

Eliminating Disparities in Mental Health: An Overview

Introduction

In 2001 former Surgeon General Dr. David Satcher released *Culture, Race and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General*. This landmark report documented the lack of access and the poor quality of mental health care that people of color had been receiving when dealing with mental illness. The message of the Surgeon General was clear: culture counts and the mental health system was leaving thousands of Americans behind. This report gave voice to millions of Americans who faced this grim reality. It also created an opportunity for people around the country to advocate for real change. Subsequent reports, including the Institute of Medicine's *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2003), the President's New Freedom Commission on Mental Health *Achieving the Promise: Transforming Mental Health Care in America* (2003), and the Agency for Healthcare Research and Quality *National Healthcare Disparities Report* (2005) have continued to highlight the myriad of barriers to accessing mental health treatment, as well as the poor quality of care received by ethnic/racial communities. These reports have provided important recommendations to address these shortcomings and to make quality mental health treatment a reality for all Americans.

Unfortunately, there has been little progress in overcoming barriers to treatment and in improving quality of care for communities of color. Much still needs to be done to make recovery from mental illness a reality for all Americans. In 2002, recognizing the unmet needs of multicultural communities, NAMI created a Center solely dedicated to addressing disparities in mental health and providing much needed education and support to minority communities. During the past 4 years, NAMI's Multicultural Action Center organized Multicultural Mental Health Symposia to highlight the mental health status and needs of the African American, American Indian & Alaska Native, Asian American & Pacific Islander, and the Hispanic/Latino communities. One recurrent theme stood out among all others: all four communities faced significant barriers to mental health treatment and often received treatment of lesser quality.

Different organizations at the local, state and national level have been addressing these disparities and have come forward with innovative approaches including community specific research, education campaigns, and cultural competence trainings. They have been striving to provide mental health services and supports to multicultural communities. NAMI's 2006 **Eliminating Disparities: Multicultural Strategic Summit** was organized in order to highlight some of these promising practices and to galvanize multicultural communities into action. Good practices in ethnic/racial mental health do exist. It is important for advocates across the nation not only to share successes but also the challenges and lessons learned when implementing these practices.

NAMI's Multicultural Strategic Summit is proud to bring together advocates from across the nation to address the current disparities in mental health care affecting communities of color and to present viable solutions to address the myriad of barriers to both access and quality of treatment.

This CD highlights the major findings and recommendations of the reports mentioned above. It provides in-depth information about each of the highlighted communities and shares information on good practices in multicultural mental health. NAMI is grateful to all Summit speakers for preparing the power point presentations included on this CD and for sharing their knowledge with NAMI members and friends.



I am especially grateful to Maria Elizabeth Diaz, who prepared the Partner Organizations Highlights based on extensive interviews with each partner; Marin Swesey, who contributed to all aspects of the planning for the Summit and the creation of this CD; Carmen Campos, for designing and producing the CDs; and finally to Beatriz Espinosa, Ana Ferrara, Fred Sandoval, Lynne Saunders, Gerry Shannon, Gloria Walker, and all NAMI members and friends who provided invaluable guidance and support.

A handwritten signature in black ink that reads "M. José Carrasco".

Majose Carrasco
Director
NAMI Multicultural Action Center

Demographics

The United States boasts a very diverse population traditionally split into five ethnic/racial groups. These include the majority Caucasian American, and the minority African American, American Indian/Alaska Native (AIAN), Asian American/Pacific Islander, and Hispanic/Latino groups. Though these groups encompass very diverse populations, it is important to create these broad categories for comparison. The 2004 U.S. Census separates the Hawaiian Native/Pacific Islander (HNPI) group from Asian American, and the present data is similarly organized. There are wide disparities between the education, financial status and language capabilities of the groups. Such deficiencies affect all aspects of healthcare including mental health. Due to the strong connection between these factors and access to mental health care, the information below provides demographic information for each of these ethnic/racial groups (see Table 1).

