BLUEPRINT
FOR THE
NATIONAL NETWORK TO ELIMINATE DISPARITIES
IN BEHAVIORAL HEALTH
(NNED)

PREPARED BY

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INTRODUCTION

The national momentum for addressing disparities in behavioral health care is at an all-time high. National reports, including the Surgeon General's *Mental Health: Culture, Race and Ethnicity* (2001), the Institute of Medicine's *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* (Smedley, BD, Stith, AY and Nelson, AR, 2002), and the President's New Freedom Commission on Mental Health's *Achieving the Promise: Transforming Mental Health Care in America* (2003) all gave impetus to the dialogue on disparities. Taken together, these reports proclaim a public health imperative to meet the needs of diverse racial, ethnic and cultural populations in the United States.

There are many efforts currently underway to address disparities in health and behavioral health care. Around the country, there are pockets of excellence in reducing disparities. However, much of this activity remains fragmented and disconnected. Additionally, research and policy efforts addressing disparities often lack the connection to and depth of involvement of the very communities they seek to serve. Thus, the nuances and knowledge that comes from those who are on the "front lines" are missing from many of the current disparity strategies. There is a wealth of information, insights, and knowledge that is simply not being shared or used to enhance or create more effective strategies for eliminating disparities in our country.

In an effort to address these concerns and build on existing policy reports and recommendations focusing on reduction of disparities, the Substance Abuse and Mental Health Services Administration (SAMHSA) enlisted the National Alliance of Multi-ethnic Behavioral Health Associations (NAMBHA) to coordinate the development of the National Network to Eliminate Disparities in Behavioral Health (NNED). NAMBHA convened two invitational planning groups in February and May, 2007. A diverse group of national, state and community leaders in the field were invited to assist in creating the NNED. Over 50 persons participated in these facilitated sessions (*see Appendix 1 for Participant List*). The major goal of the meetings was to develop a blueprint for the NNED.

This document describes the proposed Blueprint for the NNED and reflects the deliberations of these two meetings. While this is a preliminary document, it represents the thinking and discussions of a diverse group of: research, policy, and service entity leadership; national, state, and community leadership; and consumer and family leadership all dedicated to the elimination

of behavioral health disparities and the promotion of social justice and health equality for under- served communities.

The blueprint for the NNED includes the following components:

1. Definition and context of disparities and rationale for a network structure;
2. Vision statement;
3. Mission statement;
4. The initial populations of focus;
5. Core principles and values that will guide the interactions and working relationships of those who participate in the NNED;
6. The operating structure, roles and functions of the various entities comprising the NNED;
7. Priority areas for the NNED; and,
8. Recommendations for "start-up tasks" to begin implementation of the NNED.

BLUEPRINT FOR THE NATIONAL NETWORK TO ELIMINATE DISPARITIES IN BEHAVIORAL HEALTH (NNED)

1. Rationale for the NNED: The "Wicked" Problem of Behavioral Health Disparities and the Rationale for a Network Structure

Disparities have been defined as "differences in diseases, conditions, and health outcomes based on race and ethnicity" (Carter-Pokras & Baquet, 2002) or "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States" (Carter-Pokras & Baquet, 2002). Racial, ethnic, and cultural disparities persist in all aspects of American society and can appropriately be considered "wicked problems" (Clarke & Stewart, 2000). Emanating from the public policy management literature, the term "wicked problems" is used to describe problems that seem intractable, defy easy solutions or linear processes, interact with other deep-seated social and economic conditions, and persist because the design of systems put in place to solve the problems actually hinder the development of effective solutions. These problems "present a special challenge to government because they defy precise definition, cut across policy and service areas, and resist solutions offered by the single-agency or 'silo' approach (Keast et.al, 2004)."

Racial and ethnic disparities are considered "wicked" problems in American society because they have many characteristics that make them appear to be without adequate resolution:

- Racial and ethnic disparities are a part of the foundation of American society, deeply rooted in its culture from the very beginning – from the conquest of the Indians' land to African slavery to current treatment of undocumented immigrants– inequities based on class, race, and culture have been embedded in the development of our country. Disparities have a long and extensive history and are found in every sector of American society.

- These disparities are embedded in differences in income, access to information, cultural traditions and social structures (Davis, 2005).

- Disparities tend to beget disparities, resulting in a cumulative impact of inequalities that constantly perpetuate wider societal gaps. Growing up in a poor, segregated community of color leads to less opportunity for home ownership, good education, and higher wage jobs, which in turn impact access to good health care, etc.

- Racial and ethnic disparities tend to produce disproportionate results – either less access to opportunity or greater probability of adverse consequences and outcomes. For example, in his discussion of racial and ethnic disparities in behavioral health systems, Davis (2003) illustrates this point by documenting that groups of color have "less" access to many of the more positive aspects of the system (i.e., early intervention and

community-based programs, culturally appropriate providers and assessments, family support, resiliency and recovery programs, etc.) and "greater" involvement with those aspects of the system that tend to produce poor outcomes (longer stays in public inpatient facilities, likelihood of inaccurate diagnoses and poorer prognoses, involuntary commitments, and involvement with police and criminal justice systems, etc.). Thus, disparities are characterized by disproportionate over-representation in restrictive, compulsory systems (e.g., justice, child welfare, etc.) and underrepresentation in more positive, well-being oriented systems.

- Racial and ethnic disparities are maintained by an interactive process between communities of color and systems put in place to address social problems. The tendency has been to place "blame" on the culture, community or the individual, hence the term "culturally disadvantaged," and not on addressing the insidious nature of disparities.

