

**COUNTY OF LOS ANGELES  
DEPARTMENT OF MENTAL HEALTH**

**Mental Health Services Act (MHSA)  
Prevention And Early Intervention (PEI)**

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**Community Defined Evidence:  
L.A. County PEI Plan**

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# FIRST ROUND – INITIAL SOLICITATION 2008-2009

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- December 2008 solicitation letter for CDE
- Consultants provide administrative support, review and feedback
- 291 applications initially received
- 18 CDE met criteria as a qualified CDE PEI practice
- 13 selected by stakeholders for inclusion in PEI Plan

# SECOND ROUND – TECHNICAL ASSISTANCE 2009-2010

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- Conducted 6 two-part CDE workshops
- Invitees - agencies/developers that had their applications denied
- Specific technical assistance about developing and strengthening CDEs
- After workshop applicants could re-submit application
- 3 additional CDEs accepted

# THIRD ROUND –ONGOING APPLICATIONS 2010-PRESENT

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- Internal DMH EBP selection committee
- External subject matter expert review panel
- Cannot conduct research on DMH clients in order to qualify practices as CDE
- No funding to develop CDEs
- No billing to PEI allowed while CDE being developed
- Can re-submit at any time, based on additional data, research, etc.
- Technical assistance and /resources suggested
- CDE workshops held

# Current CDE Practices

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## TITLE

## TYPE

- |   |                       |
|---|-----------------------|
| 1. Asian American Family Enrichment Network Program (AAFEN)             | 1. Prevention         |
| 2. Caring for Our Family (CFOF)   | 2. Early Intervention |
| 3. Center for the Assessment and Prevention of Prodromal States (CAPPS) | 3. Early Intervention |
| 4. Loving Intervention For Family Enrichment (LIFE) Program             | 4. Early Intervention |
| 5. Mindful Parenting Groups (MPG)                                       | 5. Early Intervention |
| 6. Psychological First Aid for Students and Teachers (PFA)              | 6. Prevention         |
| 7. Reflective Parenting Program (RPP)                                   | 7. Early Intervention |
| 8. School, Community and Law Enforcement (SCALE) Program                | 8. Prevention         |
| 9. UCLA TIES Transition Model   | 9. Early Intervention |
| 10. Why Try?  | 10. Prevention        |

# CDE Application for L.A. County DMH

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- This is not a solicitation or request for proposal for a CDE.
- Review of an application does not guarantee inclusion on the PEI list of models.
- Approval of an application to be included in the PEI resource guide does not guarantee funding for the CDE practice.
- Practices or interventions which have applicability to various cultural groups, as opposed to a single cultural group, should be considered for an application of an Evidence Based Practice (EBP) or a Promising Practice (PP).

# Required Application Information

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- Target Population
- Cultural Relevance
- Risk and Protective Factors
- Level of Evidence
- Outcomes
- Description
- Staffing Requirements

- Service Delivery Setting
- Implementation Costs
- Service Delivery Costs
- Standard Training Protocols
- Proprietary Rights
- Replicability
- Sustainability

# Required Attachments

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- ❑ **CDE application form (original, signed) and .Pdf format**
- ❑ **Copies of quantitative evidence (.Pdf format), if available**
- ❑ **Copies of qualitative evidence (.Pdf format), if available**
- ❑ **Copies of assessment forms (.Pdf format), if applicable**
- ❑ **Copies of training materials (.Pdf format), if applicable**
- ❑ **Copies of outcome measures or clinical assessment forms (.Pdf format), if applicable**

# Checklist

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- Is the practice applicable only to a single racial/ethnic/cultural group?
- Was the practice developed in and used primarily in Los Angeles County?
- Can the practice be replicated by others?
- Does the practice have training materials for staff to provide the services?
- Does the practice have written evidence of effectiveness, data collection, outcomes, systematic and consistent client testimonials, etc.?
- Are you or your organization able to provide these services without additional funds from DMH?

# Review Process

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1. Review for Completeness
2. Scoring; discussion with developer
3. Review by EBP Selection Committee
4. Added to PEI Resource Guide

# CDE GUIDELINES

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**ON THE FOLLOWING PAGES ARE THE LOS  
ANGELES COUNTY DEPARTMENT OF MENTAL  
HEALTH MHSA PEI CDE GUIDELINES**



**Application Guidelines and Instructions  
for  
Prevention and Early Intervention  
COMMUNITY-DEFINED EVIDENCE  
(CDE) PRACTICES**

**2016**

County of Los Angeles Department of Mental Health  
Mental Health Services Act  
Prevention and Early Intervention

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## I. CDE GUIDELINES

As part of its Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) program planning, the Los Angeles County Department of Mental Health (DMH) developed resource guides of PEI interventions from which individual practices could be selected for inclusion in DMH's PEI Plan. Practices that targeted PEI priority populations and outcomes were included in the *Prevention and Early Intervention (PEI) Evidence-based Practices, Promising Practices, and Community-defined Evidence (CDE) Models Resource Guide 2.0 (April 25, 2011)*.

