# NAMI Virtual Town Hall:
# Criminal Justice And Mental Illness: A Webinar On The State Of The Issue

Featuring Dan Mistak, MA, MS, JD

March 20, 2024

**Shannon (00:00:00):**

Thank you all for joining us this afternoon, and for taking the time to join us to listen to this incredibly important presentation and have this important discussion. I do want to take just a moment to remind everyone when we have these presentations at NAMI, we want to have the real conversation, but that can sometimes be triggering to people it might impact, especially if you've had experiences in the criminal justice system. And so we just want to remind you that you should take care of yourself first, and if you do need support during this presentation, after this presentation, tomorrow, or even in the days and weeks following, NAMI is here to help and support. So please reach out to the NAMI helpline. It's a free nationwide peer support service providing information, resources, and referral to people with mental health conditions and their family members and caregivers, as well as mental health providers and the public.

So you can connect with the NAMI helpline via phone, email, chat, or text, and the information is being dropped into the chat box below. So please, if you need any support, please feel free to reach out to us. Next slide, please. I also wanted to take a moment to recognize National Criminal Justice Month. March is criminal National Criminal Justice Month and is a really important time for NAMI and the issues and the people that we care about. People with mental illness, as you'll hear often from us, they are overrepresented in our criminal justice system and they really deserve help and not handcuffs. And so taking this into consideration, at the beginning of this month, NAMI launched a new campaign called Overlooked: Stories of Mental Illness in the Criminal Justice System. Through this campaign, we are going to be collecting and highlighting the stories of people with mental health conditions and their family members who have been impacted by the criminal justice system because we don't do any of our work without having these stories at the forefront of our minds.

And so I would please take a moment to go to our website, learn more about this campaign, how to get involved in action that you can take moving forward. Next slide, please. Now it is my distinct honor to introduce Dan Mistak, who is our speaker for this afternoon. Dan is a close colleague and ally of NAMI. Dan and I have worked together on a number of issues. He has also been involved with the NAMI community and he brings an immense wealth of experience to this conversation today, and I'm really thrilled that he has agreed to spend this time together with us today. So Dan's impressive career includes serving as a former board member of NAMI Hawaii, thus his close relationship to this organization. He was the senior editor of the California Law Review at UC, Berkeley School of Law, and was a trial attorney who worked with justice involved individuals regarding collateral consequences of justice involvement.

He's currently the acting president and director of Healthcare Initiatives for Justice involved populations at Community Oriented Correctional Health Services. Throughout his career he's been a leader both at the federal, state and local level, really trying to change the way our systems work for those who become involved with the criminal justice system. So, Dan, thank you for being with us today and I'm going to turn it over to you to start the presentation.

**Dan Mistak (00:04:20):**

Great. Thank you so much, Shannon. Thank you so much all of my NAMI family and for all of you who are supporting me in this endeavor and for putting on this webinar, it's a real huge undertaking to do

that. So I'm incredibly grateful that you would invite me to come in to share with all of you members. So just wanted to start it out with who am I, I wanted to let you all know a little bit of where and how I'm coming to this topic. So first of all, I am currently a public interest attorney/policy nerd. I've been working on these issues around justice involvement, mental health and our criminal legal systems since I graduated from law school. And I've been working in a variety of different ways. As Shannon said, I did also take a short stint away from doing my policy nerd work in order to serve as a trial attorney for the Legal Aid Society of Hawaii.

There I was also a board member for NAMI Hawaii. So I want to send out a big aloha Mai Kakou to my family from Hawaii. If you have attended today, I hope that you're here. But this work and what I'm doing is really motivated deeply from just my own family and my own social experiences. My aunt lived with schizophrenia and bipolar disorder her entire life. And from a very young age, I was definitely acculturated to the fact that police sheriffs are the first responders in too many places whenever somebody is in the midst of a mental health crisis, that it took a long while for that to cook in order for me to try and then connect it in with career and being able to drive social change.

And so I'm really grateful for the opportunities that my family have given me in order to learn, understand more, but also all the people in my life that I've loved who have been involved with the justice system and those who are still continuing to fight for justice and to try and improve health outcomes for people across the board, especially for those who are involved with the justice system. So that's a little bit about me, but who and what is coaches? So I work for Community Oriented Correctional Health Services or COCHS, and we are a nonprofit whose goal is to build a system of care for people involved with the justice system. I actually started in 2005 with a grant from the Robert Wood Johnson Foundation in order to try and bring community health systems inside of the jail so that as people were leaving incarceration, they would already have a relationship with the provider in their community so that they can continue that relationship on the other side.

Also, to make sure that if you're entering inside of a jail, the providers in the jail know what has been going on and the community because like it or not, and the truth is that coaches doesn't love it. I don't love it, but people do receive care inside of jails. Jails are a place where healthcare is delivered. And so we think that that should be held to the same standard that we would expect out of other sorts of healthcare delivery sites such as hospitals or physician's office. And we think that if we do build a community continuity of care for people who are entering and leaving jails, entering and leaving prisons, then we're going to really improve coverage for people. We won't have people losing access to health insurance or healthcare. We're going to improve population and community health better integrate behavioral and physical health and ultimately drive down costs.

Driving all of this too is the desire to really eliminate the significant racial disparities that exist both in our health systems and inside of our justice systems, particularly inside of our behavioral health systems. We've known for decades that we have some really bad disparities when it comes to communities of color and also poor communities. And so one of our goals is to try and make sure that we aren't carving out a healthcare delivery site and then sectioning those individuals off from the rest of our community, but making sure that all of that data and all that information can transmit across to all of the different providers, hopefully with the goal of reducing the amount of times people enter incarceration to begin with. So like I said, COCHS started in 2005, but what have we done in this time? We've done a lot of work on a national level to try and work on some of these policy issues that we're going to be talking about today.

We've also provided technical assistance to local communities for them to be able to identify different opportunities to rely on health systems to try and decrease the amount of work that they're leaving for our justice systems to pick up and to really improve coordination between health and justice systems

and to make sure that the policies that we develop are supporting clinical decision making and making sure that the healthcare needs of people end up being centered. And we're really trying to change the narrative too, to understand that people who are incarcerated are just temporarily displaced members inside of our correctional institutions. To that end, we end up convening with people at the federal, state, local level in order to try and work on this. So happy to try and help you also and support you and what is going on because here's one of the things about the justice system, justice systems are a very, very local product.

Of course, states have their own departments of corrections and try and set policy at the state level, but when you're going down to a county jail, those decisions actually end up being driven by who's showing up at meetings and who's demanding change. And this is absolutely why I love NAMI and why I'm really grateful to talk to you all today because you all are the ones who can show up at those meetings and have some pretty significant impact because of some policy changes that we'll be talking about. So today what I'm hoping to do is to describe the co-evolution of our health injustice systems to describe the statutory and regulatory changes that have just happened in the last two years that are going to really reshape our opportunities to improve care delivery. Also, each of those changes are going to allow for you all to be able to have your voice heard at a variety of different levels at the local and state level, but then also about how these changes can look on the other side.

And in order to try and help you maximize that, I just want to sketch out some of the ways that you can work on your advocacy to reduce the number of people who are incarcerated. So I want to describe from the very outset one of these major themes to try and highlight today, which is that people who are inside of our justice system have some pretty deeply unmet social and health needs. And often what that means is that people end up inside of the justice system rather than having those needs met in the community. So two of these I just wanted to highlight. These are just ones that were going on in Hawaii when I was working with some friends there. Number one is just to point out that the fact is that in Hawaii's correctional system, they have had huge challenges with being able to bring in an electronic health record that's able to coordinate and identify what someone's health needs are and then to transmit that information out into the community.

