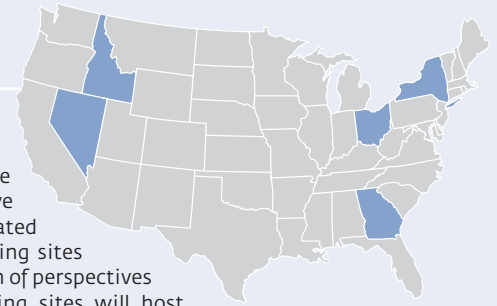


MENTAL HEALTH COURT LEARNING SITES

About the Mental Health Court Learning Sites. The number of mental health courts (MHCs) in the U.S. has grown exponentially over the past decade. State and local officials who have recently launched—or are considering whether to launch—such programs in their jurisdictions often seek out more experienced MHCs for guidance and advice.

To facilitate peer-to-peer assistance among jurisdictions that have established, or are planning to establish, MHCs, the Bureau of Justice Assistance (BJA)—through its technical assistance provider, the Council

of State Governments Justice Center—has designated five MHCs as “learning sites.” Located across the country, these learning sites represent a diverse cross-section of perspectives and program examples. Learning sites will host visits to their courts and respond to telephone/email inquiries from the field.



Bronx County, New York Mental Health Court

Program Description



I. INTRODUCTION

The Bronx County Mental Health Court (MHC) began formal operations in January 2001 and received a grant from the Bureau of Justice Assistance (BJA) Mental Health Courts Program (MHCP) in 2003. An 18-month planning period for the court began in 1999, with the support of a Community Action Grant from the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Mental Health Services (CMHS). The MHC is based on a Treatment Alternatives for Safer Communities (TASC) model that has been adapted to serve individuals with mental illnesses.

In August 2005, 225 participants were under MHC supervision on any given day. Individuals with violent or non-violent felony charges (excluding murder, sex offenses, and arson) and “serious and persistent” mental illnesses are eligible for participation; misdemeanor offenders are accepted on a case by case basis. The MHC has

Bronx County, New York Mental Health Court

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- Approximately 225 participants are under MHC supervision on any given day

Bronx County is coterminous with The Bronx, one of New York City’s five boroughs. The Bronx has a population of approximately 1.37 million; it is roughly 35 percent African American, 30 percent Caucasian (including Caucasian Hispanics / Latinos), and 35 percent from other backgrounds. Almost 50 percent of the population is of Hispanic or Latino origin. The Bronx is also New York City’s poorest borough: the median annual income is \$27,000 and 31 percent of the population lives below the poverty line.

developed detailed clinical admissions criteria (discussed below). Over 50 percent of participants have a major affective disorder of major depression or bipolar disorder; just under 25 percent have schizophrenia or schizoaffective disorder,

and about 25 percent are diagnosed with non-major affective disorders, anxiety or post-traumatic stress syndrome. Overall, about 33 percent of those accepted present with psychotic symptoms upon admission to the program.

The MHC treatment team comprises five pre-placement case managers, seven post-placement case managers/peer specialists, one clinical director, and three part-time psychiatrists. The MHC is coordinated by a project director (who does not have regular interaction with participants) and two co-directors, one of whom is a full-time researcher and evaluator and the other of whom is the medical director (and also one of the aforementioned part-time psychiatrists).

The MHC is a post-plea court: participants plead guilty and have their sentences suspended for the duration of their treatment plan. Upon successful completion of the program, participants can plea to a lesser charge. Because most participants are charged with felonies and have lengthy criminal records, their charges are generally not dismissed upon successful program completion.

The MHC is designed with a strong emphasis on linguistic, cultural, and clinical competency for the large Hispanic/Latino and African American communities in the Bronx. The MHC has recently placed an emphasis on developing prevention strategies for participants at high risk for HIV/AIDS and Hepatitis C. Roughly 12 percent of all MHC participants have HIV/AIDS and 10 percent have Hepatitis C. The MHC has also placed an emphasis on the housing needs of participants; roughly 25 percent reported being homeless in the year prior to court involvement. The MHC has

relationships with over 30 substance abuse, mental health, and specialized treatment providers for crisis, intermediate, residential, outpatient, and hospital care; and utilizes the city's centralized housing database, called Single Point of Access.¹ The MHC also assists participants with transportation, benefits, vocational assessment and entitlements.

