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Three Essays on Mental Health Courts

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THREE ESSAYS ON MENTAL HEALTH COURTS

A Dissertation
Presented to
the Graduate School of
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In Partial Fulfillment
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Doctor of Philosophy
Policy Studies

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by
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PLAIN LANGUAGE ABSTRACT

   The criminal justice system does a poor job of dealing with mentally ill offenders, with more than 40% of incarcerated offenders having a serious mental illness (*Criminalization of People with Mental Illness*, n.d.). Mental health courts (MHCs), which provide offenders with access to mental health treatment and other community resources instead of sending them to jail or prison, are one solution to this problem.

   One question I raised is what makes adopting and operating a mental health court easier or harder. Through interviews and reviews of court documents, I found that court employees working together was the most important positive factor, while financial resources were the most important negative factor. This paper shows that the main measures of success for mental health courts are reduced crime for program completers, public financial savings, and more successful lives for program graduates. What factors play a role in whether a county adopts a court is an additional question explored in this research. The results indicate that the percentage of counties in a state with an MHC was the biggest factor in whether a county adopted a court. Another question I raised in this research is how effective mental health courts are at reducing crimes nationally. I found that there were no significant changes in any type of crime before or after an MHC was adopted.

ABSTRACT

Mental illness in the criminal justice system is a major issue, with 2 in 5 incarcerated people in the US having a serious mental illness (*Criminalization of People with Mental Illness*, n.d.). Prisons have turned into "de facto" mental health facilities when these facilities are not equipped to do so. This means once individuals are released from incarceration, they are often ill-equipped to return to regular life and may get caught up in the cycle of recidivism (Slate, 2017). One method that policymakers have used to solve this problem is mental health courts (MHCs), which are pre-trial diversion programs that provide an alternative to incarceration for people with mental illnesses and connect people with treatment providers and community resources, with the goal of breaking the cycle of recidivism and improving access to mental health services.

To study the effectiveness of these courts and how counties decide to adopt these courts, this research used both qualitative and quantitative methods. Semi-structured interviews and document reviews of four counties in Virginia and South Carolina were used to study what barriers and facilitators counties face when they establish and operate a mental health court. The thematic analysis found that the main facilitator for success was people, both court employees and community employees, working together for the good of the mission, while the main barrier to success was the lack of resources. The interviewed courts showed success in many different facets, such as reduced recidivism, financial savings, and increased access to treatment. To study which policy diffusion mechanism was most important for counties deciding to adopt MHCs, a probit regression was run to measure the likelihood of a county establishing an MHC. The regression shows that the learning mechanism had the largest effect on counties considering MHCs. To study how effective mental health courts are at reducing crime rates nationally, a panel event study was used, comparing crime rates for crimes against property, society, persons, and other crimes before and after mental health court adoption. The results show that there were no significant changes in crime pre- and post-MHC adoption for any type of crime.

DEDICATION

To all my friends and family who have helped and encouraged me throughout this process.

ACKNOWLEDGMENTS

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CHAPTER 1: INTRODUCTION

Background

  Problem-solving courts use the judicial system to solve problems that are difficult to solve in the traditional judicial system. These courts use judicial monitoring, collaboration with governmental and non-governmental agencies, and a non-adversarial process with the goal of changing the negative behaviors that resulted in the offenders participating in the judicial process (Berman & Feinblatt, 2001). Problem-solving courts have six core elements: they are specialized court dockets or programs, there is judicial authority and ongoing supervision, there is collaboration in the court and with outside agencies, court personnel receive specialized training, participants receive individualized treatment, and the court is intended to be therapeutic and rehabilitative (Slayton, n.d.). The first problem-solving court was a drug court established in Dade County, FL, in 1989, and it sentenced participants to drug treatment instead of incarceration (Berman & Feinblatt, 2001). Other types of problem-solving courts help participants who are dealing with a particular issue or type of crime, such as veterans treatment courts, community courts, and domestic violence courts. Total numbers for the different types of problem-solving courts are hard to get, but as of 2014, there were over 4000 problem-solving courts in the US, with drug and mental health courts being the most popular types of courts, and that number has continued to increase (Slayton, n.d.).

  Mental health courts (MHCs) are specialized court dockets that focus on defendants with mental illness and use a problem-solving model instead of a traditional adjudication model (Almquist & Dodd, 2009). The first MHC was established in Broward County, FL, in 1997. Today, there are 751 MHCs in the US, with 46 states/ DC having at least one court. Although courts differ in how they operate, in 2004, the Bureau of Justice Assistance Mental Health Courts

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Program established ten essential elements for best practices in how mental health courts should operate: planning and administration, target population, timely participant identification and linkage to services, terms of participation, informed choice, treatment supports and services, confidentiality, court team, monitoring adherence to court requirements and court sustainability (Thompson et al., 2007).

MHCs are operated on either a pre- or post-adjudication model. A pre-adjudication model means that the charges are held in abeyance while the participant completes the program, and if they successfully complete the program, the charges are dropped (Almquist & Dodd, 2009). Post-adjudication courts require either a guilty plea or conviction to enter the court, and if the participant completes the program, their charges can be expunged or probation can be ended early. If a participant chooses to leave the program or is forced to leave due to noncompliance or a new arrest, the original sentence can be imposed.

Individual court systems decide which types of crimes and mental illnesses are eligible and the exact terms of participation, but generally, MHCs have similar characteristics throughout the country. MHCs work by having participants work with a team of court staff and mental health professionals, including the judge, defense and prosecuting attorneys, probation staff, social workers, psychiatrists, and community resource staff, to create a judicially supervised treatment plan (Almquist & Dodd, 2009; The Council of State Governments, 2005). The treatment plan varies by individual needs, but includes things such as outpatient and inpatient treatment, drug and alcohol testing, educational and vocational training programs, and referrals to other community services. Although different courts have different resources, the premise of MHCs is that participants have access to all necessary and relevant services to help their mental health recovery and stabilization.

Offenders can be referred to the program by different people, such as defense attorneys, district attorneys, jail staff, family members, or treatment providers. Once referred, potential participants are screened to ensure they meet the legal and mental health requirements to join the court. There are typically phases that a participant must move through to graduate from the program, with more restrictions in the earlier stages and fewer restrictions as the participant moves through the program. Participants are required to appear before the Mental Health Court regularly to discuss the participant's progress. Judges use incentives, such as gift cards or praise, when participants do well in the program, and sanctions, such as community service, fines, and jail time, if participants do not comply with their treatment plans. Program lengths vary but are generally between six months to two years.
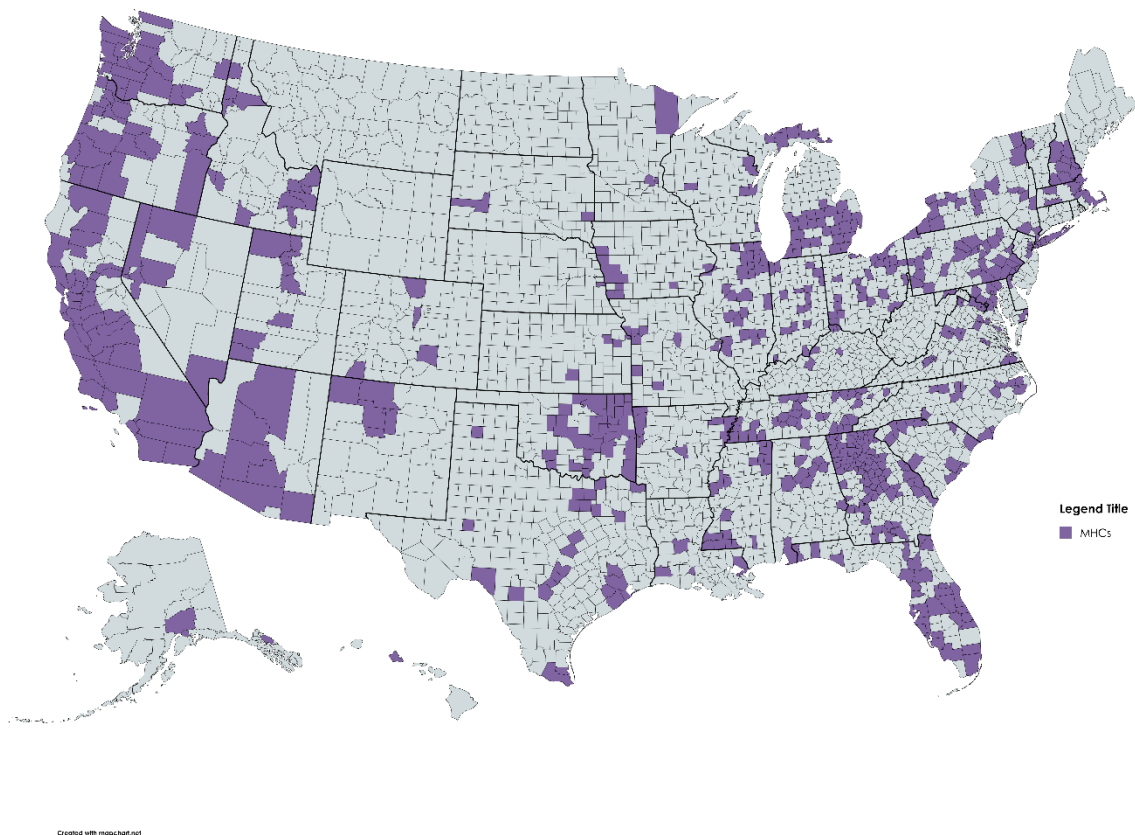
Figure 1: Counties with MHCs

Figure 1 shows the distribution of MHCs (as of 2025) in the US (*United States - Counties / Create a Custom Map*, n.d.). There are 46 states/ DC with at least one mental health court, with Wyoming, North Dakota, Maine, Rhode Island and West Virginia not having any.

Theory

The main legal theory behind mental health and other problem-solving courts is therapeutic jurisprudence, which is the study of how the law can impact people sociopsychologically (Hora et al., 1998). Every interaction someone has with the legal system impacts their mental health either positively or negatively, so the theory finds it is it is important to take therapeutic outcomes into account. Therapeutic jurisprudence aims to balance the offender's psychological health and due process rights and ensure that justice is served in each case (Lurigio & Snowden, 2009). When courts create problem-solving courts, such as mental health and drug courts, they operationalize therapeutic jurisprudence by using mental health knowledge and professionals to meet judicial and legal goals.

Therapeutic jurisprudence was initially used for drug courts, which were inspired by the spike in arrests of drug offenders caused by the War on Drugs. These courts view addiction not as a personal failing to be punished but instead as a disease that affects someone's behaviors. Dade County, Florida, established the first drug court in the nation in 1989 and more than 1000 drug courts have been established in the US by 2007. Many drug court participants also had mental illnesses, so the drug courts started establishing mental health sections in their courts. At the same time, the high number of mentally ill offenders in prisons and jails, combined with high recidivism rates for mentally ill offenders, has shown that focusing on traditional punishment has generally not resulted in crime reduction. Over time, counties established separate mental health

courts, with Broward County, Florida, establishing the first one in 1997 (Lurigio & Snowden, 2009).

Mental Health Court Literature Review

History

      The current system of mental health courts and therapeutic jurisprudence is an example of the way mental health treatment has evolved. While the full explanation of the history of mental health treatment in the US is too detailed for this research, a review of some key components is important. Dvoskin et al. (2020) discussed how mental health treatment has changed throughout the past 200 years. Prior to the 19th century, mental illness was believed to be caused by evil spirits, and mentally ill people were killed or tortured. Over time, this treatment of mentally ill people was viewed as being cruel and immoral. As social and moral perceptions of the ways to treat mental illness changed, asylums rose in popularity, giving mentally ill people a place to rest and get needed treatment (Dvoskin et al., 2020; Vogel et al., 2014). However, asylums were not as positive for mentally ill people as intended, with overcrowding causing subpar treatment, women being committed for rebelling against their abusive husbands, and people being institutionalized for a lifetime with little or no choice (Dvoskin et al., 2020).

      Another important time period for mental health treatment occurred in the 1960s with the deinstitutionalization movement. This movement proposed to move mental health treatment away from hospitals and into the community through community health services. A key factor in support of this movement was the increasing availability and efficacy of psychiatric medicines. Prior to the 1950s, psychiatric medication was not effective, and treatments relied on various techniques and medicines such as insulin comas, electroconvulsive therapies, opium, and cocaine

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(López-Muñoz et al., 2005). In 1952, Henri Laborit and colleagues introduced Largactil as an effective antipsychotic. While the US was slower to adopt Largactil, rebranded to Thorazine, it eventually became popular because clinical studies showed that it was effective for managing psychiatric symptoms. The invention of Thorazine inspired a "psychopharmacological revolution" with the invention of new psychoactive drugs such as lithium, imipramine, and chlordiazepoxide (López-Muñoz et al., 2005, p. 132). The invention of Thorazine and other psychiatric medications, like Reserpine, created a more positive experience for those suffering from mental illness by reducing the need for physical restraints, allowing for treatments and therapies to be used (Rochefort, 1984).

Another factor that influenced the deinstitutionalization movement was public awareness of the inhumane conditions in these facilities. Cases like the Willowbrook State School in New York, where patients were being researched and medically experimented on without their consent, raised awareness of the mistreatment of this population. In many cases, patients were physically harmed while living in overcrowded and understaffed facilities, which led policymakers to eventually create laws to stop the mistreatment of mentally ill people (Dvoskin et al., 2020). Exposés of the dire conditions in these facilities were published in major newspapers, magazines, and books, making the public more aware of the harm these facilities were causing (Rochefort, 1984). Legislation such as the Protection and Advocacy System for Persons with Disabilities (1975), which investigates suspected abuse and neglect of disabled people, and the Civil Rights of Institutionalized Persons Act (1980), which protects the rights of people who are in jail, prison, or medical facilities and allows the Department of Justice to investigate abuse and neglect in these facilities, were passed in support of these efforts (*Civil*

Rights Division | Civil Rights Of Institutionalized Persons, 2015; *Protection & Advocacy Systems | ACL Administration for Community Living*, n.d.; Dvoskin et al., 2020).

President John F. Kennedy signed the Community Mental Health Centers (CMHCs) Act of 1963, which was designed to fund mental health facilities in communities across America (Rochefort, 1984). While the intentions of the act were good, the implementation of this act was less successful, since the funding was reallocated for the Vietnam War, and citizens enacted ordinances to stop the establishment of these mental health centers, which resulted in only half of the proposed CMHCs being built (Slate, 2017; Teich, 2016). While the increase in community health treatment centers was beneficial for individuals who could stay in the community and get treatment, transitioning care to the community harmed individuals and families who were unable to access treatment. There was not enough planning for how previously institutionalized people would be treated in the community, and increased bureaucracy to access treatment, along with inadequate community support systems, made it hard for people to access care (Lamb, 1984).

Self-medication by using drugs and alcohol is one way that mentally ill people who lack other avenues of treatment attempt to treat their mental illness. Self-medicating behavior can turn into a substance abuse disorder if not treated appropriately. Substance abuse disorders have been shown to co-occur with mood and anxiety disorders, with a two to five-fold increase in the odds of having a substance use disorder or a mood/ anxiety disorder if the other condition(s) are present (Turner et al., 2018). In addition to drug and alcohol-related crimes, mentally ill people are arrested for non-violent offenses that are related to their mental health symptoms (*Criminalization of People with Mental Illness*, n.d.). For example, in Virginia, for fiscal year 2024, the most common offenses for behavioral health docket participants were assault, battery or wounding, obstruction of justice, and vandalism (Hade, 2024). Shelby County, TN, found that

33.1% of their mental health court participants' most serious charge was for property offenses, and 25.8% were drug-related offenses (Madden et al., 2020). Former inmates frequently had mental health disorders that predated their incarceration, and after their incarceration, they suffered from depressive mood disorders such as major depressive disorder, bipolar disorder and dysthymia, which makes it harder for them to reintegrate into society (Schnittker et al., 2012).

Mental Health in the US

Mental illness impacts many people in the United States. In 2022, the last available data, 59.3 million adults in the US (23.1% of US adults) had any mental illness (*Mental Illness - National Institute of Mental Health (NIMH)*, n.d.). The rate of any mental illness was higher for women, adults 18-25 years old, and adults with two or more races (*Mental Illness - National Institute of Mental Health (NIMH)*, n.d.). Adults with a serious mental illness- "a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities"- comprise 6% of the US adult population (15.4 million adults), with women, young adults, and adults with two or more races having a higher prevalence of serious mental illness (*Mental Illness - National Institute of Mental Health (NIMH)*, n.d.). The rate of mental illness has increased over time, from 17.7% of US adults having a mental illness in 2008 to 21% in 2020 (*Section 10 PE Tables – Results from the 2020 National Survey on Drug Use and Health: Detailed Tables, SAMHSA, CBHSQ*, n.d.). Massachusetts, Connecticut, and Maine were ranked in the top 3 states for Overall Mental Health, meaning they had a lower prevalence of mental illness and higher rates of access to care, while Montana, Arizona, and Nevada were ranked in the bottom three states (Reinert et al., 2024). There are many factors- genetics, environment, stress, childhood trauma, and brain chemistry- that can impact someone's mental health ("What Causes Mental Illness?," n.d.).

While more adults in the US need mental health treatment, there are not enough mental health providers to meet the need. There are 340 people for every one mental health provider (psychiatrist, psychologist, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses) in the US (Reinert et al., 2024). In 2024, 36% of the US population (122 million people) lived in a mental health workforce shortage area, meaning the population-to-provider ratio is at least 30,000 to 1 ("Mental Health Care Health Professional Shortage Areas (HPSAs)," n.d.). There are several reasons for this shortage, including a lack of government funding, low reimbursement rates from insurance companies and government programs, low retention of mental health professionals, increased demand for services, and professionals retiring from practice (Cordray, 2023). Potential solutions for increasing access to mental health services are to increase the number of psychiatry resident slots and increase the availability of telemedicine services (Weiner, 2022).

Efficacy of Mental Health Courts

Broward County (FL) Mental Health Court was the first MHC established, and many studies have described the court's results. Boothroyd et al. (2005) compared the clinical outcomes of 97 defendants in the Broward County MHC and 77 defendants in neighboring Hillsborough County, FL, using an ANCOVA regression. They found no significant difference in the clinical outcomes measured by Brief Psychiatric Rating Scale (BPRS) scores. However, this could be due to the quality of mental health services in the communities rather than the effectiveness of the mental health court concept. Christy et al. (2005) compared 116 Broward County MHC participants and 101 Hillsborough defendants and found that MHC participants and treatment-as-usual (TAU) offenders had similar "survival times to rearrest." Boothroyd et al.

(2003) found that participating in the Broward MHC significantly increased engagement with mental health treatment compared to defendants in the Hillsborough court.

Other studies have examined individual MHCs in the US. These studies generally compare a mental health court to a treatment-as-usual court or MHC completers to noncompleters. Most of these studies found that MHCs are effective in reducing recidivism, measured by either rearrest rates, time to rearrest or amount of time in jail (Anestis & Carbonell, 2014; Burns et al., 2013; Cosden et al., 2005; Costopoulos & Wellman, 2017; Frailing, 2010; A. E. Gallagher et al., 2018; Guthmann, 2015; Herinckx et al., 2005; Hiday & Ray, 2010; Hoff et al., 1999; McNiel & Binder, 2007; Mental Health Courts, 2024; Moore & Hiday, 2006; Ray, 2014; Yuan & Capriotti, 2019). Most of these studies used propensity score matching to account for the non-random assignment of people to TAU or MHC, although some studies, such as Cosden et al. (2005), were able to assign people to courts randomly. Wales et al. (2010) studied Washington DC's MHC using interviews with participants and non-participants and found that MHC participants had better outcomes because they felt that the judge treated them with beneficence, impartiality, neutrality and fairness, they were held accountable throughout the process, and decision-making throughout the process was transparent. While these studies show that these MHCs are effective at reducing recidivism, it is important to note that the internal factors of these counties, such as community resources, access to mental health professionals, and voter support, could be key contributors to why these courts are successful and that participant motivation to succeed could be an important, unmeasured reason why participants do not reoffend.

Some studies have analyzed multiple MHCs, some in different states, in one study. Steadman et al. (2011) studied MHCs in San Francisco County, Santa Clara County, Hennepin

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County, and Marion County for 18 months with a quasi-experimental approach. They found that

MHC participants had better outcomes regarding subsequent arrest rates, number of subsequent

arrests, reduction in pre- to post-MHC arrests, number of subsequent incarceration days and

change in incarceration days than those in the TAU group in all four locations. Keator et al.

(2013) studied the San Francisco, Hennepin, and Marion County MHCs and found that MHC

participants were more likely to receive community treatment services than those in TAU courts.

However, there was not a significant relationship between the type of treatment received and

post-MHC arrests. Ray et al. (2015) studied 8 MHCs located in the same state and found that

people with either a felony or a misdemeanor who graduated from an MHC had reductions in the

number of days in jail. Interestingly, non-completers with a felony had a reduction in the number

of days in jail, while non-completers with a misdemeanor had an increase in jail days. An

argument used to explain this finding is that the MHC treatment is too intensive for some

individuals' needs, and for some people, completing the program is too difficult (Ray et al.,

2015). Palermo (2010) compared the Washoe County and Clark County MHCs and found that

while they operate differently, they are both effective at helping mentally ill offenders. Studies of

multiple MHCs are more effective at reducing the state and local biases that could impact the

success of a court, but they also have issues with generalizability. Most of these studies focused

on counties with large populations, which were chosen because the courts serve enough people

to have a sufficient sample size for analysis (Steadman et al., 2011). These counties all have

large populations and tend to vote for Democrats in presidential elections, which could have an

impact on the support for and success of these courts (Algara & Amlani, 2021). Cities with larger

populations have more people who would benefit from this type of court, and Republican

counties would be less likely to support MHCs since these courts would not be considered

"tough on crime." These studies add depth to our understanding of how to study MHCs, and the results reveal the potential for these courts to benefit individuals and communities. They also raise questions on how best to measure the success of mental health courts for counties with smaller populations and more political variation across the community.