- The pervasiveness of disparities has led to chronic "learned helplessness" in communities and systems, so that racial and ethnic disparities become the proverbial "elephant in the room" (i.e., ignored or not acknowledged) or garner only periodic, lack-luster attention without adequate funding and support. Thus, action occurs in small, disconnected, incremental steps that often fail to produce visible or lasting results. A tacit acceptance that "disparities will always be with us" keeps efforts fragmented, poorly funded, easily overlooked and consequently with minimal expectations for change.

- There is an underlying assumption that proposed solutions (such as cultural and linguistic competence) should be derived from an empirically based scientific method that is the centerpiece of the systems that consistently perpetuate and reproduce disparities. The idea that "wicked" problems, like racial, ethnic and cultural disparities, can be solved only through the use of western epistemologies and problem-solving approaches have produced an incredibly rich documentation of theories on why disparities exist, but few, if any, effective strategies for eliminating them.

Racial, ethnic and cultural disparities become even more complex and complicated when they are embedded in a behavioral health system that experiences its own intrinsic disparity and lack of parity with other health care systems. The President's New Freedom Commission Report (2003) states clearly that the mental health system itself, is "fragmented and in disarray…leading to unnecessary and costly disability, homelessness, school failure and incarceration" (p.3). Thus, in many ways, behavioral health systems experience disparities in relationship to health care and other care-giving systems. Given these conditions, it is important to question whether eliminating racial and ethnic disparities can occur through a focus on increasing access and services in the present behavioral health care system. This adds another dimension to the solutions that must be created to improve behavioral health for diverse racial and ethnic communities.

In order to effectively address the "wicked problems" of racial, ethnic and cultural disparities within behavioral health systems, a new approach and organizational structure is required.

These issues cannot be successfully addressed within existing structures, processes, and organizational cultures. SAMHSA in collaboration with NAMBHA proposed the creation of a network configuration -- the National Network to Eliminate Disparities in Behavioral Health (NNED).

Network structures involve multiple inter-connected organizations where one unit is not merely the formal subordinate of others. A network structure usually has a broad mission, joint, strategically interdependent action, a strong commitment to overarching goals, and members that agree to commit various significant resources (e.g., human capital, funding, etc.) over a long period of time. A network approach allows for the greatest level of flexibility and inclusion, while maintaining the integrity of each participant organization. A network enhances knowledge creation and innovation, and provides timely access to knowledge and resources that are otherwise unavailable to many. A network structure also combines multiple skill sets, innovations and technologies that no one single organization or program could support.

In efforts to eliminate behavioral health disparities, the NNED will address issues of access, availability, quality and outcomes that are essential to the inclusion of all populations in the successful transformation of behavioral health care in the United States. Yet, to begin to reduce disparities, it is essential to target the issues of under-representation of people of color in quality behavioral health services and overrepresentation in more restrictive sectors of care such as child welfare and criminal justice. Understanding the interconnectedness of different service sectors involved in the behavioral health care of diverse communities is an essential underpinning of the NNED.

2. Vision

NNED VISION: ***All culturally, racially and ethnically diverse individuals and families thrive in, participate in, and contribute to healthy communities.***

This vision statement recognizes that racial, ethnic and cultural disparities are the consequence of both structural inequalities and an existing behavioral health system that has many systemic challenges. This vision does not simply suggest that all individuals, families and communities have access to the existing system, but rather that, through tackling the "wicked" issues of disparity, the behavioral health system in our country will be transformed and function better to

meet the needs of all citizens. Thus, the standards and levels of effective behavioral health will be higher for everyone.

3. Mission

NNED MISSION: ***To build, partner with, and sustain a national network of diverse racial, ethnic and cultural communities and organizations to promote policies, practices, standards and research to eliminate behavioral health disparities.***

The NNED will bring new vigor to the goal of eliminating racial, ethnic and cultural disparities with the creation of a different type of structure that recognizes the inherent strengths of relational and holistic approaches rather than traditional or linear thinking. The mission is predicated on the assumption that there are feasible and realistic strategies to reduce disparities; this knowledge and capacity lies within the communities and the individuals that live in them that experience daily such disparities, and not solely or even predominantly in outside experts and researchers. These communities, the individuals and families that live in them and those providers and leaders who work within them must be at the center of the network, and the knowledge they possess must be more widely appreciated and shared.

The mission acknowledges that researchers, policy makers and analysts, behavioral health professionals, consumers, families, youth, technology sites, and other knowledge-generating entities also have knowledge and skills that will be helpful, and input from many different types of stakeholders, with many different skills, is required to effectively eliminate racial and ethnic disparities in behavioral health. Just as the successful completion of a film requires actors, producers, musicians, writers, technicians, sales persons, distributors, etc. to bring a completed movie before the public, the NNED recognizes that it must garner the expertise and skills from a much wider variety of groups if it is to be successful in eliminating behavioral health disparities. But, unlike traditional knowledge development that begins with hypotheses and studies, the NNED will begin by making connections and building relationships based on lived experiences and events. Knowledge creation and innovation, so important for intractable problems, requires demonstrating a willingness to think and work in completely novel ways.

