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A STATEWIDE EXAMINATION OF MENTAL HEALTH COURTS IN ILLINOIS: PROGRAM OPERATIONS AND CHARACTERISTICS

ICJIA

A Statewide Examination of Mental Health Courts in Illinois: Program Characteristics and Operations

October 2015

Prepared by

Arthur J. Lurigio, Ph.D.
Department of Psychology
Department of Criminal Justice and Criminology
Loyola University Chicago

Monte D. Staton, Ph.D.
Department of Criminal Justice and Criminology
Ball State University

Shanti Raman, M.A.
Treatment Alternatives for Safe communities

Lorena Roque, M.A.
Center for the Advancement of Research, Training, and Education
Loyola University Chicago

This project was supported by Grant # 06-DJ-BX-0681 and Grant # 08-DJ-BX-0034 awarded to the Illinois Criminal Justice Information Authority by the Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice. Points of view or opinions contained within this document are those of the author and not necessarily represent the official position or policies of the U.S. Department of Justice or the Illinois Criminal Justice Information Authority.

Suggested citation: Lurigio, A.J., Staton, M.D., Raman, S., & Roque, L. (2015). *A Statewide Examination of Mental Health Courts in Illinois: Program Characteristics and Operations*. Chicago, IL: Illinois Criminal Justice Information Authority.

Illinois Criminal Justice Information Authority
300 West Adams, Suite 200
Chicago, Illinois 60606
Phone: 312.793.8550
Fax: 312.793.8422
www.icjia.state.il.us

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EXECUTIVE SUMMARY

Background

Mental Health Courts (MHCs) are designed to serve the challenging, multifarious, and extensive service needs of people with serious mental illness (PSMI). The current report describes the findings of an evaluation of MHCs in Illinois. First implemented nearly 20 years ago, MHCs provide treatment and programming in comprehensive case management strategies, which draw on permanent partnerships with community-based agencies and a wealth of providers through a brokered network of interventions. Most employ a team approach to supervision with dedicated stakeholders (prosecutors, defense attorneys, probation officers, mental health professionals), individualized treatment plans, voluntary and informed participation, specialized dockets and caseloads, and highly involved and proactive judges who preside over frequent court hearings and non-adversarial proceedings. Satisfactory program completion is defined by predetermined criteria. Clients are motivated to succeed by the threat of sanctions and the promise of rewards.

Methods

The current evaluation of Illinois' MHCs was performed in stages with overlapping data collection procedures. The first phase of the research was intended to yield a snapshot of MHC programs in the state: jurisdictions in the planning stages of MHC implementation, those with operational programs, and those still deciding whether an MHC was feasible or warranted in terms of clients' needs for services and the availability of local resources to support court operations and client interventions. All 23 court jurisdictions in Illinois were contacted for the screener survey. Given the critical role of services in client recovery and adjustment, the second stage of the evaluation involved a telephone survey of major providers in a wide variety of service domains. The next stages of the evaluation involved on-site triangulating data collection procedures in the 9 operational MHCs: court observations, focus groups with program staff members, and archival analyses. Client interviews and recidivism analyses were also performed in three programs, which were carefully selected for this purpose due to the distinctive nature of their location, size, program structure, and client population.

Major Findings

The Landscape: In spring 2010, 19 of the state's 23 court circuits participated in the screener survey. At the time of the study, 6 courts reported no plans for MHC implementation, 6 were in the planning process to establish one, and 9 had operational programs. From spring 2010 to spring 2014, the number of operational MHCs grew from 9 to 21, an increase of 133%. At the time of the screener survey, the 9 operational MHCs served a total of 302 participants; 46% were women. African Americans were overrepresented among participants relative to the local population, whereas Latinos (measured as ethnicity) were underrepresented.

Jurisdictions with no or little interest in launching an MHC were smaller and rural in composition. Courts in rural areas of the state served smaller populations, and, therefore, they had fewer PSMI and correspondingly fewer resources to meet their treatment needs. Unlike respondents who voiced no plans for an MHC, those in the planning process were all located in mostly non-rural large court circuits and counties. Overall, the planning processes in all counties were lengthy, deliberate, and collaborative. In some instances, the planning teams sought support

and consultation from colleagues in their own or other criminal court systems or from MHC experts in the state.

The first MHCs in Illinois were implemented in 2004, and the most recent one in the study period was implemented in 2008. Most of the jurisdictions with operational MHCs actually performed a formal needs assessment before launching their programs, and they consulted with experts to help design the programs. All of the jurisdictions involved law enforcement administrators in the planning and creation phases of their MHC programs.

MHC Elements and Staffing: Most Illinois MHCs were largely characterized by the 10 elements of an MHC as defined by the Council of State Governments. These included: broad stakeholder planning and administration of the program; the selection of target populations that address public safety and the link between mental illness criminal involvements; statutory exclusions of potential participants based on charges and diagnosis; terms of participation that include mandatory supervision and mental health treatment; voluntary participation and informed choice; hybrid team approaches to case management with judges, attorneys, probation officers, mental health professionals, and TASC case managers who provided supervisory and brokered treatment services; regular court hearings and phased supervision; and a wide range of treatment and service options to address clinical and habilitation needs. The roles and responsibilities of MHC personnel were generally circumscribed; however, MHC staff often discussed working together and being flexible in order to "get things done" for clients (coalescing around client needs). Staff members frequently mentioned teamwork as the key component of program and client success, and it was consistently apparent at case staffings.

MHC Services: MHCs provided a panoply of services to clients, which ranged from case management and crisis intervention to in-and out-patient treatments in the areas of mental health and substance abuse programming and aftercare. Nearly all MHCs offered clients partial (day) hospitalization, and more than half offered them inpatient hospitalization for substance use disorders and addictions. All the MHCs reported the implementation of evidence-based practices (EBPs) in their programs. The most common EBPs were, in descending order: cognitive behavioral therapy, motivational interviewing, integrative dual disorder treatment, and supportive employment. The least common EBPs were, in descending order: assertive community treatment and illness management and recovery. The most serious challenge to MHCs is the paucity of resources and services, especially in the mental health arena.

Recidivism Analyses: Among the three counties selected for an investigation of recidivism, 31% of participants were rearrested for a felony only, while half were rearrested for a felony or misdemeanor offense. The highest number of rearrests occurred within the first year of post-MHC entry. Half were rearrested during probation supervision and nearly 40% after probation release (not mutually exclusive groups). These results compare somewhat favorably with those reported in a statewide study of probationers, which found that 38% were rearrested during probation and 39% were rearrested after discharge from probation (not mutually exclusive groups) (cf., Adams, Bostwick, & Campbell, 2011).

Clients' Perceptions: The overwhelming majority of clients reported that their participation in the program benefitted them in several ways. For example, respondents indicated that the program improved their lives by fostering both general and specific improvements in their well-

being and functioning. For example, respondents stated that the program encouraged and supported changes that helped them “become better persons” and “get [their lives] back together.” These types of global betterments in their lives were the most commonly reported benefits of MHC participation and are perhaps related to elevations in self-efficacy and self-esteem, as well as alleviations in symptoms. Self-reported specific improvements related to participation in MHC fell mostly into two areas: accessibility to psychiatric care and diversion from incarceration. Specifically, respondents noted that MHC afforded them with the medications and treatments needed to facilitate their recovery from chronic mental illness. In addition, many clients recognized that participation in MHC was a desirable alternative to jail or prison.

CHAPTER ONE

Background and Introduction

Fundamental changes in mental health laws and policies have brought criminal justice professionals into contact with the seriously mentally ill at every stage of the criminal justice process. Police arrest People with Serious Mental Illnesses (PSMI) because few other options are readily available to handle their disruptive public behavior or to obtain for them much-needed treatment or housing (Teplin, 2000). Jail and prison administrators often struggle to treat and protect the mentally ill, judges grapple with limited sentencing alternatives for PSMI who fall outside of specific forensic categories (e.g., guilty but mentally ill), and probation and parole officers scramble to obtain scarce community services and treatments for PSMI and attempt to fit them into standard correctional programs or to monitor them with traditional case management strategies (Lurigio & Swartz, 2000). When the mentally ill are sentenced to community supervision, their disorders complicate and impede their ability to comply with the conditions of release and compound the difficulties of prisoner reentry (Council of State and Local Governments, 2002).

The presence of a mental disorder among justice-involved individuals complicates the supervision and custodial responsibilities of the criminal justice system. PSMI who are incarcerated in jail or prison require costly treatment and pose a burden on correctional supervision. They also spend more time incarcerated and are more likely to be victimized while incarcerated than those without serious mental illnesses (Ditton, 1999; James & Glaze, 2006). PSMI on probation or parole supervision are highly likely to violate the terms of their supervision, placing them at heightened risk of reincarceration (Skeem, Emke-Francis, & Louden, 2006). This penetration of offenders with mental illnesses into deeper levels of criminal

justice involvement has implications for public safety, public health, and public spending (Prins & Draper, 2009). The current report presents the findings from an evaluation of a fast-growing strategy for dealing with the challenges of PSMI during the pre- and post-adjudication stages of the criminal justice process: Mental Health Court (MHC).

The Development of Mental Health Courts

MHCs were developed in response to a growing awareness that substantial numbers of PSMI were appearing before the judiciary (Bernstein & Seltzer, 2003). Evidence suggests that between 15 and 20% of those in correctional populations suffer from a serious mental illness—a percentage that is substantially higher than the representation of PSMI in the general population (Ditton, 1999). Very few of these individuals met the standards for incompetency or insanity or had their illnesses addressed in sentencing or court supervision plans. As the Council of State and Local Governments (2002) observed, “People with mental illness are falling through the cracks of this country’s social safety net and are landing in the criminal justice system at an alarming rate.” Therefore, PSMI often cycle repeatedly through the criminal justice system, in part because of the court’s failure to recognize psychiatric illness as a factor that contributes to their continued criminal activity (Lurigio & Swartz, 2000).

Advocates, researchers, and legal scholars called for the creation of specialized programs that could respond justly, fairly, and humanely to PSMI at every stage of the legal process—from arrest to re-entry from prison (Lurigio & Swartz, 2000). Two converging legal trends spurred the development of MHC as an appropriate mechanism for handling the problems of criminally involved PSMI: therapeutic jurisprudence and the drug court movement. The former laid the academic groundwork for specialized courts and the latter developed and tested the basic

elements for successful specialized court operations (Watson, Hanrahan, Luchins, & Lurigio, 2001).

Therapeutic Jurisprudence

The term "therapeutic jurisprudence" (TJ) first appeared in the law literature in the late 1980s, in the context of mental health law. TJ is defined as "the study of the extent to which substantive rules, legal procedures, and the roles of lawyers and judges produce therapeutic or anti-therapeutic consequences for individuals involved in the legal process" (Hora, Schma, & Rosenthal, 1999, p. 440). Since its introduction, TJ has emerged as an approach for examining an extensive array of legal subjects, including the response of the criminal court system to the problems and needs of PSMI and how legal decisions can affect therapeutic outcomes.

Legal scholars view TJ as the application of social scientific theories and methodologies from a wide variety of disciplines for the purpose of understanding and promoting the psychological well-being of participants in the legal process. As we noted above, TJ recognizes that the law and legal actors, as well as legal rules and procedures, can all have therapeutic (favorable and healthy) or anti-therapeutic (unfavorable and unhealthy) consequences for those who are affected by the court's activities and decisions (Wexler & Winick, 1996). The concept of TJ favors the court's adoption of a problem-solving, proactive, hands-on, and results-oriented posture that is responsive to the current emotional and social problems of legal consumers.

TJ conceptualizes the law as a social force and judges as therapeutic agents who exercise the court's authority to promote clients' psychological health and social interests while protecting their due process rights and ensuring that justice is served in every case (Wexler & Winick, 1996). The National Association for Court Management and the National Center for State Courts widely touted TJ as an effective approach to the delivery of court services (Schma,

2005). Furthermore, the National Trial Court Performance Standards (Bureau of Justice Assistance, 1997) incorporated the TJ concept in Standard 4.5, which states that:

> The trial court anticipates new conditions and emergent events and adjusts its operations as necessary. Effective trial courts are responsive to emergent public issues such as drug abuse, child and spousal abuse, AIDS, drunken driving, child support enforcement, crime and public safety, consumer rights, gender bias, and more efficient use of fewer resources. A trial court that moves deliberately in response to emergent issues is a stabilizing force in society and acts consistently with its role in maintaining the rule of law (page 20).

As the above discussion suggests, mental illness falls within the purview of the TJ framework. Before the court turned its therapeutic attention to PSMI, however, it first employed TJ in its handling of drug cases.

Drug Treatment Courts

The most recent war on drugs, launched with the passage of the Anti-Drug Abuse Act of 1988, led to a massive influx of offenders at every stage of the criminal justice process, contributing to overtaxed court dockets and massive prison overcrowding (Lurigio, 2003). Specialized drug treatment courts (DTCs) were implemented in response to the unprecedented wave of drug offenders and their tendency to recycle through the criminal justice and treatment systems (Lurigio, 2000). Such drug courts are based on several major premises and include key components that have been adapted by MHCs such as specialized court dockets and a team approach to handling cases (cf. Cooper, 1998; Drug Courts Program Office, 1997).

Drug Treatment Courts regard addiction as a chronic brain disease that promotes or intensifies criminal behavior. During recovery, relapses are expected but they also afford

opportunities for personal growth and eventual sobriety. In DTCs, treatment is integrated with other rehabilitative services and with criminal justice case processing. When successfully treated, persons with addiction are less likely to recidivate in terms of rearrest, reincarceration, and outpatient admission (Lurigio, 2000). DTCs use leverage or coercion to encourage offenders to begin and remain engaged in treatment programs. Judges exercise their moral and legal authority in overseeing the recovery process, and take a strong professional interest in each offender's recovery.

The creation of MHCs not only benefited from the political support and successful implementation of DTCs, but they also gained impetus from the reported success of drug courts. Although the quality of the research undertaken to evaluate DTCs has been questionable, most reviews of such evaluations have applauded the success of DTCs in decreasing recidivism, saving taxpayer dollars, and increasing retention in treatment (National Drug Court Institute, 2004). A review of research on drug courts concluded that "we know that drug courts outperform virtually all other strategies that have been attempted for drug-involved offenders" (Marlowe, DeMatteo, & Festinger, 2003)

As the number of DTCs increased, so did the number of defendants in those courts who had mental health problems. In response to the growing presence of PSMI on court dockets, several jurisdictions—Honolulu and Ithaca, New York, for example—developed mental health tracks within their DTCs. Similarly, the DTC in Lane County, Oregon, developed two mental health tracks; one for PSMI and another for persons with personality disorders (Axis II). These consist of characterological problems and destructive behavioral patterns that affect people's relationships and overall functioning (American Psychiatric Association, 2004). San Bernardino County, California has separate drug and mental health courts, with the same judge presiding

over both (Rabasca, 2000). In the late 1990s, other jurisdictions began implementing independent MHCs.

In summary, the DTC model has transformed specialized criminal courts from adversarial and legalistic to therapeutic and rehabilitative and laid the foundation for MHCs (Fulton Hora, 2002). DTCs adopt a common mission and team approach to working with drug-involved offenders. Judges, prosecutors, defense attorneys, probation officers, and treatment providers execute a coordinated case management plan that holds offenders accountable through graduated sanctions for rule infractions and rewards them through reductions in sentences and dismissals of charges for successful program completion (Belenko, 1998).

Model Mental Health Courts

According to its proponents, specialized MHCs hold great promise for diverting PSMI from the criminal justice system and ensuring that they receive psychiatric treatment and other services (Bazelon Center for Mental Health Law, 2004). Pioneering MHC initiatives were implemented in response to three critical problems: the perceived public health risk posed by offenders with serious mental illness, the challenges and costs of housing PSMI in crowded local jails, and the criminal justice system's pervasive inability to respond effectively and humanely to PSMI (Goldkamp & Irons-Guynn, 2000). Among the first three jurisdictions to establish MHCs were Broward County, Florida; King County, Washington; and Anchorage, Alaska.

Since the inception of these and other bellwether courts, interest in MHC has grown tremendously. Numerous jurisdictions have implemented their own mental health models, tailored to local needs, resources, and political exigencies. In November 2000, President Clinton signed into law the Law Enforcement and Mental Health Project Act, sponsored in the Senate by Mike De Wine (R-Ohio) and in the House of Representatives by Ted Strickland (D-Ohio). The

law authorized the allocation of funds to support the implementation of MHCs at the county level.

In fiscal years 2002 and 2003, Congress appropriated 5 and 4 million dollars, respectively, for seed grants to help inchoate MHC programs become operational. However, the House of Representatives allocated no funds in fiscal year 2004 for the support of MHCs. Furthermore, the Senate's Commerce, Justice, State, and Judiciary Appropriations Subcommittees also allocated no dollars to launch MHCs. Despite the absence of these allocations, the number of MHCs in the United States mushroomed from 1 in 1997 to more than 100 in 2005; MHCs are now located in nearly 40 states such as California, Ohio, Florida, and Washington (Council of State and Local Governments, 2006; Steadman et al., 2005).

Researchers have distinguished between the "first generation" of MHCs, which were created in roughly the first five years of MHC's operations, and second generation courts, which were created since 2002 (Redlich et al., 2005). Although there are many overlapping characteristics between first and second generation MHCs, the second generation of MHCs are more likely to accept persons with felony or violent offenses; employ post-plea adjudication models; use jail as a sanction; and utilize court personnel or probation for supervision. MHCs rely on state and federal grants and local funding sources to support operation of the courts (Redlich, 2005). Given the current budget restriction at all three levels of government, it is unclear whether MHCs will continue to proliferate at the same pace as they have over the past decade.

Effectiveness of MHC

The number of MHCs has increased rapidly in their first 14 years of operation, with approximately 250 in operation and many in the planning stages (Steadman et al., 2011; Council

of State Governments Justice Center, 2009). After 14 years of operations, researchers continue to investigate the impact of MHCs on the judicial system, community, and participants. Mental health court outcome research focuses on recidivism rates, symptom reduction, quality of life, and service utilization. Researchers have identified promising preliminary outcomes for individuals who participate in MHCs. For example, MHCs appear to reduce recidivism among their participants (Council of State Governments Justice Center, 2008; Christy et al., 2005; Herinckx et al, 2005; Gurrera, 2005; Sarteschi, Vaughn, & Kim, 2011; Trupin & Richards, 2003).

In a recently published meta-analysis of 18 outcome studies, MHCs were associated with reduced criminal recidivism with an average effect size of -0.54 (Sarteschi, Vaughn, & Kim, 2011), especially among program graduates. Mental health court graduates were 3.7 times less likely to be arrested than non-graduates (Herinckx et al., 2005). Graduates also reported significantly more days to new arrest than non-participants (McNiel & Binder, 2007; Trupin & Richards, 2003). Researchers attribute this success to individuals' receipt of a "full dose" of MHC (Moore & Hiday, 2006).

Not only do MHCs appear to reduce recidivism, they also seem to reduce the severity of future criminal activity, at least during the year following participation (Cosden et al., 2005; Gurrera, 2005; Moore & Hiday, 2006). Among MHC participants who are rearrested, their crimes are likely to be nonviolent offenses or parole violations (Cosden et al., 2005; Gurrera, 2005; McNiel & Binder, 2007). MHC participants also reported a decrease in violent acts during MHC probation. The same sample of MHC participants reported fewer violent acts during the eight-month follow-up period, compared with a matched sample of traditional court participants (Christy et al., 2005).

MHCs have also been found to enhance the quality of life for participants. In a meta-analysis, MHC participants, on average, were more likely than non-MHC participants to report significant improvements in quality of life (i.e. overall state of health and fulfillment of family, occupational and social obligations) (Sarteschi, 2009). Preliminary research also suggests greater service utilization among MHC participants. In one investigation, MHC participants increased their service use by 62% in the eight months following MHC participation compared with the eight months prior to participation. Service utilization was also higher for MHC participants compared with non-MHC participants with mental health disorders (Boothroyd et al., 2003). Interestingly, in this study, researchers found no significant relationship between the treatments recommended during MHC hearings and the services that MHC participants actually utilized in the follow-up period (Boothroyd et al., 2003). In other words, the treatment plans recommended by MHC staff are not always utilized by MHC participants after the initial hearings. Clients' failure to seek services might be due to the lack of availability of community services, participants' treatment preferences, or a disconnection between the MHC staff and community treatment providers.

Nearly all MHCs strive to reduce the psychiatric symptoms of their participants. However, no current studies have shown that MHCs are achieving this goal (Boothroyd et al., 2005). One of the few studies that measured psychiatric symptoms actually found that participants' symptoms worsened over time in both traditional and MHCs. Researchers noted that although individuals were engaged in treatment, no record of the type and quality of service was ever examined. This preliminary analysis suggests that treatment and MHC participation alone might not be sufficient to reduce symptoms (Boothroyd et al., 2005).

Current Research

This research examined the adjudicatory and supervisory models adopted by each active MHC program in Illinois. Data was collected on performance measures that tested the effectiveness of various supervisory strategies. Current MHC programs in Illinois were investigated further by examining the perspectives of the professionals who administer and operate these programs, and clients who participate in these programs. The perspectives held by MHC professionals and clients were juxtaposed with other program data, such as graduation and recidivism rates, to explore further the effectiveness of Illinois MHC program practices and identify possible problem areas that can be addressed through policy and procedure modifications. In jurisdictions in Illinois where no MHC programs were operating currently, the research illuminated the planning process(es) for these programs in the initial stages of development and identified the factors that led to the decisions to refrain from or abandon the implementation of an MHC program.

The evaluation of Illinois' MHCs consisted of a series of cascading studies pursued in close collaboration with the Research Unit of the Illinois Criminal Justice Information Authority (ICJIA). The studies involved a variety of data collection tools and methodologies. The evaluation built on extensive research on the Cook County MHC Program and dovetailed with the efforts of the recently convened Illinois Association of Problem Solving Courts (ILAPS).

The research was multitiered and designed to extend previous surveys of MHCs in Illinois, which were conducted by members of the ILAPSC and also the Consensus Project; a project coordinated by the Council of State Governments' Justice Center and an unprecedented effort designed to improve responses to people with mental illnesses at every interception point in the criminal justice process.

The study involved a statewide survey of Illinois Circuit Court jurisdictions, the collection of archival data from all Illinois MHCs in operation, observations of staff meetings and court calls at nine Illinois MHC sites, and the administration of on-site interviews and self-report surveys at all Illinois MHC sites. In addition, client interviews and recidivism analysis were also conducted in three different Illinois MHCs.

Overall, the purpose of this research was to provide a comprehensive assessment of MHCs in Illinois, which were in various stages of development. The investigation also featured, for more in-depth analyses, courts that exemplify different types of programming and operations. The primary goal of the study was to create a composite of current MHCs in order to inform future studies and practices. Collectively, this research addressed prevailing MHC-related philosophical, political, procedural, and logistical issues at the national level in the context of the Illinois Court System. The research was intended to sharpen and expand our knowledge of MHC programs in Illinois, thereby enhancing the ability of state officials to render appropriate decisions regarding MHC operations and services. Furthermore, this research strongly supported ICJIA's aims of advancing the State's understandings of justice system trends through the application of innovative program evaluation approaches.

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CHAPTER TWO

SCREENING SURVEY

Methodology

Overview

The goal of the first stage of the MHC evaluation was to administer a screening survey to determine whether an MHC program was operating in any of Illinois' 23 Circuit Court Jurisdictions. Key research questions addressed in this stage included:

- What jurisdictional factors promoted or inhibited the initiation of an MHC, and how are those factors related?
- How was each MHC conceived, created, and implemented?
- How are clients identified and selected for program participation in each MHC?
- How does each MHC operate in terms of client assessment, service planning and delivery, as well as client monitoring, and sanctioning for non-compliance?

Findings from the screening survey also illuminated the relationships and differences between urban and rural jurisdictions, and whether MHC programs had existed and were subsequently abandoned, or were being planned as the result of perceived clients' needs for such services.

Procedures

The Chief Judge's Office in each of the 23 jurisdictions was contacted in order to help identify appropriate individuals for participation in the statewide screening survey. The survey was conducted via telephone and mail from early February to early April 2010. State Circuit Court Jurisdictions in Illinois are officially named by numbers, ranging from the First to the Twenty-Second. The Twenty-Third Jurisdiction is referred to as the "Circuit Court of Cook County". Of the twenty-three circuits, five were single county circuits (Cook, Will, DuPage,

Lake, and McHenry), and the remaining eighteen circuits consisted of two to twelve counties in each. For Illinois circuits with one county, the Circuit Court and Chief Judge's Offices are administered at the county level and located in a relatively populous city in that county. In jurisdictions with several counties, the Chief Judge's Offices are also usually located in a relatively populous county and city within that jurisdiction.

The Chief Judge's Office was contacted in each circuit in an effort to identify participants; that is, knowledgeable court officials or upper-level staff members who were able to answer questions regarding operational, planned, or discontinued MHCs in the judicial circuits. Using this protocol, callees were greeted and told that a study of Illinois MHCs was being conducted by Loyola University Chicago. They were asked for the availability or contact information of a person who might be capable of answering survey questions about the recent history of criminal justice practices in that judicial circuit. Typically, the callee would transfer the interviewer to a court official or be given that official's contact information.

After reaching court officials, the purpose of the study was explained as well as the need to identify the most appropriate survey respondent (i.e., judge, state's attorney, court administrator who had worked in the jurisdiction for a number of years and had been involved with planning the court's organization and programming). If court representatives did not identify themselves as appropriate respondents, contact information was requested for the court officials who would be the most knowledgeable participants. Using this protocol, survey respondents were recruited in 19 of the 23 (83%) judicial circuits. No court officials agreed to participate in the survey in four of the Illinois Circuit Court jurisdictions: the Fourth, Fifth, Eighth, and Fifteenth.

Participants were told that the survey would last from 30 minutes to an hour, depending on which set of survey questions was asked, and that the results of the survey would be reported to the Illinois Criminal Justice Information Authority. Respondents were assured that their names would not be used in any reports or publications. Verbal informed consent was obtained and documented on the survey forms. All survey respondents were asked a preliminary question, "Does your court jurisdiction have an existing mental health court program?" If respondents answered "yes," it was explained that a survey about the MHC program would be sent to them (Survey A) and that it would take approximately an hour to complete.

Survey A questions measured the size of the program in terms of participants and the types of personnel operating the MHC. It also examined the timing and process of MHC formation, the determination of the need for an MHC, the source of resources to fund the MHC, and the type of community in which the MHC operated. Other Survey A questions investigated the organizational structure and adjudication model of the MHC, the process and criteria by which defendants were targeted for program participation, staffing needs and how they were met (e.g., training), informational systems used, barriers to MHC program operations, and changes in the MHC program following implementation.

If respondents answered "no" to the preliminary question, they were asked "Are there currently plans to begin a mental health court program in your jurisdiction in the future?" This additional question was used to ascertain which of the two sets of survey questions (Survey B or C) would be administered. If participants replied "yes" to this question, Survey B questions were asked by telephone, either immediately or at a later scheduled time. Survey B items were developed for jurisdictions planning an MHC program; they explored the factors that played a

role in the decision to start an MHC program and examined the basic structure of the proposed program.

If participants replied "no" to the second question, Survey C questions were asked by telephone, either immediately or at a later scheduled time. Survey C was designed for jurisdictions that had neither an MHC program nor plans to begin such a program. Questions examined whether plans for an MHC had ever been discussed and, if so, why plans to start an MHC program had never eventuated out of such discussions; if not, questions probed why the possibility of establishing an MHC had not been discussed among criminal justice officials. Each of the sets of questions in these surveys was significantly shorter than the set for Survey A. Thus, the time required to administer Surveys B and C was about twenty to thirty minutes. Copies of Surveys A, B, and C are in Appendix A.

Findings

Calls to each Chief Judge's Office in the 23 Illinois Circuit Court jurisdictions revealed that nine MHC programs were in operation at the time of the survey. For each of these, a court official completed a set of Survey A questions. In the six planned MHC programs, each court official completed a set of Survey B questions. In addition, in six Illinois Circuit Court jurisdictions, court officials agreed to participate and reported that no MHC was operating or being planned in those circuits. These court officials completed a set of Survey C questions. Table 1 shows the locations of the nine jurisdictions with operational MHCs. Since the initial screening survey was conducted, court environments have changed substantially, with twenty-one MHCs operational in 2013.

Table 1: Counties with Operating MHCs as of April 2010 and Newly Launched MHCs April 2014	
Original 9 MHCs Included in Study	**MHCs Established Since Study**
1. Cook County 26th Street Men's/Women's Mental Health Court	10. Cook County Skokie Mental Health Court - 2nd Dist. (Skokie)
2. Cook County Maywood Mental Health Court (4th Dist.)	11. Cook County Bridgeview Mental Health Court – 3rd Dist. (Rolling Meadows)
3. DuPage MICAP	12. Cook County Mental Health Court- 6th Dist. (Markham)
4. Kane County Treatment Alternative Court	13. Cook County 26th Street Women's Co-Occurring Court
5. Lake County TIM	14. Lee County Mental Health Court
6. Macon County Mental Health Court	15. McLean County Recovery Court
7. Madison County Mental Health Court	16. Peoria County Mental Health Court
8. McHenry County Mental Health Court	17. Rock Island LIFE Program
9. Winnebago County TIP	18. St Clair County Mental Health Court
	19. Vermilion County Mental Health Court
	20. Will County Mental Health Court
	21. Winnebago County Youth Recovery Court (Juvenile)

Survey C: Judicial Circuits with No Plans to Begin MHCs

Of the six circuits with no MHCs and no plans to begin one at the time of this study, three consisted entirely of rural counties, while at least half of the geographic areas in the counties in the other three circuits were rural in nature (Figure 1). Survey respondents in four of these six circuits reported a lack of interest in starting an MHC. Discussions about possibly beginning an MHC had occurred in the other two circuits, but officials in one of those had determined that there was no need for an MHC in that jurisdiction. Results from the surveys of these six circuits are presented below.

The First Judicial Circuit. The First Judicial Circuit of Illinois encompasses nine counties, all rural. The total population of the nine counties in 2010 was 216,176 (U.S. Census

Bureau, 2010). The responding official from the First Circuit reported that no drug court or specialized probation program for persons with mental illness had been established in the circuit. Asked how officials in the circuit dealt with offenders with severe mental illness, the official explained that the State's Attorney recognizes that the criminal justice system is not equipped to deal with persons with mental illness. Officials try to avoid jailing persons with mental illness, and the filing of preliminary charges against such persons is rare. For such persons facing misdemeanor charges, officials engage in "collaborative" efforts to work with social service agencies and families to find the least restrictive environment in which to address their problems (i.e., to avoid jail detention). According to the official, the primary concerns stemming from such efforts were that persons with severe mental illness would have limited access to medications or would be non-compliant with their medications. The respondent indicated that no discussion about starting an MHC in the First Circuit had occurred because of the paucity of funding—not for drug treatment but for mental health treatment—and concluded: "A mental health court is needed more than a drug court." However, the respondent believed that an MHC would not be established within the next few years due to a dearth of funding for mental health services throughout the jurisdiction.

The Second Judicial Circuit. The Second Judicial Circuit encompasses eleven counties, all rural, and had a total population of 199,730 in 2010. According to the Second Circuit respondent, the circuit had no specialized probation program for offenders with mental illness, but a drug court was operating in Lawrence County. Asked how officials dealt with offenders with severe mental illness, the respondent explained that when a probationer is recognized as having a mental illness, the probation officer has the client assessed and treated by local mental health providers. Nonetheless, the official lamented the lack of funding for such providers in the

circuit. Although no discussions had focused on the possibility of creating an MHC program in the jurisdiction, the official stated that judges "are always interested in improvement of outcomes for individuals that appear in courts." Therefore, they would be receptive to the notion of planning an MHC. However, the official predicted that no MHC would be established in their circuit in the next few years, and explained that this was due to a shortage of resources to operate an MHC (i.e., too few mental health providers or workers to run the program). The official indicated that one reason for inadequate resources was the jurisdiction's location in a rural environment; nonetheless, the official speculated that an MHC might be developed in the larger counties in the circuit.

The Seventh Judicial Circuit. The Seventh Judicial Circuit encompasses six counties, half of which are rural. The total population of the circuit in 2010 was 323,003. The responding official from the Seventh Circuit stated that neither a drug court nor a specialized probation program for persons with mental illness has been planned there. In response to the question of how Seventh Circuit officials dealt with offenders with severe mental illness, the respondent explained that such offenders were referred to local mental health providers. Mental health counseling from these providers could be mandated and brokered by the probation department. The respondent was unsure if interest would arise in starting an MHC in the next few years if such an idea emerged in the Seventh Circuit, stating "I know that there have been efforts made to start a drug court. The chief judge and the district judges were talking about it, but then the state budget was decimated. Any interest in starting a drug court ended."

The Ninth Judicial Circuit. The Ninth Judicial Circuit encompasses six counties, all rural. The total population of the circuit in 2010 was 166,742. According to the Ninth Circuit respondent, no specialized probation program had been created for offenders with mental illness,

but one drug court was operating in the circuit (Knox County). The respondent explained that Ninth Circuit officials did not deal "in any specialized way" with offenders with severe mental illness. Rather, they were handled on a case-by-case basis with "no specific protocol for mental health issues in court." The respondent indicated that no discussion had transpired about the possibly of launching an MHC program in the circuit, mainly because there not enough cases of offenders with mental illness in the circuit to warrant such a court. The official also reported that no interest would congeal around the idea of starting an MHC, referring again to the low number of court cases involving mental illness and the low levels of mental health resources and funding in the circuit. The official explained that it was difficult for Ninth Circuit courts to utilize the services of psychologists and psychiatrists because few of them were practicing in the area and thus their time was limited and expensive. The official predicted that no MHC would be established in the circuit during the next few years, again due to the low number of mental health cases and lack of mental health resources in the area.

The Thirteenth Judicial Circuit. Unlike the four non-MHC circuits discussed above, the court official who responded to our survey for the three-county Thirteenth Judicial Circuit, which had a population of 198,965 in 2010, reported that discussions among circuit officials had occurred about likelihood of initiating an MHC in the jurisdiction. The official explained that offenders with mental illness were referred to the court for mental health evaluation and treatment. In 2008, a representative of a local mental health service provider formed a committee with criminal justice officials and other providers to consider the feasibility of starting an MHC. The Chief Judge and representatives from the State's Attorney's Office, the Probation Department, the Sheriff's Office, two inpatient mental health programs, and two counseling centers participated in these discussions. However, after the members of the committee had

considered the need for an MHC in the three different counties as well as the estimated number of court cases involving persons with mental illness, their cost-benefit analysis demonstrated that an MHC was unnecessary.

The committee was adjourned, and no further discussions were convened regarding the creation of an MHC. Court officials in the Thirteenth Circuit concluded that their current strategy for processing defendants with mental illness was sufficient. The official explained that no future interest in starting an MHC would likely emerge because the circuit was mostly rural with few identified cases of mental illness among criminal defendants. Officials had already determined that the cost of the MHC outweighed the benefits. For these reasons, the official believed that an MHC would not be established in the circuit within the next few years.

The Twenty-First Judicial Circuit. The Twenty-First Judicial Circuit had a population of 143,167 in 2010 and encompasses two counties, Iroquois and Kankakee, the former being rural. It was the only other jurisdiction of the non-MHC circuits in which officials had discussed the prospect of creating an MHC. The official from Twenty-First Circuit court system who responded to the survey explained that no formal diversion program or screening process, overall, was ever implemented for people with mental illness who are charged with serious crimes. However, offenders with mental illness, charged with less serious crimes, are handled on a case-by-case basis, with court personnel taking into account mental illness in decisions about the further processing of the cases. Offenders with mental illness charged with more serious crimes, such as sexual assault or murder, remain in custody, and if they are unable to make bond, they are evaluated by a forensic psychologist.

The Circuit had a drug court, and the Public Defender, the State's Attorney, and mental health providers who worked in the drug court discussed the option of creating an MHC after a

judge had broached the topic. Twenty-First Circuit officials also talked about the idea of creating an MHC with a representative from the State's Division of Mental Health and the Director of Special Court Programs in Cook County. However, the officials in the Twenty-First Circuit never progressed beyond the discussion stage because they felt that resources were insufficient to even begin planning an MHC. All available resources had been "stretched to the limit." The State had a shortage of beds for inpatient hospitalization, and the circuit was "seriously distressed" in terms of financing and providing mental health services. The official commented, "I don't see what the benefit would be in formalizing a mental health court program."

Although no plans were afoot to implement an MHC, the official indicated that judges, the Public Defender, the State's Attorney, the director of a local mental health center, the Sheriff, and the Probation Director continue to discuss the possibility of operating an MHC. The official believed that an MHC would be established within a few years but stated that a more pressing problem was the lack of mental health services in the jail. The circuit had no psychiatrist on retainer, and detention officers had to transport defendants to a psychiatrist's office if services were required. The official commented that the State's Attorney's Office deemed unacceptable the practice of filing criminal charges in order to obtain mental health services for an individual. The official believed that their court system needed better mental health screening, treatment, and services for the jail population as well as for the general population of residents living in the circuit.

Survey B: Judicial Circuits Planning Mental Health Court Programs (as of April 2010)

MHCs were being planned in six Illinois urban circuits and counties (see Figure 1): the Sixth, Tenth, Eleventh, Twelfth, Twentieth, and Cook County, which already had one MHC operating in Chicago. Each of the MHCs in the multi-county circuits was planned for the largest

counties in the circuit, except for the Sixth Circuit in which the planned location was Macon County, the circuit's second most populous county. The following are survey results for each of the six planned MHCs, including information on their planning processes.

