

University of Nevada, Reno

**Decision-Making in Mental Health Courts: A Mixed-Methods Analysis of Legal and Extra-
Legal Factors in Evaluations of Mentally Ill Defendants**

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Abstract

Mental health courts (MHCs) are specialized programs that aim to divert individuals with serious mental illness away from incarceration and into treatment. Their goal is to reduce recidivism and promote rehabilitation by addressing the underlying mental health needs that can contribute to criminal behavior. As the number of MHCs continues to increase, more research is needed to understand the processes and operations of these courts. Issues of disparity and equal access to these programs is one area in need of such research. This research describes a mixed-methods analysis grounded in classical social psychological theories of attribution and heuristics in addition to the focal concerns framework from the criminal justice literature. This dissertation describes three studies investigating decision-making among MHC workgroups. The first study describes ethnographic observations of three remote MHCs in the United States. Using a flexible coding strategy, this qualitative analysis focused on violation and termination hearings as important instances of decision-making within these programs. The second study describes another qualitative analysis of in-depth interviews with MHC workgroup members. These interviews focused on the referral and admission process as an important instance of decision making in addition to the work group members' perceptions of disparity within their programs. Finally, the third study describes an experimental survey using vignettes to investigate the effects of defendant race, gender, and offense type on MHC diversion decisions.

Keywords: mental health courts, attribution, focal concerns theory, disparity, mixed methods

Dedication

For my father, who always supported my pursuit of higher education, in loving memory.

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Chapter 1: Introduction

Recent decades have seen increasing concern over the high levels of incarceration within the United States justice system. Of particular concern is the number of incarcerated individuals with unique needs such as mental health issues, substance abuse problems, and more. Specialty courts, which were first introduced in the form of drug courts in the late 1980s (Hartley, 2019; Wolff, 2002), are an attempt to reduce these high levels of incarceration of these at-risk individuals by diverting eligible defendants to community supervision programs in lieu of incarceration. In addition, these specialty courts attempt to reduce recidivism rates by rehabilitating underlying behaviors that may have led to criminal activity. While drug courts were the first incarnation of specialty courts, the number and types of specialty courts quickly grew to include problem solving courts such as veteran's courts, domestic violence courts, and the focus of this project, mental health courts (MHCs).

Because of the ever-present issues of high levels of incarceration, and worsening problems of mental health in prisons including self-harm and suicide, MHCs were established to combat these issues. Of particular concern is the large number of people with mental health issues within the criminal justice system. Estimates suggest that 45% of federal prisoners and 56% of state prisoners may have a mental health issue to some degree (Kim et al., 2015). This is particularly concerning because poor conditions of some jails and prisons are likely to exacerbate mental illness symptoms. In addition to the inherent stress that comes with incarceration, inmates with mental illness are more likely to be subject to solitary confinement and higher rates of physical force and coercion from correctional officers (Erickson & Erickson, 2008; Snedker, 2022). This higher rate of use

of force can lead to exacerbation of symptoms associated with mental illness (Meade et al., 2017). The community supervision that MHCs provide, therefore, is a promising alternative.

Recidivism is a significant concern among offenders with mental illness, as research suggests they are more likely to be re-arrested for continued criminal behavior (Bales et al., 2017; Torrey, 2014). However, this relationship is likely indirect. Rather than mental illness itself driving recidivism, these individuals often have higher general risk factors for reoffending that are separate from their mental health conditions (Skeem et al., 2014). Additionally, individuals with mental illness have a higher likelihood of police contact compared to the general population, which may contribute to increased recidivism rates (Desmarais et al., 2014). This issue is further compounded by the fact that people with mental illness are more likely to experience homelessness, a factor strongly associated with increased interactions with the criminal justice system (Kushel et al., 2005). As a result, individuals with mental illness often become trapped in a cycle of criminal justice involvement, where inadequate treatment and the stressors of incarceration further exacerbate their symptoms and increase the risk of reoffending.

Due to the overrepresentation of individuals with mental illness in the criminal justice system, it has been argued that prisons have effectively become the de facto mental health care facilities in the United States (Schneider et al., 2007). As a result, courts, jails, and prisons have become overburdened with defendants whose needs the system is not equipped to address. This has significant consequences both for these institutions and for the individuals within them. Mental Health Courts (MHCs) were established to divert individuals with mental illness away from incarceration and into

treatment. So far, research suggests that MHCs are effective in reducing the overrepresentation of individuals with mental illness in jails and prisons (Sarteschi & Vaughn, 2013; Wolff, 2003). However, further research is needed to better understand their operations, effectiveness, and potential limitations in serving this population.

Statement of the Problem

While MHCs have received substantial academic attention, most research has centered on their outcomes compared to traditional courts—particularly their effectiveness in reducing recidivism (McNiel & Binder, 2007; Sarteschi et al., 2011; Wales et al., 2010) and addressing participants' symptoms (Boothroyd et al., 2005; Han et al., 2020). Although these studies are essential for evaluating MHCs' success, far less attention has been given to other critical aspects of their operation, such as the referral and admission process or the day-to-day functioning of MHCs and how these factors contribute to improved outcomes.

Of particular focus, this dissertation aims to investigate the issue of disparity in MHCs based on extra-legal factors. While some studies have explored demographic differences in MHC referrals, further research is needed to clarify inconsistencies in findings and assess potential disparities. This dissertation investigates the key predictors of MHC admission outcomes, with a particular focus on issues of discrimination and disparity. Previous research has suggested that certain demographic variables—such as gender, age, and race—may influence MHC admission decisions, with female, older, and white defendants being more likely to be admitted (Frailing, 2011; Luskin, 2001). However, other studies have found no such effects (Ennis et al., 2016), highlighting the need for further scrutiny. This study seeks to address these contradictions by examining

the impact of demographic characteristics (e.g., race and gender) on MHC admission decisions.

Overall, there remains a lack of sufficient research on MHC referral and admission processes. Moreover, existing studies often lack a theoretical framework to explain disparities in admissions. This dissertation aims to fill this gap by focusing on decision-making within the MHC context and developing a theoretical framework to better understand these disparities.

Chapter Overview

Chapter 1

The remainder of this chapter serves as a literature review, providing a brief history of mental health courts (MHCs) and summarizing key research on these courts since their inception. It explores various areas of study related to MHCs, including participant outcomes, standard program operations, referral and admission processes, and common criticisms of these programs.

Chapter 2

Chapter 2 outlines the theoretical background for this research. While some studies have examined disparities within MHCs, none have applied a formal theoretical framework to explain these disparities. To address this gap, this chapter draws on classic social psychological theories and criminal justice theory to guide the research. Specifically, it reviews attribution and heuristic theories from social psychology, as well as the focal concerns framework from criminal sentencing research. These theories provide a foundation for understanding legal decision-making within the context of specialty courts and mental health courts.

Chapter 3

This dissertation employs a mixed-methods approach, incorporating two qualitative studies and one quantitative study. Chapter 3 details the methods and results of the first qualitative study, which involved virtual observations of three MHCs in the United States. These observations offered valuable insights into the standard operations of MHC programs, as well as judicial decision-making regarding sanctions and terminations. This chapter describes the data collection process, analysis strategy, key findings, and discussion of these observations.

Chapter 4

Chapter 4 presents the second qualitative study, which involved 31 in-depth interviews with MHC workgroup members, including judges, attorneys, program coordinators, case managers, and treatment specialists. These interviews provided critical insights into the referral and admission process—an aspect not directly observable in Chapter 3’s court observations. Additionally, they shed light on workgroup members’ experiences with disparity within their respective programs. This chapter details the participant recruitment procedures, analytical approach, key findings, and discussion of the interview results.

Chapter 5

Chapter 5 describes the quantitative component of this dissertation, which empirically examines referral and admission decisions in MHCs based on findings from the qualitative studies. This section outlines a vignette-based experimental survey distributed to legal professionals via Prolific Academic. In this survey, participants reviewed a scenario describing a criminal offense and a defendant being considered for

diversion. They were asked to evaluate the defendant on multiple measures and ultimately decide whether to recommend diversion to an MHC. This chapter discusses the hypotheses, sample selection, survey methodology—including vignettes and measures—results, and implications of the findings.

Chapter 6

The final chapter synthesizes the findings from the previous three chapters, discussing their theoretical and practical implications. It also outlines recommendations for future research and potential policy considerations based on the study's conclusions.

Literature Review

History of Mental Health Courts

The first Mental Health Court (MHC) was established in 1997 in response to rising incarceration rates and worsening mental health conditions among incarcerated individuals (Freiberg, 2001). Like other problem-solving courts, MHCs emerged as an alternative to traditional criminal processing, emphasizing rehabilitation over punishment. These courts focus on therapeutic interventions to address the underlying factors contributing to criminal behavior (Petrila, 2003). MHCs, in particular, are designed to serve defendants with mental illness, prioritizing treatment over incarceration. Proponents argue that by addressing mental illness and its intersection with other risk factors—such as homelessness, substance abuse, and victimization—MHCs can improve outcomes for defendants and reduce recidivism.

Since their inception, the number of MHC programs have proliferated extensively in an attempt to address overrepresentation of individuals struggling with mental health in the justice system. In fact, recent estimates suggest that there are approximately 475

programs operating across the United States (Goodale et al., 2013; Snedker, 2022). Traditional correctional facilities often lack the resources necessary to provide adequate mental health treatment, contributing to a cycle of repeated criminal justice contact and worsening symptoms (Anestis & Carbonell, 2014; Kushel et al., 2005). To break this cycle, MHCs aim to divert individuals with severe mental illness away from incarceration and into treatment programs and community-based services (Griffin & DaMatteo, 2009). MHCs achieve this goal of recidivism reduction primarily by connecting participants to community services such as therapy, drug rehabilitation, transportation, housing, and vocational training (Cosden et al., 2003). By addressing underlying mental health needs, these courts not only seek to reduce recidivism but also improve participants' quality of life while alleviating the financial burden associated with traditional incarceration.

Outcomes of Mental Health Courts

Specialty courts represent a significant shift in how justice is perceived and administered, moving away from a retributive and deterrence-based approach toward a therapeutic and rehabilitative model (McGraw, 2020). Traditionally, the criminal justice system was shaped by “tough on crime” policies, such as three-strikes laws and mandatory minimum sentencing. In contrast, specialty courts reflect a growing emphasis on rehabilitative justice, which seeks to address the root causes of criminal behavior and support offenders’ reintegration into society. Much of the research on Mental Health Courts (MHCs) examines their effectiveness compared to traditional court processes. Specialty courts were introduced primarily to reduce recidivism, a goal that incarceration and conventional correctional measures have struggled to achieve (Hartley, 2019;

Mitchell, 2011). As a result, the success of MHCs and other specialty courts is often evaluated based on their impact on recidivism rates.

A review of the literature suggests that specialty courts are generally effective in reducing recidivism. While no comprehensive meta-analysis exists for specialty courts as a whole, studies have examined specific types, such as drug courts. For instance, a meta-analysis of drug courts—the most common type of specialty court—found that they reduce recidivism by 38% to 50% compared to traditional courts (Mitchell et al., 2012). Similarly, a meta-analysis on the effectiveness of Mental Health Courts (MHCs) indicates that they also reduce recidivism, albeit to a lesser extent (Loong et al., 2019; Lowder et al., 2018). While some studies in this meta-analysis found no significant differences between MHC participants and traditional court defendants, overall, research suggests that MHCs have a modest effect on recidivism reduction compared to traditional court processes (Lowder et al., 2016; Lowder et al., 2018; Sarteschi et al., 2011).

While recidivism is the primary outcome of interest, measures of participant well-being and symptom reduction have also been examined in the literature. Proponents of specialty courts argue that these programs reduce recidivism by addressing the underlying causes of criminal behavior, such as mental illness and intersecting factors like unemployment, homelessness, and victimization. Therefore, Mental Health Court (MHC) programs should theoretically improve participants' mental health and overall well-being. Research has explored this, with Han et al. (2020) finding that individuals in MHC programs reported a higher quality of life after program completion.

However, not all studies have found significant reductions in mental illness symptoms. Boothroyd et al. (2005) investigated the clinical outcomes of MHCs and their

effectiveness in connecting defendants to needed services. While the study found that MHCs were effective in linking participants to treatment, welfare, and housing services, they did not significantly reduce symptoms. This suggests that the reduction in recidivism may be due to factors other than the treatment of mental illness. The authors also argue that this could reflect the persistent nature of these disorders. Despite this, the additional services provided by MHCs—such as housing assistance and vocational training—appear to improve participants' quality of life and help reduce recidivism.

Standard Operations of Mental Health Courts

It is important to understand how MHCs operate in comparison to traditional court settings to provide context about the differences in outcomes. In contrast to traditional criminal courts, mental health courts take a rehabilitative approach to reduce recidivism, focusing on changing behaviors rather than deterring behaviors through punishment. While some MHC workgroup members focus on the disorder itself as the major contributor to criminal behavior, others emphasize ancillary factors associated with mental illness (e.g., income, housing, victimization) (Peterson et al., 2010; Snedker, 2022). In either case, MHCs attempt to address the perceived underlying cause of their criminal actions by connecting participants to various treatment services which can include sources for therapy, medication management, or psychiatric evaluation. In addition, depending on resources, MHC workgroups may be able to connect participants to other services such as housing assistance or vocational training. Ultimately these courts focus on stabilizing the mental health symptoms of participants in addition to providing assistance in other areas when possible.

Mental health courts, and specialty courts in general, are characterized by a largely cooperative process, as opposed to traditional court settings which are characterized by an adversarial process (Snedker, 2022). In contrast to adversarial courts, cooperative style courts focus on rehabilitation and problem-solving rather than focusing on the determination of guilt and innocence. In these courts, the courtroom workgroup (judges, attorneys, and other stakeholders) collaborates in order to achieve the desired outcome. MHC workgroups are staffed by a judge, a defense attorney, a prosecutor in addition to various other supporting roles such as court coordinators, probation officers, case managers, and treatment professionals. While the judge has the final decision in matters, the workgroup generally collaborates to reach a resolution.

While MHC procedures vary by jurisdiction, most follow a set of common practices (Thompson et al., 2007). One widely used approach is the *phase system*, in which participants gradually earn greater responsibility and fewer court-imposed restrictions as they progress through the program. For instance, individuals in higher phases may have longer intervals between court appearances and be expected to take on additional responsibilities, such as maintaining stable employment. The initial phase primarily focuses on stabilizing participants, often by ensuring they receive appropriate medication and determining the correct dosage. As they advance through the program, the emphasis shifts toward fostering independence. This includes securing stable housing, obtaining employment, and developing the skills necessary for long-term success (Thompson et al., 2007).

Participants' progress is closely monitored by case managers and other members of the court workgroup, who ensure compliance with court-mandated treatment and drug

testing (Frailing, 2010; Thompson et al., 2007). Regular court hearings provide an opportunity to track participants' progress and allow them to speak directly with the judge. These status hearings serve multiple functions. They allow for periodic reviews of treatment plans, ensuring participants adhere to court conditions, such as remaining drug-free. The workgroup discusses any concerns on the record, and the judge provides input and makes final decisions as needed (Thompson et al., 2007). Additionally, these hearings serve as a forum to recognize program graduates, who may act as positive role models for participants still working toward completion (Aldigé Hiday et al., 2014).

Non-compliance issues are also addressed during these hearings, with sanctions varying based on the severity of the violation. Consequences for failing to meet court requirements—such as missing treatment sessions, testing positive for substances, or failing to maintain contact with supervisors—can range from therapeutic interventions, like increased treatment sessions or reflective writing assignments, to more punitive measures, including jail time or removal from the program (Griffin et al., 2002; Thompson et al., 2007).

Notably, while incarceration is commonly used as a sanction in drug courts, MHCs tend to be more reluctant to impose jail time (Griffin et al., 2002). In instances of serious non-compliance, the typically collaborative nature of MHCs may temporarily shift toward a more traditional adversarial approach. Prosecutors may advocate for stricter penalties, such as incarceration or program dismissal, while defense attorneys argue for alternative, rehabilitative responses that allow participants to remain in treatment.

Mental Health Court Admissions

An important aspect to consider regarding MHCs, and the focus of this dissertation, is the referral and admission process. Because the legal decision-making process can be so complex, and because there is relatively less research on MHC admissions compared to outcomes, this is an area in need of more research. Admission to MHCs is a complex, multi-staged process (Snedker, 2022; Wolff et al., 2011). While it varies based on jurisdiction, generally, referral and admission to MHCs consists of three stages (Snedker, 2022). Because of the wide range of discretion throughout the process, scholars have argued that this leaves ample room for bias and discrimination in the process, preventing equal treatment based on demographic factors such as defendant race, gender, and social economic class (Sibley, 2022).

The first stage is the referral or initial screening stage in which defendants with mental health struggles must be identified and referred to the MHC workgroup (Snedker, 2022). These referrals often come from public defenders after meeting with their client, though referrals can come from many other sources including prosecutors, judges, jail staff, or even family members of the defendant (Luskin, 2001; Snedker, 2018; Steadman et al., 2014). After the initial referral, the defendant and workgroup proceed to the second stage in which the defendant will be assessed for basic eligibility. While this will differ by jurisdiction, generally this refers to two elements. First, the defendant has to be charged with an offense that the MHC will accept into their program. Some MHC programs are misdemeanor only, while others allow for defendants charged with either a misdemeanor or certain felonies. The defendant must also be assessed for a mental health diagnosis. This assessment can come from state provided treatment professionals or the

defendant may procure the assessment from a private provider. The assessment must indicate that the defendant has a diagnosis that is accepted by the court in that jurisdiction. Some jurisdictions may be limited in who they accept, restricting acceptance to only certain diagnoses (major depression, anxiety, schizophrenia, and bipolar disorder are common). While other jurisdictions may be much broader in their eligibility criteria, accepting a wider range of disorders such as dementia, organic brain damage, learning disabilities or other developmental disorders (Almquist & Dodd, 2009; Wolff et al., 2011).

In the third and final stage of the admission process, the MHC workgroup must make a final decision to either accept the candidate or reject the candidate and refer them back to traditional court. MHC programs are also ultimately a voluntary program. If a defendant prefers to remain in traditional court or would prefer to take their case to trial they may opt out of mental health court at this stage (Snedker, 2022). Overall, while the criteria are relatively straightforward, they are only the minimum requirements for eligibility. If a potential participant is found to meet these criteria, they still must apply to the MHC program in which the workgroup will make the final decision on their acceptance. MHC workgroup members may consider various factors about the defendant before making their decision, including specifics about their criminal charge, their diagnosis, and whether they have completed the program or similar specialty court in the past (McNiel & Binder, 2007; Steadman et al., 2005). As opposed to the rest of the MHC process, which is characterized as being largely collaborative, the admission process may take a more familiar, adversarial form. The defense attorney advocates for their client's inclusion in the court, while the prosecutor may advocate against it if they believe there is

a public safety risk. Generally, if a consensus is not reached by the workgroup, the judge of the MHC is given the final decision on whether or not to accept a defendant.

While these are the three primary stages, there are additional considerations that may influence acceptance into the program. Examples of two important considerations include the defendant's conviction status and competency status. Many jurisdictions require defendants to plead guilty to their charges before they can be accepted into MHC or another specialty court program (Davis, 2003). Participants may be admitted to MHC as a condition of probation or under diversion, in which even if they plead guilty now, their record will be cleared upon successful completion of the program. In cases where the defendant's competency is questioned, additional evaluations are needed to determine the defendant's status and ability to continue with legal proceedings. Defendants found incompetent are not eligible for MHC programs and are processed differently or ultimately their cases are dismissed (Snedker, 2022).

Factors Influencing Referral and Admissions

Not long after the establishment of the first MHCs, Luskin (2001) found three significant predictors of likelihood to be referred to an MHC. Defendants who were male, who committed crimes against a person (compared to property, public order, or drug offenses), and defendants with a more extensive criminal history were less likely to be referred to a mental health court. In addition, the author found an interaction between gender and age in which older men were more likely to be referred to the specialty court compared to younger men, while the opposite was true for women (Luskin, 2001).

Similarly, a study conducted in Washoe County, Nevada (where one of the first five mental health courts nationwide was established) found that men were less likely to

be accepted into the program (Frailing, 2011). This study also found that an extensive criminal history or commission of a violent felony for the current charge also predicted rejection from the mental health courts.

Previous research that examined the demographic make-up of MHCs has suggested that individuals in these programs are disproportionately likely to be female, older, and White (Cosden et al., 2003; Hiday et al., 2005). This is interesting to consider as older, White, and female defendants are not representative of the typical defendant in the criminal justice system. This follows previous research that has found that criminal justice outcomes tend to be more punitive for those who are young, Black, and male (Steffensmeier et al., 1998; Monk, 2019). Therefore, defendants who are younger, Black, and male may also be less likely to be referred or diverted to MHCs and remain in incarceration and traditional criminal processing. It is important to note that contrary to previous findings, one study investigating gender and MHC referrals found that overall admission rates did not vary by gender (Ennis et al., 2016).

The type of mental health disorder was also found to predict acceptance. Luskin and Ray (2015) found individuals with a more severe disorder such as schizophrenia or bi-polar disorder were more likely to be admitted compared to defendants with just depression. Another study conducted by Frailing (2011) found that defendants with a thought or mood disorder were more likely to be accepted compared to other disorders (e.g., personality disorder, anxiety disorder). Other variables that appear to predict acceptance into MHC programs include symptom severity and perceived treatability (measured as the number of out-patient treatment facilities the defendant attended in the past 6 months). Defendants who were not using or abusing substances at the time of their

admission or have outstanding warrants for arrest were also more likely to be admitted (Luskin & Ray, 2015). In the juvenile justice system, research has suggested that African American and Latino juvenile defendants were more likely to be sentenced to traditional juvenile corrections rather than therapeutic programs (Spinney et al., 2016).