Education:

- Latinos have a significantly lower percentage of high school graduates at only 59.6%.
- Two of the groups, Asian American and Caucasian, have incredibly higher percentage of completed higher education than the other groups, with an extremely high 48.2% of the Asian American population.

Income:

- Asian Americans have higher median household income and lower family and individual poverty rates than all other groups.
- The African American, AIAN, and Latino groups have lower median household incomes and higher rates of poverty.

Uninsured:

- Particularly higher percentages of uninsured individuals are within the AIAN and Latino populations.
- Warranting particular attention are the higher percentages of the Asian American and Latino populations not of legal U.S. citizen status, who do not have health insurance and cannot receive support from federal programs.

Language Spoken at Home:

- For the Asian American and Latino populations, percentages of individuals who speak another language at home soar above the rates in the other ethnic groups.
- Similarly, there are higher rates of limited English proficient individuals within the Asian American and Latino populations with 28.2% and 29.9%, respectively, who speak English less than “very well”. These disparities are logically related to a much higher percent of foreign born individuals in these two groups.

Table 1

	African American	American Indian/ Alaska Native	Asian American	Native Hawaiian/ Pacific Islander	Latino	Caucasian American
% of US Population	12.2	0.8	4.2	0.1	14.2	75.6
Population Count	34,772,381	2,151,322	12,097,281	403,832	40,459,196	216,036,244
EDUCATION						
% High School graduate or higher	79.3	76.6	84.8	83.9	59.6	86.1
% Bachelor's or higher	17.3	14.2	48.2	15.4	12.7	28.3
FINANCIAL STATUS						
median household income	\$30,173	\$31,605	\$56,161	\$47,442	\$35,929	\$47,450
% families at poverty status	23	20.5	9.4	2.9	20	7.5
% individuals at poverty status	25.6	24.6	11.8	16.2	22	10.3
% uninsured	21	28	20.4*	20.4*	34.3	12.9
% unemployed	6.1	14	6.3	9.9	8.9	6.2
LANGUAGE						
% speak other language at home	0.6	24.7	76.5	38.4	77.2	13.1
% speak English less than "very well"	0.2	1.7	28.2	4.7	29.9	0.7
CITIZEN STATUS						
% foreign born	7.6	4.4	67.4	21.9	39.2	7.7
% not a citizen	4	2.8	30.5	15	28.2	4.6

* data compiled for combined Asian American/South Pacific Islander

References:

- American Community Survey: Selected Population Profile, U.S. Census Bureau, 2004
- Current Population Survey Report: The Black Population in the United States, U.S. Census Bureau, March 2004
- Current Population Survey Report: Asian and Pacific Islander Population in the United States, U.S. Census Bureau, March 2004
- DeNavas-Walt, Carmen, Bernadette D. Proctor, and Cheryl Hill Lee, U.S. Census Bureau, Current Population Reports, P60-229, Income, Poverty, and Health Insurance Coverage in the United States: 2004, 2005
- Health Insurance Coverage in America: 2003 Data Update Highlights, Kaiser Family Foundation, September 2004

Major Reports: Findings and Recommendations

In 2001 the Surgeon General's Report on *Culture, Race & Ethnicity* documented barriers to treatment by racial/ethnic communities and the inequality of care faced by all minority communities. Subsequent reports have underscored these findings and have documented slow progress. Unfortunately, in 2005 the *National Healthcare Disparities Report* concluded that disparities still existed. Perhaps more alarming was the acknowledgment that while disparities in quality and access were decreasing for African American, American Indian, and Asian American communities, disparities in care were actually increasing for Hispanic/Latinos.

The reports put forth the following recommendations:

- Increase minority specific research (including research on disparities, evidence based practices, culture specific interventions, and more).
- Collect Data and Monitor Progress.
- Diversify the mental health workforce.
- Achieve cultural competence in service delivery and care.
- Train providers on cultural competence and the impact of race/culture in mental health seeking behaviors, treatment, and patient/provider interaction.
- Improve access to care by decreasing barriers to treatment (including language access, primary care settings, prevention, and more).
- Implement mental health system changes such as consistency through evidence based practices, payment systems to ensure adequate supply of services for minority communities, better communication, and more.
- Promote mental health and combat stigma.
- Educate, empower, and support consumers and families.

