STATEMENT OF

JUDGE STEVE LEIFMAN

Chair, Supreme Court of Florida Task Force on

Substance Abuse and Mental Health Issues in the Courts

before the

Subcommittee on Oversight and Investigations

of the Energy and Commerce Committee of the

UNITED STATES HOUSE OF REPRESENTATIVES

concerning

People with Mental Illnesses Involved in the Criminal Justice System

Summary

Nationwide, jails and prisons have become the largest psychiatric facilities in most states. It is estimated that there are nearly 14 times as many people with mental illnesses in jails and prisons in the United States as there are in all state psychiatric hospitals combined.

The initial closing of state hospital beds beginning in the 1950s and 1960s was a response to institutions which had largely become warehouses providing little more than custodial confinement. In 1963, Congress passed the Community Mental Health Centers Act which was intended to create a network of community-based mental health providers that would replace failing and costly state hospitals, and integrate people with mental illnesses back into their home communities with comprehensive treatment and services. Unfortunately, the comprehensive network of community mental health centers and services envisioned never materialized. The community mental health system that did emerge is too often fragmented with poorly integrated services, and enormous gaps in treatment and disparities in access to care.

Today, there are three significant areas of policy and practice contributing to the disproportionate involvement of people with serious mental illnesses in justice system: 1) Limitations on financing of services using federal resources; 2) Reliance on outdated civil commitment laws; and 3) Lack of standardized and systematic coordination of services and resources between the criminal justice system and the community mental health system.

Fortunately, there are promising solutions being developed as the result of problem-solving initiatives at the interface of the criminal justice and mental health arenas. By working collaboratively across systems and disciplines, we now have a greater understanding of the causes and consequences of involvement in the justice system among people with serious mental illnesses.

Introduction

Chairman Murphy, Vice-Chairman Burgess, Ranking Member DeGette, and Members of the Subcommittee:

Thank you for the opportunity to provide testimony today about the critically important issue of people with untreated mental illnesses involved in the criminal justice system. My name is Steve Leifman and since 1995 I have served as a judge in the Eleventh Judicial Circuit in Miami-Dade County, Florida. From 2007 until 2010, I served as Special Advisor on Criminal Justice and Mental Health for the Supreme Court of Florida. Since 2010, I have served as Chair of the Supreme Court of Florida's Task Force on Substance Abuse and Mental Health Issues in the Courts. I also serve as co-chair of the Judges' Leadership Initiative for Criminal Justice and Behavioral Health, an organization established in 2004 consisting of judges from around the country, as well as representatives from the National Center for State Courts, the National Judicial College, Policy Research Associates, and the Council of State Governments Justice Center, working to develop problem-solving approaches to address the disproportionate number of people with serious mental illnesses (e.g., schizophrenia, bipolar disorder, and major depression) involved in the criminal justice system.

When I became a judge nearly two decades ago, I had no idea I would become the gatekeeper to the largest psychiatric facility in the State of Florida. The Miami-Dade County jail contains nearly half as many beds for inmates with mental illnesses as all state civil and forensic mental health hospitals combined. Of the roughly 100,000 bookings into the jail every year, nearly 20,000 involve people with serious mental illnesses requiring intensive psychiatric treatment while incarcerated. On any given day, the jail houses approximately 1,200 individuals receiving psychotherapeutic medications, and costs taxpayers roughly $65 million annually,

more than $178,000 per day. Additional costs to the county, the state, and taxpayers result from crime and associated threats to public safety; civil actions brought against the county and state resulting from injuries or deaths involving people with mental illnesses; injuries to law enforcement and correctional officers; ballooning court case loads involving defendants with mental illnesses; and uncompensated emergency room and medical care. In addition to direct fiscal costs to the community, the added stigma of criminal justice system involvement often results in additional hardships and barriers to recovery for consumers of mental health services and their family members in terms of decreased quality of life and difficulty in accessing basic supports such as housing and treatment services.

Several years ago, the Florida Mental Health Institute at the University of South Florida completed an analysis examining arrest, incarceration, acute care, and inpatient service utilization rates among a group of 97 individuals in Miami-Dade County identified to be frequent recidivists to the criminal justice an acute care systems. Nearly every individual was diagnosed with schizophrenia, and the vast majority of individuals were homeless at the time of arrest. Over a five year period, these individuals accounted for nearly 2,200 arrests, 27,000 days in jail, and 13,000 days in crisis units, state hospitals, and emergency rooms. The cost to the community was conservatively estimated at $13 million with no demonstrable return on investment in terms of reducing recidivism or promoting recovery. Comprising just five percent of all individuals served by problem-solving courts targeting people with mental illnesses, these individuals accounted for nearly one quarter of all referrals and utilized the vast majority of available resources.