The Sixth Circuit: Macon County Planned MHC. The planned MHC in the Sixth Court Circuit, population 379,965 (U.S. Census, 2010), serves Macon County, which had a population 110,768 in 2010. Court officials began discussing the founding of an MHC in early 2008. The State's Attorney's Office and the Chief Judge contemplated the implementation of an MHC in Macon County after noticing an increase in offenders with mental illness who were clogging the court system. Interestingly, a drug court program had operated in Macon County several years before but ran out of funding and had ceased operations by the time of the survey. Planners anticipated that the MHC would be hearing a number of cases involving offenders with both substance abuse and mental health problems. Several people were involved in the planning process for the MHC, including the State's Attorney, Chief Judge, Public Defender, Decatur Police Chief, Macon County Sheriff, and St. Mary's Community Hospital Administrators. The Macon County Justice Committee also hired a consultant to assist with the planning of the MHC.

The effort to embark on an MHC in Macon County was being led through a grant administered by the State's Attorney with assistance from the Chairman of the Macon County Board and an interested judge. The respondent said that "no one" was hesitant about creating an MHC in Macon County. They recently "had a [MHC] kick-off event and sent a mass email to the Chamber of Commerce and community business leaders. [It had an] incredible response." Established MHCs in Winnebago and DuPage Counties served as models for planning the Macon County MHC. The next major task for planning was system mapping, utilizing the sequential intercept model (Munetz & Griffin, 2006). Officials planned to inaugurate MHC

operations by the spring of 2011. They still needed to decide if the court would hear misdemeanor, felony, or both types of cases, and if only Axis I diagnoses (clinical disorders) or both Axis I and Axis II (personality disorders and developmental disorders) diagnoses from the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association would be accepted.

The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, is the widely accepted nomenclature used in the categorization of psychiatric illnesses. Mental health professionals employ the manual for the purposes of patient diagnoses, tracking, research, and insurance reimbursement. Versions of DSM-III and DSM-IV (but not DSM 5) contained a multi-axial diagnostic system; the most important axes, in terms of practice, were Axis I (clinical disorders) and Axis II (personality disorders).

Although the local mental health community was "fully on board," the Sixth Circuit official explained that planners were concerned about finding the right social services and the most appropriate participants, as well as being prepared to deliver staff training, especially to the police. MHC planners in Macon County were also concerned about funding, particularly for clients without insurance. The Sixth Circuit official added that planners were trying to determine how to sustain the MHC with its own resources. The official felt that a paucity of care for persons with mental illness causes them to appear in court, which is ill-equipped to handle such cases. “Such cases waste court time.” The official also noted a lack of services for people with mental illness who could benefit most from MHCs, specifically those who need a bed in a psychiatric hospital. The official believed that the lack of such beds leads to the arrest and detention of people with mental illness.

The Tenth Circuit: Peoria County Planned MHC. The Tenth Illinois Court Circuit had a population of 346,528 in 2010, and the planned MHC was intended to serve Peoria County, population 186,494 (U.S. Census, 2010). The service area might eventually be expanded to include other counties in the circuit. Officials in Peoria County started exploring the possibility of an MHC in late 2008. The discussion originated with the Chief Judge, who was knowledgeable about persons with mental illness in the criminal justice system. He led the effort to establish the program. Three persons were involved in the planning: the Chief Judge, the State's Attorney, and the Sheriff, who had also observed a significant number of persons with mental illness in the jail. The respondent mentioned that the State's Attorney's Office had some reservations and had not yet submitted a plan of needs and spending for the program.

At the time of the survey, Peoria County officials were starting the planning process and were expecting a federal earmark that had been awarded to fund the MHC. This funding resulted from the efforts of a U.S. Senator. Peoria officials visited formally with Rock Island MHC officials to learn about how their court is organized and attended MHC workshops provided by DuPage County. The respondent added that Peoria officials had worked with the Illinois Department of Human Services, Division of Mental Health to explore intervention and services for persons with mental illness and were "partnering with the state to see what funds exist for community based services." Although final decisions had not been rendered, the planned MHC would likely hear both misdemeanor and non-violent felony cases. The Peoria County respondent anticipated that the MHC would "probably [hear] a lot of nuisance cases that are prevalent with this population." At the time of the survey, no final start date for the MHC had been announced in Peoria, and the respondent was unsure of when the court would become operational.

The criminal court in Peoria County had no specialized probation program for offenders with mental illness but did have a drug court. Asked how the population targeted by the MHC would be different from the group served by the drug court, the Tenth Circuit official stated, "This is another issue that has to be addressed. We know that a lot of people in drug courts have mental illnesses. The mental health court will probably render itself more on the side of mental health issues and people with diagnosis." The official also recognized that "some people with mental illness self-medicate."

On its way toward implementation, the Tenth Circuit official explained, "The [MHC] program is still in its infancy," but officials had contacted and were researching community-based treatment programs, hospitals with psychiatric units, and the psychology program at the local school of medicine for possible resources and partnerships. In terms of the barriers that might delay the start-up of MHC operations, the official noted the importance of the "willingness [of the] State's Attorney Office. They are the gatekeepers and willingness by them is a major hurdle."

The Eleventh Circuit: McLean County Planned MHC. The population of the Eleventh Court Circuit was 291,572, and the MHC would serve McLean County, which had a population of 169,572 in 2010 (U.S. Census, 2010). Officials first talked about implementing an MHC in 2007 after the circuit's drug court was created. The issue of co-occurring disorders among participants in the drug court program prompted the decision to implement an MHC program. McLean County officials had difficulty determining which drug court participants would benefit from mental health treatment, leading to the serious consideration of an MHC, but "the funding is limited and so far, been directed to the drug court, which lessened the need for MHC, and the push was mostly for drug courts in 2006." The respondent also commented that recently a push

to begin an MHC in the circuit has emanated from the Illinois Criminal Justice Information Authority.

A number of agents in McLean County were involved in the process of planning the MHC, including representatives from the State's Attorney Office, the Public Defender's Office, the Sheriff's Office, the Circuit Court Administrator's Office, the Probation Department, the Illinois Division of Mental Health, the McLean County Health Department, and the McLean County Veteran Services as well as a number of social service agencies and a local housing bureau. The Chief Judge was leading the planning process. The Eleventh Circuit official reported that the State's Attorney, the Trial Court Administrator, and some social service agencies have expressed doubts about launching the MHC court. The Trial Court Administrator viewed the MHC as a mechanism that benefits the court and not people with mental illness. The respondent explained that only a small portion of the total criminal justice population is mentally ill and in need of treatment services, and commented, "The mental health court isn't really improving the alternative treatment that the larger population may need."

McLean County officials planned to begin MHC program operations within weeks of the survey, which was conducted in February 2010. By March or April, they anticipated that two or three people would be participating in the new program. Although it was scheduled to start soon, McLean County officials had not yet determined if the MHC "diversion program" would be a pre-plea or post-disposition program. Although the program was designed to be a diversion program with supervision, the specifics had not yet been well-defined. The Eleventh Circuit official stated that the MHC would probably follow the McLean County Drug Court model, explaining that participants enter the diversion program after pleading guilty. If participants are unsuccessful in the drug court, they are then sentenced for their crimes. Referrals for both

misdemeanor and felony charges will be accepted into the MHC program; however, this point too had not yet been settled at the time of the survey. The Eleventh Circuit official cited the Winnebago County MHC as the primary model for the McLean County MHC.

Explaining how the McLean County MHC program would operate, the Eleventh Circuit official stated "[Referrals] will be screened [on three criteria]: first, offense, second, criminal history, and third, available treatment. For example, if they commit a violent crime, they may not be allowed into program even if they have a small criminal history or treatment is available. Another example, an offender may not be admitted if they commit a minor crime but they have a criminal history of violent felonies."

Before the MHC could become operational, the official stated that the McLean County MHC planners still needed to "normalize the diversion process, the screening instrument and secure funding." The Eleventh Circuit official explained that "funding was the key" to getting the MHC program up and running. The official added that planners had not yet addressed the acceptance of the MHC program by law enforcement agencies and the wider community; not all law enforcement agencies in McLean County were "on board" with the plan for the MHC. The official noted that the law enforcement agencies supportive of the MHC were those in which officers had Crisis Intervention Team (CIT) training. "Not a lot of police officers are trained with CIT," according to the official, but [CIT] can prevent unnecessary incarceration of persons with mental illness.

The Twelfth Circuit: Will County Planned MHC. Will County is the sole county in the Twelfth Judicial Circuit, and had a population of 677,560 at the time of the survey (U.S. Census Bureau, 2010). As in McLean County, the issue of co-occurring disorders among participants in the Will County Drug Court program led officials to consider an MHC program.

In early 2008, the Chief Judge and the Director of the Forensic Department in the Will County Health Department discussed how numerous individuals in the drug court had co-occurring disorders and could be treated for mental health problems. After this conversation, the Forensic Director also researched how mental health treatment might be provided for jail detainees who were identified through Jail Data Link (which identifies detainees that have open mental health cases with the Illinois Department of Human Services), as having previous mental health problems. Eventually, the Forensic Director called a meeting with the Chief Judge, other judges, the State's Attorney, and the Public Defender to discuss the idea of starting an MHC program. After discussing drug court participants with co-occurring disorders and detainees in the Will County Jail who were recognized (through the Data-Link system) as a having mental illness, attendees at the initial meeting all recognized a need for the program.

Another meeting was held in 2009 to begin planning the MHC; it included the new Chief Judge, the State's Attorney, a trial judge, a Health Department official, and the Public Defender. Members of this group conducted site visits at MHCs in Winnebago, Lake, DuPage, and Kane counties to learn how these MHC programs were created and operated. Will County officials also joined the Illinois Mental Health Court Association and began regularly attending meetings. At the time of the survey, the State's Attorney, the Chief Judge, judges to be assigned MHC cases, representatives of the Will County Health Department, the Public Defender, and local representatives from the National Alliance for the Mentally Ill (NAMI) were meeting once a month to plan the MHC program. The planning process involved preparing the contract for the MHC, the forms needed for its operation, and the details of the intake assessment process. According to the Twelfth Circuit official, plans had already been completed regarding the MHC

docket assignment, the design of case management for participants, the clinical psychologists for the program, and the specific psychosocial rehabilitation classes to be taught.

The official explained that the Will County Board had no money for the MHC program and was reluctant to support it. Members of the Board were uncertain about how to measure the MHC program's success, and were unsure that it would prevent recidivism after participants were released from the program and into the community. Regarding funding, the Twelfth Circuit official explained that the MHC will have to utilize whatever current resources are available, as no additional funding was obligated for the MHC. The official added that some MHC participants might have to rely on donations for medications if they have no private insurance or federal assistance.

Will County officials planned to begin MHC operations soon after the survey, at the beginning of April 2010. The Twelfth Circuit official explained that the MHC would hear both misdemeanor and felony cases, but that the majority would probably be felonies. The MHC planned to separate its group from drug court participants by requiring that MHC participants have a primary diagnosis on Axis I of the DSM-IV-R. Regarding defendants who have co-occurring problems, the Twelfth Circuit official explained that they would be "subjective cases" and appropriate referral would depend on the severity of the mental illness.

The Twelfth Circuit official also reported that MHC planners still needed to finalize the contract, the client application procedure, and the mental health assessment tools that will be utilized in the evaluation process. The official reported that two barriers might interfere with the implementation of the MHC program: "Getting all of the attorneys to agree on the contract; the Public Defender wants to ensure their clients are protected while the State's Attorney doesn't want every case dismissed. Money is also a barrier." Nonetheless, Will County MHC planners

were moving forward "with or without funding." The official also noted that MHC planners were "not sure how to measure success," adding that they would like "some sort of computer management program" to store MHC participant information, keep it confidential, and provide all involved in running the program with access to client data and the ability to update such information. Will County officials "wanted in on a pilot project for a data-sharing system that hooks up to Data Link, but the larger jurisdictions got it." The Twelfth Circuit official indicated that the data system needed for the MHC would be “pricey” but, as mentioned above, the planned MHC had no funding at the time of the survey.

The Twentieth Circuit: St. Clair County Planned MHC. The Twentieth Judicial Circuit had a population of 373,555, and the MHC there was planned for St. Clair County, which had a population of 270,056 in 2010 (U.S. Census Bureau, 2010). Initially, the MHC intended to hear only cases from St. Clair County, but officials hoped to eventually expand the program's service area to other counties in the circuit. Officials in the Twentieth Circuit first planned to inaugurate an MHC program in 2008 after reading about MHC programs in general and more specifically about MHC programs in other Illinois jurisdictions. The Twentieth Circuit Court Chief Judge was leading the initiative to create an MHC, but the St. Clair County Mental Health Board Director, the Court Psychologist, the State's Attorney, the Public Defender, and representatives from the probation department, county jail, and mental health providers in the community were all engaged in program planning. The Twentieth Circuit official who responded to the survey, however, stated that the State's Attorney was less keen on establishing an MHC. The St. Clair County official indicated that MHC planners were applying for grant funding for a third time after state budget cuts had reduced probation staff. The lack of grant and other funding

was the only obstacle to launching the MHC program. The Winnebago County MHC served as the model for the planned St. Clair County MHC program.

The Twentieth Circuit official said that the date when the MHC planned to become operational was "unknown". MHC planners had also not yet determined whether the program would hear misdemeanor, felony, or both types of cases. Although hearing both types was "ideal," the program would probably start with only misdemeanor cases. Two drug court programs, one for juveniles and one for adults, were already operating in St. Clair County. When asked about the issue of separating offenders who have mental illness from those who have only a substance use disorder, the official explained that the MHC program would strive quickly to identity detainees with mental illness, remove them from the jail, and place them into treatment. The Twentieth Circuit official was concerned that defendants in jail for more than thirty days would lose their federal entitlements. According to the respondent, the MHC program would offer incentives to clients to encourage them to stay on prescribed medications by vacating their convictions or shortening their sentences. Prior to launching the MHC program, the respondent explained that officials in St. Clair County still needed to establish how the MHC would be funded. Competition for federal dollars was intense, as no money was available from the state to fund the MHC program.

The Circuit Court of Cook County: Skokie Village Planned MHC. The Circuit Court of Cook County had a population of 5,194,675 in 2010, most of it concentrated in the city of Chicago (U.S. Census Bureau, 2010). The screening survey elicited responses from the same Cook County Circuit official for two existing MHC programs, in Chicago and in Maywood, and for a planned MHC program in Skokie, which had a population of 64,784 in 2010 (U.S. Census

Bureau, 2010). The planned MHC program would serve not only Skokie but also other nearby suburbs in Cook County.

Officials in the Cook County Circuit started planning an MHC in Skokie in late 2007. The idea was raised by persons involved in running the MHC located in the felony courthouse in Chicago. Several judges and representatives from the State's Attorney's Office, the Public Defender's office, the Probation Department, the Illinois Division of Mental Health (DMH), Treatment Alternatives for Safe Communities (TASC, Inc.), and several community service providers were involved in planning the Skokie MHC. The Presiding Judge of the Second Municipal District of the Circuit Court and a local Illinois Department of Mental Health Coordinator were at the helm of the planning process. The Cook County Circuit Court official responded that "All [court staff] are enthusiastic but community providers less so" about implementing the Skokie MHC.

The Skokie MHC planned to begin operations in August 2010. The MHC program at the Felony Courthouse in Chicago served as the model for the Skokie MHC program. Unlike the existing Chicago program, the Skokie MHC planned to hear both misdemeanor and felony cases. The responding official explained that MHC referrals would be eligible only if the primary problem was a diagnosed mental illness other than a substance use disorder; nonetheless, a secondary diagnosis of a substance use disorder would be acceptable. The official reported that a "community service system" needed to be organized before the Skokie MHC program could become operational. The official noted the lack of "funding for providers and buy-in by them" might forestall the implementation of the MHC program.

Survey A: Nine Mental Health Programs (as of April 2010)

Survey A found that nine MHCs were operating in Illinois in spring 2010, including two programs in Cook County[1] and one each in DuPage, Kane, Lake, Madison, McHenry, Rock Island, and Winnebago counties. As presented in Figure 1, all nine of the MHCs identified in stage 1 of the study were located in mostly urban areas within their respective circuits. Specifically, all of the MHCs were in urban counties as defined by Office of Management and Budget criteria (Cromartie & Bucholtz, 2008), and five of the programs were located in one-county judicial circuits and four in multicounty-judicial circuits. Only one program located in a multi-county judicial circuit was in a rural county (Whiteside County in the Fourteenth Judicial Circuit). Two programs were located in mixed suburban and rural communities; five programs were in suburban communities; and the first MHC program in Chicago was located in an exclusively urban environment.

Implementation Dates and Planning Processes

The DuPage County Mental Illness Court Alternative Program (MICAP) accepted its first participant in January 2004, and the Cook County Felony MHC in Chicago accepted its first participant a few months later. Four of the courts accepted their first participant in 2007. The most recent of the nine MHCs to accept its first participant was the other Cook County MHC, known as the "West Suburban MHC," which is located in the courthouse in Maywood. It became operational in August 2008. Thus, all nine of the programs had been operational for at least a year-and-a-half at the time of the survey.

[1] The Circuit Court of Cook County has an MHC program at 26th St. and California Ave. in Chicago, which is divided into a women's MHC and a men's MHC. However, one survey was conducted for this program as both men's and women's MHCs are operated with the same model and personnel except for the judges, which allowed for the numbers to be presented collectively for the survey. The second MHC program in Cook County is located in the suburb of Maywood and is designed to serve the western suburbs of Chicago.

Seven of the officials reported that a formal needs assessment was conducted in their jurisdictions to determine whether an MHC program was an appropriate and necessary sentencing alternative. Of the two jurisdictions that conducted no formal assessment, one reported that an investigation of jail admissions indicated that many persons with untreated serious mental illness were frequently recycling in and out of detention. Thus, the need for an MHC Program was established. In the other jurisdiction, the need for an MHC was recognized after a local NAMI representative contacted the State's Attorney's Office to discuss the "criminalization of the mentally ill. "All of the respondents reported that they informed law enforcement agencies about the proposed MHC program.

Almost all of the courts reported that they sought consultation regarding how to design the program before the MHC was established. Some consultation was solicited from extra-local sources, whereas other consultation was solicited from local sources, either from staff in their own court system or from stakeholders in their own communities. For example, officials who designed the Cook County Felony MHC consulted with Cook County Drug Court and other court personnel in the circuit as well as local mental health service providers, administrators from the Illinois Division of Mental Health, TASC, and the Chicago Police Department. In Kane County, court officials used literature from the Bureau of Justice Assistance for guidance in designing their MHC.

A steering committee consisting of Lake County court and mental health system personnel explored the need for an MHC there before developing the model for the Therapeutic Intensive Monitoring (TIM) Program. In Madison County, a team of probation staff, including a mental health specialist, a supervisor, and the Chief Probation Officer, met for a year to design the program with input from various stakeholders, and adapted court order and sanction

recommendations from officials in the Winnebago County Therapeutic Intervention Program (TIP). A Rock Island County MHC team traveled to other Illinois counties to observe and learn from these MHCs while meeting regularly to develop formal program policies and procedures. The Winnebago County respondent explained that court officials there conducted eighteen months of MHC planning activities with community stakeholders, meeting with more than 80 different representatives while formulating the structure and operations of the program.

MHC Models

All nine Illinois MHCs had elements that were consistent with the prevailing operational definition of an MHC (Redlich et al., 2006). For example, all had separate dockets for criminal defendants with mental illness and attempted to divert participants from incarceration to community-based supervision and mental health treatment. Such treatment was mandated by the court, supervised by program staff (within and outside the court system), and documented in court hearings. Staff of the Illinois MHC programs, including judges, probation officers, mental health providers, and others, offered praise and encouragement to participants for following program guidelines and rules while also enforcing sanctions for noncompliance with program conditions. All of the Illinois MHCs were voluntary; eligible defendants could choose to participate or not. Although Illinois MHCs shared these elements, the current research revealed a number of differences in program structure and operations among the nine programs.

Two generations of MHCs were identified in a nationwide study using a sample of eight MHCs started during the 1990s and another seven MHCs started after the Bureau of Justice Administration offered their first round of MHC funding in 2002 (Redlich et al., 2005). Most of the first-generation MHCs heard only misdemeanor cases, were more likely to adopt pre-adjudication than post-adjudication court models, and rarely used jail as a sanction. Half relied

on supervision by community providers rather than by probation officers. In contrast, all of the second-generation MHCs accepted felony cases and all but one adopted a post-adjudication model. The second-generation MHCs more readily employed jail time as a sanction, and a majority appointed court personnel or probation officers as the responsible agents for client supervision.

The current survey of the nine Illinois MHCs that were established between January of 2004 and August 2008 showed that most (but not all) were employing second-generation MHC models (Redlich et al., 2005). For example, all of the Illinois MHCs accepted offenders charged with felonies, with the two programs in Cook County accepting only felony cases and the rest accepting both misdemeanor and felony cases. In addition, only one Illinois MHC had a pre-adjudication model, the DuPage County MICAP. Four MHCs utilized both pre- and post-adjudication models, and the other four MHCs were post-adjudication-only in nature.

Two of the more recently implemented MHCs, the ones in McHenry County and in Kane County, employed a post-plea/pre-sentence model; participants plead guilty to enter the program but could have their sentences deferred. Charges could be dismissed or reduced for participants who successfully completed the McHenry County or Kane County MHC. The two Cook County programs adopted post-plea adjudication strategies in which defendants with mental illness plead guilty and then were sentenced to participate in the MHC as a condition of probation. The screening survey did not ask about use of jail time as a sanction; nonetheless, this question was explored in focus group interviews, and only one program, the Madison County MHC, did not use jail time as a sanction for participants.

As mentioned above, Illinois MHCs embodied most of the characteristics of second-generation of MHC models (Redlich et al., 2005), hearing felony cases, adopting post-

adjudication models, and employing jail as a sanction for noncompliance with conditions. However, not all relied on court personnel for client supervision. Only three of the nine MHCs relied primarily on probation officers or other court personnel for monitoring and supervising participants; these programs also had mental health workers, outside the court system, engage in the case management of clients. The remaining six programs relied on a combination of court personnel and community or county mental health providers for monitoring and supervision of participants.

Most of the MHC designs followed some type of established model. The MHCs in Cook County, Madison County, and Lake County were modeled after their respective drug courts. McHenry County modeled its program after the Ten Essential Components of an MHC defined by the Council of State Governments Justice Center and published in a BJA report (Council of State Governments, 2007). Four courts reported modeling their court after other Illinois MHCs, with the Winnebago County TIP being named as the most frequently adopted model.

Eligibility and Entry

All nine MHC programs required clinical criteria for eligibility and accepted persons with Axis I Diagnoses. Two of the MHCs—the DuPage County MICAP and the Lake County Therapeutic Intensive Monitoring (TIM)—accepted participants with any Axis I (e.g., attention-deficit and disruptive behavior disorders, substance-related disorders, schizophrenia, mood disorders, and anxiety disorders) or Axis II psychiatric diagnosis (e.g., paranoid, schizoid, antisocial, borderline, and obsessive-compulsive personality disorders) (American Psychiatric Association, 2000). Officials at five of the MHCs specified the Axis I diagnoses corresponding to state criteria for serious and persistent mental illness. None of the courts excluded individuals if they had a co-occurring substance use disorder. Most of the MHCs excluded individuals from

eligibility if they had primary developmental disabilities, primary substance use disorders, or traumatic brain injuries. Most of the court programs had no standard protocols for establishing the legal competence of potential participants. Instead, the state determined legal competence before an individual was referred to the court program. In all of the MHCs, community mental health service providers conducted a mental health screening to determine an individual's eligibility after referral to the program. Most MHCs conducted a comprehensive psychiatric assessment before determining eligibility, using either community mental health providers or court staff. Other MHCs conducted the assessment after a participant had been accepted into the MHC or after eligibility had been determined but before a participant had been accepted into the program.

Officials at three programs reported that more than fifty percent of referrals enter their respective MHCs, whereas the other six programs reported that less than half of the referrals enter the program. Six programs relied on defense attorneys as the most common source of referral to the MHC, whereas the respondent from Cook County stated that jail staff was the most common referral source for the MHCs in Chicago and Maywood. The respondent from the Rock Island County MHC, known as the "Live It Fully Everyday" (LIFE) program, indicated that pretrial services was the most common referral source. The length of time from referral to acceptance into the MHC took between one and two months for five of the programs, two to four months in the DuPage County MICAP, ninety days in the Kane County Treatment Alternative Court (TAC), three weeks in the Rock Island County LIFE, and one to two weeks in the Madison County MHC. In all nine programs, defense counsel helped potential participants decide whether they should enter the MHC.

Six MHCs offered a separate specialized probation program for offenders with mental illness as a possible option for referrals who were not accepted into the MHC. DuPage County's specialized probation differed from its MHC in that the probation program required mental health treatment as a condition of probation after a conviction was entered, whereas the MICAP was a pre-adjudication model. For both locations in Cook County, specialized probation was simply described as “a less intensive option” than the MHC for offenders with mental illness. In three of the jurisdictions, defendants with mental illness who were not accepted into the MHC were without the option of a specialized probation program. The official from Rock Island County explained that if a person is sentenced to standard probation and has a serious mental illness, the MHC probation officer supervises the case instead of a standard probation officer.

Participants

A total of 302 clients were participating in the nine MHC programs at the time of the survey: 163 (54%) men and 139 (46%) women; 173 participants were white (58%), 99 African American (34%), and 7 Asian (3%). The number of Latino participants in Illinois MHCs was 11(4%).The age distribution of MHC participants was skewed toward younger age categories: 77 of the participants were between ages 17-25 (26%), 74 between ages 26-35 (25%), 69 between ages 36-45 (23%), 60 between ages 46-55 (20%), and 7 between ages 56-65 (2%). At the time of the survey, the smallest of the nine programs was the Madison County MHC, which had 5 active participants; the largest was the DuPage County MICAP, which had 102 active participants.

Of the total 302 participants in the nine MHCs, 115 (38%) had been charged with misdemeanor offenses and 187 (62%) had been charged with felonies. Pursuant to Illinois statute, persons charged with a felony sex offense, driving under the influence of drugs/alcohol, armed robbery, or home invasion are ineligible for participation in MHC (730 ILCS 168/)

Mental Health Court Treatment Act). Four MHCs were willing to accept for program participation persons charged with violent offenses other than those listed in the statute, whereas the remaining five programs excluded from program participation persons charged with violent felonies. All MHCs excluded from program participation individuals with histories of sex offenses. Six MHCs excluded from program participation persons with histories of arson offenses, while five MHCs excluded persons with histories of violent crime. Two MHCs excluded persons with histories of “driving under the influence”.

All but one of the jurisdictions, the Twenty-Second Circuit (McHenry County) had a drug court.[2] The survey asked officials in jurisdictions with drug courts how participants served by the drug court differed from the participants served by the MHC. Officials responding for three of the programs explained that they differentiated defendants for drug court or MHC based on whether substance abuse was the sole or primary diagnosis as opposed to another psychiatric diagnosis. The participant from Madison County explained that the MHC there is geared toward diversion whereas the drug court had stricter sanctions and significantly longer periods of supervision.

In Rock Island, the MHC accepted offenders charged with misdemeanors and felonies, whereas the drug court accepted only offenders charged with felonies. Winnebago County officials "try to coordinate the participation [in specialty court or probation] based on need and defendants' specific issues—which program can best address needs." In DuPage County, drug court defendants enter a guilty plea even though MISA services could be provided and the plea could be withdrawn on successful completion, whereas no plea was entered when defendants were accepted into the MICAP, and a nexus between mental illness and the instant offense was

[2] Twenty-second Circuit-McHenry County officials have since established a drug court program, which began operating in late 2011.

necessary for acceptance into the program. The official from Lake County explained that all their drug court offenders were high-risk, felony, post-plea cases, whereas their mental health court (TIM) cases could be low-, medium-, or high-risk offenders, felony or misdemeanor, and pre- or post-plea; however mental illness must have contributed to their criminal justice system involvement.

Court Hearings, Length of Participation, and Phases

Programs varied in how often they held MHC hearings, from twice weekly to twice monthly. The conditions of participation for most of the courts were standardized but individualized elements were routinely added to clients' supervision plans. The DuPage County MICAP was the only MHC that did not use a standard, formal written contract between the court and the participant. All of the MHCs obtained some form of written consent from participants to release personal information. In four of the MHCs, court-supervised treatment information became part of the participants' court record.

Two MHCs—the Lake County TIM and Winnebago County TIP—had no established minimum or maximum time periods for participation. Other MHCs had minimum time requirements for participation, ranging from six to twelve months, and maximum time limits, ranging from 24 to 30 months. Almost all of the MHCs had an average length of participation in the program of one to two years, but the Madison County MHC reported only a six-month to one-year average length of participation.

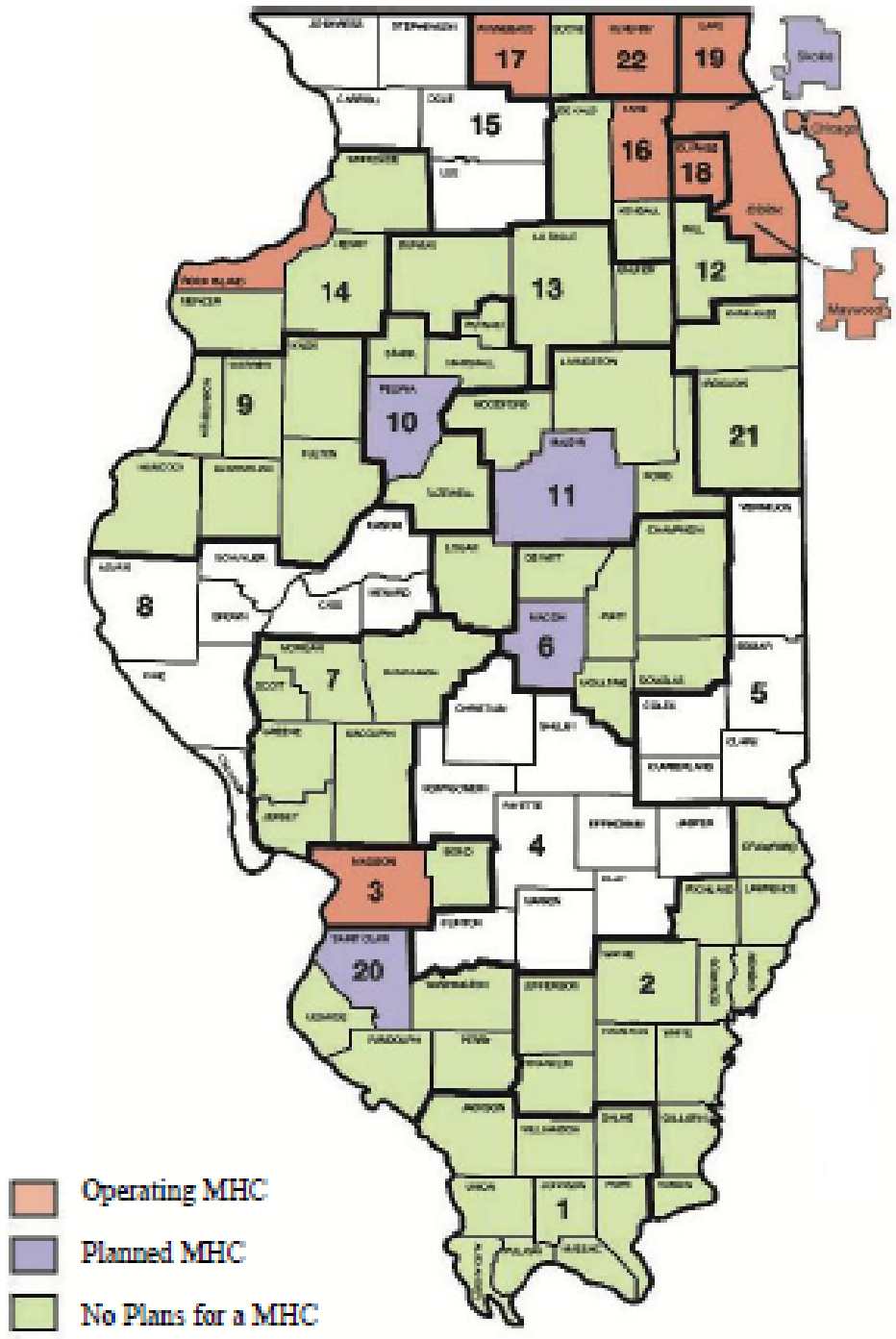
Five of the MHC programs had no structured phases of supervision, whereas four had such phases. Specifically, McHenry County MHC had 4 phases and the remaining three MHCs had three phases: the Kane County TAC, the Rock Island LIFE, and the Winnebago County TIP. All of the programs with structured phases progressively decreased the level of supervision by

lessening the required frequency of probation visits and court appearances. Typically, new participants in the first phase were required to attend hearings weekly and visits with probation officers or community supervision staff at least weekly or more often, while each successive phase reduced the frequency of required visits to a biweekly and then monthly basis.

MHC Funding

Officials reported using a variety of sources to fund their MHCs. The most common sources of funding included dedicated county funding, federal grants, 708 Board funding, and in-kind contributions in terms of personnel and other agency resources. Indeed, officials at six MHCs reported that the biggest challenge to launching and sustaining their programs was the lack of resources. Five officials reported that a dearth of mental health resources was the biggest challenge to operating their MHCs, while two officials responded that the biggest challenge to operating their programs was the difficulty of getting stakeholders to collaborate.

Figure 1. Map of Illinois Juristictions: Counties with Operating and Planned MHCs and Counties with No Planned MHCs as of April, 2010



Summary of Program Eligibility Criteria and Referral Sources

- Voluntary Client Participation (all 9 courts)
- Preadjudication Only (1 court)
- Postadjudication Only (4 courts)
- Pre-and Post-Adjudication (4 courts)
- Specialized Probation Program as Option to MHC in Jurisdiction (6 courts)
- Drug Treatment Court as Option to MHC in Jurisdiction (8 courts)
- Defense Attorneys Most Common Referral Source (6 courts)
- Jail Staff Most Common Referral Source (1 court)
- Pretrial Services Most Common Referral Source (4 courts)
- Accepts Violent Felony Cases Other than Those Precluded by Statute (4 courts)
- Accepts Felony Cases Only (1 court)
- Accepts Felony and Misdemeanor Cases (8 courts)
- Accepts Clients with Axis I Diagnoses (all 9 courts)
- Accepts Clients with any Axis I or Axis II Diagnoses (2 courts)
- Accepts Clients with Defined Serious and Persistent Mental Illness (5 courts)
- Accepts Clients with Co-Occurring Substance Use and other Psychiatric Disorders (all 9 courts)
- Histories Excluded: Sex Offenses (all 9 courts), Arson (6 courts), DUI (2 courts)
- Accepts Clients with primary Developmental Disorders, Substance Use Disorders, or Traumatic Brain Injury (2 courts)

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CHAPTER THREE

SOCIAL SERVICES PROVIDER SURVEY

Methodology

Instrumentation

The Social Services Provider Survey examined resources and services provided to MHC clients as well as the working relationships between service providers and MHC team members. Survey questions were clustered by service type, and closed-ended response options were added to many sections of the survey in order to reduce item ambiguity. The survey was conducted by telephone. Questions were parallel in sequencing, formatting, and wording but also adapted to meet the intent of specific items. For example, different services required slightly different answers based on "field-standard" lengths of participation (i.e., inpatient treatment) versus non-standard or more fluid services (i.e., case management).

The survey section entitled "Recovery Support Services" grouped certain services under headings; a "Does Not Apply/Not Offered" response option was added so that the subparts would be applicable to different participants. Specific service types were also grouped to comport with national Consensus Project categories. This was considered to be a critical feature of the instrument, as most MHC social service providers are familiar with these categories. In addition, this feature of the survey helped the research team describe in its analyses those services expressly identified as "crucial" or "best" approaches.

The opened-ended questions of the survey asked about evidence-based and other community services available to clients as well as program efforts to modify or to maintain fidelity to those practices. All other questions were asked in a closed-ended format to standardize survey administration and to facilitate data analyses. Questions designed to assess how much or

often services are utilized were similarly collapsed into categories (e.g., less than 25%, 25–50%), so that answers would not be highly subjective or widely varied and the questions would not require an inordinate amount of time to answer. The Social Services Provider survey examined four primary research questions:

- How does each MHC operate in terms of client assessment, service planning and delivery as well as client monitoring and sanctioning for non-compliance and termination?
- How well do MHC programs identify and provide services, perform coordinated case management, and fill gaps in services?
- What community-based services are available to MHCs, and how are they utilized managed, and funded?
- Are evidence-based practices being implemented in MHCs (motivational interviewing in order to improve treatment engagement and retention, trauma-informed services, etc.)?

The Social Services Provider consisted of three principal content domains: treatment and case management, recovery support services, and evidence-based practices. The instrument assessed for each MHC: available services; modes of service delivery (i.e., through MHC providers [MHC team "partner agencies"] or brokerage with external community agencies); the typical percentage of each type of service used; the adoption of evidence-based or best practice models or approaches as well as any special efforts to modify or adapt these models to ensure fidelity; and any additional services or resources provided to MHC clients in their communities. A copy of the survey is in Appendix A.

