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New York State Unified Court System

Research

The Brooklyn Mental Health Court Evaluation

Planning, Implementation, Courtroom Dynamics, and Participant Outcomes

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Submitted to the New York State Office of Mental Health

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Executive Summary

The Brooklyn Mental Health Court began operations in March 2002 as a demonstration project in the Kings County Supreme Court in Brooklyn, New York. Through addressing the treatment needs of the individual and the public safety concerns of the community, the Brooklyn Mental Health Court's ultimate goal is to reduce recidivism and stop the "revolving door" of the mentally ill in and out of the criminal justice system. The Brooklyn Mental Health Court is a joint project of the New York State Unified Court System, New York State Office of Mental Health, and the Center for Court Innovation.

With funding from the New York State Office of Mental Health, the Center for Court Innovation conducted an evaluation covering the court's planning process, which began in 2001, and its first twenty-eight months of operations (March 2002 – June 2004). The evaluation assesses the planning process; describes key features of the court's model; and presents data on courtroom dynamics, team communication patterns, and participant characteristics, outcomes, and perceptions. Major findings are summarized below:

I. Planning

The planners of the Brooklyn Mental Health Court were successful in reaching out to the criminal justice, mental health, and substance abuse treatment communities. The extensive history of problem-solving courts in Brooklyn resulted in a culture open to innovation and accepting of the mental health court experiment. Local stakeholders generally welcomed the opportunity to open the first mental health court in New York State.

During the planning process (April 2001 – March 2002), stakeholders wrestled with several challenging issues: mental health and criminal justice eligibility, managing risk/public safety, and safeguarding defendants against undue coercion to participate.

- *Mental health eligibility:* It was decided that eligible defendants must have a "serious and persistent mental illness" for which there is a known treatment – schizophrenia, bipolar disorder, major depression, and schizoaffective disorder. The implication of using this criteria was that many fewer defendants would be clinically eligible than if the court was open to all mental health disorders, including personality disorders, mental retardation/developmental disabilities, or traumatic brain injury.

- *Criminal justice eligibility:* The majority of mental health courts already in existence nationally were accepting misdemeanor offenders only. The Brooklyn Mental Health Court decided to open its doors to felony offenders instead for two reasons. First, the local stakeholders in Brooklyn were experienced in working with felony-level problem-solving courts. (The Brooklyn Treatment Court and Brooklyn Domestic Violence Court opened in 1996.) Second, stakeholders agreed that a defendant's involvement in the Brooklyn Mental Health Court should not exceed the sentence that would have been imposed under conventional case processing. Given that misdemeanor offenders in New York City were generally sentenced to very little jail time, the Brooklyn Mental Health Court was deemed more appropriate for felony offenders and "chronic" misdemeanor offenders.

- *Public Safety / Managing Risk:* Public safety was a concern of all stakeholders, particularly the judge and the District Attorney's Office. The Brooklyn Mental Health Court sought to address this concern by requiring a thorough psychiatric assessment prior to determining clinical eligibility and creating individualized treatment plans. In addition, judge and prosecutor were granted the right to unilaterally reject any referral.

- *Coercion:* Many stakeholders, the defense bar and mental health advocates in particular, expressed concern about the role of coercion in regards to a defendant's ability to comprehend the consequences of taking a plea and of the court's medication requirements. The Brooklyn Mental Health Court attempted to address these concerns by producing a series of public documents intended to clearly outline participants' responsibilities and to make the court's policies and procedures transparent. These included a list of possible sanctions/clinical responses and rewards, a participant contract and formal participation guidelines.

II. Implementation

The implementation process demonstrated that the project was successful in meeting its goals of improving the court system's ability to identify, assess, and evaluate defendants with mental illness; linking these offenders with appropriate mental health treatment; and holding participants accountable for their actions.

The Brooklyn Mental Health Court established procedures for referral, clinical assessment, court mandates, and judicial monitoring. At the same time, it was widely understood that the court would make individualized determinations in all of these areas. Even when it comes to determining when a participant is ready to graduate, the judge said he needed to review each participant on a case-by-case basis: "If I didn't look at the individual then I wouldn't be doing my job."

The Brooklyn Mental Health Court faced challenging issues during implementation:

- *Referral process:* Since there is no universal screening process for defendants with mental illness in Brooklyn, identifying eligible referrals was difficult. Referring a case to the Brooklyn Mental Health Court required a lengthy review by the assigned Assistant District Attorney, often lasting several weeks. For those unfamiliar with the Brooklyn Mental Health Court, the referral process was unclear and confusing.

- *Volume:* Volume was lower than the originally anticipated 100 new participants per year – 106 participants had enrolled after 28 months of operations. Toward the end of the evaluation period, the Brooklyn Mental Health Court was on track to enroll 60 new participants per year. Despite this increase, since there is no system-wide process for screening offenders with mental illness in Brooklyn, and it is unknown to what extent the Brooklyn Mental Health Court could increase its volume through improved identification and referral procedures.

- *Charges:* The court opened with official criminal justice eligibility limited to non-violent felony charges. Nonetheless, approximately 40 percent of each quarter's referrals were *violent* felony offenders. As the court grew in experience and size, the stakeholders expanded from non-violent felony charges to include violent felony charges on a case-by-case basis. As of June 2004, 39 percent of all enrolled participants were violent offenders.

- *Community-based services:* A primary challenge was ensuring that participants were placed in the most appropriate and effective services available. The Brooklyn Mental Health Court faced severe limitations in local treatment and housing capacity – limited availability of supportive housing, Assertive Community Treatment (multi-disciplinary team providing case management to individuals), and integrated services for co-occurring substance abuse and mental health disorders. This contributed to a statistically significant difference in the average number of days from first court appearance in the Brooklyn Mental Health Court to placement—58 days to placement for those returning to community-based pre-arrest housing compared with 116 days for those participants who needed to be placed in a residential setting.

- *Communication:* Team members completed a communications survey designed capture the patterns of communication within the Brooklyn Mental Health Court. An overwhelming majority (72 percent) reported being "very satisfied" with the quality of communication. A diagram depicting communication patterns demonstrated that much of the communication centered around key individuals, such as the clinical director, who was then responsible for sharing her knowledge with others through one-on-one interactions. These patterns of communication are reliant on the relationships and implicit trust among staff members rather than a set, institutionalized schedule of meetings.

III. Volume

The Brooklyn Mental Health Court received a total of 262 referrals during the implementation period of March 2002 - June 2004 (28 months). Defense attorneys accounted for the largest percentage of referrals (44%), and cases calendared after competency proceedings made up the second largest referral source (30%). Other referral sources included the District Attorney (10%); other problem-solving courts (5%); other judges (10%); and other (1%). Of those referred, 106 defendants (40%) enrolled as participants for a rate of 45 new participants per year.

Extending the analysis an additional two years through June 2006, the Brooklyn Mental Health Court received a total of 576 referrals of which 262 enrolled as participants. Over this more recent two-year period , court enrollment grew to a rate of 78 new participants per year.

IV. Treatment Mandates and Judicial Monitoring

In order to participate, first-time felony offenders must agree to a treatment mandate of 12-18 months, predicate felony offenders (with at least one prior felony conviction) to a mandate of 18-24 months, and misdemeanor offenders to a mandate of 12 months.

The terms “reward” and “sanction/clinical response” were purposely never defined in court documents since the team believed that the same court response may be viewed as a “sanction” for one participant and a “clinical response” for another. There was a loose understanding that a reward would be used to acknowledge a participant’s compliance; a sanction would be implemented as a punishment or consequence for non-compliance; and a clinical response would be a modification in treatment services or a treatment plan but not with punishment as the goal.

V. Courtroom Experience

Structured court observation showed that direct conversational interaction between the judge and Brooklyn Mental Health Court participants was a very common occurrence. Overall, the judge engaged in direct conversation and eye contact in 96 percent of the observed court appearances. He asked probing questions to participants in 64 percent of the appearances. Also, 63 percent of the appearances included an invitation to approach the bench. Of those, the judge shook hands or touched the hand of participants 46 percent of the time.

VI. Participant Perceptions

Participants enrolled prior to June 2003 were asked to participate in an interview at their one-year anniversary date: 31 of 37 agreed to be interviewed. Participants were asked to complete a coercion scale that measured four items: influence, control, choice, and freedom (Poythress, Petrila, McGaha & Boothroyd 2002). The scores ranged from 0 to 4.53 on the scale and the mean score was .84 (standard deviation 1.29). The low score indicates that participants perceived themselves to have a high level of independent decision-making, control, choice, and freedom. In short, the results indicated that participants did not feel coerced into the Brooklyn Mental Health Court (or at least did not feel coerced when remembering events).

Participants also completed a scale of perceived procedural justice (Poythress, Petrila, McGaha & Boothroyd 2002). The instrument consists of five items that measured the participant’s subjective experience of case processing. For all five items, the results indicated very high levels of satisfaction, with scores ranging from 6.22 to 6.96 on a 1 to 7 scale (where higher values indicating more positive perceptions).

VII. Participant Profile

The 106 participants enrolled by June 30, 2004 were mostly black/African-American, male, and single, with poor education and work histories. A total of 70% had been hospitalized for psychiatric reasons at least once in their lives; however only 30% were in treatment at the time of the arrest. Fifteen percent of participants were homeless at some time in the year preceding arrest.

Participants were about equally likely to be diagnosed with bipolar disorder (28%), major depression (25%), and schizophrenia, (26%) which together accounted for four-fifths of all diagnoses. Just under half of all participants were also diagnosed with co-occurring mental illness and substance abuse disorders.

VIII. Outcomes

The outcome evaluation examined results for the 37 participants enrolled as of June 30, 2003. The data compares the first 12 months as a participant to the 12 months preceding entry or the 12 months preceding arrest for those incarcerated at time of intake. Outcome measures were homelessness, substance abuse, hospitalizations, recidivism, psychosocial functioning, and service utilization. Overall, the participants demonstrated considerable improvements in all of these areas, suggesting that additional research with a comparison group would find that the Brooklyn Mental Health Court positively impacts these outcomes (see exhibit below).

- *Recidivism:* In addition to the Brooklyn Mental Health Court qualifying arrest, 27% of participants had been arrested at least once in the 12 months prior to enrollment. During the first 12 months of Brooklyn Mental Health Court participation, a total of six participants (16%) committed a new offense. While suggestive, this difference is statistically non-significant.

- *Homelessness:* A total of 16% of participants were homeless in the 12 months preceding enrollment compared to 11% during their first 12 months of enrollment. The average number of days homeless similarly declined (from 60 to 35 days), although none of these differences were significant statistically.

Outcome Measures

	Intake # %	Follow-Up # %
Recidivism	27%	16%
Homelessness		
Homelessness in past 12 months	16%	11%
Number of Days Homeless (median)	60	35
Hospitalizations		
Psychiatric hospitalizations in the past 12 months	50%	19%**
Number of psychiatric hospitalizations in the past 12 months[1]	.58	.27
Psychiatric emergency room visits in the past 12 months	44%	25%+
Frequency of Alcohol Use and Current Level		
Not at all in the past 6 months (frequency)	0.19	0.56**
Abstinent (current level)	0.38	0.82***
Frequency Substance Use and Current Level		
Not at all in the past 6 months (frequency)	0.15	0.61***
Abstinent (current level)	0.30	0.90***

[1]Includes only those who were hospitalized for psychiatric reasons during the first 12 months of participation
+p<.10, *p<.05, **p<.01, ***p<.001

- *Substance Abuse:* Participants showed dramatic decreases in drug and alcohol use. A significantly higher percentage of participants were reportedly abstinent at follow-up than at intake.

- *Psychiatric hospitalizations:* There are many possible reasons for psychiatric hospitalizations – not all of them with negative connotations. However, a decrease in the percentage of participants hospitalized can be viewed positively as an indicator that participants were actively engaged in treatment. There was a significant decrease—50 percent to 19 percent – in the percentage of participants hospitalized in the first 12 months in the Brooklyn Mental Health Court versus the 12 months preceding enrollment.

- *Psychosocial Functioning:* Clinical staff completed the Health of the Nation Outcome Scale (HoNOS) at intake and 12-month follow-up (The Royal College of Psychiatrists' Research Unit, 2002). The HoNOS is comprised of 12 scales that measure a wide range of health and social domains (psychiatric symptoms, physical health, functioning, relationships, and housing). Each scale is scored from 0 (no problem) to 4 (severe to very severe problem). Participants improved their functioning on nearly every scale. Participants showed statistically significant improvement on the scales measuring problems with cognition, depressed moods, living conditions, and occupations and activities.

VIII. Conclusion

During the first 28 months of operations, the Brooklyn Mental Health Court achieved its implementation goals of improving the court system's ability to identify, assess, and monitor offenders with mental illness; and using the authority of the court to link offenders with mental illness to appropriate mental health treatment services. Brooklyn Mental Health Court stakeholders and team members met several challenges and managed to overcome them with creativity and diligence.

Significant ongoing barriers include limitations in the local mental health treatment and housing capacity; reliance on an informal referral process to the Brooklyn Mental Health Court; communications dependant on inter-personal relationships rather than institutionalized meetings; and purposely vague policies on sanctions, rewards and clinical sanctions. As the court grows in size, stakeholders may find it helpful to address these issues.

Participants included in the outcome evaluation showed significant improvements in several outcome measures and a tendency toward improvement in nearly all other measures, even when the effect sizes were not statistically significant. The measures under examination went beyond traditional criminal justice indicators, including criminal recidivism as well as homelessness, substance use, hospitalizations, and psychosocial functioning. Future research may expand upon these results and provide more insight regarding whether how—and for whom—mental health courts work.

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Data for this report was gathered from the Brooklyn Mental Health Court database, the Domestic Violence Application, and the New York State Unified Court System.

Opinions expressed in this report are those of the author and do not necessarily represent the official position of the New York State Office of Mental Health. For all correspondence, please contact Kelly O'Keefe, Center for Court Innovation, 520 8th Avenue, 18th Floor, New York, NY 10018, kmokeefe@courts.state.ny.us.

List of Exhibits

CHAPTER I
INTRODUCTION

This report presents a process and outcome evaluation of the Brooklyn Mental Health Court (BMHC) during its first twenty-eight months of operations, March 2002 – June 2004. The report documents the planning and implementation process and provides a blueprint for other jurisdictions considering mental health courts. The outcome evaluation highlights key participant outcomes (program retention, recidivism, psychosocial functioning, and housing stability) and areas for future research. The evaluation is based on interviews with stakeholders, attendance at clinical team meetings, structured court observation, participant interviews and analysis of quantitative data.

The BMHC began operations in March 2002 as a demonstration project in the Brooklyn (Kings County) Supreme Court. The overarching goal of the BMHC is to reduce recidivism through engagement in appropriate treatment services and to stop the "revolving door" of the mentally ill in and out of the criminal justice system. The BMHC is a joint project of the New York State Unified Court System, the New York State Office of Mental Health, and the Center for Court Innovation.

I. Program Summary

The mission of the BMHC is to address the both the treatment needs of defendants with mental illness and the public safety concerns of the community by linking defendants with mental illness to treatment as an alternative to incarceration. Defendants who are seriously and persistently mentally ill and have committed a misdemeanor or felony, usually non-violent, are eligible for the court. First-time felony offenders are mandated to 12-18 months in treatment, predicate felony offenders (who have a previous felony conviction) to 18-24 months, and misdemeanor offenders to 12 months. Eligible defendants plead guilty at the outset of participation and are monitored regularly by the BMHC judge and dedicated clinical team while under court mandate. Upon graduation, all charges are dismissed for misdemeanor and first-time non-violent felony offenders; charges for violent first-time felony offenders (who are admitted on a case-by-case basis) and predicate felony offenders are reduced to a misdemeanor. In addition, graduating violent offenders receive probation. Participants who are unsuccessful are terminated and sentenced to jail or prison.

II. Problem-Solving Courts

The BMHC incorporates features common to "problem-solving courts" in New York State and nationwide. Problem-solving courts seek to improve the outcomes for victims, communities, and defendants (Berman and Feinblatt 2005). In the past ten years, jurisdictions have developed thousands of problem-solving courts to find solutions to difficult issues such as addiction, domestic violence, child neglect, and quality-of-life crime. These problem-solving courts include specialized drug courts, domestic violence courts, community courts, and family treatment courts. While each of these courts targets a different issue and population, most share common elements: problem-solving focus, a team approach to decision-making, integration of social services, judicial supervision of the treatment process, community outreach, judicial monitoring, and improved case outcomes for victims and defendants.

Planners of the BMHC were aware of the earlier problem-solving court models, such as drug courts, and incorporated problem-solving court elements into the BMHC's goals, objectives, and implementation strategies. These elements will be discussed throughout the report when appropriate.

III. Emergence of Mental Health Courts

A. The National Perspective

The emergence of mental health courts in the U.S. has been a response to what many judges, prosecutors, attorneys and providers know from experience - people with mental illness have not fared well under traditional case processing, and the result has been a "revolving door" between the criminal justice system and the community (Denkla and Berman 2001). Indeed, research shows that persons with mental illness are significantly over-represented in jails and prisons. Approximately five percent of the U.S. population has a serious mental illness. The U.S. Department of Justice reports a much higher figure (16 percent) of the population in jail or prison has a mental illness (Ditton 1999). The average length of stay in New York City jails for a person with mental illness is 215 days, compared to a 42-day average for all inmates (Council of State Governments 2005).

In response, mental health courts began appearing in 1997 and by the end of the 1990's there were eight well-established courts (Goldkamp and Irons-Guynn 2000; and Griffin, Steadman, and Petrila 2002). The first mental health courts demonstrated considerable diversity, but over the years, a definition emerged. Steadman, Davidson, and Brown (2001) defined mental health courts as those that 1) are criminal courts, 2) have separate dockets exclusive to persons with mental illness, 3) divert defendants from jail and/or prison into community-based mental health treatment, and 4) judicially monitor mental health treatment and potentially impose sanctions for non-compliance. Approximately 100 mental health courts that meet the above definition emerged in the U.S. as of February 2005 (The Mental Health Court Survey 2006).

In 2000, Congress passed America's Law Enforcement and Mental Health Project Act, which resulted in the Mental Health Grant Program. The Mental Health Grant Program provided grants to 23 courts in 2002 and 14 courts in 2003 through the Bureau of Justice Assistance. (There was no such funding provided in 2004 or 2005.) The U.S. Department of Justice's Council of State Governments has received a grant to provide technical assistance to the 2002 and 2003 grantees. In addition to the federal government's funding, national organizations such as the National GAINS Center, the Council on State Governments, the National Alliance for the Mentally Ill, the Bazelon Center and a host of other state and local organizations have had conferences, published papers and generally facilitated a healthy exchange of information on mental health courts.

