available resources.

Homelessness: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of homelessness in the population experiencing severe mental illness, severe SUD, or co-occurring

conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

San Francisco is implementing coordinated efforts across housing, health, and human services to address homelessness and behavioral health needs, with a focus on reducing inequitable outcomes for diverse populations. San Francisco uses a Housing First approach, recognizing that stable housing is a necessary first step in treating serious mental illness, substance use disorders, and co-occurring conditions.

On any given night, approximately 15,000 San Francisco residents are sheltered or housed through our Homelessness Response System. The SF BHS Residential System of Care delivers approximately 2,550 beds: 1,860 in mental health and 690 in substance use services (as of FY2023-2025). These beds span treatment levels, offering dual diagnosis, low-barrier, withdrawal management, therapeutic residences, and co-ops. San Francisco's Proposition C will fund 400 new beds in FY2025-2026. BHS plans to expand crisis diversion, sub-acute locked beds, and services for transitional-age youth, women with dual diagnoses, and other populations.

SFDPH BHS integrates behavioral health with housing through clinical teams in shelters, wraparound services in permanent supportive housing, and step-down models to prevent shelter-hospital-street cycling. SFDPH BHS works in close partnership with the San Francisco Department of Homelessness and Supportive Housing (HSH) to integrate behavioral health and housing services across the care continuum.

Bed shortages and long waits for subacute or dual diagnosis care continue to limit access to care. In addition to opening new treatment beds (funded by local dollars), SFDPH BHS will focus on expanding dual diagnosis and justice-involved capacity, strengthening culturally responsive and targeted outreach, and improving referral systems. These efforts aim to reduce homelessness for residents with behavioral health needs. Targeted supports will be directed to older adults, Black, Native Pacific Islander, and Latine, and other populations who are disproportionately unhoused and underserved in residential settings.

File Upload

Please identify the category or categories of funding that the county is using to address the homelessness goal

BHSA FSP
BHSA Housing Interventions
1991 Realignment
2011 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Other

Please describe other
San Francisco General Fund

Institutionalization

Per 42 CFR 435.1010, an institution is "an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor." Institutional settings are intended for individuals with conditions including, but not limited to, behavioral health conditions.
Care provided in inpatient and residential (i.e., institutional) settings can be clinically appropriate and is part of the care continuum. Here, institutionalization refers to individuals residing in these settings longer than clinically appropriate. Therefore, the goal is not to reduce stays in institutional settings to zero. The focus of this goal is on reducing stays in institutional settings that provide a Level of Care that is not – or is no longer – the least restrictive environment. (no action)

Institutionalization: Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023

How does your county status compare to the statewide rate/average?

For adults/older adults
Above

For children/youth
Not Applicable

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

How does your county status compare to the statewide rate/average?

14-day involuntary detention rates per 10,000
Above

30-day involuntary detention rates per 10,000
Above

180-day post-certification involuntary detention rates per 10,000
Not Applicable

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Conservatorships, FY 2021 - 2022

How does your county status compare to the statewide rate/average?

Temporary Conservatorships
Above

Permanent Conservatorships
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

SMHS Crisis Service Utilization (Crisis Intervention, Crisis Residential Treatment Services, and Crisis Stabilization) (DHCS), FY 2023
Increasing access to crisis services may reduce or prevent unnecessary admissions to institutional facilities

How does your county status compare to the statewide rate/average?

Crisis Intervention

For adults/older adults
Below

For children/youth
Above

Crisis Residential Treatment Services

For adults/older adults
Below

For children/youth
Not Applicable

Crisis Stabilization

For adults/older adults
Above

For children/youth
Above

What disparities did you identify across demographic groups or special populations?
None Identified

Institutionalization: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
San Francisco's institutionalization measures show higher inpatient administrative days and involuntary detention rates than statewide averages. San Francisco offers more psychiatric and crisis beds per capita

than neighboring counties. This increases client access to stabilization. However, our system has limited stepdown options, which may result in longer hospital stays before an individual is discharged to the appropriate lower-acuity setting.

Crisis service data also show that San Franciscans spend more time in stabilization services than the statewide average. This partly reflects the higher acuity and clinical complexity of our local population, including individuals with serious mental illness, substance use disorders, co-occurring conditions, and unstable housing. Local data tells us that these populations typically require longer stabilization periods before safe discharge and are most likely to experience prolonged inpatient stays and higher involuntary detention rates.

While our inpatient capacity helps to ensure that people are not turned away when in need of stabilization, the lack of sufficient residential step-down facilities creates bottlenecks and prolongs institutional care. Workforce shortages, particularly in culturally and linguistically diverse clinicians, can also limit follow-up and outpatient access for non-English-speaking and immigrant communities. Disparities across race, housing status, and language access demonstrate the need for expanded step-down programs, stronger culturally responsive services, and improved care coordination to ensure that institutional settings are used appropriately and equitably.

Institutionalization: Cross-Measure Questions

What additional local data do you have on the current status of institutionalization in your county? (Example: utilization of Mental Health Rehabilitation Center or Skilled Nursing Facility-Special Treatment Programs)

SF BHS tracks local utilization and length-of-stay data across its Residential System of Care (RSOC), including mental health rehabilitation centers, crisis residential treatment programs, acute diversion units, skilled nursing facilities with psychiatric services, and permanent supportive housing with intensive services. Local data show that individuals with serious mental illness, substance use disorders, co-occurring conditions, and unstable housing are more likely to experience extended stays in inpatient and institutional settings when appropriate step-down placements are unavailable.

While San Francisco has strong inpatient and crisis capacity, the limited availability of lower-acuity residential and community-based placements contributes to discharge delays and prolonged institutionalization, leading to higher inpatient administrative days and involuntary detention rates. Local data also indicate that workforce shortages, particularly among bilingual and culturally responsive providers, can further delay transitions to outpatient or community-based care. These findings underscore the need to expand step-down capacity, strengthen care coordination, and invest in community-based services to ensure institutional care is used appropriately and for the shortest clinically necessary duration.

File Upload

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's rate of institutionalization. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., enhancing crisis response services targeting a sub-population in which data demonstrates they have poorer outcomes)

San Francisco is implementing targeted strategies to reduce unnecessary institutionalization by strengthening community-based alternatives and improving care transitions. SF BHS is expanding the Residential System of Care by expanding dual-diagnosis residential programs, new mental health rehabilitation centers, and additional treatment beds. These investments will relieve bottlenecks that extend inpatient administrative days and ensure that individuals can move to less restrictive, clinically appropriate settings.

Psychiatric Emergency Services continues to divert residents from inpatient care when possible, while crisis teams are expanding culturally and linguistically responsive supports to improve stabilization and follow-up. By 2026, integration with the Epic Electronic Health Record system will enable better discharge tracking, closed-loop referrals, and stronger coordination with step-down facilities.

Over the next three years, SF BHS plans to expand crisis stabilization and residential services for people with co-occurring serious mental illness and substance use disorder. These individuals are disproportionately impacted by prolonged hospital stays and higher rates of involuntary detention. New programs will include additional crisis diversion beds and subacute treatment options to shorten inpatient days.

SF BHS is also prioritizing behavioral health workforce development by investing in training and recruitment to increase the number of clinicians fluent in SF threshold languages and expand culturally responsive care. These efforts will help address disparities in access faced by non-English-speaking residents.

Together, these efforts build on SF BHS system strength in maintaining inpatient and crisis capacity while addressing gaps in step-down and follow-up care. By expanding transitional programs, diversifying the workforce, and embedding equity into crisis services, San Francisco will reduce administrative days, improve discharge pathways, and ensure that residents are served in the least restrictive environment appropriate to their needs.

File Upload

Please identify the category or categories of funding that the county is using to address the institutionalization goal
BHSA FSP
BHSA Housing Interventions
1991 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)
Other

Please describe other
San Francisco General Fund

Justice-Involvement: Primary Measures

Arrests: Adult and Juvenile Rates (Department of Justice), Statistical Year 2023

How does your county status compare to the statewide rate/average?

For adults/older adults
Below

For juveniles
Above

What disparities did you identify across demographic groups or special populations?
Age
Gender
Race or Ethnicity

Justice-Involvement: Supplemental Measures

Adult Recidivism Conviction Rate (California Department of Corrections and Rehabilitation (CDCR)), FY 2019 - 2020

How does your county status compare to the statewide rate/average?

Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity

Incompetent to Stand Trial (IST) Count (Department of State Hospitals(DSH)), FY 2023
Note: The IST count includes all programs funded by DSH, including, state hospital, Jail Based Competency Treatment (JBCT), waitlist, community inpatient facilities, conditional release, community-based restoration and diversion programs. However, this count excludes county-funded programs. As such, individuals with Felony IST designations who are court-ordered to county-funded programs are not included in this count.

How does your county status compare to the statewide rate/average?
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Justice-Involvement: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
San Francisco has the lowest adult arrest rates of any California county, yet disparities remain severe. Black/African American residents are arrested at ten times the county average, and Latine/Hispanic residents are slightly overrepresented. These inequities reflect longstanding structural racism, inequities in policing, and disproportionate enforcement. Adults with co-occurring mental illness, substance use disorders, and homelessness are also at elevated risk of arrest and detention, underscoring the link between behavioral health needs and justice involvement.

San Francisco's juvenile arrest rate is above the state average and Black/African American, American Indian/Alaska Native, and Latine/Hispanic youth remain disproportionately represented among arrests and probation referrals. These trends have persisted for decades, and SF has enacted policies to decrease juvenile arrest and incarceration rates. From 2010-2022, San Francisco saw a large decline in juvenile incarceration per capita (83%), outpacing statewide decline (-50%). Rates of violent crime by youth also fell drastically (-73%) compared to statewide (-43%). Admissions to Juvenile Hall dropped by 40% between

2019 and 2023, with an average daily population of just 25 youth. These successes reflect progress with diversion and community-based alternatives; however, disproportionality continues to be driven by concentrated poverty, trauma, and educational inequities in neighborhoods such as Bayview–Hunters Point, the Mission, and the Tenderloin.

While the San Francisco Juvenile Probation Department and community partners have succeeded in reducing the system's footprint, disparities persist in both youth and adult arrests. These inequities point to the need for sustained collaboration across SF Behavioral Health Services, Juvenile Probation, Human Services Agency, Department of Children, Youth & Their Families, local schools, and community organizations to ensure that individuals with behavioral health needs are diverted to care, not custody.

Justice-Involvement: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of justice-involvement for those living with significant behavioral health needs. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

San Francisco is advancing a care-first model for justice-involved residents, grounded in cross-agency partnerships, to ensure every youth arrested is connected immediately to holistic, culturally responsive services that continue across probation, court, and counsel. The Justice Services Care Model launched in 2024 by Juvenile Probation in partnership with SF BHS, the SF Department of Children, Youth, and Families, and five community-based organizations. Restorative justice programs such as Make It Right, supported by schools and community partners, have shown reduced recidivism compared to traditional processing.

SFDPH and BHS collaborate with local courts, the SF Sheriff's Office, and the SF Human Services Agency to expand opportunities for law enforcement diversion and reentry. These court-based diversion programs connect individuals with mental illness and substance use disorder to treatment rather than incarceration, when eligible. SF also offers housing-focused programs, such as Bringing Families Home, that provide subsidies, case management, and clinical health care for justice-involved families who are experiencing housing insecurity.

To further reduce justice-system involvement, particularly for those with unmet behavioral health needs, SF BHS plans to expand crisis intervention services and increase treatment slots for individuals designated Incompetent to Stand Trial. SF BHS also plans to deepen joint planning efforts across county agencies and

with community providers. Our partners at SF Probation, DCYF, and HSA focus on justice system reform while BHS ensures behavioral health care is integrated throughout the system. For those with unmet behavioral health needs, the system offers treatment and support as an alternative to incarceration, addressing root causes to reduce recidivism. Investments in trauma-informed, culturally specific care will target Black/African American, American Indian/Alaska Native, and Latine/Hispanic communities disproportionately impacted by arrests and probation.

Since 2017, SFDPH has been awarded $20 million in grants from the CA Board of State and Community Corrections to deliver mental health and substance use disorder treatment services and jail diversion programming for those in the criminal justice system. These programs provide residential treatment beds, low threshold outpatient case management, and wraparound support services for adults with co-occurring substance use disorder and mental health disorders who have had contact with the criminal justice system. These programs are helping to reduce recidivism rates and strengthen partnerships between direct service providers working at the intersection of criminal justice, behavioral health, and substance use in San Francisco.

File Upload
SF_sharply_reduced_youth_crime.pdf
4._JPD__Annual_Data_Report_2023_FINAL_PUBLIC_9.11.24.pdf

Please identify the category or categories of funding that the county is nusing to address the justice-involvement goal
BHSA BHSS
BHSA FSP
BHSA Housing Interventions
1991 Realignment
2011 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)
Other

Please describe other
San Francisco General Fund, CA Board of State and Community Corrections Proposition 47 grant funds

Removal Of Children from Home: Primary Measures

Children in Foster Care (Child Welfare Indicators Project (CWIP)), as of January 2025

How does your county status compare to the statewide rate?

Same

What disparities did you identify across demographic groups or special populations?
Age

Removal Of Children from Home: Supplemental Measures

Open Child Welfare Cases SMHS Penetration Rates (DHCS), 2022

How does your county status compare to the statewide rate?
Above

What disparities did you identify across demographic groups or special populations?
Age

Child Maltreatment Substantiations (CWIP), 2022

How does your county status compare to the statewide rate?
Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex

Removal Of Children from Home: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
While San Francisco's foster care rate appears close to the state average, underlying inequities remain significant. Black/African American and Latine/Hispanic children remain disproportionately represented in referrals and removals, even though they make up a smaller share of the child population. Most referrals are for neglect rather than abuse, reflecting socioeconomic hardship, caregiver stress, and systemic poverty as the primary drivers of system involvement. Younger children, especially ages 0–5, are disproportionately impacted in both referrals and entries to care.

Local data confirm these patterns. The SF HSA Child Welfare Report (2023) shows that foster care caseloads declined about 10% since 2020, but disproportionality persists. Black/African American children, who represent just 5% of San Francisco's child population, accounted for nearly 29% of referrals. Referrals remain concentrated in general neglect, often rooted in housing instability and poverty. The CSA report also notes that while the County prevalence of children in care is under the state average, a higher share of non-minor dependents (ages 18–21) remain in care locally. This inflates point-in-time counts and highlights unique needs for youth aging into adulthood without permanency. Gender disparities are also evident: female children are more likely to have substantiated maltreatment, and infants age 0–1 experience the highest rates of both substantiation and foster care entry. These inequities reflect structural racism, economic inequality, and lack of affordable housing, rather than differences in parenting capacity or abuse prevalence.

Together, the data reveal that while overall foster care rates are stable and declining, disparities remain entrenched across race, age, and socioeconomic status. Addressing these inequities requires interventions beyond child welfare, involving coordinated efforts across housing, behavioral health, and family support systems.

Removal Of Children from Home: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may increase your county's level of access to care. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes

San Francisco Human Services Agency leads the county's child welfare system, with SF BHS providing critical supports for children and families with mental health and substance use needs. HSA's System Improvement Plan emphasizes prevention, equity, and permanency, with strategies that directly address disparities identified in local data.

Implementation of the Family First Prevention Services Act expands community-based prevention services designed to keep families safely together. HSA is strengthening family finding to identify kinship placements earlier, reducing reliance on group care and improving permanency outcomes. The P3 measure (permanency within 24 months) is a priority, with dedicated efforts to shorten time in foster care.

SF BHS supports these goals by expanding access to specialty mental health services for child-welfare involved youth and ensuring smoother transitions between open child welfare cases and behavioral health

care. Residential programs, family therapy, and targeted supports for parents with behavioral health needs help address underlying risk factors that lead to neglect referrals. Housing-focused initiatives, such as Bringing Families Home, provide subsidies and case management for families at risk of removal, directly addressing poverty and homelessness as drivers of child welfare involvement.

Moving forward in 2026, BHS and HSA plan to jointly expand culturally responsive prevention programs, embed equity-focused practices into all levels of decision-making, and improve coordination through shared data systems. Specific priorities include targeted support for Black/African American, American Indian/Alaska Native, and Latine/Hispanic families, expansion of behavioral health services for young children and parents/caregivers, and greater integration of housing and child welfare interventions.

Through these cross-agency efforts, San Francisco aims not only to reduce foster care entries but also to narrow racial disproportionalities and strengthen permanency outcomes for children and families most at risk.

File Upload
San_Francisco_CSA_Report_FINAL_3.17.25.pdf
report_child_welfare_8.2025.pdf
CCT-TONIC-Foster-Care-in-San-Francisco.pdf.pdf

Please identify the category or categories of funding that the county is nusing to address the removal of children from home goal
BHSA BHSS
BHSA FSP
1991 Realignment
2011 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)
Other

Please describe other
San Francisco General Fund

Untreated Behavioral Health Conditions: Primary Measures

Follow-Up After Emergency Department Visits for Substance Use (FUA-30), 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Follow-Up After Emergency Department Visits for Mental Illness (FUM-30), 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Untreated Behavioral Health Conditions: Supplemental Measures

Adults that needed help for emotional/mental health problems or use of alcohol/drugs who had no visits for mental/drug/alcohol issues in past year(CHIS), 2023

How does your county status compare to the statewide rate?

For the full population measured
Below

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity

Untreated Behavioral Health Conditions: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
The above DHCS data indicates that San Francisco's follow-up rate after an emergency department (ED) visit for mental illness (FUM-30) was at 29.8% in 2022, below the state average. However, this is likely

underreporting due to data integrity issues. SFDPH's own analysis shows that rates were substantially higher locally—60.9% in 2023 and 66.2% in 2024— both well above state and national benchmarks. SFDPH-calculated rates include data sources beyond what is available to the state, accounting for the notable difference in the DHCS-calculated 2022 rates vs. SFDPH-calculated 2023 and 2024 rates.

By contrast, follow-up after ED visits for substance use (FUA-30) is above statewide averages. This follow-up has improved due to local initiatives to rapidly connect individuals to services and supports, including offering safer use supplies while connecting individuals to proactive counseling and treatment referrals; establishing a telehealth link to connect individuals with Opioid Use Disorder with medications (buprenorphine and methadone); and a 72-hour methadone Bridge Clinic. Local data shows disparities among residents with co-occurring SUD and mental illness, people experiencing homelessness, and non-English-speaking residents, who face systemic barriers to timely follow-up and service engagement.

San Francisco has made measurable progress in connecting individuals to post-ED mental health services, demonstrating system strength. Yet inequities in follow-up and racial disparities in unmet behavioral health needs remain significant challenges, underscoring the need for focused interventions targeting both populations at highest risk and structural barriers to care.

Untreated Behavioral Health Conditions: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of untreated behavioral health conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

SF BHS is expanding efforts to reduce untreated behavioral health conditions by strengthening systematic follow-up after acute episodes of care. The Office of Coordinated Care (OCC), launched in 2022, plays a central role in linking individuals discharged from psychiatric holds (5150) and emergency settings with timely outpatient care. Since 2024, all 5150 discharges from Zuckerberg San Francisco General Hospital have been centralized through OCC to ensure consistent follow-up and connection to community services.

SFDPH and BHS are also leading a cross-system initiative to map the "5150 lifecycle," including improving communication and follow-up from private hospitals. This project aims to standardize practices across facilities, close referral gaps, and reduce the number of individuals discharged without timely linkage to care. In addition, the OCC Triage Team is piloting a new workflow with the South of Market Mental Health Clinic that connects recently discharged patients directly to a psychiatrist for medication refills while they

wait for intake appointments. This addresses a critical gap: discharged patients often leave with only a two-week supply of medication, and this pilot ensures continuity until ongoing care is established.

SF BHS will continue expanding OCC's closed-loop referral capacity through the new Epic EHR system, enabling real-time scheduling and follow-up tracking. Targeted outreach and culturally responsive navigation supports will prioritize Black/African American residents and other groups with higher reported unmet need, as identified by CHIS data. For substance use, BHS is expanding residential and outpatient options while embedding peer support and navigation services to improve FUA-30 outcomes.

Together, these initiatives aim to reduce untreated behavioral health conditions by ensuring timely follow-up, closing system gaps, and addressing disparities that persist despite progress in overall performance.

File Upload

Please identify the category or categories of funding that the county is using to address the untreated behavioral health conditions goal
BHSA BHSS
BHSA FSP
1991 Realignment
2011 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)
Other

Please describe other
San Francisco General Fund

Additional statewide behavioral health goals for improvement

Please review your county's status on the remaining eight statewide behavioral health goals using the primary measure(s) to compare your county to the statewide status and review the supplemental measure(s) for additional insights in the County Performance Workbook. These measures should inform the overall strategy and where relevant, be incorporated into the planning around the six priority goals.

In the next section, the county will select AT LEAST one goal from below for which your county is performing below the statewide rate/average on the primary measure(s) to improve on as a priority for the county.

For related policy information, refer to E.6.2 Primary and Supplemental Measures .

Care Experience: Primary Measures

Perception of Cultural Appropriateness/Quality Domain Score (Consumer Perception Survey (CPS)), 2024

How does your county status compare to the statewide rate/average?

For adults/older adults
Above

For children/youth
Same

Quality Domain Score (Treatment Perception Survey (TPS)), 2024

How does your county status compare to the statewide rate/average?

For adults/older adults
Same

For children/youth
Not Applicable

Engagement In School: Primary Measures

Twelfth Graders who Graduated High School on Time (Kids Count), 2022

How does your county status compare to the statewide rate/average?
Below

Engagement In School: Supplemental Measures

Meaningful Participation at School (California Health Kids Survey (CHKS)), 2023

How does your county status compare to the statewide rate/average?
Below

Student Chronic Absenteeism Rate (Data Quest), 2022

How does your county status compare to the statewide rate/average?
Below

Engagement In Work: Primary Measures

Unemployment Rate (California Employment Development Department (CA EDD)), 2023

How does your county status compare to the statewide rate/average?
Below

Engagement In Work: Supplemental Measures

Unable to Work Due to Mental Problems (California Health Interview Survey (CHIS)), 2023

How does your county status compare to the statewide rate/average?
Above

Overdoses: Primary Measures

All Drug-Related Overdose Deaths (California Department of Public Health (CDPH)), 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Above

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Overdoses: Supplemental Measures

All-Drug Related Overdose Emergency Department Visits (CDPH), 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Above

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Prevention And Treatment of Co-Occurring Physical Health Conditions: Primary Measures

Adults' Access to Preventive/Ambulatory Health Service & Child and Adolescent Well-Care Visits (DHCS), 2022

How does your county status compare to the statewide rate/average?

For adults (specific to Adults' Access to Preventive/Ambulatory Health Service)
Same

For children/youth (specific to Child and Adolescent Well-Care Visits)
Above

Prevention And Treatment of Co-Occurring Physical Health Conditions: Supplemental Measures

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications & Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing (DHCS), 2022

How does your county status compare to the statewide rate/average?

For adults/older adults (specific to Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications)
Above

For children/youth (specific to Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing)
Above

Quality Of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average?

For the full population measured
Not Applicable

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Quality Of Life: Supplemental Measures

Poor Mental Health Days Reported (Behavioral Risk Factor Surveillance System (BRFSS)), 2024

How does your county status compare to the statewide rate/average?

For the full population measured
Below

Social Connection: Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average?

For the full population measured
Not Applicable

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

How does your county status compare to the statewide rate/average?
Below

Suicides: Primary Measures

Suicide Deaths, 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Below

Suicides: Supplemental Measures

Non-Fatal Emergency Department Visits Due to Self-Harm, 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Above

For adults/older adults
Not Applicable

For children/youth
Not Applicable

County-selected statewide population behavioral health goals

For related policy information, refer to 3.E.6 Statewide Behavioral Health Goals .

Based on your county's performance or inequities identified, select at least one additional goal to improve on as a priority for the county for which your county is performing below

the statewide rate/average on the primary measure(s). For each county-selected goal, provide the information requested below.
Overdoses

Overdoses

Please describe why this goal was selected
Drug overdose remains one of San Francisco's most urgent public health challenges. The county continues to record among the highest rates of drug-related overdose deaths in California.

What disparities did you identify across demographic groups or priority populations among the Additional Statewide Behavioral Health Goals? For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
While the total number of overdose deaths in 2025 is lower than in 2023, disparities remain stark. Black/African American residents experience a five-fold higher risk of dying from overdose compared to the citywide rate (423 per 100,000 vs. 73 per 100,000). These inequities reflect structural racism, housing instability, and unequal access to treatment and harm reduction resources.

The majority of fatal overdoses involve fentanyl, which was detected in 72% of deaths. Polysubstance use is also common, with methamphetamine present in 51% of deaths and cocaine in 41%. The unregulated drug supply increasingly includes adulterants such as novel benzodiazepines and xylazine, which raise overdose risks and complicate medical response.

Housing status is another key driver. Approximately one in five overdose deaths occur among people without a fixed address, often those living unsheltered. Nearly one-quarter of deaths occur in supportive housing, shelters, navigation centers, or low-income housing, highlighting the vulnerability of residents even once housed.

Emergency Department (ED) data mirror these trends, with San Francisco experiencing high rates of drug-related ED visits. Adults comprise the largest share, but disparities persist across racial and housing subgroups. Youth are less impacted in absolute numbers but remain at risk given the prevalence of fentanyl in the unregulated market.

Overall, the data underscore a layered crisis; San Francisco has mobilized extensive harm reduction and treatment resources, but fentanyl, polysubstance use, racial inequities, and housing instability continue to drive disproportionate risk and mortality.

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may improve your county's level of Overdoses and refer to any data that was used to make this decision (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)
SF BHS Substance Use Services (SUS) has scaled a comprehensive overdose response informed by local data on mortality, substance patterns, and disparities. SF BHS partners with community organizations and residents that are most impacted, especially the Black/African American community, to ensure interventions are culturally responsive and aligned with community priorities.

Harm reduction is central to SF BHS approach to substance use disorder treatment. In 2024, SF BHS SUS distributed more than 200,000 doses of naloxone—an increase of 382% since 2011—including widespread distribution in supportive housing. Thousands of City/County staff and community partners have completed overdose recognition and response training through LearnSFDPH.org. These efforts have normalized overdose preparedness across public systems.

Low-threshold access to medications for opioid use disorder (MOUD) is also expanding. Since March 2024, SF BHS' navigation and telehealth program has reached more than 3,400 unique individuals experiencing homelessness, with 47% confirmed to have received MOUD. Buprenorphine delivery in supportive housing brings treatment to residents directly where they live. San Francisco also enacted the nation's first ordinance requiring retail pharmacies to stock buprenorphine and supported AB 2115 to improve methadone access statewide.

San Francisco funded its first Drug Sobering Center to provide safe short-term care, and launched "Living Proof," a media campaign featuring people in recovery to reduce stigma and raise awareness of available services.

By July 2026, SF BHS will increase naloxone distribution, expand MOUD access, expand integrated treatment in supportive housing programs, and increase culturally tailored outreach to Black/African American, America Indian/Alaskan Native, and Latine communities. These actions, grounded in data on disparities and overdose trends, aim to reduce overdose mortality, close racial inequities, and sustain progress toward stabilizing one of San Francisco's most urgent behavioral health challenges.

Please identify the category or categories of funding that the county is using to address this goal
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Community Planning Process

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 3.B Community Planning Process .

Stakeholder Engagement

For related policy information, refer to 3.B.1 Stakeholder involvement

---

Please indicate the type of engagement used to obtain input on the planning process

Focus group discussions
Key informant interviews with subject matter experts
Meeting(s) with county
Provided data to county
Public e-mail inbox submission
Survey participation
Training, education, and outreach related to community planning
Workgroups and committee meetings

Include date(s) of stakeholder engagement for each type of engagement

Type of engagement
Focus group discussions

Date
6/13/2025

Type of engagement
Focus group discussions

Date
6/18/2025

Type of engagement
Focus group discussions

Date
7/17/2025

Type of engagement
Focus group discussions

Date
7/21/2025

Type of engagement
Focus group discussions

Date
8/25/2025

Type of engagement
Focus group discussions

Date
9/12/2025

Type of engagement
Focus group discussions

Date
10/18/2025

Type of engagement
Key informant interviews with subject matter experts

Date
7/29/2025

Type of engagement
Key informant interviews with subject matter experts

Date
7/30/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/15/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/28/2025

Type of engagement
Meeting(s) with county

Date
9/8/2025

Type of engagement
Meeting(s) with county

Date
10/27/2025

Type of engagement
Meeting(s) with county

Date
11/21/2025

Type of engagement
Provided data to county

Date
9/10/2025

Type of engagement
Provided data to county

Date
10/6/2025

Type of engagement
Provided data to county

Date
11/11/2025

Type of engagement
Provided data to county

Date
11/18/2025

Type of engagement
Survey participation

Date
10/22/2025

Type of engagement
Training, education, and outreach related to community planning

Date
5/8/2025

Type of engagement
Training, education, and outreach related to community planning

Date
6/13/2025

Type of engagement
Training, education, and outreach related to community planning

Date
8/12/2025

Type of engagement
Training, education, and outreach related to community planning

Date
9/16/2025

Type of engagement
Training, education, and outreach related to community planning

Date
11/18/2025

Type of engagement
Workgroups and committee meetings

Date
5/8/2025

Type of engagement
Workgroups and committee meetings

Date
5/14/2025

Type of engagement
Workgroups and committee meetings

Date
5/20/2025

Type of engagement
Workgroups and committee meetings

Date
5/30/2025

Type of engagement
Workgroups and committee meetings

Date
6/3/2025

Type of engagement
Workgroups and committee meetings

Date
6/10/2025

Type of engagement
Workgroups and committee meetings

Date
6/11/2025

Type of engagement
Workgroups and committee meetings

Date
6/13/2025

Type of engagement
Workgroups and committee meetings

Date
6/24/2025

Type of engagement
Workgroups and committee meetings

Date
7/2/2025

Type of engagement
Workgroups and committee meetings

Date
7/11/2025

Type of engagement
Workgroups and committee meetings

Date
7/15/2025

Type of engagement
Workgroups and committee meetings

Date
7/17/2025

Type of engagement
Workgroups and committee meetings

Date
7/29/2025

Type of engagement
Workgroups and committee meetings

Date
8/5/2025

Type of engagement
Workgroups and committee meetings

Date
8/8/2025

Type of engagement
Workgroups and committee meetings

Date
8/12/2025

Type of engagement
Workgroups and committee meetings

Date
8/19/2025

Type of engagement
Workgroups and committee meetings

Date
9/2/2025

Type of engagement
Workgroups and committee meetings

Date
9/12/2025

Type of engagement
Workgroups and committee meetings

Date
9/16/2025

Type of engagement
Workgroups and committee meetings

Date
10/14/2025

Type of engagement
Workgroups and committee meetings

Date
11/14/2025

Type of engagement
Workgroups and committee meetings

Date
11/18/2025

Type of engagement
Workgroups and committee meetings

Date
12/13/2025

Type of engagement
Workgroups and committee meetings

Date
1/9/2026

Type of engagement
Workgroups and committee meetings

Date
2/5/2025

Type of engagement
Workgroups and committee meetings

Date
2/13/2026

Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals
SF BHS stakeholder groups: SF BHSA BHSA Steering Committee and Work Groups, BHSA Advisory Committee, SF BHS Client Council.
Other City and County partners: SF Department of Public Health, Emergency Medical Services, SF Department of Homelessness and Supportive Housing, SF Department of Disability and Aging Services, SF Department of Children, Youth, and Their Families.
Community-based organizations: Richmond Area Multi Services, 6th Street Community, Asian & Pacific Islander Mental Health Collaborative, Native American Health Center, Marilyn Inn Housing Community, SF City College, FACES for the Future, Tenderloin Neighborhood Development Corporation, Horizons Unlimited, Latino Commission, Golden Gate Regional Center.
Other partners: MediCal Managed Care Plans, hospitals, labor unions, independent living centers.

What are the five most populous cities in counties with a population greater than 200,000 (Cities submitting IP independently are not required to collaborate with other cities) (Population and Housing Estimates for Cities, Counties, and the State)

	City name
1	Not applicable
2	Not applicable
3	Not applicable
4	Not applicable
5	Not applicable

Were you able to engage all required stakeholders/groups in the planning process?
Yes

Please describe and provide documentation (such as meeting minutes) to support how diverse stakeholder viewpoints were incorporated into the development of the Integrated Plan, including any community-identified strengths, needs, and priorities
See the attached file with an overview of the SF BHS BHSA CPP activities and key findings. The file also includes CPP Meeting/Focus Group minutes, meeting sign-in sheets (with participant demographics), and the Fall 2025 CPP Community Survey Report.

Upload File
SF BHS BHSA CPP Overview with Meeting Minutes and Survey Report.pdf

Local Health Jurisdiction (LHJ)

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes .

Did the county work with its LHJ on the development of the LHJ's recent Community Health Assessment (CHA) and/or Community Health Improvement Plan (CHIP) ? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3.
Yes

Please describe how the county engaged with LHJs, along with Medi-Cal managed care plans (MCPs), across these three areas in developing the CHA and/or CHIP: collaboration, data-sharing, and stakeholder activities
SF BHS engaged with the LHJ and local MCPs in developing the CHA by participating in key CHA development meetings, providing feedback on the early draft of the CHA, and sharing data. BHS also shared information about our Community Program Planning processes and coordinated plans to survey the community, host future focus groups and community meetings. BHS intends to share a draft IP with the LHJ CHA development team and collaborating MCPs for their feedback and consideration. Moving forward, we intend to work closely with the LHJ and MCPs to align the BHSA IP planning process with that of the Community Health Improvement Plan.

Did the county utilize the County-LHJ-MCP Collaboration Tool provided via technical assistance?
Yes

Collaboration

Please select how the county collaborated with the LHJ
Attended key CHA and CHIP meetings as requested.

Data-Sharing

Data-Sharing to Support the CHA/CHIP

Select Statewide Behavioral Health Goals that were identified for data-sharing to support behavioral health-related focus areas of the CHA and CHIP
Access to Care
Institutionalization
Overdoses
Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)

Was data shared?
Yes

Data-Sharing from MCPS and LHJs to Support IP development

Select Statewide Behavioral Health Goals that were identified for data-sharing to inform IP development
Access to Care
Institutionalization
Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)

Was data shared?
Yes

Stakeholder Activities

Select which stakeholder activities the county has coordinated for IP development with the LHJ engagement on the CHA/CHIP. Please note that although counties must coordinate stakeholder activities with LHJ CHA/CHIP processes (where feasible), the options below are for illustrative purposes only and are not required forms of stakeholder activity coordination (e.g., counties do not need to conduct each of these activities)
Collaborated with LHJ to identify shared stakeholders that are key for both the IP and CHA/CHIP process.
Collaborated on joint surveys, focus groups, and/or interviews that can be used to inform both the IP and CHA/CHIP.
Other

Please describe how the county has coordinated stakeholder activities for IP development and the CHA/CHIP
SF BHS met with the LHJ CHA team and (1) shared BH-related data from the CHA/CHA development, including community meeting notes and key findings, (2) reviewed the draft BHSA survey tool for alignment with CHA survey tool, (3) planned to coordinate future community outreach, meetings/focus groups, and other data collection efforts for CHIP/IP development cycles.

Most Recent Community Health Assessment (CHA), Community Health Improvement Plan (CHIP) or Strategic Plan

Has the county considered either the LHJ's most recent CHA/CHIP or strategic plan in the development of its IP ? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3
Yes

Provide a brief description of how the county has considered the LHJ's CHA/CHIP or strategic plan when preparing its IP
The 2024 San Francisco CHA identified key behavioral health needs of the community. Two of the top three persistent health challenges facing SF residents are behavioral health–related: (1) mental health challenges, (2) drug-related deaths, and (3) nutrition-sensitive conditions. These findings align with SF BHS' decision to adopt the goal on overdoses in our BHSA IP. These issues are longstanding but remain unmet due to the complexity, severity, and scale of the needs in San Francisco.

San Francisco has a large population of individuals with serious mental illness, substance use disorders, and co-occurring conditions, including many who are experiencing homelessness. Many face clinical, structural, socioeconomic, and cultural barriers to accessing care. The CHA also highlights disparities in health outcomes. For example, Black/African SF residents are four times more likely to die from drug-use disorders than the overall SF population. The CHA also documents a rise in fentanyl-related deaths.

In response to the needs identified in the CHA, SF BHS plans to prioritize a continued investment in coordinated, clinically appropriate, and culturally responsive care across the continuum. BHS Substance Use Services and Crisis teams will continue working with Emergency Medical Services and other community partners to deliver prevention, crisis response, targeted intervention, and treatment services.

The CHA also identified housing and other social determinants of health as key drivers of health outcomes in San Francisco. To help meet these needs, BHS will continue our work with the SF Department of Homelessness and Supportive Housing and other community partners to deliver housing and supportive services through coordinated service referral, navigation, and case management. SF MHSA/BHSA Housing Interventions funds will continue to be dedicated to permanent supportive housing for those with the highest level of need (those who meet BHSA Housing eligibility criteria).

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes .

Please list the Managed Care Plans (MCP) the county worked with to inform the MCPs' respective community reinvestment planning and decision-making processes

San Francisco Health Plan
Anthem Blue Cross
Kaiser Permanente

Which activities in the MCP Community Reinvestment Plan submissions address needs identified through the Behavioral Health Services Act community planning process and collaboration between the county, MCP, and other stakeholders on the county's Integrated Plan?

SF BHS plans to work with our three local MCPs, including the San Francisco Health Plan, Anthem Blue Cross, and Kaiser Permanente, to inform the development of their respective Community Reinvestment Plans. SFDPH, BHS, and the MCPs are working together to coordinate the development of the CHA, CHIP,

BHSA IP, and the Community Reinvestment Plans in effort to develop shared goals and align services across the healthcare continuum. In this joint effort, BHS plans to share behavioral health-related needs data, coordinate community outreach and engagement efforts, and identify collaborative opportunities to strengthen healthcare service delivery and improve health outcomes for consumers. MCPs expect to finalize Community Reinvestment Plans by September 2026.

Comment Period and Public Hearing

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to B.3 Public Comment and Updates to the Integrated Plan .

Comment Period and Public Hearing

For related policy information, refer to B.3 Public Comment and Updates to the Integrated Plan .

Date the draft Integrated Plan (IP) was released for stakeholder comment
4/1/2026

Date the stakeholder comment period closed
4/30/2026

Date of behavioral health board public hearing on draft IP
5/7/2026

Please provide proof of a public posting with information on the public hearing. Please select the county's preferred submission modality
Link

Please provide the link to the public posting
To be posted 4/1/2026

If the county uses an existing landing page or other web-based location to publicly post IPs for comment, please provide a link to the landing page

File Upload

Please select the process by which the draft plan was circulated to stakeholders
Public posting
Other

Please specify the other process the draft plan was circulated to stakeholders
Email outreach

Please describe stakeholder input in the table below. Please add each stakeholder group into their own row in the table

Stakeholder group that provided feedback
Stakeholder feedback will be collected through 4/30/2026

Summarize the substantive revisions recommended this stakeholder during the comment period
Forthcoming

Please describe any substantive recommendations made by the local behavioral health board that are not included in the final Integrated Plan or update. If no substantive revisions were recommended by stakeholders during the comment period, please input N/A.

Substantive recommendations
Forthcoming following the Public Comment period
Confirm that the data is up to date and reflects the correct information for a Draft Plan

County Behavioral Health Services Care Continuum

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress.

County Behavioral Health Services Care Continuum

The Behavioral Health Care Continuum is composed of two distinct frameworks for substance use disorder and mental health services. These frameworks are used for counties to demonstrate planned expenditures across key service categories in their service continuum. Questions on the Behavioral Health Care Continuum are in the Integrated Plan Budget Template.

Mark section as complete

County Provider Monitoring and Oversight

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 6.C.2 Securing Medi-Cal Payment .

Medi-Cal Quality Improvement Plans

Cities submitting their Integrated Plan independently from their counties do not have to complete this section or Question 1 under All BHSA Provider Locations.

For Specialty Mental Health Services (SMHS) or for integrated SMHS/Drug Medi-Cal Organized Delivery System (DMC-ODS) contracts under Behavioral Health Administrative Integration, please upload a copy of the county's current Quality Improvement Plan (QIP) for State Fiscal Year (SFY) 2026-2027

SF BHS MHP QI Plan FY 26-27 draft 02.27.2026.pdf

Does the county operate a standalone DMC-ODS program (i.e., a DMC-ODS program that is not under an integrated SMHS/DMC-ODS contract)?

Yes

For standalone DMC-ODS, please upload a copy of the county's current QIP for SFY 2026-2027

SF BHS DMC-ODS QAPI FY 26-27 draft 02.27.2026.pdf

Contracted BHSA Provider Locations

As of the date this report is submitted, please provide the total number of contracted Behavioral Health Services Act (BHSA) provider locations offering non-Housing services for SFY 2025-26. I.e., BHSA-funded locations that are (i) not owned or operated by the county, and (ii) offer BHSA services other than Housing Interventions services. (A provider location should be counted if it offers both Housing Interventions and mental health (MH) or substance use disorder services (SUD); provider location that contracts with the county to provide both mental health and substance use disorder services should be counted separately.)

Services Provided	**Number of contracted BHSA provider locations**
Mental Health (MH) services only	43
Substance Use Disorder (SUD) services only	0
Both MH and SUD services	0

Among the county's contracted BHSA provider locations, please identify the number of locations that also participate in the county's Medi-Cal Behavioral Health Delivery System (BHDS) (including SMHS and Drug MC/DMC-ODS) for SFY 2025-26

Services Provided	**Number of Contracted BHSA Provider Locations**
SMHS only	16
DMC/DMC-ODS only	0
Both SMHS and DMC/DMC-ODS systems	0

All BHSA Provider Locations

For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes .

Among the county's BHSA funded SMHS provider locations (county-operated and contracted) that offer services/Levels of Care that may be covered by Medi-Cal MCPs as non-specialty mental health services (NSMHS), what percentage of BHSA funded SMHS providers contract with at least one MCP in the county for the delivery of NSMHS?

62

To maximize resource efficiency, counties must, as of July 1, 2027, require their BHSA providers to (subject to certain exceptions)

a. **Check whether an individual seeking services eligible for BHSA funding is enrolled in Medi-Cal and/or a commercial health plan, and if uninsured, refer the individual for eligibility screening**

b. **Bill the Medi-Cal Behavioral Health Delivery System for covered services for which the provider receives BHSA funding; and**

c. **Make a good faith effort to seek reimbursement from Medi-Cal Managed Care Plans (MCPs) and commercial health plans for covered services for which the provider receives BHSA funding**

Does the county wish to describe implementation challenges or concerns with these requirements?

No

Counties must monitor BHSA-funded providers for compliance with applicable requirements under the Policy Manual, the county's BHSA contract with DHCS, and state law and regulations. Effective SFY 2027-2028, counties must (1) adopt a monitoring schedule that includes periodic site visits and (2) preserve monitoring records, including monitoring reports, county-approved provider Corrective Action Plans (CAPs), and confirmations of CAP resolutions. Counties shall supply these records at any time upon DHCS's request. DHCS encourages counties to adopt the same provider monitoring schedule as under Medi-Cal: annual monitoring with a site visit at least once every three years. For providers that participate in multiple counties' BHSA programs, a county may rely on monitoring performed by another county.

Does the county intend to adopt this recommended monitoring schedule for BHSA-funded providers that:

Also participate in the county's Medi-Cal Behavioral Health Delivery System? (Reminder: Counties may simultaneously monitor for compliance with Medi-Cal and BHSA requirements)
Yes

Do not participate in the county's Medi-Cal Behavioral Health Delivery System?
Yes

Behavioral Health Services Act/Fund Programs

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress.

Behavioral Health Services and Supports (BHSS)

For related policy information, refer to 7.A.1 Behavioral Health Services and Supports Expenditure Guidelines

---

General

Please select the specific Behavioral Health Services and Supports (BHSS) that are included in your plan

Adult and Older Adult System of Care (non-FSP)
Early Intervention Programs (EIP)
Outreach and Engagement (O&E)
Workforce, Education and Training (WET)
Capital Facilities and Technological Needs (CFTN)

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program

Mental health services
Supportive services

Please describe the specific services provided
San Francisco's BHSA-funded Adult and Older Adult System of Care (Non-FSP) programming will offer mental health and supportive services to BHSA-eligible populations, including those with significant mental health conditions, substance-use disorders, and co-occurring behavioral health needs. Programming will offer culturally responsive and recovery-oriented services, focusing on underserved populations.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	133
FY 2027 – 2028	133
FY 2028 – 2029	133

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care
Estimates are based on number of individuals served in FY2024-2025.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Early Intervention for Youth

Please select which of the three EI components are included as part of the program or service

Outreach
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

No

Please describe intended outcomes of the program or service

Early Intervention Programming for youth ages 0–25 includes community-based outreach, service access and linkage, and treatment services for children, youth, and families. Programming spans perinatal mental health services for families with young children; school-based services for students in grades PreK–12; and targeted supports for Transitional Age Youth (TAY), ages 16–25, and other underserved populations. Services include culturally responsive and community-informed approaches for Black/African American birthing people and families (including maternal mental health care), immigrant and newcomer youth, and other priority populations. The goal of these programs is to increase timely access to behavioral health services and improve related outcomes, particularly for communities experiencing persistent disparities.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	5378
FY 2027 – 2028	5378
FY 2028 – 2029	5378

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Estimates are based on number of individuals served in FY2024-2025.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Early Intervention for Adults

Please select which of the three EI components are included as part of the program or service
Outreach
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
No

Please describe intended outcomes of the program or service
Deliver early intervention programming to adult and older adult populations (ages 26 and older), offer community-based outreach, service access and linkages, and treatment services to increase timely access to behavioral health services and improve related outcomes, particularly for communities experiencing persistent disparities. Includes targeted services for populations with serious mental illness, substance use disorders, and co-occurring disorders, populations who are homeless or at-risk of homelessness, and other underserved populations.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	15611
FY 2027 – 2028	15611
FY 2028 – 2029	15611

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Estimates are based on number of individuals served in FY2024-2025.

Coordinated Specialty Care for First Episode Psychosis (CSC) program

For related policy information, refer to 7.A.7.5.1 Coordinated Specialty Care for First Episode Psychosis .

Please provide the following information on the county's Coordinated Specialty Care for First Episode Psychosis (CSC) program

CSC program name
(re)MIND

CSC program description
The Coordinated Specialty Care for First Episode Psychosis program, (re)MIND (formerly known as Prevention and Recovery in Early Psychosis), delivers an array of services through a multi-disciplinary team in implementing evidence-based practices to individuals and families experiencing early signs and symptoms of schizophrenia and other psychotic disorders.
Services include supporting symptom remission, active recovery, and full engagement in their community and with co-workers, peers, and family members. The program has a significant outreach component and capacity building for our system designed to reduce the stigma of schizophrenia and psychotic disorders, build provider skills to recognize signs, promote awareness that psychosis is treatable, and obtain referrals.
The program is designed to serve individuals ages 14-29 who have had their first psychotic episode within the previous two years. We primarily focus on serving Transitional Age Youth (ages 16-25). Program staff conduct outreach to high-need communities, particularly low-income youth and families. Services are designed to meet clients where they are and are offered both on-site or at off-site locations throughout the city (e.g., at a client's home or school).
This program is overseen by the SFBHS Transitional Age Youth System of Care, separate from our Adult and Older Adult and Children, Youth, and Families Systems of Care.

DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for CSC. The estimated numbers of teams/practitioners reflect the numbers needed to reach the entire eligible population (i.e., achieve a 100 percent penetration rate), and DHCS recognizes that counties will generally not be able to reach the entire eligible population. These projections are not binding and are for planning purposes. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA CSC requirements

Please review the total estimated number of individuals who may be eligible for CSC (based on the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence Based Practice (EBP) Policy Guide and the Policy Manual Chapter 7, Section A.7.5). Please input the estimates provided to the county in the table below.

CSC Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	88
Number of Uninsured Individuals	<11*

CSC Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	13
Number of Teams Needed to Serve Total Eligible Population	3

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for BHSS, please provide the total number of teams and Full-Time Equivalents (FTEs) (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide CSC over this Integrated Plan period, by fiscal year.

County Actuals	**FY 26-27**	**FY 27-28**	**FY 28-29**

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	8	8	8
Total Number of Teams	1	1	1

Will the county's CSC program be supplemented with other (non-BHSA) funding source(s)?
Yes

Please list the other funding source(s)
SAMHSA Mental Health Block Grant, Medi-Cal FFP, SF General Fund.

Outreach and Engagement (O&E) Program

For each program or activity that is part of the county's standalone O&E programs provide the following information. If the county provides more than one program or activity, use the "Add" button. For related policy information, refer to 7.A.3 Outreach and Engagement .

Program or activity name
Outreach & Engagement for Transition Age Youth (TAY)

Please describe the program or activity
Provide outreach and engagement services for Transition Age Youth (TAY), ages 16-24, to connect them to behavioral health services and supports. Includes targeted outreach and engagement for LGBTQ+ TAY.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	320
FY 2027 – 2028	320
FY 2028 – 2029	320

Please describe any data or assumptions the county used to project the number of individuals served through O&E programs
Estimates are based on number of individuals served in FY2024-2025.

Outreach and Engagement (O&E) Program

For each program or activity that is part of the county's standalone O&E programs provide the following information. If the county provides more than one program or activity, use the "Add" button. For related policy information, refer to 7.A.3 Outreach and Engagement .

Program or activity name
Outreach & Engagement for the Transgender Population

Please describe the program or activity
Provide outreach and engagement services for transgender individuals to connect them to behavioral health services and supports.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	327
FY 2027 – 2028	327
FY 2028 – 2029	327

Please describe any data or assumptions the county used to project the number of individuals served through O&E programs
Estimates are based on number of individuals served in FY2024-2025.

Outreach and Engagement (O&E) Program

For each program or activity that is part of the county's standalone O&E programs provide the following information. If the county provides more than one program or activity, use the "Add" button. For related policy information, refer to 7.A.3 Outreach and Engagement .

Program or activity name
Behavioral Health Access Center – Access Line

Please describe the program or activity
BHS Behavioral Health Access Center (BHAC) and Behavioral Health Access Line (BHAL) serve as central entry points into the behavioral health system of care with a goal to promote timely access to care through coordinated screening, intake, and referral processes for those seeking services. BHAC is a 7-day/week walk-in center and BHAL operates the BHS 24/7 Access Line. Both the BHAC and BHAL provide clinical screening, referral to outpatient and residential substance use disorder and mental health treatment, crisis intervention, and referral to urgent services.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	4815
FY 2027 – 2028	4815
FY 2028 – 2029	4815

Please describe any data or assumptions the county used to project the number of individuals served through O&E programs

Estimates are based on

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).

For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name

Mental Health Career Pathways Program

Please select which of the following categories the activity falls under

Workforce Recruitment, Development, Training, and Retention

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
SF BHSA WET programs deliver workforce development, education, and training in effort to build up a qualified and diverse behavioral healthcare workforce. These programs deliver targeted supports to populations who are underrepresented in licensed behavioral health professions.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training.

Program or activity name
WET Residency and Internship Program

Please select which of the following categories the activity falls under
Workforce Recruitment, Development, Training, and Retention

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
The SF BHSA WET Residency and Internship Program offers residency, internship, fellowship, and other training opportunities for individuals who are preparing for a career in behavioral healthcare, including careers in public psychiatry, psychology, and other clinical studies. Training opportunities are offered in partnership with SFDPH BHS Systems of Care, healthcare clinics, and local hospitals. In addition to recruiting trainees who are from backgrounds that are underrepresented in licensed behavioral health professions, these programs provide training on culturally- and linguistically appropriate care to diverse populations.

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name
Vocational Programming for Individuals with Behavioral Health Needs

Please select which of the following categories the activity falls under
Other

Please define the other activity
Vocational services for individuals with serious mental illness and co-occurring disorders

Please describe efforts to address disparities in the Behavioral Health workforce.
Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
Vocational programs offer skill development and training, career/situational assessments, vocational planning and counseling, service coordination, direct job/internship placement, ongoing job coaching, and job retention services. The target population includes individuals with serious mental illness and/or co-occurring disorders. Targeted outreach focuses on underserved populations and BHS clients who are interested in securing employment. The goal is to offer meaningful, long-term employment for the target population to promote their overall wellbeing.

Capital Facilities and Technological Needs (CFTN) Program

For each project that is part of the county's CFTN project, provide the following information. If the county provides more than one project, use the "Add" button. Additional information on CFTN policies can be found in Policy Manual Chapter 7, Section A.5 .

Project name
Capital Facilities

Please select the type of project
Capital facilities project

If capital facilities project, please indicate which of the following categories the project falls under
Acquiring, renovating, or constructing buildings that are or will be county-owned. The building can be owned and operated by a non-profit if the non-profit is providing behavioral health services under contract with the county.

Please indicate if the project involves leasing or renting to own a building
No

Please describe the project
BHSA Capital Facilities funding will support the opening of a new public health service center at 1660 Mission Street. San Francisco has purchased the property (a six-story commercial building built in 1990, with underground parking and adjacent parking lot) and plans to renovate the building to accommodate the needs of behavioral health and sexual health programs. The location will offer a Health, Recovery, and Connection Center, with a sobering center, behavioral health clinics, San Francisco City Clinic, and administrative office space. Several SF BHS programs will relocate services to the new location, which will significantly expand program capacity, consolidate former locations that were not up to Americans with Disabilities Act standards, and result in cost savings for San Francisco by moving from leased to owned space. BHSA funding will support a small portion of the estimated $57 million in renovations.

BHSA Capital Facilities funding will also support renovations at the Chinatown Public Health Center at 1490 Mason Street, which offers comprehensive, multilingual (in Cantonese, Mandarin, and other languages) primary and behavioral health care, dental, and nutrition services. The center will undergo its first major renovations since opening in 1971. Renovations will include a complete seismic retrofit, accessibility

upgrades, and other improvements to reconfigure the space as a state-of-the-art health care hub. The plans include redesigning space to co-locate the Chinatown Child Development Center onsite.

BHSA Capital Facilities funding will support the renovation of the former Southeast Health Center building into a specialty behavioral health clinic, within which DPH will co-locate Southeast Child & Family Therapy Center and Families Rising. This project will not only allow services to move out of leased sites but will provide a more modern setting within which to serve patients and will allow for greater co-location of services to improve access.

Capital Facilities and Technological Needs (CFTN) Program

For each project that is part of the county's CFTN project, provide the following information. If the county provides more than one project, use the "Add" button. Additional information on CFTN policies can be found in Policy Manual Chapter 7, Section A.5 .

Project name
Information Technology

Please select the type of project
Technological needs project

If Technological Needs Project, please select the focus area(s) of the project
Electronic health record system
System maintenance costs

Please describe the project
SF BHSA Information Technology (IT) supports upgrades to clinical and administrative information systems, as well as improvements to clients' and family members' access to personal health information within various public and private settings.

Full Service Partnership Program

DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for each EBP. The estimated numbers of teams/practitioners reflect the numbers needed to reach the entire eligible population (i.e., achieve a 100 percent penetration rate), and DHCS recognizes that counties will generally not be able to reach the entire eligible population, in consideration of BHSA funding availability. These projections are not binding and are for planning

purposes only. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA FSP requirements. For related policy information, refer to 7.B.3 Full Service Partnership Program Requirements and 7.B.4 Full Service Partnership Levels of Care

---

Please review the total estimated number of individuals who may be eligible for each of the following Full Service Partnership (FSP) services (consistent with the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence-Based Practice (EBP) Policy Guide , the Policy Manual Chapter 7, Section B , and forthcoming High Fidelity Wraparound (HFW) Medi-Cal Guidance): Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT), Full Service Partnership (FSP) Intensive Case Management (ICM), HFW and Individual Placement and Support (IPS) Model of Supported Employment). Please input the estimates provided to the county in the table below

Total Adult FSP Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	1523
Number of Uninsured Individuals	140
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	378

Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) Eligible Population

Please input the estimates provided to the county in the table below

ACT Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	214
Number of Uninsured Individuals	20

FACT Eligible Population (ACT with Justice-System Involvement)	**Estimates**
Number of Medi-Cal Enrolled Individuals	107
Number of Uninsured Individuals	10

ACT/FACT Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	40
Number of Teams Needed to Serve Total Eligible Population	<11*

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and Full-Time Equivalents (FTEs) (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide ACT and FACT over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and Technical Assistance (TA) to assist counties with completing these fields.

County Actuals	**FY 26-27**	**FY 27-28**	**FY 28-29**
Total Number of Practitioners	14	14	14
Total Number of Teams	2	2	2

Full Service Partnership (FSP) Intensive Case Management (ICM) Eligible Population

Please input the estimates provided to the county in the table below

FSP ICM Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	1203
Number of Uninsured Individuals	111

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	55
Number of Teams Needed to Serve Total Eligible Population	11

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide FSP ICM over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	33	33	33
Total Number of Teams	7	7	7

High Fidelity Wraparound (HFW) Eligible Population

Please input the estimates provided to the county in the table below

HFW Eligible Population	Estimates

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	547
Number of Uninsured Individuals	<11*

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	205
Number of Teams Needed to Serve Total Eligible Population	9

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide HFW over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	48	60	60

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Teams	12	15	15

Individual Placement and Support (IPS) Eligible Population

Please input the estimates provided to the county in the table below

IPS Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	2535
Number of Uninsured Individuals	232

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	175
Number of Teams Needed to Serve Total Eligible Population	70

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide IPS over this Integrated Plan period, by fiscal year.

County Actuals	**FY 26-27**	**FY 27-28**	**FY 28-29**
Total Number of Practitioners	2	2	4
Total Number of Teams	1	1	2

Full Service Partnership (FSP) Program Overview

Please provide the following information about the county's BHSA FSP program

Will any of the estimated number of practitioners the county plans to utilize (provided above) be responsible for providing more than one EBP?
No

Please describe how the county is employing a whole-person, trauma-informed approach, in partnership with families or an individual's natural supports
The SFDPH BHS care philosophy is client-centered, strengths-based, and recovery-oriented. SFDPH, BHS, and our service provider partners work across health and social systems to coordinate and integrate service delivery for individuals with complex needs. Our FSPs deliver targeted supports to high need populations by targeting those who are experiencing homelessness and those with high emergency system use. These individuals often have complex, co-occurring behavioral health conditions and a history of trauma.
SF BHS' FSP services integrate principles of Whole Person Care and trauma-informed Care by operating with a commitment to do "whatever it takes" to improve a client's residential stability and behavioral health outcomes. FSPs deliver comprehensive care and wraparound support services to address the whole person. FSPs' wraparound approach addresses clients' social determinants of health and other factors that contribute to their long-term wellbeing. FSP staff screen incoming clients for history of traumas and are trained to work with a trauma-informed approach. Staff work with clients to identify and build on each

client's natural supports and connect them to community resources. Services can include integrated BH treatment, medication assistance, crisis intervention, individual and group therapy, intensive case management, linkage services, supportive housing, vocational assistance, and peer support.

Please describe the county's efforts to reduce disparities among FSP participants

SFDPH BHS employs a multi-faceted strategy to reduce disparities among FSP participants, which is rooted in the broader racial equity and justice, equity, diversity, and inclusion framework of the SF BHS.

Key efforts include:

- Culturally Congruent and Responsive Care: FSP services are culturally congruent and responsive. Treatment, communication, and recovery plans respond to a client's background, language, and lived experience. Program staff reflect the diversity of the participants, with multicultural and multilingual services available.

- JEDI Integration: SF BHS' BHSA programming is embedded within the Office of Justice, Equity, Diversity, and Inclusion, which provides an anti-racist framework in planning, implementing, and evaluating FSP and other BHSA-funded programs.

- Workforce Diversity: BHS aims to recruit and train a diverse behavioral health workforce that reflects the racial, ethnic, and linguistic makeup of the marginalized communities we serve.

- Data-Driven Accountability: BHS tracks and reports client demographics and outcomes for FSP participants to evaluate disparities in access, service utilization, and outcomes based on race, ethnicity, and neighborhood.

- Community Engagement centers and amplifies community voices and supports collaboration between BHS, our service provider partners, and the community we serve. This ensures services are designed to meet the needs and priorities of our community, particularly those with the highest level of need.

- Addressing Social Determinants of Health: FSP's "whatever it takes" model inherently works to reduce disparities by addressing the structural inequities that impact health, like housing, food, and employment.

- High-Need Populations Focus: FSPs are prioritized for individuals with the most severe needs, often those experiencing chronic homelessness, co-occurring substance use disorders, and frequent involvement with the criminal justice system.

Select which goals the county is hoping to support based on the county's allocation of FSP funding

Access to care
Homelessness
Institutionalization
Removal of children from home
Justice involvement
Untreated behavioral health conditions
Overdoses

Please describe what actions or activities the county behavioral health system is doing to provide ongoing engagement services to individuals receiving FSP ICM

SFDPH BHS provides ongoing engagement services to individuals receiving FSP ICM services by focusing on the core principles of the FSP model: the "whatever it takes" philosophy, a field-based service delivery, and a commitment to recovery and peer support. Continuous engagement is built into the design and delivery of FSP ICM. Programs are designed to maintain therapeutic relationships between clients and providers, prevent a client's disengagement from treatment, and promote their long-term stability and wellness.

FSP staff work with clients to co-create individualized treatment and recovery plans, fostering mutual trust and shared investment in the process. FSP services are primarily field based, meaning staff meet clients where they are (at homes, shelters, on the street) to reduce barriers to treatment. FSP ICM and ACT/FACT models mandate proactive and persistent outreach by a multidisciplinary team to re-engage clients who miss appointments or become difficult to locate. This "whatever it takes" approach is the fundamental mechanism for ongoing engagement.

SF BHS' FSP teams include Peer Support Specialists with lived experience with behavioral health challenges and recovery who offer a unique connection to clients and instill a motivating sense of hope that can be highly effective in maintaining a client's engagement.

FSP ICM programs maintain protocols and procedures to support a client's successful transition from a high-intensity FSP ICM environment to a standard outpatient care setting. These include the development of individualized coordinated transition plans, facilitating warm handoffs and linkages to outpatient services, and ensuring the receiving provider is prepared to support each client's wellness goals. This care coordination ensures clients remain engaged in services to promote their long-term wellness.

Ongoing engagement services is a required component of ACT, FACT, IPS, and HFW.
Please describe any ongoing engagement services the county behavioral health system will provide beyond what is required of the EBP
Not applicable

Please describe how the county will comply with the required FSP levels of care (e.g., transition FSP ICM teams to ACT, stand up new ACT teams and/or stand up new FSP ICM teams, etc.)
SFDPH BHS is taking steps to comply with state requirements for FSP levels of care. BHS plans to expand and enhance existing FSPs by increasing treatment capacity, including added treatment slots. Additionally, BHS is working to refine and standardize existing processes on referral, level of care, intake and stepdown to ensure clinically appropriate and equitable access to care and efficient use of available resources/treatment slots. BHS FSP-ICM will offer a stepdown and prevention model of care, serving as a lower-intensity FSP model for clients who have stabilized in ACT and are ready to transition to a less intensive levels of support. ICM will also serve as an intervention for individuals with significant behavioral health need who do not meet ACT criteria but require intensive FSP supports to prevent their condition from escalating to the ACT level. BHS conducted a readiness assessment of its FSP programs to ensure they are meeting the new BHSA requirements, including the inclusion of substance use services, which will be provided as part of the program or through service coordination. SF BHS is working to convert its existing ICM programs to meet ACT/FACT service model requirements, with a goal to meet full fidelity standards by June 30, 2029.

Please indicate whether the county FSP program will include any of the following optional and allowable services
See Outreach activities in 7b.

Primary substance use disorder (SUD) FSPs
No

Outreach activities related to enrolling individuals living with significant behavioral health needs in an FSP (activities that fall under assertive field-based initiation of substance use disorder treatment services will be captured separately in the next section)
Yes

Please describe the outreach activities the county will engage in to enroll individuals living with significant behavioral health needs into the county's FSP program

SFDPH BHS will conduct targeted outreach in hospitals, emergency services, residential programs, Navigation Centers, shelters, and SF Jail/justice system settings to identify individuals with significant behavioral health needs who may be eligible for FSP services. FSP outreach activities will include in-person engagement at initial point of contact and upon intake, which includes brief eligibility and clinical screening, case management and individualized treatment planning, warm handoffs/service referrals, and rapid connection to an FSP slot. Individuals will be assisted through expedited assessment and enrollment to ensure timely access to intensive services.

Other recovery-oriented services

No

If there are other services not described above that the county FSP program will include, please list them here. For team-based services, please include number of teams. If no additional FSP services, use "N/A"

N/A

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth in the development of the county's FSP program (e.g., review data, engage with stakeholders, analyze research, etc.) who are:

In, or at-risk of being in, the juvenile justice system

The SFDPH BHS Children, Youth, & Families System of Care (CYF) is working to align the High Fidelity Wrap mandates from BHSA Proposition 1 and FFPSA After-Care regulations to create a comprehensive HFW portfolio for youth involved in child welfare, juvenile probation, and non-system-involved youth in need of this level of care. To estimate the eligible population size, CYF reviewed two years of BHS utilization and referral data on youth who are in need of HFW services, as well as data shared by SF Juvenile Probation partners on current and projected numbers of unique clients served in wraparound services.

To understand the unique needs of youth who are in or are at-risk of being in the juvenile justice system, BHS CYF staff reviewed data related to the statewide BH goal on justice, including juvenile arrest rate, probation referral data, violent crime data, Juvenile Hall admissions data, and data on disproportionally affected demographic populations. SF Juvenile Probation partners participated in this data review, providing subject matter expertise and input on behavioral health services planning. Data included San Francisco Juvenile Probation Department Annual Data Report (2023): Arrests, referrals, admissions, and ADP trends; San Francisco County Self-Assessment (CSA, 2024): Comprehensive analysis of demographics, poverty, disproportionality, and cross-system involvement, and the Center on Juvenile and Criminal Justice (CJCJ) Fact Sheet (2024): Independent review showing SF's incarceration decline outpaces the state.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
SF BHS CYF HFW reviewed two years of BHS utilization and referral data on youth in need of HFW services, as well as juvenile probation and child welfare current and projected numbers of clients served in wraparound services. This data included demographic data on sexual orientation and gender identity. The San Francisco Department of Children Youth and Their Families 2022 Community Needs Assessment includes key behavioral health-related needs for LGBTQ+ youth. For example, 50% of SF's trans K-12 students were reported to have considered suicide between 2015 and 2019, according to the San Francisco Unified School District Youth Risk Behavior Survey.

In the child welfare system
Similar to the actions taken by SF BHS to consider the unique needs of justice-involved youth, CYF HFW population estimates were informed by SF Child Welfare Services' current and projected numbers of unique clients served by wraparound services.

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible adults **in the development of the county's FSP (e.g., review data, engage with stakeholders, analyze research, etc.) who are**

Older adults
SF BHS actively addresses the unique needs of specific eligible adult and older-adult populations in the development and operation of its FSP services through targeted programs, specialized staffing, and partnerships with CBOs.

The core strategy is to use the flexible FSP "whatever it takes" model to implement services that are culturally responsive, linguistically appropriate, and specialized for these high-need groups.

Older adults often have complex needs involving co-occurring medical conditions, potential cognitive decline, and increased social isolation. The county's FSP model addresses this by contracting with providers (such as Felton Institute) to run dedicated Older Adult FSP (OA FSP) teams. These teams focus specifically on residents aged 55 and older.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
SF BHS is committed to reducing the mental health disparities experienced by LGBTQIA+ individuals, who often face high rates of trauma, discrimination, and a lack of culturally affirming care. BHS emphasizes providing client-centered, gender-affirming behavioral health services. This is crucial for transgender and gender non-binary participants, ensuring their behavioral health treatment supports their gender identity and affirmation goals. FSP staff are expected to provide care that is sensitive to the high levels of trauma and discrimination experienced by this population, including addressing the intersectionality of identities.

In, or are at risk of being in, the justice system
Individuals with severe behavioral health needs who are justice-involved or at high risk require intense, coordinated care that spans both the behavioral health and criminal justice systems. SF BHS' UCSF-Citywide Forensics FSP team works with justice-involved individuals diagnosed with severe behavioral health disorders and co-occurring substance use disorders. Additionally, FACT programs will provide a higher level of support for justice-involved clients with the highest behavioral health needs.

Assertive Field-Based Substance Use Disorder (SUD) Questions

For related policy information, refer to 7.B.6 Assertive Field-Based Initiation for Substance Use Disorder Treatment Services

Please describe the county behavioral health system's approach and timeline(s) to support and implement assertive field-based initiation for SUD treatment services program requirements by listing the existing and new programs (as applicable) that the county will leverage to support the assertive field-based SUD program requirements and provide the current funding source, BHSA service expansion, and the expected timeline for meeting programmatic requirements to expand existing programs and/or stand up new initiatives before July 1, 2029. Counties should include programs not funded directly or exclusively by BHSA dollars. Additional information regarding assertive field-based initiation for SUD treatment services can be found in the BHSA Policy Manual Chapter 7, Section B.6.

Existing Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

Existing programs
(1) Code Tenderloin, (2) Naloxone distribution, (3) Treatment Connections and Safer Use Supplies, (4) STARR program

Program descriptions
(1) Code Tenderloin provides Street Outreach and proactive linkages to treatment. The Navigation team outreaches to all individuals on the street regardless of treatment interest and provides linkages shelter, on-demand telehealth buprenorphine treatment, transport to open-access clinics, and direct linkages to Opioid Treatment programs.

(2) Naloxone distribution program provides counseling and linkage to treatment in a low barrier setting.

(3) Treatment Connections and Safer Use Supplies program provides counseling and linkages to treatment for individuals in a low barrier setting.

(4) STARR Program

Current funding source
San Francisco Proposition C, San Francisco (local) Opioid Settlement funding

BHSA changes to existing programs to meet BHSA requirements
No changes

Expected timeline of operation
Currently in operation

Mobile-field based programs

Existing programs
Methadone Van

Program descriptions
SFDPH BHS launched the Methadone Van mobile response program nearly 20 years ago. The mobile response program is designed to increase the reach of the Opioid Treatment Program, which is based at San Francisco General Hospital. Outreach focuses on neighborhoods which have limited access to treatment options, including the Bayview Hunter's Point neighborhood.

Current funding source
DMC-ODS and San Francisco General Fund

BHSA changes to existing programs to meet BHSA requirements
No changes

Expected timeline of operation
Currently in operation

Open-access clinics

Existing programs
(1) Bridge Clinic, (2) DSAAM OBOT in primary care settings, (3) County-funded Opioid Treatment Programs (BAART Market, BAART Turk, Opioid Treatment Outpatient Program at W93, Bayview Hunter's Point Foundation, Fort Help, Westside Clinic)

Program descriptions
(1) The Bridge Clinic is an open access substance use treatment clinic that provides MAT, contingency management, and navigation supports embedded in an FQHC at San Francisco General Hospital.

(2) The Division of Substance Use and Addiction Medicine (DSAAM) Methadone Office-Based Opiate Treatment (OBOT) provides MAT in primary care settings provides MAT in primary care settings at Federally Qualified Health Centers (FQHCs). FQHCs include Tom Waddell, Potrero Hill, and the Positive Health Program at Zuckerberg San Francisco General Hospital.

(3) All San Francicso County-funded Opioid Treatment Programs are required to have drop-in, same day access to start MAT during posted intake hours. Programs are affered at the following clinics: BAART Market, BAART Turk, Opioid Treatment Outpatient Program at W93, Bayview Hunter's Point Foundation, Fort Help, and Westside Clinic.

Current funding source
San Francisco Proposition C, San Francisco General Fund, San Francisco (local) Opioid Settlement FUnd, DMC-ODS

BHSA changes to existing programs to meet BHSA requirements
No changes

Expected timeline of operation
Currently in operation

New Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

New programs
Not applicable

Program descriptions
Not applicable

Planned funding
Not applicable

Planned operations
Not applicable

Expected timeline of implementation
Not applicable

Mobile-field based programs

New programs
Not applicable

Program descriptions
Not applicable

Planned funding
Not applicable

Planned operations
Not applicable

Expected timeline of implementation
Not applicable

Open-access clinics

New programs
Not applicable

Program descriptions
Not applicable

Planned funding
Not applicable

Planned operations
Not applicable

Expected timeline of implementation
Not applicable

Medications for Addiction Treatment (MAT) Details
Please describe the county's approach to enabling access to same-day medications for addiction treatment (MAT) to meet the estimated population needs before July 1, 2029.

Describe how the county will assess the gap between current county MAT resources (including programs and providers) and MAT resources that can meet estimated needs
SFDPH BHS has continuously delivered low-barrier access and field-based substance use disorder treatment services since the early 2000s. The Substance Use Services (SUS) Methadone Van mobile response program launched nearly 20 years ago. We have offered MAT services at Federally Qualified Health Centers for decades. Our Street Outreach program launched in 2010.

San Francisco's Proposition C dollars and San Francisco's independent Opioid Settlement dollars have delivered increased funding for substance use services and supportive housing programs in 2024 and 2025. These funds supported program expansion and system improvements. This included increased Opioid Treatment Program hours to increase access to and engagement in treatment. We have seen immediate positive results of increased engagement and retention. These and other system improvements are informed by client data and outcomes tracking.

SF BHS will be able to leverage existing SUS programs (including targeted outreach, mobile field-based programming, open access clinics, telehealth MAT, and other services) to meet BHSA requirements for assertive field-based initiation for SUD treatment services. Instead, BHS will improve system coordination between mental health and substance use services. In May 2026, BHS' Substance Use Services System of Care will transition to Epic Electronic Health Record system which will improve cross-system referrals and information exchange.

SF BHS SUS aims to provide clients with same day access to MAT. This is accomplished through policy and

practice expectations. All San Francisco Opioid Treatment programs (BAART Market, BAART Turk, Opioid Treatment Outpatient Program, Bayview Hunter's Point Foundation, Fort Help, and Westside Clinic) are required to have drop-in, same day access to start MAT during posted intake hours. All providers are expected to complete timely access entry forms to monitor same day access and, if necessary, track reasons why same day access could not be rendered.
The Code Tenderloin Navigation team outreaches to individuals on the street and provides linkages to on-demand telehealth buprenorphine treatment, transport to open-access clinics, and direct linkages to Opioid Treatment programs.
In addition, SF BHS SUS operates a MAT telehealth program, Bringing Expanded Access to Medications (BEAM), which operates 16 hours each day to provide on-demand telehealth for MAT for anyone in San Francisco. BEAM also offers drop-in open access hours for in-person services. BEAM partners closely with crisis response and service navigation teams, hospitals, emergency responders, and the SF Jail to support initiating and ongoing MAT treatment. BEAM navigators help patients overcome barriers to treatment such as Insurance, IDs, and shelter resources. Finally, SF SUS ensures that MAT is available in locations that are convenient to where clients are already seeing services, for example at FQHCs and via the Methadone Van.

Select the following practices the county will implement to ensure same day access to MAT

Contract directly with MAT providers in the County
Operate MAT clinics directly
Leverage telehealth model(s)

What forms of MAT will the county provide utilizing the strategies selected above?