Procedures

Participants for the service provider survey phase of the study were identified through MHC observations and discussions with MHC team members, judges, focus group subjects, and

other MHC staff. In some jurisdictions, MHCs have one designated provider responsible for service delivery and referrals as well as client monitoring; in others, an MHC-appointed individual (e.g., service coordinator, court administrator) plays a central role in monitoring clients' service needs and the provision of client services. Nine out of nine jurisdictions participated in the Social Services Provider survey.

Following a specific script, social service agency representatives were contacted by phone or email to explain the study, to confirm participation, and to schedule appointments to conduct the telephone survey (see Appendix A). Due to the level of survey detail, which involved questions about data, such as the percentages of client service utilization, many respondents were sent electronic copies of the survey prior to the arranged appointment times in order to allow them to compile data in advance. In most cases, survey responses reflected operational and client service information since each MHC's inception.

Respondents were called by a researcher at pre-arranged times, and a brief overview of the purpose of the study and the survey was presented. Agency representatives were asked if they had any questions. After these were addressed, verbal consent was formally obtained by verifying that each respondent agreed to participate in the survey and then documenting each respondent's consent. Respondents were then told that they could ask for clarification on survey items at any point during the interview process; expanded answers to questions were noted and summarized at the end of the survey.

Data were entered, stored, and analyzed in SPSS. Survey data were reviewed and cleaned prior to analyses. Descriptive statistics were run on each survey section (Tables 1 and 2 present the Social Services Provider survey results.) Open-ended responses were explored for themes and grouped by response type for tabulation purposes.

Results

The following analyses detail service provision and utilization, and specific service-related practices in the state's operational MHCs. Service coordination is also described among the MHC team members and community-based partners. In addition, the strengths and challenges of service provision are noted in the different jurisdictions.

Assessment, Case Management, and Treatment: Service Availability and Delivery

All nine MHCs surveyed (100%) reported that the following key treatment and case management services are available to MHC clients:

- Psychiatric/psychosocial assessments
- Case management
- Emergency stabilization (crisis management) services
- Inpatient mental health treatment
- Outpatient mental health treatment
- Residential substance abuse treatment
- Intensive outpatient substance abuse treatment (IOP)
- Outpatient substance abuse treatment

Of the remaining service categories, seven of the nine MHCs provided partial (day) hospitalization services, and five of the nine reported that inpatient substance abuse treatment services were available. (See Table 1 for a detailed description of service availability and use statewide.) **For ease of reporting and discussion, the operational MHCs are referred to as MHCs 1-9.**

Service Delivery

Assessment and Case Management Services. Four MHCs (MHCs 2, 3, 4, and 5) reported having direct MHC partner agencies that deliver psychiatric/psychosocial assessments, and four MHCs (MHCs 6, 7, 8, and 9) utilized both partner and external agencies to provide these services. Four MHCs also had direct partners that provided case management (MHCs 2, 3, 4, and 6), and four MHCs used both partner and external agencies (MHCs 5, 7, 8, and 9). MHC 6 reported utilizing both direct partners and external agencies for assessments, and had a direct MHC partner for the provision of case management services; MHC 1 relied only on external referrals for both of these service types.

Mental Health Treatment Services. Of the mental health treatment services offered, MHCs 2, 3, 4, and 5 again reported having direct MHC partners that deliver emergency stabilization/crisis management services. MHC 1 provided these services through external referrals, and MHCs 6, 7, 8, and 9 used a combination of both. Inpatient mental health treatment was delivered exclusively through a direct partner in MHC 2; other jurisdictions either used external sources for these services (MHCs 1, 3, 5, and 7) or offered them through both partner and external providers (MHCs 4, 6, 8, and 9).

Outpatient mental health treatment was provided to clients directly through partners in three MHCs (MHCs 2, 3, and 4), through external referrals in three MHCs (MHCs 1, 8, and 9), and through a blend of both in three MHCs (MHCs 5, 6, and 7). Of the seven MHCs that offered partial (day) hospitalization services, MHCs 2 and 3 had established partners, MHCs 5, 7, 8, and 9 used external providers, and MHC 6 used both a direct partner and outside resources.

Substance Abuse Treatment Services. With respect to substance abuse treatment, MHCs 2 and 3 provided residential treatment through MHC partner agencies, but external

linkages were used in six MHCs (MHCs 1, 4, 5, 7, 8, and 9). Again, MHC 6 used both direct and external providers for these services. Intensive outpatient (IOP) treatment and outpatient treatment was delivered by direct partners in MHC 4, by external partners in MHCs 1, 8, and 9, and by a combination of direct and external agencies in MHCs 3, 6, and 7. MHC 2 had a direct MHC partner that provided IOP treatment services, but used both partner and external providers for outpatient substance abuse treatment; MHC 5 relied on external providers for IOP, but offered outpatient treatment through a combination of partner and external sources.

Five MHCs offered inpatient substance abuse treatment: MHCs 5, 7, 8, and 9 used external agencies while MHC 6 had both a direct partner and external providers. Overall, the central assessment, case management, and treatment services described were primarily delivered by direct MHC partners in four Illinois MHCs (MHCs 2, 3, 4, and 5), with the remaining five MHCs reporting using multiple providers for these services.

Service Utilization

Psychiatric/Psychosocial Assessments. All MHCs reported that 76–100% of clients received psychiatric/psychosocial assessments and that they received these services at varying points in programming. Clients in eight of the nine MHCs received assessments at intake, and three of the nine MHCs reported providing assessments at established time frames.

Case Management. In most (i.e., eight) of the MHCs surveyed, case management was provided to 76–100% of MHC clients; in one MHC, 25–50% received these services. All MHCs reported that participants received these services throughout programming and case management was available to clients beyond direct MHC participation.

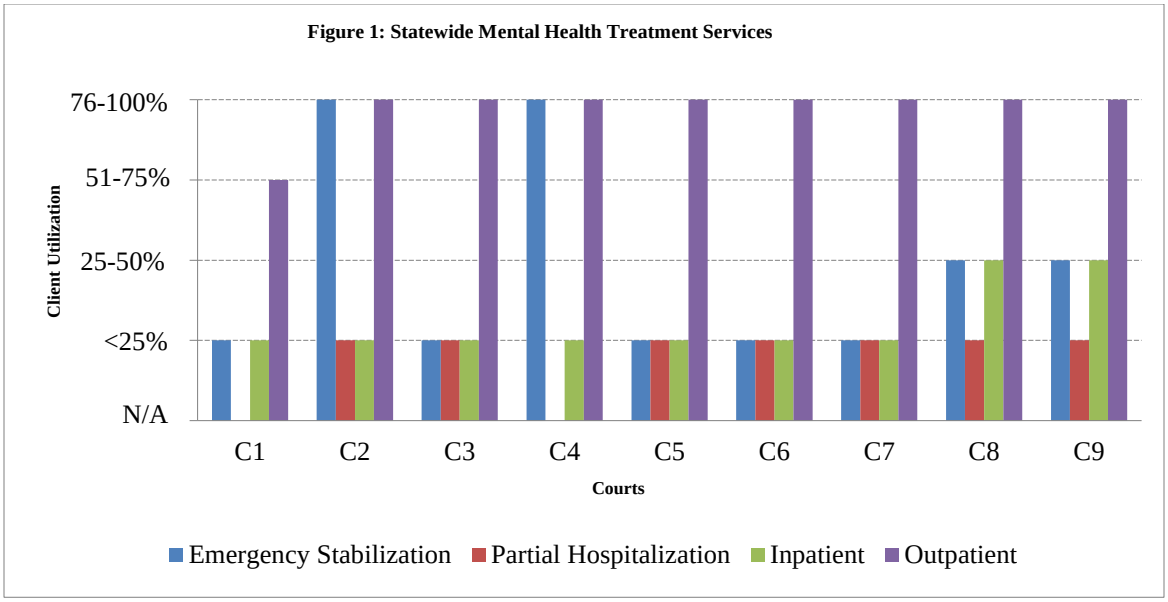
Emergency Stabilization (Crisis Management) Services. Only two of nine MHCs reported the utilization of emergency stabilization/crisis management services by 76–100% of

MHC clients. Two MHCs reported that 25–50% of clients received these services and more than half (i.e., five) reported that less than 25% of clients received emergency stabilization. Of the MHC participants receiving such services, 51–75% were reported as requiring more than one episode in two MHCs while less than 25% of clients required more than one episode in the majority of MHCs (i.e., seven).

Partial (Day) Hospitalization. Less than 25% of MHC clients received partial (day) hospitalization services in the seven MHCs in which it was available. Three MHCs were unsure about the average lengths of stay for clients, and the others reported ranges of less than one week (i.e., one MHC) to 8–30 days (i.e., three MHCs).

Inpatient Mental Health Treatment. The majority of MHCs surveyed (i.e., seven) reported that less than 25% of participants in their programs received inpatient mental health treatment, with two MHCs estimating utilization of these services at 25–50%. The average lengths of stay in inpatient mental health treatment varied among MHCs, with one MHC reporting 31–60 days, four MHCs reporting 8–30 days, and four MHCs reporting less than one week.

Outpatient Mental Health Treatment. Only one MHC reported that 51–75% of clients received outpatient mental health treatment. Overwhelmingly, 76–100% of clients received these services in the eight other MHCs, with most of these MHCs stating a service utilization rate of 100%; all received treatment throughout MHC programming. As reported, the numbers of clients who required more than one episode of treatment varied substantially among MHCs, from 76–100% (four MHCs) to 51–75% (one MHC), 25–50% (one MHC), and less than 25% (two MHCs); one MHC responded “not sure” to this survey question. Figure 1 provides an overview of client utilization across jurisdictions for key mental health treatment services.



Residential Substance Abuse Treatment. One MHC reported that 25–50% of clients required residential substance abuse treatment, but six MHCs reported that less than 25% of clients required this service. In contrast, the other two MHCs surveyed responded that 76–100% of their clients required residential treatment and that 51–75% required more than one episode. Four of the respondents stated that the average length of time clients participated in residential treatment was 8–30 days, followed by 31–60 days in two MHCs, and 61–90 days in three MHCs.

Inpatient Substance Abuse Treatment. Only five respondents reported that their MHC clients received inpatient substance abuse treatment, and service utilization rates were very different among the MHCs. Two MHCs reported that 76–100% of clients received this service; one MHC reported that 25–50% of clients received this service, and the other two MHCs reported less than 25% of their clients received this service.

Intensive Outpatient Substance Abuse Treatment (IOP). In most MHCs (i.e., six), 25–50% of MHC participants were reported as requiring IOP services. Of the remaining MHCs, one reported that 76–100% of its clients required IOP (with the same percentage reported as

requiring more than one episode); the other two MHCs reported that less than 25% of their participants required IOP services. Notably, while five MHCs reported that less than 25% of participants required more than one episode of IOP, three MHCs estimated that 25–50% of their clients required more than one episode of treatment, including one MHC that reported an initial IOP utilization rate of less than 25%.

Outpatient Substance Abuse Treatment. When asked about the percentages of MHC clients who required outpatient substance abuse treatment services, survey responses varied widely. Three MHCs reported that 76–100% of clients required outpatient treatment (with one estimating 51–75% and two estimating 76–100% of MHC clients participating in more than one episode of treatment). Five MHCs reported utilization at 25–50% and were fairly evenly split on client percentages requiring multiple episodes of treatment (between 25–50% and less than 25%). In one MHC, less than 25% of participants receive outpatient substance abuse treatment. Six of the nine MHCs surveyed reported that clients typically participated in outpatient substance abuse treatment throughout programming; whereas the remaining three MHCs indicated that their clients participated in these services for only limited periods of time. A description of client utilization among jurisdictions for key substance abuse treatment services is shown in Figure 2.

Figure 2: Statewide Substance Abuse Treatment Services

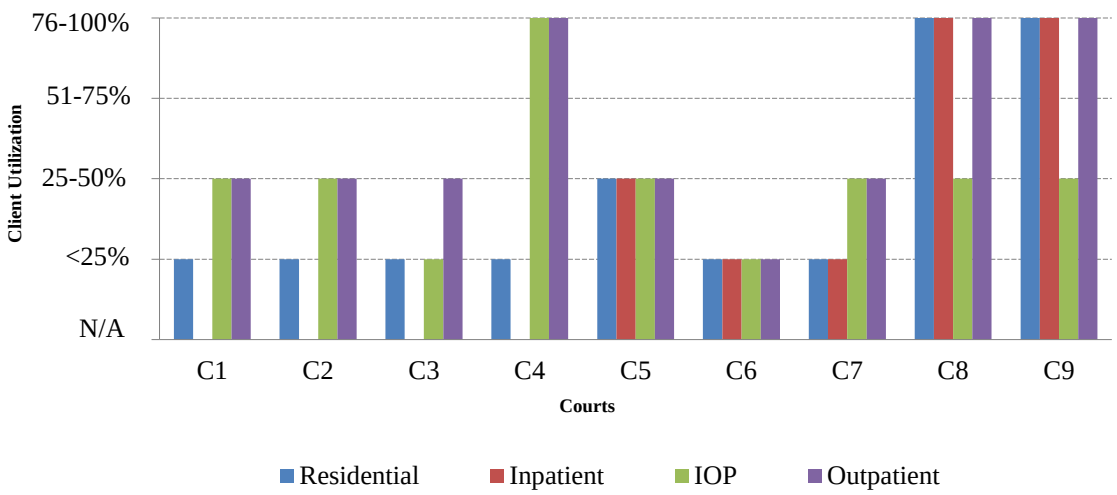


Table 1. Statewide Social Services Provider Survey Responses: Assessment, Case Management and Treatment Services Data Output

Assessment and Case Management Services	C1	C2	C3	C4	C5	C6	C7	C8	C9	Total
Psychiatric/ Psychosocial Assessments										
✓ By Partner Agencies, External Ref/linkage, Both or N/A	External	Partner	Partner	Partner	Partner	Both	Both	Both	Both	**All 9**
✓ Percent that receive assessments	76-100%	76-100%	76-100%	76-100%	76-100%	76-100%	76-100%	76-100%	76-100%	
✓ Assessment conducted at:										
- Intake?	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**8 of 9**
- Established time frames?	No	Yes	Yes	Yes	No	No	No	No	No	**3 of 9**
- Varying points in program?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**All 9**
Case Management										
✓ Provided by PA, External Ref/linkage, Both or N/A	External	Partner	Partner	Partner	Both	Partner	Both	Both	Both	**All 9**
✓ Percent that receive case management	76-100%	76-100%	76-100%	76-100%	25-50%	76-100%	76-100%	76-100%	76-100%	
✓ Case managed throughout program	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**All 9**
✓ Case management available beyond participation	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**All 9**
Mental Health Treatment Services	**C1**	**C2**	**C3**	**C4**	**C5**	**C6**	**C7**	**C8**	**C9**	**Total**
Emergency Stabilization (crisis management)										
✓ Provided by PA, External Ref/linkage, Both or N/A	External	Partner	Partner	Partner	Partner	Both	Both	Both	Both	**All 9**
✓ Percent that that receive services	<25%	76-100%	<25%	76-100%	<25%	<25%	<25%	25-50%	25-50%	
✓ Percent that require more than one episode	<25%	51-75%	<25%	51-75%	<25%	<25%	<25%	<25%	<25%	
Partial (Day) Hospitalization										
✓ Provided by PA, External Ref/linkage, Both or N/A	N/A	Partner	Partner	N/A	External	Both	External	External	External	**7 of 9**
✓ Percent that that receive services	--	<25%	<25%	--	<25%	<25%	<25%	<25%	<25%	
✓ Avg. LOS	--	8-30 d	Not sure	--	8-30 d	8-30 d	≤1wk	Not sure	Not sure	
✓ Percent that require more than one episode	--	<25%	Not sure	--	<25%	<25%	<25%	<25%	<25%	
Inpatient Mental Health Treatment										
✓ Provided by PA, External Ref/linkage, Both or N/A	External	Partner	External	Both	External	Both	External	Both	Both	**All 9**
✓ Percent that that receive services	<25%	<25%	<25%	<25%	<25%	<25%	<25%	25-50%	25-50%	
✓ Avg. LOS	≤1wk	≤1wk	8-30 d	8-30 d	≤1wk	31-60 d	≤1wk	8-30 d	8-30 d	
✓ Percent that require more than one episode	<25%	<25%	<25%	<25%	25-50%	<25%	<25%	<25%	<25%	
Outpatient Mental Health Treatment										
✓ Provided by PA, External Ref/linkage, Both or N/A	External	Partner	Partner	Partner	Both	Both	Both	External	External	**All 9**
✓ Percent that that receive services	51-75%	76- 100%	76-100%	76-100%	76-100%	76-100%	76-100%	76-100%	76-100%	
✓ Receive services throughout participation in MHC	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
✓ Percent that require more than one episode	51-75%	<25%	<25%	76-100%	76-100%	Not Sure	25-50%	76-100%	76-100%	

Table 1. Statewide Social Services Provider Survey Responses: Assessment, Case Management and Treatment Services Data Output

Substance Abuse Treatment Services	C1	C2	C3	C4	C5	C6	C7	C8	C9	Total
Residential Treatment										
✓ Partner Agencies, External Ref/linkage, Both or N/A	External	Partner	Partner	External	External	Both	External	External	External	**All 9**
✓ Percent that require services	<25%	<25%	<25%	<25%	25-50%	<25%	<25%	76-100%	76-100%	
✓ Avg. LOS	8-30 d	8-30 d	61-90 d	8-30 d	31-60 d	31-60 d	8-30 d	61-90 d	61-90 d	
✓ Percent that require more than one episode	<25%	<25%	<25%	<25%	<25%	<25%	<25%	51-75%	51-75%	
Inpatient Treatment										
✓ Partner Agencies, External Ref/linkage, Both or N/A	N/A	N/A	N/A	N/A	External	Both	External	External	External	**5 of 9**
✓ Percent that that receive services	--	--	--	--	25-50%	<25%	<25%	76-100%	76-100%	
✓ Avg. LOS	--	--	--	--	31-60 d	31-60d	8-30 d	61-90 d	61-90 d	
✓ Percent that require more than one episode	--	--	--	--	<25%	<25%	<25%	51-75%	51-75%	
Intensive Outpatient (IOP) Treatment										
✓ Partner Agencies, External Ref/linkage, Both or N/A	External	Partner	Both	Partner	External	Both	Both	External	External	**All 9**
✓ Percent that that require services	25-50%	25-50%	<25%	76-100%	25-50%	<25%	25-50%	25-50%	25-50%	
✓ Avg. LOS	30-60 d	30-60d	>60 d	30-60 d	30-60 d	30-60d	30-60 d	30-60 d	30-60 d	
✓ Percent that require more than one episode	<25%	<25%	25-50%	76-100%	<25%	<25%	<25%	25-50%	25-50%	
Outpatient Treatment										
✓ Partner Agencies, External Ref/linkage, Both or N/A	External	Both	Both	Partner	Both	Both	Both	External	External	**All 9**
✓ Percent that that require services	25-50%	25-50%	25-50%	76-100%	25-50%	<25%	25-50%	76-100%	76-100%	
✓ Offered through program participation or a limited time	Through	Through	Limited	Through	Through	Limited	Limited	Through	Through	
✓ Percent that require more than one episode	<25%	<25%	25-50%	51-75%	25-50%	<25%	25-50%	76-100%	76-100%	
Services are primarily delivered through one service Provider or Multiple Service Providers	Multiple	One	One	One	Multiple	Multiple	Multiple	Multiple	Multiple	

Recovery Support Services: Services Availability and Delivery

All (9/9) of the MHCs surveyed reported that the following recovery support services are offered to MHC clients.

- Psychotherapeutic services
- Housing services, including assistance with locating housing (six MHCs also provide assistance with financing housing)
- Securing medication/medication compliance
- Psychosocial rehabilitation services
- Benefits assistance, including both education on benefits as well as assistance in accessing or enrolling in benefits
- Self-help, peer-support groups, and/or mentoring

Of the remaining service categories:

- Employment and educational services are provided in eight of the nine MHCs (seven MHCs provide linkages to local high schools or colleges and GED preparation and testing while six MHCs offer vocational or employment training and supported employment or job placement);
- Transportation assistance (e.g., bus/train fare, ride to program-related appointments) is available in seven of the nine MHCs;
- Family services (e.g., child care, elder care, reunification programs) are available in five of the nine MHCs; and
- Civil services/legal assistance is offered in eight of the nine MHCs.

Table 2 provides a detailed breakout of service availability and use statewide.

Service Delivery

Mental Health Services. When asked about the mental health-related recovery support services offered, MHCs 2, 3, 4, and 5 reported using direct MHC partners to deliver psychotherapeutic services. MHC 1 provided these services through external referrals, and MHCs 6, 7, 8, and 9 used a combination of both. Five MHCs (2, 3, 4, 5, and 7) also offered assistance in securing medications/medication compliance through partner agencies, while the other MHCs used external referrals (MHCs 1 and 6) or a combination of MHC partner and non-partner agencies (MHCs 8 and 9).

MHCs 2, 3, 4, 5, and 7 also had direct partner agencies that provided psychosocial rehabilitation services, while four MHCs relied on external providers (MHCs 1, 6, 8, and 9). The provision of self-help or support groups and mentoring services were provided through external referrals in four of the MHCs surveyed (MHCs 1, 6, 8, and 9), while MHCs 3 and 4 had direct partners and MHCs 2, 5, and 7 used both direct and non-partner linkages for these services.

Housing, Employment, and Educational Services. Only one MHC (MHC 4) reported having a sole partner providing housing services to clients; four MHCs made external referrals (MHCs 1, 3, 8, and 9), and four MHCs used direct partners and external providers (MHCs 2, 5, 6, and 7). Of the eight MHCs that offered employment and educational services, MHC 4 was, again, using an MHC partner; the other jurisdictions either used external partners for these services (MHCs 1, 8, and 9) or offered them through both partner and external providers (MHCs 2, 5, 6, and 7).

Additional Recovery Support Services. Four MHCs (MHCs 2, 3, 4, and 5) reported having direct MHC partner agencies that provided benefits assistance services; MHCs 1 and 6 relied on external referrals for such services while MHCs 7, 8, and 9 used both partner and

external agencies to provide these services.

Seven MHCs provided transportation assistance through either direct MHC partners (MHCs 2, 3, and 4), external linkages (MHCs 1 and 6), or both (MHCs 5 and 7). Likewise, civil services/legal assistance was provided by eight MHCs statewide and through a variety of means, with one MHC using a direct partner (MHC 4), five using external resources (MHCs 1, 5, 6, 8, and 9), and two MHCs using both sources (MHCs 2 and 7). Family services were offered in five MHCs overall (MHCs 2, 4, 5, 6, and 7), with only one MHC (MHC 5) providing them through a dedicated MHC partner agency. Overall, of the nine MHCs surveyed, MHCs 3 and 4 reported having direct partners for the majority of recovery support services, while the other seven MHCs primarily used multiple providers.

Service Utilization

Psychotherapeutic Services. In all nine MHCs, individual and group therapy was provided, but client participation in these services varied. For example, individual therapy was utilized by 76–100% of clients in two MHCs and by 51–75% of clients in four MHCs, with the other MHCs reporting participation rates of 25–50% (two MHCs) or less than 25% (one MHC). On the other hand, the utilization of group therapy was lower, with five MHCs reporting participation rates of 51–76% (one MHC), 25–50% (three MHCs), or less than 25% (one MHC); in two MHCs, 76–100% of clients were participating in group therapy, but two MHCs were unsure about how many clients received this service.

Family therapy was offered in seven MHCs, but only one MHC reported client participation rates of 25–50%, with the remaining six MHCs reporting that less than 25% of clients and their family members utilized this service. Four MHCs provided family therapy to both immediate (within-household) and extended family members, while it was only provided to

immediate family members in the other three MHCs.

Housing Services. In two MHCs, 76–100% of participants were reported as receiving housing services (assistance with locating housing). Of the other MHCs, one reported that 51–75% of their clients received housing services while four reported that 25–50% of their clients did, with most providing both housing location assistance and help in financing housing. Less than 25% of clients received these services in two MHCs, but both types of assistance were offered.

Employment and Educational Services. Of the eight MHCs offering employment and educational services, only one reported a 76–100% utilization rate for these services and one reported that 51–75% of its clients receive these services. In most MHCs (four), 25–50% of clients received employment and/or educational services, with only two MHCs reporting that less than 25% of clients used the services offered (vocational/employment training, GED prep, links to schools). Figure 3 summarizes client utilization rates across jurisdictions for key recovery support services.

Figure 3: Statewide Recovery Support Services

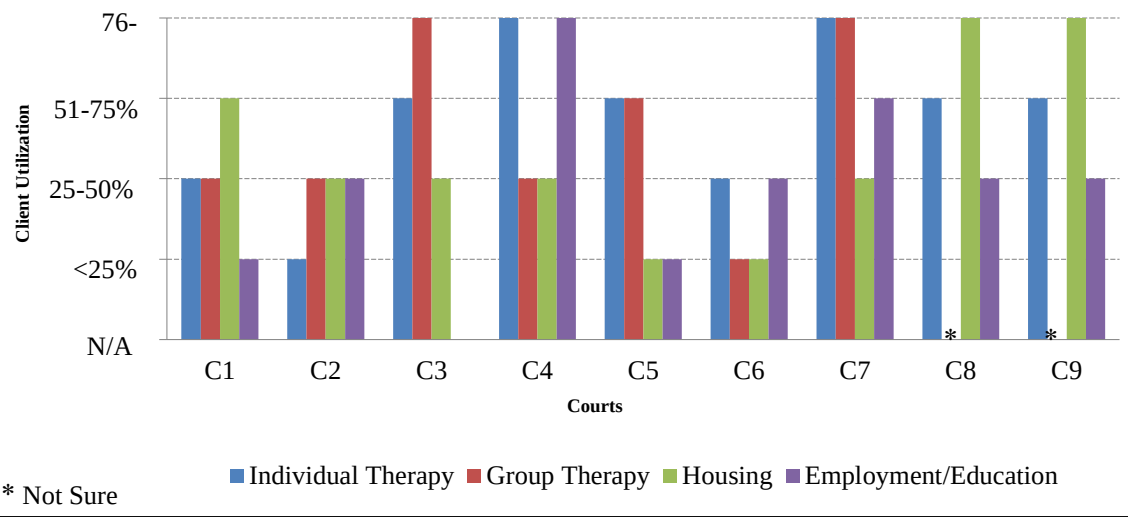


Table 2. Statewide Social Services Provider Survey Responses: Recovery Support Services Data Output

Mental Health Services	**C1**	**C2**	**C3**	**C4**	**C5**	**C6**	**C7**	**C8**	**C9**	**Total**
Psychotherapeutic Services										
Provided by MHC Partner, External linkage, Both or N/A	External	Partner	Partner	Partner	Partner	Both	Both	Both	Both	**All 9**
o % of clients that participate in individual therapy	25-50%	<25%	51-75%	76-100%	51-75%	25-50%	76-100%	51-75%	51-75%	
o % of clients that participate in group therapy	25-50%	25-50%	76-100%	25-50%	51-75%	<25%	76-100%	Not sure	Not sure	
o % of clients that participate in family therapy	<25%	<25%	25-50%	<25%	<25%	<25%	<25%	N/A	N/A	
▪ Immediate family only/Extended family also (Both)	Both	Both	Both	Both	Immediate	Immediate	Immediate	--	--	
Securing Medications/Medication Compliance										
provided by MHC Partner, External linkage, Both or N/A	External	Partner	Partner	Partner	Partner	External	Partner	Both	Both	
Psychosocial Rehabilitation Services										
Provided by MHC Partner, External linkage, Both or N/A	External	Partner	Partner	Partner	Partner	External	Partner	External	External	
Self Help, Peer-support groups, Mentoring										
Provided by MHC Partner, External linkage, Both or N/A	External	Both	Partner	Partner	Both	External	Both	External	External	
Housing Services	**C1**	**C2**	**C3**	**C4**	**C5**	**C6**	**C7**	**C8**	**C9**	**Total**
Provided by MHC Partner, External linkage, Both or N/A	External	Both	External	Partner	Both	Both	Both	External	External	**All 9**
o Provide assistance with locating housing	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**All 9**
o Provide assistance in financing housing	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No	**6 of 9**
o % of clients that receive services	51-75%	25-50%	25-50%	25-50%	<25%	<25%	25-50%	76-100%	76-100%	
Employment and Educational Services	**C1**	**C2**	**C3**	**C4**	**C5**	**C6**	**C7**	**C8**	**C9**	**Total**
Provided by MHC Partner, External linkage, Both or N/A	External	Both	N/A	Partner	Both	Both	Both	External	External	**8 of 9**
o Vocational or Employment training	Yes	Yes	--	Yes	No	No	Yes	Yes	Yes	**6 of 9**
o Supported employment or job placement	No	Yes	--	Yes	Yes	No	Yes	Yes	Yes	**6 of 9**
o GED prep and testing	Yes	Yes	--	Yes	Yes	No	Yes	Yes	Yes	**7 of 9**
o Links to local schools	Yes	Yes	--	Yes	No	Yes	Yes	Yes	Yes	**7 of 9**
o % of clients that receive services	<25%	25-50%	--	76-100%	<25%	25-50%	51-75%	25-50%	25-50%	
Additional Services	**C1**	**C2**	**C3**	**C4**	**C5**	**C6**	**C7**	**C8**	**C9**	**Total**
Benefits Assistance										
Provided by MHC Partner, External linkage, Both or N/A	External	Partner	Partner	Partner	Partner	External	Both	Both	Both	**All 9**
o Education about benefits and assist with access/enrollment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**All 9**
Transportation Assistance										
Provided by MHC Partner, External linkage, Both or N/A	External	Partner	Partner	Partner	Both	External	Both	N/A	N/A	**7 of 9**
Family Services										
Provided by MHC Partner, External linkage, Both or N/A	N/A	External	N/A	External	Partner	External	External	N/A	N/A	**5 of 9**
Civil Services/Legal Assistance										
Provided by MHC Partner, External linkage, Both or N/A	External	Both	N/A	Partner	External	External	Both	External	External	**8 of 9**
Services provided by one or multiple providers	Multiple	Multiple	One	One	Multiple	Multiple	Multiple	Multiple	Multiple	

Evidence-Based/Best Practice Services: Approaches, Fidelity, and Modifications

The third section of the Social Services Provider survey was designed to explore the adoption of evidence-based practices in Illinois' MHCs as well as the modification of those practices. All of the MHCs surveyed (9/9) indicated that some evidence-based or best practice models were delivered to clients by service providers.

- Nine MHCs (100%) offer cognitive behavioral therapy (CBT)
- Five MHCs (56%) offer family psychosocial education
- Eight MHCs (89%) offer integrated dual disorder treatment (IDDT)
- Five MHCs (56%) offer integrated treatment for co-occurring disorders
- Nine MHCs (100%) offer motivational interviewing
- Six MHCs (67%) offer supportive employment
- Three MHCs (33%) offer assertive community treatment (ACT)
- One MHC (11%) offers illness management and recovery (IMR)

In addition to these specific models, information was gathered on other evidence-based/best practices being provided to MHC clients (survey question 23j). Three of the nine MHCs surveyed indicated that the following services were also available:

- SOAR training (for benefits assistance certification) (MHC 2);
- Living In Balance, Seeking Safety (one provider) (MHC 3);
- Dialectical behavior therapy (DBT); IPS (supported employment); WRAP Plans (for psychosocial rehabilitation services); SOAR model (for benefits assistance); trauma services; and Shelter Plus Care (housing and supportive services) (MHC 4).

Fidelity to practices was considered very important to all respondents, and most maintained that services were monitored against established criteria and required ongoing

trainings. Moreover, many jurisdictions indicated that additional approaches beyond scheduled trainings were used to ensure that services were delivered consistently and that MHC staff understood the specific EBPs (survey question 24). For example:

- Fidelity to IDDT and supportive employment models was attained by setting criteria and monitoring adherence to those criteria (MHC 2);
- Evidence-based practices were monitored by model experts (Seeking Safety) during the second and fourth quarters of every fiscal year; sessions were taped, with a mental health expert collecting and rating them. Thus, twice a year, each therapist was assessed on these models to ensure fidelity (MHC 3);
- The ACT program was consistently monitored against state guidelines; other practices were monitored by individual providers (MHC 5);
- A study was conducted in cognitive programming and delivery, which validated models' fidelity (MHC 6);
- The jurisdiction's mental health board required that each funded agency use EBPs and update them annually; all providers were CARF or JCAHO accredited (MHC 7); and
- Periodic trainings on service models was provided and/or made available via community providers (MHCs 8 and 9).

Survey question 25 asked respondents to elaborate on any modifications that have been made to these evidence-based/best practice models in their MHCs. Several modifications to practice were mentioned by the MHCs:

- An assessment of partner providers to determine how many EBPs are being offered to clients and to ascertain if any modifications in those practices are necessary (MHC 3);
- Converted from the ACT to the CST system, which includes nurses rather than doctors;

community-hour involvement varies by staff position (MHC 4);

- Based on the MHC's population (and challenges specific to that population), allowances are made for program attendance, group schedules, transportation, payment issues, etc., in order to focus on individual client needs (MHC 5); and
- The ideology underlying the MHC team is to provide community-based treatment using a flexible team (rather than a prescriptive) approach (MHC 7).

When asked to detail any other important, community-based services that their MHC clients receive (survey question 26), respondents described the following:

- AA and NA groups are available in the community. However, there is stigma attached to MHC clients, so they are trying to establish a closed client-led AA meeting for themselves and their peers with assistance from the AA leader (MHC 2).
- Rather than partial hospitalization, 24/7 crisis residential services are offered, which are voluntary and provide up to 14-day stays for MHC clients (MHC 4).
- Certified recovery specialists provide peer-support services in clients' settings of choice; the MHC is also in the process of implementing a mentoring program (MHC 7).
- Rewards and incentives are used for client progress and for reinforcing program engagement and commitment (MHC 6).

Additional Information by Jurisdiction

MHC 1

- MHC 1 is the only MHC relying exclusively on external agency linkages for the delivery of assessment, case management, and treatment services as well as recovery support services.
- The county is divided in half, necessitating multiple provider referral sources. However, the area has no inpatient substance abuse programs.
- Therapy services delivered to clients are not necessarily psychotherapeutic but rather offer clients group and individual therapy.
- With respect to family programming, "family" is not restricted to biological relatives: friends and neighbors (especially for homeless clients) are considered "family" and are allowed to participate in services.

MHC 2

- Assessment, case management, and treatment services are primarily delivered through one direct service partner, with multiple providers delivering recovery support services.
- Regarding psychiatric/psychosocial assessments, all (100%) MHC clients receive this service, with reassessments occurring per Community Mental Health Medicaid Regulations (Rule 132) (governing 12-month and 6-month reviews of treatment plans).
- "Crisis" is defined very broadly—namely, any change in normal functioning (not just psychiatric emergency)—and emergency stabilization/crisis management services are delivered accordingly.
- Case management is offered throughout and beyond direct programming. However, funding dictates differences in utilization: If clients have Medicaid, no limit is placed on case management services; if clients do not have Medicaid, they typically receive up to five hours

of case management services. The same constraints and differences (Medicaid versus non-Medicaid) apply to the provision of partial (day) hospitalization services.

- In connection to inpatient mental health treatment services, the MHC reports that it has only a 3% hospitalization rate and that all clients (100%) receive some form of outpatient mental health treatment.
- The MHC provides residential substance abuse treatment for clients. The primary MHC's partner agency for services is one of only five federally integrated centers for substance abuse and mental health services under one roof.

MHC 3

- Assessment, case management, and treatment services as well as recovery support services are delivered through specific direct service partners.
- The MHC uses three primary providers, but clients go to one of the three. The only crossover occurs when clients need residential treatments; then they can stay at the "new" agency or return to the original agency to which they were originally referred.
- Clients are assigned to agencies based on where they live, so geography is taken into account in each service plan.
- The MHC offers no employment or educational services, but would like to be able to offer employment assistance as well as safe housing to clients while they are recovering.

MHC 4

- Assessment, case management, and treatment services as well as recovery support services are primarily delivered through one service partner provider.
- The MHC is committed to offering evidence-based practices. In addition to the specific models discussed earlier in this chapter, a benefits specialist is assigned to clients to conduct

benefits assistance activities (using the SOAR model). Trauma services were noted as very important for a large percentage of both male and female clients, and the MHC has a dedicated trauma therapist. Shelter Plus Care (S + C) services are tied to direct funding (HUD grants) specifically for housing for MHC clients.

MHC 5

- Assessment, case management, and treatment services as well as recovery support services are delivered through multiple providers (direct partners and external agencies).
- The MHC does not distinguish between residential and inpatient substance abuse treatment.
- Clients typically have short lengths of inpatient mental health stays (less than one week) which is undesirable from a clinical standpoint, but influenced by state funding issues that prohibit longer, more "typical" stays.

MHC 6

- Assessment, case management, and treatment services as well as recovery support services are delivered through both partner and external sources.
- Case management is offered to clients beyond participation in the MHC program through the county's health department not the MHC's case management partner agency.

MHC 7

- Assessment, case management, and treatment services as well as recovery support services are delivered through several providers (partner and non-partner agencies).
- The MHC's service delivery system includes direct MHC providers and partners from the largest mental health center in the county.
- Requirements for all clients (100%) include participation in assessment(s) and group therapy.
- The MHC team is considered critical to program success, expanding beyond traditional

teams in similar courts. For example, the team has a dedicated clinician and psychiatric nurse (both funded through the county mental health board). All clients (100%) receive case management through a team approach, stressing strong team orientation.