Outside of MHCs, other research has investigated disparity in recommending defendants for psychological evaluation (i.e., for competency assessment). While the psychological evaluation process in traditional courtroom settings is not the same as referrals to MHCs, characteristics of the defendant are likely to influence the perceptions of courtroom decision-makers in both processes and both involve evaluations of defendant mental health. Thompson (2010) analyzed the use of psychiatric evaluations in the justice system through a social constructionist perspective. They found that psychiatric history was the best predictor of evaluation recommendations, but race and gender also influenced this decision. Thompson further suggests that male and African American defendants are more likely to be viewed as “normally” criminal and rational compared to female and non-African American defendants, who are more likely to be seen as mentally ill and therefore less responsible.

Criticisms of Mental Health Courts

While MHCs have gained increased popularity and prevalence based on their promises to decrease recidivism and provide better outcomes for defendants, they are not without their criticisms. There are two primary areas of concern. First, there is the issue of extra-legal factors such as race, gender, or other demographic variables influencing the admission process. The second concern is the potential for coercion when presenting the alternative of MHC to potential participants.

The first area of concern is potential bias or discrimination in the admission process. The section above describes the general process many mental health courts employ to admit participants into the program. However, there is also ultimately a wide range of discretion employed in this decision-making process. This level of discretion, although not inherently wrong, may increase potential decisions that are arbitrary or biased, as it allows decision makers to introduce their individual values and goals into the process, whether consciously or subconsciously. This level of discretion has been a point of criticism for specialty courts in general, not just MHCs (Sibley, 2022). While it is difficult to determine exactly where the disparity begins, due to the fact that participants have to consent or volunteer to enter these programs, studies have indicated that sociodemographic characteristics have an effect on admission rates as described in the previous section. In summary, compared to the general offender population, female, White, and older defendants are disproportionately likely to be referred to MHC programs (Luskin, 2001; Snedker, 2022; Snedker et al., 2017; Steadman et al., 2005).

The selection process is also of course influenced by legal factors, such as the criminal history of the defendant or the particular crime they committed (Frailing, 2011; Luskin, 2001). Even if a particular MHC jurisdiction allows participants with certain felony charges into the program, the prosecutor or workgroup may still reject certain defendants based on the particular facts of the case. Ultimately, it has been argued that MHC workgroups may engage in a form of cherry-picking in order to select the least risky, and seemingly the most “treatable” participants (Sarteschi & Vaughn, 2013; Snedker, 2022; Wolff, 2002), perhaps in order to inflate their success rates. While it may be ideal to select the participants who will most likely benefit from the program, it is

possible various conscious and unconscious biases may influence this decision-making process.

The second area of concern that needs to be addressed is issues of perceived voluntariness and potential coercion. Perceived voluntariness is important because it has been identified as an important mediator with regards to positive outcomes (Redlich & Han, 2014; Reich et al., 2015). Therapeutic jurisprudence and procedural justice are heavily connected to ideas such as due process and having influence on the process. Therefore, if defendants believe they are making a choice to engage in a specialty court program that are more likely to do well after release and would be less likely to recidivate. However, there is indication that many participants in specialty courts may not actually be aware that the process is voluntary (Han et al., 2020). This could be due to a lack of knowledge about the criminal justice system, they may simply not realize they have a choice in the matter, or their counsel may not have adequately explained their options.

Another potential explanation for his lack of perceived voluntariness is that defendants may in fact realize they have a choice in the matter. However, the choice between a specialty court program and traditional court may seem so disparate that they feel obligated to enter the program. This comes with a secondary issue of coercion, as many specialty court programs require the defendant to plead guilty before admission (Davis, 2003). This requires defendants to admit guilt in order to receive the treatment they are promised. Prosecutors are often reluctant to leave a case open while a defendant completes a specialty court program, therefore they require guilty pleas before referral. This is a potential ethical issue, as it goes against the adversarial goals of justice in which

defendants are represented fairly in the system. The promise of treatment, an easier sentence, or even the dismissal of charges, may be enough to convince factually innocent defendants to plead guilty.

These criticisms and issues with specialty court dockets are extremely important to consider, and not without merit. The potential of rehabilitative justice is clear and is the ideal alternative to retributive policies that have contributed to mass incarceration and various other issues in the criminal justice system. However, based on consistent findings of racial disparity in many parts of the criminal justice system, these issues likely exist in specialty courts as well. Because selection is entirely based on the discretion of the judge or specialty court workgroup, this introduces countless problems regarding potential discrimination. And as described above, it may even bring into question previous research suggesting the effectiveness of these programs. Therefore, it is paramount that the selection process is studied with the same vigor that recidivism and other outcomes are studied.

Chapter 2: Theoretical Background

The previous chapter discussed the most relevant literature regarding mental health courts (MHCs). The research discussed included outcomes of MHCs regarding participant recidivism, service utilization, well-being, and mental health symptoms. In addition, research relevant to MHC admissions and the disparity present within MHCs was also discussed. While this research has provided insight into the admission process and general operation of these courts, a clear theoretical framework has not been used to explain MHC decision-making or the potential disparity in admissions. To address this gap in the literature, the studies discussed in this dissertation (Chapters 3-5) are grounded in classic social psychological frameworks of attribution and heuristics theory. In addition, the focal concerns framework from criminal justice sentencing research is also being applied to this research. The focal concerns framework has been used to explain disparities in various areas of the criminal justice system. This chapter will discuss and summarize these theories and their relevance to decision-making in mental health courts.

Attribution Theory

The first, broad theoretical framework considered for this analysis is classic attribution theory. Attribution theory largely describes how an individual perceives and explains the actions of another, attributing it to either internal forces of the actor or external forces that influence or cause the behavior (Kelley & Michela, 1980). Internal attributions refer to attributions of behavior based on innate qualities of the individual, such as their emotions, personality, or any other characteristics intrinsic to that individual's state of mind. External attributions, on the other hand, refer to attributions

based on environmental factors or temporary states of mind due to these situational factors.

Building on this framework, Weiner (1986) further refined attribution theory by introducing three key dimensions that influence how people interpret the causes of behavior: locus of control, stability, and controllability. Locus of control, following the original incarnation of attribution theory, refers to whether the cause of an event is perceived as internal (within the individual, such as effort or intelligence) or external (outside the individual, such as luck or task difficulty). Stability considers whether the cause is seen as consistent over time (e.g., ability, which is relatively stable, vs. effort, which can change from one situation to another). Lastly, controllability refers to whether the cause is something the individual can influence, such as effort, or something beyond their control, such as an inherited condition or unforeseen circumstances. While Weiner (1986) originally applied these concepts to an individual's self-evaluation of motivation and success, these factors could apply to evaluations of others as well. In the context of MHC referrals, for example, legal professionals might make a judgement on the stability of a defendant's mental illness, as that might influence their perceptions of the defendant's treatability. Additionally, they may consider the controllability of the defendant's actions and how much their symptoms contributed to the behavior. These considerations from legal professionals can influence their overall perception of the defendant's culpability.

In the context of this dissertation, it is intuitive to imagine how attribution is relevant in the realm of legal decision making. A common requirement of criminal proceedings is determining the intent of a criminal action. Therefore, a legal actor may

need to evaluate if a defendant's actions were internal or dispositional in nature, in addition to the stability of the defendant's symptoms and the controllability of the defendant's actions. One could determine that a defendant committed the action because they are "bad", "evil," or otherwise knowingly committed the criminal act due to some moral failing, an internal attribution. On the other hand, an individual could also attribute the behavior to situational or external reasons. Rather than an issue of personality or intrinsic character, one could determine the criminal action behavior was due to environmental influence such as a bad family life, influence from peers, poor economic situation, or due to a temporary state of mind such as an undue amount of stress. Relevant to the current study, mental illness could also be viewed as a situational cause of criminal behavior.

In the criminal justice system, these attributional decisions and judgements are important to consider as they can have impacts on various legal outcomes. Of particular importance is the decision on how best to address a criminal offender. In the broadest sense, a legal professional might consider if a defendant needs to be incapacitated or incarcerated, or can they be rehabilitated to prevent future criminal behavior? Studies have linked attribution theory to decision making in a legal context and the decision maker's sentencing philosophy. These findings suggest that individuals who make internal attributions are more likely to emphasize deterrence as the primary goal of sentencing (Templeton & Hartnagel, 2012) and to take an overall punitive or "tough on crime" stance (Carroll et al., 1987). On the other hand, those who make situational or external attributions are more likely to endorse rehabilitation as a primary sentencing goal (Templeton & Hartnagel, 2012). Those who tend to make external attributions also tend

to emphasize the role of government and institutions in correcting social problems that lead to crime rather than the criminal behavior of individuals (Carroll et al., 1987).

Attribution theory in the criminal justice system does not have to apply only to sentencing decisions. For example, attributional styles have also been applied towards capital punishment attitudes, perceptions of victim responsibility in sexual assault cases, processing of juvenile defendants, and parole decisions (Boots & Cochran, 2011; Carroll & Payne, 2014; Cochran et al., 2006; Lowery & Burrow, 2019; Trahan & Laird, 2018). Attribution theory may apply to specialty courts as well, potentially explaining both decisions during the admission process or decisions during the operation of the court such as with interventions, sanctions, and removal decisions.

Mental health courts specifically are an interesting legal situation to consider regarding how legal decision makers perceive the influence of mental health episodes and their role in aggravating or mitigating defendant responsibility. For instance, when an individual learns of a case involving mental illness as a factor, are they more likely to attribute their criminal behavior to an uncontrollable, external source (i.e., the mental health episode) or to internal dispositional factors (i.e., the defendant's character). In addition, it is important to consider how the decision-maker views the cause of the mental illness in the first place. Research has indicated that individuals differ to the degree to which they view mental illness as being caused by failings of the individual with the condition, or more similar to a physical disease in which the individual is not at fault for contracting it (Corrigan et al., 2003; Lyndon et al., 2019). This has implications on factors such as how treatable, dangerous, or blameworthy the defendant is evaluated to be, which are factors also relevant to focal concerns theory (see Steffensmeier et al.,

1998). This ties into the phenomenon mentioned above, in which attributional decisions are also linked to decisions about sentencing goals. Therefore, in the context of the current study, these factors can all influence whether a defendant is determined to be a good fit for mental health court or if they are rejected and remain in traditional criminal court.

Heuristics and Biased Thinking

Another important framework from social psychology to consider when discussing decision-making is the tendency of individuals to use heuristics while making judgements or evaluations. Heuristics refer to cognitive “short-cuts” in which individuals engage in quicker and more efficient problem-solving in order to reduce cognitive effort and to make decisions or judgements more quickly, particularly in situations with prominent levels of uncertainty (Tversky & Kahneman, 1974).

The relevance of heuristics and bias in the context of the criminal justice system are readily apparent. For one, it is likely that judges and other legal professionals often risk being under heavy cognitive load. Depending on the jurisdiction, they may have heavy caseloads, reducing the amount of cognitive effort they can apply to each case. In addition, depending on the complexity of the cases they are assigned to and the amount of evidence per particular case, there is likely to be substantial amounts of uncertainty when it comes to making informed decisions. Due to both factors, there is sufficient reason to believe that use of heuristics is not uncommon in legal decision making in general, and may occur during specialty court decision-making as well, whether it’s during admission, intervention, or termination decision processes.

The presence of heuristics and biased thinking has been applied to decision-making in a legal context in previous research (Jones, 2013; Peer & Gamliel, 2013). These authors note that while heuristics may be useful in general day-to-day decision making, they risk resulting in suboptimal or biased judgements when it comes to important and impactful courtroom decisions. Judges and other legal actors are ideally objective and unbiased in their decision-making, and legal actors likely strive to be as objective as possible. However, even with these goals and the training and experience they receive, judges, attorneys, and other legal professionals are still subject to biases that may occur due to the unconscious use of cognitive heuristics. Peer and Gamliel (2013) provide a summary of common heuristics that judicial decision-makers may be subject to. They note that judges and other legal actors may engage in confirmation bias by favoring evidence or testimony that supports previously accepted beliefs. They may engage in the hindsight bias, in which they assign greater ability for defendants to understand the outcome of their actions than they may realistically have had in the moment. They noted that when judges rule similar cases, they tend to make similar rulings to match the status quo. These biases, among others, could similarly have an effect on decisions regarding specialty court admission or other decisions made within specialty court contexts.

Focal Concerns Theory

The previously discussed theoretical frameworks are classic social psychological theories that explain decision-making and judgements in general. When looking at decision-making in a legal context specifically, however, the focal concerns framework has become the primary theory to describe these processes (Ulmer et al., 2022). The theory was originally developed as a means to explain differential treatment in

sentencing. Namely, why young defendants, male defendants, and Black defendants are more likely to receive harsher sentences compared to older, female, and White defendants (Steffensmeier et al., 1998). The focal concerns framework is heavily inspired by the previously discussed theories of heuristics and biased thinking.

The theory has since expanded beyond sentencing decisions to describe legal decision-making in various criminal justice contexts. For example, the theory has been applied to court decision making context beyond sentencing, such as parole decisions (Hueber & Bynum, 2006) or prosecutors' decision to bring charges to a sexual assault case (Lapsey et al., 2023). Its application has also expanded outside the courts to other criminal justice contexts, such as police officer decision making such as the decision to search a vehicle during a traffic stop (Higgins et al., 2012), the decision to submit a rape kit for forensic DNA testing (Campbell & Fehler-Cabral, 2018) and the decision to stop an individual in stop and frisk encounters (Vito et al., 2021). Therefore, his framework may be appropriate in describing the various decision-making processes that occur in MHCs as well.

Overall, focal concerns theory has been broadly applied to explain disparity and discrimination in the criminal justice system based on factors such as race/ethnicity, sex and age. The theory posits that when legal actors (judges, prosecutors, police officers, etc.) make decisions, such as determining sentence length or deciding to bring charges to a case, the actor considers three "concerns" to guide their decision making, blameworthiness, protection community, and practical concerns (Hartley, 2014). The first "concern", blameworthiness, broadly refers to the overall culpability of the accused offender. Blameworthiness may be evaluated by factors such as the perceived

permanence of the offender's capacity for criminal behavior, or the seriousness of the offense (Steffensmeier et al., 1998). The second concern, protection of the community, refers to legal professionals' principal desire or obligation to protect the community by incapacitating or deterring potential offenders. Factors such as the offender's criminal history, or their connection to the community (e.g., support network, employment, family, etc.) may influence decision makers' perception of potential risk (Steffensmeier et al., 1998). The final concern of practical constraints refers to logistical factors surrounding the decision. This can refer to factors such as courtroom workgroup dynamics and the relationships between courtroom professionals (judges, prosecution, defense, etc.). It can also refer to the strain the decision may put on public resources (e.g., overcrowding in jails in prisons, financial cost for incarcerating the offender) (Hartley, 2014). Focal concerns theory suggests that legal professionals weigh these three factors when making decisions, but because they operate under time constraints and incomplete information, they often rely on heuristics and stereotypes. This can lead to disparities in sentencing, particularly along racial, gender, and socioeconomic lines.

Focal Concerns Theory in Mental Health Court

As described above, focal concerns theory has been applied to a variety of contexts within the criminal justice system. However, to date, only one study has applied the theory to the area of MHCs. Similar to the current study, Ray & Dollar (2013) investigated MHCs using a mixed-methods approach and applying a focal concerns framework to explain disparities. However, while these authors focused on the sanction portion of MHCs, this dissertation will focus on admissions as an application of focal concerns theory.

Ray and Dollar (2013) centered their study on a single MHC in the United States and used a combination of field observations for qualitative data, and official court records for quantitative data. The authors stated that the observational data indicated gender of the defendant and their length of time in the program influenced their sanction decisions. Namely, they found that the MHC workgroup was more lenient of non-compliance for women participants. Additionally, they found that the workgroup became less accepting of noncompliance the further in the program the defendant was, as more senior participants are expected to have more consistent compliance. Through the analysis of the quantitative data, the authors also found that gender and race affected the termination decision and that these factors interacted. The authors indicated that White female participants were the group least likely to be terminated from the MHC for noncompliance. These findings follow the predictions of focal concerns theory, which posits that there is a penalty for young, Black men in the criminal justice system (Steffensmeier et al., 1998).

Beyond research of MHCs, research regarding psychological evaluations in the criminal justice system may also be relevant. While it does not use focal concerns theory as a framework, Thompson (2010) investigated the tendencies of judges to recommend defendants for psychiatric evaluation, which can be for evaluating competency or even evaluating a defendant's fitness for mental health court. While it's not directly an investigation of MHCs, these evaluations are important because they can lead to diversion decisions or alternate criminal processing such as referring defendants to MHC programs. Thompson found that overall, Black defendants, particularly male and Black defendants, were the least likely to be recommended for psychiatric evaluation, even

when controlling for mental health status and severity. Thompson suggested this may be an indication that legal decision makers may be more likely to view Black defendants as “typically criminal” while White (and particularly White and female) defendants are seen as “abnormal” and “mentally ill”, thus having less culpability for their actions. White (2016) found similar results of more harsh treatment of defendants in the juvenile justice system. They found that mentally ill juveniles overall were more likely to be recommended for some form of confinement as opposed to community supervision, and that this was even more likely for Black juvenile defendants with a mental illness.

Conclusion

This chapter summarized and discussed various important theories regarding legal decision-making and decision-making more generally. The focal concerns theoretical framework borrows from classic social psychology frameworks such as attribution and heuristic theories to describe legal decision-making. While the framework was originally developed to describe judge’s sentencing decisions, it has since been applied to other actors and other situations within the legal system. There is reason to believe that a similar decision-making process may occur in mental health courts, however this has not been investigated. There is uncertainty if specialty court team members consider the three concerns to the same extent, or if they consider the same concerns at all. And there is a question if different members of the team have different goals or considerations in this decision-making process, particularly between prosecutors and defense attorneys.

There is a need for more research regarding mental health courts, particularly in the realm of initial referrals and admissions, as these early decision-making processes can shape both individual outcomes and the broader effectiveness of such programs. The next

three chapters present a series of studies that employ a mixed-methods approach to investigating how individuals are referred to and admitted into MHCs. Specifically, the next chapter details the first phase of qualitative data collection and analysis, providing an in-depth exploration of the day-to-day operations of MHC dockets.

Chapter 3: Observations and Qualitative Analysis of Mental Health Courts

This chapter describes the methodology and results of the first portion of the qualitative study, the observations of three mental health courts (MHCs). The purpose of these observations was to understand the general operation of these courts and to highlight moments of decision-making that occur within the MHC hearings. Referral and admission decisions largely occurred outside of these hearings and occurred in court staffing which was not available for public viewing. Therefore, the primary decision-making analyzed during these observations were sanction and termination decisions. A flexible coding approach was taken to analyze the data and identify patterns and themes within the data.

Methods

Site Selection

The current study involved the non-participant observation of three MHCs in the western United States. Initial observations began in the summer of 2022 with the Washoe County MHC. As the study progressed, it was clear that having additional sites for cross comparison would be beneficial for the study. In the spring of 2023 the Sacramento County and Thurston County MHCs were added to the observation schedule. Observations for Washoe and Sacramento County concluded in the winter of 2023 and the observations of Thurston County concluded in early 2024. During the observation period, the Washoe and Thurston County courts met once weekly, while the larger Sacramento county MHC met five times per week.

It is important to note that the sites were not randomly selected but were purposefully selected. The Washoe County court was originally chosen because of

proximity, due to being in the same area of residence as the research team. It was believed that this would increase the potential for in-person meetings and interviews with the courtroom workgroup. It was also believed that due to our association with the University of Nevada, Reno, the MHC team would be more open to working with the research team. The court itself, however, has been online only through Zoom since the COVID-19 pandemic, and all observations were conducted through the Zoom platform. The Zoom link is available on the Washoe County website and is easily accessible and open to the public.

After four months of weekly observations of the initial site, it was apparent that observations of separate courts in different areas would be beneficial in order to make comparisons across courts. This is important to consider because while MHCs are established nationwide, they can vary in how they function across states (Almquist & Dodd, 2009). Sacramento County was selected due to its proximity, but also due to its size compared to the Washoe County court. While specific numbers were not collected, the Sacramento County court covers a larger population. This was evident due to the fact that the court held five MHC calendars per week compared to the one per week of Washoe County. Unlike the Washoe County docket, the Sacramento County docket is a hybrid in-person and Zoom court. Court participants can choose to appear in-person or online, and in some instances the judge may request a participant appear in-person (often for a sanction, for example). The majority of participants choose to appear through Zoom, likely for convenience. All observations for this study were conducted remotely over Zoom.

Shortly after contact was made with Sacramento County, the Thurston County court was also identified as a site for additional observations. The Thurston County MHC was found through a basic internet search, and was selected also for its size. It was the smallest of the three courts, meeting once per week and having the smallest calendar of the three courts. Unlike the other two courts, which were observed through Zoom, the proceedings of this court were broadcast on YouTube. Similar to the Washoe County MHC, the link to the online broadcast is easily accessible to the public and is posted on the county's website. Similar to the Sacramento MHC, the Thurston County MHC is hybrid so participants can appear in-person or on Zoom. Unlike Sacramento, however, the majority of participants appear in-person rather than through Zoom. Participants who appear on Zoom often are doing so because of extenuating circumstances such as illness or work conflict.

Observation Procedure

Each observation involved at least one member of the research team viewing the cases for that docket and taking detailed notes about the proceedings of each case. On days in which multiple members of the research team observed a calendar, the notes were compared to identify discrepancies. Recording of the hearings was not permitted, so there are no exact transcripts for these interactions. Therefore, all analysis is of the field notes taken by the research team. The team focused on recording the content of the hearings, what was said by the professionals of the MHC workgroups, and the decisions made by the workgroup. Greater attention was given to moments of decision-making by the team that occurred in-court, this includes hearings where sanctions were imposed or when the court discussed a participant's potential termination from the program. During this period

of data collection, the research team regularly met to discuss patterns and themes observed from the data and memoing process. A new document was created for each separate court calendar and each calendar was divided into cases. These documents were uploaded to the qualitative research software Dedoose for analysis.

