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EXECUTIVE SUMMARY FEBRUARY 2012

CRIMINAL JUSTICE INTERVENTIONS FOR OFFENDERS WITH MENTAL ILLNESS: EVALUATION OF MENTAL HEALTH COURTS IN BRONX AND BROOKLYN, NEW YORK

EXECUTIVE SUMMARY

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Criminal Justice Interventions for Offenders with Mental Illness: Evaluation of Mental Health Courts in Bronx and Brooklyn, New York

Executive Summary

Mental health courts (MHCs) emerged more than a decade ago. Initially implemented in Broward County, FL, in 1997, there are more than 250 MHCs now operating in the U.S., with others planned. The spread of mental health courts is likely due to the confluence of several trends (Denckla and Berman 2001; Fisher, Silver, and Wolff 2006; Pogrebin and Poole 1987; Rossman, Roman, et al. 2011; Teplin 1984), including:

> **What is a Mental Health Court?**
>
> Mental health courts are defined as specialized court dockets— for certain defendants with mental illness—that substitute a problem-solving model in place of traditional court processing. Participants are identified through mental health screening and assessments and voluntarily participate in a judicially supervised treatment plan developed jointly by a team of court staff and mental health professionals. Incentives reward adherence to the treatment plan or other court conditions, nonadherence may be sanctioned, and success or graduation is defined according to predetermined criteria.
>
> Source: Council of State Governments 2008

- Resources available for treating populations with mental health problems systematically shifted during the 1960s and early 1970s from residential, state-run psychiatric hospitals to community-based settings, resulting in the deinstitutionalization of individuals needing mental health services, without a concomitant increase in the availability of such services.

- Law enforcement agencies have increasingly encountered offenders with mental illness who must be processed under their purviews.

- Problem-solving courts—after which mental health courts are modeled—have evolved from an originally grassroots response (to burgeoning drug offender arrests and prosecutions that overwhelmed the capacity of courts) into a well-documented successful strategy, employed in numerous jurisdictions, to mitigate offenders' substance use, prevent relapse, support crime desistance, and achieve significant reductions in crime.

By the early 2000s, it had become starkly clear that the criminal justice system, *de facto*, was not only the primary public response to inappropriate behaviors by persons with mental illness, but also that such individuals were over-represented within criminal

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justice populations. In response, various federal agencies supported programming and services targeting offenders with mental disorders. In line with this increasing awareness, the National Institute of Justice (NIJ) commissioned an *Evaluation of Criminal Justice Interventions for Mentally Ill Offenders* (now entitled *Criminal Justice Interventions for Offenders With Mental Illness: Evaluation of Mental Health Courts in Bronx and Brooklyn, New York*) to assess two distinct approaches to handling offenders with mental health problems in the criminal justice system: 1) the Brooklyn MHC, a specialized problem-solving court operating in the Supreme Court in Brooklyn, New York, and 2) the Pinellas County Mentally-Ill Diversion Program, operating in the 6th Judicial Circuit's Public Defender's Office in Clearwater, Florida. Subsequently, the Florida site was replaced by a second MHC in Bronx, NY.

This report provides an overview of the study funded by NIJ; summarizes key findings from the process and impact components of the evaluation; and identifies implications for practice, policy, and future research.

The Criminal Justice Interventions for Offenders With Mental Illness Evaluation: Key Objectives

In October 2005, researchers in the Justice Policy Center at the Urban Institute (UI) initiated a three-year evaluation of the Brooklyn Mental Health Court and Pinellas County (FL) Mentally-Ill Diversion programs, which differed significantly both in their approaches toward offenders with mental illness and their operational structures. The research was conceptualized as two separate evaluations, unified by common research questions about the process, potential offender-level impact, and costs of these two models.

