

**San Francisco Department of Public Health**

**Behavioral Health Services**

**Latine/a/o/x & Indigenous Healing-Centered Systems Transformation Project**

**County Name:** San Francisco City & County

**Date Submitted:** January 30, 2026

**Project Title:** SF BHS Latine/a/o/x & Indigenous Healing-Centered Systems Transformation Project

**Total Amount Requested:** \$1,800,000 (\$600,000 annually)

**Duration of Project:** June 1, 2026 – May 31, 2029 (3 years)

<input checked="" type="checkbox"/> Local Mental Health Board approval	Approval Date: January 15, 2026
<input checked="" type="checkbox"/> Completed 30-day public comment period	Comment Period: Dec. 3, 2025–Jan. 2, 2026
<input type="checkbox"/> BOS approval date	Approval Date: _____
If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: <u>February 26, 2026</u>	
Desired Presentation Date for Commission: <u>May 2026</u> _____	

## Section 1: Innovations Regulations Requirement Categories

### GENERAL REQUIREMENT

- ☒ Introduces a new practice or approach to the overall mental health system
- ☒ Applies a promising community-driven practice that has been successful in non-mental health settings to the mental health system

This project introduces the National Compadres Network (NCN) La Cultura Cura curricula into civil service public behavioral health clinics operated by the San Francisco Department of Public Health (SFDPH,) Behavioral Health Services Division (BHS.) NCN is a nationally recognized, community-defined, Indigenous- and Latine-rooted healing framework.

While NCN curricula have demonstrated sustained impact in community-based organizations, education systems, juvenile justice settings, and prevention contexts, they have not been systematically integrated, operationalized, or evaluated within a county-operated public behavioral health system. This project represents a structural innovation, testing if and how

community-defined evidence can be responsibly integrated into clinical workflows, workforce development, and service delivery without being diluted from its cultural origins.

## **PRIMARY PURPOSE**

- ☒ Increase access to mental health services to underserved groups
- ☒ Increase the quality of mental health services, including measured outcomes

The project aims to address persistent disparities in engagement, retention, care experience, and outcomes for Latine/a/o/x and Indigenous clients who come into contact with our BHS system, particularly those who are justice-involved, unhoused (or at risk of becoming unhoused,) system-involved youth and families, or at risk of institutionalization.

## **Section 2: Project Overview**

### **ALIGNMENT WITH PROPOSITION 1**

The proposed INN Project aligns directly with BHSA and Proposition 1 priorities by advancing early intervention, equity-driven systems change, and community-defined innovation within public behavioral health infrastructure.

#### **Early Intervention and Prevention**

NCN curricula operate as healing-centered, relational, early-intervention strategies that address the root causes of many behavioral health issues: historical trauma, intergenerational

trauma, cultural disconnection, social isolation, and mistrust of institutions. These approaches build or strengthen protective factors such as cultural identity, a sense of belonging, purpose, and accountability, thereby preventing behavioral health conditions from escalating into severe and disabling forms.

### Support for FSP Populations

The project complements FSP models by:

- Improving engagement, retention and service delivery through culturally congruent relational practices
- Supporting holistic recovery via community-based healing structures
- Reducing premature disengagement from services among clients with serious mental illness

These elements align with BHSA goals to prioritize individuals with the most significant needs while strengthening continuity of care.

### Advancing Equity and Reducing Disparities

BHSA explicitly recognizes equity as a cross-cutting mandate. This project operationalizes equity by embedding community-defined evidence, linguistic and cultural congruence, and Indigenous knowledge systems into public behavioral health settings that have historically relied on Eurocentric clinical models, which research shows are chronically misaligned with the lived experiences of Latine/a/o/x and Indigenous communities.

