The Brooklyn Mental Health Court: Stakeholder Perceptions and Pathways to Completion

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Center for Court Innovation

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Table of Contents

Executive Summary

The Brooklyn Mental Health Court (BMHC), the first mental health court in New York State, was established in 2002 as a partnership between the Center for Court Innovation and the New York State Unified Court System. Through 2021, BMHC successfully diverted over 1,200 individuals from incarceration.

BMHC, like all mental health courts, combines treatment and judicial supervision and seeks to address the overrepresentation of individuals with mental illness in the criminal legal system. During their time in the program, participants are required to attend treatment, with case management support from BMHC clinical staff. Participants also appear regularly before the dedicated BMHC judge, who monitors program compliance and address problems that arise. While most defendants complete the program successfully and graduate, unsuccessful participants are sentenced to incarceration. The current study seeks to better understand which in-program events are associated with such unsuccessful completion and sentencing.

In 2018, BMHC received a grant from the Federal Bureau of Justice Assistance (BJA), which brought three key programmatic changes: an overall expansion of capacity, addition of dedicated staff to work with individuals with neurodevelopmental disorders as their primary diagnosis, and the introduction of a structured risk assessment tool. Additionally, the grant is intended to support BMHC's continuing work with defendants with violent felony charges.

Research Questions

Drawing on a combination of existing program data at the time of the grant award and interviews with BMHC staff and court personnel during the grant period, the current study seeks to answer the following research questions:

1. During the years leading up to the grant award (pre-grant period), did program success rates vary for specific subgroups of BMHC participants (i.e., participants facing felony charges or those with neurodevelopmental diagnoses)?

2. During the pre-grant period, which in-program experiences or events were associated with program outcomes?

3. After grant implementation began, how did stakeholders perceive the BJA-funded program enhancements?

4. After grant implementation began, what did stakeholders see as the overall program strengths and challenges of the Brooklyn Mental Health Court?

Major Findings

The following findings are based on data from the pre-grant period, to help inform understanding of past, present, and future BMHC participants:

1. **Violent felony charges did not predict program outcome.** Participants whose cases closed between 2013-2018 and entered BMHC on violent felony charges were no more likely than those entering the program on lower-level charges to be unsuccessful in the program and sentenced. Participants with violent felonies entering BMHC during the grant expansion should therefore be just as successful in the program as other participants.

2. **Co-occurring neurodevelopmental diagnoses did not predict program outcome.** Participants with co-occurring neurodevelopmental diagnoses were just as likely as participants without such diagnoses to successfully graduate. This suggests that clients with primary diagnoses of a neurodevelopmental disorder, as part of the grant expansion, will be just as successful in BMHC as other participants.

3. **Similar in-program events were associated with unsuccessful outcomes among participants entering the program on violent felonies, participants with co-occurring neurodevelopmental disorders, and the overall BMHC participant population.** Overall, participants who had a new arrest, absconded from their treatment program, posed a threat to others, had a short-term jail sanction imposed by BMHC, and those who had a psychiatric competency exam ordered were less likely to successfully complete the program.

The following findings are based on interviews with stakeholders during grant implementation:

4. **Stakeholders felt the structured risk assessment tool was unnecessary and largely duplicative of existent practices.** BMHC staff and court personnel

expressed mixed feelings regarding structured risk assessment and largely found it unnecessary for BMHC.

5. **Interviewees felt the enhancement increased program capacity.** Stakeholders appreciated the opportunity to reach more participants with grant support, while also noting resource limitations.

6. **Stakeholders identified four key program strengths.** The most commonly noted strengths included the program's ability to engage a high-needs participant population; a strong cross-agency collaboration with stable and dedicated partners; strong judicial leadership; and a clinical team with specialized expertise.

7. **Limited resources are a chief impediment.** Lack of sufficient appropriate resources was the most frequently noted program challenge. Stakeholders noted this as a challenge in supporting BMHC participants overall as well as specifically in regard to those participants with primary diagnoses of neurodevelopmental disorders.

Recommendations

1. Seek additional funding to continue—and expand as appropriate—work with the two key populations of interest served under the BJA grant: defendants with violent felony charges and individuals diagnosed primarily with neurodevelopmental disorders. This recommendation is based on relative program success rates for participants with violent felony charges and co-occurring neurodevelopmental disorders during the pre-grant period as well as stakeholder interviews.

2. Expand the resources available for the BMHC population per stakeholder requests, especially housing resources, and particularly for those with neurodevelopmental disorders. Rather than a suggestion for BMHC, this is a recommendation for policymakers to increase the availability of such resources more broadly.

3. Increase case management expertise in supporting participants with a primary neurodevelopmental diagnosis, supplementing existing expertise, per stakeholder interviews.

4. Provide additional support when possible after specific case events occur to steer participants towards program success, as identified through analyses of program data and court notes.

5. Conduct further research on who successfully graduates from BMHC and who does not, emphasizing the populations targeted by the BJA grant once there is a large enough population to conduct a rigorous evaluation.

6. Reflect on the program's experience with structured risk assessment and the tool's utility in treatment planning to determine if continued use is warranted in BMHC, based on themes from stakeholder interviews. Additionally, for practitioners in the field, we recommend ensuring stakeholder buy-in prior to introducing structured risk assessment.

Chapter 1

Introduction

Individuals with mental illness are overrepresented in the criminal legal system, including in jails and prisons. An estimate from the Independent Commission on New York City Criminal Justice and Incarceration Reform suggested that 19% of people held in New York City jails have a serious mental illness (Lippman et al. 2017). This is nearly four times one estimate of the percentage of all U.S. adults with a serious mental illness, based on federal government survey data (National Institute of Mental Health, n.d.). Another national estimate, this one from the Bureau of Justice Statistics, indicated that individuals incarcerated in jails are five times as likely as members of the general population to have experienced recent serious psychological distress (Bronson and Berzofsky 2017).

Over the past few decades, mental health courts have arisen as one policy response to this overrepresentation. Mental health courts are a type of treatment court that serve to divert people with serious mental illness or developmental disabilities away from incarceration and into community-based treatment. These courts operate on the dual premises that (1) untreated and undertreated mental illness can be a contributing factor to lawbreaking activity and (2) mental health treatment (supervised by a judicial officer) leads to better criminal legal outcomes than jail or prison (Fisler 2015). Individuals who qualify for mental health court diversion often have a mental illness that is determined by a clinician to be debilitating enough that it hinders the individual's ability to function effectively. The first mental health court in New York State, the Brooklyn Mental Health Court (BMHC), was established in 2002 as a partnership between the Center for Court Innovation and the New York State Unified Court System. Through 2021, BMHC has successfully diverted over 1,200 individuals from incarceration.

As detailed below, the current study has two areas of focus. First, drawing on existing data from BMHC from 2013-2018 at the time of the BJA grant award, we explore whether specific events during BMHC participation are associated with unsuccessful case closure in order to help inform current and future case management work. Second, we examine stakeholder perceptions of BMHC, both overall and specifically regarding enhancements under a recent Bureau of Justice Assistance award. The remainder of this chapter provides background information on mental health courts generally and the Brooklyn Mental Health Court specifically and then goes on to further describe the current study.

