

**PUBLIC  
POLICY  
PLATFORM**

**of**

*The National Alliance on Mental Illness*  
**NAMI**

by the  
Public Policy Committee  
of the Board of Directors  
and the  
NAMI Department of Public Policy and Legal Affairs

Eighth Edition  
July 2009

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

## **Acknowledgments**

The NAMI Board Members of the Public Policy Committee and the NAMI Executive Director wish to thank the many local affiliates and state organizations for their contributions to this policy compilation. We particularly wish to acknowledge the valuable contributions of the members of the NAMI Board of Directors, past and present.

NAMI establishes this policy statement to advance its mission through advocacy and education. This is an evolving document.

Public Policy Committee  
NAMI  
Colonial Place Three  
2107 Wilson Boulevard, Suite 300  
Arlington, Virginia 22201-3042  
Main: 703-524-7600  
Helpline: 1-800-950-NAMI

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

## Language

NAMI's policy is to acknowledge that severe and persistent mental illnesses are illnesses that affect the brain. Therefore, throughout this document, the term "brain disorder(s)" is used interchangeably with "severe and persistent mental illness(es)."

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder. (Revised March 2006)

NAMI requires that all NAMI documents and NAMI co-authored documents use language that puts people first. For example, "people or persons with serious mental illnesses" instead of "mentally ill people" or "the mentally ill"; and "offenders with serious mental illnesses" instead of "the criminally insane."

## Stigma and Discrimination

NAMI condemns all acts of stigma directed against persons with serious mental illnesses, whether by intent, ignorance, or insensitivity. Epithets, nicknames, jokes, advertisements, and slurs that refer to persons with serious mental illnesses in a stigmatizing way are cruel. NAMI considers acts of stigma to be discrimination.

NAMI believes, in accordance with current scientific evidence, that persons who are receiving appropriate treatment and services for a serious mental illness are no more violent than the population at large. NAMI deplores the portrayal in literature, films, and television of persons with serious mental illnesses as being prone to violence. These frequent depictions are hurtful stereotypes. The truth is that persons with serious mental illnesses are more often the victims of violence.

NAMI especially deplores the exploitation of people with serious mental illnesses by journalists, advertisers, advertising agencies, the entertainment industry, and others for commercial gain or other advantage.

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

## Table of Content

Acknowledgments.....	1
Language.....	2
Stigma and Discrimination .....	2
Table of Content .....	3
1. Identity and Mission .....	5
2. Priority and Special Population .....	6
2.1 Priority Population.....	6
2.2 Additional Support.....	6
2.3 Cultural Diversity .....	7
2.4 Adults Who Are Elderly .....	7
2.5 Adults Who Are Veterans.....	7
2.6 Persons Who Are Homeless and/or Missing .....	8
2.7 Persons Infected with the HIV Virus.....	8
2.8 Children with Serious mental illnesses .....	9
2.9 Minor Children of Parents with Serious mental illnesses.....	11
3. Treatment .....	11
3.1. Access to Treatment.....	11
3.2 Early Diagnosis.....	12
3.3 Mental Health Screening .....	12
3.4. Individual Treatment Plan .....	14
3.5 Outpatient Treatment .....	14
3.6 Inpatient Treatment.....	15
3.7 Family Involvement in Treatment .....	15
3.8 Outcome Measures .....	17
3.9 Non-endorsement of Specific Medications or Treatment Modalities.....	17
3.10 Access to Psychiatric Medications .....	17
3.11 Prescription Privileges for Psychologists, Workforce Shortages.....	18
3.12 Cultural Competence .....	19
3.13 Wellness .....	19
4. Services and Supports for Children, Adolescents, Young Adults and Families.....	20
4.1 Comprehensive Array of Services and Supports.....	20
4.2 School and Campus Based Services.....	21
4.3 Transition Age Services and Supports .....	23
4.4 Educational Programs.....	23
4.5 Training and Qualifications for Providers.....	24
4.6 Integrated Health and Mental Health Care.....	24
4.7 Family Driven and Youth Guided Services .....	25
5. Services and Supports for Adults.....	25
5.1 Community Systems .....	25
5.2 Continuity of Care .....	26
5.3 Housing.....	26
5.4 Rehabilitation, Employment, and Education .....	27

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

5.5	Consumer-run Programs .....	28
5.6	Educational Programs for Consumers and Families .....	28
6.	Financing of Treatment and Services .....	28
6.1	Private-Sector Healthcare Reform .....	28
6.2	The Role of the Public Sector .....	29
6.3	Medicaid, Medicare, and Veterans Benefits .....	30
6.4	Public Financing .....	31
6.5	Managed Care under All Payers .....	34
7.	Research .....	36
7.1	NAMI's support .....	36
7.2	Standards for Protecting the Well-being of Individuals Participating in Research .....	36
7.3	Biomedical Research .....	39
7.4	Psychopharmacological Research .....	39
8.	Quality Monitoring, Accountability, and Accreditation .....	40
8.1	Governing Boards .....	40
8.2	Hospital Standards .....	41
8.3	Smoking .....	42
8.4	Deaths in Institutions .....	44
8.5	Protection and Advocacy Services .....	44
8.6	Training of Professionals .....	44
8.7	Accreditation of Facilities and Programs .....	46
8.8	Use of Restraints and Seclusion .....	46
8.9	Application of Less Lethal Weapons by Law Enforcement Officers .....	49
9.	Legal Issues .....	50
9.1	Right to Treatment .....	50
9.2	Involuntary Commitment/Court-ordered Treatment .....	50
9.3	Advance Directives and Healthcare Proxies .....	52
9.4	Security of Trust Funds .....	52
9.5	Confidentiality .....	53
9.6.	The Americans with Disabilities Act (ADA) .....	54
10.	Criminal Justice and Forensic Issues .....	55
10.1	Ultimate Responsibility of Mental Health Systems .....	55
10.2	Therapeutic Jurisprudence .....	55
10.3	Education at all levels of Judicial and Legal Systems .....	55
10.4	Collaboration .....	55
10.5	Boot Camps .....	56
10.6	Right to Treatment (Regardless of Criminal Status) .....	56
10.7	Jail Diversion .....	56
10.8	Violence .....	57
10.9	Death Penalty .....	57
10.10	Insanity Defense .....	58
	Permission to Reprint .....	60

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

## 1. Identity and Mission

- 1.1 NAMI is a grassroots organization of individuals with serious mental illnesses and their family members whose mission is to eradicate serious mental illnesses and improve the quality of life of persons of all ages who are affected by them.
- 1.2 The primary functions of NAMI are support, education, and advocacy for consumers and their families; for research and services; and for the education of all professionals, providers, and the general public. An individual with a serious mental illness is sometimes referred to as a consumer. When speaking of NAMI members in general, we speak of family and that includes the consumer as a family member. We speak of consumer when it is necessary to make the distinction.
- 1.3 NAMI promotes the prevailing scientific judgment that "severe mental illnesses" are brain disorders, which at the present time are neither preventable nor curable, but are treatable and manageable with combinations of medication, supportive counseling, and community support services, including appropriate education and vocational training. The causes of serious mental illnesses are complex, and they are not understood thoroughly. There is a genetic component to some serious mental illnesses. Although stress or drug and alcohol abuse can precipitate or aggravate episodes of an illness, they are not primary causes.
- 1.4 NAMI's roots grew from the need of people for knowledge, understanding, sharing of grief, relief of guilt, mutual support, and mutual love. Increase in NAMI's membership is likely to be concentrated in families and consumers needing and seeking these same needs. Family means consumers and their parents, siblings, adult children, spouses, and other involved relatives.
- 1.5 While primary peer support is concentrated in local affiliates and conventions, all components of NAMI declare:
  - (1.5.1) Together we can give each other strong support;
  - (1.5.2) The illness is treatable;
  - (1.5.3) It's not anyone's fault;
  - (1.5.4) You don't need to explain anything—we already know;
  - (1.5.5) You can survive as an intact family;
  - (1.5.6) With dedication and unity, we have enormous strength through which we can accomplish constructive change.

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

- 1.6** Persons with serious mental illnesses share many similar problems with persons with other disorders and disabilities. To achieve our own goals, NAMI supports to the fullest extent possible solidarity with those persons with disorders and disabilities to effect positive changes in societal attitudes, government, education, and public and private institutional responsiveness. NAMI maintains the right to forcefully advocate for the rights of persons with serious mental illnesses, even when our views conflict with the views of other disability groups. NAMI places the highest priority on medical treatment, services, education, and rehabilitation for persons with serious mental illnesses, as well as research aimed toward the ultimate prevention and cure of these disorders.

## **2. Priority and Special Population**

### **2.1 Priority Population**

NAMI identifies as the priority population those persons of all ages who have severe and persistent mental illnesses, including: (Revised March 2006)

- (2.1.1) schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder. These disorders represent the major mental disorders that current scientific data and consensus conclude are identifiable, disabling medical illnesses, with significant biological underpinnings, and requiring treatment. (Revised March 2006)

And

- (2.1.2) Other severe and persistent mental illnesses that affect the brain:

- (2.1.2.1) with seriously disabling consequences or a high risk of mortality;  
and  
(2.1.2.2) that have a long term course.

### **2.2 Additional Support**

NAMI believes that individuals with these serious mental illnesses often require additional support to have their specific needs met and to ensure their access to integrated systems of care, education, and rehabilitation.

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

## **2.3 Cultural Diversity**

- (2.3.1) Persons of cultural, racial, religious, and ethnic diversity and those for whom English is not the primary language have unique characteristics that sometimes impede their abilities to benefit fully from existing treatment, training, and rehabilitation programs. These differences must be respected and accorded appropriate representation, both within the governance of the services sector and within NAMI.
- (2.3.2) NAMI supports expanded efforts toward recruitment and training of professionals from these groups, the development and distribution of materials in appropriate languages for use in education, encouragement of their participation in programs and services, and outreach efforts targeted to these grossly underserved groups.
- (2.3.3) NAMI urges the incorporation of ethnic and cultural perspectives and competence into the design and implementation of programs and procedures for persons with serious mental illnesses so that diagnostic evaluations, consumer and family communications, and the provision of treatment and services will be free from bias and cultural impediments.
- (2.3.4) NAMI believes that providers must have training and sensitivity to cultural diversity.
- (2.3.5) NAMI deplors the higher rates among minorities of involuntary commitment and incarceration in penal facilities that occurs among minorities with serious mental illnesses versus non-minorities with similar diagnoses.

## **2.4 Adults Who Are Elderly**

NAMI calls for the development of suitable, non-discriminatory community residences and the same improved services for elderly persons with serious mental illnesses as for other adults.

## **2.5 Adults Who Are Veterans**

- (2.5.1) NAMI believes that veterans should receive the same full range of integrated services within the hospital and upon discharge to the community that are received by other people with serious mental illnesses.

- (2.5.2) NAMI calls for veteran's hospitals and veteran's outpatient treatment programs to be held to the same standards of performance as all other hospitals and outpatient treatment programs.

## **2.6 Persons Who Are Homeless and/or Missing**

- (2.6.1) NAMI advocates for the right to treatment for persons with serious mental illnesses who are homeless and for those at risk of becoming homeless. These citizens have the same needs and rights to shelter and treatment as all other persons with serious mental illnesses. NAMI believes that persons with serious mental illnesses who are homeless should have individualized treatment plans that are integrated into existing systems of care and related health and human service systems.
- (2.6.2) NAMI urges that service providers, professionals, and others assisting persons with serious mental illnesses who are homeless show them and their families common courtesy, compassion, and respect.
- (2.6.3) When helping to reunite families, NAMI appeals to service providers, professionals, and others assisting persons with serious mental illnesses who are homeless to do what is in the best interest of all concerned, consistent with ethical and medical practices and applicable legal guidelines.
- (2.6.4) NAMI deplors the commonplace use of jails and prisons to warehouse persons with serious mental illnesses who are homeless.

