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A Process Evaluation of the Manhattan Mental Health Court

By Erin J. Farley

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Executive Summary

In response to growing numbers of defendants with mental illnesses encountering the justice system over the last 30 years, a number of alternative to incarceration programs have emerged, including specialized mental health courts. Mental health courts are modeled after drug courts (see Rempel 2014; Mitchell, Wilson, Eggers, and MacKenzie 2012; Shaffer 2011) and typically involve a separate docket and a dedicated court staff (judge, prosecutor, and defense attorney). Evaluations of mental health courts have produced varying findings, although many have demonstrated positive results across multiple outcomes, including substance use, recidivism, and mental functioning at follow-up (see Rossman, Willison, Mallik-Kane, Kim, Debus-Sherrill, and Downey 2012; Steadman, Osher, Robbins, Case, and Samuels 2010).

This report presents the results from a process evaluation examining the first three and a half years of the Manhattan Mental Health Court, a specialized docket for offenders with mental illness established in March 2011. A mixed-methods research design was employed, which included quantitative analysis of court administrative data; interviews with the presiding judge and resource coordinator; courtroom observations; and a focus group with case managers.

Major Findings

- Program Volume: From March 2011 through July 2014, 91 defendants have become participants in the Manhattan Mental Health Court (for an average of 27 new participants per year).

- Arrest Charges: Eligible defendants were arrested on felony charges. The most common type of arrest charge was property-related (40%), followed by drug sales or possession (25%), violent felony offense (20%), and all other charges (15%).

- Clinical Diagnosis: Seventy-three percent of participants had more than one diagnosis. The most frequently diagnosis was a bipolar or bipolar-related disorder (21%). Schizophrenic/Schizoaffective and psychotic disorders were each present in 17% of the sample, and major depression was present in 16%.

- Co-Occurring Disorders: Sixty-three percent of participants were diagnosed with *at least* one serious mental health disorder as well as a co-occurring substance abuse problem.

- Days to Intake: The median number of days from arrest to the beginning of intake was 171 days, with an average of 206 days (or more than six months).

- Days to Enrollment: The median number of days from intake to guilty plea/enrollment was 107 days, with an average of 124 days, or more than three months. When combining the time from arrest to intake and from intake to enrollment, participants averaged 331 days (or 10.9 months) from arrest to enrollment.

- Pre-Enrollment Detention: Forty percent of program participants were detained on Rikers Island between arrest and enrollment for an average of 97.4 days (3.2 months).

- Time in Program: Graduates were in the program for an average of 19.0 months while program failures were in the program for 8.3 months.

- Retention Rates: The retention rate for the participants who spent at least 90 days in the program was 79%; after one year, the retention rate was 67%, and after two years the retention rate was 60%.

- Mental Health Court Team: Qualitative findings reveal strong collaborative partnerships amongst team members.

- Judicial Status Hearings: Based on structured courtroom observations, a sample of 20 judicial status hearings ranged from one minute to 11 minutes in length (average = 4.10 minutes). Throughout the observed status hearings, the judge consistently made eye contact and smiled at defendants. The judge also inquired about specific aspects of the defendant's life; this included questions about their health, job, classes, vacations, and personal struggles. The influential role of the judge was emphasized by team members during interview and focus group discussions

- Housing: One of the major challenges was a dearth of adequate and appropriate housing in the community. The lack of supportive housing and treatment services for individuals with a mental health diagnosis meant that many eligible defendants experienced sizable delays in becoming an active participant, the adverse effects of which often included pretrial detention at the Rikers Island city jail. Challenges in securing appropriate housing for the mentally ill offender population is a problem that many mental health courts face both in and outside of New York (e.g., see O'Keefe 2006; Rossman et al. 2012).

- Fidelity to Model: While findings reveal a number of key challenges, the Manhattan Mental Health Court has a high level of fidelity to the mental health court model it intended to implement

Overall, the data suggest that Manhattan Mental Health Court is achieving its primary goal in providing an alternative to incarceration for defendants with mental illness, while at the same time holding defendants accountable for their behavior. In addition, courtroom observations suggest that the judge works to engage each participant during regularly scheduled judicial status hearings.

Chapter One
Introduction

The overrepresentation of people with mental illnesses in the criminal justice system has been an area of concern across the United States since the deinstitutionalization movement began in the 1960s. While specific estimates of mental illness among incarcerated populations vary, multiple studies of jail inmates have documented rates of mental illness more than three times that of the general population (James and Glaze 2006; Kessler, Nelson, McGongle, Edlund, Frank, and Leaf 1996; Steadman et al. 2009). Importantly, serious mental illness is associated with increased likelihood of substance use and housing instability, both of which predict involvement in the criminal justice system (e.g., see Reich, Fritsche, and Adler forthcoming).

Many traditional courts are not equipped to address the problems presented by defendants with mental illness. Specialized mental health courts have evolved as one alternative to traditional case processing for this group. Rooted in the drug court model, mental health courts combine targeted clinical services with intensive judicial supervision and interim sanctions and incentives. The first mental health court was established in Broward County, Florida in 1997, and currently there are more than 325 mental health courts across the nation, with seven of them located in New York City.[1]

While research findings have varied, several studies have shown positive impacts of mental health courts on participants. For example, research has found decreased substance use as well as improvements in level of functioning (Cosden, Ellens, Schnell, Yamini-Diouf, and Wolfe 2003; O'Keefe 2006). In addition, research has found that mental health court participants are less likely to re-offend, have more days before re-arrest, and have fewer arrests when compared to other offenders suffering from mental illness (Cosden et al. 2003; McNeil and Binder 2007; Rossman, Willison, Mallik-Kane, Kim, Debus-Sherrill, and Downey 2012; Steadman, Redlich, Callahan, Robbins, and Vesselinov 2010).

With funding from the U.S. Bureau of Justice Assistance, this report presents the results from a process evaluation examining the first three and a half years of the Manhattan Mental Health Court, a specialized docket for offenders with mental illnesses established in March 2011.

