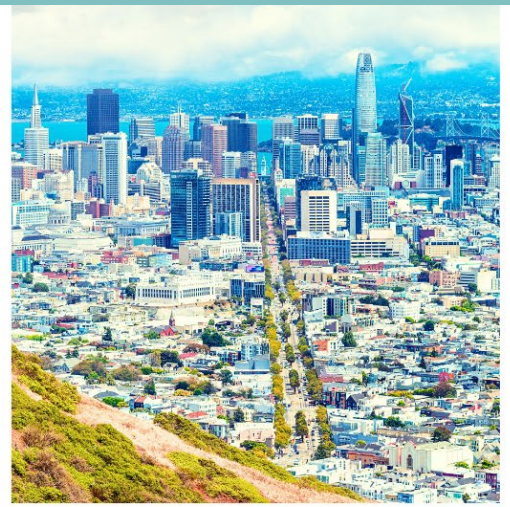


Expanding Behavioral Health Placements for a Complex Population

Findings and Recommendations of the Residential Care and Treatment Workgroup

Office of the Controller

Laura Marshall

June 26, 2025

Residential Care and Treatment Workgroup

Workgroup Overview

- Convened by Mayor London Breed and Supervisor Mandelman
- Partnered with the Department of Public Health (DPH) and the Department of Disability and Aging Services (DAS)
- Selected leading stakeholders to serve on the workgroup: hospitals, health plans, labor, legal system, etc.

Workgroup Purpose

Create a framework to address the shortage in appropriate long-term residential placements for individuals with complex behavioral health needs, focusing on settings where the City experiences the most constraints.

Residential Care and Treatment Workgroup

Controller's Office Role

From May to November 2024, the Controller's Office **facilitated sessions** and supported the workgroup to consider:

- Program capacity and gaps in key areas of the behavioral health system
- Operational barriers and pain points driving service gaps
- Cost of operating and expanding residential care programs

The Controller's Office **conducted additional analysis**:

- Interviews with local providers and hospital executives
- Market research with other counties

The Controller's Office **produced a report** to summarize findings affirmed by the Workgroup and the Workgroup's recommendations to address gaps in long-term care facilities and placement challenges for complex clients.

Residential Care and Treatment Workgroup

Workgroup Areas of Focus

Despite consistent expansion efforts over the last several years, the City experiences persistent challenges in placing clients with the most complex needs into long-term treatment programs.

The Workgroup focused on 3 levels of long-term care:

- **Mental Health Rehabilitation Centers** (MHRCs)
  - Also referred to as "Locked Sub-Acute Treatment" (LSAT)
- **Adult Residential Facilities** (ARFs)
  - Also referred to as "Board and Care"
- **Residential Care Facilities for the Elderly** (RCF-Es)
  - Also referred to as "Assisted Living Facilities"

Capacity gaps and placement challenges within MHRCs, ARFs or RCF-Es create bottlenecks across the entire system.

Mental Health Rehabilitation Centers

A "MHRC" offers 24/7 intensive psychiatric care, nursing care, and psychosocial rehabilitation services to adults with severe mental illness and/or placed under conservatorship. A MHRC is a type of locked sub-acute treatment (LSAT) facility.

Adult Residential Facilities

An "ARF" is a non–medical facility that provides basic care and supervision for adults ages 18-59 who need assistance with daily living. Programs contracting with the City may add enhanced behavioral health care in addition to basic services.

Residential Care Facilities for the Elderly

An "RCF-E" is similar to an ARF but serves people 60 years old or older. Programs contracting with the City may add enhanced behavioral health care in addition to basic services.

Key Themes from the Workgroup

Workgroup Themes: Targeted Expansion Needed

Expansion …

The City expanded behavioral health residential programs by over 400 beds since the publication of a 2020 bed optimization study that projected these needs.

However, Workgroup feedback confirmed updated modeling which found a need to add **55-95** MHRC beds and **20-40** Behaviorally Complex ARF and RCF-E beds in the coming two years.

… for Complex Clients

The City continues to face significant barriers placing clients with the most complex characteristics and health care needs.

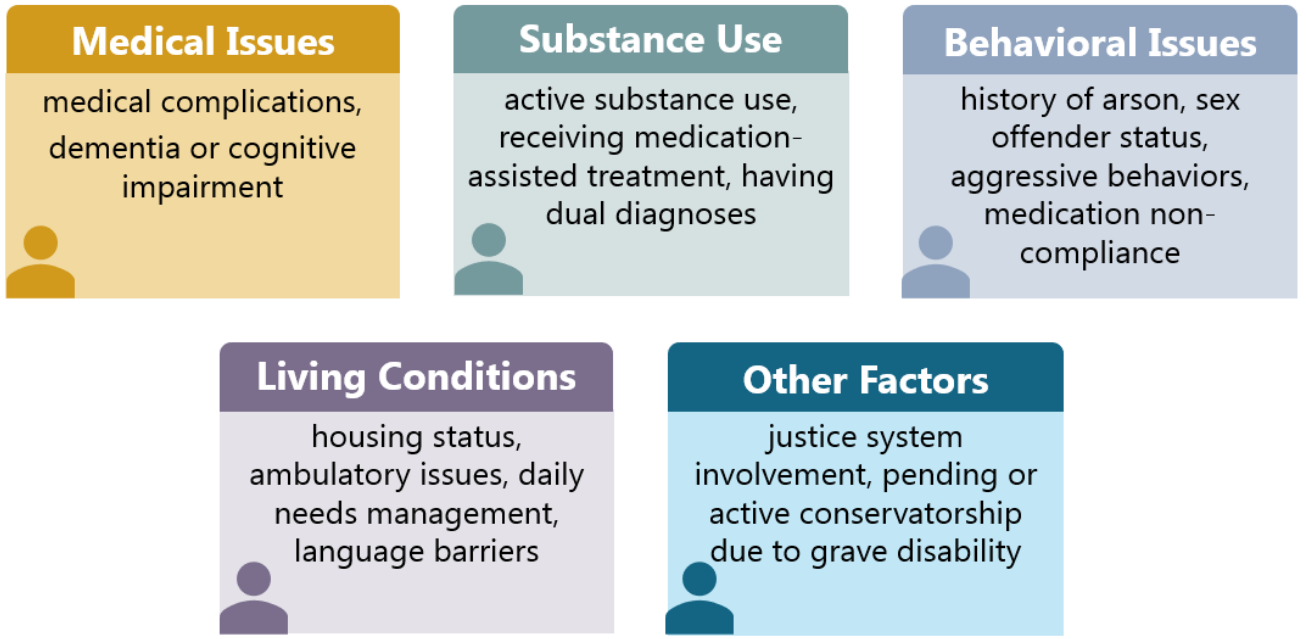
The City must focus not just on the number of beds available, but also on adding or reprogramming beds **specifically designed and reserved for the hardest to serve clients**, who may be denied placement in other settings.