The Mental Health Court Model

The first mental health court was established in Broward County, Florida, in 1997, and there are now over 300 mental health courts in operation across the United States (Council of State Governments n.d.; Rossman et al. 2012). While successful completion rates (i.e., graduation rates) vary across courts, one recent national estimate suggests that 65% of mental health court participants graduate (Kaiser 2019). Research has suggested that mental health court participation—and especially successful completion—reduces future system contact (Loong et al. 2019; Lowder, Desmarais, and Baucom 2016; Lowder, Rade, and Desmarais 2018; Ray 2014). Researchers have identified certain factors that are associated with mental health court noncompletion among participants, including race, multiple mental health diagnoses, history of problematic substance use, certain underlying charges, receipt of disability benefits, psychotropic medication prescriptions, fewer scheduled court appearances, missed court dates, positive drug tests, and new arrests (Dirks-Linhorst et al. 2013; Hiday, Ray, and Wales 2014; Linhorst, Kondrat, and Dirks-Linhorst 2015).

The Brooklyn Mental Health Court

BMHC was established to address the needs of both the overburdened court system and defendants with unmet mental health needs in Kings County, New York. BMHC serves defendants with a wide range of charges and mental health diagnoses. As of December 31, 2021, 50% of participants had a case with a violent felony as the top charge, 32% had a nonviolent felony top charge, and 18% had a misdemeanor top charge. The three most common charges for mental health court referrals in 2021 were assault (29%), robbery (17%), and burglary (16%). The most common primary diagnoses among active participants at the end of 2021 were schizophrenia (26%), bipolar disorder (22%), schizoaffective disorder (20%), major depressive disorder (8%), and post-traumatic stress disorder (8%).

BMHC defendants are typically referred to the court by their defense attorney. The district attorney's office then determines if it will consent to mental health court participation in lieu of formal prosecution. After that, a BMHC clinician conducts an assessment to confirm that the defendant has a serious and persistent mental illness or a neurodevelopmental disorder.[1]

[1] As of 2019, the BJA grant allowed BMHC to develop its capacity to work with individuals with neurodevelopmental disorders as their primary diagnosis. Prior to that point, defendants with a neurodevelopmental diagnosis were only eligible if they also were diagnosed with a severe and persistent mental illness.

This assessment is usually followed by a psychiatric evaluation by a consulting psychiatrist. If all parties agree to the individual's participation, BMHC staff works to secure appropriate treatment for the individual. Sometimes, BMHC staff also must work to secure housing, since defendants may be incarcerated on Rikers Island (New York City's main jail complex) up until their formal program entry and may not have housing. The final step in entering the program, if the defendant consents, is the "plea in": the individual enters a guilty plea in court, and that plea is held in abeyance. That is, if the participant successfully graduates from BMHC, the charge is either dismissed or reduced; if the participant is unsuccessful, they have already pled guilty and are sentenced without a trial.[2]

During their time in the program, participants are required to attend treatment, with case management support from BMHC clinical staff. Participants are also required to appear regularly in the BMHC court before the dedicated judge to monitor program compliance and address problems that may arise. The BMHC judge builds relationships with program participants and uses graduated incentives and sanctions to encourage compliance, with the end goal of graduation. While most participants complete the program successfully, not all are able to graduate, and to date it has not been clear which case events lead to unsuccessful program closure (though, as noted above, there has been research along these lines conducted at other mental health courts, e.g., Hiday et al. 2014; Linhorst et al. 2015).

Prior research specifically on the Brooklyn Mental Health Court has shown that the program leads to reductions in re-arrests and re-convictions among participants, as compared with a matched sample of individuals whose cases were processed in a traditional manner (Rossman et al. 2015). Prior research has also shown that factors associated with re-arrest among BMHC participants include younger age, prior arrests, diagnosis with a co-occurring substance use disorder, and entering the program on a misdemeanor (as opposed to felony) charge (Reich et al. 2015; Rossman et al. 2012). Reich and colleagues identified factors predicting in-program noncompliance—measured as jail sanctions during BMHC participation—including younger age, unemployment, arraignment on a property charge, and prior criminal justice history. They also found that unsuccessful program closure was associated with certain factors present at program intake: being homeless, being male, being Black, being arraigned on a misdemeanor (rather than a felony) charge, and having prior criminal justice involvement.

[2] The judge specifies the dispositions for different case outcomes at the time of plea.

The Current Study

In 2018, the Brooklyn Mental Health Court received a grant from the Federal Bureau of Justice Assistance (BJA) to expand its programming. This grant enabled BMHC to expand its capacity in two main ways: to serve more eligible defendants overall, and to work with individuals whose primary diagnosis is a neurodevelopmental disorder, such as autism spectrum disorders, intellectual disabilities, and attention-deficit/hyperactivity disorder. This second point of expansion involved hiring a new staff member, who had trained with the New York State Office for People with Developmental Disabilities (OPWDD), to work with this new population of participants. Additionally, the grant was intended to support BMHC's continuing work with defendants with violent felony charges. As part of the funding, BMHC implemented the Center for Court Innovation's Criminal Court Assessment Tool (C-CAT; Picard-Fritsche et al. 2018), to assess incoming participants for risk of both any re-arrest and re-arrest on a violent charge.[3] Table 1.1 shows the number of new BMHC participants, total and for each of the subpopulations of interest, for each full year of the BJA grant (2019, 2020, 2021) as well as for the year immediately prior to grant implementation (2018).

Table 1.1 New BMHC Participants, 2018-2021

	Total New Cases	Violent Felony Top Charge	Neurodevelopmental Disorder (Primary Diagnosis)
2018 *(pre-grant)*	129	82 (64%)	
2019	164	114 (70%)	13 (8%)
2020	66	46 (70%)	0 (0%)
2021	72	56 (78%)	4 (6%)
Total 2019-2021	*302*	*216 (72%)*	*17 (6%)*

Also, previous research has not examined what types of events *during BMHC participation* are associated with successful versus unsuccessful program completion—that is, graduation versus sentencing. This information could be useful to BMHC staff—as well as those in other mental health courts—as they work to support participants toward successful graduation. Therefore, the current research aims to understand the dynamics around

[3] The C-CAT is designed to assess both risk and needs. However, BMHC uses an abbreviated version of the tool that only assesses risk, given the program's preexisting comprehensive needs assessment.

unsuccessful BMHC program closure using the data available for closed BMHC cases at the time of the grant award (pre-grant period). Given the BJA enhancement focus on defendants with violent felony charges and those with neurodevelopmental disorders as their primary diagnoses, analyses of pre-grant period data pay particular attention to dynamics around unsuccessful closure among participants with violent felony charges and participants with neurodevelopmental disorders (who during this pre-grant period also always had co-occurring mental health diagnoses). The goals are to better understand these populations and to help BMHC staff identify, anticipate, and respond to factors that could potentially steer participants away from successful program completion.[4]

To understand both these dynamics and the perceived impact of the BJA program enhancements, in order to assist staff working with current and future BMHC participants—especially those with violent felony charges and with neurodevelopmental disorders—we sought to answer the following research questions:

1. During the pre-grant period, did program success rates vary for specific subgroups of BMHC participants? Specifically, were participants facing some charge types (misdemeanor, nonviolent felony, violent felony) or those with co-occurring neurodevelopmental diagnoses more or less likely to successfully complete the program?

2. During the pre-grant period, which case events—things the participant experienced or did *while in the program*—were associated with program outcomes? Did these differ for specific subgroups (i.e., those with violent felony charges; those with co-occurring neurodevelopmental diagnoses)?

