

Mental Health Courts in Illinois: Comparing and Contrasting Program Models, Sanction Applications, Information Sharing, and Professional Roles¹

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MENTAL HEALTH COURTS (MHCs) originated in late 1997 and were fostered by the growth of drug treatment courts, which emerged a decade earlier in Dade County, Florida (Hodulik, 2001). MHCs were developed in response to the increasing numbers of people with serious mental illness (PSMI) flowing into the criminal justice system. Modeled after drug treatment courts and predicated on the principle of therapeutic jurisprudence, MHC dockets consist mostly of criminal defendants with severe psychiatric problems, including substance use disorders (Bazelon Center for Mental Health Law, 2004). MHC clients are often referred to such courts by judges, public defenders, jail administrators, and probation officers, and then formally screened for program eligibility and acceptance (Bazelon Center for Mental Health Law, 2004). MHCs proliferated throughout the first decade of the 21st century, growing from a reported four operational programs in their first year of implementation to more than 300 programs by mid-2014. MHCs are now active in nearly every state (Council of State Governments, 2014).

Estimates suggest that between 15 and 20 percent of people in correctional populations suffer from a serious mental illness—a significantly higher percentage than the representation of PSMI in the general population (Ditton, 1999). PSMI often cycle repeatedly through the criminal justice system, in part because of the court's failure to recognize that mental disorders can contribute to crime and recidivism (Lurigio & Swartz, 2000). Hence, the progression of MHCs was hastened by a heightened awareness of the substantial numbers of PSMI appearing before the courts (Bernstein & Seltzer, 2003).

According to their proponents, MHCs hold great promise for diverting PSMI from the criminal justice system and ensuring that they receive psychiatric and other supportive services at both the pre- and post-adjudication stages of court proceedings (Bazelon Center for Mental Health Law, 2004). Pioneering MHCs were initiated to ameliorate three critical problems: the perceived public safety 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 manage PSMI effectively and humanely (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, numerous jurisdictions have crafted their own MHC models, tailored to local needs, resources, and political exigencies (Castellano & Anderson, 2013).

This article presents a study of MHC programs in Illinois, which were launched in 2004. Over a two-year period, statewide data were gathered with various approaches. The study examined the adjudicatory and supervisory models of the nine MHC programs that were operating in Illinois by the spring of 2010. The study's methodology and findings from the investigation's screener survey are detailed first. We then describe, compare, and contrast basic features of each of the nine MHC programs' structures and operations, using data from surveys, focus group interviews, and field observations. We discuss conclusions and directions for future study in the final section of the article.

Methods

The Chief Judge's Office in each of the 23 Illinois Circuit Court jurisdictions was contacted in order to help reach the person in the office most knowledgeable about MHCs. The calls identified nine operating MHC programs. The MHC program administrator at each site completed the screener survey. That person or the chief judge of the jurisdiction authorized the program's participation in the study. From 2010 to 2012, researchers made several site visits to each of the nine MHCs, where the program staff were interviewed in focus groups, and MHC staff meetings and proceedings were observed. In order to encourage open discussions, researchers promised to protect the confidentiality of the specific court locations as well as the identities of their staff members. Hence, all MHC programs discussed below are denoted by pseudonyms.

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Results

Overall Program and Client Characteristics

The nine MHC programs had a total of 302 clients enrolled, 163 (54 percent) male and 139 female (46 percent). Among all participants, 173 were White (58 percent), 99 were Black (34 percent), and 7 were Asian (3 percent). Only 11 participants identified themselves as Latino (4 percent). Blacks were overrepresented and Latinos were underrepresented in all Illinois MHCs. The ages of the MHC participants varied, with roughly 50 percent aged 25 or younger and roughly 45 percent aged 36 or older. Specifically, 77 of the participants were between the ages of 17 and 25 (26 percent), 74 were between the ages of 26 and 35 (25 percent), 69 were between the ages of 36 and 45 (23 percent), 60 were between the ages of 46 and 55 (20 percent), and 7 were between the ages of 56 and 65 (2 percent). Ages were missing from the records of 15 participants (4 percent).

The smallest of the nine programs had five active participants at the time of the survey, and the largest had 102. All of the MHCs were in urban counties as defined by the Office of Management and Budget criteria (Cromartie & Bucholtz, 2008). However, as indicated by respondents, the programs were located in diverse environments: urban, suburban, mixed, and rural (Table 1). All of the programs had been operational for at least a year at the time of the survey. Officials reported that their respective MHCs received financial support from a number of sources, including dedicated county funding, federal grants, local mental health funding, and in-kind contributions from local healthcare agencies.