What follows are brief highlights of each report.

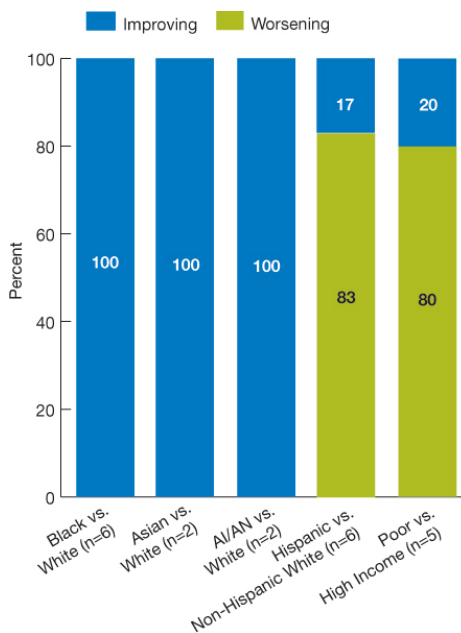
**National Healthcare Disparities Report
Agency for Healthcare Research and Quality
2005**

<http://www.qualitytools.ahrq.gov/disparitiesreport/2005/browse/browse.aspx>

Disparities still exist

- Some disparities are diminishing.
- Opportunities for improvement remain.
- Information about disparities is improving.
- Disparities are observed in almost all aspects of health care, including:
 - Across all dimensions of quality of health care including effectiveness, patient safety, timeliness, and patient centeredness.
 - Across all dimensions of access to care including facilitators and barriers to care and health care utilization.
 - Across many levels and types of care including preventive care, treatment of acute conditions, and management of chronic disease.
 - Across many clinical conditions including cancer, diabetes, end stage renal disease, heart disease, HIV disease, mental health and substance abuse, and respiratory diseases.
 - Across many care settings including primary care, dental care, home health care, emergency departments, hospitals, and nursing homes.
- While disparities in quality and access to care experienced by Blacks, Asian Americans, and American Indians were becoming smaller, disparities experienced by Hispanics were becoming larger.
 - For Hispanics, all disparities in access were getting worse except being uninsured all year.

Figure H.4. Change in disparities in core report measures of access over time for members of selected groups compared with reference group



Improving: = Population-comparison group difference becoming smaller.

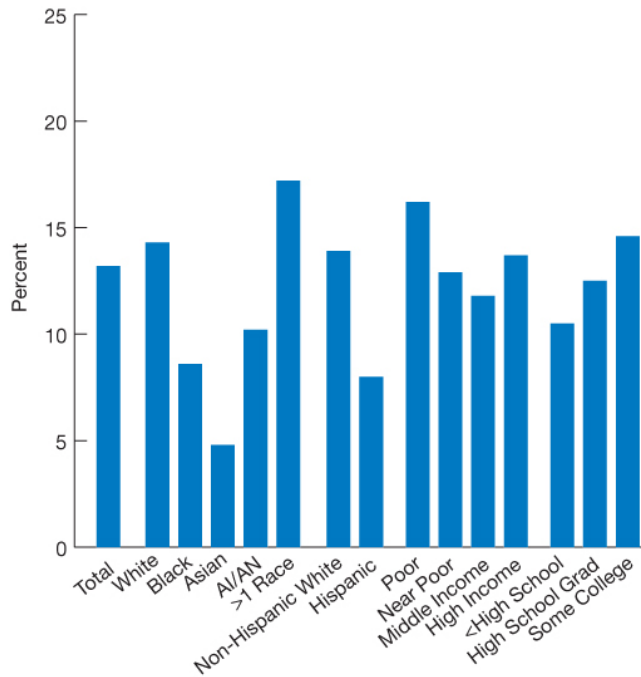
Worsening: = Population-comparison group difference becoming larger.