Workgroup Themes: Targeted Expansion Needed

The City has both a **capacity challenge** and a **placement challenge**, with highly complex clients proving difficult to place even when a bed is available.

DPH projects it may need 75 to 135 total ARF, RCF-E and MHRC beds, but these expanded beds must be targeted to a behaviorally complex population.

DPH contracts with programs to deliver residential care to behavioral health clients, and **programs may decline placements** when a client has additional complex characteristics that may make them difficult or inappropriate to serve in that setting.



Workgroup Themes: Budgetary Challenges

The Workgroup acknowledged that the operational costs of added placements creates a **budgeting challenge for San Francisco**. Implementing the recommended expansion beds could lead to new annual patch costs ranging from **$12 million to $24 million**.

ARF & RCF-E			
20 Beds		40 Beds	
Low Patch: $200/Day **$1.5 Million**	High Patch: $250/Day **$1.8 Million**	Low Patch: $200/Day **$2.9 Million**	High Patch: $250/Day **$3.7 Million**

Patch costs for complex clients at ARFs and RCF-Es may range from **$200 - $250 per client per day**.

Patch costs for MHRCs for the most complex clients may range from **$527 to $570 per client per day**.

MHRC			
55 Beds		95 Beds	
Low Patch: $527/Day[16] **$10.6 Million**	High Patch: $570/Day **$11.4 Million**	Low Patch: $527/Day **$18.3 Million**	High Patch: $570/Day **$19.8 Million**

The **City must cover the cost of expanding and operating MHRC, ARF and RCF-E placements** through local funding sources and the General Fund.

- While Medicaid or Medicare may reimburse for skilled nursing or short-term treatment, State and federal regulations limit funding for MHRC, ARF and RCF-E placements.

Workgroup Themes: Budgetary Challenges

Market Failure

The market does not sufficiently encourage placement of behaviorally complex clients into residential care, **despite supplemental funding**. Facilities have discretion on placements and the market has failed to compel them to accept the most complex clients.

Daily Patch Rates among California Peer Jurisdictions							
	San Francisco	**Alameda**	**Napa**	**Sacramento**	**San Diego**	**San Mateo**	**Santa Clara**
ARF/ RCF-E	$46-$250 ARF avg: $130 RCF-E avg: $111	$33-$230 4 Tiers	$173-$241 Avg: $201	$65	Base: $46 Enhanced: $60	In County: $41 Avg. Enhanced: $184	Base: $104
MHRC	$313-577 Avg: $506	$510-$575	$261-$504 Avg: $363	$350	$345-$485 3 Tiers	$280-$460	$350

Despite having a competitive daily patch rate compared with several peer counties, the City continues to struggle to find placements for more complex clients.

Workgroup Themes: The State's Role

The challenge of placing complex clients in care is not unique to San Francisco. The Workgroup concluded that **the State must take a proactive role in regional and statewide solutions** and support cross-county financing and collaboration. The State should support local jurisdictions through:

Coordination: The Workgroup explored options to collaborate with other jurisdictions with similar bed placement and capacity challenges.

If left to counties to negotiate a regional approach, the financial, legal, and political hurdles make it unlikely to succeed on a timeline and scale required to meet urgent behavioral health needs.

Increased Funding: The State should make key changes to the Assisted Living Waiver (ALW) to allow a higher level of participation, revise participation policies, increase reimbursement rates by region, and improve data transparency.

Regulatory Oversight: To counter market constraints, the State should lead efforts to reform placement practices, such as establishing new regulations to improve access for complex clients needing placement in a MHRC.

Workgroup Themes: The State's Role

Local and regional capacity gaps are impacted by a decrease in State Hospital bed availability.

- The **State Hospital census decreased in the last five years,** while local need for this intensive level of care has increased.
- Reductions in State Hospital bed allocations increase pressure on San Francisco's system of care. Many of these individuals are otherwise placed in MHRC facilities.

San Francisco State Hospital Clients from Fiscal Year 2020 to Fiscal Year 2024				
Fiscal Year	Average Annual Total of San Francisco County Patients	# of San Francisco County Patient Admissions	# of San Francisco County Patient Discharges	Estimated Overall State Hospital Census
FY19-20	42.1	2	2	6,317
FY20-21	38.6	2	7	6,270
FY21-22	28.1	3	16	5,913
FY22-23	22.4	4	6	5,740
FY23-24	22.0	1	4	5,724

The Workgroup recommended the State fund State Hospitals to appropriately meet the needs of counties and ensure counties receive access to beds commensurate with local levels of need.