Buprenorphine
Methadone
Naltrexone

Housing Interventions

Planning

For related policy information, refer to 7.C.3 Program priorities and 7.C.4 Eligible and priority populations

System Gaps

Please identify the biggest gaps facing individuals experiencing homelessness and at risk of homelessness with a behavioral health condition who are Behavioral Health Services Act (BHSA) eligible in the county. Please use the following definitions to inform your response: No gap – resources and connectivity available; Small gap – some resources available but limited connectivity; Medium gap – minimal resources and limited connectivity available; Large gap – limited or no resources and connectivity available; Not applicable – county does not have setting and does not consider there to be a gap. Counties should refer to their local Continuum of Care (CoC) Housing Inventory Count (HIC) to inform responses to this question.

Supportive housing
Large gap

Apartments, including master-lease apartments
Large gap

Single and multi-family homes
Not applicable

Housing in mobile home communities
Not applicable

(Permanent) Single room occupancy units
Large gap

(Interim) Single room occupancy units
Large gap

Accessory dwelling units, including junior accessory dwelling units
Not applicable

(Permanent) Tiny homes
Not applicable

Shared housing
Medium gap

(Permanent) Recovery/sober living housing, including recovery-oriented housing
Large gap

(Interim) Recovery/sober living housing, including recovery-oriented housing
Large gap

Assisted living facilities (adult residential facilities, residential facilities for the elderly, and licensed board and care)
Large gap

License-exempt room and board
Not applicable

Hotel and Motel stays
Medium gap

Non-congregate interim housing models
Large gap

Congregate settings that have only a small number of individuals per room and sufficient common space (does not include behavioral health residential treatment settings)
Medium gap

Recuperative Care
Large gap

Short-Term Post-Hospitalization housing
Large gap

(Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units
Medium gap

Peer Respite
Medium gap

Permanent rental subsidies
Large gap

Housing supportive services
Large gap

What additional non-BHSA resources (e.g., county partnerships, vouchers, data sharing agreements) or funding sources will the county behavioral health system utilize (local, state, and federal) to expand supply and/or increase access to housing for BHSA eligible individuals **?**
SFDPH BHS will leverage Medi-Cal, Mental Health Realignment funds, San Francisco General Fund s(including Proposition C), and other funding sources to increase BHSA-eligible individuals' access to housing.

In 2024, San Francisco had 16,383 permanent housing beds dedicated to adults, families, people experiencing chronic homelessness, veterans, and youth—sufficient to house approximately half of individuals currently experiencing homelessness citywide.

In addition to BHSA-funded housing interventions, SF BHS' Residential System of Care includes a range of non-BHSA residential and supportive housing resources, including short-term residential treatment programs, acute diversion units, 90-day crisis residential treatment, long-term residential care, mental health rehabilitation centers, board and care facilities, residential care facilities for the elderly, and skilled nursing facilities providing psychiatric care. SFDPH BHS also utilizes CalAIM Enhanced Care Management to strengthen care coordination and ensure individuals are connected to ongoing healthcare and supportive services.

SF BHS partners with the San Francisco Department of Homelessness and Supportive Housing (HSH), which manages all 191 BHSA-funded supportive housing units as well as thousands of additional housing units across the City. SF HSH administers San Francisco's Coordinated Entry system, the primary access point to the Homelessness Response System, providing assessment, prioritization, and referral to housing programs.

SF BHS also partners with San Francisco's Medi-Cal Managed Care Plans to implement the Medi-Cal Transitional Rent Community Supports benefit, which aligns with BHSA-funded supportive housing and supports housing stabilization during transitions.

Additional resources include No Place Like Home units managed by the Mayor's Office of Housing and

Community Development and Navigation Centers that provide temporary shelter, room and board, and intensive case management for unsheltered individuals.

How will BHSA Housing Interventions intersect with those other resources and supports to strengthen or expand the continuum of housing supports available to BHSA eligible individuals?
BHSA Housing Interventions are fully integrated into San Francisco broader housing and behavioral health systems. Housing and care providers collaborate closely with BHS and HSH to align BHSA-funded emergency stabilization units, transitional housing, and permanent supportive housing with Coordinated Entry, Transitional Rent, and other housing and service resources.

BHSA-funded emergency stabilization, transitional, and permanent supportive housing programs that offer integrated behavioral health treatment, case management, and care coordination, BHSA Housing Interventions strengthen the continuum of care for individuals with serious mental illness, substance use disorders, and co-occurring conditions. Permanent Supportive Housing Full Service Partnership (FSP) program models provide whole-person, culturally responsive, "whatever-it-takes" supports that help individuals transition from homelessness or housing instability into stable housing and remain engaged in care.

SFDPH BHS, HSH, and other county partners recognize that the need for supportive housing exceeds available supply. In response, San Francisco is implementing homelessness prevention strategies to reduce inflow into homelessness, including eviction protections, rental assistance and subsidies, tenant counseling, violence prevention, and access to primary healthcare.

What is the county behavioral health system's overall strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions?
San Francisco promotes permanent housing placement and retention for individuals receiving BHSA Housing Interventions through a coordinated Housing First approach. Housing First principles emphasize rapid access to housing without preconditions, paired with integrated, wraparound behavioral health services that support long-term housing stability.

BHSA-funded Housing Intervention programs serve individuals with the highest behavioral health needs, including those with serious mental illness, substance use disorders, and co-occurring conditions who are experiencing homelessness. Providers work closely with HSH and BHS staff to support successful placement in permanent housing and to deliver ongoing services needed for retention. These services include mental health and substance use treatment, care coordination, and connections to primary healthcare.

To support system alignment and housing stability, BHS, HSH, and housing and service providers participate in regular case conferencing to coordinate referrals, manage housing placements, and address

barriers to occupancy and retention.

What actions or activities is the county behavioral health system engaging in to connect BHSA eligible individuals to and support permanent supportive housing (PSH) (e.g., rental subsidies for individuals residing in PSH projects, operating subsidies for PSH projects, providing supportive services to individuals in other permanent housing settings, capital development funding for PSH)?

SF BHSA Housing Intervention funds will be directed exclusively to emergency stabilization units, transitional housing, and permanent supportive housing (PSH) for BHSA-eligible individuals. These programs are managed by the San Francisco Department of Homelessness and Supportive Housing.

SF HSH also operates San Francisco's Coordinated Entry System, through which individuals are assessed, prioritized, and referred to emergency stabilization, transitional housing, PSH, and intensive case management services. HSH currently manages 191 PSH units dedicated to BHSA-eligible individuals, serving adults, older adults, and transition-age youth.

Transitional housing programs support stabilization and connection to PSH, offering housing for up to two years while assisting individuals with permanent housing placement. SF BHS also provides training to staff, clinical providers, and Full Service Partnership teams to ensure consistent referral pathways and effective linkage to PSH resources.

Please describe how the county behavioral health system will ensure all Housing Interventions settings provide access to clinical and supportive behavioral health care and housing services

SFDPH BHS' Housing Intervention settings ensure access to clinical and supportive behavioral health care through a combination of onsite services and system-wide access points. Six of the 18 PSH locations provide onsite nursing services, and all housing sites offer onsite supportive services.
Individuals residing in PSH and emergency stabilization units receive intensive case management through FSPs, which provide whole-person, culturally responsive, "whatever-it-takes" care models. Transitional housing programs provide onsite case management and referrals to healthcare and behavioral health providers. Most residents are connected to primary care and outpatient mental health services through their referring programs, including substance use treatment, residential treatment, or justice system diversion programs.

SF BHS also operates a centralized Behavioral Health Access Center and a Behavioral Health Access Line to support intake, eligibility screening, referrals, and connection to crisis services for BHSA-eligible individuals.

Eligible Populations

Please describe how the county behavioral health system will identify, screen, and refer individuals eligible for BHSA Housing Interventions

BHSA-eligible individuals are typically identified and screened through the SF BHS Residential System of Care and referred to emergency stabilization units, transitional housing, or permanent supportive housing. Referrals to PSH are generally submitted by Full Service Partnership programs or other system partners to the BHS BHSA Housing Program Manager.

The Housing Program Manager conducts eligibility screening and connects individuals to available units or places them on a waitlist until housing becomes available. Following placement, the Coordinated Entry team provides housing navigation and ongoing support. Under the Medi-Cal Transitional Rent initiative, the Housing Program Manager also coordinates with Medi-Cal Managed Care Plans to process referrals for eligible individuals.

Will the county behavioral health system provide BHSA-funded Housing Interventions to individuals living with a substance use disorder (SUD) only **?**

Yes

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth **in the development of the county's Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are:**

In, or at-risk of being in, the juvenile justice system

SFDPH BHS partners with HSH to develop a shared understanding of the (affordable) housing-related needs of our community. 1,700 youth households experience homelessness each year in SF. The number of youth who are experiencing homelessness in SF is increasing. HSH has conducted communitywide surveys (319 respondents in 2023), stakeholder interviews focusing on justice-involvement with Transitional Age Youth who were experiencing homelessness and stakeholders from the justice system (11 interviewees in 2023), and 2 focus groups with youth at our Permanent Supportive Housing units (2024). The focus of the interviews was to inquire about solutions for those experiencing homelessness, especially those with additional barriers including justice involvement and Transitional Aged Youth.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)

SFDPH BHS reviewed the SF Office of the Controller 2022 Our City, Our Home Needs Assessment on the state of homelessness in San Francisco for the purpose of planning for the SF Proposition C, which will fund housing services through business tax generated dollars. The Our City, Our Home Committee collected primary and secondary data, conducting listening sessions with over one thousand stakeholders and

coordinating with multiple city departments. This assessment found that LGBTQ+ populations are overrepresented in SF's homeless population, particularly for homeless youth. 38% of homeless youth identified as LGBTQ+ in the 2022 Homeless Point-in-Time count, 7% identified as transgender, and 5% identified as a gender other than singularly female or male.

In the child welfare system
SF BHS Children, Youth, and Families (CYF) System of Care have supported the BHSA Community Planning Process in the development of this Integrated Plan. CYF has participated in data review and planning related to the BH goal to reduce the removal of children from their home. CYF works closely with the SF Human Services Agency to align programming to the needs. BHS staff also considered data on children and youth in the child welfare system as reported in the San Francisco County Self-Assessment (CSA, 2024): Comprehensive analysis of demographics, poverty, disproportionality, and cross-system involvement and data from the California Child Welfare Indicators Project.

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible adults in the development of the county's Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are

Older adults
BHS understands that SF's general population is aging and so is its homeless population. BHS partners with HSH and other agencies in SF to understand the needs of older adults as they relate to housing.

SF Department of Disability and Aging Services partnered with HSH and Mayor's Office of Housing and Community Development to develop an Aging and Disability Affordable Housing Needs Assessment in 2022. Findings show that older adults have unique needs related to housing, with many on lower, fixed incomes. Many older adults in SF experience chronic health conditions, mobility impairments, cognitive impairments, and premature mortality. The report recommends tenant- and project-based affordable housing subsidies as a critical resource for helping low-income older adults make ends meet. The report also found that the affordable housing application process can be confusing and cumbersome for older adults, communications about affordable housing often does not reach the older adult community, and that affordable housing units often lack adequate accessibility features.

In, or are at risk of being in, the justice system
SFDPH BHS engaged in cross-system data review and stakeholder input to understand the needs of justice-involved adults. BHS draws on its direct service experience through Jail Health Services, which provides integrated, trauma-informed behavioral health care in County Jails, including screening, assessment, crisis intervention, ongoing treatment, and discharge planning. BHS reviewed data demonstrating the high overlap between incarceration, homelessness, and behavioral health needs, including findings from the UCSF Benioff Homelessness and Housing Initiative 2022 report "Signals of

Distress," which highlights frequent cycling between jail, emergency services, and homelessness among high-need populations. Input from the BHSA Community Planning Process and providers serving reentry populations further informed planning. Findings emphasized the importance of coordinated discharge planning, linkage to housing and care, and supportive housing models that reduce recidivism and promote long-term stability.

In underserved communities

San Francisco's 2022 Our City, Our Home Needs Assessment found that people of color make up the majority of people experiencing homelessness, with Black/African American, indigenous, and Hispanic/Latine homeless populations at higher rates than in the SF general population. Data show this is the result of structural racism, including public policies, institutional practices, and cultural norms. Communities of color were historically segregated and had limited access to education, well-paying jobs, and continued to see a wealth gap, poor health outcomes, mass incarceration, and other negative long-term outcomes.

Local Housing System Engagement

How will the county behavioral health system coordinate with the Continuum of Care (CoC) and receive referrals for Housing Interventions services?

The San Francisco Department of Homelessness and Supportive Housing (HSH) manages the San Francisco's Coordinated Entry system, which acts as the "front door" to the Homelessness Response System. Coordinated Entry offers multiple access points for individuals experiencing homelessness to connect to assessment and referrals to housing programs. It is designed to assess, prioritize and match people experiencing homelessness to housing opportunities efficiently and consistently.

Please describe the county behavioral health system's approach to collaborating with the local CoC, Public Housing Agencies, Medi-Cal managed care plans (MCPs), Enhanced Care Management (ECM) and Community Supports providers, as well as other housing partners, including existing and prospective PSH developers and providers in your community in the implementation of the county's Housing Interventions

Local CoC

SF HSH is contracted to deliver BHSA-funded housing interventions. HSH manages the San Francisco's Coordinated Entry system, which acts as the "front door" to the Homelessness Response System. Coordinated Entry offers multiple access points for individuals experiencing homelessness to connect to assessment and referrals to housing programs. It is designed to assess, prioritize and match people experiencing homelessness to housing opportunities efficiently and consistently.

Public Housing Agency
The SF Public Housing Authority administers Project-Based Vouchers, emergency vouchers, and other U.S. Housing and Urban Development (HUD) housing supports. SF HSH meets weekly with the SF Housing Authority to support housing placement for qualifying individuals. HSH typically manages the housing units and supports with unit inspections, move in, and other supports to ensure the units are filled.

MCPs
SF BHS partners with the SF Medi-Cal Managed Care Plans (Kaiser, Anthem, and the SF Health Plan) to implement the Medi-Cal Transitional Rent community support benefit, as described above. The SF BHS Residential System of Care partners with the MCPs in operating skilled nursing facilities.

ECM and Community Supports Providers
SFDPH BHS and HSH work closely with Medi-Cal Enhanced Care Management and Community Supports providers to offer needed supports to populations served in BHSA Housing Intervention programs to connect individuals in BHSA-funded housing intervention programs to wraparound services. BHS, HSH, and ECM/Community Support providers partner to conduct cross-system referrals, share client data, and coordinate care to promote long-term housing stability.

Other (e.g., CalWORKS/TANF housing programs, child welfare housing programs, PSH developers and providers, etc.)
SFDPH and HSH also partner with other housing and service providers to coordinate housing placements and supportive services for specific populations, including families involved in child welfare and CalWORKs/TANF programs. These partnerships support cross-system and service alignment, enabling more efficient use of resources and helping ensure high-need populations are connected to appropriate housing and supports.

How will the county behavioral health system work with Homekey+ and supportive housing sites to provide services, funding, and referrals that support and house BHSA eligible individuals?
SF Mayor's Office of Housing and Community Development (MOHCD) manages Homekey+. SF HSH partners with the MOHCD to coordinate services across Homekey+ and other supportive housing services, ensuring individuals are referred and placed appropriately and that resources are utilized efficiently.

Did the county behavioral health system receive Homeless Housing Assistance and Prevention Grant Program (HHAP) Round 6 funding?
No

BHSA Housing Interventions Implementation

The following questions are specific to BHSA Housing Interventions funding (no action needed).
For more information, please see 7.C.9 Allowable expenditures and related requirements

Rental Subsidies (Chapter 7. Section C.9.1)
The intent of Housing Interventions is to provide rental subsidies in permanent settings to eligible individuals for as long as needed, or until the individual can be transitioned to an alternative permanent housing situation or rental subsidy source. (no action needed)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis?
3000

How many of these individuals will receive rental subsidies for permanent housing on an annual basis?
795

How many of these individuals will receive rental subsidies for interim housing on an annual basis?
2500

What is the county's methodology for estimating total rental subsidies and total number of individuals served in interim and permanent settings on an annual basis?
SF BHS estimates the annual number of rental subsidies and individuals to be served in interim and permanent settings based on numbers served in FY2024-2025.

For which setting types will the county provide rental subsidies?
Non-Time-Limited Permanent Settings: Supportive housing
Time Limited Interim Settings: Non-congregate interim housing models

Will this Housing Intervention accommodate family housing?
Yes

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Rental subsidies will be offered to BHSA-eligible individuals in permanent and interim housing with a goal of helping the individual sustain permanent housing. Rental assistance will primarily be directed to adults, older adults, and Transition Age Youth, with a subset directed to justice-involved populations. Rental subsidies are directed to housing providers/property managers who are contracted to administer these subsidies. Rental subsidies may be offered for as long as necessary to ensure the individual sustains permanent housing. Rental assistance is calculated based on rent reasonableness or Fair Market Rent methodology.

Will the county behavioral health system provide rental assistance through project-based (tied to a particular unit) or tenant-based (tied to the individual) subsidies?
Project-based
Tenant-based

How will the county behavioral health system identify a portfolio of available units for placing BHSA eligible individuals, including in collaboration with other county partners and as applicable, Flex Pools (e.g., Master Leasing)? Please include partnerships and collaborative efforts your county behavioral health system will engage in
As described in Housing Interventions Planning section of this Integrated Plan, SF BHS partners with the San Francisco Department of Homelessness and Supportive Housing (HSH) to deliver BHSA Housing Interventions. HSH manages San Francisco's homeless response system and supportive housing portfolio, which includes BHSA-funded housing interventions.

SF HSH manages the San Francisco Coordinated Entry System and has long-held relationships with local supportive housing providers. Coordinated Entry connects individuals who need housing assistance to supportive housing services by offering physical and virtual access points and a standardized intake and needs assessment process. Through this assessment, s individuals are prioritized for supportive housing services based on vulnerability, barriers to housing, and chronicity. The system generates a pool of eligible individuals, from which all supportive housing vacancies are filled. The goal of this process is to rapidly connect people to a housing solution by prioritizing those who are most in need.

BHSA-eligible individuals are prioritized for placement through the Coordinated Entry System or direct referral from BHS with the goal to ensure individuals with significant behavioral health needs are connected to housing and supportive services.

Total number of units funded with BHSA Housing Interventions per year
30

Please provide additional details to explain if the county is funding rental subsidies with BHSA Housing Interventions that are not tied to a specific number of units
Rental subsidies will primarily be directed to individuals via the Coordinated Entry System. However, a small number of rental subsidies will be tied to a specific unit in with our contracted housing providers.

Operating Subsidies (Chapter 7, Section C.9.2)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
132

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
BHSA Housing Interventions funds will provide Operating Subsidies for Permanent Supportive Housing (PSH) units, emergency stabilization units, and transitional housing units to support individuals with significant behavioral health needs who are experiencing or at imminent risk of homelessness. Permanent and interim housing units are available for adults, youth, and families, with dedicated units for seniors, veterans, and Transition Age Youth. Integrated supportive services, such as case management and clinical health services, are integrated within the housing programs and are designed to meet individuals' unique needs to help them sustain permanent housing.

SF BHS partners with SF HSH to manage these supportive housing programs. All BHSA-funded Housing Interventions operate under Housing First principles, prioritizing rapid access to housing without preconditions, low-barrier entry, client choice, and voluntary, person-centered supportive services. HSH receives referrals for BHSA-eligible individuals through the Coordinated Entry System, conducts intake and

eligibility screening, and assigns housing placements. BHS, HSH, and housing providers collaborate on coordinated case management to align housing and clinical services. BHS and HSH also partner with local Medi-Cal Managed Care Plans to ensure eligible individuals maximize Medi-Cal Transitional Rent community support benefits before connecting them to BHSA Housing Interventions. Operating subsidies cover essential program costs, including on-site staff salaries, utilities, maintenance, property management, and other building-related expenses necessary to ensure housing stability and long-term retention.

In addition to the units that are paid for with BHSA Housing Interventions Operating Subsidies funding, 53 units of Permanent Supportive Housing are available to BHSA-eligible individuals as these units were paid for through prior Capital Facilities investments to be reserved for BHSA clients in perpetuity.

For which setting types will the county provide operating subsidies?
Non-Time-Limited Permanent Settings: Supportive housing
Time Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units
Time Limited Interim Settings: Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls)[134] (does not include behavioral health residential treatment settings)

Will this be a scattered site initiative?
Yes

Will this Housing Intervention accommodate family housing?
Yes

Total number of units funded with BHSA Housing Interventions per year
170

Please provide additional details to explain if the county is funding operating subsidies with BHSA Housing Interventions that are not tied to a specific number of units
Not applicable

Landlord Outreach and Mitigation Funds (Chapter 7, Section C.9.4.1)

Is the county providing this intervention?
No

Please explain why the county is not providing this intervention
San Francisco will prioritize BHSA funding for operating and rental subsidies for our Permanent Supportive Housing, Transitional Housing, and Emergency Stabilization Units, as well as housing supports. These programs are managed by SF HSH. SF HSH provides Landlord Outreach and Mitigation services that are paid for by other funds.

Anticipated number of individuals served per year
0

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Not applicable

Total number of units funded with BHSA Housing Interventions per year
0

Please provide additional details to explain if the county is providing landlord outreach and mitigation funds with BHSA Housing Interventions that are not tied to a specific number of units
Not applicable

Participant Assistance Funds (Chapter 7, Section C.9.4.2)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
0

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
These funds will support Senior Administrative Staff at SF HSH who will coordinate Participant Assistance Funds (e.g. housing application fees, credit report and vital document fees, security deposits) and other community resources to help BHSA-eligible individuals meet their immediate housing needs. This staff

position further supports the administration and implementation of BHSA-funded housing interventions services by coordinating and convening SF BHS, HSH, housing providers and property managers, Full-Service Partnership program providers, and other stakeholders. This coordination helps facilitate referrals and access to the BHSA-funded housing units, service coordination and case management planning (including eviction prevention), to ensure individuals are connected to the supports they need to sustain permanent housing. This position also supports fund development and sustainability planning for supportive housing.

Housing Transition Navigation Services and Tenancy Sustaining Services (Chapter 7, Section C.9.4.3)
Pursuant to Welfare and Institutions (W&I) Code section 5830, subdivision (c)(2) **, BHSA Housing Interventions may not be used for housing services covered by Medi-Cal MCP. Please select Yes only if the county is providing these services to individuals who are not eligible to receive the services through their Medi-Cal MCP (no action needed)**

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
8576

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Housing Transition Navigation and Tenancy Sustaining Services will be offered to BHSA-eligible individuals who are not eligible for these services through a Medi-Cal Community Benefits. Services include conducting housing assessments, developing a housing support plan, housing search and placement support, move-in assistance, and other supports. BHSA clients will be provided with these services through the Coordinated Entry System and via regular (monthly/bimonthly) meetings with SF BHS, HSH, housing providers, Full-Service Partnership providers, and other stakeholders, where the team will support case management for individual clients based on clinical and permanent housing needs.

Housing Interventions Outreach and Engagement (Chapter 7, Section C.9.4.4)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
240

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Homeless Interventions Outreach and Engagement services will be offered to BHSA-eligible individuals who are experiencing or at imminent risk of unsheltered homelessness. Outreach and engagement activities may include outreaching to individuals in encampments, shelters, distributing food, clothes, and hygiene supplies, providing direct navigation to housing resources, and coordinated housing and behavioral health care resources to ensure individuals are connected to available supports to help meet their housing needs.

Capital Development Projects (Chapter 7, Section C.10)

Counties may spend up to 25 percent of BHSA Housing Interventions on capital development projects. Will the county behavioral health system use BHSA Housing Interventions for capital development projects?
No

Please explain why the county is not providing this intervention
San Francisco will prioritize BHSA funding for operating and rental subsidies for our Permanent Supportive Housing, Transitional Housing, and Emergency Stabilization Units, as well as housing supports.

Other Housing Interventions

If the county is providing another type of Housing Interventions not listed above, please describe the intervention

Is the county providing this intervention to chronically homeless individuals?
Anticipated number of individuals served per year

Continuation of Existing Housing Programs

Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending (e.g., Behavioral Health Bridge housing)
Not applicable

Relationship to Housing Services Funded by Medi-Cal Managed Care Plans

For more information, please see 7.C.7 Relationship to Medi-Cal Funded Housing Services

Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of?
Transitional Rent

For which of the following services does the county behavioral health system plan to become an MCP-contracted provider of?

Housing Transition Navigation Services
No

Housing Deposits
No

Housing Tenancy and Sustaining Services
No

Short-Term Post-Hospitalization Housing
No

Recuperative Care
No

Day Habilitation
No

Transitional Rent
Yes

When does the county behavioral health system plan to become an MCP-contracted provider?
1/1/2026

How will the county behavioral health system identify, confirm eligibility, and refer Medi-Cal members to housing-related Community Supports covered by MCPs **(including Transitional Rent)?**
SFDPH BHS will identify, confirm eligibility, and refer Medi-Cal members to housing-related Community Supports through various activities, including the use of our current workflow where referrals are received, reviewed for eligibility and sent for authorization by the Medi-Cal Managed Care Plans (MCPs). This workflow also includes partnership with the SF Department of Homeless and Supportive Housing. BHS also holds regular (quarterly) meetings with the MCPs to address any challenges and ongoing quality improvement efforts. The Medi-Cal member handbook will also be used to inform clients of these benefits and how they can be accessed.

Please describe coordination efforts and ongoing processes to ensure the county behavioral health contracted provider network for Housing Interventions is known and shared with MCPs serving your county
SFDPH BHS will continue to coordinate with MCPs and contracted Housing Intervention providers through our regular meetings between BHS, HSH, and Housing providers and quarterly meetings with the MCPs to ensure network awareness. BHS will also share information with all staff at town halls. The Medi-Cal member handbook will also be used to share information about these benefits and how they can be accessed. SF BHS will also deliver training to Housing Intervention and other BHSA service providers, as well as BHS crisis response and street outreach teams.

Does the county behavioral health system track which of its contracted housing providers are also contracted by MCPs for housing-related Community Supports (provided in questions #1 and #2 above)?
Yes

Please describe the county behavioral health system's coordination efforts to align network development
SFDPH BHS will continue to coordinate with MCPs and contracted Housing Intervention providers through our regular meetings between BHS, HSH, and Housing providers to discuss system coordination, timely access to care, and network development. BHS also has quarterly meetings with the MCPs to ensure all service agreement provisions (MOUs between each entity) are addressed. Also, care coordination meetings are used to ensure timely access to care.

What processes does the county behavioral health system have in place to ensure Medi-Cal members living with significant behavioral health conditions do not experience gaps in service once any of the MCP housing services are exhausted, to the extent resources are available?
SFDPH BHS will deliver BHSA-funded Housing Interventions in partnership with HSH to ensure Medi-Cal members with significant behavioral health conditions do not experience gaps in services once MCP housing services are exhausted. HSH also offers other supportive housing programs, rental subsidies, system navigation and case management, referral services, and other resources. All clients in BHSA-funded Housing Intervention programs work with a case manager to develop an individualized Housing Support Plan with a goal of securing and sustaining permanent housing.

Flexible Housing Subsidy Pools

Flexible Housing Subsidy Pools ("Flex Pools") are an effective model to streamline and simplify administering rental assistance and related housing supports. DHCS released the Flex Pools TA Resource Guide that describes this model in more detail linked here: Flexible Housing Subsidy Pools - Technical Assistance Resource . Please reference the TA Resource Guide for descriptions of the Flex Pool model and roles referenced below including the Lead Entity, Operator, and Funder.

For related policy information, refer to 7.C.8 Flexible Housing Subsidy Pools .

Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with

providers of housing supportive services) in the county (please refer to DHCS' Flex Pools TA Resource Guide)?
Yes

Is the county behavioral health system participating in or planning to participate in the Flex Pool?
No

Please explain why the county is not participating in the Flex Pool
SF HSH oversees the Flex Pool. SF BHS works in close partnership with HSH to deliver housing interventions and supports to those in need but will not directly participate in the Flex Pool.

Please describe any other roles and functions the county behavioral health system plans to take to support the operations or launch and scaling of a Flex Pool in addition to those described above
Not applicable

Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects

For each innovative program or pilot provide the following information. If the county provides more than one program, use the "Add additional program" button. For related policy information, refer to 7.A.6 Innovative Behavioral Health Pilots and Projects .

Does the county's plan include the development of innovative programs or pilots?
Yes

Program

What Behavioral Health Services Act (BHSA) component will fund the innovative program?
Behavioral Health Services and Supports

Please describe how the innovative program or pilot will help build the evidence base for the effectiveness of new statewide strategies

In FY2026-27, SF BHS will fund a BHSA Innovative Behavioral Health Pilot Project to reduce mental health and substance use disparities among Black/African American communities by testing and evaluating a culturally congruent, community-driven model of care. The pilot integrates evidence-based therapeutic practices with culturally adaptive engagement strategies rooted in lived experience, peer support, and trusted community institutions.

In FY2026-27, SF BHS will fund a BHSA Innovative Behavioral Health Pilot Project to reduce mental health and substance use disparities among Black/African American communities by testing and evaluating a culturally congruent, community-driven model of care. The pilot integrates evidence-based therapeutic practices with culturally adaptive engagement strategies rooted in lived experience, peer support, and trusted community institutions.

Please describe intended outcomes of the project

The pilots aim to increase access to and engagement in behavioral health services among Black/African American residents who are historically underserved and less likely to access care. By testing and evaluating culturally congruent, community-driven models that integrate evidence-based therapeutic practices with culturally adaptive engagement strategies rooted in lived experience, peer support, and trusted community institutions, the pilots seek to build trust and improve client experience. Intended outcomes include improved engagement and retention in care, reduced reliance on crisis-driven services, improved mental health and substance use outcomes, and reduced disparities in access, utilization, and outcomes. The pilots will also generate evidence to inform future expansion of culturally grounded approaches.

Workforce Strategy

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 6.C.2 Securing Medi-Cal Payment.

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

---

The county must ensure its county-operated and county-contracted behavioral health workforce is well-supported and culturally and linguistically responsive with the population to be served. Through existing Medi-Cal oversight processes, the Department of Health Care Services (DHCS) will assess whether the county:

Maintains and monitors **a network of providers that is sufficient to provide adequate access to services and supports for individuals with behavioral health needs; and**

Meets federal and state standards **for timely access to care and services, considering the urgency of the need for services.**

The county must ensure **that Behavioral Health Services Act (BHSA)-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner. Effective FY 2027-2028, DHCS encourages counties to require their BHSA providers to comply with the same standards as Medi-Cal providers in these areas (i.e. requiring the same standards regardless of whether a given service is reimbursed under BHSA or Medi-Cal), as described in the Policy Manual.**

Does the county intend to adopt this recommended approach for BHSA-funded providers that also participate in the county's Medi-Cal Behavioral Health Delivery System?
Yes

Does the county intend to adopt this recommended approach for BHSA-funded providers that do not participate in the county's Medi-Cal Behavioral Health Delivery System?
Yes

Build Workforce to Address Statewide Behavioral Health Goals

For related policy information, refer to 3.A.2 Contents of Integrated Plan and 7.A.4 Workforce Education and Training

---

Assess Workforce Gaps

What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?
18

Upload any data source(s) used to determine vacancy rate

For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates
Community Health Workers (CHW) defined in the Enhanced Community Health Workers Services benefit
Licensed Clinical Social Worker
Licensed Psychologist
Nurse practitioner
Psychiatrist

Please describe any other key workforce gaps in the county
Not applicable

How does the county expect workforce needs to shift over the next three fiscal years given new and forthcoming requirements, including implementation of new evidence-based practices under Behavioral Health Transformation (BHT) and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)?
SF BHS anticipates a growing demand for clinicians and care providers who are trained in evidence-based practices with the implementation of BHT and BH-CONNECT. Accordingly, we anticipate increased

demand for pre-licensed clinicians, peer specialists, case managers, and other support staff. We anticipate a need for administrative staff to support the implementation of these and other new state and local initiatives, as well as data teams to support outcomes tracking and quality improvement.

Address Workforce Gaps

If the county is planning to leverage the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative to address workforce gaps including for FSP and CSC for FEP, such as through applying for and/or encouraging providers to apply for the following BH-CONNECT workforce programs, please specify below.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Scholarship Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
SF BHS maintains a contact list for all eligible clinical interns that we email. SF BHS staff also check the BH CONNECT workforce program website regularly and subscribe to email updates to ensure that we can notify potential recipients of timelines and dates for submission.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Student Loan Payment Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
SF BHS maintains a contact list for all eligible clinical interns that we email. SF BHS staff also check the BH CONNECT workforce program website regularly and subscribe to email updates to ensure that we can notify potential recipients of timelines and dates for submission.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Recruitment and Retention Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
The program is new to SF BHS. As described above, staff will investigate the eligibility and send out information to our contacts.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
SH BHS will continue partnering with our contracted community-based organizations to expand and enhance their capacity to deliver services, including considering and applying to the Community-Based Provider Training program.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Residency Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
SF BHS intends to expand behavioral health workforce residency opportunities over the next two years, particularly in clinical fields that require formal training and for positions with high vacancy rates.

Please describe any other efforts underway or planned in the county to address workforce gaps aside from those already described above under Behavioral Health Services Act Workforce, Education, and Training
Not applicable

Budget and Prudent Reserve

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 6.B.3 Local Prudent Reserve .

Budget and Prudent Reserve

Download and complete the budget template using the button below before starting this section

Please upload the completed budget template
Draft Integrated Plan Budget Template Version 3.xlsx

Please indicate how the county plans to spend the amount over the maximum allowed prudent reserve limit for each component if the county indicated they would allocate excess prudent reserve funds to a given Behavioral Health Services Act component in Table Nine of the budget template

Behavioral Health Services and Supports (BHSS)
Not applicable

Full Service Partnership (FSP)
Not applicable

Housing Interventions
Not applicable

Enter date of last prudent reserve assessment
3/31/2026

Please describe how the use of excess prudent reserve funds drawn down from the local prudent reserve aligns with the goals of the Integrated Plan

BHSS
Not applicable

FSP
Not applicable

Housing Interventions
Not applicable

Plan Approval and Compliance

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 3.A.1 Reporting Period

Behavioral health director certification

Download and complete the behavioral health director certification template using the button below before starting this section

Please upload the completed Behavioral health director certification template
SIGNED_SF_Behavioral Health Director Certification_3-26-26.pdf

County administrator or designee certification

Download and complete the county administrator or designee certification template using the button below before starting this section

Please upload the completed County administrator or designee certification template
SF BHSA_County Administrator Certification_signed.pdf

Board of supervisor certification

For final submission, download and complete the board of supervisor certification template using the button below before starting this section

Please upload the completed Board of supervisor certification template

Confirm that the data is up to date and reflects the correct information for a Draft Plan

Requests

Funding Transfer Request

Please enter the proposed allocation adjustments to the tables below

	Plan year one	Plan year two	Plan year three
Behavioral Health Services and Supports (Base 35%)	35	35	35
Full Service Partnership (Base 35%)	31	31	31
Housing Intervention (Base 30%)	33	33	33
Housing Interventions for Outreach and Engagement	1	1	1

Behavioral Health Services and Supports Transfers

Enter the proposed dollars transferred into/from Behavioral Health Services and Supports (Base 35 percent)

	Plan year one	**Plan year two**	**Plan year three**
Dollars transferred from Full Service Partnerships	0	0	0
Dollars transferred from Housing Intervention	0	0	0
Dollars transferred into Full Service Partnerships	0	0	0
Dollars transferred into Housing Intervention	0	0	0

For Behavioral Health Services and Supports, please include a rationale for the funding allocation transfer request

Not applicable

Full Service Partnership Transfers

Enter the proposed dollars transferred into/from Full Service Partnerships (Base 35 percent)

	Plan year one	Plan year two	Plan year three
Dollars transferred from Behavioral Health Services and Supports	0	0	0
Dollars transferred from Housing Intervention	0	0	0
Dollars transferred into Behavioral Health Services and Supports	0	0	0
Dollars transferred into Housing Intervention	2880000	2968400	3055392

For Full Service Partnership, please include a rationale for the funding allocation transfer request

San Francisco Behavioral Health Services (SF BHS) requests a 3.5% transfer from the Full Service Partnership (FSP) component to the Housing Interventions component to better align resources with housing-related needs within the behavioral health system. Individuals served through FSP programs frequently experience housing instability alongside serious mental illness and substance use disorders, which can significantly affect treatment engagement and long-term recovery. This modest transfer will increase the housing resources available to individuals served in FSPs and other behavioral health programs to promote stability, strengthen engagement in treatment, and improve outcomes. The

adjustment will not reduce the core capacity of FSP programs. SF BHS will continue to provide intensive, field-based behavioral health services, including clinical treatment, case management, and supportive services for individuals with the highest levels of need.

Housing Interventions Transfers

Enter the proposed dollars transferred into/from Housing Interventions (Base 30 percent)

	Plan year one	**Plan year two**	**Plan year three**
Dollars transferred from Behavioral Health Services and Supports	0	0	0
Dollars transferred from Full Service Partnerships	2880000	2968400	3055392
Dollars transferred into Behavioral Health Services and Support	0	0	0

	Plan year one	Plan year two	Plan year three
Dollars transferred into Full Service Partnerships	0	0	0

For Housing Intervention, please include a rationale for the funding allocation transfer request

SF BHS is requesting a 3.5% transfer from the FSP component to the Housing Interventions component to address significant unmet needs among individuals with serious mental illness, substance use disorders, and other complex behavioral health conditions.

San Francisco has one of the highest rates of homelessness among California counties. The 2024 Point-in-Time Count identified 8,323 people experiencing homelessness in the city, reflecting the scale of housing instability affecting residents with behavioral health needs. In 2024, the San Francisco Department of Public Health identified 16,671 unhoused individuals with a serious mental illness and/or substance use disorder diagnosis. San Francisco's 2025 Homelessness Needs Assessment further identifies the need for integrated housing and behavioral health interventions and recommends expanding housing and treatment services to address the intersection of homelessness and behavioral health needs.

Community Planning Process input reinforced this need. Providers, consumers, and community stakeholders consistently identified limited housing options as a key barrier to stability and recovery for individuals with serious mental illness and substance use disorders.

Expanding the Housing Interventions component will allow SF BHS to strengthen housing-related supports that promote stability and improve outcomes for individuals served through the behavioral health system. This adjustment aligns funding with community-identified priorities and supports a more integrated approach to addressing behavioral health needs and homelessness.

Supporting Information and Data

How does the funding transfer request respond to community needs and input?

The funding transfer request of 3.5% from FSP to Housing Interventions responds directly to community needs and priorities identified through San Francisco's BHSA Community Planning Process.

As described in the Full Service Partnership and Housing Interventions transfer rationale responses above,

the scale of homelessness identified in the 2024 Point-in-Time Count and the number of unhoused individuals with serious mental illness and/or substance use disorders identified by the San Francisco Department of Public Health illustrates the unmet behavioral health and housing needs in our community. These findings are further supported by San Francisco's 2025 Homelessness Needs Assessment, which highlights the need for expanded housing resources and more integrated housing and behavioral health services to address the drivers of homelessness and improve outcomes for individuals with complex health and behavioral health needs.

Community feedback continuously reinforces these findings. Between June and October 2025, SF BHS held 12 community meetings with providers, consumers, advisory bodies, and partner agencies and administered a communitywide survey that received over 1,000 responses to identify behavioral health system needs and service gaps. Community stakeholders consistently identified housing instability and limited supportive housing options as major barriers to stability, treatment engagement, and recovery.

See attached local supporting data: San Francisco 2025 Homelessness Needs Assessment, San Francisco 2024 Homelessness Point-in-Time Count & Report, and San Francisco Behavioral Health Services 2026 CPP Overview.

The proposed funding transfer responds to this community input by strengthening the Housing Interventions component and aligning BHSA resources with strategies that support housing stability and improved behavioral health outcomes.

Please include local data supporting the funding transfer request
2024_San_Francisco_Point-in-Time_Count_Report_8_13_24 (1).pdf
SF BHS CPP Overview with minutes and survey.pdf
San Francisco 2025_Homelessness_Needs_Assessment_Final (1).pdf

Data Suppression Notice:
Values marked with "*" have been suppressed per DHCS de-identification standards. Counts between 1–10 are displayed as "<11*"

Instructions

Counties shall report their planned expenditures for all behavioral health funding sources, not limited to only BHSA, along the Behavioral Health Care Continuum in Tab One.
For Annual Updates, counties should review and make updates only to the next fiscal year. For Intermittent Updates, counties should review and make updates to the current fiscal year.
Column C: counties shall indicate whether they provide each category of services using the check box.
Columns D through I: counties shall include their estimated total expenditures for the Integrated Plan period across all behavioral health funding sources and programs by each Behavioral Health Care Continuum category. Counties should consider children/youth as 21 and under for Columns G - I.
Columns J and K: counties shall input their estimated total count of all individuals served through the county behavioral health system across all funding sources/programs. These counts may be duplicated. Counties should consider eligible children/youth as 21 and under for Column K.
Row 39: the total projected expenditures in columns D through I and total projected individuals served annually in columns J and K will be auto-populated from rows 21 through 37.
Note: For a list of all funding streams that should be included in the projected expenditures calculation for each BH Care Continuum Category, please see the Behavioral Health Services Act (BHSA) County Policy Manual Chapter 3, Section A.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table One: Behavioral Health Care Continuum Projected Expenditures

	Services Are Provided in County	Total Projected Expenditures On Adults and Older Adults			Total Projected Expenditures on Children/Youth (under 21)			Projected Individuals to be Served Annually (May be duplicated)	
		Year One	Year Two	Year Three	Year One	Year Two	Year Three	Eligible Adults and Older Adults	Eligible Children/Youth
Substance Use Disorder (SUD) Services									
Primary Prevention Services	☑	$ 541,584.00	$ 557,832.00	$ 574,567.00	$ 2,221,601.00	$ 2,288,249.00	$ 2,356,897.00	98.00	402.00
Early Intervention Services	☑	$ 6,033,125.00	$ 6,214,119.00	$ 6,400,542.00	$ 15,081.00	$ 15,534.00	$ 16,000.00	18002	45.00
Outpatient Services	☑	$ 59,431,043.00	$ 61,213,975.00	$ 63,050,394.00	$ 468,776.00	$ 482,839.00	$ 497,324.00	6366	72.00
Intensive Outpatient Services	☑	$ 12,639,509.00	$ 13,018,694.00	$ 13,409,255.00	$ 99,310.00	$ 102,290.00	$ 105,358.00	700	6.00
Crisis and Field-Based Services	☑	$ 14,070,969.00	$ 14,493,098.00	$ 14,927,891.00	$ 46,747.00	$ 48,150.00	$ 49,594.00	1806	6.00
Residential Treatment Services	☑	$ 35,646,740.00	$ 36,716,142.00	$ 37,817,626.00	$ 444,702.00	$ 458,043.00	$ 471,784.00	2525	32.00
Inpatient Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Mental Health (MH) Services									
Primary Prevention Services	☑	$ 5,064,640.00	$ 5,216,579.00	$ 5,373,076.00	$ 1,167,604.00	$ 1,202,632.00	$ 1,238,711.00	627	129
Early Intervention Services	☑	$ 16,156,048.00	$ 16,194,396.00	$ 16,680,228.00	$ 18,049,834.00	$ 17,537,322.00	$ 18,063,441.00	4803	5366
Outpatient and Intensive Outpatient Services	☑	$ 169,865,246.00	$ 174,961,203.00	$ 180,210,039.00	$ 42,837,708.00	$ 44,122,839.00	$ 45,446,524.00	29956	7517
Crisis Services	☑	$ 62,736,565.00	$ 64,618,662.00	$ 66,557,222.00	$ 6,603,437.00	$ 6,801,540.00	$ 7,005,586.00	4853	552
Residential Treatment Services	☑	$ 64,131,873.00	$ 66,055,829.00	$ 68,037,504.00	$ 1,440,331.00	$ 1,483,541.00	$ 1,528,047.00	858	24
Hospital and Acute Services	☑	$ 48,652,461.00	$ 50,112,035.00	$ 51,615,396.00	$ 3,882,524.00	$ 3,999,000.00	$ 4,118,970.00	1705	149
Subacute and Long-Term Care Services	☑	$ 52,828,326.00	$ 54,413,176.00	$ 56,045,571.00	$ 703,219.00	$ 724,316.00	$ 746,045.00	1952	39
Housing Services (MH + SUD)									
Housing Services	☑	$ 90,621,683.00	$ 93,340,333.00	$ 96,140,543.00	$ 1,451,427.00	$ 1,494,969.00	$ 1,539,818.00	28908	463
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)		$ 638,419,812.00	$ 657,126,073.00	$ 676,839,854.00	$ 79,432,301.00	$ 80,761,264.00	$ 83,184,099.00	103159	14802

Instructions

Counties shall report their planned expenditures for all behavioral health services and activities, not limited to only BHSA funded services and activities, other than those that are part of the Behavioral Health Care Continuum in Tab Two.

Rows 18 through 21: counties shall include their estimated total expenditures for the Integrated Plan period across all behavioral health funding sources and programs for each category listed. These costs are those that do not easily fit under the categories in Tab One, "BH CoC Expenditures."

Row 23: total projected expenditures will be auto-populated from rows 18 through 21.

For a list of all funding streams that should be included in the projected expenditures calculation for Table Two: Other County Expenditures please see the Behavioral Health Services Act County Policy Manual Chapter 3 Section A.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Two: Other County Expenditures			
Other Expenditures	**Total Projected Expenditures**		
	Year One	**Year Two**	**Year Three**
Capital Infrastructure Activities	$ 2,081,372.00	$ 2,143,814.00	$ 2,208,128.00
Workforce Investment Activities	$ 16,693,091.00	$ 15,474,556.00	$ 15,938,793.00
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	$ 92,961,807.00	$ 95,750,661.00	$ 98,623,181.00
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs)	$ 45,466,301.00	$ 44,841,075.00	$ 46,186,307.00
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	$ 157,202,571.00	$ 158,210,106.00	$ 162,956,409.00

Instructions

Counties shall report their planned revenue across the county behavioral health delivery system to support all behavioral health services and programs by funding source in Tab Three.

Rows 18 through 33: counties shall report projected expenditures for each funding source/program.

Row 21: for State General Fund, include funds received for the non-federal share of Medi-Cal payments.

Row 26: for Commercial Insurance (including Medicare), reporting reflects planned reimbursement obtained by county-operated providers, not county-contracted providers.

Row 35: total expenditures will be auto-populated from rows 18 through 33.

Row 36: will be auto-validated by DHCS against rows 35, 37, and 38. Validation: total projected expenditure variance should total out to $0.

Rows 37 and 38: will be auto-validated by DHCS against total projected expenditures in Tabs One and Two.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Three: Projected Annual Expenditures by County BH Funding Source			
	Total Annual Projected Expenditures (Year One)	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
BHSA	$ 96,307,621.00	$ 94,553,652.00	$ 97,390,261.00
1991 Realignment (Bronzan-McCorquodale Act)	$ 61,150,000.00	$ 62,984,500.00	$ 64,874,035.00
2011 Realignment (Public Safety Realignment)	$ 64,383,286.00	$ 66,314,785.00	$ 68,304,228.00
State General Fund	$ 13,934,700.00	$ 14,352,741.00	$ 14,783,323.00
FFP (SMHS, DMC/DMC-ODS, NSMHS)	$ 214,046,036.00	$ 220,467,417.00	$ 227,081,440.00
Projects for Assistance in Transition from Homelessness (PATH)	$ -	$ -	$ -
Community Mental Health Block Grant (MHBG)	$ 4,549,628.00	$ 4,686,117.00	$ 4,826,700.00
Substance Use Block Grant (SUBG)	$ 8,913,363.00	$ 9,180,764.00	$ 9,456,187.00
Commercial Insurance	$ 9,127,000.00	$ 9,400,810.00	$ 9,682,834.00
County General Fund	$ 355,154,872.00	$ 365,243,833.00	$ 376,201,146.00
Opioid Settlement Funds	$ 21,680,627.00	$ 22,331,046.00	$ 23,000,977.00
Other Funding Sources	**Total Annual Projected Expenditures (Year One)**	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
Other federal grants	$ 3,106,350.00	$ 3,199,541.00	$ 3,295,527.00
Other state funding (including DSH funding)	$ 2,350,000.00	$ 2,420,500.00	$ 2,493,115.00
Other county mental health or SUD funding	$ 20,351,201.00	$ 20,961,737.00	$ 21,590,589.00
Other foundation funding	$ -	$ -	$ -
Summary	**Total Annual Projection (Year One)**	**Total Annual Projection (Year Two)**	**Total Annual Projection (Year Three)**

Total projected expenditures (all BH funding streams/ programs) (auto-populated)	$ 875,054,684.00	$ 896,097,443.00	$ 922,980,362.00
Total Projected Expenditure Variance	$ -	$ -	$ -
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	$ 717,852,113.00	$ 737,887,337.00	$ 760,023,953.00
Auto-validation: Table 2: Other County Expenditures	$ 157,202,571.00	$ 158,210,106.00	$ 162,956,409.00

Instructions

Counties shall report their base BHSA funding allocations, approved Housing Intervention Component Exemptions, and planned transfers on this sheet. **All counties must complete this sheet.**

Rows 39-41: input your county's base BHSA funding allocation by component and year.

Rows 45-54: this section will be auto-populated from the sections below it.

Rows 45, 50, and 53: the total adjusted allocation percentages for each component, inclusive of both exemptions and transfers.

Rows 46, 51, and 54: is the projected amount of funding, in dollars, based on the adjusted total allocation percentages.

Row 47: reflects the unspent MHSA funding that will be transferred to each of the Behavioral Health Services Act (BHSA) component allocations.

Row 48: reflects the excess prudent reserve funding that will be transferred to each of the BHSA components.

Rows 59, 82, and 105: the base funding amount for Housing Interventions will auto-populate from Column C, rows 39-41.

Rows 60, 83, and 106: if your county has an approved housing exemption, enter the percent of funds you are moving out of Housing Interventions into the other components. Enter this percentage as a positive value. It will automatically display as a negative value in the cell.

Rows 61, 84, and 107: if your county has an approved housing exemption, enter the percent of funds you are moving out of the other components and into Housing interventions. Enter this percentage as a positive value.

Rows 64, 87, 110: the base funding amount for Full Service Partnerships will auto-populate from Column D, rows 39-41.

Rows 69, 92, 115: the base funding amount for Behavioral Health Services and Supports will auto-populate from Column E, rows 39-41.

Rows 65, 70, 88, 93, 111, and 116: enter the percentage transferred out of Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS) into Housing Interventions, respectively.

Rows 66, 71, 89, 94, 112, and 117: enter the percentage transferred from Housing Interventions into Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS), respectively.

Rows 75, 98, 121: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states "Row Equals 100%."

Rows 76, 99, 122: enter the amount you are transferring out of each component as a positive number. It will automatically display as a negative value. Ensure the validation states, "Row Does Not Exceed 14%."

Rows 77, 100, 123: enter the amount you are transferring into each component as a positive number. Ensure the validation states, "Transfers Out and In Equal."

Note: If your county plans to use Housing Intervention funds (up to 7 percent) to provide outreach and engagement, the amount of funds the county can transfer out of the Housing Intervention component (Row 76) must be decreased by the corresponding amount. Counties will document the amount dedicated to outreach and engagement in Tab 5. Housing Interventions.

Rows 78, 101, 124: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states, "Row Equals 100%."

Rows 127-132: enter the amount of MHSA funds by component allocation transferring to each BHSA component. Encumbered unspent MHSA funds tied to WET, CFTN, or INN should be included; unencumbered INN funds should also be included. Please see Policy Manual Chapter 6, Section 7 for additional information.

Row 133: the total dollar amount of MHSA Transfers to BHSA is auto-populated.

Row 136: enter the dollar amount of prior year prudent reserve ending balance

Row 137: enter the prudent reserve maximum for your county.

Row 138: the dollar amount of excess prudent reserve funding to be transferred out of the prudent reserve will auto-populate. **Negative values indicate no transfer is necessary.**

Rows 139-141: enter the amount of excess prudent reserve funds allocated to each component.

Row 142: the total transferred excess prudent reserve is auto-populated.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Four: BHSA Transfers				
County Base BHSA Funding Allocations				
	Housing Intervention	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Total**
Year 1 Component Allocation (dollars)	$ 21,600,000.00	$ 25,200,000.00	$ 25,200,000.00	$ 72,000,000.00
Year 2 Component Allocation (dollars)	$ 22,248,000.00	$ 25,956,000.00	$ 25,956,000.00	$ 74,160,000.00
Year 3 Component Allocation (dollars)	$ 22,915,440.00	$ 26,734,680.00	$ 26,734,680.00	$ 76,384,800.00
Summary (auto-populated)				
	Housing Intervention	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Totals**
Year One				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	34%	31%	35%	100%

Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 24,480,000.00	$ 22,320,000.00	$ 25,200,000.00	$ 72,000,000.00
Unspent Mental Health Services Act (MHSA) to BHSA	$ 10,914,520.00	$ 9,951,475.00	$ 24,894,004.00	$ 45,759,999.00
Excess Prudent Reserve (PR) to BHSA	$ -	$ -	$ -	$ -
Year Two				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	34%	31%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 25,214,400.00	$ 22,989,600.00	$ 25,956,000.00	$ 74,160,000.00
Year Three				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	34%	31%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 25,970,832.00	$ 23,679,288.00	$ 26,734,680.00	$ 76,384,800.00

Funding Transfer Request Allocations

Year 1

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage)

Base Component	Housing Intervention Percentage	Housing Intervention Funds
Base Percentage and Funding	30%	$ 21,600,000.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 21,600,000.00

Transferred To/From	Full Service Partnership Percentage	Full Service Partnership Funds
Base Percentage and Funding	35%	$ 25,200,000.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 25,200,000.00

Transferred To/From	Behavioral Health Services and Support Percentage	Behavioral Health Services and Support Funding
Base Percentage and Funding	35%	$ 25,200,000.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 25,200,000.00

Transfers

	Housing Intervention (1)	Full-Service Partnership	Behavioral Health Services and Support	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	0%	-4%	0%	Row Does Not Exceed 14%
Amount Transferring In	4%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	34%	31%	35%	Row Equals 100%

Year 2

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage)		
Base Component	**Housing Intervention Percentage**	**Housing Intervention Funds**
Base Percentage and Funding	30%	$ 22,248,000.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 22,248,000.00
Transferred To/From	**Full Service Partnership Percentage**	**Full Service Partnership Funds**
Base Percentage and Funding	35%	$ 25,956,000.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 25,956,000.00
Transferred To/From	**Behavioral Health Services and Support Percentage**	**Behavioral Health Services and Support Funding**
Base Percentage and Funding	35%	$ 25,956,000.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 25,956,000.00

Transfers				
	Housing Intervention (1)	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Validation**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	0%	-4%	0%	Row Does Not Exceed 14%
Amount Transferring In	-4%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	34%	31%	35%	Row Equals 100%

Year 3

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage)		
Base Component	**Housing Intervention Percentage**	**Housing Intervention Funds**
Base Percentage and Funding	30%	$ 22,915,440.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 22,915,440.00
Transferred To/From	**Full Service Partnership Percentage**	**Full Service Partnership Funds**
Base Percentage and Funding	35%	$ 26,734,680.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 26,734,680.00
Transferred To/From	**Behavioral Health Services and Support Percentage**	**Behavioral Health Services and Support Funding**
Base Percentage and Funding	35%	$ 26,734,680.00
Percentage Reduced	0%	$ -

Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 26,734,680.00

Transfers				
	Housing Intervention (1)	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Validation**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	0%	-4%	0%	Row Does Not Exceed 14%
Amount Transferring In	-4%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	34%	31%	35%	Row Equals 100%

MHSA Transfers to BHSA				
MHSA Component	**Available Unspent BHSA Funds**	**Transferred to Housing Intervention**	**Transferred to Full-Service Partnership**	**Transferred to Behavioral Health Services and Support**
CSS	$ 23,451,823.00	$ 7,973,620.00	$ 7,270,065.00	$ 8,208,138.00
PEI	$ 5,793,716.00	$ 1,969,863.00	$ 1,796,052.00	$ 2,027,800.00
Encumbered INN	$ 3,658,469.00	$ -	$ -	$ 3,658,469.00
Unencumbered INN	$ 2,855,992.00	$ 971,037.00	$ 885,358.00	$ 999,597.00
WET	$ -			$ -
CFTN	$ 10,000,000.00			$ 10,000,000.00
Total (auto-populated)	$ 45,760,000.00	$ 10,914,520.00	$ 9,951,475.00	$ 24,894,004.00

Excess Prudent Reserve to BHSA Components	
Transfer from Prudent Reserve to BHSA Component Allocation	**Amount**
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 7,259,570.00
Local Prudent Reserve Maximum (2)	$ 12,493,331.46
Excess Prudent Reserve Funding that must be transferred	**$ (5,233,761.46)**
Housing Intervention (3)	$ -
FSP	$ -
BHSS (4)	$ -
Total Transferred Excess Prudent Reserve (auto-populated)	$ -

References

1. BHSA County Policy Manual section 6.B.5 states counties may use up to seven percent of Housing Interventions component funds on outreach and engagement. The amount of funds transferred out of the Housing Interventions component into another funding component must be decreased by a corresponding amount. Counties are not required to use Housing Intervention component funding for outreach and engagement, or other funding transfer requests. It remains at the discretion of the counties to transfer up to a total of 14 percent of its BHSA funds in a fiscal year.

2. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).
3. W&I Code § 5892, subdivision (b)(6)(B) states prudent reserve funding cannot be spent on capital development.
4. W&I Code § 5892, subdivision (b)(6)(A) states counties must spend prudent reserve funds on Housing Intervention, FSP, and/or BHSS programs or services only.

Instructions

Counties shall report their projected expenditures for their BHSA Housing Interventions allocation component. Counties shall report projected expenditures for all other non-BHSA funding sources in Tab Five.

Rows 40-43: input the estimated total Housing Intervention component allocation received for each year. Row 40 will auto-populate from Tab Four in the BHSA Transfers tab. Input unspent MHSA dollars carried over to this component into row 42. Row 43 will auto-populate the sum of rows 40-42 to account for total funding.

Row 41: input the total dollar amount projected to be added to Housing Intervention component funds from the prudent reserve, if applicable. If you reported on Tab 4, row 139 that you will be transferring excess PR funds to Housing Interventions please report them here.

Rows 49-66: input the projected expenditures for each Housing Intervention component service category or program for each year.

Row 48: the aim of Housing Interventions is to help individuals achieve permanent housing stability. To the maximum extent possible, counties should seek to place individuals in permanent housing settings. Housing Interventions may only be used for placement in interim settings for a limited time, 6 months for BHSA eligible individuals who have exhausted the Transitional Rent benefit and 12 months for BHSA eligible individuals not eligible to receive Transitional Rent through their Medi-Cal MCP.

Row 53: pursuant to W&I Code section 5830, subdivision (c)(2), BHSA Housing Interventions may not be used for housing services covered by Medi-Cal Managed Care Plans (MCP). Please indicate the projected expenditures for BHSA funding ONLY in columns C, D, and E. Please indicate the projected expenditures for all other funding sources excluding BHSA in columns F, G, and H.

Row 65: input expenditures for BHSA-funded innovation pilots or projects.

Row 66: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.

Row 67: the sub-total will be auto-populated, excluding the percentage of rental and operating subsidies administered through Flex Pools.

Row 69: input the total dollar amount projected to be transferred out of Housing Intervention component funds into the prudent reserve.

Row 71: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).

Row 72: the overall total of Housing Intervention expenditures will be auto-populated from rows 67, 69, and 71.

Row 74: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to the chronically homeless population. This amount should equal 50% of Housing Interventions component allocation.

Row 75: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to serving individuals with only a substance use disorder, if provided by the county. DHCS recognizes there may be duplication with funds captured in row 74.

Row 77: the proportion of funds dedicated to capital development will be auto-populated**.**

Row 78: the proportion of funds dedicated to the chronically homeless population will be auto-populated**.**

Row 79: the proportion of funds dedicated to Outreach and Engagement will be auto-populated.

Rows 81-82: input the estimated unduplicated count of individuals that will be served across all Housing Intervention component services.

Row 84: auto-populates projected estimated amount of MHSA Encumbered INN funds that will be available in the BHSA HI component for each year.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Five: BHSA Components

Total Housing Interventions Funding (1)			
	Year 1	**Year 2**	**Year 3**
Total Estimated Housing Intervention Funding Received (BHSA Funds)	$ 24,480,000.00	$ 25,214,400.00	$ 25,970,832.00
Transfers into Housing Intervention component from Local Prudent Reserve	$ -	$ -	$ -

Total Estimated Housing Intervention Funding Allocated (MHSA - Unspent Carryover Funds)	$ 10,914,520.00	$ 6,168,316.00	$ 6,353,365.00
Total Estimated Housing Intervention Funding (BHSA + MHSA Funds)	$ 35,394,520.00	$ 31,382,716.00	$ 32,324,197.00

Housing Interventions Category						
Type of Service	**Projected Expenditures - Unspent MHSA and BHSA Funding Only**			**Projected Expenditures - All Other Funding Sources**		
	Year 1	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**
Housing Interventions Component Programs/Services						
Non-Time Limited Permanent Settings (e.g., supportive housing, apartments, single and multi-family homes, shared housing) (2)						
Rental Subsidies	$ 675,162.00	$ 695,417.00	$ 716,279.00	$ 85,938.00	$ 88,516.00	$ 91,172.00
Operating Subsidies	$ 15,644,765.00	$ 16,114,107.00	$ 16,597,531.00	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ 650,213.00	$ 669,719.00	$ 689,810.00	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2)						
Rental Subsidies	$ 2,311,261.00	$ 2,380,599.00	$ 2,452,017.00	$ 2,442,238.00	$ 2,515,505.00	$ 2,590,970.00
Operating Subsidies	$ 1,945,763.00	$ 2,004,136.00	$ 2,064,260.00	$ 339,673.00	$ 349,863.00	$ 360,359.00
Bundled Rental and Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Other Housing Interventions						
Other Housing Supports: Landlord Outreach and Mitigation Funds (2)	$ -	$ -	$ -	$ -	$ -	$ -
Other Housing Supports: Participant Assistant Funds (2)	$ 186,506.00	$ 192,101.00	$ 197,864.00	$ -	$ -	$ -
Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	$ 8,891,196.00	$ 9,157,932.00	$ 9,432,670.00	$ 4,679,436.00	$ 4,819,819.00	$ 4,964,414.00
Other Housing Supports: Outreach and Engagement (2)	$ 536,715.00	$ 552,816.00	$ 569,401.00	$ 85,938.00	$ 88,516.00	$ 91,172.00
Capital Development Projects	$ -	$ -	$ -	$ -	$ -	$ -
Housing Flex Pool Expenditures (start-up expenditures)	$ -	$ -	$ -	$ -	$ -	$ -

BHSA Innovative Housing Intervention Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 30,841,581.00	$ 31,766,827.00	$ 32,719,832.00	$ 7,633,223.00	$ 7,862,219.00	$ 8,098,087.00
Housing Interventions Transfer Information	**Year 1**	**Year 2**	**Year 3**			
Transfers out of Housing Intervention component into Local Prudent Reserve (6)	$ -	$ -	$ -			
Housing Interventions Component Administrative Information	**Year 1**	**Year 2**	**Year 3**			
Housing Interventions Component Admin Expenses	$ -	$ -	$ -			
Total Housing Interventions Expenditures (auto-populated)	$ 30,841,581.00	$ 31,766,827.00	$ 32,719,832.00			
Housing Interventions Populations to be Served	**Year 1**	**Year 2**	**Year 3**			
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	$ 27,097,262.00	$ 27,910,179.00	$ 28,747,485.00			
Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	$ 3,346,158.00	$ 3,446,543.00	$ 3,549,939.00			
Housing Interventions Component Funds Validation (auto-populated based on inputs above)	**Year 1**	**Year 2**	**Year 3**			
Housing Intervention Component Funds Dedicated to Capital Development/Total Housing Interventions Funding (7) (auto-populated)	0.0%	0.0%	0.0%			
Housing Interventions Component Funds Dedicated to Chronically Homeless Population/Total Housing Intervention Component Funding (8) (auto-populated)	76.6%	88.9%	88.9%			
Housing Interventions Component Funds Used for Outreach and Engagement (2) (auto-populated)	1.5%	1.8%	1.8%			
Projected Individuals to be Served (Unduplicated)	**Year 1**	**Year 2**	**Year 3**			
Eligible Children/TAY (25 years and younger)	281	281	281			
Eligible Adults/Older Adults	11816	11816	11816			

Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	Year 1	Year 2	Year 3
MHSA "Encumbered" INN	$ -	$ -	$ -

References
1. W&I Code § 5892, subdivision (a)(1)(A)(i) states 30% of BHSA funds distributed to counties shall be used for Housing Interventions.
2. See Policy Manual Section 7.C.9 Allowable Expenditures and Related Requirements for further information regarding allowable Housing Interventions expenditures.
3. Single room occupancy and recovery housing can be interim or permanent. If interim, Housing Interventions is limited to 6 months for those who have exhausted Transitional Rent or 12 months for those not eligible for Transitional Rent. Appendix B of the Policy Manual includes a crosswalk of coverage by select programs.
4. Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls) and does not include behavioral health residential treatment settings.
5. Counties must provide Housing Intervention services to eligible children, youth, and adults (defined in W&I Code section 5892) who are chronically homeless, experiencing homelessness, or at risk of homelessness. The provision of BHSA-funded Housing Interventions specifically for individuals with a substance use disorder is optional for counties, per W&I Code section 5891, subdivision (a)(2).
6. W&I Code § 5892, subdivision (b)(2).
7. W&I Code § 5892, subdivision (a)(1)(A)(iii) states no more than 25% of Housing Interventions funds may be used for capital development.
8. W&I Code § 5892, subdivision (a)(1)(A)(ii) states 50% of Housing Interventions funds shall be used for housing interventions for persons who are chronically homeless, with a focus on those in encampments.

Instructions

Counties shall report their projected expenditures of their Full Service Partnership (FSP) funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Tab Six.

Rows 25-28: input the total estimated FSP component allocation received for each year. Row 25 will auto-populate from Tab Four in the BHSA Transfers tab.
Input unspent MHSA dollars carried over to this component into row 27. Row 28 will auto-populate the sum of rows 25-27 to account for total funding.

Row 26: input the total dollar amount projected to be added to FSP from the prudent reserve, if applicable. If you reported on Tab 4, row 140 that you will be transferring excess PR funds to FSP please report them here.

Rows 33-42: input the projected expenditures for each FSP service category or program for each year.

Note: DHCS expects other required uses of FSP funding (e.g., mental health services, supportive services, substance use disorder (SUD) treatment services, ongoing engagement services) to be captured within rows 33-38. Any mental health and supportive service or SUD treatment service expenditures not included in these rows should be accounted for in rows 39-40, accordingly.

Row 41: input expenditures for BHSA-funded innovation pilots or projects.

Row 42: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.

Row 43: the subtotal of FSP programs/services will be auto-populated from rows 33-42.

Row 45: input the total dollar amount projected to be transferred out of FSP into the prudent reserve.

Row 47: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).

Row 48: total projected expenditures for FSP for each year will be auto-populated from rows 43, 45, and 47.

Rows 50 and 51: input the estimated unduplicated count of individuals that will be served across all FSP programs.

Row 53: auto-populates projected estimated amount of MHSA Encumbered INN funds that will be available in the BHSA FSP component for each year.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Six: BHSA Components

Total Full Service Partnership (FSP) Funding	Year 1	Year 2	Year 3
Total Estimated Full Service Partnership Funding Received (BHSA Funds)	$ 22,320,000.00	$ 22,989,600.00	$ 23,679,288.00
Transfers into Full Service Partnership component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	$ 9,951,475.00	$ 5,762,830.00	$ 5,935,715.00
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	$ 32,271,475.00	$ 28,752,430.00	$ 29,615,003.00

Full Service Partnership Category (1)									
Type of Service	**Projected Expenditures - Unspent MHSA and BHSA Funding Only**			**Projected Expenditures - Federal Financial Participation**			**Projected Expenditures - All Other Funding Sources**		
	Year 1	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**
FSP Programs/Services									
Assertive Community Treatment (ACT)(2)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$ 2,865,424.00	$ 2,951,387.00	$ 3,039,928.00	$ 1,202,632.00	$ 1,238,711.00	$ 1,275,872.00	$ 175,339.00	$ 180,599.00	$ 186,017.00
FSP Intensive Case Management	$ 20,714,149.00	$ 21,335,573.00	$ 21,975,641.00	$ 6,204,313.00	$ 6,390,443.00	$ 6,582,156.00	$ 1,661,827.00	$ 1,711,682.00	$ 1,763,032.00
High Fidelity Wraparound	$ 1,049,001.00	$ 1,080,471.00	$ 1,112,885.00	$ 589,502.00	$ 607,187.00	$ 625,403.00	$ 876,195.00	$ 902,481.00	$ 929,555.00
Individual Placement and Support (IPS) Model of Supported Employment (2)	$ 715,743.00	$ 737,215.00	$ 759,332.00	$ 49,990.00	$ 51,490.00	$ 53,035.00	$ 479,779.00	$ 494,172.00	$ 508,998.00
Assertive Field-Based Initiation for SUD Treatment Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define	$ 3,320,353.00	$ 3,419,964.00	$ 3,522,562.00	$ 345,509.00	$ 355,875.00	$ 366,551.00	$ -	$ -	$ -

Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc.): Please define	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative FSP Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 28,664,670.00	$ 29,524,610.00	$ 30,410,348.00	$ 8,391,946.00	$ 8,643,706.00	$ 8,903,017.00	$ 3,193,140.00	$ 3,288,934.00	$ 3,387,602.00

FSP Transfer Information	**Year 1**	**Year 2**	**Year 3**
Transfers out of FSP component into Local Prudent Reserve	$ -	$ -	$ -

FSP Administrative Information	**Year 1**	**Year 2**	**Year 3**
FSP Component Admin Expenses	$ 149,480.00	$ 153,964.00	$ 158,583.00
Total Full Service Partnership Expenditures (auto-populated)	$ 28,814,150.00	$ 29,678,574.00	$ 30,568,931.00

Projected Individuals to be Served (Unduplicated)	**Year 1**	**Year 2**	**Year 3**
Eligible Children/TAY (25 years and younger)	70	70	70
Eligible Adults/Older Adults	2131	2131	2131

Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year 1**	**Year 2**	**Year 3**
MHSA "Encumbered" INN	$ -	$ -	$ -

References
1. W&I Code § 5892, subdivision (a)(2)(A) states 35% of BHS funds distributed to counties shall be used for Full Service Partnership Programs.
2. May be bundled or un-bundled depending on county BH-CONNECT opt-in.