As a member of the judiciary, I see first-hand the consequences of untreated mental illnesses both on our citizens and our communities. Former Surgeon General Dr. David Satcher

once called mental illness the silent epidemic of our time. However, for those of us who work in the justice system nothing could be further from the truth. Everyday our courts, correctional facilities, and law enforcement agencies are witness to a parade of misery brought on by untreated mental illnesses.

Part of the reason for this is that, over time and as the result of the unintended consequences of efforts to provide more compassionate alternatives to institutional confinement, public mental health systems across the United States have been funded and organized in such a way as to all but ensure that the most expensive services are provided, in the least effective manner, to the fewest number of individuals; those in acute crisis in inpatient settings.

Because community-based service delivery systems are often fragmented, difficult to navigate, and slow to respond to critical needs, many individuals with the most severe and disabling forms of mental illnesses who are unable to access primary and preventive care in the community eventually fall through the cracks and land in the criminal justice or state hospital systems where service costs are exponentially higher and targeted toward crisis resolution and restoration of competency, as opposed to promoting ongoing stable recovery and community integration. As a result, instead of investing in community-based prevention, treatment, and wellness services, states and communities are increasingly forced to allocate limited mental health funding and resources to costly crises services and inpatient hospital care in both the civil and forensic mental health systems.

Historical Overview

200 years ago, people with severe and disabling mental illnesses were often confined under cruel and inhumane conditions in jails. This was largely due to the fact that no alternative system of competent, community-based mental health care existed. During the 1800's, a

movement known as moral treatment emerged that sought to hospitalize and treat individuals with mental illnesses rather than simply incarcerating them.

The first state psychiatric hospitals were opened in the United States during the late-1700's and early-1800's, and were intended to serve as more appropriate and compassionate alternatives to the neglect and abuse associated with incarceration. Unfortunately, overcrowding at these institutions, inadequate staffing, and lack of effective treatment programs eventually resulted in facilities being able to provide little more than custodial care. Physical and mental abuses became common and the widespread use of restraints such as straight-jackets and chains deprived patients of their most basic dignity and freedom. The asylums intended to be humane refuges for the suffering had instead turned into houses of horrors.

By the mid-1900's, more than a half million people were housed in state psychiatric hospitals across the United States. The system was stretched beyond its limits and states desperately needed some alternative to addressing this costly and ever-expanding crisis. Around this same time, the first effective medications for treating symptoms of psychosis were being developed, lending further support to the emerging belief that people with serious mental illnesses could be treated more effectively and humanely in the community. This period marked the beginning of the community mental health movement.

In 1963, Congress passed the Community Mental Health Centers Act which was intended to create a network of community-based mental health providers that would replace failing and costly state hospitals, and integrate people with mental illnesses back into their home communities with comprehensive treatment and services. In what would be his last public bill signing, President Kennedy signed a $3 billion authorization to support this movement from institutional to community-based treatment. Tragically, following President Kennedy's

assassination and the escalation of the Vietnam War, not one penny of this authorization was ever appropriated.

As more light was shed on the horrific treatment people received in state psychiatric hospitals, along with the hope offered by the availability of new and effective medications, a flurry of federal lawsuits were filed against states which resulted what became known as the deinstitutionalization of public mental health care. Unfortunately, there was no organized or adequate network of community mental health centers to receive and absorb these newly displaced individuals.

The fact that a comprehensive network of community mental health centers and services were never established has resulted in a fragmented continuum of care that has failed to adequately integrate services, providers, or systems; leaving enormous gaps in treatment and disparities in access to care. Furthermore, the community mental health system that was developed was not designed to serve the needs of individuals who experience the most chronic and severe manifestations of mental illnesses.

In two centuries, we have come full circle, and today our jails are once again psychiatric warehouses. There are two ironies in this chronology that have resulted in the fundamental failure to achieve the goals of the community mental health movement and allowed history to repeat itself in costly and unnecessary ways:

- First, despite enormous scientific advances, treatment for severe and persistent mental illnesses was never deinstitutionalized, but rather was transinstituionalized from state psychiatric hospitals to jails and prisons.