Workgroup Themes: Operational Challenges

Control over Client Placement

To counter market pressures, the Workgroup recommended that the City:

- Review existing **City-owned facilities** with labor partners and experts and consider whether and how to **reprogram existing sites** to serve San Francisco's most complex clients
- Retain market-constrained (i.e., fully contracted) programs for less complex clients

Facility Procurement Delays

Procuring sites is administratively burdensome: acquiring and launching a new program for vulnerable clients can take **18-24 months**, or more.

The Workgroup recommended the City develop an action plan of potential solutions to constraints including:

- Slow administrative processes
- Long community acceptance processes
- Lack of service provider capacity to own and manage facilities
- Limits to the City's low-interest loan program

Workgroup Themes: Operational Challenges

The Workgroup recommended DPH refine analysis and tracking tools to ensure projections for expansion needs are accurate, nuanced, and show the impact of changes over time.

A. By July 2025, DPH should develop a process to **track the progress of bed expansion efforts**, including the change in total beds in the system over time.

B. By December 2025, DPH should update its Bed Optimization analysis to more accurately project the number of program **slots needed to serve specific subpopulations**, including based on the type of challenges given clients may face.

When paired, these two analyses may show the success of expansion plans, viable strategies for expansion, and the impact the expansion has on clients requiring and using each level of care.

- E.g.: if the City achieves the goal of expanding MHRC beds, this may result in an increased need for new step-down levels of care, such as ARF and RCF-E beds.

Conclusion

San Francisco must urgently address the capacity, placement, and funding constraints across its residential care and treatment programs.

The Workgroup recommendations outline how the City, local and regional hospital partners, neighboring counties, and the State and federal governments can work towards resolving these systemic challenges.

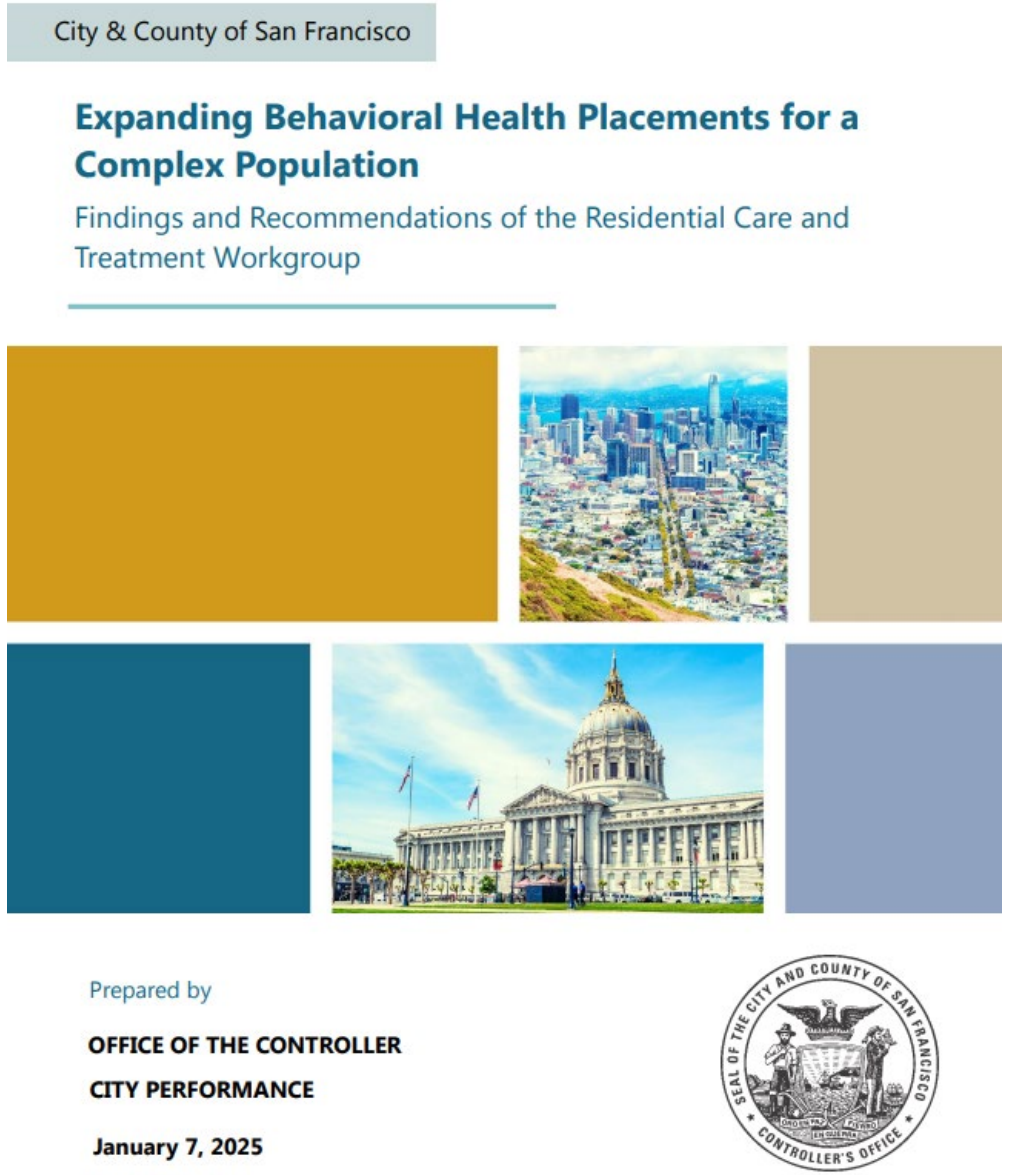
When implemented, **recommendations will help San Francisco better care for some of the most vulnerable individuals in the City**.