3. After grant implementation began, how did stakeholders perceive the programmatic enhancements (i.e., introduction of a formal risk assessment tool, increased capacity to serve more participants, and capability for working with those with a primary diagnosis of a neurodevelopmental disorder)?

[4] Given the change in eligibility criteria with the grant, the pre-grant population with neurodevelopmental diagnoses is different from the target population under the grant. However, analyses are useful to show if any differences occur in a population that all have a mental health diagnosis but only some have an additional neurodevelopmental diagnosis.

4. After grant implementation began, what did stakeholders see as the overall program strengths and challenges of the Brooklyn Mental Health Court?

Chapter 2

Methods

This study relies on data from three sources: program data from all cases closed between 2013 and 2018 at the time of the grant award, court notes recorded electronically by the judge from a subset of those cases, and semi-structured interviews with court stakeholders during the grant period. Using program data from several years leading up to the BJA grant implementation helped to provide context for the grant activities and for findings from stakeholder interviews. We utilized program data and coded court notes to respond to the research questions about the pre-grant period program outcomes (research questions 1 and 2). We used interview data collected during the grant period to respond to the research questions about perceptions of the grant-funded enhancements and overall strengths and challenges (research questions 3 and 4).

Pre-Grant Period Program Data

Researchers downloaded data from BMHC's case management database and matched it to charge information contained in a separate case-level database.[5] Analyses based on program data include all cases resulting in either graduation or sentencing between 2013 and 2018 (n=446).[6]

We examined two key predictors of program outcomes: (1) charge type (violent felony, nonviolent felony, or misdemeanor top charge) and (2) presence of a co-occurring neurodevelopmental diagnosis (as determined by court clinicians).[7] Program outcome is measured as successful program graduation versus non-completion and sentencing. The

[5] Data were matched on a unique individual-level identification number assigned by the New York Division of Criminal Justice Services (i.e., NYSID).

[6] We excluded one case (a program graduate) that did not have valid charge data. We also excluded an additional 36 cases that were closed for other reasons during this period, including warrant for more than 9 months, deceased, civil commitment, case dismissal, and compassionate relief.

[7] While the additional program capacity supported by the BJA grant is specifically for individuals with neurodevelopmental disorders, the program data we analyzed does not differentiate between neurodevelopmental disorders and neurocognitive disorders, which involve a decline in cognitive functioning (e.g., dementia).

models also controlled for race, gender, age at plea, and case closure year. Table 2.1 displays information about the sample.

Table 2.1. Sample Description, All Closed Cases 2013-2018

	Graduated	Sentenced	Total
Number of Participants	370 (83%)	76 (17%)	446
Individual Characteristics			
Average age at plea***	36	31	35
Race/ethnicity			
Black	54%	63%	55%
White	23%	15%	22%
Latinx	15%	16%	15%
Other or unknown race [1]	8%	7%	8%
Gender			
Male	77%	79%	77%
Female	23%	21%	23%
With neurodevelopmental diagnosis	29%	34%	30%
Case Characteristics			
Top charge			
Violent felony	51%	49%	51%
Nonviolent felony	31%	37%	32%
Misdemeanor	18%	15%	17%
Violation	<1%	0%	<1%
Case closed year*			
2013	16%	21%	17%
2014	18%	24%	19%
2015	14%	24%	15%
2016	15%	9%	14%
2017	16%	11%	15%
2018	21%	12%	20%

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

[1] Includes clients identifying as Asian American or Pacific Islander (23), those not identifying with any of the presented racial categories (7), and those for whom race data is missing (6).

We applied initial bivariate comparisons of the key predictor and outcome variables to document areas where successful graduates and those sentenced significantly differ (see Table 2.1).[8] We used multivariate models (logistic regression) to further examine whether

[8] We used chi-square tests to assess significant differences.

top charge, neurodevelopmental diagnosis, any demographic characteristics, or case closed year, predict sentencing (Table 3.1).

Pre-Grant Period Court Notes

We conducted analyses of case events on a subsample of cases, which we coded based on court notes as detailed below. During hearings, the judge notes case events and other items; these notes are stored in a management information system. With the judge's permission, we retrieved and coded these notes. BMHC has had the same judge since its inception, so there was no need to account for differences in note-writing between different judges.

This second dataset consisted of a subsample of nearly all the sentenced cases and a random sample (stratification process described below) of successful cases closed between 2013-2018.[9] The random sample of successful graduates was stratified based on top charge (violent vs. nonviolent) and presence of a neurodevelopmental diagnosis, to match the composition of the sentenced cases. In this way, we ensured that all three sets of analyses (full subsample, defendants with violent felony top charges, and defendants with co-occurring neurodevelopmental diagnoses) had an equal number of successful and unsuccessful cases. The result is a final sample of 75 successful graduates and 75 sentenced individuals (Table 2.2).

Table 2.2 Each Subsample Had an Equal Number of Successful and Unsuccessful Cases

	Graduated	Sentenced
Nonviolent top charge, no neurodevelopmental diagnosis	26	26
Nonviolent top charge, co-occurring neurodevelopmental diagnosis	13	13
Violent top charge, no neurodevelopmental diagnosis	23	23
Violent top charge, co-occurring neurodevelopmental diagnosis	13	13
Total	75	75

Research and program staff collaboratively generated the initial list of case events to consider for the analyses. Some incidents were coded with multiple case events. For instance,

[9] One unsuccessfully closed case was excluded because the district attorney on a concurrent case in another jurisdiction did not agree to a community sanction, so the participant was removed from BMHC's program due to an incident that predated their program participation. The subsample of 75 graduated cases is 20% of all 370 graduates during the time period.

if an individual absconded from the treatment program and subsequently missed court, resulting in the issuance of a warrant, all three events would be assigned to that case. Also, we took a fairly conservative approach to coding notes: some events seemed *likely* based on the note but were not assigned unless explicitly stated. Once all the notes were coded according to this scheme, we made adjustments, combining some codes and excluding others to best fit the data. We eliminated any case events that applied only to a specific subsample (e.g., timing of new arrests was excluded, since it only applied to cases with new arrests during the program), as well as those that did not occur during the case (e.g., problematic substance use that predated program participation) and those that researchers thought may have applied to many cases but have been infrequently noted (e.g., difficulty finding community-based services). The final list of case events, all occurring at some point after participants took a plea and formally entered BMHC, fell into three categories:

(1) Rule noncompliance

- Missing treatment sessions or being reported as disengaged during sessions (only considered as a case event if the judge did not excuse);
- Missing a court hearing or hearings (only considered as a case event if the judge did not excuse);
- Refusing to take prescribed psychiatric medication;
- Absconding from treatment program / having whereabouts unknown;
- Breaking other treatment program or BMHC rules (aside from missing sessions, missing court, refusing medication, or absconding);[10]
- Posing a threat to others, e.g., violating an order of protection, trying to bring weapons into court.

(2) Psychiatric instability

- Having a 730 exam (evaluation to determine psychiatric competency to participate in legal proceedings, pursuant to section 730 of New York State Criminal Procedure Law) ordered in BMHC and conducted;
- Being hospitalized for a psychiatric reason, unrelated to a 730 exam;
- Exhibiting another indication of psychiatric instability, i.e., that was not indicated by a 730 exam or hospitalization (for example, acting in a psychotic manner in court);

(3) Criminal legal system

- Having any new arrests during the case;

[10] Rule infractions in this category include substance use, fighting, property damage, curfew violations, and instances of unspecified noncompliance.