The NNED will fill a critical gap in the effort to eradicate disparities by:

- Highlighting priority areas critical to disparities elimination;

- Linking community providers and organizations in diverse communities with knowledge discovery centers to develop and support applied research, innovation and culturally-based practice;
- Providing an infrastructure for collecting, analyzing and disseminating information about best practices, research and policy;
- Establishing learning collaboratives and internet-based training strategies to address priority areas;
- Stimulating targeted action through "community collaboratives" to impact disparities
- Providing a coordinated response in developing recommended policy, practice and research direction to the field;
- Providing a platform to support community and systems change ;
- Eliminating behavioral health disparities through ensuring access to and availability of culturally appropriate, high quality, results-producing care.
- Influencing a national focus on the elimination of disparities;

4. Initial Populations of Focus

The vision statement pays explicit attention to the dominance of disparities for diverse racial, ethnic, and cultural groups and communities within the United States. There are many such groups, but the NNED will initially focus on: first, the largest racial/ethnic groups -- Hispanics/Latinos, African Americans, Asian Americans/Native Hawaiians and Pacific Islanders, American Indians and Alaskan Natives; and, second, new Emerging Populations that are growing and experiencing disparities in behavioral health prevention and intervention services. These include the increasing number of mixed race individuals, new immigrants and refugees from Africa, the Caribbean, the Middle East, as well as other religious and cultural groups whose values, languages, and practices make it difficult to immediately "fit in" to mainstream American society. This often creates challenges for access to behavioral health, as well as issues related to quality of care and positive outcomes.

Current census data suggests that these populations can be found in every State within our country. Latinos constitute the largest and fastest growing of these groups, now representing 14% of the population, followed by African Americans (12%), Asian Americans at 5% and American Indians and Alaskan Natives at two percent. Emerging populations are often captured within these groups or within mixed racial/ethnic identification in the U.S. Census (*U.S. Census, 2007).* Together they represent over 35% of the current U.S. population and are projected to increase to 50% by 2050.

In the planning meeting, there was consensus that the NNED must be able to address many of the diverse cultural values of each of these groups and recognize that disparities often have unique manifestations – not only between the groups, but within these heterogeneous groups.

All of the groups experience various disparities in access, availability and quality of care in behavioral health. Finally, there was consensus that for the NNED to work effectively, we must move beyond the black/white paradigm so prominent in this country, as it fails to represent the growing diversity in the country. The need for the NNED to foster honest dialogues among these groups was viewed as one of its critical roles.

5. Guiding Values and Principles

The NNED will be guided by the following values and principles

Excellence in behavioral health: Racial, ethnic, and cultural disparities in behavioral health care exist and are unacceptable. Culture, language, race and ethnicity and historic experiences related to racism, poverty, oppression and stigma influence all aspects of health and wellness, and must be addressed in policy, research and practice to establish equity in behavioral health. Disparities are the consequence of structural inequalities, and the NNED must tackle the root causes of such inequalities, not just the symptoms. Equity, given the current behavioral health system, will not be an adequate outcome. There is a need for a major transformation of behavioral health that has at its center culturally and linguistically competent interventions.

Collective advocacy and action: Despite our many differences, we are more effective, credible, far reaching and influential when we work together and act as a collective voice. We expect to be catalysts for change.

Soft Power: In contrast to traditional, hierarchical, coercive power, "soft power" is the ability to share power in a non-competitive, decentralized manner to gain trust, and to collaborate and integrate different points of view to achieve shared goals and outcomes.

Inclusion: The NNED values the diversity of knowledge, insights, opinions and experiences of all partners in the network. Partner representatives will be involved in the planning, development, implementation and evaluation of the NNED.

Community: Communities provide the most important and critical component of the NNED. Communities must define their needs and priorities; planning must be inclusive; interventions must be effective and flexible in their implementation; evaluations must be participatory and informing. The community voice, including families, consumers and youth, will be at the center of activities conducted within the network.

Respect: The NNED will consciously seek out and respect the diverse perspectives and knowledge of traditional and nontraditional providers, indigenous communities, research entities, consumers, families, youth and people in recovery.

Trust and reciprocity: Relationships among network partners will be based upon trust, respect, reciprocity, a shared vision and transparency.

Strength-based policies, practices and research: The NNED will acknowledge and draw upon the unique strengths, assets, and resilience of diverse communities, and will not do for people what they can do for themselves. The NNED will ensure that efforts build capacities

within our communities, increase social capital, and strengthen social networks at all levels. We will strive to add value and do no harm.

***Holistic view of health and wellness*:** The NNED will be grounded in a holistic approach to health and wellness that incorporates traditional healing practices, prevention, early intervention and a belief in the resiliency and recovery of individuals and communities.

Focus on the lifespan: The NNED will include behavioral health innovations across the lifespan in our communities and all efforts will be culturally and developmentally appropriate.

System Intersections: Disparities exist across all systems (health, education, criminal and juvenile justice, child welfare, etc.) and result in cumulative effects. The NNED will ensure better cross-system coordination and an understanding of the impact of these intersections on diverse communities.

Flexibility: The NNED will be flexible in its response to the diverse partners of the network, enhance existing partnerships and resources, and customize opportunities for its partners.

6. The Operating Structure

The planning group meeting began with a presentation of three network models that are currently being funded by three different government agencies:

- the National Child Traumatic Stress Network, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA);
- the Depression Collaborative, funded by the Health Resource Services Administration (HRSA); and,
- the REACH 2010 Network, funded by the Center for Disease Control and Prevention (CDCP).