The Manhattan Mental Health Court

Prior to establishing the Manhattan Mental Health Court, a planning committee was formed with representatives from the New York State Unified Court System, New York State Office of Mental Health, New York County (Manhattan) District Attorney's Office, Legal Aid Society, New York County Defender Services, Neighborhood Defender Services of New York City and New York City Department of Health and Mental Hygiene (NYC DOHMH). The Honorable Juan Merchan, the presiding judge for the Manhattan Mental Health Court, led the planning committee. Committee members discussed and agreed upon the key policies and procedures for the Court. Fundamental components of the Court were based on the ten key elements outlined by Thompson, Osher, and Tomasini-Joshi (2007). These ten "Essential Elements" include:

[1] See SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. Adult Mental Health Treatment Courts Database, http://gainscenter.samhsa.gov/grant_programs/adultmhc.asp.

1. Utilizing a broad based group of stakeholders should guide the planning and the administration of the court.
2. Eligibility requirements should consider defendants offenses, public safety, and a community's treatment capacity.
3. The time between identification and mental health court participation should be a quick as possible.
4. Terms of participation should be clear, outlining the policies and practices of the mental health court as well as case outcomes for failure and successful completion.
5. Participants should fully comprehend the program requirements before agreeing to participate.
6. Staff should connect participants to comprehensive and individualized treatment services in the community.
7. Participants' health and legal information should be strictly protected.
8. Members of the mental health court should receive special and ongoing training.
9. Participants' progress should be closely monitored and treatment should be modified to offer individualized treatment in ways that support compliance, recovery, and public safety.
10. Data should be collected and analyzed to determine the impact of the mental health court.

The Manhattan Mental Health Court opened in March 2011 in an effort to provide oversight and treatment to non-violent felony offenders suffering from mental illness. During the initial pilot year of the program, staff resources were "borrowed" from other court parts. In 2012, the Court received funding from the Bureau of Justice Assistance, which allowed the court to hire a full-time resource coordinator and increase its caseload.

Defendants eligible for the Manhattan Mental Health Court include those who are 18 years or older, arraigned on nonviolent felony charges, and diagnosed with a serious mental illness (formerly referred to as Axis-1 diagnosis). Eligible defendants may be referred by judges, prosecutors, defense attorneys, and mental health agencies.

Eligible defendants must be capable of entering a knowing and voluntary plea. Any defendant found incompetent under Article 730 of the Criminal Procedure Law is not eligible to participate in the Court. Defendants must plead guilty at the outset of participation with terms of treatment and judicial supervision ranging from 12 months to 24 months. Participants are monitored regularly by the Manhattan Mental Health Court team (through frequent judicial status hearings where progress and compliance are reviewed in court), and noncompliance may lead to sanctions and extended time in the program. Graduates have criminal charges reduced, while those who are unsuccessful are terminated from the program and receive the jail or prison sentence set forth in the plea agreement.

Specifically, the court seeks to:

1. Provide an alternative to incarceration that both holds offenders accountable through intensive court supervision and takes a problem-solving approach to the nexus of mental illness and incarceration.
2. Address the treatment needs of offenders with mental illness by providing comprehensive evaluations by medical professionals, linking them to the appropriate treatment services and providing them access to appropriate medication.

3. Provide access to services beyond mental health treatment, which include education and vocational programs, housing assistance, and substance abuse treatment.

This report is a process evaluation of the first three and a half years of the Manhattan Mental Health Court that seeks to document the evolution of policies and procedures, staffing, and operations; measure the fidelity of the court to original goals and strategies; describe the defendants who were referred to and participated in the Court and document trends in phase advancement, program status, and service utilization for participants.

Research Methods

A mixed-methods approach was employed to achieve a comprehensive understanding of the structure and operations of the Manhattan Mental Health Court. The quantitative component involved analysis of data collected through the Universal Treatment Application, a relational database that is used by problem-solving courts throughout New York State and included status (e.g., active participant, graduated, failed, etc.), relevant court dates, compliance information, and court responses to achievements and infractions. Because the Court delegates case management responsibilities to an outside agency, Federation Employment & Guidance Services (FEGS), the Universal Treatment Application does not possess information regarding participants' psychosocial assessment or treatment information. This gap in available data was supplemented with a focus group with case managers to discuss the topics of assessment, treatment, and services (see Appendix C for focus group protocol).

Qualitative methods included interviews with stakeholders including the judge (see Appendix A for interview protocol), the resource coordinator (see Appendix B for interview protocol), and a focus group with two case managers and their team supervisor (see Appendix C for focus group protocol).

Finally, court observations were conducted in order to better understand the daily operations of the Court and the interactions between the judge and the participants. Observations of judicial status hearings with mental health court participants were conducted on two days and encompassed the full court session for each day (approximately two hours). In all, a total of 41 court appearances were observed. Observations followed a semi-structured protocol that included documenting length of each court appearance, demographic and status characteristics of the defendant, and aspects of judicial interaction with defendants.

Chapter Two
The Manhattan Mental Health Court Model

Staffing and Operations

The Manhattan Mental Health Court team consists of a dedicated judge, assistant district attorney, resource coordinator, and three case managers and a team leader provided by the non-profit organization Federation Employment & Guidance Services (FEGS) pursuant to a contract with the New York City Department of Health and Mental Hygiene. Defense attorneys involved in the court include lawyers from several entities representing indigent defendants: The Legal Aid Society, Neighborhood Defender Services, and New York County Defender Services.

The Honorable Juan Merchan has presided over the court since its inception. Judge Merchan has served as a justice of the Supreme Court in New York (Manhattan) County since 2009; prior to that he presided over the Bronx Family Treatment Court for two and a half years.