Illinois MHCs embodied most of the 10 essential elements of the prototypic court, which have been widely discussed and

disseminated (Council of State Governments, 2007), such as voluntary participation and informed choice, as well as team approaches to case management with judges, attorneys, probation officers, and mental health professionals closely collaborating to monitor and serve participants. So-called "first-generation" MHCs were created in roughly the first five years of the emergence of such courts in the United States; "second-generation" MHCs were created in 2002 and thereafter (Redlich et al., 2005). First- and second-generation MHCs share many characteristics. However, second-generation MHCs are more likely to accept persons charged with violent or other felony offenses; adopt post-plea adjudication models; use jail as a sanction; and employ probation officers or other court staff to supervise clients.

The survey found that Illinois MHCs had incorporated several characteristics of second-generation MHCs (Redlich et al., 2005). For example, all of the MHCs accepted mentally ill offenders charged with felonies, and only one MHC had adopted a pre-adjudication model (Table 1). Two MHCs had implemented a post-plea, presentence model, indicating that participants plead guilty to enter the program but could have their sentences deferred. Fewer than half of the Illinois MHCs relied on second-generation supervision models in which agents of the court were largely responsible for monitoring clients (Redlich et al., 2005). Specifically, only four of the nine MHCs relied primarily on probation officers for monitoring participants. The remaining five programs relied on a combination of court personnel and community or county mental health workers (external to the court) for supervising participants.

All nine of the MHC programs reviewed clinical criteria to determine client eligibility and accepted people with Axis I diagnoses

(Clinical Disorders); two of the MHCs also accepted participants with Axis II diagnoses (Personality Disorders and Intellectual Disabilities), which are cataloged in the DSM-IV-TR, the previous edition of the psychiatric nomenclature (American Psychiatric Association, 2000). None of the courts excluded prospective clients if they had co-occurring substance use disorders. Most of the MHCs excluded individuals from eligibility if they had primary developmental disabilities, primary substance use disorders, or traumatic brain injuries.

In all the MHCs, mental health workers screened referrals to determine client eligibility. As noted above, referrals to Illinois MHCs can originate from judges, probation officers, public defenders, state's attorneys, private attorneys, and potential clients' family members. Respondents at three programs also stated that appropriate referrals were found by perusing daily jail records and talking with jail personnel about eligible participations. Respondents at five MHC programs reported that less than half of those referred entered the programs. Six MHC jurisdictions had a separate specialized probation program for offenders with mental illness, serving as a supervisory option for those who were deemed ineligible for the MHC.

The nine MHCs shared many similar features, but also differed widely in terms of program operations (see below). Most notably, the programs differed significantly in how sanctions were applied to participants who violated program rules, how MHC professionals shared information on participants, and how closely the professionals adhered to the non-adversarial process expounded in the literature on problem-solving courts (see Nolan, 2001; Ostrom, 2003; Berman & Feinblatt, 2005).

TABLE 1.

Environment, Size, and Structure of Nine Illinois MHCs

Program Pseudonym	Environment	Size	Adjudication Model	Offense level	Supervision Model
Burdon County MHC	Suburban/Rural	5	Pre- and post-plea	Felony and misdemeanor	Court and external personnel
Chandler County MHC	Urban/Rural	28	Pre- and post-plea	Felony and misdemeanor	Court and external personnel
Dreja County MHC	Suburban	9	Post-plea/pre-sentence	Felony and misdemeanor	Court and external personnel
Gillan County MHC	Urban/Suburban	62	Pre- and post-plea	Felony and misdemeanor	Court and external personnel
Hopwood County MHC	Suburban	102	Pre-plea	Felony and misdemeanor	Court personnel
Murray County MHC	Suburban	16	Pre- and post-plea	Felony and misdemeanor	Court personnel
Noone County MHC	Urban/Rural	19	Post-plea/pre-sentence	Felony and misdemeanor	Court and external personnel
Pattinson MHC	Urban	55	Post-plea	Felony only	Court personnel
Selway MHC	Suburban	6	Post-plea	Felony only	Court personnel

MHC Program Differences

Burdon County MHC

Burdon County's MHC operated in a mixed rural/suburban area. Of the nine MHC programs, the Burdon County MHC program was the smallest, with only five participants at the time of the survey. During the study, the number of participants fluctuated, increasing to ten and then falling to seven by the end of the data collection period. A supervisor from the probation department oversaw specialty courts in the county, and was also the coordinator for Burdon County MHC. Other members of the MHC team included a judge, case managers from two social service agencies, two probation officers, and an Assistant State's Attorney (ASA). These staff members regularly attended bimonthly court hearings. A public defender could attend court hearings but only as needed.