## **2.7 Persons Infected with the HIV Virus**

- (2.7.1) NAMI believes that all persons with serious mental illnesses should be encouraged to be tested for HIV. NAMI believes that persons who test positive should receive appropriate treatment for both their serious mental illnesses and HIV-related illnesses in the least restrictive setting that is safe for all concerned. The results of testing should be shared only on a "need to know" basis and should include families if they are primary caregivers. If families are not primary caregivers, persons with serious mental illnesses should be encouraged to share this information on a voluntary basis.
- (2.7.2) Persons with serious mental illnesses living in institutional settings have been identified as high risks for HIV infection. Therefore, NAMI believes that all persons with serious mental illnesses in institutional settings should be offered HIV testing and strongly encouraged to participate in testing.

- (2.7.3) NAMI urges that education, counseling, and peer support should be made available to the person with a serious mental illness who tests HIV positive and, whenever possible, should be offered to their family and staff as well.

## **2.8 Children with Serious mental illnesses**

- (2.8.1) NAMI believes that children and adolescents with serious mental illnesses have the right and must be offered the opportunity to thrive in nurturing environments.
- (2.8.2) NAMI believes that, at the earliest possible time in their lives, all children and adolescents with serious mental illnesses deserve to be diagnosed, appropriately treated, and offered the services necessary to achieve and maintain their recovery.
- (2.8.3) NAMI believes that children and adolescents with serious mental illnesses should be treated in their homes and in their communities whenever that level of treatment is appropriate to their clinical need and they should be offered a full array of demonstratively effective services at that time.
- (2.8.4) NAMI urges parents and caregivers to become well informed about the array of treatments and services that are or should be available in their community. They should be aware of the special education services that are available for the child who may require those services because of a developmental disability (DD) and/or serious mental illness.
- (2.8.5) NAMI calls on all school administrators, teachers, and other education professionals to follow the requirements of the Individuals with Disabilities Education Act (IDEA) in order to ensure that students with serious mental illnesses receive an appropriate education and related services as mandated by the law and to ensure that these students have the opportunity to lead independent and productive adult lives.
- (2.8.6) NAMI calls on federal, state and local education officials to immediately address the low academic achievement and unacceptably high drop-out and failure rates of students in the “emotional disturbance” category of the Individuals with Disabilities Education Act (IDEA). Students living with serious mental illnesses are included in that category.
- (2.8.7) NAMI calls for strong interagency collaboration between all child- and family-serving agencies, including state and local mental health systems; public and private schools; child welfare systems; and juvenile justice systems.

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

- (2.8.8) When children and adolescents are detained for mental health care or juvenile justice custody due to behavior that might be caused by a serious mental illness, their clinical status must first be evaluated by a qualified mental health professional and must be taken into account before establishing the appropriate conditions for treatment or detention. When detained, children and adolescents with serious mental illnesses must never occupy the same waiting area, living quarters, evaluation and treatment spaces as adults being served in that setting. Girls who are detained should always be supervised by a female attendant.
- (2.8.9) When children and adolescents appear to be experiencing a crisis associated with a serious mental illness, qualified mental health professionals should always be among the first responders contacted. Families should not be directed to law enforcement when a child is experiencing a psychiatric crisis at home or in the community. Every community must have access to an effective and appropriate crisis response system for children and adolescents with serious mental illnesses.
- (2.8.10) Schools should not call law enforcement as the first responder in a psychiatric crisis. The intervention of law enforcement personnel either in schools or the community should always be a last resort and should only occur when it is the only option to protect the child and/or the public. School personnel should be trained to effectively de-escalate a psychiatric crisis and schools should have appropriate links to crisis services in the community mental health system.
- (2.8.11) In the event that a child exhibits or threatens aggression or self-injurious behavior during a crisis and transportation to a treatment facility is necessary, a qualified mental health professional and/or appropriately trained law enforcement officer must first de-escalate the crisis and then arrange for transportation, preferably in a family vehicle if appropriate or in the least threatening and stigmatizing vehicle available. Adult family members, caregivers, persons known to and trusted by the child, or qualified mental health service providers should accompany the child in transit. When being transported for psychiatric evaluation, psychiatric care or juvenile detention related to a mental health issue, children and adolescents should never occupy the same vehicle or detention areas as adults. Girls who are being transported should always be supervised by female attendants. Using the appropriate vehicle and ensuring appropriate conditions for transportation, during psychiatric crisis, can avoid re-traumatizing the child, the adolescent and the family.

- (2.8.12) NAMI believes that families should never be coerced to relinquish custody of their dependent children with serious mental illnesses in order to obtain care, treatment, or an education. The health care service system must be restructured to ensure that children and families are never forced to seek mental health services in the child welfare and juvenile justice systems.
- (2.8.13) NAMI recognizes the critical role that families play in the recovery and development of their children. Therefore NAMI supports the right of families of children who have serious mental illnesses to visit and otherwise maintain as normal contact as appropriate with their children when they are being served in hospitals and other residential facilities. These facilities must not impose overly restrictive visitation limits that prohibit families from visiting their child.
- (2.8.14) NAMI calls on national, state and local leaders to take immediate action to end the workforce shortage in children's mental health services.
- (2.8.15) NAMI believes that all primary care providers, including pediatricians, family practice physicians, and advanced practice nurses must be trained to recognize the early warning signs of serious mental illnesses in children, to provide effective treatment as necessary and to develop collaborative agreements with child psychiatrists to whom they can refer children and families for specialized services.

## **2.9 Minor Children of Parents with Serious mental illnesses**

NAMI recommends that NIMH study the special problems of minor children whose parents have serious mental illnesses. The diagnosis of a serious mental illness alone is not sufficient grounds for losing custody of one's children.

## **3. Treatment**

### **3.1. Access to Treatment**

- (3.1.1) NAMI believes that individuals with serious mental illnesses must have access to treatments that have been recognized as effective by the Food and Drug Administration (FDA) and/or the National Institute of Mental Health (NIMH).
- (3.1.2) NAMI strongly opposes measures that are intended to limit, or actually do limit, the availability and right of individuals with serious mental illnesses to receive treatment with "new generation" medications such as atypical

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

antipsychotics, selective serotonin reuptake inhibitors, and voluntary electroconvulsive therapy (ECT) administered by appropriately trained and licensed practitioners.

- (3.1.3) No one currently taking a medication and doing well on that medication should be switched to another medication, even the generic version of the original, simply because the second medication is cheaper.

### 3.2 Early Diagnosis

- (3.2.1) Early diagnosis and early initiation of treatment are both medically effective and cost effective. However, safeguards must be established to ensure against the abuse of over-diagnosis and over-prescribing of medications, particularly with children, adolescents, people of color and persons who are elderly.
- (3.2.2) In particular, NAMI urges full use of the early periodic screening, diagnostic tool (EPSDT) for children. Treatment plans for children and adolescents must be reviewed every three months.

### 3.3 Mental Health Screening

- (3.3.1) NAMI strongly supports Goal 4 of President Bush's New Freedom Commission report on mental health issued in July 2003 and calling for early mental health screening. In this nation, approximately 10% of children and adolescents have mental illnesses, yet only 20% of them are identified and receiving services. Mental health screening is essential to address this gross under-identification of youth with mental illnesses. Research shows that early identification and intervention leads to better outcomes and may lessen long-term disability. It also avoids years of unnecessary suffering.
- (3.3.2) Screening for the health and well being of children is a well-established practice in this country. We screen for vision, lead poisoning, hearing, scoliosis, tuberculosis, appropriate developmental progress and more. Campaigns of misinformation, stigma and fear must not stand in the way of appropriately identifying youth with mental illnesses and intervening with appropriate services.
- (3.3.3) Federal, state and local leaders should take affirmative steps to implement mental health screening for children and adolescents, **with the following guidelines and protections in place:**

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

- (3.3.3.1) Mental health screening must be voluntary and available for all children.
- (3.3.3.2) Parental consent or consent from legally authorized surrogates must be obtained for all mental health screening.
- (3.3.3.3) Mental health screening must not be used in a discriminatory manner.
- (3.3.3.4) All individuals administering mental health screening must be appropriately trained and qualified both to administer the screening instruments and to interpret the results.
- (3.3.3.5) All information related to screening must be kept strictly confidential and the privacy of youth and their families must be protected.
- (3.3.3.6) All mental health screening instruments must be shown to be reliable and effective in identifying children in need of further assessment.
- (3.3.3.7) Validity studies must be done to ensure that screening instruments are culturally and linguistically appropriate and administered in a manner appropriate for culturally and racially diverse communities.
- (3.3.3.8) Schools must never use mental health screening results or the refusal to consent to screening as a basis for any adverse action against a child or family.
- (3.3.3.9) All children identified through screening as potentially requiring mental health services must be referred for an immediate comprehensive mental health evaluation by a qualified and trained professional.
- (3.3.3.10) Children ultimately identified as requiring mental health services must be immediately linked to and offered appropriate treatment and services and provided with comprehensive information about treatment options, the mental health treatment system, and family and community support resources.
- (3.3.3.11) Early identification and intervention must be part of a national effort to build a comprehensive children's mental health system of care for the millions of children and adolescents who require

these services and their families. Families with children living with mental illnesses deserve nothing less.

### **3.4. Individual Treatment Plan**

- (3.4.1) Every person with a serious mental illness must have an individual treatment plan (ITP) responsive to his or her changing needs. The plan needs to include, but not be limited to, health care, education, housing, rehabilitation services, and community support services. Treatment for persons with serious mental illnesses, who have other disorders or disabilities, including substance abuse (dual diagnosis), should encompass a wide array of options. Options should be determined by the consumer in conjunction with family members and those significantly involved in treatment and service provision.
- (3.4.2) A treatment plan reflecting assessed needs may include a range of available services. Criteria for determining the treatment plan should include assessment of behaviors resulting from changes in environment as well as the skills development and social supports needed to respond to these changes.
  - (3.4.2.1) Criteria for determining the treatment plan should include assessment of behaviors resulting from changes in environment as well as the skills development and social supports needed to respond to these changes.

### **3.5 Outpatient Treatment**

- (3.5.1) Outpatient treatment must be readily accessible to the individual in his or her own community. The treatment must include new-generation medications, symptom therapy, supportive psychotherapy, assertive community treatment (ACT), and rehabilitation.
- (3.5.2) Easily accessible emergency services and available 24 hours a day, seven days a week. Emergency services should not have to be accessed through the criminal justice system. If a person is in a psychotic state and is subject to arrest, specially trained personnel must have authority to determine the intervention needed and to refer to the appropriate level of care.
- (3.5.3) Partial hospitalization should be used selectively with monitoring to ensure that the stay is goal-oriented.

- (3.5.4) Treatment in the community must include new-generation medications, symptom therapy, supportive psychotherapy, and rehabilitative programs.
- (3.5.5) Community systems must be comprehensive, person-centered, and integrated and should include medical, dental, and personal-care services as well as daily-living skills, supported housing, education, and pre-vocational and vocational training.

### **3.6 Inpatient Treatment**

- (3.6.1) Inpatient services ranging from short-term acute care or respite care to long-term care must be available and accessible. Linkages between inpatient and outpatient treatment and community support systems must be in place to ensure continuity of care.
- (3.6.2) Short-term and longer-term hospitalization must be provided as determined to be necessary by the ITP.
- (3.6.3) Long-term care must be available for the few who are unable to live in their communities.

### **3.7 Family Involvement in Treatment**

- (3.7.1) Family members are a central resource in the treatment of children and adults living with serious mental illnesses and should be an integral part of the treatment team and empowered to facilitate mutually agreed upon treatment team goals. Research overwhelmingly shows that when families take an active part in treatment decisions, consumer outcomes are better. While families do not cause or maintain serious mental illnesses, their knowledge of and relationship with the consumer is unique and can be a significant help in determining the best course of treatment.
- (3.7.2) In no case should the presence of a loving, caring family be used as a substitute for a delivery system that provides for all of the person's treatment and rehabilitative needs.
- (3.7.3) The consumer is the reason the mental health treatment system exists. The consumer—or in the case of an unemancipated child, his/her representative—is the most important member of the treatment team.