During the Manhattan Mental Health Court's first year, a part-time resource coordinator was utilized to perform the administrative responsibilities. Upon receiving funding from the Bureau of Justice Assistance in March 2012, the current resource coordinator was hired. Responsibilities of the resource coordinator include overseeing day-to-day court operations, making recommendations to the judge as to sanctions and rewards, answering questions on criminal and clinical eligibility, participating in case conferences, ensuring treatment plans are delivered to the court in a timely fashion, and monitoring the progress of participants. The resource coordinator also acts as a liaison between the Court, the Bellevue Forensic Psychiatry Court Clinic, case managers, community-based treatment programs, defense attorneys, and prosecutors.

Since the inception of the Court, there have been seven total case managers provided by FEGS to work with Manhattan Mental Health Court participants. Case managers are responsible for evaluating eligible defendants, creating an appropriate treatment plan, linking participants to mental health treatment, substance abuse treatment, medical treatment and community based services. Case managers also maintain communication with treatment providers and social services agencies as well as monitor participants by maintaining weekly contact.

Court is in session one day a week, with the team meeting in person in the judge's chambers for case conferences prior to the beginning of Court. The team includes the judge, the prosecuting attorney, a case manager, the resource coordinator, and each defense attorney with a client on the calendar that day, called in individually for discussions of their clients' cases. These conferences include discussing eligible defendants, providing on compliance and making decisions as to sanctions and program advancement.

During each court session there are typically a number of court, clinical, and legal staff present including the judge, stenographer, clerk, court officers, resource coordinator, case managers, prosecutors, and defense attorneys. Clients, family, friends, as well as defense attorneys and case managers may also be present during the court session. When a client's case is called the client and the defense attorney will rise and sit at the defense table in front of the gallery, which is adjacent to the prosecutor's table. Depending on the case, the resource coordinator, case manager, or other service provider representative may be called up to speak during the court appearance. Court sessions include a variety of court appearance types, including new cases, judicial status hearings, phase advancements, graduations, and sentencing

(of successful and unsuccessful participants). In general, there are 15 cases on the calendar, each court hearing lasts a few minutes (mean = 4.10, N = 20) with the entire session lasting approximately two hours.

During interviews, current team members referred to challenges in effective communication between the Court, case managers, and service providers during the first 12 months of the Court's operations. These issues were successfully resolved with the appointment of the full time resource coordinator and the restructuring of the case management team. Accordingly, the team described current interaction between the Court and the case management team as strong, supportive, and open.

Screening and Eligibility

To be eligible for the Manhattan Mental Health Court, defendants must be 18 years or older, arraigned on a nonviolent felony offense (defendants charged with violent felonies may be considered on a case-by-case basis), and diagnosed with a serious mental illness (formerly a DSM Axis-1 diagnosis). Defendants who appear to have co-occurring substance disorders are eligible for the Court. Defendants with certain prior or current offenses, including violent, sex, gun, or arson offenses, are generally considered ineligible for the Court.

Potential participants may be referred to the court through a variety of channels, including prosecutors, defense attorneys, or community-based service providers. A successful referral requires signatures by the prosecutor, defense attorney, and client, as well as approval by the Special Litigation Bureau of the prosecutor's office. (The Special Litigation Bureau is a prosecutorial unit located in the trial division of the Manhattan District Attorney's Office.) Once all of these steps have been achieved, the transfer is finalized with the approval of the presiding judge of the court.

An initial conference among court team members involving the judge, defense counsel, assistant district attorney, and resource coordinator is required to establish the legal eligibility of the defendant. If found legally eligible, defendants are referred to the Bellevue Hospital Forensic Psychiatry Court Clinic for a full clinical evaluation. The resulting diagnosis and risk assessment is submitted to the Court, where it will be determined if the defendant continues to fit the Court's requirements. If a defendant is considered a good candidate for the program, the defendant will then be evaluated by case managers. Results from this evaluation are combined with information from the Forensic Psychiatry Clinic evaluation to create an appropriate treatment plan. Finally, if defendants are interested in participating in the program they are required to enter a guilty plea and accept a predefined alternative sentence in the event of failure.

Court Participation

Defendants who agree to become participants are required to sign a treatment plan, an "Ongoing Release of Confidential Information" form, a waiver of the right to appeal, and to enter a guilty plea on the designated charge(s). Once the defendant has become a Manhattan Mental Health Court participant, he or she will be referred to a treatment program which may involve substance abuse and medical treatment in addition to mental health treatment.

In consideration of their risks and needs, participants' service plans may include a variety of treatment programs and/or supportive housing including a long term residential program, supported community residential program, outpatient treatment program, three-quarter housing,

detox, outpatient clinic, care coordinator services with Health Home, self-help services, Alcoholics Anonymous/Narcotics Anonymous program, dialectic behavioral therapy, assertive community treatment, vocational training, as well as educational programs.

According to Court policy, program participants must successfully complete four phases, each lasting from three to six months. Phase One (Adjustment) is intended to establish rapport between participants and the team (case managers, social workers, resource coordinator, presiding judge etc.) and requires participants to begin taking medication if necessary and attend weekly or regularly scheduled court sessions. The goal for Phase Two (Engagement) is to assist participants in making positive lifestyle changes in order to build healthy supportive relationships. During this phase, it is expected that participants will be attending regularly scheduled court sessions. During Phase Three (Progress in Treatment) participants are expected to attend court sessions regularly as well as achieve a level of emotional stability that involves utilizing healthy coping strategies. The final phase, Phase Four (Preparation for Graduation) entails the participant continuing with treatment (and medication if necessary), but court attendance and case manager meetings are reduced.

Progression through each of the phases depends on the participants' compliance. Noncompliant behaviors considered infractions by the Court include failing prescribed psychiatric medications, testing positive for drugs and alcohol, refusing to give a urine sample for drug testing, lying, missing treatment appointments, missing appointments with case manager, missing scheduled court dates, leaving a program without permission, and being arrested for a new criminal offense. In response to noncompliance, defendants may receive a range of sanctions, including writing an essay, a reprimand, writing an essay, increased frequency of court appearances, bench warrant or remand to jail. For certain infractions, the court may give the participant a "second chance" or warning before implementing any sanctions. The court team may also respond to problems with adjustments to the treatment plan, including mandatory group attendance, detox, drug rehabilitation, hospitalization, or a transfer to a more or less restrictive treatment or housing setting.