Instructions

Counties shall report their projected expenditures of their Behavioral Health Services and Supports funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Tab Seven.
Row 27-30: input the total estimated BHSS component allocation received for each year. Row 27 will auto-populate from Tab Four in the BHSA Transfers tab.
Row 28: input the total dollar amount projected to the BHSS funding component from the prudent reserve (if applicable). If you reported on Tab 4, row 141 that you will be transferring excess PR funds to BHSS please report them here.
Input unspent MHSA dollars carried over to this component into row 29. Row 30 will auto-populate the sum of rows 27-29.
Rows 35-48: input the projected expenditures for each BHSS service category or program for each year. Rows 37, 41, and 44 auto-populate from their sub rows.
Row 47: input expenditures for BHSA-funded innovation pilots or projects.
Row 48: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.
Row 49: the subtotal for projected expenditures will be auto-populated from rows 35 - 37, 40, 41, 44, 47, and 48.
Row 51: input the total dollar amount projected to be transferred out of the BHSS funding component into the prudent reserve.
Row 53: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).
Row 54: the total for projected BHSS expenditures will be auto-populated from rows 49, 51, and 53.
Row 56: input the total dollar amount of Youth-Focused (25 years and younger) Early Intervention Expenditures.
Row 58: the proportion of EI funds will auto-populate from rows 30 and 37. Note: MHSA WET, INN, and CF/TN funds in Rows 67-69 will be deducted from the revenue (excluded from the denominator).
Row 59: the proportion of Youth-Focused (25 years and younger) EI funds will auto-populate from rows 37 and 56.
Rows 61-62: input the estimated unduplicated count of individuals that will be served across all BHSA-funded programs.
Rows 64-65: input the estimated amount of BHSS funds that will be transferred to WET and CF/TN for each year.
Rows 67-69: auto-populates projected estimated amount of MHSA WET, CF/TN, and Encumbered INN funds that will be available in the BHSA BHSS component for each year.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance.
These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Seven: BHSA Components

Total Behavioral Health Services and Supports (BHSS) Funding	Year 1	Year 2	Year 3
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$ 25,200,000.00	$ 25,956,000.00	$ 26,734,680.00
Transfers into Behavioral Health Services and Support component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Behavioral Health Services and Support Funding Allocated (MHSA - Unspent Carryover Funds)	$ 24,894,004.00	$ 6,678,393.00	$ 5,947,106.00
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 50,094,004.00	$ 32,634,393.00	$ 32,681,786.00

Behavioral Health Services and Supports Category (1)										
Type of Service	**Projected Expenditures - Unspent MHSA and BHSA Funding Only**			**Projected Expenditures - Federal Financial Participation**			**Projected Expenditures - All Other Funding Sources**			
	Year 1	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**	
BHSS Programs/Services										
Children's System of Care-Non FSP (25 years and younger)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	$ 444,231.00	$ 457,558.00	$ 471,285.00		$ -	$ -	$ -	$ -	$ -	
Early Intervention Expenditures	$ 20,208,524.00	$ 19,285,642.00	$ 19,864,211.00	$ 601,625.00	$ 619,674.00	$ 638,264.00	$ 4,898,703.00	$ 5,074,462.00	$ 5,226,695.00	
Coordinated Specialty Care for First Episode Psychosis	$ 746,124.00	$ 768,508.00	$ 791,563.00	$ 451,625.00	$ 465,174.00	$ 479,129.00	$ 875,474.00	$ 901,738.00	$ 928,790.00	
All Other EI Expenditures	$ 19,462,400.00	$ 18,517,134.00	$ 19,072,648.00	$ 150,000.00	$ 154,500.00	$ 159,135.00	$ 4,023,229.00	$ 4,172,724.00	$ 4,297,905.00	
Outreach and Engagement	$ 1,477,689.00	$ 1,522,020.00	$ 1,567,680.00	$ 50,000.00	$ 51,500.00	$ 53,045.00	$ 675,316.00	$ 695,575.00	$ 716,443.00	
Workforce Education and Training (WET)	$ 5,633,544.00	$ 4,696,649.00	$ 4,837,548.00	$ -	$ -	$ -	$ 3,647,385.00	$ 3,143,380.00	$ 3,237,681.00	

Dedicated BHSA WET funds	$ 5,633,544.00	$ 4,696,649.00	$ 4,837,548.00	$ -	$ -	$ -	$ 3,647,385.00	$ 3,143,380.00	$ 3,237,681.00
Dedicated MHSA WET funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capital Facilities and Technological Needs (CFTN)	$ 2,733,355.00	$ 2,785,356.00	$ 2,838,916.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA CF/TN funds	$ 1,733,355.00	$ 1,785,356.00	$ 1,838,916.00		$ -	$ -	$ -	$ -	$ -
Dedicated MHSA CF/TN funds	$ 1,000,000.00	$ 1,000,000.00	$ 1,000,000.00	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative BHSS Pilots and Projects	$ 2,331,024.00	$ 392,797.00	$ 404,581.00		$ -	$ -		$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 32,828,367.00	$ 29,140,022.00	$ 29,984,221.00	$ 651,625.00	$ 671,174.00	$ 691,309.00	$ 9,221,404.00	$ 8,913,417.00	$ 9,180,819.00
BHSS Prudent Reserve Transfer Information	**Year 1**	**Year 2**	**Year 3**						
Transfers out of BHSS component into Local Prudent Reserve	$ -	$ -	$ -						
BHSS Administrative Information	**Year 1**	**Year 2**	**Year 3**						
BHSS Component Admin Expenses	$ 1,063,599.00	$ 1,095,507.00	$ 1,128,372.00						
Total Behavioral Health Services and Supports Expenditures (auto-populated)	$ 33,891,966.00	$ 30,235,529.00	$ 31,112,593.00						
Youth-Focused Early Intervention Expenditures	**Year 1**	**Year 2**	**Year 3**						
Total Youth-Focused (25 years and younger) Early Intervention Expenditures	$ 13,704,029.00	$ 13,112,774.00	$ 13,506,158.00						
Behavioral Health Services and Supports Validation (auto-populated based on inputs above)	**Year 1**	**Year 2**	**Year 3**						
BHSS Funds Early Intervention Expenditures/Total BHSS Funding (2)	55.5%	96.5%	94.5%						
Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	67.8%	68.0%	68.0%						
Projected Individuals to be Served (Unduplicated)	**Year 1**	**Year 2**	**Year 3**						
Eligible Children/TAY (25 years and younger)	6242	6242	6242						
Eligible Adults/Older Adults	20832	20832	20832						
Projected BHSS Funds transferred to WET or CF/TN	**Year 1**	**Year 2**	**Year 3**						
BHSS transfer to WET	$ 5,633,544.00	$ 4,696,649.00	$ 4,837,548.00						
BHSS transfer to CF/TN	$ 1,733,355.00	$ 1,785,356.00	$ 1,838,916.00						
Projected MHSA-Origin WET, CF/TN and Encumbered INN Funds Available (exempt from suballocation requirements)	**Year 1**	**Year 2**	**Year 3**						
Estimated MHSA WET Funds	$ -	$ -	$ -						
Estimated MHSA CF/TN Funds	$ 10,000,000.00	$ 9,000,000.00	$ 8,000,000.00						

MHSA "Encumbered" INN	$ 3,658,469.00	$ 3,658,469.00	$ 3,658,469.00

References
1. W&I Code § 5892, subdivision (a)(3)(A) states 35% of BHS funds distributed to counties shall be used for Behavioral Health Services and Supports (BHSS).
2. W&I Code § 5892, subdivision (a)(3)(B)(i) states counties shall utilize at least 51% of BHSS funding for early intervention programs.
3. W&I Code § 5892, subdivision (a)(3)(B)(ii) states that at least 51% of funds allocated for early intervention programs must serve individuals 25 years of age and younger.
4. BHSA Policy Manual Ch. 6 § B.7.3 states that MHSA WET or CFTN funds transferred into BHSA BHSS will remain WET or CFTN funds and will not be subject to the suballocation requirements. Counties may set aside BHSS funds for WET and CFTN; the reversion period for these specific funds is ten years. All transfers into WET and CFTN are irrevocable and cannot be transferred out of WET and CFTN. Counties may continue to keep separate fund accounts to track their WET and CFTN funds.
5. BHSA Policy Manual Ch. 6 § B.8.2.2 states that the share of indirect costs attributed to BHSA funding should be in proportion to the extent the BHSA program benefits from the support activity. Proportional administrative and indirect costs will be verified through the Behavioral Health Outcomes Accountability and Transparency Report (BHOATR). Counties should ensure that their cost-allocation methodology complies with 2 CFR 200 and appropriately distributes costs in proportion.

Instructions

Counties shall report their projected spending for Behavioral Health Services Act (BHSA) plan administration in Tab Eight.

Row 27: the total dollar-amount of BHSA component allocations dedicated to improvement and monitoring activities, including plan operations, quality and outcomes, data reporting pursuant to W&I Code § 5963.04, and monitoring of subcontractor compliance for all county behavioral health programs, including, but not limited to, programs administered by a Medi-Cal behavioral health delivery system, as defined in subdivision (i) of Section 14184.101, and programs funded by the Projects for Assistance in Transition from Homelessness grant, the Community Mental Health Services Block Grant, and other Substance Abuse and Mental Health Services Administration grants by year. Under W&I Code § 5892 (e)(2)(B), the total amount shall equal 2% or less of total projected annual revenues of the local behavioral health services fund for counties with a population over 200,000 or 4% of the total projected annual revenues of the local behavioral health services fund for counties with a population of less than 200,000. Any costs that exceed that amount will be included in the governor's budget. Administrative costs for improving and monitoring will only be reported on this tab, not the BHSA component tabs.

Row 28: input amounts of BHSA component allocations dedicated to county Integrated Plan annual planning costs, including stakeholder engagement in planning and local Behavioral Health Board activities by year. Under W&I Code § 5892 (e)(1)(B), this amount shall be 5% or less of total projected annual revenues of the local behavioral health services fund. Any costs that exceed that amount will be included in the governor's budget. Planning costs will only be reported on this tab, not the BHSA component tabs.

Row 29: input total dollar amount of new and ongoing county and behavioral health agency administrative costs to implement W&I Code § 5963-5963.06 and § 14197.71.

Row 31: select your county population size. This will ensure the formatting in the Admin Spending Overages section presents accurately.

Row 34: total projected annual revenues of the Local Behavioral Health Services Fund will be auto-populated.

Row 35: the proportion of funding used for improvement and monitoring will be auto-populated from rows 34 and 27.

Row 36: the proportion of funding used for planning expenditures will be auto-populated from rows 28 and 34.

Row 38-40: based upon the county population size selected in row 31, this calculator will auto-populate any Improvement and Monitoring expenditures that exceed (2%/4%) of the total projected annual revenues of the Local Behavioral Health Services Fund and any County Integrated Plan Annual Planning expenditures that exceed 5% of the total projected annual revenues of the Local Behavioral Health Services Fund.

Table Eight: BHSA Plan Administration			
INTEGRATED PLAN ADMINISTRATION AND MONITORING	**Year 1**	**Year 2**	**Year 3**
Total Projected Improvement and Monitoring Expenditures	$ -	$ -	$ -
Total Projected County Integrated Plan Annual Planning Expenditures	$ -	$ -	$ -
New and Ongoing Administrative Costs	$ 3,759,924.00	$ 3,872,722.00	$ 3,988,903.00
Select County Population Size:	More than 200k		
Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	$ 117,759,999.00	$ 92,769,539.00	$ 94,620,986.00

Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	0.0%	0.0%	0.0%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	0.0%	0.0%	0.0%
Admin Spending Overages (in Dollars)			
Improvement & Monitoring	$ -	$ -	$ -
Planning	$ -	$ -	$ -
Total	**$ -**	**$ -**	**$ -**

References

1. W&I Code § 5963, subdivision (c) states that any costs incurred for BHSA implementation exceeding the required maximums set forth in W&I Code § 5892, subdivision (e)(1)(B) and W&I Code § 5892, subdivision (e)(2)(B) will be included in the Governors 2024-2025 May Revision.

Instructions

Counties shall report their estimated local prudent reserve maximums for each allocation component in Tab Nine.

Rows 18-19: dollar amounts will be auto-populated from Tab 4 rows 136-137.

Row 20: total excess prudent reserve dollars will be auto-populated from rows 18-19.

Rows 21-23: total dollar amounts will be auto-populated from Tab 4, rows 139-141.

Row 24: total excess prudent reserve funds allocated to BHSA components will be auto-populated from rows 21-23.

Row 25: auto-validates from rows 20 and 24 to check if the county has "No Excess" or if county must "Reduce Excess" prudent reserve.

Row 26: the total amount of planned contributions into the prudent reserve from all BHSA components allocations across all plan years will be auto-populated from Tab 5 row 69, Tab 6 row 45, and Tab 7 row 51.

Row 27: the total amount of planned distributions from the prudent reserve into the BHSA component allocations across all plan years will be auto-populated from Tab 5 row 41, Tab 6 row 26, and Tab 7 row 28.

Table Nine: Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 7,259,570.00
Local Prudent Reserve Maximum (1)	$ 12,493,331.46
Excess Prudent Reserve Funds (auto-populated)	$ (5,233,761.46)
Total prudent reserve funds above prudent reserve maximum allocated to Housing Interventions	$ -
Total prudent reserve funds above maximum allocated to Full Service Partnerships	$ -
Total prudent reserve funds above maximum allocated to Behavioral Health Services and Supports	$ -
Total Excess Prudent Reserve Funds allocated to BHSA Component Allocations (auto-populated)	$ -
Auto-validation: allocation of all excess Prudent Reserve Funds	NO EXCESS
Total Contributions Into the Local Prudent Reserve (auto-populated)	$ -
Total Distributions From the Local Prudent Reserve (auto-populated)	$ -
References	
1. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).	

Instructions

Counties will complete Tabs One through Nine prior to completing Tab Ten. Data on other tabs will auto-populate to Tab Ten.

Rows 25, 28, and 31: the new base percentage for each component will be auto-populated from Tab 4, rows 45, 50, and 53.

Rows 26, 29, and 32: the dollar amount allocated to each component for each year of the Integrated Plan will be auto-populated from Tab 5, row 40; Tab 6, row 25; and Tab 7, row 27, respectively.

Row 35: the total amount of BHSA funding for each component auto-populated from Tab 5, row 40; Tab 6, row 25; and Tab 7, row 27.

Rows 36, 43, and 50: the total amount of funding transferred from the prudent reserve into each BHSA component allocation for each plan year will be auto-populated from Tab 5, row 41; Tab 6, row 26; and Tab 7, row 28.

Row 37: the total amount of unspent MHSA-carryover funds from prior fiscal years, will be auto-populated from Tab 4 row 133.

Rows 38, 45, and 52: estimated total available funding will be auto-populated from rows 35-37, 42-44 and 49-51.

Rows 39, 46, and 53: the total amount of funding transferred from each BHSA component into the prudent reserve for each plan year will be auto-populated from Tab 5, row 69; Tab 6, row 45; and Tab 7, row 51.

Rows 40, 47, and 54: estimated expenditures for each component will be auto-populated from Tab 5, row 72; Tab 6, row 48; and Tab 7, row 54.

Rows 44 and 51: auto-populated by adding the existing year's carryover MHSA funds to any remaining funds (from all sources) not spent from the previous year.

Rows 57-59: the total amount of annual BHSA plan administration expenses from Tab 8, rows 27-29.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Ten: BHSA Funding Summary (auto-populated)				
	Housing Interventions	**Full-Service Partnerships**	**Behavioral Health Services and Supports**	**Total**
Year One				
Allocation Percentage, with Transfers	34%	31%	35%	100%
Component Allocations	$ 24,480,000.00	$ 22,320,000.00	$ 25,200,000.00	$ 72,000,000.00
Year Two				
Allocation Percentage, with Transfers	34%	31%	35%	100%
Component Allocations	$ 25,214,400.00	$ 22,989,600.00	$ 25,956,000.00	$ 74,160,000.00
Year Three				
Allocation Percentage, with Transfers	34%	31%	35%	100%
Component Allocations	$ 25,970,832.00	$ 23,679,288.00	$ 26,734,680.00	$ 76,384,800.00

BHSA Funding Summary	Housing Interventions	Full Service Partnerships	Behavioral Health Services and Supports	Totals
Year One				
Estimated Year One Component Allocations *(BHSA Funding Only)*	$ 24,480,000.00	$ 22,320,000.00	$ 25,200,000.00	$ 72,000,000.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) *(Unspent Carryover MHSA Funds)*	$ 10,914,520.00	$ 9,951,475.00	$ 24,894,004.00	$ 45,759,999.00
Estimated Total Available Funding for Year One	$ 35,394,520.00	$ 32,271,475.00	$ 50,094,004.00	$ 117,759,999.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year One Expenditures	$ 30,841,581.00	$ 28,814,150.00	$ 33,891,966.00	$ 93,547,697.00
Year Two				
Estimated New Year Two Component Allocations *(BHSA Funding Only)*	$ 25,214,400.00	$ 22,989,600.00	$ 25,956,000.00	$ 74,160,000.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 10,721,255.00	$ 9,220,155.00	$ 22,880,431.00	$ 42,821,841.00
Estimated Total Available Funding for Year Two	$ 35,935,655.00	$ 32,209,755.00	$ 48,836,431.00	$ 116,981,841.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Two Expenditures	$ 31,766,827.00	$ 29,678,574.00	$ 30,235,529.00	$ 91,680,930.00
Year Three				
Estimated New Year Three Component Allocations *(BHSA Funding Only)*	$ 25,970,832.00	$ 23,679,288.00	$ 26,734,680.00	$ 76,384,800.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 10,522,193.00	$ 8,466,896.00	$ 24,548,008.00	$ 43,537,097.00
Estimated Total Available Funding for Year Three	$ 36,493,025.00	$ 32,146,184.00	$ 51,282,688.00	$ 119,921,897.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -

Estimated Total Year Three Expenditures	$ 32,719,832.00	$ 30,568,931.00	$ 31,112,593.00	$ 94,401,356.00
BHSA Plan Admin Expenses				
Plan Admin Category	**Year One**	**Year Two**	**Year Three**	**Total**
Total Projected Improvement and Monitoring Expenditures	$ -	$ -	$ -	$ -
Total Projected County Integrated Plan Annual Planning Expenditures	$ -	$ -	$ -	$ -
Total Projected New and Ongoing Administrative Expenditures	$ 3,759,924.00	$ 3,872,722.00	$ 3,988,903.00	$ 11,621,549.00

San Francisco
Department of Public Health

San Francisco Behavioral Health Services Behavioral Health Services Act (BHSA) Three-Year Integrated Plan, FY 2026–2029

Overview and Key Findings of the Community Planning Process

Community Planning Process – Overview and Key Findings

SF BHSA Integrated Plan Community Planning Process

From June to December 2025, San Francisco Behavioral Health Services (BHS) conducted a comprehensive Community Planning Process (CPP) to inform the development of the SF BHS Behavioral Health Services Act (BHSA) Three-Year Integrated Plan (IP). The process was designed to meet BHSA statutory requirements for community engagement, transparency, cross-system collaboration, and alignment with local health priorities, while centering the needs of individuals and communities experiencing the highest behavioral health acuity, including those impacted by serious mental illness, substance use disorders, homelessness, and structural inequities.

SF BHSA Integrated Plan Development Governance Structure

SF BHS established a clear governance and accountability structure to oversee development of the BHSA Integrated Plan. The SF BHSA Integrated Plan Steering Committee oversaw the IP development. The Steering Committee was led by the BHSA Director and the BHS Managed Care Director and included eight subject area work groups. Steering Committee members met monthly, starting in May 2025 to guide decision-making, ensure alignment across work groups, and support timely completion of all required deliverables.

Eight work groups were responsible for responding to specific criteria in the Integrated Plan: Budget & Finance; Community Program Planning; Behavioral Health Goals & Measures; BHSA Funds & Programs; Housing; Substance Use Services System of Care; Mental Health System of Care; and Access & Care Transitions. Work groups met regularly and included BHS staff with participation from County partners and subject matter experts.

An Accountability Team supported the Steering Committee and work groups by tracking progress and ensuring compliance with BHSA requirements.

SF BHSA CPP Outreach and Engagement Activities

Meetings with Consumers, Providers, and Advisory Groups

SF BHS held 12 CPP meetings with BHSA stakeholder groups, including community-based providers, consumers and individuals with lived experience, the SF BHSA Advisory Committee, the BHS Client Council, and the SF Behavioral Health Commission. Meetings focused on identifying behavioral health needs, service gaps, equity concerns, and priorities for future investment.

Targeted Outreach and Systems Alignment

The BHS CPP work group conducted targeted outreach to county agencies and other partners, including the San Francisco Department on Homelessness and Supportive Housing, Disability and Aging, and Children, Youth, and Families, as well as labor unions, the Golden Gate Regional Center, and Independent Living Centers. These partners engaged in data sharing and strategy planning efforts to support systems alignment and contribute to positive health outcomes for BHS clients and the broader community.

Community Survey on Behavioral Health Needs

SF BHS administered an electronic Community Survey in the fall of 2025. The survey was translated into all SF threshold languages (English, Spanish, Chinese, Vietnamese, Russian) to ensure broad accessibility and support equitable participation in the CPP process. BHS shared the survey via mass email distribution to health care providers, in the BHS and Department of Public Health Director newsletters, hospital newsletters, and targeted outreach to BHSA stakeholder groups and community partners. Alignment with the SF Community Health Assessment and Community Health Improvement Plan BHS partnered with the SF Department of Public Health (the Local Health Jurisdiction) Community Health Assessment/Community Health Improvement Plan (CHA/CHIP) throughout the BHSA IP development process. The CHA/CHIP and BHSA IP teams reviewed BHSA requirements to align planning efforts across the LHJ, BHS, and MediCal Managed Care Providers. BHS and the LHJ also shared behavioral health needs data, planned for coordinated community outreach and engagement efforts, and aligned data collection and analysis approaches. BHS and the LHJ are planning for deeper collaboration in future cycles as CHA/CHIP and BHSA Integrated Plan timelines merge. This alignment will include coordination with SF's MediCal Managed Care Plans.

Alignment with the SF CHA/CHIP

SF BHS partnered with the SF Department of Public Health (SFDPH; the Local Health Jurisdiction) Community Health Assessment/Community Health Improvement Plan (CHA/CHIP) throughout the BHSA IP development process. The CHA/CHIP and BHSA IP teams reviewed BHSA requirements to align planning efforts across SFDPH, BHS, and MediCal Managed Care Providers. BHS and SFDPH also shared behavioral health needs data, planned for coordinated community outreach and engagement efforts, and aligned data collection and analysis approaches. BHS and SFDPH are planning for deeper collaboration in future cycles as CHA/CHIP and BHSA Integrated Plan timelines merge. This alignment will include coordination with SF's MediCal Managed Care Plans.

CPP Key Findings

Findings across CPP meetings, targeted outreach, the community survey, and existing data sources were highly consistent and mutually reinforcing. Input from community members, service providers, and system partners reflected a behavioral health landscape that is well known to BHS through ongoing engagement and service delivery. The themes that emerged were not unexpected; rather, they reaffirmed long-standing strengths within San Francisco's behavioral health system alongside persistent gaps and inequities that continue to limit access, continuity of care, and housing stability for high-need populations. Taken together, these findings underscore both the value of sustained community partnership and the urgency of targeted investments to address structural barriers, workforce capacity, and housing-linked behavioral health needs.

CPP Meetings and Targeted Outreach

Across CPP meetings and targeted outreach activities, participants identified consistent strengths and gaps within San Francisco's behavioral health system.

Identified strengths included:

A. Culturally responsive, relationship-based care models that support trust and sustained engagement
B. Peer-led and peer-informed services that strengthen connection and recovery
C. Strong family and community networks that support stability
D. Low-barrier, holistic services integrating behavioral health care with housing, case management, and basic needs supports
E. Safe and supportive program environments that promote recovery and skill-building

Key gaps and challenges included:

- Housing instability as a foundational barrier to treatment engagement and recovery
- Limited availability of step-down and supportive housing, contributing to prolonged crises
- Workforce shortages, burnout, turnover, and limited access to culturally and linguistically responsive providers
- Fragmented systems, complex intake and eligibility processes, and inconsistent cross-system coordination
- Persistent racial and equity disparities, particularly impacting Black/African American communities, transgender individuals, and people experiencing homelessness

See attached meeting minutes, notes, and sign-in documentation for additional detail.

Community Survey

A total of 1,191 individuals initiated the Community Survey, with 996 respondents completing it. Respondents represented a broad cross-section of San Francisco residents and workers, including diverse racial and ethnic backgrounds, age groups, gender identities, and lived experiences. Notably, a significant share of respondents identified as LGBTQ+, reported current or past experiences of homelessness, or identified as caregivers, veterans, or individuals with disabilities, reflecting engagement from populations most impacted by behavioral health service gaps.

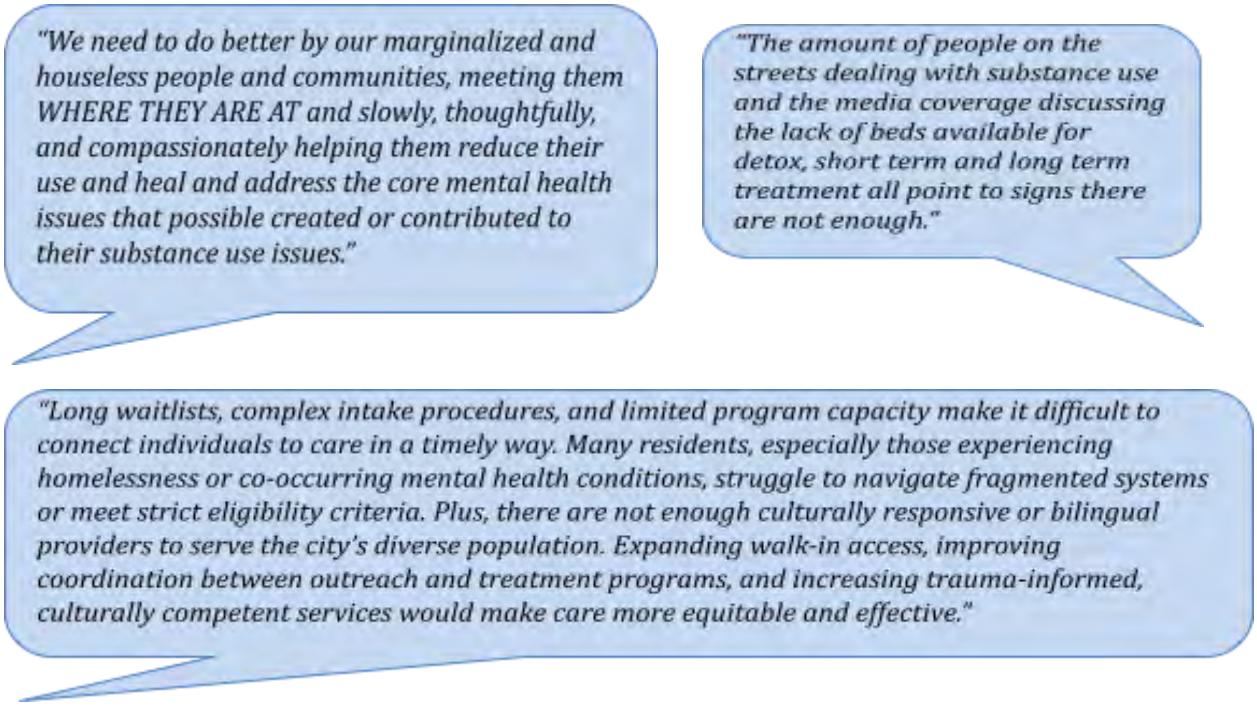
Key barriers to accessing behavioral health services included:

- Long wait times for appointments and services
- Difficulty navigating a complex and fragmented behavioral health system
- Provider shortages and limited program capacity
- Language and cultural barriers
- Insurance limitations and affordability challenges

Priority needs identified by respondents included:

- Expanded behavioral health services for underserved populations
- Improved and timelier access to mental health care
- Supportive housing and housing-linked behavioral health services
- Clearer pathways to care and easier navigation of available services

See attached Community Survey summary report for additional detail.



Key findings included:

- Mental health challenges and drug-related deaths were identified as two of the top persistent health challenges facing San Francisco residents
- Drug use disorders were among the leading causes of death citywide, with fentanyl driving the majority of opioid-related fatalities
- Black/African American residents experienced disproportionately high rates of drug-related mortality compared to the overall population
- Housing instability and other social determinants of health were strongly associated with poor behavioral health outcomes and increased risk of crisis

Together, these findings highlight the intersection of behavioral health, housing, and equity, and underscore the need for coordinated, housing-linked behavioral health strategies.

Conclusion

SF BHS' Community Planning Process reflects BHS' longstanding commitment to meaningful, ongoing community engagement and transparent program planning. The scope and quality of participation achieved through the CPP were made possible by BHS' established relationships and engagement practices developed through our previous and ongoing community engagement and program planning efforts. Our CPP findings provide insight on and reaffirmed known persistent community behavioral health needs, behavioral health system strengths, and gaps in accessibility. Together, these insights provide a strong foundation for continued collaboration under BHSA and will inform future investments, program design, and system improvements through sustained partnership and ongoing communication with community stakeholders, County partners, and Medi-Cal Managed Care Plans.

See attached:

Appendix A. SF BHS CPP Meeting Minutes and Notes
Appendix B. SF BHS CPP Meeting Sign-in Sheet (meeting participant demographics)
Appendix C. SF BHS CPP Community Survey summary report

San Francisco Behavioral Health Services
BHSA Integrated Plan FY 2026–2029
Community Planning Process Meetings June-October 2025

Date	Stakeholder Group	Key Topics
6/11/25	BHSA Advisory Committee (virtual)	BHSA Overview
6/13/25	RAMS (BHSA Provider) (in-person)	Program feedback, consumer vocational needs
6/18/25	6th Street Community Providers (virtual)	MH crisis response, SUS needs
7/17/25	Asian American, Native Hawaiian, Pacific Islander Focus Group (in-person)	Suicide prevention, MH crisis response
7/21/25	Asian & Pacific Islander MH Collaborative (virtual)	MH and SUS needs, stigma, barriers
7/29/25	Native American Health Center (BHSA Provider) (virtual)	Program feedback, population needs, barriers
7/30/25	Horizons Unlimited Latino Commission (virtual)	MH and SUS needs, stigma, barriers
8/19/25	BHS Client Council (hybrid)	BHSA Overview
8/25/25	Marilyn Inn Housing Community (in-person)	Housing stability, MH and SUS access
9/12/25	SF City College, FACES for the Future (BHSA Providers) (virtual)	Population needs, program feedback
10/18/25	Transgender Community (in-person)	Population needs, MH and SUS access
10/28/25	Tenderloin Neighborhood Development Corporation (CBO) (virtual)	MH and SUS access/barriers, homelessness prevention

San Francisco Health Network
Behavioral Health Services

Office of Justice, Equity, Diversity, and Inclusion (JEDI) –
Behavioral Health Services Act (BHSA)
Advisory Committee Meeting

Wednesday, June 11, 2025
10:00 a.m. – 12:00 p.m.

AGENDA

Welcome – Juan

- Land acknowledgement
- Labor acknowledgement

Agency/Program roll call – invite folks to write in the chat their name, pronouns, program, & agency

Wellness Activity

Announcements

- Reminder to complete meeting registration
- 2025 JEDI-BHSA Provider-Contractor Reporting Schedule.docx
- FY25-26 Performance Objectives due 8/1
- FY24-25 Year-end Program Reports – template to be sent out July 3, 2025 due September 5, 2025
- 2025 JEDI-BHS Advisory Committee Meeting Schedule.docx
- New BHSA logo (see upper right hand corner)

JEDI-BHSA updates – Jessica Brown

- DPH budget
- BHSA budget
- CCSF Hiring Freeze

San Francisco Health Network
Behavioral Health Services

• Behavioral Health Transformation Listening Sessions   • https://www.dhcs.ca.gov/BHT/Pages/Stakeholder-Engagement.aspx
Community Program Planning (CPP): Prop 1- Behavioral Health Services Act (BHSA; formerly MHSA) – Jessica Brown Feedback Questions
Public Health Institute – FACES Program Presentation
Roundtable Program Announcements • Programs are invited to share on community or program events, program updates, staff shout-outs, recruitment efforts, hiring, etc.
Next meeting: September 10, 2025
Closure

Thank you to all of our JEDI–BHSA community and provider stakeholders for all that you do!

SF JEDI BHSA Community Program Planning Session

Topic: BHSA - Prop 1

6-11-2025

Context:

Keep in mind that community feedback will inform the development of the plan and the draft plan will be made available for 30-day public comment on the website. Not all recommendations will necessarily be included in the plan as we have to work within the requirements of BHSA, but we do want to respond to the needs of the community.

Feedback questions

1. **What are your thoughts on the key changes you see with the new BHSA?**

- Speaking of Invoices. Can someone provide education on how to bill Medi-Cal for services provided under the BHSA?
    - *Staff response: We are internally thinking about a process on how to support you all have these services medi-cal billable*
- Do you have a timeline for this process to take effect?
    - *Staff response: July 2026*
- My boss requested to ask questions regarding BHSA budgets
- Not sure, but I think there seems to be more investment in housing-related initiatives.
- It was working so effectively, hard to think about all these changes, fitting square peg in round hole I currently work in workforce program, from CityWide
- The gathering of Demographics. It maybe helpful in fine tuning the people in need of Behavioral Health Services.
- I think it is taking money from prevention to housing, it's but it's good it's good to hear that prevention and early intervention remains the same by and large
- Does BHSA have any particular strategies to align our programs towards FSP or housing?
    - *Staff response: We currently have FSP, we are thinking about strategies like expanding FSP, PEI programs doing outreach/engagement. Thinking about maintaining existing housing and possibly increasing these resources.*
- Will extended families be honored in San Francisco's housing for families?
- On survey, add line to choice of “other” so people can add their identification category
- Please disaggregate Pacific Islander data from Asian data (K. Ganade)
- Gather information form decision-making settings (e.g. Youth Advisory Boards, focus groups, TAY Advisory Board (stipends for TAY who participate in BHSA discussion)

- Can we ensure that CPP attendees won't be picked up for deportation by ICE officers?
- Provide culturally appropriate food donations
- Have interpreters & translators at CPP groups
    - Reach out to CBOs' staff who can provide interpreting & translation for community members who are monolingual & perhaps not being able to read or write
    - Interpreters & translators explain to community members how important their input is
    - Have CBO staff (e.g. Homeless Children's Network, Black & Birthing Parents) that community members feel safe with to provide interpreting & translation
- Provide food vouchers & box lunches
- BHSA greet public participants & create a welcoming environment

2. **How can we engage with all of the different types of stakeholders we are supposed to engage with?**

- Thinking of ways to engage youth, focus groups, TAY population
- Town Halls meetings and street outreach that has been successful in the past.

3. **If we are not able to give away gift cards, what are some other incentives we could provide to community members who participate in community feedback meetings?**

- We're not able to give giftcards?!!
- Is this for all programs as well?
- culturally appropriate groceries
- How about food vouchers, (Food runners meals)
- box lunches

4. **What types of engagement do you want to see from SF BHSA? For example, hosting small focus groups or large town halls? Virtual or in-person? Surveys? Other? (Aiming for quality over quantity)**

- For monolingual community members, it would be helpful to reach out to organizations to host smaller listening sessions.
- Going to centers where our community is comfortable with and doing these listening sessions (bayanihan is an example)
- Host tours of other agencies and programs
- Use staff to greet the public and create a welcoming environment to engage them

- Focus groups at DPH clinics will be helpful and online links to the surveys for those with digital literacy. A group of outreach workers with the survey on a tablet could be an approach they are meeting the consumers where they are.
- Presence at community events and programs, ie junteenth, cherry blossom festival, etc
- Who is the audience this question is for?
- Does BHSA support free meals for low income seniors?
- Recent events have created further distrust of the government, unfortunately, and our families are in hiding.
- Presence at community events and programs, ie, junteenth, Cherry Blossom Festival, etc

If you prefer to submit your feedback in writing to us, please send it to bhsa@sfdph.org

Time did not permit us to ask these questions

5. How can SF BHSA continue to build trust with our stakeholders?

6. In thinking about a community that you represent, what mental health and/or substance use needs do you see in your community? What community do you represent (e.g. are you a service provider, a client, a peer)?

BHSA Advisory Committee Meeting CPP notes
June 11, 2025

Prop 1 Presentation: JEDI/BHSA Director Jessica Brown

- Funding categories: Full-Service Partnership (FSP), Housing & Behavioral Health Services & Support (BHSS)
- BHSS funding:
    - 35% of BHSA county budget
    - Outreach & Engagement; Workforce Development, Education & Training; Capital: Innovation projects

Prop 1: Housing

- Rental subsidies
- Emergency housing
- Transitional housing
- Outreach & Engagement innovations under housing
- Audience feedback: there seems to be a new emphasis on housing
- Audience feedback: Can extended families be honored in housing for families? (A. Gray)

Prop 1: Guidance

- 3-year Integrated Plan
- Implementation Date: July 1, 2026
- Community Engagement plan needs to be in 3-year Integrated Plan
- Report expenses of funds reported to the state
- Behavioral Health Services Oversight & Accountability Commission (BHSOAC) continues to oversee counties' Innovations Projects
- State BHSA: Policy Manual is secondary guidance to BHSA statewide

Community Program Planning (CPP)

- Data Collection tool: help SF BHSA collect data of people looking for services
- On survey, add line to choice of "other" so people can add their identification category
- Please disaggregate Pacific Islander data from Asian data (K. Ganade)
- Audience feedback: gather information form decision-making settings (e.g. Youth Advisory Boards, focus groups, TAY Advisory Board (stipends for TAY who participate in BHSA discussion)
- Can we ensure that CPP attendees won't be picked up for deportation by ICE officers?
- Audience feedback: provide culturally appropriate food donations (M. Chhom)
- Audience feedback: have interpreters & translators at CPP groups
    - Reach out to CBOs' staff who can provide interpreting & translation for community members who are monolingual & perhaps not being able to read or write (e.g. CARECEN, Horizons Unlimited)
    - Interpreters & translators explain to community members how important their input

    - Have CBO staff (e.g. Homeless Children's Network, Black & Birthing Parents) that community members feel safe with to provide interpreting & translation
- Audience feedback: provide food vouchers & box lunches
- Audience feedback: BHSA greet public participants & create a welcoming environment (A. Gray)

2025 BHSA Advisory Committee CPP Notes
6-11-25

- Jessica – MHSA is now BHSA and the state of California's way of ensuring, expanding & improving housing, Medi Cal billing & health equity, more expansion and support for clients
- March 2024 Prop 1 passed
    - 1% tax on personal income, new law includes BHSA & 6.4 billion dollar bond
- There were 5 funding components now BHSA has 3 funding components
    - 30% funding to Housing Intervention - policies that ensure housing (clients must meet definition / requirements of being homeless), 191 housing units, outreach / engagement with landlords, assistance with application, fees, provide on site direct navigation to housing resources, harm reduction (activities, supplies)
    - 35% funding to FSP - mental health services, substance use, supportive services, FSP case management, outpatient behavioral services for evaluation & stabilization, ongoing engagement services, primary SUD FSPs, peer support services
    - 35% funding to BHSA support / services – children, adults, & older adult systems of care, outreach & engagement, workforce education & training, capital facilities
- BHSS requirements – funds for Workforce Education & Training (WET)
    - funds for Outreach & Engagement - (O&E)
- State of CA wants more focus on early intervention vs prevention
- Prop 1 guidance – develop 3 year plan & incorporate all of BHSA, timeline is until 7/1/26 to meet Prop 1 requirements
    - county behavioral outcomes, accountability (hold CA counties accountable) transparency, provide data, community engagement, how is funding being used?
- Question from Celina Lucero about intervention vs prevention?
    - not much has changed just change language to early prevention.
    - Services will mostly stay the same
- Question about Anti DEI
    - City attorney says we can say we serve a certain population
    - we are still inclusive but also focus on marginalized
    - Administration is focused on age & race
- Question for Victor Sucy -

    - How to bill Medi Cal for services under BHSA? In the process of working on how to provide technical assistance to be able to bill to Medi Cal
- What is the timeline for this medical billing? July 2026 everything should be implemented (the integral plan)

HIRE-ABILITY
A DIVISION OF RAMS, INC

YOUR VOICE MATTERS!

Feedback BBQ

JUNE 13TH 2025
12-3PM

1234 INDIANA ST., SAN FRANCISCO, CA 94107

CALLING PARTICIPANTS OF EMPLOYMENT SERVICES FROM JULY 2024- JUNE 2025 WE WANT TO HEAR FROM YOU!

- FOOD
- RAFFLE
- FUN

RESERVE YOUR SPOT BY 6/1/2025 BY EMAILING: LAURAWESTMAN@HIRE-ABILITY.ORG OR CALLING 415-282-9675

Consumer Feedback Summary

1. Demographics

A total of 20 individuals signed in and provided demographic and background information. All submissions were anonymized for confidentiality.

Gender Identity:

Male: 12
Female: 6
Non-binary/non-conforming: 2

Age Group:

16 to 25: 1
26 to 59: 17
60 or over: 2

Race/Ethnicity:

Asian: 7
Black/African American: 2
Latino/a/e/x: 4
Native Hawaiian or Other Pacific Islander: 1
White: 4
Two or more races: 2

Agency/Program:

RAMS Hire-Ability: 11
RAMS Employment Services: 6
RAMS Help Desk: 1
RAMS Janitorial Program: 1
RAMS Other Program: 1

2. Feedback Summary

What outreach activities/locations do you suggest would be best to reach underserved communities in SF, such as Black/African American communities?

Cultural events: 11
Music-based events: 2

RAMS, Inc. Your Voice Matters Feedback BBQ

What Culturally Congruent Services do you think would best support Black/African American communities in SF?

Culturally congruent expressive arts therapy: 8
Hip-hop therapeutics: 8
Trauma-informed grounding activities: 8
Therapeutic drumming: 4

What Behavioral Health needs are unmet in the Pacific Islander, Latino/a/e/x, Arab and/or Black African American communities or other underserved communities in SF?

- HIV/Mental Health
- Home Development
- Knowledge that fresh fruits, veggies, nuts, and seeds help improve behavioral health. More teachings on how sugar and processed foods create more behavioral health issues like anxiety, depression and ADHD.
- Mental Health support groups
- Mentorship program
- Open discussion groups
- Our Voices
- Racism

6th Street Community Provider Meeting

Feedback Summary by Juan Ibarra

June 18, 2025

Topic: DPH Good Neighbor Policy along 6th Street

In general, this policy states that programs will collaborate with DPH on keeping people from actively using drugs on sidewalks, congregating/loitering on sidewalks, and keeping sidewalks clean free of trash.

Discussion and Feedback:

A community member in recovery, living in a residential unit upstairs, complains about the noise from the Sixth Street Self-Help Center (SSHC). This has been going on for a couple of years. Cherie has reached out to offer support and Hospitality House services. They have refused services.

CityTeam and HH working together to minimize complaints.

People live above SSHC…this is part of their living room. Unrealistic to expect tenants to not hang out on the sidewalk. They have visitors and do not have the room in their tiny units so they hang out in the sidewalk.

CityTeam and SSHC has a relationship with these community members.

Eileen to invite Department of Public Works and Street Teams to a future meeting to increase collaboration.

Realistically we are going to have a minimalistic effect since they (complainers) are part of the problem….so instead we will engage in damage control. They know how to reach SFPH and Supervisor Dorsi's office. They will continue to complain. I am concerned about keeping the drop in centers open.

Let's start up the morning huddle. Devote energy to the morning huddle and service connection. It's at least an answer to 'What are you doing'. The answer can be: several organization are meeting everyday in the morning to better collaborate and problem solve.

Our 6th street area is not monitored as other areas, like northern SOMA. I was here last night around 9 pm and 6th street was hot (including illicit activity). There is a disparity in the resources the city dedicates to street monitoring….there is less around our area.

A lot of people from the community are more likely to go in to program site at 7 pm vs. 4 pm. They are not ready to go to sleep at 4 pm. [The program allows unhoused community members to place their name on a waiting list for a shelter bed].

Services need to be available later on in the evening.

CityTeam asked how do they get wound care at their program.

July 17, 2025 AANHPI Suicide Risk San Francisco Department of Public Health Children, Youth, and Families System of Care Provider Focus Group

Co-facilitated by Martina Bakilana, Izzy Banayad, and Kitty McCarthy

1. Overview

On July 17, 2025, the San Francisco Department of Public Health's Children, Youth, and Families (CYF) System of Care hosted a provider focus group on AANHPI (Asian American, Native Hawaiian, and Pacific Islander) suicide risk. Co-facilitated by Martina Bakilana, Izzy Banayad, and Kitty McCarthy, the focus group brought together 18 mental health professionals from a range of community-based organizations and civil service programs to explore the rising suicide risk among AANHPI youth in San Francisco, identify contributing factors, and generate culturally responsive recommendations.

The focus group was organized in response to growing concerns over low mental health service engagement among AANHPI youth, despite documented increases in suicidality and mental health distress in this population. The focus group identified some key themes and risk factors/drivers of suicidal ideation, obstacles to early intervention and ongoing support, and recommendations to address these gaps. Insights from this focus group will inform future CYF programming and partnerships.

2. Demographics

A total of 18 individuals signed in and provided demographic and background information. All submissions were anonymized for confidentiality.

Gender Identity:

- Female: 14
- Male: 3
- Not specified: 1

Age Range:

- 26 to 59: 17
- 60 or older: 1

Racial/Ethnic Identity (self-identified):

- Asian: 10
- White: 2
- Latino/a/e: 1
- Black/African American: 1

- Bi-racial: 1
- Jewish: 1
- Asian/White: 1

Agency Affiliation:

- Community Youth Center (CYC): 1
- RAMS: 3
- OTTP-SF: 1
- Chinatown Child Development Center (CCDC): 6
- Family Mosaic Project (FMP): 1
- APA Family Support Services: 1
- DPH Primary Care Behavioral Health, Community Health Programs for Youth: 2
- Southeast Child Family Therapy Center: 1
- Mental Health Association SF: 1
- Behavioral Health Commission: 2

None of the providers who attended identified as LGBTQ+, a veteran, or have experienced homelessness.

3. Focus Group Discussion

During the beginning half of the focus group, we provided some context and framed the discussion around suicidality in AANHPI youth, specifically how AANHPI youth engagement in mental health services remains low despite rising suicide risk and mental health needs. We also provided some findings from a study that measured suicidal ideation in a large group of AANHPI adolescents. This data was then disaggregated to reveal key differences in suicide risk among subgroups. After presenting this information, we asked providers the following question: **What are some of your initial reactions to these findings? Do these facts ring true for you in your work?**

Many participants expressed that while the numbers were shocking, the data reflected their lived and professional experiences. One clinician specifically noted high rates of suicidal ideation among Filipino females they had worked with. A major focus of the discussion centered on how immigration status, identity, and acculturation intersect with suicidal ideation. While many AANHPI youth experience acculturative stress, multiethnic and multiracial youth may face greater challenges in identifying with their family or community. Recent immigrants may also be at higher risk, as assimilation often involves a painful detachment from their native culture. Participants also raised important questions about the context behind the data—such as how suicidal ideation was defined, and what role immigration status, mental health history, and family structure played in shaping these outcomes.

After this discussion, we presented a quote from a study that highlighted unique risk factors for AANHPI youth. Based on this quote, we asked the following question: **What are some unique and/or similar contributing factors to suicidal risk among AANHPI youth in San Francisco?** This discussion mainly touched on the effects of perceived and structural barriers to suicidal risk. One of the biggest factors discussed was a lack of basic needs, such as housing, food, and insurance, leading to parents being overwhelmed and emotionally and physically disconnected from their kids. The academic pressure to succeed, which is greatly emphasized in Asian cultures, was also noted as a factor to suicidal risk. The intersection between AANHPI and gender non-conforming people also increases risk, especially because many youth may feel a thwarted sense of belonging in their families and communities. Other barriers included shame and stigma to receiving mental health services, which results in many youth seeking support only when severe. Cultural barriers, such as religion/spirituality and a lack of language capacity, can cause families to not understand the importance of these services and mistrust/misunderstand systems and providers. The lack of resources and siloing of resources for youth and families further deepens this issue.

Next, participants were split into three smaller groups and were asked to answer one of the three questions below and report back their findings to the larger group after 10 minutes.

Group 1 (Compounding Factors): Research indicates that compounding factors, such as gender and sexual identity, developmental and intellectual disabilities, immigrant experience, trauma, and other comorbidities, increase suicide risk. How have you seen compounding factors impact AANHPI clients in your treatment? Some compounding factors mentioned were LGBTQ+ identity, especially since youth may feel unsafe to come out for fear of rejection in their families or communities. Family dynamics and negative family relationships were also largely emphasized; many AANHPI parents use authoritarian, traditional parenting, which may involve bullying within the family, the use of physical discipline, and the downgrading of mental health. Families may prioritize the economic over emotional needs. Additionally, families may prioritize harmony over individualism, which can lead to underreporting and minimization of sexual violence.

Group 2 (National climate): Have you observed an impact of recent national events, such as COVID-19, the political climate, anti-Asian hate, etc., on AANHPI mental health? How have they affected the clients you treat? The COVID-19 pandemic was a main point of discussion for this group, specifically its effects on socialization and suicidal ideation in AANHPI youth. They recognized an increase in suicidal ideation after the racially targeted anti-Asian hate crimes. Isolation during the pandemic had grave effects on youth mental health and social skills. Due to the normalization of virtual communication and the

development of social anxiety in youth, it has become harder to engage with them in person. Even with the current political landscape, there has been a normalization of racialized attacks. Additionally, there have been added barriers to care due to immigration fears and anti-immigrant sentiments that have been circulating.

Group 3 (Disaggregated data): What are your thoughts on how the use of the broad AANHPI category can mask differences between subgroups? When you consider the implications of disaggregated data, how could they impact your practice and the system as a whole? This group expressed that they were glad to see data regarding suicidal ideation for Filipino and Indian youth, which is typically not available in other studies. However, this group also debated whether a labeled diagnosis was helpful for specific subgroups. While some people would argue that disaggregating the AANHPI subgroup would helpful because more targeted treatments could be created, others may feel pigeon-holed. Considering the implications of disaggregated data, they discussed that this could provide an opportunity for more mental health education in schools. Mental health would be less stigmatized if it were regularly discussed in school settings where parents are invited to join in on these conversations, compared to a therapist or social worker reaching out to families to discuss mental health issues.

After engaging in a larger group discussion, we moved onto the final question that focused on recommendations: **Drawing on existing research and data analysis, we are exploring several recommendations, including: 1. Enhanced coordination between primary care and specialty mental health, 2. Increased usage of peer mentorship programs, 3. Targeted community outreach (parent groups, cultural ambassadors, etc.). What are your thoughts on these recommendations? What initiatives have been successful? What is missing? What should be prioritized?**

Participants strongly emphasized culturally grounded, family-centered, and school-based approaches/recommendations. They highlighted the critical need for community outreach through schools, including language-accessible parent education workshops and psychoeducation on mental health, suicide risk, and intergenerational communication. Many parents, especially those with limited English proficiency, struggle to recognize mental health issues, often prioritizing academics over emotional well-being. A great example of a culturally grounded, youth-run program was Buong Loob. This Filipino-centered peer support initiative had successfully trained high school and college students in mental health awareness and suicide prevention before losing funding. Participants also strongly endorsed tools like the CARS screener, which is culturally attuned to suicide risk factors of ethnic minority youth. While peer mentorship was seen as valuable, it was noted that higher-risk youth may require more structured interventions like Intensive Outpatient

Programs (IOP). A centralized, multilingual website or QR code with CYF mental health resources was identified as a critical missing infrastructure, especially for families navigating crisis. Finally, participants recommended placing mental health services where families already gather, such as churches or community centers.

4. Post Focus Group Survey

At the end of the focus group, participants were asked to fill out an anonymous post focus group survey. Below are the results of the survey, summarized with the help of the CYF Practice Improvement Analyst, Navid Elie.

Summary of Work Group Feedback

Overall Satisfaction:

- 100% of participants were satisfied with the session.

Engagement:

- 100% felt engaged and able to contribute meaningfully.

Outcomes:

- 93% felt the work group helped identify practical solutions or next steps.

Facilitation:

- 100% agreed the session was well-facilitated and stayed on track.

Suggestions for Improvement:

Three of the fifteen responses had no improvements or praised the work group, "It was great!!!"

From the remaining 12 with improvements:

- **33%** wanted more time/focus on **recommendations**/suggestions:
    - "Would be great to reserve more time for recommendations and practical next steps."
- **25%** suggested opportunities to improve small groups or the following **discussion:**
    - "Have more time, this can be 2 hours Have small group discussions before big, helps with opening up more"

Other comments:

- "Share strengths/accomplishments from previous focus groups/initiatives"
- "Recruit more Pacific Islander orgs and stakeholders"
- "Central resources handouts or link"
- "Maybe a preview of agenda so we can prepare."
- "This was great and so important. I wonder if it could become a series of at least 2-4 workshops to deep dive into this topic. A lot of information was foundational that was covered today and it would have been great to be able to keep building off of that."

Additional Comments:

Three of the fifteen responses had no additional comments.

From the remaining 12 with comments:

- **75%** appreciated having a **space** for the discussion and hope these conversations continue.
    - "Thanks for having this focus group! I am glad there's some focus on the AANHPI community and suicide risks"
    - "Very useful and important and timely"
    - "Thank you for creating these type of spaces. Very important themes to discuss"

Other comments:

- "I hope similar focus groups are being done with community partners such as Samoan community development center."
- "It might be helpful if facilitator can share some helpful resources at the end offered by DPH."
- "Thank you for this work. Would love to receive a summary to share with primary care leadership. Thank you!"

5. Next Steps

Synthesizing insights from the focus group and literature reviews, outlined below are the proposed next steps for the CYF system to explore:

- **Developing community partnerships with more Pacific Islander and Filipino organizations and establishing cultural ambassadors.**
  Partnering with already established community-based organizations, such as the Samoan Community Development Center and the Filipino Community Center, can help CYF deepen cultural understanding and improve outreach. Members of these organizations can act as cultural ambassadors because they are already embedded in the community and well-positioned to reduce stigma and build trust. Their involvement would make mental health services feel more culturally relatable and accessible, especially for families who may not otherwise engage with CYF. These partnerships would also allow services to be delivered in spaces where youth and families gather, such as community programming or schools, increasing access for communities that may not otherwise engage with CYF.
- **Improved ability to serve monolingual families through the increased usage of interpreter services.**
  Expanding language access in programs would ensure that monolingual families can fully engage with services. Hiring more multilingual staff is the best option, but not always the most viable due to resource limitations. However, language capacities can expand by increasing the use of interpretation services like language lines and in-person interpreters, and translating materials/resources. These steps would help prevent disengagement caused by communication barriers and ensure equitable access to care, especially in intensive programs that often require parent participation.
- **Increased usage of peer mentorship programs, such as Peers.net.**
  Peer mentorship programs provide youth with relatable support systems, creating low-barrier entry points to mental health care. While in-person services may not always provide access to mentors with shared lived experiences, virtual peer mentorship programs can bridge this gap. These programs create safe spaces for youth to connect with peers who understand their cultural or personal background. Virtual formats are especially helpful in the post-pandemic era, as they allow youth to engage in ways that feel private and comfortable, helping reduce the anxiety of seeking help.
- **Integrating more school-based interventions and partnerships with community agencies.**
  Schools are a critical site for prevention, especially given the connection between school-based violence and suicide risk for AANHPI youth. High school is also a critical transition stage in a child's life and can come with many mental health

challenges. Intervention strategies could include anti-bullying workshops, staff and parent support groups, and staff workshops on culturally grounded suicide prevention plans. CYF can collaborate with community agencies to deliver these services and ensure mental health is a regular, stigma-free topic. It was also suggested that public service announcements featuring AANHPI clients/families could promote the benefits of treatment to the community.

- **Creating a series of ongoing focus groups and check-ins to continue conversations on AANHPI suicide risk and review progress.**
  Continued focus groups and check-ins with providers and community members would create space for ongoing reflection and refinement of strategies. These sessions would build on previous conversations from 2022 and 2025, helping CYF stay accountable to its goals and responsive to the evolving needs of AANHPI youth and families. These groups can also dive deeper into topics regarding AANHPI suicide risk, which would be great educational material for all CYF providers.

6. Additional Resources

Linked below are some of the literature/studies mentioned and shared during the focus group:

- Lui CK, Ye Y, Gee J, et al. Unmasking Suicidal Ideation for Asian American, Native Hawaiian, and Pacific Islander Youths Via Data Disaggregation. JAMA Netw Open. 2024;7(11):e2446832. doi: 10.1001/jamanetworkopen.2024.46832
- Wyatt LC, Ung T, Park R, Kwon SC, Trinh-Shevrin C. Risk Factors of Suicide and Depression among Asian American, Native Hawaiian, and Pacific Islander Youth: A Systematic Literature Review. J Health Care Poor Underserved. 2015 May;26(2 Suppl):191-237. doi: 10.1353/hpu.2015.0059.

SAN FRANCISCO BEHAVIORAL HEALTH COMMISSION

Mayor
Daniel L. Lurie

1380 Howard Street, 2nd Floor
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@mhbsf.org
www.mhbsf.org
www.sfgov.org/mental_health

AGENDA
Behavioral Health Commission Meeting
San Francisco City Hall
1 Dr. Carlton B Goodlett Place, Hearing Room 416
San Francisco, California 94102
Thursday, July 17, 2025
6:00pm – 8:00pm

Remote Access

https://us06web.zoom.us/j/87444415689?pwd=N2tUZkpRZlU5Z zhjOE9XOWV1bEpCZz 09

Meeting ID: 874 4441 5689 Passcode: 284349 One tap mobile:

+14086380968,87444415689#*284349# US

Meeting Decorum:

Any member of the Behavioral Health Commission may call for decorum due to the disorderly conduct of meeting participants. Persons who engage in threatening and/or menacing behavior may be asked to leave.

Item 1.0 Call to Order, Roll Call, and Agenda Changes

Commissioners: Co-Chair, Kescha S. Mason (she/her), Co-Chair, Liza Murawski (she/her), Vice Chair, Lisa Wynn (she/her), Secretary, Lisa Williams(she/her), Alex Humphrey(he/him), Harriette Stallworth Stevens, EdD (she/her), Peter Murphy (he/him), Bahlam Javier Vigil (they/theirs), Carletta Jackson-Lane (she/her)

Public Comment: (For all items not on the agenda)

Item 1.1 Director's Report, Behavioral Health Services. Presentation by Hillary Kunins, MD, MPH (she/her) Director of Behavioral Health Services and Mental Health SF, SFDPH.
[See Attached - Slide Presentation]

Public Comment:

Item 2.0 Presentation and Implementation of the Community Planning Process by Juan Ibarra Behavioral Health Services Vocational Services Program Manager Office of Justice, Equity, Diversity, and Inclusion [See Attached - Slide Presentation] [See link below]

https://forms.office.com/r/MBYPG9FZgW?origin=lprLink

Public Comment:

Item 2.1 Review and adopt June 17, 2025, Special Meeting Minutes. **[Action Item]**

Public Comment:

Item 3.0 The subcommittee of the executive committee would like to recommend the replacement of two commissioners. The BHC should determine if this should be forwarded to the Board of supervisors. **[Action Item]**

[See link below]

https://codelibrary.amlegal.com/codes/san_francisco/latest/sf_admin/0-0-0-9828

Public Comment:

Item 4.0 Reports from committees on meetings, goals, and accomplishments: Implementation Committee: Implementation chair will discuss progress of the current draft of the Strategic Plan and site review updates. The implementation chair will report on the site review strategy for completing selected program reviews. Updates from the Rules and Reports Committee: Chair will provide an update on the status of the BHC annual reports. **[Discussion Only]**

Public Comment:

Item 5.0 People or Issues to be highlighted by Behavioral Health Commission **[Discussion only]**

Public Comment:

Item 5.2 Behavioral Health Commission reports by members on their activities on behalf of the commission, as authorized. **[Discussion Only]**

Public Comment:

Item 6.0 New Business
Suggestions for future agenda items to be referred to the Executive Committee. **[Discussion only]**

Public Comment:

Adjournment: (Reminder of the next meeting)

Disability Access

The ADA is a civil rights law that protects people with different types of disabilities from discrimination in all aspects of social life. More specifically, Title II of the ADA requires that all programs offered through the state and local government such as the City and County of San Francisco must be accessible and usable to people with disabilities. The ADA and City policy require that people with disabilities have equal access to all City services, activities, and BHC benefits.

People with disabilities must have an equal opportunity to participate in the programs and services offered through the City and County of San Francisco. If you believe your rights under the ADA are violated, contact the ADA Coordinator. Ordinance 90-10 added Section Site 2A.22.3 to the Administrative Code, which adopted a Citywide Americans with Disabilities Act Reasonable Modification Policy that requires City departments to: (1) provide notice to the public of the right to request reasonable modification; (2) respond promptly to such requests, (3) provide appropriate auxiliary aids and services to people with

disabilities to ensure effective communication; and (4) train staff to respond to requests from thepublic for reasonable modification, and that requires the Mayor's Office on Disability to Behavioral Health Commission, provide technical assistance to City department responding to requests from the public for reasonable modifications.

Disability Accommodations:

To request assistive listening devices, real time captioning, sign language interpreters, readers, large print agendas or other accommodations, please contact the Commission Secretary at (415) 558-6309, or commissions.secretary@sfgov.org at least 72 hours in advance of the hearing tohelp ensure availability. Language Assistance:

To request an interpreter for a specific item
during the hearing, please contact the Commission Secretary at (415) 558-6309, or commissions.secretary@sfgov.org at least 48 hours in advance of the hearing.

SPANISH:

Agenda para la Comisión de Planificación. Si desea asistir a la audiencia, y quisiera obtener información en Español o solicitar un aparato para asistencia auditiva, llame al 415-558- 6309. Por favor llame por lo menos 48 horas de anticipación a la audiencia.

CHINESE:

規劃委員會議程。聽證會上如需要 語言協助或要求輔助設備，請致電415-558-6309。請在聽 證會舉行之前的至少48個小時提 出要求。

TAGALOG:

Adyenda ng Komisyon ng Pagpaplano, Para sa tulong sa lengguwahe o para humiling ng Pantulong na Kagamitan para sa Pagdinig (headset), mangyari lamang na tumawag sa 415-558-6309. Mangyaring tumawag nang maaga (kung maaari ay 48 oras) bago sa araw ng Pagdinig.

RUSSIAN:

Повестка дня Комиссии по планированию. За помощью переводчика или за вспомогательным слуховым устройством на время слушаний обращайтесь по номеру 415-558-6309. Запросы должны делаться минимум за 48 часов до начала слушания.

POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from

the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound producing electronic devices.

KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. Ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:
Sunshine Ordinance Task Force City Hall, Room 244 1 Dr.
Carlton B. Goodlett Place San Francisco, CA 94102-4689 Telephone: (415)554-7724 Fax: 4(15) 554-5163 E-mail: sotf@sfgov.org Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from the Sunshine Ordinance Task Force or by printing Chapter 67 of
the San Francisco Administrative Code from the internet at: www.sfgov.org/sunshine.
To view Mental Health Board agendas and minutes, you may visit the MHB web page at: www.sfgov.org/mental_health. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

BHC, LOBBYIST REGISTRATION AND REPORTING REQUIREMENTS

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; website www.sfgov.org/ethics

Behavioral Health Commission (BHC) CPP meeting

Thursday, 7.17.2025

#1 Member of the public virtually attending the meeting.

Mother of a consumer for 20 years–It was a very argues road. She wanted to know why the families were not an included in the decision-making process and how proposition one funding was utilized.

In terms of the things most challenging she recalls her son being discharged from the hospital. He required a lower level of care and medication assistance. It is practically non-existent. She explained the places provided were terrible and infested with drugs. She stated that it was not a good environment for someone dealing with mental illness to get well. States that she was never consulted by the anyone over the years.

Question #2 What are the most pressing issues related to behavioral health needs in in San Francisco and your communities?

#2 Commissioner answers reported having recent experience working in single room occupancies, Navigation Centers were the Homeless community benefits from Shelter Behavioral Health Service. I believe we need to look into ways expanding and supporting the Behavioral health Specialist. They are miracle workers. Behavioral Health Specialist don't get enough appreciation.

Permanent supportive housing sites are currently struggling in terms of maintaining wellness tracks. People with mental disorders passing away in their units going weeks without anyone noticing. Mortality rates seem to be higher in these sites.

It would be interesting to see if we could expand on the program pertaining to shelter behavioral health to include seniors' programs and those with disabilities. Commissioner reported the need for more wellness checks for single room checks to reduce the mortality rate amongst those consumers living in shelters and permanent supportive housing and single room occupancy with Behavioral Health needs.

The shelter systems should allow Behavioral Health Specialist to check up on clients and take care of wellness checks. This would also be supporting the case managers by lightening their

workload and supporting engaging the consumers. Including preventing something before something severe happens.

Pertaining to the question "What barriers have you and others faced when trying to access Behavioral Health Services?"

#3 Commissioner reports services are very siloed, lots of promises, barriers for people being turned down, services seem to be cherry picking; one side or the other; it depends on who you get. There seems to be a lack of consistency, and lack of knowledge. The challenges being faced in mental health conditions and substance abuse regardless of the spectrum from intense to extreme.

Pertaining to the question "How can we better reach and engage the people?"

You have to provide services that meet the people where they are at on a continuous level. You're opening all these different sites in different places without solid pilot evidence practiced program that is client centered, nor is it culturally appropriate. We are moving into a very cultural time of change and our societal needs. These issues must come with a cultural Lense. I don't see this happening which equals death.

Question "What resources should we build on in San Francisco? "

We could start by ensuring that the case managers at community-based organizations and onsite single room occupancies are with certified peer specialist or licensed clinicians and that their client case management ratio meets the needs of the unit.

I have been reported back by two single room occupancy programs in the last two months that ten people were found deceased in their units by maintenance or pest control. They are required to have on site case management which in their contract is supportive housing on site per their contracts, which means they are required to have mental health case management to apply harm reduction and prevent death. They are not gender appropriate. Before we determine what, we need to ensure that what is in place is in sink and not siloed.

Question "What are the priority needs Behavioral health needs of the people of San Francisco?"

Commissioner stated wanting to make a proposal that we have a strategy to do some outreach to the community to become involved and to hear directly from them in different districts of San Francisco.

Public Comment: Employee of Progress foundation ADU Dore street states the laws have changed the drop ins in the DPH Clinics have discontinued the drop –in clinics due recent funding cuts. Counselor wants the drop in services reinstated. Counselor would like her clients to be able to go to Tom Wadell for their mental health needs. She reports the process was one day to get

medications after assessments done during drop-in hours at Tom Wadell Clinic. There is no more mental health drop in for services and the 10th street location is not able to handle the large employee volume consumers. Requesting to reconsider other ways to reopen drop-in services for the community of San Francisco.

CPP with RAMS: Asian & Pacific Islander Mental Health Collaborative
July 21, 2025, from 11am to 12noon (via Zoom meeting)

Group Member 1

- APIMHC represents 6 ethnic groups and adequate time is needed for planning

Group Member 2

- High number of community members
- Lack of services
- Needed information is not found in data
- There are the least of services for particular communities
- Encourage program participants to provide data
- Program does a lot of outreach to community members: but there are a small number of services
- Families who live in SROs (Single Room Occupancy) cannot move out if they want to keep receiving services from RAMS

Group Member 3

- California Youth Risk Behavior report: high suicidal ideation & suicide attempts for students in San Francisco Unified School District (SFUSD)
    - Number of SFUSD students' suicidal ideation & suicide attempts has been reduced by 35%

Group Member 4

- Outreach & prevention services are not seen on narrative reporting
- Year-End direct services
- Through SFUSD report, learned about low utilization of services by students
- Intake captures housing needs: then person and their needs are triaged for services
- RAMS helps people find and maintain housing
- Need for sustainable decision for families
- Question: how many families moved out of San Francisco & still come to San Francisco for services?

Group Member 5

- Advocate for more funding across all 6 ethnic groups of Asian & Pacific Islander Mental Health Collaborative

CPP with Native American Health Center (NAHC) – Living in Balance (LIB) program July 29, 2025

(Dallas Wahpepah & Kim Ganade)

Critical to providing services to Native American community are NAHC: LIB's Traditional Health Practitioners

- Connecting community members to social services, housing programs, substance abuse treatment & behavioral health services
- Involving NAHC'S Chief Cultural Officer

Critical to providing mental health prevention & early intervention services are Living in Balance program's:

- Use of the Native American Wellness Wheel
- events
- screenings & assessments
- referrals to other services
- focus on physical, mental, spiritual & other wellness areas
- collective team efforts: manage referring community members to housing and behavioral health care

Importance of Winter Celebration for Houseless People

- Distribution of hygiene supplies, blankets & socks
- Shared cultural stories of with winter

1. Dallas will be speaking with his team members about other feedback on current programming and suggestions for future programming

2. Dallas will complete the CPP survey
3. Dallas will email me his team members' feedback, input & suggestions

CPP with Horizons Unlimited: Emic Behavioral Health Services program & Latino Commission: Panche Be Program
July 30, 2025
(Celina Lucero – Horizons Unlimited & Debra Camarillo – Latino Commission)

Both Celina Lucero & Debra Camarillo responded to CPP survey
Kim ask Andrew Williams when Latino Commission: Panche Be program's invoices will be released
Kim monitor contracting process for Latino Commission: Panche Be program Kim send examples of DHCS approved early intervention services they will pay for
Suggestion: Kim hold contract planning group with LatinX & Mayan serving organizations to be proactive in contracting process
Kim email Horizons Unlimited's CDTA Program Manager Mario Hernandez and Latino Commission's CDTA Program Manager Andrew Williams regarding contract planning groups with LatinX & Mayan contractors
Kim will review past LatinX & Mayan contractors' Appendix A content: to begin looking at possible contract language that will meet the needs of CBOs, the city & county, the state & possibly the feds

Horizons Unlimited

To have commensurate increasing administrative duties & expense of increasing staff time needed: DCYF has grantees have 20% dedicated to administrative duties
SFDPH should follow suit with DCYF to have 20% of contract budget dedicated to administrative staff time
BHSA dollars should remain flexible (like MHSA dollars) for service provision Continue funding low-barrier programming
Have community-based evidence and community-based practices just like evidence based practices
Program model is changing: needs of youth & their families
Example: changes from case management to promotoras model

Latino Commission

Business model: contracts should be certified in a timely manner, just like practices put on to CBOs
City & County of San Francisco model of producing certified contracts needs to be more timely (rather than the current slow model)
CBOs need to incur expenses when the City & County of San Francisco is slow to certify contracts and pay for invoicing expenses
CBOs should be compensated for the expenses they incur while the

City & County of San Francisco is slow to certify contracts and pay for invoicing The City & County of San Francisco needs to be quicker in providing contracting status updates: CBOs need time to plan, forecast future programming needs because they need to plan for the future

Kimberly M. Ganade, MSW

BHS Client Council CPP feedback notes
August 19, 2025

What has helped you most in your recovery or wellness journey?

- Art, peer support groups, journaling/writing

What services or supports do you wish you had access to?

- Peer support groups focusing on decolonization of the self, post-colonial scholarship

How can services be more welcoming, inclusive, or safer?

- Not be solely rooted on Westernized academia, but to include indigenous, eastern, and non-western traditional healing techniques

What advice can you give the county about what really works?

- Dialogue works!
- Utilizing the Client Council for feedback works!
- SF Public Library has SUD services; Blue guide that has over 100 SUD services…this should be available in a lot of places. People need to have options; we need different ways to connect to people….particularly at the SFPL. I went to difference organizations listed in this blue guide, like faith-based organizations; BHS had a resource guide pre-pandemic…with actual providers.

What has helped you most in your recovery or wellness journey?

What services or supports do you wish you had access to?

- NueroDivergent client services and or groups; a client has had difficulty finding a group like this

How can services be more welcoming, inclusive, or safer?

What advice can you give the county about what really works?

Share your thoughts on mental health and substance use care in your community

DATE: Monday, August 25, 2025

TIME: 9:30 - 10:30 AM

PLACE: The Marilyn Inn, Conference Room 112
27 Dashiell Hammett Street
San Francisco, CA 94108

Food will be provided!

The Behavioral Health Services Act (BHSA) works to:

- Promote the early identification of mental health and substance use disorder problems
- Make access to treatment easier
- Deliver effective services and supports
- Eliminate stigma and raise awareness

Your feedback is crucial to ensuring behavioral health services meet the needs of our community!

San Francisco Health Network
Behavioral Health Services

Behavioral Health Services Act of San Francisco

The Behavioral Health Services Act (BHSA) was approved by California voters in November 2024.

The SF BHSA team strives to provide culturally responsive services. For interpretation services (including American Sign Language) or a physical disability-related accommodation, please contact bhsa@sfdph.org at least 10 days in advance.

San Francisco Department of Public Health: Behavioral Health Services
Behavioral Health Services Act (BHSA)
Marilyn Inn Community Program Planning
August 25, 2025
(Juan Ibarra)

Question 1: answers

- See doctor/therapist
- Staying sober
- Taking meds
- Talk to counselors here

Question 2: answers

- Going to groups
- Seeing case worker
- Asking case worker to help with ideas
- Support with transportation/connect to rides
- More support with public housing
- RAMS: vocational (clinical/janitorial)

Question 3: answers

- Homelessness
- Substance abuse support
- Hygiene supplies
- Addressing how city makes homelessness illegal & sweeps
- Medical detox
- Large size of programs making it dangerous (i.e. Walden)

Question 4: answers

- Create behavioral health housing
- Helping people find a place to live
- Going to groups
- Seeing case manager
- Helping individuals resolve in house
- Sober housing
- Individuals with GSA
- Making access to therapy easier

Question 5: answers

- Street drugs
- Paying rent
- Learning how to budget properly
- Getting assistance with substance abuse
- Drop-in centers of the Tenderloin

- Location: Nob Hill vs. Tenderloin

Question 6: answer

- Assistance with jobs that are more sustainable (not necessarily entry-level)

San Francisco Department of Public Health (SFDPH): Behavioral Health Services (BHS), Behavioral Health Services Act (BHSA) Community Program Planning with FACES for the Future, City College of San Francisco: Addiction & Recovery Counseling
September 12, 2025
(Dr. Tomas Magana – FACES, Chad Seamon – FACES, Alma Avila – CCSF, Eric Lewis – CCSF, Jessie Escobar – SFDPH BHS SUD)

City College of San Francisco: Addiction & Recovery Counseling (A. Avila & E. Lewis)

- More treatment beds needed

City College of SF: ARC program

- CCSF: ARC program needs more teachers to educate & train next generation of Substance Use Disorder (SUD) counselors
    - Professional development for SUD professionals to teach
- Addiction & Recovery Counseling program sometimes have to turn students away because their program & classes are full
- CCSF has free tuition for San Francisco residents & linkages to resources
- Need more trainings for SUD counselors
- Pass state certification exam to become certified

Post-CCSF ARC Graduation

- Challenge: cost of SUD ARC graduates to take the state exam to be certified

Field

- New restrictions: seem counterproductive to educating & training the next generation of SUD counselors
- Need apprenticeship opportunities & paid internships (e.g. HealthRight 360), young people need peer mentors)
- Latino Commission & its internships
- Consider adolescents who can become SUD counselors
- Jessie Escobar (SFDPH BHS SUD SOC): team has been looking internally within SFDPH for more funding
- Dual enrollment: young people can earn credits for high school classes AND City College of San Francisco credits
    - Tomas & Chad can speak with Sal Nunez &/or Beth Freedman

Concerns

- It seems educating & training the next generation of SUD counselor is not a priority
- Need more trainings for SUD counselors
- Help with paying for registration

FACES for the Future (Dr. Tomas Magana & Chad Seamon)

FACES program

- Workforce early exposure for high school students
- Encourage FACES students to attend City College of San Francisco
- Student work-based learning
- Refer students to interventions, build awareness & tools to use
- Career exposure

- Taking theory and place into action

Field

- Programs ready to take on interns
- San Francisco changes: new mayor committed to community, encourage dialogue
- Make tighter connections among workforce development programs (e.g. FACES for the Future & City College of San Francisco: Addiction & Recovery Counseling program)
- Promote career development
- In behavioral health, state HCAI innovate work in workforce development
- Peer-to-peer programs in peer navigation, case management, school-industry joint work
- Engage philanthropy: systems approach
- Link high school students to Public Health Youth Corp: training in service & outreach
- Behavioral youth corp & SUD youth corp in San Francisco
- Peer resources
- SFDPH BHS BHSA support services in San Francisco: referrals & linkages
- Family support: train youth at the college level
- Peer-to-peer work (e.g. Mental Health First Aid)

Opportunities

- Private funding: philanthropy
- Willing mentors?
- Joint work among FACES, City College of San Francisco, San Francisco Department of Public Health: Behavioral Health Services, Behavioral Health Services Act
    - Connect to form a pathway to school to professional health/behavioral health career
    - Create a concept
    - Pitch concept to a foundation

Contact Information

City College of San Francisco: Addiction & Recovery Counseling certificate program
Alma Avila
aavila@ccsf.edu
(415) 452-5160

Eric Lewis
edlewis@ccsf.edu
(415) 452-5159

City College of San Francisco: Health Education Department
Beth Freedman
bfreeman@ccsf.edu
(415) 452-5570

City College of San Francisco: Community Mental Health Certificate Program
Dr. Sal Nunez
snunez@ccsf.edu
(415) 452-7387

Dr. Edith Guillen-Nunez
eguillen@ccsf.edu
(415) 452-7477

Faces for the Future
Dr. Tomas Magana
TMagana@phi.org
(510) 481-4567

Chad Seamon
cseamon@phi.org
(510) 588-9096

Amy Spade
aspade@phi.org
(510) 365-3493

Transgender Community Focus Group Minutes/Notes

October 18 2025

A. WHAT SERVICES HAVE HELPED YOU IN THE PAST?

client #1: SUD treatment/detoxes/residential treatment facilities

#2: treatment, showers, community, safe spaces, drop-in hours for medical treatment

#3: Che Boutique (clothing) drop-in services, clothing closet

#4: case management, Counseling, medical assistance, A Woman's Place (group)

#5: Dept of Public Health, Transgender groups and community events health fair, Center for Excellence, food bank, Trans Drive, TBT

#6: Trans Drive, TBT, Rental assistance, Positive Resource Center, Lutheran Social Services money management program.

#7: Transgender Justice GIP with housing, Ambers Friday Night Group

#8: Warm Line, Legal help with separation from abusive Partner, Balance

B.WHAT SERVICES ARE MISSING CURRENTLY?

CLIENT #1: HOUSING, immigration support services/guidance to other services available.

#2: Legal services, access to the law

#3: not enough Trans Programs for women

#4: access to medicine, medical concerns, hormone shots, education and health screenings.

#5: Behavioral Health Services

#6 Outreach to Isolated trans seniors passing away in their apartments.

