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For NASMHPD

KAYLA BAKER:

Good afternoon, and welcome to today's SAMHSA sponsored webinar, presented on behalf of the National Alliance on Mental Illness, NAMI. Today's presentation will be recorded, and think, slight and participant certificate will be sent by your email to everyone who attends today.

" And the available and can be viewed by clicking cc at the bottom of your screen or by clicking on the link in the chance to view it a second window. We also have an ASL interpreter who should be spotless in your screen.

During the presentation please add your questions and comments in the chat box, and the questions will be asked out loud for the presenters to answer at the end of the presentation. When the presentation ends, please take your medicine to complete a brief survey of the show in your browser as you exit the platform.

Thank you again for joining us, and we will now begin today's presentation.

JENNIFER SNOW:

Good afternoon everybody. I will explain what NAMI is in a moment, but first I want to work with the objectives of what you are going to be hearing about today.

We have four objectives. We are providing an overview of mental illness in the criminal justice system. We are summarizing the importance of health coverage before and during the re-entry, so that the process by which people are re-entering their communities after incarceration, with a specific focus on people with serious mental illness.

We are going to discuss some recent policy changes and their impact on people with serious mental illness returning from an incarcerated settings. And finally, we are going to highlight resources for further learning because hopefully you will be engaged on this topic and what to learn more.

I am with the National Alliance on Mental Illness, or NAMI. NAMI is the nation's largest grassroots mental health organization and we represent people with mental illness and their families.

I have the privilege to work at NAGB's national office, but we are an alliance of over 650 state and local affiliates who have a presence in all 50 states. Our mission is to provide advocacy, education, support and public awareness, and to help improve the lives of people with mental health conditions.

I know a few folks who are attempting this in your professional capacity, but if you are somebody who is or someone you love is struggling, you are not alone. You can go to NAMI.org to get more information and be connected with life-changing resources and support groups.

That being said, let's jump into the topic at hand today. I said, my name is Jennifer Snow. I am happy to be here with you today and I am delighted to turn the conversation over to my colleague Shannon Scully who is going to take us for the start of our presentation.

SHANNON SCULLY:

Good afternoon everyone, and thank you so much for joining us. Thank you Jennifer for kicking off.

As Janet mentioned, my name is Shannon Scully and I work for NAMI National Office of the Director of General Policy and Initiatives doing any work at the intersection of the criminal justice system and mental illness and providing a lot of the reports and working closely with all of our affiliates across the country. I am so excited that there is so much interest in this topic today.

If we can get going, we will go to the next slide please.

As we kind of start this off, I really want to provide (and I really like to do this in a lot of my presentations) just some foundational information about the intersection of mental illness and the criminal justice system.

A lot of this data is going to look really familiar to many folks in this audience. but it also might be new to some of you. This is how we often communicate about a boy discussing mental illness in the criminal justice system is so important and why providing healthcare resources to folks who are at risk of becoming involved in criminal justice system is so critical. Since its founding, NAMI has been really actively involved in trying to reduce rates of mental illness inside the criminal justice system and really creative ways to think that people away from that system and into mental health care. The numbers that you are seeing on your screen really highlight why we are doing that.

It is estimated that 2 million times each year, people with serious mental illness are booked into our nation's jails. About two in five people who are incarcerated have a history of mental illness. Suicide continues to be a leading cause of death for people who are in jail. I believe that some of the earlier data is really showing it is the second leading cause of folks for people who are in jail.

It is also estimated that about 4000 people with serious mental illness are held in solitary confinement in US prisons. This shows that that there are a lot of people within the park up in the criminal of his back up after the within the system and jails and prisons to be able to treat mental illness and mental health conditions of those who are incarcerated in their facilities.

What you see on the screen right now is the sequential intercept model. NAMI partners with a lot of important organization dedicated to solving issues and the dissection of mental illness and the criminal justice system. One of them happens to be a joint partner with the Department of Health and Human Services, Policy and Research Services. It developed the sequential intercept model which is a very foundational piece of information to help people understand how to direct people out of the criminal justice system.