II. PROGRAM ELEMENTS

A. Planning and Administration

Representatives from 41 agencies participated in an extensive 18-month planning process to develop the MHC during which time the agreed upon consensus model was piloted prior to full implementation. The committee comprised state and local government agencies, representatives from the criminal justice system, family and consumer advocate organizations, treatment providers, housing providers, case management services, and a research/evaluation organization.

The large planning committee assumed advisory and oversight responsibilities after the MHC's implementation. Stakeholders reported that meetings occur at least semi-annually (usually quarterly), and more frequently when the court considers modifying or expanding its operations. The department of Probation and Pre-trial Services is no longer involved in MHC-related decision making.

The MHC has developed detailed written materials documenting the planning, implementation, and general history of the court; these include a program brochure, policy and procedures

¹ For more information on Single Point of Access (SPOA) visit: <http://www.cucs.org/hrc/housing/SPOAHousingOverview.pdf>.

manual, outcome evaluations, demographic data, training materials, and Power Point presentations. The “consensus model” mentioned above is also based on a comprehensive written protocol which was published and also made available as a Power Point training tool.

B. Court Team

The Bronx County MHC is unique in that its mental health, administrative, and criminal justice components are almost entirely independent of each other. Accordingly, staff associated with the MHC can be broken into three groups: a clinical team, coordinating staff, and criminal justice personnel. The clinical team is involved with daily decision making regarding individual participants; however, were significant changes in clinical status, program compliance, or housing introduced, they would be reviewed with criminal justice personnel as frequently as the case required.

The clinical team, which is also referred to as the “TASC team,” comprises five pre-placement case managers, seven post-placement case managers/peer specialists, one clinical director, and three part-time psychiatrists. Many of the post-placement case managers are themselves consumers of mental health services. The clinical team manages individual cases, conducts mental health and risk assessments, reports on participants’ progress, and recommends treatment adjustments to the court. The team meets weekly and is in contact daily. Decisions about participants’ treatment plans and any changes in treatment engagement are discussed in these meetings.

Upon joining the clinical team, each case manager receives at least one formal standardized

training on mental health issues and on administration of assessments. New team members’ caseloads are gradually increased over a six month period at a rate corresponding with their degree of experience. As part of their TASC orientation, clinical team members receive a general training on criminal justice issues; because clinical team members regularly appear in court, this orientation focuses on court protocols and procedures. Most of the case management staff is also fluent in Spanish.

The coordinating staff comprises a project director and two co-directors. The project director has no regular interaction with participants, but rather fulfills administrative, planning, and political functions. One co-director, who also does not have frequent contact with participants, is a full-time researcher/evaluator from New York University and the Research Triangle Institute (RTI) International, a nonprofit research corporation. This co-director also facilitates the stakeholder meetings, develops training materials and conducts cross-training for criminal justice representatives. The other co-director, who has frequent contact with participants, is the medical director and one of the three part-time psychiatrists mentioned above. This latter co-director also provides training for new clinical team members and develops training materials, establishes and nurtures relationships between the MHC and community service providers, participates in weekly clinical team meetings to provide training, consults on case-specific clinical issues, and fulfills other administrative responsibilities.

Criminal justice personnel include the judge, two court attorneys, three rotating assistant district attorneys, and court-assigned defense counsel. These staff members play a traditional role

during court proceedings and follow the recommendations of the clinical team with regard to individual participants. While the judge does not participate in the development of treatment plans, these courses of action are ultimately subject to the judge's approval. The judge receives update letters for each participant from his or her respective case manager or community service provider; and confers on any outstanding issues with the assistant district attorney, defense counsel, clinical team member, and court attorney.

Criminal justice personnel have the option to receive a Continuing Legal Education (CLE) credited three-part training on mental health, substance abuse, risk assessment and risk management issues from the co-directors.

Many of the training modules provided to the clinical team are approved for Certified Alcohol and Substance Abuse Counseling (CASAC) in New York State.

C. Timely Participant Identification and Linkage to Services

Potential participants may be referred to the MHC at any time after arraignment and before plea or trial. Referral sources include the community, family, and defense counsel; but most referrals come from the district attorney's office and other judges.