- Having a warrant issued from the mental health court;
- Being sanctioned with remand from the mental health court (i.e., temporarily sent to jail as punishment, after which individuals typically continue their participation in the program); and
- If the participant's attorney asked to be relieved.

The frequencies for these case events and other variables are in Table 2.3, for the full subsample and each subpopulation of interest (violent felony top charge and co-occurring neurodevelopmental diagnoses).

Similar to the approach with the full sample of closed cases described above, we conducted bivariate comparisons of case events between successful graduates and those who were sentenced. We included only those case events with a statistically significant relationship to final program outcome in a multivariate (logistic) model along with participant demographics and charge category (Table 3.3). Because certain case events perfectly predict the program outcome, we accounted for this with additional analyses (see Chapter 3 for further discussion). The strong relationship between in-program remand—a (typically) short-term jail stay ordered by the court as a sanction for noncompliance—and ultimate sentencing from the program led us to explore which additional case and individual characteristics predict remand itself (see Table 3.4). Given the small sample sizes of the violent felony and co-occurring neurodevelopmental samples, we did not conduct multivariate analyses with these subgroups.

Stakeholder Interviews During Grant Implementation

Researchers conducted semi-structured interviews with four clinical staff members and five court personnel between February and March 2021, approximately two years into grant implementation. Researchers invited all clinical staff members to participate. The court personnel we invited to participate include the Brooklyn Mental Health Court's presiding judge, the assigned assistant district attorney, and the defense attorneys representing most BMHC participants.

Researchers asked interviewees about their perceptions of and feedback on programmatic changes under the recent BJA grant, as well as overall program strengths and challenges. Specifically, we asked about the adoption of a formalized risk assessment tool, overall

increased participant capacity, and the new capacity to serve participants with neurodevelopmental disorders as their primary diagnosis. Most interviews lasted between 20 and 30 minutes, with one lasting close to an hour. All but one of the interviewees consented to the interview being audio recorded. Researchers analyzed interview transcripts and notes using deductive coding and thematic analysis, using Dedoose. We derived initial codes from the study framework, largely oriented around the interview questions.

Table 2.3. Subsample Descriptions

	Full Subsample	Violent Felony Top Charge Subsample	Neuro-developmental Diagnosis Subsample
Number of Participants [1]	*150*	*72*	*52*
Case Characteristics			
Program outcome			
Graduated	75 (50%)	36 (50%)	26 (50%)
Sentenced	75 (50%)	36 (50%)	26 (50%)
Case events [2]			
Rule noncompliance			
Missed treatment sessions	79 (53%)	39 (54%)	31 (60%)
Missed court dates	67 (45%)	34 (47%)	27 (52%)
Medication refusal	31 (21%)	14 (19%)	9 (17%)
Absconded from treatment program	55 (37%)	25 (35%)	20 (39%)
Other program infractions	79 (53%)	35 (49%)	30 (58%)
Posed a threat to others	7 (5%)	5 (7%)	1 (2%)
Psychiatric instability			
730 exam conducted	14 (9%)	10 (14%)	1 (2%)
Psychiatric hospitalization	24 (16%)	14 (19%)	7 (14%)
Other indicators of psychiatric instability	7 (5%)	3 (4%)	1 (2%)
Criminal legal system			
New arrest during case	58 (39%)	30 (42%)	23 (44%)
Warrant issued from BMHC	77 (51%)	34 (47%)	28 (54%)
Remand ordered in BMHC	76 (51%)	36 (50%)	29 (56%)
Attorney asked to be relieved	4 (3%)	3 (4%)	1 (2%)
Top charge			
Violent felony	72 (48%)		26 (50%)
Nonviolent felony	47 (31%)		14 (27%)
Misdemeanor or violation	31 (21%)		12 (23%)
Individual Characteristics			
Average age at plea	33	30	32
Race/ethnicity [3]			
Black	87 (58%)	42 (58%)	30 (58%)
White	30 (20%)	13 (18%)	9 (17%)
Latinx	22 (15%)	14 (19%)	6 (12%)
Other or unknown race [4]	11 (7%)	3 (4%)	7 (14%)
Gender			
Male	117 (78%)	58 (81%)	41 (79%)
Female	33 (22%)	14 (19%)	11 (21%)

[1] Twenty-six cases are included in both the Violent Felony and Neurodevelopmental Diagnosis subsamples.

[2] Participants may have had more than one case event; percentages sum to more than 100%.

[3] Percentages in two columns do not sum to 100% due to rounding.

[4] Includes clients identifying as Asian American or Pacific Islander (5), those not identifying with any of the presented racial categories (3), and those for whom race data is missing (3).

Chapter 3

Factors Predicting Sentencing in the Pre-Grant Period

Program Outcomes and Charge

Overall, 83% (*n*=370) of BMHC participants successfully graduated and 17% (*n*=76) were sentenced during the 2013-2018 pre-grant period. In bivariate analyses, sentencing versus graduation was not significantly associated with the charge level on which participants entered the program (Table 2.1). Among both graduates and those sentenced, half entered the program on a violent felony, a third entered on a nonviolent felony, and the remainder entered on a misdemeanor.

Table 3.1 (Model 1) shows the results of the multivariate model. Again, there were no statistically significant differences in program outcome based on entering charge type. This finding affirms the notion that the program can successfully expand its work with this population. When sufficient time has passed from grant implementation for an impact evaluation, individuals who entered the court on violent felonies under the BJA grant will likely be found to be as successful in BMHC as individuals entering the program on less severe charges.

Older participants were significantly less likely to be sentenced than younger participants. Specifically, the odds of being sentenced decreased by 4% for each additional year of age at plea (OR=0.96). Race approaches statistical significance in this model: Black participants had nearly twice the odds of being sentenced as white participants (OR=1.9) when accounting for charge severity, other demographic factors, and the year the case was closed. Finally, it appears that unsuccessful completion became less likely over time: cases closed in the first half of the time period studied (2013-2015) had greater odds of being sentenced than cases closed in the last year of the period (2018). Notably, while a good fit for the data, the statistical model does not have very good predictive power (Cox & Snell R^2=0.065), meaning it is missing important factors in predicting sentencing.

Program Outcomes and Co-Occurring Neurodevelopmental Diagnoses

Final program outcome did not have a significant association with co-occurring neurodevelopmental diagnosis in bivariate analysis; around a third of both groups received such a diagnosis from BMHC clinicians during the pre-grant period studied.

Table 3.1 (Model 2) shows the results of the multivariate analysis. Again, participants with co-occurring neurodevelopmental diagnoses were no more or less likely to be sentenced from the program. While this is a distinct population from individuals served under the BJA grant enhancement whose neurodevelopmental diagnosis is primary, this finding affirms the enhancement's work with the latter population and lends support to continued expansion of that work. In a future impact evaluation, participants with primary diagnoses of neurodevelopmental disorders may be found to be just as successful in the program as those without such diagnoses.

As with the prior analysis, age at plea was associated with program outcome, with older participants facing lower odds of being sentenced: odds of being sentenced decreased by 4% with each additional year of age at plea (OR=0.96). Likewise, cases closed during the earlier program period had higher odds of being sentenced than those closed at the end of the period.

Race is the one notable difference between these analyses; race did not approach a statistically significant association with sentencing when accounting for co-occurring neurodevelopmental diagnosis.

Notably, as above, while this statistical model is a good fit for the data, it does not have particularly good predictive power (Cox & Snell R^2=0.060): important factors that predict sentencing are missing from the model.