So this has made it so that we don't understand what's going on with people who are incarcerated there, which is of course going to have some pretty huge impacts on the health outcomes for people there. But I also wanted to point out that in Hawaii some people are remaining incarcerated simply because there isn't the behavioral health programming in the community for them to go to. So people are staying incarcerated because there aren't services in the community. I think that we could all probably agree that people shouldn't be incarcerated just because there's the lack of services that are necessary for them on the outside. And so really this lack of support in the community often leads to a bottleneck or people being incarcerated inside of jails for too long and prisons for too long.

And then finally, just about a week ago now, there was a news article that popped up that I thought I'd highlight, which discussed a man who was arrested who was, as they said, talking out of his head, but claiming that he was with the FBI and was working with the FBI. And so because of the way he was talking, the first responders in this case were the police. That individual ended up being arrested on the other side. I think that we can all hopefully start thinking about and moving towards a system where people who are having a crisis could be diverted or triaged into a system that might be able to meet whatever needs they're having at that moment, whether they be a mental health need, substance use need or anything like that in order to try and make sure that people don't end up inside of jails who don't necessarily need to be there. So what is the current state of our criminal justice system in this country?

This is something that I think that we all know, every time I look at it or go over these stats, it's so hard for me to believe it and to really let it sink in. But I encourage you all to reckon with this fact. But the United States is the number one incarcerator in the world. 25% of the entire world's incarcerated population is inside of the United States. That's wild. We do not have 25% of the world's population. So at this moment right now, we estimate about 2 million people are in some sort of detention, but also 10.6 million people each year get booked into jail. Obviously some of those are people who are going in and out over and over again, but that is an astronomical number of people whose lives are touched by jails. At least one in four people who go to jail will be arrested again. And many of those people who are arrested are arrested because of poverty issues, mental health issues, substance use disorder issues.

Just want to point out that some of the policy changes that we make around houselessness often are the first response is to say, well, we need to make sure that we can get some sit live bands so that we can arrest people who are sitting where we don't want them to be. This just results in people being arrested over and over again and it's not really going to some of the root of these issues. And also it is driving a crisis on the correction side as well. Besides just being incarcerated, there are 7.2 million people in the country right now on probation, parole, or community supervision. So those are people whose lives are being watched by some sort of authority, parole authority, probation authority. And that also means that those 7.2 million people could be remanded or have their parole revoked and be taken back to jail or prison based on some infractions that frankly, if we were looking at it through a clinical lens might say that we need to readjust what we're doing for this individual to try and make sure that they can adhere better to the plan that we have.

But if we're looking at it through the lens of the criminal legal system, what that means is those individuals could get pulled back into the correctional facility that they were released from. So the lens with what we're looking at, the behaviors that people are doing really can also impact where they end up going on the other side of an interaction with a criminal legal system. So in 2014, one note on data here, data is really challenging to have inside of health and justice settings. Part of that is because of the challenges with institutional review boards for people who are incarcerated. And other parts of it too is just because this is not necessarily a population that a lot of places a lot of universities or jurisdictions invest in really trying to understand and grapple with. So what that means is some of this data you're going to see is pretty old. Some of it might seem pretty dated, but the truth is that this is about as good as we can get at any moment. So in 2014, 10 years ago, it was estimated that 65 million people had some criminal record.

And of course, having a criminal record means that an individual is more likely to possibly have a longer sentence or to be detained if they are arrested. So how did we get here? And I think it's really important for us to describe these moments of how we got here because one, I think it really can help us broaden our understanding of really who are our colleagues in this, who are our co-conspirators and trying to change what this looks like, but then also to really understand where some of the policy levers might be hidden deep inside of the history of how we got here so that we can think about what do we need to pull on in order to try and make some change. When we're talking about the justice system, I think that it's impossible for us to not talk about the racist history inside of our criminal legal system.

These two articles here I think are pretty interesting articles to really give us a big overview of what was going on. But I think it's important to point out from the very beginning that policing has had its roots in the slave patrols. Individuals will be deputized to go out and try and find escaped slaves in order to be able to try and find them, bring them back to their slave owners. And of course, since then policing has evolved. It has taken on different functions inside of the state, but these sorts of things are a part of the history of policing in this country. But police also, besides just the racist roots of policing, police are essentially convened to try and control dangerous classes. Dangerous classes though has a lot of flexibility of what exactly falls inside of that category. So Gary Potter, Dr. Potter here described that the

original set of dangerous classes consisted of poor foreign immigrants and free Blacks as the quote that they found in the early research.

So surprisingly unsurprisingly, I think that the picture that I'll paint as we go on further is that people with mental health needs, unmet mental health needs too, that have often been ignored, not faced by the community, have lacked funding means that often that what will happen is that they can just be quickly lumped in with dangerous classes as if that would somehow solve the deep unmet needs that people have. And so the flexibility around the police aspect of the control aspect of policing means that we have to be hypervigilant and hyper aware of how we're trying to solve social problems through just lumping them in as a dangerous class. And hopefully we'll see and envision new ways in which we can try and meet people's social needs so that they don't get lumped into that category. So unsurprisingly, as we look at it, we'll find that people who are incarcerated have some pretty, pretty massive unmet health needs.

So we can see when we're comparing incarcerated populations to non incarcerated people, people who are incarcerated make significantly less money than people who are incarcerated. But in addition to just being involved with the justice system, which of course is going to have its own collateral consequences, it's going to have its own repercussions further down the stream. People who are leaving justice systems face higher rates of unemployment, they face housing instability, they face houselessness, they also generally have lower rates of education and literacy than other populations. So when people are released on the other side of incarceration, they really face major challenges with trying to meet the expectations of the community on the outside. And like I pointed out on the last slide, if you're failing to meet some of the expectations for society on the other side, the temptation would be to just lump people in as a dangerous category and then to deal with the needs through the justice system.

So this relationship between the unmet social needs and expenditures on our justice systems, I think has really been brought to light through a few researchers who have done some really interesting and fascinating research that has shaped my thinking on this topic. I call it a bit of a seesaw effect. And what that means is that when there's investment in punitive policies, those investments tend to come during periods of disinvestment in social programming, and then vice versa. Loïc Wacquant, who is a French sociologist who teach at UC, Berkeley, wrote a book called Punishing the Poor who goes through and describes the data on this. It's a very fascinating look in the ways in which across quite a few countries, there is a distinct trend that as spending on social services shrinks over time. The way in which that often ends up being the polity on the other side of it ends up being metabolized, is by expending more money on justice systems.

There are also really interesting budgetary concerns with this, where the federal government pays for a lot of social programming and local governments pay for justice systems, we can do a graduate level class on that another time if NAMI is interested or if you all ever want to reach out to hear more about my thoughts on that, I'd be happy to. But there's a study that looked across 18 different developed countries, and what they showed was that the more that a nation actually devoted to welfare programs, housing programs, food security programs, then they ended up being the ones who actually incarcerated fewer numbers of people. So all key points out of that were all seven of the nations that were most given to incarceration, which included the US have below average welfare spending and all but eight of the countries with the lowest prisons populations spent atypically heavily on welfare.

So there's a lot more research and those two links there that you could be able to find and follow to make that case a little bit more. But the point I'm trying to drive home is the fact that if we are really interested in trying to make a change inside of the justice systems by making impacts inside of our spending on community behavioral health, on options for people to be diverted to from justice systems for stronger reentry programs that meet people's social needs, I think we would be able to bear out

through this research that we would probably have fewer people who would be in re-incarcerated on the other side of this. I think that the United States has a very fascinating history with this, especially when it comes to mental health as well. I just want us also to think about historically, what were the promises that had been made to us who care about people who live with mental illness and people because there have been some pretty significant unmet promises here.