They published this in 2016 and it breaks the justice system into several intercepts. Model is used in a number of ways in our work at a local community work but really to kind of analyze how people at each of these intercepts, there are opportunities in which we can direct people out of the criminal justice system and into community-based care and mental health care that they very critically needed.

For the purposes of this webinar, we are kind of focused on intercept four, which is re-entry. For those of you who might be a lot more familiar with the criminal justice system, re-entry can happen at various different points within the kind of the intercept, most notably intercept two. There is a period of re-entry that can happen here, but for purposes of our discussion, so we do not get too far off track, we are really kind of focused on intercept 4.

We are really thinking about planning for people and helping them to think about transitioning from here they may or may not have been receiving inside the jail or prison, and what they are going to be doing back in their community. So some key elements in this intercept which are often considered what we call transition plan, that plan for moving into the community, medication and prescription access, how are you going to continue that care what you believe, in general go into this a little bit more in her section but we do want to parallel healthcare systems in this country when it comes to the justice system and the community-based system.

What are handled into the community service? How are we connecting people into care and community? Healthcare coverage, again, something that we are going to cover today which is Medicaid and healthcare systems in the community, as well as peer support services.

There are links, I believe the slides of going out to one, the links to the sequential The Intercept and is more information can be found on their website but you can also find a kind of information about the sequential intercept model on the Department of human services website.

So I want to die in a little bit more about who we are talking about when we are talking about people who are reentering the community. The importance of the period of reentry is 600,000 people, an estimated 600,000 people who are released from prison each year, 7.6 billion people who are estimated to be cycling in and out of our nations jails annually.

Consistently, the matter with someone is incarcerated they are very likely to return to the community. It is estimated that about 95% of people who are incarcerated eventually returned to our communities. So sometimes I really like to point out that the people who are incarcerated are part of our communities because maybe they were there before, they may not have been living there but they were in the community, and they are coming back to the community.

And then anyone who is released from prison and the population who is released from prison have a lot of chronic this is. Most notably mental illness and substance use disorder as well as a variety of chronic conditions. So the health needs of this population are great that is something we really need to be thinking about.

This is something Jen and I started doing your years ago with this presentation and we really enjoy it because we think it gives people a sense of "Oh, we are just returning to the community!" But it is not that simple. I was somebody who fought this when I first started my career as well, but something we would love for you to check out in every resource at the end of this presentation is a test to test out a reentry simulation. I have tried it several times and I do not successfully completed at all and I am someone who considers themselves pretty familiar with system and with the services that are out there. I regularly failed those simulations.

We are going to walk you for stopping of a simulation today. There are going to be some poll questions coming up, so we will encourage you to react that just make it a little bit more interactive.

OK. We are really asking the question, "Could you succeed?" So I am giving you a scenario which is very common, that people often experience. A little bit more on the side of people who are being

released from prison, but it is also people who are being released from jail. There is a lot of similarities of the a lot of differences. A lot of this relies on information related people who are being released from prison.

You are released to a bus station. It is not anywhere near your families, with your family lives, and it is the middle of the night. You are released with two weeks of medication, that if the national average of how much people are given when they leave incarceration. You have your belongings and you have $50. That $50 is on the high end of what people are getting, that they are given by the state when they are released from prison.

You have to check in with lockable officer within 40 hours, and you are only allowed three of violations and that the officer could potentially initiate proceedings to have you charged and be incarcerated. So we are going to start asking what you would do first, and where would you spend the first night?

Usually, we do this in an interactive way. If you want to answer in the chat with you think you are currently spending the first night, I will share a lot of stories from folks. People end up sleeping infestations are on the streets just because of when they are being released.

Shelter is a really great... You are on probation. Please keep that in mind. Some people say homeless shelters but a lot of homeless shelters'. So at the hour you are often released in the middle of the night, it could be 1 AM, August shelters are not an option for you.

What we hear from a lot of people is that if their family does not pick them up they often send that first night out on the street. So it is kind of a challenge. We are seeing some answers here. Let me see. A lot of shelters. Hospital lobby. A park. All of these are things that people are regularly experienced.

