COURSE CORRECTIONS
COLORADO SUMMIT ON BEHAVIORAL HEALTH & CRIMINAL JUSTICE

On March 22 and 23 of 2017, experts and leaders in behavioral health and criminal justice from Maryland, Virginia, and the District of Columbia gathered for Course Corrections: Mid-Atlantic Summit on Behavioral Health and Criminal Justice. The purpose of this gathering was 1) to acknowledge the urgent need for an alternative to incarceration and criminal justice system involvement for people living with mental illness and/or those who may be experiencing a behavioral health crisis, 2) to build consensus regarding what course corrections are most urgently required, especially with regard to supporting community reintegration, and 3) to provide recommendations for overcoming barriers to reducing incarceration, improving behavioral health outcomes, and maintaining public safety.

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

Our communities are in the midst of a public health crisis, which demands the coordination of efforts and resources along a multi-sector continuum of civic engagement including early childhood interventions, education and employment support, access to insurance coverage and health care, meaningful data collection and analysis, supportive housing, public safety officer de-escalation training, access to justice, access to diversion programs, a rehabilitation approach to corrections when incarceration is appropriate, successful reintegration, and quality behavioral health services and supports.

While access to quality behavioral health care must be a priority from early childhood onward, the effectiveness of any given treatment is undermined when such crucial additional supports of individual wellbeing such as education, employment, and housing are missing or inadequate. Consistent access to quality education, meaningful employment and/or income support, and safe and stable housing are vital to successful reintegration after justice-system involvement and preventing justice-system involvement.

Our current practice of defaulting to incarceration as a response to citizens experiencing behavioral health challenges is a grave failure to uphold the Constitution of the United States. To establish justice; ensure tranquility; provide for the common defense; promote the general welfare and secure the blessings of liberty to ourselves and our posterity, our communities **must improve our response to behavioral health crises and urgently prioritize the development of a *community health system* that can successfully ensure access to quality mental health and substance use disorder care and supports.**

To this end, we recommend and urge that the Governors of Maryland and Virginia, the Mayor and City Council of the District of Columbia, healthcare and community leadership, and the State Legislatures, take urgent steps to accomplish the following:

1) Create and deploy a public health messaging campaign to reduce stigma and discrimination associated with mental illness, substance use disorders, and other behavioral health conditions and to promote upstream interventions and civic engagement along a life-cycle continuum. Said campaign should also aim to increase awareness of public health options for the public, first responders, and the justice system when encountering a behavioral health crisis.

2) Require culturally competent behavioral health assessment tools in annual pediatric wellness exams, and provide evidence-based interventions and supports to families, regardless of income. Ensure that child care providers and schools do not discriminate against children and families who seek such interventions but are prepared to offer solutions and support.

3) Ensure that culturally competent training in mental health awareness and stigma reduction is universalized in secondary, university, and professional school programs and for individuals working with all students, including elementary and pre-school age children. Increase training requirements for all judicial system staff.

4) Eliminate damaging and discriminatory disciplinary practices in schools, including pre-kindergarten and kindergarten suspensions and expulsions, in order to shut down the school-to-prison pipeline. Instead, culturally competent and trauma-informed behavioral health and early childhood developmental support must be made widely available.

5) Fully implement and enforce relevant laws that prohibit discrimination against individuals with disabilities, such as the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and the Mental Health Parity and Addiction Equity Act, with effective sanctions to inhibit non-compliance.

6) Promote the highest standards of integrated mental health and addiction care via meaningful accreditation and implementation of evidence-based and promising treatment modalities.

7) Design and adopt a universal formulary for psychiatric medications to ensure the consistency, availability and affordability of medicines for mental health management across systems and providers.

8) Support and accelerate efforts to integrate data for the purposes of managing behavioral health crises within community health systems, as opposed to within the justice system.

9) Advance efforts to provide case management, supportive housing and supported employment for individuals with psychiatric disabilities and substance use disorders to reduce justice-system involvement. Provide a continuum of safe and stable housing, with an emphasis on low-barrier, housing first options.

10) Address behavioral health provider shortages by incentivizing the growth of the provider workforce and working with colleges and universities.

11) Ensure that crisis stabilization and hospital receiving centers have the capacity and resources to manage law enforcement diversion, to perform comprehensive multi-disciplinary assessment, and to provide wraparound services that can assist individuals in crisis and offer access to treatment and needed resources, borrowing the model from juvenile assessment centers. Any assessment of inpatient capacity needs must ensure that an expansion of inpatient beds is not used as a substitute for addressing gaps in community-based services that result in needless admissions to, and needlessly long stays in, inpatient settings.

12) Ensure that behavioral health crisis response capacity is comprehensive by evaluating resources, including assessment of need for inpatient bed expansion, and supporting additional crisis stabilization and/or walk-in centers where necessary, as well as mobile response, peer support, respite care, and ensuring that remote communities have access to telehealth and other e-health solutions as needed.

13) Offer a wide range of diversion opportunities for those individuals with behavioral health issues who would otherwise be at risk for arrest or unnecessary incarceration for all levels of offenses. Restrict competency restoration settings to outpatient providers in the community (excluding jails or other correctional facilities) for all misdemeanor and non-violent felony charges, except in cases in which the court mandates inpatient hospitalization due to an imminent threat of harm to the individual or others.

14) Universalize Crisis Intervention Team (CIT) training in police and sheriffs' departments, and among judges, prosecutors, and other attorneys state-wide, making Mental Health First Aid training immediately available and when staffing resources limit CIT participation. Encourage police and sheriffs' departments to supplement CIT with additional de-escalation training, such as ICAT: Integrating Communications, Assessment, and Tactics. Pre-employment screening for all roles in law enforcement must assess aptitude for success in mental health crisis de-escalation.

15) Implement and support behavioral health provider, law enforcement, and other first responder partnerships, such as co-responder teams, hospital receiving center, law enforcement assisted diversion (LEAD), and drop-off center models. Such models effectively reduce arrests and result in cost-savings and avoidance for law enforcement and the justice system. Facilitate said partnerships as needed through the use of oversight committees, personnel, or memoranda of understanding.

16) Identify and address persisting socioeconomic-, race- and gender-based disparities in policing and sentencing, including a particular focus when these are compounded by behavioral health issues.

17) Ensure that integrated mental health and substance abuse treatment and continuity of care are available for those who are incarcerated or detained within the criminal justice system. Ensure that all service systems (e.g., education, social services, criminal justice) are culturally competent, trauma-informed systems, understanding the role trauma plays in shaping behaviors and learning how to prevent and address trauma as early as possible.

18) Remove barriers to community reintegration for people returning from jails and prisons. Reform policy in order to alleviate collateral consequences that negatively impact the long-term wellbeing and prosperity of people who have duly served out their sentences. Implement reentry services and supports that provide a seamless transition from incarceration to the community, including in-reach, suspension rather than termination of Medicaid, pre-release benefit applications, automatic reinstatement of Medicaid upon release, low-barrier housing, and low-barrier (including no cost) access to government identification and other documents necessary to access services (e.g., police clearance, TB test, release papers).

19) Provide quality services and support for the humanity and wellbeing of officers, providers, administrators, and advocates who strive to serve individuals and the common good in challenging circumstances, including physical risks, as well as other primary and secondary traumas. Destigmatizing

and providing necessary mental and other health support, as well as professional development opportunities, to criminal justice system workers is essential for our community health, safety, and prosperity.

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