As the research proceeded, UI and NIJ recognized the necessity to alter the design, replacing the Florida site with a different program—the Bronx (NY) Mental Health Court—that 1) did not offer the same opportunities to study two distinct models and 2) required scaling back some of the anticipated project activities. The key objectives of the current research as it evolved were to conduct separate **process**, **impact**, and **cost-effectiveness** evaluations of the two NY MHCs (i.e., not entailing cross-site comparisons) to:

- Document the operational structure of each mental health court, and how it differed from business-as-usual in its respective jurisdiction.
- Identify any significant changes made to the program model during the study period, and explore the rationale for those changes.
- Examine factors that impeded or facilitated either program's ability to achieve intended objectives of providing mental health treatment and reducing participants' anti-social and criminal behavior.

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- Determine the effect of each MHC program on participants' criminal justice outcomes, specifically in terms of whether mental health court participation reduces individuals' subsequent criminal justice involvement (e.g., re-arrest and re-conviction).

- Assess whether MHCs generate cost savings for the criminal justice system and other public institutions.

Process and impact evaluation objectives were largely met; however, the cost-effectiveness component was not completed so the final study offers a guide to conducting cost analyses in place of actual findings regarding these two court programs.

The Research Strategy and Sample

To document program operations, policies, and procedures, as well as business-as-usual activities, the **process evaluation** drew on multiple data sources, relying primarily on in-person and telephone semi-structured interviews with program staff, key criminal justice partners, a limited set of mental health treatment providers who treated MHC participants, and staff at the New York City Department of Health and Mental Hygiene (DOHMH). We also conducted systematic courtroom observations to further explore the dynamics of the two MHC programs and how program philosophy manifested. Program materials and documents were used as secondary sources of information for this evaluation component, and program data were used to support quantitative process analyses.

The **impact evaluation** focused primarily on *recidivism* results, as measured by *new arrests* and *new convictions* after program admission.[1] Using a quasi-experimental design and propensity score matching, we compared the outcomes of MHC participants within each of the two studied programs to other defendants with mental illness (primarily felony offenders with Axis 1 designations, arrested in either the Bronx or Brooklyn, consistent with the MHCs' target populations) whose cases were processed as usual in the local justice system between 2002 and 2006. Consistent with our intent to conduct separate (not pooled) evaluations of the two courts, four retrospective samples—a treatment group sample for each court program and matched comparison groups for each court program—were drawn from administrative records maintained by the New York State Division of Criminal Justice Services, NYC DOHMH, and the program databases maintained by each court program.

The *treatment group for the Bronx impact analysis* consisted of individuals who participated in the Bronx MHC between January 1, 2002 and December 31, 2006. Of the

[1] *New arrests* and *new convictions* essentially include re-arrests and re-convictions of individuals who had qualified for inclusion in this study by virtue of having been arrested and incarcerated in NYC DOC—typically in the jail facilities on Rikers Island—where they had been screened and diagnosed as needing mental health services. NYC DOC admissions include criminal defendants detained after arrest, but before trial, as well as offenders sentenced to serve incarceration terms in a City jail.

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648 individuals who participated in the Bronx program, 564 were matched to 564 arrestees in jail with a diagnosed mental disorder (comparison group).

The *treatment group for the Brooklyn impact analysis* consisted of individuals who participated in the Brooklyn MHC between March 1, 2002 and December 31, 2006. Of the 327 individuals who participated in the Brooklyn program, 316 met the research criteria for inclusion in the impact analysis with 303 matched to 303 appropriate comparison cases (i.e., arrestees in jail with a diagnosed mental disorder).

Comparison groups for both impact analyses were drawn from a pool of approximately 5,000 offenders[2] entered in the *Brad H*[3] database maintained by DOHMH. The pool of potential comparison cases consisted of individuals who were 1) arrested between January 1, 2005 and December 31, 2006 in either Brooklyn or the Bronx and 2) either "designated" or "deemed" as eligible for *Brad H* services in the DOHMH database. Propensity score matching (PSM) methods were used to "match" individuals in each MHC and its respective comparison group as closely as possible.