- Second, because no comprehensive and competent community mental health treatment system was ever developed, jails and prisons once again function as de facto mental health institutions for people with severe and disabling mental illnesses.

Current Crisis

The problems currently facing our communities and criminal justice systems relate to the fact that the community mental health infrastructure was developed at a time when most people with severe and disabling forms of mental illnesses resided in state hospitals. As such, the community mental health system was designed around individuals with more moderate treatment needs, and not around the needs of individuals who experience highly acute and chronic mental illnesses. People who would have been hospitalized 40 years ago because of the degree to which mental illness has impaired their ability to function are now forced to seek services from an inappropriate, fragmented, and unwelcoming system of community-based care. Oftentimes when these individuals are unable access to services through traditional sources, their only options to receive treatment is by accessing care through the some of the most costly and inefficient points of entry into the healthcare delivery system including emergency rooms, acute crisis services, and ultimately the juvenile and criminal justice systems.

According to the National Alliance on Mental Illness, 40 percent of adults who experience serious mental illnesses will come into contact with the criminal justice system at some point in their lives. The vast majority of these individuals are charged with minor misdemeanor and low level felony offenses that are a direct result of their psychiatric illnesses. Roughly three-quarters of this population also meets criteria for a co-occurring substance use disorder, which complicates treatment needs.

Over the past 50 years, the number of psychiatric hospital beds nationwide has decreased by more than 90 percent, while the number of people with mental illnesses incarcerated in jails and prisons has grown by 400 percent. Today, it is estimated that there are nearly 14 times as many people with mental illnesses in jails and prisons in the United States as there are in all state psychiatric hospitals combined.

According to the most recent prevalence estimates, 16.9 percent of all jail detainees (14.5 percent of men and 31.0 percent of women) experience serious mental illnesses. Each year, roughly 2.2 million people experiencing serious mental illnesses requiring immediate treatment are arrested and booked into jails nationwide. On any given day, 500,000 people with mental illnesses are incarcerated in jails and prisons across the United States, and 850,000 people with mental illnesses are on probation or parole in the community. People with mental illnesses remain incarcerated 4-8 times longer than people without mental illnesses for the exact same charge, and at a cost 7 times higher.

Forensic Commitment

Individuals ordered into forensic commitment have historically been one of the fastest growing segments of the publicly funded mental health marketplace in Florida. Between 1999 and 2007, forensic commitments increased by 72 percent, including an unprecedented 16 percent increase between 2005 and 2006. In 2006, Florida experienced a constitutional crisis when demand for state hospital beds among people with mental illnesses involved in the justice system outpaced the number of beds in state treatment facilities. With an average waiting time for admission of three months, the Secretary of the Department of Children and Family Services (DCF) was found in contempt of court. The state was forced to allocate $16 million in emergency funding and $48 million in recurring annual funding to create 300 additional forensic

treatment beds. Florida currently spends more than $210 million annually – one third of all adult mental health dollars and two thirds of all state mental health hospital dollars – on 1,700 beds serving roughly 3,000 individuals under forensic commitment.

Nationally, it is estimated that $3.2 billion is spent annually for forensic competency restoration services. This figure, which is steadily growing, represents nearly one-third of all state hospital spending on what amounts to just a small fraction of individuals deemed to lack the capacity to participate in legal proceedings. Furthermore, because competency restoration has constitutional implications, it has become an entitlement program. As the number of people entering the justice system has exploded, the number of people entering the forensic treatment system has experienced similar growth. Rather than appropriating additional funding to keep up with this growth in demand, most states have simply shifted resources from the civil system to pay for the forensic system. The result has been fewer services available to those outside of the criminal justice system, which has consequently led to more justice system involvement.

State Prison Populations

People with mental illnesses also represent the fastest growing sub-population within Florida's prison system. Between 1996 and 2012, the overall inmate population in Florida prisons increased by 56 percent. By contrast, the number of inmates receiving ongoing mental health treatment in state prisons increased by 160 percent. Inmates experiencing moderate to severe mental illnesses increased by 178 percent. Based on historic growth rates, the number of beds serving inmates with mental illnesses is projected to nearly double in the next decade from nearly 18,000 to more than 32,000 beds. This represents an increase of 1,500 beds – enough to fill at least one prison – per year. Capital and operating costs for new mental health beds alone is

projected to reach nearly $2.5 billion in the next decade, with annual operating expenditures for mental health beds of nearly $750 million.