There are very few national studies of MHCs. Le Moal (2019) studied the effects of MHCs on violent and property crime rates and found that counties that have an MHC have an associated decrease in assaults, rapes, motor vehicle theft and larceny compared to counties that do not.

Meta-analyses compare the ex-ante research that has been completed on MHCs. Sarteschi et al. (2011) studied 18 adult MHC papers from 2003 to 2008 with experimental designs and found that MHCs were moderately effective in decreasing recidivism, positively improved clinical outcomes, and reduced psychiatric emergency room visits. Honegger (2015) studied 20 peer-reviewed articles and found that the MHCs reviewed resulted in improved recidivism and psychiatric outcomes. She also found that the literature has some methodological issues, which make it hard to compare articles (Honegger, 2015). Fox et al. (2021) studied 30 adult and juvenile MHC papers from 1997 to 2020 and found that participation in an MHC was associated with a 74% reduction in recidivism.

Specific Aims

Using both qualitative and quantitative methods, this dissertation will examine the effectiveness of mental health courts and how counties decide to establish mental health courts.

- Aim 1: To study the mechanisms of policy diffusion that Virginia and South Carolina counties used to establish their MHCs and the barriers and facilitators of court adoption in these states.

- o   Hypothesis 1.1: Counties in both states established mental health courts using the policy diffusion mechanism of learning.

- o   Hypothesis 1.2: South Carolina and Virginia counties faced similar barriers and facilitators in court adoptions.

- Aim 2: To determine the mechanism of policy diffusion that was used for MHC adoption.

  - o   Hypothesis 2.1: Learning is the main mechanism of policy diffusion for MHCs.

  - o   Hypothesis 2.2: Internal determinants will be a secondary determinant in the adoption of MHCs.

- Aim 3: To study the crime rates of counties with and without mental health courts to determine the courts' effectiveness at reducing crimes.

  - o   Hypothesis 3.1: MHCs will have a more substantial impact on crimes against society compared to crimes against persons, property, or other crimes.

Overall Research Design

The overall research objective of this study is to examine the effectiveness of mental health courts. This research uses both qualitative and quantitative methods to analyze whether MHCs are effective and how counties decide to adopt MHCs. Chapter 1 provides an introduction, justification for the research, and literature review. Using a qualitative lens, Chapter 2 uses an in-depth case study approach with interviews and documents to analyze how MHCs were established in Virginia and South Carolina counties. This chapter also compares the barriers and facilitators of court adoption and implementation between Virginia and South Carolina counties. Chapter 3 uses a probit regression to determine which mechanism of policy diffusion is most applicable to MHCs, using a national sample of mental health courts. Chapter 4 uses the panel event study method to study how crimes against persons, property, society, and other

crimes changed post-mental health court adoption. Chapter 5 summarizes and compares the results of these studies to create policy recommendations and future research ideas.

The studies in this dissertation build on each other; with Chapter 2 describing how and why county-level decision makers decide to establish and create a court at a micro level, Chapter 3 describing how counties decide to establish a court at a county/state level, and Chapter 4 describing whether these courts are effective at reducing crime at the county level. The three papers go through the short-term creation and the long-term implementation of these courts.

CHAPTER 2: IMPLEMENTATION OF MENTAL HEALTH COURTS IN SOUTH CAROLINA AND VIRGINIA

Introduction

Mental health courts have been shown to be effective in reducing recidivism in many studies (Anestis & Carbonell, 2014; Boothroyd et al., 2003; Burns et al., 2013). However, there are only around 700 county-level mental health courts in the US, and several states do not have a mental health court (MHC). So why, if these programs are shown to be effective, are they not adopted more widely? This is one of the questions implementation science scholars ask- what are the factors that determine whether a specific innovation is adopted into routine use (Bauer & Kirchner, 2020)? This research aims to identify the different factors that reduce and improve the adoption of mental health courts and to develop implementation strategies to increase the uptake of these important mental health care and justice innovations (Bauer & Kirchner, 2020).

Implementation studies of adult mental health courts are non-existent, and as more counties decide to establish these courts, scholars and practitioners will need to better understand what can be done to make the process of starting these courts easier.

Using the Consolidated Framework for Implementation Research (CFIR) framework as a guide, this pilot study uses interviews of key figures in mental health courts to seek to understand the underlying reasons for counties in Virginia and South Carolina to adopt mental health courts.

Literature Review

Qualitative Studies of Mental Health Courts

The qualitative literature for mental health courts generally focuses on factors that impact MHC participants' success. Some research about MHCs focused on judges' role in the courts' success (Wales et al., 2010; Yuan & Capriotti, 2019). The research found that the judge plays an

important role in the mental health court by providing strong leadership, treating participants with respect, making transparent decisions, holding both participants and employees accountable, and using incentives and sanctions effectively.

Some research focused on the participants' experiences of the court and what they found to be most helpful. Eschbach et al. (2019) used semi-structured group interviews of 11 MHC graduates to study their attitudes throughout their time in the program and found that they started the program mainly motivated to stay out of jail, then they started to make progress in the program and received positive reinforcement, and then they felt they had grown and matured throughout their time in the program. Canada and Gunn (2013) interviewed 26 MHC participants from 2 different courts about their experiences and found that support, structure, accountability, treatment and motivation were the main factors that helped in their recovery and helped reduce recidivism.

Qualitative research is also used to determine how courts operate. Gallagher et al. (2011) interviewed 59 employees from 11 Ohio mental health courts and studied how employees perceived the MHC's goals and their role, as well as fellow employees' roles in the court. They found that MHC personnel understood their own roles as well as others, appreciated others' roles, and had common goals (M. Gallagher et al., 2011). Wolff et al. (2011) used interviews of key informants and document reviews to determine how six mental health courts identified, screened and included or excluded mental health court participants and found that there was consistency between the courts in how they identify, screen and select clients.

Overall, these studies generally find that strong leadership from the judge and cooperation from court employees help participants stay motivated to complete the program and not reoffend. Qualitative research has been used in the MHC literature to study the factors that

make these courts effective from all perspectives, from the judges, other employees, and participants.

Consolidated Framework for Implementation Research

Consolidated Framework for Implementation Research (CFIR) is a determinant framework used in implementation research to assess the contextual determinants that impact whether an innovation is adopted. CFIR can be used with qualitative data, which is collected through interviews, focus groups, or surveys from people who influence the implementation outcomes (Damschroder et al., 2022). Several domains can impact implementation, and each domain has several constructs (Damschroder et al., 2022). The innovation domain studies the specific policy being implemented. Two domains analyze the setting where the innovation occurs; the inner setting domain studies the specific setting where the innovation will be implemented, while the outer setting domain studies the larger context (state, district, county) where the innovation will be implemented. The activities and strategies used to implement the innovation are categorized as the implementation process. How the roles and characteristics of the people implementing the process impact the process is categorized in the individuals domain.

In this study, the innovation domain, which is the project being implemented, is mental health courts. The inner setting, which is the setting where the innovation is implemented, is the Anderson, Newport News, Hampton and Norfolk court systems. The outer setting is where the inner setting exists: Anderson, Newport News, Hampton and Norfolk Counties in Virginia and South Carolina. The implementation process is the activities and strategies used to implement the innovation and includes getting approval on policies, determining when the court will be held, meeting with other court providers who have previously implemented a court, getting applicable laws passed, ensuring adequate funding, and other factors that go into creating a new court

system (*Anderson County Mental Health and Veterans Court | Bureau of Justice Assistance*, 2022; *CJCC February 2024 Meeting Minutes*, 2024; *CJCC June 2023 Meeting Minutes*, 2023). The individuals domain studies the roles and characteristics of people responsible for implementing the innovation, such as judges, psychiatrists, case workers, community resource providers, court employees and other professionals involved in this type of system.

CFIR in the Criminal Justice System

While CFIR has not been used to analyze adult mental health courts specifically, it has been used to analyze other court innovations intended to help mentally ill people. Van Deinse et al. (2019) studied how specialty mental health probation (SMHP) was implemented in a rural and urban county. They found that SMHP officers had a large caseload, making it hard for the professionals to add additional responsibilities. There were also issues with collaboration between probation, mental health and other organizations. At the same time, the officers were willing to work hard to make probation work and having an implementation team helped organize the implementation process of this innovation (Van Deinse et al., 2019). Hailemariam et al. (2024) did a systemic review of 13 studies on mental health interventions in the criminal justice system. They found that consistently, the inner setting and intervention characteristics were cited as facilitators of adoptions, but the studies were inconsistent in reporting barriers and facilitators (Hailemariam et al., 2024). Whitaker et al. (2024) evaluated Los Angeles County's Care Project and Juvenile Mental Health Court using both semi-structured interviews and program administrative data, and found that staffing and community resource limitations were challenges for the court, but that the court was effective in preventing recidivism, providing services for underserved youth and creating treatment plans for participants.

Staffing issues were consistently cited as an issue for implementing mental health services in the criminal justice system (Hailemariam et al., 2024; Hanna et al., 2020; Van Deinse et al., 2019; Whitaker et al., 2024). Although the staff who are working in these areas are often motivated to achieve successful outcomes, they are often overworked and do not have enough workers to fulfill their job duties (Hanna et al., 2020; Whitaker et al., 2024). This could be a problem for the implementation and continued success of an MHC, as successful implementation depends on the human capital providing these services. Another consistently cited barrier was a lack of connectivity with community-based providers (Hanna et al., 2020; Whitaker et al., 2024). The strength of mental health courts is the connections to community-based service providers who provide treatment, housing, education, and other services to those in the program. While MHCs vary in the ways they connect people to resources, either through direct referrals or case managers who help connect participants, if participants cannot get connected to services effectively or the available services are not high quality, then the desired outcomes are less likely to happen (Almquist & Dodd, 2009).

Research Purpose

The overall research objective of this paper is to determine the main barriers and facilitators of counties that start a mental health court, as well as to determine how counties decided to start courts. This study will be the first to use the CFIR framework to study adult mental health courts.

Research Questions

- How did the counties of interest decide to adopt the courts?
  - Were there important champions of these courts that facilitated their adoption? What did they do that helped the cause?

        o   Were there any detractors of these courts who were a barrier to adoption?

        o   Were there structural or institutional incentives that facilitated their adoption?

- What were the barriers and facilitators of implementing MHCs in these counties?

        o   What types of barriers were the most challenging?

        o   What types of facilitators were the most beneficial for adoption?

        o   Were there different barriers and facilitators in different states?

Data and Methodology

Methodology

This paper uses a case study method to study the adoption and implementation of mental health courts in South Carolina and Virginia. A case study studies bounded systems over time, involving multiple sources of information, and reports a case description and theme (Creswell & Poth, 2018). This study will examine four courts and will use a cross-case analysis to investigate "qualitative similarities and differences of values across several cases" (Starke, 2013, p. 567). The cases were selected nonrandomly. This paper uses a process-tracing analysis since it will investigate the causal relationship between decision-makers and the reasons for establishing a mental health court (Starke, 2013).

Sample

Four counties' mental health courts were identified- Anderson County in South Carolina, and Newport News, Hampton and Norfolk city/counties in Virginia. Virginia calls their mental health courts Behavioral Health Dockets (BHD), but they function identically to mental health courts. The reason for the different name is that in VA, only the General Assembly has the authority to create new courts, but judges have the authority to create different dockets in their courts (VIRGINIA DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL

SERVICES, 2016). Norfolk established its mental health court in 2004, Newport News

established its court in 2018, Hampton established its court in 2020, and Anderson County

established its court in 2024.

There are several reasons why these counties were picked for research. The primary

reason is data accessibility and access to key stakeholders in the region. In addition, these

counties are relatively similar demographically.
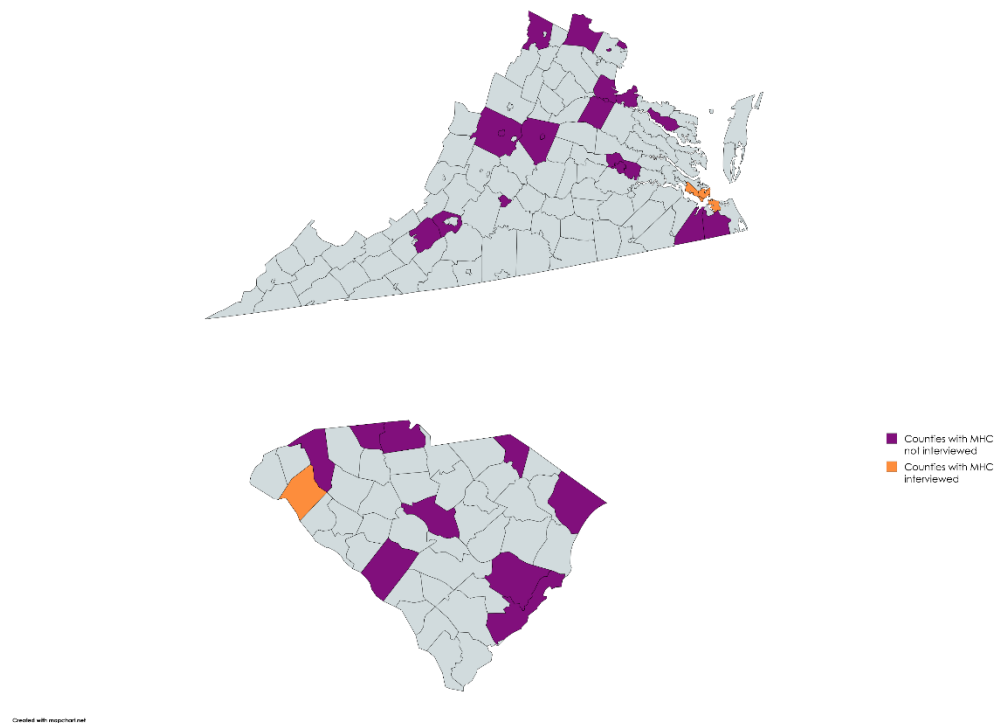
Figure 2: Map of Counties with MHCs in SC and VA

Figure 2 shows a map of counties in South Carolina and Virginia (*United States -*

Counties | Create a Custom Map, n.d.). The orange counties are the counties that were

interviewed, while the purple counties are the counties that have mental health courts but were

not interviewed.

Table 1: Demographic Characteristics of Interviewed Counties

	Hampton City (County), VA	Norfolk City (County), VA	Newport News City (County), VA	Anderson County, SC

Population estimates (2024)	137,596	231,105	183,056	217,183
Population Census (2020)	137,148	238,005	186,247	203,718
Population Census (2010)	137,436	242,803	180,719	187,126
% female	52.10%	49.40%	51.50%	51.60%
% white	39.90%	49.10%	47.00%	80.30%
High school graduate or higher %, percent of persons age 25 years+, 2019-2023	92.70%	89.60%	91.80%	87.80%
Persons without health insurance, under age 65 years %	6.10%	8.10%	7.10%	11.50%
Median households income (in 2023 dollars), 2019-2023	$67,758	$64,017	$66,718	$64,683
Persons in poverty, %	13.40%	18.30%	15.70%	13.50%
(first) MHC establishment	2020	2004	2018	2024
Total MHC Graduates	4 (as of 2022)	Unavailable	64	4

Table 1 shows the demographic information for the interviewed counties (*U.S. Census Bureau QuickFacts*, n.d.). The four counties have similar populations, percentage female, percent high school graduate or higher, median household income, and percentage of people in poverty. Anderson County has a significantly higher percentage of white population and percentage of people without health insurance than the Virginia counties.

Table 2: Health Information of Interviewed Counties

	Poor Mental Health Days (2022)	Poor Physical Health Days (2022)	Poor or Fair Health (2022)	Mental Health Providers (2024)
Hampton City, VA	5.9	4.3	18%	260:1
Norfolk City, VA	5.9	4.5	19%	310:1
Newport News City, VA	5.9	4.3	19%	450:1
Anderson County, SC	5.8	4.2	16%	520:1

Table 2 shows some health information for the interviewed counties (*Poor Mental Health Days | County Health Rankings & Roadmaps*, n.d.). The counties were similar in the number of poor mental health days, the number of poor physical health days, and the percentage of the

population reporting being in poor or fair health. Hampton, VA has double the ratio of mental health providers to population than Anderson County, SC.
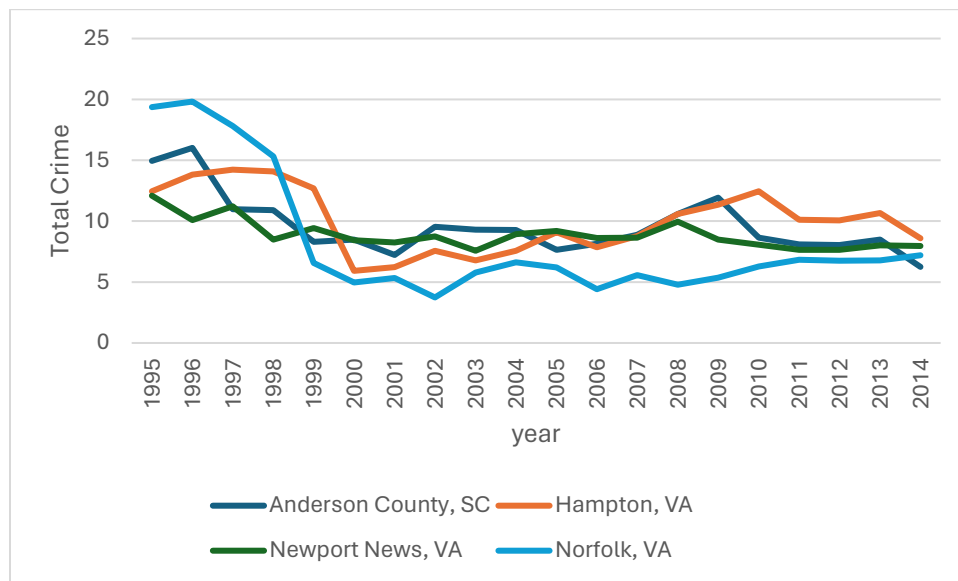
Figure 3: Total Crime Rates for Interviewed Counties (UCR)

Figure 3 shows the total crime rates (using Uniform Crime Reports (UCR) data) from 1995-2014 for the interviewed counties. The crime rates for all the counties follow a similar trend throughout this time, with higher crime rates in the late 90s and stabilizing in the 2000s.

To identify potential interviewees, the snowball sampling method was used for this research, starting with interviewing several identified professionals and asking them who else they thought would be important to interview (Creswell & Poth, 2018). Interviewees were recruited by email. Interviews were conducted through video conferencing software or in person from April 2025- May 2025.

Nine total interviews were conducted, five representing the Anderson, SC court, and four representing Virginia courts. Two interviewees represented community partners that provide services to the MHC, four were court coordinators, and three interviewees were legal professionals with a relationship with the court. Two interviewees worked with the drug court in

a county, which provides a perspective on how different problem-solving courts operate.

Interviews lasted between 14.93 and 131.97 minutes, with an average length of 43.5 minutes.

Interview Instrument

The interview questions are adapted from a previous study of a juvenile mental health court and the CFIR guide and are detailed in Appendix 2 (*CFIR Booklet*, n.d.; Whitaker et al., 2024). These questions described the position and program, innovation, resources, people, goals and outcomes, services, participants and outreach, perceptions of program effectiveness/barriers/facilitators and summary questions. To examine the policy diffusion question, the questions probed into how the courts learned from other courts.

A semi-structured interview process was used, which allowed for flexibility in questioning between participants who played different roles in the problem-solving court process, and allowed participants to expand on different topics. An iterative process was used for the questions, allowing for the questions to change for future interviews based on what others had experienced in the field.

Analyses

All interviews were either video-recorded (online) or audio-recorded (in-person) and transcribed. The transcripts were reviewed for accuracy. The interviews were coded, and themes were identified through comparison of the transcripts. The data was analyzed thematically, creating overall themes that came together from all of the data, similar to Butler (2013).

In addition to the interviews, various documents relating to the courts were coded with the same themes. These documents include social media posts, news articles about the courts, participant handbooks, and meeting minutes. These documents were either provided by

interviewees from the courts they represented or found through internet searches. They were coded in the same manner as the interviews.

Results

The results from this paper are categorized into two stages: court adoption (starting the court) and court implementation (continuing operations of the court). Introductory information is provided for the court adoption stage and barriers and facilitators are provided for both court adoption and court implementation.

Court Adoption

Legal. South Carolina passed the Mental Health Court Program Act in 2015 (Mental Health Court Program Act, 2015). This act allows for a circuit solicitor to establish a mental health court, defines what an MHC is, and establishes that the SC Chief Justice is the one who appoints the judge for the courts. Virginia passed the Behavioral Health Docket Act in 2020 and amended it in 2021 (§ 18.2-254.3. Behavioral Health Docket Act, 2020). This act is similar to South Carolina's in that they both define what an MHC is and establish that the state's Supreme Court is the organization in charge of MHCs in the state. Virginia's law has much more criteria for how a county establishes a mental health court and data reporting requirements than South Carolina's. Virginia's law establishes a state behavioral docket advisory committee, which includes members of the judicial and executive branches and community service providers. It also requires that counties with a behavioral health docket have a local behavioral health docket advisory committee and that this committee, with the help of the Office of the Executive Secretary, creates an annual report that evaluates the effectiveness of these courts. While courts in both states were established prior to the laws, these laws created statewide standards for these courts to follow.