The practices on the list were organized by their appropriateness and effectiveness in serving PEI priority populations and promoting achievement of PEI outcomes across each of the four age groupings (child, transition-age youth, adult, older adult). The list of identified services consisted of evidence-based practices (EBP), promising practices (PP), and community-defined evidence (CDE) practices were also included in the list.

DMH has a very strong interest in identifying practices or interventions which are uniquely responsive to the needs of the various cultural groups in Los Angeles County.

Definition of CDE. A CDE has been defined as “A set of practices that communities have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community (CDEP Working Group, 2007).”

The California State Department of Mental Health (SDMH) describes CDEs as follows:

*“Community-defined evidence validates practices that have a community-defined evidence base for effectiveness in achieving mental health outcomes for underserved communities. It also defines a process underway to nationally develop specific criteria by which practices’ effectiveness may be documented using community-defined evidence that eventually will allow the procedure to have an equal standing with evidence-based practices currently defined in the peer reviewed literature.*

*(PEI Resource Materials. SDMH, 2007. Retrieved October 7, 2009 from [http://www.dmh.ca.gov/DMHDocs/docs/notices07/07\\_19\\_Enclosure6.pdf](http://www.dmh.ca.gov/DMHDocs/docs/notices07/07_19_Enclosure6.pdf).)”*

PEI Priority Populations. The State guidelines for PEI focus on evidence-based services, education, support, and outreach to help inform and identify those who may be affected by some level of mental health issue. Providing mental health education, outreach and early identification (prior to diagnosis) can mitigate costly negative long-term outcomes for mental health consumers and their families. Practices in the PEI Resource Guide must address one or more of the six priority populations that are the focus of prevention and early intervention strategies.

1. Underserved Cultural Populations – PEI projects address those who are unlikely to seek help from any traditional mental health service whether because of stigma, lack of knowledge, or other barriers, such as members of ethnically/racially diverse communities, members of gay, lesbian, bisexual, transgender communities, etc.) and would benefit from Prevention and Early Intervention programs and interventions.
2. Individuals Experiencing Onset of Serious Psychiatric Illness – Those identified by providers, including but not limited to primary health, as presenting signs of mental illness first break, including those who are unlikely to seek help from any traditional mental health service.

3. Children/Youth in stressed Families – Children and youth placed out-of-home or those in families where is substance abuse or violence, depression or other mental illnesses or lack of care giving adults (e.g., as a result of a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems.
4. Trauma-Exposed – Those who are exposed to traumatic events over prolonged traumatic conditions including grief, loss, and isolation, including those who are unlike to seek help from any traditional mental health service.
5. Children/Youth at Risk for School Failure – Due to unaddressed emotional and behavioral problems.
6. Children/Youth at Risk of or Experiencing Juvenile Justice Involvement – Those with signs of behavioral/emotional problems who are at risk of or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through the MHSA Community Services and Supports.

Approval to Be Included in PEI Resource Guide. All completed and qualified applications will be reviewed. However, applicants should be aware that:

1. **THIS IS NOT A SOLICITATION OR REQUEST FOR PROPOSAL FOR A CDE.** The CDE practice must already have been implemented and with strong supporting evidence of its effectiveness prior to submitting an application. Applications describing programs that have not yet been implemented or proposals for new programs will not be reviewed.
2. Review of an application does not guarantee inclusion on the PEI list of models. All models on the list will be rated in terms of their appropriateness and effectiveness in serving PEI priority populations and achieving PEI outcomes. Reviewers respond to the question: *Does the program described in the application meet the criteria to be included in the PEI Resource Guide for CDE practices?*
3. Approval of an application to be included in the PEI Resource Guide does not guarantee funding for the CDE practice. Inclusion of a CDE in the Resource Guide does not guarantee that a practice will be selected and funded for implementation. Inclusion in the PEI Resource Guide only means that the practice could be suitable for a PEI project if the practice is selected as the best match for the project's target population and the intended outcomes for that population. No funding will be released to CDE developers
4. Practices or Interventions which have applicability to various cultural groups, as opposed to a single cultural group, should be considered for an application of an Evidence Based Practice (EBP) or a Promising Practice (PP).

Requirements for Inclusion. In order for DMH or one of its contractors to implement a CDE practice, the practice must be sufficiently well developed and described, teachable to other agencies, and delivered in a consistent manner. Only those models that are sufficiently well-articulated to be delivered in a consistent manner and to be replicated by others, that target PEI priority populations, and have some level of demonstrated effectiveness in achieving PEI outcomes will be included on the list of models. For inclusion on the list of PEI services, prospective models must:

1. Be Well Articulated. The application must include a specific description of the core components, including phases, therapeutic strategies, curricula or sequences, if applicable. If a developer cannot clearly say what the core components of the practice are, what the results of the practice are, how those results have been demonstrated, (and how those results relate to MHSA PEI), then the practice is not yet ready for inclusion in the Resource Guide.
2. Be able to be replicated by others. It is essential that the practice be well articulated so that the developer can teach others to do the practice and get the same results as the developer. The CDE developer must be committed to teaching others how to implement and sustain the practice as well have the capacity to provide implementation services (i.e., sufficient staff who can train others and support resources). The developer should have a defined mechanism by which it intends to train others.
3. Have demonstrated effectiveness. As indicated by SDMH's description above, a CDE must have some level of demonstrated effectiveness. Evidence of effectiveness may include a range of levels of evidentiary strengths from client testimonials (collected on a systematic and consistent basis) to a random assignment evaluation. Outcomes should relate to the target population and to the practice goals.
4. Have a local emphasis. CDE models are distinguished from national evidence-based or promising practices by (1) having been developed and used primarily in Los Angeles County, and (2) having not been described in academic or commercial publications. National models, on the other hand, have been described in academic and/or commercial publications that are readily accessible to service organizations at large. These national models may have been developed and used in settings in or outside of Los Angeles County.

## II. SCORING CRITERIA AND RATING SCALE

Scoring Criteria. Reviewers will evaluate the application to determine whether program met the PEI guidelines and requirements for inclusion in the Resource Guide. Specifically, reviewers will determine whether the EBP application sufficiently demonstrates the following:

1. Knowledge of the target population
2. Clear articulation of goals
3. Clear articulation of the practice
4. Practice strategies are logically related to the goals
5. Availability of training and support resources
6. Practice strategies are clearly related to the traditions, customs, experiences and belief systems of the target population (for those practices which have a stated cultural focus)
7. There is clear evidence that the practice can be replicated
8. There is clear evidence that the practice is effective

Below is the rating scale used to define the level of evidence for a program. In order for a program to be included in the PEI Resource Guide, a program must be rated as a well-supported, supported, promising, or emerging practice.

Rating	Criteria
Well-Supported	<ol style="list-style-type: none"> <li>1. There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.</li> <li>2. More than one rigorous randomized controlled trial has been conducted, using valid outcome measures, and has obtained consistent outcomes (positive effects with statistically significant results) in more than one setting and/or with more than one population.</li> <li>3. The practice can be replicated.</li> <li>4. Fidelity measures exist or can be developed from available information.</li> </ol>
Supported	<ol style="list-style-type: none"> <li>1. There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.</li> <li>2. At least one rigorous randomized controlled trial has been conducted, using valid outcome measures, and has identified positive effects with statistically significant results.</li> <li>3. The practice can be replicated.</li> <li>4. Fidelity measures exist or can be developed from available information.</li> </ol>
Promising	<ol style="list-style-type: none"> <li>1. There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.</li> <li>2. A less rigorous research and evaluation design or quasi-experimental design, using valid outcome measures and some form of control, has been conducted with evidence of positive effects.</li> </ol>
Emerging	<ol style="list-style-type: none"> <li>1. There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.</li> <li>2. The practice has sound theoretical rationale and has shown to be related to positive change through a minimum of a pre/post evaluation using valid outcome measures.</li> </ol>

### III. APPLICATION INSTRUCTIONS

Please complete the entire application; all fields are required and incomplete forms will be returned. The form has been prepared for electronic submission, and text fields will expand as needed. Please attach additional pages when needed.

DMH will not review any incomplete applications. Failure to submit completed applications with all questions answered and required documents attached will result in incomplete applications being returned. The application will then need to be re-submitted.

Application Package: The CDE application package consists of two documents:

1. CDE Guidelines and Application Instructions
2. Application for CDE Approval (fillable form)

Email Submissions: Please attach your completed application to an email message with "PEI CDE APPLICATION" in the subject line and send to [MHSAPEI@dmh.lacounty.gov](mailto:MHSAPEI@dmh.lacounty.gov)

Deadline for Submissions: Open-ended or until DMH establishes a deadline.

Questions: For questions regarding the application form, please contact PEI Administration at [MHSAPEI@dmh.lacounty.gov](mailto:MHSAPEI@dmh.lacounty.gov)

## IV. REQUIRED APPLICATION INFORMATION

The following sections provide an explanation of the questions that must be answered in the CDE Application form.

- Target Population

Target population refers to a well-defined group of individuals for whom the practice is intended. All CDE practices included in the Resource Guide must have a clearly defined target population that fits in at least one of the MHSa PEI priority populations. The target group for the practice also needs to be defined in terms of one or more of the following:

- A. Does this practice focus on a particular age group? If yes, which age group?
- B. Does this practice focus only on males or females? If so, which gender?
- C. Does this practice focus on people with a specific need or risk? If so, which need or risk?
- D. Does this practice focus on people in a particular area or setting? If so, which area or setting does this practice focus on?

- Cultural Relevance

This section explains how the practice meets the cultural needs of the population served. Each CDE developer should describe any indicators that the practice is culturally relevant to the population targeted by the practice, including but not limited to:

- A. Does this practice focus on a particular cultural group or sub-group? If yes, which group or sub-group is it?
- B. Is this practice intended to be provided in a language other than English? If so, which language(s)?
- C. How the practice provides outreach to the population it serves? Describe specific engagement strategies that are part of this practice.
- D. How are the traditions, customs and belief systems of the population this practice serves incorporated into the practice?
- E. How does this practice include elements that are easily recognizable by the specific population served as important for mental health and well-being?
- F. Does the community targeted by this practice trust the practice? How do you know?
- G. How was the practice developed? Where does it come from? What is the history of this practice in the population served?