The consumer should be encouraged to participate fully in planning,

monitoring, and evaluating treatment. Other treatment team members should assure that their focus is on meeting the consumer's needs, not the desires of the system or service providers.

- (3.7.4) Common courtesy dictates that consumers and family members be treated with compassion, dignity and respect. They must also be provided with extensive education to understand all aspects of the illness in order to be more effective in its treatment.
- (3.7.5) Family and consumer advocacy should always be encouraged. In circumstances where the mental health system is understaffed, under-financed, and services uncoordinated, or other problems impede proper service delivery, family and consumer advocacy is effective and powerful.
- (3.7.6) Sometimes, because of stigma and lack of information regarding serious mental illnesses, the family is not involved. Their absence does not usually indicate that they don't care or are not concerned. Mental health workers must understand this and work to strengthen family relationships. When family members become educated and are respectfully involved, in a way they experience as empowering, their approach to the patient and the treatment system changes.
- (3.7.7) In such cases where consumers do not want their family members involved, their wishes must be respected. At the same time, extensive educational efforts should be made to help these consumers understand that their families are not to blame for the illness and that recovery is more likely if all interested parties work together.
- (3.7.8) All treatment and services provided to children living with serious mental illnesses and their families should be child centered and family driven, with the needs of the child and family dictating the types and mix of services provided. The families, surrogate families and legal guardians of children with serious mental illnesses should drive the treatment planning and delivery process, in close consultation with the treating providers. Children living with serious mental illnesses should be included in all aspects of treatment planning whenever possible.

Family driven means that the treatment provider gives the family the information and skills to make informed decisions as equal partners in the treatment planning and delivery processes. Children living with mental illnesses should be included in all aspects of treatment planning whenever possible.

Families must have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory, and nation. This includes:

- Choosing supports, services, and providers;
- Setting goals;
- Designing and implementing programs;
- Monitoring outcomes;
- Partnering in funding decisions; and
- Determining the effectiveness of all efforts to promote the mental health and well being of children and youth.

- (3.7.9) Child-serving systems and their funding mechanisms should be designed to allow families with children living with serious mental illnesses to easily access appropriate mental health and related services. Child-serving systems should be designed with cross-system and interagency collaboration to ensure an appropriate coordination of services for children and families. Families should not be required to navigate multiple, complex and overly bureaucratic systems to access appropriate services for their child.

### **3.8 Outcome Measures**

NAMI believes that community-based services must include regular measurements of consumer and family satisfaction and dissatisfaction with these services. These measurements are best conducted by independent consumer and family satisfaction teams who interview service recipients using continuous quality improvement methodology.

### **3.9 Non-endorsement of Specific Medications or Treatment Modalities**

As a matter of policy, NAMI does not endorse any specific treatment or service for serious mental illnesses. NAMI does advocate for general models of service such as evidence-based programs and clinical practices.

### **3.10 Access to Psychiatric Medications**

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

- (3.10.1) NAMI supports the following integrated and comprehensive federal strategies to ensure open access to psychiatric medications in the current budget deficit environment.
  - (3.10.1.1.) Increase the Federal Medical Assistance percentage (FMAP);
  - (3.10.1.2) Support the adoption of a Medicare prescription drug benefit;
  - (3.10.1.3) Advocate with the Center for Medicaid and Medicare Services (CMS) to provide written guidance on carve outs to Medicaid directors;
  - (3.10.1.4) Support increased funding to NIMH for research on psychiatric medications and access to these medications.
- (3.10.2) NAMI supports the following integrated and comprehensive state strategies to ensure open access to psychiatric medications in the current budget deficit environment.

Oppose, at all costs, “fail first” provisions in state laws and policies;  
Support efforts by pharmaceutical companies to develop new medications but oppose pricing practices that make these medications unaffordable;  
Support adjunctive education programs about psychiatric medications and safe prescribing practices;  
Support the development of explicit medication access protocols.

### **3.11 Prescription Privileges for Psychologists, Workforce Shortages**

NAMI does not endorse proposals currently before state legislatures to expand prescribing privileges to psychologists. NAMI acknowledges that serious shortages exist in the mental health professional workforce, particularly in public mental health systems and in rural and medically under-served regions of the country. However, there is no current evidence that expanding prescribing privileges to psychologists will address these shortages.

Additionally, NAMI calls upon the Substance Abuse and Mental Health Services Administration (SAMHSA), working in coordination with the National Institute of Mental Health (NIMH) and other relevant federal agencies, to undertake a national study and issue a report evaluating the scope and extent of workforce shortages in the mental health field, describing the impact of these shortages on access to quality care and treatment for people with serious mental illness, and recommending strategies for attracting and retaining qualified professionals in the

mental health field, including in rural or medically under-served regions of the country.

### **3.12 Cultural Competence**

NAMI recognizes that people of color face significant additional barriers to mental health treatment. This prevents minorities with mental illness from accessing much needed care. Barriers to treatment, such as lack of language access and lack of cultural competence, must be eliminated.

Treatment plans should be relevant to the consumer's culture and life experiences. Plans shall be developed by providers who have the knowledge, skills and attitudes necessary to provide effective care for diverse populations. For people of color, recovery is more likely to occur when providers are culturally competent and when appropriate, they involve the consumer and family.

Limited English proficient (LEP) individuals must have equal access to mental health treatment. Cross-cultural communication in all services shall be available at all times through bilingual providers or certified interpreters. It is not acceptable to use family members or friends as substitutes for qualified interpreters.

### **3.13 Wellness**

- (3.13.1) People living with serious mental illnesses are at significantly greater risk for other serious medical illnesses such as diabetes, heart disease, cancer, and respiratory diseases. Recent research indicates that they also have much shorter life spans, as much as twenty-five years less than other Americans. This disparity has increased over time and demands increased attention and funding to promote wellness and preventive awareness among people with serious mental illness, their families, and health care practitioners.
- (3.13.2) Wellness is essential to treatment and recovery. Consumers, family members and providers should promote and encourage wellness. Wellness encompasses mind, body and spirit. Wellness should include nutrition, exercise, rest, dental care, physical exams, and tobacco, drug and alcohol cessation.
- (3.13.3) People living with serious mental illness have the same rights and expectations as anyone else to lead healthy lives. Wellness is an important part of the recovery process. Consumers must be empowered to achieve wellness through consumer education and peer support and taking control of their own health and recovery.

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

- (3.13.4) Providers must make wellness a priority and provide access to effective programs and exercise. Useful programs include, but are not limited to, nutrition counseling, cooking classes, exercise programs, yoga, breathing exercises, smoking cessation, drug and alcohol programs, walking trails, exercise equipment at mental health centers and drop in centers, membership in gyms, and appropriate monitoring. Those who provide meals must ensure nutritious choices, including fresh fruits and vegetables. Those who provide treatment must be aware of and actively engaged in supporting wellness; and those who provide supportive environments, including housing and clubhouses, must provide environments that reduce health risks and support overall wellness.
- (3.13.5) People with serious mental illnesses must have access to effective prevention and treatment with respect to alcohol, drug and tobacco addiction.
- (3.13.6) NAMI calls for better access to dental care. Because of the impact of mental illnesses and the effects of the medications used to treat serious mental illnesses, access to dental care is a particularly important part of wellness for individuals with serious mental illnesses.
- (3.13.7) NAMI also calls for better integration of physical and mental healthcare, including sharing relevant health indicators. Mental health care providers need to monitor key physical health indicators and the physical effects of medications. Primary care doctors must follow up on physical issues identified. There must be better infrastructure and funding to process important screening labs and tests for individuals with serious mental illnesses.
- (3.13.8) The federal and state governments should provide fiscal incentives for integration of mental, physical and dental health services and funding for successful wellness programs. State programs that seek to reward healthy behaviors must be positive, relevant to individuals with serious mental illness, and not punitive in nature.
- (3.13.9) Wellness is an important investment that will lead to decreased public cost, improved resource allocation, and reduction in stigma, thus improving the lives of all those affected by serious mental illnesses.

## **4. Services and Supports for Children, Adolescents, Young Adults and Families**

### **4.1 Comprehensive Array of Services and Supports**

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

A comprehensive array of treatment, services and supports that address prevention, early intervention, recovery, and support should be available to children, adolescents and young adults living with mental illnesses and their families. These services should be available through publicly and privately funded service systems. They should promote resiliency and recovery and include evidence and research based interventions. There must be effective system coordination and collaboration between systems serving children, youth, young adults and their family.

Services, supports and appropriate accommodations should always be timely, easily accessible, and provided in the least restrictive environment.

They should include, but not be limited to:

- Services provided in the home and community;
- Intensive case management;
- Crisis intervention services;
- School-based services;
- Wrap-around services;
- Respite care;
- Therapeutic mentoring and recreation programs;
- Family education and support programs;
- Vocational and rehabilitative services; and
- Inpatient and residential treatment.

Peer support services should be available at all times and at all levels of care.

States and communities should invest in home and community-based services as the primary treatment modality. Children should not remain in inpatient and residential treatment beyond the time of planned therapeutic benefit.

## **4.2 School and Campus Based Services**

Schools must protect the confidentiality of all students' mental health related information.

All schools, including institutions of higher education, should understand and follow federal and state privacy laws for both health information and education information and their responsibility for appropriately addressing the needs of students with mental illnesses and psychiatric emergencies under those laws.

### **(4.2.1) Elementary, Middle and High Schools**

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

Undiagnosed, untreated, and inadequately treated mental illnesses significantly interfere with a student's ability to learn, to grow, and to develop.

Because children spend much of their productive time in school and services can be integrated into their regular daily routine, NAMI believes that both public and private elementary, middle and high schools should provide and/or facilitate and sustain provision of appropriate mental health services, supports, and appropriate accommodations.

In order to assure that coordination of services can be supported and maintained and that families have adequate resources to address their needs, schools should maintain a close connection to the community mental health and primary health care systems. The caseload of school-based mental health providers should be capped at a level that ensures that they can adequately address the needs of students and their families.

School systems should be adequately funded to provide special education services and to meet the academic and functional needs of all students with brain disorders. This will require access to both public and private funding for mental health services and supports. All students should receive an education in the least restrictive setting and in general education classrooms unless their needs can only be met, and are better addressed, in a separate or alternative classroom.

The bullying that currently exists in far too many of our nation's schools disproportionately hurts students with disabilities, especially those living with mental illnesses. All schools should develop effective anti-bullying policies so that students with mental illnesses are not targeted by bullies or labeled as bullies as a result of symptoms of their mental illness.

#### (4.2.2) College and University-Based Services and Supports

NAMI believes that colleges and universities should provide a full array of services, supports and appropriate accommodations for both campus-based and commuting students. The array should include mental health evaluations, outpatient treatment, peer support specialists, integrated services for co-occurring brain and substance use disorders, on-campus support and information sources and referrals, a link to the community mental health and crisis intervention service systems, and 24 hour urgent care available daily. In no case should a student be penalized by dismissal or probation or be denied the right to enroll in a course of study solely because of a mental illness.

Support, education, and advocacy programs should be available and accessible for students and their families on college and university campuses. Colleges and universities should include comprehensive information about mental health treatment, services, and supports on their web sites and should notify students and their families about the availability of this information. They should also share information about the early warning signs of mental illnesses and develop effective suicide prevention plans responsive to the high incidence of suicide in young adults aged 15 to 24.

If a student experiences a psychiatric crisis, the college or university should immediately contact the student's family about the crisis. Colleges and universities should never use the existence of a psychiatric crisis as grounds to ask a student to leave the school. Instead, schools should develop appropriate accommodations and supports that appropriately address the needs of students experiencing a psychiatric crisis or recovering from a psychiatric crisis.

