

# **THE PROMISE OF MENTAL HEALTH COURTS**

**Brooklyn Criminal Justice System Experiments with  
Treatment as an Alternative to Prison**

**By Matthew J. D'Emic**

In the fall of 2004, a 39-year-old crack addict and her husband went on a robbery spree in Brooklyn. Captured and identified by their victims, the husband accepted a plea offer and was sentenced to a lengthy prison term. Five months after her arrest, the wife also entered a guilty plea to robbery. Instead of prison, however, her sentence was deferred and she was released for treatment. This defendant pled guilty in the Brooklyn Mental Health Court, the first such court in New York State and the latest incarnation of “therapeutic” or “problem-solving courts.”

This woman was referred to the court by her lawyer, and was found to be suffering from untreated severe and recurrent depression, accompanied by hallucinations and paranoia, as well as post-traumatic stress disorder stemming from witnessing the murder of her mother, a drug dealer, when she was eight years old. It was agreed that if she stayed in treatment and out of trouble for two years the felony plea would be vacated and the defendant sentenced to misdemeanor probation.

### **Mental health courts**

Since the concept of “therapeutic” justice took hold in connection with drug courts almost 20 years ago, the idea that the authority of a court could beneficially influence the people appearing before it has spread to myriad social problems, including the treatment of individuals who are mentally ill and involved in criminal behavior. In mental health courts, the goal is to identify defendants suffering from a serious and persistent mental illness and divert them from jail into treatment. The rise of such courts is, in many ways, linked to the wholesale closing of mental hospitals 40 or so years ago. Although the goal of deinstitutionalizing the mentally ill was commendable, there was no corresponding increase in funds for community mental health programs, resulting in transinstitutionalization, making jails and prisons the largest mental health providers in the country. The Department of Justice estimates that 16 percent of state and local prisoners suffer from mental illness, a figure that underscores the substantial cost imposed by this population on the criminal justice system (*Mental Health and Treatment of Inmates and Probationers* (U.S. Dep’t of Just., Bureau of Just. Stat.) (1999) available at <http://www.ojp.usdoj.gov/bjs/abstract/mhtip.htm>). Add to that cost the substantial harm and potential injustice incarceration extracts, and the rationale for a thoughtful “therapeutic” approach to cases involving mentally ill defendants becomes apparent.

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The Brooklyn Mental Health Court opened its doors in spring 2002 and was originally planned as a court for non-violent, adult mentally ill felony offenders. Violent felons were excluded because of public safety concerns and misdemeanors were excluded for fear of further criminalizing mental illness.

The promise of the court began with New York State Chief Judge Judith S. Kaye, a compassionate proponent of the problem-solving approach. Kings County District Attorney Charles J. Hynes, an innovator in criminal justice, signed on to the project and commissioned his counsel, Anne J. Swern, to collaborate with the New York State Office of Court Administration in establishing the court. In turn, the court system asked the Center for Court Innovation to lead the planning.

Carol Fisler of the Center for Court Innovation was in charge of planning the court, and over the course of many months held meetings with all potential stakeholders to hammer out the court’s parameters. Court administrators, the district attorney’s office, the defense bar, service providers, and the New York State Office of Mental Health all came to the table. Confidentiality issues, lengths of treatment plans, plea negotiations, and other thorny questions were raised, debated, and resolved before the court started a six-month pilot phase.

The stakeholders agreed that, in general, a guilty plea would be required for admission to the court with sentencing deferred. The plea would include acceptance of a jail term in the event of failure but a nonjail disposition upon successful graduation. The planners agreed that for a first felony offense the mandated treatment period would be 12 to 18 months with a dismissal of the indictment if the defendant succeeded. For a second felony, the treatment mandate would be 18 to 24 months with a successful outcome generally resulting in misdemeanor probation. These mandated periods are arbitrary, the result of a compromise between the district attorney and defense bar, the latter fearing longer periods of court supervision placed its clients in greater danger of failure and incarceration. As mentioned, when it started, the court was restricted to non-violent, adult felony offenders. Within weeks of operation, however, referrals by assistant district attorneys and defense lawyers were made for violent felons. Referrals of teenage defendants, usually accused of assaults on teachers or other kids, also came to the court. These referrals forced all involved to reevaluate the parameters of the court, calling for a great deal of flexibility in seeking to achieve its goal of offering help to those mentally ill defendants seeking treatment.