- Risk and Protective Factors

The concept of risk and protective factors are at the core of the prevention. **Risk factors** are defined as individual or environmental factors that are related to the increased likelihood that a negative outcome will occur.

**Protective factors** are defined as individual or environmental safeguards that enhance a person's ability to resist stressful life events, risks or hazards and promote adaptation and competence. An important but often overlooked aspect of protective process is that they only operate when a risk factor is present.

- A. List any risk factors that are reduced.
- B. List any protective factors that are enhanced.

- Level of Evidence

Developers should be able to describe how they know the practice works. Quantitative and qualitative types of evidence you provide may be based upon, but not limited to, any of the following: (a) experimental evaluation, (b) quasi-experimental evaluation, (c) informal evaluation that includes comparison of pre- and post-measures, (d) case studies, (e) informal evaluation that includes post measures only, (f) anecdotal reports, or (g) testimonials. When testimonials are included they must be in writing from current or past recipients of services.

- A Describe how you know that this practice successfully does what it is intended to do.
- B Discuss evidence of effectiveness by summarizing any and all ways you know that the practice achieves the intended results.
- C Identify and describe the methods or special measures to ensure adherence to the practice.
- D Are there relevant research publications that support the effectiveness of this model? If yes, attach copies of the research publications.
- E Do you have relevant quantitative data that support the effectiveness of this model? If yes, attach copies of the quantitative data.
- F Do you have relevant qualitative data that support the effectiveness of this model? If yes, attach copies of the qualitative data.

- Outcomes

Outcomes are the goals or the intended results that can be achieved by the practice. These need to correspond to MHSA prevention and early intervention outcomes and may include:

- A. If this is a prevention practice, please answer any that apply:
  - 1) Identify any specific problems that are prevented by this practice.
  - 2) List any other prevention goals achieved by this practice (for example, increasing mental health awareness, outreach and engagement, etc.)
- B. If this practice is an early intervention, please answer any that apply:
  - 1) Indicate any problem that this practice addresses in its earliest stages.
  - 2) List what improvements in mood or emotional state, thought or cognitive process, behavior, and/or skills result from the early intervention.

- Description

The description should clearly describe the core components define the practice so that the same practice in the same format can be provided by others.

- A. What are the essential components of the practice? Describe the activities, steps, stages, procedures, etc. that must happen for it to work.
- B. What is the reason for these essential components? Explain how the practice works and why.
- C. What is the duration of the program, including:
  - 1) Frequency of sessions:
  - 2) Session length:
  - 3) Treatment length:
- D. What is the modality of treatment (e.g., individual, group, conjoint, parent-child, etc.)?
- E. Who is required to attend the sessions (e.g., child, parent, entire family)?

- F. Is assessment a core component of the practice? If yes, list the names of the standardized assessment forms or attach copies of any assessment forms that were specifically developed for this practice.
- G. Are there any outcome measures or clinical measurement tools that must be administered during treatment? If yes, list the names of standardized measures or attach copies of any tools that were specifically developed for this practice.

- Staffing Requirements

Practice developers should be able to describe the staff needed to provide the practice:

- A. What is the minimum number of people/practitioners needed to provide this practice?
- B. Does the practitioner need to be bicultural and/or bilingual? If so, in which languages and cultures?
- C. What are the key roles or responsibilities of each person/practitioner needed to provide this practice?
- D. What are the minimum requirements for each practitioner to be able to provide this practice in terms of educational attainment and degrees, licenses, training, work or personal experience?
- E. How many years of experience must staff have in order to provide this practice?
- F. What are the optimal characteristics staff must have to provide this practice (e.g., good interpersonal skills, desire to help, knowledge of the program, clinical knowledge of children and families, etc.)?
- G. Describe the components of supervision.
- H. How many people can a practitioner work with at a time (caseload)?

- Service Delivery Setting

Practice setting refers to where the practice is provided. Settings may include, but are not limited to, homes, schools, community settings, mental health clinics, health care centers, resource centers, and faith-based or civic organizations. Some practices may be appropriate for more than one type of setting.

- Implementation Costs

Implementation costs refer to the expenses incurred by an agency seeking to adopt the CDE and offer it to consumers.

- A. What are costs for a trainer(s) for the mandatory minimum training?
- B. Are there separate costs for supervisor training?
- C. What are the costs for required training materials?
- D. What are the costs for required or recommended consultation or technical assistance?
- E. Are there certification costs for staff to provide the practice?
- F. Are there program components that may require the purchase of additional equipment, such as tape recorders, video recorders, laptop computers?
- G. What are the costs for outcome measures required by the Developer?