Overview of the Evaluation Findings

Findings from the **process analysis** suggested key differences in the problem-solving characteristics and orientation of the two mental health courts that could affect participant outcomes, including:

- **MHC Team.** Stakeholders in each MHC identified *consistent, stable participation across key courtroom actors* as a strong feature of their respective programs and a critical factor that facilitates program operations along with the *problem-solving team approach*. At the time of our study, both programs had the same judge, DA, and clinical operations (same lead agency in Bronx, same clinical director in Brooklyn) since their programs' inception. This stability likely facilitates a shared understanding of policies, procedures, and philosophy that also promotes continuity in approach.

  Stakeholders felt the team approach was beneficial, if not critical, to effectively working with offenders with mental illness. Compared to drug courts, however, much of the shared decision-making and substantive interaction among criminal justice and community partners takes place early in the treatment process, largely around eligibility determinations. Once a decision is made to accept or decline a case, much of the team work appears to occur between the clinical team and

[2] The initial DOHMH data file contained 9,439 records, but missing data on key variables reduced the number of viable cases to roughly 5,000.
[3] Since 2003, New York City has provided discharge planning services to inmates with mental illness under the settlement terms of a class-action lawsuit, *Brad H vs. The City of New York*. The lawsuit argued that given the number of inmates with mental illness who are treated by DOC, it functions as a *de facto* psychiatric hospital and, as such, must provide comparable aftercare and discharge planning services to its inmate-patients.

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mental health court judge (i.e., in the form of pre-court participant progress updates and recommendations from the clinical team). This contrasts with regular drug court case staffings where the team—which may include law enforcement representatives, prosecutors, public defense attorneys, as well as treatment staff—gathers to discuss client progress, weigh in on case advancement, and consider sanctioning options. Regardless, the benefits of the team approach in the MHC programs studied here may simply be the shared sense of responsibility and commitment to these cases that mental health court fostered across normally adversarial criminal justice actors.

- **Judicial Interaction and Courtroom Dynamics.** Most notably, although both courts self-identify as operating under dedicated dockets, the Bronx MHC docket typically included a mix of cases (close to one-third non-MHC cases compared to 18 percent in Brooklyn, of the hearings observed). Both programs required defendants to arrive at the start of court and wait together as a group for their case to be called; participants could leave, however, once their hearing was over. Unlike drug courts in which cases are placed on the docket in specific order to facilitate program strategies about using rewards, sanctions, and "the courtroom as a theater," neither of these MHC programs ordered cases in any strategic manner.

  The drug court literature suggests that judge-participant interaction characterized by direct conversation and eye contact can be a motivating factor for participants because it conveys care about the individual and interest in their progress (see, for example, Volume 3 of Rossman, Roman, et al. 2011). However, the duration of status hearings in both courts was relatively brief (typically lasting under two minutes), raising questions about how meaningful the status hearing, itself, is to the participant experience.

- **Participation in Judicial Hearings.** Based on courtroom observations, it appears that defense attorneys and prosecutors, as well as case managers in these two MHCs play a more active role in the courtroom process than their drug court counterparts (see, for example, Rossman, Roman, et al. 2011). Although a hallmark of problem-solving courts is a non-adversarial focus, this comparison suggests a relatively more robust collaborative approach in play at the two mental health courts studied here. Stakeholders in both MHCs reported that the adversarial nature of courtroom dynamics typically ends once pleas are accepted.

- **Monitoring and Testing.** Status hearings are held more frequently in the Brooklyn MHC; likewise, defendants meet with their assigned forensic coordinator prior to each status hearing to discuss progress, address any treatment issues, and submit to random drug tests. In the Bronx MHC, participants meet weekly with their TASC case manager at which time drug tests are administered. Some treatment providers also tested MHC clients for drug use.

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- **Clinical Assessment.** Although both court programs conduct two-part assessments (psychosocial assessments performed by clinical staff, and psychiatric evaluations performed by psychiatrists) to determine mental health eligibility, the Bronx TASC staff assessments incorporated a number of structured assessment instruments in the process. While both clinical teams meet to discuss cases, the Bronx MHC clinical team meetings were characterized by a greater degree of mutual decision-making with regard to treatment issues and client progress. In Brooklyn, clinical decisions were more centralized and rested with the MHC's clinical director. Lastly, the TASC clinical team is housed in a separate and neutral entity from the Bronx MHC; in Brooklyn, the clinical team is based within the court.

