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

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Abstract:

This study represents the only broad-based, statewide evaluation of mental health courts (MHCs) conducted to date. Data were collected from 2010 to 2013 at each of the nine active MHC program operating in Illinois at the start of the study. The purpose of the study was to compare and contrast the adjudicatory and supervisory models of each established Illinois MHC program by utilizing a variety of research methodologies. A four-year recidivism analysis of case-level data from three Illinois MHCs was also conducted. Illinois MHCs were largely characterized by the '10 essential elements of an MHC', such as voluntary participation, informed choice and hybrid team approaches to case manage clients. Results of the recidivism analysis suggest that MHCs compare favorably to other types of probation. Overall, findings revealed that Illinois MHCs are delivering services effectively and efficiently in a well-coordinated, client-centered team approach. Differences found among the MHCs are not evidence of significant variance from the model, and instead 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.

Keywords: mental health courts, Illinois, mental illness, criminal adjudication, recidivism

1. 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 address their disruptive public behavior or to obtain much-needed treatment or housing for them.[2] Jail and prison administrators often struggle to treat and protect the mentally ill; judges grapple with limited sentencing alternatives for PSMI who fall outside specific forensic categories (e.g., guilty but mentally ill); and probation and parole officers scramble to secure scarce community services and treatments for PSMI, often striving to fit the mentally ill into standard correctional programs or to monitor them with traditional case management strategies.[3] 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.[4]

First established in Broward County, Florida, in 1997, mental health courts (MHCs) were developed in response to the apparently escalating numbers of 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

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[2] L. A. Teplin, *Keeping the Peace: Police Discretion and Mentally Ill Persons,* National Institute of Justice, Washington, DC 2000.

[3] A. J. Lurigio, J. A. Swartz, Changing the Contours of the Criminal Justice System to Meet the Needs of Persons with Serious Mental Illness, in: J. Horney, ed., *Criminal Justice 2000, Volume III: Policies, Processes and Decisions of the Criminal Justice System,* National Institute of Justice, Washington, DC 2000, pp. 45-108.

[4] Council of State and Local Governments, *Criminal Justice-Mental Health Consensus Project Report,* Author, New York 2002.

of the 21st century, growing in number from a reported four operational programs in late 1997 to more than 400 by 2013, and active in nearly every state.[5] 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.[6] The common goals of such courts include diverting offenders from incarceration, reducing recidivism and enhancing public safety and the quality of clients' lives.[7]

MHCs are designed to serve the challenging, multifarious and extensive service needs of PSMI. MHCs 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 program 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.[8]

2. Current Research

Representing the only broad-based, statewide evaluation of MHCs conducted to date, the current research examined the adjudicatory and supervisory models adopted by each active MHC program in Illinois established by 2010. The investigation consisted of a series of data collection strategies pursued over a three-year period in close collaboration with the Research Unit of the Illinois Criminal Justice Information Authority (ICJIA). The study also involved a variety of data-collection tools and methodologies. Finally, the evaluation drew from previous research on MHC programs and dovetailed with the efforts of the Illinois Mental Health Court Association (IMHCA) and the recently convened Illinois Association of Problem-Solving Courts (IAPSC).

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 preliminary recidivism analysis for three of the MHCs, which exemplified 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. Although this research did not include a comprehensive evaluation or comparison of program outcomes, it did yield a fully descriptive snapshot of the first nine MHCs established in Illinois. The research was intended to sharpen and expand knowledge of MHC programs in the state, thereby enhancing the ability of state officials to render appropriate decisions regarding MHC operations and services.

2.1 Methodology

The evaluation of Illinois' MHCs was performed in stages, with overlapping data collection procedures. The first phase of the research was structured 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 based on 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 that were in the planning phase or that had decided an MHC was not feasible, two different telephone surveys were conducted, with a separate set of questions developed for each circumstance. 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.

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[5] National Center for State Courts, *Annual Report*, 2014. http://www.ncsc.org/About-us/Annual-Report-archive.aspx [accessed 7 May 2015]

[6] Council of State Governments, *Mental Health Courts*, 2014. http://csgjusticecenter.org/mental-health-court-project [accessed 8 July 2014]

[7] Council of State Governments, *Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court*, Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Washington, DC 2007. [hereinafter Council of State Governments (2)]; C. M. Sarteschi, Assessing the effectiveness of mental health courts: A meta-analysis of clinical and recidivism outcomes, (unpublished Ph.D. Dissertation, University of Pittsburgh), 2009. http://etd.library.pitt.edu [accessed 11 July 2014]

[8] Council of State Governments (2), supra note 6.