#7 Food programs for Trans and gender non-confirming individuals.

C.WHAT WOULD YOU LIKE TO SEE IN THE FUTURE OF TRANS SERVICES

CLIENT #1: more employment training programs, job opportunities, affordable housing

#2: getting paid money instead of gift cards

#3: coaching job, employment retention, vocational rehabilitation, better utilization of skills, life coaches, mentoring programs

#4: mental health services, better social connectedness, places to celebrate who we are and continue to feel safe.

Department of Disability and Aging Services CPP Meeting

10-27-25

1. What behavioral health challenges do you most commonly observe among the consumers you serve?
    - From the public conservator POV, lack of placements
    - Need for locked stabilization beds…need to be evaluated before next steps
    - Need more beds at the MHRC
    - Need for placement for clients that have psych and SUD….aging and cognitive issues with clients….dementia…..need to be in a locked facility
    - Would like to see more ICM services…conservators can not really provide case mgmt.
    - Need resources to be able to refer clients to BHS….serving but do not have the training
    - Challenge with folks with MH Dx and developed dementia…dementia becomes primary Dx and this flips their world
    - There are clients that are grieving….there are also client who isolate
    - When community is assessed…clients are not able to follow through with service

2. What strengths or resources currently exist within DAS or partner agencies to support behavioral health?
    - Came close to launching a program with a lic. Staff….new mayor came on board and process was frozen
    - We try to prevent isolation
    - A couple of Sr. orgs have started their BH programs….some are colocated with BHS….low barrier services.
    - Providers say that they have clients with BH needs and do not know where to send them…DAS has a foundation of where to refer clients….do not have the capacity to serve these clients
    - H&C…IHSS has the ability to pay for clean up
    - APS goes out and investigates H&C cases….get folks into services
    - Conservator takes over client decisions….get clients access to medications
    - We are Integrated unit…..for people who are looking for services….provide info on services with in and outside of DAS

3. Where do you see the biggest gaps in behavioral health services for your clients?
    - Need for more placements and beds

4. What behavioral health concerns are most prevalent among older adults (e.g., isolation, depression, cognitive decline)?
    - Combination of dementia with BH issues
    - Out in the community for those that don't deal with dementia clients, they struggle to find the right services for them

5. How accessible and appropriate are current behavioral health services for older adults? What improvements are needed?
    - People don't know what they don't know…they struggle to know what BH services are available
    - BH feels like a mystery to the community
    - Barriers to services – admin side vs. accessibility/cultural environ of services
    - DAS tries to have space for OA

6. Are there barriers (e.g., physical, communication, stigma) that limit access to behavioral health services for this group?
    - There is a lot of the able-ism, stigma and difficulty to getting people to see things from a diff POV….could inhibit people from accessing services
    - Double stigma…someone with a phys disab and BH
    - Community says those with disabilities….looking at their functional needs….system is all medicalized….needs more person centered services
    - Communication can also be a real barrier
    - Providers not just BH also social services are not trained to how properly engage with those with communication issues

7. What changes or innovations would you recommend to better support the behavioral health of DAS consumers?
    - We need to do a better job of asking what folks need…need to create a safe space to ask

8. What changes or innovations would you recommend to better support the behavioral health of DAS consumers?
    - We are seeing success….tried to launch but did not have the funding….group therapy settings….ability to address needs to lower BH acuity…lower cost model…..LCSW instead of a Psychologist
    - PEARLS evid based P2P program

Tenderloin Neighborhood Development Corporation (TNDC) CPP Meeting

10-28-25

1. What community groups in SF do you represent?
    - Who TNDC serves – extremely low income HH 80% and folks who were previously homelessness, tenants who are not white, systemic issues, and unmet needs
    - TNDC is the largest provider of affordable housing
    - 1 in 10 individuals are TNDC tenants
2. What are the most pressing issues related to BH needs in SF?
    - Like all SH providers and affordable H providers, people have extremely high acuity needs. The longer people live outside the issues grow
    - We can't support that level of acuity
    - Disproportionate number of drug related fatalities…can be addressed several ways
    - Its alarming to allow folks to die from SU
    - 1 in 10 who live in TN are TNDC tenant….lots of drug use, criminal, homeless in surrounding area…this presents a challenge…number one complaint by tenants is not feeling safe in TN
    - Not saying arrest everyone…we do not have to rely on the status quo Tx system…people need to be supported
3. What BH resources already exist in SF that we should build on?
    - Harm reduction and Housing first – the problem is that it is communicated that it does not work…the issue is that we are not doing this to scale
    - Need alternative places for those with the highest acuity in affordable housing
4. What barriers have you or others you know faced when trying to access BH services?
    - We rely on a system driven by abstinence
    - May not be what the person wants
    - If we get someone to stop using it does not tell us anything about a person….about their housing for example
5. How can we better reach people who may not engage in BH services?
    - Increase funding for BH roving teams that go out where folks are
    - Reducing arresting people
    - Trying to meet the person needs vs. trying to serve what the system needs
6. What other voices need to be heard in developing a plan for BH services?
    - Talking to people who do things differently

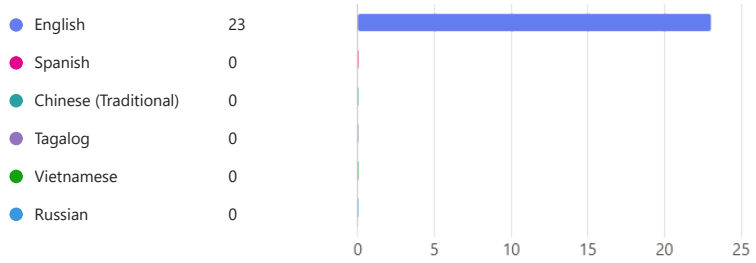
- Talk to people outside of US who are doing different treatment modalities

Responses Overview

Active

Responses	Average Time	Duration
64	03:14	112 Days

1. In which language would you like to complete this form?



2. Agency Name/Program Name (if applicable):

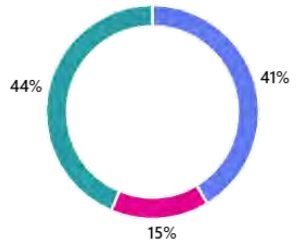
59
Responses

Latest Responses
"Curry Senior Center"
"CCSF- Addiction & Recovery Counseling Certificate"
"Public Health Institute"
...

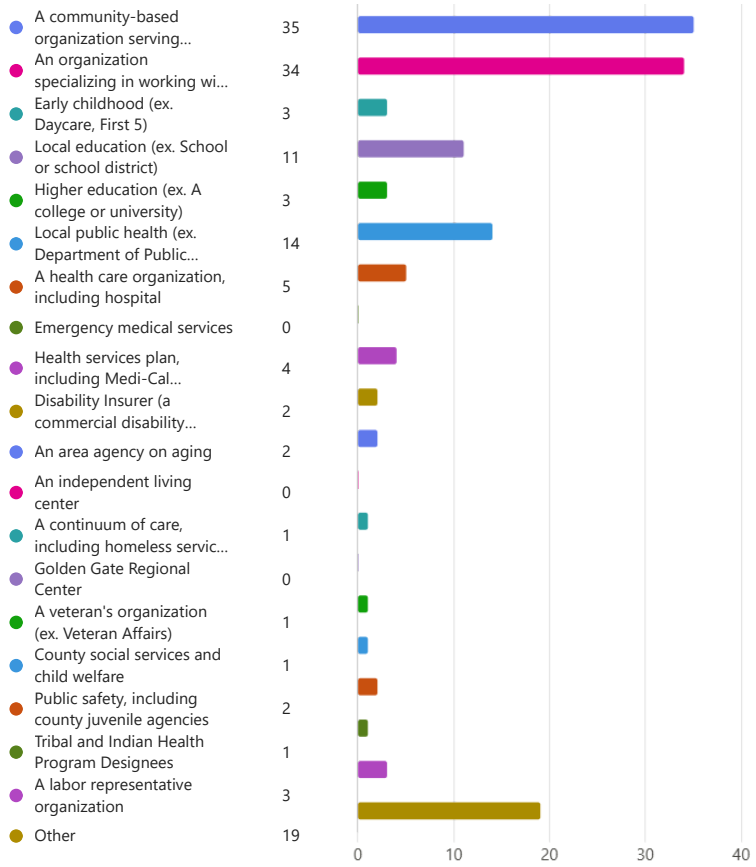
14 respondents (24%) answered Marilyn Inn for this question.

3. What is your experience with behavioral health (mental health, substance use) services? Pleas e select all that apply.

I have accessed behavioral health services before	36
One or more of my family members has accessed behavioral health services before	13
I am a provider of behavioral health services (ex. Therapist, social worker, psychiatrist)	38

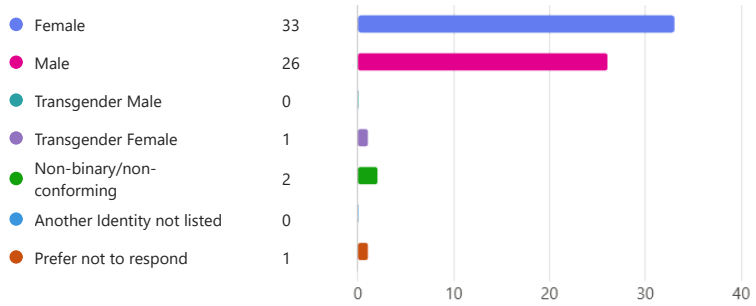


4. Do you work for or represent any of the following types of agencies? Please select all that ap ply.

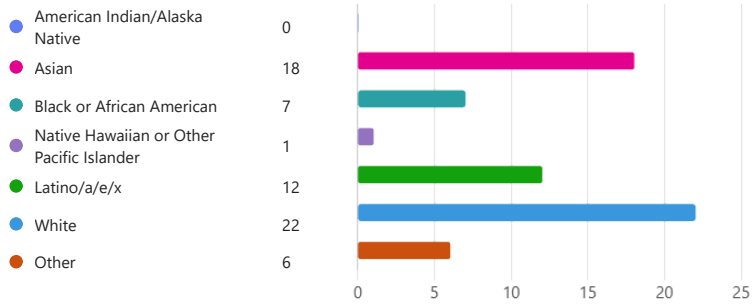


5. What is your age?

6. What is your gender identity?

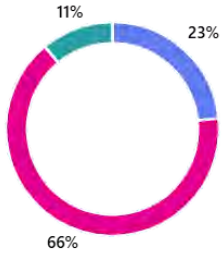


7. What is your race/ethnicity? Please select all that apply.



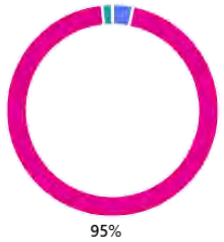
8. Do you identify as a member of the LGBTQIA2S+ community?

Yes	15
No	42
Prefer not to answer	7



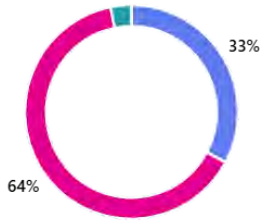
9. Are you a veteran?

Yes	2
No	61
Prefer not to answer	1



10. Have you ever experienced homelessness?

Yes	21
No	41
Prefer not to answer	2



11. Nombre de la agencia/del Programa (si corresponde):

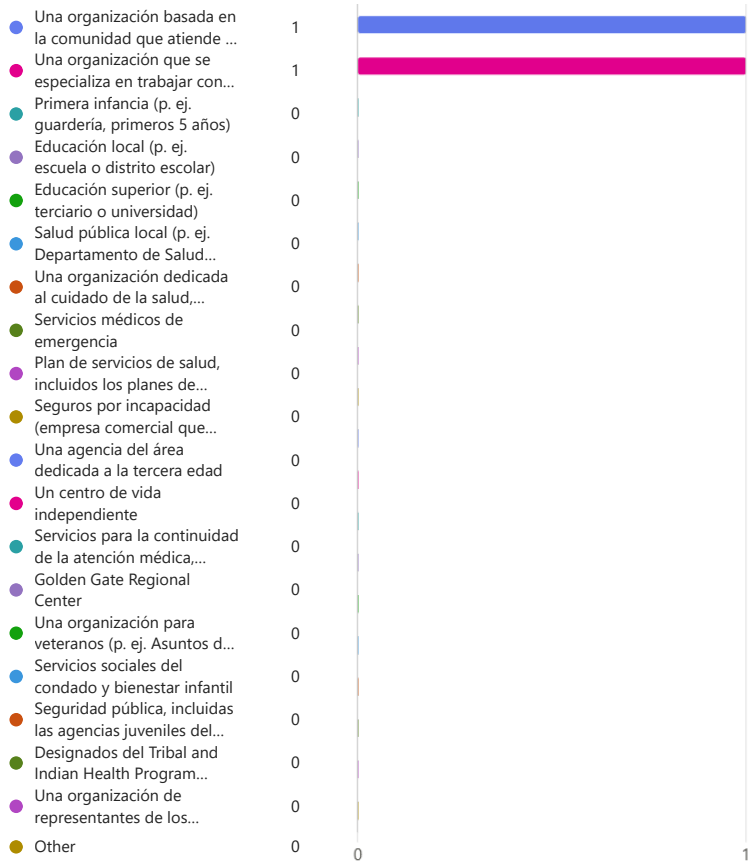
0 responses submitted

0
Responses

12. ¿Cuál es su experiencia con los servicios de salud conductual (salud mental, uso de sustancias)? Seleccione todas las opciones que correspondan.*

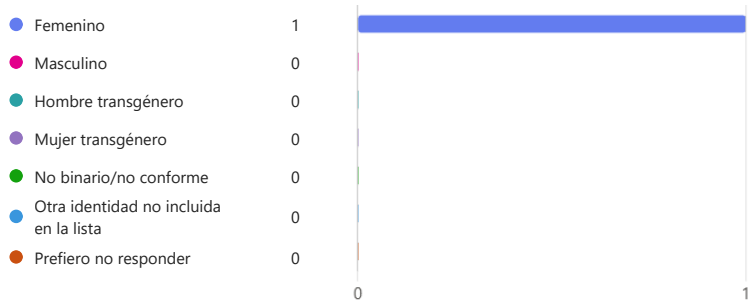
Accedí a los servicios de salud conductual antes	1
Al menos una persona de mi familia accedió a los servicios de salud conductual antes	0
Soy proveedor/a de servicios de salud conductual (p. ej., Terapeuta, trabajador/a social, psiquiatra)	1

13. ¿Trabaja en algunos de los siguientes tipos de agencias o representa a alguno de ellos? Seleccione todas las opciones que correspondan.

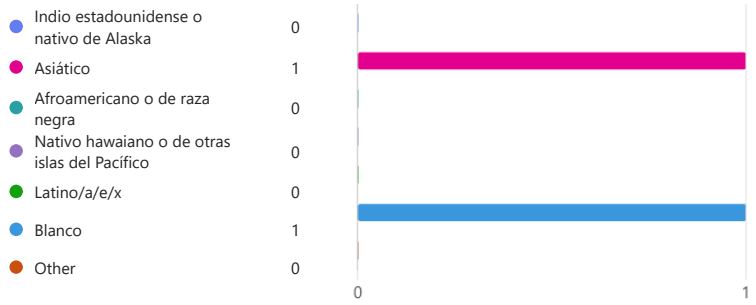


14. ¿Qué edad tiene?

15. ¿Con qué género se identifica?

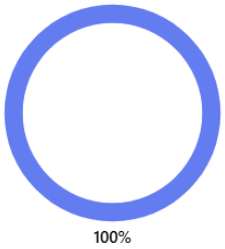


16. ¿Cuál es su raza u origen étnico? Seleccione todas las opciones que correspondan.



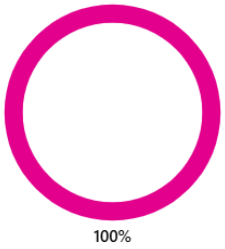
17. ¿Se identifica como integrante de la comunidad LGBTQIA2S+?

Sí	1
No	0
Prefiero no responder	0



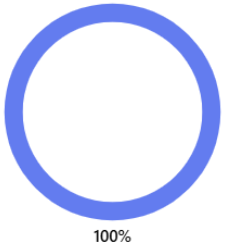
18. ¿Es veterano/a?

Sí	0
No	1
Prefiero no responder	0



19. **Have you ever experienced homelessness?**

Sí	1
No	0
Prefiero no responder	0



20. 機構名稱/計劃名稱（若適用）：

0 responses submitted

0
Responses

21. 閣下對行為健康服務（包括心理健康及藥物使用障礙治療）有何經驗？ 請選擇所有適用項。

本人曾接受過行為健康服務	1
本人的一名或多名家庭成員曾接受過行為健康服務	0
本人是行為健康服務提供者（例如：心理治療師、社工、精神科醫生）	1

22. 閣下是否受僱於或代表以下任何類型的機構？請選擇所有適用項。

23. 閣下的年齡是？

24. 閣下的性別認同是?

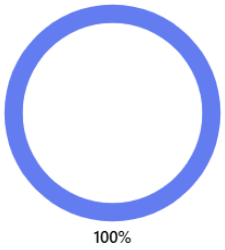
女性	0
男性	0
跨性別男性	0
跨性別女性	0
非二元性別/性別不從眾	0
未列出的其他身份	0
不願回答	0

25. 閣下的種族 / 族裔是？請選擇所有適用項。

美洲印第安人/阿拉斯加原住民	0
亞洲人	0
黑人或非裔美國人	0
夏威夷原住民或其他太平洋島民	0
拉丁裔	0
白人	0
Other	0

26. 閣下是否認同自己屬於 LGBTQIA2S+ 社群?

是	1
否	0
不願回答	0



27. 閣下是退伍軍人嗎?

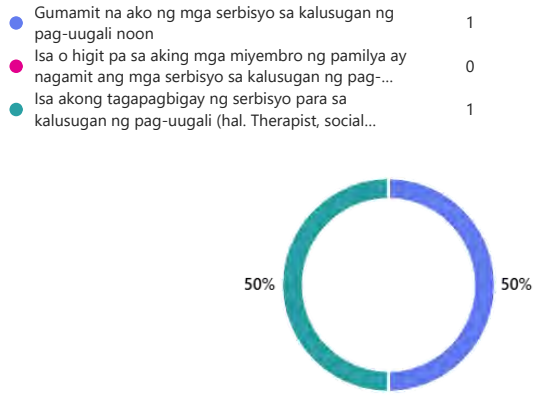
28. 閣下曾否經歷過無家可歸的情況?

29. Pangalan ng Ahensiya/Programa (kung naaangkop):

0 responses submitted

0
Responses

30. Ano ang karanasan mo sa mga serbisyo sa kalusugan ng pag-uugali (kalusugan ng pag-iisip, paggamit ng substance)? Mangyaring piliin ang lahat ng naaayon.



31. Nagtatrabaho o kumakatawan ka ba sa alinman sa mga sumusunod na uri ng ahensiya? Mangyaring piliin ang lahat ng naaayon.

32. Ano ang edad mo?

Mababa sa 16	0
16 hanggang 18	0
19 hanggang 25	0
26 hanggang 59	0
60 o mas matanda	0

33. Ano ang iyong pagkakakilanlan ng kasarian?

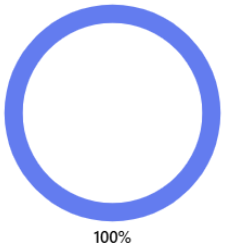
Babae	0
Lalaki	0
Transgender na Lalaki	0
Transgender na Babae	0
Non-binary/non-conforming	0
Iba pang pagkakakilanlan na hindi nakalista	0
Hindi ko gustong tumugon	0

34. Ano ang iyong lahi/etnisidad? Mangyaring piliin ang lahat ng naaayon.

American Indian/Katutubo ng Alaska	0
Asian	0
Black o African American	0
Katutubong Hawaiian o Iba pang Pacific Islander	0
Latino/a/e/x	0
White	0
Other	0

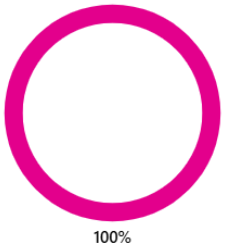
35. Nakikilala mo ba ang sarili mo na bahagi ng komunidad ng LGBTQIA2S+?

Oo	1
Hindi	0
Hindi ko gustong sumagot	0



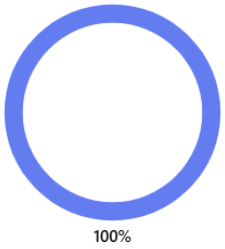
36. Isa ka bang beterano?

Oo	0
Hindi	1
Hindi ko gustong sumagot	0



37. Nakaranas ka ba na mawalan ng tirahan?

Oo	1
Hindi	0
Hindi ko gustong sumagot	0



38. Agency Name/Program Name (if applicable):

0
Responses

0 responses submitted

39. Kinh nghiệm của quý vị với các dịch vụ sức khỏe hành vi (sức khỏe tâm thần, lạm dụng chất gây nghiện) là gì? Vui lòng chọn tất cả những câu trả lời phù hợp.

Tôi đã từng tiếp cận các dịch vụ sức khỏe hành vi trước đây	1
Một hoặc nhiều thành viên trong gia đình tôi đã từng tiếp cận các dịch vụ chăm sóc sức khỏe hành vi trư...	0
Tôi là nhà cung cấp dịch vụ sức khỏe hành vi (ví dụ: Nhà trị liệu, nhân viên xã hội, bác sĩ tâm thần)	1

40. Quý vị có làm việc tại hoặc đại diện cho bất kỳ loại cơ quan nào sau đây không? Vui lòng c
họn tất cả những câu trả lời phù hợp.

41. Quý vị bao nhiêu tuổi?

Dưới 16	0
16 đến 18	0
19 đến 25	0
26 đến 59	0
60 trở lên	0

42. Bản dạng giới của quý vị là gì?

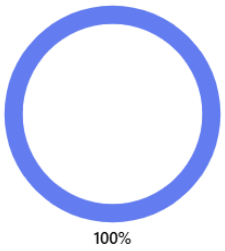
Nữ	0
Nam	0
Nam chuyển giới	0
Nữ chuyển giới	0
Phi nhị nguyên/không theo giới tính truyền thống	0
Một bản dạng khác không được liệt kê tại đây	0
Không muốn trả lời	0

43. Chủng tộc/dân tộc của quý vị là gì? Vui lòng chọn tất cả những câu trả lời phù hợp.

Người Mỹ Bản Địa/Người Alaska Bản Địa	0
Châu Á	0
Người Da Đen hoặc Người Mỹ Gốc Phi	0
Người Hawaii Bản Địa hoặc Người Dân Đảo Thái Bình Dương Khác	0
Người Mỹ La-tinh	0
Người Da Trắng	0
Other	0

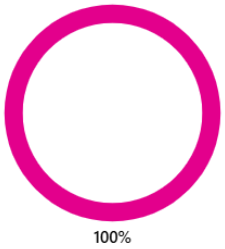
44. Quý vị có tự nhận mình là thành viên của cộng đồng LGBTQIA2S+ không?

Có	1
Không	0
Không muốn trả lời	0



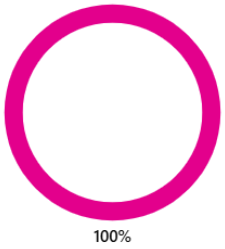
45. Quý vị có phải là cựu chiến binh không?

Có	0
Không	1
Không muốn trả lời	0



46. Quý vị đã từng trải qua tình trạng vô gia cư chưa?

Rồi	0
Chưa	1
Không muốn trả lời	0



47. Название агентства/программы (если применимо):

0
Responses

0 responses submitted

48. Каков ваш опыт получения услуг в области поведенческого здоровья (услуг по лечени ю психических заболеваний, услуг по лечению наркомании)? Пожалуйста, выберите в се варианты, относящиеся к вам.

Я ранее обращался за услугами в сфере поведенческого здоровья	1
Один или несколько членов моей семьи ранее обращались за услугами в сфере поведенческог...	0
Я — поставщик услуг в сфере поведенческого здоровья (например, терапевт, социальный...	1

49. Вы являетесь сотрудником одного из следующих типов организаций или представляет е их интересы? Пожалуйста, выберите все варианты, относящиеся к вам.

50. Каков ваш возраст?

До 16 лет	0
16–18 лет	0
19–25 лет	0
26–59 лет	0
60 лет или старше	0

51. Какова ваша гендерная идентичность?

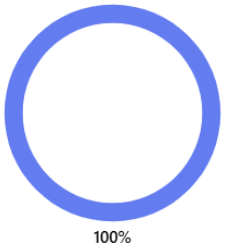
Женщина	0
Мужчина	0
Трансгендерный мужчина	0
Трансгендерная женщина	0
Небинарный/гендерно-неконформный человек	0
Другая идентичность, не упомянутая выше	0
Предпочитаю не отвечать	0

52. Какова ваша раса/этническая принадлежность? Пожалуйста, выберите все варианты, о тносящиеся к вам.

Американские индейцы/коренные жители Аляски	0
Азиаты	0
Черные или афроамериканцы	0
Коренные гавайцы или другие жители тихоокеанских островов	0
Латиноамериканцы	0
Белые	0
Other	0

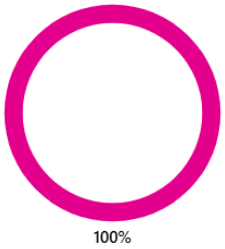
53. 1. Считаете ли вы себя членом сообщества LGBTQIA2S+?

Да	1
Нет	0
Предпочитаю не отвечать	0



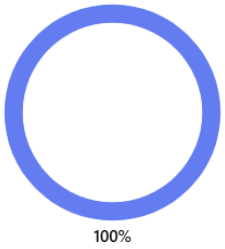
54. Вы ветеран?

Да	0
Нет	1
Предпочитаю не отвечать	0



55. Вы когда-нибудь были бездомным?

Да	1
Нет	0
Предпочитаю не отвечать	0



San Francisco Behavioral Health Services
Behavioral Health Services Act Community Survey Summary

1. In which language would you prefer to complete this survey? (N=996)

	Frequency	Percent
English	979	98.3%
Spanish	11	1.1%
Chinese	5	0.5%
Tagalog	1	0.1%

2. Do you live or work in San Francisco? (N=996)

	Frequency	Percent
Yes, I live in San Francisco	111	11.1%
Yes, I work in San Francisco	432	43.4%
Yes, I live and work in San Francisco	453	45.5%

3. How much do you agree/disagree with the following statement: In San Francisco, **mental health services** are readily available for anyone who needs them. (n=993)

	Frequency	Percent
Strongly Agree	90	9.1%
Agree	230	23.2%
Neutral	248	25.0%
Disagree	294	29.6%
Strongly Disagree	131	13.2%

4. If you responded Disagree or Strongly Disagree, please provide an explanation below. Please include any suggestions for improvement, such as offering services in my language, ensuring care providers are culturally responsive, etc.

Key themes:

- There are not enough mental health providers or resources to meet the need.
- Wait lists and wait times to see providers are too long.
- There are language/cultural barriers for those seeking services.
- Insurance is a problem – you have it, but can't access public services; if you don't have it, you can't access private resources/providers.
- Lack of affordability.
- There is limited awareness and a lack of information about available mental health services in San Francisco.
- Crisis response needs to improve.
- Providers are not held accountable for the services they deliver.
- The issue is overwhelming – "too many folks on the street".
- The overall system for addressing mental health issues is not working.

See Appendix A for all responses.

San Francisco Behavioral Health Services
Behavioral Health Services Act Community Survey Summary

5. How much do you agree/disagree with the following statement: In San Francisco, **substance use services** are readily available for anyone who needs them. (n=989)

	Frequency	Percent
Strongly Agree	106	10.7%
Agree	314	31.7%
Neutral	271	27.4%
Disagree	205	20.7%
Strongly Disagree	93	9.4%

6. If you responded Disagree or Strongly Disagree, please provide an explanation below. Please include any suggestions for improvement, such as offering services in my language, ensuring care providers are culturally responsive, etc.

Key themes:

- There are barriers to accessing substance use services including language, immigration status, stigma, perceived risk of arrest.
- There are not enough providers or services to meet the need.
- Waitlists for "available space" for detox or treatment are long.
- Many services have stopped, and those that are running are understaffed; staff are burning out.
- Access to substance use services could be increased by better promotion of services and making services more visible to all; allow walk-ins, have more free outpatient services, expand eligibility.
- Access can be increased by offering services in more languages other than English.
- Often substance abuse has a dual diagnosis with mental health disorders which can make finding a placement more difficult.
- There is a need for more ADA compliant treatment facilities.
- There is a need for more detox options, more outreach and harm reduction services, and an increased emphasis on prevention.
- Many respondents referred to their observations of unhoused people using drugs openly in the community as an indication that San Francisco is failing to address substance use.

See Appendix B for all responses.

7. What makes it harder for San Francisco residents to access mental health or substance use services? (Select all that apply.) (n=803)

	Frequency	Percent
Not knowing where to go for services	585	72.9%
Long wait times for appointments	500	62.3%
Distrust of the healthcare system	488	60.8%
Fear of stigma or being judged	458	57.0%
Not knowing how to make an appointment	419	52.2%
Limited number of providers with cultural understanding	419	52.2%
Lack of insurance	376	46.8%
Cost of care	362	45.1%
Limited service hours	348	43.3%
Lack of language and/or translation supports	315	39.2%
Caretaking responsibilities (childcare, aging parents, etc.)	303	37.7%
Difficulty getting time off work or school	293	36.5%
Lack of transportation	276	34.4%
Other (please specify)*	156	19.4%

***See Appendix C for full list of "other" barriers.**

8. Which services should the City prioritize for behavioral healthcare? Please rank your top two choices (MOST important = 2 points, 2nd most important = 1 point). (n=803)

	Ranked Sum*	% rated MOST important
Targeted behavioral health services for underserved populations (ex: those who are homeless/at-risk of homelessness, racial/ethnic minority groups, foster youth, etc.)	452	17.7%
Making mental health care more accessible	431	21.9%
Supportive housing services (ex: affordable housing and case management services)	425	19.6%
Support for those with serious mental health conditions	354	15.3%
Substance use treatment services	207	7.1%
Preventative mental health care (ex: support groups, self care, mental health education workshops)	175	7.0%
Mental health crisis response services	143	5.1%
Substance use prevention services	102	3.7%

*Numerical values were assigned to each ranking selected by the respondent for each item, and then values were summed across all respondents to determine which question items were ranked the highest.

See Appendix D for other priority areas specified by respondents.

9. For the area that you ranked as #1, please explain why and share any ideas to help improve services in this area.

Key themes:

- Must offer immediate access to mental health services – lower barriers.
- Housing and mental health are strongly connected; one cannot address mental health needs without the security of housing.
- When basic needs (e.g., housing) are met first, then people can focus more clearly on getting better and stopping substance use.
- Those who are most vulnerable and have the highest needs should be prioritized.
- Prioritizing serious mental health conditions can alleviate the need for crisis response.
- Preventative care can help to alleviate more serious cases.
- More intensive case management services can help overall.

See Appendix E for full list of responses.

10. Which of the following actions are most important for the City to take in order to better support people with behavioral health needs who are experiencing homelessness? (select up to 2) (n=790)

	Frequency	Percent
Improve or expand mental health services	284	35.9%
Make it easier or faster to get housing	283	35.8%
Create more affordable housing	241	30.5%
Improve existing housing options	180	22.8%
Improve or expand substance use services	179	22.7%
Improve coordination of services between community based organizations	176	22.3%
Improve or expand outreach services to people on the street	154	19.5%
Improve case management services	139	17.6%
More employment support (job training, resume workshop, etc.)	122	15.4%
Make sure access to programs and services are fair and equitable	118	14.9%
More financial support (rent assistance, etc.)	84	10.6%
Other*	76	9.6%

***See Appendix F for full list of other actions cited by respondents.**

San Francisco Behavioral Health Services
Behavioral Health Services Act Community Survey Summary

11. What is your age? (n=798)

	Frequency	Percent
Under 18	0	0%
18 to 24	5	0.6%
25 to 44	325	40.7%
45 to 64	398	49.9%
65+	39	4.9%
Prefer not to answer	31	3.9%

12. What is your preferred language? (select all that apply) (n=795)

	Frequency	Percent
English	768	96.6%
Spanish	64	8.1%
Cantonese	29	3.6%
Mandarin	13	1.6%
Filipino/Tagalog	11	1.4%
Other*	10	1.3%
Prefer not to answer	10	1.3%
Taishanese	3	0.4%
Vietnamese	1	0.1%
Russian	1	0.1%
Arabic	0	0%
Indigenous language from Latin America	0	0%

*Other = Burmese (n=2); Filipino; French; "completely bilingual, but prefer English"; Japanese; Khmer; Korean; Lao; Portuguese; Sichuanese; Swahili

13. What is your gender identity (select all that apply)? (n=788)

	Frequency	Percent
Female	508	64.5%
Male	203	25.8%
Prefer not to answer	46	5.8%
Nonbinary	18	2.3%
Gender expansive/Gender non-conforming	10	1.3%
Transgender Male	6	0.8%
Transgender Female	6	0.8%
Two-Spirit	3	0.4%
Another identity not listed*	4	0.5%

*Other = "Note, female and male are sexes, not genders"; Fluid; Genderfluid; Lesbian/Queer; "This question and its answer options is part of the problem; toenail

14. Do you identify as LGBTQ++ (n=790)

	Frequency	Percent
Yes	190	24.1%
No	522	66.1%
Prefer not to answer	78	9.9%

15. Are you a Veteran? (n=787)

	Frequency	Precent
Yes	19	2.4%
No	736	93.5%
Prefer not to answer	32	4.1%

16. Have you ever experienced homelessness? (n=792)

	Frequency	Percent
Yes	134	16.9%
No	601	75.9%
Prefer not to answer	57	7.2%

17. Which of the following best describe you? (select all that apply) (n=791)

	Frequency	Percent
Native American, American Indian or Alaskan Native	25	3.2%
Asian	200	25.3%
Native Hawaiian or Pacific Islander	11	1.4%
Hispanic/Latino	134	16.9%
Indigenous from Latin America	19	2.4%
African American or Black	99	12.5%
Middle Eastern or North African	8	1.0%
White	273	34.5%
Multiethnic	60	7.6%
Decline to answer	64	8.1%
Not listed. Prefer to specify*	15	1.5%

Other = Black American; Chicano; “Do you want to know my race or ethnicity – since they are different, but this question indicates that people think they are the same”; Ethnicity Jewish; European-American; Filipino; Filipino-American; Foundational Black American; human; ketchup; Moor; No; Romanian-American; Slavic

18. Do you work for or represent any of the following types of healthcare, housing, education, or human services agencies in San Francisco? **This can include working at an agency as an employee, volunteering at an agency, or serving on boards or committees.** Please select all that apply. (N=996)

	Frequency	Percent
Local public health (e.g., Department of Public Health)	430	43.2%
An organization specializing in working with underserved racially and ethnically diverse communities	211	21.2%
A community-based organization serving culturally and linguistically diverse constituents	208	20.9%
A health care organization, including hospitals	206	20.7%
A continuum of care, including homeless service providers	34	3.4%
Higher education institution (e.g., A college or university)	27	2.7%
Health services plan, including Medi-Cal Managed Care Plans (MCPs)	27	2.7%
Emergency medical services	26	2.6%
Local education (e.g., School or school district)	17	1.7%
Early childhood (e.g., Daycare, First 5)	15	1.5%
A veteran's organization (e.g., Veterans Affairs)	11	1.1%
County social services and child welfare	10	1.0%
Public safety, including county juvenile agencies	10	1.0%
A labor representative organization	9	0.9%
Disability Insurer (a commercial disability insurer that covers hospital, medical, or surgical benefits)	3	0.3%
An area agency on aging	3	0.3%
Tribal and Indian Health Program Designees	3	0.3%
Golden Gate Regional Center	1	0.1%
An independent living center	0	0%

19. Is there anything else you would like to share about mental health and substance use services in San Francisco? For example, what has worked well, what improvements would make the biggest difference, etc.?

For full list of responses, see Appendix G.

Appendix A

How much do you agree/disagree with the following statement: In San Francisco, mental health services are readily available for anyone who needs them? (Strongly Agree, Agree, Neutral, Disagree or Strongly Disagree)

If you responded Disagree or Strongly Disagree, please provide an explanation below. Please include any suggestions for improvement, such as offering services in my language, ensuring care providers are culturally responsive, etc.

- Maybe more mental health services in the Bayview Area
- I've heard from SF residents and potential clients who were not aware of the culturally congruent services for African Americans. More outreach within the program needs to happen.
- Limited bilingual providers, especially ones with an understanding of the culture; different cultures have different approaches and taboos around mental health so recognizing how to work with the specific communities can be lacking . Especially for smaller communities (e.g., Khmer speaking, Russian speaking) etc... - PES is one of the city's emergency service, but the facility itself is really run down; not ideal for folks who are already having a crisis - Really appreciate the addition of mobile crisis unit in the city!!
- ..."for anyone who CAN AFFORD THEM"... even with insurance, some plans do not cover mental health OR only cover limited amounts. Our most marginalized people and communities have a very difficult time finding affordable OR available mental health services when their work schedules can accommodate.
- Very limited services in other languages than English, especially residential services. E.g., there are no (or very few, if any) SUD residential programs available to clients speaking any Asian languages, including Chinese. 2. Not enough prescribers that leads to long-wait to see a psychiatrist or psych NP. 3. Therapy/counseling skills & tools are not standardized. LCSW/MFT/LPCC's skills vary significantly.
- a lot
- a lot of short term services. Not enough long term care facilities. ICM waitlists are really long. Really hard to get initial appointment if you do drop in for a mental health clinic.
- A public accessible central call center and satellite stations and mobile vans dedicated to mental health service would be a good starting point for health providers and the general public. Ideally this special mental health call center will be staffed with mental health nurses who have been trained to be culturally sensitive and are multilingual. These on-call nurse dispatchers will direct or triage the calls to the needed mental health staff to respond to patients or persons living on the streets who are experiencing mental health crisis.
- access is limited, gatekept, and almost impossible to navigate for those going through crisis
- Access is not available to the most vulnerable populations, and they are not trustworthy
- Access to prescribing psychiatrist is difficult. Access to therapy is also difficult.
- Access to psychiatry for medication management; Need more crisis stabilization/crisis residential; truly integrated co-occurring services.
- Accessing mental health services can be challenging mostly from a payment point of view. That is, if someone needs to be "diagnosed" before they can have formal "treatment" then that can talk a long time. There is also great stigma with having a "mental health issue".
- Accessing mental-health services can be complex and difficult to navigate. Often, connection to care happens only when someone is visibly in crisis and engaged through a community-based organization doing street navigation-level outreach. This means there is a large unseen population of individuals who are in distress, but not acutely so, and who lack clear pathways to help. We need widely available, clearly publicized channels for all San Franciscans to access

mental-health services, especially those who are experiencing emerging distress but have not yet reached a point of breakdown.

- Active recruitment by street teams to homeless population
- Acute sexual assault survivors in San Francisco do not have access to professional bedside advocacy or mental health support when seeking medical and forensic care at ZSFG after hours or on weekends. While medical and forensic services are available 24/7 through a team of specialized physician assistants and nurse practitioners, the Trauma Recovery Center's bedside mental health support is only available Monday - Friday, 8 AM to 4 PM â€" which is just 23.8% of the total hours in a week. This means that more than three-quarters of survivors (76.2%) who come for care outside of business hours do so without any trained advocate or mental health clinician present, at a time when they are most vulnerable, frightened, and in need of trauma-informed support. The lack of 24/7 advocacy creates inequities in access, undermines trauma recovery, and increases the risk of retraumatization.
- adult and child psychiatrist shortage - ongoing
- all of this is purely anecdotal but the number of people i see in my clinic every day that need mental help and are either stuck in referral hell or just cant get some one feels so over whelming and i feel the system it strained to take on all it has and more is still expected of it.
- All the suggestions above plus, because of the homelessness crisis in San Francisco, there is a huge need for mental services and there's too many steps for a person to finally get some help or an appointment wit a provider. Mental health services should be more available, maybe more crisis centers where people can get evaluated and then referred to the right level of care.
- All you have to do is walk the streets and see that mental health services are inadequate.
- Although mental health services offered in SF are great there are not enough providers and clients can end up waiting for a month or more for an appointment. And this is after having to wait sometimes a month for an intake.
- Although the city offers many programs and resources, access to these services is not as easy as it appears. Long wait times, high costs, and limited availability of qualified professionals often make it difficult for people to get timely help. In addition, many individuals experiencing homelessness or living in low-income neighborhoods struggle to navigate the complex system or meet eligibility requirements. Therefore, while resources exist, they are not truly accessible to everyone who needs them.
- Anyone who works in the system knows that services are not available for those that need them
- As a behavioral health clinician, I can confirm: the primary care BH model is structurally incompatible with actual healing. 30-minute appointment caps prioritize billing over clinical standards and systematically fail neurodivergent clients, trauma survivors, and anyone needing relational depth. Our model isn't "trauma-informed" - it's trauma-producing. We're asked to do impossible work in insufficient time, which guarantees inadequate care and burnout for providers. Improvement requires: extending appointment times (45-60 min minimum for trauma/ND work), removing rigid time pressure, training providers in neurodivergent-affirming and trauma-informed modalities, and decoupling care quality from revenue targets. Until the system stops optimizing for billing cycles, 'readily available' services will remain inaccessible to those who need them most.
- As a CCSF employee, I have tried twice to receive mental health services through EAP. Both times, I was told I could get a call back and didn't. Once, I received an apology saying that my case was mistakenly ignored. If someone was in a crisis, I wouldn't know where to refer them.
- As a crisis worker, there needs a system in place to ensure clients are linked to services. There needs to be an expansion of services to include crisis service providers or OCC to follow to

ensure linkage and follow up.

- As a provider at the ZSFG PES, I think that 24-hour social work services for psychiatric crises are essential, but our PES Citywide social workers are only present during the daytime. Of course, it all comes down to budgeting/money, but if the PES at Contra Costa Regional Medical Center can provide 24-hr social workers (who are paired one-to-one with psychiatric providers and work as a team to reach out to collateral, refer patients to services/hospitalization (taking this work off the RNs' plates so they can focus on patient and staff safety), and begin dispo planning during overnight hours so patients can be discharged/transferred promptly and reduce the number of patient's exceeding the <24-hr acuity focus of the PES unit.
- As a provider, I have seen barriers (language, cultural, wait times, accessibility [e.g., outreach needed or services only during the daytime/weekdays when people who need them must work and cannot take time off]) that prevent mental health services from being "readily available for anyone who needs them".
- As an Intensive Case Manager on a team delivering the highest level of care (Stabilization) navigating this system of care for 5 years, my clients and I run into "wrong doors" daily. There are rarely any beds available for PES and psychiatric inpatient settings. Drug treatment programs are often full or are not willing to take people for a number of reasons (the client has had an assault in the distance past, they are not addicted to stimulants, they are not able to access some non congregate sites for shelter unless they are on an opiate antagonist. This is not a housing first system of care right now. I place a lot of 5150s and more often than not my clients are seen by psych and discharged while still gravely disabled. Hospital workers have told me that they are being forced to discharge people ASAP.
- Aside from crisis services, people seeking MH services need to go through many hoops to access them, which oftentimes represents delays and/or inhibits access.
- Aside from EAP, which is a limited option for support, there are very little services available or accessible to staff, particularly Black CCSF staff who experience trauma in the workplace.
- Barriers at clinics - not enough drop ins
- Barriers that I witness: backlogs via OCC and clinics having availability. You must have a specific type of insurance to receive services. There aren't enough Spanish speaking clinicians.
- Based on my personal experience, it has been very hard to find a therapist or doctor who can see you if you are not extremely at risk. It seems like services are prioritized to people experiencing homelessness or drug addiction but there is not enough to help people not in this category. Helping both of my elderly parents access mental health services has been far more difficult and not as intuitive as the services available to the drug addicted population.
- Because of the shortage of therapist and phycologist the demand is too great.
- Being able to more effectively reach unhoused populations.
- But the mentally disabled people or homeless people probably can't take advantage of it.
- Capacity & bed shortages: Although the city has about 2,551 behavioral-health residential beds including for mental-health and substance-use, analysis shows there is still a shortfall of around 200 beds (and likely more when you factor wait-times, staffing, specialization). Wait-lists / availability of specialized services: Anecdotally (via community posts) some people report difficulty finding in-person therapists who accept their insurance; waitlists can be long, especially for psychiatrists. Some community members say that for Medi-Cal or other public insurance the options are few or providers reluctant: Language/cultural competency still a work-in-progress: Although the official services say language access is available, in practice for many communities (e.g., immigrants, non-English speakers, people who use drugs, people with overlapping substance use + mental health conditions) cultural responsiveness and trust may

still be insufficient. Integration with harm-reduction/substance-use services: Given my work in harm reduction, an important gap is how well mental health services integrate with substance-use harm-reduction programs (e.g., overdose prevention, syringe services, fentanyl test strips). SFâ€™s programs do include substance-use & mental-health combined services, but it may not fully cover client-centered, low-threshold harm-reduction settings. For example, the Access center includes on-site harm reduction (naloxone, test strips) for some clients. Stigma, trust, accessibility: For populations who are vulnerable (including people who use drugs, those with unstable housing, isolation, etc), getting through the referral system and feeling safe/accepted is still a major barrier.

- Care for mental health, low threshold drop in mh support groups (that welcome people who use drugs) individual therapy and psychiatry services are appointment based. Very difficult for folks on the street to make it to an appt 3 weeks out.
- Children with disabilities, especially autism spectrum disorder or behavioral disorders, are in need of mental health support and there are very few if any mental health providers comfortable with providing care to these children AND to their family members who have particular challenges specific to the care of their complex children. There are also an inadequate number of mental health providers that are black, speak fluent spanish, speak fluent cantonese, or look like the populations most vulnerable to behavioral health challenges in the city. Teens and young adults with physical, behavioral, developmental, intellectual disability need behavioral health providers familiar with their conditions and the challenges they experience....PLEASE CONNECT WITH THE ORGANIZATION "Support for Families of Children with Disabilities" in order to better understand the needs and the lack of behavioral health capacity in the city. Finally, behavioralists providing support in medical and dental settings would make dental and medical care possible for many youth with autism/behavioral challenges....when, currently many of these youth are not receiving needed dental or medical care....further complicating their complex lives.
- City outreach programs cannot possibly help all in need as many in need refuse help. The city outreach programs net never casts as far as needed just because the need is so great.
- Client's receive subpar services. Only able to see clinicians once every 2-3 weeks at DPH clinics. If people need higher level of care there are very little options. Too many people in the streets with severe mental illness, facing homelessness, very vulnerable. Not enough inpatient hospital beds.
- Clinicians can only meet every two weeks and there is a wait to get on the list.
- Consistent psychotherapy services aren't offered. Linkage to CBOs is no longer available. Services promised by SFDPH and CBO orgs are no longer available. Client's often report that service providers don't follow up or complete work necessary for housing, food, in-home medical recovery, employment, or SSDI benefits. Clients report that providers do not understand or have compassion for HIV, Gender Health issues, or substance use support needs.
- Cost of treatment is high and full reimbursement is not guaranteed.
- costly not enough appointments/resources
- Culturally affirming support for alternative cultures than white dominant practices. Offering culteural specific circles that adddress spiritual actions and practices. City has too many barriers to get support
- Depends on type of insurance and severity of symptoms.
- Difficult to be seen once a referral specialty mental health has been made.
- Difficult to get connected to therapy and specialty mental health care. Very limited options for those with Healthy Workers insurance.

- Difficulty finding a provider, finding a provider in network, finding a provider who is affordable, finding a provider for children. Lack of providers in general, and especially providers who speak languages other than English and/or who are Black.
- Disagree based on second-hand knowledge / reading the news.
- Distribute pamphlets to each resident of San Francisco and promote this initiative through radio and television advertisements in a variety of languages.
- Doing community work, we hear and see constantly that there are not enough spaces for folks seeking treatment, or the right kind of services available to meet the need. I would say that includes in PSH, where additional money for supportive services is at the appropriate levels to meet the actual need.
- DPH mental health clinics seem to only be available to the people with highest acuity, leaving lower acuity patients to a contracted-out company that only offers virtual services.
- Emergency services are available, but very limited connection to outpatient psychiatrists and therapists, especially for patients on public insurance. Even fewer options for patient who do not speak English.
- Employees within DPH can't always get adequate mental health care and support for themselves, through their insurance or otherwise, much less for anyone who is not insured. How can DPH employees help others with complex mental health care needs, when DPH workers can't find mental health services for themselves at times when it's needed. There seems to be a serious lack of qualified mental health providers in the community, and insurance coverage is very limited if you are so lucky as to have private insurance that offers a few sessions with a counselor or social worker. This example isn't even touching on the issue of the many DPH clients who need mental health/behavioral health services but have too many other barriers for accessing mental health services. I believe Mental Health/Behavioral services (although valued) isn't funded adequately nor is there adequate infrastructure available to increase opportunities for clients to access the services. If the City cannot ensure that the basic needs of needy residents are met (food, transportation, housing), how can the mental health of these residents be addressed. Housing the homeless, providing appropriate and comprehensive residential facilities for those in the community who already suffer mental health challenges and debilitating drug dependency issues, seems like a crucial part in improving the overall behavioral health and well-being of this City for all of its residents. I'm not opposed to bringing back Institutional types of facilities or communities where affected individuals can live and be assured that they have the appropriate care and services that are needed in a safe and caring environment, at least until adequate recovery is made to allow them to leave and live in other appropriate and supportive environments that is based on their individual needs. The way it is now, with everyone fending for themselves in this dog-eat-dog world, is not working for anyone and is not acceptable in a civilized society.
- Ensuring their are physical locations for people who need escalated support
- Even as an employee of DPH, because I do not work for BHS I have very little knowledge of the mental health services that are available to residents and who is eligible. I don't even know where to direct folks to learn more.
- Even if mental health services in English were available as needed, mental health services in home languages are very scare, especially in getting professional therapy. The coverage in this last respect is also uneven. Larger populations such as Spanish, Chinese, Filipino, Vietnamese do have some native speakers trained to help. But smaller groups such as Laotian and Khmer don't. The telephone or internet accessed interpreters used for such groups are simply untrained and lacking in the nuances needed to persuade clients to participate. There is also a failure among

mental health professionals to utilize traditional practices such as meditation etc.

- Everyone knows that services are weak in different areas of the City. There are not enough clinicians or programs targeted to those who need it most
- Everyone has to go to BHAC, and I it is painful to access. The phone tree when you call is slow, and the people triaging seem lightly trained "You need more points to get x, anything else you can think of in your history?" I have had patients who because they don't use the ER all the time, just get a list of providers via Clardendon (not sure on spelling). I have had patients call all those numbers and literally none of them are taking new patients. Also, I sent referrals in Epic, stating a patient is a high risk youth, has no phone, is going to the ER often, and then I see in the referral "called three times, no response, closing the referral." Even though my referral states no phone! I feel for patients who no phone, BHAC really fails them. I know there is the in-person option, but I have also had patients go in-person and then get turned away as there is no provider that day. We need this to be way more low-barrier. It needs to work for people who don't have phones. It needs to be more than a list of providers to call. It feels like a lot of check boxes are getting checked, and no care is happening, to be frank.
- Families we have served have experienced delays in mental health services for children and youth with disabilities. Seems like there's a lack to be able to provide culturally concordant care.
- Folks who are uninsured and or who don't have access to their parents insurance often have trouble finding MH services. Services are offered in limited languages. Gender expansive/supportive resources are not retally available.
- For adults, it can be difficult to get psychotherapy, and the system can be difficult to navigate.
- For clients, there are many amazing free or low cost services available in the city but they often have waitlists, specific eligibility requirements (age, income, etc), are temporary/time bound, are based on continued client engagement, are difficult to access (in person or virtual), etc. which can make it difficult for folks to find care and continue with care. For folks on private insurance, there are often huge waitlists and a lack of providers (I'm thinking of my own experience with Kaiser through my employer, where I have not been able to access mental health services for months), leaving a huge gap for folks on the ground doing the work to access mental health services to support them in this work and help with vicarious trauma, burnout, etc.
- For many, wait times to see a mental clinician are lengthy due to large caseloads. We need more clinicians (e.g. case managers, therapists)
- For Medi-Cal members, they might have to wait several months for an intake. For privately-insured residents, they likely do not have access to many MH services.
- For our patients with the highest need/acuity, they are met with several barriers to getting long-term stable behavioral health support. While there is no wrong door to access services, limitations on how services can be delivered and waitlists at specialty mental health clinics mean that patients can go weeks or even months without the care they need and deserve.
- For SMI, jail is the biggest provider. The message is that this people are dispensable.
- For those without a PCP or proper healthcare it is extremely hard to find quality care
- From My experine people have to have Medi-Cal to have services
- From what I've heard from community members and from what I've seen, it seems like there needs to be greater availability of services (extended hours, more languages and cultural relevant care), greater safety for providers to provide services, and greater efforts to destigmatize getting care.
- Generally, mental health services are very hard to find and impossible for many people to afford.

Appendix A

- Get drug user and sellers of the street. Enforce the current laws
- Getting access seems difficult due to insurance and provider availability.
- had myself and many clients needing access at a whim and was very difficult to find mental health provider in a crisis situation. in these situations, it's very hard to advocate for oneself so very difficult and daunting
- Hard to find therapists
- have supervisors make you feel comfortable when asking to leave early to attend therapy
- Health systems are difficult navigate, and may have mental health services available but there are long wait times to get an appointment or services that are available are not covered by insurance
- Huge barriers accessing services - long term mental health support is practically inaccessible for most patient who are impacted by their symptoms. From the process of going through the intake, to waiting months to get connected, all while primary care clinics are supposed to have same day mental health access but are not allowed to support patients long term. People get lost in transition, during long wait times, and overall get frustrated and quit trying.
- I knew of some patients in clinic who needed urgent or same-day visit with a mental health specialist but there was no such specialist available.
- I agree as long as we have cultural congruent services. Unfortunately, we do not have a lot black men clinicians providing therapy services for our young men and women.
- I agree that mental health services are available, however, there needs to be more affordable mental health resources available for the low income population. There's usually a long waiting list and the low income population I serve are usually unaware on how to get connected. If there was more marketing on how to get connected and how long a person has to wait, it might encourage them to keep trying even if it takes a little bit longer to get connected.
- I am constantly asked what pathways people can take to get a case manager as that information is not readily available. Additionally most services have a significant waiting list/waiting time.
- I am not sure of walk in services for counseling. Crisis services definitely, but with waitlists being so long, it would be nice to have drop in counseling hours for people who are feeling overwhelmed, need to vent etc. I think this would help people engage in care.
- I am not sure on this question.
- I am under the impression that you need money, an abundance of time, and personal connections to get any sort of good mental health care. I am connected to many outlets, have personal and professional relationships with many health care workers/providers, and am covered by insurance. I have had a difficult time accessing good mental health care for myself, so I can imagine it is an extreme barrier for those living without this abundance of resources.
- I believe the services are available but barriers to access are plenty due to language barriers, lack of outreach from some services, and difficulty with consistently for the clients.
- I cannot speak for my own experiences, but ICM placements are hard to make.
- I disagree because while there are mental health services in San Francisco, they are not always readily accessible. Long wait times, difficulty navigating the system, and financial or insurance barriers make it harder for many people to get the help they need. Additionally, some services may not be available in different languages or may not be culturally responsive to the needs of diverse communities, which can create additional barriers. To improve this, I suggest expanding access to mental health care by increasing funding and support for existing services, offering more multilingual options, and ensuring that care providers are trained to be culturally competent. There should also be more efforts to streamline the process of connecting individuals to services, so that people don’t face delays or frustration when seeking help

- I do not know how to access mental health resources.
- I don't actually know, but given the number of struggling people I see, it makes me think there isn't enough support or it is not reaching people
- I don't know for certain but it seems like we would see less ill people on the street if there were sufficient services available
- I don't see this readily available if I needed to. I don't know where to start.
- I don't think all San Franciscans know how to access mental health. It's not an easy process at times and especially for those without family/community support and speak different languages. For those who are not familiar with the system, they are unsure if mental health services are only for those with severe mental health issues, require payment, or near their neighborhood for easy access.
- i don't think there is awareness about what is available to people.
- i dont think that you can reach everyone with emails, commercials or word of mouth. usually the most needed care, doesn't reach the most vulnerable people, or they dont know how to reach out themselves . The city directories are huge with do many departments. There has to be more outreach to those in need who may not want to ask for help.
- I feel like there is ample access to crisis/emergency services for people with high acuity needs, but getting connecting to longitudinal psychiatry care is not so easy. The referral/appt system that grants people access to SFDPH MH clinics is too high barrier, making it inaccessible to people who need it most, who may not be able to track an appt for instance.
- I feel that if there is a person in crisis mode I have often seen police detain them spread their belongings all across the sidewalk I feel that if there was a way it could be a 24 hours rapid response team thats are community people who know how to deal with mental health issues and not someone with no knowledge on how to handle folks in crisis respond to things instead of police. find out who's doing the work in the community and bring us together to make a action plan .
- I feel that we are in a reactive, crisis response approach to mental health services. Suggestions for improvement include expanding the available inpatient psychiatric beds and ADUs, and case managers and exploring more frequent REISE/conservatorship/and legally mandated treatment to include mandated stays in mental health facilities/housing and medications. Too much emphasis on individual autonomy leaves too many people who are by and large not able to make sound decisions to protect themselves from [unintentional] self harm- and too many of these folks end up in harm's way- both low level (degraded behavior and loss of dignity, contributing to societal/civil collapse) and high grade (through hospitalizations, overdose, illness and injury). I have witnessed several psychiatric holds be dropped in less than ideal circumstances due to lack of bed availability- and while these folks are not currently suicidal nor homicidal they are still at grave disability and unable to care for themselves in a sustained manner on their own.
- I feel there are some great services out there but still think that they aren't as easily accessible
- I grew up in San Francisco and can attest to the continual decline of street conditions and perceived mental instability amongst the most vulnerable populations of San Franciscans. If I were to live in the neighborhood that I grew up in (Mission District near 16th Mission Bart), I would be truly devastated. Driving through these areas makes me incredibly disheartened. The visible and drastic discrepancy between extreme wealth and poverty is alarming. The fact that people seem "normalized" to people in distress and oftentimes ignore people strewed out on sidewalks and engaging in drugs is concerning.
- I have a friend who needed to access mental health services quickly and she has Kaiser

insurance. Kaiser could not find one of their own mental health clinicians to accommodate the time she could access services, so she was not able to receive therapy. So I suggested that she access mental health care through one of DPH: BHS, BHSA funded programs. Because she had Kaiser insurance, the programs would not allow her to access one of their therapists. So she was turned down by both Kaiser and SFDPH BHS/BHSA.

- I have experience working with justice involved individuals and often referred clients to community based mental health services. Most situations ended where the client would have to wait at least 2 weeks for an appointment depending on where they went and how they triaged. Not enough services in SF and there are not enough street teams in SF for mental health services for other languages.
- I have had patients tell me that they have trouble finding a therapist.
- I have health insurance and can seek mental health services, but there are a lot of residents who don't know these types of services are available nor where to go.
- I have homeless patients in desperate need for MH and BH services and there just isnt enough in a low-barrier drop-in clinic.
- I have personally encountered people, insured and underinsured, who have been unable to find a therapist who: 1) speaks their language/understands their culture, 2) is affordable and/or 3) covered under their insurance. As a primary care physician, I have often felt that I am their defacto BH clinician because there is NO ONE ELSE. This did not happen when I was practiced in another state.
- I have waited for months to be connected with a prescribing psychiatrist and I still have not been. Kaiser is absolute trash.
- I haven't had to access the cities resources, but I wouldn't say it's immediately obvious how to find them
- I hear consistent community feedback that mental health services are either not available or are very challenging to access. I can confirm this from personal experience as well.
- I know of PES (who is not helpful), doesn't return calls for coordinated care and discharge for clients. Terrible discharge planning, limited crisis residential options. Balls dropped, no psych emergency response team in the city, poor triage. Poor follow through with Mission Mental Health and SOMA clinics. Impossible for clients to get seen. Positive: psych case management through UCSF ED cm and Felton are wonderful.
- I really don't know what the experience is like for someone without financial ability to access mental health services.
- I see crazy people on the streets all the time. There is not availability because the system is overwhelmed.
- I see dozens of people on the streets everyday needing urgent mental health care and not getting it
- I see people in the streets all the time that need services and don't get them
- I see people on the street every day who are in dire need of mental health services. I'm sure these services exist and are probably abundant, but connection to people in need is often missing.
- I strongly disagree with the statement that mental health services in San Francisco are readily available for anyone who needs them. While the infrastructure for care exists, it does not operate equitably or safely for Black residents. The pervasive presence of racism and racial bias within San Francisco's mental health system undermines trust, clinical accuracy, and therapeutic safety for Black people. Black residents are disproportionately misdiagnosed, over-pathologized, and misprescribed medication. These outcomes reflect not individual prejudice alone but

systemic and cultural racism embedded throughout clinical training, assessment tools, and service delivery. To create a system that truly serves everyone, San Francisco must move beyond the performative implicit bias workshops that dominate institutional responses. What is urgently needed are in-person, scenario-based clinical skill-building trainings designed and led by professionals with deep expertise in racism, racial bias, and antiracist clinical practice. These sessions should equip clinicians with practical skills for identifying racialized patterns in diagnosis, documentation, and treatment decisions particularly those impacting Black and Brown clients. Additionally, internal accountability structures must be established, including regular team meetings specifically focused on reviewing how Black and Brown clients' caseloads are being managed, discussed, and supported. Supervisors and department leads should track racial patterns in referrals, medication practices, and treatment outcomes, and make these findings transparent to the public. Only by embedding antiracist accountability into the structure of care - not just the language of equity - can San Francisco claim to offer mental health services that are truly accessible and safe for everyone.

- I think mental health services are available, but getting the right level of care to people is extremely difficult. There are not enough levels of care to accommodate the wide range of mental health needs in this city, including outpatient, ICM, residential, and inpatient.
- I think services are available but if there aren't enough services to meet the needs of the growing population of folks who need support then it's not really all that accessible. There are waitlists everywhere. And the justice system is funneling serious offenders into mental health programs that weren't designed to support that population. We need programs that are designed for the justice involved and seriously mentally ill population because otherwise our programs for just seriously mentally ill or substance use are going to continue to be filled. Staff are going to continually cycle through because the population is more than what they are prepared (or trained) to handle. Service will continue to be disjointed and slow.
- I think the safety net is doing a good job making services available for very mentally ill people. I don't feel confident that insured people with moderate needs can get help.
- I think there is a disparity in patients accessing MH care who are experiencing homelessness and do not have a phone and wonder if a more low barrier model could be helpful for these patients. I think it is challenging for them to do two phone intakes and then also be scheduled for an additional 2 intake visits at the clinic itself and wonder if there could be something more streamlined, such as being able to do the full screening in one visit/phone call at BHAC.
- I think we are lacking in mental health services especially for unhoused or low income individuals, just based on the sheer numbers of folks and lack of resources that at least I am aware of.
- I think we offer a wide range of services, but many aren't easily accessible because there's limited awareness about what's available. I'd love to see a comprehensive directory of our services that also includes clear information on how to make referrals and access each resource.
- I understand there are places, but sometimes when you call the services, they are full or do not have appointments for months.
- I was in search of some mental health services for myself, and there was no mental health clinicians at any health center I went to at the time.
- I work at city and county of San Francisco, and I had a baby recently. I was experiencing really bad postpartum and asked for accommodation to work from home. But I was jumping through hoops with HR and my direct supervisor to the point I had a nervous breakdown and became depressed. It would be nice if management would help support your staff so they can also function properly at work. If you're struggling at home, it affects work as well.

- I work at ZSFGH and it is challenging to get patients in hospital and in community care in their area and their languages.
- I work for SFDPH. Despite all the money and effort that's gone into integrating and expanding behavioral health access and services...it's just not there. People need long term therapy, and psychiatrists, and they are difficult to access.
- I work in the acute mental health system and there is a huge backlog in bed availability for patients that are ready to discharge from the acute hospital and yet are not able to go to a lower level of care due to the lack of beds available. There are systemic barriers, including lack of ADA placements for patients who have both physical disabilities as well as mental health barriers, the conservatorship system that takes too long, overwhelmed conservators and case managers in the community and a system of sub-acute placements (both locked and unlocked) that can pick and choose who they accept into their limited beds, with staffing ratios that cannot care adequately for the most vulnerable and acute patients, many of which also have language / cognitive barriers, which results in patients being stuck in the hospital for months on end.
- I work in the City. I have never thought to access the mentally ill. I believe we all are in survival mode.. all over the world. The stress of survival exist in all our spaces. So therefore, we all are moving a little different than the 70's.
- I work in the ER at ZSFG and I can see many individuals daily with unmet mental health needs, including those who are unhoused and/or for whom English is not their primary language.
- I work with hundreds of people who report not being able to access the mental health services they need
- I work with kids with disabilities and it is not easy for them to find services, especially if needed in a timely manner.
- I work with previously homeless population in PSH where there is a lot of SMI. While the new BHAC allows for a drop-in for assessment and referral to community mental health, the barriers to services remain high with cumbersome intakes, appointment model
- I work with Transgender/nonbinary (TGD) patient population there is a lack of culturally competent providers that are available to Tx the unique needs of TGD patients in our system. Often patients have limited chooses, are matched with providers that do not understand gender dysphoria, and language barriers for our spanish speaking trans pts we have 40% of our panel.
- I would have no idea how to point someone toward services. What do you tell someone living on the street? I am acquainted with many un-housed people because I hand out water and fruit to those standing by the side of the street asking for help. Not once have I known how to tell someone to seek services. I would assume that the navigation center under the freeway would be a starting point for the unhoused, but for those of us who are not un-housed, I wouldn't know where to start to find services. I guess I could call 311 or 988, but if I, a high-functioning adult, don't know where to look to find mental health services, how would someone with less functional capacity figure it out?
- I would say the City has an influx of persons with mental health and just not enough resources such as clinics, Therapist, psychiatrist, language capacity, Intensive Case Management Services, onsite medication distribution, Primary care/wrap around health services. Number two It takes too long for BHAC to filter folks into necessary services.
- I'm not sure what "readily available" means in this context. Immediately? Same day? Within a week? In the experience of my clients (low or no income, of marginalized background, often co-occurring SUD and MH issues), accessing mental health services can be challenging and full of barriers like making multiple phone calls/points of contact to get to a referral or intake, lengthy intake packets, and inadequate services when there is a low enough barrier to entry to actually

access them in an immediate time frame. My suggestion would be for treatment providers to provide better instruction and expectation when it comes to timing of care so that clients know what to expect and can hopefully stay engaged throughout the process.

- I've known many low income people and people with substance use issues who can't access services well in crisis situations or in a timely realistic manner when unhoused.
- If the statement were true, we wouldn't see anyone on the street having a mental health crisis. Perhaps it's worth looking to see how other counties manage it so well.
- If you are uninsured or get picked up by the Street Crisis Team, it's easy to get mental health services. If you have insurance and therefore need to go through your insurance provider, there are many barriers put up by the provider to accessing services, especially with Kaiser, which is why I switched to Blue-Shield, which is still hard to get connected to services with.
- If you have insurance the wait list is months behind and if you don't meet their criteria they will not even refer you to a therapist even though you are asking for help.
- Impossible to connect patients to Bh services No integration
- In an Acute emergency setting- pts who meet criteria for SI/HI a lot of the time- can’t be evaluated for PES in a reasonable timeframe bc PES is usually full.
- In my community you do not know where to find support groups unless you are connected to medi-cal services. But outside of that if you have a need for support, you will be turned away. The point of service is to help people but if they can not pay the HIGH cost of support they are left in the streets.
- In my experience, even though we have insurance, it very difficult to find an appt. I have to be placed on a wait list. Patients can't wait long, maybe make appt more reachable and affordable .
- In my role as an NP for the hospital I have interacted many times with people with mental health services needs, from short term needs after an incident, to long-term needs for severe mental illness. There is a lack of availability of language-concordant, culturally competent services that are accessible for our patients.
- In order to have an opportunity to see a Behavioral Health Clinician you have to have a Primary Care provider. Its very difficult to get a Primary Care appointment especially in a short turn around.
- In SF, unless you can pay out of pocket for very expensive private pay services, you are out of luck. Medi-Cal recipients are screened out, not into services.
- In theory only is Mental Health Services is readily available. For many people of color there are very present barriers, or emotionally exclusionary factors. There are limited people of color that in fact understand the nuances that are present in such said communities, that create racial barriers such as the African American/Black or Asian, and Latin X communities, that could be better addressed by people who live, look or experience life in the same manner because of race.
- Insurance treats mental health needs as completely separate than physical health needs. It take too long to get in to mental health care and it leaves too many people without mental healthcare. For people who can pay out of pocket they have easy convenience of telehealth almost whenever they want. This creates a disparity in who and how people access care. Additionally, mental health providers commonly create rigid boundaries in what care they will or will not provide. For example, some providers will not assess for adult ADHD or treat people with substance use.
- Is people who are not benefit from this services just because they not in an institution where they can acquire this services i.e the homeless population
- It depends on who is asking for the services. If you are middle class with a decent income, our

health services we pay for are not up to par. One can wait up to 6 months just to meet with a therapist.

- It depends on your socio-economic status. If you have medica coverage and if you understand how to access services
- It is confusing how to access services, with different insurance plans having different access points. For Medi- Cal, the bifurcated system is bad for patients
- It is difficult for people with mental health symptoms to get into treatment due to the complex system of referrals needed to establish care with a city clinic.
- It is hard to find someone that is qualified, has openings in their schedule and is a match. Not to mention the fact that many have you pay out of pocket and then submit to insurance. If you are uninsured it is so much harder
- It is incredibly hard to get a mental health therapist in San Francsico, and the wait list is long. People need mental health therapy more than ever now because of all the stress.
- It is near impossible to get care for people with severe mental health disorders, especially if they are also experiencing homelessness or have SUD.
- it is not from the providers but from the bureaucracy of SFDPH
- It is very challenging for patients to be approved for mental health care, many services require tech savvy users, so not helpful for many of the clients we serve. Very limited in-person services available. Seems that behavioral health often addresses more case management needs than mental health issues which is confusing.
- It is very hard for my patients who are depressed or severely anxious to get access to a therapist. Also, it is very hard for people who don't have phones because they'll need to schedule an appointment.
- It relies on phone to conduct screening for services through BHAL, even when client comes to the clinic asking for service. Unless it's crisis, client would need to wait for the screening call from a worker they don't know. Since the screen is on the phone and they have to answer questions from a stranger, they sometimes underreport their impairments/ symptoms.
- It seems like changes in how clients enter the system are getting bottlenecked, and culturally focused clinics are not being used for their specialized knowledge, but are getting all types of clients that may be served at other clinics.
- It seems that there is a shortage of mental health providers.
- It takes a long time sometimes for people to access services, and when they get access to services sometimes it's not for as long as they would desire.
- It takes many moons to be connected with metal health services
- It takes too long to get mental health support. Thank god for HRTC . If you’re not youth good luck
- It's hard to say a blanket statement like that. I think there are mental health services available for some, but not all people. I don't think the are readily available either. There are many various hoops to jump through to take advantage of the services available.
- It's really hard to find a mental health provider, especially a psychiatrist, who accepts Medi-cal. I am a social worker and I come across many challenges in this area. I and my daughter are Kaiser members, and we've had to go outside of Kaiser to get therapists, due to the poor availability of therapists thru Kaiser
- It’s not readily clear how to connect somebody to outpatient mental health care, there is an over reliance on emergency/crisis services and not enough access to long term case management or longitudinal mental health professionals.
- its a little easier to get outpatient treatment but inpatient treatment extremely hard to get into.

- Lack of providers and long wait times
- lack of psychologists and psychiatrists in general and most are not affordable for many people
- Linkage to mental health services can take an extremely long time. Work on having a more streamline process with less paperwork that may expedite the process. Possibly, ask CBOs to reserve 2-3 clinicians to reach out to individuals within 3 days to offer at least 10 sessions until a person can be linked to a more permanent clinician. For clients with severe mental illness go back to a Sydney Lamb style of referral where one person received the referral, real tracking of the number of openings available at each ICM clinic, observe the requested clinic on the referral form and if possible assign client that clinic or another with an opening. In doing this process, as done in the past, there should be some consideration of the clinic closes to their resident. If unhoused, then the clinic that has an opening.
- long delays in getting patients with long term or higher complexity needs specialty mental health services (i.e., through ACCESS) outside of acute needs. having a tiered prioritization system with clear expectations on when patients should be seen would be helpful.
- Long wait list, lack of continuity and follow up. Long wait times even for crisis intervention hotlines.
- Long wait times to get connected with services. Service providers are already at capacity and not able to meet regularly. Most people are seen monthly which is not effective, a best practice would be weekly services.
- long wait times, especially for non-English speakers longer wait times to transfer to a new provider (for example, if therapist is not a good fit for the client or if therapist has to terminate due to no longer working for the organization)
- long wait times, lack of care providers, and emergency mental health care (so clients don't have to wait weeks for an appointment)
- long waiting lists. prioritization of people with SMI AND SUD over people who "only" have SMI.
- Long waitlists for linguistically responsive providers, especially in the child behavioral health system.
- long waits for spanish speaking families
- Lots of homeless people who are mentally ill don't have access to MH services.
- Lots of people don't have insurance, or their insurance makes accessing MH services extremely difficult, or the quality of the providers is bad, they are very low paid, none of them call you back, they see you for a short time and then quit because they are paid so little. People spend a long time on waitlists. This is all direct experience either personally or professionally since this is my field.
- Many agencies are full or waitlisted. There aren't enough shelters for teens. Spanish language services are limited, full or waitlisted.
- Many individuals continue to face significant barriers to accessing mental health services, including long wait times, limited provider availability, insurance constraints, and gaps in culturally responsive care. To address ongoing barriers to mental health access, SFDPH can continue expanding staffing and telehealth options to reduce wait times, strengthen partnerships with community-based organizations to increase service availability, and enhance culturally responsive care through targeted training and recruitment of bilingual providers. Improving insurance navigation support, offering sliding-scale options, and building integrated care models within primary care clinics will further ensure that residents, particularly those in underserved neighborhoods, receive timely, equitable, and appropriate mental health services.
- many of the unhoused in SF are in need of mental health services, including inpatient, complex case management, stable housing and mandatory involuntary treatment

- Many people who may not realize themselves that they need mental health services are living in the streets. Those that are captured by services are frequently discharged quickly to the streets.
- Many services are still in English, and it's still very difficult to find Chinese-language psychological services.
- Many services have waiting lists for psychiatry services.
- Many unhoused people do not seem to have access to any services, and the City does not seem to have enough resources and outreach efforts to reach these populations. In my neighborhood of Mission Terrace, there are unhoused people here and there, and people begging for money by the balboa bart/Muni station.
- Mental health care for veterans is not 100% covered by the VA (typically because of eligibility issues) who is forced to rely on Community Care providers to plug the gaps in care. This is due largely to insufficient staff to address the need at the local VAMC and partly due to veterans not being eligible for care and partly due to veterans not knowing they are eligible for care and/or hesitance to reach out to get care from (any) provider. The VA does an excellent job of working with local providers to get veterans access to care, but with half of veterans not engaging with the VA in the first place and many not eligible for VA services, local providers are forced to scramble to meet veterans' needs.
- Mental health care, resources and guidance is limited even for those with excellent medical insurance coverage.
- Mental health challenges don't just happen at night. They are 24/7 and there are limited services and support at those hours.
- mental health services are accessible to either homeless people or rich people. Working class people with not a lot of money for copays often times have a very hard time accessing mental health care such as therapy.
- Mental Health services are difficult to obtain if you have no coverage or if you have private insurance coverage. I believe that publicly insured people have the best chance of getting mental health services in SF.
- Mental health services are expensive. Many times you need to get referred to get access to a mental health professional. There is a lot of cultural stigma to seeking mental health services especially for API or other people of color.
- Mental health services are not equipped to respond to the needs of the community, especially the community that speaks Spanish and some indigenous language of Latin America.
- Mental health services are not readily available for working individuals.
- Mental health services are readily available TO MEDI-CAL RECIPIENTS via BHAC. For San Franciscans who don't qualify for Medi-Cal, these services can be much more difficult to obtain.
- Mental health services do not seem to meet patients' needs. If a patient is having a mental health crisis and/or serious mental illness, they may not be able to make it to appointments at a specific date, time, and location.
- Mental health services exist, but are not always readily available. There are long waitlists, and lots of navigation, insurance issues, etc. Sometimes when you get a therapist, there is not a good fit in terms of cultural humility, trust, and rapport. Then, when you finally get some momentum, your 6 months are up and you have to recertify or get kicked off. I have also seen clients really struggle while they wait for services.
- Mental Health Services exist, however there are not sufficient providers (hence not enough appointment slots); language concordance (e.g., not enough Cantonese providers in a city like SF where a large population speaks that language); not all ancillary staff are trained in de-escalation methods.