B. New York State

Under the leadership of Chief Judge Judith S. Kaye, there are five mental health courts in New York: BMHC, Bronx TASC Mental Health Court Diversion Services, Buffalo City Mental Health Court, Monroe County Mental Health Court, and Niagara Falls Mental Health Court. These courts share common goals and elements. Common goals include improving public safety; reducing the length of confinement of offenders with mental illness; improving the court's ability to identify, assess and monitor offenders with mental illness; improving the quality of life for people with mental illness; and achieving cost savings for the criminal justice system. The courts

have different operational models, but share universal elements based on the problem-solving court model such as developing mechanisms to assess and identify potential participants, providing adequate clinical information to facilitate informed decision-making, using the court's authority to reinforce treatment goals, and linking participants to services in the community. The courts differ on their specific clinical and criminal justice eligibility criteria, funding, staffing, and structure.

In addition to these court-sponsored initiatives, Brooklyn is also the home of Treatment Alternatives for the Dually Diagnosed (TADD),[1] which is an alternative to incarceration program established in 1998 by the Brooklyn District Attorney's office. The program is designed for non-violent felony and misdemeanor offenders with co-occurring mental illness and substance abuse disorders.

C. Overview of the Evaluation Literature

Despite their rapid growth, meaningful evaluations are just beginning to emerge, leaving the field with little empirical evidence to determine if these innovative courts work and what kind of outcomes should be expected. An evaluation of the Broward County mental health court found that the percentage of participants engaged in treatment increased from 36 percent in the eight months prior to first mental health court appearance to 53 percent during the eight months following that appearance; whereas a "comparison group" undergoing regular case processing did not show any change between equivalent periods (29 percent to 28 percent). All research subjects faced misdemeanor charges (Boothroyd, Poythress, McGaha, and Petrila 2003).

An evaluation of the Kings County, Washington mental health court found that participants had lower recidivism rates during a post- compared with a pre-enrollment period – although it is not tested how this change might have compared with similar defendants not enrolled in the mental health court (Trupin and Richards 2003). This same evaluation looked at a second Seattle municipal mental health court program and found that the number of days spent in jail decreased during a post-enrollment period, whereas it increased over an equivalent period for a comparison group that was referred to the mental health court but opted not to participate. As in Broward County, these defendants also faced misdemeanor charges only.

Of particular interest due to its strong research design, an evaluation of the mental health court in Santa Barbara, California randomly assigned 235 defendants to either the mental health court or to standard case processing and tracked outcomes over a two year follow-up period (Cosden, Ellens, Schneell, and Yamini-Diouf 2005). The study found that a majority of the defendants in both study groups spent less time in jail and showed improved psychosocial functioning when comparing to post- with pre-enrollment periods of time. Improvements in psychosocial functioning and quality of life measures were somewhat greater for mental health court participants, although none of these differences were statistically significant. Of note, many

[1]During the evaluation period, the BMHC required that defendants be diagnosed with serious and persistent mental illness whereas TADD accepted defendants diagnosed with other mental health disorders (such as anxiety disorders and personality disorders) as well. TADD's population had a higher percentage of defendants with co-occurring substance abuse disorders than the BMHC's population. Also, BMHC's program structure required more frequent court appearances before the judge than TADD.

defendants in the comparison group received intensive mental health services through normal case processing options available through the Santa Barbara court; therefore, although the study comprised a strong randomized trial, those randomly assigned to the comparison group did not truly provide for a sharply differentiated "no treatment" comparison.

Another randomized trial was conducted in Butte County, California. There defendants were randomly assigned to either an Enhanced Treatment (ET) or Treatment-as-Usual (TAU) group. A main component of the ET group was a mental health court. Results showed lower rates of recidivism for the 50 ET participants compared to the 43 TAU participants. Also, ET participants demonstrated statistically significant increases in participant functioning and symptomatology (Bess 2004).

Finally, a study of the Clark County mental health court in Vancouver, Washington showed reduced recidivism among mental health court participants post- compared with pre-enrollment, although questions about the validity of this study stem from the lack of a non-mental health court comparison group (Herinckx, Swart, Ama, Dolezal, and King 2005).

In sum, the evaluation literature has produced a small number of studies, some with promising results, but many with methodological or other limitations to their validity and their potential to produce generally applicable findings. For instance, many of the available evaluations focus on courts treating misdemeanor offenders, while the current "second generation" of mental health courts focuses more on offenders facing more serious felony charges (Redlich, Steadman, Monahan, Petrila, and Griffin 2005). This evaluation contributes by turning to a program primarily for felony offenders and examining both its process and outcomes.

Report Organization

Chapter I: Includes an introduction to the BMHC, an introduction to problem-solving courts, and an overview of the growth of mental health courts across the country and in New York State.

Chapter II: Documents the planning of the BMHC from the exploratory research phase through the planning process.

Chapter III: Describes the implementation of the BMHC from March 2002 – June 2004 including referral, assessment, eligible charges, and participation process.

Chapter IV: Presents and analyzes data from structured court observations

Chapter V: Presents and analyzes data from interviews with participants, including measurement of perceived procedural justice and perceived coercion.

Chapter VI*:* Analyzes communication among BMHC team members and discusses communication between BMHC team members and community providers.

Chapter VII: Describes the background characteristics of the BMHC participants and provides outcome data on the first 37 participants.

Chapter VIII: Conclusions

CHAPTER II
PLANNING

This chapter documents the planning of the BMHC from the exploratory research phase through the planning process.

I. Brooklyn Mental Health Court Goals

The BMHC was conceived as a demonstration project, intended to act as a model to be replicated by other jurisdictions if proven successful. Keeping this in mind, the planners created goals for the court at the beginning of the planning process. The goals reflected the larger problem-solving court movement and were tailored to serve defendants with mental illness:

- Improve the court system's ability to identify, assess, evaluate and monitor offenders with mental illness;
- Use the authority of the court to:
  - Link offenders with mental illness to appropriate mental health treatment services and supports;
  - Ensure that participants receive high quality community-based services;
  - Engage participants in treatment; and
  - Hold participants accountable for their actions;
- Create better understanding and effective linkages between the criminal justice and the mental health systems; and
- Improve public safety by reducing the recidivism of offenders with mental illness.

The goals listed above were useful in articulating the purpose of the court to partner agencies, stakeholders, community-based providers, and participants. The BMHC had two additional goals listed on internal documents:

- Create a replicable model of a mental health court that can be adapted by other jurisdictions to meet local needs;
- In local and national arenas, make a major contribution to the national conversation in mental health courts.

These internal goals are notable because they guided the court from planning through implementation. However, the external and internal goals did not establish specific measurable objectives by which the program could quantify impact and change. After approximately one year of implementation, program staff developed measurable objectives for some of the goals, specifically for the case processing timeline and number of referrals. These measurable objectives were helpful to the project director and could have been more beneficial to the court if they had been developed for each goal and been more widely disseminated.

> ***Recommendation:***
> The project planners developed goals during the pilot phase. The goals highlight, in broad strokes, the scope of the court. Now that the court has been open for several years, the project director and other stakeholders should revise the goals to more precisely articulate the court's focus and should set measurable objectives for each. Measurable objectives will aid the court in quantifying its success and monitoring its progress.

II. Planning

Brooklyn (Kings County) was an obvious choice when selecting a jurisdiction to model the first mental health court in New York State. Thanks to the leadership of New York State Chief Judge Judith S. Kaye, Brooklyn is home to the country's first felony level domestic violence court. The Brooklyn Treatment Court was the first drug court in New York City and one of a handful of felony level treatment courts in the nation when it began in 1996. The Red Hook (Brooklyn) Community Justice Center is the nation's first multi-jurisdictional community court that seeks to solve neighborhood problems like drugs, crime, domestic violence and landlord-tenant disputes.

A key element to the innovative climate in Brooklyn is the District Attorney, Charles J. Hynes, who has supported alternative to incarnation programs for defendants since 1990, when he started the first prosecution-run program in the country to divert prison-bound felony offenders to residential drug treatment. In 1998, the District Attorney's Office also launched Treatment Alternatives for Dually Diagnosed Defendants, an alternative to incarceration program for felony and misdemeanor offenders with co-occurring mental illness and substance abuse disorders.

The history of problem-solving courts in Brooklyn resulted in a culture open to innovation and accepting of the mental health court experiment. Many local stakeholders (judges, prosecutors, defense attorneys and other court staff) had extensive experience planning and implementing problem-solving courts in the past. These stakeholders welcomed the opportunity to open the first mental health court in New York State.

A. Timeline and Key Events

The official planning of the BMHC took place from April of 2001 – March 2002, and key benchmarks are highlighted in the timeline (Exhibit 1). The seeds of the court were planted earlier with a year-long study undertaken by the Center for Court Innovation with funding by the State Justice Institute, which resulted in a white paper examining the challenges posed to the courts by offenders with mental illness, current court-based models serving the mentally ill, and areas of concern regarding mental health courts (Denkla & Berman, 2001). This report provided a framework for the planning team and outlined issues to be addressed in greater detail.

In April 2001 the project director was hired and planning started in earnest. That spring, the project director reached out to various stakeholders in the criminal justice and mental health fields to explain the goals of the proposed mental health court, discuss obstacles and issues, and garner support. Stakeholders included but were not limited to the Kings County District Attorney's Office, New York State Office of Mental Health, New York City Department of Health and Mental Hygiene, mental health advocacy organizations, and agencies providing indigent criminal defense services in Brooklyn. Overall, the project director opted for meeting with stakeholders one-on-one or "shuttle diplomacy" for the majority of the planning process, rather than establishing a formal steering committee or planning committee structure. Two sets of larger planning meetings did take place from the spring of 2001 through the spring of 2002. The project director and representatives from the Office of Court Administration met monthly with the New York State Office of Mental Health and New York City Department of Health and Mental Health to discuss eligibility criteria, service utilization, and access to housing. A committee created to address the legal issues facing the BMHC convened a total of five times, two of which were training sessions on mental health.

Exhibit 1
Planning Timeline

2001	
April	Project director hired
April - December	Project director conducts individual outreach with stakeholders
June	Publication of "Rethinking the Revolving Door: A Look at Mental Health Courts"
July - December	Project director convenes group meetings with stakeholders
July – August	Clinical eligibility determined collaboratively between BMHC project director and OMH
July	Honorable Matthew D'Emic designated as BMHC judge
August	Cross-training on mental illness conducted for criminal justice stakeholders
2002	
January	Clinical director hired
January-May	Clinical director and project director conduct outreach targeted to community providers in Brooklyn and New York City to address the issues of housing, case management, substance abuse treatment and mental health treatment
February	Criminal justice eligibility and program mandate details established
March	First referral to the BMHC as part of pilot phase

In interviews at the beginning of the pilot phase and at the completion of the two-year evaluation period, most stakeholders were pleased with the planning process. However, some key stakeholders expressed interest in meeting more often as a group, and one said that "individual meetings left me feeling out of the loop." Another stakeholder said, "I didn't know what was happening until the court opened. I didn't contribute to the planning... I was just informed." However, the great majority of the stakeholders acknowledged feeling well-informed and regularly updated about the planning process. One stakeholder commented, "I think we got more done [in individual meetings] than at these general meetings when people like to talk and get off subject." One reason that shuttle diplomacy may have worked well is because key stakeholders in Brooklyn had extensive experience with problem-solving courts and were wrapping up a lengthy planning process for a misdemeanor domestic violence court. They shared a common knowledge of problem-solving courts and professional relationships, which allowed them to communicate with the project director individually and not feel marginalized if large meetings were not the norm.

Many stakeholders welcomed the appointment of the Honorable Matthew D'Emic as the BMHC judge in the summer of 2001. In interviews, many stakeholders praised the judge's experience with the Brooklyn Felony Domestic Violence Court, his reputation for fairness to all parties, and his overall demeanor. For his part, the judge said that he welcomed the challenge brought by the mental health court and looked forward to "ensuring that society receives its due and making

people (defendants) as productive as they can possibly be." He described the court as a "win, win" situation.

In January 2002, the BMHC hired a clinical director. For the next few months, the clinical director and project director spent the majority of their time reaching out to mental health and substance abuse providers in Brooklyn and other boroughs to introduce the BMHC and forge partnerships. In interviews, the providers stated that they were impressed that the court had been proactive and arranged introductory meetings prior to sending referrals. Those interviewed expressed that these court-initiated meetings demonstrated that their community-based work was valued and respected by the court. Senior staff at community-based providers stated that their organizations were looking forward to working with BMHC participants.

The BMHC secured early funding from various sources. The New York State Office of Mental Health provided significant funding each year to support core operations plus additional funds for the process and outcome evaluation. BMHC also received funding during the planning and start-up phase from New York City's block grant for TANF (Temporary Assistance for Needy Families) and from three private foundations: the New York Community Trust, the United Hospital Fund and the Ittleson Foundation. The New York State Unified Court System (UCS) provided standard courtroom resources initially (judge, clerk, court officers, court attorney) plus a part-time resource coordinator who was already serving in the domestic violence part. After one year of operations, the BMHC received a grant from the United States Department of Justice, Bureau of Justice Assistance Mental Health Courts Grant Program. Upon the expiration of the TANF grant in March 2004, UCS assumed funding responsibility for all positions previously supported by the TANF grant.

B. Key Issues of the Planning Process

The project director and key stakeholders involved in the planning process agreed on the over-arching goals presented in the beginning of this chapter. However, fundamental eligibility issues needed to be addressed to determine the scope of the mental health court and its target population (Fisler 2005).

- *Eligibility Criteria*

  Mental Health Eligibility:
  Mental health courts throughout the nation require that defendants be diagnosed with a mental illness, but defining "mental illness" is problematic. In line with the definition used for state mental health services, it was decided that eligible defendants must have a "serious and persistent mental illness" for which there is a known treatment: schizophrenia, bipolar disorder, major depression or schizoaffective disorder. The implication of using this criteria was that many fewer defendants would be eligible than if the court was open to all mental health disorders, such as those diagnosed with personality disorders, mental retardation/developmental disabilities, or traumatic brain injury.

  Criminal Justice Eligibility:
  At the time the BMHC was in the planning and early implementation stage, the majority of the mental health courts in existence were accepting misdemeanor offenders only. Through

individual meetings with defense attorneys, the District Attorney's Office, the judge and officials from the New York State Office of Court Administration, a plan emerged that the court would start with non-violent felony cases and consider chronic misdemeanor cases once the court was well-established. The reasoning is outlined below.

Past Experience: Stakeholders were comfortable with the idea of the BMHC accepting felony-level defendants through their experiences with other felony-level problem-solving courts in Brooklyn. Mental health clinicians and advocates said that engaging defendants in long-term treatment and judicial court monitoring had benefits that would not be seen with misdemeanor defendants who rarely faced long jail sentences.

Proportionality: Stakeholders agreed that a defendant's involvement in the BMHC should not be longer than the sentence that would have been received under regular case processing. Given that misdemeanor offenders in New York City spend very little time in jail, the BMHC was more appropriate for felony and specific, chronic misdemeanor defendants.

Logistics: Creating and implementing individualized treatment plans can take a great deal of time. Many misdemeanor defendants could be expected to receive a "time served" sentence before an assessment and community-based placement could even be completed.

- *Public Safety / Managing Risk*
  The judge and the District Attorney's Office put public safety at the top of their list of priorities when planning the mental health court. In the beginning, the District Attorney's office wanted to see significant numbers of defendants placed in restricted housing similar to residential or inpatient therapeutic communities for substance abusers. Restrictive housing as envisioned by the Brooklyn District Attorney's office proved unrealistic due to a general shortage of supportive housing in New York City and because restrictive housing is often in conflict with the mental health system's mission to promote independent living. A compromise was agreed upon so that the District Attorney's office would have ultimate veto power over the terms of each treatment plan.

  Another outstanding public safety issue revolved around managing risk and predicting violent behavior. Stakeholders discussed how to assess an offender's risk of violence and ability to function in the community. Standardized instruments are available and used widely by mental health professionals and in some mental health courts. The stakeholders determined that a thorough clinical assessment conducted by a clinical social worker and psychiatrist, individualized treatment plans, and the discretion for unilateral rejection of a referral by the BMHC judge or the prosecutor would all contribute to ensuring public safety.

- *Coercion*
  The defense bar and some mental health advocates expressed concern regarding coercion in the court. Would defendants take a plea they didn't really understand? Would participants be forced to take medication? Would mental health providers be forced to jeopardize their

relationships with their clients through reporting regularly to the court? What types of sanctions could be used?

The defense bar expressed the need to be able to explain sanctions/clinical responses and rewards to clients. Since sanction/clinical responses and rewards had not been widely used in existing mental heath courts but had been used extensively in drug courts, the project director collaborated with the District Attorney's Office, the judge, mental health providers and other stakeholders to develop a list of possible sanctions/clinical responses and rewards. The project director also created BMHC program participation guidelines and the BMHC contract, both of which were to be reviewed by the defense attorney and defendant prior to taking the plea (Appendix A). The BMHC program participation guidelines explained the program, expectations, and sanctions/clinical responses and rewards, and contained provider contact information. The BMHC contract outlined the rights and responsibilities of the defendant and the judge and was signed by the judge and defendant at time of plea. Finally, the BMHC developed consent forms, which the defendant would sign to enable the court staff and mental health providers to share information. The court also developed memorandums of understanding (MOU) to be completed by the court and participating community partners. The MOUs articulated the responsibilities of both parties and were discussed and signed when the community partner accepted its first BMHC participant.

The New York State Mental Hygiene Legal Services (MHLS) and other stakeholders voiced concern regarding the participant's right to refuse medication. MHLS feared that treatment providers would use the mental health court to coerce participants into taking medication rather than seeking a civil court order to medicate over the participant's objection. In response, the BMHC addressed the issue of medication compliance in its program participation guidelines, contract, and treatment mandate. The guidelines stated that, as a participant in the court, the defendant must agree to take the medication prescribed by his psychiatrist and speak to the treating psychiatrist or a BMHC clinical team member if having problems with medication. The guidelines stated that non-compliance with medication could result in a sanction; however, the participant would be given the opportunity to explain his situation or reasons for non-compliance prior to a sanction being imposed. In addition, a representative from MHLS observed court proceedings regularly for the first four to six months to ensure that participants' civil rights were protected in terms of medication compliance and to offer advice on civil mental hygiene procedures, as needed.

- *Priority Access to Emergency Placement Beds*
  The BMHC project director and clinical director worked with the New York State Office of Mental Health throughout the planning process and well into the second year of the court operations to establish a mechanism by which BMHC participants would have priority access to emergency placement beds. The idea was to shorten some BMHC participants' stay in jail by placing them in temporary beds while BMHC clinical staff secured a permanent placement.

  The New York State Office of Mental Health (OMH) tried to work with two partner agencies to find a creative way to set up one emergency placement bed for BMHC participants in an existing facility. These efforts proved unsuccessful. The BMHC never obtained priority

access to any type of housing. The primary reason is that housing in New York City for the mentally ill is scarce and waiting lists are long. Some agencies were given other priorities by OMH such as taking people from state hospitals or city shelters. Other agencies did not want to give priority to those who had been in jail. At one point during the second year of operations, the New York State Office of Mental Health worked out an arrangement with one partner agency to accept a few BMHC participants for temporary or emergency placements until a more permanent placement could be arranged. However, the partner agency either feared the placement would become permanent or found clinical reasons to reject the referrals and never accepted a BMHC participant.