## **PRIMARY PROBLEM**

Despite San Francisco's history of progressive behavioral health infrastructure, Latine/a/o/x and Indigenous residents remain disproportionately under-engaged in sustained behavioral health treatment, relative to demonstrated community need. SFDPH-BHS data and long-standing community feedback indicate that many clients from these populations:

- Do not initiate services despite referral or eligibility
- Do not follow through with treatment after intakes or initial contact with service providers
- Disengage early in treatment
- Enter care primarily through crisis, coercive, or mandated pathways rather than voluntarily

Contributing factors include:

- Limited cultural and linguistic congruence in care delivery and service providers
- Over-reliance on Western, individualistic therapeutic models
- None or minimal integration of Indigenous, relational, and collective healing practices
- Workforce burnout and moral distress among providers attempting to serve clients within structurally mismatched models
- The service providers who are culturally and linguistically aligned are also experiencing racism and discrimination

These challenges do not stem from a lack of need, but rather from systemic misalignment between public behavioral health delivery and community-defined pathways to healing.

This problem has been consistently identified across prior Innovations Projects—particularly those serving Black/African American, Native American, and newcomer Latine populations, which demonstrated that non-traditional, culturally grounded interventions significantly improve engagement and care experiences when embedded thoughtfully into public health systems.

#### Population to Be Served

While all clients are welcome, this project’s primary focus is Latine/a/o/x and Indigenous clients who come into contact with SFDPH Behavioral Health Services and who are overrepresented among BHSA priority populations, including individuals who are:

- Justice-involved or re-entering from incarceration

- Unhoused or at risk of becoming unhoused
- System-involved youth
- Transitional-age youth (TAY)
- Families at risk of institutionalization or conservatorship

Demographic Characteristics:

- Youth, TAY, adults, families, parents/caregivers, and older adults.
- Cisgender, transgender, and gender-expansive individuals
- Spanish-speaking, bilingual, English-speaking, and Indigenous-language speakers
- Individuals impacted by substance use, intergenerational trauma, migration stress and trauma, and systemic exclusion and discrimination
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## **PROPOSED PROJECT**

This three-year Innovation Project will implement NCN’s La Cultura Cura curricula across 3–5 pilot SFDPH-BHS clinics, selected based on:

- High Latine/a/o/x and Indigenous client utilization
- Documented engagement and retention challenges
- Readiness for innovation and workforce participation

NCN-trained facilitators, local cultural leaders, and BHS staff will collaboratively deliver:

- Healing circles and community ceremonies
- Rites of passage informed group interventions
- Family strengthening and parent leadership curricula
- Workforce training and technical assistance

The project will simultaneously test:

1. Client outcomes (engagement, retention, care experience)
2. Workforce outcomes (cultural responsiveness, burnout reduction, alignment)
3. System-level feasibility of integrating community-defined evidence into public behavioral health infrastructure

### Innovation Rationale

The innovation is not just in the curricula but also in the deliberate integration of community-defined, Indigenous-rooted healing practices within a civil service behavioral health system, a context in which such practices are typically excluded, marginalized, or relegated to external referrals.

This project represents a paradigm shift from:

- Refer-out model → embedded cultural practice
- Cultural competency training → cultural accountability and practice
- Individual symptom treatment → culturally aligned, relational and collective healing

By evaluating this integration within SFDPH-BHS, the project generates new learnings that can inform county-wide practice transformation and statewide dissemination, consistent with the core purpose of BHSA Innovation funding.

### Evaluation Approach

Consistent with BHSA Innovation intent, this project will utilize a learning-focused mixed-methods evaluation, integrating:

- Quantitative measures (engagement, retention, service utilization)
- Qualitative data (client, family, and workforce experiences)
- Continuous quality improvement (CQI) feedback loops

The evaluation will aim to determine how, why, and under what conditions community-defined healing practices can be successfully embedded within public behavioral health systems, rather than simply proving efficacy through experimental controls.

## RESEARCH ON INN COMPONENT

### Limitations of Eurocentric, Western Clinical Models for Latine/a/o/x and Indigenous Communities

A substantial body of peer-reviewed literature demonstrates that dominant Western mental health models, which are typically characterized by individualism, pathology-focused diagnosis, and verbal processing detached from cultural context, often fail to adequately serve Latine/a/o/x and Indigenous populations in the United States. These models frequently overlook the centrality of collective identity, intergenerational trauma, spirituality, family systems, and culturally grounded meaning-making, which are essential protective and healing mechanisms in these communities.