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

2.2. Findings

2.2.1. The MHC Landscape in Illinois

In the spring of 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. From the spring of 2010 to the spring of 2014, the number of operational MHCs grew from nine to 21, an increase of 133%.[9] At the time of the screener survey, the nine operational MHCs served a total of 302 participants, of which 46% were women. The survey found that in Illinois MHCs, most participants (58%) were white. However, African Americans were overrepresented among participants relative to the local population, whereas Latinos (measured as an ethnicity) were underrepresented. These disparities were replicated in subsequent data analyses, and in some MHCs, the disparities were quite pronounced.

2.2.2. Jurisdictions with no MHCs

Despite the possible benefits 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 client needs, respondents concluded that the number of criminal justice-involved PSMI had failed to reach the critical mass necessary to justify the establishment of a specialized court in order to address the problems of such offenders. With respect to the community resources, 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 when compared with drug treatment services for offenders.

Jurisdictions with little or no interest in launching an MHC were smaller and were also rural in composition; these characteristics were generally conflated. Courts in rural areas of the state served smaller populations and therefore 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.[10] In jurisdictions without MHCs, ad-hoc efforts were undertaken to respond on a case-by-case basis to assist defendants (pre-adjudication) and offenders (post-adjudication) with mental illness.

2.2.3. 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. These teams were quite inclusive involving judges, state's attorneys, public defenders, sheriffs and police administrators. In a few cases, the impetus for an MHC was the recognition that clients in local DTCs also suffered from mental illness (i.e., the clients had co-occurring disorders) and 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 draconian cuts in state services for people with behavioral healthcare problems.

2.2.4. Operational MHCs

All nine of the operational MHCs were in urban counties as defined by Office of Management and Budget[11] criteria, and five of the programs were located in one-county judicial circuits. The first MHCs in Illinois were implemented in 2004 (MHC 5 and MHC 8), and the most recent MHC in the study period was implemented in 2008 (MHC 9). Most of the

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[9] GAINS Center for Behavioral Health and Justice Transformation, *Mental Health Treatment Court*, Substance Abuse and Mental Health Services Administration, Author, Rockville, MD 2014. < http://gainscenter.samhsa.gov/grant_programs/adultmhtclist.asp?state=IL > [accessed 8 March 2014]

[10] President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, Author, Washington, DC 2003.

[11] J. Cromartie, S. Bucholtz,, Defining the 'rural' in rural America [Electronic Version], Amber Waves, 6, 2008, pp. 28-34. http://www.ers.usda.gov/AmberWaves/June08/Features/RuralAmerica.htm [accessed 18 June 18 2012]

jurisdictions with operational MHCs actually performed a formal needs assessment before launching their programs, and 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 ICJIA and the IAPSC, program development profited 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 generally characterized by the following 10 essential elements of an MHC:[12]

Element 1: Broad stakeholder planning and administration of the program.

Element 2: 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 3: Psychiatric assessment occurs before acceptance. Participants are linked to services through direct partnerships with agencies or brokerage arrangements.

Element 4: 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 5: Voluntary participation and informed choice. Legal competence is determined before referral. The public defender is consulted in decisions to enter the programs.

Element 6: A wide range of treatment and service options to meet clinical and habilitation needs.

Element 7: Signed client releases that allow staff to review and utilize information about treatment histories and current status.

Element 8: 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 9: 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 10: Programs collect data on outputs (number of defendants screened and accepted) and outcomes (number of clients successfully completing the program).

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, and 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 serve as client advocates and adversaries (in a legal sense) to the assistant state's attorneys. However, the MHC programs are generally designed to be non-adversarial, and instead utilize a team approach. 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, as these are state-organized, non-adversarial court programs. Nevertheless, in some programs, private attorneys 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.

[12] Council of State Governments (2), supra note 6.

A variety of sanctions were employed with participants at all nine MHCs. These 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. Nonetheless, 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; staff collaboration 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 acting as managers/service providers and mental health workers and TASC case managers as 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 exclusively employed a pre-adjudication model; 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. In contrast, 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.

2.2.5. Providers and Services

In general, operational MHCs in Illinois provided a panoply of services to clients, which ranged from case management and crisis intervention to inpatient and outpatient treatment 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 differed 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 varied significantly among the MHC programs.