These models were used to illustrate the various features, purposes, and work of existing networks, and to provide a starting point for discussion of a multilevel network configuration to address behavioral health disparities. From these discussions, the initial conceptualization of the NNED structure was proposed and consisted of three interlocking entities: community and ethnic--based organizations and networks; knowledge discovery centers; and a national facilitation center.

Community and Ethnic-Based Organizations and Networks (CEBONs)

Community and Ethnic-based Organizations and Networks (CEBONs) are at the heart of the NNED. The primary focus of these entities is to create a behavioral health base within a community, or for an ethnic-specific population to grow, implement and evaluate effective behavioral health strategies for eliminating disparities. Many of these organizations and local

networks provide a wide spectrum of services, including behavioral health interventions or support (i.e., promotion, prevention, treatment, recovery supports, peer support, aftercare, etc.) and are connected with the community or ethnic leadership in the communities they serve. The activities of these organizations and local networks are ethnic or community-focused and -driven. CEBONs would be expected to enter into partnerships with the NNED Facilitation Center, Knowledge Discovery Centers that are relevant to their work, and with other CEBONs where there is mutual benefit. CEBONs may participate as receivers or providers of information, innovative practices, and policies that support a priority area of the NNED's work. CEBONs will be instrumental in providing peer technical assistance and support. Selected CEBONs may also be identified as Knowledge Discovery Centers.

CEBONs may include behavioral health service providers and other community-based and ethnic-based multi-service providers serving a large population of one or more of the NNED's focus populations. This group of entities may also include community advocacy and organizing groups; consumer and family organizations; faith-based institutions; tribal organizations and other ethnic-specific community-based organizations outside of behavioral health such as community and family resource centers, mutual assistance associations, and community and neighborhood multi-service and newcomer centers, etc. CEBONs may include existing community coalitions and collaboratives that wish to address behavioral health disparities and other types of community governing councils and leadership. It is anticipated that the configuration and array of CEBONs will vary by community, ethnic-specific population, and other factors.

The **core functions** of the CEBONS as related to the NNED are to:

- **Define and document disparities**. Put a face on the problems associated with disparities, document the policy barriers that community organizations face when trying to reach out and serve individuals and families, develop strategies and mechanisms to address the barriers, and identify appropriate outcome indicators and provide outcome data as demonstration of effectiveness.
- **Promote new perspectives.** Bring local and community-based perspectives to the table and the knowledge created by experience in working with racial, ethnic and cultural communities; and shift the paradigm to community as conveners and recipients of funds.
- **Exchange and share information.** Resources within and between communities, produce fact sheets that describe the particular community being served, and participate in practice exchanges.
- **Create opportunities for community partner involvement.** Involve community partners in planning, development, advocacy, outreach and engagement activities, and

be a training setting for the next generation of community practitioners (capacity building).

- **Provide technical assistance, research and evaluation opportunities** (around implementing innovative and effective policies, procedures and best practices). Create professional pathways for community members that "go all the way up" (e.g., provide resources and opportunities for a refugee translator to become a behavioral health professional) in order to diversify the behavioral health workforce.

It is important to ensure that community engagement is developed from the specific community's perspective and not by external experts. It is also important to recognize that all too often the ideas and knowledge generated from communities of color have been under-used or used without appropriate credit or acknowledgement. Community organizations are often overwhelmed by the enormity of the task of providing good services, so communities must have an opportunity to define ways in which the NNED can support them to stay involved. Another issue of concern is the focus on the individual instead of the family. For almost all communities of color, the focus on the individual tends to conflict with strong family values and collective group processes. It is important not to split individual users of behavioral health services from families, but rather to engage all members of the family as a unit.

It is important that engagement strategies and incentives be informed by knowledge of the community and sensitivity to cultural differences within the community. One size does not fit all, and the NNED should have the capacity to "target" engagement strategies as needed to specific groups and populations within a community. Some incentives for community engagement might include: offering capacity building and technical assistance to community groups; offering networking opportunities among communities (peer-to-peer exchanges); legitimizing bartering strategies so that information and opportunities can be based on the assets of the community; and developing a social marketing campaign to recruit members. This could be coordinated through different media partners and by using local communication resources. Another opportunity for effective community engagement might also include strengthening relationships and links with existing networks (i.e., suicide prevention networks, youth organizations) or membership organizations.

Communities are the centerpiece of the NNED network because place matters greatly**.** Where one lives determines the type of access one has to the opportunity structure of American society. Too often, place is the beginning point for racial and ethnic disparities and, as such, must become the driving force behind solutions.

Knowledge Discovery Centers (KDCs)

Knowledge Discovery Centers (KDCs) will be invited to the NNED for their expertise in one or more of the priority areas identified for the NNED, for their capacity in a core function that supports the mission of the NNED, and most importantly, for an acceptance of the NNED values and principles, approach, and way of doing work. The core functions may include skills areas such as database development, data collection and analysis; training and technical assistance; policy development and analysis; and service intervention research or evaluation, participatory action research and prevention strategies. These centers may also have expertise in specific populations (e.g., refugees) or behavioral health conditions where there are documented disparities (i.e., rates of depression, suicide, disproportionality, etc.).

The KDCs will work in partnership with the CEBONs and provide national leadership and expertise. These centers may also work with community partners to develop alternatives to empirical methods of measurement and identify and document evidence-based practices and practice-based evidence models that show promise in reducing behavioral health disparities among culturally, racially and ethnically diverse populations. The number of participating KDCs will be determined as the priority areas are established by the NNED.