Recent studies indicate that Latine/a/o/x clients are:

- Less likely to engage in outpatient mental health treatment
- More likely to terminate services prematurely
- More likely to access care through crisis or coercive pathways rather than voluntary engagement.

These disparities persist even when services are linguistically accessible, suggesting that language access alone is insufficient without cultural and epistemological congruence. Scholars increasingly emphasize the importance of community-defined evidence and culturally grounded interventions that reflect Indigenous and diasporic worldviews, rather than adapting Western models at the margins.

Indigenous communities face parallel challenges, particularly related to historical trauma, forced assimilation, and the medicalization of distress that is fundamentally social, cultural, and political in nature. Research consistently shows that Indigenous healing practices, when

recognized as legitimate and integrated respectfully, support improved engagement, trust, and holistic well-being.

### Community-Defined Evidence and the National Compadres Network

NCN has been a national leader in advancing community-defined evidence practices for over three decades, particularly for Latine/a/o/x, Indigenous, and other historically marginalized communities. NCN's La Cultura Cura philosophy asserts that culture itself is a protective and healing force, and that sustainable behavioral health outcomes are achieved by restoring connection to identity, family, community, and responsibility.

NCN curricula have been implemented successfully in:

- Community-based organizations
- Youth development and prevention programs
- Juvenile justice diversion settings
- Schools
- Other community leadership initiatives

Outcomes reported across these settings include:

- Improved engagement and retention
- Reduced behavioral health crises
- Strengthened family relationships
- An increased sense of purpose, accountability, and belonging

However, despite widespread recognition of NCN's impact, these approaches have rarely been embedded in county-operated public behavioral health clinics or evaluated in that context. This represents a critical gap in the field and a central justification for this Innovation Project. Furthermore, the comprehensive NCN curricula have never been embedded in a public health system, despite that being the delivery format that yields the best results.

### Gaps in Existing Public Behavioral Health Practice

While San Francisco has demonstrated leadership in funding culturally responsive Innovation projects such as the FUERTE Project and the Black/African American Innovations Project, these initiatives consistently reveal a structural limitation. Culturally grounded healing practices are often funded as time-limited, external, or parallel interventions, rather than integrated into the core operations of public behavioral health systems.

Prior Innovations have shown that when community-defined practices are offered:

- Engagement improves,
- Care experience becomes more affirming
- Trust between communities and systems increases

Yet, once Innovation funding ends, these practices frequently remain outside of standard clinical workflows due to:

- Lack of reimbursement pathways
- Workforce training gaps
- Institutional risk aversion
- Insufficient implementation of learning within civil service systems

This project is intentionally designed to address these gaps by creating implementation and systems-level learning, not simply service-level outcomes.

### Why This Approach Qualifies as an Innovation under BHSA

Under BHSA Innovation regulations, projects may qualify as innovative if they apply a promising community-driven practice to a new setting or population, particularly when the practice has not yet been proven effective within the public mental health system. This project meets that criterion in the following ways:

1. New Setting: NCN curricula will be implemented within county-operated BHS clinics, a setting characterized by:

- Medi-Cal billing requirements

- Civil service workforce structures
- Regulatory and documentation constraints
- High-acuity client populations

This represents a meaningful adaptation, not replication.

2. Systems-Level Focus: The project does not simply deliver groups; it tests:

- Workforce readiness and transformation
- Clinic-level integration
- Administrative and billing feasibility
- Cultural accountability within public health systems

3. Learning Orientation: In line with BHSA Innovation’s intent, the project prioritizes learning over scale, generating actionable knowledge about:

- What supports or inhibits integration
- Which elements are adaptable versus non-negotiable
- How public health systems can partner ethically with cultural knowledge holders and elders

## **LEARNING GOALS/PROJECT AIMS**

The overarching goal of this Innovation Project is to determine whether, how, and under what conditions community-defined, Indigenous-rooted healing practices can be successfully embedded within county-operated public behavioral health clinics to improve engagement, retention, care experience, and system alignment for Latine/a/o/x and Indigenous clients.