- Mental health services in any language is difficult to find especially for children. Providers/clinics who take insurance either have an extremely long wait list or not taking new patients.
- Mental health services in SF are limited. There is pretty good access for acutely ill people, e.g. via PES, Dore UC, or through EDs across the City, but what is missing are services for people who are experiencing mild- to moderate symptoms. Those who routinely do not get appropriate early intervention can deteriorate, sometimes via self-medication with substances. When the system is, somewhat understandably, fully geared towards caring for people with advanced mental illness, it is really hard to see a pathway towards sustainable improvement.
- Mental Health Services includes the whole person to fulfill all their needs. There is a shortage of services in the community such as access to State Hospitals without long waits for years for a placement, Locked sub-acute facilities in the community, Board and Cares, and Mental Health Shelters.
- Mental health services is available, not readily available- to anyone who needs them. Long wait times, particularly to those who are non-English speakers.
- MH services are not as easily accessible to young adults/foster youths.
- MH services are there, however there are many people who do not know how to access those services. Many people also do not have the immediate support, sometimes people are actively in crisis, and get the MH services after.
- Mobile mental health and mobile crisis efforts need to increase. The response times are poor. Some people were not engaged by these services at all. Veterans, pregnant women and unhoused youth are in desperate need as well as those in crisis.
- More advertisement in multiple languages, eg on bus stops / buses
- More people are needed who speak the language, but especially professionals who understand the culture. It's not just about speaking Spanish; it's about knowing and validating the patient's culture, one of many points for the healing process and understanding for the patient.
- More providers with easier access to speak to humans to book appts and check in for follow up
- Most mental cases are housed in jail. There's not enough social workers and hospital stabilization is too short. Step downs are very few. When my son excelled in 360 Health Right, he was so called graduated to an SRO in the Tenderloin that would have started the crisis all over again. No physical buildings (prop 1) that support them long term.
- Most places have a conventional, structured and very long intake process which can be a barrier for a person engage in mental health services. An integrated system for mental health and substance is also needed.
- My assessment both living in SF and working for DPH is not all the services are readily available and accessible to all.
- My daughter has a history of mental health issues since she was 11; she's 25 now. It was very difficult to find appropriate services for children. Furthermore, the mental health agencies, providers, and services that accept Medi-Cal are very limited. Also, providers change frequently, and as a parent or service recipient, you have very few options to choose a provider you feel comfortable with. My daughter would sometimes manage to establish a relationship with a provider, only to be replaced a few months later. It created a lot of instability for her.
- my feeling is many people don't know what's available, if it's affordable, if it will really meet their needs (language, culture). I'm a City employee with Kaiser and it's still a real struggle to find a good fit who takes insurance and fits my schedule
- My neighborhood (SoMa) is filled with of people in need of mental health and substance dependence issues. What we are doing is obviously not working.

- My seriously mentally ill son has been kicked out of PES and inpatient SFGH and at other hospitals many times. I believe he has been blacklisted and I have been told to my face that he needs to become homeless and hit bottom so he learns to take his psych meds which by the way have never worked And he is NOT a substance abuser!! SF needs to open the 100 acute inpatient beds that they had at SFGH back in 2007 And they should not send patients to out of county for profit hospitals. Providers must take information from families and not use HIPPA as a weapon
- N/A
- Need for more psychiatric RN's who can engage with the community
- Need for Spanish speaking clinicians and need more clinicians available to low-income people.
- Need more inpatient programs and intensive outpatient
- Need more offering of mental health services to people in distress or suffering mental health diseases
- Need to boost employee moral first and the connection with each other on the team. Lower engagement and synchronicity leads to emotional strain amongst clinicians especially with those holding biases, seniority or disruptive patterns that lead to a toxic, gatekeeping environment. I say this to acknowledge that services are bleak because clinicians don't have the capacity to provide care to those outside when co-workers are another client to therapize.
- Neutral response. Not familiar with what services are available for anyone.
- no poster or ads or radio commercials to advertise resources
- non english speaking clients at a very high disadvantage of being screened out. Behavioral health access line screens out people with severe mental health issues that could not articulate well, whereas people who do not meet criteria and are just needing housing or trying to access secondary gain are able to get services immediately. The mental health screening and screeners are not equipped and doing a poor job asking necessary questions. They just read off of a questionaire taking face value answers when it is clear that this population needs more probing to understand people who may not have insight into their condition. "are you depressed?" "do you have anxiety?" how is that helpful to a non english speaker when they dont understand those terms, or there are no follow up questions? We receive people at the clinic who DO NOT meet criteria for any mental health issues that are scheduled into our appointment calendars for intake. This is ineffective and creates barriers for people who truly need help.
- None
- Not always available or hard to get appt
- not available for our poorest residents, those who don't have insurance coverage, who are on Medical, who are living in SROs or on the streets.
- Not enough access. Not enough awareness. Not enough education provided.
- Not enough availability in a reasonable amount of time; need more services in different languages
- Not enough capacity for the need, too many patients and not enough clinicians.
- Not enough funding for services. Highest property taxes in the country and more money made enforcing parking, yet one of the highest unhoused population in the nation.....where does this money go? Politicians salary. Instead of trying to "make SF look good" by doing forced tent city clean outs, put that time, effort and money into more affordable housing, homeless shelters, wrap around programs, harm reduction, and other mental health services, so that SF can ACTUALLY get back to BEING good, not just looking good.
- Not enough linguistically or culturally relevant providers. Not enough culturally relevant leadership to make decisions on behalf of populations with greatest health inequities.

- not enough mental health services, resources. I work in an ER as a Registered Nurse and would say 2/3 of all my patients need mental health services that are not currently adequate to address their needs
- Not enough providers
- Not enough resources for the population
- Not for everybody. Barriers around insurance, out of pocket costs, language and other cultural needs, and number of providers who are seeing clients.
- Not for people who don't have insurance/coverage
- not free
- Not readily available for children/young adults with intellectual or developmental disabilities. Providers are not available, do not have appropriate training, and the few that are appropriate often do not take medi-cal.
- Not sure about "readily" available. Wait times for non-emergency mental health services. Access depends on insurance coverage.
- Not sure where to go in this area to receive services
- Offering appointments in a timely manner, not eight months out.
- Offering services in Spanish for the latino community
- Offering timely psychotherapy and psychiatry services in multiple languages
- often a long wait for MHS for clients. lack of available MH appointments.
- often, real mental health is not covered by insurance and there is some out of pocket expense; 20% co-pay is actually very high for a service that is needed pretty frequently in order for it to be effective.
- One has to be highly organized, have a phone, able to wait long periods of time, and be perfect in attendance and goals to maintain connection with bh.
- Ostensibly the services are readily available; however, I have heard in reality many stories of providers on site not being present for scheduled appointments, BHAL clinicians making overly dogmatic/ obviously not thought out decisions that prolong access to care, clinics and ADUs/urgent care maintaining their own policies which conflict with how Members are informed. This all makes for a situation where many Member feels they are being "given the run around" and they end up not pursuing medically necessary treatment.
- Our intake process has changed so that there is a centeralized behavioral health access line that then referrs to the outpatient mental health clinics. Clients who are disorganized fall through the cracks. Clients opened by the central access are assigned to outpatient clinics and the people opening them do not have any descretion as to whether they are opened or not. The screening process does not often catch other resources for clients which our outpatient clinic would catch. Saving room for clients who do not qualify for other options. Additionally it creates a bottle neck and clients have to wait some time before they are evaluated and opened. When outpatient clinics assessed our own intakes while more work for us, it was more client centered and we were directly accountable for managing the community need. That ownership of the service we provide to the community made a big difference in my opinion.
- Our most vulnerable are not getting the help they need
- Our streets are full of people who need (but are allowed to refuse) help. I am often awakened during the night and disturbed during the day by their screams and shouts.
- Patients consistently report difficulty accessing mental health services. Even the patients who are able to access behavioral healthcare within our health system are limited in the number of visits that their clinicians can have with them. Mental health conditions are not time-limited, so their mental healthcare visits should not be time-limited.

- Patients in jails only receive crisis management. It would be great to offer more mental health services in the jails.
- People are having a hard time accessing BHS clinics, they need easier ways to get intake appts and more drop in availability. Funneling everything to the BHAL line is not working- people often over or under report their symptoms and circumstances on the screeners. I sat with a non-english speaking young man in great distress (not enough for a 5150) as he went through the process and he got assigned to PPN- there's no providers who speak his language!! He absolutely needs in person and culturally congruent services, and he is now unable to access them. Screeners and the BHAL line are absolutely not the answer. People need to walk in to 1380 Howard, get an assessment IN PERSON with someone who isn't just operating off of screening questionaires and get assigned to a clinic within the month at a minimum.
- People can not walk into the clinic they want to go to and enroll. They have to use a centralized phone line that relies on patients having phones for calls back. It also limits access for non-English speakers.
- People do not have a clear path to access these services.
- People have to wait a long time for intake and then get dropped quickly if they have to change appointment times or don't make it.
- People in crisis often are medicated and discharged with out a full evaluation especially if they are also using drugs. There are not enough spaces for people who need 24 hour care housing and step down housing. People are left on the streets for way too long when they have mental health issues that prevent them from receiving services.
- People must wait days, months to receive mental health services.
- People who need language assistance may not have enough access
- People who need mental services, don't necessarily know they need services. There needs to be more on-the-ground outreach to people on the streets who obviously have mental issues. On a daily basis, in my neighborhood, I see mentally challenged individuals who appear homeless, confused, angry, or lost.
- People who want behavioral health services are not connected with the correct level of service in a timely manner. Allowing outpatient clinics and programs to offer a low barrier pathway to connecting directly without the delay associated with OCC, it would support in connecting to services. Also, allowing clinics/programs to be more involved in the assessment and matching process would increase the appropriateness of referrals. More ICM programs need to be made available. Clinicians and psych providers who speak threshold languages need to be actively sought out and connected to all programs so that everyone can get services that are accessible in their language, as the language line can be a barrier to creating a personal connection to build a therapeutic relationship upon, and does not support cultural congruence.
- Prospective clients who I've referred to BHAL/OCC are often told that they need to wait several weeks/months before completing an eligibility screen, even though my clinic has 1-2 week wait times for enrollment in services.
- Providers capacity is still limited by workforce shortage, along with limitations on providers who are bilingual/bicultural, and reflective of clients served.
- Providers should make more of an attempt to provide low barrier services.
- Psych ER services is stretched thin. Psych snif or residence care is severely under served contributing to homelessness & substance abuse problem of the city.
- San Francisco has surprisingly very limited resources available to an increasing need for behavioral and psychiatric services. Patients come in to my place of work requesting behavioral health services every day and it is a struggle to connect them to the correct systems of care IF

those systems even exist. We are telling people to go to one place, West Side Crisis, which it turns out does not offer the services patients often need or the linkages to care required for patients to not derail from their already fragile lives. Patients need access to same day psych services with trained psych providers and an option to continue on LAI (long acting injectable) psych medication when they transition from incarceration or move from other states or counties. Medical providers need better access to records in order to serve patients. Patients in behavioral health crises should be seen and addressed holistically from a whole person perspective. We are missing many pieces of the puzzle addressing only fragments at a time.

- San Francisco is in dire need of treatment meds and locked subacute facilities
- San Francisco should offer more services for mental health needs. Its very scary taking public transportation dealing with the numerous mental health riders
- Services are available but they are abused, pt are placed on psych hold just for not agreeing with what the doctor wants, violating their most basic rights
- services are far from adequate for MH needs in SF. far to many bureaucratic road blocks
- Services are not often in all languages and when interpreters are used, they don't speak the language well or a version of the language that the common people do not understand. Additonally the enrollment process can be hard to navigate and seeking out help can be hard to ask for. Not all healthcare providers are culturally responsive.
- Services are not the only thing they need. They need a place where they can be stable and not be triggered. Medications and mental health services are good but getting triggered over and over again will only worsen the problem. Mental health is a very tough problem to deal with.
- Services exist but not always at the level required. Furthermore, there are significant limitations in services available in languages other than English. Lastly, there continues to be a lack of clarity around the processes for accessing treatment at various levels of care.
- Services in language are harder to access. Additionally, for those who work and have private insurance, MH care is harder to access
- services in more diverse languages. more cultural representation where a patient would feel more identify with and comfortable.
- Services need to be lower barrier and free or not require insurance. Many newcomers arrive in San Francisco fleeing unsafe conditions in other states or countries, seeking safety, affirmation, and hope. Yet they often face complex barriers to obtaining insurance or the documentation required for Medi-Cal enrollment. In moments of crisis, people should be able to immediately access someone to talk to â€" that kind of timely, compassionate connection can literally save lives. Expanding low-barrier, drop-in mental health services with wrap-around supports is essential. These spaces not only provide immediate care but also build trust and connection for individuals navigating trauma, housing instability, and identity-based marginalization. In short, low-barrier, community-based mental health care saves lives.
- Services need to be lower barrier and free or not require insurance. Many newcomers arrive in San Francisco fleeing unsafe conditions in other states or countries, seeking safety, affirmation, and hope. Yet they often face complex barriers to obtaining insurance or the documentation required for Medi-Cal enrollment. In moments of crisis, people should be able to immediately access someone to talk to â€" that kind of timely, compassionate connection can literally save lives. Expanding low-barrier, drop-in mental health services with wrap-around supports is essential. These spaces not only provide immediate care but also build trust and connection for individuals navigating trauma, housing instability, and identity-based marginalization. In short, low-barrier, community-based mental health care saves lives.
- Services only seem to be available when people are really sick. There aren’t many supportive

services.

- Services only serve certain people at certain times, if they're lucky. There are not enough inpatient beds and a new 24 hour service at Geary isn't going to do anyone who is in serious mental distress any good... they need weeks, at least, of stabilization.
- Severe shortage of mental health services for children and teens who have Medi-Cal.
- SF doesn't have mental asylum to keep mentally ill patients without their right minds. Patients aren't in their right sense how would they ask that they need help.
- SF has abundance of MH programs but there is a huge shortage of workers, especially Spanish and Cantonese speaking, the direct line staff are also very much impacted by the increased workload and high acuity of clients
- SFDPH has limited capacity for serving mono-lingual Spanish speakers and indigenous Mayan language speakers, and that makes it hard for people to access these services in a timely manner.
- Shelter Behavioral Health and Street Behavioral Health services are not robust, connected, longitudinal, nor impactful for people experiencing homelessness, systemic trauma, substance use, nor SMI. I think it is obvious that there is a schism between Behavioral Health and Medical models that seems bridgeable, but bafflingly not being addressed by leadership.
- Short of paying out of pocket, it is nigh on impossible to find a behavioral/mental health care provider in under 18 months.
- Since DPH BHS consolidated to have all medi-cal recipients go through BHAL there have been incredible barriers to care. It is hard to get someone down there, get the intake (esp if they need a language other than English), and get them connected. When they do get assessed there have been issues with long wait times in which client lose interest in getting services. Further for ICM clients the number of assessments and lack of outreach have made it virtual impossible to connect anyone expect from a hospital. Providers are calling 3 times (often to a population who does not have or is not able to keep a phone) and then closing them out. This leaves our most severe and in need folks without services.
- So difficult to find mental health clinicians who accept insurance. If they do, usually only for short term.
- So many working class people cannot afford regular therapy, and so many disabled people cannot access services and die before they get referred to an appropriate level of care.
- Sometimes it seems that there is a lack of resources and a long wait to get an intake or appt. There're not enough spanish counselors
- stigma and the access are a problem for mental heath irrelevant of payor. this will not change until mental health crisis is given the same level of attention and resource as physical health crisis like heart attack or stroke
- Stigma of seeking services, poor quality providers, facilities are not inviting,
- Strongly disagree that mental health services in San Francisco are readily available for everyone who needs them. While the city is often viewed as progressive, the reality is that there are not enough transgender-specific, culturally congruent, or culturally competent mental health providers to meet the diverse needs of our communities. Transgender, nonbinary, and gender-diverse people often face significant barriers to care from long waitlists for affirming providers to a lack of understanding or sensitivity from general mental health professionals. These challenges are even greater for those with intersecting identities, such as BIPOC individuals and especially bilingual or monolingual Spanish-speaking transgender people. Language barriers, cultural stigma, and systemic racism further limit access to affirming and safe care. Even when services exist, they are often not designed with the lived experiences of these communities in

mind. Too many providers still lack the training to understand the unique challenges faced by transgender people of color, including immigration-related stress, family rejection, discrimination, and the cumulative impact of societal erasure. The demand for competent, compassionate, and accessible care far outweighs the available resources. In the current social and political climate where transgender people's existence and rights are being openly attacked mental health care should be a lifeline. Instead, it remains a privilege that many cannot easily access.

- Substance use services for youth or TAY
- sufficient services not available for folks in crisis who need help ASAP
- Takes too long to access
- The Access Points are ludicrous! You have to call: OCC an 800 number, the call can take up to an hour, if you want someone to talk with you in another language, most times they have to call you back, in a day or 2 at a random time! If you walk in to a Behavioral Health Clinic: a person is designated to help you go through the previous process!
- The City of San Francisco has always been very wasteful, spending far too much money on mental health and substance abuse services. There are countless "non-profit" organizations involved yet what results are we seeing? None. Street drugs remain easily accessible. What is the point of providing these services? Many healthcare workers lack proper training and have zero accountability. Some leave before their shifts end, and no one checks on them. Even managers and directors often fail to show up for work. Taxpayer money is being wasted on endless, ineffective services.
- The City of San Francisco urgently needs to expand supportive housing options for adults living with mental disabilities such as schizophrenia. These homes should offer a balance of safety, structure, and independence along with access to counseling and life-skills training. Such housing would not only improve the quality of life for residents but also provide relief and stability for the families who support them.
- The Community Behavioral Health Network is available to residents and to Healthy San Francisco partipants with moderate or mild behavioral health issues.
- The demand for mental health services for children FAR exceeds the available supply in San Francisco. It's even harder for children/youth with special needs. Many mental health providers are uncomfortable treating these youth. County Mental Health resources are so limited that I have routinely seen teens with active suicidal ideation receive no services. Only when they've actually attempted to kill themselves do they seem to access County Mental Health.
- The introduction of the "Office of Coordinated Care" as the sole source of triage and intake has presented a huge barrier for folks seeking outpatient services. Outpatient behavioral health care is the most crucial service for maintaining good behavioral health over time and reducing the use of costly crisis services, inpatient care, and incarceration. This added barrier is disproportionately impacting people with language differences, and those who are already marginalized (BIPOC, Immigrant, LGBTQAI+, and disabled communities). A more flexible, timely, and responsive system is needed for folks to access this more cost-effective and life-saving care. The sudden switch to routing access through the Office of Coordinated Care rather than allowing drop-in intakes at the outpatient clinics (South of Market Mental Health, Mission Mental Health, etc.) was disastrous. The communication between OCC and the clinics was minimal at best and the result was a countless number of patients experiencing significant delays in service - if not a closed and locked door. Our clients need consistency, accessibility, and flexibility. It felt like the switch to OCC was purely an administrative decision made by people who have either never worked in direct service or are several years away from direct service

work. The city websites are also egregiously out of date when it comes to name, location, contact, and hours of service for these resources.

- The key term is the services are available. SF does a good job outreaching. But you can not make people use them if they do not understand they need them.
- The mental health services are heavily impacted and it is extremely difficult as a public health nurse to obtain mental health services for my clients while they are pregnant or when they are postpartum. It would be great if we could have more providers, more availability to reach them, on-call support and consultation for healthcare professionals, and more collaboration with public health nurses on difficult mental health cases.
- The mental health services in S.F. has loopholes placed by democratic legislators that allows felonious criminals to exploit and evade prosecution & accountable punishment. Think about it - accompanied by using gender & race or D.E I. policies, these criminals are realistically assisted in enabling recidivism. Inflicting neverending traumas & triggers to past & present victims. There is no institutions to contain these criminals which would keep such individuals sequestered to medically address their particular issues. We are also, over-whelmed by the influx of unvetted Illegal Aliens from other countries that are mentally ill with undianosed conditions. At some point compassion should be focused on our US Citizens. And not be forced to inherit these problems from other countries. This includes the war on the US to kill-off & replace our indigenous populations with deadly drugs & diseases that cause mental & physical health damages. Solution - We should urge the federal government of the drastic needs to investigate these corrupt politicians that are complicit in enacting these legislations that permit this ongoing cycle of directives to purge US Citizens. Just look @ CDC / AMA statistics of those incarcerated & deaths. They're prejudicials. We need to wake-up from woke indoctrinations.
- The need for services is great. When I was working in a community medical clinic, I would refer clients to Behavioral Health Access. They would be on long waiting lists or no one would ever call back. Now there is the BHAL Behavioral Health Access Line which refers clients to telehealth appts. Most of the clients I work with are in homeless shelters and do not have phones. They need low barrier services to mental health--even provided at the shelters.
- the only people that can get care are hose that show signs of hurting themselves or others. which does not account for the people that may not be at that point but still showing signs of needing mental health care. People that need health care support should be able to get the care without needing to go through a lot of surveys showing they are in danger.
- The people who most need mental health services are free to refuse them which means there are always severely mentally ill people on my block. One day I called the "HOT" team when a severely ill man was injuring himself. They came out, the ill man ran away. An opportunist went over to the HOT team, took as much free stuff as he could get. Then the opportunist proceeded to litter the street with the containers. This scenario plays out constantly on my block.
- The resources are there but the information on them is not. If someone who has no experience in mental health services needs them, they maybe lost on where to start .
- The services are available but its hard to access them.
- The services are scarce and have too many conditions to be able to use them.
- The statement includes the term "anyone" and I do not believe anyone has clear access to these services such as immigrants, underserved communities, minors, and people experiencing homelessness.
- The system is complicated to navigate and often requires a case manager for assistance. Which they don't have as they are not connected to services
- The system is too complicated to access. There are different problems depending on the

insurance source, but people with both public and private health insurance have problems with access.

- the system of care is following apart and it is very difficult to get people linked. Also people who do not need medi-cal services have a difficult time linking.
- the wait time for intensive case management and outpatient care is dangerously too long
- The waiting lists and inaccessibility of mental health services for people living with HIV is a significant problem, especially with an aging community of individuals living with HIV. And it is readily apparent to anyone who lives here that there clearly are gaps in both our substance use disorder populations and equally absent or insignificant for those experiencing being unhoused.
- There are a lot hoops and hurdle you have to go through just to be linked to service. This is a Health determinant that really needs to be addressed.
- there are almost no spanish-speaking therapists available. many programs do "short-term" therapy programs, which are damaging to participants. if an individual was in crisis, there are few organizations that would be available to meet with them same day.
- There are challenges with access to services, especially with other languages such as Spanish . How can DPH OCC office be more responsive in person via telehealth. Most marginalized individuals to not have access or do not know how to navigate system.
- There are challenges with community members being aware of services, wait times for existing services, and significant bureaucratic challenges with getting connected to the appropriate service, especially higher levels of care. Itâ€™s also very difficult to find providers who are competent at multiple intersections of mental healthcare, for example clients who are neurodivergent and transgender.
- There are few drop in assessments
- there are inadequate resources for immigrants and community members who are not monolingual english speakers, we often hear that there are not enough services available to spanish speakers- currently most of this work is funneled/referred-out to CBOs who are being impacted by budget cuts. How will these organizations be able to meet the growing needs of the community when their capacities are being reduced? These organizations need more resources.
- There are limitations to mental health services, I believe, in San Francisco. Often, there are unhoused and symptomatic individuals requiring immediate services, and there are delays in responding and/or adequately receiving appropriate care. There are facilities (formally part of the Dignity Health System) that seem to be revolving doors for this population. Additionally, not enough staff to respond to mental health crises in a timely manner, beds are not available, and clinicians are not willing to 5150 folks.
- There are limited options for mental health services and to access them is a process. They are not usually available in the area where people live nor are services culturally and linguistically appropriate.
- There are long wait lists for Spanish speaking children who were sexually abused. There is no where to refer children with problematic sexual behavior.
- there are long waitlist, there are insurance issues, there is a language barrier and culturally appropriate services
- There are long waitlists for most of the few agencies in town. The providers are clearly burned out and the environments are so deeply depressing.
- There are many limitations to accessing the country with a 'pending' immigration status or with insurance that only covers the basics.
- There are many programs available, but based on the population we work with in the hospital, there are often long waits for available space.

- There are no mental health clinics open after 4PM on the weekdays or any mental health clinics open on the weekends that are located close to 1380 Howard street for clients to drop in on an emergency basis to get new prescriptions.
- There are not enough available care providers to meet care needs in a timely manner.
- There are not enough maternal mental health clinicians (psychologists or psychiatrists) to provide CBT. Many of our pregnant and postpartum patients are on waitlists or can't access them.
- There are not enough mental health providers in the City to support the volume of individuals and families in need of mental health treatment (inpatient, residential, and outpatient). The City needs to hire more providers and provide funding to CBOs that allows them to hire providers at market rate so that we can increase the availability of mental health services in our City. We need providers who can speak the various Pacific Islander languages that are common in the City (Samoan, Tongan, and Fijian). We need a workforce development plan that supports high school and college students with getting into the mental health field.
- There are not enough providers
- There are not enough providers for patients who need them. We frequently have patients admitted to SFGH who are not able to receive enough services
- There are not enough services in Spanish with bicultural people. There are not enough in-person social/peer support groups.
- there are often language barriers that prevent someone from being able to access services readily
- There are often lengthy intakes and long wait lists. I wish there were more groups available for women.
- There are people wandering the streets that clearly need mental help and are incapable of making decisions for themselves. They should all have case workers regularly reaching out to them in person. Case workers should be assigned to specific individuals and/or locations and keep returning to those locations at least once a week. Individuals that will never seek mental treatment on their own (anosognosia) need to be recognized.
- There are services, but the timeliness of the services can be a challenge. We need social workers and nurses who have the time to do their due diligence and being patient with people, but we cannot expect them to do that and quickly move through people as well, we need more staff. It doesn't mean much if you're culturally competent, but you have an estimated time you're supposed to spend that doesn't accommodate the actual person or a quota to meet.
- There are services, but there may be waiting lists so there are not enough services.
- There are simply too few resources given the need, limited co-ordination with private hospitals, not enough pressure on those hospitals to step up, and not enough acute beds, affordable housing, and public housing is getting destroyed through privatization or partial privatization instead of demolition. The will is there and care workers work hard, but the limited services are triaged: clients either have to wait for services, or there is a high criteria to enroll in the services, or the services try to serve too many people or too many functions which they were not designed for - this makes the program/service almost a waste of time. I know the average SF "taxpayer" and "stakeholder" is right-wing, entitled, and insane, but the clients matter more than bigot transplants and their vanity project boutique startups do.
- There are so few places for people struggling to be during the daytime. And there are very few behavioral health professionals who know how to engage and work with folks on the street that are both available and culturally and linguistically competent that can support and assess on demand. We need more therapeutic, low barrier spaces that provide treatment on demand

across the City.

- There are still many barriers, including cultural and language barriers, as well as how these services will be paid for. There is an overwhelming need, and not enough providers in these areas.
- There are still many individuals on the streets yelling and screaming and no one is available to assist them.
- There are strong linguistic barriers that exist. There are also barriers by immigration status.
- There are usually really long wait times when I've referred patients for specialty mental health services.
- There aren't enough providers to meet the needs of the population and people with high acuity are underserved due to high rates of burnout from providers and provider options to move to better paying positions i.e. private practice.
- There aren’t any low barrier access points, a centralized line isn’t accessible to everyone. It can be intimidating and lacks a human connection. The outreach teams are also not always staffed by skilled clinicians. The city needs to invest more in licensed UCSF workers who they have already made a partnership with. These workers are quitting every day (leaving their real passion) to go to better jobs to keep up with the cost of living.
- There does not seem to be good treatment options for people who are severely mentally ill. I have tried helping 2 people experiencing psychosis get treatment to no avail. They were both 5150d then released shortly after in the same state they were in.
- There is a lack of mental health services for children ages 0-5. Lack of expertise and culturally competent clinicians. Long waitlist for those who are seeking services.
- There is a long waitlist for services.
- there is a major waitlist just to get an intake with any outpatient MH services; there are substantial barriers to care including wait times, being closed out for missing appointments, low staffing, staffing turnover... there is a paucity of psychiatry services and waitlists for seeing a prescriber are a huge barrier to care
- There is a severe lack of availability of mental health services for very low income individuals, some with diagnosed MH conditions and some without. The process to find such services is cumbersome and time consuming, often failing to result in connecting a person in need to such services.
- There is a significant deficit of mental health treatment resources. Hospital psychiatric emergency beds are turned over as quickly as possible as a 'revolving door' response to repeat visits and unmet needs.
- There is no ADA accessible 90-day residential treatment program in San Francisco that can accommodate people in wheelchairs or walkers. Clients seeking mental health care who are wheelchair/walker reliant would need to go out of county to seek services.
- There is still a lot of stigma against individuals experiencing mental health crises on the street. More adequate training and resource distribution to average community members needs to be done to let them know who to call in the case of a crisis.
- There is too much red tape regarding billing, identification and judgements made against unhoused individuals.
- There just isn't enough services offered for city workers unless it if you are having issues at work that are creating stress.
- There may be minimal services provided but these services are often short staffed and are often not low barrier.
- There might be services but people don't know about them or where they can get them. I work

and live in SF and I don't know where to reachout to find them.

- There needs to be more mental health providers and peer providers that are free and have no barriers to access and more services in a wider variety of languages.
- There needs to be more mental health providers to help those people on the streets and for those people who are actively seeking mental health services! There are not enough providers!
- There should be a way for individuals to receive access to outpatient mental health services while waiting for Medi-Cal application to approve - which can take up to 30+ days and individuals cannot afford to pay out of pocket for services. Plus, wait times for available appts in clinics can be long. Positives for mobile crisis team - 24/7, SF Mental Health online support groups, and CA Peer Warm line.
- They are available, but they are not readily available. The new- ish process of having people connected to mental health services in SF has created a huge barrier and back log for services. Turn it back to individuals being able to call individual clinics to receive services.
- They may be 'available' but there is often a long wait/delay or the service is inadequate or not specific to the person / situation.
- three are not enough services to meet everyone's needs and often the trauma level requires a higher level of care that what some CBOs offer.
- through my insurance I only have 2 sessions a month, my needs are chronic so EAP can't do anything except induce panic attacks through unhelpful breathing exercises, suicide hotlines just ask you if you have friends to call, even though friends don't know how else to help except providing those hotline numbers, and I was hired through DPH through being open about needing mental health help, but all accommodations have been removed for our team and my mental health absences stand as my biggest threat to my job. I feel nearly as vulnerable as if I was already on the street, I can barely pay rent and our slumlord doesn't help with anything despite being exposed to roaches, rats, and carbon monoxide leaks.
- To get mental health services requires an assessment to determine level of care, then a program must be found. Once a program is found then an intake appointment needs to be scheduled. At the intake appointment an assessment is completed - still no direct mental health services provided. The wait for a PPN therapist had been too long, not sure what it is presently.
- Too many folks on street Access challenges
- Triage takes a long time for people to get referred to mental health service providers.
- Trying to get an appontment at a clinic or program takes way too long and uts alnost impossible to get an poot at a clinic slose to where I live.
- Typically, if you have an HMO health insurance you have to see a primary care doctor who will then need to refer you to a mental health specialist, which can be challenging. A specific reason needs to be provided. So, I would not say it is readily available.
- Very difficult to access, there is no space, appointments take a long time or never arrive, services are not available in case of emergency and most of the time they are not in Spanish, making it difficult for people to get the service
- Very little in non-english, no PTSD treatment (beh mod or other stuff) except at VA, Hassle to get residential care, day treatments shut down, very little dual dx etc
- Wait times and appointments are long/convoluted.
- Wait times and cost are so long/high as to make them unavailable.
- wait times and lack of gaps between crisis services and other supports leave folks falling through the cracks and the cost to SF 4-5x as much. if people have no housing to discharge form a treatment program, let alone the length of time folks have to wait. our main local hospital is on diversion as often as not. additionally i have folks in locked units because of lack of step-down

for several months so they cant get out to get the services they need.

- Waiting periods for psychiatrists & therapists are quite long.
- Waitlist across the city make it impossible for ppl to receive the mental health services they need. Mostly traditional services are offered and there needs to be more untraditional services such as groups, healing circles, sound healing, music etc.
- We always need more. Especially pressing need" mental health services for veterans outside the VA. The VA only provides services for veterans that have VA benefits. Many vets are not eligible for VA benefits, for many reasons: less than Honorable discharges among them. Even for Vets with benefits, it is often nearly impossible to get their mental health needs met through the VA.
- We are lacking sufficient ADA compliant step down levels of community mental health care facilities. Our inpatient psychiatry units are overwhelmed with patients who are no longer acute (many are conserved), but there are not enough appropriate levels of community care facilities for discharge planning. It has been very difficult lately to place patients in ADUs.
- We do not have enough mental health providers nor services to meet the needs of clients in the city, especially since there are now so many drug court/"diversion" referrals forcing people into these services that they do not current want, which is not efficacious treatment and contributes to the burnout of the already bare minimum staffing for outpatient and other mental health services in the City. Also, (public) Drug use is a public health issue. Getting people wrapped up in court and arrests and punishment has and will only exacerbate the problems on our streets while contributing to provider/staff burnout and other system wide issues (see public defender's office and the recent need to release people in the jails due to lack of representation).
- We have a wait list where I work for folks to receive mental health services that are appropriate for the trauma they have endured. To me, readily available also means affordable, not just available. You might be able to find a mental health provider in private practice charging a lot, but this would not be sustainable for many folks.
- We have clients that cannot get the mental health services they need rapidly. But San Francisco is not bad when you compare it to Kaiser of Oakland mental health.
- We have gotten rid of mental health facilities, we run social workers short, we cut psych services to a small few, we don’t even pay for therapy AT ALL! Ever since Reagan Californian has taken a path that is against our moral and ethical obligations to patients. We put them on the street, where they can’t care for themselves. Fail. We admit them, clean them up and medicate them to do it again. This is insanity. We need housing, therapy, staffed beds, supports that go beyond hot teams and bert teams. Let’s help people before they are in crisis. Let’s also help get drugs off the streets and help get more legal meds, methadone clinics, outpatient support systems. Stop cutting beds!!!!
- We have great difficulty referring patients to quality mental health services, very scarce resources for ongoing therapy or management
- We have tenants of Housing First programs that do not receive adequate and appropriate mental health support services to help them stabilize and stay housed. Options for in-house and on-site peer-to-peer support programs must be bolstered. Intentional resourcing of these kinds of services is a must. UCSF's Citywide and DPH's PHACS teams are examples of existing clinical behavioral health programs that should be expanded. Additionally, cultural and language barriers are best addressed through in-house staff with lived experience that provide mental healthcare and also act as facilitators of peer-led healing frameworks.
- We live on Harriet Street between Folsom and Harrison. We often see people who are in need of mental health care (e.g., screaming, having a meltdown, hitting themselves) and are roaming the streets. However, they are there anywhere from one hour to one day and our care services

do not respond in a timely manner. They are often gone before the services can arrive.

- We need a geriatric psychiatric unit in the hospital.
- We need more "half-way" houses for the mentally handicap people of San Francisco. Reagan, when president, closed all of the facilities that house and help the people with mental illness.
- We need more hospital beds and residential beds for mental health patients in custody. Many people stay in jail longer due to lack of beds.
- We need to make our mental heath services accessible. We need to be able to state clearly online what our programs are and how to get access to them. And the answer is not "go to 1380 Howard and find out"
- We work with patients who need psychiatric support and we always encounter waiting lists or an inability to schedule appointments when attempting to refer them.
- Westside Community Services where I used to work is the only mental health clinic in SF that I'm aware of and it isn't enough. People in mental health crisis have to wait in line very early in the morning (some even sleep at the door) in order to get help. It's a great service. I'm proud to have worked there. There needs to be more.
- when I started seeking mental health support, I was asked to wait for months before being able to schedule an appointment with a psychiatrist. information about the various mental health organization, such as Rams PWC, to myself as a migrant, were inexistent.
- When my spouse needed to find a therapist and psychiatrist we struggled to find a someone local who took our insurance and was in network. We ended up having to select someone who is out of the area, and even then it was hard to find a provider. They need ongoing care and it's very complex. we tried to find a provider at UCSF or through Sutter Health but were told neither had or was taking patients. When they required intensive or inpatient psych services we were forced to take them to San Mateo. If we didn't have resources I can't imagine how much harder than it already is to access appropriate care. It also helps that I'm a medical professional so I I was able to advocate for them, if the patient who is dealing with severe mental illness had to this alone I can't imagine them navigating the system alone, as after being released from a 5150 hold they were just given a sheet of possible provider none of whom took insurance or were accepting new patients.
- WHERE CAN WE FIND HELP WITH OUR MENTAL HEALTH?
- Where? I work in public health, and outside of the EAP for us employees, I am totally unaware where the needy can receive affordable or free mental health assistance.
- While I believe that SF has a wide portfolio of diverse mental health services, I do not believe that these are "readily available" for "anyone." I speak of this from my experience as both an outreach worker (SFHOT & Street Medicine from 2015-2019), and a direct consumer (2011-present). In a work setting, it was extremely difficult to get clients who were ready into treatment (mental health or substance), not due to the client's motivation, rather the availability of beds, or the medi-cal hurdles that existed. I experienced the same with my own recovery- as a medi-cal patient I had to jump through hoops (registration, picking providers, scheduling appointments with ill-prepared staff), which felt monumental when I was really struggling. In contrast, when I was a resident of Alameda, I called a centralized line and they hooked me up right away. What good are these "readily available" services, if they are, in practice, inaccessible due to systemic obstacles?
- While I think there are low barrier services for folks in immediate crisis, I do not think that we have sufficient services for chronic issues, nor do we have sufficient services for folks who are more stable psychiatrically. Access such as sufficient providers for the needs of the community are lacking. I do think the city looks better, cleaner, less individuals living and using substances

outside, but as someone who has worked in community health, I know that BH services are not meeting the needs of San Franciscans.

- While mental health services are technically available in San Francisco, there's still something missing in the process that prevents people from actually getting the help they need. Many fall through the cracks because the system doesn't always connect them to care in a timely or effective way. It's heartbreaking to see so many people struggling on the streets without support, and it raises the question of whether San Francisco should consider stronger laws on intervention - not to take away people's freedom, but to ensure those in severe crisis receive the treatment and safety they need before it's too late.
- While mental health services are, compared to other counties/states, readily available, there are aspects that are severely lacking. For one, Monolingual Spanish speakers have to wait for over a month for an intake and then longer for an initial appointment in Specialty Mental Health. We hold some of these cases in Primary Care, but we are not equipped to manage the number of severe cases that are waiting for SMH linkage nor are we equipped to provide the support they need. In addition, WRAP-type case management services are severely lacking. ICM is expensive to run, but it is much cheaper than cycling people through ED/Shelter/Crisis Systems. There is a significantly higher need than availability of program/providers. On this note, there are many people who are non-emergent/non-severe mental illness and do not neatly fit into ECM criteria that also would benefit for case management services, particularly for youth with mental health disorders that are not developmental and adults with complex health needs but not with severe mental illness. On this note, having one or two case managers in Primary Care (not BAs, but Case Managers), would be a game changer. I say this all having worked in ICM and Primary Care for the City.
- While mental health services technically exist in San Francisco, they are not that accessible to everyone. Many residents face long wait times, limited appointment availability, and complicated referral processes. Services are often focused in certain areas, leaving gaps for low-income, unhoused, or marginalized communities. To improve, the city could expand outreach, simplify intake procedures, and ensure that providers are culturally responsive and trauma informed. Increasing availability of bilingual staff and offering consistent follow-up support would also make services more equitable and effective.
- While San Francisco has a robust behavioral health network, mental health services are not readily available to all who need them due to persistent access, capacity, and workforce constraints. The system continues to face significant bottlenecks at every level, from intake and assessment to residential, outpatient, and supportive housing placements. Wait times are prolonged, particularly for voluntary and community-based care, and many programs operate at or near full capacity. Staffing shortages and wage disparities between community providers and City employees further limit available services and continuity of care (this is a massive issue, and the County has heard this about contracts for some time). These challenges disproportionately affect low-income, uninsured, and Medi-Cal populations, as well as communities of color. To improve access, the City should: 1. Expand voluntary residential and community treatment beds, psychiatric respite, and transitional programs. 2. Invest in competitive wages and workforce stabilization across providers. 3. Extend intake hours and create additional 24/7 access points. 4. Strengthen coordination between DPH, HSH, and providers to ensure real-time placement and smoother client navigation. These steps would make "readily available" a true standard rather than an aspiration.
- While services may be "available," I'm unsure if they are accessible, barrier-free, or culturally and linguistically appropriate.

- While the infrastructure is there to connect clients to different service deliveries, the programs are understaffed because of a variety of factors, such as burnout, lack of supervisory support, lack of clinical hours guaranteed towards licensure, people in leadership roles without a clinical background, the existing staff taking on multiple vacancy roles leading to role confusion and resentment, and the lack of policies and procedures on safely engaging with clients in the community
- While there are mental health services that are available in San Francisco, they are not readily available to the degree that is often needed. As a person that works in the space of serving veterans we are often finding it difficult to provide mental health services to veterans who could utilize mental health services at the VA yet prefer to use community based systems instead. Many of those veterans are not eligible for Medi-Cal which presents an issue in terms of funding to serve those veterans with counseling and other therapeutic services via city funding sources.
- While there might be a variety of services, sometimes it is difficult to get to the right entity, as it's not a one size fits all. There needs to be a deep understanding and knowledge of what a patient's needs are, without being shuffled through the system. It is imperative that mental health practitioners are regularly trained on confidentiality, and cultural sensitivity.
- With the amount of insane people on our streets everyday it seems as if there isn't any help for the mentally ill people.
- You give everything to the immigrant population, But what about the rest of the us SF Black/African American who are struggling Food insecurity is the lack of consistent access to enough nutritious and safe food, often due to financial limitations. It can be chronic or acute, and it's different from simply feeling hungry, as it can involve consuming unhealthy food or reducing meal quantities. Causes include low income, which can also lead to higher rates of chronic disease, developmental problems in children, and negative mental health outcomes. Like I said before everything goes to the immigrants, what about the American people who has paid into USA government system. When you need assistant, you are not eligible for anything.
- Youth and family are unwilling to get service on the school time and parents don't want to take a day off. A lot of referrals came from school, not family due to the need to make their own income. Plus. adults suffer from mental health as well. The other day I just got a call from insurance company looking for Japanese speaking clinician. Not enough qualified clinicians.

Appendix B

How much do you agree/disagree with the following statement: In San Francisco, substance use services are readily available for anyone who needs them? (Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree)

If you responded Disagree or Strongly Disagree, please provide an explanation below. Please include any suggestions for improvement, such as offering services in my language, ensuring care providers are culturally responsive, etc.

- Mostly traditional services are offered and there needs to be more untraditional services such as groups, healing circles, sound healing, music etc and awareness about where these services are are needed
- offering services in my language
- Substance use services are not readily available or accessible for everyone who needs them. Many youth and LGBTQ+ community members face long waitlists, limited culturally responsive care, and strict program requirements that can exclude those who are unhoused or actively using. Services are often tied to insurance or documentation, which creates major barriers for newcomers and people in crisis. Low-barrier, harm-reduction-based, and community-rooted programs save lives. We need more drop-in style substance use supports that meet people where they are, without requiring sobriety or insurance. Suggestions for improvement: â€¢ Fund more low-barrier and peer-led recovery programs that are LGBTQ+-affirming and trauma-informed. â€¢ Expand mobile and outreach-based harm reduction services. â€¢ Integrate substance use, mental health, and housing supports under one coordinated system. â€¢ Increase bilingual and culturally specific providers who reflect the communities most impacted.
- Agree in that we have a lot of resources available (e.g., BRIDGES, OBIC, methadone clinics, etc), but folks still experience barriers such as lack of available appointments (appreciate the drop in model at MXM, BRIDGES on certain days). For example, only doing in-takes for methadone clinic in the morning (not sure about weekends?)
- -No residential rehab options for clients with mobility limitations/ in wheelchairs or with more complex medical comorbidities -only one medical detox for alcohol,
- No residential SUS for people who speak other languages than English 2. Many SUS residential providers are cherry-picking, not able to provide appropriate services to clients who have psychosis & SUD.
- 1380 Howard and Market BAART accessible in person in the morning, afternoon, and evening
- access is limited, many services aren't well known. Communication is awful.
- Access location challenge
- Accessing substance-use services is often difficult and confusing, which means many people who might benefit remain unseen and unsupported while services tend to reach those in acute crisis. We need a wide variety of entry points, both in-person and via phone, that actively reduce stigma and reflect cultural humility so that no one is indirectly turned away. The first point of contact must be highly trained; not only in gathering information and providing compassionate connection, but also in cultural competency, stigma-sensitivity, and service navigation. Service systems should also work in true collaboration between abstinence-based and harm-reduction orientations, rather than treating them as mutually exclusive. There should also be a viable “middle ground” approach for people who move fluidly between both frameworks, so everyone can be met where they are.
- Active recruitment by street teams to homeless population
- acute interventions (sobering centers, ACT consult in hospital) are available, LONG TERM services are not

- Additional residential services and sobering centers are needed. Not enough beds for people to go to help with substance use withdrawal, especially higher needs folks that have behavioral health issues at the same time.
- Again don't where to go around to receive such services
- Again the services are there but not always accessible.
- Again you have to get access to a Primary Care which there is a waitlist.
- Again, I don't think the BH Access line or BHAC is the best way. People need to be able to walk into DPH clinics. Or need to be able to access more Campus (community based) UCSF services (which are restricting their eligibility and/or have long waitlists due to staffing and burnout issues from being significantly below market equity).
- Again, substance use services are challenging to find and get into for assistance. It often takes a lot of advocacy and support from the healthcare provider for clients to be able to access them.
- Agencies have limited SUD counselors and those that are there, have too many other clients, which means I get less time with them. I also feel that a client goes through too many counselors as they leave and a new one(if available) has to step in and start all over.
- Although San Francisco offers many substance use services, I disagree that they are readily available for everyone who needs them. In reality, access to these programs can be limited by long waitlists, strict eligibility requirements, and a shortage of treatment beds. Many people, especially those experiencing homelessness or without insurance, face major barriers to receiving consistent care. Additionally, the high cost of living and the complexity of the cityâ€™s service system make it even harder for individuals to find and stay in treatment. Therefore, while substance use services exist in San Francisco, they are not truly accessible or sufficient for all who need help.
- Although the services may be available, it's only helpful if the services reach the clients who need it. Not every client who needs it knows or believes they need it because their cognitive and emotional ability to make good decisions for themselves is already impaired. I know SF City is trying to provide the resources and makes an effort at outreach to those who need it, but bigger changes to our system of overall health care will be required in order to make a difference in a more positive direction. It seems that the services being provided have only been effective for short bursts of time given that long-term solutions aren't either in place or aren't working. Health care on the grand scale in this country is broken and getting worse for so many. Dramatic change is required and I'm not certain that SF is capable of making this kind of change without sweeping State and Federal support and reform to our entire health care system.
- Always higher needs than treatment beds, especially for residential care. Also, lack of bilingual services for certain populations (e.g. Vietnamese).
- As a social worker who has worked to connect clients with multiple kinds of substance use treatment, particularly residential treatment, those services were difficult to access, with eligibility criteria that was often hard to meet. It's also very difficult to find services that are competent at working with transgender folks.
- As above, substance use disorder (which is mental health care) for veterans is not 100% covered by the VA (typically because of eligibility issues) who is forced to rely on Community Care providers to plug the gaps in care. This is due largely to insufficient staff to address the need at the local VAMC and partly due to veterans not being eligible for care and partly due to veterans not knowing they are eligible for care and/or hesitance to reach out to get care from (any) provider. The VA does an excellent job of working with local providers to get veterans access to care, but with half of veterans not engaging with the VA in the first place and many not eligible

for VA services, local providers are forced to scramble to meet veterans' needs.

- As an Intensive Case Manager on a team delivering the highest level of care (Stabilization) navigating this system of care for 5 years, my clients and I run into "wrong doors" daily. There are rarely any beds available for PES and psychiatric inpatient settings. Drug treatment programs are often full or are not willing to take people for a number of reasons (the client has had an assault in the distance past, they are not addicted to stimulants, they are not able to access some non congregate sites for shelter unless they are on an opiate antagonist. This is not a housing first system of care right now. I place a lot of 5150s and more often than not my clients are seen by psych and discharged while still gravely disabled. Hospital workers have told me that they are being forced to discharge people ASAP.
- BEAM is a shining light, allowing for low-barrier, drop-in services over the phone and in-person. BEAM is the only reason I didn't put "strongly disgree." That program should be highlighted and heralded and praised! See my comments above per BHAC, not-patient-centered, especially for poor folks with no phone.
- Better Outreach Improved Access Culturally Relatable Providers
- But the mentally disabled people or homeless people probably can't take advantage of it. Can't make sound decisions.
- Cannabis use disorder (CUD) is "substance use" and there are no CBT (Cognitive Behavioral Therapy) readily available in SF. >75% of my foster youths have CUD.
- care about
- city and partners have scaled services and I believe that substance use services are readily available. these services may only address part of the patients needs (SUD treatment) and not address SDOH that are leading to SUD.
- City outreach programs cannot possibly help all in need as many in need refuse help. The city outreach programs net never casts as far as needed just because the need is so great.
- Define "anyone who needs them"? Usually this excludes people who are above the poverty level or other income markers, but the reality is that mental health care is prohibitively expensive and those with private insurance are stuck with barely qualified online providers.
- Define readily available. A person in need of services goes to TAP, receives an ASAM assessment, then a program needs to be found where there is availability. If residential treatment is indicated then TB test required, refer to ZSFGH for TB come back to TAP with results. Instruct the person to come back tomorrow for follow-up and eventual referral to treatment.
- Disagree based on second-hand knowledge / reading the news. And challenges and limited hours.
- DPH doesn't treat providers the same - favoring county programs that are ineffective more than non-SF County providers which can make it difficult to access MAT services.
- Driving through many streets in SF--Tenderloin, SOMA, Civic Center, some of the Mission--it is clear by the number of homeless and apparent drug users that the services are either unavailable, or ineffective.
- Due to the amount of addicted people on the streets I’m not 100% sure we have services readily available.
- Even as an employee of DPH, because I do not work for BHS I have very little knowledge of the substance use services that are available to residents and who is eligible. I don't even know where to direct folks to learn more.
- Every morning while walking to the office, there are multiple people lying on the streets from using some form of substances.

- Every single study about the variables most closely related with positive treatment outcomes identifies housing as the most influential variable in the success of treatment. What this city offers is shit. Fuck DPH.
- Finding the right level of care for folks is hard, especially if they are dually diagnosed.
- For folks to have the ability to come off the streets, we need substance use services that deliberately meet folks where they are at. What we need are harm reduction spaces to first ensure that people do not overdose in a toxic illicit drug landscape created by capitalist medicine. For folks to then safely enter treatment services, we need safe use supplies and safe consumption services expanded. Safer supply programs must also be considered.
- For patients whose primary language is not English, there are very limited language-concordant services available. Also, it can be difficult for patients to navigate the limited resources that are available. Some patients who are able to access services report punitive treatment once they are in treatment programs.
- From what I've seen and heard from community members, there are not enough bed and services for community members when they want to engage. I don't know what the answer is but what's available now is not enough.
- Gender affirming SU services are hard to find. Clients often do not want to engage with staff or departments who are not culturally humble.
- Get the unhoused off the streets
- good range of services available, though abstinence-based treatment is overrepresented especially in residential treatment spaces. we need more treatment options located outside of SoMA, the TL, etc as some people do not feel able to reduce/stop use when living/receiving services in those neighborhoods where drugs are so readily available. also need expanded or different hours of operation for folks who may not be awake during typical 9-5 hours. mobile/in-home treatment options could be expanded so folks with transportation barriers or other difficulties leaving the home can still access care. more safe spaces like soma rise/sobering center for people to rest and receive care while coming down. SAFE CONSUMPTION SITES to reduce overdose deaths. bring back the tenderloin center!!!!
- Harm reduction services are heavily impacted and under-resourced
- HR360 is only game in town and they are terrible. Never answer phones, never respond to referrals, ONE DETOX for MediCal in SF.
- I knew of some patients in clinic who needed urgent or same-day visit with a Substance Use specialist but there was no such specialist available.
- I agree there are services but when someone is ready to get help and you call the places, they are full or not available to see someone.
- I am a substance use treatment provider. At my clinic we are only able to bill Medi-Cal. When our patients get private insurance, it is extremely difficult to find primary care providers who are willing and able to provide MAT (especially buprenorphine) to privately insured patients. The barrier seems to be providers stigmatizing the diagnosis/people with SUDs. Stigma is the main barrier I see for insured people. Pharmacies are not keeping an adequate supply of buprenorphine. It is very difficult to find pharmacies who regularly keep enough stock on hand. I know the SF board of supervisors passed a resolution stating that they need to keep adequate supply in stock, but the majority of commercial pharmacies in our city are failing to do so. And my clinic is bursting at the seams with patients. We provide excellent, non-stigmatizing care and we cannot be the only place where this happens. We need more staff, or more community partners, helping us to do this work.
- I am aware that they exist, but they require a lot of red tape to get into, and the limitations to

access quickly prevents those from getting help when they are ready for it. From what I have seen and heard from people searching for help is that the roadblocks and hurdles (needing a case worker, approval from some entity, or a long wait list)are the main reason they change their mind. We lack the ability to provide help when they are ready to receive it.

- I am not sure
- I am not sure about this.
- I am not sure what 'substance use services' completely entails; it that typically only for what is considered to be certain types of drugs? Food is also a substance that is used as comfort/coping mechanism, yet the resources are very much lacking. As with any type of resources, there needs to be an array of different types of assistance; for sure, that includes services available in different languages, as well as practitioners who of a sympathetic mindset who can assist patients in navigating such difficult challenges.
- I believe they are not available at any time. You may have to keep trying and eventually get a spot but it is not always available.
- I cannot respond from personal experience but witness individuals in need of substance use care across the city on a daily basis.
- i disagree because i still see a lot of people on the street on drugs
- I disagreed just by witness youths' parents suffered from substance use/relapse; witness how many on the streets.
- I do not participate in this activity & am NOT very knowledgeable about this question.
- I do think there could be more put into contingency management for substance use as it has been shown to be effective. There could be more education done for providers in regards to substance use treatment and the stigmatization of people who use substances.
- I don't actually know, but given the number of struggling people I see and the frequency with which I see people engaged openly in drug use, it makes me think there isn't enough support or it is not reaching people
- I don't believe that there is enough available for youth
- I don't believe there are enough services for the amount of people who need help. It's important to get people help when they are ready for help. To have to wait or get on list allows for distractions.
- I don't know for certain but it seems like we would see less ill people on the street if there were sufficient services available
- I don't know I don't associate with people who indulge in activities as such. Do I see homelessness? Yes, weather or not its related to abuse of substances is a big question mark.
- I don't work directly with this population so I am not too sure
- I feel like this may be easier than for someone with just mental health issues. Many places we reached out to seemed to be focused on substance abuse rehab
- I have had patients in my care who are ready to enter substance use treatment but at the time they had made the decision and were ready to present, there was not availability. After waiting a few days, their resolve was gone and the window of opportunity for them was gone for now.
- I have not seen these programs and I find that harm reduction programs are not known or easily accessible via SFDPH
- I have taken clients in the morning multiple days in a row to health right 360 and have not gotten my clients into inhouse. There were others in the waiting room who also were not seen. We also need a trans only rehab.
- I haven't had to access the cities resources, but I wouldn't say it's immediately obvious how to find them

- I help folks get into treatment and the wait can be very long. Many of the treatment options refuse my clients saying that they are not equipped to take clients with mental health symptoms such as my clients experience. Some programs (Billie Halide, Salvation Army) are very transphobic and treat trans client terribly.
- I know less about this, but I think a lot of the same things apply.
- I mean, given how many homeless people I see who are clearly struggling with drugs... it seems like the city could be doing more effective intervention. Let's consider what has worked in other places. (Like portugual for example) safe injection sites, harm reduction, workplace training, subsidized housing etc
- I previously worked at an agency in Alameda County, and we would get referrals from the City and County of San Francisco looking for services for their clients.
- I responded Strongly Disagree. San Francisco is failing people who use drugs. Over the last year and the previous Mayoral administration the City's policy choices have moved away from evidence-based harm-reduction practice and toward aggressive criminalization and program restrictions that have already worsened public health outcomes and placed frontline providers and outreach teams in harms way. San Francisco once led with proven public-health interventions: syringe services programs (SSPs), safer-smoking supply distribution, drug-checking, mobile outreach, and a pilot approach to overdose prevention centers (OPCs) through the Tenderloin Center. These interventions are empirically shown to reduce infectious disease, prevent fatal overdoses, and connect people into care. Decades of research clearly document the public-health benefits of SSPs and other low-barrier harm reduction services, and are supported by CDPH. Instead of protecting these programs, the City's recent policy decisions tie distribution of safer-use supplies to mandatory counseling or treatment referrals, restrict public distribution of smoking supplies, and have effectively stalled or reversed progress toward fully authorized OPCs and safer-supply pilots and will not authorize new SSPs. These policy shifts were publicly announced as part of the Mayor's directive and mark a clear departure from longstanding harm reduction practice in San Francisco. Overdose deaths in San Francisco have been exceptionally high since 2020, and community groups and frontline providers warn that cutting low-barrier options will push people toward riskier practices and away from lifesaving services. Local reporting and examples also document the chilling effect: nonprofit programs have announced limitations on distribution, and neighborhood disputes and litigation have emerged around supply distribution. These outcomes are predictable when public health leadership withdraws clear, evidence-based support. This is more than a policy disagreement, it is a dereliction of public-health duty. The City's messaging and operational choices have emboldened aggressive policing responses while undermining community trust in public-health interventions. Providers and mobile medicine teams report increased harassment and operational disruption; when the public health agency fails to defend evidence-based practice publicly and operationally, it both endangers clients and exposes staff to risk. Meanwhile, Los Angeles is championing harm reduction as public health, opening health hubs with co-located services, and investing in robust messaging campaigns and saving lives. San Francisco must reverse course and re-center science and harm reduction. Concrete steps DPH and the City should implement within 6-12 months: Restore and publicly defend low-barrier harm reduction. Fully reinstate public distribution of sterile supplies (including safer-smoking supplies) through SSPs and outreach, free from burdensome preconditions. Monitor and report outcomes transparently. Advance OPCs and safer-supply pilots. Prioritize reopening or establishing overdose prevention centers and carefully-designed safer-supply programs shown to reduce overdose deaths and increase linkage to supports. Expand drug-checking and rapid toxicology services. Scale portable drug-checking across outreach teams and low-barrier sites to reduce

fentanyl-related risk. Protect providers and outreach staff. Publicly defend programs at the highest levels of departmental and city leadership, provide legal/operational support when programs are harassed, and add contractual language requiring partner agencies not to harass or obstruct harm-reduction providers. Stop criminalization as first response to drug use, which is proven time and again to exacerbate overdose rates and has no positive correlation with SUD treatment engagement (this is based on multiple recent studies by the foremost researchers in the field using SF data, so it's not abstract; you're just ignoring the science in favor of politics and cowardice). If DPH does not reassert a science-based harm-reduction approach now, the City will continue to lose lives, fracture the continuum of care, and force providers to shoulder impossible risks. Public health leadership must act, publicly, urgently, and with measurable commitments, to undo the damage of recent policy shifts and restore an evidence-based path forward.

- I see dozens of people on the streets everyday needing urgent substance use intervention and care and not getting it
- I see offers and have friends who work for the services described here. Anyone who WANTS it, has the resources for help to manage substance abuse and learn more.
- I strongly disagree because, while there are substance use services available in San Francisco, they are often difficult to access. Many people face long waitlists or are unable to find programs that are appropriate for their specific needs, such as those related to dual diagnoses or culturally sensitive care. Additionally, the services that are available may not always be offered in multiple languages or be culturally responsive, making it harder for non-English speaking or diverse communities to engage with them. To improve, I suggest increasing funding for substance use treatment programs, expanding access to services for people with co-occurring mental health conditions, and ensuring that providers are trained in cultural competence. Offering more services in multiple languages and reducing wait times would also make it easier for individuals to access the care they need, when they need it.
- I strongly disagree with the statement that substance use services in San Francisco are readily available for anyone who needs them. Although a range of programs exists, they are not equitably designed or administered, and they often reproduce racial bias in both policy and practice. Black residents, in particular, are subject to criminalization, stigmatization, and clinical neglect when seeking substance use support. These inequities result in differential access to quality care, inappropriate treatment plans, and ongoing trauma for those most in need of compassionate, culturally grounded intervention. To correct these systemic failures, San Francisco's substance use treatment system must undertake a comprehensive re-education of its clinical workforce - one that centers antiracism as a clinical competency rather than a moral aspiration. This should include mandatory, in-person, scenario-based training that teaches clinicians how to identify and interrupt racial bias during assessment, treatment planning, and group facilitation. Trainers should be professionals with both clinical and antiracist expertise-individuals capable of bridging the technical and human dimensions of care. Further, the City should institutionalize routine equity audits and team check-ins to examine how Black and Brown clients' cases are managed, how recovery progress is measured, and whether outcomes reflect equitable care. These mechanisms must be integrated into ongoing supervision and quality assurance - not treated as one-time diversity exercises. Finally, substance use treatment in San Francisco must expand partnerships with Black-led and community-based organizations that have earned the trust of those most harmed by systemic racism. These partnerships can provide culturally resonant recovery models and serve as feedback loops for ensuring that services remain accountable to the communities they purport to serve.
- I think better promotion in public spaces about availability of substance use services is critical.

There is a lot of stigma around substance use/abuse so further efforts to bring awareness to substance use/addiction would be helpful.

- I think community providers are doing their best with what they have, but the need is too great. I think there are a lot of people who fall through the cracks due to many different challenges. I think this city is lacking in wrap around services to support the whole individual, not just their substance use. Suboxone is not enough to get folks off opioids, and methadone is difficult to get to, be on time for, etc., and I don't think MAT is sufficient to get folks off substances. I also think we are significantly lacking in ETOH services, as well as many other substance use treatment facilities. While I agree harm reduction can be helpful in some instances, just handing out harm reduction supplies is not going to be sufficient in supporting the other needs of the individual that are impacting their substance use d/o- such as chronic medical conditions, psychiatric illness, housing insufficiency.
- I think the City has a lot of programs but some or not really working, yet they obtain funding from the city. I think any program offering substance abuse help should have a 70 % success rate in order to continue. These programs should be working in a holistic format that includes Mental Health.
- I think the key here is "readily". I do think these services are available but people do not always know about them or they are not available in a timely way.
- I think there is too much Substance Use supply and not enough care planning to end the substance usage of Bup/etc
- I think there needs to be more on the ground outreach. There is a huge difference between increasing taxes/ having more administrative (behind closed doors) jobs and actual person-to-person interventions and interactions. I believe that actual person-to-person interventions is required and arguably a more equitable, sustainable, and ethical use of taxpayer dollars.
- I understand that folks who seek services in threshold languages have to wait for services or receive services via the translation line. In my opinion this is not the most effective way to engage folks seeking these services.
- I understand that there are services available to address substance use issues, however I don't see the effectiveness of these services based on the fact that every single day you see people on the streets experiencing substance use, the solution is more professional staff in the area to offer direct services for those who are psychotic and dangerous for the population.
- I was in court this week. The lawyer told us that the detained person couldn't get an appointment with Health 360 until Dec 8. He said he was a fentanyl addict. They let him out anyhow, even though we're told that such addicts benefit from going straight into treatment rather than living on the street where it's easy to get cheap fentanyl and then being offered a rehab place at some later date.
- I witness people using all over SOMA, especially around 6th Street. Their open drug use is detrimental to their health and that of those living around them.
- I work at a 12-24 facility - we struggle weekly to find places for teens to get substance abuse help. Resources are impossible to find.
- I work with hundreds of people who report not being able to access the substance use services they need
- I would imagine so but ultimately the availability will so in the results and outcomes.
- I've heard there is a shortage of substance use services
- I've previously worked in direct social services at a community-based organization based in San Francisco. I routinely had difficulty supporting clients to access substance use treatment services, including having to sit for hours hoping before my working hours to attempt to get into

detox. If clients were able to do this while in a precarious physical and emotional health state, then we still regularly failed to get a slot--disheartening, deleterious, and ineffective. Appropriate levels of care and steps into services are lacking. From my 15 years in public health in the city, 7 of which I spent in direct service, I'm extremely concerned by the Mayor's pivot to coercive treatment. At best, I believe parallel intervention strategies must be implemented to improve up and downstream factors that contribute to houselessness, disordered substance use, and mental health issues. Improvements to treatment access, enhancing the diversity of options, and sustaining live-saving harm reduction services must be part of this plan. Contingency management is not a substitute for evidence-based harm reduction services. Building the capacity of CBO contractors to provide appropriate services is a better use of resources than having them scurry to stand up contingency management programs.

- I'm thankful for having a BERT team in case of behavioral issues in the unit and Iact for drug addiction is helping to control our patient who dependent on substance it really mange their less cravings and less irritability as long as it's managed by the team and we can secure chat or call the team if they are in the hospital but otherwise once they have an action care plan for the patient, they're doing well and manageable
- If substance use services are readily available, why are there so many drugged-out people roaming the streets of San Francisco? It seems like substance-use services are NOT readily available, based simply on empirical evidence.
- If that were the case, I would not observe a homeless population utilizing drugs in open-air markets, nor would there be a widespread drug epidemic.
- If they were readily available and actually worked we would not have the problems that we have on our streets
- Improving, but have a ways to go. SUD is a very time intensive disease requiring complex care.
- In general there is a wait to begin accessing substance use services within DPH due to the high number of individuals seeking service. These services are also not generally offered on a drop in basis.
- In my community you do not know where to find support groups unless you are connected to medi-cal services. But outside of that if you have a need for support, you will be turned away. The point of service is to help people but if they can not pay the HIGH cost of support they are left in the streets. Open the doors and have a sliding scale for low income or no cost if you truly want to support the community.
- In my experience, many patients with substance use issues in the hospital have to jump through many hoops in order to be referred to a substance use specific placement, and the long wait and many requirements for acceptance results in the patients declining to go to a substance use program. Many of the programs that the hospital can refer to have limited language capacity and have poor staffing ratios with patient expressed concerns re: continued substance use by others while in the program.
- In my opinion we have more training and resources than other communities, however we could use more options for Detox. The city could benefit from a continuum of housing moving from still using substances but want to stop, to has stopped for less than 6 months, to abstenant housing. Our medication options are outstanding.
- In the hospital setting there are no services for night shift. And that's when a lot of people come into the ER
- Inadequate level of support given the need in city/county.
- Increase the number of clinicians in the field that can assess and begin medication-assisted treatments for substance use disorders on the streets and SROs of SF.

- Insurance barriers
- It is horrendously hard for people with disabilities to access outpatient or residential treatment. It is a nightmare for providers to help navigate patients through this process and takes so long that often patients are burned out and no longer interested by the time they are accepted into a program.
- It is very difficult for pt's to access surveys in a timely manner. There are various wait-lists, hours of operation aren't always feasible, and their a limited outpatient programs. Medical insurance is also a barrier to treatment.
- It is very hard for indigent people to be admitted to a free in-patient program within a reasonable time frame.
- It seems there are a lot of people on SF streets that could use substance use svcs
- It should be pretty clear for everyone to see the gaps in this. Beds are not being filled, and clients are being forced to go through multiple hoops to get into services - which makes them give up hope. Clients have reported that there are active drug user and active drug suppliers in SUD recovery programs and transitional housing. A person can't get sober if the drug supplier is in the next room. It's common knowledge that even staff of CBO SUD recovery agencies have died from drug related situations. Suggestion: stop bringing active drug users and dealers into sober living environments.
- It takes too long for BHAC to filter folks into necessary services. Some people never get a call back or make contact with a representative.
- It's getting better but still so limited.
- I've never been able to get my clients SUD treatment without an hours-long process of paper work and jumping through hoops; these services cannot take pets, couples, and make getting care incredibly difficult
- Just as there seems to be a shortage in facilities and clinicians in providing adequate care and services to those with mental health issues, there seems to be similar issues with those seeking support with substance use. Substance use disorders are more complex than just providing medication, it also entails a mental health issue component, facilities that can adequately treat those individuals, legal/law enforcement issues and harm reduction models do not seems to which either do not seem to adequately address the issue of substance use.
- Just make it for everyone who need the services. Than we can have a healthy population.
- Lack of providers and long wait times
- Limited residential treatment options, even for people who desperately want them. No option for medically managed withdrawal (like Joe Healy, previously). HealthRIGHT360 can only handle mild withdrawal.
- Long waiting lists
- Long waitlists. Not enough providers.
- Lots of homeless people struggling with substance use.
- Many individuals continue to face significant barriers to accessing adequate wrap-around substance use services, including long wait times, limited provider availability, insurance constraints, finical funds, and gaps in culturally responsive care. To reduce barriers to wrap-around substance use services, we can expand staffing and partnerships with community-based providers to shorten wait times and increase service availability. Improving insurance navigation support, securing additional funding streams, and offering flexible payment options will help address financial and coverage constraints. Strengthening culturally responsive care through targeted training, multilingual resources, and recruitment of diverse staff will further ensure that individuals receive timely, appropriate, and equitable support.

- Many services are still in English, and it's still very difficult to find Chinese-language psychological services.
- Many services have stopped with the new mayor and need to be restarted before we fall further back
- Many unhoused people do not seem to have access to any services, and the City does not seem to have enough resources and outreach efforts to reach these populations. In my neighborhood of Mission Terrace, there are unhoused people here and there, and people begging for money by the balboa bart/Muni station.
- More comprehensive out patient prog are needed with flexibility in admissions and content.
- More flexibility like drop-ins. People without phones or ID's face a ton of barriers in accessing treatment.
- More low barrier services needed
- most people needing this type of help, don’t want the help or refuse to think there is a problem. it society thinking if they need help they have to ask. most of this population is not able to make decisions in any case.
- Most services require three days of sobriety before they can enter residential treatment. There are not enough detox, beds, beds for languages, other than English are few and far between. There’s no accommodation for people who have service animals. Many of the treatment facilities have religious requirements that makes some people uncomfortable. The money treatment facilities, except people on methadone. They do not accommodate people to be able to pick up their methadone and keep it on site.
- My assessment both living in SF and working for DPH is not all the services are readily available and accessible to all.
- My brother recently passed away from substance use. We have tried for years to get help but do to limitations of consent, he never recieved the help he needed. There were other entities that we were able to connect him with but found that there were no follow through. We were typically told that they are understaff.
- My neighborhood (SoMa) is filled with of people in need of mental health and substance dependence issues. What we are doing is obviously not working.
- N/A
- navigating the system or getting connected to a starting access point is complicated, even for providers to coordinate linkage. Waitlists for contingency management plans, waitlist for inpatient, etc. if someone is wanting to make change there is not a door to walk through where they can connect that day.
- Need for more psychiatric RN's who can engage with the community
- Need many more detox centers, Spanish speaking rehab centers, or centers at least willing to take in Spanish speaking clients
- need more $ for skilled case management, for harm reduction services, for whole range of substance use disorders, for those who want abstinence and those who are not ready. services that won't kick folx to the street when they relapse or slip. we need safe consumption sites so that folx don't die while struggling w substance use.
- Need more sobering centers that can connect clients to substance use residential programs to help with sobriety and coping skills.
- Need more substance use services with criteria to meet to be accepted. If there is substance use, that should be the criteria needed to qualify for the program. Just because a patient fails in the program, they shouldn't be disqualified next time. Practice the recovery model and give pt's multiple chances. No one can stop cold turkey

- Neutral response. Not familiar with what services are available for anyone.
- Neutral. I believe programs need better auditing. Would love to know who is receiving the funds and their impact.
- News reports and interacting with service providers tells me there is not the capacity available which is needed to meet the demand for substance abuse issues.
- No access for kids who are not on Medi-Cal. Also, for those who are, the choice is slim.
- None
- Not as much as it was and the programs are more designed for people getting out of jail.
- Not enough beds/spaces for the high population/need. Not enough services for the majority of the substance dependent population, who is usually ambivalent about services, unstable in the community, and lacks the cognitive organization and executive functioning necessary to access the programs and follow through with treatment goals. We need more services that can meet the clients where they are at, or a clear and organized pipeline through low threshold services to more challenging ones such as outpatient clinics that require high client initiative to attend. Most of our services are designed for a significantly smaller clinical population and a significantly less acute population. The criteria for ICM, for example has sharply increased in the last 5 years. As late as 2019, most of my colleagues would have qualified for an ICM referral; now less than 10% of my clients do. The actual clinical indication didn't change, just the capacity of the system :(
- Not enough linguistically or culturally relevant providers. Not enough culturally relevant leadership to make decisions on behalf of populations with greatest health inequities.
- Not enough manpower to deal with this problem. Need a facility to properly treat/care for them.
- Not enough OPEN READY to Serve treatment spaces available
- Not enough options...same people gate keeping ways to receive treatment and support. Dominant good old boys complex expecting different outcomes. Alternate programming needed with capacity support .
- Not enough resources for those who need it
- not enough services and some CBO's promise more than they deliver (HealthRight360)
- not enough services.
- not enough space in most programs
- Not enough staff for the needs
- not enough substance use health services, resources. I work in an ER as a Registered Nurse and would say 2/3 of all my patients need mental health services that are not currently adequate to address their needs
- Not many duel
- Not readily available for children/young adults with intellectual or developmental disabilities.
- On demand treatment is not readily available
- Once again there aren't enough places for people to seek treatment and the recent focus on recovery services has limited the selection. The jail to treatment pipeline is clogging the system and taking up beds with people who are mandated into treatment which is not an effective long-term strategy to assist people with substance use issues. Also, many people who are seeking substance use treatment have comorbid mental health issues that substance use counselors are often not able to treat. Improvements: Broaden the choices of type of treatment offered to people i.e. 12 step, Harm Reduction, Contingency Management, Safe Use Sites (overdose deaths skyrocketed after closing the Tenderloin Nav Center), NOT faith-based programs. The city should be offering treatment programs itself and not farming all of them

out.