Analysis Procedure

A flexible coding approach was used to identify themes and patterns within the data. Flexible coding is a systematic approach to qualitative data analysis intended for theory generation and for working with large qualitative datasets such as this (Deterding & Waters, 2018). The authors argue that flexible coding is a preferred method for large data sets, when the data are expected to be used for multiple research projects, and when analysis involves a team of researchers. Broadly, the flexible coding approach is the inverse of the traditional grounded theory approach. The grounded theory approach generally starts with analytic, line-by-line coding and then proceeds to broader coding and analysis. Deterding and Waters (2018) argue for the opposite, to begin with broad index codes that reflect the original research questions or interview guide for the first passthrough and then to follow up with narrower analytic coding for subsequent readings of the transcriptions.

Before analysis began, the data were cleaned by separating each observed docket into its own separate document; 153 total court calendars were observed by the research team. The calendars were further separated into individual hearings that occurred in each calendar. These individual hearings served as the unit of analysis for this study. There was a total of 4351 individual hearings observed across the 153 court calendars. The

majority of observations recorded were from Washoe County (2243), followed by Sacramento County (1651) and Thurston County (457).

The notes in these individual cases ranged in length from a single sentence to multiple paragraphs depending on the length of the hearing, and the observer's ability to take notes about the case in real time. Because there were occasional issues with connectivity to Zoom, or because of schedule conflicts, a researcher was not available to observe every calendar on a weekly basis. In addition, researchers were not always admitted into the Zoom meeting on time by the courts, therefore this is not an exhaustive list of all the hearings that occurred during the observation period. For this reason, the analysis will remain qualitative in nature beyond basic descriptives and frequencies described for the data set.

For calendars in which multiple members of the research team recorded notes, the notes for each case were combined to ensure any notes missed by one observer were included from another and to ensure there were no duplicate cases uploaded to Dedoose. Following the three-stage process suggested by Deterding and Waters (2018), the analysis was started by applying index codes and creating initial memos. Each case received an initial index code identifying the primary goal or purpose of that participant's court hearing for that calendar. Individual cases were given one of the following six index codes. Cases were coded as *first appearance* if the hearing was the participant's first hearing in the MHC. Case hearings in which the participant successfully graduated were coded as *graduation*. Hearings in which the court was updated on the progress of the participant and there were no violation issues were coded as *status hearing*. Hearings in which the court discussed non-compliance or implemented an intervention or sanction

because of non-compliance were coded as a *violation*. Hearings in which the court discussed or deliberated on a participant's removal from the MHC program were coded as *termination hearing*. Finally, cases in which the participants did not appear were coded as *no show*.

Given the size of the dataset and the volume of excerpts, the analysis for this study was narrowed to focus specifically on two key areas: violations and termination hearings. Cases associated with these index codes were selected because they offered the most substantive insight into the decision-making processes of MHC work groups. Although interactions during status hearings and graduation ceremonies also shed light on the operation of MHC programs, they typically did not involve discrete decision points suitable for focused analysis. In addition, Admission decisions were conducted largely outside of the observable court hearings; therefore, terminations and violation reports were the most visible instances of decision-making within these courts. Admission decisions are the focus of the in-depth interviews described in Chapter 4.

Results

General Court Comparisons

The general operation of the three courts was broadly similar. Participants were called to the stand one at a time to discuss their case and discussions ranged from status hearings to termination hearings. For Washoe County, this was completely virtual, and participants were given speaking ability on Zoom one by one, while the rest observed. In Sacramento this was hybrid, in which some participants appeared in-person, but most appeared virtually similar to Washoe County. In Thurston County, most participants appeared in-person, with some appearing virtually if they were ill or were given

permission otherwise to appear virtually. Some of the cases appeared from in-custody, which was handled differently in each court. In Washoe County, in-custody participants appeared together in a large common room at the jail. The courtroom coordinated with jail staff to call these participants one at a time to discuss their case, again, through a Zoom connection. In Sacramento, the jail was connected to the court, so in-custody participants were brought into a cell enclosed by metal bars and plexiglass inside the courtroom itself, where they could speak to the judge and their counsel while confined. In Thurston County, in-custody appearances were much rarer compared to the Washoe and Sacramento County programs, where in-custody appearances were present in almost every docket. When Thurston County did have in-custody appearances, participants appeared over Zoom individually on a computer located in the jail, with jail staff waiting outside.

During informal conversations¹ with some of the MHC professionals, they discussed how the court had changed during the COVID-19 pandemic. Courtroom proceedings had switched to a virtual format in order to protect participants and the courtroom staff during the lockdowns. While Sacramento and Thurston County shifted to a more hybrid format as the pandemic resolved, the Washoe mental health court remained entirely virtual. In these interviews, the staff commented on how the virtual court proceedings were beneficial for the participants. It allowed participants who were in-patient or residential treatment to call in from those locations, even in groups if there

¹ After initially reaching out to the workgroup to inform them of the study, some members offered to speak to the research team about the program. These conversations were not part of the in-depth interviews described in Chapter 4 or part of the primary analysis described in this chapter. These conversations were about the general operation of the court in addition to setting up future interviews described in Chapter 4.

were multiple participants at the same treatment location. They also commented how convenient it was for participants who were employed. Previously, participants would have to ask for time off on court dates and lose those hours when they could have been working. But because of the virtual format, they were able to attend court during a break and not risk their employment.

Largely, the virtual format appeared to operate without any problems, however, there were occasional issues. In some cases, participants joined the Zoom call on their cellphones while driving. In these cases, one of the staff members, often the prosecutor, would ask the participant to pull over before continuing the hearing. In some cases when participants called in during work, they would have difficulties finding a quiet spot to speak with the judge. In one instance, a participant at work interrupted the court hearing to speak with a customer. They decided to remove the participant's speaking role in the Zoom call and bring them back at the end of the calendar, to which the judge remarked "maybe we should go back to in-person court." Overall, instances such as this were rare, but were occasionally an issue because of the virtual court format.

Dockets varied in length, but were often around two hours in duration. Washoe and Sacramento Counties were similar in size, hearing approximately 30–40 cases per docket. The court in Thurston County was much smaller, hearing approximately 10–12 cases per docket. This was evident in the time given to each case. Unless there was a termination hearing or significant violation report, cases in Washoe and Sacramento Counties were discussed and processed quickly, sometimes within a few minutes. Because of the smaller docket in Thurston County, individual cases lasted much longer,

giving the participant time to speak with the judge and time for each workgroup member to speak and feedback for each participant.

Status Hearings

The majority of cases heard across the three dockets were status hearings in which a member of the workgroup, usually the court coordinator, would give an update about the participant's progress since their last appearance. Of the 4351 hearings documented, the majority were status hearings, with 2880 (66.19%) of the hearings being identified as status hearings (see Table 1 for full descriptive statistics of identified codes and Appendix A for a glossary of the codes and subcodes us). These status hearings often included discussions of upcoming appointments, their phase progress in the program, and expectations or tasks to complete before their next hearing. Status hearings often included small talk in which the judge would ask participants how they were doing outside of the program as well, such as asking about their employment, what they are studying in school, or what they did over the weekend. In cases where participants had a good report, the judge and other workgroup members would give praise and encouragement to reinforce such behavior. Praise included congratulatory statements on something specific, such as getting a job interview or testing negative on a urine analysis. Or praise could be more general comments such as "you're killing it", "keep up the good work", "you're running a great program" or "you've come a long way." As described above, these interactions were often short, particularly in Washoe and Sacramento Counties when there was a busy docket to contend with. However, some conversations might last longer, in which the participant and courtroom workgroup would discuss sports, books they are reading, recommend television shows, or discuss other hobbies the participants were

interested in. Again, these longer interactions seemed more common in Thurston County when they had more time with each individual participant.

Table 1. Breakdown of Observation Codes (n = 4351)

Code	#	% of total	% of category
Status hearings	2880	66.19%	
Violation Hearings	730	16.78%	
<i>Testing violation</i>	500	11.49%	68.49%
<i>Treatment violation</i>	207	4.76%	28.36%
<i>Communication issues</i>	49	1.13%	6.71%
<i>New criminal charge</i>	32	0.74%	4.38%
<i>Concerning behavior</i>	31	0.71%	4.25%
<i>Failure to follow sanction</i>	25	0.57%	3.42%
<i>Missed court</i>	23	0.53%	3.15%
<i>Therapeutic intervention</i>	490	11.26%	67.12%
<i>Punitive intervention</i>	231	5.31%	31.64%
<i>No intervention</i>	71	1.63%	9.73%
Termination Hearings	153	3.52%	
<i>Participant removed</i>	60	1.38%	39.22%
<i>Participant retained</i>	58	1.33%	37.91%
<i>Participant asked for removal</i>	34	0.78%	22.22%
<i>Case dismissed</i>	1	0.02%	0.65%

Note: Individual observations could receive multiple sub-codes (e.g., a participant could receive both a testing violation and a treatment violation in one hearing).

Sometimes participants would bring up topics to discuss to demonstrate how well they were doing, or to ask for assistance from the court. For example, in one case, a participant discussed their recent success with a family court case in which they were granted more hours to spend with their daughter upon completing a parenting course. The judge, the participant's defense attorney, case manager, and prosecutor took turns to

congratulate him. Their praise particularly emphasized that the participant's hard work in treatment and the court is what led to this success, encouraging him to keep up the good work in the parenting course. The participant thanked them and asked if the court would be able to help pay for the course's fees. The judge immediately replied that they would look into options in how they could help the participant.

Compliance with therapy and mental health medication is of course an essential component of mental health treatment court. During status hearings, judges and other staff would occasionally ask participants about the benefits they believed they were getting from treatment and the overall program. One participant commented that the court and the treatment she was getting is "one of the best things ever in her life", explaining that she now has the skills to "go to work and to help herself." Other participants focus on the substance treatment, one stating that the program and treatment taught her "new coping strategies" and that "smoking weed was a bad coping mechanism that just got me in trouble." Substance use and mental health treatment were also seen as connected. For example, one participant commented that through treatment he "learned skills to cope and to figure out why he was drinking." and that because of this program "I have a good counselor, my mental health is in order and I am graduating from school."

Interactions in status hearings focused primarily on compliance with court requirements, though occasionally they would discuss treatment related topics themselves. This appeared to be more common in Thurston County, possibly due to the greater time afforded to each participant. For example, in one hearing, a participant was discussing a family member who they had been caring for who had recently passed away. The judge gave her the opportunity to talk about how she felt about the experience and

her discussions with her therapist. The judge also praised her for how strong she has been through the difficult situation, and how he believes she has become stronger through the experience. Though interactions like these were rare, there were occasions when court participants would initiate discussions such as this. These discussions showed great vulnerability on behalf of the participants and could be a therapeutic moment inside the courtroom itself.

Overall, status hearings exemplified the non-adversarial philosophy of treatment courts. These interactions often involved praise from every side of the justice system, including the judge and prosecution. In cases in which a major milestone was reached, such as phasing up in the program or a participant mentioned reaching a sobriety goal, the courtroom workgroup and other participants would applaud, similar to alcohol and narcotics recovery groups. These interactions highlight the difference between mental health court and traditional criminal court, often resembling a support group rather than a court of justice. However, in cases of violation reports and especially termination hearings, the traditional, adversarial nature of the courtroom became more apparent.

Violations

Violation reports were the next most common interaction or type of hearing identified in the data set, with 730 (16.78%) of the cases out of 4351 being coded as a *violation* hearing. Hearings were coded as violations when the courtroom workgroup discussed an infraction of the stated requirements of the MHC program. Violations ranged from relatively minor infractions such as *communication issues* with case managers or court professionals and *treatment violations* (e.g., missing a psychiatry appointment), to much more severe infractions such as *missing court* dates and being

charged with *new criminal offenses*. Violation hearings represent an area of decision-making within the MHC courtroom workgroup, as the workgroup has to decide how to respond, including whether they should sanction the participant at all and what kind of sanction is appropriate if so.

Testing Violations

Of the 730 cases coded as a violation hearing, the most common violation type were *testing violations*, with 480 (65.75%) of the violation reports including an issue with substances testing. It is important to note that a hearing coded as *violation* could have more than one type of violation and these sub-codes were not mutually exclusive. For example, a violation hearing could discuss a participant testing positive for substance in addition to missing court mandated treatment. Therefore, percentages reported in Table 1 regarding types of violations do not sum to 100%.

Drug and alcohol testing was used in all three courts, however, while Washoe and Thurston Counties required random drug testing from all participants, Sacramento County only required certain participants to regularly drug test, such as if they were identified as having a substance issue during initial evaluation. A few times during observations of Sacramento County, it was noted that the judge moved participants to the random testing line if they believed substance use may have been an issue. In all three courts, in addition to illegal substances such as methamphetamine and cocaine, alcohol and cannabis were also prohibited even though they were legal in these jurisdictions. Testing issues of course included testing positive for a prohibited substance and missing scheduled tests. Participants would also received a testing violation for providing a “dilute” test, meaning they provided a sample with insufficient concentration, often due to

consuming excessive amounts of water before the test. While dilute tests were not usually punished as harshly, judges noted that repeat dilute tests could be an indication of hiding substance use and would be treated as such. While it was rare (only five instances observed in this data), attempting to cheat during a urine analysis test was also included as a *testing violation*.

Judges and other workgroup members emphasized the importance of these tests, stating that they are the primary way of ensuring compliance in the program. In some cases, participants believed that medical issues led to dilute tests or even being unable to provide a sample at all. In these cases, the court allowed them to work with their doctor to find a resolution, but informed these participants that participants who cannot provide samples cannot be in the program because “there is no way to test them on compliance.” Overall drug testing and remaining sober were a primary concern in all three of the courts. Courtroom workgroup members expressed the high rate of comorbidity between mental illness and substance abuse in the participant population, emphasizing the need to treat both issues. Judges also expressed a concern that substances may interact with participant’s medication, inhibiting the therapeutic effects. When it comes to specific substances, use of fentanyl was treated with the most severity. Across all three courts, if a participant tested positive for fentanyl, the judges would make a specific point to discuss the danger of fentanyl use and the overdose risk.

Overall, while these were observations of mental health treatment courts and not drug courts, sobriety and drug testing were considered extremely important and ever-present aspects of these courts. Drug testing compliance was routinely brought up in status hearings, with participants being praised for making all of their testing

appointments and remaining sober. Participants often brought up sobriety as a goal and informed the court when they made certain milestones, such as being six months sober. These achievements were treated seriously by the courtroom workgroup, with participants receiving encouragement and rounds of applause from the courtroom. While mental health treatment is what sets MHCs apart from drug court and other specialty courts, drug testing and sobriety often received just as much, if not more, attention than treatment compliance.

Treatment Violations

Following testing violations, mental health *treatment violations* were the second most common violation addressed in the observed hearings. Of the 730 total violation hearings, 207 (28.36%) of them included a treatment violation of some form. Treatment violations broadly include any failure to comply with court mandated treatment. Across all three of the observed courts, participants were expected to attend some form of group counselling, individual therapy, and/or peer support groups (e.g., Alcoholics Anonymous) as part of their court mandated treatment. The specifics of their treatment requirements varied depending on the evaluation they received before entering the court, which of course occurred outside of the public hearings that were observed by the research team. Depending on the charges, some participants were also required to attend additional courses or treatment such as anger management or domestic violence classes. In addition to these appointments with therapists or group therapy, participants were also expected to take medications as prescribed by their doctors. Medication compliance was important and discussed in each of the three courts. However, in Sacramento County, medication compliance was emphasized to a much greater degree. The judge often asked participants

if they were taking medication as part of the routine status hearing update, while in Thurston and Washoe Counties medication was only brought up if it was believed non-compliance was an issue. In addition, the judge and other professionals in Sacramento County also encouraged participants to consider the injectable form of their medication rather than in capsule or tablet form, as the injectable form lasted for a month making compliance and stabilization much easier.

Treatment violations therefore commonly included failure to make appointments or failure to take medication as prescribed. Commonly, medication compliance issues involved participants refusing to take their medicine or stopping medication abruptly, but there were occasionally violations of participants consuming the wrong dosage or using other peoples' medication as well. Participants could also be found in violation if they attended treatment but were found not to be engaging, including not speaking in group therapy sessions or even falling asleep during sessions. Participants with housing issues or participants who struggled with substance abuse were often placed into in-patient treatment or sober-living as well. Failure to follow the rules of in-patient programs or absconding from those programs were also coded as a treatment violation. New participants in the court were often reminded to fill out releases of information so treatment providers could update the court on their progress. This allowed court coordinators, care coordinators, and attorneys on the MHC team to monitor treatment progress and compliance of their participants.

In addition, treatment providers were included in the hearings themselves and often worked closely with the MHC workgroup. The three courts observed in this study each had connections or working relationships with community services to varying

degrees. In Washoe County, one treatment service had staff present during court hearings to answer questions or speak about any issues with participant compliance. This allowed participants to ask questions about upcoming appointments, but only if they were receiving treatment from this particular provider. The Sacramento County MHC had staff representatives from multiple treatment providers who were often included in the discussion, and frequently asked questions by the judge and other court professionals about compliance and upcoming appointments to help remind participants about important dates. The Thurston County MHC, however, did not regularly have staff from community treatment providers present during the court hearings. It appeared that treatment compliance was monitored by the care coordinators contacting individual treatment providers outside of the hearings.

Overall, treatment compliance was measured by the courts in two ways, medication compliance and meeting appointments with treatment providers. While treatment violations were not as common as drug testing violations, judges and other courtroom professionals emphasized the importance of meeting mental health obligations. Mental health treatment compliance was a regular discussion in status hearings. Even when there was no issue or violation, judges would routinely ask participants if they were taking their medication, making their appointments, and asking them if they knew when their next appointment was. When there were issues with compliance, participants were reminded of the importance of engaging in treatment. Occasionally, judges, attorneys and other staff would discuss their own experiences with mental health, stress, and treatment to emphasize its benefit.

Other Violations

Testing and treatment violations were overwhelmingly the two most common forms of violations identified and discussed during these observations. However, there were various other violations identified that were less common and ranged in severity. Following testing and treatment violations, the third most common issue discussed in violation hearings was *communication issues*. However, the total number of violation hearings that discussed communication issues was 49 (6.71%), a much lower number compared to the total number of testing and treatment violations. Across the three courts, participants were expected to remain in regular contact with members of the courtroom workgroup, whether by phone, through text messages, or in-person meetings. In Washoe County, participants were expected to meet with the court coordinator. In Sacramento County, they communicated with their defense counsel, and in Thurston County, participants were expected to stay in communication with their assigned care coordinator. If a participant did not attend these meetings or did not stay in regular contact (usually at least once a week), they were considered in violation of the program. Often, communication violations were paired with another violation, such as testing positive for substances or missing treatment appointments as well.

While it was relatively rare, picking up a *new criminal charge* was another notable violation that was, unsurprisingly, treated very seriously. There were 32 (4.38%) violation hearings that involved discussion of a new charge. More on sanction decisions will be discussed below, but when a participant was charged with a new offense in the program, there would always be discussion if they could remain in the program. This decision would sometimes be out of the hands of the MHC, as depending on the decision

of the district attorney's office, the new charge might not even be admitted into the court; meaning the participant would have to resolve this new charge through traditional criminal court. In one instance, a participant received a new charge and was awaiting the decision from the district attorney on how that case would be handled. During this time, the participant was still engaging weekly with the MHC. The judge and other staff emphasized the importance of continuing with the program in the meantime, and meeting all of his obligations such as remaining sober, testing negative, and making his appointments. They commented on how his continued compliance could be an influential factor in the prosecutor's decision to let him remain in the MHC program. The courtroom staff, including the MHC prosecutor, expressed their desire for him to remain in the program, but also indicated that it may be out of their control.

The remaining violations were similarly rare but not as severe as acquiring new charges. There were 31 (4.25%) violations coded as *concerning behavior*, in which participants were observed by courtroom staff or treatment staff as exhibiting strange or symptomatic behavior. This code also included some instances in which participants became angry or combative with courtroom or treatment staff. These behavioral issues did not necessarily always lead to sanctions, especially if the behavior did not involve threats of violence. In the milder cases, the court would address issues of inappropriate language, rudeness, or behavior (such as repeatedly calling a courtroom staff member or treatment provider) which would be resolved with a simple warning. In cases where behavior was reported to be severely erratic, indicating potential drug use or cessation of medication, or in cases where violence or violent threats were involved, the judge went as far as remanding the participant into custody in an attempt to stabilize the participant.

Often it was noted that this behavior was against the rules of in-patient or residential treatment facilities, putting participants at risk of removal from these treatment programs.

There were 25 (3.42%) instances in which participants *failed to follow a previous sanction*, in which participants did not follow a court order for a previous violation. Examples include failing to appear for community service, or failing to write a reflective essay as instructed (more on sanctions below). In these cases, participants were often asked to complete the previous sanction plus an additional sanction. In the observations there were also 23 (3.15%) instances of *missed court* violations. Violation hearings with this code included those who accidentally missed court due to forgetting or even sleeping in. The court did not excuse these violations, but were usually fairly lenient in response. In more severe cases, participants may have missed court and absconded for longer periods of time. In instances where participants missed multiple court hearings and were not in communication with the court, and believed to be a flight risk, the judge would issue a bench warrant and their next appearance would likely be in custody, possibly with a new charge.

Finally, there were 16 (2.19%) instances of *probation violations*. These included instances of participants found living at an unapproved address, instances in which participants had contraband (e.g., drugs or drug paraphernalia, firearms or other weapons) at their residence, or instances where participants were associating with individuals whom they were not allowed to be in contact with. In cases where a participant was living in an unapproved address, or an address that was deemed unsuitable, they were likely to be recommended to an in-patient or residential program. This was, again, an

attempt to avoid substance use violations or to address an underlying cause for continuing substance abuse.