The strengths of the KDCs will be the ability to enter into a collaborative process with other KDCS and the CEBONs. There is recognition that the relationship between the KDCs and CEBONs must reflect this collaborative process and the generation of indigenous and community-driven research and innovation.

The proposed **core functions** of the KDCs are to:

- **Redevelop conceptual and methodological frameworks for the study of behavioral health disparities** and ensure that empirical as well as alternative models of measuring evidence are developed for, and with, diverse populations
- **Create a process for researching and documenting community-defined best practices** and a pathway and model for building a culturally appropriate evidence base
- **Create strategies to advocate and influence public policy**
- **Provide technical assistance and consultation** to communities related to research, evaluation, implementation strategies, policy development and advocacy;
- **Develop effective training avenues for integration of behavioral health knowledge** with other systems and professionals (e.g., primary care physicians, criminal and juvenile justice systems)
- **Mentor and support a community of learners**

- **Meaningfully engage, incorporate and partner** with the community in all levels of research (i.e., move beyond translational models), and develop and promote empowerment evaluation models

The NNED planning group suggested a range of organizations that could participate as KDCs, including: professional associations in behavioral health; national advocacy and consumer organizations; think tanks; colleges and universities; foundations and philanthropists; applied research and policy centers; ethnic-specific national or regional organizations; and county, state and federal government agencies, tribal governments and organizations. However, a participating KDC must have a stated willingness to contribute to the activities of the NNED and have a clearly documented interest or expertise in addressing an issue(s) related to disparities for racial, ethnic, and cultural groups in this country.

In order to begin to engage entities to participate as KDCs, it is important to craft appealing engagement messages and clearly delineated incentives so that organizations can understand the "value-added" nature of their participation (i.e., increased opportunities for funding; mentorships; technical assistance and consultation from experts in the field; and peer-to-peer networking, etc.).

The National Facilitation Center (NFC)

The National Facilitation Center (NFC) supports the development and operations of the network and ensures that it is meeting its stated objectives and benchmarks. The leadership for this entity would include representation from the focus populations of the NNED. As much as possible, the national entity should build on, and expand, an existing national organization. It is also possible that a core group of national organizations work to create the NFC, and eventually the coordinating entity might move to include regionally-based coordinating entities that are affiliated and connected to the national entity. In the early stages of the NNED development, the NFC will be guided by a Steward Group with proportional membership from the participating KDCs and CEBONs, including adult/youth consumers, families, and people in recovery.

The primary responsibilities and core functions of the NFC are to:

- **Develop and maintain an infrastructure** to support the ongoing functioning of the NNED;

- **Identify and engage Community and Ethnic-Based Organizations (CEBONs), and Knowledge Discovery Centers** Facilitate dialogue and provide ongoing peer-to-peer exchanges and briefings for all members of the NNED through national, regional and local conferences, meetings, and other convening activities;
- **Develop and maintain a communication strategy** that efficiently connects the entities within the NNED;
- **Define priorities for the NNED**, in collaboration with the Steward Group and partners;
- **Provide and/or broker technical assistance, consultation and support** for entities in the NNED; and create a mechanism for continuous assessment of the capacity-building needs, strengths, and incentives for ongoing engagement of entities in the NNED;
- **Share information and disseminate knowledge.** Create a formal clearinghouse, website, and other information sharing and knowledge dissemination mechanisms for NNED partners and the public;
- **Provide a national presence and influence** and develop ongoing exchanges with champions, allies and funders interested in supporting the NNED;
- **Create and implement advocacy and social marketing mechanisms** to highlight the best policies, practices, results, and successes of the NNED at the community, regional and national levels;
- **Sustain the efforts of the NNED**; Document and disseminate the process, impact, influence and outcomes of the NNED's work; Identify resources and fund-development strategies to maintain and sustain the NNED; and
- **Create a shared web**-based workspace for the Steward Group and the NNED

It is important that the NFC begin its work by assessing existing network structures and identifying their development strategies, strengths, and challenges. It is essential that the NFC develop a database of potential entities that may be interested in participating in the NNED. The NFC will articulate a developmental approach for growing the NNED. Specifically, it will determine how many entities will be involved within the initial start-up phase, and the mechanisms/criteria to be used to identify additional participants as the NNED matures. Most importantly, the NFC should be viewed as a skilled weaver – bringing all the strands together into a coordinated, well-developed, and rich tapestry of partners and products to advance the vision and mission of the NNED. The NFC will begin by developing an effective communication and operational strategy for the NNED.

It is anticipated that work on the priorities of the NNED will be completed through operational clusters that are representative of all the entities. Operational processes will be developed to address priorities among the entities in a flexible and multi-directional way. The operational clusters will primarily be composed of the CEBONs and the KDCs, with administrative, technical, convening, and operational support from the NFC.

Given the importance of place and community in addressing racial and ethnic disparities, the priority areas identified by the NNED may include place-based work (e.g., local mini-NNEDs); collaboration and partnerships between KDCs and a particular set of community-based organizations; ethnic-specific clusters that could be local, regional or national; and other such configurations that NNED members believe will achieve identified results and outcomes. The flexibility of the network structure precludes the development of specific structures for completing work on priorities, but the formations that occur for work within the NNED will be documented and evaluated so that the knowledge and lessons learned about effective strategies for eliminating behavioral health disparities can be shared throughout the network and with the larger public.