### **4.3 Transition Age Services and Supports**

NAMI urges the development of effective services that bridge the transition from child to adult for youth living with mental illnesses. These services should be available in our nation's schools and they must be provided by appropriate community agencies such as post secondary institutions, vocational rehabilitation agencies, housing agencies and other agencies, as appropriate. Planning for appropriate transition services should begin, at a minimum, by age 14 and should continue as adolescents progress into adulthood. Barriers to a smooth transition from adolescence to adulthood or to the delivery of effective transition services, such as the imposition of financial criteria or program eligibility requirements, must be eliminated.

### **4.4 Educational Programs**

- (4.4.1) NAMI believes that a transformed system of care must be focused on resiliency (increasing protective factors in a child's life, helping to ensure early identification and intervention, and a child's ability to bounce back from adversity) and recovery and driven by consumers and families. A transformed system must also guarantee the widespread availability of free mental health educational programs for children and adults living with mental illnesses and families at every stage of the life cycle, and must empower them to be teachers in the education and training of all mental health providers.

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

(4.4.2) Peer-designed and peer-directed educational programs, at every stage of the life cycle, must be valued and promoted as an integral part of the service system. Specific government grants must be made available to support the development and administration of peer-directed programs. In addition, system resources must be made available to develop and evaluate peer educational programs and to establish an evidence base comparable to the rigorous scientific studies conducted by fully funded system-based programs.

#### **4.5 Training and Qualifications for Providers**

NAMI calls for all child-serving professionals to receive training that will help them better understand early onset mental illnesses and how to communicate effectively with families about these illnesses. Healthcare providers treating children and adolescents with mental illnesses should receive as much training as necessary to ensure that they can and will provide evidence and research based treatments and service interventions.

#### **4.6 Integrated Health and Mental Health Care**

NAMI calls on policymakers, providers and public and private funders of healthcare services to place a high priority on addressing the critical need for integration of physical and mental health care. The causes of health and disease are a product of the interplay or interaction between biological, psychological, and socio-cultural factors. This is true for all health and illness, including mental health and mental illness.

Primary care and mental health care providers working with families, youth and young adults living with mental illnesses, should make a commitment to ensure that adequate time, training, and resources necessary to provide appropriate care for children, youth and adults living with mental illnesses are available and accessible when and where they are needed. They can accomplish this through collaborative practice arrangements, interagency system coordination, and interdisciplinary teamwork. The integration of physical and mental health care produces better treatment outcomes and overall better health outcomes for children, youth and adults living with mental illnesses.

NAMI believes that it is critically important that primary care providers be trained and qualified to recognize the early warning signs of mental illnesses, and to screen and evaluate children for mental health treatment needs. Because

children and families often visit primary care providers as part of well-child clinical care, this is an important opportunity to identify a child's need for mental health related treatment and services, at the earliest possible time.

#### **4.7 Family Driven and Youth Guided Services**

All services and supports provided to children living with mental illnesses and their families should be youth guided and family driven, with the needs of the child and family dictating the types and mix of services provided. (see section 3.6 on Family Involvement in Treatment)

## **5. Services and Supports for Adults**

### **5.1 Community Systems**

- (5.1.1) NAMI believes that it is the responsibility of federal, state, and local governments to develop and maintain comprehensive community support systems of treatment and services for the priority population as well as short-and long-range plans for all those with serious mental illnesses.
- (5.1.2) NAMI believes optimal treatment, favorable outcomes, and recovery are most likely to occur when comprehensive treatments and services are provided in an atmosphere of respect, acceptance, and hope.
- (5.1.3) NAMI believes that all publicly funded community service providers must offer recovery oriented, evidence-based practices and services that customers need and can readily access. These must include the availability of new generation medications, inpatient treatment, and outpatient treatment with mobile capacity, residential support services, transportation services, intensive case management, respite services, vocational and psychosocial rehabilitation, peer support, consumer-run services, and round-the-clock services that are available seven days a week.

Service providers must prioritize access to services to people with serious and persistent mental illness, providing oversight and advocacy through well-trained care managers. Services should use an integrated consumer-centered approach that may take professionals out of the traditional office setting to a location that is comfortable for the consumer.

- (5.1.3.1) NAMI endorses integrated, rather than sequential or collaborative-parallel treatment programs for persons with co-

occurring<sup>1</sup> mental illness and addictive disorders. (Revised March 2006)

- (5.1.3.2) Because the majority of people with serious mental illnesses have a co-occurring substance abuse disorder, NAMI believes that integrated mental health and substance abuse treatment must be delivered at the same treatment site using cross-trained staff.

## 5.2 Continuity of Care

- (5.2.1) Every person should have a single service manager or management team who keeps informed about every aspect of the treatment and informs the consumer and other members of the treatment team. When an individual is hospitalized, the manager should be kept informed and should become a member of the inpatient treatment team. Whenever residence in a community is interrupted for any reason, continuity of care requires that the same service manager or management team retain responsibility for the individual's treatment unless the consumer desires a change.

## 5.3 Housing

- (5.3.1) Individuals with serious mental illnesses need a wide array of options for permanent, decent, and affordable housing, based on an individual's needs and choices. These options may include group homes and independent living in apartments or houses. NAMI reinforces and encourages living in the community whenever that option is available and suitable to a consumer's needs and choices. Funding mechanisms should support consumer choice.
- (5.3.2) No individual with a serious mental illness should lose his or her housing in the community during periods of inpatient treatment.
- (5.3.3) NAMI recommends that an equitable portion of federal and state housing funds be designated for persons with serious mental illnesses and redirected to an integrated funding stream to finance the housing component of a unified system of treatment, services and supports for persons with serious mental illnesses.
- (5.3.4) NAMI opposes all statutes, regulations, and ordinances in housing that discriminate by limiting fair and equal access for people with serious mental illnesses, such as special use permits, occupancy limitations, mandated dispersal of residences, or private restrictions included in

---

<sup>1</sup> “dual-disorders” changed to “co-occurring” by friendly amendment in Board discussion 11/11/05

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

covenants, deeds, or lease agreement. In addition, NAMI insists that persons with serious mental illnesses not be specifically singled out for living arrangements segregated from other populations in publicly supported housing.

- (5.3.5) NAMI believes that in those cases where the independent living arrangement is shared by two or more persons, it is preferable that the choice of "roommates" be left up to the residents. Providers and caregivers do not have the right to restrict such choices or determine compatibility based upon age, race, ethnic background, disability, religion, diagnosis, or other such criteria. In no cases should residents in independent living arrangements be expected to develop a custodial role unless they so choose.
- (5.3.6) NAMI affirms that consumers have the right to privacy.
- (5.3.7) NAMI believes that it is not the family's responsibility to provide housing for a family member who has a serious mental illness. For those willing to accept this responsibility, there must be adequate training and education about available benefits and options.

#### **5.4 Rehabilitation, Employment, and Education**

- (5.4.1) NAMI believes that consumers have the right to participate in activities that are productive and meaningful to them and that they must be offered extensive training and rehabilitation to help them achieve their highest potential level of recovery and independence.
- (5.4.2) Individual service plans must be flexible and open-ended and based on consumer preference, allowing for change as the consumer requests it or need it.
- (5.4.3) Care managers must be responsible for providing programs for consumers to learn or relearn daily living skills, appropriate grooming and attire, medication and money management, social, physical, and recreational activities, volunteer opportunities, and whatever else the individual service plan directs (i.e. nutritional planning, transportation consulting, vocational training, etc.). Additionally, persons may need assistance with the development and/or redevelopment of their social skills and ability to meaningfully interact with others. Rehabilitation counselors must fully inform consumers of all services that will assist with their personal goals and to provide smooth and timely access to these services, including aptitude testing, vocational skills, GED education courses, job coaching and job placement.

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

- (5.4.4) NAMI believes that state vocational rehabilitation agencies and state mental health agencies should develop cooperative agreements to ensure that long-term supports are available for people with serious mental illnesses who are in supported employment.
- (5.4.5) NAMI continues to advocate for a refinement of the definition of serious mental illnesses under the Individuals with Disabilities Education Act (IDEA) in order to improve the access to the design of appropriate individual programs to meet each person's unique education needs.
- (5.4.6) NAMI endorses an affirmative-action policy for recruiting consumers as students in educational programs that will prepare them for careers in the delivery system that serves persons with serious mental illnesses. NAMI encourages hiring such persons as service providers.

## **5.5 Consumer-run Programs**

NAMI supports and encourages: 1) self-help activities; 2) consumer-run programs including peer support, housing, day centers, small businesses, clubhouses, and drop-in centers. NAMI also supports and encourages all service providers to support the development of such self-help activities.

## **5.6 Educational Programs for Consumers and Families**

- (5.6.1) NAMI believes that a transformed recovery-oriented system of care, driven by consumers and families, must guarantee the widespread availability of free educational programs for consumers and families, and must also empower consumers and family members as teachers in the education and training of all mental health providers.
- (5.6.2) Peer-designed and peer-directed educational programs must be valued and promoted as an integral part of the service system. The development and administration of peer-directed programs must be supported through specific government grants, and further system resources must be made available for peer educational programs to establish an evidence base comparable to the rigorous scientific studies conducted by fully funded system-based programs.

# **6. Financing of Treatment and Services**

## **6.1 Private-Sector Healthcare Reform**

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

- (6.1.1) NAMI supports health care for all persons with serious mental illnesses that is affordable, nondiscriminatory, and includes coverage for effective and appropriate treatment.
- (6.1.2) NAMI supports the establishment of provisions to ensure equal access to affordable health care for every American. It is critical that coverage of serious mental illnesses be equal in scope and duration to coverage of other illnesses without lifetime maximum-benefit caps and without other limits more restrictive than those required for other disorders.
- (6.1.3) NAMI urges passage of legislation to mandate nondiscriminatory coverage of serious mental illnesses with other physical diseases. Private-sector health plans must cover all proven-effective treatments appropriate to the needs of individuals with serious mental illnesses.
- (6.1.4) NAMI supports federally mandated, minimum standards for health insurance coverage. However, federal standards should not pre-empt state laws that provide higher standards.
- (6.1.5) NAMI believes that the Employee Retirement Income Security Act (ERISA) of 1974 represents a significant obstacle to state-government efforts to broaden access to services for those who have serious mental illnesses. NAMI supports efforts of states to gain waivers of ERISA and any Act on the Federal level to allow these waivers. These waivers would prohibit self-insured employers from avoiding compliance with state-mandated minimum-benefit laws.
- (6.1.6) NAMI opposes healthcare rationing.

## **6.2 The Role of the Public Sector**

- (6.2.1) NAMI affirms that a just and humane society, using the instrument of government for policy direction and public resources allocation, must care for its most vulnerable members when they are unable to care for themselves. The essential needs of these individuals and the obligations of society must be addressed irrespective of decisions which are made concerning what level of government should have control over such functions, what proportions of the financing each level should take, and how much should be privatized.
- (6.2.2) Persons of all ages who suffer from serious mental illnesses are frequently unable to provide for themselves because of acute or chronic symptoms

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

that result from their disorders. The most basic needs are for shelter, food, clothing, medical and social supports, and assistance toward self-sufficiency. All levels of government must address such needs by providing programs for income maintenance, medical treatment, medical insurance, other health and social services, shelter and housing, education, transportation assistance, legal assistance, advocacy, training, and employment assistance.

### **6.3 Medicaid, Medicare, and Veterans Benefits**

#### *(6.3.1) Medicare*

- (6.3.1.1) Medication prescribed for the treatment of serious mental illnesses must be fully covered under the Medicare Part D program.
- (6.3.1.2) Co-payments imposed on outpatient mental health services must be equalized with all other Medicare co-payments.
- (6.3.1.3) The existing 190-day lifetime limit on inpatient psychiatric hospitals must be eliminated. The existing partial hospitalization benefit should be re-examined and revised to include a continuum including intensive case management, psychiatric rehabilitation, and assertive community treatment.