CHAPTER III
IMPLEMENTATION

This chapter covers the implementation of the BMHC from March 2002 – June 2004 and is divided into the following sections:

- BMHC Team
- Screening: Assessment, Eligibility, and Volume
- Participation Process
- Technology

Over this period a process evaluation was conducted to document the extent to which implementation reflects the original design, and to highlight areas for improvement. The nature of the "original design" is based upon a composite of interviews with the project director, draft policies and procedures manuals, observation, and court "fact sheets" distributed to the public.

I. The Brooklyn Mental Health Court Team

The BMHC team consists of a project director, clinical director, social worker, two full-time and one part-time forensic coordinators, dedicated judge, resource coordinator, dedicated assistant district attorney, and designated defense attorneys.

Judge

The judge was appointed after presiding in a domestic violence court and had monitored many defendants enrolled in Treatment Alternatives for the Dually Diagnosed.

Project Director

The project director, hired in 2001, was instrumental in the planning and implementation of the court. The project director developed templates for the necessary court documents (consent forms, court contract, treatment plans) and established protocols for case processing from referral to disposition. The project director is responsible for administrative duties including staff supervision, active communication with BMHC partners and dissemination of information about the court through networking, presentations, and conferences.

Clinical Director[2]

The clinical director joined the BMHC team in January 2002. The clinical director's duties include directly supervising the clinical team; conducting psychosocial evaluations of referred defendants; communicating regularly with the assistant district attorney, defense attorneys and the judge; and acting as a liaison between the court and community partners.

Social Worker

The full-time social worker's primary responsibility is conducting psychosocial evaluations of defendants. She also takes on the role of a forensic coordinator for female clients, when necessary.

[2] Toward the end of the evaluation period, the project director assumed responsibilities outside of the BMHC. The clinical director took over many of the project director responsibilities. At this time, the clinical director holds the title of project/clinical director.

Forensic Coordinators
For the first year of operation, BMHC had one full-time forensic coordinator and one part-time forensic coordinator. In February 2003, a second full-time forensic coordinator was hired. They have a wide range of responsibilities that begin at assessment (candidacy stage) and continue until the participant is terminated or graduates. Responsibilities include but are not limited to arranging placement in the community, monitoring compliance, acting as a liaison between community providers and the court, and coordinating services for participants when community-based case management services are unavailable or inadequate.

Resource Coordinator
The resource coordinator's role in the BMHC is to monitor defendants' progress, distribute updates in court to all parties, record compliance data in the database, and stand up on cases in court when the clinical director cannot be present.

Psychiatrist
A psychiatrist under contract with the BMHC conducts psychiatric evaluations of defendants referred to the BMHC and completes a narrative report for each defendant. The psychiatrist also conducted training sessions on a weekly basis with the judge during the planning and pilot phases.

Assistant District Attorney
The designated assistant district attorney came to BMHC after gaining extensive experience with mentally ill defendants. The assigned ADA, along with the Counsel to the District Attorney, were instrumental in working out criminal justice eligibility and other issues related to referrals, charges, and dispositions. In terms of daily operations, the assigned ADA reviews each case to determine criminal justice eligibility, discusses cases regularly with defense attorneys and the clinical director, and appears in court for each session.

Defense Bar
The majority of BMHC defendants are represented by two agencies which provide services for the indigent in Kings County, the Legal Aid Society and Brooklyn Defender Services. In the first year of the BMHC, each agency designated an attorney who specialized in defendants with co-occurring mental illness and substance abuse to provide counsel to the BMHC referrals and participants. Currently, each agency still has a point person to screen cases and facilitate a case's entry to the BMHC; however, more and more attorneys from these agencies retain their clients rather than relinquishing cases to the point person.

Other Staff
In addition to the core members listed above, there are many others, the judge's law secretary, court officers, and the BMHC court clerks, who contribute to daily operations behind the scenes.

II. Referral and Assessment

A. Referrals

Referral Protocol

One of the goals of the BMHC is to "improve the court's ability to identify and assess offenders with mental illness." During the pilot phase (March – July 2002) referrals with eligible charges were restricted to competency proceedings: defendants who were restored to fitness after initially being found unfit to participate in court proceedings or defendants who were found fit to proceed after a psychiatric evaluation. Starting in July 2002, the court opened to referrals from all sources including judges, defense attorneys, prosecutors, and other specialized problem-solving courts.

When interviews were conducted with stakeholders at the beginning and end of the evaluation period, there was confusion about how to get a case on the BMHC calendar. Stakeholders had extensive experience with felony level drug courts and domestic violence courts, for which the referral processes were automated and standardized. BMHC information sheets and draft protocols stated that a referral could come from multiple sources (judges, defense attorneys, district attorney, specialized parts, and competency proceedings) but did not establish step-by-step procedures.

The procedures outlined below were developed over the course of the first several months of implementation.

Felony Cases

- Competency proceedings: Defendants found fit or restored to fitness with appropriate charges are put on the BMHC calendar by the clerk's office.

  Judges and Defense Attorneys: If a case is in another court part, the defense attorney or presiding judge can attempt to transfer the case to BMHC for the purpose of screening and assessment. Often, a BMHC team member will be given a "heads up" about the case prior to the first calendar day, but just as often the case appears without any warning and all parties begin screening the case immediately.

  The point person at each defense agency reviews cases brought to her by her colleagues. Once she decides the case is appropriate for the BMHC, she calls the designated BMHC ADA and discusses the case. The ADA may request more information from the defense attorney and the assistant district attorney initially in charge of the case before deciding whether or not the defendant can be considered. Although there is no specific data collected, the defense attorneys and ADA report that this process can take a few weeks. For such cases, the ADA acts as a gatekeeper regarding which cases appear on the BMHC calendar for assessment and which do not.

  For defense bar referrals, the designated BMHC ADA acts as a gatekeeper regarding which cases appear on the BMHC calendar for assessment. At a meeting in June 2003, the "gatekeeper" role of the ADA was modified. The ADA could no longer block non-violent felonies from being transferred to the BMHC for evaluation. The ADA's consent to evaluate

was still required for other violent felonies. This change in procedure occurred one month before the close of the evaluation period and the evaluator could not determine if this new procedure was followed or effective.

The draft policies and procedures manual states that the defense attorney referring the case should complete a "Mental Health Referral Form," which would provide the basic details of the case. The form never materialized, mostly due to the defense bar's reluctance to complete paperwork for the mental health court that they believed could be used against their client at a later date.

If the defendant is deemed not to be eligible on mental health criteria, if the judge or the prosecutor does not consent to the defendant's case being in the BMHC, or if the defendant is found eligible but chooses not to participate, the case is returned to the original judge.

Misdemeanor Cases

The BMHC stakeholders agreed to open the BMHC to felony cases and tabled the issue of misdemeanor eligibility with the intention of accepting misdemeanors in the future. No specific timeline was set for misdemeanors. A phone call from a community-based provider inquiring about a client with a misdemeanor charge in October 2002 acted as a catalyst to establish referral procedures for defendants charged with misdemeanors.

There were several significant administrative and legal procedural issues that needed to be resolved prior to accepting misdemeanor referrals.[3] Once resolved, all misdemeanor offenses became eligible but all defendants must be willing to agree to a 12-month treatment mandate and at least one year in jail if non-compliant. It should be noted that several of the participants with misdemeanor charges have mandates of less than 12 months. When asked, the project director stated that this is a result of working the bugs out of the new protocol while meeting the needs of defendants who had already served time in jail.

A Criminal (misdemeanor) Court judge, a defense attorney, or a district attorney may refer misdemeanor cases to the BMHC. The written protocol states that a referring party should call either a BMHC senior staff member or the judge or the judge's law secretary to discuss the potential referral. If the BMHC team member agrees that the case is appropriate, the clerks in Supreme Court and Criminal Court are notified to calendar the case for the BMHC part for the following Tuesday. In reality, according to qualitative interviews, the defense attorneys follow procedures very similar to those when the case is a felony: The defense attorneys call the ADA assigned to the BMHC and reviews the case on the phone.

[3] The primary legal issue involved a provision in the Criminal Procedural Law regarding the transfer of cases from Criminal Court (which handles misdemeanor cases) to Supreme Court (where BMHC is located) upon an indictment, which appeared to limit the broad jurisdiction of the Supreme Court conferred in the New York State Constitution; the primary administrative issues involved differing requirements for calendaring cases in Criminal Court and Supreme Court. The BMHC project director worked with officials at the New York State Office of Court Administration to resolve the jurisdiction issues as well as with administrators at Supreme Court and Criminal Court to finalize mechanisms for the actual transfer of cases.

If the case is deemed eligible, the DA's Office will agree to waive the indictment and file a Superior Court Information before the defendant pleads guilty, which will allow for the case to be officially entered into the Supreme Court calendar and removed from the Criminal Court calendar. If a person is found ineligible or found eligible and decides not to participate, the case is returned to Criminal Court.

Recommendation:
The referral process can be confusing and relies heavily on a lengthy review by the assigned ADA and case conferencing with defense attorneys. Stakeholders should revisit the referral process to determine if it can be formalized and streamlined.

Recommendation:
A draft policy and procedures manual, fact sheets, and other administrative documents exist. However, the confusion over how to refer a case to the BMHC demonstrates the need for a formal policy and procedures manual. A final policy and procedures manual should be created to clarify referral and other procedures for team members and inform other jurisdictions interested in adopting the BMHC procedures.

Referral Sources
The BMHC received a total of 262 referrals during the implementation period of March 2002 - June 2004 (twenty-eight months). As of June 2006, BMHC had received a total of 576 referrals, of which 50% were referred from defense attorneys followed by 35% referred from competency proceedings.

Exhibit 2
Referral Source (March 2002 – June 2004)

	Male		Female		Total	
	#	%	#	%	#	%
Referral Source						
Competency Proceedings	67	34%	8	14%	75	30%
Defense Attorney	84	42%	31	53%	115	44%
District Attorney	18	9%	9	15%	27	10%
Other Problem Solving Courts	7	4%	5	8%	12	5%
Other Judge Referrals	22	11%	5	8%	27	10%
Other	2	1%	1	2%	3	1%
Total	200	100%	59	100%	259	100%

As Exhibit 2 demonstrates, defense attorneys account for the largest percentage of referrals. Cases calendared after competency proceedings make up the second largest source of referrals. Note that a significantly greater percentage of men are referred from the competency proceedings (34%) than women (14%). According to the ADA assigned to the BMHC, this gender breakdown mirrors part Special 11. Special 11 is a specialized court room in Brooklyn with a designated judge that hears cases of defendants who have been found unfit to proceed or who are likely to be found unfit to proceed.

This trend of the majority of referrals coming from the defense attorneys followed by competency proceedings, other judges, and prosecutors has held constant since the BMHC expanded from only competency cases to all sources in July 2002.

As Exhibit 3 details, black/African-Americans make up over half of the referrals. Hispanic/Latino and white referrals make up the remaining 40% equally. The median age at time of referral is 33 years for men and 37 years for women. The range in age is 17– 69 for men and 17-58 for women. For both sexes, 25% of the referrals were less than 25 years old.

When examining all referrals as of June 2006, the data shows that the racial/ethnic make-up has remained relatively constant. Black/African-Americans make up 58% of referrals, Hispanic/Latinos 21% and whites 18%. The median age at time of referral has remained the same.

The comparison of the BMHC and the Brooklyn Treatment Court, a felony-level drug court, reveals differences in age and race/ethnicity in the referral population. First, the Brooklyn Treatment Court's median age at time of screening of 28 years old is less than the 33 years for the BMHC. Second, whites make up 19% of BMHC's referrals compared to only 3% of the Brooklyn Treatment Court's referrals. Black/African-Americans make up the majority of referrals for both courts (Rempel 2002).

Pre-trial detention represents the only significant difference between male and female referrals; men are more likely to be incarcerated at time of intake than women (73% compared to 59%). Incarceration rates are independent of severity or type of charge (felony vs. misdemeanor). Men may be more likely to be detained at time of intake than women because they may have longer and more violent criminal histories, which could result in the judges setting higher bail amounts.

Exhibit 3
Brooklyn Mental Health Court Referrals (March 2002 – June 2004)

	Male	**Female**	**Total**
	N (202)	**N (60)**	**N (262)**
Demographics			
Median Age at Entry (years)	33	37	34
Race/Ethnicity			
Black/African-American	60%	51%	57%
White/Caucasian	17%	23%	19%
Hispanic/Latino	19%	21%	20%
Asian/Pacific Islander	1%	0%	1%
Other/Mixed	3%	5%	3%
Charges			
Felony	88%	81%	87%
Misdemeanor	12%	19%	13%
Detained in Jail at arrest			
Yes	73%	59%*	70%
No	27%	41%*	30%

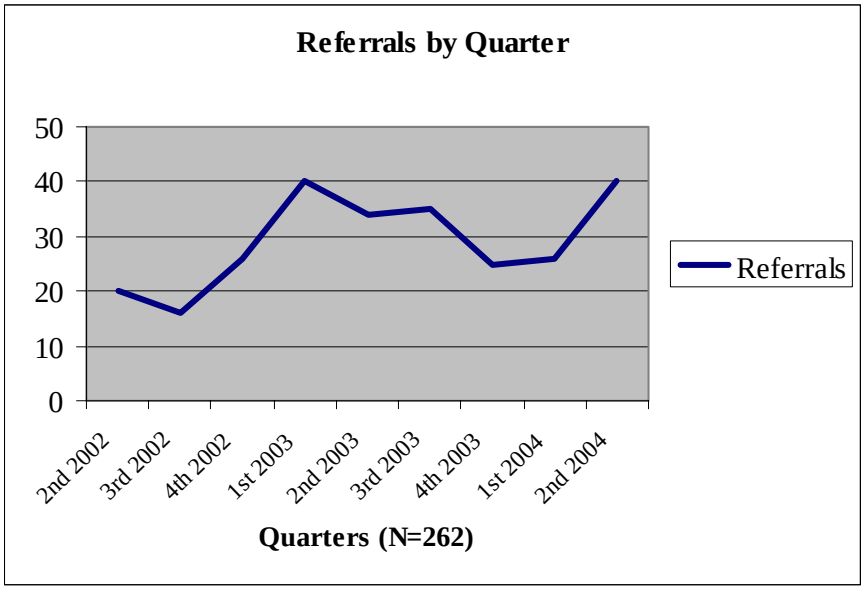
+p<.10, *p<.05, **p<.01, ***p<.001

B. Volume

Volume remained a challenge for the mental health court throughout the duration of the evaluation period. In grant proposals and the original evaluation design, the target number of participants per year was estimated at 100. In November of 2002, after seven months of operation, the project director revised estimates to 60-70 new participants annually and set targets of 8-12 felony referrals and 3-6 misdemeanors referrals per month, translating into approximately 40-45 referrals per quarter. As Exhibit 4 demonstrates, the number of referrals has varied by quarter with an average of 29. This average falls short of the revised target of 30 felony and 15 misdemeanor referrals per quarter. Since June 2004 through June 2006, the court has averaged 39 referrals per quarter.

It is difficult to estimate the number of expected referrals per quarter because the size of the referral "pool," offenders with serious and persistent mental illness arrested in Brooklyn, is unknown. Brooklyn does not have a universal screening system to assess for mental illness. When speaking with some BMHC stakeholders, it seems that the spike in referrals in the 1st quarter of 2003 represents a backlog of cases being approved for the court and the expansion of acceptable charges.

Exhibit 4
Referrals by Quarter



C. Assessment: Determining Eligibility and Profile of Defendants Found Eligible

This section discusses the process for determining eligibility, the clinical team's work surrounding eligibility, and a profile of defendants found eligible and found ineligible.

Eligibility Criteria and Eligibility Determination

Defendants must be found eligible on both criminal justice and mental health grounds. A defendant must be found to have a serious and persistent mental illness for which there is a known treatment (schizophrenia, schizoaffective disorder, bipolar disorder, and major depression). The BMHC clinical director makes the final clinical eligibility determination. For

the first several months, only non-violent felonies were eligible for the court. As the court gained confidence and experience, the list of acceptable charges expanded to include some violent felonies on a case-by-case basis and misdemeanors (the expansion of charges will be discussed below). The BMHC determines a defendant's criminal justice eligibility independent of the district attorney. However, the district attorney has final veto power.

Clinical Assessment

A thorough clinical assessment is completed in two parts. First, a psychosocial evaluation is conducted by either one of the two clinical social workers. Second, a consulting psychiatrist conducts a psychiatric evaluation. The clinical social worker and psychiatrist each write a narrative report that provides a detailed description of each candidate, including a description of the current mental illness, substance abuse history, family history, and other individual factors. The reports also contain a recommendation as to whether or not the candidate is appropriate for the BMHC. The reports are distributed in court to the judge, prosecutor, and defense attorney. It is common for the clinical director to have spoken with the other parties prior to court to answer questions and discuss the evaluations. These reports are also submitted to providers when applying for services to ensure that all involved parties have the same information from which to make decisions.

New York State has an established body of law governing certain types of psychiatric evaluations such as those completed for competency proceedings. There is no such body of law governing mental health courts, which meant that the BMHC had to create its own clinical eligibility criteria and determine how to communicate these criteria in written reports to the satisfaction of the judge, ADA, and defense attorneys. The first consulting psychiatrist noted the challenges she faced when drafting the first few psychiatric evaluations since these reports were new ground for her as well as the court. This psychiatrist was instrumental in creating the format for the written report and for establishing its contents, on which the judge, prosecutor, defense attorney, and BMHC clinical team would base their eligibility decisions.

For those who are likely to be found eligible, a treatment plant is developed. Each plan outlines a service utilization plan consisting of mental health treatment, case management services, supported housing services, and substance abuse treatment (residential and outpatient) or integrated treatment for people with co-occurring mental illness and substance abuse. Treatment plans have standard goals and objectives and the clinical team may insert additional goals or objectives specific to the individual such as seeking gainful employment or enrolling in educational classes.

The clinical team takes into consideration the person's history (psychiatric, criminal, substance abuse, family), current medication needs, functioning level, diagnosis, social support system, eligibility for benefits, and residency status among many other things when crafting a treatment plan. The primary clinical challenge facing the BMHC clinical team is not only to find services but to secure services that have been found to be highly effective, most notably integrated treatment for people with co-occurring mental illness and substance abuse disorders, Assertive Community Treatment (ACT), and supported housing. Unfortunately, these services are in high demand and often at capacity. Given the complexity of the treatment issues facing the new participants, the lack of highly effective treatment options available, and the fact that a treatment

plan must meet the clinical needs of the individual and the safety concerns of the judge and the ADA, developing individual treatment plans requires persistence, knowledge, and creativity.

