

**BUILDING TRUST AND MANAGING RISK:
A LOOK AT A FELONY MENTAL HEALTH COURT**

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Abstract

Although many mental health courts are restricted to misdemeanors, the Brooklyn Mental Health Court primarily handles felonies. This article describes a felony mental health court and explores the decision to focus on felonies, including the planning team's experiences with problem-solving courts and the effort to balance a fair court process with effective, but lengthy, treatment mandates. The author describes several ways by which the court and its partners manage potential public safety risks posed by felony offenders: thorough evaluations of offenders, individualized treatment plans, shared decision-making, candid communications between the court and its partners, and close judicial monitoring. The author also describes the ongoing program evaluation of the court and suggests areas for future research for felony mental health courts.

Building Trust and Managing Risk:

A Look at a Felony Mental Health Court

At age 26, “Irwin Smith”¹ was living on Long Island in a supported residence for people with mental illness. He had been working for several years, first at a furniture factory and then at a restaurant. He had a lapse in taking his Clozaril, a powerful antipsychotic that requires weekly blood monitoring because of its potentially lethal side effects. (Irwin doesn’t recall whether he forgot to take his medication or whether the pharmacy wouldn’t renew his weekly prescription because the lab work was missing.) He spotted a car with keys in the ignition and heard a voice telling him to “take the car and have fun.” He started driving toward Manhattan but had no money to pay the toll at the Brooklyn-Battery Tunnel – and that’s when he was arrested for driving a stolen car.

By taking a guilty plea and agreeing to comply with a court-mandated treatment plan for 18 to 24 months, Irwin became a participant in the Brooklyn Mental Health Court, a unique judicial experiment that links offenders with mental illness to community-based treatment. He lives in a supported residence in New York City, attends a day treatment program, has an intensive case manager who helps coordinate services for him, and appears regularly before Judge Matthew D’Emic, the presiding judge of the Brooklyn Mental Health Court. Irwin has never missed a court appearance, and the reports provided to the court by his housing and treatment providers are consistently positive. He is moving toward employment again, hoping to work at a concession stand in a sports arena. Since coming under the court’s supervision, Irwin has been, in all respects, a model citizen.

But Irwin wouldn’t be eligible for all mental health courts, many of which focus primarily on misdemeanors. Irwin, who had a prior conviction for a similar offense in 1996, pled guilty to a class E felony, with a prospective prison sentence in New York State of up to four years. In most jurisdictions, Irwin would serve time in prison where the primary goal of any psychiatric treatment he might receive would be to maintain order and safety in the prison, not to help him achieve any type of long-term recovery from his illness. Yet Irwin is just one of more than 160 felony offenders who have participated in the Brooklyn Mental Health Court, receiving services in the community while under the court’s supervision.

For many mental health courts, concerns about public safety are an important factor in the decision to focus on misdemeanors (Goldkamp & Irons-Guynn, 2000).² Fears about public safety are magnified when an offender has mental illness. The common perceptions of mental illness, fueled by both the news media and the entertainment industry, are that people with

¹ Names of Brooklyn Mental Health Court participants have been changed throughout this article.

² Focusing on misdemeanors is a preventive public safety strategy for many mental health courts which target low-level offenders who, without treatment and other services, might commit more serious offenses in the future. But there are additional reasons that have led mental health courts to focus on misdemeanors. Some mental health courts have been created in response to conditions in local jails: severe overcrowding, a high percentage of inmates with mental illness; one or more suicides by inmates with mental illness. Other mental health courts, especially in jurisdictions that have emphasized prosecution of drug crimes and quality-of-life offenses, have turned to mental health courts as a means of managing a high volume of misdemeanor cases and reducing the number of repeat offenders (Goldkamp & Irons-Guynn, 2000).

mental illness are prone to violence. Studies have shown that television portrays characters with mental illness as having four times the violence rate of other characters, that most movie characters with mental illness are killers and villains, and that the vast majority of newspaper stories about former mental patients focus on violent crime (Arnold & Weinerth, 2001). Many people would agree with the attitude expressed in a front-page headline in a New York City newspaper: “Get the Violent Crazies Off Our Streets!” (New York Daily News, 1999).

The leading research on violence and mental illness, sponsored by the MacArthur Foundation, paints a far different, and much more benign, picture. In the absence of drug or alcohol abuse, people discharged from psychiatric hospitals are no more likely to be violent than those without mental illness (Steadman et al., 1998). But even a small risk of violence by an offender can be unacceptable to court planners. In creating mental health courts, many jurisdictions are comfortable with assuming the risks to public safety – both actual and perceived – that might be posed by misdemeanor offenders, but not with the risks that felony offenders might present.

The Brooklyn Mental Health Court was one of the first mental health courts to handle felonies. This article explores the reasoning behind its decision to focus primarily on felony offenders, shares some of the lessons learned from the court’s first 3 ½ years of operations, and poses questions for further research and analysis.