Participants in the Burdon County MHC followed one of two tracks, depending on their criminal histories and plea status. Track I participants, generally first-time felony offenders with minor or no criminal backgrounds, entered the program on a pre-plea basis, and had their charges dismissed on successful program completion. Track II participants entered the program after pleading guilty and were sentenced to probation (typically a felony conviction) with court-mandated treatment. Track I was more common, because few appropriate misdemeanor defendants opted for Track II participation in MHC rather than standard adjudication. Generally, Burdon County MHC clients agreed to attend treatment sessions for one year; the minimum period for MHC participation was six months.

Burdon County MHC conducted hearings less formally than other Illinois MHCs. The hearings had no stenographer, court secretary, or bailiff. Rather than having staff meetings separate from court calls, the Burdon County MHC team met in a small courtroom with no audience during hearings. Participants waited on seats in a hallway just outside the courtroom. MHC staff discussed and heard participants' cases individually. After all participants scheduled to appear had been heard, the MHC staff then discussed other participants who were not yet scheduled to appear.

Burdon County MHC was the only one of the nine programs that did not use jail (detention) as a sanction for participants. Instead, the judge applied sanctions such as verbal warnings, increased frequency of required court appearances, and community service hours. The Burdon MHC team explained that

they consider jail an inappropriate sanction for PSMI.

Chandler County MHC

Chandler County comprised several small cities and rural areas. The judge, ASA, and public defender ran the MHC program along with a program coordinator, probation officers, and mental health workers from two local providers. Nine of the 28 participants in 2010 were charged with misdemeanors, while the other 19 were charged with felonies. Generally, participants enter MHC on a pre-plea basis, but some participants plead guilty to enter the program. Some participants were probationers who had violated probation and were sentenced to participate in the MHC for the violation. The minimum length of participation in the program was 12 months; no maximum length of participation was established. Chandler County MHC was designed as a three-phase program, with each phase representing a different level of supervision intensity. Generally, phase one participants were required to see the MHC judge and program coordinator every week, then gradually progressed to phase two with bi-weekly appearances, and eventually to phase three, with monthly appearances until graduation.

Chandler staff members explained that the program has organizational structure and procedures. Nonetheless, the needs of the individuals superseded the directives of specific protocols or formal operations. For these staff, the concept of putting the participant first meant tailoring the program to be responsive to individuals' needs. Flexibility was also stressed for the performance of work roles. For example, probation officers sometimes performed case management work functions, and case managers sometimes performed probation functions.

The other Illinois MHCs rewarded participants for good behavior by praising their efforts during hearings, lessening the frequency of court appearances, or formally moving them closer to graduation. MHC workers in Chandler County MHC also utilized a "lottery" system to reward participants during hearings, which served as an incentive to adhere to treatment and maintain good behavior. At every hearing, each participant who performed satisfactorily was invited to draw a slip of paper from multi-colored fish bowl, which the coordinator brought to court hearings. Each of the slips had a reward written on them, such as chips, candy, movie tickets, or other small items. The Chandler

County team reported that this system motivated participants.

Dreja County MHC

The Dreja County MHC is located in a large suburban community and staffed by a judge, ASA, public defender, head court psychologist, several mental health workers from local agencies, and a program coordinator—a position that served as both the probation officer for all MHC participants and the administrator of the program. The Dreja County MHC had nine active participants and accepted defendants charged with either misdemeanors or nonviolent felonies; at the time of the survey, all nine participants were charged with felonies. All participants entered the program on a "post-plea, pre-sentence" basis, and participants' charges could be dismissed or reduced upon successful program completion.

Akin to the Chandler County program, the Dreja County MHC was designed in three phases. Misdemeanor participants were supervised for approximately a year, while felony participants were supervised for approximately two years. Case management was performed by local mental health agencies. The program coordinator engaged in case management activities as well, and reported participants' treatment progress to the judge and to the rest of the team at weekly staff meetings. When asked about information sharing, Dreja 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 share information. Similarly, information was freely exchanged at all but one of the other MHCs.