The clinical team generates ideas for possible placement with appropriate community-based providers. Simultaneously, the forensic coordinators meet with the defendants to introduce themselves, begin building a relationship, and gather information necessary to complete the forms required to obtain services.

The forensic coordinators then start the time-consuming community-based placement process. Applications to community-based providers are faxed and mailed. Staff also follow-up with multiple phone calls to ensure receipt and check on the progress of the application. Arranging interviews for defendants detained in jail is particularly challenging. The forensic coordinator must arrange for interviews via phone, video-conference or in-person at the courthouse. Forensic coordinators repeat this process as many times as necessary in order to find appropriate placements for each defendant.

Securing housing for a person with mental illness is a major challenge. The clinical team works with the providers and family members to return detained participants to pre-arrest housing, either with a community-based provider or family members, if clinically appropriate and agreeable to the court. Clinical team members also find housing in residential substance abuse therapeutic communities and supported housing. Supported housing is accessed through a New York State Office of Mental Health pilot program, Single Point of Entry (SPOA)[4]. Although the clinical team reported no problems with this system, SPOA has not altered the reality that there are very few beds available for defendants in need of supportive housing.

Days to Eligibility Determination

In a strategic planning document outlining project goals, the BMHC set up an internal objective to determine eligibility for each referral within 21 days. The eligibility determination date is when the psychiatric and psychosocial evaluations are distributed to all parties. Overall, the median number of days from first court appearance to eligibility determination is 21 days and the mean is 31 days, which demonstrates that the court procedures instituted for determining eligibility are working fairly well and meeting the stated objective. As of June 2006, the median number of days from first court appearance to eligibility determination is 28 days and the mean is 39 days, an increase of a week from the June 2004 data.

The defendants found ineligible have a median number of days to eligibility determination of 18 days compared to 24 days for those found eligible. This difference can be attributed to the high number of defendants who are deemed to be ineligible on the date of their referral due to inappropriate charges, lack of interest on the part of the defendant, or inappropriate mental health status or history.

[4] The purpose of SPOA, which was launched as a pilot in Brooklyn at the same time BMHC opened, is to create systematic access to the very few available beds in New York State Office of Mental Health facilities in the New York City metro area rather than professionals relying on personal connections to secure interviews and placements. This means that anyone seeking a bed in one of these facilities must first complete a form for the New York City Human Resources Administration, which will then determine the level of service for which the candidate is eligible and submit an application to the SPOA coordinating agency in NYC. The coordinating agency will refer the application to multiple providers in order to set up three interviews for the candidate.

Eligibility Summary and Profiles of Eligible and Non-Eligible Referrals
Exhibit 5 below provides a summary of eligibility as of June 30, 2004. Of the 262 referrals received from March 2002 – June 2004, a total of 130 (50%) were found eligible. Of those, 106 (82%) enrolled as participants. This participation rate has held steady since the second quarter of the court. Women were slightly more likely to be found eligible (58%) than men (47%). Of those who did not enroll, five of 14 defendants declined participation, three had served nearly their full sentence, two were rejected by the District Attorney's Office, and the remaining four did not participate for various reasons.

Exhibit 5
Eligibility Summary (6/30/2004)

	6/30/2004	
1. Candidates		
Eligible for BMHC (plea date pending)	**20**	**8%**
Eligibility determination pending	**10**	**4%**
3. Participants[1]	**106**	**40%**
5. Ineligible for BMHC	**126**	**48%**
Non-Participants (eligible but not participating)	14	11%
Ineligible on mental health criteria	67	53%
Ineligible on criminal justice criteria	15	12%
Eligibility undetermined/Case transferred out of the BMHC[2]	30	24%
Total	**262**	**100%**

[1] Includes current participants, graduates, and people terminated from program.

[2] DA rejected case prior to clinical assessment or defendant refused without completing a clinical assessment.

Extending the period of analysis to June 2006 to include all 576 referrals, the data shows that a total of 301 (52%) were found eligible. Of those, 262 (87%) enrolled as participants. Of those who did not enroll (N=39), 46% of the defendants declined participation and the remaining defendants did not enroll for various reasons such as the being placed in another program, rejection by the DA's office, or having served the required amount of time.

Of those found ineligible, including non-participants, (N=126), 53% were found ineligible on mental health criteria. Exhibit 6 below details ineligibility on mental health criteria. It shows that 40% were found ineligible on mental health criteria because they had no eligible Axis I diagnosis and an additional 40% were found ineligible because they were inappropriate for community-based treatment or were found unfit to proceed.

Exhibit 6
Ineligible on Mental Health Criteria

	Male		Female		Total	
	#	%	#	%	#	%
No Eligible Axis I Diagnosis	19	37%	8	53%	27	40%
Too Unstable or Dangerous for Community	10	19%	3	20%	13	19%
Unfit / Competency Exam Requested	11	20%	3	20%	14	21%
Refused Assessment / Failed to Cooperate	6	12%	0	0%	6	9%
Inadequate Motivation	2	4%	1	1%	3	5%
Other	4	8%	0	0%	4	6%
Total	52	100%	15	100%	67	100%

Exhibit 7 and Exhibit 8 present key variables for referrals found eligible and found ineligible.

Exhibit 7 shows that ineligible defendants are significantly more likely to be detained at time of intake, to be black/African-American, and to be referred from competency proceedings. Detention in jail at time of intake and competency proceedings as a referral source are more than likely proxies for being very unstable at time of intake, which could lead to being found ineligible. Indeed, of those referred from competency proceedings, 36% were found ineligible for mental health reasons such as refusing assessment, being inappropriate for the community, or lacking of motivation. Discussions with the clinical team, prosecutor's office and defense bar did not elicit a concrete explanation as to why black/African-American referrals are less likely to be found eligible.

Referrals found eligible are more likely to have been referred by a defense attorney or district attorney. Given that defense attorneys and district attorneys often know the defendant and the details of the case, including history of mental illness prior to initiating the referral process, it is logical that such referral sources would have a higher rate of eligibility than other sources.

There were not any differences between defendants found eligible and ineligible in regards to severity of charges (felony vs. misdemeanor) nor when examining violent felonies vs. non-violent felonies. However, when the charges were broken into the categories of drug sale/possession, crimes against property, crimes against people (violent) and crimes against people (non-violent), there were some significant differences between defendants found ineligible and eligible. Defendants with violent crimes against people were more likely to be eligible and defendants charged with crimes against property were less likely to be eligible. Since violent crimes against people raise especially sensitive safety issues for victims and the community, it may be that defense attorneys and the ADA subject these defendants to particularly close scrutiny before even initiating the referral process. This in turn might result in only the most appropriate defendants who have committed violent crimes against people being formally referred, which would explain their greater likelihood of being found eligible.

Exhibit 7
Profile of Referrals Found Eligible and Found Ineligible

	Found Eligible* N (130)	Found Ineligible N (122)	Total N (242)
	%	%	%
Demographics			
Median Age at Entry (years)	34	33	34
Race/Ethnicity			
Black/African-American	52%	64%	57%
White/Caucasian	21%	16%	19%
Hispanic/Latino	22%	16%	20%
Asian/Pacific Islander	1%	1%	1%
Other/Mixed	4%	3%	3%
Race/Ethnicity Total	100%	100%	100%
Referral Source			
Competency Proceedings	17%	46%**	31%
Defense Attorney	53%	34%**	44%
District Attorney	14%	4%**	9%
Specialized Courts	2%	7%+	5%
Other Judge Referrals	12%	8%	10%
Other	2%	1%	1%
Referral Source Total	100%	100%	100%
Incarcerated at arrest			
Yes	59%	89%**	73%
No	41%	11%	27%
Charge Severity			
Felony	84%	86%	86%
Misdemeanor	16%	14%	14%
Felony Charges			
Non-Violent	54%	48%	51%
Violent	46%	52%	50%
Types of Charges			
Drug Sale and Drug Possession	20%	15%	18%
Crimes against Property	31%	19%	25%
Crimes against People (Non-Violent)	24%	28%	25%
Crimes against People (Violent)	25%	39%	31%
Charge Total	100%	100%	100%

*Eligible category includes participants(n=106), eligible candidates (n=10), and eligible but not participating (n=14)
+p<.10, *p<.05, **p<.01, ***p<.001

Exhibit 8 shows diagnoses for defendants who underwent a clinical screening and were found ineligible or eligible. Defendants found ineligible were significantly more likely to be diagnosed with schizophrenia as their primary Axis I diagnosis and more likely to have a substance abuse disorder as their secondary Axis I diagnosis. In the future, it would be valuable pinpoint whether a substance abuse diagnosis plays any role in a defendant being found ineligible.

Exhibit 8
Diagnosis for Referrals Found Eligible and Found Ineligible

	Found Eligible		Found Ineligible		Total	
	N	%	N	%	N	%
Axis I Diagnosis, Primary						
Bipolar		27%		9%**		22%
Major depression		22%		4%**		17%
Schizophrenia		27%		33%+		29%
Schizoaffective		16%		2%*		12%
Substance abuse disorders		2%		26%***		8%
Other		6%		20%		10%
No diagnosis		0%		7%		2%
Diagnosis total	124	100%	46	93%	170	100%
Axis I Diagnosis, Secondary						
Substance abuse disorders		87%		93%+		88%
Disorders diagnosed in childhood*		5%		0%		4%
Other		8%		7%		8%
Diagnosis total	75	100%	14	100%	89	100%
Axis II Diagnosis						
Personality disorders, NOS		58%		55%+		57%
Cluster B disorders**		13%		9%		12%
Mild/moderate mental retardation		0%		18%		4%
Deferred		29%		18%		27%
Diagnosis Total	38	100%	11	100%	49	73%

*Learning disorder and impulse control
**Antisocial Personality Disorder, Borderline Personality Disorder, and Narcissistic Personality Disorder
+p<.10, *p<.05, **p<.01, ***p<.001

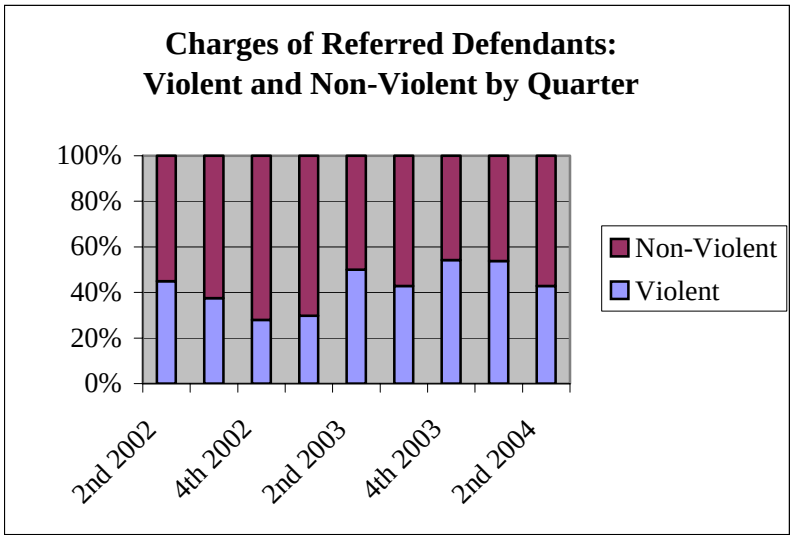
D. Charges

Felony: Violent vs. Non-Violent

In stakeholder interviews during the pilot phase, defense attorneys predicted low caseloads since defendants with violent crimes would be excluded. One defense attorney stated that she respected the prosecutor's and the judge's commitment to protecting public safety but that the majority of her mentally-ill clients were charged with violent crimes and deserved further investigation to examine the details of the case and whether mental illness played a role in the execution of the crime.

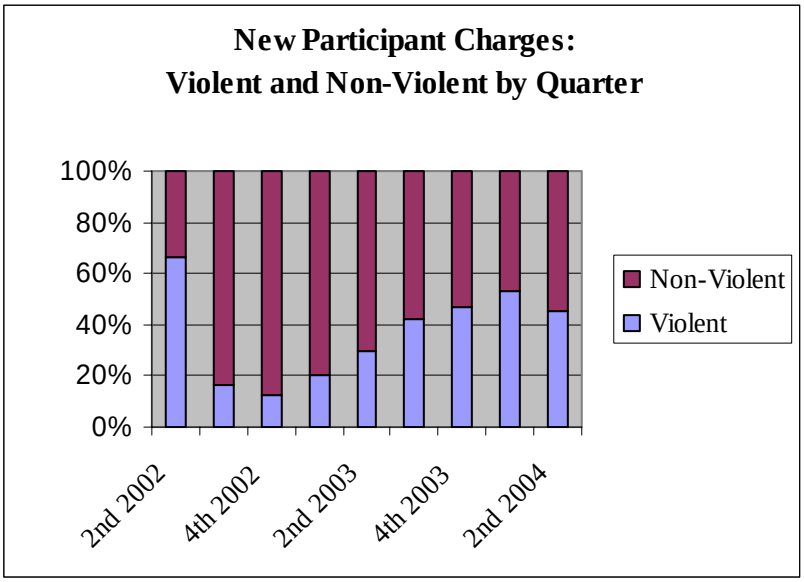
Exhibit 9 shows all referrals by violent and non-violent charges. It is clear that referrals with violent charges have been constant since the first quarter despite the fact that only defendants with non-violent charges could be found eligible officially.

Exhibit 9



As the court grew in experience and size, criminal justice eligibility expanded to include violent charges on a case-by-case basis. Exhibit 10 shows a general increase in acceptance of defendants charged with violent crimes as full-fledged participants. The judge, prosecutor, defense attorney, and clinical director proceeded carefully with each case, examining mental health status, public safety risks, past criminal charges, and current charge before offering the BMHC to the defendant. The ADA stated, "As we became more comfortable with the process and saw genuine success, we were ready to consider different charges." Overall, 39% of the 106 total participants enrolled through June 2004 were charged with violent offenses; and 46% of those enrolled in the most recent year (July 2003 – June 2004) were charged with violent offenses. As of June 2006, 43% of the 262 participants were charged with violent offenses and 42% of all referrals (N=562) charged with violent offenses.

Exhibit 10



Note: 2nd quarter 2002 represents three participants. Two were charged with violent offenses.

In summary, although there is uniformity in eligibility procedures, the process contains a number of subjective elements due to the complexity of issues presented by offenders with mental illness. The referral process includes, in many cases, a discussion between the defense and the prosecutor. The clinical assessment is an interview based on experience and clinical skills but does not rely on standardized instruments. Criminal charges, when serious, are reviewed on a case-by-case basis. This element of subjectivity makes the mental health court unique in problem-solving courts and requires diligence and dedication on the part of the stakeholders and the BMHC team members.

III. Participation Process

This section discusses the procedures related to participating in the mental health court including the decision to participate, the treatment mandate, judicial and clinical monitoring, phases, graduation/termination, and rewards and clinical responses/sanctions.

A. Decision to Participate

Even though a defendant must enter a plea of guilty in order to participate in the BMHC, the court is considered voluntary since the defendant can choose instead to return to regular case processing. The specific terms of the plea must be agreed upon by the judge, prosecutor, and defense attorney. The defense attorney reviews the treatment plan and terms of the plea with the defendant.

During the first years of the court, defendants and the judge signed a contract in court at the time of plea. This procedure was subsequently eliminated at the request of the judge who stated that court records would suffice.

B. Treatment Mandate / Plea Date

First-time felony offenders must agree to a treatment mandate of 12-18 months and predicate felony offenders (those who have a prior felony conviction) to a mandate of 18-24 months. Misdemeanor offenders must agree to a treatment mandate of 12 months.

The clinical team is responsible for escorting the participant to his provider on the plea date and ensuring that the new participant has his required medications. Providers typically require participants to arrive with a thirty day supply of medication or a prescription for thirty days of medication. During the first year of court operations, the clinical team struggled to ensure that detained participants were released from jail with adequate medication and prescriptions. The New York City jail does not have voicemail or e-mail, which presents real obstacles to BMHC clinical staff. In the spring of 2003, as the result of a lawsuit, the jail was required to offer discharge planning to mentally-ill inmates. The lawsuit laid out specific procedures for discharge planning, which resolved many of the issues the team faced regarding medication and prescriptions. When a participant is released from jail without the necessary medication, the forensic coordinator must take the participant to a local non-profit under contract with the city to receive a temporary prescription and activate Medicaid benefits, which can take the better part of the day.

C. Days to Plea Date

One indicator of case processing efficiency is the number of days from the date of first court appearance to plea date, which marks the formalization of BMHC participant status. Of the 106 participants, the median number of days to pleat date is 60, the mean is 81, and the range is 0-343 days.

Significantly, the mean number of days for those who remained in pre-arrest housing (community-based housing obtained prior to arrest) is 58 days compared to 116 for those placed in supportive housing. The difference in days to plea date for those placed in pre-arrest versus supportive housing underscores that scarce housing resources for the mentally ill create significant delays to placement and formalization of participant status – delays commonly spent in the local jail.

When extending the period of analysis through June 2006, it is evident that the trends described above continue. The median number of days to plea date is 63, the mean is 80, and the range is 0-392 days. The mean number of days for those who remained in pre-arrest housing (community-based housing obtained prior to arrest) is 56 days compared to 126 for those needing supportive housing. This is statistically significant.

Exhibit 11
Days to Plea Date by Housing Type

		Days to Plea Date		
	N	**Median**	**Mean**	**Range**
Defendant remained in pre-arrest housing[1]	48	45	58	0-252
Defendant placed in supportive housing[2]	25	105	116	28-343
Defendant placed in residential drug treatment	28	73	91	14-238
Other	5	75	75	70-75
Overall / Total	**106**	**56**	**81**	**0-343**

[1] Majority returned to family/friends or independent living. A few returned to supportive housing.
[2] Placement in a New York State Office of Mental Health residence, mental health program shelter or residence with mental health services on-site.

D. Monitoring

Judicial Monitoring

Judicial monitoring is a crucial component of the court. During the candidacy stage, defendants appear before the judge approximately once a month so the judge can receive updates to the treatment plan and monitor the defendant's mental health status. All fully enrolled participants appear in court every two weeks for the first three months and then monthly unless otherwise specified by the judge. More frequent court appearances may result from non-compliance or because the judge feels extra monitoring will encourage compliance.

Judicial monitoring is discussed in more detail in Chapter IV. Courtroom observation and interviews with the clinical team and BMHC participants all highlight that judicial monitoring is a key to success for many participants. The judge inquires about treatment progress, treatment setbacks, family, hobbies, and goals. A participant may approach the bench, a family member

may stand up with a participant, the judge may admonish loudly for the audience to hear, or he may speak quietly with a defendant. Regardless of his tactic, the goal is to encourage compliance and continued engagement in treatment.

Clinical Monitoring
The clinical team monitors defendants from the initial interview to graduation or termination. During the candidacy stage, the clinical team meets with each defendant a minimum of once a month to keep abreast of his or her mental health status, reinforce their relationship with the client, and assist with placement. Once a defendant becomes a participant, the mental health team meets with the participant after each court appearance and contacts community providers to obtain accurate updates on a weekly basis.