- Individualized plans are a key element of MHC. Thus, having a variety of service choices and providers is imperative, and client choice of providers is considered an essential element of the MHC program, with outpatient and community service provision available to assist with daily living as soon and often as needed.
- The county has a 24-hour crisis line and also offers in-facility and in-community services (to attend to emergency stabilization/crisis management service needs).
- A central goal of the MHC is to reduce reliance on inpatient treatment. Thus, all clients (100%) are required to and receive outpatient mental health treatment.
- No residential substance abuse treatment providers are located in the county, so clients are placed on waiting lists in other counties for this service.
- Family therapy is offered, but participants are difficult to engage in this service.
- With respect to additional recovery support services, the MHC has a memorandum of understanding in place for housing services with a treatment provider and utilizes a home provider as well. Assistance with entitlements is provided through an on-staff benefits specialist, and private attorneys and legal services in the county are also available. County childcare and senior services provide family services to the MHC's clients; participation in self-help/peer support groups is required (and funded through the county's mental health board).
- Transportation assistance for clients is limited, with passes and staff transportation being the only options at the time of the survey.

MHC 8

- Assessment, case management, and treatment services as well as recovery support services are delivered through direct partners for certain service types, but external referral sources are largely used.

MHC 9

- Assessment, case management, and treatment services as well as recovery support services are delivered through direct partners for certain service types, but external referral sources are predominantly used.

CHAPTER FOUR

Focus Groups, Court Observations, Participant Survey

Methodology

In order to examine program implementation and operations, the third stage of the study involved a series of site visits to each of the MHC programs operating in Illinois at the time of the evaluation. The end of stage 2 and the beginning of stage 3 of the study overlapped. Each program was visited three times. Hence, site visits for any particular program could be conducted before site visits were completed for another MHC. During the site visits, one or two focus group interviews of the professionals who staffed the MHC at each court site were conducted. The central research questions of this stage of the evaluation included the following:

- How has the collaborative process among MHC staff members, criminal justice partners, and community partners functioned in each MHC?
- What is the nature of communication, information sharing, and program staff camaraderie?
- What roles have clients and client advocates played in these communicative processes?

After completing the survey of all Illinois Circuit Court jurisdictions and operational MHCs, the officials who participated in stage 1 of the study of the operational MHCs were contacted and asked to participate in further research. Specifically, the officials at each of the nine MHC programs were invited to participate in a focus group interview of the members of the MHC team and in field observations of the MHC program's operations. Officials from each of the nine MHC programs, who were previously surveyed, agreed to participate in this stage of the study. Each of the nine MHC sites were visited on several occasions from May 2010 to June 2011 and focus group interviews were conducted with the MHC staff members at each site as well as observations of staff meetings and court calls.

A total of 26 court observations were conducted between May 2010 and June 2011, 19 of which included staff meetings and court calls. At least one full court observation (staff meeting and court call) was conducted at each of the 9 MHC sites. Three MHC programs were selected for intensive study based on their distinctiveness as determined during previous stages of the study. The three programs selected were MHC 8, MHC 1, and MHC 4. Therefore, a relatively large MHC was selected in a large city, the smallest MHC in a relatively small suburban county, and a relatively large MHC in a relatively small, mixed urban-rural county. In this stage of the research, further data collection was performed at each of the three sites, including additional court observations, individual interviews with key staff, collection of de-identified case-level datasets for quantitative analysis, and surveys of participants' opinions regarding the MHC program in which they participated.

Findings

Focus Group Interviews

At each of the nine sites, one-hour focus group interviews were conducted with the persons who worked in the MHC, including judges, attorneys, probation officers, social workers, and other court service providers. One of the MHC officials requested that two groups be scheduled on separate dates so that all of the MHC personnel could be included. Thus, a total of 10 focus group interviews were conducted at the nine MHC sites between June 2010 and April 2011, and a total of 81 MHC staff workers participated in the focus group interviews. At the scheduled focus group times, set in advance with each official at the MHC sites, the purpose of the study was initially explained to the team members and then informed consent was obtained, which contained an optional request that they agree to be audio recorded.[3]

[3] Only MHC 9, refused to be audio recorded during the focus group interview. For this focus group, the researcher who conducted the interviews asked questions and took written notes, while another researcher attended this focus

The focus group interview questions asked about the beginnings of the MHC, current program operations, problematic issues, and the relationships between MHC team members and program participants, law enforcement administrators, and community service providers. The focus group interview schedule is contained in Appendix A. The audio recordings of the focus groups were transcribed and qualitative data analysis of the transcripts were conducted using software applications for such data.

Court Observations

A series of additional site visits were made to each of the nine MHCs in order to conduct field observations of MHC operations, including staff meetings, in which referrals and participants' cases were discussed by MHC team members, and then in court calls, in which each program participant was scheduled to appear before the judge in an open-court session. Written notes were taken during each courtroom observation in order to provide details regarding how the MHC team members work together and operate the court program; how they fulfilled their roles in staff meetings and during the court calls; and how a particular day's docket transpired in terms of participant-staff interactions. The field observations focused on the staff and their reports regarding participants' successes or failures in recovery; participants' adherence to the conditions of supervision; and participants' improvements or declines in behavioral health and addiction management. The MHC's use of sanctions (positive and negative) to motivate participants was also noted.

Parallel with the interview transcripts, typed field notes were entered into the qualitative data analysis software. Interviews and observational data were coded in terms of court structures,

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group and took separate notes. This enabled the researchers to capture different perspectives and compare their written notes regarding answers to the interview questions and discussions of issues by the MHC staff in order to confirm the content of the participants' responses. Researchers then combined the notes into a single document that was added to the recording transcriptions of the other nine focus group interviews for qualitative analysis.

work roles, worker interactions, and worker-participant interactions in each MHC. The qualitative analyses identified consistent and contrasting themes regarding court operations among the MHCs as described by the workers and as observed at each program in terms of how the programs were structured, how MHC staff members worked together as a team, and how they interacted with participants.

Comparing and Contrasting MHCs

Overrepresentation of African Americans/Underrepresentation of Latinos. The survey found that African Americans were overrepresented relative to the jurisdictions' population in almost all Illinois MHCs. In MHC 8, 88 percent of participants were African American, while 33 percent of the city's population was African American, and 25 percent of MHC 8's county was African American (U.S. Census, 2010). African Americans were overrepresented in the MHC 8 compared with county jail admissions in that MHC's county, which were 66 percent African American in 2010 (Olson, 2011). Overrepresentation of African Americans relative to the jurisdiction's population also occurred in MHC 5 (9 percent of participants compared with 5 percent of the general population), MHC 3 (33%, 5.7%), MHC 6 (32%, 7%), MHC 1(20%, 8%), MHC 7 (11%, 1%), MHC 2 (25%, 9%), and MHC 4 (40%, 12%). However, within the smaller programs in MHC3, MHC 1, and MHC 7, only one to three African American individuals were participating in each program.

MHCs throughout Illinois underrepresented persons of Latino ethnicity. In MHC 8, *none* of the 55 participants was of Latino ethnicity, while 29 percent of the city in which MHC 8 was located was Latino, as was 24 percent of the county in which MHC 8 was located (U.S. Census, 2010). The county jail admissions in the county in which MHC 8 was located were 19 percent Latino in 2010 (Olson, 2011). There were no Latino participants in MHC 9, none in MHC 1 and

MHC 2, and only one each in MHC 3, MHC 6, and MHC 4. Overall, only 11 (4 percent) of the total 302 participants in the nine Illinois MHCs were Latino.

The findings of over-and under-representations of clients along racial and ethnic lines are descriptive only. Beyond the scope of the current investigation are explanations of these differences. For example, the prevalence of mental illness among criminally involved racial groups might differ because of differences in cultural definitions of mental illness, the diagnostic tendencies of clinicians, as well as expectations regarding the use of mental health services, which is often stigmatized among people of color. In addition, variation in rates of arrest and detention practices in different jurisdictions could have resulted in the racial differences in MHC client representation.

Crisis Intervention Teams. Crisis intervention teams (CIT) are specially trained groups of police officers who respond to PSMI in distress (Slate & Johnson, 2008). Professionals from a few planned and operating MHC programs recognized CITs as important to their efforts and beneficial to their communities. In the Eleventh Judicial Circuit, an MHC was planned in McLean County, and an official involved in the planning noted that not many police officers had received CIT training, but those who had were supportive of the establishment of the MHC. In MHC 8, the same probation officer and TASC case manager work in both MHC 8 and MHC 9. They noted that the local police department has a trained CIT, while in the area of MHC 9, there are a number of different police departments but no specific CITs among them. They also explained that not all law enforcement officers and departments in that area understand and appreciate the MHC's efforts and indicated that CIT training for officers in the area might improve this situation.

Information Sharing. MHC 5 had a pre-plea adjudication model, and because of this, the clinical supervisor, probation officers, and assistant public defender assigned to the program limit the information shared about participants with the judge and ASA. Participants do not sign a general release allowing the sharing of information among all staff members as in the other MHCs. The public defender works closely with the monitoring team of the clinical supervisor and probation officers and regularly shares information about participants. However, this information is not fully shared with the judge, as the public defender filters out information that could prove harmful to the participant's case if shared with the judge, and the public defender communicates these specifics to the clinical supervisor and probation officers. In this practice, the public defender plays an adversarial role, which contrasts with the non-adversarial design of other MHCs. This also contrasts with the practices of staff in the other Illinois MHCs, which have participants sign releases of information so that all MHC team members could freely discuss a participant's activities and progress. The probation officers and mental health workers in the other MHCs regularly shared both positive and negative information about participants with the judge and ASA and described a team approach in making decisions regarding how to reward and sanction participants, which required that everyone on the team to have this information.

Although workers at all MHCs, except MHC 5, generally shared all information about participants with the other workers, including judges and ASAs, some recognized that there were limits to the free sharing of information about participants. For example, when new information about an MHC participant comes to light, it might inappropriately affect adjudication of her or his case if not shared properly with all parties so that due process of law is maintained. Improper *ex parte* communications occur when one side of a legal case is able to influence the judge's

decision making, thereby receiving an advantage (Flowers, 2000). The staff in MHC 3 reported that "everybody gets everything" when asked about information sharing on the team, but they then admitted that, if an issue of *ex parte* communication were to arise, they would seek consultation.

Two instances of *ex parte* communication were observed and they were handled very differently. During a staff meeting in MHC 6, an ASA was asked not to leave the meeting before a residential provider arrived to talk about a participant's housing problems. However, the public defender in MHC 4 handled a situation that involved information sharing differently after a mental health worker indicated that a few participants were engaging in possible illegal activity. In this situation, the ASA and judge were asked to leave the room where the staff meeting was being held before the new, potentially incriminating, information about participants was discussed. A social worker on the MHC4 team explained the situation: "The public defender is concerned before a hearing, if the participant was about to have a violation or some other hearing like for a new charge, the public defender would be concerned that information [about the participant] not be shared with everyone, so the judge and [ASA] are asked to leave the room."

Ex parte communication can refer to only one party in a legal proceeding being privy to information when all parties should have the information, or it can refer to the one-sided presentation of information leading to a strongly biased point of view. In the MHC 6 example, team members respected the need and right of all parties to receive case information, while in the latter example, the Public Defender in MHC 4 attempted to protect participants' rights from the possible strong collective bias of the MHC team, which represented the state.

Program Flexibility and Work-role Sharing. Workers in MHC 5, MHC7, MHC 2, and MHC 4 all stressed the notion of being flexible in all aspects of program operations so that a

given individual participant's needs are met. These MHC professionals talked about the importance of getting to know each participant so that their approaches to client motivation and sanctioning are individually tailored to be most effective. The ethos of flexibility in operations to serve participants' needs also includes a willingness to share work tasks in assisting participants and not getting bogged down in maintaining the strict boundaries surrounding work roles. This was especially true of probation officers and mental health workers, who often worked together as a team and shared responsibilities for the day-to-day monitoring and servicing of participants.

Professional Work Roles in the MHCs

The professional work roles of MHC staff were explored. The term "professional" is used here to describe each of the essential work occupations represented in MHC programs, including judges, attorneys, probation officers, social workers, psychologists, and program administrators. Each of these occupations forms a status group, such that some occupations contain more prestige and have higher status than other occupational groups (e.g., judges are of relatively higher status in American society than are social workers) (Weber, 1978).

The trait approach in the sociology of professions has been used to define law occupations, such as judge and attorney, as professions that are distinct from other occupations. This approach refers to a number of basic characteristics or traits present in occupations that make them professions, including a specialized knowledge base grounded in well-established theories and conceptual schemes, lengthy university-based training, the high value placed on the specific services provided by the occupation, ethical standards for both client service and professional interaction, and a high degree of autonomy and self-governance (Volti, 2008). Other occupations, such as nurse, social worker, and probation officer, have been referred to as “semi-professions,” having some professional traits such as specialized knowledge but lacking others,

such as the autonomy enjoyed by professions of law and medicine (Volti, 2008). Abbott and Wallace (1990) refer to nursing, social work, and probation officers as “caring professions,” which are similar in that they originated in nineteenth century philanthropy and expanded into professions as the welfare state was established. They more or less focus on the “human qualities” of clients; they are created and sustained through the identification of a specific social problem and treatment developed for it; and they rely on bases of knowledge drawn from social sciences. Although caring professions have often been identified with female roles and have struggled to be recognized as legitimate, they should not be underestimated in that they hold significant power over clients. Caring professions not only aim to change and control client behavior, but they also shape cultural and social life more generally through their power to use definitions of reality to shape clients' lives (Abbott & Wallace, 1990).

Regardless of status, work roles are the set of expectations for a specific job position in an organization (Hodson & Sullivan, 2008). The current analysis considers the work roles in Illinois MHCs to be professional, including the traditional professions of judge and attorney and the caring professions of social worker, nurse, or probation officer. Although some of the roles might involve more autonomy in work performance than others, all are employees of a government or social service organization. MHC professional work roles are held in organizations that are part of the organizational field (DiMaggio & Powell, 1983) of specialty courts, which have been formed in Illinois during the past two decades.

In a study of eleven MHCs in Ohio, Gallagher et al. (2011) interviewed 59 MHC workers: 29 criminal justice professionals and 30 mental health professionals. Gallagher et al. (2011) found that workers understood their own professional roles and duties, attempted to understand the roles and responsibilities of other team members, and respected the opinions of

other team members, even though criminal justice concerns could differ from those related to mental health. Regardless of professional background, workers on MHC teams recognized the goals of helping participants in recovery and in reducing criminal justice recidivism.

Similar to Gallagher et al. (2011), our study of Illinois MHCs revealed that workers in the programs understood their roles and work together with team members in order to meet participants' needs. Some work roles are more consistent in some sites whereas in others, they are more fluid. Specifically, the judge and assistant state attorney's (ASA) roles were mostly consistent from site to site and had more rigid boundaries defining their tasks. On the other hand, probation officer and mental health worker roles, albeit well-defined and understood, were more fluid in that there was willingness among probation and mental health workers to share work tasks as needed in focusing on how best to meet the individual participant's needs. Administrative roles and public defender roles also varied among the sites. Differences in the structure of MHC programs and basic understandings relied on by staff members in their activities led to variation in work roles among the sites. Each of the MHC work roles is described in greater detail below.

The Role of the MHC Judge. Judges' roles were very consistent from site to site, and work tasks, including interactions with participants, were rigidly defined by legal authority. The judges in each of the nine MHC programs played the same important key role. All of the programs held participant hearings before a judge, who structured the program around the continual monitoring and evaluation of a participant's mental health treatment and adherence to probation conditions. These hearings provided an accounting of each participant's treatment compliance and progress in the MHC program. Although important decisions were made at staff meetings that were held before the participants appeared in front of the judge, in every program

observed, the hearing itself involved a judge, seated in a robe at the bench, who reviewed the progress made with the participant and acknowledged which behaviors were praiseworthy as well as those that were unacceptable. Probation officers, social workers, and public defenders would stand just behind participants when they appeared before judges, and these MHC staff members would be involved in reporting on the participant's progress. The judge would then provide praise, encouragement, or admonishment, depending on whether the reports were generally positive or negative. This communication by the judge to the participant relied on the power of legal enforcement, which could potentially, in any given hearing, create a change in the program participant's legal status.

Although each judge in the MHC programs exercised legal power, each also did so in a manner that involved personally knowing each program participant in order to provide moral support and encouragement aimed at influencing the participants to continue their treatment and to abide by probation conditions. In addition, the hearings were the only times during which judges had contact with participants, which enabled them to make their appearance before the judge at a critical moments in their program participation. The emotional support of judges combined with their power of legal enforcement on display at hearings was a foundational and organizational component of each MHC program studied.

During the study, the specific persons who served as MHC judges in MHC 9 changed, and this allows a comparison of the two courtroom observations made in the same location but at different times with different judges. Both judges were older white men, but their personality differences were notable. The first judge generally had a very outgoing personality, while the second judge was more reserved during court hearings and interactions with the researcher. Nonetheless, both judges used the technique of engaging participants in personal conversation

during hearings. Both judges would ask participants questions, for example, about how they felt in regard to a particular health condition, how their families were doing, or what sports teams they supported in upcoming games. Both judges praised those who followed program treatment plans and admonished those who did not; explained the purposes of treatment plans; encouraged those participants who expressed difficulty or doubts about the effectiveness of the program; and provided specific directives to participants regarding how many or which meetings or appointments must be attended during upcoming weeks. The personalities of the judges seemed quite different to the observer, but their methods of personal engagement with participants during hearings were quite comparable.

The judges observed in this study displayed different styles in working with MHC staff in the operation the programs. All of the judges regularly deferred to the judgment of clinicians and probation officers in determining how best to deal with a participant during the hearings. Judges would rely on these workers to help them decide if and how participants should be praised, rewarded, scolded, or sanctioned during hearings. However, judges in some MHCs took charge in leading staff meetings and court calls more than others. For instance, staff meetings in the MHC 8, which has a men's and women's court call, were led by judges who took the initiative and quickly ran meetings that involved less discussion time relative to some other MHCs. The judge of the men's MHC was especially wont to take the initiative; he quickly led a staff discussion of the MHC court call in front of his bench, right before the court call officially began. Judges in MHC 8 held MHC hearings between regular dockets that were large relative to those observed at other courts.

By contrast, the judge in the MHC 1 was much more casual during discussions of participants with other MHC staff members. The discussion and process of the hearing in MHC1

was led more by the case managers than by the judge, with input from probation officers. The MHC 1 judge worked in a courthouse that was much smaller and had much less criminal justice/court activity overall, allowing for a more leisurely pace during the hearing. But such variation did not preclude the MHC 1 judge from playing the role of legal authority and interacting on a personal level with participants during hearings, as in all other Illinois MHCs.

The Role of the ASA. Similar to the judges' roles, ASAs' roles were very consistent among Illinois MHC programs. In each of the nine mental health court programs, the ASA played the role of gatekeeper. ASAs screened referrals and evaluated the specifics of cases against prospective clients with a concern for public safety and often an inclusion of the opinions of arresting officers and victims in the process. During the referral process, the ASA would give her or his approval and the potential participant would continue through the referral process, or the case would be rejected by the ASA and the defendant would not be accepted into the MHC program. The ASAs discussed new referrals with others on the MHC team and considered their opinions. Nonetheless, a referral had to be considered acceptable by the state attorneys' offices, which was accomplished through the representation of the ASA on the MHC team, before the client could enter an MHC program.

ASAs were involved during court calls in the processing of cases, enabling defendants to enter the MHC program, and in other situations in which participants had violated the terms of probation or been arrested for another crime. When a defendant was initially brought to the MHC program, during the MHC call (in all but one pre-plea MHC program in MHC 5), the ASA read the charges and details of the state's case against the defendant into the record. The judge then explained all the rights being waived to the defendant, asking if she or he understood what rights were being waived, and describing the basics of the MHC program before officially accepting

the defendant into the program. If a participant was arrested or had been accused of violating probation after entering the MHC program, the ASA could bring further charges, including violations of probation petitions, during the mental health court call. These charges could result in the participant being terminated from the program and serving jail or prison time or more time on probation (an extended original sentence). The outcome could also be probation time considered “served” and a termination of the offender from the program.

ASAs also monitored participants’ progress, which involved tracking participants' cases during staff meetings and court calls. Although they monitored participants directly, they also did so indirectly through the reports of others on the MHC team. ASAs did not engage in a high level of direct contact with participants. Several ASAs noted the inappropriateness of being heavily involved with participants through direct contact. They were observed saying only a few words of encouragement to some participants during court hearings, but in general, as ASAs explained, they avoided developing close relationships with program participants, which would provide direction and influence, considering this kind of interaction was professionally inappropriate for a representative of the state responsible for bringing criminal and violations of probation charges against participants when required. Thus, boundaries of the ASA-client roles were rigidly defined and maintained.

Monitoring Roles: Probation Officers and Mental Health Workers. Probation officers and mental health workers, such as case managers, therapists, and nurses serve *monitoring roles*, because they are responsible for regular monitoring of participants in the days and weeks between MHC appearances. The nine MHC programs varied in terms of the number and composition of role players who engaged in monitoring. Each program had at least one probation officer on the MHC team, and two or more mental health workers. The number and the

type of mental health workers at Illinois MHCs varied. In several of the programs, one or two specific mental health service providers worked with the MHC to such an extent that their employees were regular members of the MHC team, attended all staff meetings and court calls, and spent much, if not all, of their work time serving MHC participants.

Other mental health workers, in some of the MHCs, were employees of the court or county government, such as the Court Psychologist in MHC 3 or the Clinical Social Worker in MHC 5 who was employed by the county health department. In MHC 8, one probation officer was dedicated to the program and a number of case managers from TASC, as well as a social work supervisor, were also members of the team. In MHC 5, there were several probation officers on the team and one clinical social worker from MHC 5's county department of health. In MHC 3, a probation officer dedicated to the program also served as program coordinator, fulfilling an organizational as well as a criminal justice monitoring role. MHC 4 and MHC 7 had a nurse dedicated to the team who worked specifically with participants to oversee and fulfill their medication needs.

Not all mental health workers observed were regular MHC team members. In a number of programs, a mental health worker from a provider agency attended the MHC staff meeting to report on a specific participant and, in some instances, discuss client problems. But these mental health workers only attended staff meetings as needed, and many times, there was no need to do so, as various participant issues could be briefly discussed by telephone with a regular MHC team members who could report their findings at staff meetings.

Although there were variations in staff composition, all nine MHCs had at least one probation representative and one or more mental health workers (social workers, psychologists, nurses) who cooperate and share responsibility for the regular monitoring of participants. The

probation officers focused their work on meeting criminal justice monitoring objectives, while social workers and psychologists focused on meeting clients' service and treatment needs. Nonetheless, probation and mental health workers in MHC 5, MHC 7, MHC 2, and MHC 4 characterized the sharing of responsibilities and teamwork as being critical in meeting participants' service, treatment, and monitoring needs. In the following interview exchange, the clinical social worker from the MHC 5's County Health Department and a probation officer, both members of the MHC 5 team, described their sharing of responsibilities in working with program participants:

Probation Officer: It's very much a merged thing. In fact sometimes there's even, I would say that case management, the social worker's doing, any of these guys can do the same thing except for certain things only [the clinical social worker] can do. But you know what I mean? There's sometimes whoever's available to do something is the one who does it. It doesn't matter which role they have, you know, some might call that role confusion but...

Clinical Social Worker: There's very much, you know, you may have heard the term "boundary spanning."

Probation Officer: That's it, yeah exactly.

Clinical Social Worker: Yeah, they do what I do, I do a little of what they do, it's all, it works nicely. It works really nicely.

The Specialty Courts Administrator for MHC 4 describes the same type of role sharing on the MHC 4 team:

Administrator: And sometimes there're different functions, I think, in traditional [organizations] where, well this role does this, like maybe transport to inpatient treatment or something like that. But that's not how this team works. It's who has the available time at 9:00 on Monday to take

somebody, and it's whoever is available to do it… it's very fluid and working together about what can be in the best interest of the participants.

The sharing of work roles in four Illinois MHCs is part of the organizational ethos of the program and reflects the staff's flexibility in client case management.

Administrative Roles: Court Administrator, Program Coordinator, or Program Manager. Before MHCs were introduced in the United States, Steadman (1992) utilized the concept of *boundary spanners,* drawn from the literature on organizations, to describe important role players who work in diversion programs at the intersection of criminal justice and mental health systems. Gallagher et al. (2011) found that boundary spanners knowledgeable about both criminal justice and mental health practices were present in some of the Ohio MHCs they investigated. Boundary spanners were also apparent in the administrative roles of Illinois MHCs, although not all the administrative role players could be described as boundary spanners. This is because there is variety in the administrative roles among the MHCs in terms of their professional backgrounds, their places in the structure of the criminal justice system, and their work role performance.

In MHC 8, the administrative roles were held by the director of treatment programs. This professional worked for DTCs and MHCs at several locations, including two of the MHCs observed for this study: MHC 8 and MHC 9. The director of treatment programs was employed within the ASA's Office and performed a number of administrative functions for the specialty courts, including screening the criminal background of referrals on behalf of the state attorney. Although placed in the criminal justice system, the director of treatment programs had a mental health background and thus fit the role of boundary spanner, as detailed below:

Director of Treatment Programs: "My background is clinical. I worked in behavioral health care for my entire career before coming here a little over seven years ago. So when the position that I'm in now came open then the idea was to have somebody fill that position with a clinical background so that the state's attorney's office would have more of a clinical input into some of these alternative programs. I started out with primarily drug cases. Drug diversion was the first thing that I was involved in from the beginning. I had some involvement with the, I still have some involvement with the drug court system in the county… uh, and then when the mental health court was in the process of being implemented, the thought was that given my clinical mental health background that it would make sense for me to have the position as coordinator."

Administrative roles in the other MHCs were not situated in the ASA's office. Each Illinois Circuit Court has a court administrator's office as well as a probation department. In a few of the MHC programs studied, an employee of the court administrator's office was a regular MHC team member, attending all staff meetings and court calls and providing input on participant cases while also serving an administrative function, such as organizing staff meetings or finding funds for program operations, among a number of other tasks. In MHC 4, the specialty courts administrator served an important administrative role for both the MHC and DTC programs, while also attending staff meetings and providing input on participant cases, assisting in making contacts with various governmental agencies for participant needs, and scheduling meetings with criminal justice workers as needed.

The MHC 4 specialty courts administrator had a background as a prosecutor, not as a mental health specialist, and therefore did not meet the definition of boundary spanner. In MHC 7, the program coordinator was an employee of the court administrator's office and played a very similar role to that of the administrator in MHC 4. However, the MHC 7 coordinator could be

called a boundary spanner because of previous years spent working as a social worker. Both the administrator in MHC 4 and the coordinator in MHC 7 engaged in discussions during staff meetings about how best to work with participants, but the MHC 7 coordinator did so from a mental health perspective.

In MHC 3, rather than being from the court administrator's office, the staff member occupying an administrative role in the program was an employee of the probation department. The MHC 3 program coordinator worked as a probation officer, who was part of the case management team with psychologists and community service providers, and the program manager responsible for tasks, such as organizing staff meetings. The position was considered a part of the probation department in MHC 3, but was specifically created for the program. The MHC 3 coordinator was a prime example of a boundary spanner, performing both criminal justice and mental health tasks, in the probation department, with a clinical professional background, having worked as a licensed professional counselor.

In MHC 5, along with probation officers, a supervisor from the probation office was a regular participant in staff meetings and court calls. The supervisor’s role was narrowly focused on supervising probationers, while managerial and organizational tasks were accomplished by another role player, the program manager, who was an employee of the county. The program manager for MHC 5 did not work directly with program participants, having direct contact with potential participants only when they were referred to the program and had initiated the program application process. The program manager in MHC 5 managed the DTC program in addition to the MHC program, and both were relatively large programs. This role was purely administrative and did not involve boundary spanning. The MHC 5 program manager did not have input on how cases were handled after a participant began in the program, unlike the Specialty Courts

Administrator in MHC 4 or the Coordinator in the MHC 7. Instead, the MHC 5 program manager placed much greater emphasis on acquiring resources for the MHC and DTC programs and on administrative functions, such as developing a referral and application process. MHC 5's program manager explained the role of the position as follows:

Program Manager: "I would normally be at the staff meeting, but again as an administrative [employee], I want to make sure that the people that are [working on the MHC team] have the resources to do the job that they need to do. And so if that means we need to fund, you know, electronic monitoring to keep someone from going to jail as a sanction then we'll do that. You know, because again, if someone is on a med, if we cannot put them in county jail and mess up their medication schedule, then we can do something like that. So, I just handle the day to day business part of it, but being in the meeting helps get perspective as to what do the programs need to run effectively. So, day to day decisions, [the MHC clinical social worker and probation officers] are the day to day experts; that's not my role and function. So, I just deal with the treatment providers, the billing, you know, billing to the health departments and any of the other treatment centers that are out there, program development as far as grants, [and] expansion of services."

Public Defenders: Variation in Use of Adversarial and Non-adversarial Roles. Public defenders are essential personnel in all nine MHC programs studied. However, there was variation observed among the programs in terms of the public defenders' performances of their roles. In the research literature on specialty court programs, such professionals typically assume a non-adversarial posture (see, for example, Miller & Johnson, 2009; and Nolan, 2001), which differs from the traditional, adversarial role that they occupy generally in criminal courts. Under the adversarial approach, an ASA brings charges against a defendant, while a defense attorney,

representing the defendant's interests, argues against the state's case and for the rights of the defendant.

Specialty courts, such as DTCs and MHCs, emphasize a therapeutic jurisprudence approach toward the defendant and the case against a program participant is generally held in abeyance (suspended) during the time spent in the program. ASAs and public defenders in specialty court programs have been understood in the research literature as setting aside their traditional adversarial roles in order to work together as members of the program team and to pursue the behavioral healthcare interests of the participants. Although the non-adversarial characterization was generally true for the nine MHC programs observed, it was only partially true for a couple of them. During court observations, two of the public defenders pursued a somewhat adversarial approach during staff meetings as decisions were made by the team regarding how to sanction participants who had not fully followed program rules. In these types of situations, the public defenders in two of the programs took a stance that could be described as adversarial in defending the participants' interests during the staff meetings.

The public defender in MHC 4 was a decades-long veteran of the criminal justice system. This public defender supervised the other public defenders in MHC 4 but served the participants as a regular member of the staff. During the staff meetings, when a participant's case was being discussed, several times the public defender was observed arguing against a solution being considered by the judge, clinicians, administrator, and ASA, and sometimes, as a result, a less severe punishment was meted out for the rule violation. The public defender played the adversarial role in several discussions during staff meetings regarding how to sanction program participants, always on the side of a less punitive resolution. In addition, the MHC 4 public defender limited the amount of information that was shared with the judge and ASA during the

situation discussed above as well as in others involving several participants who had possibly committed a criminal offense.

As noted previously, the public defender in MHC 5 also reported taking an adversarial approach, displaying a high level of concern about keeping some information considered harmful to the participants from the judge and ASA. MHC 5 is a pre-plea program, which is generally not the case in the other MHC programs studied. (MHC 4 reported working with some participants who have not yet entered a plea, but most of the participants have entered a plea, and participation in MHC 4 is a condition of their probation.) Because the state has not formally dealt with charges in a pre-plea program, there is concern that negative information might eventually affect the adjudication of a participant's case. Therefore, in MHC 5, the public defender worked to prevent such negative information from being shared, especially information about new applicants to the program. This tactic is described in the interview excerpt below:

Public Defender: **"**I am very particular about [information sharing]. If we're all in staffing and it's all open communication I have, it's fine, but [the MHC 5 judge] is not included on our emails and shouldn't be. We've developed a system where [others on the MHC team] got the evaluations. They can't go to her until someone's is going to be accepted into the program. She should not have that information ever, until someone's accepted into the program."

Interviewer: "So a lot of your role is to control information it sounds like."

Public Defender: "I'm an anal retentive gate-keeper of information. Of how it gets controlled, because there's certain [information] that should not be given without all parties present and that's just, legally it shouldn't be there, whether it's a wellness court or not there's [sic] due process rights involved."

Later in the interview, the adversarial approach taken while working on the MICAP team was described:

Public Defender: "Make no mistake, what I say to the judge is not what I'm telling my client in the room. You know, I may be giving the judge the whole big spiel, like well, you know, their due process rights, and this that and the other, in finding out a sanction, you know I don't think my client should be going to jail. When I'm in the side room going you know what, your butt should be sitting in jail for a weekend because you did this, this and this and I think you should be there, while I'm in front of the judge saying my client shouldn't be going to jail because of all these reasons why, you know. It's that dual role, but my client very well knows I think they should be going to jail or they should be getting the public service or they should be going to SWAP or whatever else. I have that dual role, which I, you know, will tell my client you screwed up and you deserve everything you're going to get, but I'm going to go in front of the judge and explain to the judge why you shouldn't be getting it."

Public defenders were also observed playing a role in case management for the participant in several of the MHCs observed, working with the mental health workers and probation officers on the MHC team in order to get things accomplished for participants, such as helping a participant obtain supportive services, while not necessarily focusing on legal concerns. In such situations, public defenders joined other MHC staff in helping participants as they went about their day-to-day lives.

Jail Liaisons. Three of the MHC programs utilized personnel who worked in the jail in their jurisdictions. These jail liaisons on the MHC team identified and approached detainees for possible referrals, worked with new participants not yet released from jail, and checked on participants who had become incarcerated. In MHC 4, three jail workers were employed by the

local community mental health center. These workers' responsibilities were broader than just working on the MHC 4 team; they were responsible for ensuring that mental health treatment was provided to all jail detainees who needed it. The jail liaisons also attended staff meetings, informed the team about possible new referrals, and reported on the situations of new participants not yet released from jail as well as other participants who were incarcerated for violations of probation, new criminal charges, or as a sanction for violating MHC rules. A similar jail worker was a regular member of MHC 3. In MHC 8, two employees of the court, who were on the MHC team, were responsible for finding appropriate referrals for the MHC program. They did so by regularly monitoring the jail population as well as through a variety of other ways as discussed below:

MHC worker: "Well we interview individuals in the jail. We, there's a few different ways of identifying, but we kind of look at when the court dates are, and if the court dates are in the time frame before arraignment, then we interview them, and then we kind of see do they need the program, ask them do they want the program, explain to them the benefits of the program. And if they are in agreement to volunteer for that then I will call [the ASA] and [the director] for them to run the rap sheet. And if their background is okay, then I start faxing the information to the team. So this way when the person gets finally to the correct court room the team will have some information on them."

Interviewer: "Is every individual that enters the jail screened in some way for the mental health court?"

MHC worker: "No."

Interviewer: "No? Okay, so how would you become aware of which persons maybe to notice?"

MHC worker: "Sometimes they refer themselves, and if their court date is within the right time frame, we could consider them. Sometimes we get phone calls from attorneys who are wanting to refer them to the program. And then there's a computer program called [Jail Data Link], which is a cross match of people who are in the jail who have a history with the Department of Human Services, meaning they were at *******, *******, then we look at them, interview them and see if they are within the time frames, and also too if their charges are nonviolent offences."

Not all Illinois MHC teams had a jail liaison who regularly attended meetings and who spent time at the jail soliciting and monitoring participants. However, all MHC programs had some type of contact with jail staff. In MHC 2, a few of the social workers in the program were from the local community mental health agency and they maintained regular contact with jail employees, identifying persons in jail who might have behavioral healthcare problems and therefore could be eligible for the program. This task is one of many for the MHC 2 social workers, rather than a full-time position working only with the jail as in MHC 4 and MHC 3.

Participant Survey

Methodology

A total of 32 MHC participants from the three intensively studied programs completed the survey, which included four open-ended questions. The survey was conducted during the summer of 2011 by recruiting participants before and after MHC hearings, meeting with them individually in a room separate from the courtroom, and explaining that the survey was confidential and voluntary, had no bearing on their status in the program, and was designed to gather their opinions regarding the MHC program. As an incentive for participation, each survey respondents was given a 20-dollar gift card to a local department store. After consent was obtained, participants were offered the option of responding to survey questions verbally, while

the surveyor asked questions and wrote oral responses, or of reading the survey questions themselves and responding in their own writing. Fourteen participants from MHC 8, eleven participants from MHC 4, and seven participants from MHC 1 completed the survey. The sample of 32 participants was not representative of all 128 participants in the three MHC programs at the time of the survey. A representative sample was unobtainable due to prohibitions against surveying participants who were incarcerated or hospitalized, time constraints, and limited funding. On the other hand, all of the participants in MHC 1 were surveyed.

The survey consisted of four open-ended questions asking participants what they liked best about the MHC program, what they liked least about the MHC program, what they would change in their respective programs, and what other comments they would like to make, if any (Appendix A). During the survey, when a participant asked for help and clarification they were assisted. However, attempts were made to avoid shaping answers by offering suggestions or probing for an answer when respondents answered "nothing" to one of the questions. Responses were coded and categorized, with some individual responses to a question coded in multiple categories, as some respondents provided several answers to a question.

Redlich et al. (2010) examined perceptions of voluntariness and knowledge and the legal competence levels of 200 newly-enrolled MHC participants from programs in New York and Nevada. They used a number of quantitative scales in their survey and also asked two open-ended questions, one about the disadvantages of being in the MHC and the other about advantages. The researchers found that 91 percent of the sample cited advantages to being in the MHC; 46 percent of participants in the MHC in Nevada and 59 percent of participants in the MHC in New York could not cite a single disadvantage. The first two questions of the present survey elicited participants' opinions regarding what they liked best and least about the MHC,

rather than perceived advantages or disadvantages of the program as in Redlich et al. (2010). However, answers pertinent to latter were present in many of the participant responses to the current survey.