County Need. Counties in both states felt a strong community need to change how the criminal justice system operated. Counties in both states had issues with their counties' populations' mental health, both generally and within their criminal population. In 2020, Anderson County had the "highest rates of deaths attributable to schizophrenia, delusional disorders, mood effective disorders, behavioral disorders, and intentional self-harm" in South Carolina (Morgan, 2023). It also recently ranked among the top 25% of counties in the US for persons experiencing suicidal ideation and in the top 50% of US counties for people experiencing depression, trauma survival, and psychotic-like episodes (Wilson, 2025). In Virginia, over 1 million people live with a mental illness (13.6% of the state's population), and the suicide rate is 13.3 deaths per 100,000 (Hade, 2024).

Anderson County has a jail built in the 1950s, and while it was updated and expanded upon, the main structure was outdated and overcrowded, with a population double the designed capacity. Prior to establishing its court, Anderson County studied the Anderson County Detention Center and found that over 400 people with a clinical diagnosable mental illness pass through the detention center a year (*Anderson County Receives Federal Grant to Establish Mental Health Court*, 2022). The Anderson County Sheriff's Office Detention Division receives around 4500 new arrests annually and has an average daily population of 400 inmates (*DETENTION CENTER | Anderson County Sheriff's Office | South Carolina*, n.d.). The Anderson County Criminal Justice Coordinating Council (CJCC) screened 327 people for 2 weeks at the Anderson County Detention Center and found that 11 people would be eligible for MHC services (Collins, 2019). Prior to establishing its court, Norfolk identified 140 seriously mentally ill inmates in the local and regional jails (Camarena, 2008). At the state level, 1 in 4 Virginia inmates in 2018 had a mental health disorder (Sparks, 2020). A study conducted in July

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2015 found that 16.8% of the inmates in 58 Virginia's local and regional jails had a mental illness, with 50% of those offenders having a serious mental illness (VIRGINIA DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL SERVICES, 2016). People in both states identified that they felt that the way courts were currently operating was failing people, with low-level offenders frequently reoffending, and they needed a different way to fix their recidivism.

  Learning. Courts in both states learned about mental health courts and the process of establishing them through several methods. The Bureau of Justice Assistance (BJA) benefited courts in both states. Anderson County was directly awarded a grant from the BJA, and with the grant came a technical advisor who advised on how the court should be organized and run. In Virginia, the BJA provided a 3-year federal implementation grant to the Department of Behavioral Health and Developmental Services (DBHDS) to help them create a Mental Health Docket Workgroup. This workgroup reviewed existing mental health dockets, identified best practices, and created a model that future courts could follow (VIRGINIA DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL SERVICES, 2016). Indirectly, the BJA gave grants to the Council of State Governments Justice Center (CSGJC), which, as a part of its duties, provides teaching and technical assistance to many mental health courts and other governmental organizations, as well as providing research and other resources about mental health courts. They have provided Essential Elements of a Mental Health Court, which Virginia explicitly states is a guiding principle for their behavioral health courts (Office of the Executive Secretary, 2024). South Carolina's law does not explicitly state that MHCs must follow these essential elements, but Anderson's court does seem to follow them. In addition, the CSGJC puts on conferences, such as the "50-State Summit on Public Safety" in November 2017, which

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allowed representatives from each state to come together to learn about best practices in the criminal justice field from law enforcement, behavioral health, corrections, and the legislature (Hade, 2024).

Court officials learning from other courts was also important to the creation of the courts. Starting the process, interviewees learned from seeing what other counties had done, both in state and across the country, and brought that to county stakeholders to determine whether there would be acceptance for the court in the county. As counties moved closer to establishing the court, higher-ranking officials made visits to different courts in the state and around the country to observe how different counties ran their courts. Prior to the court's establishment, an Anderson court official met at the SC Supreme Court with all mental health courts and veterans court systems in the state (*CJCC October 2023 Meeting Minutes*, 2023). During the Virginia Mental Health Docket Workgroup's tenure, they also visited existing mental health dockets in the state and collected materials that the dockets had previously developed in order to create essential elements for mental health dockets, both existing and future (VIRGINIA DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL SERVICES, 2016).

Barriers and Facilitators. One main facilitator for counties establishing mental health courts is that people were willing to work together. Interviewees from both states described how different groups of stakeholders were willing to work together because they wanted to solve the problem. Generally, judges in different counties were the ones to raise the idea of having the mental health court, potentially because they are the ones who frequently see the "revolving door of people with serious mental illness." Anderson County created a Criminal Justice Coordinating Council (CJCC) in 2018 and brought together different types of professionals, representing criminal justice, health, non-profit organizations, and the government, to discuss different ways

to improve Anderson County's criminal justice system. Through 6 years of meetings, they came together to discuss different aspects of criminal justice, including creating and establishing the MHC throughout the whole process, from studying data to determine how many people in the Anderson County Detention Center would be eligible for the court to finding a place to have court (*CJCC January 2024 Meeting Minutes*, 2024; Collins, 2019). One Anderson interviewee who had been a part of the CJCC felt that it was very beneficial, saying, "that's the only way to get things done, is when we do things collaboratively rather than independently."

Another main facilitator was the ability to start the court with minimal county funding. The startup funding differed based on the location. The Anderson, SC court was started with a $354131 grant from the BJA, which allowed them to start the court with minimal startup costs, mostly salary and equipment. Newport News and Hampton did not require additional costs to start the court, and instead relied on organizations absorbing the costs. Hampton received multiple state grants and grants from Sentara Healthcare and the United Way of the Virginia Peninsula (Sparks, 2021). People in these courts were motivated by the cause and were willing to absorb the financial impact.

Another facilitator was the community support. While generally mental health courts flew under the radar with citizens not noticing, when counties did publicize that they had started these courts, community reactions were positive. For example, under a Facebook post describing how the Anderson court received the BJA grant, people in the comment section were positive, stating that this was great news and that it was needed. In one VA county, early newspaper articles were published about the court, and people responded positively, asking questions about the court and donating resources.

One barrier to establishing the courts is financial resources, especially after COVID-19. One VA interviewee is currently in the process of establishing a new court in a nearby county, and he commented that the COVID pandemic stressed governmental agencies and made it harder for the new county's court to get the resources it needs to get started and run. Mental health stigma from the prosecutor's office was also cited as a barrier. Because prosecutors are elected to their office, if the general community feels that mental health courts allow people to get away with their crimes and question why the courts should be funded, then the prosecutor will not be willing to adopt the court. Overall, interviewees felt that establishing their court was not hindered by too many barriers.

Table 3: Court Adoption Barriers and Facilitators

Barriers	Facilitators
Financial resources (especially post-COVID)	Willingness to work together
Mental health stigma from officials	Able to start the court with minimal county funding
	Community support

Table 3 shows the barriers and facilitators for court adoption. There were more facilitators than barriers, with courts working around the initial lack of county funding to get the court started. The barriers to adoption, such as financial help and stigma against mental health courts, were seen more in the outer setting, while the facilitators were seen more in the inner setting, within the court systems.

Court Implementation

Facilitators. One major facilitator of the court's operations in both states is the collaboration between different sectors of the court. Element 8 of the Essential Elements of a

Mental Health Court explicitly states this is a required element of the courts- "A team of criminal justice and mental health staff and service and treatment providers receives special, ongoing training and helps mental health court participants achieve treatment and criminal justice goals by regularly reviewing and revising the court process" (Almquist & Dodd, 2009). Both states' mental health courts apply this principle. Virginia explicitly states in their standards that a behavioral health docket team's role is to manage day-to-day court operations and includes at a minimum, "the judge, behavioral health docket coordinator, a representative from the local Behavioral Health Authority/Community Services Board or local treatment provider, a representative from local community corrections and/or state probation and parole, a representative from the Public Defender's Office or local defense bar, and a representative from the Commonwealth's Attorney" (Office of the Executive Secretary, 2024). Newport News' team includes all of the required personnel, as well as Behavioral Health Liaisons from the Sheriff's Department, Police Department, and Fire Department, Peer Support Specialists, and representatives from the National Alliance on Mental Illness (Newport News Circuit Court Behavioral Health Docket, n.d.). Hampton's team includes all required people (HAMPTON GENERAL DISTRICT COURT, 2020). While SC does not explicitly require certain groups of people to be a part of the team, Anderson's court team uses similar types of people, with the Solicitor or Assistant Solicitor, the Mental Health Court Coordinator, the Mental Health Court Clinician, and the Circuit Court Judge comprising the team (*10th Circuit Solicitor | Oconee & Anderson SC Solicitors Office*, n.d.).

One interesting difference between the courts in the two states is who provides the community services. In the Anderson court, community services such as housing assistance and case management are provided by private charities, such as the Salvation Army, Upstate Warrior

Solutions, and Hope Missions. One Anderson service provider said the process of connecting their organization and the MHC was easy, with the court coordinator reaching out to different organizations asking for services. The Anderson service providers said that working with the mental health court was "an easy fit" and that they did not have to change how they provided services in order to work with the court. In the Virginia courts, the Community Service Board (CSB) provides the connection between the courts and social services, providing services such as medication management and sober social activities. One VA court did identify that they did work with some charitable organizations, but the CSBs were the main coordinators of partnerships with agencies. The difference between the community services does not seem to impact how participants do in the program.

In addition to the variety of types of people involved in the mental health courts, the emotional investment in the success of mental health courts was also important. Employees in several courts either started volunteering their time to get the court started or still volunteer their time, with some judges fulfilling their duties without extra pay and other organizations providing support without additional funding. Judges were frequently cited in interviews as being an important champion of the court, but police officers, public defenders, detention center operators, and service providers were also described as champions of the courts. Court officials cited the individualized attention employees were able to give to participants as a positive.

Community support was also another facilitator that helped the success of the courts. While most of the mental health courts' establishments went under the radar initially, once the courts had graduates, they received more publicity, in the form of newspaper articles and TV news reports. In addition to raising public awareness of these courts, one court official mentioned how they shared the positive results that they had received thus far, and the county official was

the one reaching out to media outlets to have them share the story. They also mentioned how sharing the positive results could help convince their county council to continue funding the court. In addition to public support, one court official discussed how previous program graduates came back to sponsor current participants. Their willingness to give back to the program helps current participants because they know how the process works, because they have been through it, while helping participants avoid the pitfalls they had previously encountered.

Barriers. One major barrier to the success of mental health courts is people not understanding mentally ill people's experiences or the role of the court. One court official discussed how other mental health officials and attorneys do not believe that mentally ill people self-medicate with drugs and alcohol and instead blame the drugs and alcohol for their mental illness. Another drug court official discussed how one county's public solicitor's office kept referring drug dealers or people with severe charges to the court, even though they would not be eligible since they had too many drugs in their possession. They discussed how some public solicitors recommended people for the court despite them showing characteristics, like being homeless or having a negative attitude, that would not lead to success in the court, and then were surprised when they were unsuccessful in the court. The drug court official also discussed how while the drug court has a higher successful completion and sobriety rate (44%) than traditional outpatient rehabs (30s%), politicians are not happy with these results, but instead complain that that these results are lower than expected (70-80%), when no traditional rehab of any kind has success rates that high. When people make decisions based on their biased beliefs, it affects who can receive services and could impact future funding if decision-makers deem the court a failure, not based on facts but solely on their misunderstandings.

Resources were also discussed as a barrier to the success of these types of courts. The long-term financial costs of these courts were one barrier. One VA court official cited their annual operating budget as $120,000 to 150,000, which mainly accounts for employee salaries. A different court official cited the costs for these courts as hundreds of thousands of dollars in the short term and millions in the long term. While courts can get started with minimal investment, to serve the maximum number of people, the court needs investment from the county. Several of these courts are in part funded by grants, which, if not refunded, could cause the court to be shut down if it cannot find a replacement source of funding. One court official discussed how grant-based funding made it hard for him to keep a job in prior drug courts, since the grant was set to expire annually. He also discussed how grants incentivized getting the job done with the lowest bidder instead of being willing to pay the price to get the highest quality- "they wanted a nice steak but they wanted Steak-umm prices." Logistical issues were cited as an issue, with making sure that service providers were able to provide their services effectively. One court official described how they provide treatment in the law enforcement center, which, while a less expensive location, causes problems for the participants since they are supposed to be getting clinical treatment in the same building where they had previously been sent to jail. COVID-19 was a challenge for both new courts and older courts in VA, with an official from an older court stating the COVID pandemic made it harder for mental health professionals to operate, and a newer court launching during the pandemic citing the challenges of dealing with lockdowns and working with participants remotely (Sparks, 2021).

The most frequently cited barrier to success for these courts is that these courts cannot serve everyone who needs them. Mentally ill people face challenges because of their mental illness that affect how successful they can be in the program. For example, people who struggle

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with psychotic symptoms and delusions have distrust of the system and paranoia, which affects their willingness to talk to court officials. The complexity of mental illness was also a challenge for participants in the court. Mental illness requires a multifaceted response, not only determining the proper medications but also attending therapy sessions and dealing with past trauma, which can take years to be able to completely overcome. In addition to mental illness, people in these programs could have prior physical health issues and comorbid substance abuse issues, which makes it harder for people to be successful in the program. While these courts are for the mentally ill, court officials frequently said that there were people who could not be helped by the courts, either because they were too mentally ill to be able to follow the rules or because they lacked the resources to be able to take in more participants. One court official said it was disheartening that they could not help more people.

Table 4: Court Implementation Barriers and Facilitators

Barriers	Facilitators
Unable to serve all who need it	Community support
Operation costs/ uncertainty of funding	Emotional investment of court employees
People not understanding mental illness	Collaboration between court employees and public services

Table 4 shows the barriers and facilitators for court implementation. Generally, people were the main facilitators of the courts, from community service boards and private charities providing services, judges and other employees working together for success, and community members showing support. The two main barriers are symbiotic; if courts had increased and consistent funding, they would likely be able to serve more people. The individuals domain is a facilitator of these courts, with people working together for the common good. Most of the

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barriers to successful court implementation, such as funding issues or decision makers not understanding mental illness, were seen in the outer setting, or the counties/ states are located.

Court Results

Graduation, or successful completion of the program, numbers for these courts vary. Anderson County graduated its first 4 participants on March 13, 2025 (@bobbyrettew, 2025). Newport News graduated 11 BHD participants in 2024 and graduated 64 participants total since 2018 ("Newport News Behavioral Health Docket Continues to Succeed," 2024). In the 2024 fiscal year, for all of Virginia, 152 behavioral health docket participants exited the program, with 91 of those graduating (Hade, 2024).

One main goal of these courts is to reduce recidivism, and these courts are successful in this regard. In Virginia, for the 2021 fiscal year, the overall rearrest rate for non-graduates was 1.9 times the graduate rates (28% vs 55.6% 3-year rearrest rate) and the overall reconviction rates for nongraduates was more than double the reconviction rates for graduates (15.9% vs 42.6% for the 3- year reconviction rates) (Hade, 2024). Norfolk evaluated its mental health court in 2008, and found that the recidivism rates for court graduates were 3.5% at 6 months, 5% at 12 months, 12.4% at 18 months, and 30% in 24 months, which were much lower than the standard recidivism rate for mentally ill offenders of 64% for 18 months post release and 77% for 2 years post release (Camarena, 2008). They found that participants who had completed the program remained out of jail for a total of 9600 days (Camarena, 2008). Court officials in Virginia corroborated this, with one court official stating their recidivism rate was in the low teens, which was a success compared to normal criminal activity, which has a recidivism rate of 60-65%. Anderson County's mental health court has been around for less than 2 years, with a limited number of graduates, so it is too soon to tell the recidivism rate, although the Anderson court

official stated their BJA advisor said they were "way further ahead for a first-year treatment court than most other courts that have been in effect for longer than a year", which is an encouraging sign.

Another success metric for these courts is whether the courts improve participants' mental health. In Norfolk's court, their evaluation study found that the participants had greater access to social services and mental health treatment compared to others trying to access these resources on their own, and the majority of participants reported that the resources were either moderately or very helpful (Camarena, 2008).

Another success metric for the courts is whether they save counties money compared to traditional incarceration. Norfolk found that their court saved $1.63 million in incarceration costs, with 21,210 reduced jail days and $76.85 cost per day of incarceration (Camarena, 2008). Virginia interviewees corroborated these numbers, with more current financial numbers being $14 a day to keep someone with a serious mental illness incarcerated compared to $3 to have someone supervised in the community, for total cost savings of around $1.5 million. South Carolina interviewees also reported similar numbers, with one court official stating that the cost of incarceration is $25,000 to $30,000 annually, just "warehousing, no treatment, no education, they're getting a guy back in" but saying that $5000 would break the cycle. In addition to the direct cost savings of not incarcerating someone, successful completion of the mental health court means that people can become gainfully employed, not solely relying on social security or other government benefits. This has a positive spillover effect for the community, with people paying taxes and child support, which means that their children do not have to be on government assistance either.

While the number of graduates of these types of courts is limited due to the scale of the program, there were many individual success stories. Interviewees from both states reported that graduates from the program had started their own businesses, got jobs, bought their own houses, reconnected with their children and other family members, and got degrees and GEDs. Some graduates give back to the organization that helped them, whether by serving as a sponsor for current participants or, in one instance, helping run a residential program. One VA graduate, who received a grant to go to trucker school, said, "They encouraged me to do it, and that boosted me even more," he said. "That support took me to a whole new level, and it's like now I can see the path that I want to see" (Dujardin, 2022).

Study Limitations

The generalizability of these results is limited due to the limited number of courts studied and participants interviewed. South Carolina has 11 mental health courts currently and Virginia has 25 mental health courts. Anderson is one of the newest mental health courts in South Carolina, with Charleston being the oldest MHC, with an establishment date of 2002. Therefore, in future studies, it would be important to interview more officials from different mental health courts in both states, because the reasons that these courts are successful could differ between counties and states. As Hon. Juliet Britton said, "When you have seen one mental health court, you've seen one mental health court, as they vary" (*A Look at Mental Health Courts*, 2024). In addition, in future research, it would be important to talk with more employees from each court, as different types of employees have different perspectives on what the barriers and facilitators are in establishing and operating a mental health court. While the interviewees generally comprised the important groups, interviewing, for example, multiple judges or public defenders, would allow for comparison between courts in different counties and states.

The reason why these courts were established might not be the same reason that courts in California or Idaho were established. However, this study aims to gain a deeper understanding of these particular cases- how these courts operate and how they were created. In addition, this study can be used to analyze how smaller counties decide to establish and operate an MHC. Most of the studies that have measured the effectiveness of MHCs have studied counties with larger populations, such as San Francisco (CA), Ramsey (MN), Clark (NV), Broward (FL), Santa Clara (CA), Hennepin (MN), and Marion (IN) counties (Boothroyd et al., 2003; Guthmann, 2015; Herinckx et al., 2005; McNiel & Binder, 2007; Steadman et al., 2011). This paper can be helpful for smaller counties that want to establish a mental health court and do not see themselves represented in the literature.

Conclusion

The results of these studies were similar to other papers in the criminal justice CFIR literature, finding that people in the courts are willing to work hard to make the courts work, and that the courts are effective in reducing recidivism (Van Deinse et al., 2019; Whitaker et al., 2024). While the studied courts were effective in their mission, they faced similar staffing and community resource limitations, which affects the future growth of the programs.

The main facilitator for both the adoption and implementation was the people. All the people interviewed were invested in the success of the courts, with some being willing to work extra and take on additional work to make these courts a success. The collaboration between different aspects of the criminal justice system and community services was also a major facilitator for the adoption and implementation of these courts, with all parties involved wanting to solve the problem and providing resources that court participants would not be able to receive

on their own. Access to resources, either through grant funding or organizations sharing their resources, was a facilitator for courts adopting and implementing their own programs.

While people were the main facilitators for success, people who are either uneducated on the issue of mental illness in the criminal justice system or biased against mentally ill people were also a barrier to the success of these courts. These people can either block these courts from getting implemented or harm the outcomes of people in the criminal justice system by either not allowing people who need help to get it or judging the results of these programs based on false expectations. While these courts had success with the number of resources they had, court officials discussed the problems with the limited resources they had, such as grants potentially not being renewed and needing more funding to reach more people more effectively.

The studied counties' courts were successful in several different facets. They graduate people, have reduced recidivism compared to traditional methods, save counties money, and most importantly, have graduates who live successful lives.

While Virginia and South Carolina courts have similar functionality and operate in the same way, there are differences between the courts in the 2 states. The main difference is that there are more legal requirements for VA courts, such as requiring specific roles to be a part of the behavioral health court team and requiring data to be collected and shared annually. While South Carolina follows these guidelines, South Carolina's mental health court law does not place the same legal requirements on its courts that VA does.

For counties to start and continue a mental health court, there are several steps that counties can take to be successful. One important step for counties considering establishing mental health courts is to educate all involved parties to make sure they know about how mental health affects a person in the criminal justice system. There are many ways people can learn

about these courts, such as visiting and learning from other courts, especially in similar counties, and learn from groups such as the BJA, CSGJC, and All Rise. Educating people in the court not only makes sure that people do not have biased, incorrect opinions, but are on the same page so they can work more collaboratively. Educating the public about the success of these courts is important for getting rid of people's biases against the mentally ill, but also influencing decision-makers whenever the decision is made to create or continue having a court. Courts do not need the largest amounts of funding to get started, especially if court officials are willing to do additional work without additional pay because they believe in the mission, but to serve a larger number of people, counties need to invest in funding these courts.