The total cost to house people with mental illnesses in Florida's prisons and forensic treatment facilities is approximately $625 million dollars annually, or $1.7 million per day. Another $400 million dollars annually, $1.1 million per day, is spent housing people with mental illnesses in local jails. Based on recent growth rates, if nothing changes state expenditures will increase by as much as a billion dollars annually over the next decade.

Impact of Failed Policy and Practice

There are three significant areas of policy and practice contributing to the disproportionate involvement of people with serious mental illnesses in justice system:

1) Limitations on financing of services using federal resources: Rules and regulations regarding federal financing and reimbursement for services provided to people with serious mental illnesses present challenges to designing effective and flexible service delivery. The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and Medicaid Services (CMS) are two agencies housed within the United States Department of Health and Human Services (DHHS). SAMHSA has identified numerous treatment modalities, such as intensive case management, psychosocial rehabilitation, supported employment, and supported housing, which consistently yield positive outcomes for people with serious mental illnesses. However, because they do not meet the CMS criteria for "medical necessity," entitlement programs such as Medicaid cannot be used to pay for such services. Similarly, restrictions on federal financial participation for services provided in "institutions for mental disease" mean that, in many instances, inpatient services are simply not covered regardless of established medical necessity.

2) Reliance on outdated civil commitment laws: Prior to the development of effective treatments for serious mental illnesses, there was general consensus that custodial confinement was the lesser of evils for people deemed to be in acute psychiatric distress. While the public had been aware of abuses and neglect that occurred in such facilities since the 1800s, the fact that there were no effective medications and few options for therapeutic intervention meant that there were often no viable alternatives for placement. As such, early approaches to civil commitment were based almost exclusively on the belief that it was the responsibility of the government to protect the broader community from people with mental illnesses who may be dangerous. In fact, the very first civil commitment law to be enacted in New York State in 1788 allowed for, "…any two or more justices of the peace to cause [a person with mental illness] to be apprehended and kept safely locked up in some secure place, and, if such justices shall find it necessary, to be there chained…"

Mental health laws predicated chiefly on dangerousness criteria to the relative neglect of need for treatment, mean that systems often have no choice but to release individuals known to be in acute distress back to the streets, often with no treatment at all. The irony is that if a hospital or healthcare professional were to discharge a person with an acute, non-psychiatric medical crisis, they could be accused of malpractice. However, when psychiatric treatment facilities engage in this behavior, most often because the imminent risk of harm has passed for the moment and/or insurance benefits will no longer pay for continued inpatient admission, they are simply following the law. This is a dangerous precedent and one which has resulted in unnecessary and harmful consequences.

3) Lack of standardized and systematic coordination of services and resources between the criminal justice system and the community mental health system: The justice system was

never intended to serve as the safety net for the public mental health system and is ill-equipped to do so. Jails and prisons across the United States have been forced to house an increasing number of individuals who are unable to access critically needed care in the community. In many cases, necessary linkages between the justice system and the community for individuals coming out of jails and prisons simply don't exist. As a result, individuals who may have been identified and received care while incarcerated are routinely released to the community with no reasonable plan or practical means for accessing follow-up services.

The failure to design and implement an appropriate and comprehensive continuum of community-based care for people who experience the most severe forms of mental illnesses have resulted in:

- Substantial and disproportionate cost shifts from considerably less expensive, front end services in the public mental health system to much more expensive, back-end services in the juvenile justice, criminal justice, and forensic mental health systems
- Compromised public safety
- Increased arrest, incarceration, and criminalization of people with mental illnesses
- Increased police shootings of people with mental illnesses
- Increased police injuries
- Increased rates of chronic homelessness

Promising Solutions

To effectively and efficiently address the most pressing needs currently facing the community mental health and criminal justice systems, it is essential that states and communities be given the resources and flexibility to invest in redesigned and transformed systems of care oriented around ensuring adequate access to appropriate prevention and treatment services in the

community, minimizing unnecessary involvement of people with mental illnesses in the criminal justice system, and developing collaborative cross-systems relationships that will facilitate continuous, integrated service delivery across all levels of care and treatment settings.