Key: AI/AN=American Indian or Alaska Native.

MENTAL HEALTH AND SUBSTANCE ABUSE

- Compared with Whites, minorities have less access to mental health care and are less likely to receive needed services.
- Racial, ethnic, and socioeconomic differences in the use of psychiatric medications and of psychiatric outpatient, emergency, and inpatient services have also been documented. These differences may reflect, in part, variation in preferences and cultural attitudes toward mental health.

Figure 3.16. Adults who received mental health treatment/counseling in the past year by race, ethnicity, income, and education, 2003



Key: AI/AN=American Indian or Alaska Native.

Source: SAMHSA National Survey on Drug Use and Health, 2003.

Reference population: U.S. population age 18 and older.

- The proportion of persons who received mental health treatment/counseling was lower among Blacks, Asians, and AI/ANs compared with Whites; among Hispanics compared with non-Hispanic Whites (Figure 3.16).
- Socioeconomic status explains some but not all of the racial and ethnic differences in mental health treatment. At every income and education level, Hispanics are less likely than non-Hispanic Whites to have received mental health treatment (Figures 3.17 and 3.18).
- At higher income and education levels, Blacks are less likely than Whites to have received mental health treatment/counseling; among the poor and among individuals with less than a high school education, Black-White differences are not significant.
- Racial, ethnic, and socioeconomic differences in substance abuse treatment are observed which may, in part, reflect variation in preferences and cultural attitudes toward mental health and substance abuse. Nonetheless there is a significant treatment gap: 15% of Blacks who needed treatment received it, 10% of Whites who needed treatment received it, 7% of Hispanics who needed treatment received it, and only 2% of Asians who needed treatment received treatment.

Language access and quality

- Language barriers may impair the development of trust, mutual respect and understanding.
- The overall proportion of adults whose health providers sometimes or never listened carefully, explained things, showed respect, and spent enough time with them was higher among individuals who speak a foreign language at home compared with individuals who speak English at home.
- Compared with Whites who speak English at home, the proportion of adults with communication problems was higher among Whites and Asians who speak some other language at home.
- Compared with non-Hispanic Whites who speak English at home, the proportion of adults with communication problems was higher among non-Hispanic Whites and Hispanics who speak some other language at home as well as Hispanics who speak English at home.

Lack of Health Insurance

- The overall proportion of persons younger than 65 uninsured all year was higher among foreign-born persons compared with individuals born in the United States (Figure 4.14).
- Compared with U.S.-born Whites, the proportion of persons under age 65 uninsured all year was higher among Whites and Blacks born outside the United States as well as Blacks born in the United States.
- Compared with U.S.-born non-Hispanic Whites, the proportion of persons uninsured all year was higher among non-Hispanic Whites and Hispanics born outside the United States as well as Hispanics born in the United States.

Achieving the Promise: Transforming Mental Health Care in America
President's New Freedom Commission on Mental Health 2003
<http://www.mentalhealthcommission.gov/>

Summary Provided by the American Psychiatric Association, 2005

In addition to highlighting issues of access to mental health services in general, the President's New Freedom Commission on Mental Health Report focused on the additional barriers to care that prevent racial and ethnic minorities from seeking services, including fear and mistrust of treatment, different cultural ideas about illness and health, differences in help-seeking behaviors, racism, differing rates of being uninsured, and discrimination by individuals and institutions.

This report also emphasized the importance of the culture of providers of mental health services as well as the culture of those seeking help. Because providers have their own culture of shared beliefs, norms, and values, they may view mental health, diagnosis, and treatment ways that may differ from the culture of the patient or client. The report suggests that without adequate training of professional to deliver culturally competent care, the burden of mental disorders on racial and ethnic minorities will only deepen and intensify.