An early example of a violent felon referral to the mental health court is that of a young man arrested for two forcible street robberies. He was in college and his actions were the result of his first psychotic break—schizophrenia

with auditory hallucinations. District Attorney Hynes agreed to allow the defendant into the mental health court. In accepting crimes of violence, however, he established a policy of requiring the victim's approval to mental health treatment. His office procedure is to contact victims in cases involving violence to inquire if there are objections to pursuing treatment instead of prosecution. In the case of the college student, both complaining witnesses endorsed the treatment alternative. The young man entered a guilty plea as agreed between his lawyer and the district attorney and began treatment. Because of the violent nature of the crime the district attorney insisted on a sentence of probation if the defendant succeeded in 18 months of treatment. The defendant (and his father) came to court weekly and his progress was noted. As the 18-month mark approached, the defendant's mother wrote to the court and District Attorney Hynes to request a dismissal instead of the probation sentence. The district attorney agreed on condition that her son stay in treatment under the court's mandate for an additional six months. The defendant did so, reenrolled in college, and graduated from the court in June 2004, two years after his guilty plea.

Since that time, almost 40 percent of referrals to the court have involved crimes of violence. Remarkably, in almost every case, the victim has agreed to a nonjail disposition or outright dismissal as a reward for success in treatment.

### **Referral, evaluation, plea, and treatment**

The court process begins with a referral from any other criminal term in the county. Judges, assistant district attorneys or defense lawyers may make referrals. Once the case comes to the mental health court, if both sides agree, a psychiatrist and social worker evaluate the defendant. These psychiatric and psychosocial evaluations report whether the defendant suffers from a serious and persistent mental illness for which there is a known treatment, which is a condition of eligibility for the court. In addition, a diagnosis, psychiatric history, and risk assessment are included. Finally, an opinion of eligibility is provided. These reports are given to the defense lawyer, assistant district attorney, and the judge. If the defendant is found eligible, the case is adjourned in order to allow the district attorney to come up with a plea offer and the clinical team to formulate a treatment plan. Once that is negotiated, the defendant enters the plea—outcomes for failure and success are placed on the record at that time—and the defendant is released to treatment.

For example, in the case of the 39-year-old female robber mentioned at the start, it was agreed that she would serve a five-year prison term if she violated the terms of her treatment plan, and a sentence to misdemeanor proba-

## **RESEARCH AND REFERENCE**

The Center for Court Innovation, which led the planning process for the Brooklyn Mental Health Court, was founded as a public/private partnership between the New York State Unified Court System and the Fund for the City of New York. The nonprofit think tank helps courts and criminal justice agencies aid victims, reduce crime, and improve public trust in justice. Among its projects are community courts, drug courts, reentry courts, domestic violence courts, and mental health courts. The center provides information on the results of its projects worldwide to criminal justice practitioners in order to allow them to institute their own problem-solving experiments.

On the center's Web site ([www.courtinnovation.org](http://www.courtinnovation.org)) are two valuable articles that offer background information and research results on the Brooklyn Mental Health Court.

- *Building Trust and Managing Risk: A Look at a Felony Mental Health Court* by Carol Fidler, director of the Mental Health Court Programs, is a detailed look at one of the first felony mental health courts in the country. Among the issues addressed in the article are why the court's planning team chose to focus on felonies rather than misdemeanors and how the court and its partners manage potential public safety risks. It also contains helpful references for further reading. To access the report, visit the center's Web site and click on "Mental Health Courts" at the bottom of the page and then the title for a PDF version of the article.
- *The Brooklyn Mental Court Evaluation: Planning, Implementation, Courtroom Dynamics, and Participant Outcomes* (September 2006) by Kelly O'Keefe provides an evaluation of the court's planning process and its first 28 months of operation. It includes discussion of key features of the court model and presents data on courtroom dynamics, team communication patterns, and participants' characteristics, outcomes, and perceptions. To access the study, go to the center's Web site and click on "publications" and then the title of the study for a PDF version of the report.

tion if she succeeded.