Let's go to our first poll. One of the first things is an IED. One of the things you are going to need to get is an ID. It is a decision everybody needs to make. I need nationally cost anywhere from $10-$50 depending on just eight. Please keep in mind if you only have $50 at this point. You need an ID for housing, benefits or to get a job.

In terms of cost, and it Baroness Mary Warnock and Jennifer it in Virginia and DC is in between us, just to show us the range of what can happen. In Maryland it costs at $15. In Virginia the cheapest is $10. And in Washington DC it is $47. That is based on a quick check before we get there.

Many of you are saying that you would pay for an ID. I had about 66% of you said yes, you are going to have that essential visa. And 34% said you will skip that.

We are going to go with the fact that you have an ID. I am going to go with Washington DC. Say that $47 of your money just went out the door to pay for that idea. So you are now down to three dollars. In your pocket, after you get that ID.

I know we talked about spending the night. Probation is going to be picky about where you stay. There are a lot of options to consider, we picked for this purpose. You can stay with family, or apartments you can get through church programs but you are going to have to stop paying rent and do not have a job. You can also stay in the hopeless shelter but I do not think I have to tell this audience that sometimes complying with the rules of the homeless shelter can be a little bit of a challenge.

I will also share, a lot of people - for purposes compliant with probation operable - sometimes you cannot be in the same race as a person who has the same kind of probation.

A lot of people stay with family. It can depend on the relationship you have with your family before after prison. But we will close the poll right now. 75% said it was for my family, 10% said they would get an apartment through the church and 19% said a homeless shelter.

We are going to stay with family. Luckily there is no record that would prohibit that. They will ask you to pitch in with resources.

So you are going to stay with your family, they are going to acquire you to help with resources. You will also need to get mental health care because you have stayed with them before while you are not well and this is a requirement they have for you to stay in the house. You will also need to deal with mental health care because it is required of your parole officer.

You are one week into being out and starting to one of them on medication. A lot of people will cut their pills and have to try to make its extent a little bit longer. But you are also not going to be able to see a provider. You are still a couple of weeks and because once we are released that we are able to try to get on Medicaid, appointment, those appointments take a really long time to get into. Anywhere between 45 to 60 days currently, in order to get an appointment with a psychiatrist.

So a few of our options are to connect with a local advocacy group to see if they can help you get some medication. You can ask your Officer for help or you can ignore it because things have been worse, right?

The overwhelming majority is thinking which is the one medication. That is an essential part of this. So we are going to go to a local advocacy group, they were able to get you another four weeks of medication. They are also offering you a lot of different opportunities. Let's say this is NAMI, they were able to provide you with the resources to get some medication and will also providing you with access to some of our support programs and 1/2 of resources to think about your mental health care. This ended up being a really good decision because you moved into somewhat mental health care and medication, but also a lot of other mental health resources to help you stay well.

So the other thing that a lot of people who have returned to the community after incarceration have a problem with is transportation. Especially if you do not live in a major metropolitan system. It is going to cost you... I always like to look up the low end for a used car, this is about $5000 plus insurance, though and is about $460,. You are not employed.

You can take a break, but that will take a lot longer. The path is also inconsistent in your area. I can about for that. I just saw a sign in my house that the bus is no longer going to stop there.

It looks like we are going to take the bus. Good option. It is a lower cost, it may be inconsistent but it is definitely workable to get to and from jobs.

So we have gone, I am going to share a little bit about the ramifications here. You have a job, but you are bringing in a minimum wage. You have a friend who offers you a night job cleaning office buildings. However, it is cash only. They pay cash or the table so you are not paying any tax on it, you will not be registering it with the government. But it would be a lot of money and you could use that money right now. Are you going to take that job or are you going to pass?

Remember, this is a side job. It is money under the table. I am going to emphasize this. We are going back and forth a little bit here. We are going back and forth a little bit here.