The City has already taken key steps to achieve its expansion goals:

- In December 2024, DPH submitted applications for Proposition 1 Bond Behavioral Health Continuum Infrastructure Program (Bond BHCIP) funding for one-time capital funds.

Questions?

Find the full report online



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https://www.sf.gov/sites/default/files/2025-01/Residential%20Care%20and%20Treatment%20Workgroup%20Report%20FINAL%201.7.25_Report%20and%20Appendix.pdf

Appendix A:
Detailed Workgroup Findings

Workgroup Findings

1. While San Francisco has expanded behavioral health residential care capacity by 20% since 2020, recent modeling indicates that the City needs additional ARF, RCF-E and MHRC treatment capacity.

The model recommends adding **55-95 MHRC beds** and **20-40 Behaviorally Complex Therapeutic beds** (either ARF or RCF-E). While the modeling did not recommend an increase in the *total* ARF and RCF-E bed count, there is limited availability of ARF and RCF-E beds for clients with complex needs.

Residential Type	Additional Beds Needed	Considerations
Mental Health Rehabilitation Centers (MHRC) / LSAT	Estimated 55-95	• Given current wait times • Potential for increase in demand under SB 43
Behaviorally Complex Therapeutic (Enhanced Residential Care / Residential Care for the Elderly	Estimated 20-40	• Highly specialized level of care for complex, high-need clients difficult to place in care.

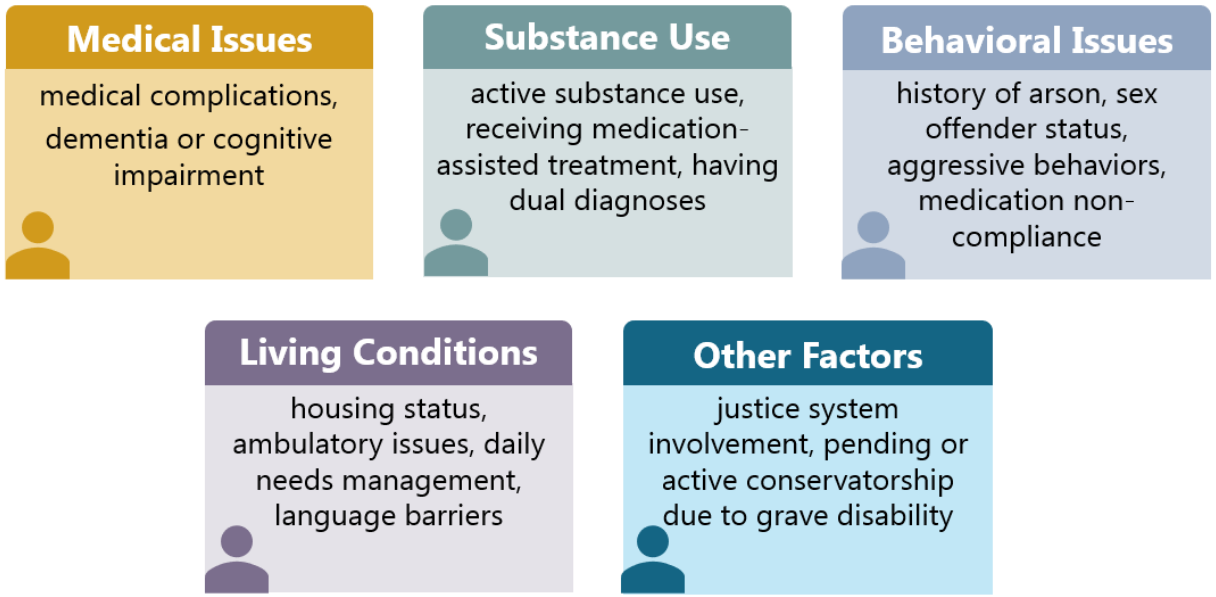
According to the Workgroup, the model may reflect an undercount of the true need as it relates to MHRCs, while others would like more data to refine assumptions about gaps in ARF or RCF-E settings.

Workgroup Findings

2. The City has both a capacity challenge and a placement challenge, with highly complex clients proving difficult to place even when a bed is available.

DPH projects it may need 75 to 135 total ARF, RCF-E and MHRC beds, but these expanded beds must be **targeted to a behaviorally complex population** that DPH has the most difficulty placing in facilities even when facilities have capacity.

DPH contracts with programs to deliver residential care to behavioral health clients. These programs **may decline placements** when a client has additional complex characteristics that may make them difficult or inappropriate to serve in that setting.



Workgroup Findings

3. The market does not sufficiently encourage placement of behaviorally complex clients into residential care, despite supplemental funding.

The City's placement challenges for the most complex clients could be considered a **market failure**. Facilities have discretion on who they accept as clients and the market has failed to compel them to accept the most complex clients.

Daily Patch Rates among California Peer Jurisdictions

	San Francisco	Alameda	Napa	Sacramento	San Diego	San Mateo	Santa Clara
ARF/ RCF-E	$46-$250 ARF avg: $130 RCF-E avg: $111	$33-$230 4 Tiers	$173-$241 Avg: $201	$65	Base: $46 Enhanced: $60	In County: $40.56 Avg. Enhanced: $184	Base: $104
MHRC	$313-577 Avg: $506	$510-$575	$261-$504 Avg: $363	$350	$345-$485 3 Tiers	$280-$460	$350

Counties provide daily **"patch" payments** to augment baseline staffing at ARFs, RCF-Es and MHRCs. Despite having a competitive daily patch rate compared with several peer counties in California, San Francisco continues to struggle to find placements for its more complex clients.