#### *(6.3.2) Standards of medical necessity for treatment of mental illness must be the same as for all other medical services.*

- (6.3.2.1) All persons served must have a documented diagnosis.
- (6.3.2.2) All persons served must have an individualized treatment plan with clinical goals and plans of action. Progress in implementing the plan must be documented.
- (6.3.2.3) Providers must be licensed, certified, or recognized by the state and meet national standards for clinical care.

#### *(6.3.4) Providers are obligated to clinically document medical necessity and accurately bill for services rendered. All records must document the medical necessity of the services rendered.*

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

- (6.3.5) Persons receiving Social Security Disability Insurance (SSDI) who seek work should be allowed to continue their Medicare insurance coverage for an indefinite period. Persons go off Medicare because they have obtained employment should be automatically re-enrolled in Medicare if they subsequently have a clinical relapse.
- (6.3.6) Comprehensive patient protections should consistently be an integral part of all health benefit programs, including Medicare. [Refer to other sections of this Platform for specific protections]
- (6.3.7) Any risk adjustment payment mechanism adopted by Medicare must include both severity and chronicity of mental illness. (Revised February, 1999)

## **6.4 Public Financing**

- (6.4.1) NAMI recognizes that the cost of not treating serious mental illnesses greatly exceeds the cost of treating them.
- (6.4.2) Public funding for services to persons with serious mental illnesses who are unable to care for themselves is the responsibility of society. Local, state and federal governments have the responsibility to develop an integrated system of care and to fund this system adequately. Accountability for expenditure of these funds for the priority population must be ensured. Where there is co-mingling of public and private funding streams, accountability measures must be stringent.
- (6.4.3) NAMI urges adequate funding to avoid waiting lists and the "dumping" of persons with serious mental illnesses from publicly funded mental health systems for any reason. On the other hand, indigent, elderly, or other persons with disabilities who do not have serious mental illnesses must not be served in the public mental health facilities.
- (6.4.4) NAMI advocates for adequate funding for both biomedical and services research related to serious mental illnesses and for federally-funded treatment and services for individuals with serious mental illnesses. NAMI insists that these biomedical and services research funds must be awarded to those grants most likely to help persons who have the most severe disabilities. Federal oversight of these grants through national institutes responsible for brain services and treatment research must continue.

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

- (6.4.5) NAMI supports consumer and family education services that enable consumers and families to communicate more effectively with service providers, better understand serious mental illnesses and develop coping skills. NAMI believes that community service providers should fund and provide free consumer and family education programs.
- (6.4.6) NAMI supports funding for respite caregivers.
- (6.4.7) *Federal Mental Health Services Funding*

NAMI must monitor the expenditure of federal mental health service funds in each state. Advocacy efforts must continue to assure that there are regulations at the federal level which require that these funds are spent on services for the priority population.

NAMI must monitor at the federal and state levels the activities and processes that assure these regulations are implemented. Failure by states to adhere to regulations should result in financial and public penalties.

- (6.4.8) *Institutions for Mental Diseases (IMDs)*
  - (6.4.8.1) The federal government currently denies Medicaid reimbursement for persons otherwise Medicaid eligible who are over 21 and under 65 years of age if such persons reside in facilities designated as "Institutions for Mental Diseases" (IMDs). State hospitals, nursing homes, and residential facilities of 16 or more beds may be classified as IMDs if they provide specialized "mental illness" services, have over 50 percent of their patients diagnosed as "mentally ill," or meet certain other criteria.
  - (6.4.8.2) NAMI believes that the application of the IMD rule most dramatically affects persons suffering from schizophrenia and other serious mental illnesses because these individuals tend to fall within the impacted age group and thereby are denied Federal Financial Participation (FFP) in their treatment solely on the basis of where they happen to be treated and reside, assuming they would meet all other Medicaid eligibility requirements.
  - (6.4.8.3) The IMD rule is thus discriminatory and works against the provision of necessary health care for young and middle-aged adults with serious mental illnesses.

(6.4.8.4) NAMI calls upon the United States Congress to repeal the IMD rule and to adopt uniform standards of Medicaid eligibility based upon individual resources and the need for services, rather than upon the location in which services are provided or the residence of the recipient.

(6.4.9) *Community Reinvestment*

(6.4.9.1) If and when public hospitals are no longer needed for the treatment of persons with serious mental illnesses, and such properties are sold or leased, the proceeds should be dedicated to community services for persons with serious mental illnesses.

(6.4.9.2) Public resources and all monies saved by reduced utilization of state hospitals as well as through other system efficiencies should be reallocated to expand community-based services and supports for persons with serious mental illnesses.

(6.4.10) *Dual-Diagnosis Funding*

NAMI supports blending mental health, alcohol, and substance abuse funds at the state level for the treatment of persons with dual diagnoses of a serious mental illness and co-occurring substance abuse.

(6.4.11) *Developmental Disabilities (DD)*

(6.4.11.1) Entitlements and programs for persons with serious mental illnesses must compare equitably with those for other physical illnesses and disabilities.

(6.4.11.2) NAMI calls for changes in federal, state, and local laws so that those basic services that are presently provided by state and local governments to persons with developmental disabilities are also provided to persons with mental illnesses.

(6.4.11.3) NAMI encourages monitoring and supporting the activities and procedures of State Planning Council on Developmental Disabilities and evaluating the criteria used by state Developmental Disabilities Councils when reviewing state plans and awarding and implementing grants.

(6.4.11.4) NAMI supports cooperation and joint planning between the Center for Mental Health Services and the Administration on

Developmental Disabilities and between State Mental Health  
Planning Councils and State Planning Councils on  
Developmental Disabilities.

**6.5 Managed Care under All Payers**

- (6.5.1) The public sector must continue to be accountable for the delivery of treatment and services for persons with serious mental illnesses even when contracting out the services to private sector managed care organizations.
- (6.5.2) NAMI advocates for research and services in response to these major serious mental illnesses in persons of all ages: schizophrenia, bipolar disorder, major depression, obsessive-compulsive disorder, and panic disorder.
- (6.5.3) There must be continued health care eligibility within the public system for persons with serious mental illnesses who are employed but cannot obtain health coverage through their employers.
- (6.5.4) State government must develop and maintain a comprehensive community-support system of treatment and services for the priority populations. State mental health agencies must continue to maintain short- and long-range plans for those with serious mental illnesses. All State Mental Health Plans must contain realistic contingencies for all ranges of ability to pay.
- (6.5.5) There must be meaningful participation of consumers and families at every stage of the redesign, implementation, evaluation, and monitoring of the managed care system. All planning and delivery of services must be culturally sensitive to ethnically diverse populations and the communities in which they are located.
- (6.5.6) Public sector entities that contract with managed care organizations (MCOs) or other entities for the management and/or delivery solely of Medicaid-funded services for persons with serious mental illnesses must exercise great caution lest they inadvertently divide the mental health system and cause dumping of persons with severely disabling serious mental illnesses who are heavy users of costly services into a public system that is generally considered to be under funded.
- (6.5.7) Public resources saved by managed care systems should be reallocated to expand services to the priority population.

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

- (6.5.8) Provider personnel, both administrators and treatment staff, must have an understanding of serious mental illnesses. They must have training to work with the priority population--including training in the consumer and family perspective--and must accept accountability for the quality of services they provide.
- (6.5.9) All provider staff must be rigorously and appropriately credentialed by appropriate state agencies.
- (6.5.10) A comprehensive array of community-support services must be available for individuals who meet the priority-population definition for people with serious mental illness regardless of ability to pay. These services must include new-generation medications, inpatient treatment, residential support services, intensive case management, psychosocial rehabilitation, consumer-run services, an around-the-clock crisis services seven days a week. Outpatient services must be mobile and accessible.
- (6.5.11) MCOs must be held accountable by the public purchasers for linkages to housing with supportive services and employment services.
- (6.5.12) There must be consumer and family involvement in individual treatment planning including choice of provider, treatment delivery, and appropriate access to peer-support groups.
- (6.5.13) Appeal and grievance procedures must be in place that are user-friendly and time-sensitive to the life-threatening nature of psychotic episodes.
- (6.5.14) The public sector purchasers must report quarterly to the public the number of recipients who 1) fail to present for services; 2) are in jail or prison; 3) have been placed in a state hospital, nursing home, or other long term case program; and/or 4) have died.
- (6.5.15) Outcome measurement for people with serious mental illnesses must be required in contracts with managed care organizations and reviewed by the public sector purchaser on a regular basis. Outcomes should include relevant and scientifically sound measures of clinical status, general health status, functioning, quality of life (such as housing status, employment status, treatment compliance, substance abuse, involvement with the criminal justice system, and involvement with meaningful activities), and subjective measures, such as consumer and family satisfaction.
- (6.5.16) *Medicaid Choice of Health Plans*

Choice of health plans should be the primary principle. However, local situations involving histories of poor quality, inadequate numbers of enrollees, possibility of adverse selection, and well-functioning, single carve-out, specialty health plans should allow for waivers to the choice principle.

## **6.6. Fundraising by Private Agencies**

- (6.6.1) NAMI strongly encourages governing boards of non-profit agencies serving those with mental illness to undergo aggressive fundraising through direct mail and special events in their own communities regardless of whether their agencies get the bulk of their funds from the state. Community fundraising will not only diversify funding streams of these agencies and augment their programs but also will raise community awareness of the needs of their neighbors with mental illnesses.
- (6.6.2) Under no circumstances should states subtract funds from any agency serving those with mental illness due to separate fundraising efforts by that agency.

## **7. Research**

### **7.1 NAMI's support**

Neuroscience research, behavioral research, pharmaceutical research, clinical research, as well as service system research are some of the initiatives supported by NAMI. To this end, NAMI endorses the Presidential proclamation of the 1990s as the Decade of the Brain, which calls upon Congress and the Executive Branch to focus more attention on research, treatment, education, and rehabilitation related to serious mental illnesses and to appropriate funds sufficient to make that promise a reality. NAMI supports both effectiveness and efficacy based research, focusing on severe and persistent mental illnesses, especially those with marked burdens of disease. NAMI expects the rigor and pace of the field of services research to be equal to that of biomedical research.

### **7.2 Standards for Protecting the Well-being of Individuals Participating in Research**

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

- (7.2.1) NAMI accepts the critical necessity for research using human subjects, acknowledges the important contribution of persons who become human subjects, and affirms that all such research should be conducted in accordance with the highest medical, ethical, and scientific standards.
- (7.2.2) National standards to govern voluntary consent, comprehensive exchange of information, and related protections of persons with cognitive impairments who become research subjects must be developed and they must include the interests of persons who become human subjects, families, and other caregivers.
- (7.2.3) Participants in research and their involved family members must be fully and continuously informed, orally and in writing, about all aspects of the research throughout the process. Research investigators must provide information in a clear, accessible manner to ensure that participants and their involved families fully understand the nature, risks, and benefits of the research.
- (7.2.4) The consent protocol must provide information that is clear and understandable on an individual basis for each participant and his or her family members. The consent protocol must provide information about the purposes and scale of the research, what is hoped to be learned, prospects for success, and potential benefits and risks to the individual (including options for treatment other than participation in research, since research is not the same as treatment). The consent protocol should also contain information about the function of the institutional review board (IRB), the identity of the IRB administrator, the address and telephone number of the IRB administrator and other information, as appropriate. The consent protocol and information for the subject and his/her family members should include a procedure for responding to medical and psychiatric emergencies. Research protocols should develop and implement a concrete plan to address these emergencies.
- (7.2.5) Whenever consent is given by someone other than the research participant, the participant and involved family members must receive information on the same basis as the person actually giving consent.
- (7.2.6) Research participants should be carefully evaluated before and throughout the research for their capacity to comprehend information and their capacity to consent to continued participation in the research. The determination of competence shall be made by someone other than the principal investigator or others involved in the research. Except for research protocols approved by the institutional review board (IRB) as

minimal risk, whenever it is determined that the subject is not able to continue to provide consent, consent to continue participation in the research shall be sought from families or others legally entrusted to act in the participant's best interests.