For successful progress through the program, participants may receive a range of positive incentives ("rewards"), including reduction in the frequency of court appearances, suspension of drug testing, certificates, phase advancement and finally graduation. For graduates, their charges may be dismissed or reduced. For those who fail, the sentence detailed in the plea agreement is imposed and often involves jail.

Chapter Three
Participant Characteristics and Program Outcomes

Court Intake and Case Volume

The goal for the first year of the Manhattan Mental Health Court was to limit participation to approximately two dozen defendants. The Court's capacity would then increase to approximately 50 participants in the subsequent years. According Table 3.1, among those screened in 2011, 35 became participants. Among those screened in 2012, 21 became participants. And among those screened in 2013, 30 became participants. Within the first seven months of 2014, 24 individuals were initialized and five became participants. As of July 2, 2014 there were 38 active participants.

Table 3.1. Annual Eligibility and Participation Volume in Manhattan Mental Health Court

Outcomes for those screened in:	March - Dec 2011	Jan- Dec 2012	Jan - Dec 2013	Jan - July 2014	Total[1]
Total N Initialized	**63**	**49**	**77**	**24**	**213**
Ineligible[2]	20	17	41	6	84
Declined participation	8	11	6	1	26
Initialized but not yet declined or enrolled	0	0	0	12	12
Enrolled	35	21	30	5	91

[1]Note: Status for one case inititalzied in 2013 missing data.

[2]Note: Reasons for ineligibility include no eligible diagnosis, too unstable/dangerous, unfit under Article 730, uncooperative, inadequate motivation, current charges, criminal history, and "other."

Table 3.2 presents screening outcomes for all cases referred to the Court as of July 2, 2014. Forty-six percent of defendants screened by the Court became participants. Among those who did not become participants, 24% refused, 42% were ineligible due to clinical reasons, and 29% were ineligible due to criminal justice reasons.

Among defendants found ineligible due to clinical reasons, the most commonly cited reason was lack of motivation for treatment (10% of all those found ineligible/not participating), followed by no eligible diagnosis (9%), unstable or dangerous (9%), and refused assessment (9%).

Among defendants ineligible due to criminal justice reasons, the most commonly cited reason was "other," which represented 21% of the ineligible/non-participant sample. Based on interviews with the stakeholders, a large portion of these "other" cases can be attributed the "gatekeeper" role of the assistant district attorney (ADAs) or the Special Litigation Unit from the Manhattan District Attorney's Office, which refused to transfer or refer these cases to the Court. Based on this information, the "other" category was relabeled as "ADA rule out," with the understanding that there may be a small number of cases that do not fit this designation. Specific past or current charges may also result in a referred defendant being found ineligible to participate. These charges include sex crimes, crimes against children, stalking[2], criminal contempt and arson.

[2] In the past Manhattan Mental Health Court had accepted participants with stalking charges but due to the challenges of monitoring these cases, defendants with stalking charges are no longer accepted.

Table 3.2. Screening Outcomes for all Defendants Referred to Manhattan Mental Health Court

	N	%
	199 [1]	**100%**
MMHC Participants	**91**	**46%**
Ineligible/Non-Participant	**108**	**54%**
Criminal Justice Reasons		
Current Charges	3	3%
Criminal History	6	5%
ADA Rule Out	23	21%
Clinical Reasons		
No Eligible Diagnosis	10	9%
Unstable/Dangerous for Community	10	9%
Incompetent under Article 730	1	1%
Refused assessment/failed to cooperate	10	9%
Inadequate Motivation for Treatment	11	10%
Other	4	4%
Refused/Opted Out	26	24%
Other Reasons	4	4%

[1] Note: 13 additional open cases were waiting for an assessment and 2 cases were identified as closed-incomplete.

Case Processing Speed

According to Table 3.3, the median number of days from arrest to the beginning of intake is 171 days, with an average of 206 days. The median number of days from intake to guilty plea/enrollment is 107 days with an average of 124 days. When combining the time from arrest to intake and from intake to enrollment, participants average 331 days (or 10.9 months) from arrest to enrollment. Extensive wait times are not uncommon in mental health courts in New York City. For example, an evaluation of the Brooklyn Mental Health Court found the average number of days from arrest to intake was 245 days with a median of 149 days and the average number of days from intake to participation was 93 days with a median of 70 days (Rossman et al., 2012).

A number of factors may account for the time it takes for eligible defendants to become active participants. According to interviews with Manhattan Mental Health Court team members, cases may sit pending in other court parts while attorneys wait for the release of hospital and psychiatric records. In addition, defense attorneys may take time considering all of the legal

options for their clients before deciding to refer them to the Court. Once defendants are identified as potentially eligible, they first must complete a full clinical assessment with the Forensic Psychiatry Clinic. It may take three to four weeks to schedule an appointment, and in turn the Clinic has two weeks to prepare its findings for the Court. After the findings by the Clinic are submitted, the team must meet to decide if the defendant meets eligibility standards based on court requirements and the findings from the clinical assessment. If the defendant is deemed eligible and appropriate, the defendant will then need to complete an assessment with case managers in order to create a treatment plan prior to formal enrollment.

It is notable that a large portion of eligible defendants are incarcerated at Rikers Island during this waiting period, which presents further obstacles. Specifically, limited access to defendants means case managers often need to return to Rikers Island multiple times over a two to four week period to complete a full case management evaluation. As with the Forensic Psychiatry Clinic, case managers from FEGS are provided two weeks to write up and submit their findings and recommended treatment plan.

Delays can also be attributed to the challenges in securing appropriate housing in Manhattan. This is not unusual, as prior studies have reported barriers to securing appropriate treatment and housing in for the mentally ill offender population (e.g., see O'Keefe 2006; Rossman et al. 2012). According to team members, defendants in need of housing who are diagnosed with a mental illness *but not* a co-occurring substance abuse problem may have to wait one to six months for a bed to become available. During this waiting period, many defendants are kept in jail. Only upon securing appropriate housing will defendants be allowed to plead guilty, be released from jail, and begin their participation.