Gillan County MHC

The Gillan County MHC is located in a mid-sized city. The MHC team included the judge, ASA, public defender, program coordinator, two probation officers, and community mental health center staff. The latter included a psychologist, a nurse, two therapists, two caseworkers, and three other staff who work at the county jail. At the time of the survey, the Gillan County MHC had 62 active participants. As with other Illinois MHCs, the Gillan County MHC was designed as a three-phase program, with periods of supervision from one to two years.

The Gillan County MHC had both pre- and post-disposition participants, and accepted both misdemeanor (58 percent of participants) and felony (42 percent of participants) cases. With pre-disposition cases,

the court would continue the cases rather than rendering a disposition and, upon successful completion of the program, dismiss the charges. For post-plea cases, the court formally accepted guilty pleas after defendants were accepted into the program.

The majority of services were provided by the local community mental health center. The nurse position was created through specialized funding to focus on medication management and other participant health issues. Three mental health workers were liaisons between the jail and the community agency. As in Chandler County, the Gillan County MHC team members were willing to be flexible in the requirements of their work roles.

The Gillan MHC judge used a variety of techniques to sanction noncompliant participants, including verbal reprimands, public service hours, writing assignments, mandated observations of court hearings from the jury box, and jail for the worst violations. The Gillan County MHC's process for selecting appropriate sanctions for noncompliant participants differed significantly from most other Illinois MHC programs. During staff meetings, sanctioning decisions arose through an adversarial process, with the ASA or others on the team arguing for the imposition of sanctions against noncompliant participants, the public defender arguing for no or less severe sanctions, and the judge rendering the final disposition. During the court call, however, the Gillan County MHC team presented a cooperative, united front.

Hopwood County MHC

Located in a large suburb, the Hopwood County MHC program was the largest program surveyed, with 102 active participants. The MHC team included a judge, an ASA, a clinical social worker from the county health department, three probation officers, a probation supervisor, and a program coordinator. Unlike most other programs studied, in which service providers from outside of government are also MHC team members who regularly attend meetings, the Hopwood MHC team consisted entirely of government (county) employees.

Hopwood County MHC accepted defendants charged with either misdemeanors (51 percent) or felonies (49 percent). A pre-plea program, participants' charges are held in abeyance and then dismissed or reduced upon successful program completion. The minimum length of participation was 12 months, and the maximum was 30 months. Hopwood County MHC staff explained that

the clinical social worker, probation officers, and public defender limited the extent of participant information that was shared with the judge and ASA due to pre-plea nature of the program. Unlike other Illinois MHCs, participants signed no overall release that allowed the sharing of information among all staff. However, they did sign releases of information when needed.

The social worker and probation officers spoke of working together to case-manage and monitor participants, instead of playing clearly separated roles. The public defender communicated with these team members regularly and motivated participants to follow their treatment plans and program guidelines when problematic situations arise. However, specifics of these contacts might not be shared with the judge and ASA, as the cases might be adjudicated at later times if participants leave the program. The public defender stated that information on participants' progress is filtered to remove details that could prove harmful to their cases. However, case progress presented to the judge during staff meetings at times brought in negative aspects of participants' performance, suggesting that the redaction of negative information is selective.

As in the Gillan County MHC, decisions regarding sanctions could be determined in an adversarial process, with the public defender arguing for no or less sanctioning and the judge making a final determination. This contrasted with the team-decision process in other Illinois MHCs, in which judges received information on both positive and negative progress from the rest of the team before rendering sanction decisions.

Murray County MHC

The Murray County MHC, in a large suburban county, consisted of a judge, a probation officer who also serves as the program coordinator, a pretrial services officer, two ASAs, two public defenders, and county health department professionals. As in Hopwood County, all were government (county) employees. When surveyed, the Murray County MHC had 16 active participants, five facing felony charges and 11 facing misdemeanors. The program accepted participants charged with misdemeanors and nonviolent felonies on either post-plea or pre-plea bases. Post-plea participants plead guilty and receive probation sentences with mandated treatment. Pre-plea cases generally consisted of low-risk defendants with a minor or no criminal history, and less serious offenses than those of

post-plea cases. Overall, clients in the pre-plea program participated for between one and two years. Post-plea clients often served felony probation sentences of more than two years, which could be reduced on the basis of participant progress.