- (7.2.7) Research participants should be encouraged to develop psychiatric advance directives prior to beginning their participation in research protocols, indicating their research and treatment preferences should they become incapacitated at any point during their participation.
- (7.2.8) Institutional review boards that regularly review research proposals for serious mental illnesses must include public participants who are consumers and family members who have direct and personal experience with serious mental illnesses.
- (7.2.9) Members of IRBs approving research on individuals with serious mental illnesses must receive specialized training about serious mental illnesses and other cognitive impairments and the needs of individuals who experience these disorders. Persons with serious mental illnesses and members of their families must be integrally involved in the development, provision, and evaluation of this training.
- (7.2.10) Without penalty, a research participant must be free to withdraw consent at any time, with or without a stated reason. Any time a participant terminates participation, regardless of the reason, investigators will make every effort to ensure that linkages to appropriate services occur with follow-up to assist that participant to establish contact with appropriate service providers and/or care-givers in a timely manner. If a participant disappears or terminates his or her continued consent, the investigator shall contact his or her family or others designated to receive notification and information.
- (7.2.11) When participation by an individual in a research protocol is completed, participants and/or their families are entitled to be informed of results as soon as this information is available, to have the opportunity to receive feedback concerning their individual participation in the protocol, to critique the protocol, and to provide input concerning possible additional research.
- (7.2.12) All participants in research protocols involving the assessment of new medications will be provided with opportunities by the investigator for a trial on the medication being studied, so long as other research on the new medication has demonstrated potential safety and efficacy.

- (7.2.13) All individuals who have benefited from the administration of experimental medications in research will be provided continual access to the medication by the investigator without cost until a source of third-party payment is found or until the medication is approved for use.

### **7.3 Biomedical Research**

- (7.3.1) NAMI strongly encourages the donation of human organs and other tissue for transplant, research, and education, and the donation of tissue samples to developing gene banks. NAMI recognizes the severe shortage for research purposes of postmortem human brain tissue of persons who were afflicted with serious mental illnesses and members of their immediate families. All brain and issue samples donated should be accompanied by appropriate clinical records.
- (7.3.2) NAMI believes that the careful, responsible use of animals is indispensable in research on serious mental illnesses. At the same time, NAMI advocates the use of non-animal systems whenever feasible and urges researchers to observe the traditional, compassionate standards of animal experimentation; and to comply fully with the Federal Animal Welfare Act.

### **7.4 Psychopharmacological Research**

- (7.4.1) NAMI supports making psychopharmacological research a priority, given its impact on persons with serious mental illness and their families.
- (7.4.2) With Board review, NAMI may support legislation to place reasonable caps on product liability awards to encourage greater research and development.

### **Disclosure of Potential Conflicts of Interest**

In order to maintain trust in the research endeavor, any situations that may create the appearance of a conflict of interest should be disclosed to potential participants in research. The source of funding for the research should always be disclosed.

Examples of other required disclosures include:

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

- Investigators or institutions holding relevant stock or patent rights, serving as a paid advisor to the sponsor, or receiving direct or indirect honoraria from the sponsor for speaking about the class of products;
- Payments contingent on the number of subjects entering and/or completing the study, including payments made to recruiting firms or individuals;
- Investigators who also serve as the primary clinician (in which case the clinician/investigator should offer the opportunity of having an independent clinician involved in significant decisions.)
- Other individuals involved in the research or funding review process must disclose any vested interests they have in the research.

## **8. Quality Monitoring, Accountability, and Accreditation**

### **8.1 Governing Boards**

- (8.1.1) NAMI recommends that 51 percent of the members of all public and private governing boards of organizations that make decisions or recommendations affecting the lives of persons with serious mental illnesses be Persons with serious mental illnesses, their families and friends.
- (8.1.2) NAMI advocates that the Congress, state legislatures, and state executives require, through legislation and/or executive order, significant and meaningful consumer and family representation on, but not limited to, the following boards and councils: all policy-making boards and commissions having jurisdiction over private and public programs providing services to persons with serious mental illnesses, advisory councils for SAMHSA and the Center for Mental Health Services, State protection and advocacy boards and advisory committees, State mental health planning councils, State planning councils for developmental disabilities, and all governing bodies that regulate licensing and quality assurance in the private sector.
- (8.1.3) While NAMI welcomes opportunities for consumers and family members to participate in task forces, study commissions, and advisory bodies related to the service delivery system for serious mental illnesses, NAMI does not consider such membership to be a substitute for full membership on governing bodies themselves.
- (8.1.4) NAMI further urges associations of elected officials to similarly support such representation. While the appropriate number of such representatives will vary depending upon the function, purpose, and size of individual governmental and private entities, NAMI believes meaningful

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

participation demands more than token representation. Therefore, such membership should be numerically adequate to assure an effective voice in deliberations, equity and balance in relation to other family perspectives, and opportunity to impact significantly upon the outcome of deliberations.

- (8.1.5) NAMI also encourages private sector care providers to include consumer and family representation on their governing bodies. Where financial hardship presents an impediment to full participation, funds should be provided to facilitate attendance at meetings.
- (8.1.6) NAMI strongly encourages consumers and family members to seek appointments to, and to participate in, relevant governmental activities at the local, state, and federal levels, including service on general purpose governing bodies and the pursuit of elective office.
- (8.1.7) NAMI urges its members to join institutional review boards that review current research studies and research grant committees as advocates for persons with mental illness, their families and friends.

## **8.2 Hospital Standards**

- (8.2.1) NAMI demands that admission, length of stay, treatment, and discharge policies of public and private hospitals must ensure that the basic rights of persons with serious mental illnesses are protected. NAMI requires that, upon intake, the results of a thorough physical and psychiatric examination be incorporated into an individualized treatment plan. These examinations should include a psychosocial history taken from available records, families, and significant others. An intake evaluation that fails to consider these records and resources is inadequate because such records may be helpful in determining patterns of illness.
- (8.2.2) NAMI urges the state departments with regulatory authority to enforce the same hospital standards upon the private sector as stated above.
- (8.2.3) The team that develops an individual treatment plan should include the consumer, the consumer's service manager, medical personnel, and, when appropriate, family members. As the consumer progresses, the plan must be changed as needed to include appropriate psychosocial rehabilitation, education, and pre-vocational skills training compatible with the combined goals of the consumer and the community. The hospital discharge plan must ensure adequate housing, medical care, and continuation of the individual treatment plan with community support

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

services and a services manager. NAMI believes that the offer, payment, solicitation, or acceptance of a referral fee in relation to delivery of medical services is unethical.

### **8.3 Tobacco Addiction**

- (8.3.1) NAMI is committed to supporting in every way the wellness of people with mental illness and in recovery. NAMI recognizes that cigarette and other tobacco use is a dangerous form of addiction. Such addiction creates more significant health problems for people with mental illness and in recovery. People with mental illness and in recovery have the right to be smoke free and tobacco free. Effective prevention and treatment, including treatment of the effects of withdrawal, are available and should be part of effective mental health care treatment and recovery. People with mental illnesses must be given education and support to make healthy choices in their lives.
- (8.3.2) Research shows that people with serious mental illnesses are twice as likely to smoke as the general population and that people with schizophrenia are three to four times as likely to smoke as the general population. The negative health effects of cigarette smoking and other tobacco use on personal health are well documented, including increasing risks of respiratory problems, cardiovascular disease, and certain forms of cancer. The negative health effects of exposure to “second hand” smoke are also well documented.
- (8.3.3) Smoking has been inappropriately accepted and even encouraged in therapeutic settings for treatment and recovery. Access to smoking is sometimes used coercively and can be a source of disruption in treatment facilities. Smoking and other tobacco use also increase stigma.
- (8.3.4) Therefore, NAMI supports and encourages smoke free and tobacco free environments in treatment and other health care facilities, group centers and common areas in housing, including prohibiting smoking and other tobacco use by health care providers, caregivers and others working in and visiting such facilities, centers and housing. NAMI opposes any practice that uses access to smoking and tobacco as a form of coercion or reward.
- (8.3.5) At the same time, NAMI recognizes that the best time to provide and support smoking and other tobacco use cessation is not when consumers are in crisis because such treatment may exacerbate psychiatric symptoms and other conditions. Nicotine addiction is powerful and withdrawal is difficult for the general population, so it is particularly difficult for

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

individuals experiencing a psychiatric crisis. Research indicates significant interactions of smoking and smoking cessation with certain psychotropic medications that can be improved through effective dosage regulation and nicotine replacement. Research further indicates certain secondary, health issues associated with smoking and other tobacco use cessation, including weight gain, that require effective monitoring, counseling, peer support, self-help and treatment.

- (8.3.6) Therefore, NAMI supports consumers in seeking smoking and other tobacco use prevention, cessation and recovery as essential to overall wellness in treatments and in programs available in the community. NAMI calls upon physicians and other health care providers, in community and inpatient settings, as well as group centers and programs, to implement educational and tobacco use cessation programs to help consumers stop and avoid tobacco addiction. Treatment and other facilities instituting smoke free policies must provide effective tobacco addiction treatment and support to consumers as well as health care providers, caregivers and others working in such facilities, who use tobacco products. Effective treatment and support must include:
- (a) Smoking and other tobacco use cessation strategies and ongoing support;
  - (b) The most effective nicotine substitution products for individuals with nicotine dependence, as well as other medical approaches with proven effectiveness;
  - (c) Socialization, recreational and other structured activities;
  - (d) Counseling, peer support and other therapeutic supports;
  - (e) Careful assessment, monitoring and adjustment to medication regimens as appropriate; and
  - (f) Effective assessment, monitoring and assistance with respect to diet, nutrition and exercise to avoid weight gain and other common secondary effects of smoking and other tobacco use cessation.
- (8.3.7) NAMI further supports incorporating tobacco usage in the definition of dual diagnosis; integration of mental health care and overall health care; more effective research at all levels on smoking, tobacco addiction and mental health treatment; and funding (including Medicaid and other

public sources) to provide access to effective smoking prevention, cessation and recovery.

#### **8.4 Deaths in Institutions**

NAMI demands systematic reporting of deaths in institutions as an aid to improving quality of care. Deaths in psychiatric hospitals, correctional institutions, and other residential facilities can be important indicators of the quality of care provided to patients, inmates, and residents, especially when such deaths result from accident or suicide.

#### **8.5 Protection and Advocacy Services**

- (8.5.1) NAMI supports federal laws that recognize the value of family and consumer representation on the governing bodies of protection and advocacy agencies, require protection and advocacy services in all treatment settings, allow for the filing of grievances against the priorities of a protection and advocacy agency, ensure family and consumer input into federal regulations, and provide for consumer and family training of staff.
- (8.5.2) NAMI holds protection and advocacy systems accountable for protecting consumers from sexual and physical abuse while in hospitals and/or other facilities.

#### **8.6 Training of Professionals**

- (8.6.1) NAMI believes that all professional and other providers who care for persons with serious mental illnesses need to be educated about these disorders and related, high-quality treatment and services. They must be sensitive to those affected. Staffing for facilities for persons with serious mental illnesses must be sensitive to the cultures and ethnicities being served.
- (8.6.2) NAMI believes that there is a severe shortage of competently prepared professionals in all disciplines to treat persons with serious mental illnesses. NAMI calls on the appropriate government agencies to provide new institutional grants to universities for facility development and recruitment of persons with culturally diverse backgrounds and those who have worked with persons with serious mental illnesses.
- (8.6.3) NAMI supports federal budget expenditures for the clinical training of professionals that provide stipends to students in psychiatry, psychiatric

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

rehabilitation, psychiatric social work, psychiatric nursing, and psychology programs at the baccalaureate, masters, and doctoral levels. NAMI believes that all grants must include a pay-back provision for two-years of service in a public sector setting.