Table 3.3 Case Processing Speed

	Arrest to Beginning of MMHC Intake	MMHC Intake to Guilty Plea (Participation Date)
Average Number of Days	205.88	123.96
Median Number of Days	171.00	107.00

Additional analysis identified 32 participants who waited in jail until their plea date and 48 who were released prior to their plea date—therefore, 40% were incarcerated for the duration of the period that preceded enrollment.[3] Whether someone remains incarcerated or not is directly influenced by bail decisions, which are initially made at arraignment (first court appearance). Numerous factors may include, but are not limited to, charge severity, community ties (i.e., employment or school status), housing status, medical coverage, and bail amount (since a defendant may be less likely to post bail if the amount is higher). Once referred to the Manhattan Mental Health Court, the judge will only consider a change in bail if there has been a legitimate change in circumstances (i.e., securing a residence) since the defendant's arraignment. Discussions with team members reveal requests for bail reductions based on a change in circumstances are infrequent.

Table 3.4 presents the results from a cross-tabulation analysis between jail status (In/Out) at time of plea and case outcome (including 24 graduates and 20 failures). The analysis reveals that

[3] Eleven cases were excluded due to inconclusive pretrial detention status based on available data.

74% of those released prior to their plea date successfully graduated from the program, compared with only 23% of those who were incarcerated until their plea date ($p<.01$).

In turn, a descriptive analysis of the time from arrest to plea date for all participants (including both open and closed cases, n =32), revealed that these participants who were incarcerated spent an average of 282 days in jail (with a median of 225.05 days) until their plea date.

Table 3.4 Jail Status at Plea Date and Case outcome**

	Not Incarcerated at Plea Date	Incarcerated at Plea Date
Graduated	74% (20)	24% (4)
Failed	26% (7)	77% (13)
Total	100% (27)	100% (17)

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

Participant Profile

Table 3.5 presents a demographic and criminal charge profile of all 91 participants. Demographic information is limited because full assessments are conducted outside the court system by case managers from FEGS (e.g., a race breakdown is unavailable). From the information available, the median age of participants is 34 years and a majority are male (78%). The most common charge was criminal sale of a controlled substance (20%), followed by larceny (19%), assault (9%), and non-violent robbery (9%).[4]

[4] Additional statistical analyses were conducted examining the relationship between participant characteristics (i.e., age, gender, charge type) and program outcome, no significant relationships were found; this may be due to low statistical power due to a small sample size.

Table 3.5. Participant Profile

	N	%
	91	**100%**
Median Age	34.0 yrs	
Sex		
Male	71	78%
Female	20	22%
Charge Type		
Violent Charge[1]	**18**	**20%**
Assault	8	9%
Robbery	5	5%
Burglary	4	4%
Criminal Possession of a Weapon	1	1%
Property Charge	**36**	**40%**
Burglary	6	7%
Larceny	17	19%
Forgery/Identity Theft	5	5%
Robbery (Non-Violent)	8	9%
Drug Charge	**23**	**25%**
Criminal Possession of a Controlled Substance	5	5%
Criminal Sale of a Controlled Substance	18	20%
Other	**14**	**15%**

[1]Note: Violent charges identified under New York Penal Law Code.

Clinical Diagnosis

Table 3.6 shows the primary DSM-V diagnoses of Manhattan Mental Health Court participants. A notable portion of participants had more than one diagnosis. Among the 89 participants with diagnosis data, 28% had one diagnosis, 42% had two diagnoses, 17% had three diagnoses, and 14% had four diagnoses.[5] The most frequent diagnosis was a bipolar or bipolar related disorder (21%). Schizophrenic/schizoaffective and psychotic disorders not otherwise specified each account for 17% of the sample.[6] Overall, 63% of the sample was diagnosed with *at least* one serious mental health disorder as well as a co-occurring substance abuse problem. In keeping with previous mental health court literature, this analysis found that participants with co-occurring disorders (e.g., see Reich et al., 2014) had particularly high rates of failure (83% of failures had a co-occurring substance abuse in comparison to 61% of graduates, $p<.10$).[7]

[5] Number of diagnoses that can be listed in the data file per person is limited to four.
[6] NOS represents cases in which the cluster of symptoms resemble a certain disorder but did not fit well enough to be categorized as such and therefore are identified with a more general label.
[7] Due to a small sample size, the relationship between primary diagnosis and case outcome could not be examined.

Table 3.6. DSM and Dual Diagnosis of Manhattan Mental Health Court Participants[1]

	Graduates[2]	Failures	Open[2]	Total[3]
	N =29	N =24	N =37	N = 89
Primary Diagnosis				
Schizophrenic or Schizoaffective Disorder	14%	17%	19%	17%
Bipolar Related Disorder	18%	17%	27%	21%
Major Depression	14%	8%	22%	16%
Mood Disorder, Not Otherwise Specified	7%	25%	11%	14%
Psychotic Disorder, Not Otherwise Specified	25%	25%	5%	17%
Other Disorder	21%	8%	16%	16%
Co-Occurring Substance Abuse Diagnosis	61%+	83%	51%	63%

[1]Note: Due to rounding primary diagnosis categories may total less or more than 100%.

[2]Note: One case missing data.

[3]Note: Two cases missing data.

+p <.10 *p<.05 **p<.01 ***p<.001 (comparison between graduates and failures only)

Program Status for Manhattan Mental Health Court Participants

Table 3.7 shows the current status for all 91 participants: 29 graduated (32%), 24 failed (26%), and 38 (42%) are still active in the program. Sixty-one percent of participants are in either Phase One or Phase Two of the program. Among the 24 participants who failed, the majority (71%) failed due to chronic non-compliance with their treatment program. A small number failed due to a new arrest or final bench warrant. The alternative sentence for failures is approximately two years of incarceration.