Table 3.1. Neither Top Charge nor Co-Occurring Neurodevelopmental Diagnosis Predict Sentencing (Unsuccessful Case Closure)

	Model 1	Model 2
N	445 [1]	446
Cox & Snell R^2	0.065**	0.060**
Dependent Variable	Program Outcome	
	Odds Ratio	
Investigated predictor		
Top charge [2]		
Misdemeanor	0.962	
Nonviolent felony	1.567	
Co-Occurring neurodevelopmental diagnosis		1.127
Demographics		
Age at plea (continuous)	0.959***	0.963**
Race/ethnicity [3]		
Black	1.943+	1.800
Hispanic/Latinx	1.590	1.488
Other or unknown race	1.312	1.176
Gender [4]		
Female	0.879	0.853
Case closed year [5]		
2013	2.824+	2.632*
2014	2.227+	2.137+
2015	2.875+	3.115*
2016	0.956	0.927
2017	1.169	1.081
Constant	0.258*	0.274*

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

[1] One case had a Violation top charge and was excluded from this model.

[2] reference category: violent felony

[3] Reference category: White

[4] Reference category: male

[5] Reference category: 2018

Program Outcomes and Case Events

We conducted additional analyses of case events associated with program outcomes during the pre-grant period on a subsample of cases closed between 2013-2018. The purpose of

these additional analyses was to identify case events that can signal to BMHC staff a need for increased participant support. All but two of the included case events had a statistically significant bivariate relationship with program outcomes. Taken on their own, nearly all measures of noncompliance with program rules, psychiatric instability, and ongoing interaction with the criminal legal system were significantly associated with sentencing (Table 3.2, column A). The only measures *not* significantly related to poor final program outcomes were request by the participant's attorney to be removed from the cases and non-specified "other" indicators of psychiatric instability.

When we included the in-program case event variables in a multivariate logistic regression model, along with demographic and charge variables, the results point to three case events that predicted sentencing during the pre-grant period:

- Participants who absconded from their program had more than 15 times the odds of being sentenced as participants who never absconded;
- Participants with a new arrest while in the program had approximately 11 times the odds of being sentenced as those without new arrests; and
- Participants who were remanded to jail as an interim sanction while in the program had over 5 times the odds of being sentenced as those who were never remanded.

Unlike in the full sample analysis, age was not significantly associated with program outcomes when controlling for case events. Results are displayed in Table 3.3.[11]

Additionally, all participants who had either a 730 exam conducted (n=14) or who were identified as posing a threat to anyone while in the program (n=7) were sentenced from BMHC rather than graduating, although program policy did not and does not establish either of these case events as an automatic cause for sentencing. Based on the model fit statistics from three additional models excluding these variables (results not shown), we determined that both variables are also important predictor variables (Mansournia et al. 2018; Rindskopf 2002).

[11] Given the differences in the effect of age in these two models, we further explored to see if younger participants—specifically those 25 and younger and hence eligible for BMHC's youth-specific programming—were more likely to experience certain problematic case events. The results from these further analyses were inconclusive.

Table 3.2. Several Types of Case Events Were Associated with Program Outcomes (Bivariate)

	COLUMN A Full Subsample	COLUMN B Violent Felony Charge Subsample	COLUMN C Co-Occurring Neurodevelopmental Diagnosis Subsample	Include in Multivariate Model?
N	150	72	52	
Rule noncompliance				
Missed treatment sessions or disengagement during session	***	**	ns	yes
Missed court dates	***	***	**	yes
Medication refusal	**	ns	ns	yes
Absconded from treatment program/had whereabouts unknown	***	***	***	yes
Other program infractions	***	***	+	yes
Posed a threat to others	* [1]	+	ns [1]	yes
Psychiatric instability				
730 exam conducted	***	***	ns [1]	yes
Psychiatric hospitalization (unrelated to a 730 exam)	**	ns	ns	yes
Other indication of psychiatric instability	ns [1]	ns [1]	ns [1]	no
Criminal legal system				
New arrest during case	***	***	ns	yes
Warrant issued from BMHC	***	***	***	yes
Remand ordered from BMHC	***	***	***	yes
Attorney asked to be relieved	ns [1]	ns [1]	ns [1]	no

ns p≥.10 (not statistically significant) + p<.10 * p<.05 ** p<.01 *** p<.001

[1] Fewer than 5% of cases had this case event.

Table 3.3. New Arrests, Absconding, and Remand Independently Predicted Sentencing (Unsuccessful Case Closure)

N	150
Cox & Snell R^2	0.604***
Dependent Variable	Program Outcome
	Odds Ratio
Case events	
Rule noncompliance	
Missed treatment sessions or disengagement during session	2.219
Missed court dates	0.911
Medication refusal	0.271
Absconded from treatment program/had whereabouts unknown	15.353*
Other program infractions	3.307
Posed a threat to others [1]	2.132 x 10^9
Psychiatric instability	
730 exam [1]	1.630 x 10^9
Psychiatric hospitalization (unrelated to a 730 exam)	1.050
Criminal legal system	
New arrest during case	11.025**
Warrant issued from BMHC	3.039
Remand ordered from BMHC	5.318*
Demographics	
Age at plea (continuous)	1.004
Race/ethnicity [2]	
Black	3.459
Hispanic/Latinx	1.236
Other or unknown race	13.206+
Gender [3]	
Female	1.970
Top charge [4]	
Misdemeanor or violation	0.200
Nonviolent felony	2.250
Constant	0.003**

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

[1] Case event perfectly predicts program failure (i.e., sentencing rather than graduation).

[2] Reference category: White

[3] Reference category: male

[4] reference category: violent felony

Characteristics Associated with Remand

Since the decision to sanction a participant with a remand is at the judge's discretion, we also hoped to better understand which case events were associated with that decision. Other than the fact that remand is the outcome variable (and excluded from the model), the model presented in Table 3.4 is identical to the program outcome model in Table 3.3. Those who were remanded were more likely to have:

- Missed program sessions or been disengaged during sessions (almost five times the odds of remand);
- Other rule infractions (more than six times the odds of remand);
- Absconded from treatment (more than four times the odds of remand; approaches significance); and
- A warrant issued from BMHC (more than four times the odds of remand; approaches significance).

Again, posing a threat perfectly predicted remand; model comparisons show this to be an important predictor variable for remand as well as for program outcome.

Table 3.4. Certain Program Infractions Independently Predicted Remand

N	150
Cox & Snell R^2	0.497***
Dependent Variable	Remand
	Odds Ratios
Case events	
Program noncompliance	
Missed treatment sessions or disengagement during session	4.934**
Missed court dates	1.204
Medication refusal	2.263
Absconded from treatment program/had whereabouts unknown	4.612+
Other program infractions	6.058**
Posed a threat to others [1]	1.056×10^9
Psychiatric instability	
730 exam	0.639
Psychiatric hospitalization (unrelated to a 730 exam)	1.917
Criminal legal system	
New arrest during case	1.472
Warrant issued from BMHC	4.661+
Demographics	
Age at plea (continuous)	1.014
Race/ethnicity [2]	
Black	1.922
Hispanic/Latinx	0.540
Other or unknown race	0.855
Gender [3]	
Female	1.248
Top charge [4]	
Misdemeanor or violation	0.926
Nonviolent felony	0.741
Constant	0.013**

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

[1] Case event perfectly predicts remand from BMHC court part.