- Service Delivery Costs

Service delivery costs refer to how an adopting organization will fund the service? Consideration includes staff time including travel and set up if necessary.

- A. What are the ongoing service delivery costs for this practice?
- B. Are there ways in which the costs may be reduced?

- Standard Training Protocols

In order to evaluate this category, the developer should include some or all of the following: manuals, training curricula, apprenticeship information, mechanisms for ongoing consultation, coaching or support for implementation.

- A. Describe the training protocols for this practice (include any prerequisites, length of training, persons that must be trained, and additional training requirements).
- B. How does a new practitioner learn how to do this practice?
- C. Is there a manual, a curriculum that must be followed, or a specific set of skills that must be learned? If yes, describe or list the training materials or specific set of skills to be learned
- D. Are booster trainings or other trainings required on an ongoing basis? If yes, describe the booster trainings required.
- E. Does training involve apprenticeship or an internship? If yes, describe the apprenticeship or internship training.
- F. Is training of supervisors required? If yes, describe the protocols for the supervisor training.
- G. Is certification or accreditation required? If yes, describe the certification or accreditation requirements.
- H. Attach any available manuals, curriculum, lists and description of skills, or other documents describing the core components of the practice to a new practitioner.

- Proprietary Rights

Proprietary means that the program or practice cannot be used without consent of the developer. Neither the training nor the materials are in the public domain so an agreement must exist between the developer and the adopting agency.

- A. Are the rights to implementing this program owned solely by the developer?
- B. Are the rights to provide training in this practice owned solely by the developer?
- C. If no, how is it determined that someone is authorized to provide training in the practice?

- Replicability

The CDE model should be clearly described and developed so that other providers can replicate and implement the program on their own.

- A. Describe the mechanism and strategy for other agencies to implement the CDE.
- B. What type of support does the developer provide for ensuring that the practice will be successfully replicated and implemented?

- Sustainability In order for programs to have a positive impact on consumers and families members, they must survive beyond the initial training of practitioners. Agencies must plan for ongoing training and support. Practices that offer frequent training, have a train-the-trainer model or a certification/proficiency process are more likely to be sustained over time.

- A. How often is training available in this practice?
- B. Is there a train-the-trainer model available? If yes, describe the protocols for the train-the-trainer model.
- C. What are the costs for the train-the-trainer model?
- D. Are there required annual or recurring licensing or other fees to sustain this practice? If yes, describe the annual or recurring fees.

## **V. RESOURCE GUIDE FORMAT**

This following table shows how the information from the CDE application form is presented in the PEI Resource Guide.

<b>Program Name</b>	
<b>Target Population</b>	<p>A. Does this practice focus on a particular age group? If yes, which age group?</p> <p>B. Does this practice focus only on males or females? If so, which gender?</p> <p>C. Does this practice focus on people with a specific need or risk? If so, which need or risk?</p> <p>D. Does this practice focus on people in a particular area or setting? If so, which area or setting?</p>
<b>Cultural Group Relevance</b>	<p>A. Does this practice focus on a particular cultural group or sub-group? If yes, which group or sub-group is it?</p> <p>B. Is this practice intended to be provided in a particular language other than English? If so, which language(s)?</p> <p>C. How does this practice outreach to the cultural population it serves? Describe specific engagement strategies that are part of this practice.</p> <p>D. How are the traditions, customs and belief systems of the population this practice serves incorporated into the practice?</p> <p>E. How does this practice include elements that are easily recognizable by the specific population served as important for mental health and well-being?</p> <p>F. Does the community targeted by this practice trust the practice? How do you know?</p> <p>G. How was the practice developed? Where does it come from? What is the history of this practice in the population served?</p>
<b>Risk and Protective Factors</b>	<p>A. List any risk factors that are reduced.</p> <p>B. List any protective factors that are enhanced.</p>
<b>Level of Evidence</b>	<p>A. Describe how you know that this practice successfully does what it is intended to do.</p> <p>B. Discuss evidence of effectiveness by summarizing any and all ways you know that the practice achieves the intended results.</p> <p>C. Identify and describe the methods or special measures to ensure adherence to the practice.</p> <p>D. Are there relevant research publications that support the effectiveness of this model? If yes, attach copies of the research publications.</p> <p>E. Do you have relevant quantitative data that support the effectiveness of this model? If yes, attach copies of the quantitative data.</p> <p>F. Do you have relevant qualitative data that support the effectiveness of this model? If yes, attach copies of the qualitative data.</p>
<b>Outcomes</b>	<p>A. If this is a prevention practice, please answer any that apply:</p> <ol style="list-style-type: none"> <li>1) Identify any specific problems that are prevented by this practice.</li> <li>2) List any other prevention goals achieved by this practice (for example, increasing mental health awareness, outreach and engagement, etc.)</li> </ol> <p>B. If this practice is an early intervention, please answer any that apply:</p> <ol style="list-style-type: none"> <li>1) Indicate any problem that this practice addresses in its earliest stages.</li> <li>2) List what improvements in mood or emotional state, thought or cognitive process, behavior, and/or skills result from the early intervention.</li> </ol>
<b>Prevention: Universal/Selective</b>	<p>A. Is this a universal prevention practice?</p> <p>B. Is this a selective prevention practice?</p> <p>C. If a selective prevention practice, indicate which specific group this selective prevention program targets.</p>
<b>Early Intervention</b>	<p>A. Is this an early intervention?</p>
<b>Description</b>	<p>A. What are the essential components of the practice? Describe the activities, steps, stages, procedures, etc. that must happen for it to work.</p> <p>B. What is the reason for these essential components? Explain how the practice works and why.</p> <p>C. What is the duration of the program, including:</p> <ol style="list-style-type: none"> <li>1) Frequency of sessions</li> <li>2) Session length</li> <li>3) Treatment length</li> </ol> <p>D. What is the modality of treatment (e.g., individual, group, conjoint, parent-child, etc.)?</p> <p>E. Who is required to attend the sessions (e.g., child, parent, entire family)?</p> <p>F. Is assessment a core component of the practice? If yes, list the names of the standardized assessment forms or attach copies of any assessment forms that were specifically developed for this practice.</p> <p>G. Are there any outcome measures or clinical measurement tools that must be administered during treatment? If yes, list the names of standardized measures or attach copies of any tools that were specifically developed for this practice.</p>