Workgroup Findings

4. San Francisco must cover the cost of expanding and operating ARF, RCF-E and MHRC programs through local funding sources and the General Fund due to current state and federal funding limitations.

ARF & RCF-E

Medi-Cal does not reimburse for non-medical expenses. Unlike many residential treatment programs, **Medi-Cal does not cover stays at ARF and RCF-E programs**.

The City may receive Medi-Cal reimbursement when a resident receives a medical visit, but the City must cover the costs for basic daily care and facility space through **unreimbursed local sources**.

MHRC

Medicaid prohibits using federal funds for "Institutions for Mental Diseases" (IMDs). All of the City's MHRC contracts are IMDs.

The City pays a daily patch rate negotiated based on the complexity of a client. That patch must be covered entirely by local funding, as the **IMD exclusion prevents the City from receiving Medicaid reimbursement for this intensive type of treatment**.

Workgroup Findings

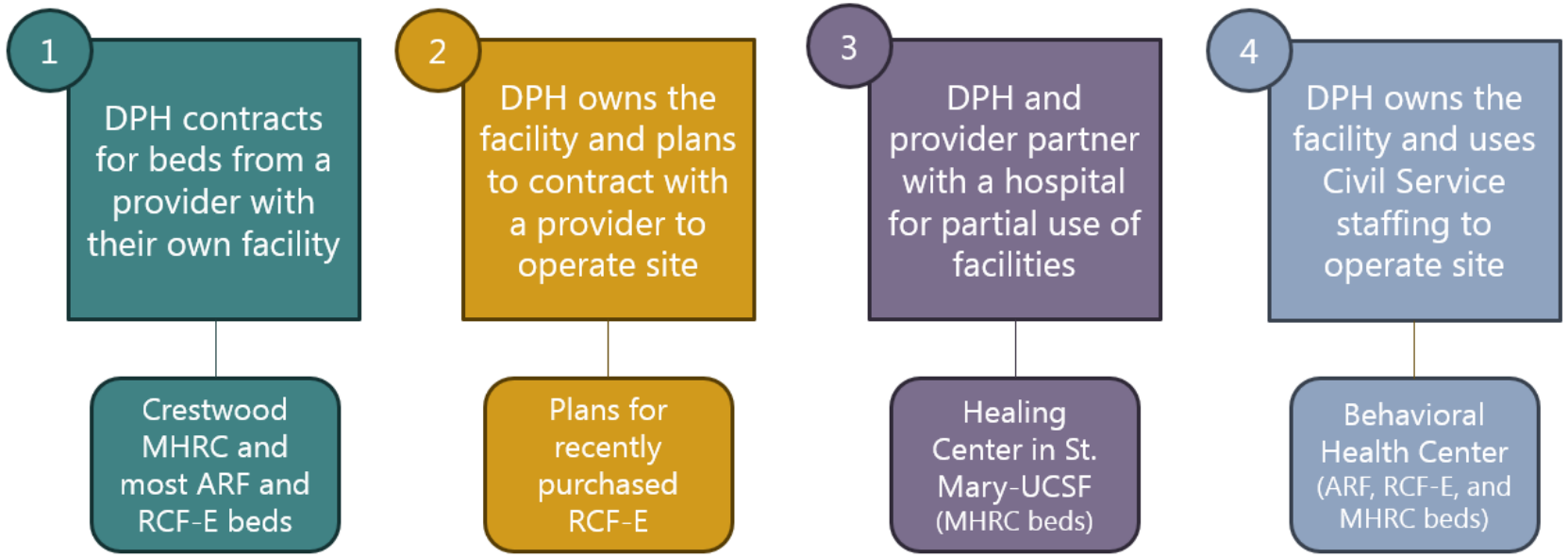
5. Facility procurement is administratively burdensome, and the City often struggles to expand programs with the necessary expediency.

San Francisco uses a variety of strategies to achieve its bed expansion goals. A recent Controller's Office report provides details about the operational challenges with these various approaches to bed expansion.

Model #1 may be the fastest option for expansion, though this may not address market barriers.

Models #2 or #3 may be most viable for MHRC programs that require hospital-grade buildings.

While such facilities are rarely available for purchase, there are good examples of collaboration with hospitals on shared use of space.



Workgroup Findings

6. Mirroring nationwide and statewide trends, the City and its service providers face persistent challenges with recruiting, hiring, and maintaining skilled staff.

Programs delivering behavioral health services struggle to recruit and retain staff, especially staff with specialized experience like serving clients with dual diagnoses.

ARF and RCF-E operators most often employ direct care workers such as personal care aides, home health aides and nursing assistants. Recent data shows that direct care workers have low wages (below the national average living wage for adults with no children), limited access to benefits, and are disproportionally women and people of color.

The Workgroup affirmed that if hiring continues to be a challenge, changes to workflows and policies won't be able impactful without the staff to implement them.

For more on healthcare staffing challenges and opportunities in San Francisco, see the Mental Health SF Staffing Analysis.

Workgroup Findings

7. Existing systems and regulations are not responsive to and may prevent appropriate service delivery to complex clients.

Interviewed clinical providers speculated that San Francisco and other counties may not yet offer the **right model of care** that appropriately serves the most complex clients in the system.