The Planning Process in Brooklyn

In Brooklyn, during a year-long planning process that included the New York State Unified Court System, the New York State Office of Mental Health, the Center for Court Innovation, the Kings County District Attorney’s Office, several New York City government agencies, public defender organizations, mental health treatment and other service providers, advocacy groups, and consumers who had been in the criminal justice system, a consensus to handle felony cases in the Brooklyn Mental Health Court was reached fairly easily. How did this happen? What were the key factors that led to this decision?

“Problem-Solving Justice.” Mental health courts are one of the newest forms of “problem-solving courts,” which bring new approaches to difficult cases where social, human and legal problems intersect. Under Chief Judge Judith S. Kaye’s leadership, New York State has created an array of problem-solving courts that work in collaboration with communities, service providers and other government agencies to help find solutions to problems like addiction, domestic violence, child neglect and quality-of-life crimes. While conventional courts focus on processing the cases that come before them, problem-solving courts focus on achieving positive outcomes for victims, defendants and communities (Berman & Feinblatt, 2001; Berman & Feinblatt, 2002). Mental health courts, for instance, attempt to achieve two separate but interrelated outcomes by linking offenders with mental illness to treatment as an alternative to incarceration: improved psychiatric stability for the offenders and improved public safety. Building on the model of drug courts, mental health courts seek to work with mental health agencies, families, housing providers and others to help an offender with mental illness lead a crime-free life in the community.

When planning for the Brooklyn Mental Health Court began in early 2001, the New York State Unified Court System had already made a strong commitment to problem-solving courts in numerous arenas: community courts that focus on quality-of-life issues in a particular neighborhood, drug treatment courts in both criminal and family courts, domestic violence courts and others. Brooklyn had been the focal point for many of New York's important problem-solving initiatives, largely due to the vision of its District Attorney, Charles J. Hynes, who is committed to crime reduction strategies that include intervention, prevention, rehabilitation and community outreach as well as the investigation and prosecution of crime (Kings County District Attorney's Office (A), 2004). The Brooklyn Treatment Court is the largest drug court in the state, the Brooklyn Domestic Violence Court was the first specialized court for domestic violence cases in the state, and the Red Hook Community Justice Center is the nation's first multi-jurisdictional community court, with one judge handling civil, family and criminal matters that affect the quality of life in a poverty-stricken neighborhood.

Many of the members of the Brooklyn Mental Health Court planning team had been active in planning and implementing these specialized courts in Brooklyn and were well-acquainted with problem-solving courts, two of which – the Brooklyn Treatment Court and the Brooklyn Domestic Violence Court – were already handling felonies. Their practical experience had taught them what research studies confirmed: in drug courts and other alternative-to-incarceration programs for addicts, offenders charged with felonies have better outcomes than misdemeanor offenders. Specifically, felony offenders generally stay in treatment longer, graduate from drug courts at higher rates and have lower recidivism rates while under court supervision (Rempel & DeStefano, 2001).

These results shouldn't be surprising. There are at least two compelling reasons why felony drug offenders do better than misdemeanants. First, when the stakes are higher, compliance with a court mandate will improve. Someone facing a period of jail time measured in weeks or months may well decide, when the demands of treatment get tough and the temptations to use drugs become powerful, that it makes more sense to just do the jail time. But someone facing several years in state prison has an entirely different calculus and a much more powerful motivation to avoid sentencing. Second, it takes time to engage in treatment. A longer course of substance abuse treatment, whether mandated by a court or not, will produce better outcomes over the long run than a shorter one (Simpson et al., 1997; Marlowe et al., 2003; De Leon et al., 1972). Treatment mandates for felonies are usually longer than for misdemeanors, often significantly longer. The length of the mandate results in longer stays in treatment, which leads to better outcomes for the individual in treatment and, in turn, for the community that is damaged by addiction and drug-fueled crime.

Another asset during the Brooklyn Mental Health Court's planning stage was the fact that several members of the planning team also had direct experience working with felony offenders with mental illness. In 1998, the Kings County District Attorney's Office launched a program called Treatment Alternatives for Dually Diagnosed Defendants (TADD), an alternative-to-incarceration program for both felony and misdemeanor offenders with co-occurring mental illness and substance abuse disorders (Kings County District Attorney's Office (B), 2004). And in the Brooklyn Domestic Violence Court, over ten percent of the defendants were diagnosed with mental illness, and many of them were mandated to treatment in lieu of incarceration through the TADD program. Judge D'Emic, who had been a judge in the Brooklyn Domestic

Violence Court for five years before being asked to take on the Brooklyn Mental Health Court, had substantial experience monitoring violent felony offenders, including offenders with mental illness, in the community.

Cumulatively, these experiences with problem-solving initiatives had given Judge D’Emic, the prosecutors and the defense attorneys on the planning team a great deal of familiarity and skill with court-supervised treatment for felony offenders with various combinations of substance abuse, mental illness and histories of violence.

Being Effective and Being Fair. The decision to handle felonies wasn’t a foregone conclusion, though. To a large extent, the decision was reached in the course of balancing the need to craft effective court orders with the demands of constructing a fair process.