<b>Staffing Requirements</b>	<p>A. What is the minimum number of people/practitioners needed to provide this practice?</p> <p>B. Does the practitioner need to be bicultural and/or bilingual? If so, in which languages and cultures?</p> <p>C. What are the key roles or responsibilities of each person/practitioner needed to provide this practice?</p> <p>D. What are the minimum requirements for each practitioner to be able to provide this practice in terms of educational attainment and degrees, licenses, training, work or personal experience?</p> <p>E. How many years of experience must staff have in order to provide this practice?</p> <p>F. What are the optimal characteristics staff must have to provide this practice (e.g., good interpersonal skills, desire to help, knowledge of the program, clinical knowledge of children and families, etc.?)</p> <p>G. Describe the components of supervision.</p> <p>H. How many people can a practitioner work with at a time (caseload)?</p>
<b>Service Delivery Setting</b>	<p>A. Identify and describe where the practice is provided.</p> <p>B. Indicate the type of place where practitioners meet with clients, family members or significant others, for the purposes of delivering the practice (e.g., community center, family home, school, clinic).</p>
<b>Implementation Costs</b>	<p>A. What are costs for a trainer(s) for the mandatory minimum training?</p> <p>B. Are there separate costs for supervisor training?</p> <p>C. What are the costs for required training materials?</p> <p>D. What are the costs for required or recommended consultation or technical assistance?</p> <p>E. Are there certification costs for staff to provide the practice?</p> <p>F. Are there program components that may require the purchase of additional equipment, such as tape recorders, video recorders, laptop computers?</p> <p>G. What are the costs for outcome measures required by the Developer?</p>
<b>Service Delivery Costs</b>	<p>A. What are the ongoing service delivery costs for this practice?</p> <p>B. Are there ways in which the costs may be reduced?</p>
<b>Standard Training Protocol</b>	<p>A. Describe the training protocols for this practice (include any prerequisites, length of training, persons that must be trained, and additional training requirements).</p> <p>B. How does a new practitioner learn how to do this practice?</p> <p>C. Is there a manual, a curriculum that must be followed, or a specific set of skills that must be learned? If yes, describe or list the training materials or specific set of skills to be learned</p> <p>D. Are booster trainings or other trainings required on an ongoing basis? If yes, describe the booster trainings required.</p> <p>E. Does training involve apprenticeship or an internship? If yes, describe the apprenticeship or internship training.</p> <p>F. Is training of supervisors required? If yes, describe the protocols for the supervisor training.</p> <p>G. Is certification or accreditation required? If yes, describe the certification or accreditation requirements.</p> <p>H. Attach any available manuals, curriculum, lists and description of skills, or other documents describing the core components of the practice to a new practitioner.</p>
<b>Proprietary Rights</b>	<p>A. Are the rights to implementing this program owned solely by the developer?</p> <p>B. Are the rights to provide training in this practice owned solely by the developer? If no, how is it determined that someone is authorized to provide training in the practice?</p>
<b>Sustainability</b>	<p>A. How often is training available in this practice?</p> <p>B. Is there a train-the-trainer model available? If yes, describe the protocols for the train-the-trainer model.</p> <p>C. What are the costs for the train-the-trainer model?</p> <p>D. Are there required annual or recurring licensing or other fees to sustain this practice? If yes, describe the annual or recurring fees.</p>
<b>Replicability</b>	<p>A. Describe the mechanism and strategy for other agencies to implement the CDE.</p> <p>B. What type of support does the developer provide for ensuring that the practice will be successfully replicated and implemented?</p>
<b>Developer Contact Information</b>	<p>Name of Developer(s)</p> <p>Organizational or University Affiliation</p> <p>Address</p> <p>Telephone Number</p> <p>Fax Number</p> <p>Email address</p>

# CDE APPLICATION

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**FOR A WORD VERSION, FILLABLE APPLICATION,  
PLEASE CONTACT:**

**[MHSAPEI@DMH.LACOUNTY.GOV](mailto:MHSAPEI@DMH.LACOUNTY.GOV)**

# CDE APPLICATION

2016

This form is fillable. Use additional pages as needed. Answer all questions and attach required supporting documents. Incomplete applications will be returned.