CHAPTER 3: POLICY DIFFUSION OF MENTAL HEALTH COURTS

Introduction

This chapter examines the role of policy diffusion in the spread of mental health courts. There are currently 741 mental health courts in the United States, with 46 states/ DC having at least one court. The first mental health court was established in Broward County, Florida, in 1997, and it aimed to reduce jail overcrowding and improve outcomes for mentally ill offenders (*Mental Health County Court – Seventeenth Judicial Circuit of Florida*, n.d.). Mental health courts are a specific type of problem-solving court that uses the legal principle of therapeutic jurisprudence to solve problems that are resistant to the traditional justice system. Other types of problem-solving courts include drug, veterans, and domestic violence courts. The literature has shown that mental health courts have been effective in reducing recidivism, criminal behavior, and improving health outcomes (Keator et al., 2013; Palermo, 2010; Sarteschi et al., 2011; Steadman et al., 2011). As the positive results of mental health courts have become more publicized, more counties have adopted the courts to help meet local community needs.

Policy adoption and implementation are critical components of the policy process. Both policymakers and policy scholars are interested in learning why local and state governments choose to adopt new policies, especially policies from other jurisdictions. A better understanding of the mechanisms by which governments choose to consider a new policy is important as counties, states, regions, and the nation consider the most effective and innovative public policies.

This chapter begins with a literature review of the policy diffusion and internal determinants literature and uses the event-history analysis methodology to study the mechanisms by which counties decided to establish mental health courts. The results of the probit regression

show that the learning and competition mechanisms were associated with an increase in a county's likelihood of establishing a mental health court, while the normative emulation mechanism was associated with a decrease in a county's likelihood of establishing a mental health court.

Policy Diffusion Literature Review

Policy Diffusion

Policy diffusion is how one government is influenced by the choices of other governments to create policy, while policy innovation happens when a government introduces a new policy that may result in policy diffusion by other communities (Shipan & Volden, 2008, 2012). Policy diffusion assumes that a policy is transferred from one jurisdiction to another and is adopted because it has proven effective in other communities.

The mechanisms that explain how policy diffusion occurs are learning, competition, coercion, and mimicry (Marsh & Sharman, 2009). The learning mechanism states that a government uses rational decision-making to copy different governments because the adopted policy creates more effective outcomes than the alternative and, therefore, chooses to adopt the policy for their own community. The mimicry mechanism explains how governments adopt policies not because the policy is necessarily more effective than the status quo, but because the municipality wants to have similar policies to communities that share similar political values and other shared norms and culture. Mimicry tends to be more focused on symbolism than reasons of efficacy (Marsh & Sharman, 2009). The competition mechanism describes how governments consider the effects on other governments adopting a policy and whether it will bring positive or negative economic spillovers to their community before deciding whether they should adopt that policy (Shipan & Volden, 2008). Finally, the coercion mechanism explains how governments are

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forced to adopt policies from the state and federal government (Marsh & Sharman, 2009; Shipan & Volden, 2008).

Policy innovation and policy diffusion are both theories about how communities decide to create, adopt, and implement policies. Policy innovation primarily happens through two methods. One is the internal determinants model, which states that social, political, and economic characteristics internal to the area cause policies to be adopted (Berry & Berry, 2007). For example, increasing crime rates and high rates of mental illness in a county could cause a county to investigate getting an MHC. The other is policy diffusion, which says that areas are inspired by other communities to adopt a policy because of the perceived success of the policy (Berry & Berry, 2007).

There are many examples of policy innovation and diffusion across different geographies and policy types. Berry and Berry (1990) studied states that adopt lotteries and found that both internal determinants and the number of previously adopting states affect the probability of a state adopting a lottery. Mitchell and Stewart (2014) studied inter-county antismoking laws in Missouri and found that the learning and competition mechanisms were significant in how anti-smoking policies diffused, with larger counties being more likely to learn from other counties and small counties being more likely to be affected by economic competition. Gilardi and Füglister (2008) used dyadic event history analysis to study health insurance subsidy policies in Switzerland and found imitation and learning were important mechanisms of policy diffusion and that similarity between cantons was more important than geographic proximity. Knott (2023) studied Texas's alcohol regulations and found that there was a significant increase in the probability of a county allowing for the sale of liquor and mixed beverages when the neighboring counties loosened their alcohol laws, and counties with a high level of Baptists had a significant

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increase in resistance to loosening alcohol restrictions. DellaVigna and Kim (2022) studied 700 US state level policies from the 1950s-2010s and found that from the 1950s-2000s, states were more likely to adopt policies if nearby states had adopted the policies, while from the 2000s on, whether states were more politically aligned had more of an effect than geographic proximity for whether states adopted a policy.

There has also been research related to the policy diffusion of drug courts, which is another type of problem-solving court that aims to resolve substance abuse disorders through a rehabilitation lens instead of a punitive lens. Mak and Rutledge (2019) studied county-level drug courts in California, Florida, and New York and found that as the number of counties that adopt drug courts increases, more counties are likely to adopt drug courts, even if they were initially ideologically resistant. They also found that larger localities are more likely to adopt judicial innovations when they learn about other counties' experiences, since they do not need to copy smaller counties (Mak & Rutledge, 2019). Douglas et al. (2015) studied the different levels of government that influence whether a county adopts a drug court. They found that policy diffusion patterns changed over time. When the courts were first created, they were diffused horizontally, from county to county, with early Florida counties observing how effective the Miami drug court was and wanting to solve their own drug problems. Increased federal drug court funding and the creation of the National Association of Drug Courts increased the reach of drug courts nationwide and increased the role of "top-down go-betweens" at the federal level (Douglas et al., 2015). State governments followed and, over time, also became more involved in the implementation of drug courts. Hartley and Douglas (2007) found that drug courts in Arizona, Missouri, New York, and South Carolina were spread through isomorphic forces, either through mimicry, coercion or normative forces.

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Pistone (2018) studied the regional diffusion of mental health courts and found a regional pattern related to whether a county in a state adopted a mental health court. She also found that a state's population and wealth had an impact on whether counties in a particular state adopted mental health courts. Easterly (2017) studied factors that affect the adoption of Veterans Treatment Courts (VTC) and found that early-adopting states were 82% more likely to have a presiding judge who either was in the military or had immediate family in the military than later-adopting states. Veterans and governmental variables were significant, while criminal variables were not strong predictors of early adoption. An increase in the number of states with a VTC was associated with a slower rate of diffusion (Easterly, 2017).

Internal Determinants

Castro and Guimaraes (2020) studied different determinants that support innovations in Brazilian judicial systems and found that innovation can be influenced by institutional, organizational, inter-organizational, and individual levels. Organizations often resist change because of the nature of bureaucracy and institutional resistance to innovation and change. Sliva (2016) found that economic and political determinants are the main internal determinants of whether a state adopts sentencing and corrections policies. Sliva (2018) further studied the internal determinants of whether states adopt restorative justice policies and found that the percentage of Black people in a state, the percentage of state-level female legislators and state incarceration rates were the main determinants of whether states would adopt these policies. Button (2017) found that counties with veterans treatment courts were more likely to have a local military base and Veterans Affairs (VA) hospital, larger VA compensation expenditures per capita, lower crime rates, higher per capita income, larger minority population and a smaller

veteran population than counties that do not. These examples illustrate that a community's characteristics can influence whether it adopts specific policies.

Research Purpose

This study will focus on counties in the United States that established MHCs from 1997 to 2021 to determine the nature of policy diffusion as it relates to when and where these courts spread. While Mak and Rutledge (2019) studied policy diffusion for drug courts in 3 states; this study will be the first to study policy diffusion nationwide for mental health courts.

Research Questions

- Which policy diffusion mechanism is the most significant for explaining the growth of MHCs?

- What internal determinants increase the likelihood of a county adopting an MHC?

Data

Analytic Sample

This study will use all counties in the US that established an MHC at some point between 1997-2021, not including Alaska because its county borders change frequently. The starting year of 1997 was chosen because the first MHC was established in 1997. The ending year of 2021 was chosen because more recent data were not available for all states.

Outcome Variable

The dependent variable is zero if a county has not adopted an MHC and 1 in the year of adoption. A county is dropped the year after the court is established because they are no longer "at risk" of getting an MHC. Some counties have more than 1 MHC, but this study will only focus on the counties switching from untreated to treated.

Independent Variables

Explanatory Variables. For this research, the variable that measures competition is the proportion of all contiguous counties to a given county that have adopted an MHC before a given year, similar to the approach used by Mak and Rutledge (2019). Theory holds that counties are more likely to adopt a policy if there are positive spillovers from nearby counties and less likely to adopt a policy if there are negative spillovers to neighboring counties (Shipan & Volden, 2008). In the case of mental health courts, there are unlikely to be negative spillovers if a neighboring county adopts a problem-solving court. It is more likely that a county would have positive spillovers, such as decreased recidivism and increased community safety, if a neighboring county has a mental health court (Mak & Rutledge, 2019). Therefore, this variable is believed to be positive, but not functionally significant, holding all else constant.

The variable that measures normative emulation is the proportion of larger (population-wise) neighboring counties that adopted an MHC before a given year (Mak & Rutledge, 2019). Previous literature holds that the main county is more likely to adopt a policy innovation if a larger neighboring county adopts the policy, holding all else constant (Bouché & Volden, 2011; Mak & Rutledge, 2019; Shipan & Volden, 2008). According to the emulation mechanism, if there are 4 contiguous counties to a target county with MHCs, but one county is substantially larger in population, the larger population would have an outsized effect on the likelihood of the target county adopting an MHC.

The variable that measures learning is the proportion of counties in a state that have adopted an MHC before a given year (Mak & Rutledge, 2019). Previous literature holds that as more counties in a state experience a policy change, the early adopters share information about

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how effective the policy is, so other counties are more likely to adopt the policy (Mak &
Rutledge, 2019).

Although an important mechanism in the policy diffusion framework, coercion was not
included in the model. Coercion requires the federal or state governments to force and
incentivize counties to establish a policy, and this generally does not hold for mental health
courts. While states have laws defining what MHCs are and creating requirements for these
courts, counties are free to adopt or not adopt these courts.

Control Variables. Several control variables explain county-level differences. Using county-
level controls allows for analysis of whether neighboring counties/ counties in the same state are
adopting mental health courts because of how similar they are on political, economic and
criminal demographics (similar internal determinants) or because of the policy diffusion
mechanisms (Shipan & Volden, 2008). Similar variables have been used in the policy diffusion
literature to control for county-level effects (Bouché & Volden, 2011; Button, 2017; Mak &
Rutledge, 2019; Shipan & Volden, 2008). Property, society, person, and other crime rates per
1000 people will be used to measure the rate of criminal activity in a particular county. The
crime rate variables were created by summing all the crimes in a category in a given county-year,
dividing by the total population, using the National Incident-Based Reporting System (NIBRS)
data, and multiplying by 1000. The types of crimes that are included in each category of crime
are listed in Table 14. Crimes against society and property are predicted to have a positive
impact on the likelihood of a county adopting an MHC because most MHC participants are
arrested for nonviolent felonies or misdemeanors. The crimes against persons variable is not
likely to have a significant impact because most mental health courts do not accept participants
who have committed violent crimes. The other crime variable is uncertain due to the unknown

nature of the crimes. The crime variables will be lagged by 1 year because decision-makers decide whether to create an MHC based on prior years' data. Counties with more crimes, specifically more society and property crimes, would investigate what other counties in the state/ nearby counties are doing to reduce these types of crimes, and could be more interested in establishing a court. For example, one interviewed VA court official saw a high amount of recidivism in low-level misdemeanors and was inspired to start learning about MHCs.

The dataset includes NOMINATE economic data to measure the ideological positions of House members for that state and region on economic issues such as taxation, spending and redistribution, on a scale of -1 to 1, with lower numbers representing left-wing positions and higher numbers representing right-wing positions as well as NOMINATE social data to measure House members' ideological positions on social issues such as civil rights, immigration, and "lifestyle" issues, on a scale of -1 to 1, with lower numbers representing anti-establishment positions and higher numbers representing pro-establishment positions (*Dw-Nominate-Guide · GitHub*, n.d.; Kane & Weiss, n.d.). Generally, anti-establishment positions tend to be supported by politicians who support more progressive positions and vice versa for pro-establishment politicians. NOMINATE economic is predicted to be negative, meaning that the lower a House member scores (the more left-wing), the more likely that someone would be supportive of spending money for the court. NOMINATE social would likely have a negative coefficient, since lower-scoring anti-establishment politicians would be more likely to push to establish a mental health court to stop the criminal justice system status quo. Ideologically, Republicans are generally less likely to support MHCs because they support "law and order" and would likely perceive MHCs as not being a strong enough punishment (Schanzenbach & Tiller, 2007). These variables are important for controlling for the impact of political partisanship. Counties that

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voted for House members who are more right-wing and pro-establishment would be less likely to push their local governments to establish an MHC, and local decision-makers would be less likely to research these courts.

Additional control variables include socioeconomic and demographic variables that have been shown to be important considerations for potential criminality. The unemployment rate is the county's unemployment rate each year. Poverty percent is the estimated percentage of all people in a county who live in poverty (US Census Bureau, n.d.). Both economic variables are likely to have a negative relationship with the likelihood of a county starting an MHC. In counties with higher unemployment rates and higher poverty percentages, counties would not be looking at what other counties are doing in regards to mental health courts and would be less likely to adopt a mental health court because the community resources that these courts rely on would likely have fewer resources available and have more people using them, which would cause court implementation to be unsuccessful. For example, one interviewed VA court official commented that starting a new court post-COVID is harder than pre-COVID because COVID took away a lot of community resources and financial support. Black is the percentage of Black people who live in a given county in a particular year. The relationship between the percentage Black and the likelihood of a county starting a mental health court is likely to be positive; since Black people are overrepresented in the criminal justice system and are less likely to receive any mental health care service, there could potentially be more of a need for mental health courts (Division of Diversity and Health Equity & Murray, 2017; Ghandnoosh, 2023). County officials would be more likely to investigate criminal justice reforms, including mental health courts, if citizens are concerned about a disproportionate number of Black people being arrested. All variables will be interpreted to determine whether they are associated with an increase or a

decrease in the predicted probability of a county establishing an MHC. More information about these variables is in Table 13.

Table 5: Policy Diffusion Descriptive Statistics

Variable	Obs	Mean	Std. Dev.	Min	Max
MHC	8251	.062	.24	0	1
Lagged Competition	7754	.072	.149	0	1
Lagged Normative Emulation	7754	.052	.123	0	1
Lagged Learning	7764	.055	.087	0	.5
Total Population	8251	264545.75	426369.87	2200	5373418
NOMINATE Economic	8233	.166	.406	-.676	.931
NOMINATE Social	8233	.088	.324	-.893	.995
Poverty Percent	7277	13.634	5.536	2.5	45.6
Society	2587	2240.418	3409.333	0	30690
Person	2587	801.611	1254.255	0	11168
Property	2587	1134.074	1849.966	0	16190
Other	2587	1608.718	2740.555	0	24286
Unemployment Rate	8249	5.95	2.783	1.1	30.6
Black	8251	.118	.142	0	.819
Lagged Society Rate	2377	11.825	9.774	0	75.615
Lagged Person Rate	2377	3.942	3.159	0	17.176
Lagged Property Rate	2377	5.265	4.898	0	39.53
Lagged Other Rate	2377	8.396	9.43	0	119.053

Table 5 shows the descriptive statistics for the counties that get an MHC at some point for the years up to and including the year they get the court. Observations are the total number of occurrences (county-year) in the sample. Similar to the whole dataset's descriptive statistics (Table 9), crimes against society were the most committed type of crime, with an average of 2240.42 crimes. Unemployment rates, total population, and percentage of Black people were higher in the MHC sample compared to the full sample, while the percentage of poverty is lower in the MHC sample. House members in MHC counties had lower NOMINATE scores for both economic and social sectors than House members in the full sample, meaning that they vote more left-wing and more anti-establishment.

Statistical Method

A quantitative methodology for policy diffusion is the state-year event history analysis (EHA), pioneered by Berry and Berry (1990) in their paper examining how states decide to

create lotteries. The dependent variable in these analyses is a dummy variable, with one identifying if an event occurred and 0 if an event has not occurred, with the event being whether the area adopts the policy. The 0/1 variable is an observable dependent variable representing the unobservable hazard rate or the probability that an individual will experience an event at a given time (Berry & Berry, 1990). While Berry and Berry were one of the first in the policy diffusion literature to use this method, others have also used the state-year EHA to explain the spread of drug courts, veterans treatment courts, and antismoking policies (Button, 2017; Easterly, 2017; Mak & Rutledge, 2019; Shipan & Volden, 2008). The EHA model examines "time to adoption" of a particular policy and uses it to assess the primary rationale for a policy adoption.

A probit regression will be the primary model used to analyze the research questions. A logit model will be used as a validity and robustness check (Berry & Berry, 1990; Mak & Rutledge, 2019; Makse & Volden, 2011; Shipan & Volden, 2008). Probit and logit models are both regressions with a dichotomous dependent variable, with the difference being that in a probit model, the error term is normally distributed, while in the logit model, the error term is logistically distributed (M. A. Bailey, 2019).

Statistical Model

The model for this paper is a probit model, with a binary dependent variable (whether the county adopts an MHC in a given year) and is shown in (1).

$$
\begin{aligned}
P(MHC = 1|X) \\
= \phi(\beta_0 + \beta_1 competition_{it} \\
+ \beta_2 normative\_emulation_{it} + \beta_3 learning_{it} \\
+ \beta_4 covariates_{it} + \alpha_i + \epsilon_{it})
\end{aligned}
\tag{1}
$$

Where α_i represents random effects.

Results

Table 6: NIBRS Policy Diffusion Marginal Effects

Delta-method

	dy/dx	std. err.	z	P>z	[95% conf.	Interval]
Lagged Competition	0.301	0.066	4.550	0.000	0.171	0.430
Lagged Normative Emulation	-0.243	0.074	-3.290	0.001	-0.388	-0.098
Lagged Learning	0.423	0.070	6.030	0.000	0.286	0.560
NOMINATE Economic	0.042	0.015	2.830	0.005	0.013	0.071
NOMINATE Social	0.002	0.019	0.100	0.922	-0.035	0.038
Poverty Percent	0.005	0.001	3.600	0.000	0.002	0.008
Lagged Society Rate	-0.004	0.001	-3.690	0.000	-0.006	-0.002
Lagged Person Rate	0.005	0.004	1.270	0.206	-0.003	0.012
Lagged Property Rate	-0.001	0.002	-0.310	0.758	-0.005	0.004
Lagged Other Rate	0.002	0.001	2.760	0.006	0.001	0.003
Unemployment Rate	-0.006	0.002	-2.540	0.011	-0.011	-0.001
Black	0.145	0.057	2.540	0.011	0.033	0.257

Table 6 shows the average marginal effects for the probit regression. For a 1% increase in competition, the likelihood of a county establishing an MHC is increased by .301, conditional on all other variables. This result means that as the percentage of larger counties with an MHC increases, counties will be more likely to establish an MHC. This result aligns with the theory that counties will be more likely to adopt a court when there are positive spillovers from neighboring counties. Previous problem-solving court policy diffusion literature does not discuss competition, with Mak and Rutledge (2019) stating that counties would not have economic incentives to establish a drug court, which also likely holds for mental health courts.

For a 1% increase in normative emulation, the likelihood of a county establishing an MHC decreases by .243, conditional on all other variables. This means that as the percentage of counties with larger populations with mental health courts increases, the likelihood of a county establishing a mental health court decreases. This result does not align with the theory, which states that smaller counties will be more likely to adopt policies if nearby larger neighbors have

them (Shipan & Volden, 2008). Learning had the largest effect, with a 1% increase in learning being associated with an increased likelihood of .423 of a county establishing an MHC, holding all else constant. This means that as the percentage of counties with mental health courts in a state increases, the likelihood that a county creates a mental health court increases. This result does align with the theory that counties are more likely to adopt a policy if other counties within a state adopt it. This result also aligns with the problem-solving court policy diffusion literature, with other studies finding that learning is an important policy diffusion mechanism for problem-solving courts (Douglas et al., 2015; Mak & Rutledge, 2019).

Table 15 shows the probit coefficients with the NIBRS data. Results with Uniform Crime Reports (UCR) data (Table 17 and Table 18) were similar to the results with NIBRS data. The logit results with NIBRS data (Table 16) were similar to the probit results, passing a robustness check.

Competition and learning were positively significant, meaning that as there is an increase in the percentage of contiguous counties with MHCs and/or the percentage of counties in the state with an MHC, counties are more likely to adopt an MHC. Interestingly, as the percentage of larger-population contiguous counties with MHCs increases, the likelihood that a county adopts an MHC decreases. This could be an effect of the positive externalities these courts have on neighboring communities; as MHCs cause crime to decrease in the communities that have them, they could cause crimes to decrease in smaller neighboring counties to an extent that the courts are not needed, or could be an effect of limited funding, since larger counties would require more funding to start and continue the courts, there would be less available funding for smaller counties to start a court.

One limitation of the model is that not all counties with mental health courts have their

establishment date publicly available, which means they could not be included in the model.

Another limitation is that crime data and diffusion variables were only lagged for a year, even

though counties generally take longer than a year to decide that they need a court and open it (for

example, Anderson County, SC started to discuss establishing an MHC in 2019 and had its first

court participants in 2024) (Criminal Justice Coordinating Council January Meeting Minutes,

2019; Meadows, 2025). Another limitation of the model is that the policy diffusion variables

could capture other state-level factors that impact whether counties adopt these courts, but are

not specifically competition, normative emulation or learning. While these variables (or similar)

are frequently used in the literature, it is possible that there are alternative ways to measure

counties' motivations (Bouché & Volden, 2011; Mak & Rutledge, 2019; Shipan & Volden,

2008).

Conclusion

House members' economic stances were more significantly correlated to MHC adoption

than their social stances. This could signal that in many counties, it would be more beneficial to

use economic arguments, such as decreased jail costs due to lower recidivism and a decrease in

the use of high-cost mental health treatments, to advocate for these courts (Ridgely et al., 2007).