Once the plea is entered the defendant is released to treatment. Frequent court appearances are required—weekly in the beginning—and the defendant is awarded four phase certificates to mark his or her progress in court. Sanctions are imposed for setbacks, ranging from submission of written essays explaining aberrant behavior to more frequent court appearances to, if necessary, short-

term incarceration. Throughout the court's mandate its clinical team remains in contact with treatment providers, receiving frequent reports on the defendant's progress. Successful participants graduate at the close of their mandated period and receive a dismissal or other nonjail sentence; failures go to prison.

### **The clinical team**

The Brooklyn Mental Health Court is unlike many other mental health courts in that it has an in-house clinical team. The team consists of a clinical director with a master's degree in social work who formulates all treatment plans; a senior forensic social worker who does the psychosocial evaluations; and three case coordinators who are responsible for daily contact with treatment providers, following up on the progress of each defendant, and preparing a one-page "report card" for the court and counsel at each court appearance. The team meets daily, which allows the court to advance the cases of struggling defendants or, if necessary, to order bench warrants for defendants who have left their treatment programs.

### **Treatment plans**

After five years of operation, 344 defendants have participated in the Brooklyn Mental Health Court. Of those, the court sentenced 38 and graduated 162—an 81 percent success rate. (Of the remaining 144 defendants, most are still participating in the court while awaiting program placement or evaluation; a few have died or become unfit to proceed to trial.) Unlike drug treatment courts, where the charges and treatment protocol are similar for all participants, mental health courts see a variety of charges and require a broad range of treatment plans. For example, in the Brooklyn court, diagnoses of illness break down as follows: schizophrenia, 21 percent; bipolar disorder, 24 percent; major depression, 30 percent; schizoaffective disorder, 12 percent; other, 13 percent. Of these, about half are also drug addicted requiring residential drug treatment with a psychiatric component. That leaves fully half of mental health court defendants with treatment plans allowing them to live in the community, at home, in supported housing, or with a relative while attending outpatient programs. It should further be noted that because of the great variation in diagnoses, treatment plans are often modified over time.

An example of this involves a 64-year-old woman who came to the court accused of assaulting her elderly mother who was suffering with Alzheimer's disease. On close analysis, the court discovered that the defendant had recently retired after 34 years in the same job, becoming the sole caretaker for her mother and disabled older brother. Referred to the mental health court with an initial diagnosis of single-episode depression, the defendant started a

treatment plan consistent with that diagnosis, after pleading guilty to assault. As the case proceeded, however, her depression deepened to the point where she decompensated in court. Because of this ongoing depression, the clinical team amended her treatment plan to include a partial hospitalization program, among other things, as well as a change in medication by her psychiatrist. After months of struggling, the new treatment plan stabilized her and she graduated from the court with a dismissal of her case.

Another example is that of a 17-year-old runaway from Massachusetts indicted for assault for slashing her pimp in an attempt to escape prostitution; he was fully pressing the case and one of the few complainants who rejected treatment for a defendant. Despite this complainant's objection, the district attorney nevertheless agreed to mental health court treatment. Diagnosed with major depressive disorder and co-occurring substance abuse, this young girl was placed in residential drug treatment with outpatient mental health care. Despite facing two years in prison on her guilty plea, she ran away and was eventually arrested and returned to court on a bench warrant. After several weeks in jail, a new program was found with a different therapy and medication regime. She stayed, flourished, graduated, and was sentenced to a conditional discharge on a misdemeanor. Her felony plea was vacated. She also reunited with her father and is now working.