- The President's New Freedom Commission Report recommends improving access to quality care that is culturally competent. According to the report, culturally competent services are "the delivery of services that are responsive to the cultural concerns of racial and ethnic minority groups, including their language, histories, traditions, beliefs, and values."
- The Commission recommends that States address disparities as part of their Comprehensive State Mental Health Plans, which could include: setting standards for culturally competent care; collecting data to identify points of disparity; evaluating services for effectiveness and consumer satisfaction; developing collaborative relationships with culturally driven, community based providers; and establishing benchmarks and performance measures.
- State plans should promote increased opportunities to include individuals from diverse cultural backgrounds in the mental health workforce. Similarly, the Commission also recommends efforts to recruit, retain, and enhance a diverse workforce throughout the country. These efforts should include: recruiting and retaining racial and ethnic minority and bilingual professionals; developing curricula that address the impact of culture, race, and ethnicity on mental health and mental illnesses, on help-seeking behaviors, and on service use; training and research programs targeting services to multicultural populations; funding these programs; and engaging minority consumers and families in workforce development, training, and advocacy.

Unequal Treatment: Confronting Racial and Ethnic Disparities in health Care
Institute of Medicine Report 2003
<http://iom.edu/?id=16740>

Summary Provided by the American Psychiatric Association, 2005

In response to the body of research revealing that racial and ethnic minorities have less access to and experience a lower quality of health care, even when variables such as insurance status, income, age, co-morbid conditions, and symptom expression are taken into account, the U.S. Congress requested the Institute of Medicine to assess the extent of racial and ethnic differences in healthcare, evaluate potential sources of racial and ethnic disparities in healthcare, and provide recommendations for eliminating healthcare disparities.

Key findings:

- Racial and ethnic disparities in health care exist, and because they are associated with worse outcomes in many cases, are unacceptable.
- Racial and ethnic disparities in health care occur in the context of broader social and economic inequality.
- Many sources may contribute to racial and ethnic disparities.
- Bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers may contribute to racial and ethnic disparities in health care.
- Minority patient refusal rates do not fully explain health care disparities.

Recommendations:

1. General Recommendations
 - Increase awareness of racial and ethnic disparities in health care.
 - Increase health care providers' awareness of disparities.
2. Legal, Regulatory, and Policy Interventions
 - Avoid fragmentation of health plans along socioeconomic lines.
 - Strengthen the stability of patient-provider relationships in publicly funded health plans.
 - Increase representation of racial and ethnic minorities among health professionals.
 - Apply the same managed care protections to publicly funded HMO enrollees that apply to private HMO enrollees.
 - Provide greater resources to the U.S. Department of Health and Human Services Office of Civil Rights.
3. Health Systems Interventions
 - Promote consistency and equity through evidence-based guidelines.
 - Structure payment systems to ensure an adequate supply of services to minority patients.

- Enhance patient-provider communication and trust by providing financial incentives to reduce barriers and encourage evidence-based practice.
 - Support the use of interpretation services.
 - Support the use of community health workers.
 - Implement multidisciplinary treatment and preventive care teams.
4. Patient Education and Empowerment. Implement patient education programs to increase knowledge of how to access care and participate in treatment decisions.
 5. Cross-Cultural Education in the Health Professions. Integrate cross-cultural education into the training of current and future health professionals.
 6. Data Collection and Monitoring
 - Include measures of disparities in performance measurement.
 - Monitor progress toward eliminating disparities.
 - Report racial and ethnic data by Office of Management and Budget categories, but use subpopulation groups where possible.
 7. Research Needs
 - Collect and report data on health care access and utilization by patient race, ethnicity, socioeconomic status, and primary language.
 - Conduct further research to identify sources of disparities and promising intervention strategies.
 - Conduct research on ethical issues and other barriers to eliminating disparities.