### Learning Goals

1. Client Engagement and Retention: We want to learn whether the implementation of NCN curricula within BHS clinics improves:

- Initial engagement
- Ongoing participation
- Retention in care

2. Client and Family Care Experience: We want to learn how clients experience care at SFDPH-BHS when healing-centered, culturally congruent practices are embedded in clinical settings.

Key questions:

- Do clients report greater trust, safety, and relevance?
- Do clients feel more respected and involved/invested in their care?
- Does care feel less stigmatizing and more affirming?

3. Workforce Transformation, Sustainability and Retention: We want to learn how participation in NCN-informed practice impacts:

- Providers' cultural responsiveness
- Moral distress and burnout
- Alignment between provider values and system demands

This learning is essential for long-term sustainability, as workforce buy-in and well-being are vital for establishing these practices in a public health system.

4: System Feasibility and Implementation: We want to learn whether public behavioral health systems can:

- Integrate community-defined practices without cultural extraction
- Support documentation and billing (e.g., CPST) appropriately
- Maintain fidelity while allowing contextual adaptation

Findings from this project will contribute to:

- County-level policy and practice decisions
- Statewide BHSA Innovation learning
- Broader dissemination on integrating community-defined evidence into public behavioral health systems

This directly fulfills the purpose of the BHSA Innovation component, which is to strengthen and transform the mental health system through applied learning.

## **EVALUATION OR LEARNING PLAN**

### Evaluation Framework and Rationale

Consistent with the intent of the Behavioral Health Services Act (BHSA) Innovation component, this project will use a learning-focused mixed-methods evaluation designed to generate actionable implementation knowledge rather than to establish clinical efficacy through experimental control alone.

The BHSA Innovation framework emphasizes:

- Learning that contributes to systems transformation
- Evaluation designs that are appropriate to complex, real-world public systems
- Approaches that are culturally responsive and inclusive of lived experience

This evaluation approach is aligned with:

- Prior San Francisco and Napa County Innovations Projects (e.g., FUERTE; Black/African American Innovations; Native American Historical Trauma Project), which used mixed-methods learning designs to examine engagement, care experience, and system feasibility rather than randomized trials.
- Guidance from the MHSOAC that Innovation projects should prioritize how and why approaches work in public systems, particularly when introducing community-defined practices.

## Evaluation Questions

The evaluation will be structured around the following primary learning questions:

### 1. Client Engagement and Retention

- Does the integration of NCN curricula within BHS clinics improve engagement and retention among Latine/a/o/x and Indigenous clients?
- How do engagement patterns compare before and after implementation at pilot sites?

### 2. Care Experience and Cultural Congruence

- How do clients and families describe their experience of care when healing-centered, culturally grounded practices are embedded in clinical settings?
- What aspects of NCN-informed practice are perceived as most meaningful?

### 3. Workforce Experience and Readiness

- How does participation in NCN-informed practice affect provider cultural responsiveness, role clarity, and burnout?
- What supports are required for sustained workforce adoption?

### 4. System Feasibility and Sustainability

- What operational, administrative, and documentation practices support or hinder integration of community-defined evidence into public behavioral health clinics?
- Which elements appear most viable for continued funding beyond Innovation funding?

## Data Sources and Participants

### 1. Client-Level Data

Quantitative sources:

- Clinic-level engagement and retention indicators derived from existing BHS administrative data systems (e.g., attendance, duration of participation, continuity of care)

- These indicators have been used consistently across prior SFDPH and Napa County Innovations Projects to assess access and engagement trends

Qualitative sources:

- Semi-structured interviews and focus groups with participating clients and family members
- Facilitated in the client's preferred language (Spanish, English, or Indigenous languages, if available,) in line with culturally responsive evaluation practices

## 2. Workforce-Level Data

Quantitative sources:

Pre- and post-participation surveys assessing:

- Cultural responsiveness
- Confidence working with Latine/a/o/x and Indigenous clients
- Perceived alignment between clinical practice and community values

Validated survey domains will be drawn from instruments commonly used in public behavioral health workforce assessments, including measures referenced in prior Innovations Projects.