Other demographic variables had the predicted results and were similar to previous literature.

Similar to Mak and Rutledge (2019), learning was the policy diffusion mechanism with

the largest effect. As more counties in a state adopt mental health courts, more counties will be

more likely to adopt these courts. Some states create organizations that regulate and support

problem-solving courts, which may contribute to this effect. For example, Georgia created the

Council of Accountability Court Judges (CACJ) in 2015, which provides training resources,

grants, certification and standards for each type of accountability court (*Council of Accountability Court Judges*, n.d.). Ohio's Supreme Court has a specialized docket section that provides support for these courts through certification processes, data collection, and resources that help courts become and stay operational (*Specialized Docket Section » Supreme Court of Ohio*, n.d.). As of 2016, 19 states have statewide standards either for mental health courts specifically or problem-solving courts generally, and these states tend to have more MHCs (Waters & Wurzburg, 2016). Having statewide organization and/or statewide standards makes it easier for counties considering court adoption to know what is necessary for implementation and to have the resources to achieve those standards.

In addition to state organizations, state funding is another factor impacting how counties decide to establish courts. In addition to federal grants from the Bureau of Justice Assistance, state and local funding are important in ensuring these courts have the necessary resources to operate. MHCs use state resources such as the legislature, the State Department of Human Services, and the State Justice Department, as well as accountability court organizations to fund the courts, so if there is more state-level infrastructure to support these courts, then counties would be more likely to be able to create an MHC (*Council of Accountability Court Judges*, n.d.; Feder & Vigna, 2021).

CHAPTER 4: NATIONAL EFFECTIVENESS OF MENTAL HEALTH COURTS

Introduction

This chapter studies the effectiveness of mental health courts at a national level. Many studies have been conducted that study the effectiveness of mental health courts at an individual level (Anestis & Carbonell, 2014; Boothroyd et al., 2003, 2005; Christy et al., 2005; A. E. Gallagher et al., 2018), and several studies have been conducted to study the effectiveness of mental health courts in multiple cities, mainly focusing on larger cities (Keator et al., 2013; Palermo, 2010; Ray et al., 2015; Steadman et al., 2011). Most of these papers have found positive outcomes across a range of communities with these courts. One of the reasons for the positive outcomes could be that certain internal determinants of counties, such as political alignment and population, are key drivers for the success of these courts. As one interviewee said, certain aspects of problem-solving courts are easier for larger counties to adopt.

There are currently 751 mental health courts in the United States, with 46 states/DC having at least one court. The counties these courts are in are diverse, yet the literature mainly focuses on a few. As more counties establish these courts, scholars and practitioners will need to have a better understanding of how effective these courts are nationally, not just in bigger cities. This research begins to build on this research stream by examining the effectiveness of mental health courts at a national level. Using panel event studies, this research examines 487 courts across the country and finds no significant change in any type of crime post-mental health court adoption.

Literature Review

Mental Health Court Criminal Outcomes

To study the effectiveness of mental health courts on criminal outcomes such as recidivism, several methods have been used. One method that has been used is comparing a mental health court to a treatment-as-usual (TAU) court and comparing the outcomes, such as time to rearrest, rearrest rates or days in jail (Anestis & Carbonell, 2014; Christy et al., 2005; Cosden et al., 2003, 2005; Frailing, 2010; A. E. Gallagher et al., 2018; Han & Redlich, 2016; Hoff et al., 1999; Keator et al., 2013; Lowder et al., 2016; McNiel et al., 2015; McNiel & Binder, 2007; Moore & Hiday, 2006; Steadman et al., 2011). The results of these papers showed positive outcomes, such as lower rearrest rates, longer times to rearrest, and fewer days in jail for mental health court participants compared to TAU offenders. However, selection into mental health courts is not random. Court officials feel that it would be unethical to withhold services from potential participants. In addition, participants can choose not to enter the court, even if they are eligible. Cosden et al. (2003, 2005) randomly assigned 235 volunteers, assigning 137 to the mental health court and 98 to TAU, and studied their outcomes over time. Propensity scores, which use covariates such as demographic, mental health, and criminal activity data to calculate probabilities that a person would be picked for selection, were used to control for the nonrandom assignments in several studies (Anestis & Carbonell, 2014; A. E. Gallagher et al., 2018; Lowder et al., 2016; McNiel et al., 2015; McNiel & Binder, 2007; Steadman et al., 2011). Other studies generally matched samples on key variables (Christy et al., 2005; Keator et al., 2013; Moore & Hiday, 2006). Some studies did not control for the differences between these groups at all (Han & Redlich, 2016; Hoff et al., 1999). Especially in the studies that did not use propensity score

matching, it is likely that there were differences in the groups that could have affected the outcomes.

Another method of studying these courts that has been used is to compare the outcomes of participants pre- and post-court enrollment (Burns et al., 2013; Herinckx et al., 2005; Hiday & Ray, 2010; Kothari et al., 2014; Palermo, 2010; Yuan & Capriotti, 2019). Some of these studies have used MHC non-graduates as a control group (Costopoulos & Wellman, 2017; Dirks-Linhorst & Linhorst, 2012; Eckberg, 2006; Guthmann, 2015; Hiday & Ray, 2010; Madden et al., 2020; Ray et al., 2015; VanGeem, 2015). These studies also found positive results for these courts, such as reduced recidivism for program completers post-graduation, compared to non-graduates. Again, neither who is a participant in the court nor whether a participant completes the program is randomly assigned. Participants are removed from the court for several reasons, including non-compliance, being found incompetent to stand trial, drug or alcohol use, incurring additional charges, or simply not wanting to be in the program. Therefore, there are likely demographic or psychological differences between those who graduate and those who do not.

There are some papers that have studied who is selected into these courts. Luskin (2001) studied the Psychiatric Assertive Identification and Referral (PAIR) program in Indianapolis. She found that having felony convictions, being charged with a crime against a person and being male decreased a defendant's likelihood of being sent to the program. She also found that being older had a positive impact on men's likelihood of being diverted, while being older had a negative effect on women being diverted (Luskin, 2001). More recently, Wolff et al. (2011) studied the selection and admission process of 24 mental health courts and found that there was generally consistency between mental health courts in how they identify, screen, and select mental health court participants. They also found that differences in the client pool for these

courts could be because of different eligibility requirements, inconsistent program recruitment, or improper matching of offenders to programs (Wolff et al., 2011).

People who choose to enter mental health courts are highly motivated, either by reaching rock bottom and wanting to get better or by being motivated by the elimination of jail time once they complete the program (Wolff et al., 2011). Those who would self-select into the program would also likely be motivated to continue to work through the program, either through internal or external motivation. In this case, it could be that highly motivated people would successfully improve their time to rearrest or the number of days they spend in jail, no matter what type of program they are enrolled in. The mental state of offenders, in terms of how motivated an offender is to graduate from the mental health court and what motivated them to commit the crimes in the first place, is an unmeasured endogenous variable. The connection that the papers showed between mental health courts and crime rates could just be a spurious correlation (VanGeem, 2015).

One paper studied the effectiveness of mental health courts on jurisdictional crime rates, similar to this paper (Bullard & Thrasher, 2016). Bullard and Thrasher (2016) studied 11 Oklahoma mental health courts and found that four mental health courts had a statistically significant decrease in crime rates post-mental health court establishment, while seven courts had either no change or a significant increase in crime rates. Their study differs from this paper in many different aspects. Their study was only for one state, while the study in this paper includes all states (excluding Alaska). They did not include all the mental health courts in this state (37 courts), nor all the courts where the establishment date is available (13 courts), while this paper includes all mental health courts in the US (excluding Alaska) with an available court establishment date. In addition, they used ANOVA statistics for their results and did not publish

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a table of their findings. They used the results from the quantitative section of their paper to form

the groups for the second part, which studied why the more successful courts were successful.

They found that more successful courts had more intense monitoring, more treatment options,

additional program supports, and differences in incentives (Bullard & Thrasher, 2016). While the

conclusions they came to regarding characteristics of court success are interesting, the fact that

the authors did not show the ANOVA results to tell the audience which courts were successful or

not successful weakens the conclusions of this paper.

Study Locations

Of the studies that specified where the MHC of interest was located, 21 counties in the

US were studied. The most frequently studied county was San Francisco, CA, which was studied

in 8 papers (journal articles and technical reports) (Callahan et al., 2013; Han & Redlich, 2016;

Keator et al., 2013; Lindberg, 2009; McNiel et al., 2015; McNiel & Binder, 2007; Redlich et al.,

2012; Steadman et al., 2011). Other frequently studied counties were Santa Clara, CA, Hennepin

County, MN, and Marion County, IN, with 6, 5 and 5 mentions, respectively (Callahan et al.,

2013; Han & Redlich, 2016; Keator et al., 2013; Luskin, 2001; Redlich et al., 2012; Steadman et

al., 2011). Broward County, FL, frequently cited as the first MHC, was only named in 3 papers,

and these papers were earlier in the literature (Boothroyd et al., 2003, 2005; Christy et al., 2005).

The reason San Francisco, Santa Clara, Hennepin, and Marion counties were so frequently

studied, and frequently studied together, is likely due to the MacArthur Mental Health Court

project. The MacArthur MHC Project was a longitudinal study, covering the years 2004-2008,

which collected interview, criminal justice, and court data from the four courts from both newly

enrolled MHC participants and mentally ill offenders in the regular court system (Policy

Research Associates et al., 2025). The interview data were collected during enrollment and 6

months later, and court and criminal data were collected for 18 months post-MHC or post-arrest (Policy Research Associates et al., 2025). Several studies cited the MacArthur MHC Project dataset as their main source of data (Callahan et al., 2013; Han & Redlich, 2016; McNiel et al., 2015; Redlich et al., 2012).

Table 7: Demographic Information for Top 5 Studied MHC Counties and United States

	Broward County, FL	Marion County, IN	Hennepin County, MN	Santa Clara County, CA	San Francisco County, CA	United States of America
Population estimates (2024)	2,037,472	981,628	1,273,334	133,132	827,526	340,110,988
Population Census (2020)	1,944,375	977,203	1,281,565	127,647	873,965	331,449,281
Population Census (2010)	1,748,066	903,393	1,152,425	116,468	805,235	308,745,538
% female	50.90%	51.60%	50.30%	47.90%	48.70%	50.50%
% white	62.40%	61.80%	72.90%	31.90%	50.80%	75.30%
High school graduate or higher %, percent of persons age 25 years+, 2019-2023	90.30%	87.70%	94.00%	94.00%	88.80%	89.40%
Persons without health insurance, under age 65 years %	14.60%	9.80%	5.20%	3.30%	4.20%	9.50%
Median households income (in 2023 dollars), 2019-2023	$74,534	$63,450	$96,339	$173,670	$141,446	$78,538
Persons in poverty, %	12.70%	15.60%	10.10%	7.80%	11.90%	11.10%
(first) MHC establishment date	1997	1996	2003	1998	2002	n/a

Table 7 shows the demographic information for the top 5 researched counties with MHCs and national statistics (*U.S. Census Bureau QuickFacts*, n.d.). Comparing the studied counties to the USA, the female population percentage, percentage of population with a high school diploma, and percentage of people in poverty are generally similar. The USA generally has a higher percent of the white population and percentage of the population without health insurance

than the studied counties. The USA generally has a lower median household income than the studied counties.

Table 8: Health Information for Frequently Studied Counties and USA

	Poor Mental Health Days (2022)	Poor Physical Health Days (2022)	Poor or Fair Health (2022)	Mental Health Providers (2024)
Broward County, FL	5.3	3.7	20%	380:1
Marion County, IN	5.7	4.3	22%	260:1
Hennepin County, MN	4.8	3.5	13%	160:1
Santa Clara County, CA	4.5	3.4	15%	220:1
San Francisco County, CA	5.0	3.6	13%	90:1
United States of America	5.1	3.9	17%	300:1

Table 8 shows health information for the frequently studied counties and the USA (*Poor Mental Health Days | County Health Rankings & Roadmaps*, n.d.). The USA and the frequently studied counties show similar numbers for poor mental health days, poor physical health days, percentage of the population in poor or fair health, and the ratio of mental health providers to population.

While studying any mental health court is important for gaining further understanding of the courts as a concept, frequently studying the same courts does not give a complete understanding of how these courts work nationally. The frequently studied counties have different demographics compared to the USA, which would affect when counties decide to establish a court, what resources the courts can operate with, and how successful the courts are. "When you have seen one mental health court, you've seen one mental health court," Judge Britton (an Oregon Municipal Court Judge) said, and perhaps the same could be said for studying one mental health court (*A Look at Mental Health Courts*, 2024).

Research Purpose

The overall research objective of this paper is to compare crime rates in counties that have an MHC and counties that do not have an MHC from 1997 to 2021. This study will be the first to measure the effectiveness of mental health courts nationally.

Research Questions

- Are crime rates lower in counties after MHC adoption than in counties without these courts?

- Do MHCs have a larger impact on one type of crime than other types of criminal activity?

Data

Analytic Sample

All counties in the US were included in the sample, excluding Alaska's counties because the county boundaries change frequently, thereby making data collection inconsistent over time. The first MHC was established in 1997, and for this reason, was chosen as the first year of analysis. The ending year of 2021 was chosen because more recent data were not available for all states.

Treatment

Treated group- Counties that have a mental health court from 1997 to 2021

Control group- Counties that never had a mental health court from 1997 to 2021

This data is based on the establishment year of the court, which comes from publicly available information on the court website, news articles about the court, the Substance Abuse and Mental Health Services Administration database, acts establishing the courts, or emails from individual mental health courts (*Adult Mental Health Treatment Court Locator | SAMHSA*, 2023).

Outcome Variables

The outcome variables are crime rates per 10,000 people for crimes against society, person, property, and others, using the National Incident-Based Reporting System (NIBRS). The

crime rate variables were created by summing all the crimes in a category in a given county-year, dividing by the total population, and multiplying by 1000. Table 14 shows which crimes fall into each of the categories.

Control Variables

The main explanatory variable is time to court, which is the length of time between the target year and the year the county established the court. The time to court variable is hypothesized to have a negative relationship with crimes, meaning that as the length of time the court has been in operation increases, the crime rate would likely decrease. While establishing an MHC may have short-term impacts, participants are generally enrolled in the courts for 6 months to 2 years, depending on the court, and it takes time for community partnerships to be established, so any decrease in crime will be experienced in the long term. The effect is believed to be more significant for crimes against society and property, since most MHCs only accept people who have committed misdemeanors and/or nonviolent felonies. The establishment of the court will most likely not have a significant effect on violent crime rates since most MHCs do not accept participants who have committed violent crimes. The effects of court adoption on other crimes cannot be determined because of the unknown nature of the crimes.

To control for political partisanship, NOMINATE economic and social data are included. NOMINATE economic data measures the ideological positions of House members for a state and region on economic issues such as taxation, spending and redistribution, on a scale of -1 to 1, with lower numbers representing left-wing positions and higher numbers representing right-wing positions, and NOMINATE social data measures House members' ideological positions on social issues such as civil rights, immigration, and "lifestyle" issues, on a scale of -1 to 1, with lower numbers representing "anti-establishment positions" and higher numbers representing

"pro-establishment positions" (*Dw-Nominate-Guide · GitHub*, n.d.; Kane & Weiss, n.d.).

Generally, anti-establishment positions tend to be supported by politicians who support more

progressive positions and vice versa for pro-establishment politicians. Both NOMINATE

variables are hypothesized to be positive, since ideologically, Republicans (who tend to be more

pro-establishment) would push for "tough on crime" policies, which would increase the arrest

rate. For example, Republican judicial appointees are known to give longer sentences than

Democratic judicial appointees (Schanzenbach & Tiller, 2007). These variables are a proxy for a

county's political stances, and counties in more left-wing/ anti-establishment counties would be

more likely to push for these courts to be operated/ implemented and would likely vote for

officials who would push for increased federal, state, or grant funding.

　　Additional control variables include socioeconomic and demographic variables that have

been shown to be important considerations for potential criminality. The unemployment rate is

the county's unemployment rate each year. Poverty percent is the estimated percentage of all

people in a county who live in poverty (US Census Bureau, n.d.). Both economic variables are

believed to have a positive relationship with crime rates, since poor people are more likely to be

arrested and charged, due to the inability to pay fines and other fees, barriers to reentry into

society after their initial arrest, which cause a revolving door of recidivism, and the

criminalization of homelessness (Dolan & Carr, 2015). In addition, lower-income people may

not be able to get access to mental health treatment because of the high cost of healthcare. Black

is the percentage of Black people who live in a given county in a particular year. Black is likely

to be positive, since Black people are overrepresented in the criminal justice system

(Ghandnoosh, 2023). In addition, Black people generally receive lower quality of mental health

care, when they receive it at all, with only one-third of Black people who need mental health care

receiving it (Division of Diversity and Health Equity & Murray, 2017). Some courts have made their demographic information available. For fiscal year 2024, Virginia Behavioral Health Docket participants were 42% Black and 33.6% unemployed (Hade, 2024). In Shelby County, TN, through 2019, 59.5% of referrals and 58.3% of the graduates were Black (Madden et al., 2020). For the interviewed courts, participation in these courts was generally majority Black and lower income. Therefore, this demographic information could have an impact on who is selected for these courts as well as who is generally arrested more.

Statistical Method

In this paper, a panel event study is used to study the effect of mental health courts on crime rates. Mental health courts were established in different years, so the panel event study standardizes the time pre- and post-court establishment by creating leads and lags, as well as controlling for political and demographic effects that would affect crime rates. Panel event studies have been used in several different fields, including fertility studies, higher education, and family planning (M. Bailey et al., 2017; Mavropoulos, 2024; Suhonen & Karhunen, 2019). The model is based on Clarke and Tapia-Schythe's work (2021) and is shown in equation (2).

$$
y_{gt} = \alpha + \sum_{j=2}^{J} \beta_j (lead\ j)_{gt} + \sum_{k=1}^{K} \gamma_k (lag\ k)_{gt} + \mu_g + \lambda_t + X_{gt}'\Gamma + \epsilon_{gt} \qquad (2)
$$

Y is the dependent variable (crime rates), μ_g represents county fixed effects, λ_t represents year fixed effects, $X_{gt}'\Gamma$ represents the time-variant control variables, and the leads and lags are binary variables that show that a given court was adopted in a given number of periods away from a specific year (Clarke & Tapia-Schythe, 2021).

J is the total number of leads, which is years prior to the mental health court establishment and is defined in equation (3). An individual lead is denoted as j and $(Lead\ j)_{gt}$ is defined in equation (4).

$$(Lead\ J)_{gt} = \mathbb{1}\left[t \leq Event_g - J\right] \qquad (3)$$

$$(Lead\ j)_{gt} = \mathbb{1}\left[t = Event_g - j\right] for\ j \in \{1, \ldots, J-1\} \qquad (4)$$

K is the total number of lags, which is years after the mental health court establishment, and $(Lag\ K)_{gt}$ is defined in equation (5). An individual lag is denoted as k and $(Lag\ k)_{gt}$ is defined in equation (6).

$$(Lag\ K)_{gt} = \mathbb{1}\left[t \geq Event_g + K\right] \qquad (5)$$

$$(Lag\ k)_{gt} = \mathbb{1}\left[t = Event_g + k\right] for\ k \in \{1, \ldots, K-1\} \qquad (6)$$

Preliminary Statistics

Table 9: Descriptive Statistics

Variable	Obs	Mean	Std. Dev.	Min	Max
MHC	83998	.064	.245	0	1
Treated	84108	.156	.363	0	1
Total Population	84053	96603.441	310563.73	1	10105708
NOMINATE economic	83981	.229	.371	-.676	.936
NOMINATE social	83981	.159	.316	-.992	1
Poverty Percent	77778	15.179	6.151	1.7	62
Society	35956	633.254	1606.887	0	30690
Person	35956	278.484	734.324	0	21385
Property	35956	347.403	928.445	0	16190
Other	35956	598.401	1583.631	0	46299
Unemployment Rate	84013	5.866	2.711	.7	38.3
Black	83998	.092	.147	0	.867
Society rate	35956	10.046	26.867	0	1000
Person rate	35956	3.62	4.746	0	266.55
Property rate	35956	4.171	8.116	0	1000
Other rate	35956	8.952	16.451	0	916.667

Table 9 shows the summary statistics for the control and outcome variables. Observations are the total number of occurrences (county-year) in the sample. On average, there were more crimes against society, with a mean of 633.254, than crimes against property, persons, or other. Congresspeople had a mean NOMINATE economic score of .229, meaning that on average, they held more right-wing economic views and a mean NOMINATE social score of .159, meaning that on average, Congresspeople held more pro-establishment positions.