The Steward Group

The NNED planning groups recommended the formation of a Steward Group to guide the early development of the NNED and to implement the NNED blueprint. The Steward Group will be critical to ensuring that the NNED remains aligned with its mission and its guiding principles. This group will also establish a set of benchmarks for the ongoing development of the NNED and will work closely with the NFC to continue to clarify the operations, structure, and sustainability of the NNED. The Steward Group will be proportionally representative of the types of entities within the NNED and the voices of family, consumer, youth and people in recovery.

7. NNED Priority Areas

In developing and selecting priority areas for the NNED, the planning group adopted a set of criteria to guide its work.

The criteria are:

- Not duplicating work already completed or underway;
- Linking with, and building upon, existing work to the greatest extent possible;
- Ensuring that the work is consistent with the guiding principles and values of the NNED;
- Ensuring that the work has community buy-in and is embedded in an area of work that has been identified or endorsed by the CEBONs (i.e., growing out of community strengths and needs) or through culturally and linguistically competent research and policy analyses;
- Assessing whether the work is feasible, plausible, and able to be completed in a timely manner; and
- Ensuring that the work will have an impact on the behavioral well-being of ethnic, racial, and culturally distinct communities.

The planning group selected community engagement and education/training as two of the priority areas to be addressed by the NNED. The parameters of inquiry related to each of the two priority areas are discussed below.

Priority 1: Community Engagement

Community engagement is a critical first priority because if this is not done respectfully and effectively, it will be difficult to realize the goals of the NNED. Reducing and eliminating mistrust in racial, ethnic and cultural communities is essential. There have been many attempts to engage communities (also called stakeholder engagement) and the NNED can learn from the history of successful and unsuccessful efforts. We can also learn from the experiences that communities themselves have gathered when they have decided to self-organize around various issues.

It is important that the NNED approach in this area is built upon a careful examination of the lessons already learned, such as:

- Each community's needs are different.
- Successful community engagement requires ongoing and persistent efforts.
- Community members can often define the continuum of care much better than external professionals or providers..
- Successful community engagement identifies community leadership and strengthens their capacity to do the work.
- Data gathering approaches should always be culturally appropriate.
- In entering communities, the approach must come from a "positive" perspective and not rely on the usual "deficit" messages.

The goals and objectives of the NNED's community engagement strategies include:

- Being culturally, linguistically and educationally appropriate with the specific communities and documenting the approaches so that others can replicate them or learn from the mistakes.
- Building local capacity and sustainability.
- Creating supportive networks within communities that are multi-directional.
- Modeling ways that research centers, universities, think tanks, and other groups outside of communities can authentically partner and collaborate with communities to produce mutually beneficial results and outcomes.
- Building inter-group and intra-group respect and coalitions to support advocacy for more effective behavioral health programs and policy changes.

Specific Strategies and Activities for Community Engagement

The types of strategies and activities that are needed in the area of community engagement include:

- Assisting communities in developing community profiles that establish a baseline for measuring results and outcomes of actions over time.
- Identifying and developing effective and culturally appropriate methodologies for community engagement and assessments that can be shared within the network and with other organizations.
- Developing effective anti-stigma campaigns – the issue of behavioral health stigma is pervasive in, and perpetuated within, many culturally diverse groups.
- Expanding the behavioral health workforce capacity within communities by further development of cultural broker, promotoras/es, cultural case management, and other liaison models, including efforts to create career development and permanent funding streams for this cadre of critical workers.
- Developing and sharing a community-level data set that can be used to develop community profiles, assist in strategic planning and program development, grant and contract development, etc. that is built around accessible public sector databases and community data collection efforts.

Potential NNED Niche/Tasks in Community Engagement

- Take a more systematic look at what already exists before we define a community engagement process.
- Develop and support surveys of the community at large to identify critical areas of need within NNED's targets.
- Support or launch media campaigns that increase acceptance of behavioral health issues in diverse communities.
- Create awareness in communities about what behavioral health disparities are and their impact on people.
- Create the capacity to assist other organizations in developing their capacity to engage communities.
- Teach the community how to interface with the system to get the services they need.
- Create a "community certification" from NNED for communities who have met a certain level of proficiency in addressing disparities.

Priority 2: Workforce Education, Training and Leadership

Another critical priority identified by the planning group was Education and Training. A trained multicultural workforce is essential to the elimination of behavioral health disparities. The definition of "workforce" must be broadened so that it is not just a certification process. The group also acknowledged that the workforce plan developed by the Annapolis Coalition (2007) and potential partnership with them and others for this priority would honor the NNED principle of not duplicating work that has already been done and linking with others.

The NNED approach in this area acknowledges the major shortage in the current behavioral health workforce and that racial, ethnic and cultural groups are significantly under-represented at all levels of this workforce. This shortage and lack of diversity is at a crisis point, and transformation of the behavioral health system, as well as culturally and linguistically competent care, cannot be realized without significant attention to this area. An ill-prepared, poorly-trained workforce lacking proportional cultural representation and concomitant skills ensures the continuation and growth of racial, ethnic and cultural disparities as the country's population becomes more and more diverse.

The goals and objectives of the NNED's education and training strategies would include:

- Significantly expand the number of competent and diverse individuals within all levels of the behavioral health workforce;
- Improve the quality of skills of those serving racial, ethnic and culturally-diverse groups among the current behavioral health workforce (and for those to come);
- Highlight current career ladder initiatives for natural leaders (natural helpers, promotora/es, etc.) that are funded and built into the structure of state and local behavioral health authorities, colleges and universities, etc.
- Develop earlier entry-points into the behavioral health career ladder (e.g. high school curricula, behavioral health charter schools and high schools, etc.).
- Advance the use of technology to ensure access to, and availability of, trained behavioral health professionals in all communities (i.e., web-based courses, tele-medicine, tele-health, and other technology-based mechanisms).