On average, it takes 19 months for successful participants to reach graduation. Key milestones towards success are phase advancements. Phase advancement is usually first suggested by the defense attorney or presiding judge during a conference session with the Court team. According to interviews, the advancement of participants is granted upon the consensus of the team. Interviews further revealed that even fully compliant participants rarely advanced at the minimum three-month mark. Instead, phase advancement takes an estimated four to five months.

Table 3.7. Current Program Status of Manhattan Mental Health Court Participants

	N	%
	91	**100%**
Open	**38**	**42%**[1]
Phase One	9	24%
Phase Two	14	37%
Phase Three	6	16%
Phase Four	6	16%
Pending Graduation	3	8%
Graduated	**29**	**32%**
Failed	**24**	**26%**
New Arrest	6	25%
Chronic Noncompliance	17	71%
Bench Warrant- Final	1	4%

[1] Note: Due to rounding percentages may total to less or more than 100%.

Court Appearances, Infractions, and Sanctions

Participants are required to complete 12 months, at a minimum, in the program in order to graduate. Noncompliance may result in a number of outcomes including a warning, a sanction, a delay in phase advancement, or the participant being returned to an earlier phase.

Table 3.8 shows the number of court appearances participants had during their tenure in the program. On average, participants had 21.17 court appearances, with graduates having significantly more on average than failures (25.14 v. 16.38, $p<.001$). Of note, on average failures had significantly more appearances *per month* than graduates (3.58 v. 1.34, $p <.05$), meaning that while failures spent a shorter amount of time in the program, they had greater court appearance requirements. Increasing the frequency of appearances may be used as a sanction in response to participant infractions; however, they are also used as a way to provide greater support for struggling clients through increased court and judicial contact.

Table 3.8. Judicial Supervision: Court Appearances for Monitoring

	Graduates	Failures	Total
	N = 29	N = 24	N = 53
Total Number of Appearances[1]			
Ten (10) or Fewer	0%	33%	15%
Eleven (11) through Twenty (20)	35%	42%	38%
Twenty-One (21) through Thirty (30)	38%	13%	26%
More than thirty (30)	28%	13%	21%
Median Number of Appearances	23	15	20
Average Number of Appearances	25.14*	16.38	21.17
Rate of Appearances/Month			
Median rate of Appearances/Mo.	1.22	2.27	1.56
Average Rate of Appearances/Mo.	1.34*	3.58	2.36

[1] Note: Due to rounding, percentages may total more or less than 100%.

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

Table 3.9 shows rates of infraction and typical types of infractions committed by program participants. Overall, 73% of participants committed at least one infraction. One-hundred percent of those who failed had committed at least one infraction in comparison to 52% of graduates (p<.001). On average, failures had significantly more infractions in comparison to graduates (6.0 v. 2.4, p>.001).

The most frequently cited infraction was involuntary termination by treatment program, followed by absconding/failure to appear in court, and new arrest. Involuntary termination by program may result when the participant exhibits behavioral problems, like threatening the staff or peers, *not* associated with their mental illness. Finally, 23% of participants were identified as having a positive toxicology or missed urine test. Based on interviews with members of the team, these participants were most likely sent to detox or rehab in response to this infraction.

Table 3.9. Infractions for Manhattan Mental Health Court Participants

	Graduates	Failures[1]	Total
	N = 29	N = 24	N = 53
Average Number of Infractions	2.4**	6.0	4.0
Percentage of Participants with at least one Infraction	52%***	100%	73%
Percentage of Participants with 5 or more Infractions	24%+	48%	35%
Top Six Infractions			
Treatment- Involuntary Termination by Program	3%***	50%	25%
New Arrest	31%	38%	34%
Treatment - Absconded or Failed to Appear	14%*	38%	25%
Positive Toxicology/Missed Urine Test	14%+	33%	23%
Court - Failure to Appear	17%	25%	21%
Treatment - Missed Appointment	31%	17%	25%

[1]Note: One case missing data.

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

Table 3.10 displays the common types of sanctions used in the Court. Overall, 69% of participants received at least one sanction, including 96% of failures and 48% of graduates (p<.001), suggesting that some infractions are tolerated by the court as a normal part of treatment. In addition, program failures had a significantly greater number of sanctions on average in comparison to graduates (3.9 v. 1.9, p<.01). The most frequently cited sanction was the issuing of a warrant, followed by verbal admonishment, jail, and then writing an essay. Forty-two percent of those who failed the program had received a jail sanction, whereas only 7% of those who graduated the program had received a jail sanction (p <.05).

While essays were utilized as a sanction in only 11% of the total cases, interviews revealed that they are seen by team members as an important tool of the Court. Essays are intended to encourage the participant to reflect on the consequences of their non-compliant behavior. For example, defendants are asked to write an essay about the repercussions of drug use, how it affects their family and their future. Or if a defendant is facing a two year incarceration sentence, s/he may be asked to write an essay answering what would it mean to them to lose two years of their life.

Table 3.10. Sanctions for Manhattan Mental Health Court Participants

	Graduates	Failures[1]	Total
	N = 29	N = 24	N = 53
Average Number of Sanctions	1.9**	3.9	2.8
Percentage of Participants with at least one Sanction	48%***	96%	69%
Percentage of Participants with 5 or more Sanctions	17%	35%	25%
Top four Sanctions			
Warrant Issued	28%	42%	34%
Court- Verbal Admonishment	28%	29%	28%
Jail - Indefinite/Judges Discretion	7%*	42%	23%
Essay/Letter/Journaling	10%	13%	11%

[1]Note: One case missing data.

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

Time in the Program and Retention Rates

Table 3.11 displays the length of time participants stayed in the program. Overall, the average time in the program was 14.15 months. Failures averaged significantly shorter time in the program in comparison to graduates (8.29 v. 19.00, p<.001). Team members noted that the amount of time a graduate is in the program (average of 19 months) is an indication that even graduates have setbacks (i.e., relapse), which delay their phase advancement; team members also noted that even compliant participants may spend more time in each phase than the three-month minimum.