- only for folks who are ambulatory, have no serious mental health or medical services, are able to interview well and meet their own needs w/ following up. if someone has mental health also, they aren't prioritized because they're too difficult.
- Our streets are full of people who need (but are allowed to refuse) help. I regularly have to step out into the street in order to walk around people who are doing drugs on the sidewalk or who are bend over in the "fentanyl fold" position.
- Patients come in all the time ready to make a change but the referral process and lack of social worker resources/referrals make quick access to treatment very difficult
- Patients need to be in the right place at the right time in order to access these services. Many providers don't know how to connect folks with services aside from having them present at BHAL, which is usually a big barrier. Some of the newer programs like RESTORE depend on the patient calling at 2:30pm the day of and then having the clarity of mind to collect their documents from the PCPs office. Many patients experiencing substance use problems don't even have phones. In addition, current trainings are focused on helping people reduce their tobacco or alcohol use, not reduce their meth or fentanyl use.
- Payor complications--MediCal enrollment, commercial insurance, Kaiser.
- People do not have a clear path to access these services that is ready visible to ALL.
- People in San Francisco still on the streets non medicated
- People who need substance use services, don't necessarily know they need those services. There needs to be more on-the-ground outreach to people on the streets who obviously have substance use issues that may be related to mental issues. On a daily basis, in my neighborhood, I see substance use challenged individuals who appear homeless, confused, angry, or lost.
- people wo are struggling have to go through detox before getting care. and sometimes other points of proving they need help and want it. When if someone says yes to care they should be placed in the right care to get help. and not have to wait before they get needed care. some of these places want you to stay in programs that don't allow them freedom to access the rest of the world. Most times they put people in more danger not having freedom while being in a program for help. It's more like a prison system and not help or care.
- residential bed shortage ongoing
- Residential treatment programs are not long enough to be effectively help someone reach sustainable sobriety. Programs should be at least a year long (especially for those who use crystal meth). There should also be more sober living cites.
- Same answer as before. There aren't enough services for the amount of people that need them. Also, most services available are abstinence based and have a high bar for entry. That doesn't work for the kinds of people who need these services. Harm reduction is proven to work in other countries but the way we implement is different than how it works elsewhere. My suggestion would be to focus on staffing retention and listening to what staff in those programs/clinics say is needed.
- same as above
- Same as above
- Same as above with substance use services. They are intertwined with mental health services.
- Same as above; resources are focused on Medi-Cal recipients. I am a little less aware of the recovery landscape than the mental health resources landscape for folks who don't have Medi-Cal.
- Same as above.
- Same note as above. I appreciate it's a difficult issue because the research shows that people

have to want help, and for every person, it's different. Do they have to hit bottom? Is a harm reduction approach preventing them from hitting bottom? What's more effective and what's the most humane approach?

- Same question as above, what does "readily available" mean? I would say they are, but it's not always adequate services. For example, a client could present to HealthRIGHT and make it into withdrawal management same day and then routed into residential, but as a former employee there who treats many former HealthRIGHT clients, I can attest to the lack of adequate SUD services. HealthRIGHT is just an example, this is a persistent issue across other low barrier programs like Salvation Army. If a client is skilled and savvy enough to make it in somewhere with more trained and competent staff, that's great, but it's not often possible for the most acute clients in need of immediate placement.
- same response as previous explanations. The cycle is guided by corruption. It's like a bleeding cut, no soap or medications to address the issue. Just washed over by tap water.
- same. We need to make our substance services accessible. We need to be able to state clearly online what our programs are and how to get access to them. And the answer is not "go to 1380 Howard and find out"
- San Francisco faces a serious gap in accessible substance use treatment. Current treatment programs are not well known, and the entry process is often confusing and discouraging for residents seeking help. As substance use continues to rise in our city, it is essential to expand and streamline treatment options ensuring that ongoing care is available, affordable, and easy to navigate for those who need it most.
- San Francisco has generous substance abuse assistance but compliance is very very difficult with this illness. This is why we need to re-establish long-term custodial and residential support for severe long-term illnesses like addiction and psychosis. Patients and families need to feel that there is support as long as it's needed. Bouncing patients back and forth from the ED to residential to the street and repeat is detrimental and is more expensive than providing residential supportive care.
- Science proven, healthy, compassionate, and patient centered substance use services are NOT readily available for "anyone who needs them". We need to do better by our marginalized and houseless people and communities, meeting them WHERE THEY ARE AT and slowly, thoughtfully, and compassionately helping them reduce their use and heal and address the core mental health issues that possibly created and/or contributed to their substance use issues.
- See explanation above. Cut politicians salaries until the city is cleaned up and most (if not all) the folks who grew up there but can no longer afford to live there can get back into having safe and supportive housing, put that money into services that will address the root of the problem!
- seeing many drug use in the street on a daily basis when going to work
- Services are siloed, not enough services for the demand
- services are under staffed, leading to burnout; underpaid staff leads to looking for other higher paying jobs or returning to university for another degree to get paid higher.
- Services for regulating or stopping drug use are insufficient to meet the need. Furthermore, for the Spanish-speaking community, service centers are not adequately designed to connect with Latino culture, nor with the languages ??of the indigenous community, much less with the Spanish-speaking community.
- services not readily available for people who may have mobility issues as many SUD residential programs have stairs and elevators often not working for months at a time.
- SF need more Substance use services like residential programs that are ADA compliant and can support people with disabilities/ assisted devices.

- Similar to the situation described above in the mental health SOC, Member receive mixed and confusing messages about access to treatment which frequently causes Members to lost focus in their goals.
- similar to what I said above. lots of services are also specific and targeted to certain populations only. insurance is a mess...hard to get services with certain insurance companies. i also had a single father who had custody of his son but could not get into any programs. only programs for moms with kids existed.
- similarly, lack of detox beds usually
- Similarly, substance use services are geared towards people with complex polysubstance use disorders and the system is full to the brim with patients who have a very complex pathology, and often a mix of substance use disorders, mental health disorders, and resulting medical comorbidities. This group also seems to be facing complex psychosocial pressures, e.g., unstable housing or homelessness, poverty, etc.
- so access but only with advocacy to access. not many with SUD can advocate
- sometimes it's hard to get a hold of programs like healthright 360 or to get client into detox. also, there is not much language capacity especially for asian languages.
- Substance abuse services aid the problem by giving the addicts awards for being addicts. basically paying them to stay addicted.
- Substance abuse shelters and treatment facility need to be available for all ages offering services in every San Francisco district.
- Substance services are not available we should have public health nurses community base where they can reach homeless people
- Substance use disorder has risen causing treatment centers less effective causing many to return to use.
- Substance use services are available, not readily available- to anyone who needs them. Long wait times, particularly to those who are non-English speakers.
- Substance use services are available, such as BHAL/BEAM, Scope. However those seeking treatment are not always ready for the medication assisted treatment programs. The environment does not help substance use, constant struggle since the drug market is still heavy in the SF area.
- Substance use services are not readily available or accessible for everyone who needs them. Many youth and LGBTQ+ community members face long waitlists, limited culturally responsive care, and strict program requirements that can exclude those who are unhoused or actively using. Services are often tied to insurance or documentation, which creates major barriers for newcomers and people in crisis. Low-barrier, harm-reduction-based, and community-rooted programs save lives. We need more drop-in style substance use supports that meet people where they are, without requiring sobriety or insurance. Suggestions for improvement: â€¢ Fund more low-barrier and peer-led recovery programs that are LGBTQ+-affirming and trauma-informed. â€¢ Expand mobile and outreach-based harm reduction services. â€¢ Integrate substance use, mental health, and housing supports under one coordinated system. â€¢ Increase bilingual and culturally specific providers who reflect the communities most impacted.
- Substance use services in San Francisco are not readily available - they're punitively selective. Current systems prioritize abstinence-only models that exclude neurodivergent individuals, criminalize sex workers, and marginalize communities already targeted by law enforcement. Services don't address why people use substances (trauma, economic abandonment, unmet neurodivergent needs) and instead demand compliance or punishment. Actual accessibility requires: (1) harm reduction as primary framework, not supplementary; (2) peer-led,

community-designed services with decision-making power; (3) no abstinence requirements for housing or support; (4) neurodivergent-affirming care that understands substance use as potential self-regulation; (5) explicit protection for sex workers, undocumented folks, and those with histories of incarceration. Until services stop being surveillance mechanisms disguised as treatment, they remain inaccessible to those most harmed by current policy.

- Substance use services such as detox programs to help pts with withdrawal sx can be full and difficult to access when a pt is ready to enter. Wait times can decrease pt's willingness to enter tx. Services are most often in English, with few language concordant and culturally competent substance use services available.
- sufficient services not available for folks in crisis who need help ASAP
- The amount of people on the streets dealing with substance use and the media coverage discussing the lack of beds available for detox, short term and long term treatment all point to signs there are not enough services
- The beds are few and far between
- The city does not have a modality that provides the aftercare for recovery. By giving people methadone is the easy answer
- The city is providing more and that is working but we need more spaces activated that people can trust as safe and non-punitive. Once there, folks need language and cultural support as well as access to options like detox, RESTORE style beds and medications and transpose a huge piece of that puzzle if folks need to go somewhere to access services once they get the help they are asking for.
- The City of San Francisco has always been very wasteful, spending far too much money on mental health and substance abuse services. There are countless "non-profit" organizations involved yet what results are we seeing? None. Street drugs remain easily accessible. What is the point of providing these services? Many healthcare workers lack proper training and have zero accountability. Some leave before their shifts end, and no one checks on them. Even managers and directors often fail to show up for work. Taxpayer money is being wasted on endless, ineffective services.
- The demand appears to be far greater than the capacity to meet the demand. Referrals require follow-up and without much provider capacity, potential clients/patients are not followed up with in a timely manner which delays care.
- The hospital needs a detox unit.
- The lack of ADA accessible treatment beds and absence of an actual medical detox for alcohol is embarrassing. The city has been making strides in treating opioid use disorder and that's wonderful, but treatment is still grossly inadequate.
- the money funneled to substance abuse an harm reduction services are far too low
- The paucity of services that specifically address meth use and fentanyl is and continues to be shameful. And we still lack affordable outpatient recovery AS WELL harm reduction services that even approach the need.
- The population I witness when I come to work at 5:30 am is either choosing not to be helped or are not being isolated in a realistic standard of care. My walk from Civic Center BART to 49 South Van Ness at 5:30 am is not the sanitized version the 8 am crowd gets. Typical SF a bimodal city or 43 billionaires with 1% of it population homeless and we get to hear the endless dribble of progressive denial that feeds into the Trum mentality of extremism.
- The services may or may not be available but there are a lot of severely addicted people on our streets not getting treatment. They may not want to be treated but they clearly need it. I'm guessing it's partly that they refuse services but regardless the end result is they're not being

treated.

- The statement includes the term "anyone" and I do not believe anyone has clear access to these services such as immigrants, minors, and people experiencing homelessness.
- The SUS continuum offering needs to be more expanded to support higher acute SUD needs. Currently there is not sufficient providers online who can treat the severity we see on a daily, due to, increase in drugs on the market.
- there are insufficient substance use treatment programs for people who speak Spanish, especially residential
- There are many barriers to substance use services, primarily a lack of beds in treatment programs. Additionally, many clients are barred from services because of behavioral concerns, acute medical needs, or acute psych symptoms. Anyone should be able to get same-day treatment, but this is not the case.
- There are next to no services for substance use. Less now than EVER before. It is great that people can get suboxone easier than ever but beyond that. People that want to go to rehab die on the streets waiting for a service that doesn't exist. The mayor said he was opening more beds for recovery and its harder than ever to get in
- There are no providers, sites where I can take a Client same day for substance use TX.
- There are no services for youth/children. There is also normally a waitlist for most programs which is hard when someone wants to stop they should go in right away. There shouldn't be a wait.
- There are no substance abuse programs supporting monolingual clients (e.g. Cantonese, Spanish) or have language appropriate staff 24/7 to support them in the program.
- There are not enough available and qualified care providers to meet care needs in a timely and safe manner.
- There are not enough beds for those most in need, especially for most of our clients living in poverty.
- There are not enough long term treatment options. I believe we need a multi year approach of detox, harm reduction or abstinence, sober living communities and reintigration and job placement. 90 days is often not adequate for people as the brain cannot repair itself that quickly. Stop putting addicts back into SRO hotels after treatment. You're setting them up to fail.
- There are not enough of the right care people need. Safe detox sites, no matter how long it takes.
- There are not enough substance abuse programs and services in this city, and the fact HealthRight 360 is the main access point for SUD treatment is crazy. The fact that HR360 is individually choosing who can and can't be admitted to residential SUD services to multiple SUD programs throughout the city in insane. Turn it back to individual programs being able to accept people into their programs. ALSO, the fact that there is only 2 ADA beds for SUD treatment in the whole city and the fact that Health Right 360 holds them is ludicrous!!! You absolutely have to provide 100 more ADA beds for SUD residential treatment. There needs to be accountability and transparency. the whole SUD assignment system needs to be overhauled!!!
- There are not enough SUD for youth services for preventive outpatient. Same as above not enough Spanish Speaking providers for SUD.
- there are often language barriers that prevent someone from being able to access services readily
- There are often long waits to get into detox or a treatment program. Also, to get into tx program requires LOTS of specific paperwork, which is often a problem d/t no PCP to complete the paperwork. THIS IS A HUGE PROBLEM!!!

- There are only a few pathways to recovery services for the low income public.. Inpatient is pretty much only HealthRight
- there are service but they aren't always accessible when people need them.
- There are services, but the timeliness of the services can be a challenge. We need social workers and nurses who have the time to do their due diligence and being patient with people, but we cannot expect them to do that and quickly move through people as well, we need more staff. It doesn't mean much if you're culturally competent, but you have an estimated time you're supposed to spend that doesn't accommodate the actual person or a quota to meet.
- There are strong linguistic barriers that exist. There are also barriers by immigration status.
- There are thousands of vulnerable people on the streets that could potentially qualify for substance use services. San Francisco has a very small number of these places. not enough for lots of people in need. As far as I know, we still do not have a detox program and it takes even months for a person to wait before getting accepted into a residential substance use program.
- There are very few programs that we can send patients with dual diagnoses to
- There are waiting lists - so when people find they are ready and seek care -the opportunity is lost.
- There are waiting lists!
- There is a lack of available beds for substance treatment, especially dual diagnosis treatment.
- There is a pharmacy desert in Bayview that greatly limits access to MOUD for Bayview residents.
- There is limited resources available
- There may be many programs available, but based on the population we work with in the hospital, there are often long waits for available space, leading sometimes even the most determined to relapse before obtaining a spot.
- There need to be more free outpatient services for folks with substance use challenges
- There needs to be a priority on maintaining the name and location of Behavioral Health and Substance Use support services. I understand that contracts change frequently, but the constant change in name / location / phone number is deeply problematic for people needing to access these resources. I am thinking from the perspective of the folks that BHS serves, as well as the Case Managers, clinicians, and staff supporting these people. The city websites are also egregiously out of date when it comes to name, location, contact, and hours of service for these resources.
- There needs to be more street teams that go out into highly drug infested communities. Services should be offered to people that don't have transportation or the means to go to a hospital or drug treatment facility.
- There needs to be real treatment on demand and long term follow up. Also a recognition that substance abuse without a psychotic disorder such as schizophrenia can be treated with 12 step programs or therapy but the true dually diagnosed people need special care as they have brain disorder in addition to substance abuse This is the population that now winds up in jail and prison
- There only a few and usually they our full and person has to wait
- There seem to be many services but it has been hard to connect them from the primary care setting and relies on patients to call or go to another location.
- There's a lot of shame and guilt placed on individuals that seek substance use services. There's not enough resources and emphasis on prevention.
- There's only 1 harm reduction (not full abstinence based!) group open to cis women with stimulant use disorder and it's during business hours that most jobs won't accommodate with pay or flexibility.

- There's lots of resources for adults but not youth or TAY
- They are not readily accessible for many people who need them. Long waitlists, complex intake procedures, and limited program capacity make it difficult to connect individuals to care in a timely way. Many residents, especially those experiencing homelessness or co-occurring mental health conditions, struggle to navigate fragmented systems or meet strict eligibility criteria. Plus, there are not enough culturally responsive or bilingual providers to serve the city's diverse population. Expanding walk-in access, improving coordination between outreach and treatment programs, and increasing trauma-informed, culturally competent services would make care more equitable and effective.
- They are underutilized
- They aren't available in a timely manner for people who are in crisis or unhoused or who have challenging behaviors. I has improved some over time but the barriers are still too high and behavioral expectations are unreasonable for many people with behavioral health and cooccurring mental health disorders.
- They were available, many services have been discontinued due to budget cuts
- This access should be at every clinic, regardless of what services is provided. There should be staff that can help individuals with substance use services!
- This is another area where the wait list is too long. Also, if Trans People need substance abuse services, there is a lot of Transphobia within different substance abuse treatment facilities in San Francisco.
- This one seems more on the mark. There appear to be lots of efforts to help those who struggle with drugs.
- This question does not even make sense. What are substance use services? Substance use recovery services? There are plenty of services that are giving out and enabling drug use. There are not enough services that provide actual medical treatment to help people with their substance use disorders.
- Too much wait time to go into a program and housing is part of it.
- Transition places are a great need. Initiating moud on the street is very difficult. We need more programs like restore and programs to meet the treatment initiation needs of people who use crack and speed. Withdrawal management services that are medical is huge need. For people who want abstinence or to reduce their tolerance/dependence and use fentanyl or heroin there is nothing that is easy to access. Night time, 24 hour services should be available for moud and methadone access that is low barrier and easily accessed would help so many people post overdose, people in withdrawal who need support and are open to change.
- Treatment on demand services are not readily available.
- Very few substance use providers focused on adolescents, even fewer that are linguistically responsive, and none that provide integrated specialty MH and substance use services. There are also no providers that serve the child and adolescent system of care that provide medical treatments for substance use (e.g., buprenorphine)
- Very little in non-english, no PTSD treatment (beh mod or other stuff) except at VA, Hassle to get residential care, narcan shortages, lack of harm reduction services, everything is abstinence based, no housing post treatment, very little dual dx etc
- Very similar to above everything going through TAP/ BHAL has made accessing services more challenging. Additionally some of the partner agencies clients are then referred to require a clean UA to begin services which does not make sense. If client's use were under control such that they could provide a clean UA they would not be in as dire a need for services.
- Veterans and other community members have been turned away from substance abuse

programs routinely for "not meeting criteria." Those seeking support should have access to services. Community members should not have to walk down the street seeing those under the influence, actively using in the moment, vomiting and defecating on the streets, because they were denied services for "not meeting criteria" when seeking help to abstain from substances.

- Voluntary services are readily available. But--there are a lot of very disabled people that current legislation, funding, and social standards do not let us commit to involuntary drug treatment. In addition, because of the peculiarities of funding, the availability of services for substance abuse treatment are not what they could be. Unspoken in all this is: even if there was free buffet menu of services, it's not clear to me that we'd get a good uptake even if we had infinite services. Worse--providing shelter has just meant everyone died alone in their rooms. I don't know what the answer is. It doesn't seem this should be it. I mean--it's down? but why? Deaths. 2025: 497 (preliminary, as of September 2025) 2024: 635 2023: 810 2022: 649 2021: 642 2020: 726 2019: 441 2018: 259
- Walk anywhere in the tenderloin or SOMA neighborhoods. Not enough services that meet people in the streets where they are. Not enough services for other languages as well.
- We are fortunate in SF that there are a lot of resources for substance use. However, they are not always accessible whether it is due to office hours (e.g., only able to perform take-ins for methadone clinics in the morning).
- We do not have enough mental health providers nor services to meet the needs of clients in the city, especially since there are now so many drug court/"diversion" referrals forcing people into these services that they do not current want, which is not efficacious treatment and contributes to the burnout of the already bare minimum staffing for outpatient and other mental health services in the City. (public) Drug use is a public health issue. Getting people wrapped up in court and arrests and punishment has and will only exacerbate the problems on our streets while contributing to provider/staff burnout and other system wide issues (see public defender's office and the recent need to release people in the jails due to lack of representation).
- We have had patients with substance abuse problems, that keep coming to our hospital for the same reason, medications (Dilaudid, Oxy etc.). These patients could be offered services while in house, maybe they have, but patients are discharge and then when they come back they need another dosage of the same medications, that they are addicted to. Some patients can be probably transferred to half way hospitals for treatment of their addiction, but we don't have hospitals or long term care facilities that deal with these problems.
- We have limited sober living housing units; a lot of my patients are in recent remission but report triggers because they are on SROs where there is significant use around them.
- We have no community medical detox centers (like Jo Healey)
- We know there are wait lists and folks are often turned away or told to come back, meaning many times, we loss an opportunity. There need to also be more low threshold access points to a full range of services from safe supplies to abstinence and everything in between. Harm Reduction needs to be funded at levels to actual meet the need.
- We live on Harriet Street between Folsom and Harrison. We often see people who are in need of substance care (e.g., having a mental episode, huddled under blankets doing crack) and are roaming the streets. However, they are there anywhere from one hour to one day and our care services do not respond in a timely manner. They are often gone before the services can arrive.
- We need medical detox and more quality low barrier SU programs with no waiting and low barrier.
- We need more beds. I work at the jail where people languish due to lack of beds for residential substance abuse treatment.

- We need more services that truly reflect the culture and realities of substance use in our city. I'd love to see expanded street outreach and harm reduction approaches that focus on education and providing supplies for clients who are acute or unhoused. More funding should also go toward specialized training and certifications for teams like ICM and other direct service providers who are on the frontlines helping them build stronger skills to address and respond to substance use, including alcohol and other drugs counseling. Additionally, there's a need for more training around assessment and treatment for dual diagnoses, as well as educational campaigns with accessible materials to inform both clients and the broader community.
- we need more substance use and mental health services.
- we should be doing MORE programs like INSPIRE to address meth use and incentivize MORE people to use MOUD tx for their opioid addiction
- We talk about this and culture we do not see as a main problem. Language could possibly be. If people do not want the services they will find an excuse.
- What I have been told (though I'm not sure how accurate this is) is that there are waits for beds in substance abuse programs so even when a person is ready to accept help, its not readily available and in the timeframe when the person is waiting for a bed to open up, they lose their motivation for change.
- when i say i strongly disagree i mean getting them help to end their addiction that matters there is no end to pamphlets or people telling them turn to got of just be strong i mean real valuable help is not easy to come by
- When placements are unavailable for dual dx people to stabilize in, they are unable to decide to go to drug treatment
- When voluntary substance use in the outdoors results in overdosing, these substance users need public health providers to intervene and act immediately to place them in rehab program to prevent future overdosing. San Francisco needs more aggressive actions to reduce substance use in the streets.
- WHERE?
- While I feel that we have a HUGE amount of resource for people with SUD, and that services are available for anyone who needs them, I do not believe that people who "need" them are accessing them often enough. And part of this is owing to the dual-diagnosis nature of SUD+ other mental illness
- While I think that accessing medications for substance use services is low barrier in the city and readily available, I feel like there is a less access to individual counseling services/therapy for people in recovery as well as limited spots of treatment beds that result in longer wait times for some programs. Wonder if it would be possible to have an outreach based team that could do recovery counseling and support in supportive housing
- While many organizations are working on substance use initiatives, more funding and support is needed to support the work non-profits and the city and county are doing WITHOUT stigmatizing or criminalizing those living with SUD.
- While services may be "available," I'm unsure if they are accessible, barrier-free, or culturally and linguistically appropriate.
- While substance use services exist in San Francisco, there's still something missing in how people actually get connected to care. Same issues noted above.
- While the BEAM program has made Suboxone readily available, there is not enough housing to go with it. Most clients tell me they can't get clean if we leave them on the streets or in a shelter. They need the stability of supportive housing too. Also there are too many barriers to Methadone and not enough resources for treatment of stimulant use

- While the infrastructure is there to connect clients to different service deliveries, the programs are understaffed because of a variety of factors, such as burnout, lack of supervisory support, lack of clinical hours guaranteed towards licensure, people in leadership roles without a clinical background, the existing staff taking on multiple vacancy roles leading to role confusion and resentment, and the lack of policies and procedures on safely engaging with clients in the community
- While they may be available, they are hard to access
- whilst substance disorder is not seen as the same as other disease processes it will not be accessible due to stigma and perceived risk of being arrested or incarcerated
- With the amount of drug addicts on our streets everyday it seems as if there isn't any help for the drug addicts.
- Working in Primary Care, it is clear that there are gaps in connecting people to substance use treatment. Many people are unwilling/unable to commute to SOMA to request substance use treatment. Having satellite clinics that offer linkage would be helpful and not at Primary Care clinics. While Primary Care is a great option and should be utilized, it also should NOT be the only option for Satellites. As Behavioral Health staff, while our jobs are to provide "short term solution based care," we end up being chronically overwhelmed with supporting people meeting their basic needs. There are not enough medical detox beds available in the City and Residential Treatment is also limited.
- Yes, that's a huge problem; they're very accessible and doctors hand them out like candy. Sometimes drugs aren't the initial solution; it's simply a matter of listening with empathy and guiding the patient to rediscover the starting point that caused the situation.
- You have to know where to go to receive services. Also, there is a wait list for SUD services.

Appendix C

What makes it harder for San Francisco residents to access mental health or substance use services?

- "The leadership" team of SFDPH does not allow for the leadership team of other agencies to partner with them. They are still using an old system of telling people what they should do/
- Aggressive policing and criminalization; particularly impacts people who use substances, limiting access to SSPs and low-barrier care. 2. Programmatic shutdowns or policy shifts; recent reductions in low-barrier harm reduction services and delayed OPC/safer supply implementation have decreased access and increased risk.
- abstinence only requirements
- Addiction
- administrative barriers to care, low staffing
- ALL above for various people.
- All of teh above
- All of the above.
- Basic survival needs for homeless people
- Behavioral Health Access Center is terrible system
- Behavioral Health Issues
- being able to manage going to treatment/residential when have family responsibilities
- Being able to obtain services before or after work. Privacy, fear of employer/coworkers knowing. Services being available throughout the community, not just downtown.
- Being so disregulated/disabled that they can't pursue services
- But the mentally disabled people or homeless people probably can't take advantage of it.
- case manager has too many cases to follow up with staff timely.
- centralized access is difficult to access to those who don't answer their phone. Therefore, all those who are not ready to receive mental health services take up all the intake slots while those who are ready are unable to access because they prefer in person drop-in.
- changing names/locations/phone numbers of service providers causing system-wide confusion from both people needing services and the people supporting folks who need services
- Clients are unable to take care of their MH needs, if they are still struggling with substance use. Ongoing substance use prevents treatable mental health needs.
- Concern that access to behavioral health services may affect the participant's immigration status
- criminalization of mental health (PD having 5150 writing ability)
- Culturally congruent health services are needed. The way you care for the white man, is different from how you care for the black man.
- Cumbersome intake processes
- Denial that there is a problem:
- Difficulty in finding parking space
- Disqualified Staff
- Due to anasignosia, many people who need treatment don't want it because they don't know there is anything wrong with them. And we currently don't have a good system for getting people to be treated who don't seak it out. 5150s don't help if you just release the person in a day or two and they go back to what they were doing. They're are
- Folks that are clearly in danger due to mental health but just keep cycling in and out of the system until someone gets hurt
- Getting a referral from a primary care doctor.
- had previous poor experience of health care including mental health
- Hard to find mental health care for mental illness which is not severe. West side crisis and PES

are good for severe mental illness.
- Harder?
- having no housing, unable to afford basic needs, have no where to go when they complete treatment so they are referred BACK TO A SHELTER
- High cost of living exacerbates all of the above
- housing, safe and supportive environment to access services
- I would add the system is too bureaucratic and the people needing help become easily overwhelmed due to not knowing how to navigate the system.
- I would like to HIGHLIGHT Lack of Language support and complete lack of ethnic/cultural understanding!
- If their acuity isn't high enough they won't get an intake at a DPH clinic
- immigration status
- Inadequate services available to meet patients/community members where they are at; lack of infrastructure to effectively support the growing need
- Individuals who do not have documentation may fear getting deported for seeking out services
- inflexibility with where and when services happen and expecting strict adherence to appts for folks not functioning at that level
- Insurance companies making it hard to get services so they don't have to pay for the healthcare.
- Insurance difficulties
- It depends on the severity of illness! Please specify.
- Lack of a reason to assent to treatment
- Lack of availability!!!!
- lack of capacity
- lack of clinicians who provide regular visits for CBT
- Lack of community support i.e. case managers/social medicine
- Lack of connection in the community; parents need to connect with other families, and young people or adults with these conditions need a space where they can talk confidently about these issues.
- Lack of consistent providers
- Lack of diversity at various DPH-run sites
- Lack of facilities!!!!!
- Lack of follow-up or ongoing support after initial contact
- Lack of in person, lack of clinicians
- Lack of insight into own mental health/substance use condition, or not desiring services.
- Lack of low threshold programs with harm reduction approach
- Lack of motivation for fixing the mental health or substance use
- Lack of physical structures, beds, housing
- Lack of presence in visible, on the ground, presence in neighborhoods.
- Lack of providers trained to work with children and youth with disabilities
- lack of providers with training and willing to work with people with developmental or intellectual disabilities.
- Lack of providers/services who accept Medi-Cal or insurance, as opposed to self-pay
- Lack of regular technology access
- Lack of residential and hospital beds
- Lack of services for Behavioral Health
- Lack of support to navigate services

- lack of understanding their condition, or not knowing there is help
- Legislations by corrupt politicians who control the state's elections creating anti-American one party laws. favoring
- limited mental health and SUD services available
- limited number of providers
- Limited number of providers and mental health focused clinics
- Limited number of providers and providers that accept more than just PPO insurance
- Limited number of providers who are willing to meet with patients in person.
- limited numbers of providers period!
- limited providers, incentiving/$ models of treatment, types of medical facilities for the various substances (alcohol, stimulants, opioids..), legality/criminal laws, limited providers willing to utilize 5150/SB43 , etc, conservatorship process takes long, no real helpful model - harm reduction versus forced treatment issues; people with substance use disorders willing to make a life change and get sober
- Linkage to appropriate services based on need
- Making an appointment and talking to a qualified provider is only the first step. Sometimes there are many treatments that don't work and then people give up instead of keeping on trying to overcome all the obstacles noted above.
- Mental health issues for kids are different than substance abuse treatment options for homeless adults---so, looking at the kids first: Not enough multilingual providers. Probably the issue is a poor differential for "language pay"; for homeless substance using adults; frankly, I don't know. many aren't much interested in stopping their use. So--I don't know that we're equipped to do involuntary treatment and I don't think society has signed off on that yet. If ever.
- Mental illness itself.
- mental illness prevents motivation to seek services
- motivation/cooperation, housing
- My guess is that those who would benefit most from an intervention do not seek care when they should as they don't see their problem as severe enough to warrant care
- No ADA accessible residential treatment programs.
- no desire
- No medical program in SF and no quality programs
- No pressure to address any issues
- No providers available in health plans or at health centers.
- Non compliance, not wanting to get help
- Not avare of the situation
- Not being able to walk into any clinic and get seen that day.
- Not being in a frame of mind to go get help
- Not easily accessible
- Not enough case manager to support with getting to appointments, symptoms are barriers to getting to appointments for care
- Not enough housing to stabilize people long enough to effectively engage in care
- not enough mental health institutes to have them live in thanks to Ronald Reagan
- Not enough options for mental health care.
- Not enough outpatient programs and residential beds available at all
- Not enough providers
- Not enough providers period!

- Not enough providers/open appointments available
- Not enough slots of services
- Not enough spaces, and not always the service that people are actually seeking for their need. People who have cycled through are skeptical of trying the system again.
- Not hard at all!
- Not having the other critical life pieces in place in order to actually spend time and energy on mental health. Its hard to go to therapy if you are housing or food insecure, or if you just dont have enough free time bc you have to be working so much
- Not interested
- Not knowing where to begin finding services.
- Not knowing where to start.
- not knowing who can take care of animal/store cars
- Not lack of transportation, but time it takes to transit (I.e. public transit may go there, but take much longer than a car ride which incurs higher cost for fuel or fare)
- Not willing to Recover
- Ntoo complicated to navigate the system
- OCC is cumbersome and not always knowledgable
- Our school system that can't help children become adults.
- paranoia, fear, severe depression
- Parking around the SFGH hospital
- Patient unreliability.
- People from outside of SF come for drug tourism and stay to use the services, creating backlogs for SF families to get help for themselves
- People have to want to change
- people who need MH or SUD services need direct access to the clinics and staff who can readily provide those services. The way it works now is there are lots of people who help to "coordinate and link" the people to services and they get confused why they have to talk to so many people when all they need is a therapist or a psychiatrist
- person need to be ready to accept he/she needs help
- Physical/behavioral/intellectual disability
- Prevalent provider stigma around harm reduction
- Pt does not have the motivation to make a change.
- residents have expressed to me that the above are the main reasons
- see my previous answer
- Serious mental illness and addiction to substances which are readily available
- services are full
- Services not available
- some people don't have mental issue
- Staff Incompetence
- Substance use and lack of motivation, lack of interest
- Systematic supremist system
- The availability of drugs
- The cost for therapy is through the roof!!!!
- The lack of empathy and support in the process.
- The mental health and substance use disorders themselves interfere with patient's ability to plan ahead and persevere through the aforementioned barriers to care.

- the ones that need it should be forced to take it or go to jail. they should not be allowed to roam freely under the influence or mentally ill .
- The people who need the services the most will never seek it out themselves. There are people who are dealing with SMI, serious mental illness, that are being treated like they have agency to make decisions, but they don't. They will never recognize that they have an illness whether its mental or substance use disorder. They need to be forced into treatment for both mental health and substance use disorder.
- The poverty suffered by those with a need for those services
- the reduction in harm reduction services and related low-barrier-to-entry programs
- There is not enough SUD Detox Treatment center for our clients to choose from
- There own personal belief
- To many steps involved to access care.
- too little time allocated for services before they have to leave (30 and 60 days is not enough to get clean/sober and find housing, employment and services.
- Too many clients/patients not enough addiction and recovery counselors. Addiction and mental disorders have always been rampant and more obvious since mental facilities closed in the 80â€™s.
- Too many steps to get care which leads to people giving up
- Trans people feeling unsafe, no culturally congruent programs.
- Transphobia and Homophobia and Racism and Fatphobia
- Triage for referral process lengthy or unresponsive
- understaffing because of lack of guaranteed hours towards clinical licensure for 2930s
- Unwillingness to access services
- Veterans own issues with avoiding getting care.
- wait times for residential services/housing. how can one really adress their mental health or substance use withoutr a roof over their head?
- When employees providing these services are ill supported and experiencing burnout, the clients directly absorb their disposition

Appendix D

Which services should the City prioritize for behavioral healthcare?

- . MY team is staffed at 60% and losing 2 more positions leaving us at 44% staffed (we have 2 direct staff to 1 manager now). No staff means no care!!!!! Also targeted BHS such as ICM waitlist is 6+ months so people wait to discharge, holding up the service bed they're in waiting for ICM provider.)
- make mental health and substance use services more accessible 2) substance use treatment services
- 1st most important - A primary focus on US Citizens & Legal Residents.
- 1st most important: Childrens' mental health services--they are all the innocent civilians of this war.
- All extremely important & should be prioritized
- All of the above is extremely important. It's hard to rank choices
- All of these are equally important! If not addressed at one level it evolves to anther! I don't see the priority for Children Behavioral Services here!
- all of these are most important.
- Also providing supportive housing services at a lower acute stage since housing is usually provided at an acute stage where the benefits might be less impactful in overall behavioral change impact stage
- Building more state hospitals, locked sub acute treatement facilities and more board and cares.
- Capacitate longitudinal programs over short term linkaage services
- Children and youth
- Children, youth and families
- easy access to affordable housing or support services
- Education & building stronger families.
- Especially for parents who are pregnant or perinatal.
- For now, i would say help those in need and if we can get it under control (not sure it ever will be) then focus on preventive. But both are very important.
- Full Pysh Assessment services (1st most important)
- Funding for building provider capacity
- Get the crack and fentanyl off the streets. Break down encampments which breed communal drug use
- Give people in the street a choice of treatment or jail. Remaining on the street can not be an option.
- Giving clinicians the resources they need to provide comprehensive services
- Help with getting a job would be nice as well as more housing options
- Hiring more psychologists or psychiatrists to provider CBT and other mental health services
- HOUSING FIRST and robust harm-reduction services are needed more than ever.
- Housing is overpriced based on the income.
- I would say behavioral health...I cannot seperate or prioritize Mental health services or Substance Use services. They are equally important and often together. I
- In addition to the above, ongoing outreach and follow-up support.
- include veterans in targeted underserved populations
- Increase staffing for those who provide behavioral health services - staff are burnt out
- Increased placements for consevatees
- It's important to understand that the city CANNOT pay for this long term. But San Francisco could set an example that would be picked up statewide and nationwide. This is a global

problem -- not just a San Francisco problem.

- Jobs and other vocational opportunities
- keeping LGBTQ+ specific services available for those who need that specialized care
- Less incarceration and police. Statisticaly we know this is ineffective, makes a persons situation infinitely worse, and cost a ton of money and recourses. More wrap around care
- Look for the root cause of why substance use is high!
- Make day treatment available again. I think itâ€™s been gone for over 10 years.
- Making mental health care more accessible and Support for those with serious mental health conditions
- Making mental health more accessible means being able to provide long term services where people are able to get to them (like primary care clinic for patients who are too disorganized to go through the process of connecting to specialty mental health).
- Making service last for longer periods of time and carry over between systems. Carry over when people age out.
- many stressors can be prevented if the city implemented universal basic income to all residents making less than 100,000. this can be funded by diverting the overinflated police budget.
- Mental health care and SUD services are intertwined. They are both necessary on equal levels.
- Mental health crisis response services is a tie for second
- Mental health is wealth, if we lose this it’s gonna be to late so preventative measure is a must inorder to prevent this mental illness
- Mental health services for folks with se
- More locked facilities
- More long-term locked placements
- MORE services
- More treatment center and residential care program
- None of these. Need cost of living to go down.
- Not allowing people to refuse mental health care if they need it
- People experiencing DV and fleeing DV situations need to be prioritized for housing and services
- Placements for people who need to be conserved, with appropriate mental health, substance use AND low level (non-acute) medical supports
- Preventative MH services for racial/ethnic minor groups (managing stress or specific difficult situations)
- Re train them to become humanized
- See previous answer.
- SF needs day treatment programs or drop in centers for people with MH or SUD to have a safe place to get a cup of coffee, engage in groups or activities. There's no place like this now and so we wonder why we see so many people with MH challenges on the streets. 20 years ago SF has day treatment, socialization, and club house programs and that worked really well for clients
- So hard to rank - who needs it the most, what will impact the most people, what impact is achievable, ROI, ...
- Stop creating a 2 tierd system--one for those with Medi-Cal and another for those with commercial insurance.
- Substance use and prevention go hand in hand. Most substance users have existing mental health issues. It is difficult to rank between mental health crisis response and substance use treatment/prevention services.
- Support for those with serious mental health conditions and addiction is just as important as

education

- Supporting families with children; especially the mental health of parents.
- Supportive housing services INCLUDING behavioral health, psyhciatry, and social work.. case managers are not qualified enough to handle some (if not majority) of client issues
- Targeted behavioral health services for and by queer people
- Targeted behavioral health services for underserved populations (ex: Underserved language/ethnic populations and elders). Homeless/at-risk of homelessness are a smaller portion of the total SF population but they absorb significant resources and minimal impact!!
- The City must fully empower and resource the entire harm reduction and behavioral health continuum, including syringe services programs, safer-use supplies, drug checking, overdose prevention centers, and mobile outreach. Policy must reverse recent moves that undermine science and evidence-based care, and the City and Department of Public Health must publicly defend and support providers implementing these interventions. Workforce investment is critical: staff must be paid competitively, supported, and protected to ensure continuity of care and high-quality services. Prioritizing these actions will save lives, reduce preventable hospitalizations and criminal legal involvement, and strengthen both mental health and substance use systems for the people who need them most.
- The City should prioritize ending wasteful spending on these services and begin holding organizations, management, and staff accountable.
- The crisis response team should not allow people in need to refuse services and having more longterm locked beds.
- The priority population should include individuals diagnosed with schizophrenia and other serious mental health conditions. Supportive housing and treatment programs need to distinguish between those who struggle with substance use and those who do not. Currently, San Francisco’s system tends to prioritize homelessness related to substance use, while adults living with mental disorders who may be housed but still require structured support are left with very few resources to improve their quality of life.
- these two are of equal importance
- they are all important. be everywhere, helping everyone to get them what they need.
- This question is an example of a "false choice" many off these items should be a shared top priority and can exist in the same places (e/.g., housing, supports, treatment, etc...)
- too many are a priority
- When people are are living with unsheltered homelessness it is unlikely that they will have enough stability to effectively address their mental health and substance use issues.

Appendix E

Which services should the City prioritize for behavioral healthcare?

For the area that you ranked as #1, please explain why and share any ideas to help improve services in this area.

- <my explanation falls under "What makes it harder for San Francisco residents to access mental health or substance use services?">
- 1 and 2 are neck in neck to me but given a ranked choice and the limits of not being able to place 2 as rank #1, I think they go hand in hand on the lines of intergenerational trauma. people whose cultures have been deemed backward and so forth, displaced under such reasons, who made it into main stream as antagonists villains due to various political or religious conflicts, who have been displaced, in my view have a more difficult time integrating and finding housing given the moral and cultural conflicts they find themselves in, and due to the marginalized/invisible status in main stream media or organized culture / traditional educational systems.
- Build Trust Through Community Engagement Involve community leaders, faith-based organizations, and advocacy groups in designing and evaluating programs. Host listening to sessions with underserved populations to understand their specific needs and barriers. 2.Expand Mobile and Community-Based Services Deploy mobile mental health and substance use treatment with qualified staff to reach people where they are â€" on the streets, in shelters, or in community centers. Partner with local organizations and outreach workers who already have trust within these communities. Increase Culturally and Linguistically Competent Care by hiring and training providers who reflect the cultural and linguistic backgrounds of the populations they serve. 3. Increase Culturally and Linguistically Competent Care by hiring and training providers who reflect the cultural and linguistic backgrounds of the populations they serve. Incorporate cultural values and beliefs into treatment approaches to make care more relevant and respectful. 4. Integrate Behavioral Health with Primary Care and Social Services by creating one-stop centers where individuals can access mental health care, medical care, housing support, and case management in one place. 4.Strengthen Peer Support Programs Employ peer specialists people with lived experience of homelessness, substance use, foster care etc. to help clients build trust and stay engaged in treatment. Offer peer-led support groups and mentoring programs. 5.Improve Access Through Technology Offer free or low-cost access to phones, tablets, or Wi-Fi for those without stable housing.
- Not necessarily putting unhoused to shelters, but having a designated area to camp where services are available. 2. City leaders often believe that bringing employees back to offices will help revive the city. In reality, it's the residents who keep San Francisco vibrant. Office spaces are taking up areas that could otherwise support housing for San Franciscans, and the return-to-office push displaces, rather than helps, those who are unhoused. There needs to be a shift in leadership thinking toward what truly makes the city livable for its residents.
- Better bilingual pay for clinicians who speak the City's needed languages; we lose mental health workers to Kaiser and other counties--and we lose the ones who speak other languages (or don't even have them show up as applicants) most of all 2) Decrease time to hiring and cut the paperwork 3) Frankly; find a way to assess productivity of bad clinicians, put them on an improvement plan--and --find a way to separate if that fails.
- A focus on prevention gives people support and tools so they can take care of themselves and make healthier choices. Prevention can be taught to everyone including youth and adults. It's also the most cost efficient strategy that reaches a wide audience. Prevention takes a proactive approach instead of reacting to the issue.

- A lot of homeless around SF and most of them are drugs abuser and heard city fund them by handing out money and drugs so easily. So my suggestion is to be strict with the funding and access to drugs. Have them earn it by providing a work program in exchange for the money.
- A lot of the people I see on the streets without homes look like they are substance abuse people and having support while having housing should help them tremendously.
- A lot of the people that we see are homeless and it is difficult to find spaces for them in the system. SUD shelter would be helpful plus beds and access to sober living and transitional housing.
- A number they can call
- Access and care availability is important.
- Access to service is key for getting treatment
- Accessibility and availability are the best abilities.
- Accessing mental health services will help people not have crisis that make them alienated from the community and loose their jobs and then wind up on the street. Substance abuse prevention services help people not become addicted to illegal drugs and then become problems for the city.
- Addressing your mental health or substance use is near impossible when you are in a housing crisis. Additionally, the majority of affordable housing tends to be in the Tenderloin or other areas where access to drugs is easier, therefore not conducive to sobriety, (not to mention the depressing conditions of many SRO's).
- Adequate resources for mental health treatment are simply not there.
- affordable housing
- Affordable housing is arguably the most important service gap in San Francisco
- Affordable housing services is the 1st most important 1 so no one will be homeless.
- Affordable Housing will allow the unhoused to get off the streets and simultaneously connect them to services that they need with case management to help them be accountable and more successful in treatment.
- Again it is very difficult to access long term mental health care for people with ongoing or complex mental health issues. In many ways it seems like the only way may people get any help is by getting hospitalized for 72hrs 5150 or get arrested in put in jail. Our mental health services should do better than wait for people to get to extremes.
- Again, and I'm writing this knowing that this will probably not happen, an early intervention aimed at mild to moderate symptoms has potential to yield markedly improved outcomes. People living with complex mental illness for longer tend to have markedly reduced improvement and are less likely to regain functionality.
- All of the above is a number one priority. Forget about Ferris wheels. Forget about painting benches. Get rid of all the government waste. Give needed services to the people.
- All of these items listed are priorities so this choice is sadly an artificial first as all are critically needed. Given the limited number of inpatient beds in San Francisco, I would propose this being addressed given the need for this resource to address issue of people with severe untreated and often undiagnosed mental health needs that can at times be complicated further by substance use.
- Allow clinics to have drop-in or more independence to work with their intake schedules, so that people who don't rely on phone screening can have an alternative to seek services. Those who are not ready to receive services, like substance users or people who are homeless, it might be better to have someone to work with them to help them develop motivation and readiness before making an outpatient referral.

- Allow family members to refer and make decisions on behalf of the person at risk. With mental health and substance use, they are not fully capable to make good decisiosn on their behalf. This is what happened to my brother. He denied all services becuase he didn't think he needed it. And now we lost him forever. He could have recieved help they many times we referred him.
- Allow people to walk into clinics and enroll same day rather than a central line and wait.
- am writing this as someone who has worked very closely with the mental health clients for many years. I have seen firsthand their challenges, progress, and the unique support they require. I am nobody big to say this, but sometimes I am their eyes and ears working one-to-one with them every day, understanding their struggles and small successes. I know how important itâ€™s to have more programs like BHC
- Any and all affordable housing within the city should have case management services
- any movement on housing would serve as a preventative measure
- Appointments are a joke. There are none.
- As a mother I had to be my son's social worker. To make sure that he can go through the beaurocracy and logistics. Each program was siloed and not keeping records.
- As a person who works directly in psychiatric emergency, I find that most of our clients come asking for support with housing. Also, our clients conditions worsen or are challenged by access to housing.
- As a social worker in the medical field for the last 10+ years, people need to know that mental health services are out there and easily accessible. Likely would need to educate more PCPs on options, since for a lot of folks, this would be the first person they would speak to if they were having mental health symptoms. Hospital staff should also be better educated on options to best support folks to connect to out patient services from the hospital.
- As I said previously - people are having a hard time accessing BHS clinics, they need easier ways to get intake appts and more drop in availability. Funneling everything to the BHAL line where the person on the other side asks them a long list of questions is horrible patient care and the opposite of what someone likely needs when getting connected to services. People need to walk in to 1380 Howard, get an assessment IN PERSON with someone who isn't just operating off of screening questionnaires and get assigned to a clinic within the month at a minimum.
- As indicated previously, if a person is even able to get an appt, there are very long waiting lists and clients say that no one ever contacted them to start tx.
- As mentioned above, most people don't know where to go to seek health, and there certainly are not enough culturally appropriate services offered.
- At risk populations tend not to seek out help through the DPH system of care. Be proactive and meet at risk populations in the field and offer same day services including shelter.
- Awareness of mental health is the very first need for patient. Educational workshops give the fundamentals of arrays of help.
- Basic human needs should be met before a person can be expected to be motivated to make additional positive life changes. Black/African American residents report having less access to housing (PSH). I am not sure why this is.
- Basic Malsow's pyramid of needs. How do you have a healthy lifestyle if you are living on the street?
- because housing is at a premium in San Francisco, I believe we should get people housed first and then provide them the support needed to remain housed.
- Because I think it the most important.
- Because patient with severe mental disorders are unable to control their behavior, it is increasing the challenge to handle them at the PCBH clinic.

- Because preventative care is not covered by many of our contracts we have to wait until a client HAS a DX for treatment unstead of helping then NOT GET a DX. Also many contracts cover one on one therapy services for people with DX and they have to go through the entire CANS/7 Domain processes it is A LOT of work to provide group community mental health prevention services.
- Because those suffering a mental health crisis are not in a good position to seek mental health services, by the very nature of the crisis such persons are suffering. It needs to be readily, and easily, available TO ALL.
- Because with housing and supportive housing comes better opportunities for mental health and successful substance use treatment. Makes it possible for people to have better success with jobs and more
- Behavioral healthcare would be bolstered if folks on the streets had more access to mental health services that are dignified and motivate folks, with attention paid to the challenges related to their housing status. Despite folks still struggling with their substance use while in housing, and targeted services being needed for that, part of the equation is also uplifting peer mental health and physical safety support on an individual basis as well as fostering deeply inclusive group spaces.
- believe that if there is more support for those with serious mental health conditions, then perhaps there would be less crisis responses needed
- BHAL/OCC seems profoundly disorganized and chaotic. I would recommend restructuring and possibly hiring more staff to account for wait times.
- both mental health and substance use needs are a priority and need to support those most vulnerable.
- Bring the bed capacity of different levels of care into compliance with the bed optimization study.
- But the mentally disabled people or homeless people probably can't take advantage of it. Can't make a sound decision. Maybe take drugs when mentally disabled instead of their required medication.
- By providing supportive housing services, individuals will have less pressure/stress to lead them down the mental health issue road.
- Clients needs accessible access to services
- Consistent housing is a foundational element for most people to maintain mental health stability and sobriety.
- Cost of living is extreme, and i believe when someone has their own space it can make them feel more secure and able to focus on other needs.
- Criteria for Crisis taking a person having a psychotics episode is to strict. suicide/ harming others is not the only reason a person gets placed on a 5150 hold
- currently the outpatient community mental health clinics are tasked to treat this group, though not fully equipped/nor is this level of care very appropriate for this group as need more ICM level of care. Also, the people who used to come to outpatient & were more appropriate for this level of care, could participate in treatment, are not prioritized for services.
- cuts across the city mental health services are problematic since we don't have enough to begin with. We need MORE funding for all programs.
- Decrease recidivism for crisis and housing instability
- Different interventions will help different groups of people, so having a more targeted approach to subsets of the population is likely to be beneficial.
- Do root cause analysis of why these people are doing substance or drug abuse? don't answer it

by availability of the drugs, look for a different answer.

- drain on system, family, friends and community in dealing with people who can't take care of themselves due to serious mental health issues
- due to stigma not many people are aware about mental health and how it can be life threatening and that its okay to be not okay
- easier to access affordable housing. More subsidies, more low income and middle income BMR units. Discounted HOAs for BMR units.
- ECM programming is critical to reach and hold members with serious MH conditions and support coordination of their healthcare, access to resources and social determinants of health -- this is a vital and effective program that provides critical linkages and continuity of treatment services for their serious MH conditions.
- Education and ongoing support groups will reach the most people
- Encompasses many of the other areas.
- Establish a wholistic path for individuals entering their healing journey to fully restore themselves to an independent city resident. Finding strategies that fully restore individuals that go beyond picture perfect social media post or annual reports.
- Even though there are a multitude of programs that provide mental health services, ppl with SMI still severely fall through the cracks. ICM waitlists are long, it is hard to conserve ppl, if ppl get 5150d, often times they get released right upon getting to the hospital w out being in a hold and released back to the public. Lots of ecm programs are short term or for connection to care. There are very few board and cares. Some ppl go from street/shelter to PSH when they are not ready to be housed. There should be some education before they get to PSH to avoid common problem behaviours such as hoarding, room habitability, violence, etc. if there are problems in housing they often times just get transferred to a different building rather than addressing main problems.
- Every single person living on the street right now is going through a mental health crisis. There needs to be more people talking to these people and gaining their trust to go into treatment or shelter.
- Every time I do to the city for work, I see people who clearly need substance use support.
- Every week mental health clinic does intake, then assigns to providers. They work hard. The hiring process takes so so long. It is an unhealthy environment; people are easily burned out.
- Everyone deserves and needs mental health services. We are in a state of a mental health crisis service desert. A lot of people in need of mental health services have un-addressed trauma. These are members of our community from all sectors, class, race, religion. I believe mental health services are one of the most under funded, over impacted, unappreciated services in the health professions. It may sound crazy to pay LCSW's and ASW's a livable wage to help keep from burn out and high turn over. We need different models of care that allow for wrap around services and interconnected services within the community so patients don't fall between the cracks, so people can catch a break when they need one, so asking for help doesn't mean going to 5 different health care providers (if you have the stamina just to try to get the support and medication you need). We need to destigmatize care for mental health and substance use. We need more groups to bring people together for mental health support as this is an important part of recovery and community.
- Everyone needs a place to call home.
- Everyone should have minimal problem accessing healthcare
- Everything on that list is important but stabilizing folks is key. Access to housing options, beds with support, not congregate shelter, and safe spaces to be, allow for relationship building and a

bridge to receiving services for mental health and Substance use.

- Expand network of private and nonprofit mental health providers who accept Medi-Cal, especially for children and teens. This may require working with SFHP to increase reimbursement for these providers. Case management is not helpful for patients who want services and are sitting on long waitlists at multiple organizations.
- Expand residential treatment options, step-down options, and withdrawal management options.
- Expanded Harm Reduction sites, to include harm reduction therapy, harm reduction supplies, harm reduction safe consumption sites, drug testing, access to same day addiction treatment for folks without insurance or with medi-cal, access to low-barrier mental health for co-occuring disorders
- Expanding low or no cost therapy and counseling options for every resident of San Francisco is critical in both prevention and intervention for mental health and substance use challenges and crises. We definitely need to invest in more services for underserved populations and in expanding the number of providers from underrepresented communities (reducing barriers to entry to training and education (cost, unpaid internships, etc). We also need to invest in improving all the social determinants of health, especially housing and other basic needs, because we cannot help folks' mental health needs when their basic survival needs are not being met. This takes structural change, including even greater investments in affordable housing, more employment opportunities, and a system-wide redistribution of wealth to address root causes of poverty (lack of opportunity, discrimination, gentrification, redlining, etc etc)
- Fentanyl crisis
- Fentanyl is destroying the lives of many San Franciscans. It is also unsightly for tourists.
- Find homeless on street all over the city on a repeated basis.
- Fix the bottle neck of everything going through BHAL. Either return to clinic intakes/ referrals or develop multiple sites/ staff to do ore intakes more quickly and accessibly. Also increase outreach ability to begin services for those with serve BH issues.
- Focusing on services for underserved populations impacts every other category listed. My suggestion is to continue with some of the exceptional trainings offered for clinicians, especially in the ARCH academy and Dante King's Anti-Black racism trainings. Also incorporate feedback loops into the process of planning from underserved populations. We have some resources already in the Racial Justice Action Plans, and the Gould report. Direct timely qualitative feedback loops from clients served are important to develop.
- for all population regardless of their legal status and social economic status.
- For most of the clients I work with, housing is their #1 priority and need and their stability in MH or SUD services is hindered by lack of housing. So many people stay on the streets because they do not think shelter or temporary housing options offered are safe or supportive for recovery.
- For patients that have been diagnosed with serious mental health. Once they complete treated for the crisis should be followed up in some type of mental health clinic provided by the city for the first 30 days to stabilize a patient on the medication and get them set up with a clinical provider to help them with psychiatric care. Once you get a patient stabilized on their medication, they can do very well if there are programs that they can go. Mental health is not like physical health. You can't just give a person a pill and say take this and you'll be fine without any follow up or conversation with anyone about what caused the imbalance and how to treat imbalance in a long-term form and making them feel like that people instead of just somethings wrong with them.
- For the 1st most important thing I chose that making mental health care more accessible,

because it is a struggle to to get your first appointment to receive care I believe that walk-ins should be a thing again.

- For the pt who comes in Gravely disabled bc of their mental health condition; wearing improper clothing, responding to inner dialogue, unbathed, homeless, disconnected-there is zero support for them.,
- for their safety and others around them.
- FREE housing. The city keeps trying to shuffle around contracts, fit highly acute people into SROs that even most healthy people couldn't stay in, and weren't designed for long-term living. Public housing already exists and is being destroyed, it is not effective to build "affordable" housing that is mixed-sector, mixed-income etc. Large housing projects were not actually bad, they just became high-crime when other services like health care were drastically cut and people were left to fend for themselves. It is not affordable to build housing or for the city to contract with housing providers. The housing is too expensive. Building housing has a MINIMAL impact on rising rents. The city needs to regulate landlords and developers more strictly to keep the price down. The massive spike in rents due to deregulation and tech companies is what put most of our clients on the street, and forced most of their support system to leave the city. Most of them used to get by on GA with some help from their cousins and neighbors. That community support no longer exists and all that burden has fallen on providers and programs that were designed to clinically orient clients and intervene in their case, not literally MANAGE their entire life from sunrise to sunset. I know it takes courage to stand up to landlords and developers, but vacancy tax, strict rent control, strict anti-eviction laws, price caps, etc are literally the only way to keep housing affordable enough for our clients AND our programs. Every program that I've worked at in the last decade had to shrink due to losing properties, and because they couldn't afford high rents; some of them had to lay off staff because staff needed higher income to be able to afford the rents. Some of our programs are being double- and triple-gouged by price-gouging on the part of the landlords. I think eminent domain to seize properties from crooked landlords and repurposing them as public housing and free housing for clients might be necessary. There was an attempt at a "housing-first" policy, but all it did was warehouse disruptive clients and prevent them from being transferred to an appropriate level of care. A real "housing first" policy would aim to keep people's entire family, community, support system housed by preventing eviction. It will take years for San Francisco residents and their families and communities to repair the damage of 2011-2017.
- From my observation as a Senior who frequently rides Muni & observes very serious mental cases in my regularly Muni travels that needs to be addressed & be a priory in S.F.
- generational poverty, structural and systemic racism
- Get the drug seller off the street and stronger law enforcement
- Getting appts at community clinic is much easier to make but once a referral to specialty is made, long wait or no response or runaround when Behavioral Staff at community clinic try to help inquire on behalf of patient.
- Getting people housed is the first and most important step. Without a place to feel safe and protected there is no chance for the other things to fall into place. I have heard over and over that the reason the unhoused are using substances is to stay alert to avoid having their possessions stolen, or thrown out in a street sweep. The longer they have to use, the more dependent they become on substances, and they are typically the substances that take over their self restraint and many times their mind.
- Giving people the tools and training to maintain a healthy life is vital to long-term success.
- Harm reduction and the broader behavioral health continuum must be the Cityâ€™s top priority

because it directly saves lives, prevents crises, and strengthens engagement with people who use substances, many of whom also experience homelessness, serious mental health challenges, or systemic inequities. Recent policy shifts in San Francisco have undermined evidence-based interventions, restricted access to low-barrier services, and allowed preventable harm and death to increase. The City and Department of Public Health must reverse course and publicly defend harm reduction as a core public-health strategy. To improve services in this area, the City should: Fully resource and expand harm reduction programs, including syringe services programs (SSPs), overdose prevention centers (OPCs), drug-checking services, mobile outreach teams, and harm-reduction vending machines in accessible locations. Allow and expand distribution of safer-smoking supplies, ensuring equitable access across neighborhoods. Establish additional low-barrier drug sobering centers, including a strategically located site closer to the Mission district to meet high-need populations. Invest in the workforce, offering competitive salaries, hazard pay, and protections for frontline staff, including mobile medicine teams and harm-reduction providers, to ensure continuity and high-quality care. Expand 24/7 access points across the continuum, including mental health, substance use, and supportive housing services, with coordinated intake and navigation to prevent clients from falling through gaps. Embed accountability mechanisms in all contracts, requiring all partner programs to collaborate and EXPLICITLY PROHIBIT harassment or obstruction of harm-reduction services (the way that Tenderloin Housing Clinic, Salvation Army, and Positive Directions have been doing of other providers, like The Gubbio Project, SF AIDS Foundation, and GLIDE, in their quest for additional contracts that actually cost the city more while they try to dismantle Housing First). Strengthen data collection and public reporting on access, outcomes, and utilization to ensure transparency and inform continuous improvement. By taking these steps, San Francisco can restore a science-driven, equitable, and fully integrated behavioral health and harm-reduction system, reduce preventable deaths, alleviate pressure on emergency and criminal legal systems, and reinforce trust in public-health institutions. Without decisive action, the City risks further fragmentation of services, preventable overdoses, and continued inequities in care access.

- Have a true "No wrong door policy" - let clinicians folks if they walk-in the clinic
- Have drop-in options for accessing mental health care where no appointment is needed. More mental health providers that can meet people where they are physically located outside of an agency or office setting. Street based service providers, peer providers and providers who are trained in cultural humility, trauma informed and in harm reduction practices. Services should be free! There also needs to be more services for youth and teens, caregivers and the elderly.
- have late clinics open for those operating off hours, put up more advertisements so SF residents would know what is readily available; provide town hall meeting to provide more information/updates; put up pop-up clinics where the population who needs the services to be accessible
- Have mental health clinics that are open for for emergency drop in during weekday evenings and weekends.
- Have more service portals
- Having a safe place to live helps mitigate many of the life stressors that people experience, improving mental health and substance use disorders
- Having access to permanent housing and case management support makes managing mental health and substance use disorders easier for anyone.
- Having housing is essential for mental health and limited in this city.
- Hello, I have met quite a few clients who really want support obtaining mental health services but are unable to make it to outpatient mental health support due to physical limitations and

mental limitations (depression, isolation, etc.). Expanding mental health services to 'meet clients where they're at," may be a great move. Physically meeting client's weekly or monthly in their environment might make a difference in their access to MH.

- Higher acuity in clients impacted by MH and street substances. We need more permanent supportive housing w/clinical support instead of the ones we have now where clients have to move every 3-6 months
- Hire more bilingual staff
- Hire more providers. Embed Psychiatric/Mental Health NP's in all units at SFGH. Provide Telehealth access to Psych services, increase available appointments.
- Hire more psychologists or psychiatrists to provider CBT and other mental health services, especially for pregnant and postpartum patients.
- Hire more therapists; do something about the facilities issues - people cannot be seen in buildings that are not healthy or where there isn't enough space for appointments.
- homelessness & substance use & mental health crisis goes hand in hand
- Homelessness and housing instability are incredibly devastating to our neighbors' wellbeing. Diversion from chronic homelessness is one of the most impactful health interventions that can be made for anyone. I would like to see the city invest money directly into new PSH housing stock.
- Homelessness and the unrelenting stress of becoming unhoused leads to mental health crises from toxic stress and to deepening of the resultant physical traumas and social disconnections leading to further mental health needs.
- Homelessness in sf has grown in last 5-10 yrs & needs support
- Homelessness is heavily tied to mental health and substance use. Even when offered housing, many people cannot function in that setting. We need to first address the mental health aspect. And not in a way we have been which is letting mentally unhealthy people roam free and do whatever they want, including harming others. We need structure and strict rules to ensure these people are actually getting help. It’s not inhumane to keep someone in a structured hospital environment. It is inhumane to let someone who can’t take care of themselves wander on the streets with maggots infesting their legs, starving and using drugs til they eventually OD.
- Homelessness, mental health conditions, and substance use are complex issues and I don't have all the answers to solving them. But, it seems like we need to have accessible services ready at the waiting when folks are ready to seek them. It seems like many of our neighbors on the streets have mental health conditions that are not being addressed and they need support as these mental health conditions only become more compounded by the traumas and vulnerabilities they face by unstable housing.
- Hot line for non-urgent counseling
- Housing a huge part of the problem and needs to be part of the solution.
- Housing and basic needs being met would likely address the majority of mental health problems.. of course there's always need for more support but a big part is lack of basic needs being met
- Housing and basic needs stability is ground zero for mental health stability
- Housing and stability are needed for folks to recover from mental health and substance abuse issues. Short term shelter is not an answer.
- housing first and harm reduction approaches have been proven to work
- Housing first is an evidence based approach that works. No one should be expected to address any mental or physical health while also attending to their survival needs on the street.
- Housing first model

- Housing insecurity is a major stress that exacerbates all other mental and physical health conditions AND we have seen success in “prescribing” housing as part of the fentanyl/open air drug market response work.
- Housing is a double-edged sword, since it can be sufficient reason/motive to continue substance use or mental health challenges.
- Housing is crucial to stability
- housing is healthcare! especially in sf where the cost of living has sky rocketed this is a priority issue.
- Housing is healthcare. Shelter and SRO placements are not permanent housing.
- housing is most important
- housing is most important for stabilizing and helping someone create other changes. SF needs far more supportive housing, say, thousands of more beds and staff to support. Housing first!
- Housing is often very important in stabilizing mental health. There is a lot of supportive housing, but we still need more.
- Housing often is an issue for folks experiencing severe mental illness and/or with substance use. It is difficult for folks to focus on recovery, attend appointments, or manage stressors when they do not have a place to stay safely. - I have had many patients benefit from intense case management but we do not have enough providers/support for them to do their work. Hence, the criteria to get case management is a very high threshold. We need to invest in more human resource here so that more folks can benefit from this resource while providers are not burning out.
- Housing people requires more than just a roof. The supportive services are not there. Clients are living like they are unhoused only inside.
- Housing should be a universal right. The lack of stable housing affects mental health and the willingness to seek help
- housing, and outreach case managers
- How to access the right department and/or program in SF.
- I am a proponent of investing in prevention. There is a lot of funding and resources placed into those already in crisis. It would be helpful to try to try to avoid those situations through proven prevention projects
- I am a psychiatrist working with patients with SMI. The city needs more access to long term beds, inpatient beds and residential treatment beds. Appreciate the efforts made to expand but the need still exists. Also, greater number of residential beds that can accommodate greater than 90d stays- many patients are not ready to step down to a lower level of care by then.
- I appreciate this service, but would like to see a few more teams available. When I reach out via phone it takes a while to get a live person. By this time, the client is no longer interested, or has learned how to act as though there is no crisis.
- I believe a housing first initiative is imperative and we have plenty of real estate to do it. People cannot be expected to heal from trauma, feel safer, using healthier coping mechanisms and get their life together when they are living on the street (and being harassed by police, witnessing or experiencing new traumas every day). They need some kind of foundation and security. Case managers will also know how to better access them - again use skilled and licensed social workers! Not episcopal, etc.
- I believe early intervention reduces the long-term social, economic, and health impacts of addiction on individuals, families, and communities. By investing in prevention, the City can address root causes such as trauma, poverty, and mental health challenges before they escalate into chronic substance use disorders that strain emergency, medical, and justice systems.

Prevention programs, especially those centered on education, harm reduction, and community engagement, promote resilience, equity, and overall public safety, aligning with SF's commitment to holistic, person-centered care and the reduction of health disparities across diverse populations.

- I believe if start before there is a problem I think the better chance of alleviating an issue and identifying needs.
- I believe if we continue efforts in expanding entry points into Mental Health Services we can serve more and understand the needs of the community. Work being done currently with BHAL/BHAC supports these efforts, but possibly offering mobile outreach to assess and enroll prospective clients, where there is an epicenter of need, can increase volume of folks assess/enrolled/and connected to services.
- I believe making mental health care more accessible will trickle down and support improvement across the other areas listed
- I believe people of color and gender identity issues have a harder time seeking services due to stigma or the feeling of being judged. Being a person of color, I oftentimes hear people state that mental help doesn't work or they don't want people to think they are crazy. I think if mental health issues were brought to the fore front more it would be more widely accepted.
- I believe that being unhoused worsens mental health. I also believe that folks that have been unhoused or have severe mental health issues need support to become stable in housing and that SROs are chaotic environments that do not serve as true housing
- I chose targeted behavioral health services because in my experience mental health clients who go from manageable to crisis level mental health usually are those that are TAY transitioning or folks that are traumatized by the dangers of being homeless.
- I come across many clients who are not housed, or in temporary housing.
- I donâ€™t think people using know they need the support and we have the obligation to do so without judgement.
- I feel it would be more helpful for Mental Health providers to be more at the schools and also more involved with the schools. Maybe provide school groups. There are a lot of issues that involve the schools, and some parents or families do not know how to navigate the school system.
- I feel most of the problems come from substance use like mental etc etc
- I feel that available long term supportive housing is one of the key issues that affects people in San Francisco accessing mental health or substance abuse resources. It is also not a guarantee that people in these situations stay stable or housed which may exasperate their situation and spiral into an even worse predicament.
- I feel that most people with mental health issues aren’t diagnosed properly or given the proper care
- I feel that responding to mental health crisis would prevent it from escalating to emergency.
- I have heard how difficult it is to get off fentanyl and meth. I have also heard that addiction is a disease/condition that really means periods of sobriety and relapse. So to me, it makes sense that we should of course keep our work in substance use treatment but really also focus on stopping people from ever touching these substances.
- I have seen a lot of trauma and tragedy come from circumstances in which we fail to provide help for those with severe/serious mental health issues, and either the person suffering, or others around them are injured or harmed.
- I have seen many people in crisis on the streets without any help. Theres too many people in crisis everyday and not enough help.

- I just don't think we concentrate on how accessible our services actually are
- I just went to a meeting with the DHSH and they noted that the majority of families who are unhoused report mental health concerns. And that MH concerns also impact their housing retention.
- I like the pop-up clinics that street medicine conducts, I think there should be more of these. More street teams, with a van, or larger vehicle to bring services to people and a space to perform medical procedures: wound care, PAP smears, I&D. I also like what the city did with the tenderloin linkage center, minus it being a safe use space, I felt like having an open area for folks to use, in the same space we wanted to get folks help made it difficult to really help folks out of their substance use. But I did like how it was this free-standing space where a variety of providers could see people, and the location was perfectly central to where many of these individuals stayed/spent most of their time. I also feel like places like MXM are helpful, but the wait is often long, and for some of our traumatized unhoused folks, being inside for that long is not a reality, which is a barrier to helping some of our folks with the most needs.
- I live in SOMA and people are using openly along 6th street and the surround areas of 6th and Howard. I have to hold my breath when I walk to and from work every day to avoid inhaling what they smoke out of their pipes. Please help issue crisis response teams to these areas to keep people from using in highly trafficked areas and offer those people help. It is very sad that children have to encounter this drug use as well.
- I picked the first response because the system is extremely hard to navigate and it is filled with people contradicting each other about the availability of services. I picked number two because there is so much bigotry, racism, homophobia, transphobia, and misogyny within the system to the point that it is a turn off.
- I put Supportive Housing services first, because Housing First still is the best model for addressing all these problems. I say that as a former recovering addict that benefited directly from harm reduction services, housing first at PSH site, then out-patient harm-reduction services and then finally substance use treatment toward abstinence. The journey from the street to finally choosing an abstinence plan took more than 24 months. Thank God for the Housing and harm reduction services that kept me alive and helped get to a place where I could begin making healthier decisions for my life. Supportive HOusing First works! I also say that as someone who has since worked in recovery programs, and as a community organizer and policy advocate providing services in the Tenderloin and SOMA for over 15 years now since I've been clean.
- I ranked SUD treatment first because I believe the Mayor is immovable and that it's strategic for the city to lead on a culturally appropriate approaches, given ongoing Federal threats of intervention and uncertainty in the funding environment. I think it's critical the city provide a range of competent providers, interventions tailored to populations who use substances, responsive prevention services, and ongoing quality improvement. Pragmatically, given rates of arrest and incarceration, I think it's vital and that jail health services and post-release care receive increased investment, including for psychosocial care. This could include proactively convening community's of practice for providers (especially frontline workers tasked with difficult work and the least compensation) and expanding funding for programs that foster peer leadership and programming to engage community members. Along with this, we need to solve related policy issues. For example, why are patients in custody in the city's jails and at the outpatient pharmacy at ZSFG unable to obtain all recommended care due to SFHP's FY budgetary limits, when CalAIM's justice involved reentry waiver is reimbursing services. This is a needless administrative issue that adversely impacts patients and wastes providers time.