70% said they would take the job he percent said they would not. When this job comes up in simulations, when you take the job, your parole officer shows up to see where you are living, asks

where it is from and finds out that you are working under the table. This gets you into trouble. It is often a prohibition that they have… you have a ding against you on that.

You go to check in with your probation officer at your regularly scheduled time. You also have to get to work, and if you do not get to work, you are out a full days work of that money. So what are you going to do? Do you leave a note and make it to work in time, or do you wait? You know you have to check in with the officer.

Just watching the numbers on this site, it is such a challenging question! We are almost at a 50-50 split.

About 52% percent went to check-in. That was a good option. Your probation officer has the discretion to issue a violation if you skip check-ins. And what I will check this that a lot of people working in these positions have a lot of discretion. Maybe you left a note, but in this situation when we are doing these what we say is that if you left, got probation officer did not like it and it is a violation. So it was a good idea to wait to check-in, but you also miss out on that cash that you could have gotten at work.

Alright. You are on your bus. And, there was an accident. So you were on a bus home from work, there was an accident, you could not get off the bus to walk home because you are too far and you are late so your parole officer issued you a violation for your curfew. That brings you up to two violations. Something that this point we are up to 3, and we and the simulation with you being arrested again for that violation.

I think our intent in having you do this is that obviously, there are a lot of different scenarios about how this could go. Things are very difficult obviously. It is hard to speak about anything consistently because the criminal justice system is very inconsistent across the country. It obviously varies state to state that something is in instinct, it can vary county to county or community to community. This is just to try to get a little bit of a taste of what it may be like to try to re-enter and some of the challenges that a lot of people face in trying to re-enter the community.

The reality of re-entry, just to remind you, is that 58% of people released are arrested again with infringers. What I will share it is that if you go back further down the data, they are not arrested for new crimes. A lot of the time they are re-arrested for violations of their probation or parole… some kind of requirement by the Court.

So when you read about recidivism rights, really looked into that data because often it is not new crimes, it is related to your requirements of release.

10 to 20 is the number of probation requirements on average that somebody has daily. I will share, I always comment on this, I do not know if there is 20 things that I am required to do on a daily basis or that I could not skip something that I should probably do on a daily basis and be OK. That is a lot of things to try to do if you just think about the context of your own life.

27% if the unemployment rate for people who are formerly incarcerated. The current national unemployment rate is 3 1/2%. It is a very high unemployment rate for people who are incarcerated.

Of the 13 times more likely to be homeless because there are a lot of barriers to accessing housing and stable housing for people who were formerly incarcerated.

Following incarceration, people are hundred and 20 times more likely to have a failed drug overdose and then the risk of suicide drastically increases. So there is a lot of need to ensure that someone is connected to care in those days and weeks following every entry.

It can take anywhere between 24 hours and 60 days for Medicaid benefits to be reinstated. Obviously there is a lot of variation on this state to state about whether a Medicare terminates when a person is incarcerated, but you are looking at a period of time of potentially up to 60 days before your benefits could be turned on that you are able to access healthcare services.

Even after, you know, I think we kept about this briefly, even after you have access to Medicaid benefits or any kind of health benefits, you are still looking at 67 for an in person visit and 43 days for tele-health in order to access a psychiatrist right now in the United States. So the wait times are really long.

There is a strong connection between healthcare for Medicaid and reentry. Not only does it improve health but it reduces recidivism and prevents the incarceration and support successful reentry. And potentially recycled back into the justice system. There are a lot of benefits especially when it comes to the goals of folks within the justice system at the goals of the justice system which is also what you think arrest rates and recidivism. Those are consistent goals of criminal justice policy and implementation of criminal justice programs.

The data shows that it is incredibly important to connect people to healthcare because it can help us to achieve some of those goals on the criminal justice side.

I am going to hand it over to Ken, because he is going to start talking about access to healthcare and some changes that have been happening around policy which could be a benefit to achieving some of the justice system goals and our public health goals.

JENNIFER SNOW:

Thank you so much for that. I really enjoyed watching the chat. Thank you for doing that wonderful exercise. Thank you to everyone he was having conversations in the chapter, sharing of resources and maybe coming up with additional ideas for option that somebody could be.