Table 3.11. Time in Program (in Months)

	Graduates	Failures	Total
	N = 29	N = 24	N = 53
Median	17	5	16
Mean	19.00***	8.29	14.15

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

Table 3.12 displays retention rates for participants. Retention rates represent the percent of total enrolled participants who are active or have graduated (those who failed or warranted would be identified as not retained), as of 90 days, six months, one year, and two years. According to Table 3.10, the retention rate for the participants who had spent at least 90 days in the program was 79%; after one year, the retention rate dropped to 67%, and after two years the retention rate dropped to 60%.

Table 3.12. Retention Rates for MMHC Participants

Length of Time	N	Retention Rate
90-Days	87	79%
6 Months	80	75%
1 Year	66	67%
2 Years	37	60%

Interactions between Participants and the Judge

Prior problem-solving court research has suggested that the quality of interaction between the judge and the participants is an important factor driving participant success (Picard-Fritsche, Kralstein, Bryan, and Farley 2011; Rossman, et al. 2011). At the Manhattan Mental Health Court, these interactions were observed over the course of two court dockets in spring 2014.

Among the 41 observed court proceedings, 60% of the defendants were male and 80% were observed to be members of a racial minority. The judge directly interacted with all 41 of the defendants brought before him, frequently beginning with probing questions like "how are you feeling?", "tell me about…", or "what's going on…?" Among the 20 court appearances in which time was recorded, cases ranged from 1 minute to 11 minutes (average = 4.10 minutes). Appearances that tended to take longer involved defendants who were new to the court (there were a total of six defendants who were referred to as new cases/not yet participants), defendants entering a plea, or noncompliant participants.

Five appearances involved participants advancing to the next phase and one involved completion of the program. These appearances were distinctly different from as they entailed the receipt of a certificate and clapping from the staff and audience. In addition, the program graduate was given the opportunity to speak. He thanked members of the team and took a picture with the judge. Among the 41 case appearances observed over the two day period, four participants were given sanctions in response to infractions. Three of the sanctions involved the defendants writing an essay and the fourth involved an increase in drug testing.

Throughout the case proceedings, the judge consistently made eye contact and smiled at defendants. The judge also inquired about specific aspects of the defendant's life; this included questions about their health, job, classes, vacations, and personal struggles. A key third party in these conversations were the case managers, who frequently included personal information in their case updates. Participants generally responded positively to the judge's inquiries. For one defendant who seemed to be reserved and uncomfortable answering questions in an open courtroom, the judge brought him up directly to the bench to speak one-on-one (an atypical practice for drug courts but common in other mental health courts, e.g., see O'Keefe 2006). During these interchanges the judge seemed to actively listen making sure to respond directly to each defendant's replies, statements, or questions.

The influential role of the judge was emphasized by team members during interview and focus group discussions. For example, referring to the judge as "powerful tool" one team member explained:

I see it over and over again in our clients that they don't want to disappoint the judge, they are ashamed and embarrassed for disappointing the judge or they are so eager to share their good news and impress the judge, so I think that relationship with the Court really drives so much of the successes.

Another team member emphasized the judge's ability to instill hope in the participants:

…there is such a human aspect of him and I have a sense that he is doing this job because he really has the desire to help the population and I think that translates with the client, for those that do really well in the program is because you have a sense that he is giving them hope. A lot of [the] time they are lacking that and I think it is an important key in order for them to go on and progress in life.

Team members also spoke of the participants' ability to detect the judge's genuine interest in them, in comparison to judges in the traditional court parts:

Because if you do something that he feels that you should not have done, he will tell you in a very nice way, and if you do well he also gives you praises … if you didn't do what you needed to do [he will say] …you know you can do better, you have that ability to improve yourself….

Chapter Four
Conclusion

Overall, the data suggest that the Manhattan Mental Health Court is achieving its goals in providing alternatives to incarceration for defendants with mental illness while also holding them accountable for their offense(s). Based on interviews with team members, the change in clinical staff in conjunction with the hiring of a full time resource coordinator, which occurred in March 2012, has improved the court's fidelity to its original goals and strategies. In addition, courtroom observations reinforce statements made during interviews and focus group that the judge works to positively engage each participants with individualized attention and genuine interest. Empirically grounded conclusions as to the efficacy of the Court in reducing future involvement in the justice system, cannot be drawn from the current study, which is confined to documenting and analyzing court process.

One of the major challenges for Manhattan Mental Health Court is housing. A lack of supportive housing and treatment services—coupled with other case processing delays in identifying many eligible defendants and, subsequently, in assessing and enrolling them—leads to a lengthy period (usually exceeding nine months) from arrest to the outset of mental health court participation. While individuals wait for housing or treatment services to become available, they often remain incarcerated at the Rikers Island city jail.

In light of preliminary findings concerning successes (positive judge-participant interaction), challenges (e.g., extensive wait times for enrollment), and substantive differences between participants who graduate and fail (e.g., those with a co-occurring disorder are more likely to fail), a more in-depth examination of the court's clinical and criminal justice impacts (i.e., recidivism) is justified.

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Appendix A.
Judge Interview Protocol

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1. How long have you been a judge with the MMHC? What was your judicial/professional experience prior to MMHC?

2. How would you describe the goals of MMHC?
    a. You were part of the planning process, what were some of the initial planning issues? (space, getting attorneys on board, figuring out case management, pulling in scarce resources – like a court coordinator from another court)
    b. Do you have a sense of whether the MMHC model has changed over the years?
        i. Volume (goal to increase to 50 a year)
    c. Would you say there are any differences in how the MMHC is designed vs. how it is implemented in everyday practices? If yes, what are they?

3. Do you have a sense that a majority of eligible defendants are being referred to MMHC or might there be untapped eligible defendants? What are the barriers to these defendants?
    a. Eligible defendants may be flagged by a variety of people (jail staff, family, defense attorney, community based providers etc.). Who is the most common referral source and has that changed from the inception of the court? Are there any other common referral sources not mentioned in the original list?