Participant Survey Results

What Participants Liked Best About the MHC: When asked, "What do you like best about the mental health court program?" only one of the 32 participants could not name anything he liked about the program, responding "I do not like being in this program as it is too harsh and unreasonable." This was a participant in MHC 1, the only one of the three programs in which we were able to survey all participants. The remaining 31 participants (97% of total) stated at least one thing they liked best about the MHC.

Eleven participants stated that what they liked best about the MHC were the general improvements in themselves and their lives that were attributable to their participation in the program. For example, a respondent in MHC 8 reported, "The mental health court saved my life. They gave me an opportunity to restore my life back together again." A respondent from the MHC 1 stated, "It makes me have to change where I can be a better person." Comments about general improvement in themselves or their lives constituted the largest category of responses to the question.

Other responses to the question of what was liked best about the MHC referenced specific improvements that arose from participation in the program. Seven participants reported that what they liked best was the medication or treatment that they received through the program for their mental illnesses. For example, an MHC 8 participant stated that the best thing was "that they provide me with meds and treatment," while an MHC 4 participant liked best how "they have me on the right meds so I don’t hear voices anymore." Similarly, two participants stated

they liked best their improvement in mental health. Four participants stated they liked best their recovery from drugs and alcohol use disorders, with an MHC 8 participant reporting "It's a good program, helped me stay focused on my sobriety." Two participants referred to supportive services in answering what they liked best about the MHC, one listing "housing," the other listing "social security disability" and "Medicaid."

Seven participants reported that the support of the program staff was what they liked best about the MHC. AN MHC 8 participant stated, "I like the support of the court, TASC, and my probation officer," and an MHC 4 participant liked best that "[MHC] staff are there when you really need them for anything." Responses about social support were not limited to MHC staff, as two participants reported liking best the social connections that they had made with other participants in the program. AN MHC 1 participant liked best "Coming together with other people who are trying to change their lives," while an MHC 4 participant liked best: "Listening to the experiences of other court participants, other people who have had trouble with substance abuse and their own mental health. Just listening to how they deal with their mental health and their own particular life situations."

A number of participants referred specifically to liking best the aspects of the program related to their criminal justice disposition. Six participants stated that they liked best that they were avoiding incarceration. For example, an MHC 8 participant answered simply, "It keeps me out of jail/pen," and an MHC 4 participant explained, "What I like best about the mental health court program is that it gives people who get into trouble because of their mental disability a chance rather than locking us up and making us worse." Others referred to different aspects of the criminal justice process. One participant liked best "avoiding a felony record." Two participants stated that they liked best the program's protection of legal rights of PSMI.

Similarly, one participant liked being recognized as an individual by the MHC, expressing, "I like the opportunity to be heard and understood other than being seen as somebody who only broke the law for selfish gains."

What Participants Liked Least About the MHC: Responses to the question about what participants liked least about the MHC produced a wider variety of responses than those to the question about what they liked best. The answers regarding what was liked least were more individualized and less clustered around specific issues. Eleven participants (34 percent) did not state anything when asked what was liked least, with several simply responding, "nothing," and others explaining that they could not complain about or find fault with the program. For example, an MHC 4 participant explained, "There is really nothing that comes to mind when I think, with what is wrong in the program. I've always done good [in the MHC] and I've seen the negative side of criminal court - jail and prison − so I count the program as a blessing."

The most common aspect identified as least liked about the MHC involved having to go to numerous appointments for court calls, group therapy, individual treatment, or 12-step meetings. Three participants stated they did not like having to attend repeated court calls; one participant explained, "I sometimes don't like having to appear in court because I travel a long way." Three other participants indicated that the program requires too many appointments. One of these disliked "the stress of trying to make it to all my appointments as well as doing that which I should," and another said, "I do have other things, a life outside." One participant felt that there was too much information being presented at group appointments, making it difficult to comprehend the proceedings. Another participant did not like going to treatment appointments because they were "too repetitive," suggesting that they always required participants to do the same thing as the previous appointments. However, one participant liked least that there was not

enough time spent in mental health treatment, suggesting that too much time was being spent in court.

A few participants disliked how the MHC was organized and operated by staff. One participant stated that there were "too many people involved," while another explained that some members of the MHC staff were "stuck up." One participant complained that the MHC did not provide enough help with employment, saying, "A job would help me become a useful member of society. The court needs to make an effort to help me re-enter society with access to training and employment programs." Another participant felt that people were not informed enough about consequences of bad behavior in the program. Two participants liked least being tested regularly for illicit drug use.

Some participants were critical of other aspects of the MHC program. One participant liked least that the program's mandatory and special conditions of participation (e.g., curfews, treatment sessions, reporting to probation officer). Another participant did not like the lack of control over one's life that was experienced while being in the program. One participant liked least that the MHC program "takes a long time," while another complained specifically about spending too much time in a "recovery home." Similarly, another liked least that the MHC caused the participant to be separated from family.

A few participants displayed ambivalence in stating what they liked least about the MHC program. For example, one participant answered, "I would say the medication but it works very well for me." A participant who complained about there being too many appointments ended the response with "in order to stay sober, though, I have to stay connected." And a participant who liked least being tested for drugs also explained that the MHC workers "make sure I'm clean from crack, that's what I used. I'll be clean a year later this month."

What Participants Would Change About the MHC

Like the responses to the question about what participants disliked about the MHC, responses to the question of what participants would change about the MHC tended to be specific and sometimes related to the previous questions. Eleven participants (34 percent) said that there was “nothing” they would change about the program. Five of the ten participants who reported disliking “nothing” about the program said that they would change “nothing” about the program. On the other hand, six participants who had no suggestions for changes to the MHC did find something to dislike about it in the previous question.

Four participants suggested lessening the frequency of MHC-mandated activities. One participant wanted to decrease the frequency of court appearances, and another wanted to decrease the frequency of 12-step meetings. Two participants wanted fewer treatment appointments, with one participant explaining that a lengthy drive was required when going to appointments.

A few participants wanted to change the time commitment of the MHC—either time available for other activities during participation or the total length of time involved in participation. One participant wanted to lessen the time commitment of the program because she "need[s] more time with family and consideration that I am a mother." Two participants would decrease the overall length of the MHC program. One of these participants stated, "The only thing that comes to mind is that I would change the duration of the program to an individual basis if the person does well for long enough period of time I, they should be awarded appropriately."

A number of changes suggested by clients involved MHC staff. One participant wanted more support from MHC staff, while another stated that MHC staff members should be less strict

and more understanding. A female participant stated, "I would let the women go wherever they want to go after they did [their] treatment," complaining about perceived control of her residential situation. Another participant complained that staff members were too selective, and more staff members were needed so that more persons would be allowed into the program. One participant would lower caseloads to increase one-on-one staff-participant interactions so that the clients' needs are met. Another participant suggested that only one person, a case manager or a probation officer, needed to monitor a participant, not both. Finally, a respondent suggested that MHC staff members and participants should celebrate the successes together in a party held every month.

Other changes were suggested for MHC programs. One participant would change the MHC so it was "integrated more into talks with doctors, or be directed to a doctor who [is] best qualified to diagnose my illness to help me recover." Another participant suggested that the MHC "should make an effort to encourage gainful employment [and] access to training programs." One other participant stated that the MHC needed to provide more assistance with food stamps and other benefits.

Several participants referred to making improvements in services through increased funding. Two participants suggested that more funding was needed so that more MHCs could be started in other locations. One participant wanted the State to provide more funding to improve a local halfway house and treatment center. Another participant wanted more funding for the overall criminal justice system and training for criminal justice staff.

Additional Comments from Participants About the MHC

Participants were asked if they had any other comments that they would like to share about their respective MHC programs. Six participants declined to add any more comments.

Additional comments from other participants were almost entirely positive. Six participants commented simply that the program was “good” or “helpful.” Another participant from MHC 8 commented, "Thanks for being there for me when no one else would," as if speaking to the workers in the MHC program. Two other participants also wanted to express gratitude when asked for additional comments, including one MHC 8 participant who stated, "I thank the mental health court for giving me a chance to recover on the outside and not being locked up," and an MHC 1 participant stated, "I would like to thank the people of the MHC program for this opportunity to change, correct, and make things right in my life and my loved ones’ [lives]."

Four participants commented that the MHC helped them avoid being in jail or prison. Four other participants spoke of how the MHC helped them improve their lives. Another three participants commented about how the MHC has helped them stay clean and sober. One participant spoke about the need to give up control to the MHC, explaining:

“They really good people. If you are willing to participate it’s not what you want to do, it’s what they want you to do. But it’s not anything wrong, they trying to help you. And they spend a good deal of time with you and want what’s best for you.”

Another participant stated simply that the MHC workers are doing the best they can with limited resources. Yet another participant shared the belief that police are treating the participant differently now because the MHC has taught officers about mental illnesses. Only three of the additional comments were negative. One participant complained that the treatment schedule involves too many appointments, and provided a detailed and reduced schedule. Another participant complained that a defendant should not have to plead guilty to two felonies in order to enter the MHC, but instead should have charges reduced to misdemeanors. Finally, the only

participant to find nothing to like about the MHC (from MHC 1, the only MHC from which all participants were surveyed) added a comment simply expressing dislike for the program.

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CHAPTER FIVE

Recidivism Analyses

The current chapter examines the recidivism rates of MHC for up to three years, which is the time frame often used in recidivism studies at the state level (e.g., Lurigio & Snowden, 2013). Recidivism was defined as rearrest. Three MHC jurisdictions were included in the study; these have been labeled MHC 1, MHC 4, and MHC 8 (the case-study courts). These jurisdictions were selected because they varied in terms of a few key descriptor variables (see below and Chapter Six for examples of these differences). In the original evaluation plan, researchers proposed to conduct the recidivism analyses in the case-study sites. Thus, these three sites were ultimately selected as the jurisdictions for the recidivism study.

The primary outcome variable was time-to-rearrest (from program entry date to rearrest up to three years in follow-up). We attempted to include two other outcomes for exploration in the study: violation of probation and probation termination status within the three samples. However, the dates of probation violations were not systematically recorded; hence, the time-to-violation was impossible to calculate precisely; this variable and was therefore excluded from the analyses.

Methods

Selected for the present analyses was a sample of 224 individuals admitted to MHC in three counties between January 2008 and December 2010, providing three years of recidivism data from admission to the program to rearrest. Of these, 90 were enrolled in MHC 8, 108 in MHC 4, and 26 in MHC 1. MHC 8 is a felony court in which clients are placed on intensive supervision in lieu of a prison sentence. In MHC 1 and MHC 4, probation officers supervise offenders convicted of both felony and misdemeanor offenses. Clients in MHC 8 are case

managed by Treatment Alternatives for Safe Communities (TASC), which assesses, refers, and monitors clients in drug treatment and mental health services throughout their probation terms. MHC 8 operates in a large urban environment. MHC 1 accepts clients at both the pre-plea and post-plea stages of the adjudication process and monitors clients in tracks. MHC 4 accepts clients at pre-disposition and post-plea and supervises clients in three phases from most to least strenuous levels of supervision.

Data Sources

Mental Health Court Data. Two data sources were used to explore the characteristics of MHC clients. In MHC 8, data from the TASC Client Tracking System (CTS) provided information on client demographic characteristics; TASC assessment data, including mental health diagnoses; substance abuse services for which referrals were made and services were received; and termination (discharge) data. In MHC 4, data were obtained from the Specialty Courts Administration Office, and in MHC 1, from probation department records.

Criminal History Records. Criminal history records were obtained from the ICJIA. The requested data were drawn from records stored in the Illinois State Police's Criminal History Record Information (CHRI) system, which is the state's central repository for criminal histories. Using identifying information, including name, date of birth, and State ID or Individual Record (IR) numbers, histories of arrests and convictions were retrieved in electronic format for 210 MHC clients (93 percent of the total sample).

The CHRI data were obtained in September 2012, imported into an SPSS database, and linked to the MHC client data for the purpose of analysis. Client's arrest data were matched in CHRI to obtain the date of first felony or misdemeanor arrests, if any, after their admission to

MHC. Felony arrests were defined as at least one charge coded as Class 1, 2, 3, 4, or X in the CHRI data; misdemeanor arrests were defined as at least one charge coded as Class A, B, or C. Additional data elements were extracted for each participant using the CHRI datasets. The dataset (*n*= 210) included 80 cases from MHC 8, 25 from MHC 1, and 105 from MHC 4. The time intervals between entry into MHC and the procurement date of the criminal history data, ranged from 20 months to 6 years and 4 months. During this interval, clients were considered at risk for rearrest for the purposes of the study. Only four clients in this sample were admitted to MHC prior to January 2008 (three from MHC 1 and one from MHC 4).

All analyses were performed separately for each county. Frequency analyses were conducted to describe client characteristics and arrests. Specifically, univariate analyses examined client descriptor and outcome variables. Survival analyses were performed to examine the rate of rearrest for each group during each follow-up period; the researchers adjusted for varying lengths of observation or time-at-risk. The endpoint for these analyses was either the first rearrest recorded in the CHRI data or non-arrest by September 2012. Survival analyses were conducted for the first felony arrest and the first felony or misdemeanor arrest. A Cox regression model of survival was used to quantify the contributions of age, gender, race, and county in explaining the survival outcomes. Clients varied greatly in terms of the severity of crimes for which they were convicted and placed on MHC probation. Therefore, in an exploratory analysis, the proportion of unsatisfactory termination outcomes also was examined in each county.

Findings

Descriptive Statistics

Table 1 shows the descriptive statistics for each sample, by county, including demographics, psychiatric diagnosis (when available), and criminal history prior to entry into

MHC. As noted, all clients in MHC 8 were convicted of felonies, whereas 90% of the clients in MHC 4 and 38% of those in MHC 1 were convicted of misdemeanor charges only. As seen Table 1, felony clients in MHC 8 were older and overwhelmingly more likely to be African American than were felony and misdemeanor clients in MHC 1 and MHC 4. Clients in MHC 8 also had lengthier criminal records; on average, they had more than 30 previous arrests compared with 10 and 4 previous arrests among clients in MHC 4 and MHC 1, respectively. Nearly three-quarters of the clients in MHC 1 were men, compared with approximately half of those in the other two counties.

Data on education, employment, housing status, and marital status were available only for MHC 8 and MHC 1 (data not shown). In these counties, the majority of clients was single, unemployed, and had less than a high school education. In MHC 1, 45% of clients lived in independent housing, and 55% lived in either supportive housing or institutional settings. In MHC 8, more than one-third of the clients were homeless at the time of intake.

Primary psychiatric diagnosis was available only for a subset of clients (85% in MHC 8, 81% in MHC 4, and 65% in MHC 1). Among clients for whom a diagnosis was available, the majority suffered from mood disorders, such as depression and bipolar disorder. The extent of missing data on psychiatric diagnoses precluded the use of this variable in subsequent analyses.

Arrests Post-Intake in MHC

Table 2 shows the mean number of years between a client's entry into MHC and the date at which arrest data were obtained for each of the samples in the three counties (i.e., September 2012). Common charges included simple assault, theft, disorderly conduct, and possession of a controlled substance. The average date of admission to MHC in MHC 1 was earlier than in the other two counties; hence, these clients were observed for approximately six months longer, on

Table 1.
Selected Characteristics of Clients Admitted to Mental Health Court Between 2008 and 2010, Three Counties

Characteristic	MHC 8 (*N*= 90)	MHC 4 (*N* = 108)	MHC 1 (*N* = 26)
Mean age (range)	43.0 (19-63)	35.5 (18-69)	32.0 (18-55)
Male (%)	54.4	53.7	69.2
Race/Ethnicity (%)			
African American	75.6	37.0	26.9
White	14.4	60.2	69.2
Hispanic other	6.7	1.9	0.0
Other	3.3	0.9	3.9
Highest Current Charge (%)			
Felony	100.0	9.3	61.5
Misdemeanor	0.0	90.7	38.5
Mean Number of Prior Arrests (Range)	31.5 (1 – 89)	10.6 (1–66)	4.5 (1 – 17)
Primary Psychiatric Diagnosis (%)			
Bipolar disorder	35.6	13.9	26.9
Depression	14.4	30.6	7.7
Mood disorder NS	0.0	12.0	0.0
Psychotic or schizoaffective disorder	33.3	23.1	23.1
Anxiety disorder or PTSD	1.1	1.9	3.8
Missing data	15.6	18.5	38.5

Table 2. Years Observed and Arrests Post Entry to Mental Health Court, By County

County	n	Mean Years observed (SD)	Arrested on felony charges (%)	Arrested on felony or misdemeanor charges (%)	Mean Number of felony arrests (SD)	Mean number of felony or misdemeanor arrests (SD)
MHC 8 (100 percent felony clients)	80	3.32 (0.92)	41.3	58.8	1.0 (1.6)	1.7 (2.8)
MCH 1 (62 percent felony clients)	25	3.83 (1.24)	40.0	52.0	0.8 (1.1)	2.3 (4.6)
MCH 4 (10 percent felony clients)	105	3.13 (0.84)	21.9	48.6	0.3 (0.7)	1.0 (1.4)
Total	210	3.29 (0.95)	31.4	52.9	0.6 (1.2)	1.4 (2.6)

average, than those in the other counties. This difference was adjusted in the survival analysis. Table 2 also shows whether clients were arrested post-MHC entry and the average number of these rearrests (unadjusted for differences in the interval of observation). During the observation period, among the three counties, 31% of clients were arrested for a felony only and 53% percent for any charge (a felony or misdemeanor) after their entry into MHC. Clients in MHC 4, who were convicted mostly for misdemeanor charges, were much less likely to be arrested for felonies and slightly less likely to be arrested for misdemeanors than were clients in the other two counties. In a sample of standard probationers, with up to a five-year follow-up period researchers reported that during probation supervision 47% of the sample was rearrested for a felony offense and 29% for a misdemeanor offense. After discharge from probation, 42% were rearrested for a felony offense and 35% for a misdemeanor offense (Adams, Bostwick, & Campbell, 2011).

Survival Analysis

Table 3 shows the results of the survival analysis for felony arrests and Table 4 for felony/misdemeanor arrests. These analyses adjusted for the varying lengths of observation for clients after their entry into MHC by grouping the number of arrests among clients in each year (up to 4 years) after entering the program. As shown in Tables 3 and 4, in each county, the highest number of arrests occurred during the first year post-MHC entry. For example, in MHC 8, 17 clients were arrested on felony charges in the first year after their entry into MHC (Table 3). Among the 66 clients in the three courts who were arrested on any felony charges after admission to MHC, half were arrested during active MHC probation supervision (n =33) and 39% (n = 26) after their probation was completed (the probation termination date was unavailable for 7 clients). Over the 4 years displayed in the table, clients in MHC 1 were the least

Table 3. Number of Felony Arrests and Proportion Surviving (Not Arrested) by Year, and Mean Survival Time

County	Year Post MHC Entry	Number of Arrests	Proportion Surviving	Mean survival time (years) (95% CI)
MHC 8 (*n* = 80)	First	17	.79	3.16(2.76, 3.55)
	Second	7	.70	
	Third	7	.59	
	Fourth	2	.52	
MCH 4 (*n* = 25)	First	4	.84	3.40(2.64,4.17)
	Second	5	.64	
	Third	1	.60	
	Fourth	0	.60	
MHC 1 (*n* = 105)	First	11	.90	4.39(4.00,4.79)
	Second	7	.83	
	Third	2	.80	
	Fourth	3	.70	

Table 4. Number of Felony or Misdemeanor Arrests and Proportion Surviving (Not Arrested) by Year, and Mean Survival Time

County	Year Post MHC Entry	Number of Arrests	Proportion Surviving	Mean survival time (years) (95% CI)
MHC 8 (*n* = 80)	First	24	.70	2.59 (2.20,2.99)
	Second	8	.60	
	Third	10	.44	
	Fourth	5	.30	
MHC 1 (*n* = 25)	First	6	.76	2.96 (2.14,3.79)
	Second	5	.56	
	Third	2	.47	
	Fourth	0	.47	
MHC4 (*n* = 105)	First	35	.67	3.05 (2.58,3.52)
	Second	6	.61	
	Third	4	.56	
	Fourth	6	.37	

likely to be rearrested for a felony charge, and 70% survived arrest-free for a felony charge after four years (Table 3). The mean "survival time" (i.e., mean number of years to the first felony arrest) was more than 4 years in MHC 1, compared to 3.16 and 3.4 years in MHC 8 and MHC 4, respectively. However, when felony and misdemeanor arrests were taken together (Table 4), clients in MHC 4 were similar to those in the other two counties (37% of MHC 4 clients survived to year 4 without either type of arrest).

Figures 1 and 2 present the proportion of clients who remained arrest-free over time in the three counties. Figure 1 shows the felony arrest data only and Figure 2 the combined felony/misdemeanor arrest data. In each figure, the horizontal axis represents years since MHC entry, and the vertical axis represents the proportions of the clients who were arrest-free. Clients who had not been arrested by the time the data were obtained in September 2012 ("censored observations") are included in this graph and identified by a hatch mark (+) to indicate the length of time they remained arrest-free. In interpreting these graphs (Kaplan-Meier curves) (e.g., Figure 1), at 4 years post-MHC entry, approximately 80% of clients in MHC 4 were arrest-free on felony charges, compared to approximately 60% of clients in MHC 8 and MHC 1. When misdemeanor arrests are included (Figure 2), the three counties are more similar to one another; however, MHC 1 clients retained a slight advantage into year 4 in terms of rearrests. For felony arrests, Figure 1 also demonstrates that the downward curve was steepest in the first year (i.e., clients were most at risk for felony arrest during that year), whereas the uniformity of slopes in Figure 2 indicates that felony and misdemeanor arrests were more evenly distributed across years.

Figure 1. Time to Arrest After Entry into Mental Health Court: Felony Arrest

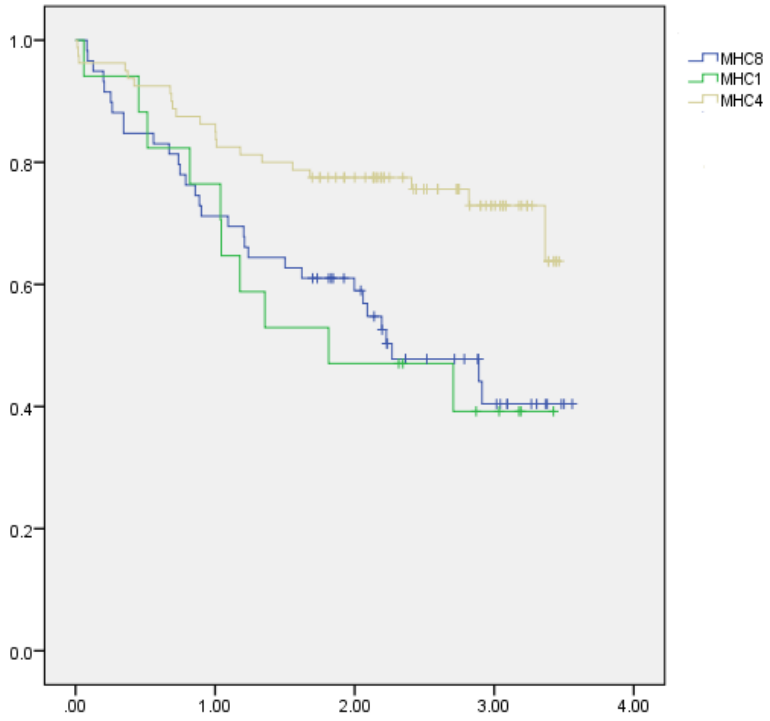
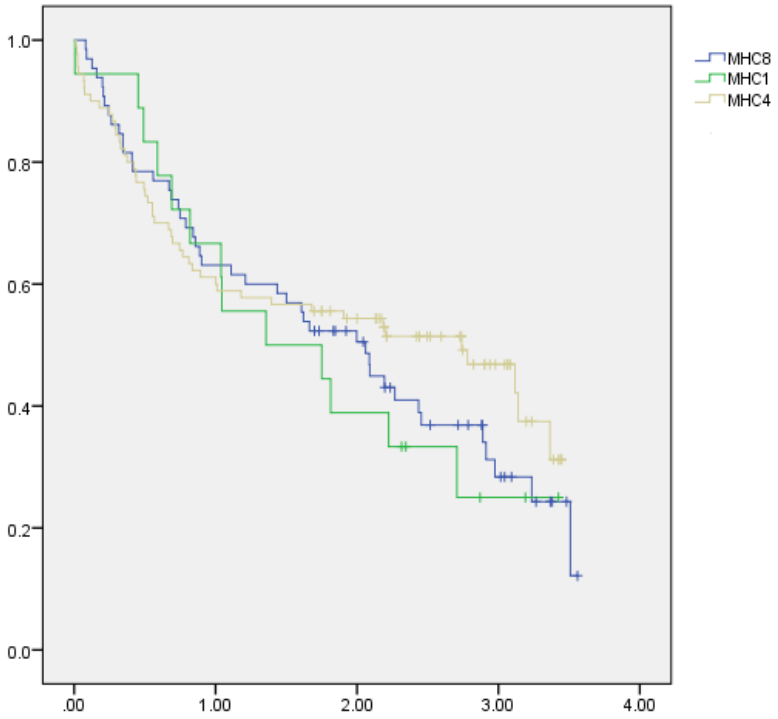


Figure 2. Time to Arrest After Entry into Mental Health Court: Felony or Misdemeanor Arrest



Cox Regression Model

Table 3 and Figure 1 suggest that clients in MHC 4 were less likely to be rearrested on felony charges than were clients in other counties. To a large extent, this difference can be explained in terms of the less serious charges for which MHC 4 clients were convicted. However, to examine the observed differences between counties further, we generated a Cox proportional hazards regression model that included county as well as demographic variables, with the outcome variable being the survival (non-arrest) rate on felony charges over time (Cox, 1972). This analysis tested the effects of each demographic variable on the survival function after controlling for the others. This model included race (white vs. nonwhite), age at entry, county and gender. When these variables were entered into the analysis, clients in MHC 8 were more likely than were clients in MHC 4 to have been arrested on felony charges; however, the difference was marginally statistically significant (adjusted odds ratio [AOR] = 1.81, $p = 0.05$). Male clients were more than twice as likely as were female clients to be rearrested on felony charges (AOR = 2.30, $p < 0.001$) after controlling for county, age, and race. Age and race/ethnicity were not significant in this model.

Violations of Probation

The clients in the MHC samples had committed crimes of varying severity at admission into MHC, including the vast majority in MHC 4 who were convicted of misdemeanor charges only and all the clients in MHC 8 who were convicted of felony charges only. An intensive level of supervision might be less appropriate for some clients (e.g., those convicted of misdemeanors) than for others (e.g., those convicted of felonies). Highly intensive supervision strategies could lead to the incarceration of low-level offenders who might otherwise have remained out of jail at little risk to community safety, albeit with untreated mental illness in some cases. Thus, given the

overall goal of reducing recidivism, evaluations of MHC programs should certainly consider not only arrests but also probation violations that can lead to incarceration.

Neither the states' attorneys' data nor the state police data contained the dates of probation violations or the outcomes of those violations; therefore, a survival analysis could not be conducted. Violations of probation were recorded in a different manner in the TASC records for MHC 8 than in the other two counties. In MHC 8, 24% of the cases with a final disposition code had a violation of probation code, and 20% had a "probation termination unsatisfied" code. In MHC 1 and MHC 4, approximately one-third of clients were coded with an unsatisfactory termination codes; however, very few (< 1%) were coded with a violation of probation revocation code.

Discussion and Limitations

Among clients who participated in the three MHCs, the analyses indicated that more than 60% had not been arrested on a felony charge as many as four years after their entry into the program. As noted, these clients had extensive histories of arrests prior to probation. This follow-up period is longer than those typically examined in recidivism research. For example, Olson (2011) found that 53% of persons released from the Cook County Jail returned to the jail within 3 years; the proportion was higher for non-violent drug and property crimes, which are common offenses among those sentenced to MHC in Illinois. Each additional year in which clients remain arrest-free enhances public safety and reduces costs to taxpayers. MHC 8's low rate of felony recidivism (41%) is especially significant given the extremely high-risk characteristics of the MHC 8 sample, including high levels of homelessness and unemployment, felony convictions, and an average of more than 30 arrests prior to their entry into MHC.

Although they varied by site, the recidivism rates for MHC participants were similar to rates found within the standard probation population. For example, MHC 4 had primarily misdemeanor clients; hence, they were less likely to be rearrested for a felony charge but did not necessarily fare better in a survival analysis when both felony and misdemeanor arrests were examined in the analyses. MHC 8 supervised only probationers convicted of felonies and its clients had significantly more previous arrests. Nonetheless, the survival time of the court's clients (without rearrests) was similar to those in the other two sites. Therefore, MHC supervision might have helped reduce the criminal involvement of these clients because the program provided treatment for clients' behavioral healthcare problems.

Most clients in MHC 4 and a significant minority in MHC 1 were convicted of misdemeanor charges. Therefore, a more appropriate outcome in these counties was rearrest for misdemeanor *or* felony charges. The MHC cannot be credited with reducing felony rearrests among clients who were not initially charged with felonies. In the latter analysis, recidivism rates were higher. Nonetheless, approximately half of the clients in MHC 1 and 37% of clients in MHC 4 were free of either type of arrest after four years.

The current analyses had several limitations. First, only three of the nine MHCs were included in the recidivism analyses. For methodological and resource considerations, the selection of these three courts was appropriate and reasonable. However, the degree to which these three courts provide an unbiased estimate of recidivism of MHCs is unknown. Second, criminal history data were missing for approximately 8% of the study's cases. Approximately 15% of the arrest records used for analysis of outcomes lacked information about charges (i.e., felony versus misdemeanor). These records were excluded from the analyses, which might have inflected the results in favor of the effectiveness of MHC. On the other hand, most low-level

arrests, particularly in urban areas, rarely lead to prosecution and sentencing (Lyons, Lurigio, Roque, & Rodriguez, 2013). Clients who live in communities with a substantial police presence—mostly clients of color—are at a higher risk of arrest because of where they reside. Therefore, these rearrests might not be valid measures of actual recidivism (i.e., the commission of a new crime). Third, the study included no groups of offenders that would have allowed comparisons of outcomes between MHC and non-MHC clients. Fourth, the recidivism analyses incorporated no information about service needs or services accessed or received. Similarly, the analyses contained no information on the severity of mental illness, the intensity and length of treatment, and whether status at discharge affected arrest rates in the follow-up period. Such data were unavailable, unusable, incomparable, or inaccessible among the sites selected for the analyses. Furthermore, the efforts and resources required to locate, interpret, and code such data were beyond the scope of the current study.

The recidivism analyses suggest a number of practical implications. If one of the primary goals of MHC is to reduce serious criminal activity, then efforts focused on felony offenders might lead to an even more effective and efficient use of court resources. For low-level offenders who have not been convicted of felonies, all infractions and incarcerations should be recorded during their supervision, including those involving technical violations, which can be forerunners to criminal activity and treatment failure. In addition, among all three counties, female MHC clients were significantly more successful than were male MHC clients. Perhaps mental health services should be tailored more closely to the service needs of men (i.e., more [male] gender-sensitive). However, missing data rendered it impossible to ascertain whether these observed gender differences could be accounted for by differences in primary psychiatric diagnosis or

other factors.

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CHAPTER SIX

Descriptions of Each MHC's Structure and Operation

In studying the nine different MHCs in Illinois, many similarities were discovered among them but also wide variability in terms of certain aspects of program operations. Some of these involved program structure, others involved performance of professional roles. Detailed below are the various program structures utilizing survey data, focus group interviews, and field note observations from the nine MHC sites. Later, we describe the range of professional work roles and how they remain consistent or vary across the nine sites.

Mental Health Court 1 (MHC1)

- **Number of participants:** 5 (4 men, 1 woman)
- **Level of offense heard:** misdemeanor and felony
- **Adjudication model:** both pre-plea and post-plea with sentence to MHC
- **Supervision model:** court staff and mental health providers

MHC1 began operations in a mixed rural/suburban area in the fall of 2007. Of the nine MHC programs, the MHC1 program was the smallest, with only five participants at the time of the survey, including four males and one female. Four of the participants were white, while one was black. None were of Hispanic/Latino ethnicity. During other phases of data collection, the number of participants fluctuated, increasing to ten and then falling to seven by the end of the study.

A drug court program had been established in the county of MHC1 over a decade earlier. Eventually, a member of the local 708 Board (also known as Community Mental Health Boards, these entities are established by a community, municipality, or township for the purposes of planning and funding mental health, developmental disability and substance abuse services)

contacted probation and suggested there may be a need for a mental health court in the county due to people incarcerated in the county jail who were possibly in need of mental health treatment. The 708 Board was able to provide money to help pay for costs of MHC1, including a caseworker from each of two community mental health agencies serving the catchment areas of the jurisdiction. At the time MHC1 began, the county probation department was able to provide a position to oversee and work exclusively with the MHC program, but since that time the county and its criminal justice system experienced major budget cuts and the position was eliminated, along with a number of probation officer positions.

A supervisor from the probation department currently oversees all specialty courts in the county, and is also the coordinator for MHC1. Other members of the MHC1 team include a judge, case managers from two social service agencies, two probation officers, and an Assistant State's Attorney (ASA). These staff members regularly attend court hearings, held twice a month. A public defender may attend court hearings, but only as needed.

The MHC1 program is supervised as one of three alternative courts (including a drug court and a veterans' court) all operating under the same guidelines for participation. Participants in the alternative courts follow one of two tracks, depending on their criminal backgrounds and plea status. Track I participants, generally first time felony offenders with little or no criminal backgrounds, enter the program on a pre-plea basis, signing contracts to voluntarily participate in court-mandated treatment. On successful completion of treatment requirements, the court dismisses pending charges against Track I participants, and no conviction is added to their records. Track II participants enter the program after pleading guilty and are sentenced to a term of probation with court-mandated treatment. The length of the terms may be reduced for participants who show substantial progress in treatment. Upon successful program completion,

participants are released from probation but have the convictions on their criminal records. Although both tracks are possible, the coordinator explained in interview that the MHC1 program is currently geared toward Track I participation, referred to as "diversion." This also reflects a change in MHC1 over time, as the program initially was aimed at lower level offenders. However, after operating for more than a year, there were few appropriate misdemeanor defendants who opted for the MHC rather than regular adjudication. The Probation Director communicated the issue with the State's Attorney's office, and an agreement was made that appropriate defendants with more serious felony charges could participate in the MHC, although an ASA would closely monitor referrals and participation to protect public safety and ensure cases were not likely to become problematic. The program reports a combination of misdemeanor and felony participants.

Referrals to MHC1 can come from a number of sources, including police, jail staff, judges, the drug court, ASAs, and family members, but the most common referral source is defense attorneys. About 80% of referrals eventually enter MHC1. After the program receives a referral, an ASA reviews it for approval. During the referral process, public defenders or private defense attorneys, who may have made the referral, explain the program and the legal options to the potential participant. If the ASA and defense attorney agree to proceed with the referral, a formal motion to assess is signed by the judge and filed with the court. A social worker from one of the mental health providers is then responsible for conducting a mental health assessment. The social worker, who also works as a case manager for MHC participants, conducts the assessment and discusses the program with the referral to determine appropriateness of the program and the new referral's desire to participate. Next, the MHC staff discusses the referral, and if all agree to proceed, the referral formally enters the MHC program during a hearing. One of the case

managers schedules an appointment to meet with the new participant and begin the process of linking them with services.

Referrals to the MHC1 must present with Axis I diagnoses, which correspond to state criteria for serious and/or persistent mental illness in order to be accepted into the program. MHC1 accepts participants with misdemeanor charges, but most participants are felony offenders as the substantial participation requirements and time commitment of the program may outweigh the consequences of a misdemeanor record for that level of offenders. The court uses a formal, standard written contract, although terms of participation are individualized based on the clinical diagnosis. Generally, the initial agreement is to participate in treatment for one year, although the minimum period for the MHC is six months. Time may be extended if participants are noncompliant or need time to achieve significant progress in treatment. The standard criterion for graduation from MHC1 is treatment adherence during a period of time specified by the court. Participants sign a release of information allowing court staff to communicate with providers about their cases, but supervised treatment information does not become part of the participants' court records.

On entering MHC1, participants are assigned to one of the two case managers based on where the participants reside. Most of the services provided to a participant are from the community mental health agency that serves the part of the county where they live, but there are a few mental health providers available if needed for participants other than the two service providers that regularly work with MHC. The case manager develops a recovery plan that outlines the treatment modalities for the participant. This plan may include community support services, individual substance use counseling, psychiatric services, and other services. If participants have private psychiatrists, then the case managers monitor whether or not they are

following up with psychiatrist visits and taking their medications. The case managers report at MHC1 hearings every two weeks for felony participants and once a month for misdemeanor participants.

MHC1 is the only one of the nine programs that did not use jail as a sanction for participants. There is sanctioning for noncompliant participants, which includes making verbal warnings, increasing frequency of required appearances to the MHC, and assigning community service hours. However, MHC1 staff explained that most participants are compliant and sanctioning is relatively rare.

MHC1 operates hearings on a less formal basis then other Illinois MHCs. The hearings do not have a stenographer or court secretary, and have no regular bailiff in the courtroom. When the judge enters the room there is no formal announcement for all to rise. Because the program has a low number of participants relative to the others in this study, the dockets are small (between three and seven persons on observation). Rather than having staff meetings separate from court calls, MHC1 staff meets in a small courtroom with no audience during the hearing. Participants wait on seats in a hallway just outside the courtroom, sometimes with family, friends, or counselors, waiting for their probation officers to call them inside.