I think the main message that this simulation was trying to illustrate is that what my new friend Ruth Romero in the chap said. She said "This system sucks!" And I would agree. That is what we were trying to illustrate here.

The good news is that there are some options, new options that are making this a bit better. So I am going to jump into that here, talking a little bit first about what is Medicaid.

Medicaid was created in 1965, along with Medicare. It is the nation's largest health insurance program, covering 72 million people. Mostly people with low incomes. It is a partnership program that is run jointly between the federal government and state governments. The federal government set general rules about who always qualifies for Medicaid and services that must be covered, and then states have considerable flexibility to cover additional people, additional healthcare services, or not.

Medicaid pays for about 1/5 of all healthcare spending in the United States. The what is Medicaid need for help? In a nutshell, MedicAlert means a whole lot mental health and people with mental health conditions, especially for people with mental health illness. The overlap between Medicaid and mental health really cannot be understated.

Medicaid is the largest factor of mental health and substance use services in this country. One in three people with mental errors the light on Medicaid and about two in five people on Medicaid have a mental illness, so you have a connection both ways.

Medicaid also provides vital wraparound services but the people who have Medicare, and also about one in 10 veterans who were able to use Medicaid to use wraparound services, that they might have the veterans administration.

As I said, Medicaid is the largest payer of mental health and substance use disorder care in the country. It pays for one in every four dollars spent on mental health and substance use care in this country. So, changes to Medicaid have a huge impact on mental health and substance use disorder care and people's access to care.

Select go to

, and talk about who is covered by:.

Eligibility have changed over the past 60 years. Originally it was aimed at covering certain categories of low income people. Families with children, pregnant women, people who were elderly, people who were blind, people who have disabilities. People in the groups typically receive some sort of public assistance and as a result of that they would automatically qualify for Medicaid.

Just to underscore, you had to have a low income and be part of a specific category. And that is really what is represented under the first part of this umbrella. People who fit into a category because they were elderly, had disabilities, having children, or parents.

As you can see that on BURNELL RICHARDSON:, everyone. There were people who had low income or no income at all, but they did not fall into one of those. They were generally referred to as childless adults, but I want to be clear that that plaything is not always true. Because for example, my parents would be considered childless adults because that child, me, is an adult now. So while they are parents, they would not be Paris in terms of Medicaid eligibility.

Just to say there are a lot of people who were not covered under the Medicaid umbrella. The Affordable Care Act of 2010 changed that. And for the first time, it really filled out the umbrella, or attempted to, and we will get to enablement. It expanded coverage to everyone who had a household income under 138% of the federal poverty level, so you no longer have to fit into a certain category. All you had to do was show that you had low income, and you would be eligible for Medicaid.

Lisa was the plan. The Supreme Court changed that. One of the first rulings related to the Affordable Care Act determined that the expansion was not constitutional, and therefore, it became voluntary, so states had a choice of whether or not to fill out the blue part of the umbrella or not.

So what have states decided? As you can see in this light, the vast majority of states decided that they wanted to take up the Medicaid expansion population. 40 states as well at the District of Columbia have expanded Medicaid. They are in dark blue! The green states have not expected mental state. So going back to that umbrella analogy, people who are no income who live in a green estate do not qualify for Medicaid unless they also meet one of the eligibility categories that we discussed previously.

So bringing it back to the conversation at hand, a large portion of people leaving incarcerated settings have no income, or to be honest, no income and they are adults. So, the Medicaid expansion presents an anonymous opportunity to expand eligibility to people within the incarcerated settings.

So I have set the table, so if you look at expanded Medicaid it would seem that there is a huge potential for an overlap with people who are incarcerated because again, "Childless adults of low income." So does that mean that everyone who was incarcerated is going to be eligible for Medicaid? Not really. It is quite tricky.