- I ranked support for those with serious mental health conditions as #1 as that is the population that I work with and see most. There is a serious lack of beds for acute mental health (currently only 22 acute beds / 22 sub-acute beds at ZSFG) which means it's very difficult to get in for treatment if you are in the psych emergency and contributes to recidivism. There used to be 88 acute beds at ZSFG, and they were full all the time. This cut in beds has resulted in many more people with serious mental health conditions on the streets and in the community, without easy access to acute care treatment and stabilization, until they are so decompensated that it makes it so much harder to recover. There is also difficult staffing ratios in these highly stressful and acute settings, which results in a lot of turnover.
- I see mentally challenged people, or people on illicit substances on daily basis. Most of them seem homeless.
- I see so many on the streets who are clearly having some psychiatric problems
- I see too many needles and homeless people on San Francisco sidewalks. I feel unsafe walking alone in some areas of civic center and downtown, even during day time.
- I see too many people doing drugs on the street. They need help.
- I think if someone has affordable houses and someone taking care of them with a case manager, they are more likely feeling more supported and less likely to have behavioral issues. We need to find areas that already have buildings but are not being used or in disrepair and convert them into affordable housing.
- I think if we prioritize the most impacted communities, then we will be setup to support the more general population. Addressing issues for priority populations benefits everyone: better language access, cultural humility, and complex needs. There can be band-aid/short term solutions to meet the immediate need, but long-term strategy involves engaging youth of color at early ages to be supported to become mental health providers, therapists, etc.
- I think it does not matter if you are rich or poor mental health is a big problem in the city
- I think it would be best if the City invited community partners to be a part of a task force, if it has not already done so.
- I think it's better to be proactive vs reactive whenever you can. I think it's going to take coordination between multiple city agencies including the justice/police system/DPH, etc. I also think that being preventative would be more cost effective for a city with a reported budget crisis. A lot of the folks experiencing behavioral health issues (not all of them) are also using substances.
- i THINK people want treatment but don't necessarily want to be in a shelter
- I think that population is overlooked , esp. the youth .
- I think that targeted BH services for underserved will also help support those with serious mental health conditions and some of the other services listed
- I think that there are people in crisis now and need help. This needs to be addressed first as it is no longer preventative care.
- I think that we should always equitably prioritize resources for underserved communities and make sure any type of health care are accessible for every San Franciscan.
- I think there are many people going through difficult mental health situations and there aren't enough places to turn to for services.
- I think there’s a major gap when it comes to mental health education. I see so many clients who have been accessing services for years often at an acute level yet have little to no understanding of what their diagnosis actually means, and their families often don’t either. There’s an assumption that people already have this knowledge, when in reality, both clients and their families could benefit from basic education on mental health topics like depression, anxiety, and

trauma. I'd love to see more citywide campaigns that use media to raise awareness especially around substance use, overdose prevention, Narcan, and overall mental health literacy.

- I think we live in a city that has a big population that is affected by outside forces (homelessness, expensive housing, substance use, overdose, suicidal ideation, IPV, etc.) and I think it would be best if we can help those who are having mental health crisis and need support. A lot of people don't know support exists. I think it's important that trust worthy people (doctors, social workers, community, people that see the struggle) learn about these resources and are able to advertise them or use them as resources when people come in. It might need more outreach than just doctors visits. I know myself, the last person I want to talk about my mental health is my PCP.
- I want to specifically point out by "targeted" that I am not including those who are unhoused or substance using adults. It seems the vast majority of services and funding in behavioral health go to these populations. Where more funding is needed, and one could say this is "preventative" is for children and adolescents in our city. There are approximately 55k youth under the age of 18 enrolled in Medi-Cal in SF County. Based on epidemiological data, we would expect about 20% of youth to qualify for specialty mental health services in any one year, so roughly 10k kids. This is a very conservative estimate of the need as both mental health prevalence in youth has increased since the pandemic AND this is based on population estimates and Medicaid youth are expected, due to conditions associated with SDOHs, to likely have not only higher prevalence, but less access to care. Based on data from 23-24 CANS annual reports from BHS CYF, only around 1,300 youth were served in the CYF system. This is no where near the numbers we expect, even when accounting for youth receiving services through other systems like HSA, DCYF, schools and primary care. Our SMH penetration rates for youth are also below the state average based on the last available data from DHCS from 2022.
- I would focus first on underserved populations who are near-acute or already exhibiting high-risk factors, because too often help only arrives after substance use and its impacts become severe. For example, individuals recently released from jail (for low-level substance possession) or discharged from the hospital following a mental-health crisis are prime candidates. These situations frequently co-occur (people self-medicate), so intervening earlier can prevent the escalation of a substance-use disorder.
- I would like to see more access for children who are sexually exploited and sexually abused.
- I would not have chosen any one particular choice to be more important than another. Only chose 1st most important because choosing one was the only option offered
- I'm no expert, but access is almost always the most important thing. Access covers cost issues, logistical access, knowledge of service. Its a big category, seems the appropriate first choice.
- I've utilized Crisis Response Team for assistance twice and their response was not as quick as I expected. They were also limited in accessing services that should be available for them to access.
- If a reported incident need a crisis response, there's usually delays in getting affected person/group the service needed.
- If housing were generally more affordable in the bay area, people would be healthier. If people didn't have to work so hard to survive here, they would have more time to make healthy food, exercise, meditate, go to therapy, care for their relationships etc. At their core, most people want to be healthy and happy. The answer to many social problems in the bay area is to simply make life more affordable. Take the boot off of working people's necks, and give us the space to actually breath. Healthier choices will follow.
- If people are able to get help before they go into an episode it will help better

- If people know where they can reach out for help it would be a big step in their recovery.
- If someone has mental health it requires everyone around them to be supportive. High anxiety is a real thing that can turn into depression and mental health issues.
- If there is mental health education workshops available so staff also can link them the service when they come to workshop, they want instead feeling isolation and using substance to cope with. From my working experiences with a lot of Spanish and Chinese speaking, that show parents lack of knowledge and resources, so that it impacted to their youth. I believed building strong foundation is more important than busy for help them seeking treatment everywhere.
- If we can get seriously mentally ill and addicted folks off the streets and onto appropriate levels of care the entire city will improve and be able to help more people needing less care.
- if you give a man a fish he eats for a day if you teach a man to fish he eats for a life time but that only works if there are fish and the man isn't starving. treating one of the symptoms of drug abuse will help us treat the cause later.
- Im injection should be available/mandatory when so many times pills failed, keep them stable
- Immediate and accessible mental health care and education are most important response to addressing all these mental health pandemics and addictions.
- In clinic (e.g., Potrero Hill 2 yrs ago), there were patients who needed and were interested to know about Substance Use Tx options, but none of staff (nursing or other) had time to at least have a preliminary conversation with the patients, and a lot time was being eaten from the clinic provider's time (causing delays in seeing subsequent patients)
- In order to avoid long term issues the priority is to promote and let people know where the services are available first.
- In order to take some control in your own life, even with assistance, there in needs to be access to a stable and safe environment where basic needs can be meet i.e. sleeping without fear, bathroom, maybe kitchen access. Eliminating these issues, can help the person focus on their mental and health issues.
- in particular - more emphasis and focus on individuals with SMI who do not have SUD's.
- Increase capacity. You can't do any of the preventative or focused efforts if you don't have capacity.
- Increase staffing for those who provide behavioral health services - staff are burnt out. The demand for services is higher than staff available to meet that need. Acuity in clients is rising and so are staff caseloads. There needs to be a more nimble way to meet the needs of SF residents.
- increased need for services- telehealth to improve SUD treatment, reduce crime, improve health care outcomes, etc.
- Individuals with serious mental health conditions are the most at risk. They have difficulty accessing the care available to them because many of them lack the support. When given instruction, there is no follow through. I am not aware of case management services we currently offer but some clients have requested case management services.
- Individuals with serious MH issues seem to not know where to go to obtain immediate services when in need, they often self medicate with substances which exacerbates their MH issues. Once they stabilize, there are not enough positive resources for them such as work.
- Institutionalizing mental health care requires a level of committment from all levels to not only acknowledge the need to care for onesself but also create spaces to do just that. Build it in so no one is obligated to deny oneself support due to normalizing practices of not taking care of onesself
- Integration

- It addresses challenges before they escalate into crises. Many people in San Francisco don’t have access to consistent mental health education or safe spaces to talk about stress, grief, or trauma until they’re already in crisis. Expanding support groups, community workshops, and outreach in neighborhoods especially for low-income and marginalized populations could build awareness and resilience. Offering programs in multiple languages, integrating peer-led groups, and promoting self-care education through community centers and housing programs would make preventative care more accessible and effective.
- It gets people a roof over their head, off the streets if they want it, and the help they may need.
- It is a known fact that people experiencing housing crisis tend to suffer from mental health disorders and often times substance use, providing these individuals with a safe space will to live will indubitably contribute to healing 01other aspects of themselves
- It is clear that many of our homeless population need more support in improving their mental health. It is however, hard to say if they need the support or to have their basic physical needs met first.
- It is difficult guiding clients through the mental health referral process when they have limited means of communication and will likely be lost to the process if it is lengthy. More drop-in clinics with therapists available to refer to SF clinics.
- It is proven that crime rates fall when the city's poorest residents have access to their basic needs. insuring a universal basic income for residents would improve health outcomes
- It is very difficult for people to become healthy if they don't have housing and someone to help them continually access the care they need. Ideally you need someone at the housing site who checks in on them and makes sure they get to their appointments, or takes their meds. More supported housing with onsite case management is needed.
- It makes sense to target BH services for underserved populations to ensure health equity concerns are addressed.
- It provides a person a sense of stability and continuity allowing them to be able to think of next steps
- It seems as there are limited resources and space available for underserved communities, but they are the ones that would benefit the most even if they are not showing any symptoms. Targeting them early on could prevent them from becoming homeless or engaging in risky behavior.
- It seems like if you have medi-cal and you aren't linked to some kind of FSP, ICM, etc., its impossible to access mental health care
- It seems like there's not that many facilities that are available and open to support these serious mental health people due to budget issue. Many facilities are forced to close and there's no other place to accommodate these people that needed treatment. Sending them back home to family care is not sufficient and will cause harm to others.
- It seems that many of the clients that I have met are those who have gotten lost in the system of care with no follow up by previous providers including from some mental health clinics that do not have the capacity to outreach clients in the community. Part of preventing ongoing my crisis.
- It seems to me that many of the unstably housed are people with serious mental illness. I do think that support includes access to housing.
- It should be available for everyone, because there is a lot of people who need to get treated and receive help due to their mental health or behavioral issues.
- It sounds good.
- It takes a lot of courage to seek mental health services to begin with, Having an inviting

atmosphere and genuine welcoming and helpful staff would be comforting. Having a culturally diverse staff would be helpful as well, some people would like to talk to a professional that looks like them, just for a sense of relatability.

- It will be great if there is online chat services.
- It's dehumanizing to live here and ignore folks who are using drugs and nodding out in public or having a mental crisis.
- It's important to understand that the city CANNOT pay for this long term. But San Francisco could set an example that would be picked up statewide and nationwide. This is a global problem -- not just a San Francisco problem. We need a new generation of long-term custodial (for some buildings) and non-custodial behavioral health campuses with proper services and community oversight. This is what families want for their ill loved ones. We would all benefit.
- Its's self explanatory.
- I worked many jobs were folks were having a mental health crisis and their only option were policy who really were very much either were going to take them to jail after you press charges or you can continue to deal with this. and/or 1.5 hour wait with scrt
- Lack of housing / homelessness seems to me the biggest contributor to crisis situations and is the first barrier to true recovery for our most vulnerable residents with serious conditions
- Lack of housing exacerbates mental health deterioration and substance use disorder. There needs to be more affordable housing for San Franciscans. We do NOT need more housing for high income people.
- Lack of housing is the most significant social determinant of health. Housing, including shelters/respites and interim housing, should be the first thing to be taken care of.
- Lack of long term housing solutions is problematic: housing is basic needs.
- Lack of long-term housing leads to vicious cycle of continued decline in mental health and substance use. Prioritize housing to facilitate treatment.
- Lack of stable housing exacerbates all mental and behavioral health challenges.
- Longer treatment timeframes for inpatient care and wrap around services at discharge. https://jamanetwork.com/journals/jama/fullarticle/2091312
- Low-barrier, drop-in services, both emergent (like Westside Crisis) and urgent, as well as one-time visits and longitudinal, where people can access a prescriber, a therapist, a peer to help them manage.
- Maintain and expand services for racial/minority/ linguistic competent mental health services
- Make sure commercial pharmacies actually have adequate stock of buprenorphine. More medical providers accepting privately insured patients for substance use treatment. Especially in primary care. Helping break down stigma on the part of providers that has made a barrier in this area. Maintain or increase city funding for SUD treatment sites. Our city cannot afford to lose any access to these services, and we would all benefit from even more of these sites.
- Making mental health care accessible (without negative stigma) is crucial and needs to be improved. Create more mental health services at health clinics so that there is no stigma when a person goes into a health clinic for mental health services - no one knows why they are going into the clinic.
- Making mental health more accessible means being able to provide long term services where people are able to get to them (like primary care clinic for patients who are too disorganized to go through the process of connecting to specialty mental health). People don't care if they can see a behavioral health clinician that same day, they care about being able to access their service reliably and for as long as their condition requires it.
- Making mental health more accessible will have people seek out help rather than holding on to

it and not address the underlining issues. I shouldn’t have to worry about cost when life is really a lot and I’m the point where I no longer want to be here but I do because I got kids, but feeling like there’s no one I can call without fear of having to pay for it, it makes people not want to seek help.

- Mandatory treatment.
- Many individuals don't have stable housing to practice self-care, have a safe space, lack of support system, lack of advocacy and linkage support. Supportive housing helps and case management helps individuals manage their mental health symptoms, provides team collaboration, stability in the community, navigating the health care systems, and promotes independent living. One can't expect a homeless person to take prescribed meds that need to be stored in a fridge, when they have no safe housing, have no food, and have mental health diagnosis that makes it impossible for them to know how to navigate their health.
- Many of my clients at AHP are struggling with maintaining stable housing, especially given the cost of living in the city. Having stable housing would greatly improve the wellbeing of many and would alleviate many of the mental health challenges they face.
- Many people want residential treatment but have disabilities and cannot be served in the city's residential treatment centers. Many report going to 1563 Mission to be turned away. Getting down there is very challenging, then to wait for hours to be screened and then turned away is very disheartening. The BH Access line is staffed by people who don't know the particular substance use programs and can provide no detailed advice.
- Many programs and services only respond when a crisis. Many of the times there are signs and people need support. They don't know where to turn and the services available like warm lines and drop-in counseling are either have little or limited capacity. When seeking crisis support, many folks can't afford the cost.
- many supportive programs do not want to take on homeless because they don't want to end up evicting the client when they are not following the rules in their placement.
- Many times, we see that the unhoused experience more mental health symptoms due to lack of housing stability. Once people have housing and food security, they then can focus on their mental health needs, otherwise, they are looking only at surviving.
- Medicine in general should be preventative and not make people sick with so many drugs; recreation is important, promoting culture, art and education are very important points to occupy the mind and create, search, heal.
- Mental and substance use should not be set on aside bec who have to have preventative measures inorder not to make this as an illness
- Mental health care and SUD services are intertwined. They are both necessary on equal levels. Provide more dedicated psychotherapy services and provide case managers that are separate from psychotherapy services and allow for clients to meet weekly for psychotherapy to work on their mental health stabilization goals.
- Mental Health care is functioning and thriving. Without access to mental health care, you have implications for more serious issues within our communities that can possibly be avoided.
- Mental health challenges can lead to substance abuse
- Mental health concerns are affecting all demographics, so ease of finding services to begin to address those issues is a start. More signage in public places for government health care
- Mental Health Conditions is serious and often over looked.
- Mental health crisis response services are the front line of mental health emergencies.
- Mental health crisis response services instead of law enforcement is the only way to decriminalize this disease process.

- Mental health crisis response services must be prioritized because far too many people in crisis especially unhoused residents and LGBTQ+ individuals are still met with law enforcement rather than trained mental health professionals. Police are not adequately equipped with crisis intervention or de-escalation training, and as a result, encounters too often escalate into violence, criminalization, or trauma instead of care. For people experiencing severe mental health episodes in public spaces, these responses can be life-threatening. The City must invest in community-based, non-police crisis teams that respond with compassion, cultural humility, and trauma-informed care. Expanding mobile crisis units, embedding crisis clinicians in shelters and community centers, and ensuring 24/7 availability can prevent unnecessary hospitalizations and deaths. Partnerships with trusted community-based organizations can also build safety, trust, and long-term stability for those most impacted.
- Mental health crisis support will provide and over arching treatment plans though social services and preventative healthcare services. The goal is to provide appropriate care such as emotional support and care coordination to long term services, that could potentially reduce homelessness, substance abuse, hospitalization, and arrest.
- Mental Health education is key for prevention.
- Mental health education needs to occur in middle school and high school at the latest. Same with substance use education.
- Mental health is a major issue in the world today.
- MENTAL HEALTH IS NOT A COMMON THING TO TALK ABOUT BUT MANY PEOPLE ARE SILENTLY HAVING MENTAL HEALTH ISSUES.
- Mental health looks accessible, but trying to get into clinics have more than a 6month wait list. More tele-health appts should be available for disabled. Targeted services for underserved populations would be helpful because they are the ones who need it the most and can't navigate the system on their own.
- Mental Health Services must be made available for all patients so that there's an easy access to the service- phone or on-line connectivity; know what resources are available; know the signs of an impending crisis; and/or identify and prevent for a crisis to occur.
- Mental health services seem to be most readily accessible to the homeless population and drug addicted persons. I see a huge gap in what is available to every other population, most notably the elderly. MHS are already hard to access if you have insurance and can make time available, it is especially hard when almost all of the resources are being allocated to drug addiction/substance abuse and homelessness.
- Mental health services, include substance use disorder treatment and psychiatric treatment, can only do so much when people do not have their basic needs (i.e., a safe place to sleep) met and are continuing to live in the traumatizing circumstances of poverty and trying to survive.
- Mental health should be talked about more, Mental health issues should be shown just as much importance as physical health issues, with insurance my therapist charged $85 an hour. I couldn't afford even one session
- Mental health symptoms are increasing, prevention of people with serious mental health ending up in the street
- Mental healthcare in San Francisco needs to be more widely available. There are some programs that have more availability for specific target groups, but for individuals who may not identify with or be eligible for targeted services, they are much harder and more time consuming to connect with.
- Mental healthcare is often overlooked, minimized and mocked. It needs to be openly discussed and hopefully as it's discussed more, the stigma is reduced. People may be more willing to

access mental healthcare if they are made to feel welcome and supported. I am not sure how to go about accomplishing improvement with services in this area; perhaps better case management, ambassadors, community outreach/community meetings in partnership with mental health organizations; making rounds to schools, workplaces, and neighborhoods

- Mental illness is invisible, you never know what someone is going through. Yes, the unhoused and underserved are at a higher risk but here are others struggling that you aren't able to directly see.
- mental/behavioral health can't be adressed well without housing. Prioritize building housing or using vant buildings etc to create housing. For one example, there is an empty building on market near 15th that has beena closed down church for the last 19 years and has never been used for anything since. Why?
- MH treatment on demand
- Money should be spent on those who really need the assistance, and not to those who abuse the system and who do not have serious mental health conditions.
- More access, more information given to those who need it most.
- More accessibility like mobile services
- More accessible in more locations with faster appointments, but people are put on a waiting list for service and can spend more than a year waiting.
- More affordable apartments then luxury apartments.
- More available preventative health care services available is a protective factor that can help decrease severe MH/substance use outcomes. CBO's being able to offer more regular play groups, parent support groups, youth programs, etc.
- More clinicians who are bilingual and/or come from a multi-cultural background
- more culturally sensitive groups and activities that are harm reductive based (Fun) and all inclusive.
- More customer service to engage clients to come back
- more licensed psychologists who can formally diagnose - not just psychiatrists who can prescribe and talk therapists that often cause more harm in their inability to create a specified treatment plan. More women, gender diverse, and queer providers, more ACTUAL trauma informed providers, more service animal / emotional support animal outreach services or link to care. Ensure work places have confidential spaces for telehealth appointments, link staff to care who consent to it and do not have support at home to help them care for themselves enough to get to work, mandatory classes to learn how to navigate insurance since I thought I asked the right questions the first year and ended up accuring so much debt that I didn't see a doctor for the full year despite hospitalized overnights for severe health emergencies. Make mental health PTO separate than physical health PTO, assess employers impact on mental health, ACCESS TO FREE FOOD AND TRANSPORTATION for gov workers, it's so hard to make ends meet nowadays.
- More low barrier access to SMI MH treatment and easier access to therapy/counseling for substance use disorder recovery in a drop in or outreach model
- More outreach and public service announcements
- More providers are needed immediately!
- more psychiatrists in the SFHN system more mental health providers who accept medi-cal
- More services are needed that are same day accessible with supportive hours of operation especially for out-patient support.
- More services available at different settings (outpatient clinics, medical clinics, schools, libraries, etc) with expanded service hours.
- More services for older adults and those with serious mental health conditions and cognitive

decline

- More sober living options for shelter and housing (outside TL and SoMa!!) in additional to usual harm reduction options.
- more staffing, more places to get low barrier care, more intake points, more flexibility in scheduling, less wait time
- More support groups. less criminal stigma
- More supportive housing that are outside of the tenderloin and 6th st. Those areas are incredibly triggering for people with both MH and SUD issues. It also consolidates vulnerability to one area, making it difficult for people to better their lives. Services would benefit from being spread out around the city. Additionally, housing should feature safe outdoor spaces, such as a courtyard, where people can enjoy the outdoors without being overly exposed on city streets.
- More teens are using substances and we have no where to send them for treatment that takes Medi-Cal.
- More triage/urgent care clinics/services sites for the public to access
- Most of our supportive housing is not that supportive one case manager for a whole building and then not in office 40 hours a week either.
- Most of the time people/patient don't have the education or awareness that such service exists or is accessible. I believe in mental health issues and it is a serious matter. Mental health services should be more accessible.
- Most of these patients are homeless, they need a place to be able to get clean and they need to get to a better state of mind, this can only happen if they feel secure.
- most of these people in this population either doesn't want help, due to mental issues, social issues, homeless or scared to ask for help due to ICE/ legal prosecution, related to crime, runaways using drugs to help with the pain/ mental issues. They all stay hidden because our society treats people in this population like they don't matter. etc, very sad
- Most people can't afford to live in SF off of the income that they make. Most people are one paycheck away from becoming homeless. There needs more affordable housing, and programs that can assist prior to you falling behind on your rent and being evicted. When you have to choose between feeding your family and having a roof over your head, it can deteriorate your mental health.
- Most people who suffer from mental illness do not or can not afford Neuropsychological testing to better get more accurate clinical Diagnosis. instead of being diagnosed solely on the DSM. Upon showing up at PES from Intoxication from street drugs or someone else's Prescription medication, and getting diagnosis that's not true but based on what they see being presented according to the DSM.
- My clients are foster youths - teens and NMD (non-minor dependents) who all deserve MH services. But due to the limited clinicians who are culturally competent, foster youths do not connect with MH services.
- N/A
- NA
- navigators to assist clients in literally getting through the door of MH clinic and act as clinical Liaison to support intake and follow up. Navigators can be current ICM/ ECM/ psh cms. Prioritize longitudinal support by paying them more and building clinical bench among staff vs a billion short term response/linkage services
- Need ADA accessible 90-day and year-long residential programs.
- Need more access to talk therapy for low income people available in Spanish and other languages.

- need more institutes to have as housing
- Need more nurses and staff for each in patient.
- Need places for people who are fully in crisis. People screaming on the streets who are screaming at passerbys
- need to be available in order to get help
- Need to ensure low barrier housing is available to all, connect those leaving treatment with housing, ensure those in housing get rent paid to enter treatment, Cant address mental health if no housing.
- Need to help people in acute psychiatric crash
- Need to higher more therapists to work at DPH clinics, stop farming out lower acuity patients to telehealth services.
- None of the other choices matter to someone who is struggling to keep a safe roof over their heads at night, or who doesn't have a safe place to keep their stuff.
- not accessible for most has been my expereince
- Not enough servies available and takes too long to get an appointment.
- Not enough supportive housing. Many severely mentally ill people cannot cope with congregate housing options such as shelters.
- OCC needs to work out their kinks--I have sat with clients trying to go through OCC. The workers don't seem very skilled and take a long time to read through their questions.
- Offer more "walk-in" or drop-in services and after-hours weekend availability, for instance, the SFDPH BHS Access Center has weekend hours to lower barriers.
- Offer treatment to addicts and if they refuse they cannot be allowed to unpack and live on our streets. Too often I'm walking down the street with or without my child and people are actively using, high and agressive, having a mental health crisis on our doorstep or worse defecating on our sidewalks or spraying diarrhea on my car. The city allows them to exist in the mission but not the marina.
- Old treatment approaches are ineffective. Old ways of thinking are influencing treatment approaches.
- On-the-ground interventions. I really think there needs to be more of an interactive and in person approach. The City has the funds and does increase the budgets for administrative and behind closed doors jobs, and I don't think this is proving to be as effective.
- Once mental health is addressed then other areas of life is more manageable, and the education and crisis prevention will ensure long-term recovery
- Open drug trade drives the lifestyle of homelessness and inhibits desire to change Drug use worsens serious mental illness and causes psychotic breaks in previously well people Making drugs unavailable is the first step to treating addiction. Addicts can manage withdrawal
- Our society gives up on so many who might offer so much promise with just a little help with mental health
- Our streets are fulled with substance users/needles/paraphernalia. More outreach from substance use prevention service are needed in addition to treatment services to provide a supportive atmosphere for people who do not want to be inpatient for treatment services.
- Our system is reactive rather than proactive. Prevention is important to avoid or minimize long-term problems.
- outreach and making services available to all
- Patients often complain about issues with getting medication/keeping it safe from others when they are unhoused. Also difficulty with transportation and getting to appointments.
- People appear to be suffering on the street and living in survival mode most of the time

- People are often Peer Pressured into using drugs without understanding the risk
- People are openly doing drugs in the streets. Overdoses out of control.
- People can't afford housing, become homeless, get assaulted on the streets, have more trauma, engage in substance use to cope. The city's cost of rent is out of control and people are suffering because of it.
- People cannot get sober or maintain psychiatric stability without housing. Also, the evictions need to stop. It is unacceptable that we are evicting people from supportive housing for exhibiting symptoms of their illness. While I understand the person not be able to remain in the housing, there must be a targeted intervention that establishes an alternative path such as conservatorship and LSAT placement, psychiatric hospitalization, transfer to different housing, transfer to treatment, etc.
- People experiencing homelessness are not accessing mental healthcare until they are causing a disturbance or injuring themselves some others. Well, they are sometimes picked up by police/emergency services a psycho out of the hospital quickly and never get full attention or care for their ongoing mental health issues.
- People need more information about whether you are helping.
- People need their basic needs met.
- People need to be able to access a variety of mental health services that are modern. We know so much more about how people heal from trauma but our systems are not particularly trauma informed. We need more drop in,low barrier, open access spaces. We also need have a variety of modern modalities
- People need to be safely and securely housed in order to access the benefits of mental health. Without housing, MH services don't feel effective.
- People need to belong, participate and feel successful
- People need to know how to get help, especially if they do not have insurance. People need to feel there is sincere help waiting for them and not bureaucracy and judgement.
- People of color and underserved populations are the most at risk for losing housing due to mental health issues. Also, the biased opinions of workforce creates inequities within the healthcare system, thus not serving the populations effectively.
- People on the street will be abused and become sick with tuberculosis etc. The street is not a place to live for anyone.
- People seeking mental health services often find it difficult to find places that offer such services.
- People seem to cycle through so anything that better sets folks up for success and changes their situation/surroundings.
- People with high acuity mental health issues are heavy users of resources and therefore costing the city incredible amounts of money. Having services available that can those with serious mental health issues should help to lower costs for the city and that money can be deployed elsewhere like targeted services or substance use treatment.
- People with serious mental health conditions should be the top priority and get taken cared asap.
- Peoples main reason for substance abuse is being without home on the streets and using drugs to cope with safety and being able to stay up all night as protection.
- Person-centered care for this group includes providing services "where they are"; in a tent; in a coffee shop; in a therapy room. Reduce accessibility issues.
- Please fund more Intensive Case Management services; we have so many people who are NOT ABLE to manage their basic medical care, income and retain housing.

- Please promote the available services and arrange for Mayor Lurie to make a formal announcement regarding San Francisco's offerings. Alternatively, the Director of the San Francisco Department of Public Health (SFDPH) could engage directly with the public to provide this information. If stakeholders demonstrate a commitment to supporting the most vulnerable members of society, they can play a pivotal role in promoting the overall health of San Francisco.
- Poor mental health can't be addressed if it isn't accessible.
- Preventative mental health can hinder the need for clients to be on the waitlist for mental health services.
- preventative mental health care is a proactive approach to getting people the care that they need before it turns into a crisis. A proactive approach instead of a reactive approach
- preventing before escalates, 2nd Understand int
- Prevention is better than cure.
- Prevention is better than cure. Educating the public about mental illness will allow them to understand symptoms and seek help faster before they become serious.
- prevention likely gets you the most bang for your buck and helps people before things get worse
- prevention services. there are not enough providers. attracting those that keep an open door policy to services versus that require referrals, insurance approvals.
- Preventive care is essential to prevent the situation from worsening. If you did it well, it will decrease the risk of mental crisis, mental issues
- Priority is given to people who are not linked to behavioral services and who are also at higher risk of overdosing or using emergency rooms.
- Programs that have flexibility to outreach to folks wherever they are. Our ICM and FSP programs used to be able to do that, but now with fee for service, we cannot afford to do the street outreach and engagement that is needed, sadly.
- provide more open beds.
- Provide telephone number for those who has questions and need to make an appointment. Assistance in other languages.
- Providing structured supportive housing creates a vital stepping stone for individuals living with mental health conditions. In the right environment, people can receive the stability and guidance needed to thrive. Supportive housing helps residents build life skills, manage their conditions effectively, and take meaningful steps toward independence and improved quality of life.
- Reduce the cost of living in San Francisco and Improve training in health care staff to actually explain health system to LEP patients
- Reduced services, housing, employment opportunities, racism and increase of deadly drugs in the community has created a more vulnerable population that is at risk of self medicating to cope with their situation.
- Rent is too expensive and many people cannot afford to eat and pay rent each month, thus driving up depression, anxiety, and worry
- Research has shown that when people do have housing, which is a basic need, they can then focus on getting better and stopping substance use gradually. Without housing, itâ€™s impossible to expect someone to get better if theyâ€™re worried about where they will sleep day after day.
- Residents have said they have no way to contact social workers or the programs at General. They can't make appointments or speak to a live person about their concerns or when they need help with food or transportation.

- Safe, easily accessible housing for all who need it. Especially those with SUD treatment specializations.
- Same response as previous answer.
- San Francisco currently lacks 24/7 mental health support for acute sexual-assault survivors receiving emergency medical and forensic care at the Rape Treatment Center (RTC) at ZSFG. These patients are experiencing an acute trauma crisis, yet bedside mental health services are only available Monday - Friday from 8 AMâ€“4 PM â€” just 23.8% of the week. The remaining 76.2% of survivors seen at night or on weekends receive no trained crisis counselor, advocate, or mental-health clinician at bedside. This gap undermines trauma-informed care and places the burden of emotional crisis management on medical providers, whose role is focused on medical and forensic needs rather than acute psychological stabilization. Survivors who lack immediate mental-health response are more likely to experience PTSD, avoidance of follow-up care, and decreased engagement with justice and recovery systems. To improve services: Fund and implement a 24/7 trauma crisis response team embedded within the RTC to provide on-call bedside advocacy and immediate mental-health support for adult survivors. Develop dedicated funding streams (e.g., MHSA innovation or workforce grants) to sustain licensed mental-health clinicians and advocates who specialize in sexual-assault crisis intervention. Until acute sexual-assault survivors have equitable access to bedside mental-health crisis response at all hours, San Francisco cannot truly claim that mental-health services are readily available for anyone who needs them.
- San Francisco has some of the highest rates of co-occurring mental health and substance-use disorders in California. The city reports that: Thousands of residents experience serious mental illness, with a disproportionate burden among people who are unhoused or living in poverty. Nearly half of all overdose deaths involve people with a documented mental health condition. Chronic stress from homelessness, trauma, and economic instability compounds depression, anxiety, and PTSD. These intersecting issues mean that access to compassionate, nonjudgmental mental health care can literally be life-saving.
- San Francisco needs to release the money set aside for affordable housing and build 100% below market, affordable subsidized housing.
- See my previous answer regarding housing as the most influential piece of successful treatment. The fact that you have to ask these questions highlights the absolute fucking lack of knowledge and intelligence at city hall. Fuck all of you.
- See previous answer.
- Seems like the services are not easily attain you need to end up in PES to have an appointment
- Series mental health conditions can have consequences to innocent victims. These patients might attack someone, so should be immediate care.
- Serious conditions are not managed in a 'whole patient' way - instead you go one place for substance, another for MH, another for residential
- Serious mental health conditions are complex and difficult to treat long-term.
- serious mental health issues are concerning for both client's safety & other's, as I have witnessed while both living & working in SF
- Serious mental illness is not a behavioral issue it is a brain disease and should be treated at such. SF needs to be recognition that this population needs life long support similar to those with autism or dementia
- Serious mental illness not only impacts the individual but their family, neighbors, the community
- Services should be readily available with low barriers to those show need and want access.
- Services should cater towards vulnerable population

- Services should target the demographics that are most impacted and do so in a culturally appropriate manner.
- SMI pts are least likely to ask for services but need them Priorities should be with those with thought disorders and not personality disorders.
- Some people enter treatment but don't stay, or keep relapsing. Clients in treatment also tend to use the emergency room for primary care services, so the City should develop a system to provide urgent care or primary services to clients in residential programs so they don't tie up the emergency care system.
- Stable housing is an important protective factor in preventing and improving public health outcomes; particularly for communities who experience compounding risk factors because of historical trauma and contemporaneous systemic inequity.
- Stable housing is difficult to find in San Francisco, and it can tremendously improve a person's health outcomes.
- Statistically proven time and time again. One must be housed and fed in order to stabilize physically, mentally, and substance wise. It's almost impossible otherwise. I'm dumbfounded at this city policy that is going away from statistically proven methods for appearances. Shameful and will be held to account eventually.
- Still see many homeless in serious need almost every day
- Substance Disorder is a public safety issue.
- substance use prevention services will heelo reduce substance use as people can easily acess and education provided
- Substance use treatment programs are very much needed in SF. They need to be visible and low barrier to access.
- Substance users are high utilizers of services, and treatment is rarely available on demand
- Substance users often have mental health issues and they need services from health care teams from multidisciplinary medicine. There is no one solution to the open drug use in San Francisco. This is going to take a village of health care givers working collaboratively improve the health of San Francisco.
- Support organizations that offer services to underrepresented communities.
- Support would include as needed: sheltered housing, family of client support, home visits, mobilizing the community through traditional support networks such as temples, churches, NGOs etc.
- Supportive housing is essential because stable housing is the foundation for recovery. San Francisco has invested heavily in this, but for some reason, it’s still not enough - people continue to fall through the cracks. The City could strengthen accountability of suppliers and ensure long-term follow-up. Other countries showing success focus on providing permanent housing immediately alongside wraparound mental health and employment support - helping people rebuild stability before addressing other challenges.
- Supportive housing is the prerequisite for all other behavioral health interventions. Without stable housing, mental health treatment, substance use services, crisis response, and preventative care all fail. People experiencing homelessness are managing survival, not recovery. Unstable housing perpetuates trauma, triggers crisis, and makes any therapeutic work impossible. Housing-first approaches are evidence-based AND they center human dignity over punitive systems. San Francisco's current crisis reflects policy failure: gentrification and speculation have priced out low-income residents; supportive housing stock is criminally insufficient; and case management is often surveillance disguised as support rather than genuine partnership. Until housing is treated as a human right not a scarce commodity or

reward for 'compliance' behavioral health services remain luxury goods for the housed.

- Supportive housing services = not enough supportive housing readily available or conveniently located near public transportation/resources. I work within DPH and our patients frequently have to extend their admissions by several days (sometimes up to a week) because the type of supportive housing they need is not readily available. This creates delays in transitioning the patient from inpatient to outpatient treatment, costs the city significantly more money, and sometimes impacts other inpatient care when our unit becomes completely full, requiring us to divert our patients to other hospitals.
- Supportive housing services and case management would be critical; there are many of my patients with poorly controlled mental health and remain housing referral status and have been waiting for months and months.
- supportive housing works, without basic stability of having a place to stay lives remain very chaotic especially for people with mental health issues.
- Targeted behavioral health services for underserved populations (ex: Underserved language/ethnic populations, elders, at-risk for homelessness due to income disparities). Homeless population is a smaller portion of the total SF population but they absorb significant resources and minimal impact!!
- Targeted services for underserved populations due to folks falling through the cracks. Something that could be helpful would include being able to engage effectively with some sort of walk in clinic that was not attendance based.
- Teach in schools, community centers, churches, and other places where people gather families and young people can learn consequences of addictions and be more realistic about it.
- Teens, TAY, BIPOC, LGBTQ+, pre/postpartum birthing people continue to have high rates of depression, anxiety, self-harm and attempted/suicide. We see these rates continuing to rise after the pandemic.
- The "no wrong door" method is great...for a crisis. But the city has very few realistic options for longterm connections (like a therapist). This creates the problem of having to wait for a crisis, getting care in the moment, maybe some short-term follow-up, but no longer term services to prevent the crises from happening.
- The are so many cases still in SF using substance use in the street and even they are house.
- the best way to help is before the situation becomes serious , if we can reach the people before the situation becomes a bigger issue and the same goes for substance abuse , to teach before the problem occurs as with most other issues , the preventative , as it goes with criminal activities reach out before the situation becomes worse or before it becomes anything.
- The biggest barriers we see are mistrust because people who have accessed substance use treatment are then tossed out on the street afterwards or in housing where people are using substances making it impossible to reduce harm and/or be in recovery.
- The city already does a pretty good job of this with excellent street teams, the problem is that there are not enough of them to cover the need.
- The city already knows where the concentration of people are that need help. The city needs to address this by forcing people off the streets and into some kind of mental, medical, housing help. It should not be an option for people to live on the street. It is not healthy for them, nor for the people around them.
- The city and authorities used to work closer with Social Workers and community psychiatry to support clients in the community having a mental health crisis access care. Now it is an uphill battle. 8 out of 10xs when services are called for a mental health crisis especially in 5150 a client the response is either client does not want to go we can't support, nor take them or what

is the reason for the call leading to a long period of advocacy. Or, the wait is up to 2-3 hours for someone to arrive. Often leading to the client left behind having to wait until the client gets worse or harms a person on the street due to mental health decompensation. Ideas, prioritize request from clinical social workers for services, hold clients in the hospital longer than 4 hours once pumped with Ativan. Go back to prioritizing clients with severe mental illness into housing (this changed with BHS dissolved into HSA and clients with severe mental illness lost direct access to DAH housing). Re-open psych unit in ZSFGH for mental health care. The closure also gummed up the process and removed access to mental health care when in crises.

- The City is infamous for having a population with serious mental health conditions and therefore infamous for being unsafe and a potentially terror-filled destination. Speaking from experience.
- The city's psychiatric emergency service, inpatient service and post discharge system of care (ADU) are long overdue for upgrades in facilities, staffing and programming. Sending a patient to PES involves acknowledgment that the process will likely add additional trauma to the patient and sadly, result in further harm. There are absolutely wonderful examples of excellent care but I fear these are exceptions given the rush to 'catch and release' people ASAP. Additionally, the challenge of getting severely mentally ill patients connected with 'specialty' mental health is frustrating and seems overly complex and takes a LONG time with often poor results. I understand that mental illness itself is frustrating and complex - and that often the folks who need it most are the least to seek or accept care - but I wonder if we as a city could provide better care to folks who are clearly SMI. This includes revisiting conservatorship and longer step down hospitalization options.
- The crisis response teams should not allow people in need to refuse services and the city needs to have more longterm locked beds.
- The harm reduction needs to change. It is not working.
- The insurance-based system leaves a lot of people without access to care. Setting up a public system that can take both private and public insurance would be best alternative.
- The main problem that has impacted everyone that I have worked with is housing. Options for affordable, safe housing and non-congregate shelter options OUTSIDE OF THE TENDERLOIN would address the primary stressors for medi-cal recipients. Identifying ways that the city could convert office spaces into housing units, and identifying spaces that could be used as shelters would support all facets of behavioral health work. The beds that magically appear during special events (ex. Dreamforce, AIPAC, Super Bowl, World Cup, etc.) need to be available year round.
- The majority of people dont get sober when they're unhoused. Supportive housing at least gives them a safe place to explore harm reduction and recovery at their pace. People only get sober when they are ready and some will never be ready before the disease kills them.
- The methamphetamine epidemic and resulting time-limited and prolonged psychotic episodes should be a focus, and the ideal intervention would be for providers at all SFDPH sites (ED, hospital, clinics, street services) to have immediate access to prescribe all commonly available long-acting injectable (LAI) antipsychotics (not just first-generation Haldol and Prolixin LAI, but second-generation Invega Sustenna, Abilify Maintena and Uzedy (Risperidone)).
- The MHSA plans have not designated funding to veterans beyond capital expense made years (a decade?) ago. There has been no funding for ongoing culturally appropriate veteran care.
- The ones with serious mental health should be prioritize before they do any harm to themselves and or the community
- The people doing drugs outside are lacking a home. Someone getting housing is proven to reduce ER visits and related expenditures, proven to reduce mental health issues, proven to

reduce problematic drug use, proven to save lives, etc etc etc. We do not have a drug issue in this city. If you are wealthy and have a home, drug use is more than accepted and permitted in this City. The problem is that people do not have homes/housing. In the wealthiest city to ever exist. We need to put people into homes. This will reduce SO many related issues that get exacerbated by unsheltered homelessness. Everything else is just a band-aid.

- The people who are the hardest to reach/treat keep cycling through the system because there aren't many placement options for people with mental health + substance use issues + medical issues. They are really taxing on our healthcare workers, hospitals, city agencies, the courts AND their needs aren't being met - largely because there just aren't placements who are willing or able to do what it takes to help stabilize these very sick and challenging individuals.
- The push to limit ICM services has been extremely harmful to the system. The MOT program was so badly organized and managed that it was never a credible resource. I wish that folks at 1380 would LISTEN to billing providers before implementing these types of changes; I think it would save us all a lot of time and our Members would be better served. I understand that an MMP has experience/skill set that I don't have, is it that hard to understand that the same might be true for an MD, LSCW, MFT, healthworker etc?
- The reason I ranked it number 1 because we have patients that struggle with severe mental illness that are un-housed and decompensating. Some of our patients are un-housed and untreated which leads to decompensation and risk for hospitalization.
- The societal cost associated with serious mental illness is not only measured in dollars spent on individuals (high services users including hospitalizations, 911 calls), but is also unmeasured in terms of burn out among city inhabitants and visitors (who are losing compassion for anti-social behaviors), and also among first responders and hospital staff/clinicians who are also experiencing high levels of moral distress in caring for people with severe mental illness OUTSIDE of psychiatric spaces. Improving services in this area might include increasing the number of available residential care options and requiring these for folks with serious mental illness (alongside requiring Rx treatment); empowering behavioral health groups to require treatment/residential stay for people with serious mental illness, development of shared units in hospitals/ED settings staffed with both medical AND psychiatric trained staff
- The typical complaint is " No one can help my family member. I have gone to all the agencies and they tell me to dial 911. The police come, he goes to hospital for a couple of days and returns home. It is viscous cycle. "
- The underserved community are the most vulnerable. To help improve services in this area is to prioritize services and see them immediately, not schedule an intake appointment and tell them to come back at a later date. We lose them.
- The underserved population has the most distrust of serves so outreach is important, meeting people where they are at is important.
- There are a lot of sick people living on the street currently if we focused on their mental health first instead of trying to combat peoples' addictions, it would help solve some of the substance use issues because people are sick and that is why they use substances. Talking to people asking them deeper questions about where they are currently with their mental health. Also most people go to Kaiser, making them create mental health pathways to help people focus on their mental health as wellness and not craziness.
- There are almost no services for severely mentally ill people
- There are drugged out mentally unstable people all over our streets. It is really a humanitarian crisis. I used to love walking long distances all over the city but now, if I do, I find myself crossing to the other side of the street to avoid someone who is clearly having a mental health crisis. Its

also really sad to see people shooting up, smoking crack or speed, or appearing to do all kinds of other drugs as they lay, splayed out on sidewalks. I've encountered many, many people flagrantly using drugs out in the open, on the sidewalks. We certainly need, I believe, safe injecting sites because the reality is that people are never going to stop buying and using drugs. But our streets would be safer and less scary if innocent people just trying to go about their day didn't have to encounter this all the time. As much of a bleeding heart liberal as I am, I think the problem for years has been the people who advocate for the free will of these poor, lost souls who cant take care of themselves and have poor insight and judgment, not to mention often poor impulse control. Their freedoms often seem to take precedence over the freedoms of our city and community as a whole to have safe, clean streets free of the chaos, danger, sadness and dysfunction that our streets have become as a result of this.

- there are limited resources right now. Those with more serious mental health needs should be prioritized
- There are lots of people suffering with mental health needs that may not be as visible as those in the street but might still experience similar comorbidities and barriers. Targeting those folks might help prevent further decline that might eventually lead to homelessness or conservatorship needs.
- There are many barriers to getting patients in need the intensive case management services. Once stabilized frequent users OF PES AND IMPATIENT are quickly dumped back into outpatient programs, which are unable to provide the level of care. People often need to remain stable in the community. So then, they become unstable. I think we need day treatment programs again that would operate seven days a week to give people something productive to do. Also, please stop lumping together substance use disorders with psychiatric disorders.
- There are many people who are unstable, unhoused, and sometimes coupled with substance use disorders. Some of these people's mental health issues are due to substance use, while others may be more organic in nature. They need support to stabilize to get off the street or substance, or to have them moved along to the next phase of support, such as a treatment or housing. These are chronic issues, and people would thrive once they are stabilized, coupled with receiving support services as needed.
- There are many people with severe mental health issues out on the streets, and they are some of the most vulnerable populations in the City. They need priority and more attention.
- There are so many community members that I come across on an Everyday basis, whether commuting to/from work, running errands/moving about the city on public transit, or being at work, that I see obviously suffering from substance use disorders. There cannot be enough available services for this many people to continue to be in this situation, all through the city.
- There are so many negative downstream effects of untreated mental illness, including substance use and homelessness. Treatment of severe mental illness is imperative and should be prioritized. Increasing access by offering low barrier services, advocating for less administrative burden to offering specialty mental health services, flexibility in how and where services are offered.
- There are specific groups that bear the burden of the shortages and gaps disproportionately. Those should be prioritized
- there are TONS of programs out there that help put a band- aid on the problem of an ever-growing population of people who are completely lost. This begins at home with the family, community, and education of our children to keep them feeling like active and loved members of their community. I really don't know where to start as I am tired. I think that ultimately there is too many of us. It's the most sensitive and abandoned ones that end up in these situations.

- There are too many homeless people and they need somewhere safe to live.
- There are too many homeless people with mental health issues on our streets. Jail is not the place for them and that is where they are being taken too. Now how do we improve it I am at a loss there, maybe contacting their families see if they can help. Build more facilities that can meet their needs
- There are too many homeless that lack services
- There are too many mentally unstable people roaming the streets that are causing harm to others and themselves. They need more people to reach out and give more care, even if that means free mental health services provided to them.
- There are too many residents with untreated mental health. Providers need to be more skilled at recognizing mental health issues in the early stages to prevent an increae in symptomologyare address, the less severe the conditions
- There are too many with mental health issues walking the streets with no where to go and trying to self medicate with street drugs
- There are very few culturally-congruent mental health providers for the transgender community
- There aren't enough treatment center or residential services for families.
- There is a dearth of culturally and linguistically concordant psychiatric and behavioral health providers, specifically those that speak Spanish, that are first or second generation, especially in maternal mental health/perinatal mental health. I also don't see enough telehealth options on offer.
- There is a lack of resources to stabilize those who are chronically gravely disabled. The threshold for treatment of GD is ridiculously high and due to the non acute nature, routinely triaged to the bottom.
- There is a movement to liberate methadone which this city could learn from. Presently, it can be difficult to access MAT in the midst of a drug contamination crisis.
- There is a need for expanded MH services.
- There is a shortage of services, providers, and treatment options so accessibility should be addressed first.
- There is not enough capacity for people with mental health challenges, for instance, people with severe mental health issues can only see their provider twice a month. High caseloads mean providers cannot follow up regularly.
- There is not enough SUD Detox Treatment center for our clients to choose from. The Inpatient treatment here in the city most likely has drugs in the house. How will clients get clean.
- There is severe underservice for people with SMI.
- There is such a vast range of mental and behavioral health issues which underserved populations are enduring, more targeted specialist may help with proper identification of these issues resulting in more effective treatment plans implemented for these specific individuals.
- There needs to be access to services regardless of uninsured or under insured.
- there needs to be more of an expansion on preventative mental health care options at primary care and BHS in order to minimize the risk of clients cycling through the psychiatric emergency rooms. From my experiences as a behavioral health clinicians, clients lack the coping skills needed to regulate their emotions and distress that results in them utilizing PES, especially during after hours. By expanding more preventative mental health care options, providers will be able to better work with clients on skills development during sessions--efforts that could mitigate the risk of a psychiatric hospitalization.
- There should be comprehensive audits to evaluate the effectiveness of all mental health and substance abuse services. Ineffective programs must be eliminated. Investigations should also

determine which site staff may be contributing to the problem by selling drugs to patients and worsening their situations. The practice of giving out gift cards to patients must stop. It only encourages harmful behavior. Many individuals know how to exploit the system and use the money to buy drugs. Staff often stay silent to protect their jobs and keep their sites open. The City of San Francisco is wasting taxpayer money and will eventually be held accountable by the public.

- There's a lack of support
- These are most underserved and less likely to reach out for care
- These are often the most vulnerable and underserved client populations.
- They are the most likely to die.
- They need more education on mental health
- They need tough love accountabiliy facts not babying them disabling them
- They're the most vulnerable with the least options. It seems like the most humane approach.
- This diverts other City emergency services
- This is a city, state and country issue.
- This is a problem faced by most people
- This is prioritized first because underserved groups such as people experiencing homelessness, racial/ethnic minorities, and foster youth face the highest behavioral health needs and the greatest barriers to care. Focusing on targeted services helps close equity gaps, reduce crises, and improve long-term outcomes. Strengthening culturally responsive care, expanding mobile and community-based services, and improving coordination across housing, health, and social services are key strategies to enhance access and impact.
- This is the root cause if prevention services are adequately given and advertised to the homeless population and mental health communities it will alleviate the more serious cases.
- This need has only increased due to many factors affecting the mental health of individuals of all ages
- This population is harder to reach out due to their ongoing complex and comorbid conditions, language and cultural barriers, untreated mental health, long hx of trauma, and issues with trust. It needs specialized care providers who understand and know how to utilize harm reduction, motivational and relational techniques to help them stay engaged in low threshold services. Genuine compassion, treatment with dignity and acceptance are important when working with other human beings.
- Those homeless people who hang out on market street and on haight street. force them to accept behavior health/substance abuse services or get off of the sidewalks. make them contribute, rather than take.
- Those most in need refuse care and them not getting care is expensive for society, not just financially but physically and emotionally as well. They injured themselves and others. They attack others. They damage property and steal things.
- Those who are most at risk require the most intensive services. Our system does not have enough ICM level services and often the services that do exist are not well staffed.
- To develop programs collaborating with nonprofit organizations to develop workforce development and temporary housing programs
- To get people off of the streets and back into a healthier lifestyle with their loved ones
- too many mentally ill people walking on the streets and they are left on the streets
- too many people clearly having mental health crises wherever we walk in the city
- Too many people in San Francisco still struggle to find timely, affordable, and culturally responsive care when they need it. Ideas: Make it easier to get help right where people already

go like primary care clinics and community sites and cut down the red tape that keeps folks from staying connected to care.

- Too many people need MH services and are not getting them. Democratize MH care don't specialize it.
- Too many people wigging out on the streets, not harming anyone just being loud and annoying.
- Too often I hear that SF is the place to go for drugs, you can buy, sell & use all on the spot. I see this myself daily on my way to work, especially the use.
- Transgender/nonbinary undeserved population highest rates of individuals homeless, there is often intersectionality with being immigrants, TAY, racial minorities. Culturally congruent programs are essential. Trained staff that are competent with TGD pops are essential--not just a pronouns training; but getting employees that are passionate about serving this community will help them stay in care and get connected to services.
- Trauma can lead to serious mental health issues and/or substance use issues. Often these issues are connected. Those with the most severe mental health issues really need wrap around supportive care, and there really aren't a lot of places for those folks to get that kind of care besides with the city and county public services.
- Tx services seem to be available, but a lot of people are not ready for Substance Tx or many people come from other parts of the County and are specifically here for the drugs and supportive services, so they want to maintain use in SF while accessing low barrier services. This is a struggle and don't know how to address it.
- Underserved communities have a variety of challenges and ensuring they are getting treatment options helps improve their overall health.
- Underserved populations are at greatest risk and need, and prioritizing behavioral healthcare for them shores up the foundations for the health of the community at large.
- Underserved populations are the most at-risk group of individuals It'd be a great idea to promote preventative mental health care to these groups, although, any workshops/support groups need to have motivating incentives for attendance. After any workshops, there must be follow through with those individuals who attended to ensure consistency and understanding.
- Underserved populations in general have less access to behavioral health services as well as have a fear or stigma of being judged due to lack of knowledge and education about mental health
- Underserved populations usually are the the homeless population.
- underserved populations, by definition, need more services to achieve equitable access to care. focusing on populations with higher/potentially higher needs is both responsive and preventive. each group should receive care that accommodates their specific needs, withe burden of care/service coordination placed on the system and not the individual: people with insecure housing should have housing case management and financial support services integrated with behavioral care; people of minority racial/ethnic/gender groups should have care adapted to cultural needs in their preferred language and provided by someone trained to provide culturally appropriate services. services should be offered in both traditional clinic settings and nontraditional spaces that increase likelihood of engagement in care (homes, cultural/religious gathering spaces, free meal program sites, etc)
- Unhoused people in every neighborhood of the City, some are dangerous and posing thread to the residents (like yelling, cursing, and physical assault). We as residents would like to see safer streets and more family friendly neighborhood for our children and elderlies.
- Until clients have their basic needs met (consistent and safe housing, consistent food, transportation, and child care), their mental health care needs won't be met. That would be like

putting a loose Band Aid over a major severed artery. Discussions, counseling, and support groups (that they can't get to) would be of little use to these folks who are living a day to day existence. Core necessities must be fulfilled before the other work of targeted mental health services can be completely effective.

- use of prevention services
- Using peers
- Vets that are homeless or at -risk for losing housing. VA services to not meet the needs of this population, as they often do not have VA benefits
- vulnerable SF residents do not have the technology resources, language abilities, transportation options to access mental health/substance abuse treatments. public announcements (i.e BHAC/BHAL phone number in different languages on posters on busses, public areas)
- Waiting list for Mental Health services are too long and hard to access. Accessibility is the key. They way services are organized at the moment is not effective. Some mental health providers caseloads are not full or scheduled.
- We are a City known for providing resources, providing targeted population with the resources to become a functioning adult should be our top priority which includes access to housing, mental health services, job opportunities for those who are underserved in San Francisco
- We are in great need of having a trained person who can have a coffee shop conversation with a person who is in great need of both mental and physical help. It appears to me that many of our health care professionals have outstanding I.T. skills. The purpose of having a street corner conversation is a lost art.
- We are seeing the smallest ethnic population (African Americans) suffer from the highest rates of overdosing. We need to tailor the services to understand and then meet the needs of the African American population. We all know that African Americans have been long marginalized, and the drugs are a way of dealing with some of the challenges. So to eliminate the disparities amongst African Americans you have to look at all their social determinates of health. Looking solely at substance use is not going to fix the problem. We have to ensure when a person goes into treatment, they have a place to sleep, food to eat and a job. Having these things will better position the person to level up and beat substance addiction.
- We as San Franciscans need to facilitate as many Preventative mental health care programs as possible: support groups, self-care, mental health education workshops; in order to prevent an escalation/deterioration of someone's behavioral health.
- We desperately need more ICM staff. The acuity of our caseloads is going up, and ICM programs have been understaffed for some time, meaning outpatient staff are trying to carry more severely ill patients with less time to see each patient. We need to start meeting the needs of our patients better (more frequent visits/appts) and not expecting clinicians to carry caseloads of 50-70 ill patients.
- we did a needs assessment, too, and so many people attributed mental health issues to not having housing or not having affordable housing, and also said they needed basic economic support. we cannot expect people to be well mentally when they cannot even have their basic needs met. human rights to safe housing, food, and income are critical for mental health.
- we don't have placement or enough ppl to help manage our patients
- We have a group of highly unstable individuals who cycle through the city ERs, and getting them into residential treatment and supportive housing would improve the quality of life for people living here.
- We have a housing affordability crisis and cannot meet demand.
- We have thousands of people unhoused in SF, and even more living in fear of becoming

unhoused. It is difficult to manage your mental health when you are worried about surviving. There are very few people who are able to live comfortably in SF and can take the time needed to address BH issues.

- We have very few treatment centers. Not enough sober living
- We in community mental health do not have access to resources to help support clients that are facing housing challenges such as finding an affordable place to live when they are on a fixed income (usually SSI).
- We need a more robust continuum of care that will support patients in their recovery and prevent the inpatient hospital system from being backed up with patients at inappropriate levels of care.
- We need action we done enough planning.
- We need more access to psychiatry. Psychiatric services are hard to access and have long wait lists. If hiring psychiatrists is too costly then we should train more psychiatric nurses and psyche techs to be able to treat patients more cost effectively. Also, we need more peer-support groups.
- We need more housing for the mentally ill so they aren't living on the streets.
- We need more mental health services and providers across the board. It is not accessible for anyone and although targeting populations is helpful, it means some are left behind. It should be a service available and accessible to all.
- We need more staff and beds to address the needs of individuals addicted to substances in the community.
- We need more targeted behavioral health services that meet the needs of new arrivals and are seeking gender affirming services.
- We need more welcoming spaces for people to get well. Our unhoused cannot work on mental health issues or SUD treatment when they are cold and unsafe.
- We need to focus more on prevention. There's been an impressive increase in treatment, but we know that prevention can really make a difference and we need both approaches in order to achieve our goals.
- We need to get help for the people who are most severely mentally ill/addicted, as they tend to cause the most destruction in the community. Again repeated hospitalizations and 5150s don't help if you just release them again without substantive long-term treatment.
- We need to get the chronically ill help ASAP
- We need to make our mental heath and substance use services accessible. We need to be able to state clearly online what our programs are and how to get access to them. Even if it requires a referral. Patients deserve to know what all the options are and how to get access to them. This information is somewhere and we need to have it online.
- We need to train paramedics so that they know how to respond to mental health crisis and mental health issue caused by substance use.
- We see many people in the streets of SF who are already well into their addictions that they need programs already in place to help them get treatments services. Prevention only works for relapse and those who have accepted they have a problem and want to stay clean. However, most need the treatment to get to that point.
- We will always have mental health. The substance use is bad virus that is way to accessible. The stuff on the streets now is so addictive and some people just do not understand how bad it is. Stop the freebies to people coming here it makes acquiring a habit to easy. Teach people how to fish. Get rid of sanctuary and find another way to help.
- We work in a population of extremely acute MH services and many of our clients need a higher

level of care and we are highest. Many of our clients become violent and need many 5150's. recently clients have attacked our staff and we are still waiting on transfer

- When I graduated with a MA from a psych program I looked for a placement site for over a year (none of the ones that wanted me as a trainee could pay anything at all and I was expected to do that for 2 years) Too much, ridiculous bureaucracy. There are plenty of people who want to become counselors but education is extremely expensive. So, the system keeps those that want to help out (my case is not the exception). These surveys are pointless if there is no interest (or power) to transform that system.
- When I see the Street Crisis Response Team talking to those on the street who need services, I can see my tax dollars at work and making a difference. Knowing that the Police or Sheriffs are not being involved assures me that those teams are not trying to do double-duty with their jobs protecting all of us AND solving street problems. The more Crisis Response Teams that are patrolling, the better!!
- With preventative steps and support as the foundation this could also prevent further prolonged mental health issues that later turn to and add substance abuse.
- With so many people on the street, I can only assume that there isn't enough transitional housing. Likewise support for serious mental health issues.
- With stable housing, the unhoused can then focus on the next aspect of barriers that they have to face.
- Without adequate support, residents go into a preventable crisis, get placed on a 5150, and overwhelm our EDs and emergency response teams. If we prioritize MH accessibility, we can mitigate the crisis that costs our City way too much money. Hire new MH providers. Build a MH workforce development plan. Pay CBOs enough money to hire providers to supplement the work that the City is doing. Get health insurance companies to offer more comprehensive MH services.
- without housing all the treatment we do doesn't help someone longterm. we currently honor someone completing 90 substance use program with a shelter referral. unacceptable. also we have hundreds in board and care and no way to help them move out on their own because their not high enough priority.
- without housing it is hard to stabilize behavioral health needs
- Without housing there is no way they can focus on their wellness. Without housing, there isnt any kind of stability where they can start with a schedule to go to appointments. Their main concerns for food and water are addressed through st anthonys or glide or other places for food, but without permanence, they cannot even start thinking about work or appointments with their mental and medical services to get better
- without housing, barriers to care including addressing mental illness and SUD are insurmountable. with homelessness (and at risk for homelessness) not addressed, we should expect that SUD and mental health problems continue.
- Without safe shelter, everything else suffers in a person's life.
- without stable housing, nothing else works
- work with trusted CBOs who know the community
- you can provide services to clients but if they don't have access to housing alone will make it difficult for clients to stay in treatment. Some clients with severe mental health/substance use will need long term case manag3ement which is not always available
- You can't go anywhere in SF without seeing someone slumped over from drug use. There should be more targeted assistance for substance use treatment & prevention on the streets of SF.
- You cannot help someone if they're not housed first. They'll be re-traumatized in the streets.

With the federal government pushing back against housing first, the city has to step forward to make up for the failure of the federal government.

- You have to start with the most severe cases, you cant combat homelessness or drug addiction or overdoses without the proper investment to help the people who need it most.
- You need housing and a supportive environment to improve your mental health.
- You tax American citizens dollars but when you need service, they are not available due to income restriction's. Approximately two-thirds of adults with a substance use disorder (SUD) are employed, accounting for around 30.1 million employed Americans in 2022. Studies indicate that 70% of people who use illegal drugs are employed.
- You're more likely to have successful outcomes working with people before they begin using substances than afterwards. You might have more success if the all the conflicting messaging around drug use within the city and state were cleaned up. Where on one hand we rail against tobacco use, but seem to support or at least appear neutral on the usage of other more illicit drugs (ie. promoting safe usage). Harm reduction doesn't help as it becomes more a message of use the things that "we" believe are ok, while individuals make their own choices experimenting with drugs and combinations of drugs that they believe are ok. How can you be critical of what they do or their choices, given the contradictions in your own positions? If you want to be successful in this mission, you will need to pick a side
- Youth focus psychoeducation on substance use, cannabis / opioids (pills) , vaping
- Youth need education and other alternatives

Appendix F

Which of the following actions are most important for the City to take in order to better support people with behavioral health needs who are experiencing homelessness?

- Aging and high acuity individuals who have experienced homelessness need more that case management to secure, transition and maintain permanent supportive housing. Without assistance -their mental and physical health is at risk and they may lose housing or need higher levels of care.
- ALL above are needed.
- all of the above
- All of the above
- all of the above are very important; very hard to narrow down to 2 choices. Also, to better support people, it depends on the reasoning behind the homelessness; from there, a plan can be coordinated/accessed
- All of the above!
- all of the above. get people off the streets and stable so they can work and life in safe areas
- All the above!
- Assure that job training and employment opportunities are aligned with the needs of the individual and are not just generic job offerings
- Before offering a variety of services, you first need to know how to reach out to people in need and help them stay engaged and connected to care providers. Building trust and initial rapport are essential to avoid losing vulnerable individuals.
- Change involuntary commitment policies. People who are severely mentally ill or addicted are not in a place to use employment programs or apply for affordable housing. They need long term care for acute cases which often involves involuntary commitment.
- Create a program that can do many of the topics mentioned; create more affordable housing and make it easier and faster to get housing and / or provide rental assistance. Secondly, Improve coordination of services between community based organizations and this would improve case management services and possibly support substance use services as well as mental health services.
- Create a workforce development strategy that brings in people who are bilingual, multicultural, and willing to be trained. Give them real opportunities, access to mentors, and to good-paying internships and jobs.
- Create more affordable housing OUTSIDE of the Tenderloin neighborhood.
- create more supportive housing specifically for people with chronic mental illness
- Create multi-disciplinary crisis care centers who can deal with ALL of the problems at hand, not just one of them
- Create programs that care for the whole person, which creates an environment to thrive mentally, This includes food, healthcare, housing and jobs. A safe body supports a safe mind and vise versa. Treat the WHOLE person.
- Culturally congruent services.
- diversity, education that's more up to date, promoting stories of marginalized demographics, training patience and non victimisation to city employers, moving away from opressor opressed, victim abused rhetorics, truth no matter the cost as the guiding philosophy, and acceptance of differing views, decriminalization of substance use, and promotion of education in regard to substance use
- Do at least yearly audits of the equity and fairness of the Denial-of-Service (DOS) and rejection of acute referrals for LLOC/diversion programs (Dore Urgent Care, Hummingbird/Baker, Geary CSU, SOMA Rise) so that certain patients with difficult behaviors/personality traits are not

unfairly rejected/denied service based on random whim or prejudice.

- don't need to "create" when there's a lot of empty housing that just not made available
- education and empowerment is the key; make able not disable this population.
- Enforce the law that says if offered a shelter bed, people can't stay on the street.
- Expand the ability for people who have lived in permanent supportive housing and are stable the ability to move out of that housing with a subsidy into the community and free those units up for people experiencing homelessness that can benefit from onsite supportive services. Often people is PSH have no alternative because their incomes do not support market rents.
- Face the fact that allowing people to live on the street is a draw for more people to come.
- Find some magical way to get people who would rather take another fix of fentanyl or meth or both: to seek treatment instead. and I have no idea what that is.
- focus good education from little when kids are young.
- force them off of the sidewalks,
- Fund group therapy led by professionals with in person interpreter support
- Get drugs off the streets. Breakdown encampments. Clean up sidewalks, disallow malingering and trash spreading/hoarding
- HARM REDUCTION SERVICES AND HOUSING FIRST
- Help the people who are doing the right thing keep getting Continuous care and support.
- Hire case managers and less therapists
- hire more 2932s to provide clinical supervision to 2930s. guarantee clinical hours towards licensure for 2930s, regardless of what setting they work in
- Hiring more qualify employee instead just newly graduates students
- Honestly, ALL of these.
- Housing for both populations needs to have mental health support and housing.
- I will state that while many of your youth and families are experiencing homelessness, this seems very targeted and not aligned with the question above. The definition of "targeted behavioral health services" shouldn't only focus on unhoused adults which this is very much alluding to.
- If people refuse services stop letting them create a public health and safety crisis in our city.
- If singles, you should look to invest more in group type housing where more emphasis can be placed on ensuring people maintain the treatment regimens necessary for them to reach a point where more independent living options can be considered. If families, then partnerships with groups outside of the city who can provide the needed services where less of the influences which drive relapses will be available.
- Improve coordination among cbo's, dph and all players so that we can all get folks to the MH and SUD treatments that are available. Monthly meetings like we did with Covid, invite all to the table.
- Improve or expand outreach services to people on the street + provide resources
- Improve police services
- Increase funding for a full range of harm reduction services from safe supplies and education all the way to abstinence. We need a full range of options, its not one or the other.
- Intensive, wraparound care & supports (beyond one CM per 40 residents) in PSH
- Make it easier or faster to get housing and Improve or expand substance use services
- Make more affordable housing options out of existing vacant housing that is not currently designated as low income housing
- Make wrap around services and supportive housing more common

- Mandatory housing and service enrollment for benefit accezs
- More culturally competent/trauma informed clinicians.
- More holistic support that offers housing while in treatment, case managment, and mental health support.
- More housing outside of the TL
- More long term mandated treatment sites. People need a long time to heal and we expect them to do it quickly and in difficult environments
- More supportive housing with fewer restrictions.
- Not allow people in need to refuse services and more longterm locked beds.
- offer drop in services
- People should be required to work in exchange for benefits. When everything is free, there is no motivation to work. Unless the conspiracy is true and low welfare programs are intentionally designed to keep people trapped at the bottom while the rich continue to get richer and the poor become even poorer.
- Policy to protect affordable housing improvement/expansion so that it actually benefits the people in need of housing
- Promote drug free Housing and stop this open drug market in the streets
- Provide camp site
- Provide support and education on daily living tasks (managing finances & paying bills, managing medications, grocery shopping, job training, personal grooming, etc.)
- provide treatment before they become homeless . Work to change the LPS laws to that need for treatment instead of grave disability required to hospitalization
- Quit giving homeless people with drug addictions cash. We need to stop making drug use easy and open. We tried. It didn't work. It's worse than ever. If people cannot take care of themselves they need intervention to get them on a better path before they're able to care for themselves. I propose a type of assisted living where we make sure people eat. Shower. Get clean clothing. Take their medications. And once they're stable and doing ok we can tackle their addiction issues and homelessness. But without someone else doing the work most of these people will not be able to change their cycle
- same answer from previous questions.
- send back the out of towners to their city of origin to make it easier on focusing the native San Franciscans .
- Streamline services to avoid redundancy and utilize resources efficiently.
- Strengthen accountability and oversight to make sure contracted providers are actually delivering results and using funds effectively.
- The City should seriously (re)consider how CBOs and DPH work in tandem and look towards simplifying the system of care.
- The community-based model was well meaning but it's a proven failure. Behavioral health needs to be put back into the hands of trained professionals. The unable homeless are on the streets because of illness, not ill because they're on the streets. If their illness makes working and getting housing difficult, they need long-term focused housing and care, not the key to an empty apartment and the opportunity to get sicker from street predators. This model should include work opportunities within the housing and care complexes. If we can pay prisoners for their work, we can pay the behaviorally unwell as they feel able to work. There's no reason that these communities could not include public-facing businesses like cafes, stores, etc to offset costs and provide patients with work they're able and willing to do. And this should NOT be a reason to remove them from their housing. Some patients may never be fully able to be

independent. They should have the housing and care they need. Ironically, this was the purpose of the old "mental institutions" in the past. But they had few options, they were chronically underfunded, and their closed nature could lead to abuse and inappropriate placement. We can use the building model again with updated care and oversight techniques. Since mental health is such a problem for prison inmates (up to 70%!), nonviolent offenders could be moved to low-level prison campuses. Remove the razor wire and put in welcoming features and there's no need to build as much and various levels of behaviorally ill patients will have beds (upgraded, please!) already in place.

- The reason this list exists is because all of these are equally important and they prevent homelessness!
- This question alone is identifying ways to not acknowledge all are important and possible to do all with the appropriate orgs in place with the right peope.
- This question is an example of a "false choice" many off these items should be a shared top priority and can exist in the same places (e/.g., housing, supports, treatment, etc...)
- We could tackle both homelessness and mental health/substance abuse issues if we had housing that was focused on mental health services where patients could be treated and connected with services.
- While I do think housing is important, I don't think it's the only thing. But access to shelter is very important too.
- You also have to take into consideration the fact that many people don’t want services.
- You cant dump clients in housing and then expect them to understand how to live and function

Appendix G

Is there anything else you would like to share about mental health and substance use services in San Francisco? For example, what has worked well, what improvements would make the biggest difference, etc.?

- The problems are very difficult & require many facets in attempting to resolve a major difficulty in S.F. that cannot be dissolved easily. I do not have the answers to this very complicated problem in S.F. Very sorry that I cannot be more helpful in my answers to a difficult issue in S.F.
- No
- 75% of admitted psychiatric patients in our facility are taking up a bed that is needed for a patient in crisis. Those 75% are not safe to discharge because there is no availability in the community to keep them and the public safe. The hospital is not a hotel. It is a place for treatment. SF needs to have more resources in the community so we can discharge that 75% to free up beds for patients in crisis and needing treatment immediately.
- A continuous or routine method for assessing provider/administrator morale, burnout and "therapeutic nihilism" at various coordinating sites/services, and publication of these anonymized survey results with chance for provider/administrator/team feedback for specific reasons for concerning results at specific sites. Too many people working in the public system are providing sub-optimal care and coordination due to their own work-related mental health issues like burnout.
- A huge need for mental health services is destigmatizing HPV. 80% of people have human papilloma virus and it should be addressed more as a cancer prevention than a STD. This affects many young women's mental health having news of the diagnosis and only women can be tested. In my experience, many young women are becoming suicidal and don't feel comfortable to talk about it with peers or get support based on the stigma of having a "STD". It needs to be talked about and normalized, especially due to its impact on the mental health of those who receive positive test results, despite it usually being asymptomatic.
- A living wage would make the greatest difference but more realistically, benefits requirements and eligibility limits need to be updated to reflect today's realities. We also need housing options that allow people to live with privacy and dignity. I've spent time in many SROs in the Tenderloin, and the conditions are deeply dehumanizing. I've seen disabled residents unable to leave their buildings because the elevator has been broken for years, shared bathrooms and kitchens that are never cleaned, and environments that essentially become petri dishes for illness. Building owners aren't stepping up, and residents feel forgotten and helpless. They're not without responsibility, but the truth is that our current systems simply aren't working. For years, I've watched the same drug dealers on the same corners. Even when they're arrested, they're often back within hours. There is no fear of consequences. I've seen people buy a hit, use it immediately, collapse forward, unable to stand or respond, and then get pushed into doorways by their dealer to be out of sight. Many of the dealers are victims themselves, but this cannot be something we grow numb to. The complexities of people's situations in this city require a unique, compassionate, and realistic approach especially in a place where even the most basic accommodations require a high-paying job. I see people whose long-term substance use has altered their cognitive functioning so severely that the level of employment needed to survive here is simply out of reach. I've seen families who, through no fault of their own, fell into homelessness and were placed in open shelters with no privacy. Their children witness violence, untreated mental health crises, and trauma that fractures the family's ability to recover. The Bay Area lacks a centralized system that communicates effectively, eliminates redundancies, supports people fully, and still holds them accountable. We also need a taxation system that

requires billionaires and corporations - many of whom profit directly from the inequities driving this crisis to contribute meaningfully to the solutions. And we need a training program that prepares counselors to provide the needed services and the funds to pay them a decent living wage. With AI taking off and taking all of the jobs, these issues are about to get a lot worse. Ultimately, we need to build campuses that offer housing, employment, education, detox, and mental health services in one place. Communities where residents help build the facilities, where people with lived experience deliver services, where learning leads to opportunity, and where purpose is restored. An ecosystem that meets basic needs, yes - but also provides dignity, belonging, and a true pathway out of cyclical poverty. One that flourishes through a system of accountability that also prevents greed and extortion.