Table 10: NIBRS Crime Frequencies

UCR ARREST OFFENSE CODE	Freq.	Percent	Cum.
All Other Offenses	12,381,676	21.34	21.34
Drug/Narcotic Violations	7,361,387	12.69	34.03
Simple Assault	6,782,297	11.69	45.72
Driving Under the Influence	4,605,673	7.94	53.66
Shoplifting	4,083,003	7.04	60.70
Liquor Law Violations	2,515,749	4.34	65.04
Disorderly Conduct	2,281,255	3.93	68.97
Aggravated Assault	1,937,173	3.34	72.31
Drunkenness	1,935,061	3.34	75.64
All Other Larceny	1,654,452	2.85	78.50
Destruction/Damage/Vandalism of Property	1,332,100	2.30	80.79
Drug Equipment Violations	1,279,619	2.21	83.00
Burglary/Breaking and Entering	1,164,933	2.01	85.01
Trespass of Real Property	1,007,899	1.74	86.74
Bad Checks	815,149	1.41	88.15
Weapon Law Violations	781,933	1.35	89.50
Intimidation	781,227	1.35	90.84
Stolen Property Offenses	477,778	0.82	91.67
Motor Vehicle Theft	445,169	0.77	92.43
Robbery	419,780	0.72	93.16
False Pretenses/Swindle/Confidence Game	408,855	0.70	93.86
Family Offenses, Nonviolent	404,707	0.70	94.56
Counterfeiting/Forgery	390,043	0.67	95.23
Theft From Building	379,936	0.65	95.89
Runaway	357,225	0.62	96.50
Curfew/Loitering/Vagrancy Violations	347,406	0.60	97.10
Theft From Motor Vehicle	326,626	0.56	97.67
Impersonation	142,707	0.25	97.91
Prostitution	130,871	0.23	98.14
Forcible Fondling	130,219	0.22	98.36
Embezzlement	123,582	0.21	98.57
Forcible Rape	122,327	0.21	98.79
Kidnapping/Abduction	114,345	0.20	98.98
Credit Card/Automatic Teller Machine Fraud	112,029	0.19	99.18
Arson	64,034	0.11	99.29
Murder/Nonnegligent Manslaughter	58,973	0.10	99.39
Theft of Motor Vehicle Parts/Accessories	55,364	0.10	99.48
Assisting or Promoting Prostitution	46,916	0.08	99.56
Statutory Rape	34,069	0.06	99.62
Pornography/Obscene Material	32,837	0.06	99.68
Pocket-picking	32,768	0.06	99.74
Forcible Sodomy	28,075	0.05	99.78
Identity Theft	19,732	0.03	99.82
Sexual Assault With An Object	14,804	0.03	99.84

Purse-snatching	13,942	0.02	99.87
Theft From Coin-Operated Machine or Device	13,622	0.02	99.89
Betting/Wagering	9,361	0.02	99.91
Animal Cruelty	9,138	0.02	99.92
Operating/Promoting/Assisting Gambling	6,067	0.01	99.93
Peeping Tom	5,917	0.01	99.94
Incest	5,632	0.01	99.95
Extortion/Blackmail	4,616	0.01	99.96
Welfare Fraud	4,177	0.01	99.97
Negligent Manslaughter	4,012	0.01	99.98
Purchasing Prostitution	3,872	0.01	99.98
Wire Fraud	3,518	0.01	99.99
Bribery	2,919	0.01	99.99
Gambling Equipment Violations	2,377	0.00	100.00
Human Trafficking- Commercial Sex Acts	1,016	0.00	100.00
Hacking/ Computer Invasion	369	0.00	100.00
Human Trafficking -Involuntary Servitude	157	0.00	100.00
Sports Tampering	49	0.00	100.00
Total	58,012,524	100.00	

Table 10 shows the frequencies of the types of crimes committed in the sample. Not counting All Other Offenses, Drug/ Narcotic Violations were the most commonly committed type of crime, with 12.69% of total crimes, followed by Simple Assaults, comprising 11.69% of total crimes.

Table 11: Percentages of Types of Crimes

	Percent	Cum.
Property crimes	21.53	21.53
Person crimes	17.26	38.79
Society crimes	39.25	78.04
Other crimes	21.96	100.00
Total	100.00	

Table 11 shows the percentages of different categories of crimes committed in the sample. Crime against society is the largest percentage, with 39.25% of crimes committed in the sample. Table 14 shows which crimes fit into each of these categories.

Table 12: Percentage of Counties with Mental Health Courts

year	N	Mean	Min	Max
1995	3110	0	0	0
1996	3110	0	0	1
1997	3110	.001	0	1
1998	3110	.001	0	1
1999	3110	.002	0	1
2000	3111	.004	0	1
2001	3111	.009	0	1
2002	3111	.013	0	1
2003	3111	.022	0	1

2004	3111	.029	0	1
2005	3111	.035	0	1
2006	3111	.04	0	1
2007	3111	.05	0	1
2008	3111	.056	0	1
2009	3111	.067	0	1
2010	3111	.071	0	1
2011	3111	.077	0	1
2012	3111	.084	0	1
2013	3111	.096	0	1
2014	3111	.104	0	1
2015	3111	.118	0	1
2016	3112	.126	0	1
2017	3112	.135	0	1
2018	3112	.142	0	1
2019	3112	.147	0	1
2020	3112	.152	0	1
2021	3112	.156	0	1

Table 12 shows the summary statistics for the percentage of counties in the US that have

MHCs. In 2021, the last year in the dataset, 15.6% of US counties had an operational MHC. As

this is a binary variable, 0 means a county does not have a mental health court in a given year, while 1 means a county does have a mental health court in that year.
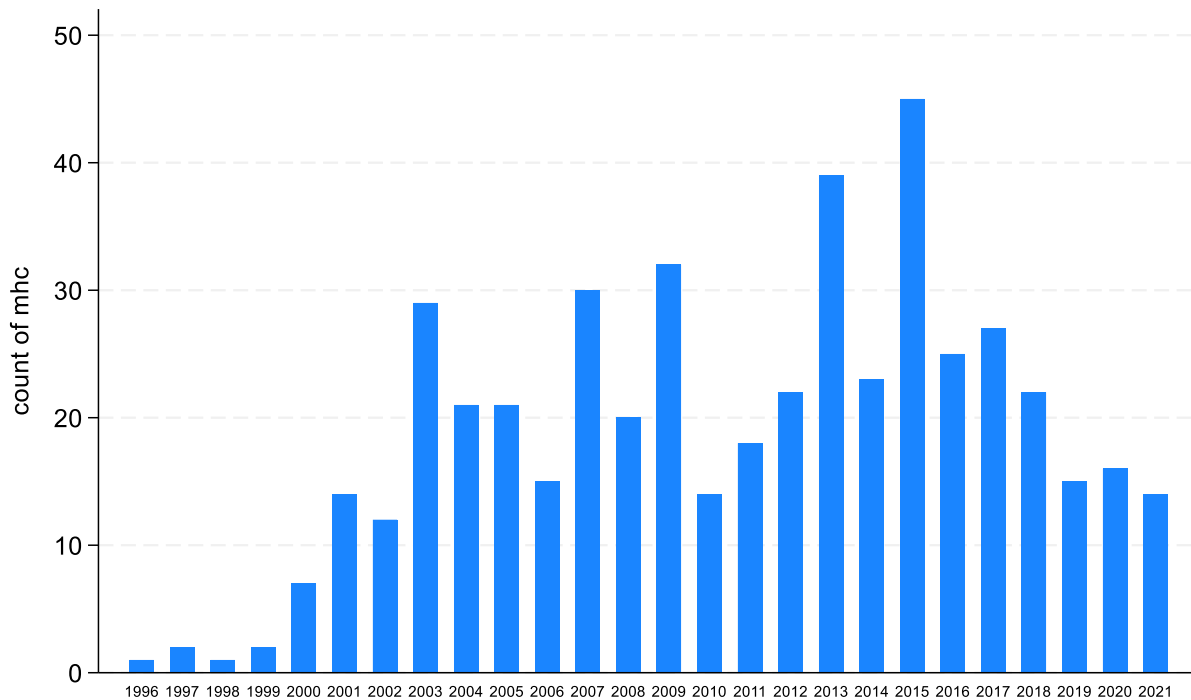
Figure 4: Mental Health Courts Establishment Dates

Figure 4 shows the distribution of mental health court establishment dates for unique counties from 1996-2021. The year with the most counties establishing their first MHC is 2015, with 45 counties establishing these courts. There is a large increase in growth in the early 2000s, with a peak in 2015, and a decline after.
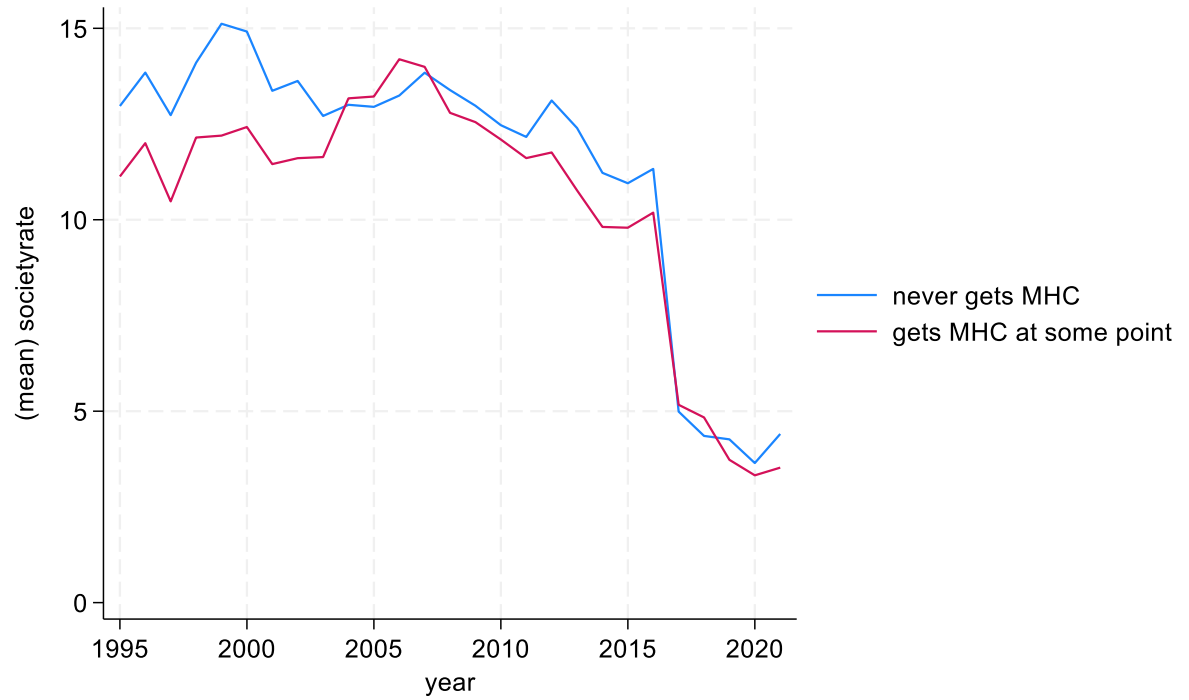
Figure 5: Mean Crimes Against Society Rate for MHC vs non-MHC

Figure 5 shows the mean annual crimes against society rate for counties that get an MHC and counties that do not. The crime trends are similar for both groups.
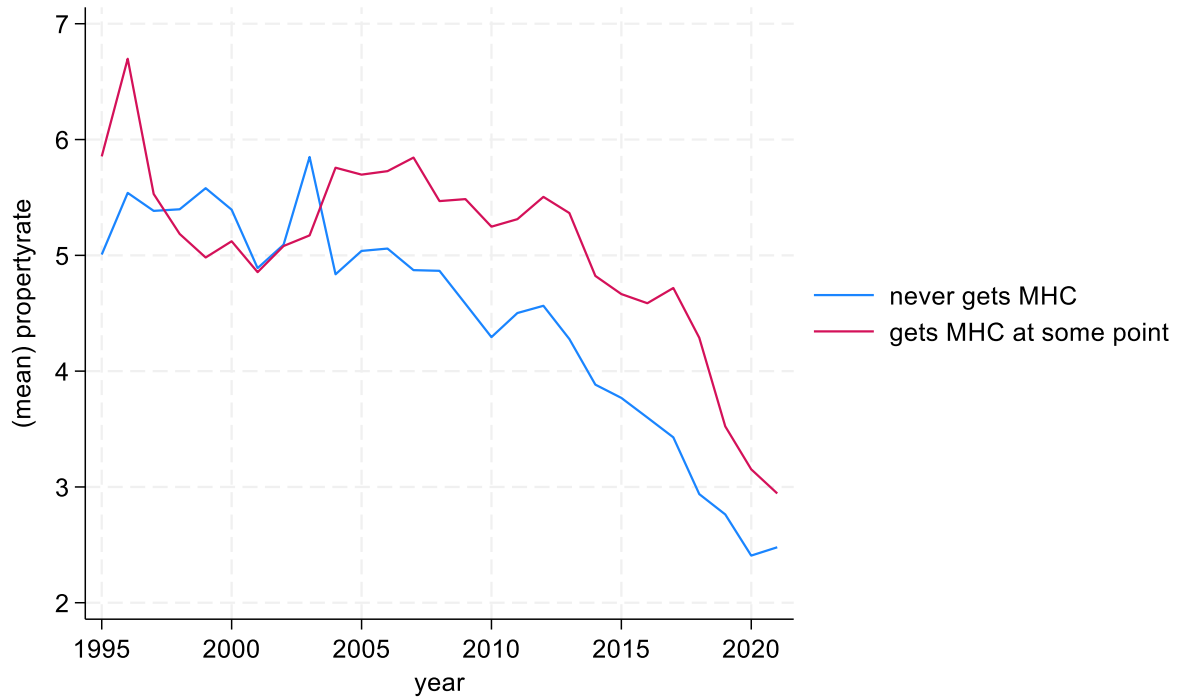
Figure 6: Mean Crimes Against Property Rate for MHC vs non-MHC

Figure 6 shows the mean annual crimes against property rates for counties that get MHCs and counties that do not. After 2004, the average crime against property rate was higher for counties with an MHC.
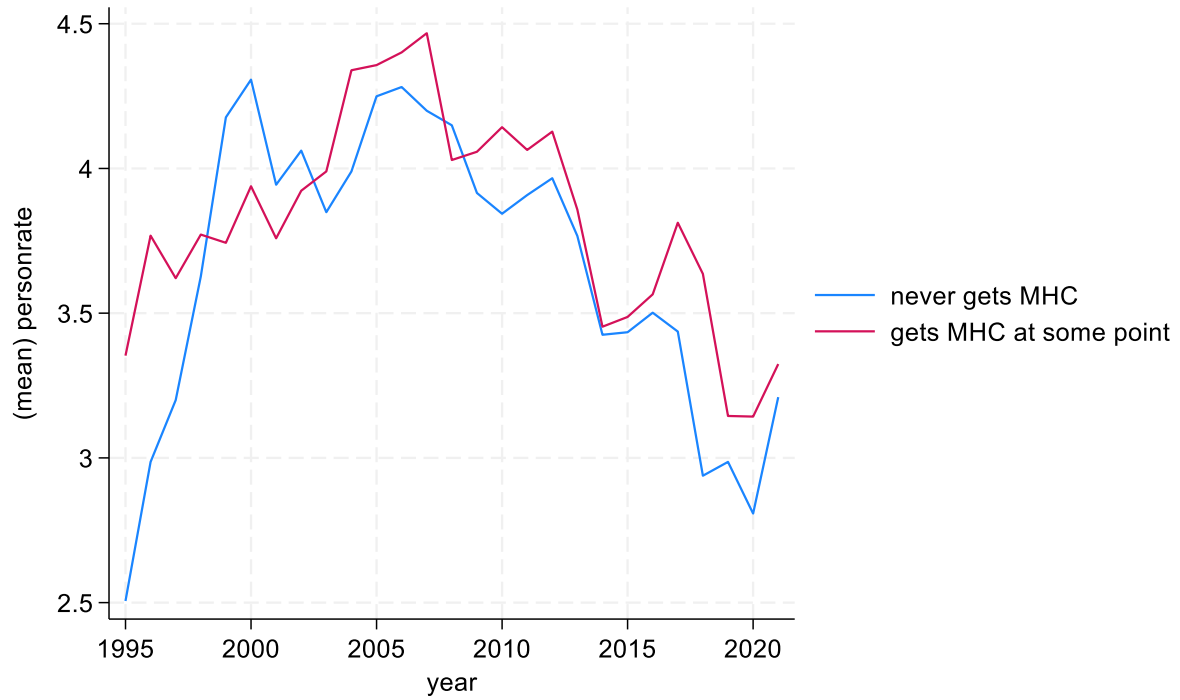
Figure 7: Mean Crimes Against Persons Rate for MHCs vs non-MHC

Figure 7 shows the average annual crimes against persons rate for counties that get MHCs compared to counties that do not. Both groups follow similar trends, but counties with MHCs had higher crimes against persons rates.
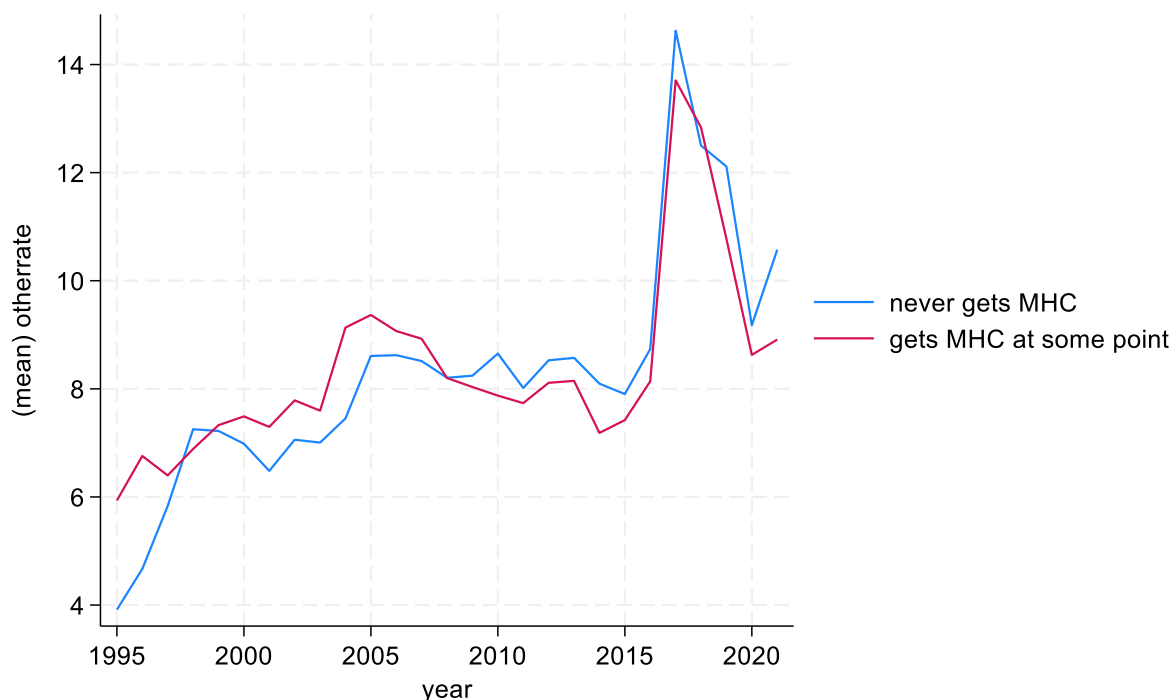
Figure 8: Mean Other Crimes Rate for MHC vs non-MHC

Figure 8 shows the mean annual other crimes rates for counties that get MHCs and counties that do not. The rates follow similar trends, with MHC-adopting counties having slightly higher rates until the late 2000s, then having lower other crime rates than non-MHC-adopting counties. Generally, counties with and without MHCs have similar crime rates over time.

Results

The results are shown in the event study plots.