Medicaid has historically played a rather small. People who were incarcerated due to something that was enacted in 1965, is known as the inmate exclusion policy, and it does not get at someone's eligibility for Medicaid. But it prevents Medicaid from paying for any services for people who were incarcerated. There is a small exemption for inpatient care when they leave an incarcerated setting but basically want to become incarcerated your Medicaid eligibility is irrelevant because Medicaid cannot pay for any services you might receive in and incarcerated setting.

So this exclusion policy has left financing and oversight of healthcare in prisons and jails in the hands of state and local governments. So as a result, what they have done is that they typically suspended or terminated someone's eligibility at intake. So you get arrested, you become incarcerated, your Medicaid eligibility is, that I provided in, put in a suspended status or a terminated status.

So this is a real disruption. It means that anyone who arrived back is going to leave the automated system without that healthcare coverage, because the coverage has been suspended or terminated. So it is tricky.

The good news if there has been a recent policy change that has allowed more opportunities to print Medicaid inside the walls. So let's look at this timeline: 1965, Medicaid was established and it

said "No Medicaid for people who were incarcerated." Not much happened for close to 40 years and then in 2024, CMF told states that they were permitted to suspend a person's Medicaid so that they could be more quickly reinstated when people were released from incarceration.

This is the first time that there was a recognition of "We need to do something to help people get reconnected to care once they leave incarceration."

In 2016, CMS encouraged and recommended that states suspend someone's eligibility without them being terminated. Small steps. Good steps. But the good news came in 2018. As part of the bipartisan piece of legislation known as the Support Act, (Inaudible) Medicaid should play a large (in incarcerated sectors. And if one is perfect. With the issue some guidance is based on how Medicaid waivers could be used to support re-entry. We will get to those in a minute.

It was 2018 that Congress passed the law, in 2023 CMS released guidance on what we call the Medicaid re-entry section 1115 waiver demonstration opportunity. That really is a mouthful. It allows state Medicaid programs to cover a of Sepsis, before what somebody believes and incarcerated septic... that is in state prisons, counties, cities, tribal jails and youth correctional settings depending on the state.

So let's look a little bit into those waivers that I mentioned. Be clear, we can spent an entire webinar talking about Medicaid section 1116 waivers. Some of you know a whole lot about this already, but if you have never heard about them before, do not worry. Only really need to know is that it where there is a way that the state can voluntarily raise that to do something innovative that was not conceived in the original Medicaid law.

The guidance that came from the federal government says that states can provide a that Medicaid benefits to individuals during the period of up to 90 days before they are released from incarceration. So basically, Medicaid can pay for care 90 days prior to release in order to stay connected to healthcare after they returned to communities, after that time incarcerated is finished.

There were three things that the feds said they had to cover. The first was case management, those services to help people understand and get connected to care. Second, they had to -- Medicaid (indiscernible) and provide a record of medication upon me. Help people have a little bit more time before people are in desperate need of additional medication.

States are able to do more than the three services, but those are identified as the minimum number of benefits that would be included in these waiver packages.

The good news is we have seen incredible interest from states in regards to these waiver opportunities. You will see on this map, CMS has approved Medicaid re-entry for in 19 states. So those are the dark blue here. They implemented their waivers on state-specific time frames. So some of these provisions have been approved but they have not yet gone into effect. You have another eight states and the District of Columbia that have submitted approvals that feds are considering. Those are represented in green here.

When we submitted the slide, there were nine that were pending. Since that time, Rhode Island has pulled back that application, so that slide is a little out of date. But what excites me most about this map is that a lot of times, we look at maps and we look at states in context of red or blue states. There is no red or blue here at all, but more red states have applied for this waiver. It has been something that across political statements people have recognized the challenges that people who are incarcerated face when they are re-entering their communities and recognize how Medicaid can play a critical role in helping that. So this, to me, is a wonderful positive like to see the outcome of interest from states. And it was only 2013 that this was first announced as a possibility. In other situations where waivers have been presented, it took a lot more time before this number of states were approved.

We talked a little on this timeline slide, in 2023 an additional bar was half that will require states to provide case management as well as screening diagnostics and referrals to youth who are incarcerated in the 30 days prior to release and then 30 days after release. So there are specific populations that they apply to, and it is basically under age 21, and under age 26. The care.