Court Comparisons

Violation rates differed across courts, with Washoe County having the highest ratio violation hearings to overall observations (22.20%) followed by Thurston County (14%) and Sacramento County (10.18%). Table 2 provides a breakdown of the difference in types of violations by court. Testing violations were the overwhelming majority of violations in both the Washoe and Thurston County courts. While testing violations were still prominent in Sacramento County, there were fewer of these violations compared to treatment violations. This is likely due to Sacramento County having less of a focus on substance testing, as not every participant was required to randomly test for substances.

Table 2. Violation Type by Court

Violation	Washoe		Sacramento		Thurston	
	#	%	#	%	#	%
Testing violation	359	72.09%	71	42.26%	50	78.13%
Treatment violation	124	24.90%	74	44.05%	9	14.06%
Communication issues	32	6.43%	13	7.74%	4	6.25%
New criminal charge	19	3.82%	11	6.55%	2	3.13%
Concerning behavior	16	3.21%	11	6.55%	4	6.25%
Failure to follow sanction	21	4.22%	4	2.38%	0	0%
Missed court	17	3.41%	5	2.98%	1	1.56%
Total	498		168		64	

Interventions and Sanctions

As a treatment-focused specialty court, mental health courts take a unique approach to addressing violations of the program. Unlike traditional courts, each of the three observed MHCs focused on *therapeutic interventions* as opposed to *punitive interventions* such as community service, fines, or jail time in response to violations. However, *punitive interventions* were used in certain situations. As was clear in all three of the courts, jail was seen as an absolute last resort in response to violations or unwanted behavior from participants. In general, each court followed a process of escalating interventions or sanctions based on severity of the violation and repeated violations.

In this analysis, interventions were broadly separated into two categories, *therapeutic interventions* and *punitive interventions* (see Tables 2 and 3 for a breakdown of intervention types). Of the 730 total violations, 490 (67.12%) received a *therapeutic intervention* while 231 (31.64%) received a *punitive intervention*. Another 71 (9.73%) violations received *no intervention*. These were often cases in which a participant was excused for a particular violation, such as missing court or an appointment due to a medical emergency. There were also cases in which the court was waiting for more information before deciding on a sanction or deciding if a sanction should be used at all. For example, participants may have disputed the results of a urine analysis, in which case the sample would be sent out for further testing. In these cases the court would wait until receiving the new results before making an intervention decision. It is important to note, again, that these codes were not mutually exclusive. In some cases a participant may have received a combination of interventions, such as if they had multiple types of violations

that required different responses. Or they may receive an intervention for one violation and no intervention for another.

Therapeutic Interventions

Therapeutic interventions referred to interventions which were more unique to mental health courts and treatment courts. These interventions focused on rehabilitation and attempts to address perceived underlying causes of the participants' criminal behavior. At the most basic, participants would be given a *warning* for committed violations. There were 146 (29.80%) violation hearings that included a *warning* as at least one of the interventions. These interventions were straightforward, involving the judge informing the participant what the violation was and asking them not to do so again. Judges often stated explicitly to defendants that they were receiving a warning "because you're new to the program" or "because this is your first testing issue." Judges also informed participants that future violations would have more severe consequences. For example, in one interaction the prosecutor remarked "if you miss another appointment you can count on coming back [to court] every week." In another, the judge commented his urine analysis levels of kratom, which is an herbal substance that can produce opioid and/or stimulant like effects (National Institute on Drug Abuse, 2022). The judge stated: "these levels need to be gone by the 5th and if not we are recommending a higher level of care or for you to return to your sentencing court."

Following a warning, there were a few other therapeutic interventions the courts turned to. The interventions observed in this dataset included *increased care*, *coordination with treatment providers*, *communication changes*, *reflective essays*, and *increased drug testing* (see Table 3 for a breakdown of therapeutic intervention types).

These other therapeutic interventions did not appear to differ based on severity but on the specific needs of the participant. And while each court used each of these interventions to some extent, there appeared to be preferred interventions across the three courts. Though it is of course impossible to conclude significant differences in intervention preference from the qualitative data alone, and due to the fact that there are not equal numbers of observations across the court.

Table 3. Breakdown of Therapeutic Responses to Violations (n = 490)

Code	#	% of total
Warning	146	29.80%
Increased care	112	22.86%
Coordinating with treatment providers	97	19.80%
Communication	78	15.92%
Reflective essays	77	15.71%
Increased drug testing	71	14.49%

Increased care refers to interventions when the court would order the participant to engage more in some form of treatment. This was the second most common therapeutic intervention, with 112 cases (22.86%). In Washoe County, this often took the form of self-help “marathons”, in which the participant was asked to attend self-help meetings (e.g., Alcoholics Anonymous or similar support groups) daily until their next court hearing. Sacramento and Thurston Counties would also ask participants to engage in more self-help groups, though not necessarily in the form of a “marathon.” Another example of increased care commonly seen across all three courts to some extent was increasing participants’ level of care to an in-patient or residential facility. This was done as a more serious intervention, usually after a participant had absconded for a period of

time, received a new criminal charge, or had multiple and continuing substance use violations.

Another common theme of therapeutic interventions was *coordinating with treatment providers* (97 cases, 19.80% of therapeutic interventions). Interventions with this code were somewhat varied but involved the court ordering participants to interact with doctors or treatment providers to alter their medication or therapy. In some cases, this is simply ordering the participant to reengage with treatment. In one instance, the treatment provider spoke in court, stating that the participant had missed his injection earlier that day and was combative when contacted by phone. The judge required the participant to get the injection by the afternoon calendar or he would face jail as a sanction instead. In another instance the court was speaking with a participant who had been reported to the mental health response team for “erratic, but non-threatening behavior.” In addition to asking for a drug test to rule that out, the judge requested that he move his next doctor’s appointment up to see if medication changes could be helpful.

Communication from the participants was emphasized as important by the judge and other court professionals as well. Therefore, another common intervention (78 cases, 15.92% of all therapeutic interventions) was to *communicate* with the court. As described above, participants were required to contact some members of the court team (court coordinator, care coordinator, or defense counsel) at least once a week. In cases where there was a violation, they may be asked to meet, call, or even text more often than weekly, sometimes as often as once per day. In one instance, a participant had relapsed on alcohol use after the death of a pet. The judge emphasized the importance of communicating substance use early rather than waiting for them to get the urine analysis

results, further stating “we want to help you work on this, the sooner you reach out the sooner we can help.” The court requested that he check-in with his care coordinator daily as an intervention, saying “we want the best for you, so if we miss something we feel bad about it because we want to help you.”

Reflective essays were also used across all three courts (77 cases, 15.71%). This could be a response to a number of violations but ultimately involves the participant doing some written assignment to reflect about what led to the violation or what changes need to be made. For example, when one participant had relapsed on substances, the judge asked him to write an essay and said to “ask yourself what happened and what it is that draws you to want to use meth.” In another instance, when a participant missed multiple drug testing dates. She said she missed one date because it fell on a holiday and falsely believed testing was closed, and the second time was her fault for missing the bus. The judge responded, “write an essay on what you just said and how you can change it, so you won’t miss again.” Another intervention similar to these essays was the use of food and drink logs for those having issues with dilute tests. The court required participants with dilute testing issues to track what they ate and drank in order to help them understand why they might be receiving dilute tests.

Finally, participants with recurring substance use problems were often ordered to *increase drug testing*, which was imposed in 71 of the observed cases (14.49%). In cases of continued substance use, the courts would often request more regular urine analysis tests from the participant. Under normal circumstances, participants would be on a random testing line, which would result in a few tests randomly scheduled throughout the week. However, when sanctioned, they would be required to test more frequently, often

every day for a period of time (until their next court hearing, for a number of weeks, etc.). In Sacramento County, where some participants did not necessarily have to randomly test as part of their probation, these participants were instead put onto random or scheduled testing if substance use was suspected. Judges would often remind participants the importance of these tests, saying “being clean and sober is critical to success.” This intervention was often paired with other interventions (therapeutic and punitive) depending on the participants' violation.

Overall, as a therapeutic court, these interventions were the most common and the first response to violations, depending on the severity of the violation. In some interactions, members of the courtroom workgroup (often the defense counsel) would remind the court that as long as the participant is engaging with the court, their response should be to increase care or to try something different rather than jail or other, more punitive sanctions. However, for repeated violations, which indicate non-engagement, or for sufficiently severe violations, *punitive interventions* were an option used by these courts.

Punitive Interventions

Punitive interventions refer to more traditional sanctions that might be observed in a more traditional criminal or probation style court. The *punitive interventions* observed in this dataset included *increased court appearances*, *extending program time*, *community service*, *set termination hearing*, and *jail* (see Table 4 for a breakdown of punitive intervention types). Unlike *therapeutic interventions*, these interventions focused less on rehabilitation and more on traditional punitive goals of deterrence. However, the court would emphasize how these interventions still followed the overall therapeutic

goals of the program as they were deterring behaviors detrimental to recovery. Jail specifically was also seen as a tool for stabilization in addition to deterrence, rather than retribution. Also, unlike the *therapeutic interventions*, there was a clearer step up in severity of the *punitive interventions*, with sanctions becoming more severe depending on the participants' violation history and the seriousness of the violation.

Table 4. Breakdown of Punitive Responses to Violations (n = 231)

Code	#	% of total
Set termination hearing	98	42.42%
Community service	81	35.06%
Jail	75	32.47%
Extend program time	27	11.69%
Increased court appearances	20	8.66%

The least severe of the punitive interventions observed in the dataset was simply increasing the frequency of court hearings (20 cases, 8.66%). As described above, participants were required to attend weekly court hearings when first entering the program. These continuances increased in length as participants progressed in the program, with late-stage participants having four- or five-weeks in-between appearances. A simple sanction then is to order participants to move back to one-week continuances as a deterrent of specific behavior. In many cases, the judge or prosecutor also requested this sanction in conjunction with a *therapeutic intervention* to make sure they are “back on track” with drug testing or making their appointments.

Another intervention used for participants, often those further along in the program, was to *extend their time in the program* (27 cases, 11.69% of punitive interventions). Participants in the Washoe and Sacramento County programs were

expected to graduate in about one year and participants in the Thurston County program were expected to graduate in two years. However, if participants were having issues with violations, particularly near the end of their program, the court had the ability to extend their probation and keep them in the program for longer in which they had to continue attending court and submitting drug tests. Thurston County specifically had a policy in which the participants needed to have six months free of violations before graduation. Graduation delays in Washoe and Sacramento County ranged from one month to six months, though there was no indication in these data on how these timeframes were determined. Judges indicated that these delays were also to help ensure participants were stable before graduation, or to make sure “everything is in order” to set participants up for success. This, again, shows that while this was a more punitive intervention, it still contributed to some extent, the therapeutic goals of the court.

In instances where participants continued to have the same violation such as missing tests, testing positive, or missing appointments, court ordered *community service* was the standard response (81 cases, 35.06% of punitive responses). Again, while this was a *punitive intervention*, the purpose of this sanction according to the court professionals was to encourage compliance with the therapeutic requirements. In one case, a participant who had been missing tests was ordered to complete four hours of community service. The court coordinator stated that “the sentiment of the team is that this should be a non-issue at this point”, to which the judge agreed and said it was to “remind him of the importance of testing.”

In an interesting departure from the other MHCs, Thurston County required all participants to complete a certain number of community service hours as part of the

program rather than as a sanction. Participants were encouraged to find an organization or a form of community service that interested them or was meaningful to them. In addition, the participants were expected to speak in court about the community service they chose and what their experience was like sometime before their graduation. It is unknown from these observations why community service was treated as such in the Thurston County program. However, future research on community service as a therapeutic tool rather than a punitive sanction may be worthwhile.

The most severe sanction, short of removal from the program, was sentencing non-compliant participants to *jail*. Jail appeared to be seen as a last resort across all three of the courts and was never the preferred option as an intervention. In some instances, participants were reassured that they were not going to be placed in jail as a violation. In one instance a participant had missed a drug test and reported to someone on the team that they were concerned about going to jail. In the hearing, the judge assured him that “we try not to use that as a response to folks who are struggling.” This sentiment seemed true across all courts, with jail being reserved for a few situations. For example, participants who had committed a new offense were jailed as part of the arrest process, though this was not necessarily a sanction given by the MHCs. As described previously, after receiving a new charge, a participant may or may not remain in the program depending on whether or not the new charge is eligible for the MHC program.

When it comes to sanctions given by the MHC, it appeared that jail was reserved for two situations. First, jail was used when participants repeatedly violated the requirements of the court and the previous therapeutic and punitive interventions did not work, or the participant failed to do those interventions. For example, in one instance a

participant had been sanctioned multiple times for continued marijuana use. The judge had noted that this participant was doing everything else that was required in the program stating “let’s look at the good stuff, you’re coming to court, you’re not hiding or disappearing, I appreciate that...that means there is progress and I want to recognize that.” However, the previous interventions they attempted did not work. In the same hearing the judge stated “I don’t know what else to do but give you a day in jail for every positive UA...I don’t want to do that, I would like you to have the determination yourself so I don’t have to use jail time.” This participant abstained from cannabis for approximately one month before receiving his next positive urine analysis, leading to the jail sanction being instated.

The second situation in which *jail* was used as a sanction was when the MHC workgroup was concerned about stability or the participant being a flight risk. For example, in one instance a participant was out of custody and waiting for a residential treatment spot to open up. While waiting for a treatment spot to become available, the court reported that he was attending out-patient therapy and groups but was also testing positive for substances and missed a court date and missed some appointments. The judge ultimately decided to remand the participant into jail because they want to make sure he stays sober, and the missed court date and appointments were worrying. He said to the participant, however, “Don’t give up hope because the plan is to get you in a residential program.”

Finally, the most commonly observed punitive sanction observed in this data set was the scheduling of a *termination hearing* or “order to show cause” (98 cases, 42.42% of punitive responses). These will be discussed more in-depth in the next section but

repeat violations or even after a particularly severe violation, the court would schedule a termination hearing to discuss the participant's continuation in the program. This does not mean the participant was immediately removed from the program, and in most cases were not. But the hearing itself appeared to serve as a reminder to the participant of what is at stake and what behaviors could end up in their termination and return to traditional court. Therefore, the hearings themselves served as a deterrent to continuing violating behavior on their own.

In sum, *punitive interventions* were used much more sparingly compared to *therapeutic interventions*, befitting the therapeutic and rehabilitative goals of the courts. When these sanctions were used, it was because previous attempts to bring participants into compliance had failed or due to extreme circumstances, such as the commission of a new offense. Even when *punitive interventions* were used, they had therapeutic goals in mind, such as maintaining participants' stabilization and sobriety, or deterring behavior that would hinder recovery and treatment.

Factors Influencing Sanction Decision

The primary purpose of this qualitative analysis was to investigate the decision-making process that occurs within MHCs. The previous sections discussed the common violations observed in this dataset and the different types of interventions and how they were applied. This section summarizes the observed factors that may have influenced decision-making during the violation hearings. There were four potential factors observed in this dataset that influenced sanction decisions, the *severity* or *type* of violation, *violation history*, the participant's *time in the program*, and the *accountability* of the participant.

Similar to research on traditional criminal sentencing in which offense severity and criminal history are major determinants of sentencing decisions; the violation *severity* or *type* and the participant's *violation history* are important factors in sanction decisions within MHCs. As described above, therapeutic interventions were the most commonly used, regardless of the violation. The only violation severe enough to warrant a more punitive response regardless of history appeared to be receiving a new criminal charge. Committing a new criminal offense almost always resulted in a termination hearing (described more below). While they were not automatically removed from the program, there would almost certainly be a discussion about termination.

As described above, participant's *violation history*, and relatedly, their *time in the program*, also influenced sanction decisions. The three courts prioritized therapeutic interventions for first time violations and for participants new to the program. Judges and other staff (e.g., court coordinator) would explicitly mention these factors when explaining sanction decisions. Making statements such as, "because this is his first issue, the team recommends a warning" or state that the participant "is still new to the program and was very honest about his use, so I think the therapeutic approach is best." In a more extreme example, there were some questions about a participant's recent positive test for opioids which the participant claimed was from codeine prescribed to him by the dentist. He further stated that he had brought the prescription to the test to show the staff at the testing facility. The judge noted the participant had a perfect track record and said the positive test "came as a big surprise to everyone when we saw it and we will probably be giving you the benefit of the doubt."

If a participant has a long history of violations, especially if it is the same violation, the court will consider more punitive sanctions. In one instance, a court coordinator stated about a participant “there are a total of seven testing issues in the program, all have been missed tests. The sentiment of the team is that it should be a non-issue at this point and would recommend the court to impose the four hours of community service suspended last time there was an issue.” Similarly, in another instance, a participant was ordered to do a self-help marathon after a relapse. The participant stated that stress and pain from an illness led to the use. The judge responded, “You are going to learn how to handle that, you have been here since November, so you have to have learned how to do this.” These examples show that time in the program, separate from the number of previous violations, can influence sentencing as well. As participants near the end of the program, they have higher expectations about what they should be able to do.

One final theme observed as relevant to sanction decisions was the perceived *accountability* of the participants. Members of the courtroom workgroup expressed the importance of being upfront about issues such as substance use, relapses and other struggles within the program. The court was much more serious about attempts to avoid confronting these problems or attempts to obfuscate them. For instance, in one violation hearing the court was discussing a participant’s use of methamphetamine and their attempt to avoid a urine analysis by forging a document from a doctor suggesting he had tested positive for COVID-19. The hearing started with the prosecutor stating:

The state has a lot of concerns about the behaviors they’ve seen here. The meth use is concerning, but if that was the only thing that was a concern I think we’d be

having a very different conversation. What we are seeing here are overwhelming efforts to conceal and hide to the point of forging documents.

The judge further emphasized the importance of trust and honesty in the program, stating that these actions were a violation of that trust. The judge further explained his original intention was to sanction him with jail time but ultimately decided against it because of his admission to his mistakes during the hearing. Across all three courts, the workgroup emphasized the importance of seeking out help and being forthcoming with issues. Judges across the courts expressed how they are “here to help” but cannot do so if participants are unaccountable.

Court Comparisons

Table 5 provides a breakdown of the frequency of intervention application across the three courts. Note that a participant may receive multiple interventions during a single hearing (e.g., asked to increase communication with the court and write a reflective essay). Therefore, the number of intervention types does not sum to equal the overall amount of therapeutic and punitive interventions.

Therapeutic interventions were consistently more common than punitive interventions across the three courts, however, there were differences in the preference of interventions used across the three courts. While the Washoe and Sacramento County courts were most likely to use a simple warning as a therapeutic intervention, warnings were rarely used by the Thurston County court. Instead, this court was more likely to require the participant to increase communication with their care coordinator (e.g., call or text daily) in response to even minor violations.

Regarding punitive violations, the MHC in Washoe County was much more likely to schedule a termination hearing in response to severe or repeated sanctions compared to the other two courts. In Sacramento County, the most common punitive intervention observed was to increase appearances with the court (e.g., appear weekly instead of every two weeks). There were very few punitive interventions observed in Thurston County generally, however, jail was the most common punitive intervention that was applied.

Table 5. Intervention Type by Court

Intervention	Washoe		Sacramento		Thurston	
	#	%	#	%	#	%
Therapeutic Intervention	336		102		52	
<i>Warning</i>	107	31.85%	35	34.31%	4	7.69%
<i>Increased care</i>	83	24.70%	18	17.65%	11	21.15%
<i>Coordinating with treatment providers</i>	56	16.67%	28	27.45%	13	25.00%
<i>Communication</i>	45	13.39%	8	7.84%	25	48.08%
<i>Reflective essays</i>	63	18.75%	6	5.88%	7	13.46%
<i>Increased drug testing</i>	55	16.37%	16	15.69%	0	0.00%
Punitive Intervention	163		55		13	
<i>Discuss termination</i>	84	51.53%	12	21.82%	2	15.38%
<i>Community service</i>	69	42.33%	10	18.18%	2	15.38%
<i>Jail</i>	46	28.22%	3	5.45%	6	46.15%
<i>Extending program time</i>	20	12.27%	3	5.45%	4	30.77%
<i>Increased court appearances</i>	6	3.68%	14	25.45%	0	0.00%

Termination Hearings

In cases of repeated violations or particularly severe violations, the courtroom workgroup has to consider the termination of non-compliant participants. *Termination hearings* were relatively rare. Of the 4351 total hearings observed, only 153 (3.52%)

involved discussion of a termination. Of those 153 *termination hearings*, the participant was removed in 60 of those cases and was retained in 58. In another 34 cases, the participant no longer wished to participate in the program and asked to be removed. The final outlying case was a special circumstance in which the participant's case was dismissed and their obligations to the court were dropped. This section will discuss the themes identified in these termination hearings and discuss what factors are considered in the workgroup's deliberation.

Termination hearings appeared to be similar across the three courts. The interactions during observations indicated that termination decisions were discussed in staffing prior to court, as in many of the hearings court professionals would mention that these discussions had occurred. In many cases, if the entire team agreed to retain the participant, the participant was simply told they will remain in the program and they would discuss next steps during the hearing, such as treatment changes or completing applications for in-patient treatment. In cases in which there was disagreement, there would be a more formal termination hearing. These hearings resembled a more traditional, adversarial criminal court, in which the prosecution and defense had an opportunity to speak and argue their respective cases. The participant was usually given their chance to speak as well, as the judge often wanted to hear from the participant and often asked if they wanted to remain in the program. At the end of these arguments, the judge would make their decision to either *retain* or *remove* the participant from the program.

As described above, *termination hearings* were a result of either severe violations such as receiving a new charge or absconding from a treatment program; or for repeated

violations such as continually testing positive for substances or missing treatment appointments. Across the courts, various members of the courtroom workgroup expressed that their philosophy is to always try to increase treatment or provide options if the participant is interested in continuing the program. This was reflected in many of the termination hearing decisions if the participant was retained. If a participant had primarily engaged in out-patient treatment before the termination hearing, they would often be recommended for an in-patient facility or be ordered to apply for a sober living environment. These facilities were considered a higher level of treatment that could give the participant more stability. If a participant was already in one of these programs or had recently absconded from one before the termination hearing, their willingness to return to a program or to enter a new one could be a factor in the participant's favor. However, if a program refused to readmit a participant because of behavior issues or because of the participant's charge (e.g., arson or sexual offense), this would hurt the participant's chances of being retained in the court.