So I just wanted to read this quote from President John F. Kennedy who said that "If we launch a broad new mental health program now, it'll be possible within a decade or two to reduce the number of patients now under custodial care by 50% or more. Many more mentally ill can be helped to remain in their homes without hardship to themselves or their families. Those who are hospitalized can be helped to return to their own communities. Central to a new mental health program is comprehensive community care. Merely pouring federal funds into a continuation of outmoded types of institutional care, which now prevails would make little difference." I think to this day we still can see this as a guiding star. Unfortunately, what President Kennedy was hoping for never came to fruition because as we did deinstitutionalize, as we did start shutting down some of these institutions that were poorly managed, that were not meeting people's needs, we unfortunately didn't do the second half of that by really trying to create comprehensive community mental health care.

And so what we saw on the other side of that is that there were pretty significant changes to what happened to the population who was incarcerated. So I want to be very clear that we also on top of the deinstitutionalization program that ended up not having the community supports, we also were passing some pretty Draconian crime bills at this time. We were really responding to dealing with pretty significant social upheaval as well inside of this country at the same time. So while not the only, or even the main cause of the expansion of the criminal legal systems in this country, in the carceral state researchers Steven Raphael at UC, Berkeley estimated that four to 7% of the rise in incarceration comes from the deinstitutionalization without the subsequent creation of a robust community system. So here you can see as people who are in inpatient hospitalization decreased, the number of people who were institutionalized in total actually had a massive increase on the other side of this. I really do want to point out too that there are some pretty important demographic differences between the populations involved.

The few community programs that did exist did not flow to already disenfranchised populations. And so we really saw pretty massive explosions of Black and brown communities who were incarcerated on the other side of this as well. So there is a relationship inside of our own history, a pretty evident relationship too between the decrease in the relationship between deinstitutionalization and then really the hidden reinstitutionalization that happened through our criminal legal systems. And this is what we see on the other side of this. People who are inside of jails and prisons have serious psychological distress histories of mental health disorders and then point out that no indication of mental health problems, this is their language from the BJS data. Definitely want to do a major asterisk here, which is that we don't do a great job of screening and diagnosing people who are incarcerated as well for mental health conditions. So these are self attestations of a lot of people and attestations of the jails and prisons.

But we can see that people who are incarcerated in jails, 43% of them have a mental health, have a history of mental health conditions. And then closely associated with this, I hope in this process too, you'll see that I'm not just talking about mental health needs, I'm talking about behavioral health more broadly because so many people who have substance use disorders are often self-medicating. That's how they end up being with a substance use disorder as well. So there is a major overlap too between the clinical criteria for drug dependence while people are incarcerated and also their unmet mental health needs as well. So jails and prisons are incarcerating people who have pretty serious mental health needs. They also have substance use disorders, and those are often separated from our community

systems as well. When people are entering in, leaving correctional facilities, these are pretty massive moments of health needs in people's lives.

Fewer than one in 10 people who are arrested and test positive for a substance use disorder have received any sort of treatment in the previous year. So as people are coming in, they have substance use disorder needs and few of them have received treatment in the community beforehand. As people are leaving incarceration, they're more likely to die from all causes including heart disease, homicide, suicide, cancer, and other accidents. So people are 12 times more likely to die in the two weeks following release than people in the population at large. And then if we start thinking about this in terms of overdose, people are 120 times more likely to die of an overdose, and that data comes from studies in Massachusetts, but also one in Washington state found very similar data. So interestingly enough too, people as they're entering incarceration with chronic conditions have not had community treatment before they were arrested as well.

So 80% of people who are entering the jail with a chronic condition really have not really had this managed in the community beforehand. So jails in particular are places where people come in with some pretty serious physical health needs, some pretty serious mental health needs, and some pretty serious substance use needs. And as I'm going to note in a moment, there are some statutory and regulatory barriers that have kept us from being able to coordinate better with these systems as people are leaving too. We see from this data from Prison Policy Institute that people who were incarcerated have pretty staggeringly high rates of houselessness, especially women and people of color.

And I know from my time in NAMI Hawaii that one of the major challenges that people face is that if families are trying to take care of people in their family who have mental health needs, if they end up needing to reach out to the police or sheriffs or anyone on the other side for them to be able to get help with somebody who they just can't manage or help them with what their needs are, there aren't a lot of avenues to help that individual other than them being arrested and taken to jail. Once they're arrested and taken to jail. If there's a protective order that the family takes out, that means that individual can't come back to the only family that they had, the only people who are taking care of them. So that means that people end up becoming unhoused. In a place like Hawaii, that means that you are going to face a lot of challenges with finding housing on the other side of that. So incarceration, it really can cause challenges for families to continue to support the individual going through.

And then when they're released on the other side, there can be a lot of collateral consequences that increase the chance that somebody's going to be unhoused on the other side of this. So that's the current state of where we are. And I think the question that I want to ask us and to really get us to maybe think about is can we invest of the needs of the people who are involved with the justice system on one side of the seesaw in order to try and reduce our reliance on the justice systems on the other side? What is standing in the way of that? Well, I think that we can try and look at this question based on by trying to analyze what is our system of care for people that we need to beef up to try and be able to try and support people when they're on the outside? What are the barriers that make it so that people end up incarcerated rather than supported inside of community settings? And I think that Medicaid is really the key component of this.

So a lot of you out there may have people in your life that you're caring for or that have commercial insurance, but there's a significant number of people who are involved with the justice system are actually going to be Medicaid eligible beneficiaries. So Medicaid's role in the criminal legal system though has really evolved, particularly since 2014. So before the Affordable Care Act, about 90% of the people who are involved with the justice system had no access to health insurance. They weren't employed, they didn't qualify for Medicaid, they may have qualified but just might not have anyone to help them get through the qualification process because it's incredibly challenging to get needs-based

Medicaid for many people. But since 2014, with the expansion of Medicaid, in expansion states now, if you make below 138% of the federal poverty line, you are now eligible for Medicaid services for the first time. That means in many states that have expanded Medicaid, 80 to 90% of people leaving incarceration can be enrolled in Medicaid the moment they leave the door.

But besides that, the Affordable Care Act also strengthened the access to the mental health and substance use disorder benefits for people who were Medicaid beneficiaries. So the Medicaid program is basically a different program than it was since 2014. It's a significantly powerful program. It's a powerful program in order for us all to be able to advocate for change and to try and be able to support the services for people that we were trying to advocate for by trying to bring those benefits into the Medicaid system. And so some states have been really trying to smooth the connections to Medicaid for people before they're leaving incarceration, and they're trying to do that by having a different set of reentry protocols or programs. Some states by statute are trying to make sure that individuals leaving incarceration can have access to Medicaid, but we have to think that Medicaid has been around since 1965.

Jails and prisons have been around since this country has ever existed. And so now we're trying to have these two systems that have never really communicated before, communicate with one another. And what that means is that a lot of reentry programs can be significantly challenged with trying to connect with all the different human service programs in order to make sure that people have what they need when they leave. So our next step is to try and make sure that we can continuously cover people before they ever enter incarceration, if they ever do enter incarceration, that they can maintain that coverage. And then once people are released on the other side, they can continue to meet services or connect with the providers that they've been meeting with in the community beforehand to make sure that they're getting the things that they need so that they don't end up back inside of justice systems. So what stands in the way of this?

There's a pretty big barrier that's been standing in the way of trying to make that continuity of care system and that barrier is something called the inmate exclusion. So COCHS, we try and use a lot of person-centered language when we're talking about people. We try not to use the words inmate and detainee anymore in order to make sure that we are respected and treating the humans that are going through these systems as humans, but the language of the inmate exclusion sticks around because it is inside of our statutes. So what does the inmate exclusion say? So in 1965, when the amendments to the Social Security Act created Medicaid, they carved out two populations who even though they were otherwise eligible for Medicaid, would not be able to receive Medicaid services. The first were people who were in institutions of mental disease, those are IMDs.