## 1. NAME OF CDE PRACTICE TO BE CONSIDERED FOR INCLUSION IN LACDMH PEI RESOURCE GUIDE

## 2. DEVELOPER CONTACT INFORMATION

**NAME OF PRACTICE DEVELOPER**

**Organizational or University Affiliation**

**Address**

**Telephone number**

**Fax Number**

**Email**

**Website Address**

**Other Developers**

## 3. Number of years doing Practice:

## 4. Is this Practice currently being implemented by you or your agency?

Yes  No

If yes, in what year was the practice implemented?

## 5. TARGET POPULATION

A. The State PEI Guidelines list six Priority Populations for PEI planning and project development. Check the MHSA PEI priority population(s) that best matches the main target of this practice:

- Underserved Cultural/Ethnic Populations
- Individuals with Early Signs of Severe Mental Illness
- Children/Youth in Stressed Families
- Trauma-Exposed
- Children/Youth at Risk for School Failure
- Children/Youth at Risk of or Experiencing Juvenile Justice Involvement

B. Does this practice focus on a particular age group?

Yes  No

If yes, which age group?

C. Does this practice focus only on males or females?

If so, which gender?

D. Does this practice focus on people with a specific need or risk?

Yes  No

If so, which need or risk?

E. Does this practice focus on people in a particular area or setting?

Yes  No

If so, which area or setting?

## 6. CULTURAL GROUP RELEVANCE

- A. Does this practice focus on a particular cultural group or sub-group?  
 Yes  No  
 If yes, which group or sub-group is it?
- B. Is this practice intended to be provided in a particular language other than English?  
 Yes  No  
 If so, which language(s)?
- C. How does this practice outreach to the cultural population it serves? Describe specific engagement strategies that are part of this practice.
- D. How are the traditions, customs and belief systems of the population this practice serves incorporated into the practice?
- E. How does this practice include elements that are easily recognizable by the specific population served as important for mental health and well-being?
- F. Does the community targeted by this practice trust the practice? How do you know?
- G. How was the practice developed? Where does it come from? What is the history of this practice in the population served?

## 7. RISK AND PROTECTIVE FACTORS

- A. List any risk factors that are reduced.
- B. List any protective factors that are enhanced.

## 8. LEVEL OF EVIDENCE

- A. Describe how you know that this practice successfully does what it is intended to do.
- B. Discuss evidence of effectiveness by summarizing any and all ways you know that the practice achieves the intended results.
- C. Identify and describe the methods or special measures to ensure adherence to the practice.
- D. Are there relevant research publications that support the effectiveness of this model?  
 Yes  No  
 If yes, attach copies of the research publications.
- E. Do you have relevant quantitative data that support the effectiveness of this model?  
 Yes  No  
 If yes, attach copies of the quantitative data.
- F. Do you have relevant qualitative data that support the effectiveness of this model?  
 Yes  No  
 If yes, attach copies of the qualitative data.

## 9. OUTCOMES

- A. If this is a prevention practice, please answer any that apply:
- 1) Identify any specific problems that are prevented by this practice.
  - 2) List any other prevention goals achieved by this practice (for example, increasing mental health awareness, outreach and engagement, etc.)
- B. If this practice is an early intervention, please answer any that apply:
- 1) Indicate any problem that this practice addresses in its earliest stages.
  - 2) List what improvements in mood or emotional state, thought or cognitive process, behavior, and/or skills result from the early intervention.

## 10. PREVENTION: UNIVERSAL/SELECTIVE

- A. Is this a universal prevention practice?  Yes  No
- B. Is this a selective prevention practice?  Yes  No
- C. If a selective prevention practice, indicate which specific group this selective prevention program targets.

## 11. EARLY INTERVENTION

- A. Is this an early intervention (check one box)?  Yes  No

## 12. DESCRIPTION

- A. What are the essential components of the practice? Describe the activities, steps, stages, procedures, etc. that must happen for it to work.
- B. What is the reason for these essential components? Explain how the practice works and why.
- C. What is the duration of the program, including:
- 1) Frequency of sessions:
  - 2) Session length:
  - 3) Treatment length:

- D. What is the modality of treatment (e.g., individual, group, conjoint, parent-child, etc.)?
- E. Who is required to attend the sessions (e.g., child, parent, entire family)?
- F. Is assessment a core component of the practice?
  - Yes     No
  - If yes, list the names of the standardized assessment forms or attach copies of any assessment forms that were specifically developed for this practice.
- G. Are there any outcome measures or clinical measurement tools that must be administered during treatment?
  - Yes     No
  - If yes, list the names of standardized measures or attach copies of any tools that were specifically developed for this practice.