Policies and services must be adopted which prevent individuals from unnecessarily entering the justice system to begin with, and which respond to individuals who do become involved in the justice system quickly and effectively to link them to appropriate community-based services that will foster adaptive community living and decrease the likelihood of recidivism to the justice system. Fortunately, numerous programs have been developed that seek to establish collaborative relationships among stakeholders in the criminal justice and community mental health treatment systems, with the goal of facilitating enhanced linkages to community-based mental health and substance abuse treatment. Examples include crisis intervention teams, post-booking jail diversion programs and mental health courts, reentry programs that assist with linkages to treatment and support services, and community corrections programs that employ specially trained officers who apply problem-solving strategies to enhance compliance with terms of probation or parole (for an online database of collaborative criminal justice/mental health programs from across the United States, visit http://csgjusticecenter.org/reentry/local-programs-database/).

11th Judicial Circuit Criminal Mental Health Project

The Eleventh Judicial Circuit Criminal Mental Health Project (CMHP) was established in 2000 to divert individuals with serious mental illnesses or co-occurring SMI and substance use disorders, who do not pose significant public safety risks, away from the criminal justice system into community-based treatment and support services. The project operates two primary components: 1) pre-booking diversion consisting of Crisis Intervention Team (CIT) training

provided at no cost to all law enforcement agencies in the county and 2) post-booking diversion serving individuals arrested and charged with misdemeanor and less serious felonies. To date, the CMHP has provided CIT training to approximately 4,000 law enforcement officers from all 36 municipalities in Miami-Dade County, as well as Miami-Dade Public Schools and the Department of Corrections and Rehabilitation. Countywide, CIT officers respond to roughly 16,000 mental health crisis calls per year. In 2012, CIT officers from the Miami-Dade Police Department and City of Miami Police Department responded to nearly 10,000 mental health related calls, resulting in over 2,100 diversions to crisis units and just 27 arrests. As a result, the average daily census in the jail dropped from 7,800 to 5,000 inmates. The county was able to close one entire jail at a cost-savings to taxpayers of $12 million per year.

Post-booking jail diversion programs operated by the CMHP serve approximately 500 individuals with serious mental illnesses annually. Over the past decade, these programs have facilitated roughly 4,000 diversions of defendants with mental illnesses from the county jail into community-based treatment and support services. Recidivism rates among program participants charged with misdemeanors decreased from roughly 75 percent to 20 percent annually. Individuals charged with felony offenses have demonstrated reductions in jail bookings and jail days of more than 75 percent, with those who successfully complete the program having a recidivism rate of just 6 percent.

Judges Leadership Initiative

In 2004, the Judges' Leadership Initiative for Criminal Justice and Behavioral Health (JLI) was created. Led by an advisory board comprising judges from around the country, the organization includes representatives from the National Center for State Courts, the National Judicial College, Policy Research Associates, and the Council of State Governments Justice

Center. The organization brings judges from all levels of state judiciaries together to improve judicial understanding of, and responses to, individuals with mental illnesses in our nation's courts. The JLI's mission is to stimulate, support, and enhance efforts by judges to take leadership roles on criminal justice and behavioral health issues to improve judicial, community, and systemic responses to justice-involved people with behavioral health issues.

Since its establishment, the JLI has promoted improved understanding of the effective responses to defendants with mental illnesses through three benchbooks titled, the *Judges' Guide to Mental Health Jargon*, the *Judges' Guide to Mental Health Diversion Programs*, and the *Judges' Guide to Juvenile Mental Health Jargon*. It has also developed a benchcard, *Judges' Guide to Mental Illnesses in the Courtroom*, provided technical assistance to state supreme court chief justice-led planning efforts in 11 states, and embarked on a collaborative outreach effort with the Department of Veterans Affairs to address the mental health needs of criminal-justice involved individuals who have served in the military.

From 2010 to the present, the JLI has partnered with the American Psychiatric Foundation and a newly convened *Psychiatric Leadership Group for Criminal Justice* to develop a training program for judges on mental illnesses in the courtroom and a bench card listing observations and recommended responses for judges who believe mental illness may be affecting a defendant appearing in court. The module has been presented to enthusiastic judicial audiences in Illinois, Wisconsin, Oregon, and Utah, with 2014 trainings planned for Missouri and Texas. Pairs of judges and psychiatrists from around the country have been prepared to present the module.

Typical or Troubled?™ Program

Recently, the CMHP partnered with the American Psychiatric Foundation and Miami-Dade County Public Schools to implement the *Typical or Troubled?*™ School Mental Health Education Program for all public junior high and high schools in the Miami-Dade system. The program will train over 500 teachers, school psychologists, social workers and guidance counselors on early identification of potential mental health problems, will educate and engage parents and will ultimately link students with mental health services when needed.