So states, another indication of Congress recognizing that we need to do better to connect people with services upon release.

Then another bipartisan law in 2024, so just the last year, requires that beginning next year, all states will have to suspend eligibility, not terminate for everyone who is incarcerated, and there is also some grant funding that came along with that legislation.

This is the industry that I have been a consistent drumbeat bipartisan legislation to expand Medicaid into incarcerated settings, to help people get connected to care and improve health outcomes.

So what else is happening with Medicaid re-entry? There has been a lot of bipartisan interest. But the good news is, we are just starting on this journey. There are two significant pieces of legislation that NAMI has answered and worked with our advocates to increase the number of members of Congress who support these bills, that I want to talk to your attention. I hope that you can think about supporting them in your own capacity, talking to your legislators about supporting pieces of legislation.

The first is called the re-entry act. That would more explicitly create the option for states to provide Medicaid coverage 30 days prior to release. It was introduced in both House and Senate left Congress. It was introduced in the house in the Congress, and we are pending introduction in the Senate, hopefully we can get there shortly.

The second piece of legislation in the June causes continuity of care act. This deals with people before they have been adjudicated for a crime and the ability to get Medicaid coverage when they are in a pre-trial detention situation. When we wrote the slides, it was just introduced in the house. Since we submitted despite it has been introduced in the Senate, it has passed 1720, both pieces of legislation are bipartisan, recognizing this is not able to think of a right date issue, this is a smart policy things to help improve the life of people who are just as involved when they are in a consummated second.

So how can you get involved? I hope this conversation, but the exercise at the beginning well at the discussion about Medicaid had excited you about the possibility of doing work with in your state to try to help people get better connected to care upon release. So how can you get involved? First, I would encourage you to think back to that map to take a look at it actually have been in conversation to see if your state has submitted a re-entry waiver proposal yet. If they have not submitted one, we encourage you to look around and see what is happening in your state. You can also connect with your local NAMI you will be able to give you a sense if this is on your radar.

If your state is considering it or has submitted a proposal you can provide feedback on the proposal. Share. The public comments. Encourage states to move forward because they know that these options are going to help people get better access to it.

If you are in date who has an approved equipment look toward implementation and the way that you might be able to impact implementation.

We also want to make sure that you are aware of the additional resources. NAMI what of an organization called the health and re-entry project, or HARP, on the report called "Paving the Path to

More Healthy Re-entry" which is available on our website. When I am finished talking I will drop a link in the chat for you to access directly, or maybe if Shannon will if she is quicker than I am.

There is the online the entrance of the which will develop, similar to what we started this conversation with today. But if you would like to see the online of the exquisite electoral we encourage you to try that.

We also link to some of our work on re-entry and expanding access to care for those who are just as involved. There is also additional information at the US Department of Justice and National Institute of Justice level, as well as SAMHSA.

With that, we can move to countries. I have not been monitoring the capital I didn't know if there are specific questions that we have in hand but I would welcome the opportunity. Because that what we have presented today had reignited your thinking about re-entry. I know that from the discussion many of you are already very involved in this but I would love the opportunity to open up the conversation.

KAYLA BAKER:

Thank you so much for your presentations. We do have a few questions. Let's see...

How is the criminal justice helping people get by, if it makes it even harder for people to bounce back in life? The process of re-arrestiing works against the entire process of a person being able to get on their feet. How does this help?

SHANNON SCULLY:

You are right. And it is how our criminal justice system is set up. The criminal justice system is set up as crime and punishment, but what showed up a lot if the research is that a lot of the reasons why people are the incarcerated is joined by economics, health, so those are drivers of involvement in the criminal justice system.

The system is just not set up to be able to meet. As we try to do his reforms, in many ways we are applied in a public health solution is criminal justice reform. You know, that is a lot of the lands that people really captive come at different.