So we're seeing in the last few years, there have been some changes to Medicaid that will allow for people who are in institutions of mental disease to receive services. And that's because we understand that clinically some people are going to need some inpatient care at times. And so if Medicaid can't pay for that, then we're carving out a huge chunk of services that an individual might need in order to be successful. The other population that has been carved out from being able to receive services even though they're otherwise eligible, are what are called inmates of a public institution. Those are people who are incarcerated in jails, prisons, juvenile justice facilities, some reentry centers, some halfway houses are considered, public institutions. And what that means is that the moment that you're booked into a jail, and may I remind you that you can be booked into a jail even if you haven't done anything wrong, just if you're suspected of doing something wrong, if there might be charges that are going to be brought against you, you could be booked into a jail.

The moment you're booked into that jail, you lose access to your Medicaid services. The exception to that, of course, because this is legal world, there's always exceptions to exceptions. And that is if

somebody was an inpatient hospital stay that exceeded 24 hours, but all other services are cut off, this was created in 1965. Like I said, the purpose was to try and prevent cost shifting. I think that that's a really noble, also really noble goal. We don't want to have local jurisdictions that say, let's just incarcerate and lock everybody away because we can get the federal government to pay for all of these different services that are necessary for this and we will put it on the federal bill. Makes sense. Absolutely don't want something like that to happen. But unfortunately, that doesn't mean that we aren't still institutionalizing people inside of these facilities.

And then creating a black box where the people who are incarcerated there are completely disconnected from the broader health system and the inmate exclusion really does reflect unfortunately, the way that we often do policy inside of the United States, which is really through a patchwork method. We want to just try and get this chunk and this chunk at a different time. And what that means is that people with mental health needs, people who are incarcerated, they often don't rise to the top of who we consider and think about when we're trying to pass policy in the United States, which is why, again, I'm so grateful to be talking to all of you because you are the ones who will make sure that that rises up to the top. So the inmate exclusion has really been standing in the way from being able to try and make sure that if people are receiving Medicaid in the community, that they can still continue those services while they're incarcerated and then be able to receive those services on the outside.

I know for people like my aunt who were receiving certain medications, maybe her medications were being changed and that's why she was incarcerated, why the sheriffs were coming from the very beginning. We would want to try and have a system that we could identify perhaps this person is having this mental health challenge right now because they haven't filled their prescription for the last three months. That would be really excellent and wonderful data to be able to understand whether or not the most appropriate place for that individual to go would be to a jail or whether or not it'd be to reach out to their provider, to reach out to their community members in order to find out if there's a better way for that individual to be supported. So the inmate exclusion causes significant challenges being able to just coordinate care across different providers. Well, the inmate exclusion, I'm happy to say, is something that is being slowly chipped away.

Of course, it's being done in a patchwork way. This is still the United States, we're still going to do things with little tiny chunks, little bites along the way. But last year, almost a year ago now, April 17th, 2023, the Centers for Medicare and Medicaid Services released a state Medicaid director letter called Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for individuals Who Are Incarcerated. Really wonderful and a title that gets you at the edge of your seat. But really what it means is that for the first time ever, the federal government is telling states that if you interested in trying to make sure that you could try and coordinate care for people before they leave incarceration, we will allow you to start using Medicaid services up to 90 days before someone released from incarceration. Now, for our populations that are in jails, that's going to be the majority of people who are incarcerated for the entire time that they're incarcerated.

This could for the first time make sure that we have a coordinated system of care for people who are receiving, who are Medicaid beneficiaries, to also make sure that the care that they're receiving in the community transitions with them inside of jails and prisons. And then as they're leaving, that care would also transition with them one more time to the outside. It's also going to make sure that we have better data on what's going on for folks who are incarcerated, I'll talk about that in a moment, but that also that we understand what often happens inside of the black box of incarceration. So who are the people who are eligible for this new waiver? There's a lot of flexibility what states could decide in this process. Many states are targeting this to just mental health and substance use disorder. But really if you're a

Medicaid beneficiary, the state could decide to maintain your Medicaid benefits up to 90 days before you're released.

Also, what facilities are eligible for this? It can again be decided by the state, but it does not include federal facilities. And then what benefits are we talking about? What Medicaid benefits? Because Medicaid has a broad set of benefits that can be included inside of any state's medicaid plan, but there's a lot of flexibility about what states can actually ask for inside of these benefit packages. And the sky is the limit on that, but the ceiling is that these must include medication assisted therapy, 30 days of bridge medication for people who are being released and also case management for people before and after they're being released. These waivers are happening at the state level, so states are the ones who request this. This is a really important point, and I'll definitely circle back around to this at the end, but advocacy on these 1115 waivers is really an important way of having your voice heard in order to shape and make major changes about what happens while people are incarcerated.

So these waivers are going to happen on a state by state process. There are three states right now who have waivers that have been approved. California had theirs approved last January. Washington State had theirs approved in June, and just last month, Montana had their waiver approved. None of them have gone live yet with actually allowing for the Medicaid services while people are incarcerated, but that's because we're really trying to bring together some pretty significantly different ways of doing healthcare, if you will, because like I said, the silo of correctional facilities and then the silo of community healthcare are being asked to come together for the first time in 80 years. This slide is just to help spell out more how these services are supposed to be done. These are the three that are required inside of any covered benefit. I'll let you all look at this once this PowerPoint is sent around to all of you.

This is just a little bit more of those details. And again, this is the floor. This is the bare minimum that states are supposed to ask for in order to receive one of these waivers. They can ask for the entire set of benefits if a state would like. But I think more important, and what's so important for all of you as well is that while CMS is listening and taking these waivers, there's a huge, huge opportunity for you all and for your voice to be heard in the investment and the reinvestment aspects of these waivers. So for the most part, criminal justice dollars are local dollars. There are state dollars too, of course, for the prison systems, but counties are spending a lot of money to pay for the services that are offered inside of jails across the country. Now, the federal government doesn't want to just offset those dollars.

Like I said, the reasonable why the admit exclusion exists is to try and stop that cost shifting. So the way that CMS is trying to ask states to craft these waivers is to first of all, make sure that the money that's offset, well, they're allowing states to request money in order to try and get these systems up and ready for this in order to be able to bring in health information technology, to hire new staff, to be able to try and professionalize a lot of the community-based organizations who might be offering reentry support already. But all of those offset dollars state and local dollars have to be used to be reinvest in improving community-based physical and behavioral health services, health information technology and data sharing, and community-based provider capacity. So for every dollar that's being offset, those are offset. Those are all dollars that you all, I hope, are going to be showing up at meetings and saying, we need this, we need that.

These are the things that we've experienced at our time at NAMI per our time of being and offering these services when nobody was out there doing this. And we want to make sure that these reinvestment dollars are going to flow towards what we think matters for people. That is absolutely huge. We know how things work often with reinvestment is that if no one's showing up, the money is just going to flow to the path of least resistance. We want to put up a lot of resistance in order to make sure that the things that are being done on the other side of this are going to be focused on where we have disinvested for so long. So I think that that's really absolutely important takeaway from this.

So I just wanted to touch on one point and why this matters and try and use this old... We've used this visual for a long time here at COCHS, and I'm very happy to say that I think that the hope from this visual is actually going to be coming to fruition very soon. So this is just a picture of what it looks like when it comes to health information technology inside of jails. So if you're in a community system, you know hopefully ideally, all of your different providers are going to be able to communicate with one another and share care about what's going on with you inside of the community. So if you go and see your primary care doctor, hopefully they're going to have all your data and information from a tertiary care provider. They're going to be able to gather any of the labs that may be a tertiary care provider requested so that they can keep you informed of what's going on.