Cases referred by the district attorney's office are screened by the office's "alternatives to incarceration" (ATI) unit that administers a standardized, seven-question screening instrument developed by the MHC's clinical and evaluation team. The ATI unit is trained by the clinical team to recognize signs of psychiatric issues. Screening

takes place in the holding cells of the Bronx courthouse. This initial screening is conducted before an individual pleads guilty. After screening by the ATI unit, defense counsel is notified and the case is adjourned—regardless of the results of the screen. The individual's case is then brought to the clinical team for detailed screening and assessment that includes use of the Historical, Clinical, and Risk Management (HCR-20) Violence-Risk Assessment tool.²

The clinical team assesses all screened individuals and makes recommendations to the district attorney's office and judge regarding acceptance into the program. Individuals who meet the MHC eligibility requirements and agree to participate plead guilty. The length of the screening and assessment process ranges from a few days to a few weeks. Approximately 65 percent of defendants screened are accepted into the program.

Most participants (roughly 70 percent) await treatment placement in jail. Given the seriousness of some of their crimes, MHC participants are not released for treatment in the community until the appropriate placement has been secured. As a result, between 30 to 90 days elapse between arrest, acceptance into the MHC, and placement in a community treatment program.

Regular meetings between the district attorney's office and court team are held to discuss further refinements to the screening procedures.

D. Target Population

The district attorney's office has developed an eligibility protocol that defines the criminal justice criteria for participation in the MHC. Potential

². For more information on the HCR-20 Violence-Risk Assessment tool, visit <http://www.violence-risk.com/hcr20annotated.pdf>

participants may be charged with violent or non-violent felonies (in some cases, the MHC accepts misdemeanors) excluding current charges of murder, sex offenses, and arson. Individuals with past murder, sex offenses, or arson charges may be accepted on a case-by-case basis.

The clinical team has developed a detailed eligibility protocol that defines the mental health criteria for participation in the MHC. Participants must have “severe and persistent” mental illness, which the MHC defines as a primary mental disorder that results in a functional deficit in “the ability to recognize and avoid danger; self-care skills sufficient to maintain reasonable health and welfare; the ability to maintain reasonable interpersonal relationships; the ability to engage in vocational, household, or educative activities; or the ability to remain clinically stable in the community without the need for psychiatric hospitalization or mental health outreach services.” Participants must also be at low risk for violence when engaged in appropriate treatment; clinically stable; compliant with medication and treatment services; in jeopardy of incarceration pending trial; willing to accept a criminal plea bargain in which the MHC is case manager and monitor; and willing and able to undergo a multi-tiered assessment to determine eligibility.

Participants generally have an Axis I diagnosis, but some participants may have developmental disorders. As mentioned above, 50 percent of participants have major depression or bipolar disorder; 25 percent have schizophrenia or schizoaffective disorder; and about 25 percent have less severe affective disorders, anxiety or post-traumatic stress disorder. Of these participants, 32 percent also have psychotic symptoms upon admission.

E. Terms of Participation

The terms of participation are explained to potential participants before they plea and again in court by the MHC judge. Because the MHC is a post-conviction court, individuals agree to receive a sentence to a treatment program in lieu of incarceration. The length of participation in the MHC is open-ended, but is usually 18 to 24 months. Successful discharge criteria include a stabilized psychiatric condition, abstinence from drugs and alcohol for at least a six month period, successful completion of the treatment program, and successful transitioning from treatment to independent living. Participants may be expelled from the program if no community-based treatment is likely to restore them to stability, the likelihood of serious physical harm to self or others becomes unmanageable in their community setting, the participant refuses to comply with program requirements, a treatment placement cannot be found, or the client withdraws or is rearrested.

Although the MHC has developed written protocols for general terms of participation, participants do not receive these terms in writing and do not sign a contract when entering the program. Defense counsel does not play an integral role in the process of determining who participates in the MHC.

As mentioned above, participants plea to a lesser charge upon successful completion of the program. Because most participants are charged with felonies and have lengthy criminal records, their charges are generally not dismissed.

F. Informed Choice

As previously mentioned, terms of participation are explained to participants in the court of original jurisdiction before they plea and again in the MHC. Participants have access to counsel when deciding whether to enter the MHC, but the degree of defense involvement varies from one defense attorney to the next. Participation in the MHC is voluntary; participants can choose not to enter the program and can withdraw at any time. Competency issues are generally resolved before MHC-involvement but, if necessary, can be assessed any time during the program.