Monitoring during the candidacy stage is time-consuming. Unlike in many other problem-solving courts, where the intensive work doesn't begin until after the onset of participation, in the mental health court, the clinical team is very busy during the candidacy stage, helping the candidate establish a connection to the court, assisting the candidate in managing the mental illness, and arranging necessary interviews for services in the community. For those candidates who are not detained in jail at time of intake, the clinical team remains in frequent phone contact as well as holding in-person meetings at the courthouse, as needed. For those who are detained in jail, the clinical team will meet with them after court appearances or when they are brought to the courthouse for an interview.

Once a defendant has been admitted to the BMHC as a participant, monitoring becomes more routine, since the participant is engaged in services and appears before the judge regularly. The forensic coordinators summarize feedback from providers in a progress report for each participant. Clinical team members speak to the participants regularly, and it is common for the clinical director to receive calls from providers and participants at all hours of the night and weekends. The frequency and mode of communication (phone calls, on-site visits at providers' offices or meetings at the courthouse) vary greatly from participant to participant depending on the needs of both the participant and the provider.

E. Phases of Participation (I – IV)
Each participant must pass through four phases before graduating. Unlike in drug court or other specialized courts that have specific behavioral requirements and time markers for each phase, the phases in the mental health court mark overall progress in treatment. Certificates, awarded at the end of each phase, serve to encourage participants to continue their treatment and to maintain compliance rather than marking specific accomplishments such as being drug-free for two months.

Phase I: Adjustment in treatment
Phase II: Engagement in treatment
Phase III: Progress in treatment
Phase IV: Continued progress and preparing to graduate

The duration of the phases depends on the length of the mandate, with the exception of the first phase, which lasts three months from the plea date. For 12-month mandates (misdemeanors) and

12 to 18-month mandates (non-violent felonies), all phases are at least three months each. If the participant remains in the BMHC longer than 12 months, the phases are adjusted accordingly. For 18 to 24-month mandates, phases II - IV are each five months in duration.

When a participant is due to receive a phase certificate, the clinical director reviews the participant's engagement or progress in treatment and makes a recommendation to the judge to award or withhold the certificate at the upcoming court appearance. The judge considers this recommendation when deciding to award the certificate or wait until another court appearance.

F. Graduation / Failure

Official BMHC documents state requirements for graduation: participants must comply with their treatment mandate and not commit any new offenses. In practice, a new offense is not automatic grounds for termination. If a participant commits a new offense the judge will consider the nature and severity of the crime, the participant's compliance to date, and the participant's motivation to remain compliant. The judge will speak with the prosecutor and the clinical director prior to making a decision.

Upon graduation, misdemeanant and first-time non-violent felony offenders have their plea vacated and all charges dismissed. Predicate felons and first-time violent felony offenders see their guilty plea vacated and their felony charge downgraded to a misdemeanor. Violent felony offenders receive a probation sentence, which remains in effect post-graduation. The judge will begin considering graduation at the earliest possible date. For example, if the participant's mandate is 12-18 months, the judge will begin to consider graduation close to the 12-month mark. This involves reviewing treatment compliance and re-arrest history, if any. When asked to articulate how he decides when a participant is ready to graduate, the judge said he needed to review each graduation case-by-case: "If I didn't look at the individual then I wouldn't be doing my job."

If a participant fails to comply with the mandate, the participant is sentenced based on a pre-negotiated sentence determined at the time of plea. In practice, as exhibit 12 shows, 32 percent of participants have had a pre-negotiated alternative sentence of one year in jail and the remaining 68 percent have had alternative sentences that would require time in prison, which means a minimum term of one year (and longer for some participants). As of June 30, 2004, seven participants had been terminated. All seven participants were sentenced to the exact prison alternative determined at the time of plea.

Exhibit 12
Alternative Sentences for Non-Compliance

	All Participants (%)
Jail	
One year jail	32%
Prison*	**68%**
Minimum: 1 - 2 years	31%
Minimum: 3 - 5 years	29%
Minimum: > 5 years	8%

***The majority of prison terms involve a minimum and maximum length.

The data as of June 2006 shows some changes. On the surface, the data shows an increase in pre-negotiated alternative sentences of one year in jail (38%) and a decrease in those facing prison sentences (68% to 62%). However, a closer look at prison sentences shows an increase for pre-negotiated alternative minimum sentences of five years from 8% in June 2004 to 14% in June 2006.

G. Rewards and Clinical Responses / Sanctions

At the time of planning and at the request of the defense bar, the project director developed a list of rewards and sanctions/clinical responses as a response to non-compliance. This list gave the defense attorneys an idea of what they could expect for their clients from both a clinical and criminal justice perspective.

The terms "reward" and "sanction/clinical response" were purposely never defined in court documents but there was a loose understanding that a reward would be used to acknowledge a participant's compliance and continued success; a sanction would be implemented as a punishment or consequence for non-compliance; and a clinical response would be a modification in treatment services or a treatment plan because of noncompliance—but with the goal of encouraging future compliance, not of "punishment." It was understood from the onset that these terms would not be defined for two reasons: 1) a sanction for one participant may be viewed as a reward for another and 2) the team did not want a participant to view a modification to his or her treatment plan as punishment. Regardless of the term being used, the goal was to motivate compliance and engage the participant in the court process.

Three illustrative examples are below:

- The judge tells the participant he must come to the courtroom and observe court every day of the week until the judge notifies him he can stop observing.

- A participant has been compliant except for one instance of testing positive for drugs two months earlier. The participant requests to travel to see a family member. The judge denies the request since he and the clinical director believe the participant needs to be engaged longer in treatment before given permission to travel.

- A participant is in a residential drug treatment program. She gets into a fight at the program and is forced to leave without any warning. The clinical team fears she will relapse and decompensate if she remains in the community while looking for a new placement. The judge remands her to jail until a placement with a residential treatment provider can be found. The judge and the clinical team explain to the participant why they are remanding her to jail.

For many participants, the first example is clearly a sanction. However, there are some participants who would view coming to court as a reward since it would be yet another opportunity to speak with the judge. The second example could either be a sanction or clinical response depending on the circumstances, and the third example is clearly a clinical response even though at first glance jail would traditionally be considered a sanction.

Sanctions and clinical responses have not been captured systematically by the BMHC team. One reason is that it is difficult to track something that is clearly not uniform and requires interpretation from the clinical team or the judge. A second reason is that the technology does not have the ability to track compliance in the form of sanctions/clinical responses. Since so little is known about how mental health courts use sanctions/clinical responses or rewards, it would be beneficial to define more clearly the terms and track usage to explore if they impact compliance or program success.

> ***Recommendation:***
> The Brooklyn Mental Health Court could benefit from examining the usage of sanctions/clinical responses and rewards in order to more clearly articulate the policies of the court and explore their relationship to compliance and successful completion. The BMHC should develop a qualitative research plan to explore the issues surrounding rewards and sanctions/clinical responses to inform court operations and research.

IV. Technology

Many problem-solving courts seek to promote informed-decision making in the courtroom through innovative computer technology. To meet the technology needs of the BMHC, two databases were used to collect information, both of which were created by the Center for Court Innovation.

The first database, known as the "DV application," was created specifically for two domestic violence courts in Brooklyn and the Bronx. The judge was familiar with it from presiding in the Brooklyn Felony Domestic Violence Court. In Brooklyn, the DV application has separate calendars for the felony domestic violence court, the mental health court, and Treatment Alternatives for the Dually Diagnosed cases. It maintains basic information regarding the criminal cases, including but not limited to charges and court appearances. The DV application does not adequately track compliance (rewards, sanctions, and clinical responses) for a mental health court. The application does allow for the judge to record notes on individual participants at each hearing. These notes assist the judge in engaging participants and encouraging compliance.

The second application is an Access database, known as the BMHC database, designed to collect data such as demographics, eligibility, psychosocial, treatment compliance, and program outcome variables. From March 2002 – December 2002, data was collected in spreadsheets with limited information. In December 2002, the Access database was implemented and the clinical team and project director began entering data. Although the BMHC database contained all the necessary elements, the design did not adequately reflect the work flow of the clinical team. In an effort to streamline the database, the BMHC database was completely revamped in July 2004.

In the first several months of operations, there were often inconsistencies between the DV application and the traditional court calendar as procedures were created for court clerks to maintain parallel systems. This resulted in felony-level cases not being entered into the BMHC database in a timely manner and missing data on appearances for these early participants. In addition, the senior court clerk stated that the clerk's office would only enter misdemeanor cases if the defendant took a plea and became a participant in the BMHC. This means that data on

appearances for defendants with misdemeanor cases is spotty at best, since there are several appearances before the eligibility determination date and plea date.

The new version of the BMHC database is an improvement; however, BMHC stakeholders may have been overzealous in their desire to collect data. The result is a complex database that requires the clinical team to collect and enter data from a variety of sources, such as completed public assistance forms, psychosocial evaluations, and court files. Other than the eligibility data collected by the project director, the data entry is the sole responsibility of the clinical team and is overwhelming and time-consuming. The result is incomplete data.

Recommendation

The BMHC database is well organized but very detailed. The number of variables can be daunting to clinical staff, often resulting in poor data collection. The project director, in conjunction with the research team at the Center for Court Innovation, should decide on a core group of variables to collect consistently to improve data collection and decrease missing data.

CHAPTER IV
COURTROOM EXPERIENCE

The BMHC is an unusual court. The audience fills up with participants and family members. Sidebar conversations take place between clinical team members and attorneys. Attorneys and clinical team members move in and out many times throughout the course of the morning to speak to participants and candidates in the hallway. Bench conferences and sharing of artwork or creative writing by participants are all common occurrences. Yet what may appear chaotic to an outsider is a well organized court to BMHC members and participants. This chapter describes the courtroom experience by presenting data from structured court observation.

I. Courtroom Observation

Qualitative observations were conducted from March 2002 – April 2003. Structured, quantitative court observations were conducted on a monthly basis from March 2003 – June 2004, as presented in Exhibit 13.

Qualitative observations revealed that basic processes such as the distribution of forms or awarding a participant a phase certificate were refined during court's first sessions. The first few months also saw the judge conferencing frequently with the BMHC psychiatrist and clinical director for clarification on mental health issues or services offered by local providers. As the calendar grew and all parties became more comfortable, candidates and participants started speaking more often, appearing in court when their attorneys could not be present, and waving at the judge from the audience. The judge began to expand clinical responses/sanctions beyond reprimands to include making a participant come to court daily and refusing a pass to see family on the weekend.

Observation notes highlight that the judge is willing to address and be addressed by candidates and participants in unconventional ways within the limits of maintaining order and public safety. He will make eye contact with anxious candidates and participants or wave to family members. For example, one participant asked the judge to shake his hand with a specific hand and accept a gift with the other hand. The judge complied with the request but was still very clear that he expected the participant to remain in compliance with the court's mandate.

Exhibit 13 represents the court experience quantitatively and shows a great deal of consistency in courtroom behavior and procedures. Participation is defined as instances when a party spoke in court other than stating their name or providing basic information for the record. The data shows that when a candidate (not yet fully enrolled) is appearing in court all parties actively participate, including the defendant. Discussions during the candidacy stage often center on the progress and timeline of the evaluation, which requires input from all parties.

Participation for participant appearances is remarkably different than candidate appearances and is limited largely to the judge, defense attorney, and BMHC participant. Communication focuses on the progress report, next steps, and an exchange between the judge and the participant. The clinical director and the ADA remain silent unless there is a specific issue to address.

Exhibit 13
Court Observation

	Candidates	Participants	Overall
Appearances Coded[1]	40	78	118
Duration[2]	2	2	2
Participation			
Judge	100%	100%	100%
Clinical Team Member	30%	12%	17%
Assistant District Attorney	55%	8%	24%
Defense Attorney	80%	80%	81%
Defendant	40%	90%	73%
Judge's Communication			
Direct Conversation	68%	96%	91%
Eye Contact	69%	94%	90%
Probing Questions	6%	64%	54%
Defendant Approached Bench	31%	63%	57%
Judge Shook Hands with Defendant	60%	46%	47%
Parties Approached Bench without Defendant	20%	4%	12%
Clinical Response/Reward/Sanction			
Good Report Mentioned/Positive Feedback	n/a	63%	63%
Negative Report Mentioned/Negative Feedback	n/a	23%	23%
Warrant	n/a	1%	1%
Certificate Awarded	n/a	10%	10%
Other			
Family Member Present	5%	13%	10%
Artwork/Special Skill Performed	3%	7%	5%

[1]Appearances coded March 2003 - June 2004

[2]Median hearing length rounded to the minute

The structured court observation highlights signature patterns and behaviors of the BMHC judge for engaging the participant or candidate and managing the busy calendar. One way that the judge engages the participant or candidate is through direct conversation, eye contact, and probing questions in open court. Direct conversation is defined as questions posed directly to the candidate or participant along the lines of "How are you today?" or "Tell me how's it going?" and probing questions are defined as questions about the defendant's life, detailed questions about treatment, or overall well-being such as "Are you still drawing?" or "What is it that you don't like about it (the program)?" Overall, the judge makes direct conversation and eye contact with approximately 90% of those appearing before him. He asks probing questions to 64% of the participants and 6% of the candidates. One participant said, "He remembered that my mom was sick. That made me feel good." And another participant said, "He respects me. He asked me questions." In the course of direct conversation or probing questions, the judge refers to the progress reports submitted by the clinical team. The judge uses the reports as a basis for his comments, such as, "It looks like you are doing well," or, after reviewing a document with poor ratings, "What's going on?"

In addition to communicating openly in court, the judge uses bench conferences as another way to communicate with both participants and candidates. What started out as a one-time event turned into a regular and effective method to engage BMHC participants. The judge says, “I didn’t do it with any plan in mind. This one guy was nervous and the only way to get him to talk was to bring him up to the bench…to engage human to human…I think it is effective because people have been given short shrift their entire life. ..if they can be engaged then they can have faith in themselves and hope for the future.” In 57% of the observed court appearances, the defendant approached the bench, and of those appearances, the judge either shook hands or touched the hand of 47% of the defendants during the bench conference. In 12% of the cases, bench conferences took place without the defendant present to discuss sensitive matters that the judge deemed inappropriate for open court.

It should be noted that the judge’s ability to engage the participant and candidate in direct conversation is facilitated by the DV application on the computer at the judge’s bench. The DV application allows the judge to record comments and notes while hearing cases. These notes provide an excellent source of information for the judge when seeing defendants from month to month. He often makes notes about progress in treatment, family members who have been ill, and other milestones in the participants’ lives. The judge says these notes assist him in monitoring the defendant’s compliance and substantively engaging the defendant. The judge stated, “It [technology] is one of my greatest public safety tools.”

CHAPTER V
PARTICIPANT PERSPECTIVE

Participants enrolled during the period of March 2002 - June 2004 were asked to partake in an interview at their one year anniversary date. Of the 37 participants eligible to complete the interview, 31 agreed to it, three refused, and three were either warranted, sentenced or hospitalized and thus unavailable. The goal of the interviews was to better understand the BMHC experience from the perspective of the participant and to ask for constructive criticism. The interview instrument included measures of perceived coercion, perceived procedural justice, and additional items focused on the BMHC experience such as court appearances, phase certificates, and the role of the BMHC team.

I. Perceived Coercion

The definition and role of coercion is at the center of any discussion surrounding mental health courts. The questions researched in the literature include whether or not legally-imposed treatment affects clients' perception of coercion and if court monitoring impacts participants' compliance or perception of coercion (Rain et al. 2003).

The BMHC is considered voluntary because defendants have a choice of whether to enter a plea of guilty in the BMHC or appear before another judge for regular case processing. However, questions about coercion persist. Participants were asked to complete a modified version of the MacArthur Perceived Coercion Scale to explore the idea of coercion and how it related to a participant's overall experience in the court, compliance, and outcomes. The scale was modified in an evaluation conducted of the Broward County Mental Health Court (Poythress, Petrila, McGaha & Boothroyd 2002), which used the scoring mechanism developed by Gardner, Hoge & Bennett (1993). The scale measures four items: influence, control, choice, and freedom. The scores range from 0 (low) to 5 (high).

When conducting the interview, participants were often confused and required the interviewer to repeat questions multiple times. It was clear that participants were not concerned with coercion and were often confused as to why the questions were being asked. Participants would interrupt and say "I like Judge D'Emic" or "I'm here. I like it." Participants were interviewed after being in the BMHC for one year and may not have been able to recall their decision-making a full year earlier. BMHC stakeholders decided not to interview participants at time of program entry since the court was new and had yet to establish concrete procedures for taking a plea when the study design was created. A stronger design would have been to interview participants when taking their plea and then again one year later to determine if their perceptions of coercion changed over time and if their understanding of the instrument would have been clearer at the time of plea.

The scores ranged from 0 to 4.53 and the mean score was .84 (standard deviation 1.29). Individual scores for each question are not provided in Exhibit 14 since only the overall score is considered meaningful, as described by the authors of the scale. The low score indicates that participants perceived themselves to have a high level of independent decision-making, control, choice, and freedom. In short, participants did not feel coerced into the BMHC, or at least did not feel coerced after having spent the year in treatment monitored by the judge and clinical team. These results are comparable to those from the Broward County Mental Health Court evaluation,

which found a mean score of .69 (standard deviation 1.30). Although it is interesting to show the BMHC scores in relation to another mental health court, it should be noted that there are significant differences between the courts. For example, at the time of the evaluation, Broward County Mental Health Court accepted only misdemeanor cases, and participants completed coercion measures immediately after their first mental health court hearing.

Exhibit 14
Perceived Coercion

1.	Was it your decision to keep your case in the mental health court…? (Entirely what you wanted…entirely what other people wanted)
2.	How much control did you have over whether you would keep your case in the mental health court or have your case go to another judge? (Very much…None/Not at all)
3.	Overall, would you say that you chose to keep your case in the mental health court, or that someone else made you keep your case in the mental health court? (Yes, No)
4.	How free did you feel to do what you wanted about keeping your case in the mental health c ourt or going back to a regular court? (Very much…None/Not at all)

II. Perceived Procedural Justice

Research shows that people care about having a voice and being treated with dignity in the court process, regardless of the outcome (Sydeman, Cascardi, Poythress & Rittenband 1997; Tyler 1990). Procedural justice measures the participant's subjective experience of case processing. Stakeholders were interested in knowing if participants felt they were being treated fairly in the BMHC and if their voices were being heard.

The instrument used to measure procedural justice was the same as the one used for the Broward County Mental Health Court, although modified slightly to fit the timeline of the BMHC. The origin of the Broward County Mental Health Court scale is Cascardi, Poythress & Hall (2000). The original scale asks a set of questions about the judge and a set of questions about the defense attorney. Since the BMHC is a court-based program, this evaluation only asked questions pertaining to the judge. The instrument consists of five items, and participants rated each item from 1 (not at all) to 7 (definitely).