Well, unfortunately, we carved out a pretty key chunk of where important health information lies, and that's inside of jails. So if you're taken to a jail, they often have homegrown systems. Often those systems are just paper records, but really a lot of that data that's collected there stays inside of the jail. And so what can happen on the other side of some of these waivers with these investment dollars and reinvestment dollars is that now jails will be a part of these shared data systems. So it isn't just the nerdy aspect of being able to have a jail be a part of now your health information exchange.

It's also a really important and key way for those primary care providers to be able to identify, oh, the reason why John who showed up and I was adjusting his medications didn't show up for his follow-up appointment is because it looks like he was booked into the county jail. Maybe I as a primary care provider can reach out and talk to the jail about what's going on and even go in and see what's going on with that individual, talk to them, be able to actually connect with them and figure out what's happening so that they can be released, so that they can reenter, and so that we can be able to manage what is going to happen on the other side and balance out whatever would need to be balanced out on these medications to be able to support them on the other side.

So when I'm talking about nerdy, boring things like health information exchanges, I hope that you're also seeing that data is power, knowledge is power, and that being able to understand more about what's going on inside of these facilities gives you brand new levers for creating pathways out of jails, but also could help you identify very quickly when someone's been booked in and perhaps even have case management systems that will allow for a case manager to show up at booking to be able to allow that individual to be diverted away from the justice system if they're known by people in the community. So the health information exchange aspect, the data exchange aspect of this is a really interesting and fascinating component of this that I just wanted to highlight for us to think about.

But besides these regulatory changes that are happening at the national level that states can ask for, I just want to point out that there is still a lot of legislative interest in this, and the legislative interest is bipartisan. It has also gone across both the Trump administration, the Biden administration, and that these are things that everyone is really interested in trying to accomplish. The question is, do we have functioning government to be able to pass laws? TBD, we'll find out on some of this, but all of these different laws are bills that have been introduced a few times into a few different congresses are trying to take different bites out of the inmate exclusion policy from different points of view. The one I want to highlight at the very bottom is the one called the Kids Care Act, and this would remove the inmate exclusion for pretrial juveniles and require that correctional settings provide EPSD services for eligible juveniles. The Kids Care Act was passed as a part of the Omnibus Appropriations law of 2023.

This goes into effect January 1st, 2025. I suspect that if you were to call a lot of your Medicaid offices and ask them, what are you doing to make sure that the Omnibus Appropriations law of 2023 is going to go into effect very smoothly on January 1st, 2025? I think that you will probably not get a lot of great answers. I hope that we are going to be able to make up for... I think by how far we're behind by January 1st, 2025. But this is a massively important change that is going to affect absolutely every state across

the country. So the two components of the Omnibus Appropriations law that I think are important to highlight is section 51 21, which is going to require every public institution to begin screening and diagnosis for sentence juveniles Medicaid, word for juveniles. 30 days before release, the wiggle room in the legislation says, or as soon as practicable or something like that, which means that some jurisdictions may try and push this until an individual is out of these facilities. That's just a side note on that.

But begin screening and diagnosis for sentence juveniles 30 days before release and allow for 30 days of enhanced case management both before and after release. That enhanced case management. There is no wiggle room on that jurisdictions January 1st, 2025 if you are a juvenile by Medicaid's definition, which does vary by state, but for most states it's 21. Or if you are an aged out foster youth, it can be up to the age of 26. You are required to have 30 days of enhanced case management before and after release. That is absolutely massive. And might I remind you that just because you are a Medicaid eligible juvenile does not mean that you are just in a juvenile justice facility. So this law is going to impact jails, prisons, juvenile justice facilities, any public institution because of the way the statute was written.

In addition to that 5122, section 5122 would allow for a state to opt to maintain Medicaid benefits for incarcerated unsentenced juveniles pending disposition. So there's a lot of things that I just threw at you all, some pretty major shifts. Like I said, since 1965, this has been the law of the land and it's changing now. And I know a lot of you are wondering "How do we get started?" Well, I wish that there were just one simple way to try and prime you all to get started on this, but the truth is that jurisdictions are going to vary dramatically on where you are in this process. Some of you may know exactly who your sheriff is, know exactly who's doing probation work, know exactly who's doing drug courts inside of your jurisdiction. Some of you may say, "I don't even know what a sheriff is now at this point. I don't even know if we have sheriffs." And that's totally fine. I think that criminal legal systems are some of the most opaque and challenging systems to understand.

The only things that I think are more opaque and challenging are probably Medicaid systems. And so in order to make sure that I had job security for the rest of my life, I picked the overlap between the two of them. I think that if I could give the most generalizable way of thinking about this, the way to get started is just know where you are, know what state you are in, know where you are when your collaboration is going on, and then to also know where are the levers in all of this. And then finally, just like anything else, start pulling on this. So here's a little advocacy workflow I made. This is just, obviously this is not going to be sufficient to cover what everyone needs, but if you were interested in trying to pull some of these levers that I've been talking about today, first question to ask yourself is "Are we in a Medicaid expansion state?" If you're not a Medicaid expansion state, then a lot of the population that we're talking about here still might not be Medicaid eligible.

And so you've got some options on the other side of that. You can advocate for Medicaid expansion in your state. North Carolina has had some pretty massive success with collaborations between correctional facilities and sheriffs and mental health community in order to advocate for expanding Medicaid in your state. Really, really great model for being able to work on that. But also you have the opportunity to just collaborate with justice system partners, find alternatives to incarceration or reentry service across the board, start convening. I think a lot of convening is totally worthless, but I think when we're trying to convene across these partners who have never really convened before, this is a chance to start learning each other's language and to know who you are. If you are a Medicaid expansion state. Next question is asked, is your state applying for an 1115 waiver? And if you are, the 1115 waiver process is a fascinating process to become a part of. Each state puts together their own 1115 waiver, and then they submit it for public comment.

That's a moment in time when you can say, we want this, this, and this, or You're not doing this the right way that we think, and it would be better if you did x, y, or z, or we fully support what's going on here. So I think it's a really great opportunity to comment at the state level. Once you get the state comment period over, it gets bumped up to the federal level where there's another comment period where you can still make your voice heard or you can partner with other NAMIs that across different states in order to talk about why this is so important for your state. If a waiver isn't being applied for yet, and I think we're up to 18 states that have applied or in some process in this application, it's time to start advocating for the waivers and to collaborate on improving the system delivery, understand what your gaps are, and then for everyone across the board, it is how now do we take these opportunities brought to us by these 1115 waivers or spying ahead of what these 1115 waivers could mean?

And how do we start making sure that the money, the reinvestment money, and the investment money flows to where it needs to go in order to create the system that we want for people who are inside of this system? A great place to start to understand those gaps is something called the sequential intercept model. I'm certain that many of you have heard of this before, but it's a really great place to start and it's a good thing to do over and over again. I was just on Oahu helping people go through the sequential intercept model to just understand the state of the justice systems and health systems identifying gaps. But what you do in this process is you go through, you bring health people justice system people together, and you just go through the flow. Okay? What happens when 911 is called? What happens when 988 is called, which is an on this intercept map? Local law enforcement gets deployed. Okay, what is the different ways in which local law enforcement decides whether or not someone's going to go to a detention on the other side of this?