Qualitative sources:

- Focus groups with clinicians, peers, and facilitators at pilot sites
- Reflective feedback sessions incorporated into CQI cycles

## 3. System- and Implementation-Level Data

- Documentation of implementation processes (training hours, supervision models, clinic adaptations)
- Meeting notes and reflections from clinic leadership and NCN facilitators

- Review of CPST documentation practices informed by the BHSA INN Project description, which clarifies allowable service categories and innovation-related learning

### Data Collection Methods

Data Type	Method	Frequency
Engagement & retention	Administrative data extraction	Quarterly
Client experience	Interviews / focus groups	Annually
Workforce surveys	Pre/post surveys	Annual
Workforce experience	Focus groups	Annual
Implementation learning	CQI meetings, field notes	Ongoing

This multi-layered approach reflects best practices in implementation science, particularly for culturally grounded interventions introduced into complex service systems (Aarons et al., 2011; Proctor et al., 2011.)

### Cultural Responsiveness in Evaluation

Cultural humility in evaluation will be ensured through:

1. Community-informed design

Evaluation tools and protocols will be reviewed with NCN cultural leaders and local stakeholders to ensure alignment with Indigenous and Latine/a/o/x worldviews, consistent with approaches used in the Native American Historical Trauma and Traditional Healing Innovation Project

2. Language access

All client-facing evaluation activities will be conducted in Spanish, English or an Indigenous language using culturally congruent facilitation practices informed by the Latinx Glossary to avoid deficit-based or stigmatizing language.

3. Relational evaluation practices

Data collection will emphasize trust-building, storytelling, and relational accountability rather than extractive or purely transactional methods, consistent with NCN philosophy

### Continuous Quality Improvement (CQI)

Evaluation findings will be integrated into Plan-Do-Study-Act (PDSA) cycles at each pilot site. This approach has been used effectively in prior SF Innovations Projects to:

- Adjust implementation in real time
- Respond to workforce and client feedback
- Strengthen fidelity while allowing contextual adaptation

CQI activities will include:

- Quarterly learning meetings
- Feedback loops with clinic leadership
- Iterative refinement of facilitation and documentation practices

### Limitations and Learning Orientation

Consistent with BHSI Innovation intent, this project acknowledges that:

- Outcomes may be influenced by external system factors such as staffing issues, housing instability, justice involvement, immigration enforcement, etc.
- Findings are context-specific to San Francisco's public behavioral health system

Rather than controlling for these variables experimentally, the evaluation will document how they interact with implementation, generating practice-relevant learning for future scaling and adaptation.

## Section 3: Additional Information for Regulatory Requirements

### **COMMUNITY PROGRAM PLANNING (CPP)**

#### Community Program Planning Process

The CPP process for this INN Project builds on existing SFDPH-BHS stakeholder engagement structures and mirrors the participatory planning approaches used in prior approved Innovations Projects.

Planning activities include:

- Engagement with Latine/a/o/x and Indigenous community stakeholders
- Consultation with NCN cultural leaders
- Input from BHS clinic leadership, frontline staff, and peer workforce
- Coordination with the Office of Justice, Equity, Diversity, and Inclusion (JEDI)

This process aligns with CPP requirements outlined in the BHSA INN Project Description, including training stakeholders on Innovation purpose, learning goals, and non-supplantation requirements.

#### Stakeholder Representation

Stakeholders involved reflect:

- Individuals with lived experience of behavioral health services
- Community cultural leaders and healers
- BHS clinical and non-clinical staff
- Spanish-speaking/Indigenous language-speaking and bilingual/multilingual participants

This mirrors CPP approaches used in:

- The FUERTE Project, which emphasized community co-design for Latine populations
- The Black/African American Innovations Project, which demonstrated that culturally grounded planning improves relevance and uptake
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## **BHSA GENERAL STANDARDS**

### A. Community Collaboration

This Innovation Project was developed through meaningful collaboration with community stakeholders, consistent with BHSA requirements for participatory planning.