Figure 9 shows the event study plot for crimes against society, Figure 10 shows the event study plot for crimes against property,

Figure 11 shows the event study plot for crimes against persons, and Figure 12 shows the event study for other crimes. Time periods -6+ to -1 represent the number of years prior to the county establishing a mental health court, 0 represents the year the county established an MHC, and

time periods 1 to 5+ represent the years after counties establish a mental health court. The time period of -1, the first lead prior to court adoption, is excluded from the sample to measure the differences between the counties that have a mental health court and the counties that do not have a mental health court. The time periods of -6 years to 5 years were chosen because many of the courts in the sample have been around for more than 5 years. The dots on the graph for each year are point estimates of the leads and lags. The dots on the ends of the graph are different colors, representing the endpoints. The endpoints show an estimate of the long-term impacts of mental health court establishment for the periods beyond the shown leads and lags. The lines on each point estimate represent the 95% confidence interval for each estimate.
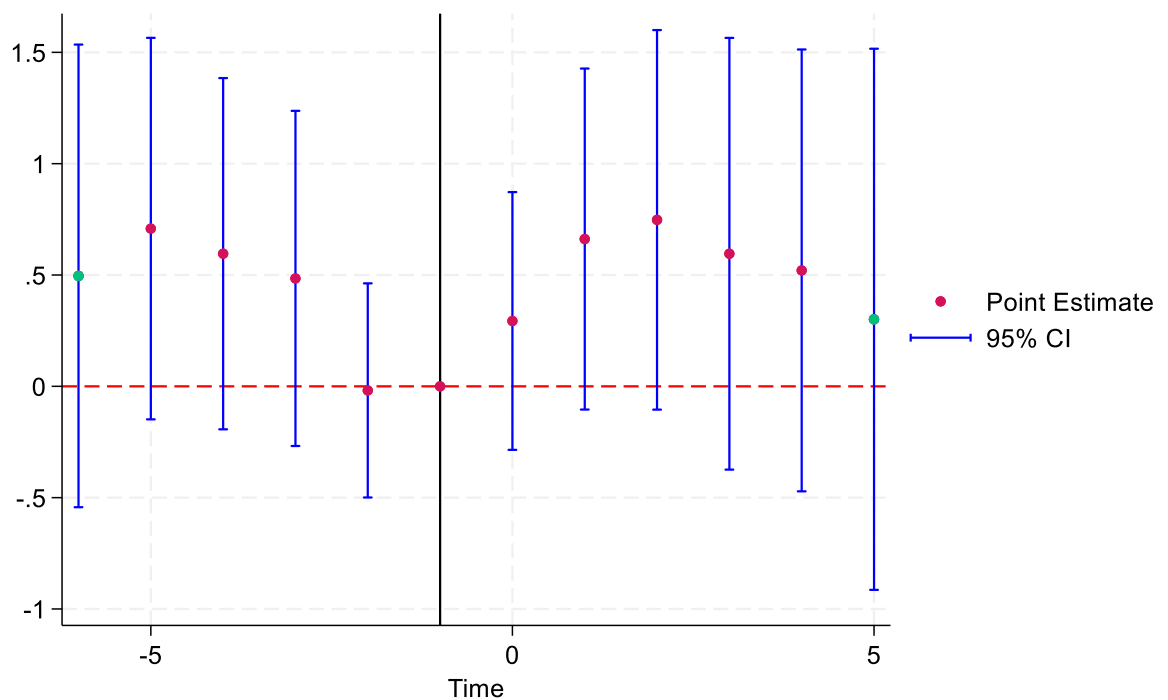
Figure 9: Society Rate Panel Event Study

Figure 9 shows the results of the panel event study for crimes against society. There is no significant change in crimes against society, as shown by the confidence interval for each period post court adoption including 0.
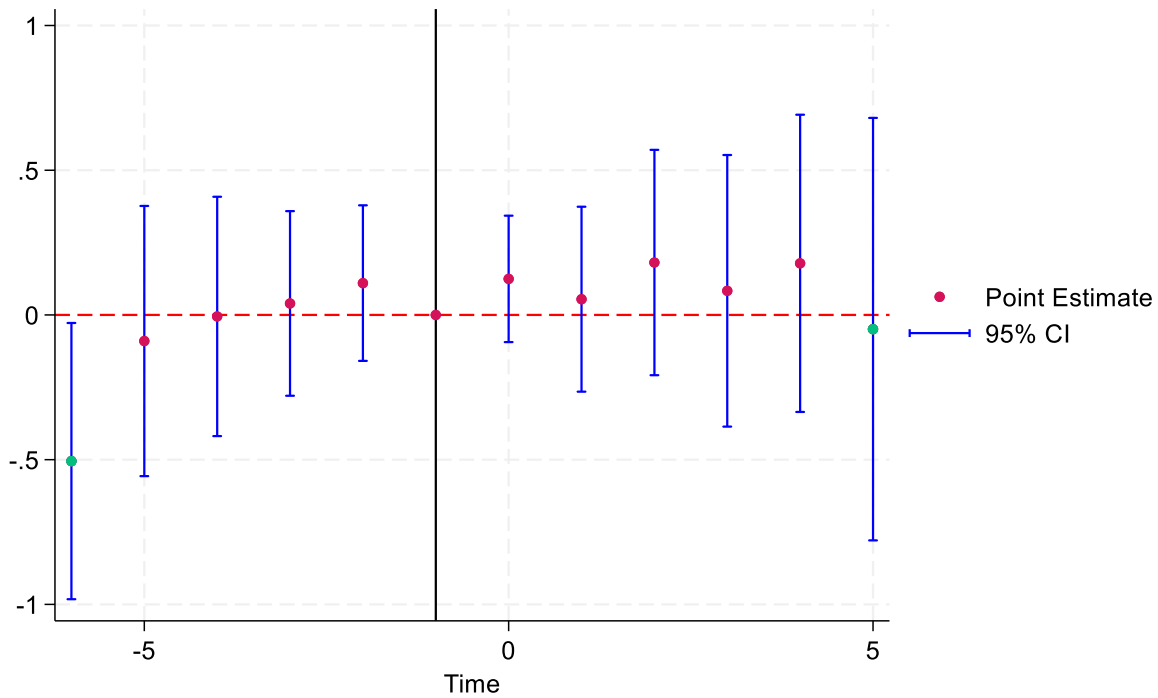
Figure 10: Property Crime Rate Event Study

Figure 10 shows the event study results for crimes against property rate. This also does not show a significant change in crimes against property rates post-mental health court adoption, as shown by the 95% confidence intervals including 0.
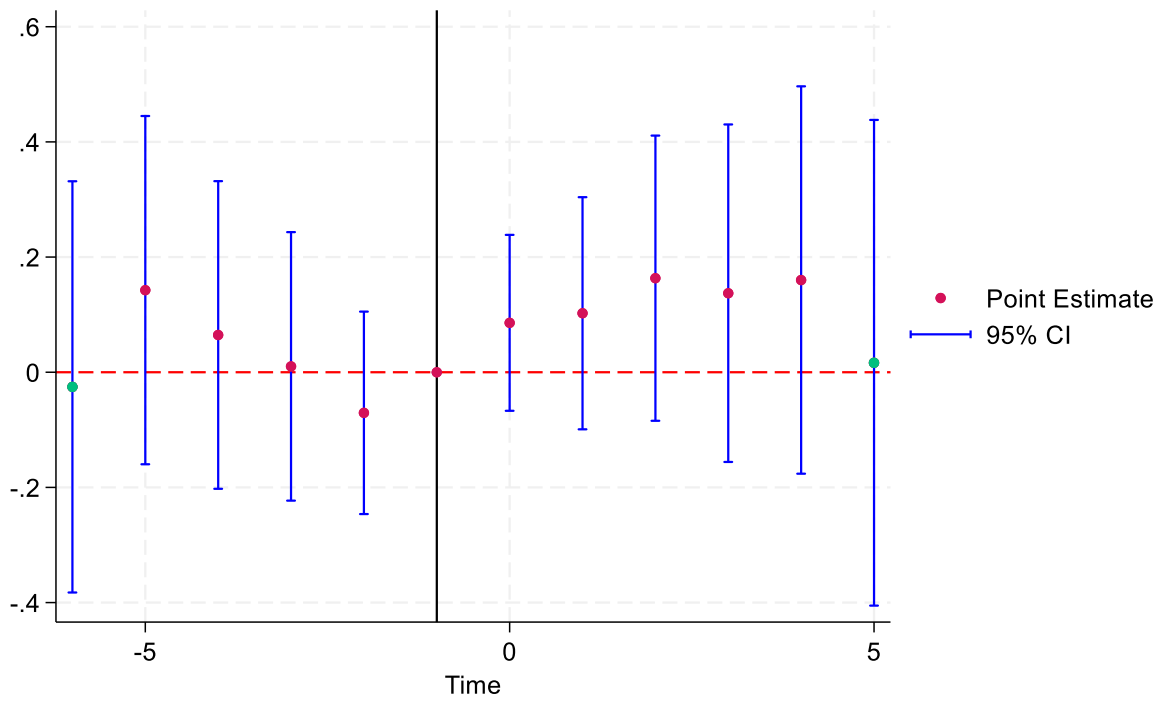
Figure 11: Person Crimes Rates Event Study

Figure 11 shows the results of the event study for crimes against persons, which show that there is no significant change in these crimes in mental health court adoption, which is shown by the confidence intervals including 0.
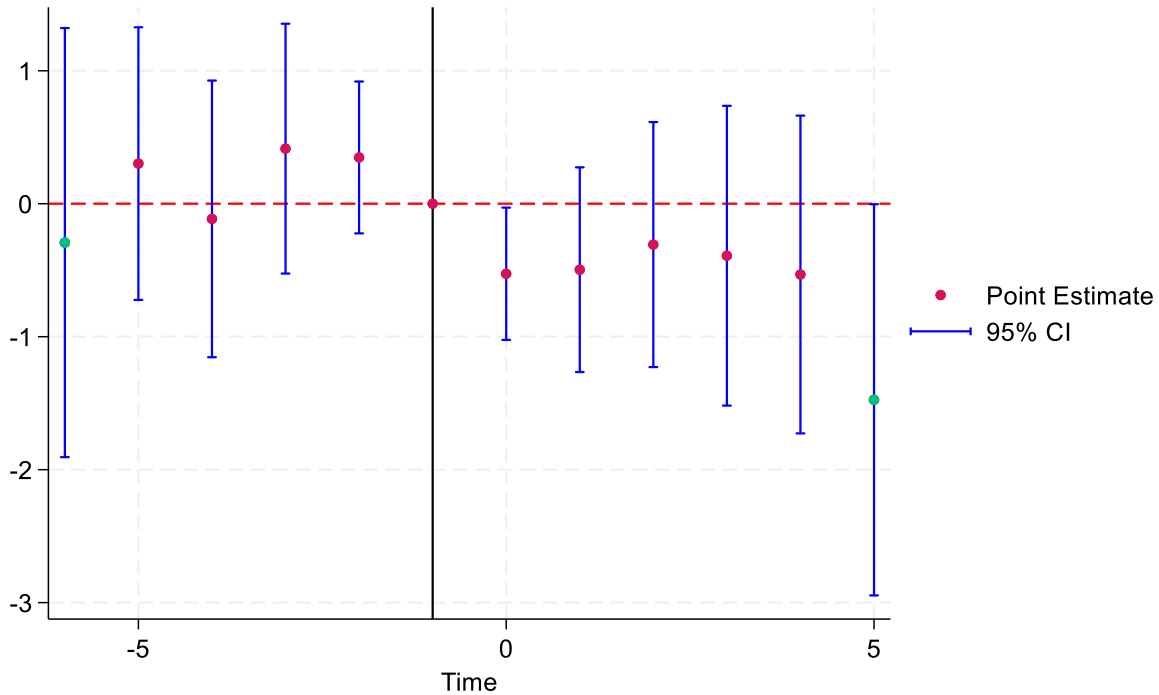
Figure 12: Other Crimes Rate Event Study

Figure 12 shows the results of the event study for other crimes, and shows that there is no significant effect of mental health court adoption on this type of crime, and is shown by the 95% confidence intervals including 0.

Table 19 shows the regression results for all the panel event studies. None of the leads or lags were significant at the 5% level. One lead (lead 6 for property crime rate) and two lags (lag 0 and lag 5 for other crime rate) were negatively significant at the 10% level. Overall, mental health court adoption did not have a significant effect on any type of crime.

The NOMINATE economic variable was positively significant at a 5% level for crimes against society and for crimes against persons, meaning that as a county's House representative becomes more right-wing economically, those types of crimes increase, holding all else constant. The NOMINATE social variable was positively significant at the 10% level for crimes against society and at the 5% level for crimes against persons, and negatively significant at the 10%

level for other crimes. For crimes against society and persons, as a county's House representative holds more pro-establishment positions, those types of crimes increase, holding all else constant.

Percent poverty was only significant for crimes against property, with a positive significance at the 5% level. Black was positively significant at the 5% level for crimes against property, at the 1% level for crimes against persons, and at the 10% level for other crimes. The unemployment rate was negatively significant at the 1% level for other crimes.

The results of these panel event studies show that mental health courts do not cause a significant change in crime rates. The lack of a decrease in crime, especially for crimes against society and property, could be because the court enrollment is a small percentage of total criminal activity, and therefore participants' changes in criminal behavior could be too small to be caught in the data or it could be that the courts are not effective in reducing crime. The lack of an increase in crime is a positive sign. Court naysayers would say that letting participants be in the public while they are receiving care instead of being incarcerated would be dangerous because they would commit more crimes, but this does not appear to be the case. While court enrollment data was not available for all courts, SAMHSA provided average approximate enrollment data for some courts and some states provided total enrollment numbers (*Adult Mental Health Treatment Court Locator | SAMHSA*, 2023; Bender & Smith, 2022; Idaho Supreme Court, n.d.; Jones & Becker, 2020; Office of the Executive Secretary, 2024). Using the highest number of any ranges and dividing the state total by the number of courts in the state, the average enrollment in these courts was 37.46 participants, with the lowest single court enrollment equaling 1 participant (MD) and the highest single court enrollment at 382 participants (Spokane, WA). Given that the smallest 2023 county population of counties with a mental health court is 2337 (Webster County, GA) and the largest county population is

5,087,072 (Cook County, IL), mental health courts serve a very small percent of the population. Overall, the small percentage of the population served by these courts makes it less likely that the effect of these courts would be seen in the crime rates data.

The NIBRS dataset does not identify the incidents at a personal level, making it impossible to track recidivism. Potentially, future research would have more years of crime data, more years of mental health court establishment, and more availability of mental health court establishment date information, increasing the amount of data available to study.

Using Uniform Crime Reports (UCR), which spans from 1997- 2016, with missing data for 2015, shows similar results, as shown in Table 20,

Figure 13, and

Figure 14. One major difference between the UCR and NIBRS results is that for property crimes, there was a negatively significant result at the 5% level, for 5+ years post mental health court establishment. The differences between these two results could be the differences in crimes measured and the length of time of the two datasets.

Conclusion

The results of the panel event study show that mental health courts do not have a significant effect on crime rates. This is likely not an indictment of the mental health court system as a whole, but rather a sign of how limited the scope of these courts is. Only 15.6% of counties ever get a mental health court, and even if potential participants have a qualifying mental illness and type of crime, not all who are eligible to enter these courts can enroll, due to a lack of resources. The accessibility of these courts is limited due to the time and resources required to sustain these types of courts. Because of this, the impact these courts have may be limited in scale and scope. Future research would incorporate more crime data and mental health

court data, and as mental health courts increase in both the number of courts and the number of participants served, the decrease in crime shown in the literature could also be seen as statistically significant nationwide.

However, not finding a statistically significant decrease in crime rates does not mean that mental health courts do not have positive outcomes. Many interviewed said that the courts were successful, with a high percentage of graduates and reduced recidivism. Interviewees shared success stories of participants who had gotten jobs, reconnected with their families, and received an education, among other successes. Generally, individuals who complete the mental health court program get help for their mental illness, which allows their lives to be more stable by getting employment and housing. This allows them to become productive members of society. The literature shows significant reductions in recidivism for MHC graduates, showing that graduates have limited or no interaction with the criminal justice system, although whether the change in outcomes is due to the courts or participants' motivation to change is uncertain. Mental health courts save counties money compared to the traditional justice system, due to reduced incarceration costs (Kubiak et al., 2015; Lindberg, 2009; Ridgely et al., 2007). These individual results have positive spillover to the rest of their community, but these results are more diffuse and harder to measure. Mental health courts have several benefits for the criminal justice system, such as reduced prison/ jail healthcare costs due to fewer mentally ill people incarcerated, and reduced prison overcrowding, since people who have committed less severe crimes are not incarcerated (Adler & Flood, 2022; Biden, 2022). Though not shown in the crime data, these benefits show that mental health courts positively impact the community.

CHAPTER 5: CONCLUSION

Summary

The body of this research begins with Chapter 2, which uses interviews of key court personnel in problem-solving courts in South Carolina and Virginia and document reviews to discuss barriers and facilitators faced when they adopted a court and whether these differed between states. The results of the case study found that the facilitators and barriers in the counties were similar across states. Courts were facilitated by people within the court and in the community working together to solve the problem of criminalization of mental illness in their communities, and often faced barriers of not having enough resources to serve all the people who needed these services. Chapter 3 examines how counties decide to adopt mental health courts, using probit regressions comparing counties that established courts in different years to measure which policy diffusion mechanisms were important for court adoption. The results show that the learning policy diffusion mechanism, meaning that the more counties in a state decide to adopt an MHC, the more likely a county will adopt an MHC, had the largest effect on whether counties decided to adopt these courts. Normative emulation and competition were also significant factors in whether counties adopted an MHC. Chapter 4 analyzes the effectiveness of mental health courts at reducing crime rates nationally. To do this, a panel event study was run, measuring the crime rates pre- and post-court establishment for crimes against society, persons, property, and other crimes. The results of these panel event studies find no significant change in crimes for any of the crime categories.

While the effectiveness paper found no significant changes in any crime post-mental health court adoption, the barriers and facilitators paper showed many positive results of the courts. This research reviewed that the interviewed counties had increased financial savings due

to decreased incarceration days, reduced recidivism of program graduates compared to nongraduates and treatment as usual mentally ill offenders, increased access to mental health and other community resources, and the individual success stories of graduates getting jobs, starting businesses, reuniting with family members, and overall living productive, successful lives.

Recommendations

For future research, more court officials from different courts in VA and SC could be interviewed for a more holistic understanding of how these courts started and continue to operate, Additional research on whether differences in how courts operate, such as length of time in the program or types of crimes that participants have committed, have an impact on recidivism or crime rates, would be useful to help determine if there is an optimal institutional/organizational structure of these courts. Different levels of court (municipal, general, district, etc.) could impact which cases are taken and how successful participants are. In addition, the goals of mental health courts are not only corrections-based (reduced recidivism, reduced days in jail, etc.) but also to improve the quality of life for people with mental illness and increase access and participation in effective treatment (Almquist & Dodd, 2009). While most of the MHC literature is focused on criminal outcomes, studying the effectiveness of these courts in increasing the quality of life and access to treatment is also important. As Chapter 2 shows, the interviewed MHCs had increased access to treatment and successful life outcomes because of the program and improved criminal justice outcomes. Studying how courts improve treatment outcomes nationally and whether different aspects of how the courts operate impact therapeutic outcomes is also important to show the success of these courts.

For counties, especially in smaller counties, that are deciding whether they should establish a mental health court, this research can be used as a tool to determine whether they

should establish a court. Most of the effectiveness literature on MHCs is focused on larger cities and smaller counties may feel that these examples do not apply because they do not have the same size population as those studied under the MacArthur MHC Project (Callahan et al., 2013; Han & Redlich, 2016; McNiel et al., 2015; Redlich et al., 2012). In addition, most of the frequently studied counties are either on the West Coast (Santa Clara and San Francisco Counties, CA) or the Midwest (Marion County, IN and Hennepin County, MN). Studying how counties in the South (Anderson County, SC, and Newport News, Hampton, Norfolk Counties, VA) establish and operate these courts is important because these counties have different political, socioeconomic and demographic factors that would impact how they decide to establish a court, operate, and evaluate the court's effectiveness long term.

For counties with a mental health court, this research could be leveraged as additional support and advocacy for nearby counties that are interested in establishing a court. Knowing that the percentage of counties that have an MHC in a state influences whether other counties in the state establish a court, counties with mental health courts could organize their mental health courts and other problem-solving dockets into a statewide organization, such as Georgia's Council of Accountability Court Judges and/or create statewide standards for courts, like Virginia's. Organizing courts into state organizations and/or establishing state standards creates an institutional structure and guidelines for prospective courts that they can use instead of creating everything on their own. The standards and statewide problem-solving court organizations create systems of accountability for all courts by creating minimum standards of operation and implementing internal monitoring (CSG Justice Center Staff, 2016). Allowing prospective courts to meet with current courts and including them in training sessions, both within state conferences and learning from external sources such as All Rise or the Council of

State Governments Justice Center, allows courts to learn what other courts have done and judge whether implementing different organizational strategies may be applicable to their court. Knowing that financial resources are a barrier for further court expansion, state governments and state problem-solving court organizations could offer grants for new and existing courts to sustain ongoing operations and necessary expansions to meet the needs of more people. In addition, counties with mental health courts should publicize their court's establishment date, since there were many counties with mental health courts that were not included in the analysis because their establishment year was unavailable.

For the general population, this research makes people aware of what mental health courts are and their role in the justice system. In the interviewed counties, citizens were generally unaware of these courts prior to adoption, but once the first group of participants had graduated, media attention and community members' support increased. Raising public awareness and spreading information about the courts could help sway and improve public opinion and, therefore, persuade decision-makers to investigate establishing new courts and continuing to provide resources to existing courts.

Contributions to the Field

The dataset of adult mental health courts is the most up-to-date list of mental health courts currently available. SAMHSA, which used to compile a list of these treatment courts, last updated its list in 2019. They now rely on the National Treatment Court Resource Center's list of courts, which has not been updated since 12/31/2023, and only has information about these courts at the state level ("Interactive Maps," n.d.). The dataset in this paper is up to date as of early 2025 and has information for the name of court, county, state, and establishment date (if available).

For the barriers and facilitators paper, this paper is the first to study the barriers and facilitators of adult mental health courts in multiple states. Whitaker et al. (2024) uses similar methodology, but studies two juvenile court systems in the same jurisdiction (Los Angeles, CA, a frequently studied state in the mental health court literature). This study is unique because it examines adult mental health courts in 2 Southern states, which have been studied less. The paper in Chapter 3 is the first of its kind to use the policy diffusion framework to help explain the spread of mental health courts. Most of the policy diffusion problem-solving court literature studies drug courts and only focuses on a few states, while this paper studies how mental health courts spread nationally. For the effectiveness paper, this paper is the first in the mental health court literature that studies the effectiveness of mental health courts nationally, as measured by crime rates. Bullard and Thrasher (2016) studied how mental health courts affected crime rates for 11 courts in Oklahoma, but their study was only for one state, and did not account for all of the mental health courts in this state (37 total courts), nor all of the courts where the establishment date is available in Oklahoma (13). In addition, they also used a different statistical method and used Uniform Crime Reports (UCR) data. The comparable study here uses panel event studies and National Incident-Based Reporting System (NIBRS) data, which includes more individual-level crime, and other factors that could explain crime rates. Overall, this research extends the research on problem-solving courts, and specifically mental health courts, by examining the effectiveness of these courts nationally, using a policy diffusion framework, and studying the barriers and facilitators of these courts in 2 Southern states.

CHAPTER 6: APPENDICES

Appendix 1: Variable Information

Table 13: Variable Definitions and Sources

Category	Variable Name	Specific Aim	Data Source	Definition
Location				
	FIPS	1, 2	(*Census Bureau Data*, n.d.)	Federal Information Processing Standard state and county code
Time				
	Year	1, 2		
MHC				
	MHC	1, 2	Individual MHCs	Whether the county has an MHC each year
	treated	1, 2	Individual MHCs	Whether the county ever has an MHC
Demographic				
	Total Population	1, 2	(*Census Bureau Data*, n.d.)	County population
	Black	1, 2	(*Census Bureau Data*, n.d.)	% county population that is Black
	Unemployment rate	1, 2	US BLS (*LAUS Home*, n.d.)	# of unemployed people as a % of the labor force
	NOMINATE economic position	1, 2	Voteview DW-Nominate Data (Lewis et al., 2021)	House member's ideological position on economic matters. [-1,1] lower numbers for left-wing positions, higher numbers for right-wing positions (Kane & Weiss, n.d.)