The results in Exhibit 15 demonstrate a high level of satisfaction with participants' case processing and judicial monitoring. The high scores reinforce the positive comments regarding the judge provided by the participants during the interviews. Participants raved about the judge's listening skills, his knack for remembering personal details of their lives, and his ability to respect them in a way often missing in other court proceedings. One participant said, "I've been to a lot of court rooms in my life. And, I've never met a judge like him. He respects me. I'm sick. That means a lot to me to be respected now." Another participant said, "I've got no complaints. He asks about me, my husband, and my son. Sometimes I asked for something and he said no. He's the boss, so it's okay."

Exhibit 15
Perceived Procedural Justice

		Mean (S.D)
1.	While your case has been in the mental health court, have you had enough opportunity to tell the judge what you think he needed to hear about your personal and legal situation?	6.22 (1.48)
2.	While your case has been in the mental health court, has the judge seemed genuinely interested in you as a person?	6.78 (.698)
3.	While your case has been in the mental health court, has the judge treated you respectfully?	6.93 (.267)
4.	While your case has been in the mental health court, has the judge treated you fairly?	6.96 (.192)
5.	Overall, are you satisfied with how the judge has treated you and dealt with your case?	6.78 (.641)

III. Attitudes about the Court Team and Specific Program Elements

In addition to the questions about coercion and procedural justice, the participants completed 12 items with a scale ranging from 1 (strongly agree) to 5 (strongly disagree). The 12 items focused on participants' feelings toward key stakeholders (clinical team, defense attorney, the judge), court processes (phase certificates, judicial court monitoring) and if the participant would recommend the court to someone else. Overall, the results demonstrate a very high level of satisfaction with court stakeholders and court processes.

Exhibit 16
Additional Participant Questions

		Mean 1 (strongly agree) 5 (strongly disagree)
1.	The phase certificate encouraged me to continue with my treatment.	1.63
2.	Coming to court on a regular basis encourages me to continue with my treatment.	1.85
3.	I like sitting and watching others appear before the judge.	2.48
4.	I find it helpful to meet with the clinical team when I come to court.	1.59
5.	I would recommend the Brooklyn Mental Health Court to someone else.	1.52

Participants agreed that frequent judicial monitoring helps them continue with their treatment, as does receiving the phase certificates. Even though participants realized that the frequent visits with the judge were helpful and positive, they were fairly unified in their dislike of sitting and waiting for their turn to appear before a judge (M=2.48). Participants were often hesitant to give negative feedback and would qualify this answer with statements, such as "I like the judge but I hate waiting," or "I have to make up the time on the weekend but it's okay."

Participants agreed or strongly agreed with the statement, "I would recommend the BMHC to someone else." When asking for suggestions and feedback, participants returned to this statement frequently. One participant commented, "It's great you're giving me a chance. Others need chances, too." Another said, "You should make all those other courts like this one."

Recommendation

There are many more questions to be answered in future research, such as does perceived procedural justice and perceived coercion change over time? Does perceived procedural justice differ when participants are asked about prosecutors and defense attorneys? Does either perceived procedural justice or perceived coercion affect treatment compliance? BMHC should strive to include these questions or similar ones in future research.

CHAPTER VI
COMMUNICATION

This chapter presents an analysis of communication among BMHC team members and between BMHC team members and community providers.

I. Network Analysis of Communication

A. Stakeholder Survey

BMHC stakeholders were asked to complete a communications survey in June 2004 to capture the unique patterns of communication within the BMHC. The survey asked the respondent to assess how frequently he or she had communicated with individual colleagues over a three month period (Exhibit 17). The survey also asked how satisfied respondents were with the frequency and quality of the communication (Exhibits 18 and 19). Three respondents completed questionnaires slightly later but were instructed to use the same timeframe. If colleagues had conflicting results, either the colleagues were contacted to discuss results and asked to agree on an average score or, if the discrepancy was not large, then the average of the two responses is represented on the chart. This analysis only reflects communication in the early summer of 2004 and does not reflect the patterns of communication during the entire implementation period.

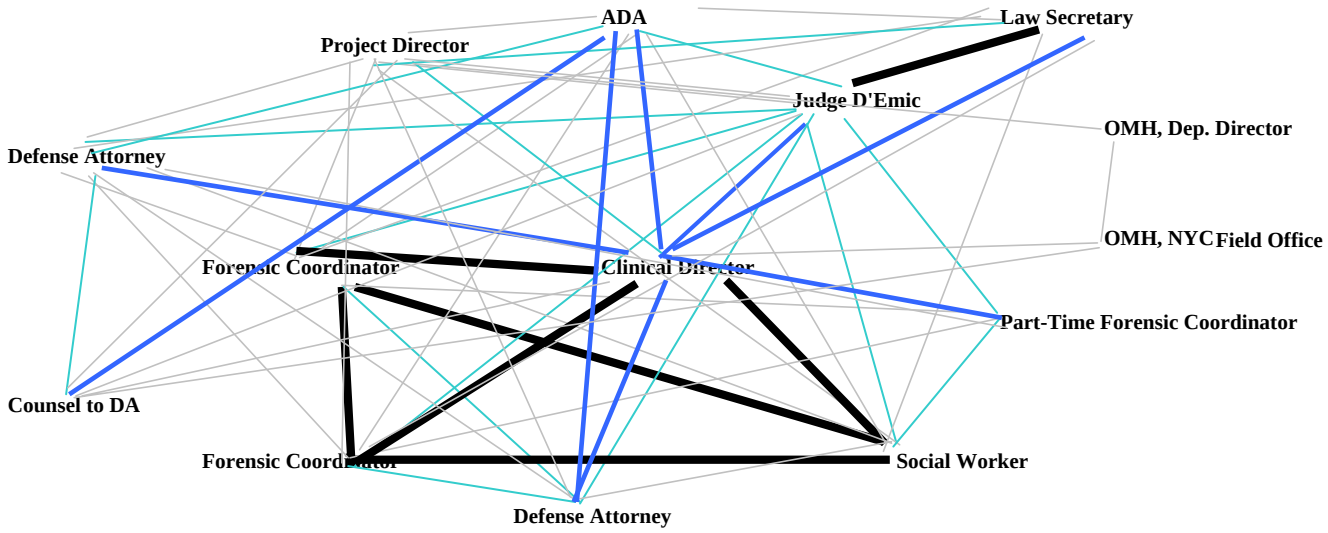
Once the planning phase ended and the implementation phase began, those involved in implementation continued the practice of individual communication rather than regular group meetings. This operating style (Exhibit 17) means that the clinical director represents the hub of communication. The clinical director communicates a minimum of five days a week with her immediate clinical staff (forensic coordinators and social worker) and approximately three to four days a week with the prosecutor, defense bar, the judge, and the judge's law secretary. Clearly, she plays a significant role in keeping various parties informed and updated.

Exhibit 17 also reflects the team approach adopted by the clinical team (social worker, forensic coordinator, clinical director) as it shows the primary communication of the forensic coordinators and the social worker is with the clinical director and each other. The clinical team meets at least once a week to review each client and team members speak daily to keep each other abreast of every client's status. The necessary information is then streamlined through the clinical director to other BMHC partners.

The defense and prosecution agree that they communicate approximately three to four days a week. In qualitative interviews, both parties explained that this communication centers on getting a case into the BMHC. Both parties enjoy steady independent communication with the clinical director.

Exhibit 18 shows high levels of reported satisfaction with communication among BMHC colleagues. Overall, 86% of respondents are very satisfied or satisfied with their frequency of communication. An overwhelming majority (72%) said that they were very satisfied with the quality of communication with BMHC colleagues (Exhibit 19). No one reported feeling dissatisfied or very dissatisfied with either the frequency of communication or the quality of the communication.

Exhibit 17
Map of BMHC Colleague Communication



Communicate 1 or Fewer Days/Week
Communicate 2-3 Days/Week
Communicate 3-4 Days/Week
Communicate 5 or More Days/Week

It is clear that the patterns of one-on-one communication meet the needs of the current BMHC partners. Some problem-solving courts promote a collaborative approach often involving regular staff meetings to review cases. These meetings bring together the prosecutors, defense attorneys, judge, clerk, case managers, and community partners to review cases with the goal of sharing information to ensure swift and unified responses to participants. The cases in the BMHC, unlike other problem-solving courts, have highly individualized treatment plans and present unique challenges in terms of public safety. It is particularly interesting that the BMHC continues its pattern developed in the planning stage of one-on-one communication amongst team members rather than team meetings. This current model of communication clearly meets the needs of the BMHC colleagues, as shown in Exhibits 18 and 19; however, it is reliant on the relationships and implicit trust among staff members rather than a set, institutionalized schedule of meetings. The court must be careful to re-evaluate its communication patterns if any key staff member were to be replaced, particularly the clinical director.

Exhibit 18

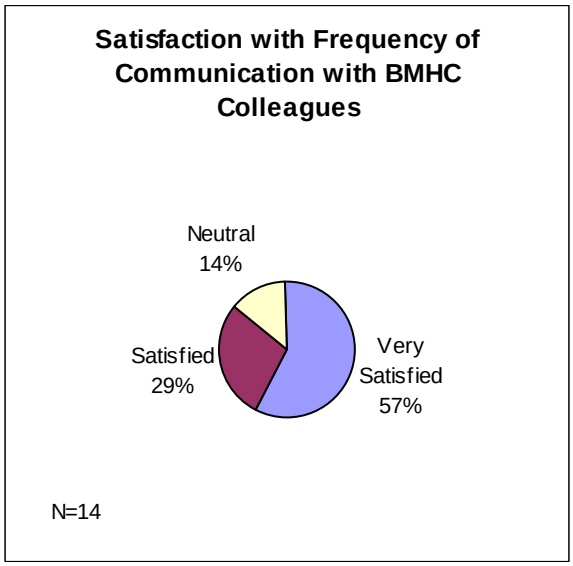
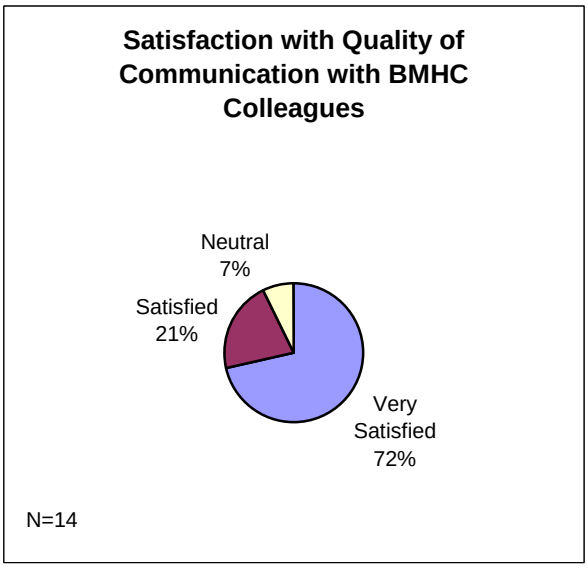


Exhibit 19



B. Relationship with Providers

BMHC providers and the BMHC clinical team (clinical director, forensic coordinators, and social worker) are in constant communication due to the quick-changing nature of mental illness and the fact that nearly all participants are living in the community in non-restrictive housing. The purpose of the constant communication is for the clinical team to provide support to the community providers, maintain the mental and physical health of the participants, and ensure public safety. BMHC clinical staff is in regular contact with providers from the time a clinical team member completes an application package to the time the participant graduates or leaves a program. Forensic coordinators speak with each provider on a weekly basis to check in on participants. If a provider has issues or needs relating to a BMHC participant, the clinical team speaks with the appropriate staff at the agency and with the participant, possibly holding case conferences at the provider agency and making after-hours phone calls. As time permits, clinical staff makes regular visits to providers to check in and provide support. In turn, community providers submit a completed compliance form each time a participant has a court appearance to the forensic coordinator.

The evaluator completed interviews with providers at the beginning and end of the evaluation. Providers interviewed during the pilot phase were usually senior level staff who had agreed to accept BMHC referrals in a meeting with the project director and clinical director. Providers interviewed at follow-up were mid-level staff or line staff who had worked with BMHC participants. Providers also came to a roundtable discussion led by a team of outside evaluators in the spring of 2004.

In the follow-up interviews and roundtable discussion providers were asked about their experience working with the BMHC staff and participants. Providers commented repeatedly on the excellent support provided by the BMHC clinical team. They said they never felt alone when working with BMHC participants. The fact that the clinical director was there to talk to a

participant or find a more appropriate placement, as necessary, meant a great deal to the providers. Providers specifically mentioned the site visits made by the clinical director and the project director prior to the pilot phase of the court. They felt these visits demonstrated respect for their work and helped to prepare them to accept a BMHC participant. Providers enjoyed the roundtable discussion immensely and a few providers asked to have more roundtable discussions.

Recommendation:
Although policies and procedures for the BMHC are formalized, communication among BMHC colleagues relies on individual relationships rather than a formalized means of communication. Regular meetings may help foster communication and protect the court in the event that key personnel, such as the project director or judge, were to leave. The BMHC project director should arrange for quarterly meetings with the BMHC team to review policies and court procedures.

Recommendation:
The BMHC community providers enjoy good relationships with BMHC's clinical team and reportedly enjoyed visiting the court and meeting the judge. The BMHC clinical director should arrange bi-annual meetings with community providers to thank the providers, allow them to meet the presiding judge, and offer feedback.

CHAPTER VII
PARTICIPANT OUTCOMES

Who is the BMHC serving? What are their outcomes? And who benefits most from the BMHC? This chapter seeks to answer these questions by presenting:

- Intake data such as demographics, socioeconomic status, criminal justice background, and mental health characteristics for all participants enrolled before June 2004.
- Participant progress in the mental health court as of June 2004, including a comparison of those participants who graduated and participants who were terminated.
- Analysis of outcome data before and after entrance into the BMHC for the first 37 participants in terms of homelessness, hospitalizations, recidivism, substance abuse, and psychosocial functioning.

Data in this chapter was gathered from multiple sources. Case processing data, including court appearances, criminal charges, and dispositions, was recorded in the DV application (described in Chapter III). Program data and participant data such as mental health diagnoses, service utilization, length of mandate, substance abuse history, hospitalizations, and homelessness were gathered from the BMHC database. Recidivism data was obtained from the New York State Unified Court System.

I. Participant Profile

Exhibit 20 presents descriptive data gathered at intake for all 106 participants enrolled by June 2004. Overall, the participants are mostly African-American, male, single, and have poor education and work histories. The majority have been hospitalized for psychiatric reasons at least once in their lives; however, only a few were in mental health treatment at time of arrest.

- **Race and Ethnicity:** African-Americans make up 51% of participants and whites 21%; Hispanics make up 25% (regardless of race); and other 4%;
- **Homelessness:** 15% of participants were homeless in the year preceding arrest;
- **Diagnosis:** About one quarter of participants were diagnosed each with bipolar disorder, major depression and schizophrenia, with schizoaffective disorder and other diagnoses making up the final quarter. In addition, 48% of participants suffered from co-occurring disorders;
- **Psychiatric Hospitalizations:** 69% of participants reported being hospitalized at least once in their life for psychiatric reasons, and 32% reported that they had been hospitalized for psychiatric reasons in the 12 months prior to arrest;
- **Charges:** 85% of participants were charged with a felony, of which 37% were charged with violent crimes against people; and
- **Treatment Mandate:** The majority of participants (60%) received a 12-18 month mandate (first-time felony).

Exhibit 20
Participant Profile

DEMOGRAPHICS	
Median age at entry	34
Race/Ethnicity	
Black/African-American	51%
White/Caucasian	21%
Hispanic/Latino	25%
Asian/Pacific Islander/Other	4%
Single (never married)	74%
SOCIO-ECONOMIC STATUS	
High school degree/GED	42%
Living arrangements at time of intake	
Alone/Family/Others	80%
Community Residence	4%
Single Site Supported	4%
Psychiatric In-Patient	3%
Homeless	8%
Homeless in past 12 months	15%
Days homeless in past 12 months (average)	107
Employed full-time/part-time	13%
MENTAL HEALTH FACTORS	
Diagnosis	
Bipolar Disorder	28%
Major Depression	25%
Schizophrenia	26%
Schizoaffective Disorder	14%
Other	7%
Co-Occurring Disorders	48%
Hospitalized for psychiatric reasons ever	70%
Receiving mental health treatment at time of arrest	30%
Psychiatric hospitalizations in past 12 months (average)	0.58
Days hospitalized in past 12 months (average)[1]	34
CRIMINAL JUSTICE FACTORS	
Charges	
Felony	85%
Drug Sales/Drug Possession	16%
Crimes against property	28%
Crimes against people (violent)	37%
Crimes against people (non-violent)	18%
Other	2%
Length of Treatment	
12 months or less	14%
12 to 18 months[2]	60%
18 to 24 months[3]	26%

[1] Includes only those with psychiatric hospitalization in past 12 months
[2] Includes one sentence for 12 to 24 months,
[3] Includes one sentence for 30 to 36 months

II. Status in the Brooklyn Mental Health Court

Exhibit 21 shows that as of June 30, 2004, 72% of the enrolled participants were in good standing and 5% were still active but either remanded/serving a jail sanction or warranted. A total of 18 participants had graduated and 5 had been terminated; these participants will be discussed in detail in the following sections.

Exhibit 21

Program Status	**6/30/2004**	
	N	%
1. Open	76	72%
2. Graduated	18	17%
3. Remanded/Serving Jail Sanction	4	3%
4. Warranted	1	1%
5. Terminated/Sentenced	7	7%
Total	**106**	**100%**

Of the 37 participants that had been enrolled at least one year as of June 30, 2004, 38% had open cases, 46% had graduated, 13% were terminated, and 3% were warranted. This indicates a one-year retention rate of 83%.

As of June 2006, of the 262 participants, 35% had open cases, 42% had graduated, 8% terminated, 8% warranted/remanded, and 6% were administratively closed (Administratively closed refers to those participants who neither graduated nor was sentenced. Reasons for administratively closing include death or a finding of legal incompetence.)

As of June 30, 2004, 80% of all participants had completed phase I, 58% had completed phase II, 42% had completed phase III, and 17% had completed phase IV (graduation). Of the seven participants who were terminated, four never completed phase I, two were terminated after completing phase I, and one was terminated after completing phase II.

Exhibit 22
Phase Completion: Expected vs. Actual
Median Number of Days per Phase

	Phase I		**Phase II**		**Phase III**		**Phase 4[2] /Graduation**	
	Actual # Days	Expected # Days	Actual # Days	Expected #Days	Actual # Days	Expected # Days	Actual # Days	Expected # Days
Less than 9 month mandate[1]	67	90	98	60	44	60	42	60
9-12 month mandate	95	90	95	60	91	60	70	60
12-18 month mandate	105	90	85	90	91	90	112	90
18-24 month mandate	105	90	154	150	130	150	140	150

[1]The first few participants with misdemeanor charges had mandates less than 12 months.
[3]The phase IV certificate was awarded the same day as graduation or the week prior to graduation.