The county health department was the main mental health provider, but a few other agencies were involved in serving participants' behavioral healthcare needs. Therefore, the probation officer and county case managers usually work together in the case management of post-plea participants, and the pretrial services officer worked with the case managers in a similar way. Murray County MHC staff explained that monitoring is similar for pre- and post-trial participants regarding frequency of contact—although pretrial services staff typically make home visits, whereas the probation officer typically scheduled participant visits at the probation department.

Noone County MHC

The Noone County MHC served several small cities and rural areas. MHC staff included a judge, a program coordinator, a probation officer, two ASAs, two public defenders, and two staff from the primary mental health provider in the county. One was a nurse who dispensed medication and monitored the health of MHC participants; the other was a clinician who provided direct services to participants and also served as treatment liaison between the MHC and other community mental health agencies.

At the time of the survey, the Noone County MHC had 19 active participants: five were charged with misdemeanors and 14 with felonies. As in Dreja County, participants in the Noone County MHC entered the program by pleading guilty to their charges and having their sentences deferred. Similar to other Illinois MHCs, the Noone County program was structured in three phases. The minimum time required in the program was 12 months and the maximum was 24 months. Almost all participants who completed the program and successfully graduate have their charges dismissed.

Staff of the Noone County MHC reported that the roles of the probation officer, nurse, and mental health clinician overlapped in their efforts to monitor and support participants. Additionally, the program coordinator was employed by court administration but had a mental health background. As with other Illinois MHCs, these team members

expressed a willingness to be flexible and to share the performance of work functions.

Pattinson MHC

The program in the city of Pattinson was the only MHC divided into separate programs for men and women, with 30 participants and 25 participants, respectively, at the time of survey. The two programs shared most of the same staff, but had two different judges. MHC staff included the two judges, two public defenders, ASA, probation officer, social workers, clinical staff supervisor, program coordinator, and county jail staff.

On behalf of the ASA, the program coordinator screened referrals to the Pattinson MHC. Several staff stressed the importance of a system that cross-references consumer data from the Illinois Department of Mental Health with detainee mental health data from the jail. Detainees identified through the system are screened to determine if they have been diagnosed with mental health disorders and are being charged with non-violent felonies. Eligible detainees are referred to the MHC staff, who approach them to discuss possible participation in the program.

The program worked solely with defendants charged with non-violent and non-sexual felony offenses or felony probation violations. Participants entered the Pattinson program by pleading guilty to their charge and then being sentenced to 24 months of MHC probation. Monitoring during the program was performed by the probation officer and by case management staff, who work for an agency under contract with the MHC. After initial appointments with prospective participants, the case managers developed treatment plans with input from other MHC staff, and then referred participants to mental health and social service programs.

Selway MHC

The Selway MHC is located in a suburb in the same county as the Pattinson MHC. Of the nine programs, the Selway MHC was the second smallest, with only six participants at the time of the survey. The Selway MHC was modeled after the Pattinson program, having the same basic requirements for participation and utilizing a number of the same staff. A number of community service providers, including a local hospital, rehabilitation center, and housing agency, had representatives who regularly attended staff meetings held twice monthly before MHC calls.

The members of the Selway MHC staff who also worked with the Pattinson MHC noted an important difference between the programs. The Pattinson police department had a trained Crisis Intervention Team (CIT), which could be called to the scene of incidents involving offenders with mental illnesses. In the home county of the Selway MHC, a number of different police departments had jurisdiction but no CIT. Selway MHC staff explained that the lack of crisis intervention training created challenges in working with officers. In addition, the program staff had problems cooperating with local providers.

Summary and Conclusions

Although Illinois MHCs varied in size and in adjudication and supervision models, program operations in the nine MHCs were similar. In every program, participants appeared individually before judges in court hearings. Uniformly, judges had a highly motivational and supportive relationship with each participant. All of the programs had staff meetings to discuss participant referrals and progress, and a person who worked as a program coordinator, who might also serve as a probation officer. In all but two of the MHCs, ASAs screened referrals; in the Pattinson and Selway MHCs, a program coordinator screened referrals on behalf of the ASA. All but one of the programs had at least one public defender regularly participating in staff meetings and court calls. The Burdon County MHC called on a public defender as needed. All of the programs blended the roles and functions of probation officers and mental health workers monitoring participants and reporting their progress during court hearings. MHC staff often talked about working together and being flexible in order to “get things done” for participants and to meet their individual needs.