<u>Specific Strategies and Activities for Workforce Education, Training and Leadership</u>

The types of strategies and activities that are needed in the area of education and training include:

- Aggressive collection, analysis and dissemination of data profiling problems and challenges that groups of color face in entering behavioral health professions and training.
- Requiring licensure and certification competencies in cultural and linguistic competencies for all sectors of the behavioral health workforce.
- Supporting improved wages and expanded functions for bachelor-level behavioral health professionals.
- Providing incentives for bi/multi-cultural and bi/multi-lingual individuals.
- Creation of culture-specific training programs.
- Supporting generalist training that includes broad characteristics of shared experiences of underserved populations (racism, oppression, poverty, and relation to behavioral health problems and well-being, etc.) for all behavioral health professionals and those studying to enter the field.
- Supporting increased federal funding and loan forgiveness programs for expansion of the behavioral health workforce.

- Designating behavioral health workforce as a shortage area at the national level.

Potential NNED Activities/Tasks in Education/Training

- Develop, highlight, and support surveys of the community at large to identify critical issues related to entry and retention in behavioral health professions.
- Accumulate, promote and disseminate approaches to recruitment and retention of groups of color into behavioral health professions in higher education and entry/retention in the behavioral health workforce.
- Create recognition, awards, and other incentives for public, non-profit, and private sector innovators and innovations in increasing the diversity of the behavioral health workforce.
- Create recognition, awards, and other incentives for public, non-profit, and private sector innovators and innovations who implement effective training programs to improve the skills and quality of care delivered by the behavioral health workforce.
- Hone a feasible agenda for policy change and advance through public education and communication strategies.
- Develop papers and articles and host conferences and briefings that describe the state-of-the-workforce and showcase effective strategies for increasing workforce diversity and quality.
- Develop pathways for those who have been trained in their countries of origins in behavioral health but who cannot practice in this country due to certification and licensure restrictions.
- Develop specialized curricula to teach people to be trained behavioral health interpreters.
- Train faith-based leaders and other community providers to understand, assess, and support individuals with behavioral health needs, thus expanding the community capacity to intervene and make appropriate referrals and requests for services.
- Identify and link with other state and national organizations that have an interest or track record related to workforce diversity and training issues.
- Advocate for greater investments in developing a diverse behavioral workforce at the state and local level.

The NNED planning group also identified several additional priority areas that are important to eliminating racial, ethnic and cultural disparities in behavioral health. These include:

- Integration of health and behavioral health
- Integration of mental health and substance abuse programs within communities of color
- Practice models for addressing the mental health needs of those involved in the juvenile justice and criminal justice systems
- Identification, documentation and dissemination of best practices and indigenous and practice-based evidence in communities of color

These and other priority areas will be adapted and further developed as the NNED moves forward. It is also important to acknowledge that there may be other priority areas that will need to be addressed based on further development of partnerships within communities.

8. Recommendations for "Start-Up" Tasks to Begin Implementation of the NNED.

"Start-up" tasks to begin implementation and launching of the NNED include the following:

- Complete the NNED Blueprint and vet it with planning groups for review and comment.
- Select and convene the Steward Group to further delineate the structure and operational processes of the NNED. This group may be composed of volunteers from the planning groups, as well as greater representation from community, family, persons in recovery, and youth organizations.
- Develop a process for sharing the NNED Blueprint with other key constituency groups (such as community groups, researchers, funders, etc.), soliciting their review and feedback. This can include discussions/presentations at professional meetings, community forums, etc.
- Create a communication strategy for the NNED.
- With guidance from the Steward Group, begin identification of potential member organizations and priority projects for the NNED.
- Clearly delineate the benefits and incentives of NNED partnership, as well as the assets that each partner offers the NNED.

CONCLUSION: THE VALUE-ADDED

There are many organizations doing excellent work toward eliminating disparities in behavioral health. There are increasingly more federal, state and local agencies that are recognizing the urgency of addressing these issues. In fact, there is a long litany of groups and organizations that have this as a primary goal. Today, there are millions of dollars being spent to study disparities, build community capacity and transform behavioral health. How will the NNED add value? The NNED will not supplant or compete with any of these existing efforts but will be an important "connector." The NNED will join groups that have a shared vision but are working in isolation or with little awareness of other effective efforts to reduce disparities and improve outcomes.

The NNED will play a critical role by: starting with communities instead of ending there; linking disparities in different service sectors; connecting organizations that may not typically be involved in other national networks (e.g., providers of both traditional and nontraditional services, indigenous community agencies and family and youth organizations); creating new, mutually beneficial partnerships between research centers and communities; and promoting peer-to-peer exchange and service enhancements.

We realize that we have to institute a paradigm change that includes ourselves and our organizations and set-out on a journey that asks us to think and act in very different ways than

we have been trained or rewarded. This is uncharted territory. We have to acknowledge that within our groups of color, there are many tensions, many inter-group and intra-group beliefs and challenges that will have to be acknowledged and resolved respectfully. We also acknowledge that we have yet to develop effective strategies for fully engaging and working in equal partnerships with communities, families and youth. In some of our cultures, this type of collaboration conflicts with basic values and structures – we will have to find ways to accommodate and respect those values and structures without compromising the guiding principles on which the NNED is based. There are no research protocols, manuals, or even many promising pathways. We must be innovators and willing to make mistakes along the way. We will have to look outside of our knowledge areas, our comfort base, to find the mentors, coaches and pioneers to assist us in moving forward. The NNED will demand that we share our knowledge and our resources in new ways that will advance our mutual goals.