[2] Reference category: White

[3] Reference category: male

[4] reference category: violent felony

Case Events for Select Subpopulations

Overall, during the pre-grant period, similar lists of case events predicted sentencing among the two select subpopulations—participants entering the program on violent felonies and participants diagnosed with co-occurring neurodevelopmental disorders—as in the overall BMHC population. That is, BMHC staff can be attuned to occurrences of the identified case events without regard to participant membership in one of these sub-populations.

Participants Entering on a Violent Felony Charge Among those participants entering BMHC on violent felonies, case events related to sentencing were nearly identical to the list among the full subsample (Table 3.2, column B). That is, noncompliance with program rules, psychiatric instability, and ongoing interaction with the criminal legal system were also associated with sentencing for those entering the program on a violent felony. The only events *not* significantly related to program completion for this population (when not accounting for other factors) were medication refusal, psychiatric hospitalization, request by the attorney to be removed from the case, and other (non-specified) indicators of psychiatric instability.

Participants Diagnosed with a Co-Occurring Neurodevelopmental Disorder A smaller set of case events have a significant relationship with program outcomes among the subsample of participants diagnosed with co-occurring neurodevelopmental disorders (Table 3.2, column C). Among these participants, only missing court dates, absconding from the treatment program, and having either a warrant issued or remand ordered in BMHC were significantly related to sentencing.

Both of these subsamples are too small to conduct any meaningful multivariate analysis. The contracting list of bivariate associations is potentially the result of diminishing sample sizes (from 150 in the full sample to 72 in the subgroup charged with a violent felony to 52 with a neurodevelopmental diagnosis), rather than real differences among groups.

Chapter 4

Stakeholder Perceptions

Interviews with nine stakeholders (four BMHC staff members and five court personnel) addressed interviewees' perceptions of three aspects of the BJA enhancement, approximately two years into the grant period: adoption of a formalized risk assessment tool (C-CAT), increased capacity overall, and increased capacity to serve participants with neurodevelopmental disorders. In addition, we asked interviewees to reflect on program strengths and challenges. While the grant enhancements have not been in place long enough to conduct an impact analysis of the grant enhancements, these interviews provided valuable qualitative insights into those enhancements and other aspects of BMHC's program.

Adoption of Formal Risk Assessment Tool

Researchers interviewed program staff after they received C-CAT training. The tool, introduced at BMHC as part of the grant enhancements, is intended to help program staff assess defendants' overall risk of re-arrest as well as their risk of re-arrest for an act of violence. At the time of these conversations, two interviewed staff members had already started using the tool, while two others had not.[12]

One prevailing attitude, expressed by six interviewees, is that BMHC had already been assessing prospective participants for risk, albeit without a formalized tool. Some shared that they had always, if implicitly, used a similar model for risk assessment. Five interviewees elaborated that they were confident in the program's consulting psychiatrists' ability to properly assess for risk during psychiatric evaluations.

> The psychiatrist is a very capable forensic doctor who is able to do not only good evaluations that confirm whether or not the person fits our criteria with regard to having a major mental disorder, but in addition, we get very decent—what you could characterize loosely as a risk assessment, and also an assessment of the person's ability to comply.

[12] As of publication, all BMHC staff have begun using the C-CAT.

Some interviewees commented that there is always risk in a program such as BMHC, and that the people involved accept that level of risk.

> Sometimes you just have to be careful, you always have to be careful and I always say that you can't do this job if you're afraid. Otherwise everyone's in jail, everybody stays in jail and you're not going to take any risk. But if you want to do the most good, then you have to take some risks.

Another interviewee spoke more strongly on the point, questioning the purpose of formalized risk assessment: "What difference does it make? We take them anyway. You know, we take difficult [participants]. They don't just take easy [participants]."

While interviewees were largely content with the status quo of their assessment protocols, three stated that they believed the C-CAT would assist them with appropriate treatment planning. One of them explained, "Obviously you don't want to over-supervise people and you don't want to give them more than they need to keep everyone safe."

Some interviewees expressed apprehension about formalized risk assessment as a practice. Concerns that risk assessment tools often lead to "labeling," "essentializing," or otherwise categorizing individuals based on perceived risk were salient during these conversations. One interviewee expressed concern about race and gender disparities in risk assessment. Another worried that the risk assessment process might lead some people to be detained longer on Riker's Island, as the additional documentation may lengthen the BMHC enrollment process.

While the C-CAT risk score is intended to be used only for service planning in BMHC, three interviewees also expressed concern that the risk assessment tool might potentially be used to restrict eligibility for BMHC participation. On the other hand, interviewee suggested that adopting the C-CAT could allow the court to identify and admit higher-risk individuals with serious or violent charges.

Some interviewees struggled with how the tool is meant to be used and how it can support their work. As an illustration, one interviewee perceived a purported link between risk score and program outcome, finding such a link lacking: "We've had many people with … seemingly low risk that struggle very much through this program, and some people that are very high on risk and have gone through the program very well and easily."

Increased Participant Capacity

One aim of the BJA grant was to increase participant enrollment by roughly 20%.[13] Interviewees appeared generally aware of efforts to expand capacity, noting an increase in BMHC staff. Echoing sentiments shared by several interviewees, one interviewee noted that additional staff enabled them to "give more time and care and attention to our caseloads." Other interviewees shared that the increased participant capacity had resulted in larger caseloads but that the additional work was manageable.

While the court's capacity to serve participants has increased, most interviewees reported that resources, including housing and treatment options, have not grown in the same way. Interviewees reported that there are still many prospective participants who are incarcerated and awaiting placement into the community. According to one interviewee BMHC "need[s] more programs to be available so that [participants] aren't waiting to be placed."

Interviewees noted two specific populations felt to be better served based on the enhancement: youth and those with primary neurodevelopmental disorders.[14]

Participants with Neurodevelopmental Disorders as Primary Diagnosis

Prior to receiving the BJA grant, individuals with a neurodevelopmental disorder as their primary diagnosis were not eligible for BMHC. Previous eligibility criteria excluded individuals with such diagnoses who did not also have a co-occurring mental health diagnosis. The grant allowed BMHC to hire dedicated staff to work with this population that may have previously "fall[en] through the cracks." Interviewees shared that staff members are working hard to navigate and find resources specifically for those with neurodevelopmental disorders. One interviewee explained, "Despite the scarcity of resources, BMHC staff is doing their best to work with disability agencies and holding them accountable for needed support."

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[13] As shown above, in Table 1.1, enrollment increased from 129 in 2018 to 164 in 2019, a more than 25% increase in the first year of the grant. Fewer new participants enrolled in the subsequent two years, as a result of the COVID-19 pandemic and its impacts.

[14] BMHC received an additional grant from another source during the same period as the BJA grant, which allowed the program to expand its work with the youth population

However, interviewees report challenges in accessing appropriate resources and navigating essential partnerships. The New York State Office for People with Developmental Disabilities (OPWDD) functions as the gatekeeper for services for this population. Many interviewees, both staff and court personnel, shared that they found that working with this agency is "difficult for us to navigate," a "learning curve," and "challenging." Some interviewees felt that communication between BMHC and OPWDD could be improved. Others shared that age restrictions for OPWDD designation make it difficult to access resources. One interviewee observed, "A lot of our [participants] have never been involved with OPWDD before because they're older. If they weren't diagnosed with a developmental disability before the age of 22 … they will never get services with OPWDD" as a matter of policy.