Without exception, the mental health professionals consulted in the course of planning the Brooklyn Mental Health Court advised the planning team that there are no quick fixes in the treatment of mental illness and that short treatment mandates were almost certainly not going to yield positive outcomes. Research shows that psychiatric patients who remain under outpatient commitment orders for a sustained period of time (six to nine months, or more) while receiving intensive services show fewer hospitalizations, shorter hospital stays, greater adherence to community treatment, fewer acts of violence and fewer instances of victimization than patients receiving similar services under outpatient commitment orders for shorter periods (Swartz et al, 2001). Mental health advisors to the planning committee counseled that participants in the court should be mandated to treatment for at least a year, and even longer if feasible. Also, drawing on the research from drug courts, several stakeholders believed that the consequences for failing to comply with treatment mandates should be steep enough to provide real motivation for participants to comply. They urged that the jail sentences for program failure should be a minimum of one year, and longer if warranted by the crime involved.

Mental health consumers involved in the planning process concurred with both of these premises. Several of them described how they didn’t recognize their own need for treatment even after they had been arrested or incarcerated and that short stays in jail – even stints of several months – were just “skid bids” that were preferable to treatment. A number of them thought the Brooklyn Mental Health Court should only handle felonies because misdemeanors didn’t carry enough of a threat of incarceration to motivate an offender to engage in treatment. At one focus group, some ex-offenders with mental illness urged court planners to mandate treatment for at least two years, while others suggested that the mandate should be even longer (Denckla & Berman, 2001).

At the same time that some members of the planning team were urging treatment mandates and jail sentences for program failure that were one or more years for the sake of the court’s effectiveness, defense attorneys considering the prospect of a misdemeanor court raised vigorous concerns about proportionality. As expressed by defenders, the principle of proportionality holds, first, that the length of court supervision in an alternative-to-incarceration program should never be longer than the period of incarceration or probation that the defendant would have received in a conventional court and, second, that the potential sentence a defendant faces for failing to comply with the conditions of release should never be more severe than the sentence that would have been imposed in a conventional court. The Urban Justice Center uses a

marketplace analogy to illustrate proportionality: Just as there is a marketplace for used cars, there is a marketplace for offenses, with jail sentences reflecting the “going rates” of each category of offense in a particular jurisdiction (Barr, 2001). A calculation by a defendant and his or her attorney as to whether an alternative-to-incarceration program is attractive or not always takes place in the context of that marketplace. Defense attorneys who believe that a mental health court’s treatment requirements (and potential punishments in the event of failure in treatment) are worse than the “going rate” may well advise their clients to pursue their case in a conventional court.³

So what does the criminal justice marketplace look like in Brooklyn? From 1999 through 2001, 93 percent of the misdemeanor offenders in Brooklyn who received jail time were sentenced to 90 days or less. In fact, 75 percent were sentenced to 30 days or less (State of New York, Division of Criminal Justice Services, 2002). Add to this the fact that in New York City, jail sentences are often reduced by one-third for good behavior, which means that over 90 percent of misdemeanants in Brooklyn serve less than 60 days in jail.

The defense attorneys on the Brooklyn Mental Health Court planning team, although strongly supporting alternatives to incarceration for their clients with mental illness, were concerned that the factors being urged for program effectiveness – treatment mandates of at least one year and potential jail sentences of a year or longer for program failure – were disproportionately onerous for misdemeanor offenders facing such short jail sentences. From a defense attorney perspective, those proposed program parameters made more sense for felony offenders (and for chronic misdemeanor offenders who, because of their criminal histories or the severity of their current offenses, were facing one-year jail sentences).

In short, a caseload in Brooklyn consisting of felonies with a secondary focus on misdemeanants facing a year in jail worked for two reasons: clinicians and researchers told the planning team that it would enable the court to craft longer, and thus more effective, treatment sentences, while defenders believed that it would help address their concerns about misdemeanor mental health courts that sentenced offenders to disproportionately long mandates.

Nuts and Bolts. Another simple but compelling practical factor contributed to the decision to handle felonies: the length of time involved in assessing defendants and lining up appropriate community-based services for them. The mental health professionals on the planning committee cautioned against adopting the standard practice of drug treatment courts, which strive to assess defendants and move them into treatment programs as quickly as possible after arrest – within days, if feasible. In contrast, mental health agencies typically have a more extended intake process spanning a period of weeks in order to gain a full understanding of a client’s needs and develop an individualized treatment plan. Lining up mental health services rarely happens as quickly as placement in drug treatment programs: it can take weeks to arrange for a continuing day treatment program and community-based case management services, and it can take months to find a place in a supported housing program. The planning committee

³ A survey conducted by the Bazelon Center for Mental Health Law reports that 40 percent of the mental health courts responding to the survey supervise defendants for periods of time that significantly exceed the possible length of incarceration or probation for the offense, and 64 percent use jail time as a sanction for noncompliance with treatment (Bernstein & Seltzer, 2004).

recognized that most misdemeanor offenders would be able to complete a short-term jail sentence long before all the necessary community-based mental health services were in place, another reason to limit the court to felony offenders.

Prosecutor's concerns. Issues of proportionality and practicality may weigh in favor of a focus on felonies, but why should a prosecutor agree to handle felonies in a mental health court? After all, the prosecutor has the greatest exposure if something goes terribly wrong with a participant in a mental health court.