- Access to meeting with mental health providers in-person. Access to walk-in services as an approach to encourage the seeking out of services. Access to culturally appropriate services - opportunities for clients to meet with people who look like them, speak their language of origin, and understand the cultural nuances that affect residents' desire to seek and stay in care.
- Addressing the opioid and fentanyl problem was one of the best things to happen during the time period of the last decade. Hopefully we can use the limited resources though this upcoming fiscal cliff so that more people in the area can stay alive or access a better life.
- Affordable housing is key, and options for sober living housing for which people are able to live without being triggered by people who use around them. Additionally highly recommend more hours and more mental health providers for people with specialty mental health needs. It is VERY difficult to ask a very anxious patient or depressed patient to show up to an appointment if they have any other SDOH that can affect their access. I have had a patient who has missed two BH intake appointments already due to severe depression and not wanting to leave and also a component of not being organized. I also want more psychiatry / BH integration into the primary care clinics in DPH, as well as WPIC. There is much need and psychiatric staff are often understaffed so we have to refer to Westside or something else. Finally, we need more residential treatment options. A lot of the existing options such as Salvation Army run very strict programs that do not work for all patients. We need housing supports that also have programs with varied approaches and supports for patients with SUD who are engaged in care and motivated to reduce use.
- Again, I believe they have mental health issues, then leading to substance as one of coping strategies.
- Allowing community members to work with their own community. There is a trust factor that is undeniable and cannot compare to anything else.
- appreciate all the system does to help our clients and the greater San Francisco Community. OCC needs some help though.
- Appreciate the increase in mobile crisis programs and 24 hour access/substance use lines.
- At ZSFG the biggest improvements have been a behavioral emergency response team, video interpreter phones, wrap around project, substance use navigators, the bridge clinic, low barrier access to BUP, EMS 6, supportive housing (sro with nurses and case managers on site),
- board and care centers for ppl with SMI. more ICM programs. More long term behavioral health programs. Short term/linkage to care problems create a bandage and the client is often time recycled through the system. Not house ppl unless they are ready to be housed and to live in a community. Educational workshops regarding room habitability to not using alone in an sro. etc. Support and training for behavioral health dept and dph for bh clinicians and health workers doing this work because they witness a lot of trauma day in and day out.
- Bringing in diverse staffs that understand and have lived experience of those marginalized

groups and their values and beliefs bringing in staffs that truly practice cultural humility when working with people other than their own ethic background. ongoing training for staff on how to be mindful and humble to all. how to eliminate micro aggression in the work place

- Case management services at initial treatment, during, and after have worked well for some for individuals to receive ongoing support and guidance through navigation of resources (ID, housing, food, benefits, transportation, etc), one on one help / accountability, and partnership. Don't give up on hope. Thank you for this survey.
- Clinical Social Workers at UCSF who work mostly with BIPOC, Medi-Cal insured, unhoused folks (Campus clinics) are paid 30% less than their UCSF Clinical Social Workers colleagues in the SAME title (and union contract) that choose to work on the Health side (in Parnassus or Mission Bay) which are more privately insured parts of UCSF and have more affluent patients. These pay inequity issues (discriminatory practices) are drawing away skilled workers from staying in the trenches on these issues. This workforce of over 100 Masters level, licensed and skilled workers can be so much better utilized if we stop the retention and burnout issue. The city provides funds for these UCSF workers - you have a responsibility to check on how the university is upholding their part of the deal & responsibility to the community. This work is not all done by DPH 2930s and 2932s, we are a team sometimes working next to each other in the same clinics (with UCSF workers making far less than their DPH colleagues as well).
- Closing the RCFE is a BIG mistake in my opinion. It is one of the resources that is high quality and can be relied upon for consistently stable housing and services. I am angry at the shortsightedness of closing one of the few resources that really works and matters in our system of care. This is being done despite feedback from clinicians in the system of care and clients who will now loose the stability they once had. We are going to be doing a survey about what to "do" about these clients when thy are not served by an organization in the private sector. Also it will be the private sector complaining about these clients! I hope our mayor sees this!
- consolidating data collection and tracking of patient/client encounters with CBOs has helped reduce redundant services. continuing to improve care coordination between service providers (ex: during transitions to and from higher levels of care, during times of individual crisis, during times of provider turnover) will help prevent people from slipping through holes in safety net
- contact and consistence follow up
- Continuity and collaboration of care needs to be improved as well as tracking of high-utilizers in the system. Other countries like Switzerland, Portugal, Sweden, etc. have systems that work for hard-core substance users that we can implement to get people out of the merry-go-round of relapse/critical care.
- Coordinated efforts, inpatient services and home health nursing has worked very well
- Coordinated Entry and the current housing pathway is so opaque and people that are even working there are not able to help providers understand how long the waits are and what barriers are existing to keep people out of housing. Substance use treatment programs and psychiatric emergency services and inpatient settings are so under resourced, under staffed that they are often not even available. ER visits rarely result in any real linkages for clients to care. Lastly, a two tier system exists within UCSF as part of the affiliation agreement with the city that makes it so master Level Clinicians working to serve under insured or state insured clients are paid 33% less than their counterparts in hospital settings creating a constant rate of attrition, burnout and morale injury that has real-world negative impacts to the most vulnerable members of our community.
- Create more opportunities for mental health professionals to support our underserved communities.

- Creating a continuum of coordination among community-based organizations is key.
- Creating more board & cares or purchasing old B&C's, staffing them with mental health professionals who can support residents with linkage and stability in the community. There are many empty buildings throughout the city, held by greedy landlords who would rather not rent out at an affordable price. Many of the housing options are unattainable by middle class residents, so pretty much impossible for homeless and low-income individuals/families to have access to.
- Crisis services SCRT and 220 Geary are of a huge help. More crisis beds on the weekend and overnight. It sounds like that is in the pipeline which is a huge help.
- CUD is a serious problem in our adolescents and young adults who can become paranoid, unmotivated, unsuccessful in maintaining a job, unable to get a high school diploma, obesity, especially among our foster youths who I care for as a PHN.
- culturally congruent services; collaborative services/care across the service lines would improve services. Mental health and substance abuse treatment programs are working silo in the past few years rather than collaborative care coordination.
- Discontinue the resources/drugs that make it hard to get.
- DPH needs to increase salaries for the front line staff instead of creating more top level administrators who has limited understanding of the actual work and struggle of the front line staff. Take a look at the salaries of front line staff and administrators over the last 10-20 years especially the new positions that make more than $300k in the last 5 yrs and you will understand why we have such a problem
- Drop in clinics work well for people experiencing homelessness. As well as stabalization hotels though the stay could be longer with additional support for accessing housing while staying there. Increased housing assistance at shelters. And better treatment options, PRC Baker Place is incredible and should be the model that other treatment centers are based on.
- Education is a vital part of addressing both mental health and substance use challenges in our city. San Francisco should prioritize community-based education that teaches individuals about maintaining mental and physical health, understanding substance use, and accessing available services. By increasing awareness of local resources, treatment options, and support organizations, the city can help residents take proactive steps toward stability and improved quality of life. Knowledge is prevention, empowerment, and a path toward healing.
- end the open-air drug markets
- Ensure that patients leaving the hospital or jail have a seamless transition to outpatient or residential treatment. Too many patients fall through the cracks and recirculate through the system. Make sure they get connected to follow up care before they leave the hospital or jail, otherwise they are likely to be lost to follow up.
- Ensuring that PCP are trained and assessing/offering SUD Tx, contingency management, other SUD services in care--especially at all public health clinics. Walk in access points that offer safe spaces for Pts to rest, get a snack, get connected--build rapport for folks to trust and often want to engage in change and services. More Roving/ICM CM services that are more available for folks that are falling through the cracks--proactive CM not reactive where folks only get it if they are in crisis enough, hit PES, etc.--lower barrier ICM is necessary.
- Expand Street Medicine services to include mobile substance use disorder treatment
- faster, more available, easier to access services, and more outreach availability. Also being more trauma informed by not making clients go through multiple intakes/ screenings, and reducing barriers to care.
- Focusing on harm reduction has been effective for many of my clients

- For substance use services, the city should prioritize safe use/safe consumption sites.
- Free mental health services such as puppy therapy.
- friendly staff support
- Funding has been cut and will continue to be cut over the next 2 years for mental health and SUD services. At the same time, promises have been made by the Mayor and Public Health officials about providing adequate support without overburdening the current DPH workforce. It's been told to staff multiple times that leadership is working to "preserve current jobs" without addressing how they plan to deal with the shortage of services that current workforce will need to absorb. The current outlook seems to be that effective services can't be provided without overburdening current staff. Budget cuts are already being felt by frontline staff.
- Get city run hospitals and nurses and medical staff because the medical system is not aligned with the residents on how to get drug users on the street into treatment.
- getting rid of leadership positions and staff who are not working effectively, but milking our system
- Give good incentives to our mental healthcare workers, psychologists, psychiatrists neuropsychologists
- given the current political and economic landscape it is anticipated that mental health and substance use behaviors will likely be exacerbated across the board, but especially within underserved communities like those that are undocumented or with limited English proficiency. What is the plan to support these populations?
- Go do some basic fucking googling about what contributes to decreased substance use and success in treatment. Jesus fucking Christ you people are as fucking dumb as fucking rocks. Daniel Lurie should take a dive off the Golden Gate. I hear the water is warm. Assholes.
- Harm reduction must continue to be offered in SF, abstinence-based programs tend to only work for a small group of people experiencing homelessness and/or substance abuse.
- Having a larger focus on PREVENTION which means we start tackling mental health and substance use concerns in childhood and adolescence. We will not get a handle on our homelessness crisis on the street without addressing the factors that led to these conditions in the first place, almost always starting in childhood and adolescence. The less the city and DPH cares about children, youth, and families, the greater these problems persist, and the cycle continues of young families leaving the city to areas that have greater investment in children (including the education of children, which I know is not DPH's scope but nonetheless, related).
- having case managers or health experts out and see what they can assist with in-person instead of being in office waiting. Having check-ins with people outside where they are with basic follow-ups or if needed more intensive assistance. waiting for someone that needs help to come in is just not going to work.
- Help people get off the street - most people feel anxiety and depression because it's triggered by something unpleasant in their lives. If they have a safe place to sleep, that can take them out of a negative environment and start to think about the next priority.
- Hire more workers to help and not just pay the hire ups more money to distribute work. We need more people to reach out and go out to help. Not working behind a desk to talk about it.
- housing first has been shown to make the biggest difference. Then increase access to residential and outpatient services, including safe use/harm reduction modalities with clear boundaries that are enforced on where different substances can be used.
- housing housing housing housing housing... can't stress the important of housing to lead all other solutions
- Housing people does not stop people from using substances-I can't even count the number of

people who I know who are stably housed/educated/employed who use drugs regularly. Also, more people should be educated on people with dual dxs (mental health + substance use) and what treatment options for these folks can look like. Leadership should actually ask mental health professionals (psychiatrists, psychologists, social workers, etc) what treatments actually work and how best to encourage people to use services/supports. Food for thought: If we keep giving people free housing and benefits (which it seems that is all we do), what reason do these folks have to change their behaviors? Like why would anyone stop using drugs if their basic needs (rent/food) are being taken care of? Where is the personal accountability?

- Housing. Housing. Housing. Housing.
- I am not an expert on which solutions are most effective. I work for DPH, and deeply want us to be better at addressing the needs of the homeless, the mentally ill, substance users, everyone who is forgotten by our system. That desire for a kinder world does not make me an authority on which of these services are the best ideas for focuses, or which areas we lack most. Like, we absolutely need more homeless services, but we also have some of the best homeless services in the country. How do we evaluate that in a survey like this?
- I believe our patients would benefit from having more support on the streets and more access to affordable/reliable housing. Many patients have long hospital stays due to beds not being available. On top of support with mental health and medications, maybe more can be done to help provide meals/food, especially those who live on the streets.
- I believe that Harm Reduction has not been very successful in keeping some individuals housed. It is difficult to stay housed when the disease of addiction is an issue. This can cost millions of dollars in evictions, and decluttering services for agencies such as HomeBridge. Decades ago, sobriety was an important factor in getting government funded housing. Today it is not. I have not seen anyone who is in the active addiction avoid eviction yet, unless they experience a lifestyle change.
- I believe that the Wellness Recovery Action Plan should implemented throughout the Health Department and how we interact with participants as a whole and individually.
- I believe that we do have a problem in San Francisco, but we also have imported homeless people from all over the USA. Most patients I have been in contact with, 90% of them come from faraway and they are here due to monetary issues and most of them have an addiction to drugs. When asked they let me know they came with a friend or they left family members in another state, or they flew in to get some type of treatment. I don't think housing will resolve the problem, but maybe building facilities where they can get sober, at the same time they get some type of training so they can survive after they become sober. Case management will help a lot with the needs of every individual, it will help with the right placement.
- I believe the focus has shifted in a way in which does not help those with mental illness. Providing areas where they can safely do drugs and providing housing for mentally ill population does not help the problem. More outreach and support services are the better way to go. Providing those with the support they need and not supporting such activities that is deterimental to their well being. Giving them opportunities like programs to attend, jobs they can work, education they can receive to make them feel a part in society and find a sense of normalacy. Providing housing to those who don't even want to stay in the homes provided because they rather be in the streets where the drugs are at. More sub acute units are better to help stabilize them to get them into a point where they are willing to stay in homes and not succumb to substance abuse is a priority.
- I continue to hear that San Francisco is rich in resources but can do better in collaboration. There's lot of siloed work that makes it challenging and complicated to work in SF. I can only

imagine how challenging and complicated the systems can be for community members.

- I do not know that the Office of Coordinated Care has been sufficiently staffed for it's work load.
- I do see improvements in the downtown area like Union Square. But I feel like some of the homeless individuals have now moved to the outer parts of the city, like the Sunset.
- i feel like all the things that i have said are disparaging the amazing work you guys are doing and you are apricated
- I have seen first-hand how important and vital harm reduction services and the overall approach and philosophy of harm reduction has improved lives and saved lives of directly impacted, marginalized people with behavioral health struggles. There is a massive effort to discredit harm reduction. This is because it works. Dead people can't get sober. Dead people can't enter recovery when they are ready. Harm reduction saves lives. Since we started cutting these vital harm reduction services, the accidental overdose rate has more than doubled in SF. Thank you and take care.
- I know that the city is trying hard to accommodate folks with chronic substance use and mental health issues. Making it more challenging is that SF is a magnet for these populations, who come here seeking the help they can't find in their place of origin.
- I know the city budget is always an issue. As someone working in this field, I promise that cutting funds and services in this already stressed area is going to result in worse health for all, and make our city a less pleasant place to live and work. Please think about the ramifications of cutting services that are so vital and already so impacted.
- I like what the street health team are doing out in the streets in regards to behavioral mental health, but I also want to understand why hasn't there a street team to target families with children who are also unhoused who are not going to school because they're unhoused. I've come across at least 20 families in the bayview with children under the age of 10 that are homeless, the access point is a joke please address this because there's so much focus going to adults and the families are being discarded. Can the city think about splitting the street health team to target families, including HOT, HEART and Code tenderloin ? Since it's so much money going to them anyways?
- I see a lot of formerly homeless people being given housing and this is great. However, education needs to be provided for formerly homeless people to learn to live in doors. Sanitation, proper food storage etc. These individuals often have no idea how to prevent a cockroach, bed bug, and/or rodent infestation from taking over their apartment and spreading to infest entire buildings. Creating housing is useless if the sanitation conditions in the building become equal to that of the streets.
- i see the facebook adds about helping our community and those who have been able to connect and get into programs to help addictions, mental health and homelessness. Congrats!! we need to do more, to help all in our communities. While big corporations makes millions off the back of middle class, all those millions should be funneled back into our communities to help others. Insurance companies are allowed to get rich off tax breaks, and claim denials for the enrichments of their wallets. all the long our government allows this and supports all those tax breaks to hurt the population. Its disgusting .
- I take care of patients everyday with mental health and substance abuse issues and those who are unhoused, marginally housed, etc. I have spent the last 10 years alone, in the city of SF, trying to help patients with these challenges. There are no easy answers here and it is incredibly difficult. Where I work, it is not unusual to have to literally chase these people around who have cancer, who are very sick, who need care- yet- its like they don't want to be found. Their phones are disconnected, or they never answer them, or they don't return your messages. They are

often just struggling to survive in a city that is unbelievably expensive, with some of the highest levels of income inequality, and they frequently have complex substance abuse and/or mental health issues on top of the medical problems I'm trying to help them with. Its frankly exhausting and heartbreaking and at times, can make it difficult to maintain your compassion when they are rude or lash out at you when you're just trying to help. But I've lived and or worked in SF for 40 years and I've never seen it as bad as it has been in the last 10-15 years. We have allowed these people to take over our streets aided by the homeless advocates who feel someone who is mentally ill, with poor judgement and insight and who is unable to care for themselves, to wander around our streets aimlessly (and often high or drunk, which doesn't help with the mental health symptoms they already struggle with) and with our increasingly lethal and toxically polluted drug supply leading to even scarier and more dangerous presentations in these folks.) Their freedom to do this have been prioritized over our city and community's right to safe and clean streets free from the social ills that plaque us being constantly thrust in front of our faces. I no longer enjoy walking around the city or even coming to the city much other than to work. Its notable that sections of the city which are more affluent have MUCH less of this than neighborhoods where it is tremendously concentrated unfairly-the poorer, less white areas. I also think its beyond affordable housing because though we certainly need MUCH more affordable housing, there is a fairly large subset of the "hardcore homeless" who refuse to go inside, no matter what, unless they are offered their own house, which is rare. I have actually spoken with staff who work in our city's shelters who have confirmed that there are many homeless folks who are determined to stay living on out streets, no matter what. I think many things could help: 1) Not allowing people to camp on the streets just because they do not want to go inside 2) Setting up a large city-sanctioned parking areas for people who want to live in their vans and RVs- there are many industrial areas on the outskirts of the city with ample land to do this 3) converting unused commercial real estate into low income housing. There are many, many buildings that are completely empty that need to be converted to housing. 4) spreading this low income housing throughout the city instead of concentrating it just in the Tenderloin, Mission, and SOMA 5) Making this low income housing with wrap around case management, substance abuse, and day program services to serve those with mental health and substance abuse issues. What we are seeing on our streets largely is due to mental health hospitals closing and now these folks are wandering all over our streets with complex needs. Merely providing them housing is not going to stick and they are not going to thrive when they have such huge mental and substance abuse problems. In addition, I believe abstinence, or very clearly working towards that, should be a requirement of securing low income housing and case management services.

- I think clinic leadership and system of care leadership needs to do a better job of retaining 2930s in the workforce, such as hiring more 2932s and guaranteeing the 2930s clinical hours towards licensure. It is extremely problematic for associate clinicians to be doing clinical work, but not have it counted towards licensure, which partially explains why some 2930s end up leaving the county to go to other organizations
- I think harm reduction recovery groups work well, I think 12 steps program are rooted in a wrong all encompassing approach to substance use that is hurting more than helping the san francisco community while creating a facade a success and supporting the same mechanisms of criminalization that perpetuate the issues leading people into various mental health and substance consumption over and over. I think there are some wrong ideas floating around that if you’re against abstinence programs and pro harm reduction you automatically want to use, which is completely false. I think the idea of self-medication is by no means as promoted when it comes to people who consumed at this or other period in life. I think the biggest difference

would be if people in power, be it in the various recovery groups or in the various city departments, would stop generalizing and look at individuals as individuals, as people who have gotten to a certain diagnosis or to consuming certain substance/(s), in their own way, pushed by this or that forces, that other persons who got to be diagnosed similarly or consumed a similar substance, might not have been led into it (substance/diagnosis) by the same circumstance. Moving away from us vs them or us and them kind of mentalities towards a more global humanity view of people. Not seeing differences as threats, but as opportunities. Not promoting pathologizing philosophies and speaking out whenever encountering however difficult it might be (being a minority facing a majority is not easy to speak up one's mind, particularly a minority from a historically vilified and demonized group). allowing time for healing. not rushing people to say this or that that confirms one's already established beliefs. opening a 24/7 center for peers to stop by when in crisis without criminalizing or involving authorities (simply, a place where volunteers peers with lived experience get to hang out, stop by, at any time of day, if in crisis or in need of some mental/emotional support, like a warm/crisis line but in-person). there might be some other things but for now I am grateful for Rams PWC, which I think does an amazing job, week in and week out. also, I am grateful for Sunset Mental Health, and for the Bay Area Hearing Voices Network. obviously, destigmatizing mental health and substance use is crucial, and I believe not patronizing or infantilizing or promoting patronizing and infantilizing views is highly important as well. calling such out whenever it happens would be a great improvement, that would allow for the collective healing of the human race to occur. not treating mental health as "other", not "othering" people who access behavioral health services, and calling it out as it happens, is equally important as well.

- I think increasing vocational rehab would help people experience a sense of accomplishment, dignity, and community. We aren't asking anything of the people we serve, which makes it very difficult to measure progress for them and treating providers. Really, the bar couldn't be any lower and we wonder what goes wrong.
- I think partnering with more faith leaders in the community can be very impactful in the long term. A lot of the issues in SF is not just physical and mental but also spiritual. Folks getting connected to a faith community can help with a sense of belonging and support. I've seen many lives transformed form the programs such as Teen Challenge which serves adults coming out of recovery.
- I think SF does a phenomenal job of supporting the community in an ethical and empathetic process. There are a lot of weeds that need to be pulled and getting the substance out of the system would be a huge priority. So maybe more enforcement that can remove the substance. Hold people accountable.
- I think street medicine/support teams have been effective but they have to have places to bring patients and resources to offer
- I think that getting more qualified trained SUD counselors will help to meet the need of so many people seeking services. It is good to have treatment beds, housing and other services, but without the qualified people to carry out these activities, it means nothing. Burn out rate is high and real.
- I think that the people who are doing this work really care but need to be supported. If programs were originally created to service a specific population/client, we can't simply tell them to service a whole other population. We'd need to support the expansion or services by either investing in the programs we currently have to support learning, staff retention, and general resources. Or we need to start opening more programs to service the different client populations and their needs. We need to get better at education and prevention for substance

use and mental health services across the city whether that be jails, hospitals, or these community programs. Currently, our justice system is saying that SMI clients shouldn't be in their jails. Great but now where do they go? Into programs that weren't designed or made to support people who are SMI and also serious offenders. With this situation, there should've been a plan or place created for them to get the support they need while also acknowledging and addressing the potential community safety risks.

- I think that the system needs to have a multi-pronged approach treating mental health, treating substance use, and treating mental health and substance use together. I think the city has moved to try to come up with a one size fits the problem approach that appeals to voters that is always about short term gains and instead the city should be working on a long came as many people will be needing services for a very long time. also trying harder to connect clients to a system that doesn't work for them is ridiculous.
- I think that we really need ethnic, gender, and sexual orientation appreciation classes because there is so much hatred and lack of understanding between marginalized groups. There seems to be a lack of awareness that the system is exploiting all of us and we need to band together to protect each other from it. Fighting amongst ourselves is what the rich and powerful want so they could continue to control us.
- I think the city is headed in the wrong direction under the current leadership. Forcing treatment on people who are not ready for it is highly unsuccessful and uses up so many resources. If people really don't like the sight of people struggling on the street - ask yourself how they end up there. For people who end up unhoused, for whatever reason, drug use is practically mandatory. You cannot survive living on the street without needing methamphetamine to keep you awake at night when you are most vulnerable. Consider how practical it is to put someone through treatment, then have no place to go, no job they can get or one that doesn't pay enough to find a roof and food. People can't survive here in this economy and then they're punished for it. It makes the streets yucky for the tech bros and the wealthy transplants. Maybe if corporations here paid their fair share, it could fund a lot of the resources needed bridge the disparities.
- I think the Street Medicine team is an excellent example of what works well- meeting folks in their environment, not expecting rigid adherence to appt times and locations, non-judgmental care, would like to see more of this for MH. Providing more PSH with private bathrooms and outside the TL/6th St so more people will accept housing offered. More sober living options in housing for people who want that.
- I think the substance use treatment services have improved (methadone, buprenorphine, etc. availability). That's so important. It would be great if SU and MH leaders could agree on practical and realistic metrics and simple definitions to track progress over time. Also, there are too many SU programs with overlapping and confusing goals- consolidation would be better for all involved.
- I think we should focus on having a billing person meet with every potential and existing client. To help tgd city and the pt understand what they qualify for for services
- I think what has worked well is the exposure in commercials and advertisement of mental health. Making it sound like it is more common than people think. It is upfront and people who have been hiding, can come out and admit they need help.
- I think you need to separate out mental health and substance use completely in a survey such as this. They are overlapping but separate issues.
- I truly believe any initiative that focuses on providing stable housing will address the root of many of these related issues, and dollars spent on housing and housing access will go the

farthest. There are excellent programs and compassionate providers of mental health, substance use, other care and wraparound services, working in our community, but without a housing and food plan, these treatments outcomes can feel temporary.

- I was involved in providing medical support services at 1064 & 1066 Mission Streets, as part of St. Anthony's Medical Clinic and in collaboration with ECS. This was an *enormously* supportive partnership for residents at those sites who wanted more services, many of who had intensive care needs. This on-site medical/case management model would be invaluable to implement at other PSH sites, especially those for patients with comorbidities, such as mental health considerations AND substance use issues, or simply serious mental health/substance use issues. I no longer work at that site, but saw it making an immense difference in the lives of quite a few patients. E.G., residents staying in housing rather than being evicted (by improving their relation to their community), assisting residents with complicated interpersonal situations (and probably also avoiding evictions), and navigating complicated medical care, such as cancer treatments.
- I was really pleased to learn recently that SF health plan medi-cal now has app based, virtual mental health services through growtherapy.com. This has made accessing therapy and medication management much easier for my TAY clients.
- I wonder if any team reaches out to the homeless in Chinatown. Most are elderly Chinese speakers. Some may have a mental health illness.
- I work in mental health and there are just so many trainings, ao many audits, so much paperwork it is very overwhelming for the provider and client. It is a HUGE barrior to provide timely easy access services and to preventing burn out.
- I work in PSH. The skill / clinical exp and job retention among support service providers is low. Likely due to low wages. If investments were made to capacitate these longitudinal services including SW supervision, clinical standardization and accountability, clients in PSH would thrive with needs met through trusting relationships onsite vs having to refer out for even the most basic linkage.
- I would like to highlight how dysfunctional, specifically, the transitional age youth services are (ie: TAY). Since TAY services have joined the larger triaging flow at BHAC, I have never been able to have had a patient served for their mental health. Truly, Epic e-consults go nowhere, phone calls to BHAC end in a list of numbers to call, and no one is connected. Youth should be such a population to target, before illness worsens. I can't think of a more high risk group that has no access to any behavioral health in the DPH.
- I would like to see more BHSA funding for veterans. Many people believe that veterans get all that they need from the federal government. That is not the case, not all veterans are eligible for VA services, many members of particularly underserved and vulnerable cohorts, LGBT+, minority, justice involved, those whose mental health and SUD resulted in being kicked out of the military, transgender veterans, women and more. All San Francisco veterans deserve to receive culturally appropriate care in their community. This means direct care through veteran specific services and ensuring that the broader FSP systems have meaningful partnerships and subcontracts with entities which can provide the care they need.
- I would love to partner on this work with all of you. I work for SFDPH Maternal, Child, and Adolescent Health and we are conducting a needs assessment and action plan to tackle mental health. We asked many of these questions to our community partners and clients and got a lot out of it. Please feel free to connect with me at jessica.alegria@sfdph.org. Some things we have heard work well (from youth): wellness centers, drop-in youth friendly hubs, having providers with lived experience, providers with cultural competency, being offered incentives (gift cards, money, food, basic hygiene supplies), youth like when CBOs and providers

collaborate. Improvements: strengthen collaboration, more funding, addressing root causes of mental health (social determinants, like housing, food, safety), having skilled providers who reflect the communities they serve.

- Iâ€™ve observed a growing disconnect between leadership decisions and the realities faced by frontline providers and clients. There seems to be a lack of transparency and responsiveness that, while perhaps unintentional, has led to confusion, low morale, and missed opportunities for meaningful progress. The vision feels unclear, and the support for staff navigating complex cases often feels insufficient.
- IF kids are allowed to be exposed to all of this open drug market See people use openly with no care or concern . What do we expect to happen in there future. No matter how good of a home they come from Youth are often times more influenced by the community and the environment in which they are in. & They should not be forced to see that in San Francisco.
- Improved coordination between services, less steps, easy and clear for patients.
- improvements are direly needed
- Improving access to drug treatment programs or detox centers for those with pets they are unwilling or unable to separate from is pertinent.
- Increase publicity in areas with mental health services and improve current substance addiction prevention services.
- Instead of cutting services to the poor they should reinstate and expand programs that have been cut.
- Investing in community building will lead to more human connections and more connections will lead to improved mental health and reduced substance use. Lets invest in the community , building spaces and curating activities that allow people to be and engage in fulfilling activities without the burden of financial extraction and exhaustion which is at the forefront of community breakdown.
- It is extremely hard getting clients the proper level of care they need. We are at the highest level with FSP, Acute Linkage and ICM and many of our clients need conservatorship and locked facilities. we need more support!
- It is important for programs that focuses on eliminating stigma is founded. People want to hear what has worked for others, and service providers want to hear how they can support consumers success in recovery. Also, what has helped others by being educated stay out of crisis. I heard this group speak SOLVE and they were amazing, it helped me to feel more normal, they were people who went through what I went through and were doing good.
- It is very important to make changes in healthcare reception, making it preventive rather than abortive, with more empathy and greater promotion of holistic health; "less profit-driven and more humane."
- Itâ€™s really reassuring to see the non-emergency and non-police services out and about in the community and working with the homeless!
- Just keep them . They are greatly needed
- Juvenile probation access to substance use preventions and/or treatment
- Language ability and cultural sensitivity is directly tied to both access and efficacy of treatment
- Language/culture programs are effective.
- Less bureacracy for CBO's trying to provide the highest quality services they can, and pay what it actually costs to delivery services
- let's add options to the recovery services, including abstinence based and more access to groups noting that our current harm reduction approach doesn't work for everyone. And PLEASE let's partner with and support law enforcement to reduce the WILD amount of narcotics available in

our city. It's cruel to everyone.

- Limiting BHCs at the city to "mild to moderate" and limiting the amount of sessions we are allowed to have is incongruence with the need/acuity of our patient population, meaning that we cannot give them services they deserve.
- listen to families. help them to keep their loved ones at home by providing comprhensive wrap around care for those with schizophrenia and bipolar disorder so that they do not become homeless in the first place. Stop placing SMI in SFO;s with substance abusers. Stop changing case managers and psychiatrists . My loved one had 5 different doctors in one year and no follow up when he dropped out of services.
- Listen to the people of the community and actually work with the organizations that are doing the work in the TL partner with us let's come together.
- Listening and meeting people where they are at with compassion and empathy is key to sustaining relationships and helping people be able to live life with dignity and hope.
- Living on the street has been normalized and does not seem to be applied to Grave Disability.
- Long-term care like that provided at the ARF and Behavioral Health Center Hummingbird are very important in the larger scheme of stabilizing and supporting people with severe mental health issues.
- Make it easier for everyone at any age to access mental/behavioral health.
- many things, but basically empowering people experiencing homelessness and substance use, understanding neural pathways and developing new neural pathways and empowering individuals overcoming trauma as well as being less permissive and more directive.
- maybe have supportive housing where someone can wrap around services in one place along with job training to keep their housing.
- Medications are difficult to obtain reliably due to national-level decisions and worldwide shortages.
- Mental health and substance abuse are intertwined issues. While mistakes are made, in my experience everyone working in this space is going above and beyond, but there just aren't enough of us to handle the workload, awareness of issues/services/providers for these problems aren't widely known, and outreach is usually the first thing to go when the budget is cut.
- Mental health and SUD services can be dauting and should be easily accessible
- Mental health services for homeless pregnant/postpartum people are important to help prevent generational trauma.
- Mental health services shouldn't be limited. Not limited by where you live or how you identify or how much you can afford. Healthcare, food, housing and education should be available to all.
- Mental health services, psychiatric services, or support for individuals seeking to regulate their alcohol or drug use do not require issuing a citation and sending them to drug or mental health court. The community needs culturally relevant services accessible in their language to initiate their process of empowerment and self-determination in managing their personal health and well-being.
- Mental Health SF called for an Office of Private Insurance Accountability. This has not been created. The County's MHP and SUDS are overwhelmed in part because we have to serve ineligible clients who have been ignored by their insurance companies. We should be holding these companies accountable to their beneficiaries rather than serving clients with access to another network at the expense of the uninsured/Medicaid population.
- Mental health would improve greatly if people have access to housing. That may mean giving priority to long time SF residents and Working class family vouchers. The city is not sustainable

as is. SF residents are being pushed out daily. The SF that remains will be the 1% and the lowest income. And crime will increase.

- MH staff are underpaid and massively overworked. If they got paid more and had lower productivity standards, I believe this would make space for high quality work and increase ability to meet the demand overall.
- More access to treatment, harm reduction treatments, open overdose prevention sites. More mental heath , easier housing, supportive housing, fix SRO rules that make it so people can either die alone or use on the streets
- More acute beds with additional staffing Easier / quicker / more access to community placements ADA access and language support in community placements
- More clinicians and more peers to help avoid burn out!
- More in-person services for mental health treatment, streamlined intake process Substance Use : develop programs for people with mobility issues who may require support from a caregiver
- More law enforcement that actually enforce the law, such as no camping on the public sidewalk, or in front of private property, no panhandling, no littering
- More money to hire and compensate mental health therapists, peer mental health support specialists and SUD counselors who are of color and are bilingual.
- More options for treatment. more harm reduction services. Messaging on how these are statistically proven. Stop the sweeps. Differently imagined help for our most mentally unstable. Housing is the foundation. More case managers with less of a case load. Hire peers and people of community
- more stimulant harm reduction groups and options for more demographics, more buffers between being 5150'd and homeless if an employed person with no support is having a mental health crisis, food programs, free bus programs, more CBO's to work at outside or 9-5 timeframes, more work from home options, more information about the impact of poverty on employees, more information of burn out for CBO workers in these times, more support for 1st generation and immigrant families during the ICE raids, preventative harm reduction groups if you're starting a new habit that you don't see as harmful yet but want to stay accountable for, stimulant user support groups outside of business hours
- More weekend and after hours support and services, or at least an on-call number to provide more concrete directions and support to clinical staff working with behavioral health/substance abuse patients.
- My family member has severe mental health issues. Siblings support housing and everything else but we are unable to convince person to take steps towards ANY outside help. Drain on us financially, emotionally, mentally. He hasn't even seen a doctor in 30 years. At home services are needed for him but none exist.
- n/a
- N/A
- NA
- Need City officials to continue trying to reach those in need, to value them as human beings who are less fortunate or experiencing crisis.
- Need safer clinic lobbies. Always should be a deputy and security there for safety of clients. Mental Health services in San Francisco are great!
- no
- No
- No, I think we're good.
- No.

- none
- None
- OCC scheduling our intakes has made our service access more difficult. We tend to be getting clients who are not appropriate based on our mission, and we continue to be asked to add more intake slots, even though they are not being filled.
- One area that could help is to support organizations through staffing models that allow for drop-in or same day services. It is extremely discouraging to an individual that is motivated to access services to be told their intake will take place in 2-3 months or more. Being able to match the client's motivations with services will allow for greater success.
- Open-air drug use and drug dealing remain incredibly visible in the streets. Street outreach and substance use treatment need to be expanded to deliver care that's easily and readily available.
- PAy equity is important
- Pay providers more and offer more services for free
- Peer Counseling
- People are suffering. And those that witness suffering are also suffering. Substance use is dangerous and heartbreaking. I am so happy to see sober shelter options. People need to be able to self referral at anytime of day. That window of change opens and closes. The decision to face trauma and heal has to be balanced by having something to live for. A shitty sro with no bathroom does not inspire people to create a home. That's why they may be housed and also stay on the street. Something about the housing does not match the deficits in our population who have minimal life skills and profound trauma. We need to reward people who are stable. Instead we focus all our efforts on people who can sustain housing and have minimal readiness for change. Let's balance that with housing people who we can transfer to a less dependent state.
- People cannot just work and live in a shelter. A city with no housing is not a place for mental health. To nurture a housing solution, people need to have a more structured environment.
- Please ask constituents living on the streets, SROs, shelters, etc. What they think would help them in getting better and what they need!
- Please clean up the sidewalks. It's so depressing and unhealthy yo have excrement and trash spreading. Providing housing to a person who can walk outside and buy fentanyl is not an answer. Get the drugs off the sidewalks. Public housing is full of serious drug users and hoarders. These people are off the sidewalk but perpetuating dependence not only on drugs but on public health services and tax payer money.
- Please help stop drug use in streets. I'm at the point where I am choosing not to have children because where I live, that means taking my child on walks around the block where people are doing drugs. That's a sad scenario so I rather not bring them into that. My circumstances don't allow me to move away, and I love my apartment, but the drug use is a sad and terrible problem that takes away from people's livelihood.
- Please help, but not cut other public health services!
- Please make more assisted livings available, especially via coordinated entry!
- Please more equable services that includes everyone, not just migrants. We are American's and can't the services we need.
- Prevent influx of homeless people to come to San Francisco. If the homeless have relatives living outside San Francisco, promote the connection between them so that homeless can have a better support system to improve their living condition, may consider financial support to initiate the connection. Tighter control of substance /drugs availability in San Francisco.
- Provide appropriate language and cultural representatives. Low threshold setting. Harm

reduction therapy, motivational interviewing and relational techniques. Affordable housing can help people get stabilized and regain their mental stability with a variety of support services.

- Psychiatry services are notoriously hard to access. Clinics need more addiction medicine specialists to help people with harm reduction strategies. People need communal spaces to spend time at instead of being on the street, because that's where their community is (not allowed to see guests inside their homes). Constant elevator issues, lots of problem for disables and elderly folks.
- Quit making it easy for drug addicts to be addicts .
- Read the "rat park" experiment: https://www.psychiatrictimes.com/view/what-does-rat-park-teach-us-about-addiction
- readily available and effective interpretation support - are there effective AI solutions?
- Recovery is possible for every person. This person is in need of a hand up the scale. We have far too many residents of San Francisco that are cast into the night. This is a very negative life style. It is negative for this person and also can be a negative event for the medical professional who may treat them in an E.R. situation.
- Response to crisis has been effective. I'm interested in this effort as a public health nurse. Please contact me if there is a need or opening. Mayela.gutknecht@sfdph.org
- San Francisco could lead on this. Gavin Newsom has called for a new generation of long-term custodial behavioral health campuses. He's right. Most of the people on the street are behaviorally ill. We need to stop referring to this population as "the homeless". The homeless well are a very small and different group. The key to an apartment does not solve behavioral illness. Leaving people to "their lifestyle" on the street as a choice is not compassion. Our streets cannot be open wards for the behaviorally ill. The community model was well-meaning but it is a demonstrable failure. Gavin Newsom is right.
- San Francisco has an extensive network of behavioral health and harm-reduction services, and many programs demonstrate strong, client-centered care. Mobile medicine teams, psychiatric respite, outpatient treatment programs, and supportive housing initiatives have helped stabilize clients, reduce emergency department visits, and connect people to ongoing care. Peer and culturally responsive staff, integrated mental health and substance use treatment, and coordinated case management have also proven effective in improving outcomes. Significant gaps remain, however. Access is limited by insufficient voluntary treatment beds and methadone, short service/intake hours, and insufficient staffing pipeline, and city leaders who perpetuate stigma and undermine low-barrier, irrefutably effective evidence-based care. For substance use services, aggressive criminalization, restricted harm reduction programs, and delays in implementing overdose prevention centers, safer supply pilots, and drug-checking initiatives have reduced low-barrier access and contributed to preventable deaths. These preventable deaths are the responsibility of Mayor Daniel Lurie, Kunal Modi, Mary Ellen Carroll, SFPD, city leaders who have contributed to this shameful abandonment of public health, and a castrated DPH. Dr. Daniel Tsai is a BRILLIANT public health official. Let him off the chain and let him lead.
- San Francisco has made major investments in mental health and substance use services, and the resources are there, but the system still struggles. The biggest improvements could come from stronger accountability for service providers, faster access to care, and better follow-up to ensure people don't fall through the cracks once they enter the system.
- San Francisco has many dedicated providers and community-based organizations doing life-saving work, but the system remains fragmented and difficult to navigate especially for youth, LGBTQ+ residents, and unhoused people. What works best are low-barrier, relationship-based

programs that meet people where they are, such as drop-in centers that integrate mental health, substance use, and basic needs support. These models build trust and reduce crisis-level interventions by offering care before situations escalate. The greatest improvements would come from sustainable funding for CBOs, better coordination between city departments, and investments in a culturally responsive workforce that reflects the communities being served. We also need to expand non-police crisis response teams, after-hours care, and harm reduction services that don't require insurance or sobriety. San Francisco can lead by investing in community-rooted, trauma-informed, and affirming care that treats behavioral health not as a privilege but as a fundamental right.

- San Francisco's homelessness crisis is tightly linked to mental health needs. Around 35â€“45% of unhoused residents report a mental health condition, and many have experienced severe trauma, violence, or loss. Without stable housing or mental health support, people often cycle between emergency rooms, jails, and shelters. Expanding trauma-informed, housing-linked mental health care is essential to breaking this cycle.
- Services exist but are underutilized. In many primary care clinics and BHS clinics providers have small caseloads and number of visits.
- Services targeting people living on the streets have scaled tremendously in the last few years which is incredibly important to deliver care to a population facing high barriers. I would like to see the City develop a strategy on addressing risk of homelessness to try to keep more from entering this population.
- Services works well when there is encouragement for agencies to communicate with each other and are invited to visit each other for introduction and education about the services offered especially for the new incoming employees. Such as visiting agencies during their staff meetings. If the issue with the red tape in securing housing could be addressed. For example a client was approved for housing an SRO was identified and the interview along with signing paperwork with the property management was signed. It still took the client 8 months to actually move in due to waiting for a signed paper from HSA to authorize the move in. This was stressful for the client and clinician in creating alternative ways to support client unhoused on the street and retains a decrease in substance misuse in order to stay stable. Another improvement, hold clients in a mental health decompensation that has been off medication requiring for medical care longer than 1 day for stabilization. This plan of quick catch and release of clients stating "its ok we know we will see them again in a few days..." is not fair to the client or the clinician who is expected to follow the client in the community and keep stable in ICM.
- SF developed Housing First but doesn't follow it. First, house everyone, then provide social services and maintain providing support.
- SF has done so much wonderful work to improve SUD and MH services so I do want to give props. I really appreciate prioritizing BH services. I've seen it work well to offer access to SUD services with broader access and with the lowest barrier walk in models (ex. BEAM/Code Tenderloin/CBHS partnership). The challenges that come up the most for my clients are long housing wait lists, shelters don't feel safe, too few shelters accommodate couples and those shelters feel exclusive/hard to get into, residential treatment programs don't accomodate couples, treatment programs are very structured with little in-between options between outpatient care and residential (ex a program that would allow someone to go to work).
- SF spends so much money and resources targeting the most visible, highest needs individuals- people living on the street with substance use and mental health issues, which pulls away from the resources available for the less visible/invisible individuals who also have significant mental health needs like suicidality, self-harm, childhood trauma/PTSD, and debilitating anxiety and

depression--especially children and adolescents. I am concerned that without more resources and attention spent on the mental health needs of children, adolescents and their families, we are setting up the conditions for another generation of unhoused adults with substance use and severe mental health needs. I am also concerned that if SF provides more services to individuals who are visibly unhoused/living on the street than other counties, this will become a draw for residents of other counties seeking services.

- Sometimes there are to many restrictions to get services
- STAND UP TO BIG TECH!! STAND UP TO BIG REAL ESTATE!! STAND UP TO "SMALL BUSINESS" OWNERS WHO THINK THEY RUN THE CITY!! They are not interested in real collaborative partnership with the rest of the city. They have been dogwalking the city for decades and that's how we got here! Let's focus on the working class overall, and our substance dependent, mentally ill, and homeless family and friends will benefit as well.
- stop cutting and start funding all services, particularly school-based.
- Stop! Cutting! Services! Improve and build on them. Give them more support.
- street outreach is great; 24hour call in support; the Linkage Center/TL Center was great until it was killed-we need something like that again.
- Strengthen the relationships between DPH and CBOs
- Substance users in San Francisco are often seen on the streets using drugs openly at all times, day and night. San Francisco needs 24/7 street medicine outreach services to treat and prevent overdose and help people reduce substance use.
- Supportive housing for patients who want to stay sober, and expand to other neighborhoods outside of SOMA and the TL.
- Tailor the wraparound to the individual where he is. Make sure that the individual doesn't fall between the silos. More psyche beds for stabilization. Listen to families. Actual buildings to support long term.
- Take hard look for supporting the B.H.S. that help clients after D/C in community ie, 12,steps services A.A,N/A O.A S.L.A D.A G.A and so on also family Al-Anon and Nar-Anon for family support of the B.H.C Clients thank you for listening.
- Team Lilly is a remarkable program where nursing support is provided for pregnant and recently delivered mothers using substances are able to maintain contact/custody with their newborns while they are actively participating in substance abuse treatment. Identifying life changing opportunities like this...the trauma of the threat of losing one's child...as the motivator to keep someone from lapsing into substance use. Similar concepts where participating in substance use treatment enables the person to get help to prevent known/feared traumatic events like losing housing for their children or having to go back to an unsafe environment or losing contact with people they love....as motivators for them to remain in substance use treatment. Delancy Street Foundation....also a model program we could be partnering with....or learning from?
- Telehealth on the street shows promising results
- Thank you for asking for input.
- Thank you for asking.
- Thank you for this work. It's incredibly hard to see so many people having drug-induced psychosis on a daily basis. It has made the city unlivable in certain areas, like the Tenderloin. I suggest we create something other than the criminal justice system. I would like to see the most drugged out people on the streets taken to a special, locked hospital, where they can come down and regulate. We can't arrest people with drug addiction, but they need help. A group of specialized medical detox centers would be a starting point. But we can't keep living with this cancer of ongoing drug-related psychosis. It's ruining the city.

- Thank you!
- The centralized referral system I was told had been tried before. It failed. If that is true why was it used again? The leadership of the SFDPH does not have flexibility and forecasting skills. It uses a model they relies on top down management. Consequentially it does not have partners but disgruntle provides.
- The city has made meaningful progress in expanding access to behavioral health and substance use services, especially through harm reduction and community-based outreach. However, the system still needs more coordination between prevention, treatment, and recovery programs to ensure continuity of care. Greater investment in early intervention, particularly for youth, unhoused individuals, and communities disproportionately affected by substance use, would make the biggest difference. Strengthening collaboration between city departments, healthcare providers, and community organizations, while addressing workforce shortages and reducing wait times for treatment, would further enhance the effectiveness and equity of services across the city.
- The city should invest more money in community agencies; they are an important point of contact with the community, referring them to services. Communities feel comfortable using them to obtain quality services more quickly, as they help them understand and navigate the systems of this country, which are so different due to the lack of English language skills.
- the community mental health clinics are a great resource & provide good services; however, the more acute populations (e.g. homeless, substance using, legal/criminal involvement in addition to mental illness) really need more ICM than outpatient level of care. There is always a huge waitlist for ICM, but is sorely needed to better serve these acute clients.
- The connection between ACES and adult Mental Health are important to highlight and to consider.
- The county needs to do better in making SUD services available and improve MAT provider rates to reflect the cost of care. This will help to increase access to treatment because providers will be in a position to expand access.
- The folks I see with serious SUD that get housed outside of the TL do so much better. The folks I see with SMI do so much better when they get social support through social groups, DBT groups, etc. Community is so important, and our BHS clinics and other areas need to do a better job helping their patients grow their communities in a positive way.
- The lack of care for providers in mental health outpatient services is appalling! we serve populations that put us in risky position for injury, mental and physical trauma, and fatal situations, and yet we do not get the safety support we need to function without having to fear for our safety. Assaults and serious threats have been made to our clinics and yet we do not have appropriate security support to make us feel we can do our work properly. It is demoralizing and insulting. We get "community ambassadors" who are sitting ducks when real threat and crisis happens. We have de escalation classes but these will not help when an active shooter (who has actually threatened us) actually happens in our clinic. The quality of community ambassadors is suboptimal, who are on their phones, looking bored, unattentive at best. Does a fatality need to happen before we do anything about this? I keep getting emails about how concerned leadership is about our welfare, but this is absolute lip service. Please give us quality security or send deputies in our outpatient clinics so we have at least someone who has training, and authority to do what is necessary to contain crisis in our outpatient clinic. I am keeping a screenshot of this survey so that when anything happens to our clinic, this outcry is a reference point that I have said my piece. Please help and protect us by sending more appropriate security measures. I would also suggest cameras in our clinic, both outside,

hallways and inside our lobby for our protection.

- The quality of housing HAS to change. I remember housing someone who had been stable and sober for some time, and literally the only option was the decrepit ass Mission Hotel, where he was surrounded by triggers and an environment that would send even the strongest into disarray. He relapsed soon after. This is not an isolated story. Throwing people into housing is the beginning of recovery and not the cusp. We can do better. People deserve kitchens and living rooms and not shoeboxes of doom.
- The root of substance abuse often lies in childhood trauma and abuse. An imperialist, white supremacist, capitalist, and patriarchal society perpetuates power imbalances that exploit and harm the most vulnerable. San Francisco has long catered to capitalist interests, and the result is deep socioeconomic disparity. The homelessness crisis - rooted in substance abuse and underlying mental health issues is, in many ways, a problem the city itself has created. To truly thrive, the city must shift its focus from catering to businesses to supporting the people who live here.
- The SF DPH budget deficit is very concerning. The federal elimination of medicare provisions to states just makes it alarming to the max.
- The small but mighty PHACS team delivers buprenorphine to people's homes. We need more programs like this.
- The system SF has, hasn't changed in decades. There's no new blood or new ideas allowed in. The same, tired and burned out providers-turned-administrators have been running the same old agencies with that same old mentality, and have effectively become the obstacles they started fighting against in their early years. At every meeting there are always the same people.
- There must be some research in countries with fewer issues highlighting courses of action to recognize and treat mental health - which could hopefully dramatically improve out rates of incarceration, reduce people using the ER as their primary healthcare provider, help people stay in homes and be safe...like single payer healthcare? Perhaps paid for in part by taxing those that have seemingly endless funds (billions and trillions of dollars). Just saying.
- There needs to be more coordination between the organizations in the field. Their needs to be more room for meditation and yoga type practices.
- There needs to be more training about harm reduction across the board
- There should be a limit of 2 times a year that rehab is available, there should be consequences for the ones who abuse the system and not allowing others to have the opportunity to go
- there should be more Live In substance abuse programs in the city like Tom Wydell and Walden house, these programs have proven success rates .
- There's plenty of resources out there, it is more about increasing the ability to access those resources through timeliness and assistance with transportation and scheduling.
- This is prioritized first because underserved groups face the highest behavioral health needs and the greatest barriers to care. The improvements that would make the biggest difference include expanding mobile and community-based services, increasing culturally responsive care, and strengthening coordination across behavioral health, housing, and social services. Additionally, ensuring that executive leaders are current or recent residents of the communities they serve can help ground decisions in lived experience and promote more equitable, informed policy choices.
- This kind of survey is needed for Development of and adjustment of services.
- too much free benefits to giving out at the same time, makes people doesn't want to work and become lazy, should set up a time limitation of the benefits, Example, only give 2 yrs or 3 yrs help at the same time provide education to upgrade them to get a job.

- Trauma informed care is everything. Long acting injectable buprenorphine for opioid use changes lives. Contingency management has changed a lot of lives. Our behavioral health providers and our PharmD providers that work as BH providers are amazing and appreciated.
- Two things the City should consider: 1. Lobby the State to move towards a regional Medi-Cal system: the housing crisis in SF makes people mobile. When a San Franciscan is couch surfing in Alameda/Marin/San Mateo and is taken to an East Bay/Marin/San Mateo ER, their health insurance is often switched to Alameda/Marin/SM (and vice-versa), rendering them ineligible for services in their home county - which, in turn, needs to provide pro-bono services or have their reimbursement significantly reduced. This is tremendously costly for the local jurisdiction and totally unnecessary as clinics and hospital should be able to bill for rendered Medi-Cal services regardless of County affiliation. 2. SF should lead a California based conversation about where permanent supportive housing is built. Building a single unit in SF is the price of 5 units in Sacramento County, and you would probably get 6-9 units in Yolo. If state wide approach (should probably be national, but here we are), permanent supportive housing, residential care, substance use services, and other resources could be built where cost of construction and labor is lower and this could serve to "re-industrialize" depressed regions as locals could get job training as Case Managers, Social Workers, etc. and earn a decent living, and we could move towards taking care of this problem and approach this problem as a State. It is absolutely bananas that the onus is on local municipalities to fund and maintain infrastructure to address homelessness and mental illness, when high needs populations are inherently mobile and understandably gravitate towards cities that offer services. 3. Along these lines, another thing to consider for equitable distribution of resources, would be to condition and design public benefits and support systems (e.g., Medi-Cal, SNAP, GA, etc.) so that there would be a certain amount of time before people can transfer benefits to a new county (look at what Canada does with provincial health insurance: 3 month lag time where the new province bills the old province's health insurance for services utilized). During this period, San Francisco could charge Solano/Yolo/Stanislaus for services rendered for their residents and vice-versa. This could lead to more incentive for repatriation and/or financial reallocation from "low-service counties" to "high-service counties" and result in slightly fairer distribution of resources. This could also create an incentive to either develop services that wrap around the local population, or simply outsource services elsewhere (which happens every day) but with the onus of then reimbursing other jurisdictions for services utilized by their residents for a certain amount of time. While this would probably have to be on the county level, each county could then tax their respective municipalities and unincorporated areas to pay for this and then we could finally inch closer to a fairer model.
- UCSF Case Managers seem to have the training & experience to deeply serve their clients. Felton, HR360 & SFCHC could REALLY take lessons!!!
- UCSF Citywide employees are under paid by 30% compared to UCSF hospital employees and it needs to be made equal
- Unless we purged California's voter rolls & outlaw mail-in ballots & prosecute the Sate's One Party System. More deaths of US Citizens & Legal Residents cocntinues this genocidal cycle .
- we are so understaffed that knowing our team is getting smaller is so painful. i get holding off on the positions that weren't filled but to also say no filling of new vacated positions has newer folks looking for jobs outside of the city. The wealth of knowledge and loyalty, let alone reduction in mistakes by not having new staff every year is worth investing in. Also again you can invest in all the treatment programs you want, but if people have no where to continue building on their gains, and are just returned to being homeless then why even offer services?

- WE DONT EVEN KNOW WHERE TO LOOK FOR HELP
- We have expanded substance use treatment beds, but there is no one to staff programs. Many staff in residential programs work 2 jobs and already have many responsibilities at home which means a high burnout and turnover rate. Increase educational opportunities for staff to train better and get better paid so they don't have to work 2 jobs. Also, at a State level. Audit CCAPP, they run a horrid business model which prevents staff in programs to get certified and are very expensive.
- We need a more coordinated map of what services are available with more accountability to improve consistency of the services actually rendered.
- We need a more robust response to people who are unstable or unhoused, experiencing mental health and substance use issues. Placing someone who is homeless into housing is not the only solution to this matter. Many of these people either have untreated mental health issues or are unstable, continue with substance use due to other issues such as trauma, etc., and it requires a team of people to keep them stabilized and housed. As providers there are issues when folks are unstable and we find clinicians reluctant to issue 5150s/SB43 and or move forward with conservatorship. There are often delays, and it becomes a lengthy process after filing multiple APS reports, calling 911 and having them evaluated by providers to only be cleared or discharged immediately back into the streets or housing, unstable. The use of a harm reduction model or the other alternative of criminalization or forced treatment, there has to be a happy medium to treat people which we seem to be a work in progress.
- We need culturally congruent wrap around services.
- We need more people to accompany people to treatment and mental health facilities from programs that are working with folks on the street. A warm handoff should include a person that is helping the individual navigate the system.
- We need more SU MH services that are trained to work with gender expansive communities.
- We need to focus on prevention and on user/person experience in these services.
- We need to improve shelter conditions! Shelters are often not following the shelter standards of care document laid out by the City, for example not providing access to laundry or clean bedding. Also, the Meals on Wheels food at shelters is often reheated or stored incorrectly resulting in people getting sick and subsequently not trusting the food. Adequate shelter is key to helping people heal and transition towards housing. It's an absolute shame that the Monarch and Adante are closing.
- we need to prioritize funding education, clinics in schools, violence prevention services. We need to house everyone. If we taxed businesses and the wealthy and stopped spending money on making the city pretty and spending money on police officers there would be plenty of money for what people really need.
- We need to return to a model that does not allow people to live in the streets. Itâ€™s not good for the community and even worse for people living in the streets.
- We need to start getting use off the streets. SF residents should be able to walk to and from work safely. Offer these people housing in a drug rehab environment. Our streets are littered in feces and drug use. Please help clean up Howard Street.
- We spend so much money per person without getting a good return. We need to revamp the treatment pathway from detox treatment and sober living
- we typically have over 50 applicants for 4 intern positions. The need for vocational opportunities is great.
- what happened with Mental Health San Francisco? Were its goals accomplished? How can all the different federal state and local funding sources, plus private insurance, be integrated to

create one understandable system, where people can go to access care. One of the biggest problems is the bifurcated system under Medi-Cal, with an artificial distinction between mild to moderate and moderate to severe - people don't neatly fall under those categories.

- What has worked well has been building resource centers in churches. People turn to their faith in time if crisis, and supporting and empowering churches to be an initial intake center, trained first responders and equipped to guide individuals to the right resource would be powerful! There us already trust, transparency and hope within the church, so people can be vulnerable and helped.
- What we have done in the past does not work. We need to try something new. We have spent so much money, even GIVING moneh to drug users. We hand out pamphlets on how to use fentanyl. It's ridiculous. We've had enough. Hold people accountable for their crimes and violence against the residents of San Francisco and institute reforms. We cannot continue on this path of catering to the whims of every homeless person who arrives here. We need structure to help these people. We do not need to keep spending billions on the few while neglecting the mass of residents in the city. A homeless budget should not exceed a public school budget. Cut the hand outs and don't let people take advantage of our city and they will eventually stop taking advantage of us. We need to check ourselves back to some common sense functionality or we are doomed. I've always been progressive. But this level of recklessness has definitely tainted my thoughts and views and makes me distrust progressive politics and programs. Everything is worse every time we try something even more progressive and bleeding heart. It's hurting our city and its residents who aren't abusing nurses, abusing bus drivers, abusing strangers on the streets, abusing case workers. I have no empathy left. I've been burned too many times by people Who come Here specifically to manipulate and reap the benefits of our politics and services while hurting our residents who make that possible for them
- What's worked: peer-led programming, harm reduction models, and community-designed services consistently outperform expert-driven approaches. But these are underfunded exceptions, not the rule. What's broken, systemically 1. The PCBH model is revenue-optimized, not clinically sound. It's marketed as 'efficient' or 'helping more patients,' but what that actually means is: clinicians see more people for shorter appointments, generating more revenue. This isn't evidence-based care--it's volume-based extraction. Thirty-minute appointments guarantee inadequate care for trauma, neurodivergence, and complex presentations. Providers are burned out; clients are failed. 2. 'Trauma-informed' and 'culturally-responsive' are labels without teeth--most services are still pathologizing, rigid, and designed for neurotypical, housed, documented people. 3. Substance use services prioritize punishment over harm reduction. Sex workers, undocumented immigrants, and those w/ incarceration histories face compounded barriers and surveillance. 4. Neurodivergent folks are systemically excluded--our protocols don't accommodate processing time, sensory needs, or alternative communication styles. Biggest changes: (1) Decenter the medical model. Move toward community-based peer support, harm reduction as primary framework, and co-design with those most impacted. (2) Fund housing and economic support as foundational everything else fails without it. (3) Decouple clinician compensation from appointment volume; extend appointment times and remove rigid time pressure. (4) Mandate actual accountability for 'cultural competency' hire from affected communities, give them decision-making power, pay them. (5) Explicit non-collaboration with law enforcement and child protective services case management must be trusted, not coercive. (6) ND-affirming practices built in from the start, not retrofitted. Until the system stops being designed for profit and compliance, services will remain inaccessible to those most harmed. This isn't a resource problem - it's a values problem.
- When possible, increasing SFDPH's transparency for policy, program, and funding related

changes for the impacted communities, workers, and other stakeholders at implementing organizations.

- While I don't work directly with Behavioral Health clients, I've spoken to those who do and to those who have used city services. One thing that has come up consistently is the need to helping people to establish a healthy life after receiving care. This includes more job training with sponsored programs where people can get job experience and help in finding and keeping housing.
- without having directly experienced homelessness &/or worked directly in the community with people experiencing homelessness, I don't believe that I can really rank what areas to prioritize.
- Yes , While San Francisco has made progress in community-based mental health and substance use services, stronger coordination is still needed. Long-term confinement is not effective; residential care models such as ARF and RCFE show much higher success rates and should be expanded
- Yes. Mental health and substance use services in San Francisco are broken. The city continues to spend enormous amounts of money with little to no measurable results. Drugs are still easily available on the streets. Overdose rates are rising. People are not recovering. They are being recycled through a system that does not work. Very few programs show any real success. Many staff are poorly trained and lack accountability. Some are even accused of selling drugs to patients. Gift cards are handed out to individuals who use them to buy narcotics. This is not treatment. It is enabling. The city must conduct full audits of every program and every site. Cut the ones that do not work. Investigate staff and management. Require work or community service in exchange for benefits. Stop rewarding destructive behavior. Stop protecting broken systems just to keep jobs and contracts alive. Taxpayer money is being wasted. Public trust is being destroyed. San Francisco must face the truth and take action before the damage becomes irreversible.
- You didn't include the Faith-Based Organiztions
- You need to prioritize safe housing that is immediately available to individuals fleeing DV. this housing/ program needs to accept the individual with their pet(s), that is fleeing the situation. Shelters are often times worse for the individual than staying with their abuser.
- Zuckerberg San Francisco General Hospital (ZSFG) is the only facility in San Francisco County where adult survivors of sexual assault can receive a medical forensic examination. This means that every adult who experiences a recent sexual assault, regardless of where in the city the assault occurred, must come to ZSFG for emergency medical care, evidence collection, and documentation. The medical and forensic components of this care are provided 24/7 by a team of highly trained physician assistants and nurse practitioners who specialize in sexual assault response. However, there is no equivalent 24/7 access to mental health crisis support or bedside advocacy for these survivors. Currently, licensed clinicians and advocates from the Trauma Recovery Center (TRC) are only available Monday through Friday, 8 AM to 4 PM, covering just 23.8 percent of the week. As a result, the vast majority of survivors who arrive nights, weekends, or holidays go through the forensic and medical process without any trained rape crisis counselor or mental health professional present. Expanding mental health crisis response at ZSFG through sustainable funding for licensed clinicians and trained rape crisis counselors embedded directly within the hospital would make the single greatest difference. These professionals should be part of the on-site emergency and forensic response team, available 24/7 to provide immediate psychological stabilization, crisis counseling, and advocacy. Embedding this support within ZSFG, not just through the TRC or outside programs, would ensure that every survivor has access to trauma-informed emotional care at the bedside

regardless of when they seek help. It would allow medical and forensic providers to focus on their specialized roles while working collaboratively with mental health professionals. It would strengthen coordination between ZSFG's Emergency Department, Behavioral Health Services, and the forensic medical team, reduce long-term trauma symptoms such as PTSD, anxiety, and depression by addressing psychological needs at the time of crisis, and demonstrate San Francisco's genuine commitment to equity, public health, and survivor-centered care. Until this change is made, the city's behavioral health system will continue to leave its most acutely traumatized patients, sexual assault survivors, without adequate crisis mental health support at the very moment they need it most.

WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 5. COMMUNITY MENTAL HEALTH SERVICES [5000 - 5987] *(Division 5 repealed and added by Stats. 1967, Ch. 1667.)*

PART 3.7. OVERSIGHT AND ACCOUNTABILITY [5845 - 5847] *(Part 3.7 added November 2, 2004, by initiative Proposition 63, Sec. 10.)*

5847. Integrated Plans for Prevention, Innovation, and System of Care Services.

(a) Each county mental health program shall prepare and submit a three-year program and expenditure plan, and annual updates, adopted by the county board of supervisors, to the Behavioral Health Services Oversight and Accountability Commission and the State Department of Health Care Services within 30 days after adoption.

(b) The three-year program and expenditure plan shall be based on available unspent funds and estimated revenue allocations provided by the state and in accordance with established stakeholder engagement and planning requirements, as required in Section 5848. The three-year program and expenditure plan and annual updates shall include all of the following:

(1) A program for prevention and early intervention in accordance with Part 3.6 (commencing with Section 5840).

(2) A program for services to children in accordance with Part 4 (commencing with Section 5850), to include a program pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9 or provide substantial evidence that it is not feasible to establish a wraparound program in that county.

(3) A program for services to adults and seniors in accordance with Part 3 (commencing with Section 5800).

(4) A program for innovations in accordance with Part 3.2 (commencing with Section 5830).

(5) A program for technological needs and capital facilities needed to provide services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850). All plans for proposed facilities with restrictive settings shall demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting, such as permanent supportive housing.

(6) Identification of shortages in personnel to provide services pursuant to the above programs and the additional assistance needed from the education and training programs established pursuant to Part 3.1 (commencing with Section 5820).

(7) Establishment and maintenance of a prudent reserve to ensure the county program will continue to be able to serve children, adults, and seniors that it is currently serving pursuant to Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act, Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs, and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act, during years in which revenues for the Behavioral Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index.

(8) Certification by the county behavioral health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements.

(9) Certification by the county behavioral health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the requirements of the Mental Health Services Act.

(c) The programs established pursuant to paragraphs (2) and (3) of subdivision (b) shall include services to address the needs of transition age youth 16 to 25 years of age, inclusive. In implementing this subdivision, county mental health programs shall consider the needs of transition age foster youth.

(d) Each year, the State Department of Health Care Services shall inform the County Behavioral Health Directors Association of California and the Behavioral Health Services Oversight and Accountability Commission of the methodology used for revenue allocation to the counties.

(e) Each county mental health program shall prepare expenditure plans pursuant to Part 3 (commencing with Section 5800) for adults and seniors, Part 3.2 (commencing with Section 5830) for innovative programs, Part 3.6 (commencing with Section 5840) for prevention and early intervention programs, and Part 4 (commencing with Section 5850) for services for children, and updates to the plans developed pursuant to this section. Each expenditure update shall indicate the number of children, adults, and seniors to be served pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) and the cost per person. The expenditure update shall include utilization of unspent funds allocated in the previous year and the proposed expenditure for the same purpose.

(f) A county mental health program shall include an allocation of funds from a reserve established pursuant to paragraph (7) of subdivision (b) for services pursuant to paragraphs (2) and (3) of subdivision (b) in years in which the allocation of funds for services pursuant to subdivision (e) are not adequate to continue to serve the same number of individuals as the county had been serving in the previous fiscal year.

(g) The department shall post on its internet website the three-year program and expenditure plans submitted by every county pursuant to subdivision (a) in a timely manner.

(h) (1) Notwithstanding subdivision (a), a county that is unable to complete and submit a three-year program and expenditure plan or annual update for the 2020–21 or 2021–22 fiscal years due to the COVID-19 Public Health Emergency may extend the effective timeframe of its currently approved three-year plan or annual update to include the 2020–21 and 2021–22 fiscal years. The county shall submit a three-year program and expenditure plan or annual update to the Behavioral Health Services Oversight and Accountability Commission and the State Department of Health Care Services by July 1, 2022.

(2) For purposes of this subdivision, "COVID-19 Public Health Emergency" means the federal Public Health Emergency declaration made pursuant to Section 247d of Title 42 of the United States Code on January 30, 2020, entitled "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus," and any renewal of that declaration.

(i) Notwithstanding paragraph (7) of subdivision (b) and subdivision (f), a county may, during the 2020–21 and 2021–22 fiscal years, use funds from its prudent reserve for prevention and early intervention programs created in accordance with Part 3.6 (commencing with Section 5840) and for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850) for the children's system of care and Part 3 (commencing with Section 5800) for the adult and older adult system of care. These services may include housing assistance, as defined in Section 5892.5, to the target population specified in Section 5600.3.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, may implement, interpret, or make specific subdivisions (h) and (i) of this section and subdivision (i) of Section 5892 by means of all-county letters or other similar instructions.

(k) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

(Amended by Stats. 2025, Ch. 243, Sec. 17. (SB 862) Effective January 1, 2026. Inoperative July 1, 2026, by its own provisions. Repealed as of January 1, 2027, by its own provisions.)

Jesse Rawlins, Policy Manager
Tenderloin Neighborhood Development Corporation
201 Eddy Street
San Francisco, CA 94102

April 22, 2026

Dr. Hillary Kunins, Director of Behavioral Health Services and Mental Health SF
San Francisco Department of Public Health
101 Grove Street
San Francisco, CA 94102

City and County of San Francisco Board of Supervisors
1 Dr. Carlton B. Goodlett Place, Room 250
San Francisco, CA 94102

San Francisco Behavioral Health Services Commission
1 Dr Carlton B. Goodlett Place, Room 416
San Francisco, CA 94102

RE: Increasing Housing Subsidies for Fiscal Year 2026-2029 BHSA Three-Year Integrated Plan

Dear Board of Supervisors and Commission Members,

The Tenderloin Neighborhood Development Corporation (TNDC) is writing to express concern about the operating subsidy levels for the Full Service Partnership Permanent Supportive Housing in the Behavioral Health Services Act (BHSA) Fiscal Year (FY) 2026-2029 Three-Year Integrated Plan. **For the Plan, we are requesting that the MHSA/BHSA housing subsidy program be funded based on Fair Market Rents (FMR) with annual increases to effectively operate supportive housing.**

As an example, MHSA/BHSA referrals are made to 51 units in TNDC's supportive housing buildings. For just over half of these units, the Local Operating Subsidy Program (LOSP) administered by the Mayor's Office of Housing and Community Development (MOHCD) or a Project-Based Voucher contract (PBV) administered by the Housing Authority of the City and County of San Francisco provide operating or rental subsidies that cover the total cost of operations for these units. However, for another 21 units across three of TNDC's buildings, the MHSA/BHSA-funded annual operating subsidy is under-sized. It totals $190,000, which is $9,000 per unit per year or $750 per unit per month, which is woefully inadequate to effectively operate supportive housing units. To ensure that supportive housing units can be effectively operated, the MHSA/BHSA funded subsidy amounts should be increased to match FMR. Underfunding operating subsidies of the housing for people in Full Service Partnerships is not aligned with BHSA's goals of supporting long-term recovery and stabilizing people with acute behavioral health needs. To increase and

right-size the amount of financial assistance for subsidies so that funding matches the cost of operations, we recommend applying the funding formula used by the Department of Housing and Urban Development (HUD) for the Housing Choice Voucher (HCV) program that is widely known as Section 8. For the HCV program, HUD uses a locality's FMR to calculate subsidy amounts. Using FMR, MHSA/BHSA subsidies would total $21,000 per unit per year, more than twice what they are currently. The under-sizing of MHSA subsidies has been compounded over the years, since they have remained flat for each of the last six years. In contrast, the HCV program provides annual increases based on FMR that cover operating expense inflation. **Accordingly, the MHSA/BHSA housing subsidy program should be funded using FMR with initial rates of $21,000 and receive annual increases.**

Additionally, we recommend that the San Francisco Department of Public Health (DPH) ensure that supportive housing providers are effectively engaged in matters pertaining to funding, programming, and operating supportive housing. We recommend that Behavioral Health Services staff with the Department of Public Health (DPH) conduct regular meetings to discuss the adequacy of BHSA housing-related expenditures with the housing providers receiving BHSA funding. This engagement should inform further BHSA expenditure planning.

We appreciate the opportunity to provide these recommendations for BHSA housing subsidies to utilize FMR that aligns with the HCV program. This will ensure that the costs for operating units are correctly resourced, which sustains supportive housing and creates better outcomes for our sector and those experiencing acute behavioral health needs.

Thank you,

Jesse Rawlins, Policy Manager
Tenderloin Neighborhood Development Corporation

CC: Daniel Tsai, Director, Department of Public Health
Dan Adams, Director, Mayor's Office of Housing and Community Development
Shireen McSpadden, Director, Department of Homelessness and Supportive Housing
Jessica Brown, Director, Office of Justice, Equity, Diversity, and Inclusion/Behavioral Health Services Act, Department of Public Health
Danyelle Marshall, Deputy Director, Office of Justice, Equity, Diversity, and Inclusion/Behavioral Health Services Act, Department of Public Health

President, District 8
BOARD of SUPERVISORS

City Hall
1 Dr. Carlton B. Goodlett Place, Room 244
San Francisco, CA 94102-4689
Tel. No. 554-6968
Fax No. 554-5163
TDD/TTY No. 544-5227

RAFAEL MANDELMAN

PRESIDENTIAL ACTION

Date: 05/14/2026

To: Angela Calvillo, Clerk of the Board of Supervisors

Madam Clerk,
Pursuant to Board Rules, I am hereby:

☐ Waiving 30-Day Rule (Board Rule No. 3.23)

File No. _____ _____
(Primary Sponsor)

Title. _____

☒ Transferring (Board Rule No 3.3)

File No. 260448 Department
(Primary Sponsor)

Title. Resolution authorizing adoption of the San Francisco Behavioral Health Services Act Three-Year Integrated Plan for Fiscal Years (FY)

From: Public Safety & Neighborhood Services Committee

To: Budget & Finance Committee

☐ Assigning Temporary Committee Appointment (Board Rule No. 3.1)

Supervisor: _____ Replacing Supervisor: _____

For: _____ _____ Meeting
(Date) (Committee)

Start Time: _____ End Time: _____

Temporary Assignment: ◉ Partial ○ Full Meeting

Rafael Mandelman, President
Board of Supervisors

City and County of San Francisco
Daniel L. Lurie
Mayor

San Francisco Department of Public Health
Daniel Tsai
Director of Health

April 27, 2026

Angela Calvillo, Clerk of the Board
Board of Supervisors
1 Dr. Carlton B Goodlett Place, Room 244
San Francisco, CA 94102-4689

Dear Ms. Calvillo:

Attached, please find an original and two single-sided, black and white copies of a proposed resolution for Board of Supervisors approval that would adopt the San Francisco Behavioral Health Services Act (BHSA) Three-Year Integrated Plan, FY2026-2029.

The Mental Health Services Act (MHSA) was passed in 2004 through a ballot initiative (Proposition 63) and provided funding to support new and expanded county mental health programs. In March 2024, California voters passed Proposition 1, a two-bill package that includes the BHSA and Behavioral Health Infrastructure Bond Act of 2024. Moving forward we will refer to the Act as BHSA. As required by the State, San Francisco's draft BHSA Three-Year Integrated Plan FY2026-2029 was submitted to the State Department of Healthcare Services (DHCS) on March 31st and is currently posted for 30-day public comment (April 1-30). This item was also heard at the Health Commission on April 6th. It is scheduled to be heard at a public hearing at the San Francisco Behavioral Health Commission on May 7th, as required by the State to access BHSA funding. Welfare and Institutions Code Section 5847 requires adoption of the Three-Year Integrated Plan by the County Board of Supervisors prior to submission to the State Mental Health Services and Oversight Accountability Commission.

The following is a list of accompanying documents:

- WIC § 5847
- San Francisco Behavioral Health Services Act (BHSA) Three-Year Integrated Plan, FY2026-2029

Should you have any questions, please contact Jessica Brown, MPH, Director, Office of Justice, Equity, Diversity, and Inclusion/Behavioral Health Services Act. Ms. Brown can be reached at Jessica.N.Brown@sfdph.org.

Sincerely,

Dan Tsai
Director of Health