- (8.6.4) NAMI asks that all academic curriculum and training programs preparing providers to serve persons of all ages with serious mental illnesses include knowledge based on scientific research, proven psychosocial skills for psychiatric rehabilitation in the community, and attention to the development of compassionate, caring, and accepting attitudes towards consumers and their families.
- (8.6.5) NAMI believes that all academic curricula and training programs, to be successful, must involve family members and consumers.
- (8.6.6) NAMI requests that all pre-service training and continuing-education programs for providers be multi-disciplinary, culturally diverse, and targeted toward the development of clinical expertise in working with under-served people, including elderly persons with serious mental illnesses, children and adolescents with serious mental illnesses, and adults disabled by serious mental illnesses.
- (8.6.7) Fellowships must be provided to residents and junior faculty members in child psychiatry programs with adequate financial stipends for their training.
- (8.6.8) NAMI identifies as an urgent priority the awarding of federal and state training grants for fellowships and stipends for advanced education of all professionals who want to specialize in the care of children with serious mental illnesses.
- (8.6.9) Educational materials must reflect current knowledge about the treatment of serious mental illnesses. Professionals and other providers must understand and value recovery from mental illness and integrate its concept into their professional practice. All professionals serving persons with mental illness should encourage implementation of advance directives or healthcare proxies.
- (8.6.10) Consumers and family members should be encouraged to participate in the educational process of professionals and other providers who treat or work with persons with serious mental illnesses.

- (8.6.11) NAMI calls upon faculty of seminaries and schools of religion of all denominations to prepare clergy for service by including content about serious mental illnesses in their curricula.
- (8.6.12) NAMI endorses an affirmative action policy for recruiting consumers with serious mental illnesses as students in educational programs that will prepare them for careers in the service delivery system.

## **8.7 Accreditation of Facilities and Programs**

- (8.7.1) NAMI urges that all facilities and programs serving persons with serious mental illnesses, including: hospitals, community mental health centers (CMHCs), clinics, day centers, psychosocial rehabilitation programs, vocational programs, community housing, correctional institutions (jails, prisons, and diversion programs), nursing homes, other institutions, and networks and programs seek accreditation as a means of avoiding at least some of the most conspicuous shortcomings they might possess.
- (8.7.2) NAMI also urges that all facilities and programs serving persons with serious mental illnesses should use vigorously the devices of periodic self-study with impartial, external review to seek continuously the improvement of their performance. The self-study process should include full participation of consumers and family members. Such participation as well as membership on the governing boards should be one standard for accreditation.  
Such external review should include broad and convenient opportunities for confidential interviews with consumers and members of their families.

## **8.8 Use of Restraints and Seclusion**

- (8.8.1) The use of involuntary mechanical or human restraints or involuntary seclusion is only justified as an emergency safety measure in response to imminent danger to one's self or others. These extreme measures can be justified only so long as, and to the extent that, the individual cannot commit to the safety of themselves and others.
- (8.8.2) Restraint and seclusion have no therapeutic value. They should never be used to "educate patients about socially acceptable behavior;" for purposes of punishment, discipline, retaliation, coercion, and convenience; or to prevent the disruption of the therapeutic milieu.

- (8.8.3) Restraints shall be used only on the order of a physician with competency in psychiatry or a licensed independent practitioner recognized by state law. These professionals must be competent in providing alternatives to restraint, eliminating circumstances which give rise to the possible need for restraint, and applying restraints in safe and appropriate use. Restraints shall only be used for emergency safety use. Within an hour of initiating restraint, the physician or licensed independent practitioner shall complete a face-to-face evaluation of the patient. While in restraint the patient shall be continually and directly observed, person-to-person, by an appropriately trained professional. Specific behavioral criteria written by the physician, including the patient's verbal assurance of safety, shall specify when the restraints will be discontinued, to ensure minimum usage.
- (8.8.4) Every restraint shall generate an incident analysis. An incident analysis is a process of identifying the basic or causal factors that underlie variation in performance, including occurrence or possible occurrence of a reportable event. The incident analysis shall be available to the designated legal entity within the state which will investigate reportable deaths and serious injury. Any death or serious physical injury associated with the use of restraint shall be reported to a designated legal entity within the state for investigation.
- (8.8.5) The family, client, and involved staff should undergo a debriefing after each restraint or seclusion incident, within 24 hours. The circumstances leading to the restraint or seclusion and a discussion of why alternatives to restraint or seclusion failed should be documented in the clinical record. Future suggested interventions should be discussed at these debriefings. Following each use of restraint and seclusion, the patient should receive counseling specific to the incident.
- (8.8.6) Treating professionals must adhere to the patient's advance directive, if there is one.
- (8.8.7) Medication is typically important for the treatment of the symptoms of mental illness. However, medication should never be used for the purposes of discipline, staff convenience, immobilization, or reducing the ability to ambulate.
- (8.8.8) Any institution using seclusion, restraint, time-out, or brief physical holds must provide appropriate initial and recurrent training of staff, not only in the safe application of these interventions, but also in techniques of de-escalation which reduce the need for these interventions. No staff member

should be involved in seclusion or restraint before completing the required training.

- (8.8.9) When treating children and adolescents with mental illnesses, facilities and governing policies should differentiate between seclusion, inclusionary time-outs, and exclusionary time-outs.
  - (8.8.9.1) Seclusion is the involuntary placement of a child or adolescent, for any period of time, in a locked room where the child or adolescent is alone and is physically prevented from leaving.
  - (8.8.9.2) Inclusionary time-out is an involuntary procedure where a child or adolescent is separated from his/her peers in the presence of his/her peers.
  - (8.8.9.3) Exclusionary time-out is an involuntary procedure where a child or adolescent is separated in a designated area away from his/her peers but is not physically prevented from leaving.
- (8.8.10) If children and adolescents are to be secluded, the order must be by a physician or a licensed independent mental health practitioner competent in these procedures and recognized by state law.
- (8.8.11) While in seclusion and/or restraint, the child or adolescent should be constantly, visually monitored by staff. Video monitoring, if used by itself, is not sufficient.
- (8.8.12) When treating children and adolescents with mental illnesses, mechanical restraint, brief physical holding, and "therapeutic holding" should be differentiated.
- (8.8.13) Mechanical restraint should be generally avoided and used only in rare circumstances to protect the child or adolescent from self-harm and harm to others in emergency situations.
- (8.8.14) Brief physical holding is a form of temporary physical restraint and is different than "therapeutic holding." "Therapeutic holding" is not supported by adequate scientific evidence or detailed practice guidelines, and, therefore, is not supported by NAMI as an accepted form of treatment.

- (8.8.15) Brief physical holding should only be carried out by professionally recognized and trained mental health professionals licensed by a governmental body.
- (8.8.16) Escorting and immediate physical separation of children and adolescents in conflict are not considered restraint.

### **8.9 Application of Less Lethal Weapons by Law Enforcement Officers**

- (8.9.1) The National Alliance on Mental Illness (NAMI) believes that the use of conducted energy devices (including stun guns, tasers, impact delivery systems, or any other similar non-firearm weapons) used by law enforcement officers responding to individuals with serious mental illness should be permitted only if the responding officer concludes that an immediate threat of death or serious injury exists, which cannot be contained by lesser means, and/or is likely to be hazardous to the officer(s), the individual, or a third party. Such devices should not be deployed when other means or methods of de-escalations are appropriate, available, and suitable for the crisis event, nor should these devices ever be used as a means of intimidation or inappropriate coercion.
- (8.9.2) NAMI further believes that states should include, in statute, a requirement for the development and enforcement of standards and minimum training requirements for all law enforcement, corrections and other personnel who use or may potentially use these devices in the performance of their duties. This mandatory training must include information about effective methods of responding to people with mental illness in crisis with verbal and non-verbal crisis de-escalation techniques.
- (8.9.3) States should also strictly define in statute categories of professionals who are authorized to use these devices in the performance of their duties and should strictly prohibit usage of these devices by those not identified as authorized users in statute.
- (8.9.4) NAMI calls upon the states and the federal government to fund and promote research that documents the incidence of use of these devices and investigates both the short term and long term physical and psychological impact on people who have experienced the application of such devices. This research also should determine the potential dangers associated with risk factors, including but not limited to age and pre-existing medical conditions.

- (8.9.5) Each use of these devices should be investigated by the respective law enforcement agency or institution in the same way that use of a firearm would be investigated by a law enforcement agency.

## **9. Legal Issues**

### **9.1 Right to Treatment**

- (9.1.1) NAMI believes that every person with a serious mental illness is entitled to the same level of service afforded other physical illnesses. Every person is also entitled to be fully informed about specific medications and procedures and the risks, possible undesirable side effects of such medications and procedures, and other options. The risks and possible undesirable side effects of refusing treatment and what the alternatives are should also be a part of this information process. Every consumer has a right to be part of individual treatment planning. Every consumer has the right to be informed of all community services and supports.
- (9.1.2) With adequate professional consultation, every person with a serious mental illness who has the capacity and competence to do so should be entitled to manage his or her own treatment. When an individual lacks capacity and competence because of his or her serious mental illness, however, the substitute judgment of others--subject to sufficient safeguards with frequent review--may be justified in determining treatment and possible hospitalization.

### **9.2 Involuntary Commitment/Court-ordered Treatment**

- (9.2.1) NAMI believes that all people should have the right to make their own decisions about medical treatment. However, NAMI is aware that there are individuals with serious mental illnesses such as schizophrenia and bipolar disorder who, at times, due to their illness, lack insight or good judgment about their need for medical treatment. NAMI is also aware that, in many states, laws and policies governing involuntary commitment and/or court-ordered treatment are inadequate.
- (9.2.2) NAMI, therefore, believes that:
- (9.2.3) The availability of effective, comprehensive, community-based systems of care for persons suffering from serious mental illnesses will diminish the need for involuntary commitment and/or court-ordered treatment.

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

- (9.2.4) Methods for facilitating communications about treatment preferences among individuals with serious mental illnesses, family members, and treatment providers should be adopted and promoted in all states.
- (9.2.5) Involuntary commitment and court-ordered treatment decisions must be made expeditiously and simultaneously in a single hearing so that individuals can receive treatment in a timely manner. The role of courts should be limited to review to ensure that procedures used in making these determinations comply with individual rights and due-process requirements. The role of the court does not include making medical decisions.
- (9.2.6) Involuntary inpatient and outpatient commitment and court-ordered treatment should be used as a last resort and only when it is believed to be in the best interests of the individual.
- (9.2.7) States should adopt broader, more flexible standards that would provide for involuntary commitment and/or court ordered treatment when an individual, due to mental illness
  - (9.2.7.1) is gravely disabled, which means that the person is substantially unable, to provide for any of his or her basic needs, such as food, clothing, shelter, health or safety; or
  - (9.2.7.2) is likely to substantially deteriorate if not provided with timely treatment; or
  - (9.2.7.3) lacks capacity, which means that, as a result of the serious mental illness, the person is unable to fully understand—or lacks judgment to make an informed decision about—his or her need for treatment, care, or supervision.
- (9.2.8) Current interpretations of laws that require proof of dangerousness often produce unsatisfactory outcomes because individuals are allowed to deteriorate needlessly before involuntary commitment and/or court-ordered treatment can be instituted. When the "dangerousness standard" is used, it must be interpreted more broadly than "imminently" and/or "provably" dangerous.
- (9.2.9) State laws should also allow for consideration of past history in making determinations about involuntary commitment and/or court-ordered treatment because past history is often a reliable way to anticipate the future course of illness.