In these adversarial hearings, the prosecution was first to present their arguments. These arguments would usually be an overview of the participant's history in the program, including a description of the violations that led to this point. If the participant had termination hearings in the past, the prosecution often discussed those as well. As mentioned above, increased treatment is the primary response to struggles with treatment or substance use. Therefore, violations that suggested the participant was untrustworthy or not engaging in the program received the most focus. In one case in which a participant was removed, the prosecutor stated, "the problem wasn't that he continued to test positive, but that he absconded and stopped testing." In another instance, the

prosecution highlighted a participant's previous termination hearings for cheating on a drug test and deceitful behavior after a positive alcohol test. The prosecutor finished by stating "he is fully capable of completing the program but is not doing so. He makes promises when he is facing termination, but after that does not live up to those promises." These quotes suggest that perceived trustworthiness of the participant and perceptions of their engagement with the program are crucial factors considered during termination hearings.

Following the prosecution's arguments, the participant's defense counsel would present theirs. Reflecting the other side of the prosecutors' arguments, the defense focused on the accomplishments of the defendant in the program and their wishes to remain in the program. For example, in response to the prosecution, the defense stated.

I nor my client deny the significant and lengthy history of testing issues. Usually when there is such a history there are also issues of compliance in other areas such as treatment or completing sanctions. None of that has occurred in [client's name]'s case, he has never had a bench warrant, and he has completed every jail sanction required of him.

Additionally, the defense often highlighted the situational factors that led to the violation and subsequent termination hearing. In one case, the court was discussing a participant's removal due to him absconding after being told to enter transitional housing at the

Salvation Army. The defense argued:

He did go to the Salvation Army, but they refused to admit him because he was on substances. He indicated he was going to go to detox but instead went to stay with his family and got clean on his own...He ran into a strange set of circumstances because he knew he wouldn't be allowed in the facility and that he was still struggling with circumstances. Now that he's clean he can go to the Salvation Army and give him this last chance. If he can't finish it, then he's out.

These quotes reinforce the previous observation, that the question of a participant's trustworthiness and willingness to engage are crucial factors considered by the courtroom workgroup. These quotes show how the defense advocates for their clients by highlighting their accomplishments and explaining how circumstances beyond their control led to the violations in question.

Based on the observed interactions, the courtroom work groups, prosecutors included, always appeared willing to give participants another chance. In fact, many of the participants who were *removed* from their program were on their second or third *termination hearing*, meaning they had been given multiple chances in the past. This ties in with another factor considered with regards to termination decisions, which is the expenditure on the limited resources available to the court. For example, in one instance a participant was in front of the court for their third *termination hearing* in the program after reported behavioral issues including hostility directed toward staff at their in-patient facility. The prosecutor ended their argument stating “[facility name] is offering another chance but he is unsupevisable, and I believe it should go to someone who has not had multiple opportunities already.” In a similar case in which a participant had absconded multiple times from treatment programs, the prosecutor simply stated, “The state respectfully requests he be removed so the resources can be better spent elsewhere on someone else.” In a third scenario, the judge also echoed this concern for resources, telling one participant “This is serious stuff and it’s time consuming for the staff trying to help other people. If people aren’t taking advantage of the help, then they need to go someplace else.” Overall, these quotes emphasize the MHC’s concern about resource expenditure and the participants’ interest in the program or ability to use these resources.

Beyond the more adversarial hearings, it is important to note that many of the *termination hearings* were quick and straightforward. This could be due to an agreement reached in staffing before the *termination hearing* occurred. For example, in one case, the court coordinator stated as a team,

We are concerned that it's not a resistance to the program, but a capacity issue to comply with the program. We feel we're having a positive impact, but not at the level we'd like. Since she is still able to receive resources, we ask that she continue with the program but she makes herself available to check in with my office Monday through Friday to make sure she can ask questions and stay on track.

In a similar case in which a participant was removed, the judge started the hearing simply stating, "We discussed the matter in great length yesterday and concluded that the case will be deleted...we tried to use the tools at our disposal and regrettably they just didn't take." Of course, these staffing meetings were not observed directly by the research team, so it is unclear the exact reasoning why certain participants were retained or removed from the program, or if there was a more adversarial process behind the scenes.

Termination hearings could also be quick due to more logistical reasons. For example, in one instance, a participant was planning to move outside of the state, so all parties agreed it was in the best interest of the participant to be removed from the program. While all the courts discussed giving participants "another chance" at least in informal terms; the Sacramento County program formally placed participants in "last chance contracts" as a condition of remaining in the program. If a participant was under one of these contracts, any further violation would lead to immediate removal from the program.

Mental health courts are also, ultimately, a voluntary program. If participants no longer wish to engage in the treatment or do not believe it is helping them or in their best interests, they are free to leave the program. In some cases, these participants were returned to their sentencing court for their case to be processed by another judge. In some cases, especially if the charge was lighter, participants may have enough credit for time served and their cases are resolved. In most of these hearings the participants did not state why they wanted to leave the program, they simply stated they wished to leave the program. In cases where the participants gave reasons, the common reason given was because they had served the underlying sentence already, sometimes while waiting in-custody for a treatment spot to open at an in-patient facility. For example, in one case the participant stated “I am frustrated because I have been denied every program. I appreciate the court, but I’ve spent three months in jail, and if I spend another three it will be time served on my charge.”

In summary, termination hearings are an important point of decision making within mental health courts. As opposed to traditional criminal courts, mental health court workgroups are largely collaborative in nature, in which the judge, defense, prosecution and other court and treatment staff work together to serve the participants. However, termination hearings more closely resembled the adversarial nature of traditional courts in which defense advocated for their clients while the prosecution argued with community safety and resources in mind. Each of the three courts emphasized the importance of giving second, even third and fourth chances to participants if they were still interested in treatment. Participants were ultimately removed, then, for not engaging

in the program, for exhibiting untrustworthy and deceitful behaviors, or when the court decided the limited resources would be better utilized by other potential participants.

Court Comparisons

Table 6 shows the retention and removal rate during termination hearings across the three courts (excluding hearings in which charges were completely dismissed or the participant requested to be removed from the program). While the majority of termination hearings resulted in the participant being retained in Washoe and Thurston County courts, the opposite was true in Sacramento County. It is important to note however, that unlike Washoe and Thurston county, terminations were discussed primarily during staffing rather than in the hearings themselves. Therefore it is possible that cases in which the participant was retained were not always mentioned in the observable court hearings.

Table 6. Termination Decision by Court

	Washoe		Sacramento		Thurston	
	#	%	#	%	#	%
Termination Hearings	83		25		11	
Retained	50	60.24%	5	20.00%	8	72.73%
Removed	32	38.55%	20	80.00%	3	27.27%

Discussion

The purpose of this qualitative study was to gain a better understanding of the operation of mental health courts, specifically the decision-making process that occurs in more adversarial moments such as sanctions and termination hearings. This is important because there is little research investigating the more specific functions and operations of MHCs. Previous studies have focused primarily on outcomes, which have suggested the

effectiveness of MHCs in terms of reducing recidivism and improving the quality of life of its participants (Han et al., 2020; Loong et al., 2019). However, without more research on the operations of the court, it is difficult to understand why MHCs are effective or how to increase their efficacy.

Previous qualitative observations of a mental health court have suggested the importance of therapeutic jurisprudence in facilitating positive outcomes. They posit that the positive interactions between the participant and the judge (and possibly the rest of the courtroom workgroup) lead to these positive outcomes (Fisler, 2005; Frailing, 2010; O'Keefe, 2006). The current study supports these previous findings. In each of the three courts observed, the conversations between the participants and the judge were the primary point of interaction in the hearings. When a participant was doing well (i.e., not receiving a sanction or in a termination hearing), these interactions were largely positive, involving messages of encouragement, reassurance and praise.

Unlike previous studies, the current study involved observations of multiple courts instead of a singular mental health courts, allowing for more comparisons. This was possible due to the virtual nature of the hearings following procedure changes during the COVID-19 pandemic. Comparisons between these courts did reveal different levels and types of interactions between the three courts. The main difference appeared to be related to the size of the court. Because of the larger size of the Washoe and Sacramento County programs, individual hearings were processed much quicker on the docket in order to accommodate all of the participants, leaving less time for conversation between the two parties. In the Thurston County MHC, there was more time for the judge to speak with participants about their lives and struggles, allowing for rapport building. In

addition, the smaller docket size and increased time allowed for the other members of the courtroom work group, including defense, prosecution, and case coordinators, to speak with the participants as well.

This rapport building could also affect participant compliance with the court. Table 3 reported the frequencies of violations across the three courts suggesting that Sacramento and Thurston County courts had lower rates of non-compliance among their participants compared to Washoe County. While interaction time may have an effect on this, Sacramento did notably have the lowest non-compliance rate even though Thurston County had the greatest amount of time allotted to each individual participant, suggesting other factors have influence as well. If these interactions and rapport building are associated with the reduced recidivism and other positive outcomes of mental health court, it is important to consider how the number of participants per docket and the time devoted to each participant may affect outcomes. Further research is needed to determine the strength of this association.

In addition, these frequencies also suggest differences in focus across the three courts. While the most common violation type in Washoe and Thurston County were testing violations, Sacramento County had nearly equal rates of testing and treatment violations. Notably, Sacramento County did not require every participant to engage in random drug testing which suggests a smaller focus on substance testing as a requirement. In addition, Sacramento County had representation from multiple treatment providers regularly present during hearings. This may have made treatment violations more identifiable because of the access to the treatment providers records on appointment schedules.

Unique in the current study was the focus on sanctions and termination hearings as important points of decision making within the observed MHCs. These are important areas to consider as it is concerned with how participants experience the program, and ultimately which participants continue with the program and which ones are removed. While all three courts similarly imposed therapeutic interventions more often than punitive interventions, there were differences in which types of sanctions were preferred. Notably, unlike the other two courts, Thurston County rarely responded with only a warning even to first time and minor infractions. Instead, participants were often required to increase communication with their care coordinator and asked to either text or call their coordinator daily until their next hearing. While this response is still relatively minor, the increased contact does add another level of accountability to the participants and can further help facilitate rapport building with the workgroup.

Sanction and termination decisions are particularly important to consider with regards to disparities in MHCs. While the research is inconclusive, some studies have suggested that there are age, gender, and racial disparities in MHC participation rates (Cosden et al., 2003; Frailing, 2011; Hiday et al., 2005; Luskin, 2001). If these disparities do exist, it could be due to differential applications of sanction and termination decisions in addition to initial referrals and admission decisions.

A multitude of studies have been conducted regarding decision-making and disparities in a criminal justice context, ranging from decision-making at the court level such as sentencing and diversion decisions, to decision-making at the police level such as traffic stops and stop and frisk decisions. However, there is a lack of research on decision-making specifically within specialty courts and specifically mental health courts.

Focal concerns theory has been a popular framework to investigate these disparities across multiple contexts, suggesting that disparities result in differential judgements on the blameworthiness, risk, and practical concerns of different defendants due to time and cognitive constraints to fully assess these three factors (Campbell & Fehler-Cabral, 2018; Crow & Adrion, 2011; Higgins et al., 2012; Steffensmeier, 1998).

These observations suggest that the predictions of focal concerns theory may apply to MHC decisions as well. Much like sentencing decisions, sanction and termination decisions in mental health court appear to consider factors such as blameworthiness, risk, and various practical concerns. A common conceptualization of blameworthiness in literature is the severity of offense committed, with defendants who commit more severe offenses being seen as more blameworthy (Bond & Jeffries, 2011; Crow & Bales, 2006; Homer & Higgins, 2022). We see a similar pattern in this qualitative data, in which more severe violations such as being charged with a new offense or absconding for long periods are treated more harshly. Another way blameworthiness could be conceptualized in this context is the intention behind the offense. The courts were concerned with participants' interest in treatment and their engagement with the program and ultimately were interested in helping the participants. Therefore, it appeared that offenses related to relapses or mental health symptomology were treated differently than offenses believed to be attributed to deceitfulness or more general criminal thinking.

Risk in previous focal concerns literature is measured as criminal history, with defendants who have a longer criminal history being seen as greater risks to the community (Bond & Jeffries, 2011; Crow & Bales, 2006; Homer & Higgins, 2022). In

the current study, concerns of repeated violations were observed. Participants were told explicitly that repeated violations would lead to more harsh sanctions. Similarly, repeat termination hearings were also an explicit factor in the decision to remove or retain participants. The courts often gave participants second, if not third and fourth chances. However, previous termination hearings were also often brought up as arguments from the prosecution in current termination hearings as a reason for removal.

The practical constraints or consequences of sentencing are the most widely defined of the three focal concerns. Steffensmeier et al. (1998) originally defined this concern as any factors that might influence sentencing decisions such as the impact on working relationships among courtroom professionals, the defendant's ability to "do time" and the resources needed to incarcerate or otherwise process a defendant. In the context of these mental health court hearings, practical considerations might include the availability of treatment services, health problems of the participant and the extent of their mental health symptoms. In the observation data, it was noted that treatment services might refuse to accept certain participants based on their previous offenses or behavior. Therefore, if no in-patient services would accept a participant and they were not trusted by the court to only receive out-patient services, they were likely to be removed. Some participants had other health problems that might prevent their ability to meet court requirements, such as reliably providing samples for drug testing, which could factor into removal decisions. Finally, if a participant's diagnosis or mental health symptoms were too severe, they might be considered unsupervisable or not appropriate for the level of services that the MHC had access to, resulting in removal.

It is important to note that the primary claim of the focal concerns framework in regard to decision making is that defendant characteristics such as race, gender and age are important influencers. Steffensmeier and colleagues (1998) argued that due to large caseloads and limited time to fully consider the three focal concerns, judges and other professionals rely on cognitive heuristics to make sentencing decisions. Therefore, unconscious biases based on demographic factors could have an undue influence on legal decision making. In the current data, there was no explicit mention of demographic factors in decision making. Therefore, this data cannot support this specific claim of focal concerns theory.

The current study is not without its limitations. While this study addresses limitations of previous qualitative observations of mental health courts by comparing three separate courts, the qualitative nature of this study still limits generalizability of the findings. Sites were not selected randomly but for convenience. Additionally, all three sites were located in the western United States, meaning there could be regional differences not identified in the current study. However, there were notable differences between the courts in workgroup composition and size which did highlight differences in operation and procedure. This indicates that it is worthwhile for future research of mental health courts, whether qualitative or quantitative, to include cross-comparisons between multiple jurisdictions. Another limitation of this study was the lack of data on court admissions. Because admissions were dealt with largely outside of these court dockets, other methods are needed to understand how participants are admitted into MHCs and whether there are disparities in these decisions.

Due to its nature, qualitative research of course comes with other limitations. The current study cannot be used to draw causal conclusions about factors such as participant race, gender or age and its effects on workgroup decision-making. In addition, while data collection involved multiple researchers the analysis was limited to one researcher, increasing issues of researcher bias and subjectivity with regard to the conclusions. To address issues of bias and subjectivity, findings were interpreted with previous theory (focal concerns) and previous qualitative studies of mental health court in mind. And while causal conclusions cannot be drawn from this data, the qualitative findings provide detailed insight into the operation of mental health courts and highlight avenues for future research.

Conclusion

The current study demonstrates the key differences between mental health courts and traditional criminal courts. These observations show the therapeutic goals of the court in action, including the conversations between judges and participants, conversations that often include praise, encouragement and reassurance. These data also show a similar sanction process across courts, in which the workgroups focus on therapeutic interventions before escalating to more punitive actions. The data also demonstrate the collaborative nature of the mental health court overall but also shows relevant instances of adversarial interactions during certain termination hearings, in which the prosecution and defense counsel have different goals for the resolution of a case.

This research also highlighted some key differences between these courts, namely in the quality of interactions between the courts. Each court had different levels of

interaction between participants and courtroom professionals. For example, there were differing levels of treatment provider involvement across the three courts, with multiple providers appearing during the Sacramento County program's hearings to provide information to the court and participants, while Thurston County had no treatment provider representation. There were also differences observed based on the comparative sizes of the court dockets. Washoe and Sacramento County were similar in size, having 30-40 participants per court calendar while Thurston County may only have 10-15 cases heard in the same amount of time. Because of this, hearings in Thurston allowed for longer and more personal conversations between participants and the courtroom workgroup. Future research should investigate more specifically these factors as potential variables that can influence MHC outcomes (e.g., recidivism rates and participant quality of life).

This study also demonstrates the importance of qualitative methods in research of mental health courts and other legal contexts. The current research provides insight into the nuances of interactions between participants and courtroom professionals. Quantitative research alone is not able to identify these nuances in the interactions that occur within these courts. Learning more about these nuances can help identify how MHCs are effective at reducing recidivism compared to traditional courts and give insight into how to make MHCs even more effective. Future research of mental health courts should incorporate qualitative and mixed-methods research in addition to quantitative research in order to better understand the intricacies of these courts. More research is needed to understand the decision-making that occurs within mental health courts and how it relates to both the outcomes and the potential disparities within these courts.

Chapter 4: Interviews and Qualitative Analysis of Mental Health Court Professionals

Following the collection and analysis of the observations, interviews were conducted with legal and treatment professionals who had experience working in mental health courts. The purpose of these interviews was to gain insight into the perspectives of mental health court (MHC) professionals including those who work on the legal side and those who work on the treatment side of the team. In addition, these interviews provided greater insight into the admission process of MHCs, which was not readily available from the observations discussed in the last chapter. A specific area this analysis focused on is the issue of disparities within mental health court participation as described in previous chapters. Therefore, it is important to consider what factors might contribute to these issues. Overall, these interviews provided more information on the decision-making processes within these courts and the direct perspectives of these professionals.

Methods

Sample

Data for this study were collected through in-depth interviews of MHC workgroup members through a combination of convenience and snowball sampling. Contact was initially made with members of the three courts observed as described in the previous chapters. To increase the sample pool and to speed up data collection due to low response rates, contact was made with various across the United States. Courts were identified through a web search and were contacted through email. All participants were asked to refer to any colleagues from their workgroup or other jurisdictions that might be

interested in participating. Data collection started in the spring of 2024 and concluded in the fall of 2024.

At the end of the data collection period, a total of 31 in-depth interviews were conducted. The participants in this study were all MHC workgroup members across 16 different MHC programs. Job titles of participants included judges, prosecutors, defense attorneys, case managers, program coordinators, therapists, probation officers, and treatment liaisons. This sample therefore provided a mix of perspectives from different positions from both the legal and treatment roles of the MHC programs (see Table 7 for a breakdown of the sample by position).

Table 7. Breakdown of Interview Sample by Position (n = 31)

Position	#	%
Judge	5	16.13%
Care coordinator/Case worker	9	29.03%
Prosecutor	3	9.68%
Defense attorney	2	6.45%
Program manager	7	22.58%
Therapist/Treatment	3	9.68%
Probation officer	2	6.45%

Data Collection Procedure

Participants were identified through a web search of MHC programs in the United States. Potential participants were contacted through email listed on their respective programs' websites to gauge initial interest. Interested participants were given the informed consent to provide more information about the interview, the data collection procedure and further informed that the interview would be recorded. All participants

who expressed initial interest ultimately agreed to participate after reading the consent form. Interviews were conducted through the Zoom platform for recording purposes and because participants were located throughout the United States.

The interviews were semi-structured, focusing on the IRB approved questionnaire provided in Appendix B. However, some additional probing questions were asked based on participant responses and what they perceived as important or interesting points of discussion. The questionnaire focused on overall evaluation of the MHC (e.g. philosophy, effectiveness, and potential improvements), the admission process, the basic function of the court, and the courts response to non-compliance. Interviews varied in length, ranging from 30 to 90 minutes. The audio of the interviews was recorded and auto transcribed through Zoom's recording and transcription features. The transcriptions were checked by the research team in order to correct mistakes from the auto-transcription and to remove identifying information of the participants.

Analysis Procedure

These interviews were analyzed using the flexible coding approach as described in the previous chapter. Stated briefly, flexible coding is a qualitative research method to organize and analyze qualitative data beginning with broad index coding followed by narrower and more specific coding of themes and patterns (Deterding & Waters, 2018). Coding began by creating broad index codes for the primary questions included in the interview guide (see Appendix B for the full interview guide). After creating these broader index codes, further analysis and memoing was focused on one topic or index code at a time (e.g., admissions, sanctions, evaluations of strengths and weaknesses, etc.).

The textual data from these interviews was extensive. Participants were asked about topics ranging from admissions, basic operations, sanctions and more. Therefore, for the current study, the analysis focused more closely on areas not accessible from the observations, namely admission decisions and workgroup members' perceptions of disparities within their courts. These results describe various patterns and themes identified from participants' responses to these questions.

Results

The goal of this research was to gain a better understanding of how participants are identified and diverted into mental health courts, what factors go into this decision making, and how disparity could manifest at the admission stage of the program. Therefore, this results section is divided into three sub-sections. The first subsection includes interviewees' descriptions of the overall admission process from initial identification and referral to the workgroup's final determination. The second subsection describes the factors interviewees identified as disqualifying or precluding a candidate from admission into an MHC program. The final subsection includes interviewees' perspectives and comments on disparity in their respective programs due to participant race and gender. Note, all names used in this chapter are pseudonyms to maintain anonymity.

