



Community-Defined Evidence Practices

Through decades of data, there is a clear need for new strategies to help reduce behavioral health disparities in BIPOC and LGBTQ+ communities. Community-defined evidence practices (CDEPs) can offer a role in the State's efforts to reduce behavioral health disparities and advance behavioral health equity. The term "community-defined evidence practice" derives from what a community considers healing as well as their cultural, linguistic or traditional practices. A common definition of CDEPs describes "a set of practices that communities have used and 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."[xxiii] A healing practice that has been used for centuries or even millennia is also a reasonable example of empirical evidence. For example, Native Americans were practicing population health, cognitive behavioral therapy, and group therapy (talking circles) for hundreds of years before it was discovered by Western medical model practitioners.[xxiv xxv] CDEPs in BIPOC and LGBTQ+ communities are part of their very culture, history, values, and teachings.

CDEPs originate within the community, often through organizations that serve them, and can range from behavioral health treatments to community outreach to other services and supports.[xxvi] Examples of these types of practices include but are not limited to: traditional healing, life coaching, circles of care, mindfulness, radical inclusivity, and culturally and linguistically appropriate outreach.[xxvii] Again, many have been in practice for years, even centuries before the Western medical model existed. However, communities and populations are not homogeneous and often differ by region. One community-defined evidence practice is not necessarily effective in similar communities. CDEPs must be embraced based on local experiences.

CDEPs are provided by numerous qualified health practitioners, including those who do not have a medical or behavioral health license. In fact, being a qualified health professional from the dominant culture (e.g., a doctor of medicine or psychologist) may be a deficit that may not help the CDEP given the different paradigms and epistemologies. Examples of other types of qualified health professionals include peer specialists, community health workers, trained facilitators, promotoras, and traditional healers. Many CDEPs also serve BIPOC and LGBTQ+ communities who are Limited English Proficient (LEP).

The Office of Health Equity (OHE) in the California Department of Public Health (DPH) has invested significantly in these types of critical services through the California Reducing Disparities Project (CRDP) in order to build an evidence base for their effectiveness.[xxviii] The goal of the CRDP is to use a rigorous, community-participatory evaluation process to demonstrate that selected community-defined evidence practices (CDEPS) are effective at preventing or reducing the severity of mental illness in African-American, Asian and Pacific Islander, Lesbian, Gay, Bisexual, Transgender, Queer and Plus (LGBTQ+), Latino and Native American communities as opposed to traditionally funded behavioral health services based on Western clinical models. The CRDP project is also providing evidence to support the assertion that there are different approaches to behavioral health and wellbeing outside of the Western medical model.