Exhibit 22 shows the expected and actual dates that participants received phase certificates. It demonstrates that participants received certificates on or close to the expected (scheduled) date. Those participants with mandates of less than nine months have the greatest variation in phase III and phase IV. This may be due to the fact that there are only five participants with this mandate

and their length of treatment is not uniform. Also, those participants with the 18 to 24-month mandates spent more time in phase III than participants with other mandates.

III. Graduation and Termination

This and following sections focus on the 37 participants who entered the BMHC before June 30, 2003 and follows them through their first year as participants. Of these first 37 participants, 17 graduated and 5 were terminated as of June 30, 2004.

The median number of months to graduation is listed below:

- 9 to 12-month mandates: Median number of months to graduation was 12 (N=3).
- 12 to 18-month mandates: Median number of months to graduation was 12 (N=9).
- 18 to 24-month mandates: Median number of months to graduation was 19 (N=5).

Terminated participants averaged 16 months from plea date to termination date. Three of the five terminated participants were warranted for very lengthy periods of time prior to being sentenced.

Appendix B offers a profile of the graduated versus terminated participants. It is difficult to draw comparisons between these two groups from such small numbers. The graduated and terminated participants appear quite similar in terms of psychiatric hospitalizations in the 12 months preceding BMHC, lifetime psychiatric hospitalizations, global assessment functioning score, median age of entry into the BMHC, severity of arrest charge, and alternative sentences. Those terminated were more likely to be female and white. When the clinical team was asked for insight as to why the five terminated participants did not succeed, the clinical director responded that they were not ready for treatment in the community and/or never became fully engaged and were not able to benefit from the court monitoring or phase certificates.

Judicial Monitoring

The judge's frequent monitoring, particularly the current judge's style of connecting with the participants one-on-one, engages the participants in the court process. The clinical director believes that the participants respond to the attention and value their relationship with the judge. Indeed, some participants have requested not to graduate and offered to continue seeing the judge regularly post graduation. A few participants have returned to see the judge.

Phase Certificates

In interviews, participants clearly noted that phase certificates encouraged them to continue with their treatment. Of the five participants who were terminated, three never completed phase I. For a population that rarely completes a program or a course of study, the phase certificates mark accomplishments and encourage the participant to remain compliant until the next phase certificate.

IV. Other Participant Outcomes

This section examines participant outcomes for the 37 participants enrolled as of June 30, 2003. The data compares the first 12 months as a participant to the 12 months preceding entry into the BMHC or the 12 months preceding arrest for those detained at the time of intake. In the discussion below, "participants" refers to the 37 participants included in the preliminary outcome study. The reader should note that, while suggestive, the results presented in this section do not

comprise an “impact” evaluation, since participant outcomes are not compared with those of other defendants who never entered into the BMHC.

Staff completed forms at baseline and again at 12-month follow-up. Questions were not asked directly to the participants. Appendix C presents the complete data set for the “outcome” evaluation. Highlights of the data set are discussed below.

A. Homelessness

As shown in Exhibit 23 the percentage of participants who experienced homelessness and the median number of day s homeless decreased while participants were enrolled in the BMHC. A total of 16% of participants reported being homeless in the 12 months preceding their enrollment, compared to 11% who reported experiencing homelessness during their first 12 months as a BMHC participant. The median number of days homeless decreased from 60 days pre-BMHC to 35 days homeless during the first year of participation. These differences were also not significant.

Exhibit 23
Homelessness

In the past 12 months	**Intake** # %	**Follow-Up** # %
Homeless	16%	11%
Median number of days homeless	60	35

B. Drug and Alcohol Use

Clinical staff was asked to report on participants’ drug use and alcohol use at intake and 12 months following intake. Overall, participants showed dramatic decreases in drug and alcohol use. From intake to follow-up, the data shows a significant decrease the frequency of use for participants using alcohol or drugs “1 or more times in the past week” and a significant increase in the percentage reporting use “not at all in the past six months.” When looking at the current level of alcohol and drug use, similar gains are evident. A significantly higher number of participants were reportedly abstinent at follow-up for alcohol and drug use than at intake. Also, the percentage of participants who reported their current level of drug and alcohol use as “dependence” decreased significantly.

Exhibit 24
Drug and Alcohol Use

	Intake	Follow-Up
Frequency of alcohol abuse		
1 or more times in past week	0.44	.00***
1 or more times in past month, but not in past week	0.71	0.04
1 or more times in past 3 months, but not in past month	0.00	0.08
1 or more times in past 6 months, but not in past 3 months	0.00	0.15*
Not at all in the past 6 months	0.19	0.56**
Never	0.27	0.19
Current level of participant alcohol use		
Abstinent	0.38	0.82***
Use without impairment	0.03	0.00
Abuse	0.22	.00**
Dependence	0.22	0.03*
Institutional remission[1]	0.00	0.00
Never	0.16	0.16
Frequency of drug abuse		
1 or more times in past week	0.58	0.03**
1 or more times in past month, but not in past week	0.06	0.09
1 or more times in past 3 months, but not in past month	0.00	0.00
1 or more times in past 6 months, but not in past 3 months	0.00	.02**
Not at all in the past 6 months	0.15	0.61***
Never	0.21	0.10
Current level of participant drug use		
Abstinent	0.30	0.90***
Use without impairment	0.00	0.00
Abuse	0.17	0.03
Dependence	0.43	0.03***
Institutional remission	0.00	0.03
Never	0.12	0.07

[1]Participant stopped using drugs or alcohol while in jail, prison, or hospital setting.
+p<.10, *p<.05, **p<.01 ,***p<.001

C. Hospitalization

Psychiatric hospitalizations occur for different reasons depending on individual circumstances. A hospital stay may mean a participant is not fully engaged in treatment or that a participant's treatment needs are not fully met. Regardless of the reason, psychiatric hospitalizations are not a sign of failure or viewed negatively by providers or BMHC court staff. Exhibit 25 shows a significant decrease in the percentage of participants who were hospitalized for psychiatric treatment from 50% to 19% when comparing the 12 months preceding enrollment with the first 12 months as a BMHC participant. Of those who had psychiatric hospitalizations, the number of days hospitalized remained fairly constant and the average number of psychiatric hospitalizations decreased slightly from .58 at intake to .27 at follow-up.

Exhibit 25
Hospitalizations in the Past 12 Months

In the past 12 months	Intake # %	Follow-Up # %
Psychiatric hospitalizations	50%	19%**
Total # of days hospitalized for psychiatric reasons (average)	23	21
Number of psychiatric hospitalizations[1]	.58	.27
Psychiatric emergency room visits	44%	25%+

[1]Includes only those who were hospitalized for psychiatric reasons during the first 12 months of participation
+p<.10, *p<.05, **p<.01 ,***p<.001

D. Recidivism

Over three-quarters of BMHC participants (78%) had been arrested at least once as adults prior to the incident that qualified them for the BMHC. In addition to the BMHC qualifying arrest, 27% had been arrested at least once in the 12 months prior to enrolling in the BMHC. During the first 12 months of BMHC participation, a total of six participants (16%) committed a new offense. Charges included criminal possession of marijuana, grand larceny, criminal possession of stolen property, loitering for purposes of prostitution, and criminal possession of a dangerous weapon. While suggestive, this difference in recidivism is non-significant.

In all cases, the new arrest was not automatic grounds for sentencing. Of the six participants who re-offended during their first year of participation, two eventually graduated, three were sentenced after lengthy warrants, and one was administratively terminated because of complications due to pending federal charges.

E. Psychosocial Functioning

One way to measure effective participant outcomes is to examine changes in their overall functioning. Participants were hypothesized to have increased psychosocial functioning after one year in the BMHC.

The clinical director and clinical social worker completed the Health of the Nation Outcome Scale (HoNOS) at intake and 12-month follow-up (The Royal College of Psychiatrists' Research Unit, 2002). The instrument was designed by The Royal College of Psychiatrists and has been tested for reliability and validity. It is designed to be used by clinicians, researchers, and providers repeatedly over time. The scores for individual scales are to be compared to one another to determine the impact of interventions, and to create a picture of the client's overall functioning. The HoNOS is comprised of 12 scales that measure a wide range of health and social domains (psychiatric symptoms, physical health, functioning, relationships, and housing). Each scale is scored from 0 (no problem) to 4 (severe to very severe problem).

Overall, as shown in Exhibit 26, participants improved their functioning on nearly every scale. Participants showed statistically significant improvement on the scales measuring problems with cognition, depressed moods, living conditions, and occupations and activities.

The HoNOS does show a slight, non-significant increase in problems with hallucinations /delusions and other mental and behavioral problems. After reviewing the raw data, it is clear that this increase can be attributed to two outlier participants. One person was in the process of adjusting his medication and another participant often experienced paranoia as the time for her next injection drew near.

Exhibit 26
Health of the Nation Outcome Scale

		Intake	Follow-Up
1.	Overactive, aggressive, disruptive, or agitated behavior	.39	.39
2.	Non-accidental self-injury	.00	.00
3.	Problem drinking or drug taking	.44	.39
4.	Cognitive problems	.94	.21***
5.	Physical illness or disability problems	.38	.29
6.	Problems with hallucinations or delusions	.15	.29
7.	Problems with depressed moods	1.59	.79***
8.	Other mental and behavioral problems	.73	1.03
9.	Problems with relationships	1.41	1.26
10.	Problems with activities for daily living	1.21	1.03
11.	Problems with living conditions	1.53	1.00**
12.	Problems with occupations and activities	2.09	1.24***

+p<.10, *p<.05, **p<.01 ,***p<.001

F. Service Utilization

Clinical team members were charged with tracking participant service utilization in: name of providers, type of providers, start date of service and end date of service. The database did not capture the specific activities or treatment received at the community-based provider. For example, the database tracked that a participant was placed in residential substance abuse treatment but did not capture if the person was in group therapy or when the person moved from one phase of treatment to the next.

Exhibit 27 shows the types of services received at baseline by the first 37 participants during their first year as BMHC participants. The chart shows that 73% were receiving mental health services. The remaining participants'(27%) mental health needs were being met on site through their community provider, such as residential drug treatment or outpatient day treatment. Since these services were arranged by a provider, they are not tracked in the BMHC database. The chart also shows that 70% of participants were linked with New York State Office of Mental Health's Intensive Case Management (ICM) services.

Exhibit 27
Service Utilization at Baseline

	Female		Male		Total	
	#	%	#	%	#	%
Intensive Case Management (ICM)	7	70%	19	70%	26	70%
Supported Housing	2	70%	2	70%	4	11%
Mental Health Treatment	6	60%	21	78%	27	73%
MICA Treatment	4	40%	6	22%	10	27%
Substance Abuse Treatment (Outpatient)	4	40%	2	7%	6	16%
Substance Abuse Treatment (Residential)	0	0%	10	37%	10	27%
MICA Housing	2	20%	5	19%	7	19%
Vocational Rehab/Education	0	0%	2	7%	2	5%
ACT Team	0	0%	1	4%	1	3%
Total (current participants)	**10**		**27**		**37**	

In their first year as participants, seven participants (19%) changed providers at least once and of those seven participants, two participants changed providers multiple times. In most cases only the provider changed and the treatment modality did not change.

As discussed in Chapter 3, the clinical team is creative when drafting a treatment plan and the result is "wrap-around" services for participants. This means that the participants' needs are met through multiple providers and multiple services. The first cadre of participants had a median number of three providers simultaneously.

Tracking service utilization was a challenge for the clinical team. These first participants were fairly stable in terms of longevity with providers; however, as the court grew in size it became clear that participants were changing providers more often either by design (emergency shelter to more permanent housing) or by necessity (being forced to leave a program), and these constant changes were difficult to track consistently. Also, just noting dates and type of program does not adequately capture the amount of work the clinical team puts into finding new services, nor does it explain why new services were required.

> ***Recommendation:***
> Due to the work required to place participants with community providers, and the fact that placements can change rapidly, the clinical team is unable maintain adequate data entry and the result is that service utilization data lacks quality and specificity. The project director and research team should develop a realistic plan to adequately track service utilization.

CHAPTER VIII
CONCLUSIONS

During the first 28 months of operations, the Brooklyn Mental Health Court generally achieved its goals of improving the court system's ability to identify, assess, and monitor offenders with mental illness; and of using the authority of the court to link offenders with mental illness to appropriate mental health treatment services.

Brooklyn Mental Health Court stakeholders and team members also confronted several important challenges. Some were overcome with creativity and diligences, while others persist to this day. Since many are likely to be faced by other mental health courts now opening across the country or by established programs looking to constrict or expand eligibility, reviewing them may be instructive. They include:

- *Clinical Eligibility:* The Brooklyn Mental Health Court opted to limit eligibility to defendants with "serious and persistent mental illness for which there is a known treatment" (schizoaffective, schizophrenia, major depression, and bipolar disorder).
- *Criminal Justice Eligibility:* Unlike most of the mental health courts that had previously opened, the Brooklyn Mental Health Court opted to work primarily with felony level defendants, whose greater legal exposure allowed them to be mandated to the longer periods of treatment that their illnesses required.
- *Eligibility of Violent Defendants:* Although defendants arrested on violent charges were at first excluded, this policy became more flexible over time, as it became clear that mental illness was sometimes an underlying factor leading to violent crimes; more than one third of participants to date have entered with a violent charge.
- *Coercion:* Brooklyn Mental Health Court team addressed concerns surrounding coercion to enroll and coercion to take medication in several ways. Enrollment in the court is voluntary, and the program participation guidelines and program contract clearly spell out the rights and responsibilities of the defendant and the judge. Medication compliance, on the other hand, is required; however, participants receive opportunities to discuss medication with team members and the judge.

Besides the preceding challenges that the Court resolved, significant ongoing barriers include limitations to local mental health treatment and housing capacity; reliance on an informal referral process; lower-than-planned program volume (which relates, in part, to the lack of an automatic referral process); and purposely vague policies on sanctions, rewards, and clinical responses:

- *Community-based Services:* The Brooklyn Mental Health Court clinical team continues to face daily challenges of placing participants in appropriate mental health treatment and housing services, sometimes leading to delays in placement and a frequent need to place participants in "wrap around" services with multiple providers at the same time.
- *Referral Process:* The referral process is not automated and may be a contributing factor to lower-than-planned volume. Team members must explore ways to streamline this process, making it speedier and easier for defense attorneys and others to understand and navigate.
- *Sanctions, Rewards, and Clinical Responses:* The Brooklyn Mental Health Court began implementation with purposefully vague definitions of sanctions, rewards, and clinical

responses. As the court moves forward, there may be value in documenting these court elements in order to better articulate and formalize the court's model.

Despite these barriers, many of the evaluation's key findings are exceptionally promising. Participants interviewed about their Brooklyn Mental Health Court Experience perceived themselves to have a high level of independent decision-making, control, choice, and freedom. Participants also demonstrated a high level of satisfaction with their case processing and judicial monitoring. Courtroom observation showed a judge interacting with participants regularly and using individualized techniques to engage participants.

Also, the participants included in the outcome evaluation showed significant improvements in several outcome measures and a tendency toward improvement in nearly all other measures, even when the effect sizes were not statistically significant. The measures under examination went beyond traditional criminal justice indicators, including criminal recidivism as well as homelessness, substance use, hospitalizations, and psychosocial functioning. The encouraging outcome results, coupled with an unusually high one-year program retention rate of 83%, suggest that the Brooklyn Mental Health Court has a meaningful positive effect on its participants. Future research may expand upon these results and provide more insight regarding whether, how—and for whom—mental health courts work.

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Appendix A

BROOKLYN MENTAL HEALTH COURT

PROGRAM PARTICIPATION GUIDELINES

Welcome to the Brooklyn Mental Health Court!

This handbook is designed to:

- Answer questions
- Address concerns
- Provide information about the Mental Health Court

As a participant in the Brooklyn Mental Health Court, you will be required to follow the instructions given in court by the judge and comply with the treatment plan developed for you by the Mental Health Court staff. This handbook will explain what is expected of you. It will also provide general program information.

Ask your Mental Health Court case manager or your defense attorney to explain anything in this handbook that you do not understand!

What is the Brooklyn Mental Health Court?

The Brooklyn Mental Health Court is a special part of the Kings County Supreme Court. It is a court-supervised program for those arrested in Brooklyn who have mental health issues, who need treatment and other services, and who choose to participate in the Court program instead of having their cases proceed in the regular court process.

What do I have to do?

The Brooklyn Mental Health Court has prepared a treatment plan for you based on an assessment of your needs for mental health treatment, substance abuse or alcohol treatment, case management services, and housing. In order to participate in the Court, you must agree to comply with this treatment plan and to sign a contract in court, which is an agreement between you and the judge. This contract explains what is expected of you and what will happen if you do not follow the rules. The judge will also sign the contract, which is written specifically for you based on your current charges, your prior criminal history, and your treatment plan. Before you sign the contract, you will have an opportunity to review it with your defense attorney and have your questions answered.

How long will I be involved in the Mental Health Court?

The Brooklyn Mental Health Court is a four-phase program that lasts from 12 to 24 months. The amount of time you spend in the Mental Health Court is determined by your plea and by your individual progress in treatment. While you are participating in the Mental Health Court, the judge and your Court case manager will monitor your participation and progress in treatment.

Discharge, termination or voluntary withdrawal from the Mental Health Court will result in sentencing on the charges to which you pled at the time you signed your contract.

What's in it for me?

Services: *The staff of the Mental Health Court will help you get case management services, mental health treatment, and, if your treatment plans calls for it, substance abuse or alcohol treatment and supported housing.*

Recognition of progress: *As you progress through the phases of your treatment plan, your achievements will be publicly recognized by the Mental Health Court judge and you will receive certificates to acknowledge your accomplishments.*

Dismissal or reduction of your charges: *If you successfully complete your mandated treatment plan, your criminal charges will either be dismissed or reduced. Your Court contract will specify what will happen when you complete the Brooklyn Mental Health Court program.*

Opportunity: *The Mental Health Court offers you a chance to avoid jail or prison on your current charges and to move forward in your life.*

Remember that there are many people who make up the Brooklyn Mental Health Court team, and they all want to see you succeed. If you take advantage of the assistance offered, you can discover many ways to make a better life for yourself.

What are the rules of the Mental Health Court?

To remain in the Brooklyn Mental Health Court, you must follow these rules:

1. Appear in Court as scheduled

You will be required to appear in front of the Mental Health Court judge on a regular basis. The judge will be given progress reports regarding your attendance and participation in your treatment program and the other components of your treatment plan. The judge will ask you about your progress and discuss any problems you may be having.

You will also be required to meet with your Mental Health Court case manager each time you have a court appearance before the judge, and you may also be required to attend additional appointments with your case manager on days when you do not have a court appearance before the judge.