- **Treatment Provider Networks.** Unlike most drug courts (the generic model adapted by MHCs) that typically rely on less-than-a-handful of substance abuse treatment providers, these two courts used extensive numbers of different treatment providers (e.g., 100 or more) to provide both community-based and residential treatment that met the needs of their participants. One of the courts had a policy of not using a provider unless at least two MHC participants simultaneously could be enrolled in treatment; this practice was intended to ensure that participants would have a "natural support group" of other MHC persons as they moved through their treatment experiences.

  While both MHC programs work with relatively extensive provider networks, stakeholders nonetheless identified a *lack of community-based treatment options as a key challenge* to program operations. Consequently, both programs place participants with providers in other boroughs and outside of New York State to address treatment needs. Common placement issues included 1) a general lack of programs, 2) too few programs providing housing accessible to criminal justice populations with mental disorders, as well as 3) a dearth of programs to meet the special needs of other sub-groups in the MHC programs (e.g., Spanish-speakers, adult clients with dependent children). This was particularly challenging for the Bronx MHC, which served a higher concentration of Spanish-only speakers and a community where poverty and substance abuse were more entrenched. Compounding this challenge is the time it takes to secure open treatment slots that can accommodate defendants in need of community-based services. Stakeholders expressed concern that clients awaiting placement remain in jail, where they often deteriorated due either to a lack of treatment or the stressful experience of incarceration.

- **Treatment Placement.** Both court programs placed participants into community-based treatment. However, in Brooklyn, the decision to accept a client was contingent upon securing treatment. Clients did not enter a guilty plea to the program until the clinical team had identified and "locked in" a treatment slot. As a result, all persons accepted to the Brooklyn MHC had access to treatment. By contrast, the Bronx program operated under an intent-to-treat model. Clients pled into the program first, often before the clinical team had located a treatment

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placement. The vast majority of Bronx MHC participants were successfully placed into treatment within one to two months, but roughly one-fifth were not.

- **Referral Mechanisms.** Both courts accepted clients through a variety of referral sources, including prosecutors, defense attorneys, and other judges or court parts. Prosecutors were often the "official" referral source into both MHCs, through whom defense referrals were often made. However, the two programs differed with respect to certain systematic referral mechanisms. The Narcotics Bureau of the Bronx DA's office routinely used a mental health checklist to screen for potential referrals to the mental health court; this likely contributed a greater share of participants with co-occurring disorders. Also, in the Bronx, approximately one-third of participants had initially been enrolled in the jurisdiction's drug court, then were transferred to mental health court, suggesting a need for additional screening of drug court participants. In Brooklyn, by contrast, cases referred for competency proceedings were routinely calendared to the MHC for consideration once a defendant was restored to fitness; this likely added more severely mentally-ill participants to the Brooklyn caseload.

- **Use of Rewards and Sanctions.** Both MHCs employed rewards and sanctions, but the Brooklyn program used a greater variety of rewards (e.g., verbal recognition from the judge, certificates for phase advancement, and small gifts at graduation). In contrast, the Bronx MHC did not mark treatment progress, citing that the objective of mental health courts is not to cure participants' mental health. In general, responses to non-compliance were addressed on case-by-case bases, and participants were given frequent second chances. In contrast to many drug courts, remand to jail was typically a last resort for the two MHCs in this study. This seems to tacitly recognize a key difference between participants in MHCs and those in drug court programs: the primary treatment issue in drug courts is substance abuse, which is not only a health issue, but also a justice issue as substance use is illegal. By contrast, mental illness is not, in and of itself, illegal behavior, although those who suffer from mental illness and find themselves in a MHC have committed other infractions that brought them to the attention of the court.