There is no staff meeting held prior to the court call, rather the relevant case manager and probation officer will report to the judge regarding recent treatment progress of a participant. While a participant waits in the hallway, the case manager reports to the judge on his or her current treatment adherence and progress, while the assigned probation officer adds input regarding criminal justice supervision of that participant. The judge listens, comments on the participant's progress, and then discusses how the participant should be dealt with during the appearance, with the case manager making recommendations and the probation officer adding

input. After this discussion they decide on how to move forward, and the participant is then called in to appear before the judge.

When participants appear before the judge, they engage in personal greetings and conversation as in other courts. Participants may receive praise for program adherence and progress in other areas, or may receive sanctioning for not following guidelines or other misbehavior. The same personal relationship dynamics between judges and individual participants exist in the MHC1 as it does in other Illinois MHCs, but the difference from other Illinois MHCs is there is no audience other than MHC staff who observe these individual MHC1 hearings. (The exception to this occurs when a participant graduates at a hearing, as other participants are called in to witness the event and celebrate.) The judge offers encouragement and directives to the participant, with commentary from the case manager and probation officer involved. Then the participant and staff say good-bye, the participant leaves, and the staff begins reviewing the next case. In this way, each participant's case is separately discussed and heard. Sometimes, both before and after the court session, MHC1 staff discusses other participants not scheduled to appear.

An Assistant State's Attorney regularly attends the MHC1 hearings, and may comment on a case during the discussion before the participant is called into the room, but during the hearing is generally quiet, occasionally providing legal documents and opinions about a case to the judge. A public defender or other defense attorney is not regularly present, unless one is needed due to a change in a participant's legal and program status, at which time one of the staff will contact the public defender or private attorney and ask that defense attend the hearing.

Mental Health Court 2 (MHC2)

- **Number of participants:** 28 (19 men, 9 women)

- **Level of offense heard:** misdemeanor and felony
- **Adjudication model:** pre-plea and post-plea with sentence to MHC
- **Supervision model:** court staff and mental health providers

MHC2 is in a county made up of several small cities and rural areas. With 28 participants, the MHC2 program had a large number of participants relative to the county's local population of roughly 150,000 residents. Twenty-one participants were white and seven were black; none of the participants were Hispanic. Relative to the race and ethnicity of the county population, blacks are overrepresented among participants and Hispanics are underrepresented, a trend found in a number of other Illinois MHC programs.

The program was created after an Associate Judge recognized a need for the jurisdiction to deal differently with specific mentally ill individuals from the community who were repeatedly arrested, and to avoid having persons needlessly decompensate in jail by not being moved into treatment. Initially, the judge and a few officials began discussing a MHC, and then visited the MHC4 program. Soon the Associate Judge and representatives from the State's Attorney's Office, Public Defender's office, court services, and two local mental health providers began meeting and planning a MHC. MHC2 accepted its first participant in the spring of 2007. The Associate Judge, an Assistant State's Attorney, and public defender operate the MHC2 program along with a Program Coordinator, probation officers, and several mental health staff from two local providers of case management services. Both agencies provide a number of mental health services to program participants, but a few other agencies may also provide services depending on specific needs. The Coordinator for the program works out of the probation department, and is also involved in other specialized probation programs for county court jurisdiction.

MHC2 program workers explain that referrals may come from a number of sources. One important way appropriate persons may be identified is via a list of persons incarcerated in the jail faxed to one of the two previously mentioned mental health agencies every weekday, where an employee working with the MHC2 program scans it to see if any persons who receive services have been incarcerated. Similarly, the other mental health agency will contact someone at the MHC2 program if one of their mental health staff discovers that one of their participants has been arrested. MHC2 staff discussed that some referrals come from local police officers who have received Crisis Intervention Training. Other referrals may come from a judge who notes a defendant acting strangely, a probation officer with past experience with a mentally ill defendant or his or her family, the public defender's office, the state's attorney's office, private attorneys, and family members. The MHC2 program accepts 33% of all referrals.

After a referral to the program, the MHC2 Coordinator does a criminal history check, both local and nationwide. The Coordinator, representing probation, advises the MHC team of the referral including offense description, criminal history background, known mental health diagnosis, and status of court proceedings. The Assistant State's Attorney can veto a referral if the criminal history or specifics of the case are unacceptable. The Coordinator and a mental health worker in the MHC2 program screen a referral independently. Once both screenings are accomplished the entire MHC team discusses the case and decides whether or not to accept the referral into the MHC2 program.

The MHC2 program accepts participants with a primary Axis I diagnosis, meeting state criteria for serious and/or persistent mental illness. Although participants with co-occurring disorders are accepted into the program, it excludes those who have a primary substance use disorder. The program accepts both misdemeanors and felonies, excluding sex offenses and

others according to state law. Nine of the 28 participants in 2010 were misdemeanor offenders, while the remaining 19 were felony offenders. Generally, participants enter the MHC2 program on a pre-plea basis but there are some participants who have pled guilty. For pre-plea participants, charges are held in abeyance and then dismissed upon successful program completion, while other participants enter a plea of guilty to their charges and are sentenced to program participation for a minimum of 12 months. Some participants are probationers who have violated probation, and are sentenced to participate in the MHC2 program for the violation.

If pre-plea participants are unsuccessful in the MHC2 program, their cases are returned to the court of original jurisdiction for adjudication. Post-plea participants who are unsuccessful may have their cases returned to the court of original jurisdiction for sentencing, or the MHC2 judge may determine that enough time has been served and no more probation is warranted. On entering the MHC2 program, new participants agree to a standard contract that mandates the treatment plan of one of the mental health providers. New participants also sign an initial release of information allowing court and mental health staff to communicate, and may be asked to sign subsequent releases if needed for other reasons. The minimum length of time for participation in the program is twelve months, while there is no established maximum. MHC2 is designed as a three-phase program, with each phase representing a different level of intensity of supervision. Generally, phase one participants are required to see the MHC Judge and Program Coordinator every week, then gradually progress to phase two with bi-weekly appearances, and eventually to phase three, nearing graduation and with monthly appearances.

Participants receive most services from one of the two mental health providers. A case manager from one of these two providers will work with new participants by scheduling mental health assessments and eventually developing service plans. Service plans typically include

medication management and monitoring, group and individual therapy, and psychiatric treatment. Other providers of services such as housing or drug rehabilitation are available in the area for participants.

As in other Illinois MHCs, a probation officer and a mental health worker are jointly responsible for monitoring each participant between MHC2 court hearings. Probation officers may have participants come to the department for office visits, they may visit participants at their homes, or they may see participants at one of the facilities of the two primary mental health treatment agencies. Regardless, probation officers frequently communicate with assigned case managers between hearings to discuss participants' needs, recent progress, and problematic issues. Both the probation officer and the case worker see the participants once a week or more in phase 1 of the program. They meet with other members of the MHC2 team during weekly staff meetings before hearings to discuss each participant's progress.

When interviewed, several MHC2 staff members explained that the program may have organization and structure, but that the needs of the individual participant are more important than following specific protocols in program operations. For these staff, the idea of putting the participant first means allowing the program to be flexible so that it can be tailored for individual need. Flexibility is stressed not just for program design, but also for the performance of work roles. MHC2 staff explained that work roles are fluid, for example at times probation officers may perform case management work tasks, and case managers may perform probation work tasks, all part of a collective effort aimed at meeting the individual needs of the mentally ill participant.

The other Illinois MHCs reward participants for good behavior by praising their efforts during hearings, lessening the frequency of court appearances and, in some programs, formally

moving them to a phase of the program closer to graduation. Team members in MHC2 reward participants in these ways, but also utilize a 'draw' system during hearings, which serves as an incentive for participants to adhere to treatment and maintain good behavior. At every MHC2 hearing each participant who has performed in the program satisfactorily is allowed to draw a paper slip out of a multi-colored bowl, called the 'fish bowl', which the Coordinator brings to court hearings. Each of the paper slips have a reward written on them such as chips, candy, $5, $10, or $25 gift cards for department stores, movie tickets, or other small items. The judge may reward a participant that has done exceedingly well since the last hearing with extra draws, or may sanction a participant for missing treatment appointments or other misbehavior by taking away the draw. MHC2 study respondents report this system works well to motivate some of the participants, but not all.

The MHC2 staff utilizes a variety of sanctions for participants who do not follow program requirements. Sanctions utilized include verbal admonishments, increased frequency of court appearances, no draws from the fishbowl, community service hours, and jail for the most serious violations. MHC2 workers refer to the concept of an individualized approach when discussing sanctioning, explaining that each participant responds to different types of rewards and punishments. In operating the program, the MHC2 team gets to know each participant and consider which type of sanction or reward is most effective for a particular individual in a given case. As they did when discussing work roles, MHC2 team members stressed that there needs to be flexibility in practices with participants, each of whom should be dealt with using an approach tailored to individual need.

Mental Health Court 3 (MHC3)

- **Number of participants:** 9 (8 men, 1 woman)

- **Level of offense heard:** misdemeanor and felony
- **Adjudication model:** post-plea with sentence deferred
- **Supervision model:** court staff with mental health backgrounds

MHC3 is in a suburban county of over half a million people. The idea for beginning a MHC program was first promoted by the county's Chief Judge, who discussed starting the program with another judge (now the MHC3 Judge), and a psychologist who oversees a county department providing all psychological services to the court and the sheriff's department. This Court Psychologist called on the services of another mental health professional who had past experience in establishing specialty courts. Together, they conducted a mental health needs assessment for the jurisdiction and found that there was a need among the jail population for treatment and medication for Axis I diagnoses. The mental health professionals also relied upon the Ten Essential Elements of specialty courts, promoted by the Council of State Governments (cite?), in designing the mental health court program. The MHC Judge brought in additional personnel, including an Assistant State's Attorney and an Assistant Public Defender who both agreed to work regularly with the MHC. Several of these staff attended a SAMHSA GAINS Center conference in California, a national consultation and technical assistance program designed to help communities achieve integrated systems of mental health and substance use services for individuals in contact with the justice system. After returning with a basic understanding of how mental health courts operate, the MHC Judge hired a Program Coordinator, a position which would serve as both probation officer for all MHC participants and administrator for the program. The Chief Judge, working with a U.S. Representative, obtained a federal earmark to finance the court. A task force was organized, including the MHC staff and representatives from local service providers who were invited, and the group began meeting and

planning to begin the MHC program. The MHC3 Judge and other staff visited MHC4 to observe a court call there. After months of planning, the Chief Judge announced the new MHC, and the first participant entered in the spring of 2006. The current MHC staff includes the MHC Judge, Program Coordinator, ASA, an Assistant Public Defender, Court psychologists, local mental health treatment providers, and clinicians at the county jail.

Referrals may come from jail staff, probation officers, judges, the drug court and most commonly, from defense attorneys. After a referral is made, the Program Coordinator does an initial screening, meets with a potential participant to determine eligibility issues, such as residency status, and conformity of the criminal charge to Illinois statute for mental health courts. The referral is then passed to the State's Attorney's office, and the ASA considers the referral's criminal history to determine acceptability to the program from the state's attorney's office's perspective. If the ASA determines the referral is acceptable, a psychologist who works for the court conducts a psychological evaluation, even for those referrals with have a documented diagnosis. After this is accomplished, the team discusses the case, determines whether or not the referral can begin the program, and then the Program Coordinator refers the prospective participant to an appropriate mental health agency in the community for service and treatment planning.

In the spring of 2010, MHC3 had nine active participants, eight males and one female. Four participants were white, three were African American, and one was Asian. One was also listed as Latino on the survey. As with most Illinois MHCs, black participants were overrepresented and Hispanic participants were underrepresented relative to the local population. During an individual interview, the Program Coordinator explained that at the time of the survey the number of program participants was lower than usual, and that typically there are around

twelve to fifteen participants. The Coordinator also stated that, out of 184 referrals, 31 had become participants (about 17%).

The program accepts defendants with a primary Axis I diagnosis; although participants with co-occurring disorders are accepted into the program, it excludes those who have a primary substance use disorder who may be referred to the local drug court. The MHC3 program accepts both misdemeanors and nonviolent felonies, although at the time of the survey all nine participants were felony offenders. All participants enter the program on a "post-plea, pre-sentence" basis, meaning defendants plead guilty to their offense and have their sentences deferred. Participants' charges may be dismissed or reduced upon successful program completion. Depending on the specifics of the case, participants who are unsuccessful in the program may serve a deferred sentence, or have their case returned to the court of original jurisdiction for sentencing.

The MHC3 program is designed in phases, as a two-tiered program: misdemeanor participants are supervised for approximately a year, while felony participants are supervised for approximately two years. Felony participants go through a three-phase program, while misdemeanor participants go through a two-phase program. The phases represent different levels of intensity of supervision. Felony participants start out in phase one seeing the MHC Judge and Program Coordinator every week, and gradually progress to phase two (bi-weekly appearances) and then to phase three (monthly appearances). Misdemeanor participants start out in phase one (weekly appearances) and then gradually progress to phase two (bi-weekly appearances). All participants must sign a formal, contract of standard terms of participation, although individualized terms are routinely added.

Along with weekly visits with the Judge and Program Coordinator, MHC3 program participants see a service provider throughout the week, in many cases on a daily basis. There are a number of service providers in the jurisdiction, including transitional housing programs, homeless shelters, domestic violence shelters, and several mental health agencies. The MHC3 program has a residency requirement; participants must reside in the jurisdiction, and often this eligibility requirement is met by finding residential treatment programs for participants, which allow them to live in the county of MHC3. There are three mental health agencies providing much of the case management and treatment planning services for MHC3 participants: two providers in the south and one provider in the north. One provider specializes in substance use treatment, including inpatient treatment. Case management is provided by the mental health agencies, but the Program Coordinator does some case management work as well in the role of probation officer, and maintains regular contact with the treatment providers. Thus the Program Coordinator provides reports on participants' treatment progress to the MHC Judge and the rest of the staff at weekly staff meetings, held before MHC3 calls, although treatment providers also attend staff meetings in person as needed.

When asked about information sharing, MHC3 staff responded that "everybody gets everything," explaining that when participants enter the program they are required to sign releases of information allowing the team to freely share information even though the case has not been fully adjudicated. In addition, participants are required to sign other releases regarding information sharing with service and treatment providers, and the Program Coordinator maintains communication with providers to ensure that the MHC3 program and its releases are working in conjunction with information releases which providers utilize. The MHC3 staff expressed awareness of the issue of *ex parte* communication, and acknowledged that there have

been ethical issues involving attorneys disclosing information about new criminal charges. For those situations, MHC3 team members ask for consultation from the National Center of Court Innovation in New York to help work through ethical dilemmas and professional issues regarding information sharing.

As the MHC3 program is structured in phases, the MHC Judge may at times, after consulting with the rest of the team, sanction a noncompliant participant by moving her or him down from a phase nearing graduation to one requiring more frequent appearances. MHC3 staff report also using writing assignments for participants as sanctions; for instance, the team decided and the judge required during a hearing that a participant write an essay about the negative effects of cocaine use after experiencing a relapse. Reported sanctions also include assignment of additional meetings or group appointments, community service hours and, for repeated or serious program violations, jail time.

Mental Health Court 4 (MHC4)

- **Number of participants:** 62 (32 men, 30 women)
- **Level of offense heard:** misdemeanor and felony
- **Adjudication model:** pre-plea and post-plea with sentence to MHC
- **Supervision model:** court staff and mental health providers

Criminal justice officials in the county of MHC4 began considering the possibility of beginning a mental health court program in 2003 after a county jail study revealed an overrepresentation of persons with serious mental illness in the jail population. The Chief Judge supported the study and, after reviewing the results, contacted another interested judge to discuss the benefits of starting a MHC. The judges contacted the President of the local community mental health center, who then formed a coordinating council of 80 community members. This

group spent 18 months planning and developing resources for the MHC4 program. The MHC4 team includes the MHC judge, Assistant State's Attorney, Assistant Public Defender, Specialty Courts Administrator, two probation officers, and community health center staff including a psychologist who conducts assessments, a nurse, two therapists, two case workers, and three other mental health staff who work at the county jail.

In February of 2005, MHC4 accepted its first participant. By the spring of 2010, MHC4 had 62 active participants (32 males and 30 females). Thirty-seven of the participants were white, and 25 were African American. In addition, one of the participants was of Hispanic/Latino ethnicity. This is yet another Illinois MHC with an overrepresentation of blacks and underrepresentation of Hispanics relative to the local population.

Referrals may come from a variety of sources: a family member, a probation officer, a public defender, or the state’s attorney's office, with the latter two providing the majority of referrals. These sources fill out referral forms that are sent to the Administrator who records the information and sends them to the psychologist. (Note: Referred defendants must have a criminal case or petition to vacate pending.) The psychologist meets in person with the referred defendants to conduct full mental health assessments and provide clinical diagnoses for the court. The psychologist gathers information from a variety of sources, including medical histories, substance use issues, and criminal backgrounds, and then makes determination on whether a diagnosis is related to a defendant’s criminal history. Upon completion, assessments are sent to members of the MHC4 team for discussion at staff meeting to determine whether or not to accept the case. If referrals are deemed appropriate for the program, the Assistant State's Attorney contacts the law enforcement agents involved with bringing charges and, in some cases, victims

to gain their approval of offenders' participation in the mental health court. Overall, about 21% of referrals are accepted into MHC4.

Defendants with primary Axis I diagnoses, in alignment with state criteria for serious and/or persistent mental illness, and/or with co-occurring disorders are accepted into the MHC4 program. MHC4 has both pre-disposition and post-plea participants, and accepts both misdemeanor and felony cases. About 58% of participants in the program have been misdemeanor cases, and 42% felony. With pre-disposition cases, after defendants sign consent forms, they are brought into the court to formally enter MHC4. The court will continue the cases rather than determining dispositions and, upon successful completion of MHC4, dismiss the charge. If pre-disposition participants are not successful in the program, the cases may be returned to the court of original jurisdiction for adjudication. For post-plea cases, the court formally accepts guilty pleas once defendants have met all of the requirements for the MHC4. Participants who have pled guilty but decide not to complete the program can voluntarily withdraw, face sanctions of serving county jail time, and then transfer to standard probation. For other participants who are not meeting program requirements, the state will file petitions to vacate probation, and have disposition hearings to determine sentencing.

MHC4 is designed as a three-phase program. Participants start out in phase one with intensive support and supervision, seeing the MHC Judge and probation officer every week, gradually progress to phase two with reduced support and supervision, and then move to phase three with minimum support and supervision leading to graduation. Terms of participation are individualized based on need, although MHC4 utilizes a standard formal written contract. Participants also sign a release of information on entering the program allowing court and mental

health staff to communicate. There are no established minimum or maximum time periods of participation in MHC4. Generally, participants spend from one to two years in the program.

MHC4 court hearings and staff meetings are held weekly. Monitoring of participants between MHC4 hearings is accomplished by probation officers and mental health staff from the mental health center. Each participant meets with an assigned probation officer on a regular basis, at least weekly at the beginning of the program, and also meets regularly with a mental health worker, generally a case manager. A few participants have private mental health care providers that report to the probation officer rather than attending staff meetings. However, most participants have regular contact with a case manager and other clinicians from the primary agency, such as the nurse, trauma therapist, dual diagnosis therapist, and others, depending on the specific treatment plans developed. These mental health professionals maintain regular contact with MHC4 probation officers regarding activities of participants. The community mental health center is heavily involved because it is the only community outpatient mental health provider in the county. Some participants may receive services from other mental health agencies, such as housing, assisted living, and inpatient drug rehabilitation, but the majority of the services are provided by the designated mental health staff on the MHC4 team. A MHC4 nurse position was also created through specialized funding to focus on medication management and other health issues of participants. Additionally, three mental health jail staff work as liaisons between the jail and the community agency so that incarcerated individuals receive mental health treatment. These liaisons occasionally attend MHC4 staff meetings, at times making referrals or reporting on MHC4 participants who have been incarcerated for sanctioning or new arrests.

Similar to the MHC2 program, MHC4 personnel conveyed a willingness to be flexible in the performance of work roles. The Administrator, probation officers, and clinicians spoke of working together as a team to best suit the needs of participants. They explained that work tasks to assist participants are not rigidly defined by roles, but rather are shared by the different members, each of whom performs tasks when needed that may not typically be part of their professional roles.

A variety of sanctions are utilized by MHC4 for participants who are non-compliant, including verbal reprimands, public service hours, writing assignments, and jail for the worst violations. In some instances, violators may be required to come forward and sit in the jury box at the beginning of a MHC4 court call. This sanction provides others in the court with direct views of these participants, which they, in turn, may find embarrassing. This also serves as temporal punishment, as participants must wait and are not allowed to leave until the hearings are over. During staff meetings held prior to court calls, sanctions are thoroughly discussed before being applied. Sanctioning decisions may sometimes occur through adversarial processes; in this area, the MHC4's process of determining appropriate sanctions for noncompliant participants differed significantly from those in other Illinois MHC programs. Specifically, as observed in several cases discussed during MHC4 staff meetings, the Public Defender argues for no or less sanctioning, while the ASA or others on the team may argue for more sanctioning, and the judge makes a final determination. During the MHC4 court call, however, the team members maintain a united front, and do not engage in arguments about sanctioning appropriateness in the presence of participants or other court observers.

Mental Health Court 5 (MHC5)

- **Number of participants:** 102 (54 men, 48 women)

- **Level of offense heard:** misdemeanor and felony
- **Adjudication model:** pre-plea
- **Supervision model:** combination court and county mental health staff

The total population of the county of MHC5 is less than one-fifth the size of the county of MHC8, yet the MHC5 program was the largest MHC studied, with 102 active participants in the spring of 2010—48 females and 54 males. Eighty-four participants were white, nine were black, six were Asian, and 8 were of Hispanic/Latino ethnicity. As in other Illinois MHCs, blacks were overrepresented in MHC5 relative to the local population, while Asians and those of Hispanic ethnicity were underrepresented.

MHC5 was the first MHC program established in Illinois, beginning operations in early 2004. As early as 1998, local advocates from the National Alliance for the Mentally Ill (NAMI), after hearing about this new court model at a NAMI convention, began talking with officials at the local health and probation departments, suggesting the need for a program. In addition to NAMI, the State's Attorney in the county played a key role in locating resources, planning the program, and getting MHC5 started: a process which took six years. Although a drug court had been established earlier in the jurisdiction, MHC5 staff report that their MHC program was not modeled on the drug court, which operates with different rules and personnel as an entirely separate program.

The MHC5 team consists of a judge, Assistant State's Attorney, a senior clinical social worker from the county health department, one part-time and two full-time probation officers, a probation supervisor, and a Program Manager, out of the Court Administrator's office. Unlike other MHC programs studied, where service providers from outside of government are MHC staff members who regularly attend meetings, the MHC5 team is made up entirely of

government employees, who attend staff meetings held once a week before MHC calls. Some participants have private attorneys who occasionally attend parts of staff meetings, but representatives from various social service agencies do not. Instead, the probation officers contact service providers regularly via telephone and visits to get updates on participants' progress. Some of these providers are located outside the county, as MHC5 accepts some referrals who reside in another county. Participants who are local and must rely on public services do so through the MHC5 county's health department. The Senior Clinician refers them to appropriate county services, and serves as their case manager for treatment as well as other public services.

When MHC5 began, the Public Defender's office was the primary referral source and NAMI also made a number of referrals. As the program grew and became more well-known locally, referrals began to come from a variety of sources, including police departments, the health department, the local community mental health center, private attorneys, and family members. A referral is made via the filing of an application order by a defendant, which continues the case for three to four weeks so that the Assistant State's Attorney (ASA) can screen the defendant for MHC5. The ASA runs the defendant’s criminal background and learns specifics of the current charge. The ASA also considers whether or not a pattern of behavior is a public safety concern, and talks with victims and police officers about the offense to see if they object to participation in MHC5.

The program accepts both misdemeanor and felony defendants. In the spring of 2010, 51% of participants faced misdemeanor charges while 49% faced felony charges. Generally, violent offenses are excluded, as are a number of offenses per Illinois statute including sex, DUI, armed robbery, and home invasion offenses. Once the ASA deems cases appropriate for MHC5,

the cases are continued another four to six weeks while the Clinical Supervisor conducts intake assessments with the referrals to determine the validity of mental illness, its primacy relative to substance use issues, and whether or not a nexus can be established between the mental illnesses and the criminal charges. During this time probation officers conduct LSI-R (Level of Service Inventory–Revised) screenings, a risk-needs assessment for offender treatment planning. If the Clinical Supervisor determines that there are mental illness-crime connections, the team then discusses each referral at staff meetings and determines which individuals are appropriate to begin the program. Those referrals deemed appropriate have their cases continued another two to three weeks until acceptance orders are prepared and formal acknowledgments of willingness to participate are entered in court. MHC5 accepts participants with Axis I or Axis II mental health diagnoses, and the primary diagnosis for those with illicit drug issues must be mental illness rather than a substance use disorder. Forty-four percent of MHC5 referrals eventually enter the program.

MHC5 is a pre-plea program in which participants' charges are held in abeyance and then dismissed or reduced upon successful program completion. The minimum participation period in MHC5 is twelve months, while the maximum is thirty months. For those who do not successfully complete the program, participants may accept a plea agreement or have their cases returned to the court of original jurisdiction for adjudication.

MHC5 staff explained that, because the program is pre-plea, the Clinical Supervisor, probation officers and Assistant Public Defender assigned to MHC5 limit sharing participant information with the judge and ASA. Participants do not sign one overall release allowing the sharing of information among all staff, as is done in other MHCs, although they may sign releases of information when needed. In explaining how the team works together, the Clinical

Supervisor and probation officers spoke of working mutually to case manage and monitor participants, rather than playing clearly separated roles. The public defender communicates with these team members regularly, and motivates participants to follow their treatment plans and program guidelines when problematic situations arise. Yet specifics of these contacts may not be shared with the judge and ASA, as the cases may be adjudicated at later times if participants leave the program. The public defender described that information on participant progress is limited by discussing each case with the Clinical Supervisor and probation officers and then determining what information is shared with the judge, including filtering out information that may prove harmful to the participant if shared. However, case progress presented to the judge during staff meetings at times did bring in negative aspects of participants' performance, suggesting that editing of negative report information is selective. The ASA described playing the role of gatekeeper for entry into MHC5, while the public defender described playing the role of gatekeeper of information during program participation. The MHC5 judge employs a variety of sanctions with participants, including increased frequency of meetings or groups, participation in county work program requirements, added electronic monitoring, and time in jail. As in MHC4, decisions on such sanctions as serving hours in the county work program or spending time in jail may be arrived at in an adversarial process, with the Assistant Public Defender arguing for no or less sanctioning and the judge making a final determination. This contrasts with the team-decision process in other Illinois MHCs, wherein the judge receives full information on both positive and negative progress from the rest of the team before rendering sanction decisions.. The adversarial process described during interviews was actually observed in only a few cases being discussed during a staff meeting; other cases discussed involved the judge and the rest of the team working cooperatively to decide sanctioning. Overall, concerns about

protecting participant's rights in MHC5 results in limited information sharing with the judge, a difference in the process of decision-making for sanctions in some cases, and a more adversarial role for the public defender compared to other MHCs.

Mental Health Court 6 (MHC6)

- **Number of participants:** 16 (7 men, 9 women)
- **Level of offense heard:** misdemeanor and felony
- **Adjudication model:** both pre-plea and post-plea with sentence to MHC
- **Supervision model:** court staff with criminal justice backgrounds

The MHC6 program serves a county with a total population of over half a million people. MHC6 was created after court and county personnel, including a Circuit Judge and representatives from the State's Attorney's office, Public Defender's office, and the county health department, began meeting to plan a drug court program. The group determined that a separate court was needed to deal with persons whose criminality was linked to mental illness rather than addiction. After the drug court was established and had been running for several months, the independent mental health court program was instituted, with some drug court participants transferred to the new mental health court. MHC6 staff now include the judge, the Assistant Director of Adult Probation, a probation officer who also serves as Program Coordinator, a pretrial services officer, two assistant state's attorneys (ASAs), two assistant public defenders, and county health department workers, including a supervisor and two case managers with clinical social work backgrounds. The MHC6 docket is heard weekly.

In the spring of 2010, MHC6 had 16 active participants, seven males and nine females. Five of the participants faced felony charges, while 11 faced misdemeanors. Ten participants were white, six were black, and one was Hispanic. MHC6 is another example of an Illinois MHC

in which, among participants, blacks are overrepresented and Hispanics are underrepresented relative to the local population. The MHC6 program accepts defendants with Axis I or Axis II diagnoses. Defendants with co-occurring disorders are also eligible for the MHC6 program, but those who have primary substance use disorders are excluded and may be referred to the local drug court. The MHC6 program accepts participants with misdemeanor and nonviolent felony offenses on either post-plea or pre-plea bases. Post-plea participants plead guilty and receive probation sentences to comply with the treatment requirements of the MHC6 program during their probationary periods. Some participants were serving regular probation sentences and were referred for probation violations. Participants who enter the program on a pre-plea basis are placed on bond conditions that compel them to follow the court's treatment requirements, and, if they are successful in completing the program, their charges are generally dropped.

Referrals come from a number of sources, including defense attorneys, judges, law enforcement officers, jail staff, mental health providers, family members, pretrial services, and probation officers. Sixty-four percent of referrals eventually enter the MHC6 program. Staff in the pretrial division of the county court system often identify individuals who have mental illness listed in bond reports, which can lead to referrals of pre-plea cases. If the referrals come from the probation department, these are post-plea cases in which the probation officer has determined that probationers may have mental illness, making them appropriate for the MHC6 program. Generally, pre-plea cases involve persons considered to be low risk, because they do not have much or any criminal histories and their offenses are often less serious than post-plea cases. There are no established overall minimum or maximum participation time periods in MHC6.The participation requirement for pre-plea cases is generally between one and two years. Post-plea

cases are often felony probation sentences of more than two years, which may be reduced to 18 to 24 months depending on participant's progress.

New referrals must sign petitions to enter the program and waivers of confidentiality allowing MHC6 staff to share information. An ASA reviews each referral and acts as a "gatekeeper," rejecting some referrals which go no further, but accepting others which are then sent to case managers for further consideration. The case managers, who work for the county health department, complete formal mental health assessment forms for each referral, capturing historical and diagnostic information from participants. Case managers also gather information from previous treatment provider reports and from family members. This information is used to verify diagnoses and determine how needs can be met by the MHC6 program. Occasionally individuals are referred who have never been diagnosed with mental health disorders before. In these instances, the case managers may ask for psychological evaluations from probation services, or have participants receive psychiatric assessments. After this process is complete, and diagnoses are confirmed or determined, the case managers develop primary treatment plans for the referred individuals. The Coordinator places all assessed referrals under a "pending" section of the twice weekly staff meeting report, and the MHC6 team then discusses the referrals and votes on whether or not they should participate in the program.

Most services for participants in the MHC6 program are provided through the case managers, who manage participant referrals to psychiatric care and therapy, while also determining what financial resources exist to cover these services for participants. The probation officers also have regular contact with participants, and during staff meetings may suggest participant needs for the MHC6 team to discuss. Typically, the probation officers oversee all justice and administrative activities pertaining to their cases. Once preliminary treatment plans

have been received from the case managers, the probation officers may refer participants to community agencies, because not all resources are available through the county health department. For example, a number of participants need residential dual diagnosis treatment, which is typically obtained from a mental health agency through the probation department, and funded by the probation department. However, the county health department is the main provider; MHC6 staff report there are only a few other agencies involved in providing services to program participants. Because of this, the probation officer and county case managers usually work together in case management of post-plea participants, and the supervising officer for pretrial services also works with the case managers in a similar way. In addition, the Assistant Public Defenders assigned to the MHC6 were observed during staff meetings working to assist with case management functions such as providing rides for participants to service appointments and assisting them with paperwork.

In an interview the MHC6 staff described that monitoring is similar for pre-trial and post-trial participants regarding frequency of contacts, although pre-trial services staff typically make home visits whereas the probation officer dedicated to the mental health court typically schedules participant visits at the probation department. The MHC6 probation officer explained that sometimes as a sanction the judge may require participants to visit the probation department, or even the judge's office, more than once a week, possibly every weekday. Other sanctions for noncompliance include formal verbal admonishment by the judge during court hearings and, for the most serious violations of program requirements, days in jail.

The judge of MHC6 may drop charges (pre-plea) or reduce or end probation sentences (post-plea) for participants who successfully complete the program. Participants who are not successful and fail to comply with MHC6requirements may face one of several possible

outcomes. If unsuccessful participants entered the program on post-plea bases and the charges were relatively serious, such as felony level, then the state files petitions to revoke their probation and negotiate jail sentences with those participants. Although entitled to hearings on the petitions for revocation, these participants usually come to an agreement on the jail sentences without asking for a hearing. MHC6 may sentence other post-plea participants with felony cases to jail or prison terms after revoking their probation. For participants who are noncompliant and unable to finish satisfactorily but have relatively minor offenses, the ASA and judge may agree to terminate them from the program without further jail sentences or sanctions. When pre-plea cases are terminated from the program, the state pursues charges and, if former participants are convicted, this results in a jail or prison sentences or standard probation sentences, and criminal records.

Mental Health Court 7 (MHC7)

- **Number of participants:** 19 (6 men, 13 women)
- **Level of offense heard:** misdemeanor and felony
- **Adjudication model:** post-plea with sentence deferred
- **Supervision model:** court staff and mental health providers

MHC7 serves a county made up of several small cities and rural areas numbering over 300,000 in population. In the spring of 2010, MHC7 had 19 active participants, six males and 13 females. Sixteen participants were white and 2 were African American, while the other 2 were reported as "other" and "Latino" on the survey question on race According to these responses, black participants are overrepresented in MHC7 relative to the largely white local population, while Hispanics are underrepresented.

The idea of beginning the MHC7 program first emerged in the county during circuit judge meetings in late 2003 and early 2004 as judges engaged in general conversation about future ideas for courts. At the time, the judges did not believe that they had the manpower or the support of the bar association to proceed. But collectively, the judges noted how often they were seeing the same defendants known to have mental health issues, and often also substance use issues, repeatedly in their courtrooms (a core group of about 25 to 30 defendants according to the estimate of the MHC7 judge). Interestingly, the process in the county differed from other counties in that a drug court program had been discussed in 2001 and briefly initiated, but was discontinued within months as neither unified resources nor financial stability were in place to sustain the drug court program. The MHC7 program, conversely, received more broad-based support in its initial stages after the idea gained momentum when the State's Attorney and the county board formed a task force of judges, several county board members, and the sheriff and representatives from that department, including corrections, office personnel, and a deputy. Soon court services, social service agencies, representatives from the National Alliance for the Mentally Ill (NAMI), the local 708 Board, and the county health department were also involved in discussion groups about beginning an mental health court. The concept came to fruition in April of 2007 when the MHC7 program accepted its first participant. The task force continued to meet during the first few months of program operations to ensure that, unlike the previous drug court attempt, the MHC had enough resources in place to sustain itself.[4]

MHC7 conducts hearings twice a month. Members of the MHC7 staff include the judge who is designated to preside over the mental health court docket, the Program Coordinator, a designated probation officer, assistant state's attorneys, public defenders, and two mental health

[4] Court and county officials in the county of MHC7 have since made a second attempt at a drug court program, which began operations in late 2011.

workers from the primary mental health provider in the county. One of these staff is a nurse who focuses on medication and health monitoring of program participants, while the other is a clinician providing direct services to some participants and also serving as a treatment liaison between the MHC and other community mental health agencies. The Program Coordinator is an employee of the court administrator's office who serves an important administrative role for the MHC program: attending staff meetings and providing input on participant cases, pre-screening referrals, assisting in making contacts with various governmental agencies for participant needs, and setting up functions with criminal justice representatives as needed.

The majority of referrals to MHC7 come from the Public Defender's office, but are also received from a variety of sources including private defense attorneys, family members, police officers, or the jail. The MHC7 judge is also responsible for initial hearings for all newly arrested defendants, which occur every morning. If the judge believes one of the defendants at these hearings suffers from mental illness, the case is referred to the Program Coordinator, and the offices of both the State's Attorney and the Public Defender are alerted that the defendant may be a candidate for mental health court. The Program Coordinator conducts a pre-screen of all new referrals to determine if they meet program eligibility requirements.

Once referrals have been prescreened, those cases judged potentially appropriate for the MHC7 program are referred to the mental health clinician responsible for conducting assessments; these assessments are often done while the referred defendants are still in jail. MHC7 staff members consider referrals to be appropriate for the program if, during the assessment process, the defendants display willingness to comply with program parameters, and a desire to learn social skills and life skills. After assessments are completed, and screenings has been completed by the State's Attorney's office, the MHC7 team discusses those results and case

specifics to determine whether or not the referrals are suitable for the mental health court. Such discussions occur during regularly held staff meetings, wherein progress with other active cases is also discussed. After the staff collectively decides that referrals are appropriate, their cases are scheduled for appearance in the regular MHC7 call in order to formally enter the individuals into the program. MHC7 accepts 25% of all referrals.

The Program Coordinator has the goal of sending either acceptances or denial notices to the defense attorney within 30 days of the initial referrals. This benchmark is established as it is believed that the faster referrals are able to enter the MHC7 program, the more likely the program will be effective and the defendants will successfully complete it. A concern expressed during interview is that defendants who linger in jail for some time may decompensate, thus rendering them unfit to enter the program. On the other hand, a significant number of referrals have already returned to their homes after meeting bond and being released from jail before subsequently being referred to the MHC by their defense attorneys. For those referred individuals who are in custody and homeless, after treatment providers have visited them and conducted assessments in jail, the individuals are transferred directly from jail to a group home on entering the program. Occasionally some participants living at home with family may be referred to residential services if the court staff determines that residential treatment would be beneficial.