For example, some providers must currently choose whether to refer clients with multiple needs either to a medical setting that does not offer substance use and/or mental health treatment or to a mental health and/or substance use treatment program that lacks the ability to care for that individual's medical needs.

Few programs offer comprehensive treatments due to historically **siloed funding, regulatory, and licensing systems**.

Providers emphasized the need to improve housing as settings for care, including adding services to help complex clients remain stable in housing as well as improving the connection between residential treatment and housing settings.

Workgroup Findings

8. Changes in the State Hospital referral process create gaps in capacity for San Francisco clients who would be best served in this setting.

Some of the MHRC capacity gaps may be impacted by **placing clients in MHRCs who would be better served at a State Hospital**. The State changed the county referral process to State Hospitals resulting in fewer beds allocated to San Francisco, from 42 clients served five years ago to 22 in 2024.

San Francisco State Hospital Clients from Fiscal Year 2020 to Fiscal Year 2024				
Fiscal Year (FY)	Average Annual Total of San Francisco County Patients	# of San Francisco County Patient Admissions	# of San Francisco County Patient Discharges	Estimated Overall State Hospital Census
FY19-20	42.1	2	2	6,317
FY20-21	38.6	2	7	6,270
FY21-22	28.1	3	16	5,913
FY22-23	22.4	4	6	5,740
FY23-24	22.0	1	4	5,724

The State Hospital census overall fell from 6,317 patients in June 2020 to 5,724 patients in June 2024.

Appendix B:
Detailed Recommendations

Recommendations

The Workgroup's findings highlight complex and interrelated challenges that will require an array of strategies to address.

In some cases, the City can take actions itself to fulfill its bed expansion and placement goals.

However, the City must also collaborate with local, regional and statewide partners, and must advocate for greater support from the state and federal governments to sustain its bed expansion.

The Workgroup's recommendations outline the options and opportunities San Francisco can pursue to create lasting change in the system of care.

Recommendations

1. To address capacity gaps, the City should complete a net expansion of its ARF, RCF-E and LSAT treatment programs.

New program slots should be specifically designed for and should have an explicit commitment to serve highly complex clients. The expansion should include:

- A **net of 20 to 40 ARF and RCF-E beds** operating within the system by December 2027.
- A **net of 55 to 95 MHRC beds** operating within the system by December 2027.

Assuming the expansion of ARF, RCF-E, and MHRC beds come online over two years, the City may anticipate General Fund costs of:

- FY 2025-26: **$13.2 million** General Fund patch costs to support 20 ARF and RCF-E beds, and 55 MHRC beds at the highest patch rate.
- FY 2026-27: **$23.5 million** General Fund patch costs to support 40 ARF and RCF-E beds, and 95 MHRC beds at the highest patch rate.

The Mayor and the Board of Supervisors should prioritize these services and **sustain their associated costs within the City's budget**.

Recommendations

1. To address capacity gaps, the City should complete a net expansion of its ARF, RCF-E and LSAT treatment programs.

ARF & RCF-E			
20 Beds		40 Beds	
Low Patch: $200/Day **$1.5 Million**	High Patch: $250/Day **$1.8 Million**	Low Patch: $200/Day **$2.9 Million**	High Patch: $250/Day **$3.7 Million**

Patch costs to provide higher levels of care for complex clients may range from **$200 - $250 per client per day** depending on the level of care needed (an increase from the current $150 average).

Facility purchase costs vary widely and depend on the condition of the site. DPH recently purchased a 54-bed facility which did not need rehabilitation for **$13.8 million**.

MHRC			
55 Beds		95 Beds	
Low Patch: $527/Day[16] **$10.6 Million**	High Patch: $570/Day **$11.4 Million**	Low Patch: $527/Day **$18.3 Million**	High Patch: $570/Day **$19.8 Million**

Patch costs for MHRC programs range between $313 to per day to $570 per day, depending on the level of care needed; for the most complex clients, a range of **$527 to $570 per client per day** is needed.

MHRC facilities must meet facility standards that are **similar to hospitals**. San Francisco has a limited number of suitable buildings. Estimates for acquiring a MHRC facility are in the tens of millions of dollars.

Recommendations

2. To counter market pressures, the City should implement strategies to achieve a net expansion of these programs that provide the City with more control over client placement.

The City should…

Review all existing City-owned facilities and, with labor partners and facility licensing experts, consider whether and how to **reprogram these existing facilities to serve San Francisco's most complex clients**. This would allow the City to retain market-constrained (i.e., fully contracted) programs for less complex clients.

With guidance from legal experts, implement **new contract terms** to ensure providers accept placements, such as incentives for accepting more complex clients and/or contract penalties for denial of complex clients. As feasible, the City may implement these terms when:

i. Partnering with private operators to expand facilities and secure dedicated beds for San Francisco via contracts.
ii. Actively seeking out new facilities for City acquisition with contracted services.

Recommendations

3. To address capacity gaps, local and regional hospitals should leverage underutilized spaces to develop MHRC programming for placement by the City or hospital partners.

The City should…

Initiate conversations with leaders at local and regional private hospitals to **explore options for utilizing hospital space for a MHRC expansion** by December 2025.

The City has limited options to provide MHRC beds within San Francisco, though clinical providers noted that in-county placements can improve care coordination. Regional hospital partnerships with the City would enable San Francisco clients to receive care in, or close to, their home county.

An example of this approach is the Crestwood San Francisco Healing Center at the St. Mary-UCSF campus which provides 54 beds within the City's existing MHRC portfolio.

