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| Mental Health Courts in Illinois |
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Mental health courts in Illinois

Based on the principle of therapeutic jurisprudence and modeled after drug treatment courts, mental health courts provide comprehensive case management strategies incorporating partnerships with community-based treatment providers. Individuals who come into contact with the criminal justice system and are determined to be eligible for mental health courts are offered the opportunity to participate voluntarily. Most of these courts employ a team approach to supervision that includes prosecutors, defense attorneys, probation officers, and mental health professionals. Mental health courts have specialized dockets and caseloads that provide individualized treatment plans and highly involved judges who preside over frequent and non-adversarial court hearings. Successful program completion is defined by predetermined criteria and clients are motivated to succeed by the threat of sanctions, such as increased court appearances or community service, and the promise of rewards.

[The evaluation and assessment conducted by Loyola University Chicago](http://www.icjia.state.il.us/assets/articles/MHC_Report_1015.pdf) yielded a snapshot of jurisdictions with operational programs, those in the planning stages of court implementation, and those exploring the need and feasibility of a mental health court. The evaluation involved a mixed method approach that included surveys of all jurisdictions in Illinois as well as on-site data collection in nine jurisdictions operating mental health courts during the 2010- 2011 study period. Client interviews and recidivism analyses also were performed at three courts for more in-depth analyses.

**Key findings**

Of the state’s 23 court circuits, 19 completed the survey. Six courts reported no plans for mental health court implementation, six were in the planning process to establish one, and nine had operational programs.

Most jurisdictions with operational courts performed a formal needs assessment and consulted with experts before launching their programs. The study found Illinois mental health courts were largely characterized by the [10 elements of a mental health court as defined by the Council of State Governments](https://csgjusticecenter.org/wp-content/uploads/2012/12/mhc-essential-elements.pdf). Additionally, all of the jurisdictions involved law enforcement administrators in the planning and creation phases of their programs.

Jurisdictions with no or little interest in launching a specialty court were smaller and rural in composition. Courts in rural areas of the state served smaller populations with a lower prevalence of mental illness requiring fewer resources to meet their treatment needs. Mental health courts are more likely to exist in jurisdictions where high rates of mental illness in the criminal justice-involved are common.

**Clients served**

The nine operating mental health courts reported serving a total of 302 participants, 54 percent of whom were men. Fifty-eight percent of participants were white and 34 percent were black. Slightly over half were between the ages of 17 and 35 (Figure 1).

Jurisdictions operating mental health courts varied in the point at which participants became engaged with the courts. One mental health court used a pre-adjudication model and four utilized both pre- and post-adjudication models. The remaining four of the nine courts were post-adjudication-only. Two mental health courts employed a post-plea/pre-sentence model; participants plead guilty to enter the program with the possibility of a deferred sentence and charges that are reduced or dismissed. The Cook County program adopted a post-plea adjudication strategy in which defendants with mental illness plead guilty and are then sentenced to participate in the court program as a condition of probation.

Community mental health service providers screened individuals to determine program eligibility in the nine jurisdictions. All mental health courts required clinical criteria for eligibility and accepted persons with Axis I diagnoses (clinical disorders). Two courts also accepted participants with any Axis I or Axis II psychiatric diagnosis

(personality disorders). Individuals with co-occurring substance use disorders were accepted by all the courts.

Officials of three mental health courts reported that more than half of individuals referred enter their program. The other six reported that less than half of the referrals enter the program. Most programs relied on defense attorneys for the majority of court referrals. In Cook County, jail staff made the most referrals. Acceptance into the program is based on offense charge, criminal history, diagnosis, and available treatment options. The [Illinois Mental Health Court Treatment Act](http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2947&ChapterID=55) deems ineligible for the program persons charged with a felony sex offense, driving under the influence of drugs or alcohol, armed robbery, or home invasion. Thirty-eight percent of program participants in the nine jurisdictions surveyed were charged with misdemeanor offenses and 62 percent were charged with felonies. Four of the nine operational courts accepted individuals charged with violent offenses allowable by statute.

**Court operations**

Participation ranged from one to two years. Four courts had structured phases that progressively decreased supervision levels and frequency of probation and court appearances. All of the courts provided a wealth of services, ranging from case management and crisis intervention to in-and out-patient treatment in the areas of mental health and substance abuse programming and aftercare. Seven of the nine courts offered clients partial (day) hospitalization and all offered inpatient and outpatient mental health treatment. Five of the nine offered inpatient hospitalization for substance use disorders and addictions and all offered residential, outpatient and intensive outpatient treatment for substance use. All courts reported the implementation of evidence-based practices in their programs, most commonly cognitive behavioral therapy, motivational interviewing, integrative dual disorder treatment, and supportive employment. Those surveyed reported the most serious challenge to the program was limited resources and services, especially in mental health treatment.

**Recidivism and mental health outcomes**

Three of the operating mental health courts were selected for an analysis of recidivism, beginning with entry into the program and continuing for up to three years. Among the 224 participants studied during this time period, 53 percent of the participants were rearrested for any charge (felony or misdemeanor), with 31 percent for felony charges and 22 percent misdemeanor. The highest number of rearrests occurred within the first year of program participation. By comparison, [a statewide study of probationers](http://www.icjia.state.il.us/publications/examining-illinois-probationer-characteristics-and-outcomes), found that 47 percent of the sample were rearrested for a felony during probation and 42 percent were rearrested for a felony following probation discharge.[[1]](#endnote-1)

The overwhelming majority of participants reported the program benefitted them. Respondents indicated the program was encouraging, supportive and improved their lives. Specifically, respondents noted that the program made accessible medications and treatments needed to facilitate their recovery from chronic mental illness. Many said participation in the mental health court was a desirable alternative to jail or prison.

**Implications for policy and practice**

Access to treatment and medication and monitoring of progress are key goals of mental health court programs. Program staff discussed the need for collaboration and flexibility, and uniting around the needs of the participant to “get things done” for them. Staff members frequently mentioned teamwork as the key component of program and participant success, and teamwork was consistently apparent at case staffing meetings.

The most serious challenge to mental health courts were limited resources and services, especially in the mental health arena. Few treatment providers were available in some areas of the state and funding to support the programs was limited. Transportation for clients in rural areas was also an obstacle. Court administrators are strongly encouraged to register program participants for federal entitlements through the Affordable Care Act (ACA), which provides those eligible with broad coverage for substance use disorders and addictions and other psychiatric disorders.

Operating courts appeared to be adhering to the guidelines set by the Council of State Governments. Services were delivered efficiently and effectively in a well-coordinated, client-centered team approach that seemed highly responsive to the participants’ individual needs. The differences among them represented responsiveness to the unique culture of the court, the niche-filling character of the program, the expectations of program stakeholders, and the nature and extent of the local service environment.

Across the three sites, more than 60 percent of clients had not been arrested for a felony charge during the study period. This is especially significant given the high-risk characteristics of the clients. Each additional year in which clients remain arrest-free enhances public safety and reduces costs.

1. Adams, S.B., Bostwick, L., & Campbell, R. (2011) Examining Illinois probationer characteristics and outcomes. Chicago, IL: Illinois Criminal Justice Information Authority. [↑](#endnote-ref-1)