### **Criticism and failure**

Advocates for the mentally ill are sometimes critical of mental health courts as coercive and stigmatizing, since the person suffering from mental illness cannot participate in the court unless he or she pleads guilty with the threat of prison as the price of failure. (*See, e.g.*, [www.nmha.org/position/mentalhealthcourts.cfm](http://www.nmha.org/position/mentalhealthcourts.cfm)). To answer some of these concerns, the Brooklyn court created documents that make transparent the responsibilities of participants as well as the policies and procedures of the court. These include a contract between the court and the participant, a list of possible sanctions, rewards, and clinical responses, and formal participation guidelines. Although it is true that diversion into treatment upon arrest and before arraignment may be optimal for quality-of-life infractions, it is not practical in cases involving felonies. At all times, especially in violent cases, a balance must be maintained between meeting the treatment needs of the defendant and protecting the safety of the public.

Take the case of a middle-aged pharmacologist charged with driving while under the influence of drugs and alcohol. He had a previous conviction for the same offense. Offered treatment he pled guilty, facing 18 months to three years in prison if he failed, but winning a conditional discharge if he successfully completed treatment. Unfortunately, after several months in the mental health

court, this defendant chose to get behind the wheel of a car drunk and on drugs. He caused property damage, though no one was injured. Despite pleas for another chance from the defendant and his family, the court sentenced the defendant as agreed at the time of his plea. The jeopardy to public safety was too great to allow the defendant to remain at liberty.

Mental health courts are also criticized as a poor solution to a public health crisis—the lack of adequate funding. (See generally Heather Barr, *Mental Health Courts, An Advocate's Perspective*, Urban Just. Center, 2001). Again, this is regrettable, but funding decisions are made by the legislative and executive branches of government among many interests competing for finite resources. The fact that the judicial branch is taking a new approach in criminal cases involving defendants suffering from mental illness in no way changes that fact or interferes with the efforts of advocates to increase funding for mental health programs.

Others contend that such courts chip away at the adversarial system and are too far removed from the judiciary's traditional role, wrongly blurring the line between advocacy and impartiality. (See, e.g., Morris Hoffman, *The Drug Court Scandal*, 78 (No. 5) NO. CAR. L. REV., 1480 [June, 2000] and Leslie Eaton and Leslie Kaufman, *In Problem-Solving Court, Judges Turn Therapist*, N.Y. TIMES, April 26, 2005, at A1.) However, as Chief Judge Kaye noted, “the traditional approach yields unsatisfying results,” (*Therapeutic Justice in Alaska's Courts*, 19 ALASKA L. REV. 1 (2002)), commenting that “when mental illness is a factor in lawlessness and that fact is ignored, the result can be an unproductive recycling of the perpetrator through the criminal justice system, with dire consequences to us all.” (NYS Office of Mental Health Release, Nov. 25, 2002.)

## Preliminary research

In a study recently completed by the Center for Court Innovation, graduates of the court were interviewed after the Brooklyn Mental Health Court's second year of operation. (See sidebar; Kelly O'Keefe, *The Brooklyn Mental Court Evaluation: Planning, Implementation, Courtroom Dynamics, and Participant Outcomes* (September 2006); go to [www.courtinnovation.org](http://www.courtinnovation.org) and click on “publications” for a PDF version of the report.) The evaluation found that participants in the court perceived themselves to have a high level of independent decision making, did not feel coerced into the court, and were highly satisfied with the level of procedural justice. In addition, the lives of the participants, measured in terms of recidivism, homelessness, substance abuse, hospitalization, and psychosocial functioning improved.

## Conclusion

There are now more than 150 mental health courts in operation in the United States and more in the planning stages. Research needs to continue to assess their effectiveness. Anecdotal evidence is an insufficient basis for public policy. The arguments of the courts' critics cannot be summarily dismissed. On the other hand, prior to the inception of mental health courts, judges, district attorneys, and defense lawyers had only two choices when faced with mentally ill defendants: plea or trial. Mental health courts offer a third option: treatment as an alternative to incarceration with safeguards for public safety. The preliminary research is promising. ■