Admissions to Mental Health Court

Initial Identification and Open Referrals

Regarding the initial identification, referrals were often cited as the primary means to find participants who might be suitable for the MHC programs. These responses indicated that referrals could come from almost anywhere. Referral sources mentioned in

the responses included attorneys, judges, probation officers, treatment providers, jail staff, and even family members or other community members. Claire², a case coordinator from a Midwestern County stated:

So, anyone can make a referral, right? Now most of my referrals come from attorneys whether they are assistant district attorneys, public defenders, or private bar attorneys...community members can call, case managers can make referrals. It's pretty much anyone who knows about the program and knows how to find me can make a referral and if it's viable we will pursue it.

This system was referred to as an "open referral" system, meaning anyone can refer a defendant in the criminal justice system to an MHC program, including non-legal sources. This includes therapists, case managers or other employees from treatment providers in addition to family members, community members or even the defendant themselves. However, many of the interviewees noted that attorneys and defense counsel specifically were the most common referral sources. Interviewees indicated that defense attorneys simply have the most contact with defendants and therefore are the most likely to notice certain symptoms or behaviors that might indicate someone is a good fit for the program. Others indicated that the defense counsel will ultimately be the one to fill out the required paperwork as well. Heather, a prosecutor from a western state, commented:

So basically, through their, I mean, the main referral source and that is their defense counsel. Because defense attorneys have to be...the client obviously has to agree to participate but also their attorney needs to be on board, advising that's legally what's in their best interest. And they're also the ones who fill out the referral form and do the record gathering.

While many stated that attorneys were the most common referral source, some statements were contrary to this, suggesting it depends on the structure of the court as this

² All names are pseudonyms to maintain anonymity of the study participants

structure could influence the most common referral source. Jennifer, a court coordinator from a midwestern court, described that their court might be different from others because they had two tracks, a conditional deferment and post-conviction track. Jennifer stated:

So, for the conditional deferment track those individuals are usually referred by their attorneys, so their attorneys would identify them as a potential candidate and then they would send the referral to me. For the post-conviction track, I would say like 90% of those referrals are coming from probation officers who are identifying people who are struggling on probation with a mental health diagnosis and sending them to me.

This quote suggests that defense attorneys remain the primary referral source for the conditional deferment track, and probation officers become the primary referral source for the post-conviction track.

Mariah, a case manager from a southern court, highlighted treatment services, rather than legal professionals, as a major source of referrals stating

Our local mental health authority refers a lot of people. If the case manager there knows they have a client that's been arrested...they don't necessarily have to be in services with the local mental health authority, but most of them are.

Therefore, while many of the interviewees indicated that attorneys were the primary referral source, there were interviewees that reported different experiences.

Though it was expressed as a rare occurrence, some interviewees noted that even family members or other community members not associated with the courts or treatment services could refer someone to the program. Greg, a court coordinator from a western court, stated in an interview, "Usually it's the attorneys involved that make these recommendations. That being said, anybody can refer. I mean, we just got a guy referred, his wife referred him, you know? And she was actually the victim of his crime." Though

it was not mentioned by any of the interviewees, knowledge of MHC programs or specialty courts in general among the general public may be important to consider.

Family members and similar referral sources may be less common because of a lack of knowledge about the services available compared to attorneys who are familiar with their local court programs. So, while most interviewees cited attorneys as the primary referral source, others had different experiences or perceptions of the primary referral source.

Overall, legal sources, and particularly defense attorneys, were indicated as the primary first point of contact for potential MHC participants.

Awareness of Mental Health Courts. Another recurring theme that emerged in this data was the concept of community awareness of their respective MHC programs. Because these courts relied on open referrals, interviewees described efforts to disseminate information about their program in order to find more participants. This is an important factor to consider, as some interviewees indicated that certain sources, such as private defenders, are less likely to be aware of MHC programs. Program awareness is therefore an important factor that could influence admission rates and result in disparities. Brittney, a court coordinator, discussed the awareness of the program within their legal jurisdiction stating:

I do believe it could be better, in my sense...it's not bad but it always could be better...Obviously I work closely with the public defender's office here so they're well aware of the program. But maybe private attorneys outside of the courthouse may not know of the program...And maybe that's where I step in and do more community things of touching base with local law offices and stuff like that, just to briefly explain what the program is.

From a midwestern court, one court coordinator, Claire, described a similar effort to spread awareness of the MHC.

I've done several lunch and learns, so to speak, where we talk about the treatment courts, how the program works, and I leave behind contact information. I also created information graphics that I do leave with the general public when I go to different events so that they can be aware of it. I attend the local community justice council meetings to let people know about the program and the progress the program is making...so there's multiple avenues for people to find out about the mental health treatment court program here.

These quotes suggest that there are multiple factors that are important to consider and could influence the likelihood of referrals. Factors such as whether the defendants' attorney is public or private counsel, the age of the MHC program, and the general public's awareness of the MHC program. More established programs could be more likely to have a reputation and therefore be well known in a community, increasing the likelihood and rate of referrals both from legal professionals and community members.

Identification at Arrest. The majority of the interviews discussed the above described "open referral" process, in which anyone can refer a defendant to the MHC. One judge from a court on the East coast, Carla, described a different system. Judge Carla indicated that before having an open referral process, potential participants were instead identified at initial booking in jail.

When we first started the court we took aim at the first intercept. So if you're looking at a sequential intercept map...we really targeted the first moment they would enter the jail system and at the time we had doctoral students from [institution name redacted]...and so when people would get to magistrate court that would be the first hearing upon arrest, that you have to be magistrated within 24 hours of arrest, they would be screening people at that first intercept.

In another interview, Thomas, a court coordinator from a court on the west coast, similarly indicated that participant identification could occur at the jail, though just noted this as a possibility as part of the overall "open referral" process rather than a system of evaluation provided to all defendants.

So usually they'll enter the jail, they'll be evaluated, they'll meet, they'll be assessed at the jail as far as their intake process goes. Sometimes someone can identify them at that level like a police officer or someone doing the processing paperwork at the jail. They'll start at the lower courts...the municipal courts somewhere along those lines and that's when they start meeting with an attorney. Usually, the attorneys have the funds to have them evaluated and then they could start that process there.

Brittney, a court coordinator from a midwestern court, discussed a recent change in the law and how it affected the referral process. Brittney stated:

So, from my understanding, a few years ago before the law changed, people typically, when they were arrested, stayed in jail until a court date and things like that. Also, the coordinator before was able to identify any possible client participants that could be eligible for the program. See why they're arrested, their history and actually go walk across to the jail to go speak with them and stuff like that, you know, there was easier access. But with the law changes, a lot of times, people are released before any time in jail. So, a lot of times we get referrals from their lawyers.

This indicates that depending on local laws and procedures, identification in general could be more difficult.

These quotes indicate another potential system in which MHCs attempt to more thoroughly and proactively identify participants at first contact rather than waiting for referrals. However, there were clear complications and trade-offs with this process compared to the more common open referrals. The system described by Judge Carla appeared to have a more defined process in which defendants could be identified without relying on an external party to identify their symptoms. They described a system in which every incoming defendant would receive an assessment upon arrest which likely allowed for more thorough screening and identification. However, this system also required a dedicated resource of trained evaluators to work at the jail and identify potential participants. They accomplished this through a relationship with a local institution that

was able to provide doctoral students as part of their education and training. While this identification process might be more thorough at identifying participants and preventing defendants in need from “slipping through the cracks,” it was also only possible because of their access to these doctoral students. Therefore, this system likely is not feasible for smaller courts without access to the resources needed, which an open referral system does not require.

The quotes from Thomas and Brittney are likely more representative of the average MHC, in which jail identifications are part of the open referral process or are a duty of the MHC staff. They made it clear that defendants could be identified at this early intercept in the jail, but was overall difficult due to time restraints or lack of resources in general. Brittney’s experiences highlight how recent changes to the law led to defendants being released from jail at a much earlier stage, making early identifications at arrest even more difficult. Therefore, these changes led to further reliance on referrals from outside parties to identify potential participants.

A final note to consider in comparing open referrals to an identification system at first contact is the issue of expediency. Multiple interviewees expressed their frustrations with identifying participants in a timely manner in order to better serve them and connect them to needed services. Heather, a prosecutor, stated:

Usually, it seems they’re in the court system for a while as their attorneys get to know them and get to know what’s going on. We’ve done everything we can to try to make this a quicker process, to get people screened through the court...Unfortunately I see that oftentimes, the first time I've even seen this name or see this person come across my desk, they’ve already been in custody for 6 months or 4 months.

Overall, while open referral was the standard system to identify and recruit participants for MHC, it is important to note that other methods existed or at least existed in the past. A more proactive effort on the MHC work groups' behalf to identify defendants with mental illness at first contact has its advantages compared to an open referral system. These advantages include expediency and fastidiousness, as more defendants are directly identified and can be quickly connected to services after processing. However, this system obviously requires dedicated resources, making it a much less common system compared to relying on referrals.

Identifying Characteristics. Another recurring theme that emerged from responses regarding referrals was discussion about identifying characteristics that might indicate a defendant as an eligible participant for MHC. These interviewees identified symptomatic behavior, concerns of competency, and previous connection to mental health services as three of the initial factors leading towards initial identification and eventual referral to their MHC program. In one interview, Teresa, a treatment liaison to a western court, stated competency and previous connection with services as primary identifying factors. Teresa stated:

Oh, the main one is if they're enrolled for behavioral health services. Or there is... if they're not enrolled, but they have like issues, and they're worried about their competency. Because, you know, they're doing strange things, you know? They're behaving strangely, or they're hearing voices.

Heather, a prosecutor, similarly highlighted behavioral symptoms and previous diagnoses as primary indicators of eligibility.

I train folks in my office and I also do trainings with adult probation and parole and some other agencies to make them aware that when they see someone, maybe there's someone on their probation caseload, who seems to need a higher level of services or is struggling with a severe mental illness...So we take like a SPMI

population, severe and persistent mental illness. And so, the initial criteria is, they have either...I mean schizo- anything, schizophrenia, schizoaffective, and then bipolar. And so that's kind of the initial criteria. We also, I think, kind of look for folks, are they on psych meds, because we are a medication compliance court and that is required for ongoing participations...They need to take those and so that's another thing that will help flag for us.

This quote highlights previous engagement with treatment services as primary identifiers.

This could indicate that defendants without a prior diagnosis or treatment history may be less likely to be identified as quickly or identified at all.

Of the participants in the sample who discussed identifying characteristics, the three initial indicators discussed were observable symptoms, competency, and connection to local mental health services. Specific symptoms were, for the most part, not discussed by interviewees except for "hearing voices", otherwise mental health issues were largely described as "strange behaviors", related to issues with competency, or described as specific diagnoses such as schizophrenia, schizoaffective, or bipolar disorder.

Though it was only discussed by one of the interviewees, Heather, the type of offense could also serve as an early indicator of someone who might benefit from an MHC program. In this interview, Heather stated:

It's been interesting doing the screening process, because there's now just certain offenses, I mean, arsons are huge, certain kinds of lewdness. Anytime someone, for some reason, takes a rock and throws it into a car window...Like I can even read like a news headline and I'll be like "oh, that's one of ours"...There's no rhyme or reason to that, necessarily, but just an observation.

It is important to note that Heather was the only participant in this sample mentioned offense type as an early indicator of someone who might be a suitable candidate for an MHC program. If certain offenses are perceived as being connected with mental health, however, it is important to understand what offenses are viewed as mental health related

by legal professionals. This may be hard to determine, however. In a separate question, interviewees were asked if they perceived common offenses in their program. Responses to this question widely varied, including assault, theft, vehicle theft, robbery, burglary, domestic violence, substance possession, driving under the influence, trespassing, disorderly conduct, and arson. Others stated they had not observed any patterns of commonalities in offenses or stated that their participants varied widely with regard to their charges. Therefore, offense type may not be an appropriate means to identify potential participants for MHCs, as offense types among this population can be quite varied.

In summary, these findings further highlight the complex and even subjective referral process that these courts use to identify potential participants. Potential identifying symptoms were rarely discussed and were either stated vaguely (strange behavior) or interviewees referenced more extreme symptomatic behavior (hallucinations, hearing voices). While one interviewee suggested that type of offense could be an early indicator, responses to a separate question from the interview guide suggested that a large variety of offenses are processed through mental health courts. These quotes also indicated that more concrete factors such as receiving treatment from a mental health authority or taking medication may be important signs for defense attorneys, probation officers, or other potential referrers to seek out. Only one of the participants interviewed directly mentioned a training program to help professionals identify signs that defendants are struggling with mental illness and may be eligible for MHC.

Post-Referral Screening and Admissions

After initial identification and referral, the MHC workgroup ultimately must decide to admit or reject a referred candidate to the program. This section focuses on the interviewees' comments regarding their respective courts' process for how this decision is made and what other factors may influence the decision. In general, the interviewees in this study indicated a collaborative process between the members of the MHC workgroup. Many described an open discussion process in which the various team members would discuss whether a candidate is a "good fit" for the program as well as an opportunity for team members to discuss concerns they have with a potential candidate. One case manager from a southern MHC, Mariah, described the initial processing of a referral. This included conducting risk and needs assessments in addition to the collection of needed documentation that would be presented to the workgroup.

They'll meet with me first and I kind of go through their life history, what their needs are, talk a little bit about their mental health, their substance use, criminal history, stuff like that. We do a risk assessment with them...and then we have probably three different substance use screeners, and then one like readiness to change screener...and then we have a college here that has their psychology department that works with us as well...So then they do their kind of own assessment with them...And then really, everyone around the table kind of votes on if they think that they would be good for the program or not.

Many of the interviewees made similar statements about the admission process, describing a series of assessments and an eventual discussion or vote among the workgroup to determine if the candidate would be accepted. While most if not all of the interviewees describe this collaborative process, some of those interviewed also emphasized that the judge of the MHC made the final decision. Though these individuals

also stated that judges often, if not always, went with the team's decision. One prosecutor, Brett, stated:

Ultimately the final decision is up to the judge that oversees the court. But it's left very much to a team dynamic. Maybe one or two people don't think that this person's appropriate, but four or five think that they do. Oftentimes it's gonna go with what the majority of the team thinks. But ultimately, it's up to the judge.

Overall, the findings of this qualitative analysis reflect the collaborative nature of specialty and treatment courts when it comes to MHC admission decisions. Multiple parties, including prosecutors and defense attorneys, engage in discussions about how best to serve potential candidates. Many of those interviewed suggested an overall positive workgroup experience in which members were free to speak and voice concerns and a general desire to serve potential candidates as best they could. These findings also highlight the subjectivity involved when screening a candidate for admission and highlights that perceptions of eligibility can differ between workgroup members.

Workgroup Disagreements. Interviewees were also asked to discuss conflict and disagreements among the workgroup regarding admissions. Many of the interviewees expressed that disagreements were rare and that their workgroups often agreed and worked well together. Others emphasized the importance of objective measures, such as the use of assessments to determine participant need and risk, in order to reduce subjectivity and disagreements. One court coordinator, Greg, stated:

It's usually pretty cut and dry, like it just doesn't happen very often where we're on the fence mostly because we try and use objective measures to determine whether somebody's coming in or not. I think where we have more of that disagreement is when we need to terminate somebody...and that's where we really have big conversations.

Eight of the participants interviewed directly discussed examples of disagreements among the team that had occurred. Based on their responses, points of disagreement included concerns about reoffending, danger to others, and treatability of the participant.

For example, regarding concerns about reoffending and danger, one judge, Helen, stated:

When I originally started the docket, and again, this was because the docket was very new. And particularly the prosecutor's office, they didn't know what that was going to look like, and so of course they had fear that I'm going to sign off and put someone in this docket, and then they're going to reoffend and then I'm going to have allowed someone to re-injure the community in some way...so when I first started this docket, there were a lot more disagreements.

This quote emphasizes how disagreements could occur based on the roles of the workgroup. While the MHC is collaborative, the prosecutor's role is still focused on ensuring public safety. In another interview, the hesitancy of case managers was emphasized because of their closer proximity to the participants. This court coordinator, Greg, stated:

Oftentimes it's the case managers, like the people that have to work day to day with these people that have maybe the most concerns. Because they're, you know, if somebody's in a bad way, or is shown to be violent, they're the ones that they'd have to kind of deal with this. So, I think they're a little more hesitant sometimes, if there's a particularly rough crime or rough charge that we're looking at.

Finally, some of those interviewed discussed the issue of treatability as a point of disagreement. One case manager, Jessica, said "We have discussions, oftentimes if in jail they've been refusing medication for their mental health, that's often brought up as a possible red flag that they may not be cooperative with their medication." One prosecutor, Brett, discussed a more serious case of treatability issues, stating that if there is no suitable treatment provider for a participant that may be a point of contention among the team. He stated:

We use a single treatment provider because they're the only ones that are willing to send a representative and participate in our staffing and our court. So, if there's been a problem where they are no longer welcome at that treatment provider, that can be an issue. If say, someone has a significantly violent offense or violent history...now I have to raise a concern that we are putting that person into a population that is otherwise vulnerable, and they could take advantage of. There are also issues at times where we have people with, say, some type of intellectual disability and our treatment services are not necessarily built to accommodate someone that has some type of developmental function delay or something like that. We're not really able to make progress with that person so we don't want to keep them basically indefinitely in our program in a stagnant state.

Overall, disagreements for the admission process, at least based on the responses in this sample, appeared to be rare. Many of those interviewed emphasized that the workgroup often agreed on the majority of cases brought to them. Many also indicated that they admit most defendants who are referred to them or try to admit as many as they can. Only three of the interviewees gave estimates of admission rates within their court. One interviewee, a court coordinator, indicated that the majority of defendants are accepted.

There are varying degrees of what the team's willing to accept into the program...I will say that we accept most people. If we have a referral list of seven people, we will probably admit six, or, you know, five or six out of those people. And it goes back to what services we're able to offer, what services we're able to provide those persons and to help treat those persons.

The other two who made specific estimates of admission rates suggested a more competitive program, stating that acceptance rates of "60/40" or "50/50". For example, one treatment specialist, Erica, stated:

It's probably about 60/40 and that's just from my mental health perspective. I don't know how many clients that get screened, and they get stopped at the legal criteria. But for me it's about 60/40, and the ones that don't get into the program are more often like substance use primary...where they don't have a really significant history of mental health issues. But they do have a lot of substance use concerns, and in that case, we try to find out if they are eligible for our recovery court which is more substance use focus.

Overall, these quotes provide insight into the intentions of workgroup members in searching for potential candidates and highlight the complexity of finding candidates that can be successful in the program. While most, if not all, of those interviewed expressed a desire to admit and help defendants, they also indicated the need to locate participants who would benefit from these services and who did not pose a risk to treatment staff, other MHC participants, or the community in general.

Blocked Referrals by Legal Actors. The previous section discussed disagreements within courtroom workgroups regarding admission. However, it is also important to note that MHCs are part of a larger justice system in which other legal actors, namely judges and prosecutors outside of the MHC workgroup, can influence or outright reject MHC diversion. In one interview, Bruce, a judge from a southern court, describes how referrals can come from various sources (police officers, other judges, etc.) but describes the district attorney as a “gatekeeper”. The judge stated:

There are a couple of a number of different ways they can be selected for the program. Initially the district attorney’s office in our county is kind of the gatekeeper. People don’t get into any of our specialty courts, including the mental health court unless the DA’s office agrees to let them apply...so the DA’s office can make a recommendation in deciding to make it part of a plea bargain arrangement along with the defense lawyer, and if they agree, and then the client agrees to want to try to get their case handled through the mental health court then they make an application.

This quote highlights two important considerations. First, as was expressed by multiple interviewees, mental health courts and other specialty courts are ultimately voluntary. Defendants cannot be required to complete these programs and must agree to participate in MHC as opposed to continuing through traditional criminal court. Second, this quote highlights that other legal actors such as prosecutors outside of the MHC

workgroup may disagree with diverting particular defendants. These disagreements centered around issues of treatability, recidivism, and risk to the community, much like the disagreements within the workgroup itself.

The concept of “gatekeeper” was also mentioned in a separate interview with a defense attorney, Tatiana, from a midwestern court. In her discussion, Tatiana identified both prosecutors and judges as having the ability to deny potential MHC participants. However, their comments suggested a more fractured relationship between the MHC and outside legal agents. Rather than disagreements being simply a matter of community safety or recidivism risk, there was a perceived element of misunderstanding regarding mental health. Tatiana stated:

Lots of times we have prosecutors who don't recognize mental health as being what precipitates some of the criminal offenses, and so, they won't agree to it or believe incarceration is a better answer. So, if we get shot down by a prosecutor it doesn't get transferred. If we get shot down by a judge...you know we have judges who think that we're not heavy handed enough with our clients in our court and so they may be reluctant to transfer something. We have prosecutors and judges who, you know, don't wanna really give up a case for whatever reason, and I'm not saying that's always nefarious.

This quote further highlights the complexity of MHC and specialty court referrals in general. Prosecutors and other judges may have interests in retaining certain defendants within their court or may otherwise be reluctant to allow certain defendants to transfer to mental health court. This court also suggests how legal professionals outside of the MHC workgroup might have negative perceptions of the court and its ability to handle certain defendants or have separate views on mental health and how it should be treated in the criminal justice system. Therefore, it is important to understand the perceptions of mental health among legal actors in general, not just those who work in

MHC programs. Stigma towards mental health is therefore an important measure to consider in future research.

To summarize this section, admission to MHC programs involves a complex and multi-step process. Unless the court has a system for identifying participants shortly after arrest or in the jail system, MHCs appear to rely on referrals. These could be referrals from anyone, including community members outside of the legal system. However, referrals more often than not come from defense attorneys and public defenders in particular. This is due to the fact that defense attorneys have the most contact with defendants and are therefore likely to notice symptoms or other indicators. This is also due to the fact that public defenders appear to be more likely to be even aware that the MHC program exists and is an option for their clients. After referral, the interviewees described a days-long if not weeks-long process of assessments and collection of documents in order to establish eligibility. At the end of this process, MHC workgroup members ultimately vote to determine which participants are admitted. This system allows for flexibility but also leaves ample room for discretion and subjectivity, which can lead to bias and discrimination (Sibley, 2022). The next session discusses more in-depth, what factors are considered for admission and why participants may be rejected by the court.