The City should create plans to actively engage local and regional hospitals on opportunities to expand the number of beds available.

Recommendations

4. To better understand the system's capacity gaps, DPH should refine its existing analysis and tracking tools.

A

By July 2025, DPH should develop a process to **track the progress of bed expansion efforts**, including the process used to expand (e.g., acquisition, contracting), target populations to be served, and the change in total beds in the system over time.

B

By December 2025, DPH should update its Bed Optimization analysis to more accurately project the number of program slots needed to serve specific populations, including based on the type of challenges given clients may face. With a greater understanding of the number of clients with specific barriers to care and placement gaps, the City can add capacity targeted to these vulnerable individuals.

C

Paired together and with **regular updates** over time, these two analyses may show the success of treatment program expansion plans, viable strategies for expansion, and the impact the expansion has on clients requiring and using each level of care over time.

Recommendations

5. To address the time-consuming nature of expansion efforts, the City should develop a plan to address known barriers and delays in acquisition and/or contracting for new treatment facilities.

Currently, acquiring and launching a new program can take **18-24 months, assuming a smooth process**. However, the City has an immediate need for programs to care for vulnerable clients across several levels of care. The City must act with urgency to ensure clients receive the care they need, including for clients under conservatorship who are in the care of the City due to a grave disability.

The Mayor should direct relevant departments to convene, discuss barriers, and produce and action plan summarizing potential solutions by December 2025, in part to address the following constraints:

- Slow administrative processes and regulated steps for formal approvals.
- Lack of staffing for specialized functions, including asset management, real estate acquisition, facility licensing issues, etc.
- Long community acceptance processes for new programs.
- Backlog and delays in due diligence and renovation timelines.
- Lack of capacity among service providers to own facilities, manage the asset, and/or manage property.
- Current limits in the City's low-interest loan program.

Recommendations

6. To address staffing challenges, the City should accelerate its work to implement the recommendations made in the 2024 Mental Health SF Staffing Analysis.

The strategies in the Mental Health SF Staffing Analysis report identified options and strategies to consider, noting that addressing staffing gaps will require multiple coordinated strategies. Examples include:

- Exploring opportunities to adjust staffing models to leverage non-licensed paraprofessionals.
- Exploring where service providers can implement wage increases for hard-to-fill positions per their unique operational needs.
- Supporting service providers in their efforts to address wage pressures by reviewing existing contracts and assessing where contract or budget modifications may be appropriate and feasible for the overall system of care.

DPH provides ARF and RCF-E operators patch rates that are tiered to provide enhanced levels of care for clients in based on additional services they may require. To address the needs of the client population with greater complexity of needs, DPH may need to **review its patch rate structure** to ensure that the rates offered adequately supports the more intensive base levels of care needed to address the needs of a client population with greater complexity of needs.