In 1990, Charles J. Hynes, the Kings County District Attorney, started the Drug Treatment Alternative to Prison Program (DTAP), the first prosecution-run program to divert prison-bound felony offenders to drug treatment (Kings County District Attorney's Office (C), 2004). A recent evaluation of DTAP has shown lower rates of re-arrest and re-incarceration among participants than individuals in a matched comparison group who received sentences of incarceration rather than treatment, as well as significant cost savings compared to the costs of incarceration (The National Center on Addiction and Substance Abuse at Columbia University, 2003). Hard data, therefore, supports the belief of the District Attorney's Office that in selected cases treatment offers better prospects for public safety. The Kings County District Attorney's Office views the rigorous monitoring and intensive treatment offered by programs such as TADD and the Brooklyn Mental Health Court as "an investment in treatment in order to prevent the re-occurrence of crime – particularly violent crime – by offenders with mental illness" (Denckla & Berman, 2001).

Another factor in the District Attorney's agreement to allow felonies into the Brooklyn Mental Health Court was the decision made during the planning process that offenders would be required to plead guilty in order to participate in the court. This enables prosecutors to secure felony convictions without having to conduct trials, thus saving resources and sparing witnesses, who are often victims, from the burden of testifying. Should a participant fail in treatment, the offender is sentenced to a jail or prison term agreed to at the time of the guilty plea. And when a participant successfully completes his or her treatment mandate, the District Attorney's Office has helped to turn an offender into a law-abiding member of society.

The District Attorney's Office was willing to consider handling selected violent offenses in addition to nonviolent felonies in the Brooklyn Mental Health Court, as long as prosecutors had a right to veto any offender's participation. All members of the planning team wanted to proceed extremely cautiously with violent offenders and to be particularly restrictive during the initial implementation of the court. The team agreed to consider only a limited number of violent offenses on a case-by-case basis – second degree robbery, second degree assault, and burglary – and to require the consent of the District Attorney's Office before any defendant charged with one of these offenses could be evaluated by the court's clinical team.

Consensus Through the Planning Process. At the conclusion of the planning process, the planning team agreed to a program structure that kept the primary focus of the Brooklyn Mental Health Court on nonviolent felonies but that would also permit the court to handle some misdemeanors and violent felonies. First-time felony offenders are required to participate in treatment for 12 to 18 months, predicate felony offenders for 18 to 24 months, and misdemeanor offenders for 12 months. For first-time nonviolent felony offenders and misdemeanor offenders,

all criminal charges are dismissed upon successful completion of their treatment mandate, while violent first-time felony offenders and all predicate felony offenders have their felony charges reduced to a misdemeanor upon successful completion (with a sentence of probation for violent offenders). Misdemeanor offenders face a year in jail if they fail to meet their treatment obligations; felony sentences for program failure are determined on a case-by-case basis at the time a defendant takes a guilty plea and begins participating in the court, but are never longer than the sentence that the offender would have faced in a conventional court.

Life in a Felony Mental Health Court: Lessons About Managing Risk and Building Trust

This program model, and the decision to keep the primary focus of the Brooklyn Mental Health Court on felonies, was a logical outcome of the planning process in Brooklyn; in fact, there was no vocal constituency for a misdemeanor mental health court at any point during the planning process. Other jurisdictions and other planning teams, of course, face different factors and considerations that, to date, have led most often to the creation of misdemeanor mental health courts. But while the decision in Brooklyn to focus on felonies may be unusual, the lessons that can be drawn from the Brooklyn Mental Health Court are significant for all mental health courts. So what does the Brooklyn Mental Health Court look like in operation, and what can it teach other jurisdictions interested in working with a felony or other high-risk population? In particular, how has the court addressed the public safety issues – real and perceived – presented by its felony participants?

In its first 3 ½ years of operations, the Brooklyn Mental Health Court received more than 430 referrals. Two hundred eight defendants took guilty pleas with a promise of having charges reduced or dismissed upon completion of a specified period of treatment. Of those, 20 percent were charged with misdemeanors, 37 percent with nonviolent felonies, and 43 percent with violent felonies.

Seventy-five participants graduated from the court after complying with all treatment requirements, and 13 were sentenced for persistent failure to comply with their treatment mandates or for committing new offenses. At any moment in time, 70 to 95 percent of active participants were in substantial compliance with their court mandates and making progress toward graduation. Participants for whom bench warrants were issued for absconding from treatment programs or failing to appear in court often returned to court voluntarily and asked for the opportunity to continue participating in the court. Even those who were jailed on new arrests for minor charges often continued participating in the court when new services in the community could be arranged for them.

Lesson 1: Managing Risk Takes Many Forms. The process of managing public safety risks is a joint effort involving the Brooklyn Mental Health Court judge, clinical staff, defendants, prosecutors, defense attorneys and service providers. The first critical step, of course, is a thorough psychiatric evaluation and psychosocial assessment of each offender. Each offender accepted for participation in the court is seen by both a social worker and a psychiatrist, each of whom writes a lengthy narrative report providing a wealth of information to the judge, the prosecutor and the defense attorney about the offender's social and psychiatric history,

family, community ties, an assessment of risk of violence⁴, and his or her treatment needs. The clinicians determine whether the offender has a disorder for which there is a known effective treatment, whether the offender's disorder contributed in some way to his or her criminal activity, and whether treatment appears likely to help the offender live a crime-free life in the community.