Additionally, staff and court personnel indicated that resources are scarce, particularly those that would be useful for a neurodevelopmentally diverse population. Staff members struggle to locate supportive and stable housing programs and community programs that cater to individuals with neurodevelopmental disorders who do not also have a mental health diagnosis. The scarcity of resources for participants with neurodevelopmental disorders is a barrier to efficient treatment. Unsatisfied with the program's capabilities in that area, one interviewee suggested that BMHC acquire further specialized staff to assist with navigating the resources available to the population.

Program Strengths

Interviewees primarily identified program strengths across four areas: participant engagement, collaboration, judicial leadership, and clinical expertise.

Engaging a High Needs Participant Population Asked to reflect on programmatic strengths of BMHC, interviewees observed the court's influence in keeping court-involved participants committed to their treatment programs. They felt that BMHC positively impacts both the individual participants and the broader community by diverting participants with serious mental illness from incarceration and into treatment. Interviewees reported that the court does this by utilizing its connections in the community to link participants who would otherwise go without to appropriate services.

Staff members also expressed a sense of fulfillment when they witness a participant succeed through the program and return to the community.

> It's funny, you always wonder, am I doing a good job? Have I made the connection? ... You know when you really find out? It's at the end, when it's time to graduate and suddenly they come in and they're ebullient and they say, "Oh thank you so much, you have done so much for me." … [Y]ou really see like, wow, someone is really grateful for the work we've done.
>
> Having someone commit a crime while they weren't receiving mental health treatment or using substances [and then go on to] get the right treatment, stop using drugs, or get on the right medication … To see them gain employment, gain housing, get their entitlements in order, to complete [the program] … to have someone come back and say, "I didn't get arrested, I got rescued." That's very refreshing and rewarding.

Cross-Agency Collaboration with Dedicated Players It was apparent that the BMHC staff and court personnel interviewed value much of the work done by BMHC and those who contribute to that work. Most interviewees observed that the collaboration between the clinical team, judge, prosecution, and defense partners plays an essential role in BHMC's continued success. Interviewees rated all professionals involved with BMHC as essential to maintaining participant engagement. Some interviewees also shared that the collaboration between program staff and other court personnel allows participants to be released quickly from incarceration.

Interviewees also felt that maintaining continuous partnerships contributes to program success. The BMHC program has been operating with consistent court personnel for roughly two decades, including the judge, prosecution, defense attorneys, and other staff members. Nearly all interviewees emphasized the benefit of such stability.

Strong Judicial Leadership While all individuals involved in BMHC programming are highly regarded, interviewees conveyed particular appreciation for the court's dedicated judge. Staff and court personnel discussed the judge's dedication to the participants. They shared that the judge works diligently to maintain a relationship with participants and described the judge as "warm and welcoming." Participants will sometimes come back just to talk to the judge after they have left the program. One interviewee stated, "We have a judge that really cares about our [participants], that doesn't treat them just like they are someone that's coming through the court system that we're helping." Many of the interviewees, staff and court personnel alike, shared similar sentiments.

Clinical Expertise Interviewed court personnel expressed appreciation for the clinical team as “solid” and “knowledgeable.” These interviewees remarked that the clinical team's evaluation, risk assessment, and individualized treatment plans contribute to the court's high success rate. Staff interviewees similarly value their colleagues. Furthermore, interviewees believe that the clinical team's presence in the courthouse has a positive impact on participant engagement.

Program Challenges

Interviewees noted program challenges in three primary areas: lack of suitable resources, position of BMHC within the legal system, and challenges related to COVID-19.

Lack of Appropriate Services and Resources The most widely mentioned challenge is the shortage of suitable resources for participants. Interviewees reported a scarcity of basic supports like supportive housing, mental health programs, crisis centers, and government assistance. A majority of those interviewed emphasized the need for supportive housing for mentally ill court-involved participants. One interviewee explicitly linked the scarcity of appropriate resources to delays in getting individuals out of detention and noted the need for more programs to avoid delays in placement. Many individuals who are eligible for BMHC find themselves residing in the Riker's Island jail while awaiting suitable housing for their return to the community. The insufficiency of these resources reflects public policies that create challenges for BMHC's participant population and the court's efforts to support their participants.

Furthermore, interviewees noted that additional resources like technological devices (such as mobile phones, tablets, or desktop computers), proper clothing, and transportation could support participants in maintaining their compliance with court requirements.

Position within the Criminal Legal System Two interviewees discussed the distinct role that BMHC operates in as a part of “the system”: as a court-based program, it cannot separate itself from the legal authority of the court system. As such, it is often difficult for participants to separate the mental health court from other legal system experiences—for instance, previous interactions with police or in other court settings—that may have left them distrustful and traumatized. “Certain individuals cannot disconnect. They've probably had a very horrifying experience with police for a large number of years where they can't separate the judge, the DA, the lawyer, the case manager, from law enforcement.” Some interviewees

suggested that having a physical location not in the court building could help alleviate some of these concerns.

Related to alternative space, two interviewees suggested that a sort of "clubhouse model" could benefit participants' recovery. A clubhouse is a community-based space that emphasizes peer recovery and socializing in addition to supporting treatment and other service linkages. Clubhouses offer a unique path to rehabilitation where those involved are not considered "clients" of the program but are instead members who are offered access to community resources that will re-integrate them into society. One interviewee who raised this observed that such a model could enhance BMHC's services by providing participants with socialization and a sense of community.

Challenges Related to COVID-19 Finally, both staff and court personnel noted additional challenges that the program had faced due to COVID-19. Traditionally, participants would appear in person for their arraignments, compliance reporting, and case management. During the citywide shutdown for the pandemic, many courts began transitioning to remote operations. Interviewees expressed that in-person connections were imperative for building and maintaining trust with their participants. Accordingly, many treatment modalities are felt to be more effective when facilitated in-person as opposed to virtually. There are also inevitable technical challenges that occur when operating remotely from the courts. Many participants lack the technology to successfully attend programming or maintain remote compliance with the court, according to two interviewees. Conversely, a separate interviewee noted that virtual programming had its benefits, observing that some participants may be more willing to actively and honestly participate if they are not physically surrounded by their peers.

Chapter 5

Discussion & Recommendations

Overall, our findings suggest that during the pre-grant period BMHC was successful in supporting participants with a range of charges and diagnoses, including violent felony charges and co-occurring neurodevelopmental disorders. However, not every participant was able to successfully graduate; based on analyses of pre-grant period data, certain case events may act as flags indicating the need for additional support for participants to steer them towards success. Under the BJA grant, expanding their staff allowed BMHC to serve more participants, including those with primary neurodevelopmental diagnoses. Simultaneously, the program's efforts to serve participants effectively is often made more challenging by a lack of external resources to fully support BMHC participants, or in some cases, to allow potential participants out of jail in order to join the program.

Summary of Findings

Factors Predicting Sentencing in the Pre-Grant Period

Successful completion is no less likely among participants with violent felony charges and/or co-occurring neurodevelopmental diagnoses. Neither top charge type (misdemeanor, nonviolent felony, violent felony) nor a diagnosis of a co-occurring neurodevelopmental disorder were significantly associated with program graduation for BMHC participants between 2013-2018. This finding diverges from findings by Reich and colleagues (2015), who found BMHC participants with misdemeanor charges to be less likely to graduate than those with felony charges. However, that study and the current one both find participants with violent felony charges to be no less likely to graduate than others. The current findings suggest that participants admitted since grant implementation with violent felony charges and/or primary diagnoses of neurodevelopmental disorders will be just as likely to successfully graduate from BMHC as other BMHC participants.