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

- (9.2.10) An independent administrative and/or judicial review must be guaranteed in all involuntary commitment and/or court-ordered treatment determinations. Individuals must be afforded access to appropriate representation knowledgeable about serious mental illnesses and provided opportunities to submit evidence in opposition to involuntary commitment and/or court-ordered treatment.
- (9.2.11) Responsibility for determining court-ordered treatment should always be vested with medical professionals who—in conjunction with the individual, family, and other interested parties—must develop a plan for treatment.
- (9.2.12) The legal standard for states to meet to justify emergency commitments for an initial 24 to 72 hours should be "information and belief." For involuntary commitments beyond the initial period, the standard should be "clear and convincing evidence." Involuntary commitments and/or court-ordered treatment must be periodically subject to administrative or judicial review to ascertain whether circumstances justify the continuation of these orders.
- (9.2.13) Court-ordered outpatient treatment should be considered as a less restrictive, more beneficial, and less costly treatment alternative to involuntary inpatient treatment.
- (9.2.14) Efforts must be undertaken to better educate justice systems and law enforcement professionals about the relationship between serious mental illnesses and the application of involuntary inpatient and outpatient commitment and court-ordered treatment.
- (9.2.15) Private and public health insurance and managed care plans must cover the costs of involuntary inpatient and outpatient commitment and/or court-ordered treatment.

### **9.3 Advance Directives and Healthcare Proxies**

NAMI supports the efforts of states to develop processes by which caregivers and service providers work collaboratively with persons with serious mental illnesses to develop plans for treatment, services, and supports that are followed, when, and if, needed in the future.

### **9.4 Security of Trust Funds**

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

NAMI believes that the assets of trusts established for the benefit of persons with serious mental illnesses should be secure from capture for any purposes other than those prescribed in the documents establishing the trusts.

## 9.5 Confidentiality

- (9.5.1) NAMI acknowledges the dramatically changed environment of data linkages, data integration and initial inability to control access or identify recipients once data has been communicated without prior approval.

With the advent of electronic medical record systems, NAMI supports having safeguards for patient confidentiality to prevent inappropriate access to psychiatric information and drug and alcohol information.

- (9.5.2) NAMI supports the involvement of consumer and family members as partners in the development of policy and use of data for decision making and the collaborative use of information by all stakeholders.
- (9.5.3) NAMI supports the key roles of mental health professionals and practitioners and their responsibilities, as part of good professional practice and professional ethics, to share information with both their patients or clients and family members and other verified caregivers.
- (9.5.4) NAMI believes that national standards should be adopted for maintaining the privacy and confidentiality of individually identifiable medical records. These standards should serve as a floor, not a ceiling, for health privacy protections, and should apply to all entities, private and public, governmental and non-governmental which access health care records for any reason. States should be encouraged to add specific protections not provided under Federal law.
- (9.5.5) NAMI believes that consumers (patients) of healthcare services own their own health records, especially those parts including any individual identifying information, while providers and managed care organizations are custodians of these records. Consumers have the right to inspect and amend their own healthcare records. Providers and managed care organizations should be allowed the use of aggregate data for purposes of quality assurance, and research.
- (9.5.6) Federal legislation should require that consumers/patients provide informed consent for any use or disclosure of individually identifiable health information which pertains to them. Lack of initial informed consent should not exempt providers and managed care organizations

from providing emergency care, urgent care or medically necessary care to persons suffering from mental illnesses.

- (9.5.7) Federal legislation protecting privacy and confidentiality of individually identifiable health information should contain strong and effective remedies for violations of these protections.
- (9.5.8) NAMI believes that treatment providers are responsible for making known to caring families and caregivers any information necessary to the ongoing care of persons with serious mental illnesses. Professionals are obliged to accept information from family members or others who function in a caregiving role. In the event a patient objects to disclosure, the provider should use best clinical judgment in determining how to proceed.
- (9.5.9) NAMI believes that law enforcement authorities must obtain search warrants or comparable determinations of probable cause by judges or magistrates before they can access individually identifiable medical information.
- (9.5.10) Federal and state legislation should be drawn so as to protect individual privacy rights to the maximum extent feasible, while not impeding the conduct of biomedical, clinical or pharmaco-epidemiological research or treatment.
- (9.5.11) When one physician makes a formal referral to another physician, clinical information, including information about medications, shall be made available to enhance clinical outcomes and avoid adverse treatment outcomes. When there is no formal referral, it is the responsibility of each treating professional to obtain information necessary to assure the provision of appropriate care and treatment.  
In all cases, the exchange of such information shall be treated confidentially and protected. The sharing of clinical information or refusal to consent to sharing of clinical information shall not be used to deny treatment, adversely affect services, or otherwise discriminate against persons with severe mental illnesses.

## **9.6. The Americans with Disabilities Act (ADA)**

NAMI believes that a serious mental illness by itself does not constitute sufficient reason to deprive a person of the right to a free and appropriate education, the right to vote, or any other civil liberty. NAMI supports full and rapid implementation of the Americans with Disabilities Act (ADA) and enforcement

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

of its statutory protection against discrimination in education, employment, public accommodation, and other life endeavors.

## **10. Criminal Justice and Forensic Issues**

### **10.1 Ultimate Responsibility of Mental Health Systems**

Mental health systems have ultimate responsibility for treating all people with severe mental illness. A substantial number of people with severe mental illness require twenty-four hour, seven day a week structured care, either for long or short periods of time. It is never appropriate to allow the care of such persons to be shifted to the criminal justice system.

### **10.2 Therapeutic Jurisprudence**

NAMI endorses the principal of therapeutic jurisprudence, which emphasizes that the law should be used, whenever possible, to promote the mental and physical well being of the people it affects. For example, in a system characterized by therapeutic jurisprudence, people with serious mental illnesses charged with non-violent crimes are diverted into programs designed to address their treatment and service needs, rather than incarcerated. Individuals with serious mental illnesses convicted of serious crimes are provided with humane and appropriate treatment while incarcerated. And, these individuals are provided with appropriate linkages to needed services and supports upon discharge to enable them to successfully reenter their communities.

### **10.3 Education at all levels of Judicial and Legal Systems**

NAMI believes that education about serious mental illnesses at all levels of judicial and legal systems is crucial to the appropriate disposition of cases involving offenders with serious mental illnesses. Judges, lawyers, police officers, correctional officers, parole and probation officers, law enforcement personnel, court officers, and emergency medical transport and service personnel should be required to complete at least 20 hours of training about these disorders. Consumers and family members should be a part of this educational process.

### **10.4 Collaboration**

NAMI believes that state and local mental health authorities must work closely in conjunction with state and local correctional and law enforcement agencies to develop strategies and programs for compassionate intervention by

law enforcement, jail diversion, treatment of individuals with serious mental illnesses who are incarcerated, and discharge planning and community reintegration services for individuals with serious mental illnesses released from correctional facilities.

### **10.5 Boot Camps**

Youth with serious mental illnesses should never be placed in boot camps, “scared straight” or similar programs that use punishment as the primary source of behavior change. There is sufficient evidence that these programs are non-therapeutic and cause harm. In some cases, placement in boot camps has led to the unnecessary and tragic deaths of these youths.

### **10.6 Right to Treatment (Regardless of Criminal Status)**

- (10.6.1) Humane and effective treatment for serious mental illnesses while in correctional settings is the constitutional right of inmates with severe mental illnesses. NAMI strongly urges the enactment of state statutes expanding treatment programs within prison and jail settings, including first line access to new generation medications whenever clinically indicated.
- (10.6.2) NAMI endorses state laws and policies establishing systems of community treatment for offenders with serious mental illnesses who are released on parole and/or are in the community on probation or parole status.

### **10.7 Jail Diversion**

- (10.7.1) NAMI believes that persons who have committed offenses due to states of mind or behavior caused by a serious mental illness do not belong in penal or correctional institutions. Such persons require treatment, not punishment. A prison or jail is never an optimal therapeutic setting.
- (10.7.2) NAMI supports a variety of approaches to diverting individuals from unnecessary incarceration into appropriate treatment, including pre-booking (police-based) diversion, post-booking (court-based) diversion, alternative sentencing programs, and post-adjudication diversion (conditional release).

## 10.8 Violence

- (10.8.1) NAMI believes that, in the overwhelming majority of cases, dangerous or violent acts committed by persons with serious mental illnesses are the result of neglect or inappropriate or inadequate treatment of their illness. State and local mental health authorities must develop policies and programs to provide care and appropriate treatment for persons who suffer from serious mental illnesses that produce behaviors assessed and labeled by society as “criminal” or “violent.” Where a mental illness and substance abuse co-occur they should be treated with integrated treatment.

## 10.9 Death Penalty

NAMI opposes the death penalty for persons with serious mental illnesses.

- (10.9.1) NAMI urges jurisdictions that impose capital punishment not to execute persons with mental disabilities under the following circumstances:
- (10.9.1.1) Defendants shall not be sentenced to death or executed if they have a persistent mental disability, with onset before the offense, characterized by significant limitations in both intellectual functioning and adaptive behavior as expressed in their conceptual, social, and practical adaptive skills.
- (10.9.1.2) Defendants shall not be sentenced to death or executed if, at the time of their offense, they had a severe mental disorder or disability that significantly impaired their capacity
- (a) to appreciate the nature, consequences or wrongfulness of their conduct, (b) to exercise rational judgment in relation to conduct, or (c) to conform their conduct to the requirements of the law. A disorder manifested primarily by repeated criminal conduct or attributable solely to the acute effects of alcohol or other drugs does not, standing alone, constitute a mental disorder or disability, for purposes of this provision.
- (10.9.1.3) Sentences of death shall be reduced to lesser punishment if prisoners under such sentences are found at any time subsequent to sentencing to have a mental disorder or disability that significantly impairs their ability
- (a) to understand and appreciate the nature of the punishment or

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

its purpose, (b) to understand and communicate information relating the death sentence and any proceedings brought to set it aside, or (c) to make rational choices about such proceedings.

## 10.10 Insanity Defense

NAMI supports the retention of the “insanity defense” and favors the two-prong (“ALI”)<sup>2</sup> test that includes the volitional as well as the cognitive standard.

### (10.10.1) “Guilty but Mentally Ill”

NAMI opposes “guilty but mentally ill” statutes as presently applied because they are used to punish rather than to treat persons with serious mental illnesses who have committed crimes as a consequence of their serious mental illnesses.

### (10.10.2) “Guilty except for insanity” and other alternative terminology for the insanity defense

NAMI supports systems that provide comprehensive, long-term care and supervision to individuals who are found “not guilty by reason of insanity”, “guilty except for insanity”, and any other similar terminology used in state statutes<sup>3</sup>.

### (10.10.3) “Informing Juries about the Consequences of Insanity Verdicts”

---

<sup>2</sup> The “ALI test” refers to the rule for insanity adopted in Section 4.01(1) of the American Law Institute’s Model Penal Code. The Code states that “a person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality (or alternatively, wrongfulness) of his conduct (cognitive standard) or to conform his conduct to the requirements of law (volitional standard).”

<sup>3</sup> States currently apply three different terms to verdicts incorporating a formal finding or acknowledgement of mental illness.

“Not guilty by reason of insanity” is the traditional term used when a person is determined as not criminally responsible due to mental illness. Individuals found “not guilty by reason of insanity” are typically sentenced to secure psychiatric treatment facilities instead of prison.

“Guilty but mentally ill” (GBMI) statutes have been adopted in the criminal codes of a number of states. These statutes currently function very similarly to “guilty” verdicts. An individual found GBMI could be sentenced to life in prison or even to death. Additionally, a verdict of GBMI does not guarantee psychiatric treatment.

“Guilty except for insanity” statutes have been adopted in several states such as Oregon and Arizona as substitutes for “not guilty by reason of insanity.” These states have developed effective systems for providing long-term treatment and supervision to individuals who are found “guilty except for insanity.”

NAMI Believes that juries in cases where the insanity defense is at issue should be informed about the likely consequences of an insanity verdict to enable them to make a fair decision.

## **Permission to Reprint**

Persons or organizations may copy sections from this document for republication or distribution; however, all reprints must cite NAMI as the source.

Clarification, supporting documents, or further information about NAMI's policies may be obtained by writing to the Public Policy Chair, Board of Directors, NAMI, Colonial Place Three, 2107 Wilson Boulevard, Suite 300, Arlington, VA, 22201-3042, or by calling NAMI at 703-524-7600.