The psychiatric evaluations and psychosocial assessments are used on occasion for screening out an offender who poses too high a risk of violence or too low a likelihood of engaging in effective treatment,⁵ but their greater significance is in laying the foundation for an individualized treatment plan for each offender accepted for participation in the court, a second critical element in managing the risks presented by felony offenders. Each treatment plan is designed to maximize the likelihood that a particular offender will be engaged in treatment, achieve psychiatric stability and avoid crime. Each plan identifies mental health treatment, substance abuse treatment, case management, education and/or employment services that address the offender's specific clinical needs as well as the public safety requirements articulated by the judge or the District Attorney's Office.

To accomplish this, the court-mandated treatment plans draw on a wide range of mental health treatment services to meet offenders' needs, including day treatment programs, individual therapy, intensive psychiatric rehabilitation treatment programs, psychosocial clubs, and assertive community treatment (ACT) teams. Given the significant increase in risk of violence associated with drug and alcohol abuse (Steadman et al., 1998), substance abuse treatment, on its own or integrated with mental health treatment, is a critical element in treatment plans for offenders who have a history of alcohol or drug abuse. In fact, about one-quarter of the court's participants are mandated to residential drug treatment programs, and another fifty percent receive outpatient substance abuse treatment or mental health treatment that incorporates treatment for substance abuse. The majority of treatment plans also include community-based

⁴ Although research indicates that actuarial methods of risk assessment are superior to clinical methods in predicting violence (Rice et al, 2002), and although members of the court's clinical team have been trained in the use of the HCR-20 Violence Risk Assessment Scheme, the court opted not to administer any actuarial risk assessment instruments in its evaluations of offenders. One simple reason is time: completing an actuarial risk assessment would considerably lengthen the time required to complete a psychiatric evaluation and psychosocial assessment. But a more important factor was the court's determination that any potential decrease in the court's ability to predict violence would be more than compensated by the numerous and complex mechanisms in place for managing risks presented by individual offenders, which are discussed in detail in this section.

⁵ During the planning process, defense attorneys expressed concern that information disclosed during the evaluation process could be used against a defendant who opted out of or was excluded from the Brooklyn Mental Health Court. They feared that a defendant might make statements about the instant offense that could be used by the prosecutor at trial; they also feared that a judge might use a mental health professional's assessment of a defendant's potential risk of violence, or even the mere fact of a defendant's mental illness, to impose a more severe sentence. Representatives of the District Attorney's office sought to assure defense attorneys that they had not used comparable information in the prosecution of cases against defendants considered for participation in the Drug Treatment Alternative to Prison program or Treatment Alternatives for Dually Diagnosed Defendants program and that they intended to maintain that practice for the Brooklyn Mental Health Court. In drafting consents for the release of confidential information about psychiatric treatment, the planning team agreed to language permitting the Brooklyn Mental Health Court staff to redisclose such information to the defense attorney and the District Attorney's Office solely for purposes of establishing the defendant's eligibility for participation in the court and preparing a court-mandated treatment plan, thus limiting the prosecutor's ability to use any information obtained during the evaluation of a defendant in any proceeding outside of the Brooklyn Mental Health Court.

case management services, providing a far greater level of care coordination than the court staff can give. About a quarter of the treatment plans for participants in the court provide for supported housing, which includes both community residences with 24-hour on-site staff and supported apartment programs with less intensive clinical support. And for the nearly fifty percent of program participants who live in their own apartments or with family members, making sure that a full array of treatment and case management services is in place helps to achieve the dual goals of psychiatric stability for individual offenders and public safety for the community.⁶

For a few participants charged with violent crimes, treatment plans have been further individualized for public safety purposes by lengthening the period of mandated treatment and considering family supports. “Arthur Howard” is one example. Responding to internal voices, he had set a fire which destroyed his mother’s home. Although he could have been ruled ineligible on the basis of the arson charge, the victim – his mother – was extremely reluctant to proceed with the case and urged the District Attorney’s Office to consider treatment instead of prosecution. After consulting with the Fire Department, the District Attorney’s Office agreed to consider Arthur’s participation in the Brooklyn Mental Health Court if an appropriate treatment plan could be arranged and asked the court’s clinical team to try to arrange a supported housing placement with 24-hour supervision. Despite persistent efforts by the court’s clinical staff, no supported housing provider was willing to take him because of the arson charge. Five months after he had first been referred to the Brooklyn Mental Health Court, Judge D’Emic and the District Attorney’s Office agreed to accept a treatment plan that included a day treatment program five days a week, an intensive case manager who would meet with Arthur at least once a week, and a commitment by Arthur’s mother, made on the record in open court, to supervise his medication and support his participation in treatment. The court’s clinical director visited the mother’s new apartment before Arthur was released from jail to satisfy the court that the home was in a safe neighborhood and could provide a stable environment for Arthur. Arthur’s treatment mandate is for a period of 36 months, and he made weekly appearances before Judge D’Emic for the first three months of his participation in the court, always accompanied by his mother.