So sequential intercept model then brings you all together and then allows you to start identifying gaps and then thinking about where and how you could to tackle this challenge. Just for an example, intercept two to talk about, to just draw out what this could look like. So if we were to identify what was happening at Intercept two, we might want to then come together and say, look, we need to improve the coordination for our screenings so that if people are, first of all, that we could have more people screening for competency. And then if people are being restored to competency, how do we do that in the community? How do we create that system? How do we actually allow for Medicaid dollars to flow towards those systems so that people can be restored to competency in the community? Also, how do we start coordinating with health plans?

Managed care plans are going to be a huge part of this future and it's an important language to start learning how to speak. So how do we then rely on health plans and community providers so they can come into arraignments or be a part of pretrial evaluation so we can improve the chances that somebody will be released on their own recognizance or not need to be detained at all? How do we bring in peer support at the very beginning of appearances in order to try and help people avoid incarceration? And then also, how do we bring in really robust mental health screenings that can be reimbursed through Medicaid, so it creates the incentives to do better mental health screenings and diversions. These are the sorts of things that we could really start diving into if you do a sequential intercept model in your local jurisdiction.

So that is a lot of information to throw at you, and I'm so glad that I see 87 questions up in the question and answer part. I'm going to gulp loudly after I'm doing this, but also really look forward to puzzling through some of these questions with you. But this is my takeaway. Health and justice systems are deeply intertwined, they've always been intertwined. Disenfranchisement justice systems, unmet social needs are all connected to one another even if it's not overt. So by really trying to improve and strengthen our health systems, we're going to be having an impact on our justice systems. And if we want to improve our health systems, we have to also look at the way the justice system is playing a part inside of the way that those functions to that point, statutory and regulatory barriers that have been

causing so many challenges for a long time and have exacerbated disenfranchisement are changing for the first time ever.

That creates brand new opportunities for being a part of community involvement in commenting on these waivers, calling your legislators in order to ask them to support some of these bills, but also then just making sure that you are being a part of the reinvestment strategy on the other side. So that is the major point too, is that these federal changes are creating brand new levers, new cracks inside of the wall that for a long time we've never been able to crack into and now we can really improve these linkages and this is what NAMI does so well. You all have been working towards this for a long, long time, and so now it's just about being able to flow into those spaces that have been opened up and then create a lot of the breathing room to make a system that's going to make sure that people are not going to jails not being arrested because of their unmet mental health needs, but really can have a robust system in order to support people wherever they're at.

And that we don't have these black boxes of correctional systems where people's health gets worse and where we can really invisibilize and ignore people's unmet health needs. So I just again, want to thank you all, want to thank NAMI, want to thank Shannon, and all the team at NAMI for this support, and I'm really looking forward to answering some of your questions now.

**Shannon (00:59:00):**

Great. Thank you so much. And as Dan mentioned, we are getting to about 98 plus 99 plus questions in the Q&A. Please feel free to keep dropping your questions. We may not get to every single one of them, but we will work really hard to get to a lot of them. I may do some grouping here just so we can get some because there's some big themes that I'm starting to identify that folks have questions about. So Dan, one of the things that I think is a really common experience among our NAMI community is that there is a lack of communication between jails and the health system. And so you bring up this idea about more information sharing between the two of them. And so the first big question I think everybody had that I started seeing pop up as you were discussing this is how does HIPAA apply to some of this work that will be starting as states take on these 1115 waivers and start needing to have some of this communication happen?

**Dan Mistak (01:00:06):**

Right. I mean, I think that that is such an important question and it also faces, frankly, a lot of challenges. Jails and prisons are not really built to have some of the highest quality privacy aspects. I will say this though, HIPAA does have baked into it a break the box or a break the glass emergency for people who are in correctional facilities if there are an emergency that is happening. So I think some of this hasn't really been well litigated or really drawn out in order to be able to determine really what it means. But people who are... A lot of these jails who are not used to needing to be HIPAA-compliant are going to have to become HIPAA-compliant. And also on top of that 42 CFR part two, when it comes to substance use disorder treatment, all of these things are things that jails are going to have to start doing.

And these are the sorts of things that we want jails and prisons to start doing as well. It's really important to protect privacy. So I should also point out that some of these incentive programs have some expectations and requirements that individuals are able to receive access to their health information are able to query and find out what's going on with their own care. There's a lot of public choice, I mean, a lot of expectations that people can direct their own care inside of our Medicaid system. And I frankly think that jails are going to be hard-pressed to make sure that that happens. But these are our expectations when it comes to healthcare for people. And so I think that there is a lot of really interesting things that are going to evolve over the next decade as this is coming into being.

**Shannon (01:01:43):**

Thank you so much for that, Dan. And I will share that Dan and I think have a lot of these conversations just about the opportunity. And so I know that there's a lot of questions and I think Dan has a lot of thoughts about and has given a lot of thought to how this will shape up. And so we will answer these to the best we can, but just to really want to emphasize to folks we are at a really, Dan pointed this out at the beginning of his comments, we are at a very pivotal moment in which this could bring a lot of really great change to our community.

So, Dan, I really just want to stick on the information exchange, and I know this is a question that comes up a lot and there's a lot of concerns about abuse by the system if there is certain information shared. And so do you have any thoughts about or know of how states might be, some of the early states might be addressing some of these concerns about maybe sharing, if information gets shared about a substance use disorder or the fact that someone has a history of using drugs, how do we work to prevent and make sure that as we're building this new system we can really prevent some of abuses happening?

**Dan Mistak (01:02:55):**

Right. So I mean this is the challenge. This is a really hard question, Shannon. This is a graduate level questions on these sorts of things, but these are absolutely essential important questions, right? Because I also want us to think in our mind of the challenges of what this would be if an individual is coming into a correctional facility. I often describe that as an emergency department. So you have somebody who's coming in and they could be in the midst of a methamphetamine induced psychosis, they could be prodromal schizophrenic, they could have any variety of issues that are going on with them. And it's important to know and understand the health status of somebody, but also to be able to understand how you're supposed to be able to care for them. And too many jurisdictions across the board just go towards, well, we'll just put somebody in segregation in order to make sure that that we're meeting their needs.

So what I would say is as it stands right now, there are unfortunately not a lot of robust systems to protect people's health information while they are incarcerated. But HIPAA and 42 CFR part two do provide actually more meaningful ways to be able to allow people to have redress if there is an abuse. We can't ever guarantee that this information isn't going to be shared because frankly, there are times when that information is going to be important to share with correctional staff, which is why HIPAA has that carve out for corrections in the break the glass scenario.

But I would say is that just in this process, it is going to continue to be a really important part to make sure that there are policies and procedures in place that protect the security of the individuals while they're incarcerated, but also protects their ability that this information isn't going to be used against them in a court or in a trial. And also just to maintain a watchdog status on or whether anyone is abusing that break the glass scenario, it is a very specific opportunity of when correctional facilities are going to be using this. So this is why partnerships with folks like NHELP, ACLU, any of these health litigation firms is going to absolutely be important too in this process. I wish I had more answers on all of this, but this is the frontier that we're at right now.

**Shannon (01:05:17):**

Yeah, absolutely. And we've had a lot of folks comment in here, "Why not just provide people with care inside the community?" And there's been a lot of questions about, "Well, why aren't jails and prisons providing good quality care?" Can you maybe just touch on a little bit about what we know about the

standard of care inside jails and prisons and what some of these policy changes, the opportunities, some of these policy changes really have and why that's the case?

**Dan Mistak (01:05:54):**

Great. Perfect. So let's talk about community healthcare to begin with. Community healthcare is heavily regulated, so we have tons of people who are looking to make sure that care is delivered at appropriate time. We've got regulations that determine when and how you're supposed to see a specialist, how much time is supposed to happen with that, whether or not you have the provider options to choose what's going on with your provider. There are quality metrics, there's reporting requirements from your providers. Providers inside of the community have to be able to be Medicaid providers. It is heavily regulated. Now, let's talk about jails and prisons. What is actually driving how healthcare is delivered there? It is unfortunately, lawyers who are driving that, which I love lawyers. I am lawyers. But the truth is that healthcare inside of jails is really determined for the most part by litigation.