Just as all the MHCs provided a spectrum of assessment and treatment services, the programs also offered a wide range of recovery support services to clients. These included housing, psychosocial rehabilitation, benefits enrollment and peer support. In addition, MHCs 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).

2.2.6. Recidivism analysis

A recidivism analysis explored arrests and time-to-arrests in three MHCs that were carefully selected for this purpose due to the distinctive nature of their location, size, program structure and client population. Other outcome variables included probation violation and probation termination statuses. The analysis also incorporated client demographic characteristics, diagnoses and services received. The sample consisted of 210 offenders admitted to MHCs between January 2008 and December 2010. Survival analyses were conducted by county and examined the effects of age, gender and county on the number and nature of rearrests.

As displayed in Table 1, among the three counties, 31.4% of participants were rearrested for a felony only, while 52.9% 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).[13]

Table 1. Years Observed and Arrests Post Entry to Mental Health Court, By Program

Program	n	Mean Years observed (SD)	Arrested - felony charges (%)	Arrested - felony or misdemeanor charges (%)	Mean Number of felony arrests (SD)	Mean number of felony or misdemeanor arrests (SD)
MHC 8	80	3.32 (0.92)	41.3	58.8	1.0 (1.6)	1.7 (2.8)
MHC 1	25	3.83 (1.24)	40.0	52.0	0.8 (1.1)	2.3 (4.6)
MHC 4	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)

Table 2 shows that the mean year survival times for a felony rearrest were 3.2 (MHC 8), 3.4 (MHC 4) and 4.4 (MHC 1). The proportion of clients who were rearrest-free four years after discharge was 52% in MHC 8, and 60% in MHC 4. In MHC1, the largest program with 105 clients, this figure was 70%. Male clients were significantly more likely to be rearrested than were female clients.

Table 2. 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	

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

[13] See S. Adams, L. Bostwick, R. Campbell, *Examining Illinois Probationer Characteristics and Outcomes*, Illinois Criminal Justice Information Authority, Chicago, IL 2011.

disorders.[14] 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.[15]

3. Future research

Future studies of Illinois' MHCs are recommended. 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 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.[16] 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[17] and in alignment with identified goals and objectives, including reductions in client recidivism.[18] 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.[19] 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. [20]

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 secure mental health and other services for clients 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).[21]

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.[22]

As described above, MHCs in Illinois have been implemented in alignment with standard MHC structures and procedures.[23] At the time of the study, the courts in operation appeared to be adhering to most of the essential elements

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[14] National Institute of Corrections, *Mapping the Criminal Justice System to Connect Justice-Involved Individuals with Treatment and Health Care under the Affordable Care Act*, Author, Washington, DC, 2014.

[15] M. McDonnell, L. Brookes, A. J. Lurigio, The Promise of Healthcare Reform in Transforming Services for Jail Detainees, *Health and Justice* 2, 2014, pp. 1-9.

[16] See, e.g., S. B. Adams, D. E. Olson, R. Adkins, *Results from the 2000 Illinois Adult Probation Outcome Study*, Illinois Criminal Justice Information Authority, Springfield, IL, 2002.

[17] Council of State Governments (2), supra note 6.

[18] Ibid.; H. J. Steadman, *A Guide to Collecting Mental Health Court Outcome Data,* Council of State Governments, New York, 2005.

[19] Ibid.

[20] Division of Mental Health, State of Illinois, *Illinois Mental Health Court System,* 2013. < https://sisonline.dhs.state.il.us/MHcourt > [accessed 8 July 2014]

[21] M. W. Epperson, K. E. Canada, J. Thompson, A. J. Lurigio, Walking the Line: Specialized and Standard Probation Officer Perspectives on Supervising Probationers with Serious Mental Illnesses, *International Journal of Law and Psychiatry*, 37 (5), 2014, pp. 473-483.

[22] See e.g., A. J. Lurigio, Criminalization of the Mentally Ill: Exploring Causes and Current Evidence in the United States, *Criminologist* 38, 2013, pp. 1-8.

[23] Council of State Governments (2), supra note 6.

that have been touted as the defining characteristics of a prototypic MHC/DTC, which are principally drawn 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 the MHCs are not evidence of significant variance from the model; rather, 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. [24]

[24] See e.g., C. M. Sarteschi, M. G. Vaughn, K. Kim, Assessing the Effectiveness of Mental Health Courts: A Quantitative Review, *Journal of Criminal Justice* 39, 2011, pp. 12-20.

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