	NOMINATE social position	1, 2	(Lewis et al., 2021)	Congressperson/ Senator's position on social matters. [-1,1] lower numbers for anti-establishment positions, higher numbers for pro-establishment positions (Kane & Weiss, n.d.)
	Poverty Percent	1, 2	(US Census Bureau, n.d.)	estimated percentage of all people in a county who live in poverty
Crime data				
	Violent Crime Rate	1, 2	UCR (*Uniform Crime Reporting Program Data Series*, n.d.)	(Number of murders, nonnegligent manslaughter, forcible rape, robberies, and aggregated assaults/ total population) *1000
	Property Crime Rate	1, 2	UCR (*Uniform Crime Reporting Program Data Series*, n.d.)	(Number of burglaries, larcenies, and motor vehicle thefts/total population) *1000
	Society Crime Rate	1, 2	NIBRS (*National Incident-Based Reporting System (NIBRS) Series*, n.d.)	(Total society crimes/ total population) *1000
	Person Crime Rate	1, 2	NIBRS (*National	(Total person crimes/ total

			Incident-Based Reporting System (NIBRS) Series, n.d.)	population) *1000
	Property Crime Rate	1, 2	NIBRS (*National Incident-Based Reporting System (NIBRS) Series*, n.d.)	(Total property crimes/ total population) *1000
	Other Crime Rate	1, 2	NIBRS (*National Incident-Based Reporting System (NIBRS) Series*, n.d.)	(Total other crimes/ total population) *1000
Diffusion				
	Competition	2	Individual MHCs	% of contiguous counties that have adopted MHC
	Normative Emulation	2	Individual MHCs	% of larger contiguous counties that have adopted MHCs
	Learning	2	Individual MHCs	% of counties in the state that have adopted MHC

Appendix 2: MHC Interview Questions

(*CFIR Booklet*, n.d.; Whitaker et al., 2024)
Position Description
1. First, could you tell me a little bit about your current position(s) and the type of work you do at the organization?
    a. What are your primary job responsibilities at the MHC?
    b. How long have you been in your current position?

Program Description

1. In a few sentences, can you describe the Mental Health Court? (how many participants/ graduates, types of violations that are eligible)
    a. Do you have any materials you could send us that provide a description of the MHC? (handbook, policies and procedures)
2. Imagine a "typical" participant of the court. Walk me through what the participants experience from referral to the program until their services are completed.

We are interested in understanding how the MHC began and was implemented in (Anderson/ Greenville).
Innovation
1. Do you know how County officials discovered MHCs and became interested in them?
2. How did local officials learn about MHCs? Probe: (Anderson) Criminal Justice Coordinating Council, visits to other courts, government agencies
3. What costs were incurred to implement the intervention?
4. What was the general level of receptivity to adopting and implementing the MHC in the county?
    a. Why?
    b. Who was more and less receptive to implementing?
5. What challenges have you experienced in implementing the court?
6. What has facilitated the implementation success of the court?

Resources
(Resources may include operating and capital funding, dedicated personnel time (e.g. have new staff been hired, or is implementation a collateral duty), space, equipment, and/or information technology. Step through each to ensure all necessary resources are explored and fully described.)
1. Did you have sufficient resources (financial, human, organizational, etc.) to start and continue the court?
2. Were there other kinds of financial resources or incentives that influenced the decision to implement the court?

People
1. Are there people in your organization who championed (go above and beyond what might be expected) the MHC?
    a. Were they formally appointed to this position, or was it an informal role?

        b.   What position do these champions have in your organization?

        c.   How did they help with implementation? Getting people to use the intervention?

  2. Can you describe people's perception of this champion/individual?

        a.   To what extent do you respect the opinions and actions of the champion?

Goals and Outcomes

1. What are the main goals and objectives of the program? Probe: measurable short- and long-term goals (recidivism, crime rates, access to mental health services)
    a. What do you think is the target problem to be addressed by the program?
    b. Are there specific types of crimes or criminal behavior that MHCs were targeted to mitigate?
    c. Are there types of crimes that are more difficult to impact with MHCs?
    d. Do you feel that these goals and objectives are attainable? Have these goals been met thus far?

Services

1. What are the core services provided in the program? Probes: therapy, support groups, drug screens
2. What promising practices or evidence-based practices are utilized in the MHC?

Participants and Outreach

1. What is the age range, gender, family structure, employment status, and other demographic info of the average participant?
2. How are participants referred to the court (e.g., program referral, self-referral)? Probe: relationships established with organizations to make referrals to the program (jail, lawyers, probation officer)

Perceptions of Program Effectiveness/Barriers/Facilitators

1. How well do you think the program meets the needs of the participants you serve?
    a. What does success look like for participants in this program?
2. Are there any challenges that participants encounter in this program? If so, what are the challenges they experience?

Final Questions

1. Is there anything else you think would be valuable for me to know about this program?
2. Is there anyone else you would recommend that I talk to?
3. Do you have any other questions for me at this time?

Extra (Operations) Questions

1. How are the courts funded?
2. What stakeholders/partner agencies do you work with?
3. What is the frequency and types of communication you have with partner agencies/organizations? Probes: discussing specific cases, submitting data, obtaining procedural/policy information about the program, and receiving or making referrals.
4. What are the facilitators and barriers to working with community stakeholders/partner agencies?
5. What is the staffing structure? Probes: # of staff, staff responsibilities.

6. What is the training plan for each staff member? Probes: minimum requirements, training types (e.g., trauma-informed) and providers, supervision, frequency of training and supervision.

Appendix 3: NIBRS Offense Codes

Table 14: NIBRS Offense Descriptions

Crimes Against Persons	Crimes Against Property	Crimes Against Society	Other
Aggravated Assault	Arson	Drug/ Narcotic Violations	Runaway (not a crime)
Simple Assault	Bribery	Drug Equipment Violations	All Other Offenses
Intimidation	Burglary/ Breaking and Entering	Betting/ Wagering	
Murder and Nonnegligent Manslaughter	Counterfeiting/ Forgery	Operating/ Promoting/ Assisting Gambling	
Negligent Manslaughter	Destruction/ Damage/ Vandalism of Property	Gambling Equipment Violations	
Justifiable Homicide	Embezzlement	Sports Tampering	
Kidnapping/ Abduction	Extortion/ Blackmail	Pornography/ Obscene Material	
Forcible Rape	Fraud Pretenses/ Swindle/ Confidence Game	Prostitution	
Forcible Sodomy	Credit Card/ Automated Teller Machine Fraud	Assisting or Promoting Prostitution	
Sexual Assault with An Object	Impersonation	Weapons Law Violations	
Forcible Fondling	Welfare Fraud	Curfew/ Loitering/ Vagrancy Violations	
Incest	Wire Fraud	Disorderly Conduct	
Statutory Rape	Pocket-picking	Driving Under the Influence	
Human Trafficking-Commercial Sex Acts	Purse-snatching	Family Offenses, Nonviolent	
Human Trafficking Offenses-Involuntary Servitude	Shoplifting	Liquor Laws Violations	
	Theft from Building	Peeping Tom	

	Theft from a Coin-Operated Machine or Device	Trespass of Real Property	
	Theft from Motor Vehicle	Purchasing Prostitution	
	Theft of Motor Vehicle Parts or Accessories	Animal Cruelty	
	All Other Larceny		
	Motor Vehicle Theft		
	Robbery		
	Stolen Property Offenses		
	Bad Checks		
	Identity Theft		
	Hacking/ Computer Invasion		

(Department of Justice, 2011; *NIBRS Offense Codes and Description*, 2024)

Appendix 4: Additional Tables

Table 15: NIBRS Probit Policy Diffusion Results

MHC	Coef.	St.Err.	t-value	p-value	[95% Conf	Interval]	Sig
Lagged Competition	2.207	.484	4.56	0	1.257	3.156	***
Lagged Normative Emulation	-1.784	.542	-3.29	.001	-2.846	-.723	***
Lagged Learning	3.105	.515	6.03	0	2.096	4.114	***
NOMINATE Economic	.307	.108	2.83	.005	.095	.52	***
NOMINATE Social	.013	.136	0.10	.922	-.254	.281	
Poverty Percent	.039	.011	3.62	0	.018	.06	***
Lagged Society Rate	-.031	.008	-3.70	0	-.047	-.014	***
Lagged Person Rate	.034	.027	1.27	.205	-.019	.088	
Lagged Property Rate	-.005	.017	-0.31	.758	-.038	.027	
Lagged Other Rate	.014	.005	2.76	.006	.004	.024	***
Unemployment Rate	-.046	.018	-2.54	.011	-.081	-.011	**
Black	1.066	.42	2.54	.011	.244	1.889	**
Constant	-1.971	.143	-13.80	0	-2.251	-1.691	***

Mean dependent var		0.085	SD dependent var			0.279	
Number of obs		2301	Chi-square			155.760	
Prob > chi2		0.000	Akaike crit. (AIC)			1198.404	

*** p<.01, ** p<.05, * p<.1

Table 16: NIBRS Logit Policy Diffusion Results

MHC	Coef.	St.Err.	t-value	p-value	[95% Conf	Interval]	Sig
Lagged Competition	4.072	.859	4.74	0	2.389	5.755	***
Lagged Normative Emulation	-3.376	.965	-3.50	0	-5.268	-1.485	***
Lagged_learning	5.594	.941	5.94	0	3.75	7.438	***
NOMINATE Economic	.59	.216	2.73	.006	.167	1.013	***
NOMINATE Social	.078	.271	0.29	.772	-.452	.609	
Poverty Percent	.075	.022	3.49	0	.033	.118	***
Lagged Society Rate	-.06	.016	-3.67	0	-.092	-.028	***
Lagged Person Rate	.072	.054	1.35	.178	-.033	.177	
Lagged Property Rate	-.017	.034	-0.49	.624	-.083	.05	
Lagged Other Rate	.027	.009	2.96	.003	.009	.045	***
Unemployment Rate	-.09	.038	-2.34	.019	-.165	-.015	**
Black	2.062	.807	2.55	.011	.48	3.644	**
Constant	-3.512	.291	-12.08	0	-4.082	-2.942	***

Mean dependent var	0.085	SD dependent var				0.279
Number of obs	2301	Chi-square				154.750
Prob > chi2	0.000	Akaike crit. (AIC)				1202.309

*** p<.01, ** p<.05, * p<.1

Table 17: UCR Policy Diffusion Results

mhc	Coef.	St.Err.	t-value	p-value	[95% Conf	Interval]	Sig
Lagged Competition	1.538	.288	5.34	0	.974	2.102	***
Lagged Normative Emulation	-1.177	.329	-3.57	0	-1.822	-.532	***
Lagged Learning	2.751	.342	8.04	0	2.081	3.422	***
NOMINATE Economic	-.03	.064	-0.47	.64	-.155	.095	
NOMINATE Social	-.073	.085	-0.86	.388	-.239	.093	
Poverty Percent	.016	.006	2.55	.011	.004	.028	**
Lagged Property Rate	.006	.009	0.68	.494	-.012	.025	
Lagged Violent Rate	-.036	.024	-1.53	.126	-.083	.01	
Unemployment Rate	-.019	.011	-1.69	.091	-.04	.003	*
Black	.211	.201	1.05	.294	-.183	.606	
Constant	-1.928	.084	-23.04	0	-2.092	-1.764	***

Mean dependent var	0.059	SD dependent var				0.235
Number of obs	6973	Chi-square				232.873
Prob > chi2	0.000	Akaike crit. (AIC)				2911.360

*** p<.01, ** p<.05, * p<.1

Table 18: UCR Policy Diffusion Marginal Effects

	Delta-method					
	dy/dx	std. err.	z	P>z	[95% conf.	Interval]
Lagged Competition	0.167	0.031	5.310	0.000	0.105	0.229
Lagged Normative Emulation	-0.128	0.036	-3.570	0.000	-0.198	-0.058
Lagged Learning	0.299	0.038	7.930	0.000	0.225	0.373
NOMINATE Economic	-0.003	0.007	-0.470	0.640	-0.017	0.010
NOMINATE Social	-0.008	0.009	-0.860	0.388	-0.026	0.010
Poverty Percent	0.002	0.001	2.550	0.011	0.000	0.003
Lagged Property Rate	0.001	0.001	0.680	0.494	-0.001	0.003
Lagged Violent Rate	-0.004	0.003	-1.530	0.127	-0.009	0.001
Unemployment Rate	-0.002	0.001	-1.690	0.091	-0.004	0.000
Black	0.023	0.022	1.050	0.294	-0.020	0.066

Table 19: NIBRS Effectiveness Panel Study Results

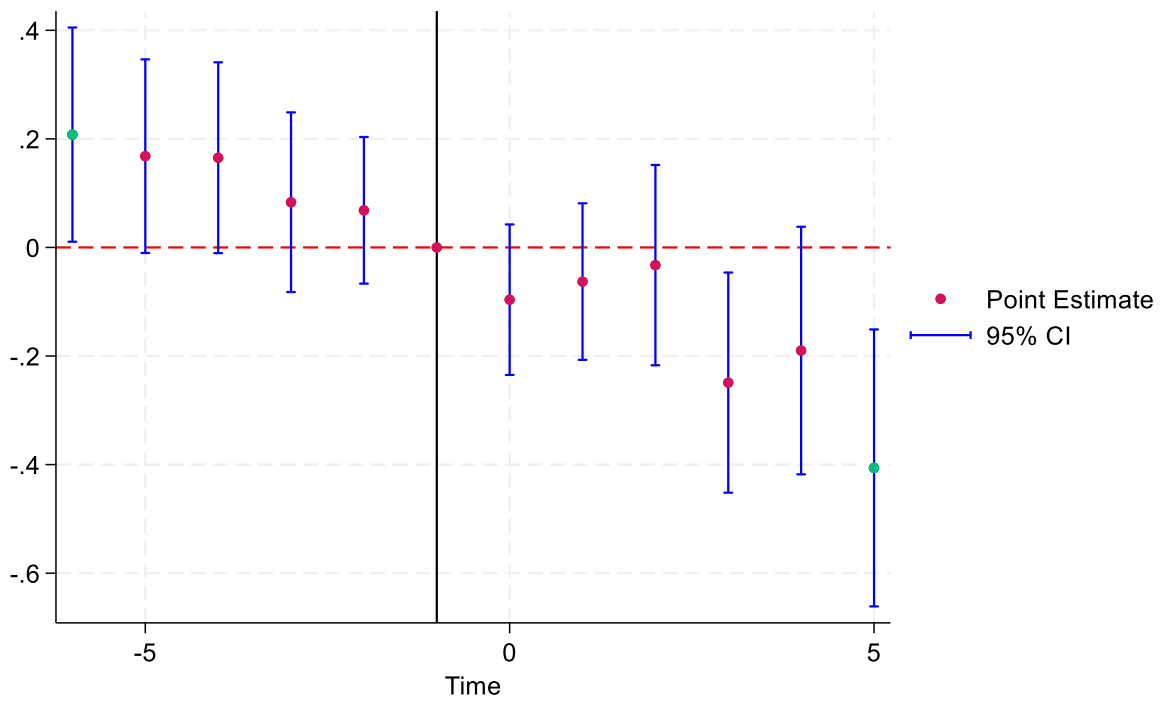|	(1) societyrate	(2) propertyrate	(3) personrate	(4) otherrate
lead6	0.496	-0.505*	-0.0254	-0.292
	(0.94)	(-2.08)	(-0.14)	(-0.36)
lead5	0.708	-0.0901	0.143	0.302
	(1.62)	(-0.38)	(0.92)	(0.58)
lead4	0.596	-0.00513	0.0647	-0.114
	(1.48)	(-0.02)	(0.48)	(-0.21)
lead3	0.485	0.0398	0.0102	0.414
	(1.26)	(0.24)	(0.09)	(0.86)
lead2	-0.0184	0.110	-0.0705	0.348
	(-0.07)	(0.80)	(-0.79)	(1.20)
lag0	0.294	0.125	0.0858	-0.527*
	(0.99)	(1.12)	(1.10)	(-2.08)
lag1	0.661	0.0544	0.102	-0.496
	(1.69)	(0.33)	(1.00)	(-1.26)
lag2	0.748	0.181	0.163	-0.307
	(1.72)	(0.91)	(1.29)	(-0.65)
lag3	0.595	0.0833	0.137	-0.391
	(1.20)	(0.35)	(0.92)	(-0.68)
lag4	0.521	0.178	0.160	-0.532
	(1.03)	(0.68)	(0.93)	(-0.87)
lag5	0.301	-0.0491	0.0164	-1.475*
	(0.49)	(-0.13)	(0.08)	(-1.97)
NOMINATE economic	0.942**	-0.258	0.360**	0.183
	(2.69)	(-1.41)	(3.10)	(0.46)
NOMINATE social	0.732*	-0.0224	0.296**	-0.890*
	(2.12)	(-0.14)	(2.93)	(-2.10)
poverty_percent	0.00200	0.0590**	-0.00561	0.0472
	(0.05)	(3.04)	(-0.45)	(1.18)
Black	10.27	13.32**	14.36***	18.28*
	(1.22)	(3.02)	(3.82)	(2.26)
unemployment_rate	-0.0560	0.0262	-0.0135	-0.215***
	(-1.20)	(1.26)	(-0.99)	(-3.80)
_cons	7.739***	2.615***	1.558***	2.763**
	(8.06)	(5.51)	(4.45)	(3.15)
N	34994	34994	34994	34994

Figure 13: UCR Property Crimes Panel Event Study
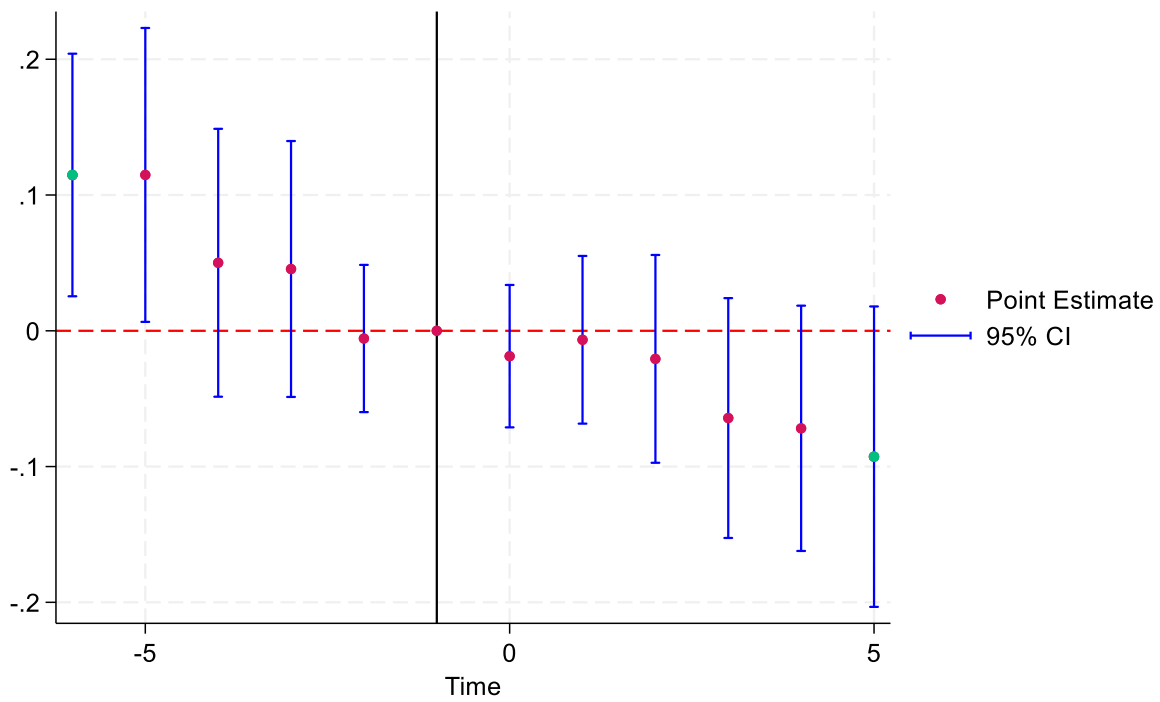
Figure 14: UCR Violent Crimes Panel Event Study

Table 20: UCR Panel Event Study Results Table

	(1) p1propertyrate	(2) p1violentrate
lead6	0.208*	0.115*
	(2.07)	(2.52)
lead5	0.168	0.115*
	(1.85)	(2.08)
lead4	0.165	0.0501
	(1.84)	(1.00)
lead3	0.0833	0.0455
	(0.99)	(0.95)
lead2	0.0684	-0.00568
	(0.99)	(-0.21)
lag0	-0.0962	-0.0187
	(-1.36)	(-0.70)
lag1	-0.0629	-0.00662
	(-0.86)	(-0.21)
lag2	-0.0326	-0.0207
	(-0.35)	(-0.53)
lag3	-0.249*	-0.0643
	(-2.41)	(-1.43)
lag4	-0.190	-0.0718
	(-1.63)	(-1.56)
lag5	-0.406**	-0.0927
	(-3.12)	(-1.64)
NOMINATE economic	0.220***	0.0305
	(3.87)	(1.33)
NOMINATE social	-0.0724	-0.0459
	(-1.15)	(-1.87)
poverty_percent	0.0183*	-0.0160***
	(2.34)	(-4.56)
Black	0.823	2.031**
	(0.69)	(2.92)
unemployment_rate	0.0474***	-0.0205***
	(4.89)	(-4.45)
_cons	4.629***	1.710***
	(26.31)	(18.84)
N	59055	59055

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