On January 18 and 19, 2018, twenty two national leaders and experts convened on the campus of Georgetown University in Washington, D.C. for Course Corrections: National Summit on Mental Health and Criminal Justice Law and Policy. The purpose of this gathering was to build consensus regarding priorities and opportunities for aligned policy reform advocacy and litigation activities that would jointly aim to improve mental health outcomes, reduce incarceration, and increase national prosperity and wellbeing.

In conclusion, *Course Corrections* participants observe the following:

In twenty-first century America, mental illness far too often is criminalized and stigmatized. Behaviors associated with mental illness are mistaken for, and treated as, willful criminality. Services in the community that are supportive of good mental health outcomes and socially acceptable behavior are woefully insufficient, and persisting stigma and inadequate funding are barriers to access. Rather than supporting people's health and social development, and providing access to quality treatment, care, and education, we default to incarceration, where mental health declines further, causing negative behaviors, more severe disability, and worsening prognoses.

With only 4%[1] of the world's population, the United States has 21%[2] of the world's incarcerated population. The Land of the Free holds more people behind bars in jails and prisons per capita than any other country on the planet, at a cost to society that exceeds $1 trillion per year, or six percent of the nation's gross domestic product.[3]

More than half of all incarcerated people in the United States have a mental health diagnosis[4], and the number of people with mental illness who are in jails and prisons vastly exceeds the number of people receiving treatment in state psychiatric hospitals.[5]

In jails and prisons, people in poor mental health are prone to victimization and disciplinary problems, and are housed in solitary confinement or administrative segregation at higher rates than those without mental health needs. Already isolated in their families and communities by stigma and misunderstanding, incarcerated people in poor mental health are subjected to the ultimate isolation of

[1] U.S. and World Population Clock. United States Census Bureau. Updated 4 June 2018. Retrieved 4 June 2018. [https://www.census.gov/popclock/]
[2] Walmsley, Roy. World Prison Population List (tenth edition). From World Prison Population Lists. 21 Nov 2013. Retrieved 4 June 2018. [http://www.prisonstudies.org/sites/default/files/resources/downloads/wppl_10.pdf]
[3] McLaughlin, M., Pettus-Davis, C., et al. The Economic Burden of Incarceration in the U.S. July 2016. Concordance Institute fo Advancing Social Justice. George Warren Brown School of Social Work. Washington University in St. Louis. Working Paper #CI072016
[4] James, D., Glaze, L., Mental Health Problems of Prison and Jail Inmates, Bureau of Justice Statistics Special Report, September 2006, NCJ 213600
[5] Serious Mental Illness Prevalence in Jails and Prisons, Treatment Advocacy Center-Office of Research and Public Affairs, Background Paper, September 2016.

prolonged enclosure in spaces that measure approximately 6 feet by 9 feet, with no meaningful human contact, and sometimes with as few as only two or three hours a week outside their cells.

Isolation, segregation, and separation from human contact are tied to poor mental health even in the community. Loneliness and alienation are tied to depression and anxiety. Punitive enclosure within a small cell for weeks, months, and years at a time is devastating for any person's mental health and approximately 80,000 to 100,000 prison inmates are held there at any given time with about 20% of the entire prison population subject to solitary over the course of a year. There is no empirical evidence that solitary confinement makes prisons safer; conversely, prisons that use solitary confinement at higher rates become more violent and costly to manage.[6]

The vast majority of incarcerated people will return to the community. When they are released, sometimes directly from solitary cells and in poorer mental health than ever, they reoffend at a disproportionately high rate, and sometimes pose a greater threat to public safety than before they entered the facility.[7] In 2015, the United Nations published the Revised Standard Minimum Rules for the Treatment of Prisoners. These revised rules, also known as the Nelson Mandela Rules, contain provisions that prohibit indefinite or prolonged solitary confinement and exclude the use of solitary confinement for certain populations whose conditions would be exacerbated by solitary confinement, such as those with certain physical or mental disabilities.[8]

Relying on the justice system to manage mental health is neither just nor healthy, nor is it sound fiscal policy. Our nation's public health, public safety, and economic wellbeing are inextricably intertwined and in crisis. A resolution to this crisis demands an enlightening of public understanding of mental health, and a rebalancing of community investment, shifting a significant portion of that $1 trillion of direct spending and social costs related to the justice system toward health and education, where the funds will yield additional long term savings and enhanced economic growth, as well as positive outcomes for individuals, families, and communities.

To achieve this rebalancing of investment, we are committed to align our policy advocacy and litigation efforts toward the following:

Through persistent collaborative effort across multiple points of intervention, the nation should reduce its **jail and prison populations by at least half**;

The nation should **end the use of prolonged solitary confinement** defined as longer than 15 consecutive days, should ensure that cases of solitary confinement longer than a few days are subject

[6] See T. Kupers, T. Dronet et al, Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs," Criminal Justice and Behavior, 36, 1037-1050, October, 2009. [http://solitarywatch.com/wp-content/uploads/2011/08/unit-32-article-cjb2.pdf]

[7] Briggs, C., J. Sundt, and T. Castellano. 2003. "The Effect of Supermaximum Security Prisons on Aggregate Levels of Institutional Violence." *Criminology* 41:1341–76.