Mental Health: Culture, Race and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General 2001

<http://www.mentalhealth.samhsa.gov/cre/default.asp>

Summary Provided by the American Psychiatric Association, 2005

The Surgeon General's Report provides comprehensive coverage of the issues related to the mental health of racial and ethnic minorities. *The report finds that significant disparities exist regarding the mental health services delivered to racial and ethnic minorities: Racial and ethnic minorities have less access to and availability of care, receive generally poorer quality mental health services, and experience a greater disability burden from unmet mental health needs.*

The main message of the report is "Culture Counts." The report includes discussions of the cultural and social factors that contribute to mental illness; the social and economic environment of inequality including racism, discrimination, violence, and poverty that leave minorities with greater exposure to mental illness; the racism and discrimination that have an adverse effect on mental health; the mistrust of mental health services that deters minorities from seeking help; and the clinical environments that are often inadequate to accommodate the needs of racial and ethnic minorities.

The remainder of the report is devoted to issues relevant to each of the major racial and ethnic groups in America: African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics. Major issues discussed include availability of services, access to services, utilization of services, and appropriateness and outcomes of services. A review of these issues for each group is consistent with the main finding that access and availability of appropriate services to racial and ethnic minorities is lacking.

The report also makes several recommendations for eliminating mental health disparities.

- *Expand the science base.* This includes more research to assess the influence of variables such as acculturation, stigma, spirituality, socioeconomic status, education, and perceived discrimination on mental health outcomes. Further study is also needed on the efficacy of evidence-based treatments for racial and ethnic minorities, the differential response to medications by race and ethnicity, clinician bias and diagnostic accuracy, and the differences in stress, coping and resilience that will provide the groundwork for new prevention and treatment strategies.
- *Improve access to treatment.* Improving access to treatment includes improving geographic availability of mental health services, integrating mental health care and primary health care, improving language access, and coordinating care to vulnerable, high-need groups such as people who are incarcerated or are homeless.

- *Reduce barriers to mental health care.* Reducing barriers to mental health care requires addressing the cost of services, the fragmented organization of these same services, and the stigma toward mental illness.
- *Improve quality of mental health services.* To improve quality of care, the report encourages providers to deliver treatment based on evidence-based professional guidelines, with treatments being tailored to the individual according to the person's age, gender, race, ethnicity, and culture. Of course, more research is needed on adapting evidence-based treatments for effectiveness with racial and ethnic minorities. Further study of "ethnic-specific" and "culturally competent" practice models may reveal how these models can contribute to important aspects of quality care for racial and ethnic minorities.
- *Support capacity development.* All mental health professionals should develop their skills in tailoring treatments to age, gender, race, ethnicity and culture. However, racial and ethnic minorities are encouraged to enter the field because they are underrepresented among providers, researchers, administrators, policy makers, and consumer and family organizations. Further, leadership from within the community is required to better facilitate the design, planning and implementation of mental health service systems.
- *Promote mental health.* The reduction of negative social conditions such as poverty, community violence, racism, and discrimination is likely vital to improving the mental health of racial and ethnic minorities. Efforts to prevent mental illness and promoting health should build on community strengths such as spirituality, educational attainment, local leadership, and focus on families.

The CD prepared for the Summit provides brief overviews of multicultural mental health issues and the power point presentations prepared by the speakers. The documents have been organized as follows:

Mental Health Status by Community

The files on this section provide brief overviews of mental health issues by community.

- African American Community Mental Health Fact Sheet
- **Initiating a Genetic Study with African American Patients** by Randye Sample, Ph.D., College of Physicians and Surgeons, Columbia University.
- American Indian & Alaska Native Communities Mental Health Fact Sheet
- **American Indian Mental Health** by Angie Stratig, MSW and Jessica Gourneau, Ph.D., American Indian Family Center.
- **Disparity of Health Services, and Research: A National Strategy for Native Mental Health and Addictions Prevention and Treatment** by Dr. Dale Walker, One Sky Center.
- Asian American & Pacific Islander Communities Mental Health Fact Sheet
- **Are Asian Americans Ahead of the Mental Health System?** By Dr. Anand Pandya, Member of the Board of Directors, NAMI National.
- **Asian American Elders: Culturally Competent Approaches** by Yilo Cheng, MSW, Mental Health Project Manager, Asian American Federation of New York.
- Hispanic/Latino Community Mental Health Fact Sheet
- **The Current Status of Latino Mental Health in the United States** by Henry Acosta, Deputy Director, New Jersey Mental Health Institute Inc. / Project Director, Changing Minds, Advancing Mental Health for Hispanics.
- **Working with the Latino Community** by Martha Silva, Director NAMI Latino Program, NAMI NJ.