The extent to which the observed differences in judicial-participant interaction and courtroom dynamics affect participant outcomes is unclear. Two aspects of mental health courts are theorized to promote beneficial therapeutic outcomes: 1) mental health treatment and 2) ongoing judicial monitoring. The latter is hypothesized to promote treatment adherence, thereby improving mental health outcomes and reducing criminal behavior. While Brooklyn participants fared slightly better than Bronx participants with respect to criminal justice outcomes, both groups had considerably better outcomes than their matched comparisons subjected to "business-as-usual court processing," suggesting that *regular and frequent monitoring of offenders with mental illness—rather than the type of therapeutic courtroom model— may be the critical factor in participant success.* In either case, the outcomes from the analysis of systematic courtroom observations

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suggest that additional research is warranted to explore which aspects of courtroom dynamics and interactions have the most impact on long-term defendant outcomes.

Key findings from the **impact** evaluation are consistent with the extant research on mental health courts. A summary of the study's impact evaluation findings includes:

Mental health court participants were significantly less likely to recidivate, as compared to similar offenders with mental illness who experienced business-as-usual court processing:

- **Re-arrest.** In the Bronx impact evaluation, the *re-arrest* rate was 69 percent for the MHC participants and 75 percent for the comparison group. The difference of 6 percentage points is statistically significant at the .10 level, suggesting that MHC participation reduces the chance of being re-arrested. Similarly, the *re-arrest rate* for Brooklyn MHC participants was approximately 60 percent, as compared to 68 percent for the comparison group, a statistically significant difference at the .05 level.

- **Re-conviction.** The effect of Bronx MHC participation on *re-conviction* was not statistically significant; nearly 62 percent of both the treatment and comparison groups were re-convicted. In Brooklyn, however, MHC participation resulted in a reduction of nearly 17 percentage points in re-conviction. The average *re-conviction rate* for the MHC treatment group was 40 percent, as compared to 56 percent for the comparison group, statistically significant at the .01 level.

The age, criminal history, and substance use of program participants were significant predictors of recidivism.

- With respect to the offender characteristics explaining recidivism, age was a significant predictor of recidivism in the Bronx and Brooklyn evaluations. The recidivism rate was significantly higher for younger offenders.

- Other predictors of recidivism worth noting are the use of hard drugs, the number of prior property offenses, and offense variety score. In Bronx, hard drug users and offenders with extensive property offending history were significantly more likely to recidivate (odds ratios 2.1 and 1.2, respectively). In Brooklyn, those who have engaged in a variety of offenses were more likely to recidivate than those who did not.

Survival analyses showed that program participants were significantly more likely than comparison subjects to refrain from recidivism.

- In Bronx, the MHC treatment group had a 31 percent smaller hazard of recidivism than the comparison group, which was constant and stable over time.

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Similarly, program participants showed a lower recidivism rate than comparison subjects in the Brooklyn evaluation.[4]

Implications for Policymakers, Practitioners, and Researchers

Although MHC participants in this study had better criminal justice outcomes than mentally ill offenders in the matched comparison groups, recidivism is still high. Many researchers and advocates assert that mentally ill individuals are trapped in a "revolving door" of the criminal justice system, cycling in and out of correctional facilities due to their mental illness and lack of treatment. Yet others claim that mental health has little relation to criminal behavior and vice versa, citing the fact that the majority of individuals with mental illness do not commit crimes. Regardless, incarcerated individuals with mental health problems have more extensive criminal histories (James and Glaze 2006) and higher levels of criminal activity post-release (Baillargeon Binswanger et al. 2009; CSG Undated; Mallik-Kane and Visher 2008). The relatively high recidivism rates for both of the study's treatment groups may lend additional credence to the assertions of Skeem and colleagues (2009) that the majority of offenders with mental illness come in contact with the legal system for the same reason as other non-mentally ill offenders: criminogenic needs. Two studies—Girard and Wormith (2004) and Skeem et al. (2009)—found that offenders with mental illness score higher, than offenders without mental illness, when assessed for criminogenic risk-needs. MHC participants may benefit from the kind of cognitive behavioral programming that addresses criminogenic (criminal) thinking. Although the Brooklyn MHC assessed for criminogenic risks-needs, it is unclear what role cognitive behavioral therapies (CBT) played in the court's treatment regimen. A growing literature on evidence-based practice suggests that CBT is critical in mitigating future offending among offenders with high criminogenic risk-needs.