Disqualifying Factors

As the previous sections indicated, not every defendant referred to a mental health court is considered eligible or a “good fit” for the program. Certain characteristics or facts of a case might outright disqualify a defendant from participating in an MHC program. To get a better sense of what factors might be disqualifying, participants in the

current study were asked, “what factors might prevent someone from being accepted into the court?” This section describes the common responses from the participants regarding what factors would preclude a defendant from being diverted or admitted to their court.

Logistical Issues

Post referral, the first obstacle that may preclude a defendant from entering an MHC program is a simple logistical issue. Logistical issues in this context refer to disqualifications based on basic administrative factors such as being a resident of the county or qualifying for treatment services. One court coordinator, Greg, described taking a “10,000-foot view”, in which the initial assessment makes certain that the defendant reaches basic requirements of the court. They stated:

We want to make sure this person meets the criteria. Make sure they’re of age, make sure they live in the county, make sure they don’t have charges that, you know, would keep them out of our program. Make sure they have a mental health diagnosis, you know, just things like that, the things we need to have.

Unsurprisingly, as this quote highlights, defendants have to meet basic requirements to enter the court. Defendants can be rejected based on these simple details before considering factors such as offense, diagnosis, recidivism risk or other factors. Rejection due to logistical issues does not necessarily mean they are refused services entirely. For example, an underage defendant may be directed to a juvenile treatment court or a defendant without a clear mental health issue may be diverted to a drug court or other specialty court instead. Ensuring that a defendant is a resident of the county appeared to be a particularly important logistical concern. It was not clear how often this occurred, but defendants who committed an offense while traveling or otherwise not as a permanent resident of a jurisdiction appeared to be overall unsuitable for these programs.

Sara, a case manager from a west coast MHC, emphasized the need to meet these basic requirements as a way to ensure efficient use of resources and to ensure defendants can meet the needed requirements.

We've had other potentials living out of state and they weren't necessarily residents when they got their charge. So, things like that are helpful things to kind of look for whether or not realistically they can meet those obligations. Because in our court, right, when they get started, they're coming in every single week, right? ...Realistically, are we going to be able to set them up for success if they do not qualify for housing or treatment? Things like that. So, these are definitely components we do consider because like I said, we just want to set them up for success.

Disqualifying Offenses

The most commonly stated reason for denying a defendant from mental health was for having a criminal charge explicitly not accepted by the program. Courts differed in their specific criteria, with some courts allowing felony offenses while others did not. Even among the courts that did allow felony offenses, serious violent crimes and homicide charges were, unsurprisingly, a disqualifying offense. Many stated risk to the community and the severity of the crime as obvious reasons for not allowing these defendants. But others also stated the simple logistical issues with admitting those with homicide or other severe charges as they simply would not be able to complete the program while awaiting trial or while incarcerated if found guilty. For example, Hailey, a case manager from a west coast MHC, stated "It might sound kind of like a logical answer, but you know any sort of attempted murder charges...They aren't going to be released, especially if they're found guilty, so that's kind of a given."

Some indicated that this restriction extended to prior record as well, not just the current charge being considered. One program manager, Patricia, interviewed stated

“Anyone that has been previously convicted of a serious, violent offense or sex offense is ineligible.” Similarly, a case manager, Jessica, stated “The following would disqualify the offender, if the person had prior conviction of causing the death of another person, or causing serious or substantial body injury that would automatically exclude them.” Therefore, an extensive criminal history with certain, severe charges could also preclude defendants from an MHC program even if their current offense is not restricted.

Four offenses that were commonly mentioned as precluding admission into an MHC program were homicide, aggravated assault (particularly crimes involving possession of a firearm), sexual offenses, and arson. Interviewees expressed two reasons for why these offenses could be disqualifying. The first was the risk of reoffending and the risk to community safety. Because of the severity of the crimes, sentencing judges may deem these defendants a “community safety risk” and the risk of reoffending was considered too great for a defendant that would be in the community rather than incarcerated. The second reason stated was the difficulty of connecting these defendants to treatment services. Because inpatient facilities are worried about protecting the other patients in their facility in addition to their own property, they may be reluctant to provide housing or other services for defendants that pose a high risk. Gabrielle, a defense attorney from a west coast MHC, described this problem:

The reasons we would typically deny somebody, which I don't always agree with, is if they have a long history of violence and they're recommended, let's say, for an inpatient or residential program and we know we're not going to get that individual into such a program. That would be also, unfortunately true, for somebody with an arson charge or somebody who's a registered sex offender...And that's true in all specialty courts, we have no programs that are willing to take them and that's just been a huge problem.

This further highlights that MHCs are restricted on what they can do based on the treatment facilities located locally and these facilities' internal rules and regulations.

Some of those interviewed also indicated that while they generally do not allow certain severe charges, such as aggravated assault or crimes with sexual component, exceptions can be made. Based on the current data, this is accomplished primarily through plea negotiations during which state prosecutors can reduce charges for otherwise disqualifying charges. For example, Mariah, a case manager, described a case in which the candidate had severely injured a police officer.

We have one right now that's kind of a weird situation, but she did kick an officer and broke his leg, so she got aggravated assault. But when she broke his leg and he went to the hospital, he found out he had bone cancer and that's why his leg broke so easily. So, she does have an aggravated charge, but because of what happened in her mental state at the time, the DA's office agreed to lessen the charges upon completion of the program. So, we sometimes have people that were originally charged with aggravated offenses, but the DA's office does drop it down so that they can do the program.

In a separate interview, Ellen, a treatment liaison to a midwestern MHC, described a similar situation in which a defendant committed an offense with a sexual component, but the charges were ultimately lessened.

One that I can think of that stuck out was one where...I think the charge ended up being like disorderly conduct. But what really happened was a little more...he kind of followed a woman and when interviewed he said he wanted to do something inappropriately sexual to her but he never acted on it...so I think there was some back and forth with that one because of his risk factors.

These examples show that while certain charges can indicate too great a risk factor, exceptions can be made by the district attorney. While objective factors such as level of charge appear to be the primary driver behind admission decisions, these examples demonstrate areas of discretion and subjectivity.

As an exception to this norm, there were three interviewees from one court who emphasized that unlike most other MHC programs, they focus on identifying defendants that are the highest risk and the highest need. This included admitting defendants charged with arson or sex offenses. Helen, the judge of this particular court docket, explained the reasoning behind this decision:

What I see our role as...you know, we're not here to duplicate traditional work, resources, and outcomes that already exist...So it's challenging but we make it our goal to find, to brainstorm, to create opportunities for these folks too. Because if you don't create those opportunities, if you can't live here, and you can't get treatment here, then all you're going to do is reoffend.

She also explained the initial difficulties of connecting participants in their court with treatment services and the steps they have taken that were successful.

So, we really go out of our way to make those things happen. And we've had success with that. We now have a contract with housing where we can house our sex offenders. Arsonists are a little more difficult...But there are those reentry folks, in the community, mostly with lived experience, who are saying "I will take that risk." It might be three apartments in the entire city that is gonna house those folks, but if those apartments exist, we will dig them out and connect our people to that as best as we can.

While this court was definitely the exception based on the interviews from this sample, these interviews do highlight the different focuses among MHC programs. Some courts described their intention to identify high need and high-risk participants. They described themselves as a "last chance" for many of their participants, serving defendants who have committed felonies and have an extensive record within the criminal justice system. The above court is a more extreme example of this, as they accept defendants with felony charges that the majority of MHCs reject.

Other courts indicated that they were focused on finding low or medium risk participants instead, focusing only on misdemeanors or relatively minor felony charges.

For example, Clark, a case manager from a west coast MHC, described what he saw as perfect fit for a specialty court.

I recently had someone get on my caseload, and this is how I view therapeutic court, I thought he would be a perfect fit for it. Young guy, he's 24, I think he was drinking with his girlfriend, and he snapped and he attempted to choke her. Police were called, he was booked in on DV and it was his first time ever getting a charge and it was his first time ever having a charge happen with something tied to it, you know, mental health or substance abuse. So, I like to view the mental health court as an early intercept model where we can get this guy in. We can help him figure out himself and have these charges dismissed because he's young and he's never had any charges before, and he doesn't have to worry about having those charges or a felony for the rest of his life.

These differing philosophies between courts are important to consider. While some courts focus on diverting low risk and arguably “non-typical” defendants early from the criminal justice system, other courts focus on high risk and habitual offenders who have been in the system for a long time. Both forms of MHCs have their purposes but are ultimately targeting separate and unique populations. Therefore, it is important for research regarding MHC outcomes to consider the goals or “type” of MHC being studied.

To conclude this section, it is also important to note some discussion regarding the more minor offenses considered by MHCs. While it is unsurprising that certain severe crimes may preclude defendants from entering the program, it was also noted that defendants who commit minor misdemeanors may also be less likely to find themselves in an MHC program in some cases. However, this is more likely due to the defendants themselves opting to serve their time in the traditional court system. But MHC workgroup members may be less inclined to seek out defendants with minor, low stakes offenses. One case manager, Mariah, stated:

People can come in with a misdemeanor, but we do kind of look at it like, is it worth their time? Because if they're just looking at 60 days, do they really need

us? If they say they want to, we're willing to let them in, but do they really want to be in a program that's a yearlong versus just kind of serving out that time, so we do look at that.

In summary, MHC programs have the challenge of identifying candidates they think will be a good fit for the court which can be a balance of conflicting goals. Suitable candidates appear to be defendants who do not pose undue risk of reoffending or are a violent risk to the community, while also being in a position where they can benefit meaningfully from the program and the services it provides. In general courts appear to be searching for mid-range offenders, those that have committed serious enough offenses to warrant a program that may be a year or two years long, but offenses that are not so severe that they prevent access to treatment or pose too high of a risk to the community or other participants in the court. But this also varies by the specific program and the goals of that program, as other courts may be looking for high risk and high-need participants.

Disqualifying Diagnoses

Many of the workgroup members interviewed also indicated that certain diagnoses could preclude a defendant from being accepted into the program. Similar to how offense criteria differed between courts, diagnosis criteria were also dependent on the court. Some of those interviewed noted that their court had very specific criteria on diagnosis, with only a handful of diagnoses being allowed within their program. For example, Mariah, a case manager from an MHC located in the southern United States, directly stated that participants in their program needed to have “either major depressive, bipolar, schizoaffective, or schizophrenia.” Other courts indicated a much broader range

of diagnoses. Thomas, a court coordinator from a western MHC program, described how his program had recently changed their laws to allow a much broader range of conditions.

So, it's anyone with a mental health or intellectual disability that's qualified for our program. They need a current mental health evaluation...it has to identify a mental health disorder and then it also has to have a recommendation for length and type of treatment. So that's what we're looking for. Just brass tacks to have someone qualify for our program.

Therefore, there was clear variation between the different programs in terms of qualifiable diagnoses. It is important to consider the state and local laws in which an MHC program is located, as there may be absolute restrictions on the diagnoses they can accept.

Based on the current data, there were two explanations given by MHC workgroup members for why only certain diagnoses were admitted and others were disqualifying. The first, and less common explanation, was an issue of severity. Some indicated that they need to establish that the defendant has a "severe and persistent mental illness" and that some symptoms or diagnoses might not qualify. For example, Judge Lorena from a midwestern MHC program stated:

First of all, they have to have something that can be considered a qualifying diagnosis, because there's a list of diagnoses that we have, because we don't just take everything. Nobody can say "I'm feeling sad today", that doesn't mean you qualify...So we have them screened by the screener to see if they would be an eligible candidate, and then we have them screened by either the treatment provider, the psychiatrist or somebody that will give them a diagnosis.

This explanation appeared to be an issue of ensuring defendants had a true mental health issue and were not using the program as a means to escape jail or other punishment.

However, relatively few of those interviewed in this sample mentioned that as a concern.

The other explanation for restricting diagnoses was the issue of available resources and treatability. Many of the MHC workgroup members interviewed indicated concern with defendants, in particular, who had a personality disorder or a traumatic brain injury (TBI) diagnosis. Based on responses from those interviewed, these diagnoses were not always disqualifying, especially if they had a comorbid diagnosis that was qualifying (e.g., bipolar, schizoaffective, schizophrenia). However, personality disorders and TBI diagnoses were viewed as more difficult to treat or required different treatment that the program did not have the resources for. One quote from Judge Helen demonstrated this concern with personality disorders.

I hate to say this because we don't exclude people with personality disorders in addition to another mental health diagnosis...but sometimes you'll have somebody, they've got a bipolar diagnosis or they have a schizoaffective diagnosis, but they have a partner personality disorder, you know? Borderline personality, a narcissistic personality, and we're not going to exclude them out of the gate, usually. Sometimes we'll give them a go, but a lot of times if you're having that initial conversation...They're just people that are going to continue to try to manipulate to the point that they're just not going to buy in.

This quote highlights the common concern that workgroup members expressed with personality disorders in particular. There was belief that personality disorders were particularly difficult because these defendants would be manipulative or otherwise would not fully engage with treatment and the MHC program. There was concern that this would reflect badly on the program to have participants who blatantly tried to manipulate the program. There were also concerns that allowing these participants to continue was not fair to the other participants who were engaging in treatment and were invested in using the court's resources and graduating.

There was a similar concern with those that had a TBI or intellectual disability, as there was a belief that they may be unable to complete the requirements of the program (e.g., making appointments, regularly attending court) or because of the higher level of treatment needed. Jessica, a case manager, stated: “If they have an extremely low IQ, just because it’s very heavy on the therapy side. So sometimes, if their IQ is too low, then that disqualifies them as well.” Brett, a prosecutor from a western MHC program, commented on these problems as well.

There are issues at times where we have people with, say, some type of intellectual disability, and our treatment services are not necessarily built to accommodate someone that has some type of developmental function delay or something like that. We’re not really able to make progress with that person. So, we don’t want to keep them basically indefinitely in our program in a stagnant state.

As described above, however, there are courts that have a wider range of qualifying diagnoses including intellectual disabilities. Therefore, the availability of certain treatment services may dictate which diagnoses are qualifying across jurisdictions. Therefore, because MHCs often have partnerships with local mental health treatment services, their qualified diagnoses are dictated by the treatment services available in a community. In addition, these diagnoses did not appear to be completely disqualifying. If a candidate had a disqualifying diagnosis in addition to a co-morbid or partner diagnosis that was qualifying, they could still be considered. One treatment provider, Erica, stated:

So, the exclusions, like I said, would be things like TBI or substance induced symptoms. But even then, we made exceptions for those where it’s like, this person clearly has some significant mental health concerns. And could they benefit from our program? And so that would be something like, you know, this is one that may not meet all of that criteria immediately, but we want to make sure that they’re in because they could benefit from it.

This indicates, again, the level of discretion present within these programs and the ability for MHC workgroups to make exceptions and as the above quote again demonstrates, many if not all of those interviewed expressed a desire to help any participant they believe would benefit from the program. It appears most exceptions discussed were exceptions made in order to include more participants rather than exceptions made to exclude participants. However, unconscious bias can influence when exceptions are made, so it is important to understand where and how exceptions are made.

Establishing a Nexus

Combining concerns of offense and diagnosis, some courts also mentioned the need to establish a “nexus” between the offense and the defendant’s diagnosis and how a lack of connection could be a disqualifying factor. In the context of MHCs, establishing a nexus refers to the need to connect that the symptoms of the diagnosis, the state of being unmedicated, or some other factor related to the diagnosis led to the criminal offense. Some discussed this nexus as an absolute requirement to get into the program, saying it helps justify why the defendant should be in the program and helps them make an argument to the district attorney or sentencing judge to divert the defendant. Brittney, a court coordinator, explained:

We kind of look at what past diagnosis they have and how they arrived to receive that diagnosis, and what their experience has been with treatment thus far. And kind of trying to identify, okay, if they have been untreated for XYZ mental health concern, what would that look like? So, what are the symptoms and did those symptoms contribute to the incident in any likelihood? For example, I have several individuals who maybe have a pretty recent bipolar diagnosis, so some of those have pretty extreme risk-taking behaviors, impulsivity, things like that. We can make a pretty direct correlation to “okay, they were acting impulsively, and then this is what occurred, and we can help them with that symptom by providing XYZ treatment. So that’s what they want to see.

This quote shows that establishing the nexus between a participant's diagnosis and their offense can be beneficial. This connection can help persuade stakeholders to the benefit of diverting the participant by explaining how treatment will prevent future reoffending.

On the other hand, some of those interviewed indicated that this nexus was not required at all in their programs. In these courts, if the defendant was not disqualified based on the offense and had an eligible diagnosis, they were eligible for the program. Judge Lorena simply stated: "I don't even look at the charges half the time. We just want to see if they qualify with a qualifying diagnosis and that's all we look at." Among the courts that did not explicitly require a nexus, it appeared that establishing the nexus was superfluous and unnecessary. They viewed the nexus as irrelevant, believing that if they were in the criminal justice system and they had a qualifying diagnosis, the MHC would likely be able to help them.

Therefore, some programs required the establishment of a nexus in order to admit participants, while others did not consider the nexus at all. This appeared to be an important decision among the programs with each approach having benefits and drawbacks. Heather, a prosecutor from an MHC in a western state, discussed their perspective on establishing the nexus and their personal conflict with requiring that nexus or not. They described at times that the connection could be tenuous, but still could be made, meaning the nexus might be unnecessary and maybe even arbitrary. However, they also indicated that those with a clearer nexus of symptoms and criminal behavior were often the most successful, as they had a clearer path for treatment that would prevent

future recidivism. However, they also noted that too strict a requirement on establishing this nexus could preclude defendants who could benefit from the program. She stated:

I will tell you, in my experience, the more clearly mental health related it is, typically the more successful we are...As opposed to someone who has a criminal history that's 85 pages long with a lot of fraud, DUIs, higher criminal thinking based offenses, that aren't as clearly tied to mental health issues...and you know those are actually often the cases we struggle with the most and have the least success with. So, I've gone back and forth on that...I think it might exclude too many people if I required a very clear nexus always, but I do think it's important to have some kind of something.

These findings indicate that there is variation in how courts approach the issue of establishing a nexus. Some view it as a necessity while others are only interested in the presence of a diagnosis. It is a difficult choice, as requiring a clear nexus may help identify the participants who will benefit the most from the program. However, requiring a strict nexus may also preclude participants who would be successful even without a clear connection between their symptoms and the offense they are charged with.

These findings indicate the need for further research on the benefits of requiring a nexus between diagnosis and offense. Courts that require this specific nexus may have better outcomes because they are able to identify participants who will benefit the most from an MHC program. However, it is also possible that participants benefit from MHC regardless of if their diagnosis was directly connected to their offense. Simply having access to the resources and services provided by the court may reduce recidivism, therefore requiring a nexus is unnecessary. It is beyond the scope of the current research, but future research should consider comparing the outcomes between MHCs that require a nexus versus those that do not require a nexus.

Other Disqualifying Factors

Largely, reasons for not admitting referrals seemed to be concerned with objective factors described above, such as having a disqualifying diagnosis or offense, or for not meeting basic requirements (e.g., living in state, accepted by in-patient treatment services). To conclude the discussion of disqualifying factors, this section will cover the remaining factors discussed by the participants in the study.

The remaining responses observed in this data set included seemingly more subjective evaluations of the participant. Subjective because these participants were not being disqualified based on having an objective diagnosis or because they were charged with a specific disqualifying offense (homicide, arson, etc.) These subjective evaluations included beliefs that the participant may be too violent, high risk or perceptions that the participant lacked sufficient interest or motivation to complete the MHC program. Regarding evaluations of violence and high risk, this consideration involved more than simply the offense the defendant was charged. As described above, certain offenses like homicide, crimes involving firearms, arson, or sex related offenses were automatically disqualifying. However, not all violent offenses would automatically disqualify a participant, but these cases were looked at with greater scrutiny. For example, Greg, a court coordinator, commented on how two defendants who were charged with the same offense may or may not qualify for the MHC program based on the specific facts of the case.

We don't automatically disqualify anyone other than that [sex crimes], but things that we'll look at pretty heavily are like crimes of violence...crimes of manufacturing or distribution of substances...It won't disqualify somebody automatically, we've taken lots of people with both of those. Just, you know, do you have a heroin operation out of the trunk of your car and you're selling it to

people or are you just using or selling so you can continue use or using with your friends? You know, did you club somebody nearly to death with a baseball bat or did you accidentally get into a fight? All those things matter, and so yeah, again, those aren't for sure outs, but we'll look at those last two, we'll take a harder look at those.

These decisions, therefore, appear to involve a level of subjective evaluation. Two offenders may be similarly charged with a violent crime, but the workgroup may be less likely to admit an offender who was believed to have instigated a fight or engaged in extremely violent behavior versus an offender who was merely involved in a fight. The extent of damage caused in the fight also appears to be a possible factor that could disqualify a participant.

Heather, a prosecutor, also spoke to this evaluation of *how* violent an offender could be and how that could affect their ability to complete the MHC program. They described a case they had recently denied:

There are some folks who, their baseline is, even when medicated, even with the appropriate supports. I just denied someone who had some just incredibly random and volatile, I mean, you know, beat someone within an inch of their life just on a bus. And they had some of these outbursts...I mean even to keep them in a structured setting like a secure setting like inpatient hospitalization...And so that's someone where I'm saying I don't feel confident that, even with a higher level of supervision and a lot of eyes on this person...I'm still not confident that person is going to necessarily be successful.

This, again, speaks to a subjective evaluation beyond the offense they were charged with. This defendant's offense was perceived as excessively violent, random, and volatile, which precluded them from being accepted into the program. The prosecutor in this case seemed to be concerned with the potential risk of admitting this defendant in addition to their ability to be successful in a program.