The MHC7 accepts defendants with only Axis I diagnoses; although participants with co-occurring disorders are accepted into the program, it excludes those who have a primary substance use disorder. Both misdemeanors and felonies are acceptable offense types, including some violent felonies if the charges are not specifically proscribed by Illinois law regarding MHC programs. At the time of the survey, five participants had misdemeanor cases and 14 had

felony cases. As in MHC3, participants in MHC7 enter the program on a post-plea, pre-sentence basis by pleading guilty to their offenses and having their sentences deferred. Formal terms of participation are established, with individualized requirements routinely added. Participants sign initial release of information forms on entering the program, allowing the court and mental health staff to communicate, while subsequent releases of information for other purposes may be utilized.

The program is structured in phases, with phase one requiring the most frequent contact with probation and the court (weekly visits with the probation officer and court appearances twice a month). There are three more stages of progress to the highest, phase four, during which participants near graduation and may come to court on a monthly or even—for those doing "really well"—a bi-monthly basis, while also seeing the probation officer monthly. However, even in this last phase most participants have regular contact, sometimes weekly and often over the telephone, with the nurse and mental health clinician. Standard criteria for completion of the fourth phase and graduation from the program include a specified period of time of treatment adherence, and employment or other involvement in structured activities. The average length of participation in the program is one to two years, with twelve months being the minimum period of time required in the program and twenty-four months the maximum.

MHC7 utilizes a variety of sanctions for noncompliant participants, including verbal reprimands, essay assignments, online research assignments, community service, curfews, increased frequency of court appearances, and jail. Regarding termination from the program, the Program Coordinator reported that over the previous year six people had been terminated for noncompliance or had opted out and entered pleas, although a total of 35 individuals had participated in the MHC. Participants who are unsuccessful in the program may have their cases

returned to the court of original jurisdiction for sentencing. Although formal discharge hearings are possible to determine whether or not participants are going to be discharged, participants who do not adhere to MHC7 program requirements will more commonly voluntarily leave the program, or there may be plea negotiations with the public defender or private attorneys and the ASA. If participants facing termination have been in the program for over a year and have misdemeanor cases, the ASA will accept pleas to the charges and close the cases. Almost all participants who complete the program and successfully graduate have their charges dismissed,.

The nurse, mental health clinician, and probation officer for MHC7 maintain regular contact with each other in monitoring and coordinating participants' activities and services. They describe taking a team approach to providing case management and meeting participant needs, working together to pursue referrals for services, solve problems, and deal with any issues that may arise. In addition, they attend staff meetings held every two weeks (occasionally more often) with other members of the team to discuss participant progress and concerns. At these meetings other members of the team, i.e. public defenders, judge, coordinator, may also contribute to case management by providing information about possible resources and considering how best to meet participant needs. The Assistant State's Attorneys do not become directly involved with participants, as in other jurisdictions, but they too are involved in staff meeting discussions, and may offer opinions about participants or make connections with law enforcement as needed.

Staff of MHC7 spoke of some overlap between the roles of the probation officer and the mental health clinician and nurse, in terms of monitoring and providing support for participants. As was the case in MHC2, MHC4, and MHC5 programs, team members in MHC7 expressed a willingness to be flexible, and explained that they help each other at times in the performance of work functions. For example, if needed, the probation officer may assist with a mental-health

related task, or the clinician may help the probation officer with a monitoring issue. However, the probation officer, nurse, and mental health clinician also described their roles as being specifically defined, and these are made clear during initial contacts with new participants. The three staff meet together with individual participants entering the program and discuss the individuals' treatment needs and participation goals. They refer to the psychological and mental health assessments previously conducted with the new participants, as well as level-of-service inventories, and ask for input from the participants regarding their perceptions of needs and goals and preferences of possible treatment providers. At this time the nurse works to identify a psychiatrist for participants, if one has not already been determined, or works with the participants to consider their treatment recommendations, including medications, from their current psychiatrists. The nurse also focuses on treatment and medications for other health conditions, and discusses these with the participants. The mental health clinician discusses mental health treatment needs with each participant, determining which providers participants would prefer to receive services from, and developing plans for accessing these services regularly. Such treatment is often provided directly by the mental health clinician or the community mental health center where the clinician works. The probation officer discusses the participant's court orders, including specifics of program compliance, and requirements and goals regarding public service work, random urine screens, residential arrangements, home visits, and employment. Collectively, the three staff members engage participants to set up workable plans that fits their individual needs and preferences and meet the requirements of the program, and then help participants carry out those plans.

Mental Health Court 8 (MHC8)

- **Number of participants:** 55 (30 men, 25 women)

- **Level of offense heard:** felony
- **Adjudication model:** post-plea with sentence to MHC
- **Supervision model:** court staff and mental health providers

Mental Health Court 8 had been operating almost six years at the time of the survey. The program serves a large city in an urban county. The idea for the program formed when staff operating the local drug court discovered a large need for mentally ill substance abuse (MISA) treatment among participants. Also, some criminal justice officials, including judges, learned about MHCs being developed elsewhere through conferences and judicial literature. A non-profit behavioral health agency, already involved in operating the drug court, was a "driving force" behind planning and strategy meetings for the MHC, and obtained a federal grant to begin the program.

Unlike any other court researched in this study, the MHC 8 program is divided by gender, so that court hearings for a women's program are held on one day of the week, and court hearings for a men's program are held on another day. This followed the model previously established by the county's drug court program, after staff determined that some female participants were being negatively affected by men in that program with whom they had relationships. The men's and women's MHC programs involve most of the same staff, but have two different judges. In general, the same overall processes and rules are in place for both programs, and hearings for both are held in the same courthouse, albeit in different courtrooms on different floors. For the purposes of this study, MHC8 is considered to be one overall program that can be compared to the other eight MHC programs studied which do not separate hearings by gender.

The MHC 8 staff includes two judges (men's and women's programs), an Assistant State's Attorney, two Assistant Public Defenders, a probation officer, social workers, case manager, and

a clinical staff supervisor from the behavioral health agency, an Administrator of Programs (out of the State's Attorney's office), and county jail staff. This team regularly attends staff meetings held before MHC court calls, with the men's and women's calls each held once a week. Mental health staff from various other community service providers may attend staff meetings on occasion as needed. Additionally, interns from graduate psychology programs at local colleges and universities are utilized for tasks such as psychological assessments, and may also attend staff meetings.

Referrals to the MHC8 program can come from a number of sources, but most referrals come from the county jail. Several staff stressed the importance of a data linkage system that connects consumer data from the Illinois Department of Mental Health with jail data on detainees. This management information system allows county employees working with the MHC to identify detainees who have previously received state services due to a mental health condition. Detainees identified through the system are then screened to determine if they have been diagnosed with mental health disorders and are being held for non-violent felonies. Those individuals determined to be appropriate are then referred to the MHC staff and approached about possible participation in the program. Detainees' defense attorneys will also be contacted and included in the process, typically public defenders. If the detainees express interest, MHC clinicians and designated Assistant Public Defenders will meet with them in the jail to explain the program more fully. For both jail detainees and all other referrals, the Administrator runs criminal background checks to ensure that the criminal histories of referrals will not prevent approval of participation in the program by the State's Attorney's office. In addition, all screened referrals are discussed by the MHC staff in meetings, who collectively decide whether or not to accept individuals into the program. About 55% of referrals eventually begin the MHC program.

In the spring of 2010, the men's MHC program had 30 participants while the women's program had 25. Noticeably, among the 55 program participants, 48 (88%) were black, while 7 (12%) were white. A separate survey question asked for the number of participants who were of Hispanic/Latino ethnicity, and the response was zero. The overrepresentation of black participants and underrepresentation of Hispanic/Latino participants was even more pronounced in MHC8 than it was in other Illinois MHCs. All participants were charged with felonies, and nine percent were first-time offenders.

The program works solely with defendants who have primary Axis I diagnoses, and are charged with non-violent and non-sex offense felony offenses or felony probation violations. As one staff member explained, MHC8 is a felony program because it is conducted in a courthouse that only hears felony cases. Misdemeanor cases are heard in various other court locations in the city. However, the program's 24-month intensive probation requirement is also a lengthy probationary sentence compared to what misdemeanor defendants may otherwise face. At the time of the survey, the urban county was operating one other felony MHC program, Mental Health Court 9, which is discussed below, and planned to open one other soon; both are in suburban locations.

Participants enter the MHC8 program by pleading guilty to their charge and then being sentenced to 24 months of MHC probation. For some participants, the 24-month requirement may be reduced slightly, while for others it may be extended if they incur new charges. New participants sign formal, standard written contracts, which routinely have individualized terms added, as well as release of information forms allowing the court staff, mental health staff, and others to share information. The criteria for graduation from the program include a specified

period of time adhering to treatment, as well as a specified period of time remaining drug and alcohol free.

Monitoring during the program is accomplished by a dedicated probation officer, who meets with program participants up to once a week, and by case management staff. After initial appointments with prospective participants, the case managers develop treatment plans with input from other MHC staff, and then refer participants to other mental health and social service programs. The local area has a number of service providers which case managers utilize. Participants may be referred to other agencies that can also provide case management services, which could involve individual and group therapy, inpatient treatment, outpatient treatment, residential programs, substance use treatment, and/or psychosocial rehabilitation. As one staff explained, case management is provided for criminal justice purposes, and case managers function as "brokers" of service provision, depending on participant need and court status, from a myriad of options available in the area.

The judge and the rest of the staff in the MHC8 program apply various sanctioning methods when program participants are noncompliant; these methods were discussed during the focus group interview and observed during MHC hearings. In staff meetings held before each MHC hearing, the team discusses each participant on the day's docket, as well as others and new referrals. At this time, case managers and the probation officer provide reports to the judge on each participant's treatment progress and, collectively, the MHC team makes decisions regarding the need for sanctions—whether or not to sanction and, if warranted, what type of sanction to levy. Judges for both the men's and women's program engage participants on a personal level during hearings, as judges in other Illinois MHCs do, and offer praise for participants who have been following program requirements, while admonishing those who fail to follow treatment

plans or violate program or residential rules. Judges displayed patience for participants who made mistakes, such as missing appointments, but had been in the program for a number of months and had histories of compliance. During hearings, judges asked why the mistakes occurred, then mildly verbally reproved the participants while praising their past efforts. Judges also showed patience with participants who made mistakes while new to the program, and provided mild admonishment combined with explanations of the needs to follow program guidelines in the interest of successfully completing treatment. Judges made the strongest verbal warnings to those participants who repeatedly violated plans and rules, sometimes threatening—and at times initiating—incarceration or removal from the MHC program.

Another basic sanction determined during staff meetings involved changes to or continuances of the length of time between scheduled court hearings. If participants had, in the opinion of the MHC team, displayed strong adherence to the program for a significant length of time, then the team might decide to reduce the frequency of court appearances (i.e. from weekly to bi-weekly or monthly). The judge would then present the schedule changes to the participants during the hearings, and note its meaning as a sign of progress. Conversely, if participants had not displayed significant progress, then the MHC team might decide on reducing the length of time between hearings, or continuing weekly appearances. During hearings along with verbal admonishment, the judge would then present the frequent appearance schedule as required due to participants' lack of progress.

Participants also faced sanctions if they had substance use issues and relapsed, which would be detected through drug screens conducted by the case managers or probation. Such drug-involved participants might be required to receive inpatient treatment in the county jail health facility for a period of time, at the end of which they were released into an inpatient

treatment facility while continuing in the MHC program. If participants were seriously noncompliant, such as repeated refusals to participate in treatment over time, the Assistant State's Attorney filed violations of probation, and the participants were remanded into custody. This often involved participants being ordered to inpatient beds in the county jail health facility for mental health treatment. Eventually, if the judge determined that the violations warranted dismissal from the MHC program, the individuals might attend a MHC hearing, be removed from the program via probation revocation, and be re-sentenced on the guilty plea, which could result in a multi-year prison term. However, in some cases the judge, in consultation with the rest of the MHC team, might decide that noncompliant participants did not need further prison sentences or probation monitoring. In those instances, the participants were "PTUed," or terminated from probation unsatisfactorily, with no further sentence. Such cases generally involved participants who, although unable to successfully complete the MHC program, had served significant time on probation.

Mental Health Court 9 (MHC9)

- **Number of participants:** 6 (3 males, 3 females)
- **Level of offense heard:** felony
- **Adjudication model:** post-plea with sentence to MHC
- **Supervision model:** court staff and mental health providers

MHC9, which began in August of 2008, is in a suburban location in the same county as MHC8. Of the nine MHC programs, MHC9 was the second smallest, with only six participants at the time of the survey, including three males and three females. Four of the participants were white, one was black, and one was Asian. None were of Hispanic/Latino ethnicity.

A local township government was instrumental in beginning MHC9. The director of the local mental health commission obtained a grant and contacted the MHC8 team, explaining the need to set up a mental health court in that area. The director also contacted judges at the local courthouse who assisted in scheduling a regular mental health court time and having a judge assigned to hear cases.

MHC9 is modeled on MHC8, having the same basic requirements for participation. These include only accepting non-violent, non-sex offense felony offenders and probation violators with an Axis I diagnosis. MHC9 also utilizes a number of the same staff persons, including the behavioral health agency clinical staff and supervisor, and the Administrator of Programs out of the State's Attorney's office. During the study the probation officer from MHC8 also began to work at the suburban MHC9 in addition to the urban court. A number of community service providers, including a local hospital, rehabilitation, and housing services, have representatives who regularly attend staff meetings, which are held twice monthly before MHC calls. Some of these representatives participated in the focus group interview. Interns from local psychology graduate programs assist the program as needed.

When asked about referrals, MHC9 staff discussed that they may come from a number of sources, including the county jail, judges who note erratic behavior of defendants, and defense lawyers. A social worker explained that the majority of referrals come from the medical facility at the jail. The Illinois Department of Mental Health data management system described earlier is utilized, cross-matching the daily jail census with Department records of service provision. Referrals from the police are made during local arrests. The assignment of cases to a court district depends on where the case originated: where the offense occurred and where subsequent charges are filed. However, in interview MHC9 staff explained that a case had been accepted

from a neighboring municipal district that had no MHC program. A social worker also noted that a participant was allowed to transfer MHC programs and report to probation at the courthouse in the neighboring city, as this was closer to the participant's residence.

The Administrator of Programs runs a background check for the State's Attorney's office to screen all MHC9 referrals. Approved participants enter the program by pleading guilty and receiving a 24 month sentence of MHC probation. The program accepts non-violent felony offenders, but no misdemeanors, as in MHC8. Court case managers follow the same assessment and service planning procedures. Referrals must have mental health diagnoses completed prior to being assigned case managers, who then conduct assessments and develop service plans. A case manager explained that during this process they rely heavily on information from collateral sources, such as other service providers in the community. Monitoring during the program is accomplished by the probation officer and by case managers.

The members of the MHC9 staff who also work with MHC8 noted an important difference between the programs. The police department of the MHC8 city has a trained Crisis Intervention Team (CIT) that can be called at the scene of incidents involving offenders thought by other officers or citizens to have mental illness. These are police officers especially trained to defuse crisis situations in which a person has become psychotic. In the area of MHC9 there are a number of different police departments, but no specific CITs among them. "That hasn't been big in the … suburbs" is how one staff member explained the lack of crisis intervention training. MHC9 staff explained that officers from several suburban police departments and the sheriff's department have worked with them in dealing with participants, but they also described issues with other officers and departments where there was a lack of training and a lack of cooperation with the program and with providers.

As in the other MHCs, basic sanctions in the MHC9 program include verbal praise or admonishments from the judge regarding recent program participation, or continued, increased, or decreased periods of time between scheduled court hearings. In discussing sanctioning, the staff explained that jail incarceration is used as a last resort for a pattern of noncompliance. The Probation Officer explained that often this involves repeated positive drug screens, and the concern that filing a violation of probation might be necessary to transfer the participant back into treatment. When participants are incarcerated for a probation violation, the judge works to have them sent to the large county jail health facility in the city. Even when violations of probation are filed and participants are incarcerated, the team explained that they work hard to "keep folks in the program" rather than having them terminated from MHC9 and re-sentenced.

CHAPTER SEVEN

Summary and Conclusions

First established in Broward County, Florida, in 1997, Mental Health Courts (MHCs) were developed in response to the apparently escalating numbers of people with serious mental illness (PSMI) who were involved in the criminal justice system. Based on the principle of therapeutic jurisprudence and modeled after Drug Treatment Courts (DTCs), MHCs proliferated throughout the first decade of the 21st century, growing in number from a reported four operational programs in late 1997 to more than 300 by mid-2014, and operational in nearly every state (Council of State Governments, 2014). The precipitous growth of such programs—also known as problem-solving or specialty courts—was spurred by federal support from the Bureau of Justice Assistance's Mental Health Court Program. This program has accorded dollars, training, and technical guidance to more than 100 MHCs in more than 40 states (Council of State Governments, 2014). The common goals of such courts include diverting offenders from incarceration, reducing recidivism, and enhancing public safety and the quality of clients' lives (Council of State Governments, 2007; Sarteschi, 2009).

MHCs are designed to serve the challenging, multifarious, and extensive service needs of PSMI. They provide treatment and programming through comprehensive case management strategies, which draw on permanent partnerships with community-based agencies and a wealth of providers through a brokered network of interventions. Most employ a team approach to supervision, with dedicated stakeholders (prosecutors, defense attorneys, probation officers, mental health professionals), individualized treatment plans, voluntary and informed participation, specialized dockets and caseloads, and highly involved and proactive judges who preside over frequent court hearings and non-adversarial proceedings. Satisfactory program

completion is defined by predetermined criteria. Clients are motivated to succeed by the threat of sanctions and the promise of rewards (Council of State Governments, 2007).

Methodology

The evaluation of Illinois' MHCs was performed in stages, with overlapping data collection procedures. The first phase of the research was intended to yield a snapshot of MHC programs in the state: jurisdictions in the planning stages of MHC implementation, those with operational programs, and those still deciding whether an MHC was feasible or warranted in terms of clients' needs for services and the availability of local resources to support court operations and client interventions. All 23 court jurisdictions in Illinois were contacted for the screener survey. Two survey approaches were employed. For those jurisdictions in the planning phase or uninterested in an MHC, two different telephone surveys were conducted, one set of questions for each type. For those jurisdictions with an operational program, a comprehensive written questionnaire was administered to examine program implementation and client characteristics.

Given the critical role of services in client recovery and adjustment, the second stage of the evaluation involved a telephone survey of major providers in a wide variety of service domains. The survey questions were primarily closed-ended and standardized to enhance the understandability and applicability of the questions, and to structure the analyses and interpretation of the data.

The next stages of the evaluation involved on-site triangulating data collection procedures in the nine operational MHCs: court observations, focus groups with program staff members, and archival analyses. Interviews with MHC clients and recidivism analyses were also

performed in three programs, which were carefully selected for this purpose due to the distinctive nature their location, size, program structure, and client population.

Findings

The MHC Landscape in Illinois

In spring 2010, 19 of the state's 23 (83%) court circuits participated in the screener survey. At the time of the study, six courts reported no plans for MHC implementation, six were in the planning process to establish an MHC, and nine had operational programs - two MHCs in one circuit court and one MHC in seven other circuits. From spring 2010 to spring 2014, the number of operational MHCs grew from nine to 21, an increase of 133% (GAINS Center for Behavioral Health and Justice Transformation, 2014). At the time of the screener survey, the nine operational MHCs served a total of 302 participants; 46% were women. The survey found that in the nine MHCs, most participants (58%) were white. However, African Americans were overrepresented among participants relative to the local population, whereas Latinos (measured as ethnicity) were underrepresented. These disparities were replicated in subsequent data analyses, and in some MHCs, they were quite pronounced.

Jurisdictions with no MHCs

Despite the inherent appeal of the MHC model and its philosophical underpinnings, a few judicial circuits in the study were disinclined to pursue the implementation of such a program. Among the surveyed jurisdictions that eschewed the creation of an MHC, decisions were rendered after careful consideration of client needs and community resources, particularly mental health services and other treatment options. With regard to the former, respondents concluded that the number of criminal justice-involved PSMI had not reached the critical mass necessary to justify the establishment of a specialized court to address such offenders' problems. With respect

to the latter, participants noted the dearth of both funds and providers necessary to treat PSMI. Some emphasized the relative paucity of dollars dedicated to the purchase of mental health services, which are typically underfunded compared with drug treatment services for offenders.

Jurisdictions with little or no interest in launching an MHC were smaller and rural in composition; these characteristics were generally conflated. Courts in rural areas of the state served smaller populations, and therefore, they had fewer PSMI and correspondingly fewer resources to meet their treatment needs. The dearth of mental health services and practitioners in rural areas of the country has been noted in national studies (President's New Freedom Commission on Mental Health, 2003). In jurisdictions without MHCs, ad-hoc efforts were undertaken to respond on a case-by-case basis to assist defendants (preadjudication) and offenders (post-adjudication) with mental illness.

Programs in the Planning Process

Unlike respondents who voiced no plans for an MHC, those in the planning process were all located primarily in large, metropolitan court circuits and counties. Overall, the planning processes in all counties were lengthy, deliberate, and collaborative. In some instances, the planning teams sought support and consultation from colleagues in their own or other criminal court systems or from MHC experts in the state. The planning teams also referred to established models of MHC structures and operations. The planning teams were quite inclusive, and they involved judges, the state's attorney, public defenders, sheriffs, and police administrators. In a few cases, the impetus for an MHC was the recognition that clients in the local DTCs also suffered from mental illness (i.e., they had co-occurring disorders), and they could therefore benefit from psychiatric services as well. The most reluctant members of the planning teams

were usually representatives of the State Attorney's Office or the County Board; the former were typically concerned about public safety issues and case dismissals. The latter were worried about financial constraints, particularly in the aftermath of the drastic cuts in state services for people with behavioral healthcare problems.

Operational MHCs

As the responses to questions about the planning process suggested, the nine MHCs that were operational in 2010 were located largely in urban jurisdictions. The first MHCs in Illinois were implemented in 2004 (MHC 5 and MHC 8), and the most recent one in the study period was implemented in 2008 (MHC 9). Most of the jurisdictions with operational MHCs actually performed a formal needs assessment before launching their programs, and they consulted with experts to help design the programs. All of the jurisdictions involved law enforcement administrators in the planning and creation phases of their MHC programs.

Owing in part to the support, advocacy, and proactivity of the Illinois Criminal Justice Information Authority and the Illinois Association of Problem-Solving Courts, program development benefitted greatly from the advice and experiences of other MHCs in the state. A supportive network of cooperation and information-sharing contributed to the rapid growth of MHCs in Illinois. The transmission of knowledge and expertise led to uniformity in court structures and operations. Most Illinois MHCs were largely characterized by the following 10 essential elements of an MHC (Council of State Governments, 2007):

- Broad stakeholder planning and administration of the program. (**Element 1**)
- The selection of target populations that address public safety and the link between mental illness and criminal involvement. Statutory exclusions of potential participants based on charges (e.g., sex crime and arson) and diagnosis (e.g., no primary substance abuse

disorder, developmental disabilities, or traumatic brain injury). Clients can be convicted of felonies and (or) misdemeanors. (**Element 2**)

- Psychiatric assessment occurs before acceptance. Participants are linked to services through direct partnerships with agencies or brokerage arrangements. (**Element 3**)
- Terms of participation that include mandatory supervision and mental health treatment. Separate dockets for people with mental illness (Axis I and II and co-occurring disorders). (**Element 4**)
- Voluntary participation and informed choice. Legal competence is determined before referral. The public defender is consulted in decisions to enter the programs. (**Element 5**)
- A wide range of treatment and service options to meet clinical and habilitation needs. (**Element 6**)
- Signed client releases that allow staff to review and utilize information about treatment histories and current status. (**Element 7**)
- Hybrid team approaches to case management with judges, attorneys, probation officers, mental health professionals, and Treatment Alternatives of Safe Communities (TASC) case managers who provide supervisory and brokered treatment services. (**Element 8**)
- Regular court hearings, which varied in frequency among jurisdictions. Phased supervision with graduated reductions in intensity as clients progress through the program without incident or rule-breaking. Contingency case management strategies are applied (rewards and punishments [almost all involving jail time or increased reporting and community service hours]). (**Element 9**)

- Programs collect data on outputs (number of defendants screened and accepted) and outcomes (number of clients successfully completing the program). (**Element 10**)

Models of Illinois MHC operations are in many respects highly traditional. Program staff members function as a courtroom work group with a judge at the helm. Indeed, judges are the predominant figures in each of the operational MHCs; they are intensely hands-on during hearings and are the instrumentalities of client change. Assistant state's attorneys are the gatekeepers, who screen all referrals for client eligibility and acceptance. Public defenders represent the legal rights and interests of clients, and they serve as client advocates and adversaries (in a legal sense) to the assistant state's attorneys. Probation officers monitor the conditions of MHC supervision and chart client progress. Court administrators, also known as program coordinators and managers, are the linchpins in court operations. Private attorneys are never regular MHC team members of course; however, in some programs, they did attend staff meetings at specific times when their clients' cases were discussed. In three jurisdictions, liaisons on the MHC team identified and approached potential referrals, worked with participants not yet released from jail, and monitored participants who had returned to detention. Mental health professionals and addiction specialists, including TASC case managers, are responsible for assessments, service provision, and sometimes, case management and supervision.

A variety of sanctions were employed with participants at all nine MHCs, which included communicating verbal praise and admonishment, lessening or increasing the frequency of court appearances, and imposing or removing community service hours. In one MHC, clients were rewarded at each hearing by allowing them to draw from a multi-colored bowl, called the "fish bowl," which contained rewards such as chips, candy, gift cards, movie tickets, and other small items. As noted above, jail time was meted out as a sanction in eight of the nine MHCs;

however, one MHC staff member explained that the program never used jail as punishment for participants, viewing it as an inappropriate sanction for PSMI.

As also suggested above, the roles and responsibilities of MHC personnel were generally circumscribed; nevertheless, MHC staff often discussed working together and remaining flexible in order to "get things done" for clients (coalescing around client needs). Staff members frequently mentioned teamwork as the key component of program and client success, and it was consistently apparent at case staffings. Judges and assistant state's attorneys participated heavily in team building, staff meetings, and case hearings. The MHC workgroups were close-knit teams with sometimes dissolvable and interchangeable roles and functions. "Functional crossovers" frequently occurred with probation officers qua case managers/service providers and mental health workers and TASC case managers qua rule enforcers. These crossovers were accomplished through frequent communication. Therapeutic jurisprudence reigned supreme: Client well-being, recovery, and adjustment were of paramount importance at all times in all MHCs.

Despite a wealth of commonalities, the nine MHCs also had notable differences. For example, two of the programs accepted only felony cases; one employed a preadjudication model only; and four employed a mixed pre- and post-adjudication model. Two other programs adopted a deferred or reduced sentencing model. Primary referral sources can be jail staff, public defenders, or pretrial service workers. The length of time between program referral and acceptance varied significantly among the programs, from one to two weeks to two to four months. The size of the programs also varied, from five (MHC 1) to 102 (MHC 5) participants. Staff in most of the programs explained that criminal justice and mental health information for each potential and existing client was freely shared among all work roles, which was possible

because defendants signed waivers. Nonetheless, in the largest MHC, the judge and public defender reported that they restricted the sharing of case information with each other and with other MHC staff.

Providers and Services

Overall, the operational MHCs in Illinois provided a panoply of services to clients, which ranged from case management and crisis intervention to in- and out-patient treatments in the areas of mental health and substance abuse programming and aftercare. Nearly all MHCs offered clients partial (day) hospitalization, and more than half offered clients inpatient hospitalization for substance use disorders and addictions. Among the different service types, the courts accessed services for their clients through direct partnerships with agencies and through brokerage arrangements with external agencies. These relationships varied by MHC and by the types of services found within and among the MHCs.

As expected, the majority of MHC clients received psychiatric/psychosocial assessments, case management services, and outpatient mental health treatment. Crisis management, psychiatric inpatient and day hospitalization, and residential substance abuse treatment were offered to fewer clients in fewer courts. Inpatient, intensive outpatient, and outpatient substance abuse treatment were more common and were offered to a higher number of clients. The rates of client participation in outpatient substance abuse treatment were quite variable among the MHC programs.

Just as all the MHCs provided a spectrum of assessment and treatment services, they also offered a wide range of recovery support services to clients. These included housing, psychosocial rehabilitation, benefits enrollment, and peer support. In addition, they provided employment and educational services, as well as transportation and legal assistance. Clients were

more likely to receive individual therapy than group or family therapy. Overall, half or fewer MHC clients utilized housing, employment, and educational services.

All of the MHCs reported the implementation of evidence-based practices (EBPs) in their programs. The most common EBPs were, in descending order: cognitive behavioral therapy, motivational interviewing, integrative dual disorder treatment, and supportive employment. The least common EBPs were, in descending order: assertive community treatment and illness management and recovery. More than half of the courts (56%) offered family psychosocial education and integrative treatment for co-occurring disorders. In addition, one-third of the MHC respondents also reported that they provided their clients with benefits assistance and dialectical behavior therapy, as well as housing and supportive employment services.

Respondents underscored the importance of maintaining fidelity to EBPs. Establishing program criteria and monitoring the implementation of those criteria helped in achieving adherence to the practices. Moreover, staff members were trained (and retrained) on EBP models and implementation protocols. In one court, an expert rated taped therapy sessions in terms of client-staff interactions and other components of the EBP model. In other jurisdictions, EBPs were monitored relative to state guidelines or were subjected to fidelity reviews and model validation studies. One court mandated that service providers be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Recidivism Analysis

A recidivism analysis explored arrests and time-to-arrests in three MHCs. The analysis also incorporated client demographic characteristics, diagnoses, and services received. The sample consisted of 224 offenders admitted to MHC between January 2008 and December 2010.

Survival analyses were conducted by county, and these examined the effects of age, gender, and county on the number and nature of rearrests.

Among the three counties, 31% of participants were rearrested for a felony only, while half were rearrested for a felony or misdemeanor offense. The highest number of rearrests occurred within the first year of post-MHC entry. Half were rearrested during probation supervision, and nearly 40% after probation release (not mutually exclusive groups). These results compare somewhat favorably with those reported in a statewide study of probationers, which found that 38% overall were rearrested (for any felony and misdemeanor) during probation and 39% overall were rearrested (for any felony and misdemeanor) after discharge from probation (not mutually exclusive groups) (cf., Adams, Bostwick, & Campbell, 2011). The mean year survival times for a felony rearrest were 3.2 (MHC 8), 3.4 (MHC 4), and 4 (MHC 1). In MHC 4, the proportion of clients who were rearrest-free four years after discharge was 80%; in both MHC 8 and MHC 1, this figure was 60%. Male clients were significantly more likely than female clients to be rearrested.

The most serious challenge to MHCs is the paucity of resources and services, especially in the mental health arena. MHCs are strongly encouraged to register clients for federal entitlements through the Affordable Care Act (ACA), which provides those eligible with broad coverage for substance use disorders and addictions, as well as other psychiatric disorders (National Institute of Corrections, 2014). Jurisdictions with MHCs should follow the Cook County Court System's lead in the successful enrollment of criminally involved persons in jails and on probation for CountyCare and ACA healthcare benefits (McDonnell, Brookes, & Lurigio, 2014).

Future Research

Future studies of Illinois' MHCs are recommended. Such studies should solicit the input and guidance of members of the Illinois Center of Excellence for Behavioral Health and Justice. Specifically, the screener survey of the 23 jurisdictions should be updated in 2015 in order to explore the current status of the courts by using the same three-survey approach: one for the original nine MHCs in operation to ascertain whether they have instituted changes in protocol, client composition, funding streams, or service provider networks; one for those that reported being in the contemplative or planning stages of program implementation to determine whether they have moved closer to or further away from the establishment of an MHC; and one for courts with no plans for MHC implementation to explore whether they have reconsidered the possibility of inaugurating such a program in their jurisdictions. All of the changes along the preceding lines would be very interesting to document for the state, as well as for the research field in general.

Each of the nine original courts could also be asked to select a random sample of cases (size to be determined by power analyses) that have been discharged from the program for at least one year. With researchers' oversight, a data collection form could be completed on each client; this data collection tool could be modeled after the instrument created for the Illinois probation outcome studies (e.g., Adams, Olson, & Adkins, 2002). In addition, if not already in place, each MHC should formulate a long-term data collection and evaluation plan to ensure that the court continues to function in accordance with proper court designs and protocols (Council of State Governments, 2007) and in alignment with identified goals and objectives, including reductions in client recidivism (Council of State Governments, 2007; Steadman, 2005). Additionally, a further study of the documentation of client data should be undertaken to determine whether standard data collection tools are being employed in all active MHCs in

Illinois, and in order to create a statewide repository for such information (Steadman, 2005). In September 2009, the Illinois Mental Health Court Database System was launched at the Illinois Integrated Justice Information System Summit and at the Statewide Judges Conference. These data could be highly useful in future process and outcome evaluations of MHCs in Illinois (Illinois Mental Health Court System, 2014).

For post-adjudication programs, the ultimate questions are whether MHCs add value to the supervisory experiences of probationers, lead to reductions in rearrests and revocations, and enhance the well-being and quality of life of their clients. For pre-adjudication programs, the ultimate questions also include whether the programs effectively (and truly) divert PSMI from further criminal justice processing and obtain for clients mental health and other services to facilitate their recovery and habilitation. A federally funded study of probationers with mental illness was completed in Cook County in 2014. The research compared three groups of probationers with mental illness in terms of their perceptions of their experiences and their performances while on probation. The groups are PSMI on MHC, specialized mental health probation, and standard probation supervision (the usual services and supervision) (Epperson, Canada, Thompson, & Lurigio, 2014). Among the most important findings of this research was the emphasis that clients placed on the quality of their relationships with their probation officers. In particular, probation officer characteristics such as trust, support, and caring were critical variables in terms of offenders' satisfaction with their supervisory experiences.

This research could be replicated in other large jurisdictions in which the same outcomes are measured for MHC, specialized supervision (if a mental health unit is being implemented outside of Cook County), and standard probation clients with mental illness. An important aspect of the proposed replication is the exploration of the nexus between mental illness and

criminality, as well as the effects of psychiatric treatment on recidivism. Several recent studies and literature reviews have suggested a paradigm shift in the conceptualization of these putative relationships (e.g., Lurigio, 2013).

As described above, MHCs in Illinois have been implemented in alignment with standard MHC structures and procedures (Council of State Governments, 2007). At the time of the study, the courts in operation appeared to be adhering to most of the essential elements that have been touted as the defining characteristics of a prototypic MHC/DTC, which are drawn principally from the literature on problem-solving courts. Hence, the answer to the question of whether MHCs are "working" is affirmative. In general, they are delivering services effectively and efficiently in a well-coordinated, client-centered team approach that seems to be highly responsive to the individualized needs of clients. The differences among them are not evidence of significant variance from the model; instead, they represent responsiveness to the unique culture of the court, the niche-filling character of the program, the expectations of the program stakeholders, and the nature and extent of the local service environment. The answer to the question of whether MHCs in Illinois "work" is a somewhat tentative "yes" based on the preliminary recidivism data collected in this study and reviews of previous research on such courts (e.g., Sarteschi, Vaughn, & Kim, 2011).

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Appendix A

Study Instruments

Master MHC Screening Survey

Instructions to researcher: *After calling the respondent at the appointment time and introducing yourself, explain that the survey will take thirty to forty-five minutes and read the following:*

"You are being asked to participate because you are a knowledgeable about court issues in your jurisdiction over the past few years and the study is considering how Mental Health Court programs are debated or planned, and if currently operating the processes of the Mental Health Court in your jurisdiction. If you agree to be in the study you will be asked to answer survey questions about the Mental Health Court, or plans to possibly start a Mental Health Court, in your jurisdiction.

You will not be asked to identify or provide identifying information about any specific individuals with criminal records or any clients in the Mental Health Court program. The jurisdiction will be identified with data presented from this survey. We will not disclose your identity or identifying information in any work drawn from this interview. With participation there is a risk that loss of confidentiality can occur, although every effort will be made to keep everything confidential and your name will not be used in the results of this study. There is no direct benefit that you will receive from participating in this study.

Participation in this study is voluntary. If you do not want to be in this study, you do not have to participate. Even if you decide to participate, you are free not to answer any question or to withdraw from participation at any time without any negative consequences.

Do you have any questions?"

Answer any questions asked, then ask:

"Do you consent to participate in this research?"

DOCUMENT VERBAL CONSENT BELOW, ASSIGN AN ID NUMBER, DATE, SIGN, AND PROCEED TO THE NEXT PAGE.

Respondent consents to participate?

□YES □ NO

Respondent ID# Assigned:_____

Jurisdiction:_____

Date:_____

Researcher:_____

Survey of Illinois Mental Health Court Programs and

Plans for Mental Health Court Programs

SURVEYER INSTRUCTIONS: After calling the appropriate Illinois criminal justice official and gaining consent, the first question you should ask is:

"Does your court jurisdiction have an existing mental health court program?"

YES NO

IF YES: Proceed to Page 3, Survey A, Question A1.

IF NO: Ask the following question:

"Are there currently plans to begin a mental health court program in your jurisdiction in the future?"