A third element in the management of risk is the nature of the participation decision itself. Participation in the Brooklyn Mental Health Court is voluntary on the defendant’s part. But two other people must concur in the participation decision as well: the Mental Health Court

⁶ Each treatment plan draws from the best available services in the community, which are not always the perfect services that the court and its partners might hope for. Supported housing is extremely scarce, for instance, as are fully integrated treatment programs for people with co-occurring substance abuse and mental disorders. During the planning stage, both prosecutors and defense attorneys familiar with drug treatment programs and drug treatment courts assumed that many of the Mental Health Court participants would be placed in residential programs that exercise the degree of restriction and control over clients typically found in therapeutic communities providing substance abuse treatment for addicts. But the criminal justice members of the planning team learned during the early months of the court’s operations that the world of mental health services differs profoundly from the world of drug treatment services. Mental health housing and treatment are almost always decoupled, in striking contrast to the structure of drug treatment programs where treatment often takes place in the residential setting. And treatment and housing providers in the mental health community are focused on helping consumers achieve the maximum amount of independence possible, in contrast to the strict regulations that typically limit an addict’s freedom while residing in a therapeutic community.

judge and the prosecutor. Either one can unilaterally reject a potential participant. Conversely, knowing that they share the responsibility for each offender's participation, the judge and prosecutor may be willing to give the benefit of the doubt to an offender whom neither one would want to take a chance on alone. And whenever an offense involves violence, the District Attorney's Office obtains the consent of the victims before agreeing to let a defendant participate.

A fourth element in managing risk is the frequent and candid exchange of information between the court staff and the service providers who work with the court's participants. Consents signed by the participants authorize the providers and all members of the court team – judge, clinical staff, prosecutor and defense attorney – to share treatment-related information with each other. The court's clinical team has telephone conversations at least once a week with each provider; the providers also send written reports once a month and agree to provide immediate notification of specified events. When the service providers share information with the court about emerging problems, the providers and the court can coordinate their efforts to prevent small problems from becoming large, improve compliance with treatment, and minimize the prospect of new offenses.

A final critical element in managing risk is judicial monitoring. All problem-solving courts use judicial authority to change offenders' behavior and improve the well-being of communities. A judge's power is most obvious when an offender has pled guilty or been convicted and knows that he will be sentenced to jail or prison if he does not live up to his commitment to participate in treatment (Kanapaux, 2002). But a judge's power operates in more subtle ways as well. The very solemnity of a courtroom and the judge's black robes communicate authority to the defendants in the courtroom (Butler, 2003). In many problem-solving courts, judges use an array of graduated rewards and sanctions to motivate and reinforce progress in treatment – praise, certificates, admonitions, increased or decreased frequency of court appearances, and imposition or lifting of restrictions on activities are examples of mechanisms that judges use to change an offender's behavior. But often the more subtle aspects of a judge's relationship with a defendant, established over repeated court appearances, are even more important. The desire to please the judge or avoid the judge's disappointment or anger can be a powerful motivating force (Fisler et al., 2003; Berman & Feinblatt, 2002). In fact, judges foster therapeutic alliances with defendants by using the same techniques – empathy, acceptance, warmth, and allowance of self-expression – that therapists use with their clients (Clark, 2003; Winick, 2003; Winick & Wexler, 2003). Perhaps most important of all, a trustworthy judge who treats a defendant with respect will engender, in return, respect by the defendant for the judge, the court process, and the treatment mandate (Petrucci, 2003; Warren, 2003; Winick, 2003).

In the Brooklyn Mental Health Court, Judge D'Emic's close supervision of and relationship with each participant are essential elements in managing public safety risks. All participants are required to come to court every two weeks for their first three months in the program and once a month thereafter. The use of rewards, sanctions and clinical responses are highly individualized, with Judge D'Emic relying heavily on the advice of the court's clinical team to determine what actions he might take to try to help each participant succeed in treatment. In practice, the rewards used most frequently by Judge D'Emic are verbal praise and encouragement during court appearances, reduction of the frequency of court appearances, and issuance of certificates upon the completion of phases of supervision (each phase generally lasts

between three and five months). The most frequent sanctions have been verbal reprimands and increased frequency of court appearances – once a week for participants whose compliance has been uneven or even daily for participants who have stopped attending treatment programs.

In some instances, Judge D’Emic has used jail as a sanction. Some participants who engaged in heavy drug use have been remanded to jail after absconding from or being thrown out of treatment programs until new placements could be arranged. A few have been held in jail for several months following new arrests but released to the community to continue participating in the Mental Health Court when new services could be lined up. Several participants who repeatedly failed to attend intake appointments, attend treatment sessions, or comply with other aspects of their court-mandated treatment plans have been remanded by the judge to stays in jail ranging from one day to three weeks. One woman whose compliance with her treatment plan had been extremely erratic was remanded for one week seven months into her court mandate. Two months after her release she thanked Judge D’Emic, saying that although she hated it when he put her in jail she realized that he had helped her when he did it.

