API – What works in our communities

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CDE Guidelines

As part of its Mental Health Services Act (MHSA) Prevention & 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 & Early Intervention (PEI) Evidence-based Practices, Promising Practices, and Community-defined Evidence (CDE) Models Resource Guide 2.0 (April 25, 2011).*
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 PRIORITY POPULATIONS

1. Underserved cultural populations – those who are unlikely to seek help from any traditional mental health services whether because of stigma, lack of knowledge, or other barriers

2. Individuals experiencing onset of serious psychiatric illness – first break

3. Children/youth in stressed families

4. Trauma-exposed – traumatic events over prolonged conditions

5. Children/youth at risk for school failure – due to emotional and behavioral problems

6. Children/Youth at risk of or experiencing juvenile justice involvement
Requirements for Inclusion for LACDM CDE Application

1. Be well articulated with description of the core component.
2. Be able to be replicated by others – so it can be taught to others.
3. Have demonstrated effectiveness – range of levels.
4. Have a local emphasis – developed and used primarily in LACDM, described in academic or commercial publications, not a national model.
Questions that must be answered

1. What population well-defined for whom the practice is intended
2. What is the population’s relevance – explain how the practice meets the cultural needs of the population served
3. What factors – individual or environmental factors that are related to the increased likelihood that a negative event will occur
4. What proactive factors – safeguards that enhance a person’s ability to resist stressful life events, risks or hazards and promote adaptation and competence
5. What level of evidence – describe how the practice works with quantitative and qualitative evidence
6. What outcomes – goals or intended results by using this practice
7. What does the practice entail – description of the core components of the practice
8. What requirements to provide the practice
9. What service delivery setting
10. What are the costs and service delivery costs
11. What standard training protocols
12. What are dietary rights
13. What are dietary capability
14. What is dietary inability – training beyond the original practice
References


CDE Application Revised 2/7/14