NAMI Greater Des Moines
Federal Issues and Legislation
Veterans, Medicaid Work Requirements, ERPO's

View this email in your browser

Veterans deserve mental health care

When Veterans transition out of service into civilian life, they can experience many challenges.

To help, Sen. Jon Tester (D-MT) and Sen. Jerry Moran (R-KS) recently introduced a bipartisan bill, S.785, *The Commander John Scott Hannon Veterans Mental Health Care Improvement Act.*

This bill will help Veterans access better care—care they deserve and need. NAMI worked with a bipartisan group of legislators on key parts of the bill, including provisions to:

- Provide veterans with a full year of VA health and mental health care after transitioning from the Armed Forces
- Increase access to online Cognitive Behavioral Therapy (CBT)
- Create a Precision Medicine for Veterans Initiative to identify brain and mental health biomarkers
- Provide $10 million to increase availability of and locations for VA telehealth care

S. 785 celebrates the legacy of retired Navy SEAL Commander John Scott Hannon, a member of NAMI Montana, who died by suicide last year after fighting a courageous battle with post-traumatic stress, traumatic brain injury and bipolar disorder.

CDR Hannon embodied the strength of veterans with mental health conditions. This bill honors his passion and efforts to improve veterans' mental health care.

You can help. Click here to ask our U.S. Senators for their support of S. 785.

Medicaid Work Requirements Struck Down

Yesterday, a U.S. District Court Judge ruled, for the second time, against taking away Medicaid coverage from people who do not meet work requirements in Kentucky and Arkansas. NAMI applauds this ruling, as work requirements hurt people with mental illness.

More than 10 million people with mental illness across the country rely on Medicaid, including many who live with severe conditions. While NAMI supports the goal of employment and recognizes that people with mental illness are disproportionately unemployed, **cutting off Medicaid for people with mental illness won't improve their mental health—or help them get or keep a job.**

The Centers for Medicare and Medicaid Services (CMS) has approved work requirements in eight states, including Arkansas and Kentucky. Seven more states have work requirement proposals pending. Prior to the ruling, Kentucky's work requirement was set to go into effect next Monday, April 1. In Arkansas, **more than 18,000 people have lost their Medicaid coverage under the work requirement.**

While states may exempt some vulnerable people from work requirements, most states do not have effective ways to do so. Additionally, there are people with mental illness who have not been determined disabled, but may not be ready to work, including:

- Young adults with the first symptoms of a serious mental illness;
- People whose mental health symptoms are so severe they are not able to navigate the disability system; and
- People who have been discharged from psychiatric hospitalization but need ongoing treatment.

Unfortunately, because of the complexity of work requirement programs, many people with mental illness fall through the cracks and lose their coverage.

NAMI has submitted comments opposing each state's work requirement proposal, reiterating that it would be more effective for states to invest in robust, evidence-based Supported Employment programs that many people with mental illness need to get and keep competitive employment.

In January, NAMI filed an amicus brief in the lawsuit against the work requirements in Kentucky, along with The American Academy of Pediatrics, The American College of Physicians, The American Medical Association, The American Psychiatric Association, The

Catholic Health Association of the United States, and March of Dimes. In November, NAMI filed an amicus brief in a similar lawsuit in Arkansas. You can read both briefs and a joint statement issued by NAMI and the above groups here.

We expect that the Administration will fight this decision and appeal the ruling.

NAMI Provides Testimony to Senate Judiciary Committee on Extreme Risk Protection Orders

Yesterday, Ron Honberg, Senior Policy Advisor, testified on behalf of NAMI in front of the U.S. Senate Judiciary Committee on Extreme Risk Protection Orders (ERPOs). The Committee held the hearing to consider guidelines for state action on ERPOs, also known as Gun Violence Restraining Orders.

ERPOs establish procedures to prohibit individuals who pose risks of violence to self or others from possessing firearms for a defined period. Currently, 14 states (California, Connecticut, Delaware, Florida, Illinois, Indiana, Maryland, Massachusetts, New Jersey, New York, Oregon, Rhode Island, Vermont, and Washington) plus the District of Columbia have laws authorizing these orders.

NAMI believes that ERPOs can be lifesaving when they appropriately implemented. However, NAMI urged the committee that the criteria for issuing an ERPO should be based on specific, real-time behaviors and evidence-based risk factors for violence rather than targeting or singling out people with mental illness.

Ron testified, “An individual’s history of mental illness or specific diagnosis is not a good predictor for violence.” He noted that while some symptoms of severe mental illness, such as delusions and paranoia, are a risk factor, overall, only 4% of violent acts in the U.S. are attributable to mental illness.

“It is therefore neither necessary or appropriate to specifically identify mental illness as a risk factor in state or federal ERPO laws.”

NAMI also reminded the Committee that people with mental illness are more often victims of violence than perpetrators. Tragically, the greatest threat of gun violence is suicide—which accounts for 60% of gun deaths in the U.S. each year.

NAMI has six recommendations to maximize the positive impact of ERPOs and to prevent unintended consequences:

1. Determinations of risk should be based on an individualized assessment and grounded in evidence.
2. Any person subject to an ERPO petition should be afforded due process protections.
3. Law enforcement officers responsible for removing firearms from individuals under an ERPO should receive training on crisis de-escalation and crisis intervention.
4. Stigmatizing language should not be used in writing or describing these laws.
5. Health professionals should also have the ability to initiate petitions for ERPOs.
6. Key stakeholders, including law enforcement, families, health professionals and others, should be educated about these laws and how to utilize them.

To read our statement and Ron's full testimony, click here.