Judicial monitoring includes close attention to drug use, which is monitored by many of the participants’ treatment programs as well as by the court staff. Because of the heightened risk of violence caused by drug and alcohol abuse, the court takes alcohol and substance abuse seriously but also recognizes, as drug courts have learned, that relapse is part of the recovery process. In fact, recent studies suggest that more than half of all *successful* drug court graduates test positive for drugs at some point during their time in treatment (Rempel et al., 2003). As with other infractions of program guidelines, the court’s focus with substance abuse is on finding an approach that will help a participant succeed in treatment and stay out of jail.

Other mental health court judges have recommended using a lot of praise and patience, rather than sanctions, to help encourage defendants with mental illness comply with court requirements (Fox, 2002). In the Brooklyn Mental Health Court, it is much more common to adjust the services a participant receives than to impose a punitive sanction. “Veronica Harding”, for example, is a 45-year-old woman who dropped out of high school, had no significant work history, had been in a methadone maintenance program for 20 years, and had several convictions, mostly for pick-pocketing and shoplifting. She also has a diagnosis of schizoaffective disorder (a combination of a thought disorder and a mood disorder). When she joined the Brooklyn Mental Health Court program in July 2002 after pleading guilty to a felony charge of grand larceny, her treatment plan provided for her to continue attending her methadone maintenance program but also required her to receive individual therapy. Veronica came to court regularly, attended almost all of her therapy sessions and was making progress toward her GED. On September 24, 2002, Judge D’Emic noted in court records, “Defendant doing great.” But Veronica didn’t appear for her next court appearance on October 8: she had been arrested and incarcerated on a misdemeanor theft charge and was appearing in Criminal Court.

Under the terms of her contract with the Brooklyn Mental Health Court, Judge D’Emic could have sanctioned Veronica and even terminated her from the program. Instead, when Veronica acknowledged that she had messed up and said that she wanted to continue in treatment, the clinical team arranged for more intensive services: she began attending a five-day-a-week substance abuse treatment program which offered groups and services that her methadone maintenance program did not provide, she began receiving care coordination services

from an intensive case manager at a community-based mental health agency, and she continued with her individual therapy. By early December, she had earned a certificate for completing her first phase with the Brooklyn Mental Health Court. At a court appearance in early January 2003, she announced with pride that she had a job as an inventory clerk – her first real employment in nearly 20 years. And in February 2004, she graduated from the Brooklyn Mental Health Court: her felony guilty plea was vacated and she was sentenced to a conditional discharge on a misdemeanor offense of petit larceny.

Lesson 2: Trust is Crucial. The Brooklyn Mental Health Court consists of an intricate set of relationships among all the players involved: the judge, the defendants, the prosecutors, the defense attorneys, the court's clinical staff, and the treatment and other service providers working with the defendants in the community. The strength and stability of these relationships provide a foundation for the effective operation, and ultimate success, of the court. And that strength and stability derive from the trust that the players have in each other and in the fairness of the court process. In fact, a great deal of trust has been established among the core members of the court team. What are the key elements of this trust, and how did trust develop?

Trust among the judge, prosecutor, defense attorneys and court clinical staff. Through several years of collaborating in other problem-solving courts in Brooklyn and the year-long planning process for the Brooklyn Mental Health Court, the core members of the court team developed a thorough understanding of each other's goals, concerns and motivations and learned that they all shared a belief that treatment goals for individual defendants and public safety goals for the community are interrelated. The public defenders learned that the District Attorney's Office was willing to take chances on individual defendants and not opt for easy convictions or punitive sentences if an assessment showed that appropriate treatment and supports could help a defendant live responsibly in the community. The prosecutors and the judge saw that the defenders appreciated their responsibilities to preserve public safety and recognized that a bad incident involving any individual participant could put the entire program in jeopardy.

Both prosecutors and defenders developed substantial trust in the court's clinical staff over the first year of operations. Procedures were put into place at the outset to ensure that the information generated by the clinical team would be shared equally and simultaneously with the prosecution and defense, thus emphasizing the neutrality of the court's clinical staff. Trust in the clinical staff is also grounded in the training and experience of the mental health professionals on the court's team. The consulting psychiatrists are trained in forensic psychiatry and have significant experience working with offenders in psychiatric hospitals, correctional facilities and community settings. Both of the social workers on the court's staff had previously worked on an assertive community treatment (ACT) team for court-mandated clients, treating people who were under criminal justice supervision as parolees or probationers or under civil outpatient treatment orders, and received training in clinical risk assessment procedures.

But the confidence that the lawyers have in the court's clinicians grew as the lawyers began receiving psychosocial assessments and psychiatric evaluations that discussed the defendants' clinical needs, risk factors and recommended treatment with detail and candor. The prosecutors' confidence that the clinicians recognized public safety concerns increased significantly about two months after the court began accepting referrals, when the clinical team

recommended that a woman charged with assault *not* be allowed to participate because the risk that she might commit another violent act was too great.