So there's a case called Estelle v. Gamble that basically set the standard. The healthcare is determined based on the eighth amendment of the Constitution. It is not based on any broad idea of how we think people should receive care, but the eighth amendment prohibits cruel and unusual punishment. And so the court in Estelle v. Gamble said that a jurisdiction that has incarcerated somebody cannot be deliberately indifferent to the serious medical needs of someone who's incarcerated. What that means is lawyers since 1976 when this case was first litigated, have had to figure out what does it mean to be deliberately indifferent? What does it mean for something to be a serious need? And so we have a complex set of jurisprudence that ultimately just is based around how do we protect the jurisdiction from being sued, not really driven by clinical decision making or anything like that.

So what that's meant is that there are industries now of providers who offer care inside of facilities that often are made up of, frankly, providers that would not be able to become Medicaid providers in the community. So what we're doing now, when we're bringing Medicaid inside of these facilities, we're also importing all of those really important standards, those really absolutely important rights that an individual has when they're incarcerated. And I would just say that we treat people who are beneficiaries of a health program significantly different than we treat people who are inmates of a public institution with all of the stigma that is associated with just those words. So all that to say is I want to point out that I 100% agree that people who have unmet health needs that can be treated in the community, should be treated in the community.

That's absolutely where it should be. We should not be incarcerating people because of their unmet mental health needs. But because we do live in a world where people are taken into jails, where our systems are so broken that people do become incarcerated because of their unmet health needs, I want that care to be high quality. I want it to be transparent, I want it to be able to have other opportunities for people to look in. And I want that information to be protected too. I want that information to not be used against them in a trial or even in a paternity case or a custody case or any of the other civil cases where an individual might have something that happens to them too. So yeah, all that to say is, I agree, community is much better, but if they're going to be inside, we want high quality transparent, connected care.

**Shannon (01:09:27):**

Absolutely. And this leads into your comments lead a little bit into my next question because sometimes when we talk about people who are incarcerated, when we talk about people with mental health conditions who are incarcerated, we do put a lens on them as if they're there for their mental health condition or they don't have resources in the community. But there's a question that came through

about, well, what if the person becomes incarcerated and they have private insurance? What does that mean with these new systems? Because there are people who just end up incarcerated for reasons that might not be because of their condition, but they might have a condition that needs to be treated and they may have private insurance. So how does the private insurance market play into these reforms that we're pushing for?

**Dan Mistak (01:10:15):**

Yeah. And I think that this is a really interesting point of advocacy as well. So the components that we're talking about that I've talked about mostly today of course, have been focused on Medicaid just because vast majority of people who are incarcerated are Medicaid eligible in expansion states. The statutory language that is being changed is Medicaid statutory language. So that's why this is mostly talking about Medicaid plans. I will say that a lot of commercial programs are also mirroring this and saying, we aren't going to pay for services that happen while someone is incarcerated. So there are advocacy.

There is advocacy that can be done at the state level, I think, to make sure that those types of riders that exist inside of insurance programs are removed. And so I think that's another really fascinating aspect of all of this, but the challenge is that the population of that is so small that it's really hard to build, I would say maybe some force enough to try and get this to happen. So I'm just curious about how much force we could build with that. But that's a completely different set of, I think, levers to pull on these issues.

**Shannon (01:11:45):**

And so, again, how quickly this topic can expand to all different areas, this really does really bring a lot of transformative change. This is one small, small change, small, I say small, but it's pretty large to federal law or federal policy. But the other question I think, and this is another layer on top of it, is that our community is also very acutely aware of is the IMD exclusion. And so how do you see needs for reform in the IMD exclusion play into this? Because often that is another barrier to accessing hospital-based care, which we know many people who end up in the jail system really do require a hospital level basis of care. So what are your thoughts on how IMD might also be impacted by some of these changes?

**Dan Mistak (01:12:40):**

Yeah, so I think one, I just need to start by saying what happened with Willowbrook and the reasons why the things that were driving deinstitutionalization in this country were because there were absolutely horrific abuses that were happening inside of these institutions. And frankly, these IMDs were being used as a way to just invisibilize and try and eliminate some of the challenges that we saw in being able to meet people's needs. And frankly, where we were at that point in understanding people's mental health needs in general. So I think that as a reaction to that, we put in the IMD exclusion inside of the Medicaid program because we didn't want to just have a program that would just pay for people to be institutionalized and that we would never see ever again.

But we have entered a phase where we understand better that certain people do need an amount of time inside of a facility in order for them to be able to, particularly if they have a substance use disorder, to be able to receive treatment in a place in a setting that's going to allow them to be able to have a firm foundation so that they can receive what they need in the community on the other side. So what I would say is that there has been pretty marked advancements made on trying to modify the IMD exclusion. In fact, the camel's nose under the tent for me to start ranting about these 1115 waivers to get CMS on board was the fact that California received their IMD waiver, I think back in 2016 or '17 or earlier than that. Hard to remember now, time is being compressed.

So this really made us reevaluate, okay, we have these things that are in here, but what we really want are, instead of just trying to follow all these statutory and regulatory issues, how do we actually create a good system that's going to respond to people's health needs? And the fact was that the opioid epidemic was just blowing out of control inside of the United States. And so we were able to say, okay, well, people are going to need to be inside of IMDs in order to receive substance use treatment medications for opioid use disorder.

So what are we going to do in order to allow that to happen? We'll use waiver authority to make sure that that goes on. And that was my moment when I said, "Well, wait a second." If we're bending these waivers in order to try and create a continuity of care to support people who are receiving MOUD, why are we still continuing to carve out a place where some pretty significantly needy people are receiving care all the time and receiving that care that is completely disconnected from the broader community that happens in a complete vacuum. And frankly that we don't have any insights into what's going on there. And if we can use that waiver authority for IMDs, we need to be able to use that waiver authority for these 11 for people who are incarcerated as well. So I see that these two things are really deeply connected to each other.

What I say is that if we need to make sure that Medicaid can go wherever people are receiving care because we want to create continuity of care, we want to create a fully integrated health system, and you don't do that by carving out different providers, you're not going to have a fully integrated system of care if you suddenly start saying, actually, if you're in a hospital, you're going to be inside of a different payer system and we're not going to even bother talking to you and we're not going to communicate with you at all. That is not a way to create a meaningful health system. And so frankly, I think things like the middle of a public institution has just strengthened the power of correctional facilities to continue to invisibilize how we really treat people with mental health needs in this country. And so Medicaid is a really powerful light that shines inside these facilities, and I think that it's going to be pretty eyeopening to a lot of policymakers in this process.

**Shannon (01:16:37):**

Wonderful. And so there is a little bit, and I'm hoping you can answer this, there's a lot of people that are wondering about, well, "Why does the Americans with Disabilities Act not apply and hasn't applied towards the quality the type of healthcare that you have access to inside corrections?" Can you maybe shed some light on this because I know a lot of people see it as a tool and something that people with mental health conditions should be able to leverage to protect access to their care?

**Dan Mistak (01:17:24):**

Yeah, so what I would say is that for me, a really powerful advocacy tool has been saying, "What is the federal government doing when it comes to the opioid epidemic?" And whenever I see the federal government doing something around the opioid epidemic, I say, okay, well, what are they going to do now for everyone else of people with mental health conditions or people who have needs? And so I think it's really important to point out that last November, the Department of Justice released a document that said that the ADA does indeed apply to people who are receiving medications for opioid use disorder in correctional facilities. So their ruling was, or what they stated in their document was that if you were receiving medications for opioid use disorder in the community, you're arrested and taken to jail. The jail has to continue your medications for opioid use disorder, otherwise it's a violation of the ADA.