The project builds on:

- SFDPH-led community engagement processes documented in prior Innovations Projects serving Black/African American, Native American and Latine/a/o/x populations, which emphasized co-design with community leaders and individuals with lived experience
- Ongoing consultation with the National Compadres Network, whose curricula are explicitly designed to be implemented in partnership with local communities rather than imposed as standardized clinical interventions

Community collaboration occurs at multiple levels:

- Design: Selection and adaptation of NCN curricula informed by local Latine/a/o/x and Indigenous stakeholders
- Implementation: Engagement of cultural practitioners, peers, and clinic staff
- Evaluation: Inclusion of participant and community feedback in CQI cycles

This approach is consistent with the BHSA Innovation Partnership Fund framework, which explicitly calls for community-defined practices and lived experience leadership as cross-cutting requirements.

## B. Cultural Competency

Cultural competence in this project is operationalized as cultural accountability and congruence, not cultural awareness alone.

The project aligns with findings from:

- **Alegría et al. (2010, 2017)**, who document that culturally incongruent mental health services contribute to lower engagement and higher dropout rates among Latine populations, even when language access is present.
- **Gone & Kirmayer (2020)**, who emphasize that Indigenous mental health outcomes improve when interventions align with Indigenous epistemologies rather than adapting Western models superficially.

NCN's La Cultura Cura framework explicitly centers Indigenous and Mesoamerican values such as relationality, reciprocity, responsibility, and collective healing, which have been identified in the literature as protective factors for Latine and Indigenous mental health (Kirmayer et al., 2014)

All project activities will be delivered:

- In Spanish and/or English and/or Indigenous languages, as appropriate and available
- Using culturally grounded facilitation practices
- With ongoing consultation to prevent cultural extraction or misapplication

## C-D. Client-Driven and Family-Driven Care

This project reflects client- and family-driven principles by:

- Prioritizing voluntary engagement rather than crisis-driven entry points
- Incorporating family and community roles central to Latine/a/o/x and Indigenous worldviews
- Valuing narrative, ceremony, and collective meaning-making as legitimate healing processes

These principles align with:

- Findings from **Organista et al. (2018)**, which emphasize familismo and collective identity as central to effective mental health engagement for Latine/a/o/x communities.
- SFDPH Innovations learning indicates that family-inclusive and community-based approaches improve perceived relevance and trust in services and service providers

#### E. Wellness, Recovery, and Resilience-Focused

The project is grounded in a healing-centered rather than pathology-centered model.

This orientation is supported by:

- SAMHSA’s recovery framework defines recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
- **Brave Heart et al. (2011)** and **Yellow Horse Brave Heart (2003)**, who document that healing-centered, culturally grounded approaches are critical for addressing historical and intergenerational trauma in Indigenous communities.

NCN curricula operationalize wellness and resilience through rites of passage, accountability practices, and restoration of cultural identity, rather than symptom reduction alone.

#### F. Integrated Service Experience for Clients and Families

This project advances integrated service experience by:

- Embedding community-defined practices within existing BHS clinic structures
- Supporting coordination between clinical staff, peers, and cultural facilitators
- Reducing fragmentation between “clinical” and “cultural” services.

Previous SF Innovations Projects show that integration, rather than referral-out models, improves continuity of care and decreases disengagement for historically underserved populations.

## Section 4: INN Project Budget and Source of Expenditures

### OVERALL BUDGET SUMMARY

Total INN Request:

\$1,800,000 over three years (\$600,000 annually)

The proposed budget supports a time-limited Innovation project designed to test the feasibility, impact, and sustainability of integrating National Compadres Network (NCN) community-defined curricula within 3–5 SFDPH Behavioral Health Services (BHS) clinics.