Similarly, both prosecutors and defenders saw over the course of the early months that the Brooklyn Mental Health Court judge was firm with participants, holding them accountable for achieving the goals set out in their treatment plans but giving them support in meeting those goals. Referrals by defense attorneys to the court increased steadily over the first year of operations as they gained confidence that their clients would be given help when they were having troubles adhering to their treatment plans as well as receiving sanctions that were proportionate to the infractions involved.

Trust between the Brooklyn Mental Health Court and its community-based partners. The relationship between the court and the community-based treatment, housing and case management agencies working with the court's participants is grounded in detailed, timely and candid communications. Those communications begin when the court's clinical staff submits an application for services on behalf of a defendant, sending the provider the same detailed narrative reports by a social worker and a psychiatrist that are used to determine whether the defendant is eligible to participate in the court. These reports often disclose unfavorable information about a client which may impede the process of lining up services in the short run but helps ensure that the providers who ultimately agree to work with a participant fully understand his or her treatment needs.

A member of the court's clinical team will usually accompany a new participant to a housing program or outpatient treatment program, and site visits to providers are common. Clinical staff frequently attend case conferences with providers, especially when problems with court participants emerge. When a participant has been violating program rules, the court's clinical staff and the provider will strive for consistency in their responses. Complete agreement is sometimes difficult to achieve: on a few occasions, providers have requested that Judge D'Emic remand a participant to jail when the court team thought that incarceration would be too harsh a response to the infraction. The process of discussing the problems and possible responses is invaluable, however, in building trust between the court and the providers.

Trust between the participants and the court. Most important of all is the trust that the Brooklyn Mental Health Court judge vests in each participant that he or she will honor the agreement to stay in treatment and refrain from committing any new offenses. For a number of the participants, the judge, the clinical staff, the prosecutor, the defense attorney and the treatment providers are all taking a leap of faith – but no defendant would be allowed to participate in the court unless that faith were well-founded. In turn, the court team hopes – and expects – that each participant will feel that that Brooklyn Mental Health Court is fundamentally fair, that he or she will be listened to and treated with respect, and that the court will honor its end of the contract.

Program Evaluation and Future Research

The trust that has developed among the judge, the defendants, the prosecutors, the defense attorneys, the court's clinical staff, and the community-based providers oils the system: the District Attorney's Office and service providers are willing to take risks on individual defendants, the defense attorneys are willing to lend their support to the program and recommend participation to their clients, the judge is willing to risk exposure to criticism if any defendant violates the terms of his or her agreement with the court, and the criminal justice and mental health systems are able to move beyond their sometimes conflicting positions to find new ways of working together. But will the Brooklyn Mental Health Court achieve the dual goals it has set out: improved psychiatric stability for its participants and improved public safety for the community?

The Center for Court Innovation will be addressing these questions in a process evaluation and preliminary outcome evaluation of the court. The process evaluation will document the implementation and early operations of the Brooklyn Mental Health Court and describe participant characteristics through interviews with stakeholders, structured observations of court proceedings, case studies, collection of participant profile data (including demographics, criminal history, psychiatric diagnoses, history of homelessness, history of hospitalizations, medication status, and health care coverage status) and documentation of treatment and other services received. The outcome evaluation will examine the court's impact on recidivism, incarceration, hospitalization, and psycho-social functioning for participants during the one-year period immediately following program entry, comparing post-enrollment experience with the defendant's status at the time of enrollment in the court and during the one-year period preceding enrollment. Participants' perceptions of procedural fairness and coercion will also be measured, using the MacArthur coercion scale as adapted for the current evaluation of the mental health court in Broward County, Florida (Poythress et al., 2002).

In early 2001, when there were fewer than two dozen mental health courts in the United States, Steadman, Davidson and Brown noted that mental health courts have "a very brief history, an unclear conceptual model, and unproved effectiveness" (Steadman et al., 2001). In late 2005, with approximately 125 mental health courts now in operation (Council of State Governments, 2005), the same comment is largely true. The Center for Court Innovation and other stakeholders in the Brooklyn Mental Health Court seek to design future research that will help explore questions that are particularly relevant for mental health courts handling felonies:

1. How effective are mental health courts that handle felonies compared to those that handle misdemeanors? Do mental health courts see better outcomes for offenders, victims and communities when the offenders face longer treatment mandates and longer potential jail sentences?
2. Do participants in felony mental health courts perceive more or less coercion and more or less procedural justice than participants in misdemeanor mental health courts? What is the relationship between perception of coercion and program outcomes?
3. What impact, if any, will mental health courts – either felony or misdemeanor – have on public perceptions of mental illness, violence and crime? If mental health courts can succeed

in helping to engage offenders in treatment and live crime-free lives, can those courts also help to break down the stigma and misconceptions that keep so many people with mental illness isolated and marginalized?

Mental health courts continue to provide a promising opportunity for shifting the treatment of offenders with mental illness out of correctional institutions and back to the community-based service providers that are best equipped to help people with mental illness lead stable and crime-free lives in the long run. As more mental health courts with their varying program models begin operations, there will be increased opportunities to answer some of these questions and provide guidance from both research and experience for mental health court practitioners.

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