G. Confidentiality

Participants sign release forms to authorize program staff to share all relevant personal information. Risk assessments, which require participants to sign a release, are conducted for all participants early in the admissions process; these assessments include all of an individual's available historical data. Upon successful completion of the program, clinical information is removed from the criminal record.

H. Treatment Supports and Services

As mentioned above, the MHC has relationships with over 30 substance abuse, mental health, or specialized treatment providers for crisis, intermediate, residential, outpatient, and hospital care (including a psychiatric emergency program at the Bronx-Lebanon Hospital); and utilizes New York City's Single Point of Access for housing. Availability of integrated treatment depends on the specific provider.

In addition to cross-training community treatment providers, the MHC's post-placement clinical team addresses limitations in treatment

services. For example, if a provider focuses primarily on substance abuse, the clinical team can augment the treatment services with its own mental health expertise. The post-placement clinical team supplements the work of community treatment providers in a number of ways: participants in outpatient treatment programs have weekly appointments at the MHC office and receive updated assessments; case managers conduct random urine testing; and participants in residential treatment programs receive monthly visits from the clinical team. The clinical team has developed a number of protocols for consultation and members are available for crisis intervention, medication consultation, and re-assignment decisions.

In spite of the focus on supplementing available treatment, the MHC continues to struggle to find enough beds for individuals with co-occurring disorders.

I. Monitoring Adherence to Court Requirements

Because the MHC is geared heavily toward clinical case management, criminal justice personnel play a small role in monitoring participants' adherence to court requirements. All decisions regarding adjustments to treatment plans, the frequency of court appearances, and graduation from the program are made by the clinical team. In this sense, the court itself does not routinely employ sanctions or incentives independent of those recommended by the court team. The judge provides encouragement to participants, presents them with graduation certificates, in limited circumstances remands them to a brief jail stay, or sentences participants to their original prison terms if they do not successfully complete the treatment program.

Participants appear in court once every three months, or more frequently at the recommendation of the clinical team.

Both the clinical and criminal justice personnel report that they do not frequently use jail as a sanction for non-adherence to court requirements; however, participants may be re-arrested for new crimes.

J. Sustainability

The MHC collects comprehensive data for all aspects of the court's operations and outcomes. As mentioned above, one of the MHC's co-directors is a full-time researcher/evaluator affiliated with New York University and RTI International, and data collection is built into the program design. The relevant data collected has been converted into multiple evaluation reports and PowerPoint presentations for national conferences and training purposes.

Because the clinical team has incorporated formalized and on-the-job training into the program design, the functioning of the clinical team

does not depend on the personality of any individual team member. The three psychiatrists and clinical director who are members of the clinical team train replacement staff on the MHC's model and on its general operating procedures.

The MHC has become an institutionalized aspect of the Bronx court system and does not depend on the personality of any individual team member. Other judges have substituted for the MHC judge in his absence.

The MHC was planned under the principle that the program could be sustainable even without continued funding through in-kind contributions of time and resources by the various stakeholders. Even so, the MHC requires continued funding to support its assessment, linkage, case management and evaluation operations, and the MHC's various vested agencies have applied for and received funding from the New York City Counsel, the New York State Department of Probation and Correctional Alternatives, and a number of significant federal grants.

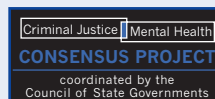
To learn more about the **Bronx Mental Health Court**, visit:
<http://consensusproject.org/mhcp/>

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The Mental Health Court Learning Sites Program is supported by the Bureau of Justice Assistance (BJA). More information on BJA can be found at <http://www.ojp.usdoj.gov/BJA/>

To learn more about the Mental Health Court Learning Sites, visit <http://consensusproject.org/mhcp> or contact:

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To download other mental health court resources, please visit <http://consensusproject.org/mhcp/info/mhresources/pubs/>:

- *The Essential Elements of a Mental Health Court*
- *A Guide to Collecting Mental Health Court Outcome Data*
- *A Guide to Mental Health Court Design and Implementation*
- *Navigating the Mental Health Maze*

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