Best Practices in Multicultural Mental Health Advocacy & Treatment

While Disparities in mental health still exist for ethnic/racial communities, some efforts have been implemented in order to solve this problem. As the reports and documents provided above showcase, this is a very complex problem that requires major interventions at very different levels. The files on this section highlight some practices that have proven to effectively address disparities in mental health care.

Research

- **Brief overview of the National Institute of Mental Health Minority Research Efforts.**

- **Evidence Based Practices** by Dr. Ernest Marquez, NIMH.
- **Preliminary Findings on Public Attitudes Towards Genetic Research** by Eleanor Murphy, School of Public Health, Columbia University.

Cultural Competence in Service Delivery

- **Cultural competence in Service Delivery** by Ed Wang, Psy.D., Director, Office of Multicultural Affairs, Massachusetts Department of Mental Health.
- **Achieving Cultural Competence** by Celestine Willis, M.A., Linda Denson, and Joyce Lane, Ph.D.
- **Effective Strategies for Promoting Systemic Cultural Competence** by Cathy Cave and Miriam Delphin, Ph.D.
- **CLAS Standards - Culturally and Linguistically Appropriate Services**

Community Outreach, Education and Support

- **Consumer and Family Education and Support** by Maggie Luo, M.A., Program Coordinator, Chinese American Mental Health Outreach Program, NAMI New Jersey.
- **Outreach: Reaching Out to Diverse Communities** by Gloria Walker, Member NAMI National Board of Directors.
- **African American Outreach: NAMI Tennessee** by Clarence Jordan, Operations Offices, NAMI Tennessee.

Advocacy and Coalition Building

- **Advocacy and Coalition Building** by Molly Cole, Executive Director, FAVOR, Inc.

Language Access

- **Improving Meaningful Access to Services for Persons with Limited English Proficiency (LEP)** by Dr. Juan Ramos
- **Title VI of the Civil Rights Act: Language Access to Health Care** by Majose Carrasco, NAMI Multicultural Action Center

NAMI Multicultural Partners Highlights

NAMI works with a variety of national, state and local organizations committed to improving mental health in communities of color. These organizations have extensive knowledge and expertise on areas such as advocacy, education, treatment, and training. The provided profiles briefly highlight each of the following organizations and their priorities, programs, and resources. The profiles of 3 NAMI offices have been included as examples of the type of work NAMIs are doing across the nation.

- Advocates for Latino Mental Health Advancement (ALMA)
- American Psychiatric Association (APA)
- American Psychiatric Foundation
- Asian American Federation of New York
- Asian Community Mental Health Services
- Center for Reducing Health Disparities
- Standing Rock Sioux Tribe
- Children and Adults with Attention-Deficit/Hyperactive Disorder (CHADD)
- Circles of Care Evaluation Technical Assistance Center
- Latino Behavioral Health Institute (LBHI)
- NAMI Alaska
- NAMI New Jersey
- NAMI Urban Los Angeles
- National Alliance of Multi-Ethnic Behavioral Health Associations (NAMBHA)
- National Asian American Pacific Islander Mental Health Association (NAAPIMHA)
- National Association of State Mental Health Program Directors (NASMHPD)
- National Council of La Raza (NCLR)
- National Latino Behavioral Health Association (NLBHA)
- National Mental Health Association (NMHA)
- National Organization for People of Color Against Suicide (NOPCAS)
- New Jersey Mental Health Institute
- One Sky Center
- Yale Program for Recovery and Community Health

NAMI's Multicultural Action Center

The files on this section provide an overview of NAMI's Multicultural Action Center and NAMI's public policy platform.

NAMI 2006 Eliminating Disparities: Multicultural Strategic Summit Agenda