Some demographic groups were more likely to be unsuccessful in the program and sentenced. Age was associated with program outcome; older participants were significantly less likely to be terminated and sentenced. In fact, the program rolled out a specialized program track for young adults around the same time that the BJA enhancements were introduced. Additionally, in the charge category model, Black individuals had almost

twice the odds as their white counterparts of being sentenced. These findings are consistent with prior research (Rossman et al. 2012).

Similar sets of in-program events were flags for future sentencing among participants with violent felony charges, participants with co-occurring neurodevelopmental disorders, and the general BMHC population. Case events that predicted sentencing include having a new arrest, undergoing an assessment for psychiatric competency, absconding, receiving an interim jail sanction for program noncompliance, and posing a threat to others. These findings identify specific events that can flag for BMHC staff when a participant may need additional support, inclusive of participants with violent felony charges and/or primary diagnoses of neurodevelopmental disorders.

Certain in-program events were associated with court-ordered remand. Receiving an in-program jail sanction, in turn, was predicted by missing or being disengaged during treatment sessions, absconding, having a warrant issued from the mental health court, posing a threat, and other rule infractions.

Perspectives on BJA Program Enhancements

Stakeholders expressed mixed feelings regarding risk assessment and largely found it unnecessary for BMHC. Interviewees expressed satisfaction with existent informal assessment protocols implemented by the clinical staff and consulting psychiatrist. Regarding the implementation of a structured risk assessment, interviewees expressed mixed opinions: some felt the C-CAT tool offered new opportunities while others expressed concern that the formalized tool may generalize and label participants inappropriately. Some interviewees also noted that BMHC has always and knowingly engaged with high-risk participants; given the court's comfort with risk, these interviewees questioned the need for an additional risk assessment protocol.

Stakeholders appreciated the opportunity to reach more participants, while also noting resource limitations. Interviewees were generally supportive of the expanded capacity to serve more participants under the grant, yet also noted ongoing challenges with accessing external resources, particularly housing. Some of these challenges reflect a general scarcity of resources; for individuals with primary diagnoses of neurodevelopmental disorders, interviewees cited additional challenges related to accessing state resources through OPWDD.

Program Strengths and Challenges

Stakeholders identified the entire BMHC team and the program's success at engaging participants as key program strengths. According to interviewees, key program strengths include the program's ability to engage a high-needs participant population; a strong cross-agency collaboration with stable and dedicated partners (consistent with a previous study; Rossman et al. 2012); strong judicial leadership; and a clinical team with specialized expertise.

Lack of sufficient appropriate resources was the most frequently noted program challenge. Program challenges identified by interviewees include a scarcity of appropriate resources and services such as mental health treatment programs, supportive housing, benefits, technology, and transportation. In particular, the lack of stable supportive housing creates a delay in community placement for many. Such delays frequently mean that individuals remain incarcerated on Riker's Island (where their condition may worsen), unable to begin services through BMHC. Prior research has likewise raised the concern about insufficient housing resources for mental health court participants across New York State, and in New York City in particular (Hahn 2015).

Other challenges include the situation of BMHC in the criminal legal system and challenges related to COVID-19. Another challenge identified was the negative association some participants have with the legal system overall. Staff shared that it can be difficult for participants to disassociate the mental health court from law enforcement entities that participants do not trust. Finally, the COVID-19 pandemic has also brought specific challenges: some interviewees observed that virtual programming created a barrier for some participants who lack technological access and hindered staff members' ability to facilitate the trusting relationships garnered from attending in-person sessions.

Study Limitations

One limitation of this study was the lack of program and outcome data from the grant period. However, the grant period was not long enough for a sufficient number of new participants to go from referral to case closure while allowing time for robust analyses; this concern is especially true for the sub-populations of interest. Also, the case events analyses were limited by a fairly small sample size and by data concerns related to coding the case events. Specifically, some case events may have been present in additional cases but not recorded explicitly in the court notes, meaning that they were not included in the current analysis.

Additionally, since the focus here was on only one mental health court, quantitative findings may not be generalizable to other mental health courts.

While most eligible stakeholders did participate in qualitative interviews, the total number of interviewees was still small. This means that sub-group analyses were not possible to determine, for example, if certain themes were more salient among clinical staff or among defense attorneys. It is also possible that a broader set of stakeholders may have revealed different findings, particularly if those who declined or were unavailable to participate in the current study had very different experiences than those who did participate.

Recommendations

Based on the study findings, we make the following recommendations:

1. **Seek additional funding to continue—and expand as appropriate—work with the two key populations of interest served under the BJA grant: defendants with violent felony charges and individuals diagnosed primarily with neurodevelopmental disorders**. Findings show that during the pre-grant period, participants with violent felony charges and participants with co-occurring neurodevelopmental diagnoses were no less successful than other participants. Even though participants with co-occurring neurodevelopmental disorders (served during the pre-grant period) and participants with primary diagnoses of neurodevelopmental diagnoses (newly served under the grant) are distinct populations, the success of the former in prior years suggests that the latter will also be successful. Notably, since its inception, BMHC has worked with individuals with violent felony charges; that history and current findings lend support to the current movement for felony decarceration.

2. **Expand the resources available for the BMHC population, especially housing resources.** This pertains to resources available for the BMHC-eligible population overall as well as specifically for those with primary diagnoses of neurodevelopmental disorders, and is recommended based upon stakeholder interviews. *This is not a recommendation for BMHC*—rather, it is a call to policymakers at all levels to increase support. While interviewees mentioned several specific resources, housing came across as the biggest concern. If policymakers are serious about treating rather than criminalizing mental illness, then a more robust housing policy must be a part of legal system reforms.

3. **Increase case management expertise in supporting participants with a primary neurodevelopmental diagnosis.** Also reflecting interviewee feedback, BMHC should consider bringing more case management expertise to their staff specifically for those with neurodevelopmental disorders, including working with and navigating OPWDD and related resources. This could be a valuable supplement to the staff's current expertise in that area.

4. **Swiftly respond to infractions and other case events known to be associated with future bad outcomes.** Based on analyses of pre-grant data, this study identifies specific in-program events that are associated with future sentencing from the program. BMHC should continue to prioritize swift therapeutic responses after such events to steer participants towards program success. Further research can potentially help to identify predictors of problematic court events, providing mental health court staff with useful information to support struggling participants.

5. **Conduct further research on who successfully graduates from BMHC and who does not.** Such research could include an impact evaluation of the program expansion under the BJA grant once a significant number of cases have closed within the respective enhancement areas, an evaluation of the specialized youth track to determine if younger participants still tend to be less successful than older participants, and research to better understand any potential racial disparities in program outcomes.

6. **Reflect on the program's experience with the C-CAT to determine if continued use of the tool is warranted in BMHC.** While some interviewees saw promise in the structured risk assessment tool regarding treatment planning, there was also a strong sentiment that it is unnecessary for this program and, according to some, potentially harmful. As the tool is used more regularly its utility in treatment planning in BMHC should be assessed. Additionally, for practitioners in other programs considering introducing structured risk assessment, we recommend ensuring there is stakeholder buy-in prior to introducing any such tool, including from staff who will be responsible for administering the tool.

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