You must attend all scheduled court appearances and all scheduled appointments with your Mental Health Court case manager. Depending on your situation, you may have to come to court several times a month. As you make progress, your court appearance and appointment schedule will be reduced.

2. Follow your treatment plan

Your treatment plan will include some or all of the following components:

- *Medications*
- *Regular appointments with a psychiatrist*
- *Participation in a mental health treatment program, such as a day treatment program*
- *Participation in substance abuse or alcohol treatment*
- *Intensive or supported case management services*
- *Housing with social services provided*

Your treatment plan may include additional components as well, such as participation in educational or vocational programs or in self-help or support groups.

Specific rules about some treatment plan components are discussed below.

Medications. ***It is extremely important that you take the medications that your treating psychiatrist prescribes for you!*** *The judge and staff of the Brooklyn Mental Health Court recognize that many medications have very unpleasant side effects, that many medications do not work equally well for all patients, and that it can be very difficult for a doctor and a patient to find the best combination of medications for that patient. But for most participants in the Mental Health Court, medications will be essential for managing symptoms of illness and living successfully in the community.*

If you have complaints about the medications your treating psychiatrist has prescribed for you, you must tell your psychiatrist, who may be able to prescribe a different medication or additional medications to treat side effects. If you continue to have complaints about your medications and feel that your psychiatrist is not responding to your concerns, you should tell your Mental Health Court case manager, who will discuss your concerns with your psychiatrist and see whether any acceptable alternatives are available.

Refusal or repeated failure to take medications may result in sanctions being imposed by the Mental Health Court judge. Before any sanctions are imposed, you will have an opportunity to explain your reasons for not taking medications to your Mental Health Court case manager and the judge.

Mental health treatment program. *Your treatment plan will require that you participate in a mental health treatment program. Your treatment provider will tell the Mental Health Court when you are attending, when you are absent, and how you are doing in your program. You must attend all scheduled treatment appointments and follow all the rules of your treatment program.*

Substance abuse or alcohol treatment. *All candidates for the Mental Health Court will be asked about their history of substance or alcohol abuse, and all participants in the Mental Health Court will be required to give urine samples when they first enter the Mental Health Court program. Participants may be required to participate in drug or alcohol treatment and to submit regular urine samples, both at court and at their treatment program, if they:*

- *have a history of substance or alcohol abuse*
- *have current charges or previous convictions involving drug-related offenses,*
- *have positive results in a urine test, or*
- *while participating in the Mental Health Court program, show signs of possible drug use.*

As with your mental health treatment, you must attend all scheduled substance abuse or alcohol treatment appointments and follow all the rules of your treatment program. Your substance abuse or alcohol treatment provider will tell the Mental Health Court how your attendance is and how well you are doing.

Case management services. *Community-based intensive and supportive case managers help consumers to coordinate the services they need in the community. Your treatment plan may require you to accept the services of a community-based case manager, who will visit you at your home and your treatment program and assist you with getting a variety of services. Your community-based case manager will also provide information to the Mental Health Court on how well you are following your treatment plan and how you are doing in treatment.*

Housing. *Some participants in the Mental Health Court will be required to live in a particular type of housing or in a particular housing facility, which may offer an array of services for residents. If your treatment plan specifies the type of housing you must live in or a particular housing facility, you must live where specified and you must follow all of your housing provider's rules. Your housing provider will give information to the Mental Health Court about how well you are following your treatment plan.*

Phases. *Your treatment plan is divided into four phases:*

- *Phase 1: Adjustment*
- *Phase 2: Engagement*
- *Phase 3: Progress*
- *Phase 4: Preparation for graduation from Mental Health Court*

You will receive a certificate upon completion of each phase.

3. Infractions, rewards and sanctions

There are consequences – both good and bad – for your conduct while you are a participant in the Mental Health Court. If you comply with your treatment plan and live a crime-free life in the community, you will be acknowledged and rewarded in a number of different ways. Conversely, if you fail to comply with your treatment plan or commit any new offenses, you will be sanctioned. Ultimately, good participation and compliance with treatment will be rewarded by having your criminal charges reduced or dismissed, and failure in the program will result in serving the jail or prison sentence specified in your Court contract.

Infractions. The following events will be treated as infractions of the Mental Health Court program:

- Missed treatment appointments
- Missed appointments with Mental Health Court case management staff
- Missed court appearances
- Failure/refusal to take medications
- Refusal to give urine sample
- Infractions of rules of treatment or housing provider, including verbal threat of violence
- Other noncompliance with treatment plan
- Abuse of drugs and/or alcohol
- Absconding from treatment program or supervised housing
- New criminal offenses

***Clinical responses and sanctions*. The Mental Health Court judge will respond to all infractions by imposing a sanction or requiring that you participate in a treatment-related activity. The judge may also mandate a change in your treatment plan. Examples of clinical responses and sanctions include the following:**

- Reprimand
- Increased frequency of appointments with your Mental Health Court case manager
- Increased frequency of appearances before the Mental Health Court judge
- Penalty box (observing Court activities from the jury box)
- Mandatory NA/AA/Double Trouble
- Mandatory group attendance (i.e., money management, anger management, family relations)
- Loss of privilege at your treatment or housing program
- Community service
- Unannounced visits by Mental Health Court staff
- Imposition or increase in frequency of urine testing
- Detox/drug rehab
- Transfer to more restrictive housing or treatment program
- Hospitalization – voluntary
- Hospitalization – involuntary
- Bench warrant
- Jail sentence (1 to 28 days)

***Rewards*. In addition to advancing to the next phase and receiving a dismissal or reduction in charges upon graduation, demonstration of effort and progress in treatment will be acknowledged. Potential rewards include:**

- Reduced frequency of appointments with your Mental Health Court case manager
- Reduced frequency of appearances before the Mental Health Court judge
- Transfer to a less restrictive housing or treatment program
- Suspension of urine testing requirements
- Certificates or other mementos of progress
- Phase advancement
- Participation in court-sponsored social or cultural event
- Participation in speakers bureau

What else is expected of me?

The expectations of the Brooklyn Mental Health Court are:

Treat others with respect.

You should respect the opinions and feelings of other participants in and staff of the Mental Health Court. Verbal or physical threats to anyone will not be tolerated. Any inappropriate behavior will immediately be reported to the Court and may result in a severe sanction or your termination from the program.

Avoid all drug-related activity and abuse of alcohol.

You will not possess, sell or use alcohol or illegal drugs. Any relapse by you involving drugs and/or alcohol must be reported to your Court case manager immediately.

Be law abiding.

You must refrain from any further violation of the law. Additional offenses may result in being terminated from the Mental Health Court.

Important Names and Numbers

Brooklyn Mental Health Court
360 Adams Street, Brooklyn, New York 11201

My attorney:
Name:_____
Telephone #:_____

My Mental Health Court case manager:

Name:_____
Telephone #:_____

My community-based case manager:
Name:_____
Telephone #:_____

My mental health treatment program:
Name:_____
Address:_____
Telephone #:_____

My substance abuse and/or alcohol treatment program:
Name:_____
Address:_____
Telephone #:_____

My housing program:
Name:_____
Address:_____
Telephone #:_____

BROOKLYN MENTAL HEALTH COURT

NAME: _____ DATE: _____

Dkt/SCI/Ind. #: _____

Defendant: By entering this plea of guilty and agreeing to participate in the Brooklyn Mental Health Court program, I understand and agree to the following:

1. I have reviewed the treatment plan prepared for me by the Brooklyn Mental Health Court and will comply with that plan.
2. I have reviewed the Brooklyn Mental Health Court Program Participation Guidelines and will comply with the rules and procedures set forth therein.
3. I will lead a law abiding life until the successful completion of my Brooklyn Mental Health Court mandate.
4. I understand that failure to comply with the rules of the Court, my treatment program or my housing provider may result in sanctions by the Court which may include incarceration and/or a change in my treatment plan.
5. If I fail to complete my Court mandate, I will receive a jail/prison sentence of _____.
6. Any new arrest may result in immediate termination from my housing program, my treatment program and the Brooklyn Mental Health Court and the imposition of up to the maximum jail/prison sentence specified above.

_____
Brooklyn Mental Health Court Client

Judge: By accepting your plea of guilty and your promise to comply with your treatment plan, the Brooklyn Mental Health Court agrees to the following:

1. The Brooklyn Mental Health Court will help you get treatment, case management and/or housing services as described in your treatment plan.
2. A Mental Health Court case manager will meet with you regularly to discuss your participation and progress in treatment.
3. The Brooklyn Mental Health Court will hold you accountable for your actions. Successful compliance with your treatment mandate will be rewarded and acknowledged through the different phases of treatment. Sanctions, including jail time, will be imposed for failure to comply with your treatment plan or with the Court's rules and directions as outlined in the Brooklyn Mental Health Court Program Participation Guidelines.
4. The Court will impose the agreed upon jail/prison sentence if you fail to complete your treatment mandate.
5. If you successfully complete your treatment mandate, the Brooklyn Mental Health Court will:
   __ dismiss the charges against you and seal the record of those charges.
   __ reduce the charges to a misdemeanor with no further sentence imposed.
   __ reduce the charges to a misdemeanor with a sentence of probation for _____.

_____
Judge, Brooklyn Mental Health Court

Appendix B
Participant Profile

	Graduated N (17) # %	Terminated N(5) # %
DEMOGRAPHICS		
Median age at entry	39	35
Male	71%	40%
Race/Ethnicity		
Black/African-American	65%	40%
White/Caucasian	12%	60%
Hispanic/Latino	23%	0%
Single (never married)	71%	80%
SOCIO-ECONOMIC STATUS		
High School Degree/GED (minimum)	47%	60%
Lives with family/relatives/alone	76%	80%
Homeless in first 12 months as BMHC participant	1%	0%
Days homeless in first 12 months of BMHC participant	10	0
Longest Employment (years, average)	1.81	7.60
Employed Full-Time / Part-Time	6%	20%
MENTAL HEALTH FACTORS		
Axis I Diagnosis (Primary)		
Bipolar	29%	20%
Major Depression	12%	40%
Schizophrenia	35%	40%
Schizoaffective	18%	0%
Other	6%	0%
Co-Occurring Disorder (Yes)	41%	60%
GAF Score (Median)	55	55
Lifetime Hospitalizations (Average)	2.63	3.60
Number of psychiatric hospitalizations in 12mos.(Average)	0.53	0.40
Days hospitalized in past 12 mos. (Average)	30.71	20.00
Defendant has been in alcohol treatment (lifetime)	29%	17%
Defendant has been in drug treatment (lifetime)	41%	32%
CRIMINAL JUSTICE FACTORS		
Charges		
Misdemeanor	18%	20%
Felony	82%	80%
Length of Treatment		
9 to 12 months/12 moths	12%	20%
12 to 18 months[1]	53%	80%
18 to 24 months[2]	35%	0%
Alternative Sentence		
Low (years, median)	2	2
High (years, median)	4	4
Recidivism		
Within 12 months of enrolling in BMHC	6%	60%
Lifetime (Yes)	71%	100%

Appendix C
Outcome Measures

	Baseline									Follow-Up								
	Male			Female			Total			Male			Female			Total		
	N	#	%	N	#	%	N	#	%	N	#	%	N	#	%	N	#	%
SOCIO-ECONOMIC STATUS																		
GED/High School Diploma (Yes)	19		70%	8		8%	27		73%									
Monthly Income (Average $)	27		$238	10		$279	37		$249									
Minor Children (Yes)	8		30%	2		20%	10		27%									
Living Arrangements																		
Alone	6		22%	1		10%	7		19%	5		19%	0		0%	5		14%
With Spouse	0		0%	1		10%	1		3%	0		0%	1		11%	1		3%
With Parents	12		44%	1		10%	13		35%	4		15%	0		0%	4		11%
With Relatives	2		7%	2		20%	4		11%	2		7%	2		22%	4		11%
With Others	2		7%	2		20%	4		11%	2		7%	0		0%	2		6%
Community Residence	2		7%	2		20%	4		11%	2		7%	1		11%	3		8%
Single Site Supported	0		0%	0		0%	0		0%	1		4%	3		33%	4		11%
Substance Abuse Setting	0		0%	0		0%	0		0%	8		30%	0		0%	8		22%
Homeless: Streets	2		7%	0		0%	2		5%	0		0%	0		0%	0		0%
Homeless: Shelters	0		0%	1		10%	1		3%	0		0%	0		0%	0		0%
Homeless: Program Shelters	1		4%	0		0%	1		3%	0		0%	0		0%	0		0%
Other	0		0%	0		0%	0		0%	3		11%	2		22%	5		14%
Living Arrangement Total	27		100%	10		100%	37		100%	27		100%	9		100%	36		100%
Employment Status																		
Employed Full-Time	1		4%	0		0%	1		3%	2		8%	0		0%	2		6%
Employed Part-Time	1		4%	1		10%	2		5%	1		4%	1		11%	2		6%
Odd Jobs	1		4%	0		0%	1		3%	0		0%	0		0%	0		0%
Shelter (non-integrated)	0		0%	0		0%	0		0%	1		4%	0		0%	1		3%
Not in labor force: Student	0		0%	0		0%	0		0%	1		4%	0		0%	1		3%
Not in labor force: Disabled	16		59%	2		20%	18		49%	8		31%	3		33%	11		31%
Unemployed	4		15%	4		40%	8		22%	7		27%	2		22%	9		26%
Unemployed - Not Looking	3		11%	3		30%	6		16%	4		15%	3		33%	7		20%
Other	1		4%	0		0%	1		3%	2		8%	0		0%	2		6%
Employment Total	27		100%	10		100%	37		100%	26		100%	9		100%	35		100%

	Baseline									Follow-Up								
	Male			Female			Total			Male			Female			Total		
	N	#	%	N	#	%	N	#	%	N	#	%	N	#	%	N	#	%
Benefits																		
SSI	13		48%	5		50%	18		49%	16		59%	4		40%	20		54%
SSD	3		11%	1		10%	4		11%	2		7%	1		10%	3		8%
Public Assistance	14		52%	2		20%	16		43%	5		19%	2		20%	7		19%
Medicare	3		11%	1		10%	4		11%	2		7%	1		10%	3		8%
Medicaid	18		67%	7		70%	25		68%	20		74%	5		50%	25		68%
Food Stamps	11		41%	4		40%	15		41%	7		26%	2		20%	9		24%
Pension	2		7%	0		0%	2		5%	2		7%	0		0%	2		5%
Social Security	1		4%	0		0%	1		3%	2		7%	1		10%	3		8%
Vet. Benefits	1		4%	0		0%	1		3%	2		7%	1		10%	3		8%
Benefits Total	27			10			37			27			10			37		
HOMELESSNESS																		
Homeless in the past five years	8		30%	5		50%	13		35%									
Number days homeless in the past five years (average)	8		68	4		466	12		201									
Homeless in the past 12 months	4		15%	2		20%	6		16%	27		3	10		1	36		0
Number of days homeless in past 12 months (median)	4		53	2		365	6		223	3		73	1		10	4		57
HOSPITALIZATIONS																		
Any psychiatric treatment prior to arrest	8		30%	4		40%	12		32%									
Any mental health treatment at time of arrest	12		44%	3		30%	15		41%									
Lifetime hospitalizations	23		85%	5		50%	28		76%									
Number of lifetime hospitalizations (average)	23		4.43	5		4.40	28		4.43									
Psychiatric hospitalization in past 12 mos.	14		54%	4		40%	18		50%	5		14%	2		20%	7		19%
Number of pyschiatric hospit. in past 12 mos. (average)	14		1.21	4		1.00	18		1.17	5		1.60	2		1.00	7		1.43
Total # of days hospitalized in past 12 mos. (average)	13		23.00	4		23.00	17		23.00	5		19.00	2		27.50	7		21.43
Psychiatric ER visits in past 12 mos.	13		36%	3		30%	16		44%	6		22%	3		30%	9		25%
Number of psychiatric ER visits in past 12 mos. (average)	13		0.65	3		0.60	13		0.64	6		2.17	3		2.00	9		2.11
ER visits/admits for general health in past 12 mos.	1		4%	2		20%	3		8%	1		4%	2		20%	3		8%

	Baseline						Follow-Up					
	Male			Female			Total			Male			Female			Total		
	N	#	%	N	#	%	N	#	%	N	#	%	N	#	%	N	#	%
DRUG AND ALCOHOL USE																		
Alcohol treatment, lifetime	10		40%	2		22%	12		35%									
Drug treatment, lifetime	14		39%	6		60%	20		56%									
Frequency of alcohol abuse																		
1 or more times in past wk	10		42%	3		33%	13		39%	1		4%	0		0%	1		3%
1 or more times in past mo, but not in past wk	3		13%	1		11%	4		12%	1		4%	0		0%	1		3%
1 or more times in past 3 mos, but not in past mo	1		4%	0		0%	1		3%	3		13%	0		0%	3		10%
1 or more times in past 6 mos, but not in past 3 mos	0		0%	0		0%	0		0%	3		13%	1		14%	4		13%
Not at all in the past 6 months	6		25%	1		11%	7		21%	14		58%	4		57%	18		58%
Never	4		17%	4		44%	8		24%	2		8%	2		29%	4		13%
Current level of participant alcohol use																		
Abstinent	12		48%	3		30%	15		50%	22		88%	6		75%	28		85%
Use without impairment	1		4%	0		0%	1		3%	0		0%	0		0%	0		0%
Abuse	6		24%	1		10%	7		23%	0		0%	0		0%	0		0%
Dependence	5		20%	2		20%	7		23%	1		4%	0		0%	1		3%
Institutional remission[1]	0		0%	0		0%	0		0%	0		0%	0		0%	0		0%
Never	1		4%	4		40%	5		17%	2		8%	2		25%	4		12%
Frequency of drug abuse																		
1 or more times in past wk	15		60%	6		75%	21		64%	0		0%	1		10%	1		3%
1 or more times in past mo, but not in past wk	2		8%	0		0%	2		6%	3		12%	0		0%	3		9%
1 or more times in past 3 mos, but not in past mo	0		0%	0		0%	0		0%	1		4%	0		0%	1		3%
1 or more times in past 6 mos, but not in past 3 mos	0		0%	0		0%	0		0%	4		16%	2		20%	6		30%
Not at all in the past 6 months	4		16%	1		13%	5		15%	15		60%	5		50%	20		667%
Never	4		16%	1		13%	5		15%	2		8%	2		20%	4		57%
Current level of participant drug use																		
Abstinent	7		30%	3		43%	10		30%	21		84%	7		78%	28		82%
Use without impairment	0		0%	0		0%	0		0%	0		0%	0		0%	0		0%
Abuse	5		22%	0		0%	5		15%	0		0%	1		11%	1		3%
Dependence	11		48%	4		57%	15		45%	1		4%	0		0%	1		3%
Institutional remission	0		0%	0		0%	0		0%	2		8%	0		0%	2		6%
Never	3		13%	0		0%	3		9%	1		4%	1		11%	2		6%

[1]Participant stopped using drugs or alcohol while in jail, prison, or hospital setting.