4. How would you define "success" in terms of MMHC?
    a. Is the average time for a participant who does well (12 months)?

5. Thinking about respondents who seem to do well in MMHC, what stands out as some of the key characteristics or reasons associated with these success cases?
    a. Any specific examples?

6. Thinking about respondents who do not do well in MMHC, what stands out as some of the main reasons for their lack of success?
    a. Any specific examples?
        i. To what degree does this relate their mental illness diagnosis?

7. Now I would like to ask you about the types of sanctions and rewards that are offered in MMCH?
    a. What are the most common sanctions (and infractions, reasons for sanctions)?
        i. Effectiveness?
    b. What are the most common rewards (achievements, reasons for rewards)?
        i. Effectiveness?
    c. Are rewards and sanctions determined on a case-by-case bases, or is it a matter of sticking to a certain schedule or set of criteria?
    d. Are any sanctions/awards specifically tailored toward the mentally ill?
    e. How important are the reports from the mental health programs in terms of determining rewards and sanctions?

f. Do you have any ideas for additional rewards or sanctions? If yes, what are they?

8. As a judge, what are the most rewarding aspects of your experience presiding over cases that appear before MMHC?

9. What are the most challenging aspects of your experience presiding over MMHC?

10. Are there any procedural or programmatic issues that are currently being discussed or debated regarding the MMHC process? If yes, what are they?

11. What, if anything, would you suggest to improve MMHC process and outcomes?

Appendix B.
Resource Coordinator Interview Protocol

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1. How long have you been the resource coordinator with the MMHC? What was your professional experience prior to MMHC?

2. How would you describe the goals of MMHC?
    a. Do you have a sense of whether the MMHC model has changed over the years?
        i. Volume (goal to increase to 50 a year)
        ii. Case management arrangements with the various sites
            1. Access to and services offered?

3. Do you have a sense that a majority of eligible defendants are being referred to MMHC or might there be untapped eligible defendants? What are the barriers to these defendants?
    a. Eligible defendants may be flagged by a variety of people (jail staff, family, defense attorney, community based providers etc.). Who is the most common referral source and has that changed from the inception of the court? Are there any other common referral sources not mentioned in the original list?

4. Thinking about respondents who seem to do well in MMHC, what stands out as some of the key characteristics or reasons associated with these success cases?
    a. What is the average time for a participant who does well (12 months)?

5. Thinking about respondents who do not do well in MMHC, what stands out as some of the main reasons for their lack of success?
    a. To what degree do these reasons relate to their mental illness?

6. What are the most common sanctions and rewards (and infractions/achievements, reasons for)?
    a. Which rewards and sanctions appear to be most effective?
        i. Are any specifically tailored toward the mentally ill?
    b. How important are the reports from the mental health programs in terms of determining rewards and sanctions?

7. In MMHC, can you explain how a respondent goes from Phase I to Phase III?
    a. Who makes these decisions?
    b. Do you think respondents understand what it takes to move to each phase?
    c. Do you think these phases help respondents to work toward a goal?
    d. Are there any unique challenges for phase advancement for defendants with mental illness?

8. How well do service providers and case managers communicate with the court?
    a. Are there any barriers to effective communication?

9. Are there any procedural or programmatic issues that are currently being discussed or debated regarding the MMHC process? If yes, what are they?
    a. Are there any gaps in services that you feel need to be addressed?

10. What, if anything, would you suggest to improve MMHC process and outcomes?

Appendix C.
Focus Group Protocol for Case Managers

Prior to beginning the focus group, each participant will receive a copy of the consent form and to provide oral consent.

1. Could we start by having everyone introducing themselves and saying how long they have been a case manager for MMHC, and what their prior professional experience entailed?

2. How would you describe the goals of MMHC?
    a. Do you have a sense of whether the MMHC model has changed over the years?
        i. Volume (goal to increase to 50 a year)
        ii. Case management arrangements with the various sites
            1. Access to and services offered?

3. Do you have a sense that a majority of eligible defendants are being referred to MMHC or might there be untapped eligible defendants? What are the barriers to these defendants?
    a. Eligible defendants may be flagged by a variety of people (jail staff, family, defense attorney, community based providers etc.).
    b. Who is the most common referral source and has that changed from the inception of the court?
    c. Are there any other common referral sources not mentioned in the original list?

4. What instrument do you use to conduct assessments of eligible defendants?
    a. Is this the same instrument you have been using since MMHC opened?

5. What questions are the most useful in identifying defendants with mental health issues?
    a. How do you determine a dual diagnosis?

6. What are the most common treatment/program placements for eligible defendants?
    a. What are the factors that you use to make placement decisions? (residential, short-term, outpatient, intensive outpatient)
    b. How do you handle cases that involve dual diagnosed defendants?

7. Thinking about respondents who seem to do well in MMHC, what stands out as some of the key characteristics or reasons associated with these success cases?
    a. What is the average time for a participant who does well (12 months)?

8. Thinking about respondents who do not do well in MMHC, what stands out as some of the main reasons for their lack of success?
    a. To what degree do these reasons relate to their mental illness?

9. What are the most common sanctions and rewards (and infractions/achievements, reasons for)?
    a. Which rewards and sanctions appear to be most effective?
        i. Are any specifically tailored toward the mentally ill?
    b. How important are the reports from the mental health programs in terms of determining rewards and sanctions?

10. In MMHC, can you explain how a respondent goes from Phase I to Phase IV?
    a. How does your (or the program) communication with the court steer a participant's phase advancement?
    b. Do you think respondents understand what it takes to move to each phase?
    c. Are there any unique challenges for phase advancement for defendants with mental illness?

11. How is the communication (flow, quality) between you, service providers, and the court?
    a. Are there any barriers to effective communication?

12. Are there any procedural or programmatic issues that are currently being discussed or debated regarding the MMHC process? If yes, what are they?
    a. Are there any gaps in services that you feel need to be addressed?

13. What, if anything, would you suggest to improve MMHC process and outcomes?