Typical or Troubled?™ is an educational program that helps school personnel distinguish between typical teenage behavior and evidence of mental health warning signs that would warrant intervention. The program includes culturally sensitive technical assistance for school personnel on best practices and educational materials in English, Spanish and forthcoming in Haitian Creole. To date, the program has been used in over 500 schools and school districts, in urban, suburban and rural areas, and educated more than 40,000 teachers, coaches, administrators, and other school personnel across the country.

Leveraging Information Technology

People with serious and persistent mental illnesses who become involved in the criminal justice system demonstrate substantial disparities in rates of access to community-based mental health and primary care services. Patterns of service utilization tend to reveal disproportionate use of costly crisis and acute care services, with limited and inconsistent access to prevention and routine care. Traditionally, criminal justice/mental health responses targeting these individuals have been oriented around interventions that are provided only after an individual becomes involved in the justice system.

Recent developments in information technology have begun to explore whether advanced data analysis tools, such as predictive analytics, may be used to identify patterns of behavior and service utilization which precede crisis episodes. Doing so would represent substantial progress in the ability to administer services and supports proactively, and to developing more effective and targeted treatment protocols. Since 2012, Otsuka Pharmaceuticals, IBM, and the South Florida Behavioral Health Network have been working to develop such a system to enhance care coordination, reduce fragmentation in the system of care, ensure greater accountability, and identify warning signs of potential crises before they occur so that less costly prevention services can be administered. The system is designed to connect providers of mental health services including system leaders, payers, community mental health centers, hospitals, criminal justice systems, and social program organizations. It is expected to help create more comprehensive patient health records. Customized to meet the unique needs of each community that uses it, the focus across users will remain on improving the quality and efficiency of patient care.

The technology platform combines IBM software to coordinate care, and various data management tools with Otsuka's deep disease-specific subject matter expertise in mental health to improve the following:

- Utilization management, including eligibility, enrollment and consent
- Care coordination across clinical and social programs settings
- Insights into patient risk factors, crisis onset, crisis patterns, and costs
- Patient engagement in care management plan
- Organizational change management support

Conclusion

Research and practice have generated many creative and inspired problem-solving initiatives at the interface of the criminal justice and mental health arenas. By working collaboratively across systems and disciplines, a greater understanding of the causes and consequences of involvement in the justice system among people with serious mental illnesses has blossomed. We now know much more about what works and what does not work in the effort to address the problems associated with untreated mental illnesses and criminal justice system involvement.

Going forward, the ability to effectively design, implement, and fund high quality services targeting specialized treatment needs of people with mental illnesses involved in or at risk of becoming involved in the criminal justice system will require a collective commitment to re-evaluating some basic assumptions about the problems we are trying to solve. The current state of affairs in mental health policy and practice has led to a "perfect storm" of sorts. The gap between research and practice is substantial. There are many examples of high quality programs demonstrating "what works" in different communities and at different points in the criminal justice system. Yet one look at "treatment as usual" in many communities would suggest that our typical practice of mental health interventions in criminal justice settings has remained stagnant for decades.

As states and communities struggle with economic hardships, maintaining funding for existing services (let alone securing additional resources) is challenging. One reason for this is that many jurisdictions have become acquiescent to systems of care driven by disproportionate investment in costly, deep-end crisis service at the expense of more effective and sustainable prevention and community treatment. We need to reexamine the ways in which existing

resources are allocated to ensure that states and communities consistently purchase appropriate services that are likely to produce a favorable return on investment.

Technology permits the sharing of information around the world, yet organizations within local communities remain siloed. We need to implement information technology solutions that facilitate more efficient information sharing, and analyses that facilitate better community coordination and organization of the systems of care. We also need to reevaluate policies and laws surrounding mental health and provision of involuntary treatment services, particularly during times of crisis and early episodes of onset of illness. Responding more effectively and strategically in these situations is critical if we are to prevent chronic impairment, reduce demand for services in acute care and institutional settings, and promote recovery in the community.

The policies and laws that guide much of what we do today were an effort to correct the consequences of an abusive and coercive system of care. There is no argument that bad treatment, in bad hospitals, driven by bad policies, was bad for people, but the circumstances that exist today are much different, and our policies and laws should reflect the contemporary landscape of science and the community.