[8] United Nations Office on Drugs and Crime, The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), General Assembly resolution 70/175, adopted on 17 December 2015.

to due process review, and should exclude youth, pregnant women, and individuals with physical or mental disabilities from solitary confinement in its jails, prisons, and juvenile detention facilities, as a key indicator of a transformed system;

The nation should dramatically **expand access to quality mental health services and wrap-around safety net services including affordable housing in the community**; and

The nation should **expand and improve the quality of mental health, vocational, educational, and other rehabilitative services in jails and prisons**.

To these ends, we recommend and support the following as priority areas of aligned reform effort at local, state, and national levels:

1. **Public and leadership education**—the urgency of disentangling mental health and criminal justice is not widely understood, nor is there widespread awareness of the prevalence of solitary confinement and the poor outcomes associated with this and other justice system practices. Raising public and leadership awareness about the high costs and poor outcomes of current practice, along with messaging campaigns to reduce stigma and discrimination associated with poor mental health, are key foundational steps to taking advantage of shifting political opportunities and achieving the desired culture change.

2. **Eliminate perverse financial incentives for mental and behavioral health provider organizations**—due to current payment structures, mental and behavioral health providers that fail to provide care for individuals in the community, profit from being able to provide care to incarcerated individuals. Payment and reimbursement must be restructured to incentivize health care providers to provide effective community-based care, so that the mass incarceration of the patient population is no longer a gain for the private health care industry.

3. **Pre-arrest, pre-filing diversion**—Training law enforcement officers to recognize and deescalate mental health crises, and ensuring that officers have sufficient access to health care services and supports as an alternative to arrest, are key strategies to reduce jail populations and improve health outcomes. District Attorney partnerships with health care providers are a secondary opportunity for diversion, as an arrested individual can be directed into care and treatment instead of being charged with a crime.

4. **Bail reform**—the prevalence of money bail contributes to large jail populations and is unjust to the poor. Qualification for pre-trial release should be determined by public safety risk assessment, and not by finances. Risk assessment should be informed by adverse mental health symptom recognition and treatment practices to ensure that mental health conditions do not preclude pretrial release.

5. **Sentencing reform**—the United States is unique among developed nations for its long sentences. Mandatory minimum sentencing has removed judicial discretion. Parole and early

release have been drastically curtailed. A return to indeterminate sentencing and judicial discretion with judicial oversight in place, and a restoration of parole programs that expedite community reintegration would preserve public safety and reduce prison populations. At the very least, judges should be able to bypass mandatory minimum sentences when a crime is linked to an individual's mental illness.

6. **Reentry support and transition planning**—barriers to reentry (including restrictions on voting rights, access to employment, education, traditional and supportive housing, and other public benefits) must be removed to support successful community reintegration and to reflect correctional and justice systems that have effectively served their purposes. Reentry support can best be achieved by requiring federal, state, and local departments of corrections to create a **transition planning process** which designates a qualified staff person to conduct a needs assessment and referral plan for each reentrant prior to actual release. As prison systems should avoid releasing inmates directly from solitary confinement, staff should provide general population step-down transition planning within the corrections setting, at least 90 days prior to release.

7. **Data gathering**—jails and prisons must screen for mental health conditions including traumatic brain injury, to better address the specific needs, treatments, and behaviors of people experiencing mental health conditions entering the facility. Nationwide, correctional facilities must integrate standardized, disaggregated data collection throughout operations, in coordination with community mental health providers, to better understand where individuals are entering and exiting the criminal justice system, whether they are being held in confinement, whether there is disproportionality in justice system interventions, and the nature of improvements over time.

8. **Oversight and reporting standards**—the rampant use of prolonged solitary confinement in our jails and prisons without regard for the harm caused to those subjected to it, or to the communities into which they return, persists in part because there is no responsible body monitoring corrections practices to prevent these abusive practices. Most jails lack unified oversight or standards for their mental health care practices. Beyond citizen awareness of mental health and criminal justice issues, persistent public oversight must be instituted to review the reformation of jails and prisons as well as the expansion of access to mental health care in the community.

   The federal prison system, which should be a model for state prison and jail practices, lacks any kind of independent oversight, even though the federal Bureau of Prisons (BOP) is a part of the Department of Justice. Abuses of solitary confinement, in particular of people with mental illness, are rampant in the BOP. The role of the Justice Department is to defend claims of constitutional violations, brought against the BOP, rather than acting in an oversight role. The federal government should create an independent monitoring system outside the Justice Department to address these practices.

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