Differences among the nine MHCs were notable. In most of the programs, staff explained that criminal and health information for each referral and participant was freely shared among all work roles, which was facilitated by defendants signing waivers. However, in the largest program, Hopwood County MHC, the public defender and mental health workers limited the sharing of case information with the judge and other county staff. Teamwork was stressed in all programs; nonetheless, in two of the programs—the Gillan County and Hopwood County MHCs—the public defenders played an adversarial role during staff meetings.

A diverse set of sanctions (punishments) and rewards were employed with participants at all nine MHCs. Such sanctions included issuing verbal praise and admonishments, lessening or increasing the frequency of court appearances, ordering community service hours, and mandating brief jail stays for the most serious rule violators. However, Burdon County MHC staff explained that they do not use jail as punishment for their participants, viewing it as an inappropriate sanction for PSMI. The Chandler County MHC used a “fishbowl” of small rewards such as candy and movie tickets to motivate participants.

The continued growth of MHCs in Illinois and other states demands further investigation of the operations and staffing of such courts. Future research on MHCs should investigate how limits on information sharing affect the teamwork of MHC staff, and what types of situations warrant the withholding of information about participants from the judge and other MHC team members. Research should also consider the circumstances in which public defenders might need to assume an adversarial role on behalf of MHC participants. Finally, research should examine the use of sanctions and rewards to motivate MHC participants, and whether jail is an effective and humane sanction for PSMI.

References

- American Psychiatric Association. (2004). *Diagnostic and statistical manual of mental disorders*. Washington, DC; Author.
- Bazelton Center for Mental Health Law. (2004). *The role of specialty mental health courts in meeting the needs of juvenile offenders*. Judge David L. Bazelton Center for Mental Health Law. Washington, DC.
- Berman, G., & Feinblatt, J. 2005. *Good Courts: The Case for Problem-Solving Justice*. New York: The New Press.
- Bernstein, R., & Seltzer, T. (2003). Criminalization of people with mental illnesses: The role of mental health courts in system reform. *University of the District of Columbia Law Review*, 7, 143-162.
- Castellano, U., & Anderson, L. (2013). Mental health courts in America: promise and challenges. *American Behavioral Scientist*, 57(2), 163-173.
- Council of State Governments. (2007). *Improving responses to people with mental illnesses: The essential elements of a mental health court*. Washington, DC: Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice.

- Council of State Governments. (2014). *Mental health courts*. Retrieved July 8, 2014, from <http://csgjusticecenter.org/mental-health-court-project>
- Cromartie, J., & Bucholtz, S. (2008). Defining the "rural" in rural America [Electronic Version]. *Amber Waves*, 6, 28-34. Retrieved from the World Wide Web on August 3, 2010: <http://www.ers.usda.gov/Amber-Waves/June08/Features/RuralAmerica.htm>
- Ditton, P. (1999). *Mental health and treatment of inmates and probationers*. Bureau of Justice Statistics: Special report. Retrieved May 2, 2014 from <http://www.ojp.usdoj.go/bjs/abstract/mhtip.htm>
- Goldcamp, J., & Irons-Guynn, C. (2000). *Emerging judicial strategies for the mentally ill in the criminal caseload: Mental health courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage: A Report on community justice initiatives*. Philadelphia, PA: Crime and Justice Research Institute.
- Hodulik, J. (2001). The drug court model as a response to 'broken windows' criminal justice for the homeless mentally ill. *The Journal of Criminal Law and Criminology*, 91(4), 1073-1100.
- Lurigio, A. J., & Swartz, J. A. (2000). Changing the contours of the criminal justice system to meet the needs of persons with serious mental illness. In J. Horney (Ed.), *NIJ 2000 Series: Policies, processes, and decisions of the criminal justice system* (Volume 3) (pp. 45-108). Washington, DC: National Institute of Justice.
- Nolan, James L. 2001. *Reinventing Justice: The American Drug Court Movement*. Princeton, NJ: Princeton University Press.
- Ostrom, B. J. 2003. "Editorial Introduction: Domestic Violence Courts." *Criminology and Public Policy*, 3(1), 105-108.
- Redlich, A. D., Steadman, H.J., Monahan, J., Petrila, J., and Griffin, P.A. (2005). The second generation of mental health courts. *Psychology, Public Policy, and Law*, 11(4), 527-538.