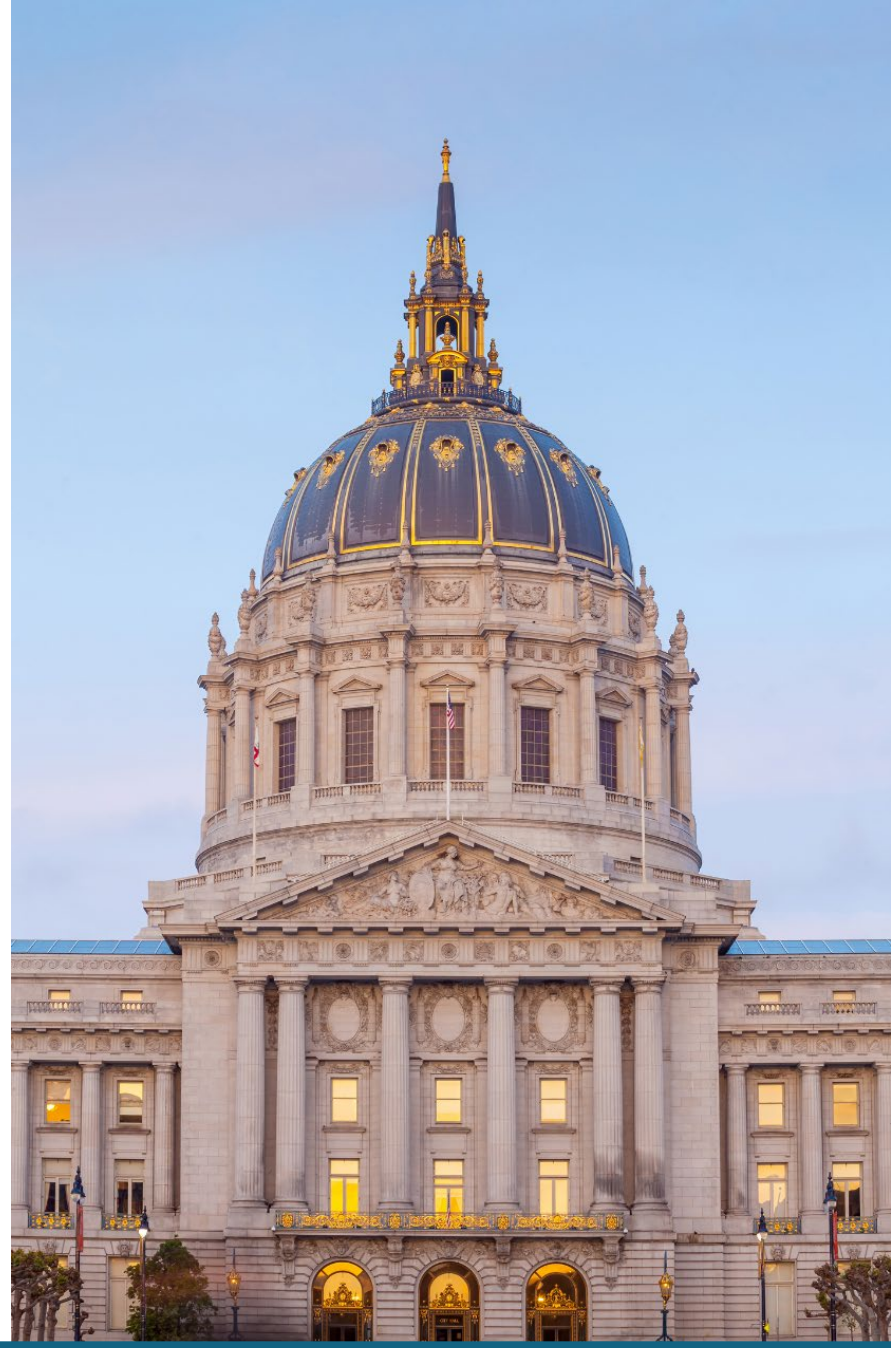
Recommendations

Solutions Requiring Partnerships and Advocacy

The challenge to place complex clients in care is not unique to San Francisco. Jurisdictions across California face similar placement and capacity challenges. Clients could benefit from collaboration between jurisdictions and hospital systems to expand placement options.

San Francisco and other counties cannot achieve a sustainable expansion of programs without increased support from the state and federal governments. There are key gaps in the system that may require legislation, new regulations, or new programming to address.

The recommendations in this section speak to the **joint and coordinated advocacy approaches** the City and its statewide partners should pursue over the coming year to push for state or federal policy solutions to key Workgroup findings related to funding, capacity, and placement challenges.



Recommendations

7. To address local funding constraints for these services, the State and federal governments should provide enhanced funding to supplement the cost of currently unreimbursed local programs.

A

The federal government should expand Institution for Mental Disease (IMD) Waiver programs for 60 days and beyond.

The City and statewide partners should advocate for federal government approval of the IMD Waiver to enable counties to bill Medicaid for up to 60 days of a patient's stay at a MHRC facility.

The City and statewide partners should advocate for an extension of this waiver beyond 60 days. On average, San Francisco clients remain in a MHRC facility for two years; even **a 60-day IMD Waiver would account for less than 10% of a typical stay**, and the typical county costs.

Recommendations

7. To address local funding constraints for these services, the State and federal governments should provide enhanced funding to supplement the cost of currently unreimbursed local programs.

B

The State should make key changes to the Assisted Living Waiver (ALW) to allow a higher level of participation, revise participation policies, increase reimbursement rates by region, and improve data transparency.

The City should advocate to the State to **increase the ALW program's capacity, fund additional placements,** and review and **revise restrictive program policies** that impede greater facility participation to enable more San Francisco clients to be placed in care.

The ALW acts like DPH's patch in that it covers basic care and supportive living services for Medi-Cal eligible people aged 21 and older. The State should **create regional reimbursement rates** rather than statewide tiers to make the ALW rates more competitive in San Francisco and incentivize operators to participate.

The State should **improve data transparency** about ALW participation to help jurisdictions understand and manage their client placements and leverage ALW more effectively to serve clients with varying levels of complexity.

Recommendations

8. To address local capacity gaps, the State should expand capacity across the State Hospital system and restructure how counties are allocated beds to account for county-specific levels of need.

With statewide partners, the City should advocate to the State to fund an **increase in the overall portfolio of available State Hospital beds to match statewide needs**.

The State has proposed allocation plans that prioritize counties based on population; this would likely result in fewer total beds allocated to San Francisco, further limiting access for San Francisco's most complex clients.

Rather than allocating based on population, the State should **establish an allocation process based on each county's level of need**. San Francisco can leverage enhanced internal tracking of client complexities per Recommendation #4 above to demonstrate local need to the State as part of its advocacy approach.

Recommendations

9. The State should play a larger role in supporting county partnerships to increase capacity across the state.

The State could **incentivize collaboration** through the planning and roll-out of Proposition 1 funding. Interviewed jurisdictions cited "money and politics" as barriers to formal collaboration across counties. State direction, and potential regulatory shifts, may be needed to assist jurisdictions to implement partnerships.

By July 2025, the City should agendize discussions with the California Association of Behavioral Health Directors to **determine whether cross-county partnerships on treatment program expansion is feasible and/or appropriate**. As part of this dialogue, San Francisco officials should explore how jurisdictions that have received State funding via BHCIP Rounds 3 and 5 and Proposition 1 Bond BHCIP plan to use these funds, and whether there may be opportunity for partnership within that use.

Through conversations, jurisdictions may learn what challenges may impede collaborative expansion, strategize options to resolve those issues, and highlight opportunities for mutual success.

Recommendations

10. To address placement challenges, the State should lead efforts to reform placement practices and create more transparency and oversight for the system.

A

The State should lead efforts to **improve access to MHRC facilities**. Current regulations allow MHRCs to set program guidelines that may restrict access for patients with certain histories, behaviors or care needs. The State can establish new regulations that limit discretion and can play a greater role in ensuring vulnerable individuals, such as people who have been conserved, are not denied care at a setting that might be best suited to their needs.

B

The State should establish a statewide **Office of Mental Health Conservatorships**.

C

The State should **enhance the Statewide bed inventory** to include information about cost, utilization, waitlist and other factors.

D

The California Health and Human Services' Behavioral Health Task Force should use at least one of their monthly meetings to **hold a hearing** with an agenda focused on complex patient placement.