Budget development is informed by:

- Cost structures documented in the NCN Summary LCC Overview & Services
- Prior approved San Francisco Innovations Projects with comparable scope and staffing models
- Allowable uses of Innovation funds outlined in the BHSA INN Project Description

### BUDGET CATEGORIES AND JUSTIFICATION (ANNUAL)

#### 1. Personnel and Staffing (\$220,000/year)

Positions include:

- Project Manager: Oversight of implementation, clinic coordination, compliance, and reporting
- Evaluation & CQI Support: Data coordination, learning documentation, and reporting

Justification:

Prior SF Innovations Projects demonstrate that dedicated project management is essential for:

- Maintaining fidelity to Innovation goals

- Supporting clinic-level implementation
- Coordinating evaluation and CQI activities

## 2. NCN Curriculum, Training, and Technical Assistance (\$180,000/year)

Includes:

- Licensing and delivery of La Cultura Cura and related NCN curricula,
- Training-of-trainers and facilitator development
- Ongoing technical assistance to pilot clinics
- Cultural consultation to support fidelity and ethical implementation

Justification:

The NCN Summary LCC Overview documents that curriculum delivery is inseparable from cultural guidance and technical assistance, particularly when implemented in institutional settings. Funding supports authentic transfer of community-defined evidence, not stand-alone curriculum materials

Comparable investments in culturally grounded training and TA are documented in prior SF Innovations (e.g., FUERTE), which emphasize that workforce development is a core Innovation cost rather than an ancillary expense.

## 3. Peer and Community Facilitator Support (\$90,000/year)

Includes:

- Stipends or contracts for community cultural practitioners
- Peer facilitators with lived experience
- Compensation for participation in training, facilitation, and evaluation activities

Justification:

Both BHSA and MHSOAC guidance emphasize the importance of lived experience and community leadership in Innovation projects. Prior SF Innovations explicitly funded peer and cultural leadership roles to ensure authenticity and engagement.

#### 4. Evaluation and Learning Activities (\$60,000/year)

Includes:

- Qualitative data collection (interviews, focus groups, etc.)
- Survey administration and analysis
- Learning documentation and reporting
- Capacity building

Justification:

Innovation funds are explicitly intended to support learning and evaluation, not service expansion alone. The mixed-methods approach mirrors evaluation designs approved in prior Innovations Projects and aligns with BHSA guidance.

#### 5. Operating Expenses and Materials (\$50,000/year)

Includes:

- Group materials consistent with NCN curricula
- Professional translation and interpretation
- Space-related costs
- Culturally appropriate materials that support engagement and implementation
- Training materials

Justification:

Culturally grounded group interventions require appropriate materials and language access to maintain fidelity, as documented in NCN implementation guidance.

#### CPST Justification

Consistent with the BHSA INN Project Description, certain activities within this Innovation may align with Community Psychiatric Support and Treatment (CPST) when they:

- Support engagement, skill-building, and stabilization

- Are delivered to Medi-Cal eligible clients
- Are documented appropriately

CPST-aligned activities include:

- Facilitated healing circles that support emotional regulation and social functioning
- Family and community-based skill development tied to recovery goals
- Peer-supported engagement activities documented in the clinical record

Importantly, this project does not rely on CPST reimbursement for sustainability during the Innovation period. CPST alignment is explored as part of learning and feasibility, consistent with Innovation intent, rather than as a guaranteed funding source.

#### Non-Supplantation

Innovation funds will not supplant existing services or funding streams. NCN curricula and related activities are not currently offered within SFDPH-operated BHS clinics. All funded activities represent new or adapted approaches, consistent with CCR Title 9 Innovation requirements and prior SF Innovation approvals.

#### **Sustainability Strategy**

Decisions regarding continuation beyond the Innovation period will be informed by:

- Evaluation findings
- Workforce readiness
- Feasibility of integration within existing funding structures

Potential sustainability pathways include:

- Partial integration of NCN-informed practices into clinic workflows
- Ongoing workforce development supported through non-INN funding
- Alignment with Medi-Cal allowable services where appropriate

This approach mirrors sustainability strategies used in prior SF Innovations, which emphasized institutional learning before scale.

### Dissemination of Findings

Findings will be disseminated to:

- SFDPH – BHS leadership and stakeholders
- Community partners and participants
- State entities, including MHSOAC, as part of Innovation reporting

Dissemination methods include:

- Written reports
- Presentations to advisory bodies
- Practitioner-oriented summaries highlighting implementation lessons

This approach is consistent with dissemination plans approved in prior Innovations Projects.

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