So, you are right. But I will share, while what we often present about the criminal justice system (because I think it is kind of the more consistent experience for folks) nationally, that it is a challenge in that it is not set up to help people succeed There is a lot of really great work happening locally in which people are really committed to this idea. And when I say people, it is not just an advocate... it is judges, service, Chiefs of Police who are really interested in this idea ain't around mental illness and criminal justice. All Behavioural Health Link criminal justice. Their system is not the system to really help people get connected to care and they have really committed to this idea that if we connect people to care they are not going to show up in our justice system.

There is a lot of great work happening locally. I would encourage you to check out resources from the (unknown term) Center, which is funded by the US Department of Human Health and Services and comments. There is a lot of great information in there about behavioral health and the justice system and reforms that are being made.

The Office of Justice programs at the US Department of Justice offer has some really great the resources and information just about some reforms that we are really trying to make with the federal system.

I would also encourage you to reach out and connect with your local NAMI. A lot of our NAMI are locally involved in system reform, especially when it comes to people with serious mental illness, maybe ensuring that we are connecting them to care. So that can be a great resource to find out what is happening locally and what is the best practices that are starting to float to the top with some people.

I hope that answers the question.

JENNIFER SNOW:

If you don't mind me jumping in just a little, I think neither Shannon nor I know people in this space are looking at this Medicaid re-entry opportunity as the solution. We have no illusions that connecting people to healthcare is going to automatically equal a smooth transition or overcome all of the barriers that people have to face, but it is clearly a step in the right direction. When you help people with their healthcare, when they are leaving incarcerated settings, you are in a much better position to focus on some of the more immediate needs like "Where are you sleeping tonight? How are you getting connected to employment opportunities?"

So just to be clear, this is one tool in the toolbox. One way to help ease the transition, but by no means are we looking at this as the only solution for all of the barriers that people think.

KAYLA BAKER:

Thank you both. We have time for maybe one more question. Is the waiver program at risk with the Medicaid cuts?

JENNIFER SNOW:

That is a great question, and we really struggled with the best way to raise that in the context of this presentation. As folks might have heard, the President signed into law the one big beautiful Bill act on 4 July. It makes some significant changes to the Medicaid program: $1 billion in cuts for the 10 years, an estimated 12 million people losing access to Medicaid.

One of the most significant ways that people are going to lose access to coverage is proven to work recording requirements. I am going to choose to be optimistic here. There is an exemption in the workbook requirements section for people who are incarcerated and it provides a three month window before work requirements would kick in.

I would like to think that is an indication that Congress did not want to impart the work that had been done on re-entry. With the new requirements, obviously a lot is still on. But I would like to be hopeful that the re-entry waivers will be able to continue and that the new work reporting requirements will not provide an immediate barrier to that.

I think three months to find a job after release from incarceration is not going to be easy, but it is at least a little bit of 1/2. So I am going to choose to be optimistic today, but definitely, if you would like to learn more, NAMI.org/medicaid, we have a lot of resources in our fight against the legislation… resources that I think will provide helpful framework moving forward.

KAYLA BAKER:

We'll just share real quick, I know that there is a lot of conflict about how this will change access to care in the community. What I encourage people to think about while they are thinking about mental illness and justice system reforms is just that… This because you implement a perform, it does not come with all these new resources. We pulled from the same resources as people who were formerly incarcerated. These resources, whether it is full-court or probation or parole, it all comes from the same system.

So again, hoping that had a thinking about what this new space... (indiscernible), we just encourage thinking about the formerly incarcerated into this framework for support in your communities.

SPEAKER:

(indiscernible)

SHANNON SCULLY:

Here is our contact information. Again, there is a ton of information on NAMI.org. You can sign up for newsletters and other information. And then obviously, if you have specific questions, feel free to reach out to Jane or myself stop we are happy to get back to you and engage more in this conversation with you.

Thank you all.

JENNIFER SNOW:

Thank you for doing a brilliant job!

KAYLA BAKER:

Thank you so much for attending today. We are incredibly grateful to our presenters, SAMHSA NAMI for hosting this presentation. Please take a moment to complete the survey that will pop up. This concludes today's session, and you may now disconnect.

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