Policymaker support for and interest in criminal justice alternatives for mentally ill offenders is strong and the number of mental health courts is growing. Although the field has not yet produced as many studies documenting the effectiveness of mental health courts as exist for drug courts, there is a growing body of research which consistently provides empirical support that mental health courts are effective in reducing recidivism and positively impacting participant functioning. The findings of this study only further reinforce this trend. Therefore, it may well be prudent to fund additional studies that support cross-site evaluation of multiple jurisdictions with their different policies and practices to extend our knowledge of mental health court effectiveness.

Beyond outcomes, however, little research has been conducted on questions of mental health court efficiency and cost. One study (Ridgeley et al. 2007) investigated costs for a mental health court in Allegheny County. This study found that the jurisdiction's mental health court costs were similar to those of the traditional court system. The authors

[4] In Brooklyn, the rate at which the treatment group outperformed the comparison group changed over time. The difference in the hazard rate of recidivism between the treatment and comparison groups was relatively larger during the first year of program participation.

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speculated that it was likely that the mental health court might become less costly over time.

Future work can build upon this promising research base. Methodological weaknesses of individual studies (e.g., sole reliance on self-reported outcomes, lack of random assignment, and short-term follow-up) make it difficult to reach confident conclusions. Most outcome studies examine individual courts, which may account for conflicting findings across studies; however, existing meta-analyses help provide overall estimates of mental health courts' effectiveness. Nevertheless, it is still important for researchers in the field to expand the evidence base with strong research designs in multisite studies. Outcome studies also should include process components so that researchers can isolate possible causes of differing outcomes and levels of success. With modest graduation rates in some courts (e.g., Hiday and colleagues [2005] found a little more than half of MHC participants graduated from the court in their study), it also is important to evaluate the relative outcomes of program graduates versus those who fail to complete the program. While future work should continue to examine important criminal justice *and* mental health outcomes, researchers also should begin to explore some additional issues, such as:

- Cost-effectiveness of mental health courts.

- Identification of mental health court best practices including essential program components, in keeping with the growing emphasis on implementation of evidence-based practices. Future research should focus on identifying precisely which MHC policies and practices generate high performance in terms of recidivism and improved mental health status.

- Development of research-driven standards to guide MHC court practices. The drug court field has received considerably more attention than MHCs and has matured to a state where researchers can say with a fair degree of confidence what works best to achieve reductions in crime and drug use among substance-using offenders in these programs. If evidenced-based standards of practice can be identified, there is the potential to systematically introduce improvements across current and future MHC programs by developing an accreditation program.

- Effectiveness of mental health courts for sub-populations (e.g. first-time offenders vs. offenders with extensive criminal histories; individuals with more or less severe psychopathologies).

- The relative value of various features or components of the mental health court model, or of differing models.

- Causes of program failure by individuals and ways to retain participants.

- Longer term impacts.

- Client perspectives.

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- Public opinion of mental health courts.

Continuing to describe and evaluate mental health courts will assist in the improvement of existing courts and help practitioners and policymakers to design and implement future programs with evidence-based practices. Findings from the current study support this objective by contributing additional findings to the field through a multi-site process and outcome evaluation of mental health courts in New York City, and by using sophisticated analytic techniques to control for selection bias, the largest methodological threat to mental health court evaluation research.

Conclusions

This study identifies characteristics of the Bronx and Brooklyn MHCs that may contribute to participants' criminal justice outcomes, which favorably compared to those of other offenders with mental health disorders. Several avenues for future research have been identified that will address key gaps in the extant research and ideally advance both policy and practice, in the process.

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