This blueprint is the first step in a challenging journey, but one that promises great rewards for the health and well-being of our communities.

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Appendix 1 – Participant List

February 2007 NNED Planning Meeting

Ignacio Acevedo-Polakovich	Dean's Office, Louis de la Parte Florida Mental Health Institute
Henry Acosta	New Jersey Mental Health Institute
Sergio Aguilar-Gaxioia	Center for Reducing Health Disparities (CRHD) - University of California at Davis Health System
Mona Amer	Program for Recovery and Community Health Psychiatry, Yale University School of Medicine
Hank Balderrama	National Latino Behavioral Health Association (NLBHA)
Barbara Bazron	American Institutes for Research
Dolores BigFoot	Department of Pediatrics, University of Oklahoma Health Sciences
Karen Blasé	National Implementation Resource Network, University of South Florida
Delia Carmen	The Annie E. Casey Foundation
Maria Carrasco	NAMI Multicultural Action Center
Nancy Carter	NAMI Urban Los Angeles
Patrick Chaulk	The Annie E. Casey Foundation
Andrea Copeland	New Horizons Community Mental Health Center for Public Policy
Don Coyhis	White Bison, Inc.
Jeff Davis	First Nations Behavioral Association
King Davis	Hogg Foundation for Mental Health
Miriam Delphin	Department of Psychiatry, Yale University
Trina Dutta	Center for Mental Health Services, Substance Abuse and Mental Health Services Administration
Holly Echo-Hawk	Echo-Hawk and Associates
Kana Enomoto	Office of the Administrator, Substance Abuse and Mental Health Services Administration
Migali Fana	National Alliance of Multi-Ethnic Behavioral Health Associations
Lewis Gallant	National Association of State Alcohol and Drug Abuse Directors
Terry Gock	Asian Pacific Family Center
Tawara Goode	National Center for Cultural Competence, Georgetown University
Carmelita Grady	CRP, Incorporated
Rachel Guerrero	Office of Multicultural Services
Renata Henry	Division of Substance Abuse and Mental Health
Mario Hernandez	Louis de la Parte Florida Mental Health Institute, University of South Florida
Larke Huang	Office of the Administrator, Substance Abuse and Mental Health Services Administration
Dennis Hunt	Center for Multicultural Human Services
DJ Ida	National Asian American Pacific Islanders Mental Health Association
Mareasa Isaacs	National Alliance of Multi-Ethnic Behavioral Health Associations
Laurence Jackson	Progressive Life Center
Audrey Jordan	The Annie E. Casey Foundation
Yeshashwork Kibour	Center for Multicultural Human Services
Ford Kuramoto	National Asian Pacific Families against Substance Abuse
Ken Martinez	Technical Assistance Partnership, American Institutes for Research
Oscar Morgan	National Leadership Council for African American Behavioral Health
Mikisha Nation	Emergency Mental Health & Traumatic Services Branch, Substance Abuse and Mental Health Services Administration
Abel Ortiz	The Annie E. Casey Foundation
Jan Richardson	CRP, Incorporated
Britt Rios-Ellis	National Council of La Raza Raul
H. Sally Smith	Bristol Bay Area Health Corporation
Altha Stewart	Stewart Behavioral Health Associates (SBHA)

Joy Thomas Moore	JWS Media Consulting
Henrie Treadwell	Community Voices
Andrea Vincent	CRP, Incorporated
R. Walker	American Indian & Addictions Research, Portland VA Medical Center
Ed Wang	Office of Multicultural Affairs, Massachusetts Department of Mental Health

May 2007 NNED Organizing Committee Meeting

Henry Acosta	New Jersey Mental Health Institute
Meg Backas	Mary's Center for Maternal and Child Care
Barbara Bazron	American Institutes for Research
Kisha Braithwaite	Department of Psychiatry and Behavioral Sciences, Morehouse School of Medicine
Maria Carrasco	NAMI Multicultural Action Center
Copeland Andrea	New Horizons Community Mental Health Center for Public Policy
Holly Echo-Hawk	Echo-Hawk and Associates
Rachele Espiritu	Change Matrix LLC
Migali Fana	National Alliance of Multi-Ethnic Behavioral Health Associations
Larke Huang	Office of the Administrator, Substance Abuse and Mental Health Services Administration
Andrew Hunt	Center for Mental Health Services, Substance Abuse and Mental Health Services Administration
Anisha Imhoff-Kerr	Youth Advocate
Mareasa Isaacs	National Alliance of Multi-Ethnic Behavioral Health Associations
Davis Ja	National Asian American Pacific Islanders Mental Health Association
Yeshashwork Kibour	Center for Multicultural Human Services
Jeffrey King	First Nations Behavioral Association
Ford Kuramoto	National Asian Pacific Families against Substance Abuse
Ken Martinez	Technical Assistance Partnership, American Institutes for Research
Oscar Morgan	National Leadership Council for African American Behavioral Health
Mikisha Nation	Emergency Mental Health & Traumatic Services Branch, Substance Abuse and Mental Health Services Administration
Cynthia Newbille	East District Family Resource Center
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Sandra Spencer	Federation of Families for Children's Mental Health