YES NO

IF YES: Proceed to Page 16, Survey B, Question B1.

IF NO: Proceed to Page 20, Survey C, Question C1.

SURVEY A: For Jurisdictions with Existing Mental Health Court Programs.

A1. Please provide the following information:

- Court Jurisdiction: _____
- Address _____
- City _____
- State and Zip _____
- Email: _____
- Phone: _____

A2. Court/Program Name:

A3. Geographical Area Served:

A4. Please identify the type of community your mental health court serves by selecting one of the following:

- Urban
- Suburban
- Rural
- Mixture of urban, suburban, and / or rural

A5. At what level of government does your court operate? [select one]

- Municipal
- County
- State
- Other _____

A6. When did the court accept its first participant?

- Month: _____ Year: _____

A7. How often does your program hold a mental health court docket? [select one]

- Every day
- Twice weekly
- Weekly
- Monthly
- Other _____

A8. How often does the mental health court team meet to staff cases? [select one]

- Every day
- Twice weekly
- Weekly
- Monthly
- Other _____

A9. Who participates in staffings?

_____

_____

_____

_____

A10. If your court is over one year old, about how many individuals participate in your program each year? [select one]

- The court is less than one year old
- 0-50
- 51-100
- 101-200
- 201-500
- More than 500

A11. How many people are currently in program?

_____

A12. Please provide the numbers or percentages of males and females among participants.

- Males _____
- Females _____

A13. Please provide the numbers or percentages of participants of each race:

- White _____
- Black _____
- Hispanic _____
- Asian _____
- Native American _____
- Pacific Islander _____
- Other (list) _____

A14. Please provide the numbers or percentages of participants in each age category:

- 18-25 _____
- 26-35_____
- 36-45 _____

- 46-55_____
- 56-65 _____
- Over 65 _____
- Other (list) _____

A15. Does your court require any of the following clinical criteria for eligibility?

[select all that apply]

- The court does not have any clinical requirements for eligibility
- The court accepts participants with any Axis I or Axis II mental health diagnoses
- The court accepts participants with only Axis I diagnoses
- The court accepts participants with Axis I diagnoses if the diagnoses correspond to state criteria for "serious and / or persistent mental illness"
- The court accepts participants with _____

A16. Which (if any) clinical criteria **exclude** individuals from eligibility? [select all that apply]

- Primary substance use disorders
- Co-occurring substance use disorders
- Developmental disabilities
- Traumatic brain injuries
- Other

A17. How were clinical eligibility criteria established? [select all that apply]

- They were established in consultation with mental health treatment providers
- They were established with an understanding of the jurisdiction' s treatment capacity
- They were established according to the jurisdictions' needs
- They were established through the court's experience and expertise
- Other _____

A18. The court accepts individuals charged with: [select all that apply]

- Ordinance offenses / violations

- Misdemeanors
- Misdemeanor probation violations
- Felonies (property)
- Felonies (nonviolent)
- Felonies (violent)
- Felony probation violations
- Felonies, excluding _____

A19. Please provide the numbers or percentages of misdemeanors and felonies among participants.

Misdemeanors _____

- Felonies _____

A20. How many of the current participants are first-time offenders?

_____

A21. Does an individual's criminal history affect his or her eligibility? [select all that apply]

- ☐No
- Yes, individuals with past violent crimes are excluded from participation
- Yes, individuals with past sex offenses are excluded from participation
- Yes, individuals with past "driving under the influence" offenses are excluded from participation
- Yes, individuals with past arson offenses are excluded
- Other _____

A22. From which of the following sources does the mental health court receive referrals?

[Please circle all that apply]

- Law enforcement
- Jail staff
- Probation officers
- Judges

- Magistrates
- Drug court programs
- Pretrial services staff
- Prosecutors
- Defense attorneys
- Mental health / substance abuse treatment providers
- Family/friends of the defendant
- Defendants themselves (self referral)

A23. Which of the above referral sources is the most common?

A24. Please briefly describe the referral process.

A25. What is the typical length of time from referral to acceptance into the program?

A26. What percentage of referrals is accepted/opt in?

A27. What is the primary reason for those not accepted? (If more than one is named please rank from 1 = most important to least important).

□ • Ineligible because of mental disorder (e.g., nSPMI, or only substance abuse disorder) Relative rank:_____

• Ineligible because of criminal charges (e.g., charged with a violent offense)

Relative rank:_____

• District Attorney's office declined

Relative rank:_____

□ • Public Defender's office/private defense attorney declined

Relative rank:_____

□ • Judge declined

Relative rank:_____

• Probation declined

Relative rank:_____

• Mental health provider declined

Relative rank:_____

□

• Client declined –opted out

Relative rank:_____

• Other, specify: _____

• Unknown

A28. What are the court/sentencing options for clients that are not accepted or opt out? [select all that apply]

• Usual non-specialty court proceedings
• Drug court
• Other specialty court
• General caseload probation
• Mental Health Probation
• Jail/Prison

A29. Who conducts a mental health **screening** to determine individuals' eligibility once referred to the court? [select all that apply]

• Community mental health service provider
• Court personnel with mental health background/experience
• Court personnel with a criminal justice background / experience
• Pretrial services staff
• Public defender
• District attorney
• Probation officer
• Other: _____

A30. Who conducts the mental health **assessment**? [select all who apply]

- Community mental health service provider
- Staff of mental health court
- Pretrial services staff
- Corrections staff

A31. When is a full mental health assessment performed? [select one]

- Before eligibility is determined
- After a participant has been accepted into court
- Other _____

A32. By what legal mechanism are participants accepted into the court program? [select all that apply]

- Participants' charges are held in abeyance and then dismissed upon successful program completion
- Participants plead guilty and have their sentence deferred
- Participants are sentenced to participation after a finding of guilt
- Participants are sentenced to participation after committing a probation violation
- Participants opt into the court after committing a probation violation
- Varies depending on charge
- Other _____

A33. How are cases disposed when participants successfully complete the program?

[select all that apply]

- Participants' charges may be dismissed upon successful completion
- Participants' charges may be reduced upon successful completion
- Participants' time under supervision may be reduced
- Participants' records may be expunged

A34. How are cases disposed when participants **do not** successfully complete the program?

[select all that apply]

- Participants must serve their deferred sentence
- Participants are returned to the court of original jurisdiction for case processing
- Participants are returned to the court of original jurisdiction for sentencing
- Participants' cases are processed by the mental health court for charges that were held in abeyance

A35. Describe your court's terms of participation: [select one]

- They are individualized based on the offense
- They are individualized based on the clinical diagnosis
- They are individualized based on the offense and the clinical diagnosis
- They are standard with individualized terms routinely added
- They are standard and apply to all participants

A36. Does the court use a formal written contract (between the court and the participant) which is standard and applies to all potential participants? [select one]

- Yes
- No
- Contract includes some standard conditions/some individualized

A37. Is your program structured in phases?

- Yes
- No

If yes briefly describe phases_____

A38. Has the court established minimum and maximum periods of participation?

[select all that apply]

- Yes, the minimum number of months is _____
- Yes, the maximum number of months is _____
- No, there are no minimum or maximum periods of participation

A39. Are their standard criteria for graduation? [select all that apply]

- Specified period of time drug/alcohol free
- Specified period of time without court sanctions
- Specified period of time treatment adherence
- Employed or otherwise involved in structured activities (student, volunteer)
- Completion of phased program
- Other
- No standard criteria

A40. If your court is over one year old, what is the average length of participation in the court? [select one]

- 0.5 years or less
- 0.5 years to 1 year
- 1 year to 2 years
- Three years or more
- The court is less than one year old
- The court does not collect this information

A41. Do participants provide **written** consent to release personal information? [select one]

- Yes, participants sign a single release
- Yes, participants sign multiple releases whenever information is requested or shared
- Yes, participants sign an initial release upon joining the program and subsequent releases when additional information is requested or shared
- No, participants agree to share personal information by virtue of joining the court program
- No, participant consent is not needed because service providers are allowed to share information by statute

A42. Does court-supervised treatment information become part of the participants' criminal record? [select one]

- Yes
- No

A43. Does the court program have standard protocols for establishing the legal competence of potential participants? [select one]

- Yes, the court program has a system for establishing legal competence aside from the state system
- No, the state determines legal competence before an individual is referred to the court program

A44. About how long does it take to assess a participant's legal competence? [select one]

- 24 hours
- 48 hours
- 72 hours
- One week
- One month
- Other: _____

A45. Once legal competence has been assessed, how long before a participant's **clinical** competence is assessed? [select one]

- The court program does not assess clinical competence
- The court program does not make a distinction between legal and clinical competence
- 24 hours
- 48 hours
- 72 hours
- One week

- One month
- Other: _____

A46. Does defense counsel help potential participants decide whether they should enter the court?

[select one]

- Yes
- No

A47. Monitoring and supervision of court participants is primarily carried out by___. [select one]

- Court team members: mental health background
- Court team members: criminal justice background
- Community mental health service providers
- Other: _____

A48. Which of the following services are regularly and directly available to court participants? [select all that apply]

- Emergency psychiatric services (crisis stabilization)
- Inpatient mental health treatment
- Outpatient mental health treatment
- Substance abuse treatment (independent from mental health treatment)
- Integrated substance abuse and mental health treatment
- Medication management
- Individual psychotherapy
- Group psychotherapy
- Family therapy
- Victim-defendant mediation
- Assistance in locating housing
- Assistance in financing housing
- Assistance in accessing benefits (e.g. Medicaid, SSI, SSDI, veterans)
- Transportation (e.g. bus fare, rides to program-related appointments)
- Child care

- Supported employment
- Court sponsored “alumni” groups
- Civil (legal) services assistance
- Other _____

A49. Are the court-supported services indicated above available to participants once they graduate?

[select one]

- Yes
- No
- Some

A50. How is the mental health court program funded?

[select all that apply]

- No dedicated or additional funds, in kind personnel from participating departments only
- Dedicated County funding
- Court fee’s charged to defendants
- Foundation grant
- State grants
- Federal grant
- Other. Please describe: _____

_____

A51. What was the biggest challenge to getting your mental health court up and running?

[select one]

- Lack of interest
- Lack of resources
- Political opposition
- Difficulty to get stakeholders to work together

• Other. Please describe: _____

_____

A52. What has been the biggest challenge to OPERATING your mental health court? [select one]

• Lack of mental health resources
• Lack of housing
• Lack criminal justice resources
• Lack of judicial support
• Lack of community support
• Difficulty getting stakeholders to work together
• Political resistance
• Other. Please describe: _____

SURVEY B: For Jurisdictions with plans to begin mental health court programs.

B1. Please provide the following information about yourself:

- Name: _____
- Title: _____
- Address _____
- City _____
- State and Zip _____
- Email: _____
- Phone: _____

B2. Tentative Court/Program Name:

B3. Geographical Area the Court Will Serve:

B4. Please identify the type of community the mental health court will serve by selecting one of the following:

- Urban
- Suburban
- Rural
- Mixture of urban, suburban, and / or rural

B5. At what level of government will the court operate? [select one]

- Municipal
- County
- State
- Other _____

OPEN ENDED QUESTIONS

SURVEYER INSTRUCTIONS: Ask the following questions and allow the respondent to fully answer while taking notes. If additional room is needed, take notes using the extra paper that is provided with this survey. If needed, ask the respondent to slow down and clarify points made. Full quotations of important points are desirable, but notes are acceptable if you are unable to provide full quotation as long as they accurately represent the statements of the respondent.

B6. When did the issue of possibly creating a mental health court first come up?

B7. Where did the idea emerge?

B8. Who is involved in the planning process?

B9. Who is leading the charge?

B10. Who is less enthusiastic about beginning a mental health court?

B11. At what point of the planning process are you at?

B12. Are there any existing MH courts that have acted as a model for you in the planning process?

B13. When does the court plan to begin hearing cases?

B14. Will the court hear misdemeanor cases only, felony cases only, or both?

B15. What still needs to be accomplished before the MH Court is established?

B16. What are the barriers to accomplishing it?

B17. Please feel free to add any other relevant comments if there is something important that has not been discussed.

SURVEY C: For Jurisdictions with no plans to begin a mental health court program.

C1. Please provide the following information about yourself:

- Name: _____
- Title: _____
- Address _____
- City _____
- State and Zip _____
- Email: _____
- Phone: _____

C2. Court Jurisdiction:

C3. Geographical Area the Jurisdiction Serves:

OPEN ENDED QUESTIONS

SURVEYER INSTRUCTIONS: Ask the following questions and allow the respondent to fully answer while taking notes. If additional room is needed, take notes using extra paper. If needed, ask the respondent to slow down and clarify points made. Full quotations of important points are desirable, but notes are acceptable if you are unable to provide full quotation as long as they accurately represent the statements of the respondent.

C4. Has there been any discussion about establishing a MH Court?

YES NO NOT SURE

If YES continue to question C5, if NO or NOT SURE skip to question C13.

C5. How did that discussion go?

C6. Who brought it up?

C7. Who was involved in the discussion?

C8. Is anyone still discussing the possibility of a mental health court?

YES NO NOT SURE

If YES ask C9 then skip to C17, if NO or NOT SURE skip to C10 and continue.

C9. Who is discussing the possibility of a mental health court?

After answering C9 skip to C17.

C10. When did the issue drop off the agenda for the jurisdiction?

C11. How did the issue drop off the agenda?

C12. Was there a decision not to pursue this, or just a loss of interest/political will?

C13. Do you think there would be any interest in a MH Court if the topic was discussed?

YES NO NOT SURE

If YES ask C14, if NO skip to C15, or if NOT SURE skip to C16.

C14. Why do you think there would be any interest in a mental health court?

After answering C14 skip to C17.

C15. Why don't you think there would be any interest in a mental health court?

After answering C15 skip to C17.

C16. Why aren't you sure whether or not there would be any interest in a mental health court?

C17. Do you think a mental health court program will begin operations in this jurisdiction in the near few years?

YES NO NOT SURE

If YES skip to C18, if NO skip to C19, or if NOT SURE skip to C20.

C18. Why do you think a mental health court will begin in this jurisdiction in the next few years?

END SURVEY

C15. Why don't you think a mental health court will begin in this jurisdiction in the next few years?

END SURVEY

C16. Why aren't you sure whether or not a mental health court will begin in this jurisdiction in the next few years?

END SURVEY

Social Service Providers Survey

Instructions to researcher: *After calling the respondent at the appointment time and introducing yourself, explain that the survey will take about twenty minutes and read the following:*

"Thank you for considering taking part in this project.

The current study is designed to gain a better understanding of the kinds of services available to the clients of Mental Health Court programs in Illinois. You are being asked to participate because you are knowledgeable about social services provided to the Mental Health Court. If you agree to participate in the study, you will be asked to answer questions about the services available to Mental Health Court clients in your jurisdiction. You will not be asked to identify, or to provide any identifying information about, any specific clients in the Mental Health Court program. Your jurisdiction will be identified, but we will not disclose your name or identity in any of the data reported from this interview. With participation, there is a slight risk of the loss of confidentiality; nonetheless, every effort will be made to keep these data confidential. There is no direct benefit to you for participating in this study. However, current and future Mental Health Court clients and staff members could directly or indirectly benefit from what we learn in the survey.

Participation in this study is voluntary. If you do not want to take part in this study, you do not have to participate. Even if you decide to participate, you are free to refuse to answer any questions or to withdraw from participation at any time without any negative consequences.

Do you have any questions?"

[NOTE: Document questions asked here, if any.]

_____

_____

_____

_____

Answer any questions asked, then ask:

"Do you consent to participate in this research?"

DOCUMENT VERBAL CONSENT BELOW, ASSIGN AN ID NUMBER, DATE, SIGN, AND PROCEED TO THE NEXT PAGE.

Respondent consents to participate?

YES ☐ **NO** ☐

Respondent ID# Assigned:_____

Jurisdiction: _____

Date: _____

Researcher: _____

Instructions to researcher: *When participants answer "**Yes**," please ask all of the corresponding subparts to that question; when participants answer "**No**" or "**Not Sure**," please proceed to the next question.*

Which of the following treatment and case management services are regularly available to Mental Health Court (MHC) participants?

1) Psychiatric and/or psychosocial assessments **No** ☐ **Yes** ☐ **Not Sure** ☐

Are these assessments provided……..?

1a. Directly, through MH Court partner agencies? ☐

Indirectly, through external referrals/linkages? ☐

Both? ☐

Not Sure ☐

Approximately what percentage of MHC clients would you say receive these assessments?

1b. Less than 25% ☐

25–50% ☐

51–75% ☐

76–100% ☐

Not Sure ☐

Do MHC clients receive these assessments……?

1c. At program intake? No ☐ Yes ☐ Not Sure ☐

1d. At established timeframes in the program? No ☐ Yes ☐ Not Sure ☐

1e. At varying points throughout the program? No ☐ Yes ☐ Not Sure ☐

2) Emergency stabilization (crisis management) services **No** ☐ **Yes** ☐ **Not Sure** ☐

Are these emergency stabilization (crisis management) services provided……..?

2a. Directly, through MH Court partner agencies? ☐

Indirectly, through external referrals/linkages? ☐

Both? ☐

Not Sure ☐

Approximately what percentage of MHC clients would you say require emergency stabilization (crisis management) services?

2b. Less than 25% ☐

25–50% ☐

51–75% ☐

76–100% ☐

Not Sure ☐

What percentage of clients would you estimate require more than one episode of emergency stabilization (crisis management) service?

2c. Less than 25% ☐

25–50% ☐

51–75% ☐

76–100% ☐

Not Sure ☐

3) Case management **No** ☐ **Yes** ☐ **Not Sure** ☐

Is case management provided……?

3a. Directly, through MHC partner agencies? ☐

Indirectly, through external referrals/linkages? ☐

Both? ☐

Not Sure ☐

Approximately what percentage of MHC clients would you say receive case management services?

3b. Less than 25% ☐

25–50% ☐

51–75% ☐

76-100% ☐

Not Sure ☐

On average, do clients typically receive case management……?

3c. For a limited period of time? ☐

Throughout MHC programming? ☐

Not Sure ☐

3d. Is case management available beyond MHC clients' participation in the MHC program?

No ☐ Yes ☐ Not Sure ☐

4) Partial (day) hospitalization services **No** ☐ **Yes** ☐ **Not Sure** ☐

Are day or partial hospitalization services provided……?

4a. Directly, through MHC partner agencies? ☐

Indirectly, through external referrals/linkages? ☐

Both? ☐

Not Sure ☐

Approximately what percentage of MHC clients would you say receive day or partial hospitalization services?

4b. Less than 25% ☐
25–50% ☐
51–75% ☐
76–100% ☐
Not Sure ☐

What would you say is the average length of stay in day or partial hospitalization services?

4c. One week or less ☐
8–30 days ☐
31–60 days ☐
61–90 days ☐
91–120 days ☐
Not Sure ☐

What percentage of MHC clients would you estimate have more than one episode of day or partial hospitalization services?

4d. Less than 25% ☐
25–50% ☐
51–75% ☐
76–100% ☐
Not Sure ☐

5) Inpatient mental health treatment **No** ☐ **Yes** ☐ **Not Sure** ☐

Is inpatient mental health treatment provided……?

5a. Directly, through MH Court partner agencies? ☐
Indirectly, through external referrals/linkages? ☐
Both? ☐
Not Sure ☐

Approximately what percentage of MHC clients would you say receive inpatient mental health treatment?

5b. Less than 25% ☐
25–50% ☐
51–75% ☐

76–100% ☐

Not Sure ☐

What would you say is the average length of stay in inpatient mental health treatment?

5c. One week or less ☐

8–30 days ☐

31–60 days ☐

61–90 days ☐

91–120 days ☐

Not Sure ☐

What percentage of MHC clients would you estimate have more than one episode of inpatient treatment?

5d. Less than 25% ☐

25–50% ☐

51–75% ☐

76–100% ☐

Not Sure ☐

6) Outpatient mental health treatment **No** ☐ **Yes** ☐ **Not Sure** ☐

Is outpatient mental health treatment provided……?

6a. Directly, through MH Court partner agencies? ☐

Indirectly, through external referrals/linkages? ☐

Both? ☐

Not Sure ☐

Approximately what percentage of MHC clients would you say receive outpatient mental health treatment?

6b. Less than 25% ☐

25–50% ☐

51–75% ☐

76–100% ☐

Not Sure ☐

On average, do clients typically participate in outpatient mental health treatment…….?

6c. For a limited period of time? ☐

Throughout programming? ☐

Not Sure ☐

What percentage of MHC clients would you estimate have more than one episode of outpatient treatment?

6d. Less than 25% ☐
25–50% ☐
51–75% ☐
76–100% ☐
Not Sure ☐

7) Residential substance abuse treatment **No** ☐ **Yes** ☐ **Not Sure** ☐

Is residential substance abuse treatment provided……?

7a. Directly, through MH Court partner agencies? ☐
Indirectly, through external referrals/linkages? ☐
Both? ☐
Not Sure ☐

Approximately what percentage of MHC clients would you say require residential treatment?

7b. Less than 25% ☐
25–50% ☐
51–75% ☐
76–100% ☐
Not Sure ☐

What would you say is the average length of time clients typically participate in residential substance abuse treatment?

7c. One week or less ☐
8–30 days ☐
31–60 days ☐
61–90 days ☐
91–120 days ☐
Beyond 120 days ☐
Not Sure ☐

What percentage of MHC clients would you estimate have more than one episode of residential treatment?

7d. Less than 25% ☐
25–50% ☐
51–75% ☐

76–100% ☐

Not Sure ☐

8) Inpatient substance abuse treatment **No** ☐ **Yes** ☐ **Not Sure** ☐

Is inpatient substance abuse treatment provided……?

8a. Directly, through MH Court partner agencies? ☐

Indirectly, through external referrals/linkages? ☐

Both? ☐

Not Sure ☐

Approximately what percentage of MHC clients would you say receive inpatient substance abuse treatment?

8b. Less than 25% ☐

25–50% ☐

51–75% ☐

76–100% ☐

Not Sure ☐

What would you say is the average length of participation in inpatient substance abuse treatment?

8c. 30 days or less ☐

31–60 days ☐

61–90 days ☐

91–120 days ☐

Not Sure ☐

What percentage of MHC clients would you estimate have more than one episode of inpatient substance abuse treatment?

8d. Less than 25% ☐

25–50% ☐

51–75% ☐

76–100% ☐

Not Sure ☐

9) Outpatient substance abuse treatment **No** ☐ **Yes** ☐ **Not Sure** ☐

Is outpatient substance abuse treatment provided…..?

9a. Directly, through MH Court partner agencies? ☐

Indirectly, through external referrals/linkages? ☐

Both? ☐

Not Sure ☐

Approximately what percentage of MHC clients would you say require outpatient substance abuse treatment?

9b. Less than 25% ☐

25–50% ☐

51–75% ☐

76–100% ☐

On average, do clients typically participate in outpatient substance abuse treatment….?

9c. For a limited period of time? ☐

Throughout programming? ☐

Not Sure ☐

What percentage of MHC clients would you estimate participate in more than one episode of outpatient substance abuse treatment?

9d. Less than 25% ☐

25–50% ☐

51–75% ☐

76–100% ☐

Not Sure ☐

10) Intensive outpatient substance abuse treatment **No** ☐ **Yes** ☐ **Not Sure** ☐

Is intensive outpatient (IOP) substance abuse treatment provided……?

10a. Directly, through MH Court partner agencies? ☐

Indirectly, through external referrals/linkages? ☐

Both? ☐

Not Sure ☐

Approximately what percentage of MHC clients would you say require IOP treatment?

10b. Less than 25% ☐

25–50% ☐

51–75% ☐

76–100% ☐

Not Sure ☐

On average, do clients typically participate in intensive outpatient substance abuse treatment for…..?

10c. 30 days or less? ☐

30–60 days? ☐

Over 60 days? ☐

Not Sure ☐

What percentage of MHC clients would you estimate participate in more than one episode of IOP substance abuse treatment?

10d. Less than 25% ☐

25–50% ☐

51–75% ☐

76–100% ☐

Not Sure ☐

11) Of the treatment and case management services just discussed, would you say these services are primarily delivered through….?

One (1) service provider? ☐

Multiple service providers? ☐

Not Sure ☐

Which of the following other recovery support services are offered to Mental Health Court participants?

12) Psychotherapeutic services **No** ☐ **Yes** ☐ **Not Sure** ☐

Are these services provided……?

12a. Directly, through MH Court partner agencies? ☐

Indirectly, through external referrals/linkages? ☐

Both? ☐

Not Sure ☐

Approximately what percentage of MHC clients would you say participate in <u>individual</u> psychotherapy?

12b. Less than 25% ☐

25–50% ☐

51–75% ☐

76–100% ☐

Not Sure ☐

Does not apply/Not offered ☐

Approximately what percentage of MHC clients would you say participate in <u>group</u> psychotherapy?

12c. Less than 25% ☐

25–50% ☐

51–75% ☐

76–100% ☐

Not Sure ☐

Does not apply/Not offered ☐

Approximately what percentage of MHC clients would you say participate in family therapy?

12d. Less than 25% ☐

25–50% ☐

51–75% ☐

76–100% ☐

Not Sure ☐

Does not apply/Not offered ☐

12e. On average, are these family therapy services provided to…….?

Immediate (i.e. within-household) family only? ☐

Extended family members? ☐

Not Sure ☐

13) Housing services **No** ☐ **Yes** ☐ **Not Sure** ☐

Are these services provided……..?

13a. Directly, through MH Court partner agencies? ☐

Indirectly, through external referrals/linkages? ☐

Both? ☐

Not Sure ☐

Approximately what percentage of MHC clients would you say receive housing services?

13b. Less than 25% ☐

25–50% ☐

51–75% ☐

76–100% ☐

Not Sure ☐

Do these services include……?

13c. Assistance in locating housing? No ☐ Yes ☐ Not Sure ☐

13d. Assistance in financing housing? No ☐ Yes ☐ Not Sure ☐

14) Employment and educational services **No** ☐ **Yes** ☐ **Not Sure** ☐

Are these services provided……..?

14a. Directly, through MH Court partner agencies? ☐

Indirectly, through external referrals/linkages? ☐

Both? ☐

Not Sure ☐

Approximately what percentage of MHC clients would you say receive employment or educational services?

14b. Less than 25% ☐

25–50% ☐

51–75% ☐

76–100% ☐

Not Sure ☐

Do these services include……..?

14c. Vocational or employment training? No ☐ Yes ☐ Not Sure ☐

14d. Supported employment or job placement? No ☐ Yes ☐ Not Sure ☐

14e. GED preparation and testing? No ☐ Yes ☐ Not Sure ☐

14f. Links to local high schools and/or colleges? No ☐ Yes ☐ Not Sure ☐

15) Assistance securing medication/medication compliance **No** ☐ **Yes** ☐ **Not Sure** ☐

Are these services provided…..?

15a. Directly, through MH Court partner agencies? ☐

Indirectly, through external referrals/linkages? ☐

Both? ☐

Not Sure ☐

16) Psychosocial rehabilitation services **No** ☐ **Yes** ☐ **Not Sure** ☐

Are these services provided…….?

16a. Directly, through MH Court partner agencies? ☐

Indirectly, through external referrals/linkages? ☐

Both? ☐

Not Sure ☐

17) Benefits assistance (for example, Medicaid, SSI, SSDI, Veterans' and/or Women's benefits)

No ☐ **Yes** ☐ **Not Sure** ☐

Are these services provided……?

17a. Directly, through MH Court partner agencies? ☐

Indirectly, through external referrals/linkages? ☐

Both? ☐

Not Sure ☐

Do these services include…..?

17b. Education on benefits No ☐ Yes ☐ Not Sure ☐

17c. Assistance in accessing or enrolling in benefits No ☐ Yes ☐ Not Sure ☐

18) Transportation assistance (for example, bus or train fare, rides to program-related appointments)

No ☐ Yes ☐ Not Sure ☐

Are these services provided……..?

18a. Directly, through MH Court partner agencies? ☐

Indirectly, through external referrals/linkages? ☐

Both? ☐

Not Sure ☐

19) Family services (for example, child care, elder care, reunification programs)

No ☐ Yes ☐ Not Sure ☐

Are these services provided……..?

19a. Directly, through MH Court partner agencies? ☐

Indirectly, through external referrals/linkages? ☐

Both? ☐

Not Sure ☐

20) Civil services/legal assistance **No ☐ Yes ☐ Not Sure ☐**

Are these services provided……..?

20a. Directly, through MH Court partner agencies? ☐

Indirectly, through external referrals/linkages? ☐

Both? ☐

Not Sure ☐

21) Self-help and/or peer-support groups, and/or mentoring **No ☐ Yes ☐ Not Sure ☐**

Are these services provided……?

21a. Directly, through MH Court partner agencies? ☐

Indirectly, through external referrals/linkages? ☐

Both? ☐

Not Sure ☐

22) Of the recovery support services just discussed, would you say these services are primarily

delivered through….?

One (1) service provider? ☐

Multiple service providers? ☐

Not Sure ☐

23) Do you know of any evidence-based or best practice models that MH Court providers deliver to clients? **No ☐ Yes ☐ Not Sure ☐**

Please indicate which specific models or approaches, if any, you are aware of providers offering to clients

23a. Assertive Community Treatment (ACT) ☐

23b. Cognitive Behavioral Therapy (CBT) ☐

23c. Family Psychoeducation ☐

23d. Illness Management and Recovery (IMR) ☐

23e. Integrated Dual Disorder Treatment (IDDT) ☐

23f. Integrated Treatment for Co-Occurring Disorders ☐

23g. Motivational Interviewing (MI) ☐

23h. Supported Employment (SE) ☐

23i. None of the Above ☐

23j. Are there any others you know that your partners provide? _____

_____

_____

24) Can you briefly describe any efforts you are aware of that have been made to ensure fidelity to these evidence-based/best practice models?

_____

_____

25) Do you know of any modifications that have been made to these evidence-based/best practice models for your mental health court population?

_____

_____

26) If clients receive any other important, community-based services we have not discussed, please briefly describe these services.

Thank you again for your time!

If you have any questions about this survey or study, please contact Mr. Monte Staton at 773-392-0412.

Focus Group Interview Questions for

Mental Health Court Team Members

1. How was the MHC in this jurisdiction created? What was the impetus or driving force for its creation? How was it conceived and implemented?

2. How does the mental health court operate? Can you describe its organization and how it functions?

3. Can you describe how a person becomes a participant in the mental health court and what then happens?

4. How are clients assessed when they enter the MHC program? How are their needs identified?

5. How are client service plans developed? Who are the professional role players in service planning? How are clients provided services?

6. Who is responsible for case management? How does this role player coordinate services from various providers? How does this role player work with the judge in motivating clients?

7. How are clients monitored? What type of sanctioning is used when clients are non-compliant? How are clients terminated, and how often does this occur?

8. Can you describe the relationships between the clients and the MHC team? How much contact do clients have with the team? What is the quality of those contacts?

9. Can you describe the collaboration that goes on between the MHC team and criminal justice partners that you work with? Are there any issues limiting the level of collaboration with criminal justice partners?

10. Can you describe the collaboration that goes on between the MHC team and community partners that you work with, such as service providers and client advocates? Are there any issues limiting the level of collaboration with these groups?

11. Has there ever been an issue with a lack of services? Can you describe the issue or issues? How were service gaps filled?

12. Can you describe the communication and information sharing that goes on between team members? How have clients and client advocates played a role in these communicative processes?

13. Can you describe a particularly problematic case in the mental health court? How was the case resolved or what was its outcome? How might the problem be avoided in the future?

14. Can you describe a particularly successful case in the mental health court? How was it successful?

15. How successful has the mental health court been since its inception? What are the current issues facing the mental health court?

16. How has the mental health court changed since it began?

Illinois Mental Health Courts Study: Client Survey

Note to respondents: In answering the following, PLEASE DO NOT PROVIDE ANY IDENTIFYING INFORMATION ABOUT YOUR SELF! Do not provide your name, race, age, gender, address, diagnosis, offense status, or any other specific information about yourself.

1. What do you like best about the Mental Health Court program?

2. What do you like the least about the Mental Health Court program?

3. What would you change about the Mental Health Court program?

4. Are there any other comments you would like to make about the Mental Health Court program?

NOTE: The statements below refer to your mental health court probation officer. Please read each statement and circle the value that best fits your agreement with the statement.

1. My probation officer for the mental health court cares about me as a person.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

2. I feel free to discuss the things that worry me with my probation officer.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

3. My probation officer explains what I 'm supposed to do and why it'd be good to do it.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

4. My probation officer tries very hard to do the right thing by me.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

5. When I have trouble doing what I am supposed to do, my probation officer talks with me and listens to what I have to say.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

6. If I break the rules, my probation officer calmly explains what has to be done and why.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

7. My probation officer is enthusiastic and optimistic with me.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

8. I feel safe enough to be open and honest with my probation officer.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

9. My probation officer talks down to me.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

10. My probation officer encourages me to work together with him/her.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

11. My probation officer trusts me to be honest with him/her.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

12. My probation officer really considers my situation when deciding what I'm supposed to do .
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

13. My probation officer seems devoted to helping me overcome my problems.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

14. My probation officer puts me down when I've done something wrong.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

15. My probation officer is warm and friendly with me.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

16. My probation officer treats me fairly.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

17. My probation officer really cares about my concerns.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

18. My probation officer really cares about my trust.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

19. If I'm going in a bad direction, my probation officer will talk with me before doing anything drastic.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

20. I know that my probation officer truly wants to help me.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

21. My probation officer considers my views.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

22. I feel that my probation officer is looking to punish me.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

23. My probation officer gives me enough of a chance to say what I want to say.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

24. My probation officer makes unreasonable demands of me.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

25. My probation officer expects me to do all the work alone and doesn't provide enough help.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

26. My probation officer knows that he/she can trust me.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

27. My probation officer is someone that I trust.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

28. My probation officer takes enough time to understand me.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

29. My probation officer takes my needs into account.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

30. My probation officer shows me respect in absolutely all his/her dealings with me.
1=Never 2=Rarely 3=Occasional 4=Sometimes 5=Often 6=Very often 7=Always

APPENDIX B:

Form IC-1: Informed Consent for MHC Team Members

Consent to Participate in Research Page 1

Project title: A Study of Illinois Mental Health Courts
Principle Investigator: Dr. Arthur Lurigio

Introduction:
You are being asked to take part in a research study funded by the State of Illinois and being conducted by Dr. Arthur J. Lurigio, Professor of Criminal Justice and Psychology at Loyola University Chicago.

You are being asked to participate because you are a Team Member of the Mental Health Court program in your jurisdiction and the study is considering the operational processes of Mental Health Courts (MHCs) in Illinois.

Purpose:
The purpose of this study is to provide a comprehensive assessment of all MHCs in Illinois.

Procedures:
If you agree to be in the study you will be asked to participate by filling out a questionnaire and taking part in a focus group interview. You will be asked questions about your work with MHC team members, the creation of the Mental Health Court, its current operations client services, monitoring, and sanctioning, collaborations with criminal justice and community partners, successes and failures of the MHC, and changes to the MHC since it began. The questionnaire will take about ten minutes. The interview questions are just a starting point to get you to discuss all of these issues, and you can feel free to talk about related things that you think are important. You will not be asked to identify any specific individuals with criminal records and you must avoid naming anyone or pointing out anyone as an example.

Risk/Benefits:
Your participation is confidential and we will not disclose your identity or identifying information in any work drawn from this interview. With participation there is a risk that loss of confidentiality can occur, although every effort will be made to keep everything confidential and your name will not be used in the results of this study.

There is no direct benefit that you will receive from participating in this study.

Consent to Participate in Research Page 2

Confidentiality:
Your name will not be written on the questionnaire, interview form, or audio tape (if tape is utilized). Your name will not be included in the results in the final report of this study. Dr. Arthur Lurigio (or an Interviewer working with him) will not disclose your name to anyone reading the report or asking about the report. Dr. Lurigio will store the questionnaires, interview forms and audio tapes, as well as this form which will be the only item with your name on it. These forms and tapes will be kept by Dr. Lurigio in locked files in separate areas and will only be used for this research project. As soon as the audio tapes are typed up by Dr. Lurigio or a Research Assistant working with Dr. Lurigio, the tapes will be erased, taken apart, and thrown away.

Voluntary participation:
Participation in this study is voluntary. If you do not want to be in this study, you do not have to participate. Even if you decide to participate, you are free not to answer any question or to withdraw from participation at any time without any negative consequences.

Contacts and Questions:
If you have any questions about this research study, please feel free to contact Dr. Arthur Lurigio at (773) 508-3500, or Project Manager Monte Staton at (773) 392-0412.
Mr. Staton can also be reached via e-mail at monostate@yahoo.com.
If you have questions about your rights as a research participant, you may contact the Compliance Manager in Loyola's Office of Research Services at (773) 508-2689.

Statement of Consent:
Your signature below indicates that you have read and understood the information provided above, have had an opportunity to ask questions, and agree to participate in this research study by answering interview questions. You will be given a copy of this form to keep for your records.

_____ _____

Participant's Signature **Date**

_____ _____

Researcher's Signature **Date**

Optional: By checking the box below and signing my initials I agree to allow the interview to be audio taped.

_____

Loyola University Chicago: Lakeside Campuses
Institutional Review Board for
The Protection of Human Subjects

Date of Approval: 11/15/2010

Approval Expires: 10/27/2011

Illinois Criminal Justice Information Authority
300 W. Adams Street, Suite 200
Chicago, Illinois 60606
Phone: 312.793.8408
Fax: 312.793.8422
TDD: 312.793.4170

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