We are seeing now different jurisdictions settling with the Department of Justice on exactly this issue. Allegheny County and Pennsylvania, Kentucky had a settlement. Utah right now is communicating with

the Department of Justice about exactly these sorts of issues. So what I would say is that the a, in my opinion is still a very powerful tool for being able to drive change and to not give up because it is just started being able to be a tool that's usable inside of medications for opioid use disorder. And this actually becomes a really powerful argument too for why an 1115 waiver matters, because now jails across the entire country are going to be in violation of the ADA If they aren't continuing medications for opioid use disorder, how are they going to pay for this? My statement back is, "Well, this is why you need to have an 1115."

So combine the A changes that are happening for MOUD, combine that with the changes for 51, 21 or 51, 22. Those things are things that states are not going to be able to opt out of. So using an 1115 waiver is a really powerful way to not only be able to fund all of this, but to make sure that you have a say in the entire process all along the way and what it's first going to look like and then how that's going to be reinvested on the other side.

**Shannon (01:19:45):**

Wonderful. One of the things that has popped up a couple of times here is we spent a lot of time talking about jails and state prisons. What about the federal system? Where do federal prisons fall into all of this, and can we expect to see impact in those spaces as well?

**Dan Mistak (01:19:55):**

Yeah, that's the harder one. So explicitly inside of the 1115 waiver guidance, it says that you cannot ask for the federal government to... You can't ask for a waiver of the inmate exclusion for people who are in federal facilities. And that's because it's really challenging because the federal government's already paying for this and you can't. Medicaid is a federal state partnership, so the state pays 10%, the federal government pays 90%, but if the federal government's already paying 100%, then they're not going to be interested in this. But I will say the statutory changes though are going to be a little bit different. So this is a statutory change, and it is going to mean that people who are incarcerated, if there were a statutory change that were not just those last 30 days, that would impact actually what goes on inside of federal prisons. But I just think right now it's going to be a relatively negligible impact on federal prisons, to be honest.

**Shannon (01:21:00):**

And I would just note some of those statutory changes that Dan is talking about, NAMI is advocating on those changes. You can go to our website to learn more about how to get involved in our advocacy work that's at nami.org/advocacy. Actually, I may have that website wrong, but nope, it's advocate for change, advocacy-advocacyforchange. I'm going to drop it into... Thank you, Jessica. She just dropped it into the chat and apologies to our director of advocacy if he is on this call. But then the other question that I want to make sure that we address a little bit here is a lot of people are wanting to know, well, how do I find out, and I think you touched on this a little bit, but how do I know if there's a pending waiver? How do I know if my state's already working on this? Where do I find out all that information?

**Dan Mistak (01:22:00):**

Right. Yeah, so Kaiser Family Foundation does a really great job of tracking all of this. I have my own personal spreadsheet because these things change, but the Kaiser Family Foundation I think is really going to be the most useful. I'm happy to share that link with you on the other side. It's nice. You could just click justice Involved waivers, and you can also see that some of them are not just trying to tackle the inmate exclusion component of trying to waive that inmate exclusion component of the Medicaid

plan in the state, but are actually also trying to increase access to case management. Utah has a waiver that isn't even trying to tackle the inmate of a public institution component of it, but is also trying to create more robust services for people who could be involved with the justice system or leaving the justice system to begin with.

So happy to share that with you on the other side, and then you all can find out where you are. I will say that their website is sometimes a little bit slow because it doesn't necessarily update every day and that some components of this are in the comment period right now. And so I think it'd be really... I don't know, I was going to say if you reach out to Shannon from certain states, but she'll know maybe where they are in the process too, because some of them are in the public comment period from the state that doesn't show up on the waiver tracker. And I even think when it's in the federal comment period, it doesn't show up on the waiver tracker either, unfortunately.

**Shannon (1:23:20):**

As you can probably tell from Dan's comments, we at the national office and those of us working very deeply on this also want to deeply understand how to better find out the secret world that is CM at the Center for Medicaid and Medicare Services and how to find all that out. I would also offer that you can reach out to your state NAMI. We are working with our state NAMIs all the time monitoring when these waiver opportunities are posted and working with our state NAMIs to make sure that we are commenting on them and encouraging the federal government to approve them as quickly as possible. I also wanted to note another resource we have that I believe actually has a link to the Kaiser Family Foundation. Inside of it NAMI did a joint report with a group called the Health and Reentry Project or HARP, and I just dropped into the chat for everyone. You can access the report. It provides a lot more depth on the things that Dan has covered because it's easier to sometimes do that in a bulky document than in an hour long webinar.

**Dan Mistak (01:24:30):**

I did want to point out real quickly, Shannon, with somebody who made a really great point that, well, first of all, HARP is wonderful for resources. They're relatively new and they are going in all the guns blazing, so it's wonderful. But we're talking about 1115 waivers here, and I should just point out that there are many, many 1115 waivers. They don't all just have to deal with justice involvement. So if you do go and look and see what is a waiver that exists right now, just because it says 1115 doesn't necessarily mean it's going to cover justice involvement. This is really weedy and nerdy work, but the Kaiser Family Foundation Tracker is also very, very useful because you can click on the ones that are just for justice involvement and it'll populate that list for you.

**Shannon (01:25:20):**

Absolutely, and that's a really good point to make. The 1115 waiver is a tool that we use a lot and states use a lot to create flexibilities within the Medicaid program and to really explore how we can better provide access to healthcare for folks. And I'm being given a three-minute warning that we were almost in the end of our time. Dan, is there anything else that you would like to... You got the last closing comment here.

**Dan Mistak (01:25:45):**

Yeah. I again want to express my gratitude one last time for all of this. NAMI has been such an important part of my family's life and my own life, and has been absolutely essential for making some of these changes along the way. So I so deeply appreciate that. And what I would say is this is a moment that

NAMI is built for, you all are. Know and understand so deeply the gaps inside of your system, and this is exactly when you need to have your voice heard. So first of all, I would encourage you to be a part and commenting on waivers as they're going forward, but also as those reinvestment dollars start coming back to your jurisdictions, I think understanding those gaps and making sure that money gets directed towards the programs that support people and make sure that they don't become incarcerated or reincarcerated is exactly where you all are going to have to be. And I look forward to being a part of this battle with you all now and forever. So I'm again grateful for you all in this process.

**Shannon (01:26:47):**

Thank you so much, Dan, and we will definitely have you back as we've made our way down the road a little bit more, and hopefully we'll see you again in the future to talk about all the wonderful changes that have made and the impact that it's having. So thank you very much. I also want to note that we tried to get to all of your questions. We will go through all of these as well as the ones that were submitted ahead of time that you submitted prior to the webinar, and we will do our best to get through all of them and to answer them to the best of our ability. So thank you all again for visiting us today and joining us for this very important discussion. I also wanted to just make sure that we highlighted again, please, if you want to contribute your story to our advocacy work, please visit our overlooked campaign website.

There are links there for you to connect to our advocacy work and to share your story so that you can contribute to the work that NAMI is doing to make these policy changes that we see that are so important. I also want to make sure that you save the date for our upcoming NAMI Ask The Expert, which will be Thursday, April 18th 4:00 to 5:30 Eastern time, How Employment Supports Mental Health Recovery. And so please look for that posting and the ability to register for that webinar. But we will be bringing that to you through our Ask The Expert webinar series. Again, thank you to all of you who participated in today's event, and we look forward to bringing you more of this content.