### 13. STAFFING REQUIREMENTS

- A. What is the minimum number of people/practitioners needed to provide this practice?
- B. Does the practitioner need to be bicultural and/or bilingual? If so, in which languages and cultures?
- C. What are the key roles or responsibilities of each person/practitioner needed to provide this practice?
- D. What are the minimum requirements for each practitioner to be able to provide this practice in terms of educational attainment and degrees, licenses, training, work or personal experience?
- E. How many years of experience must staff have in order to provide this practice?
- F. What are the optimal characteristics staff must have to provide this practice (e.g., good interpersonal skills, desire to help, knowledge of the program, clinical knowledge of children and families, etc.)?
- G. Describe the components of supervision.
- H. How many people can a practitioner work with at a time (caseload)?

### 14. SERVICE DELIVERY SETTING

- A. Identify and describe where the practice is provided.
- B. Indicate the type of place where practitioners meet with clients, family members or significant others, for the purposes of delivering the practice (e.g., community center, family home, school, clinic).

### 15. IMPLEMENTATION COSTS

- A. What are costs for a trainer(s) for the mandatory minimum training?
- B. Are there separate costs for supervisor training?
- C. What are the costs for required training materials?
- D. What are the costs for required or recommended consultation or technical assistance?
- E. Are there certification costs for staff to provide the practice?

### 16. SERVICE DELIVERY COSTS

- A. What are the ongoing service delivery costs for this practice?
- B. Are there ways in which the costs may be reduced?

### 17. STANDARD TRAINING PROTOCOLS

- A. Describe the training protocols for this practice (include any prerequisites, length of training, persons that must be trained, and additional training requirements).
- B. How does a new practitioner learn how to do this practice?
- C. Is there a manual, a curriculum that must be followed, or a specific set of skills that must be learned?
  - Yes     No
  - If yes, describe or list the training materials or specific set of skills to be learned
- D. Are booster trainings or other trainings required on an ongoing basis?
  - Yes     No
  - If yes, describe the booster trainings required.
- E. Does training involve apprenticeship or an internship?
  - Yes     No
  - If yes, describe the apprenticeship or internship training.
- F. Is training of supervisors required?
  - Yes     No
  - If yes, describe the protocols for the supervisor training.
- G. Is certification or accreditation required?
  - Yes     No
  - If yes, describe the certification or accreditation requirements.
- H. Attach any available manuals, curriculum, lists and description of skills, or other documents describing the core

components of the practice to a new practitioner.

### 18. PROPRIETARY RIGHTS

- A. Are the rights to implementing this program owned solely by the developer?  
 Yes  No
- B. Are the rights to provide training in this practice owned solely by the developer?  
 Yes  No  
If no, how is it determined that someone is authorized to provide training in the practice?

### 19. SUSTAINABILITY

- A. How often is training available in this practice?
- B. Is there a train-the-trainer model available?  
 Yes  No  
If yes, describe the protocols for the train-the-trainer model.
- C. What are the costs for the train-the-trainer model?
- D. Are there required annual or recurring licensing or other fees to sustain this practice?  
 Yes  No  
If yes, describe the annual or recurring fees.

### 20. REPLICABILITY

- A. Describe the mechanism and strategy for other agencies to implement the CDE.
- B. What type of support does the developer provide for ensuring that the practice will be successfully replicated and implemented?

### 21. PERSON SUBMITTING APPLICATION

Name  
Organizational or University Affiliation  
Address  
Telephone number  
Fax Number  
Email

### 22. KNOWLEDGE ABOUT PRACTICE

- A. How did you learn about this practice?
- B. How will this practice enhance the service array of your community?
- C. Are there any unmet needs that will be addressed by this practice?  
 Yes  No  
If yes, describe these unmet needs.

### 23. IMPLEMENTATION PLANS

- A. Do you have any experience with this practice?  
 Yes  No  
If yes, describe your experience.
- B. Are you currently implementing this practice?  
 Yes  No  
If yes, describe how and when this program was implemented.
- C. Have any of your staff been trained in this practice?  
 Yes  No
- D. Are you planning on implementing this program in your agency?  
 Yes  No  
If yes, describe your plans.

### 24. CONFLICT OF INTEREST

- A. Are you connected in any way with the developer of this practice?  
 Yes  No
- B. Did you help develop this practice?

- |  |
|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No             |
| C. Do you have any connections with any trainers of this practice?   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No             |
| D. Are you or is your agency an authorized trainer of this practice? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No             |

To assist DMH in the processing of your application, please make sure that the following required documents are included in this CDE Application Package (check box to indicate the required document is included):

- CDE Application Form (Original, signed) and .pdf format
- Copies of Quantitative Evidence (.pdf format), if available
- Copies of Qualitative Evidence (.pdf format), if available
- Copies of Assessment Forms (.pdf format), if applicable
- Copies of Training Materials (.pdf format), if applicable
- Copies of Outcome Measures or Clinical Assessment Forms (.pdf format), if applicable