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My role is to emphasize that there is more to NAMI than a relationship with Fuller Torrey and involuntary outpatient commitment, but when one reads the Clearinghouse's newsletter and other consumer-based newsletters you only see that.

NAMI advocates the Omnibus Mental Illness Recovery Act, which we've been working on with our state chapters since February 1999.

We have two national staff members who coordinate consumer activities: Maggie Scheie-Lurie and Lainie DeMelle, both of whom are here today.

The Omnibus Recovery Act has multiple components, but it is not comprehensive and does not include every important issue that faces the field. This is an effort to organize NAMI chapters around the country around nine key elements that we think will promote a more responsive, more appropriate public mental health system that leads to recovery.

The elements are:

1. Consumer/family participation in mental illness services planning: increases involvement in a variety of forums, such as state mental health planning councils and state Medicaid advisory councils, including advocacy for an accountability template to ensure responsive treatment.
2. Parity: NAMI does prioritize the population that is the sickest, most disabled population, which is always the last to be served. Our strategic approach to parity is to at least serve the sickest, most disabled population, and ultimately full parity for everyone.
3. Access to newer medications: There are restrictive formularies to deny access to newer medications. This is a major issue in such states as Utah, Florida, Tennessee and Texas. Utah had the audacity to write to people saying, Use old medications because they're cheaper, even though we know the side effects are worse. This is a big battleground.
4. For the small cohort of the population that is most severely disabled, whom for whatever reason traditional services have failed, the promotion of the Assertive Community Treatment model, not as coercive but as 24-hours-a day assistance.
5. Work Incentives for Persons with Severe Mental Illness: Andrew Sperling of NAMI chaired the coalition that worked to get this law passed. This just means state Medicaid agencies have the option. The law is not self-implementing; it will only work if consumers and families and the whole community back home will work to broaden eligibility.

6. Restraint and Seclusion: limits the use of involuntary mechanical and physical restraints solely to instances involving emergency safety situations. There is a coalition working on this, and it is a major component of the NAMI Omnibus Mental Illness Recovery Act. Eight national advocacy organizations work together to ensure appropriate use of restraint limited solely to emergency safety responses.
7. Reduction in the criminalization of persons with severe mental illness: It provides for specialized training for police and probation officers and establishes mental health courts to divert non-violent offenders with severe mental illnesses away from incarceration into treatment.
8. Access to permanent, safe and affordable housing with appropriate community-based services: It establishes a Mental Illness Housing Assistance Program to assist persons with severe mental illnesses in securing adequate housing and in developing new, permanent housing.
9. Unimpeded access to treatment of childhood mental illnesses: This develops an adequately funded system to meet the needs of children and youth and their families, including the prevention of custody relinquishment solely to access mental illness treatment.

That's a broader look at NAMI. We stand ready to try to implement a core of policy planks, and these are our organizational priorities.