Stephanie, a probation officer from a western MHC, echoed Greg's concerns with substance distribution. While this is not a violent offense, it is still viewed as particularly risky because of the defendant's proximity to the other participants who are viewed as highly vulnerable. Stephanie stated:

There are certain things we look at. We do this on a case-by-case basis but I think one of the criteria that we take into consideration is if someone is distributing substances. Obviously, our population is really vulnerable, so you want to be careful and make sure that you're not bringing somebody into the court and into the program who's going to be dealing drugs to all of their peers.

These quotes indicate that there is, again, a level of discretion when it comes to admitting potentially violent or high-risk defendants. Though the majority of acceptances and rejections may be based on objective measures (e.g., their specific charge, risk assessments, their specific diagnosis, etc.) there is still a level of subjectivity in unique or more extreme cases. While discretion is not inherently wrong or damaging to this process, it opens the process to unconscious biases and heuristics that can lead to disparities. This level of discretion may be important even to identifying participants who will make the most of their programs and the resources provided. It is important, however, to understand the factors that lead to disqualification and how they relate to other extra-legal factors such as participant demographics.

Perceptions of Disparity in Mental Health Courts

As described previously, the primary goal of the current study is to investigate the potential issue of disparities in mental health courts as identified in previous academic works (Frailing, 2011; Luskin, 2001; Snedker, 2022; Snedker et al., 2017; Steadman et al., 2005). While there is currently no reason to suspect intentional or conscious biases resulting in this disparity, it is important to understand how implicit biases or systemic

obstacles can influence patterns of selection or otherwise result in disparities. This final section describes interviewees experiences and perceptions of disparity within their respective mental health courts.

Issues of bias or disparity were not a topic that interviewees initiated themselves or were discussed as a factor impacting admission or sanction decisions. This is understandable however, as complex issues of systemic factors and, naturally, unconscious biases are unlikely to be salient factors when discussing factors that might influence admission decisions. However, as one of the final questions in the interview guide, participants were asked directly if they noticed any discrepancies or had any experiences related to disparities caused by race, gender, age or other demographic variables. This line of questioning provided some interesting insight into the experiences and perspectives of these workgroup members and their beliefs on how disparities occur or how discrimination presents itself within mental health courts.

There was substantial variance in responses to this question. Approximately half of the respondents indicated that they had not perceived issues of disparity based on demographic factors. The other half indicated that they believed demographic disparity or discrimination was an issue or at least could be an issue within MHCs or specialty courts in general. In addition, among those who stated discrimination was an issue, there was a variance in beliefs on how the disparity manifested (e.g., disparity based on race versus gender) and the potential origins of the disparity (e.g. how cases are charged, stigma among certain populations, etc.)

Approximately half of those interviewed stated that they had not observed issues of disparity or discrimination within their MHC program. Some of those who indicated

this expanded upon their statement, with some explaining the process their court uses to identify disparities or otherwise explaining why it was a non-issue. For example, Jennifer, a court coordinator, explained the software in place to monitor issues of equity and inclusion.

No, I haven't noticed any. And I also use, I don't remember the name of the tool, it's something that NADCP came up with, a tool to look at equity and inclusion. Like, of the individuals that are referred, who are we accepting? And then following them throughout the program, who's graduating and who's getting terminated? And is there any like, racial inequality? Or even sexual orientation, gender, age, it looks at all of that. I use that tool, and it hasn't flagged anything.

While this qualitative data does not indicate how many programs use software like this or how many programs closely track participant demographics, it does indicate that it is a concern among some of the programs and they are taking proactive efforts to combat disparity.

Some of those who said they did not believe there was an issue noted that there are discrepancies in race or gender but also noted that it matched the overall demographics of their city or county. This, again, indicates that many programs do track this demographic information and some even make comparisons with larger populations to help ensure equal representation. For example, Stephanie, a probation officer, discussed how lower numbers of minority participants reflected their county's population.

We've talked about it quite a bit. It's all about the way that you look at the data, right? Because I think what it always comes back to for us is we have fewer minorities in our program, but it's also representative of our county, right? So, I think that we align well with like what our county's population looks like. I don't think that there's any like hidden bias impacting that, at least from what I've seen and from what I can tell on this end...But that's what I always hear when that conversation comes up, is yes we have fewer minorities but at the same time, it's reflective of our county...I think it's good we're talking about it, though.

This also highlights the importance of considering geographic regions for future research. Participants for this qualitative study were recruited from courts across the country and these jurisdictions almost certainly varied in terms of the heterogeneity of their overall population. Because many studies that investigate mental health court programs focus on a singular court, differences in findings regarding demographic disparity may be explained by these limited sample sizes and the overall population differences between geographic regions. Therefore, it is important for studies investigating disparity to consider demographic information in terms of the overall population in that jurisdiction and to make comparisons across jurisdictions.

Among those who indicated that they do believe disparity is an issue, some stated that they believed it was possible or even likely but did not state any specific instances of discrimination that they had observed. For example, Gabrielle, a defense attorney from a western MHC discussed how a lack of diversity in their workgroup could lead to admission disparity.

I'm sure it's there. Do we have a very diverse clientele population? We do, in terms of race, gender, we actually even have a few transitioning individuals, so LGBT, but I know the bias is there. Just in the judicial system entirely. So, I know it's there. If you look at the team, I think we're entirely White. I think we're heavily female except for the judge and I guess the specialty court coordinator... We're probably all upper class, educated, and predominantly female.

Greg, a court coordinator, indicated a similar sentiment, believing that they have a generally diverse client pool, but believed that there is likely disparity that still exists as part of the larger criminal justice system. In addition, Greg described their team's efforts to identify and combat disparities.

I think we're getting a pretty good mix of people. I don't see that there's, you know, a ton of disparity there...I can't speak to everything here in the criminal justice system but I mean I'm sure that there is...Some of these new standards that we're rolling out are like going even as deep as asking like, who's getting what sanction? Or who's getting what reward? Like are we rewarding women more than men? Are we sanctioning people of color more than people not? I mean, just really kind of taking a deep dive into that. And I think I'm sure we're going to find that there probably are inequities there that we need to resolve and fix. So, we're in the process of kind of working on that right now.

While Gabrielle and Greg did not identify any specific examples of disparity within their system, their comments indicate their belief in the possibility of disparity existing within their programs. The following subsections discuss comments from interviewees who noted more specific areas of disparity based on participant race, ethnicity, and gender.

Race and Ethnic Disparities

Some of those interviewed spoke more specifically on areas in which they believed there was discrimination. Of those that mentioned race or ethnic based disparities, they indicated that minority participants appeared to be, overall, underrepresented in the courts, consistent with previous findings. For example, Judge Lorena explained their experience with drug court and mental health court. They identified some potential causes of this disparity, ranging from disparity at initial referral, disparity based on the program's criteria, and even disparity due to greater mental health stigma among minority populations. However, Judge Lorena indicated that she ultimately does not know where the disparity stems from.

We don't normally turn away anybody from our program unless they don't have a qualifying diagnosis. But I have noticed in the past, in the drug court that I participated in and even in my mental health court, proportionality wise, there are less African Americans or minorities in our programs...And I don't know if that's because of who is screened for the program, who refers them, or criteria, or just the stigma...so I don't know what the issue is. But yes, there is a pattern, and I have seen it.

Notably, this quote indicates there is a belief that disparity could occur at multiple stages of the court process (referral, screening, etc.) or be due to feelings of stigma from the participants themselves.

While some of those interviewed, like Judge Lorena, indicated that racial and ethnic minorities were underrepresented, others indicated the opposite was occurring. Some of those interviewed commented that their MHC programs were overrepresented with non-White defendants. This is noteworthy because, while it still indicates a disparity in MHC admissions, it is not consistent with the general findings in the literature which suggests that MHC participants are predominantly White. Alexis, a social worker who works with treatment courts in a midwestern state, described their experience with multiple courts across urban and rural regions and how they saw the influence of participant race in those courts.

So, we have nine courts that we are managing. Each of those just nine courts for us behave very differently from the others. Each court team is unique because of the makeup of the teams and also just like different regional areas. So, I have some city courts and then I have some very rural courts, and they have drastically different perspectives and experiences just based off of that. So, you know, I've also experienced where a lot of the court teams are primarily White and so they're coming at it from a White perspective. Then suddenly you're noticing that a lot of the participants are individuals of color. And so, I think it can be hard for them to have this common ground or understanding. And I think there's definitely been instances that, you know, cases that I don't think would have even made it to the referral process, in a situation where someone was White. So, I'm definitely noticing that type of thing and I think our courts are aware of it and trying to be as culturally aware and inclusive as possible. But I definitely still see and notice those types of things.

Some of those interviewed offered additional speculation on why these racial and ethnic disparities exist within the court. Brett, a prosecutor, discussed the role of stigma as a potential factor for the underrepresentation of Hispanic participants in their court.

Our provider has Spanish speaking therapists, and they can do Spanish speaking groups, we will accommodate their needs. but we have found that generally, even when they're referred, they choose not to participate in the program, unfortunately, primarily due to the title of the program. They don't like that it's called mental health court. There, culturally, is very much an aversion to any type of mental health treatment or admitting that there is a mental illness of any kind.

This is important to consider as MHCs are ultimately a voluntary program. Therefore, it is important to understand how stigma on behalf of the participants can lead to hesitancy to engage in these programs. In a separate court, Gabrielle, a defense attorney, suggested that disparities could occur during the initial identification and referral stage.

I think it's going to originate at the outset in terms of identification, both self-identification and identification by the attorney. That's because if you are White and upper class you're more likely to have obtained those mental health services in the past and identified that you had a mental health need. Versus a person of color who came from a very chaotic background, who simply had no means to access such services, didn't even know they existed and so had no knowledge.

This follows previous findings discussed above, as previous connection to mental health services serves as an important indicator that a candidate may be suitable for MHC.

Therefore, race and ethnic disparities in MHC can be a combination of different mechanisms. Potential candidates and their families may be less aware of the mental health services available to them, including MHCs, and may be less likely to use them if they are aware. And referral sources (e.g., defense attorneys) may be less likely to identify these potential candidates because they are less likely to have a history of mental health care or service utilization.

These quotes provide potential insight into why these disparities exist. As suggested by the second quote, disparities could exist because of attorneys (or other legal agents) failure to identify mental health symptoms and thus initiating the referral process. Both quotes suggest the issue of stigma and self-identification of mental illness and how

those forces may result in disparities. Because mental health courts are ultimately voluntary, it is also important to consider how cultural beliefs about mental health manifest in different communities.

Gender Disparities

Gender disparity was also discussed among those interviewed. However, contrary to previous findings, none of the interviewees described a disparity in which women were overrepresented in the court. This is in contrast to previous research which suggested that women are more likely to be admitted to MHC programs compared to men (Frailing, 2011; Snedker et al., 2017). A common sentiment among interviewees who perceived a gender disparity was that it was expected, as men are more likely to enter the criminal justice system in general. For example, one court coordinator, Patricia, simply stated “I think we definitely have more males than women and I think that’s just in general, when it comes to the criminally justice involved, you’re gonna see more males in those demographics than women.”

Judge Helen speculated more on the issue of gender disparity in her court, noting that not only are there far fewer women in her MHC program, but also noting how women participants see much less success in the program. She stated:

So, race and ethnicity, I think we’re pretty solid. It is the gender gap for us. In my docket it is very heavily male, 90% male. And we bring in women, but so many times, they’re not staying. And I think they’re not staying because I think by the time some of these women get to my docket they’re there because they are so badly traumatized that I don’t know that they’re open to that. And what I see with them is them eventually saying “F this, I don’t want it. I don’t care, do what you want.” or they just drift away...But we do have some successful women, a few. But for me it’s the gender gap and you know, we are very conscious of it. If women are coming up, you know, we’re putting them on the docket.

These results highlight the importance of further investigating gender disparity within mental health courts. While previous studies suggest that women are overrepresented, this qualitative analysis suggests that they are underrepresented. However, if we consider that men are more likely to enter the criminal justice system initially, it may be reasonable that there are fewer women in these courts.

Based on the comments provided by Judge Helen, it may be even more important to consider the different experiences of men and women participants in MHC programs. Women may find themselves in these programs due to very different circumstances (i.e., trauma from victimization). In addition, as the previous quote suggested, it is also important to track graduation rates and outcomes from these programs to ensure that individuals are equally benefiting from and completing these programs. It is possible that there is little disparity in admissions and instead the disparity is due to certain demographics dropping out or being terminated from the program at different rates.

A small number of those interviewed discussed separating the men and women into separate MHC dockets. Stephanie, a probation officer, mentioned that they had recently returned to a combined male and female docket. They explained that this was due to there being fewer numbers of women being referred in recent years. The officer further explained that they had originally separated the dockets based on scientific literature regarding women's experiences with abuse and trauma.

The only reason we did it was because there was some literature that came out, or at least that we became aware of... but a few years ago that suggested that it might be beneficial. Especially because a lot of our women have trauma around, you know, abuse from men or different things. So, we were trying to be just considerate of that.

Judge Helen, who expressed difficulty retaining female participants in her court, also discussed her desire to have a separate male and female docket and the roadblocks to establish separate dockets.

Another thing we would love to do is, if we get enough women, and know that this is being done in some other specialty courts, is breaking into gender specific status review sessions. And that would really help the women, right? I think that they could have conversations they're not comfortable with having in front of men. Because let's face it, many of them have been victimized by the men in their lives and they're not comfortable. But every time we get three, four, or five women and we can start creating this group, then we lose one or two.

Future research regarding split dockets would be worthwhile as it could improve outcomes for MHC participants and women participants in particular.

Discussion

Chapter 4 addresses a notable gap identified in Chapter 3, which presented findings from a qualitative analysis of field notes from virtual observations of three mental health courts. While that analysis offered valuable insights into court operations, particularly sanctioning and termination decisions provided limited information about the referral and admission process, as these typically occur outside of public hearings and were not readily observable. These interviews with legal and treatment members of MHC programs provide more context for the referral and admission process in the current chapter (Chapter 4). In addition, these interviews also provided insight into these workgroup members' personal experiences with MHC, the admissions process, and their perceptions of disparity within their programs. Following the overall goal of this research project, these findings can help identify disparity within MHCs and how they manifest. While the third subsection is concerned with the issues of discrimination bias observed in

the system, each section will be discussed in terms of how various factors of the referral and admission process can lead to disparity.

Referral and Admission Process

These results support previous research and overviews of MHCs that conclude MHC selection and admissions is a multi-stage process (see Snedker, 2022). The responses from interviewees suggest a similar multi-stage process, in which potential participants are identified and referred at the first stage, assessed for eligibility and risk in the second stage, and in the third stage approved or denied by the MHC workgroup.

Following previous literature, this analysis also suggests that the majority of referrals come from attorneys, and public defenders in particular. However, these results also suggest that while this may generally be the case, specific courts or jurisdictions may operate differently. Some of those interviewed suggested that depending on the track, probation officers may be the most common referral source. Others indicated that local mental health authorities are also an important source for referrals. Interviewees also discussed their efforts to inform their colleagues and community members about their MHC program. The efficacy of these education efforts can be an interesting avenue of research as public awareness of MHC programs continues to grow. As awareness of MHC programs increases, community referrals may also increase.

In addition, interviewees highlighted that these programs are voluntary, and defendants can decline to enter at any time in the admission process or even during the program. Interviewees also made note that other legal actors outside of the MHC workgroup, such as the district attorney's office or a sentencing judge can prevent a candidate from being diverted. For example, if they feel a candidate is unsuitable for the

program, the prosecutor wishes to take the case to trial, or if they feel the candidate is too great a risk to remain in the community.

Interviewees also discussed factors that they and other referral sources might look for that indicate a potential candidate for MHC. These factors included: behavior consistent with mental health symptoms, concerns of competency, and previous connection to mental health services. This is important to note as previous research has indicated gender, and race may affect evaluations of these factors. For example, research has indicated that male and non-White defendants may be less likely to be referred for psychiatric evaluation in the criminal justice system (Thompson, 2010). This indicates a differential perception of a defendant's behavior as a result of "mental illness" or "typical criminal behavior" which can carry over to evaluations for MHC referral.

In addition, research has also highlighted racial and ethnic differences in mental-health stigma and seeking treatment in which non-White individuals with mental health symptoms are less likely to seek treatment (De Luca et al., 2016; Shim et al., 2009). Similar research has also suggested that women are more likely to seek out mental health care compared to men (Mackenzie et al., 2006). If a history of mental health treatment or diagnosis is indeed a factor that influences referral, as some interviewees indicated, racial and gender differences in self-stigmatization and help-seeking would affect this. Therefore, it is important to consider how differences in cultural and community perceptions of mental health can lead to potential candidates being missed or self-selecting out of MHC diversion.

Many of those interviewed in the current study highlighted the strategies they employed to maintain objective assessments. However, respondents also spoke on

situations that indicate there are multiple areas of discretion and subjectivity present within the process as well. While these areas of subjectivity are likely unavoidable, it is important to understand how bias can lead to disparity and how it can be resolved within MHCs and other specialty courts. Overall, these findings indicate the importance of understanding how MHC candidates are identified and how demographic factors interact with evaluation of these candidates.

Disqualifying Factors

Overall, interviewees suggested that particular offenses and diagnoses could be disqualifying. Specific laws and policies differed across programs, but most interviewees reported that they reject defendants with charges of homicide, arson, and sexual offenses. Similarly, with regards to diagnoses, most interviewees indicated they were more reluctant to admit defendants with personality disorders, traumatic brain injury (TBI), or intellectual disabilities.

Beyond these more concrete disqualifying factors, interview participants also noted more subjective evaluations of referrals that may lead to disqualification. Some of the interviewees indicated that their court requires a nexus to be established between the diagnosis and the offense, though few discussed specifically how that nexus was established. In addition, there was also discussion of perceived dangerousness of the participant or perceived disinterest from the participant as reasons to disqualify them, characteristics that are more difficult to measure through objective means. Therefore, while most disqualifications appear to be based around objective measures such as diagnosis or criminal charge, there is room for discretion and subjectivity among the legal actors in the process.

Discretion is important in MHCs and the legal system in general because it allows for flexibility in decision-making, ensuring that individuals who may benefit from the program are not excluded due to rigid criteria. However, unchecked discretion can also lead to inconsistencies or potential biases in how exceptions are applied, raising concerns about fairness and equitable treatment.

In the context of MHCs, participants noted that discretion is often used to expand program eligibility rather than to exclude defendants. Interviewees frequently described a willingness to “give them a shot,” even when some workgroup members expressed concerns about a defendant. This suggests that, at least within this sample, discretion tends to favor inclusion. However, it is crucial to examine whether certain defendants are more likely than others to benefit from these exceptions, raising questions about potential disparities.

For instance, some interviewees mentioned that defendants with disqualifying charges were occasionally allowed into the program after a deal was made with the district attorney’s office to reduce their charges. While there is limited research on charge reductions specifically in the context of MHC admissions, broader studies on plea bargaining have found racial and gender disparities (Berdejó, 2024). These studies suggest that male and non-White defendants are less likely to receive charge reductions, which may, in turn, make them less likely to qualify for MHC if a reduction is necessary for admission.

Similarly, research has identified racial and gender disparities in criminal defendant referrals for psychiatric evaluation (Thompson, 2010). Findings suggest that African American and male defendants are more likely to be perceived as “typical

criminals,” whereas White and female defendants are more often seen as “mentally ill” and, therefore, less blameworthy. While this study did not directly examine MHC admissions, similar biases may influence diversion decisions, potentially contributing to disparities in access to these programs.

Disparities in MHC Admissions

In addition to general questions about the referral process and disqualifying factors, interviewees were also asked directly about their experiences with disparity in their respective MHC programs. The results of this qualitative analysis reflect the mixed findings of previous quantitative research. Some interviewees stated that they were unaware of any disparity and even discussed their strategies for identifying and combating disparity. Others indicated that they believed disparity was possible if not likely, and some discussed more specifically how disparity manifested in their court. Some of these results even contradicted previous quantitative research. For instance, participants in the current study indicated that women are underrepresented in MHCs and more likely to drop out of these programs, in contrast to previous quantitative studies suggesting that women are more likely to participate in MHC programs than men (Frailing, 2011; Luskin, 2001). There was also a mix of experiences regarding racial and ethnic disparity, with some suggesting that non-White participants were overrepresented while others suggested they were underrepresented. Previous quantitative findings suggest that if there is a race disparity, non-White participants are underrepresented (Frailing, 2011; Luskin, 2001; Snedker et al., 2017).

When discussing why this occurred, many said they were unsure of the mechanisms that led to disparity. Some interviewees made suggestions, stating that

disparity started at the policing level, or believed that certain participants were more likely to drop out of the program. Others suggested that some participants, African American and Hispanic participants in particular, were less likely to join the MHC program at the outset due to stigma towards mental health treatment. This coincides with previous research that finds greater levels of mental health stigma in these communities (DeFreitas et al., 2018; Fripp & Carlson, 2017). These studies further suggest that African American and Hispanic individuals are less likely to seek mental health services because of this stigma. These communities may similarly be less likely to participate in mental health court as part of these cultural differences in perceptions of mental health.

Overall, the results of this qualitative analysis supports the idea that any potential disparity in MHC admissions and outcomes is a complex interplay between multiple factors. As evident from these interviews, finding and admitting participants is a long, multi-stage process in which defendants need to be identified, referred to a program, approved by the MHC workgroup, approved by the district attorney's office and sentencing judge, and ultimately the participant must also agree to enter the program. Therefore, disparities could occur at any one of these points in the process.

Considering Focal Concerns Theory

As discussed in the literature review (see chapter 2), focal concerns theory is commonly used as a framework to explain disparity within the criminal justice system. As a brief overview, there are two major claims of the theory. The first states that legal decision-makers consider three factors when making decisions (e.g., sentencing, or diverting a defendant to a specialty court program), blameworthiness, community protection, and practical constraints. The second states that because decision-makers have

limited information regarding the defendant and the case, they may rely on biases and easily accessible heuristics. Therefore, disparities can be a result of subconscious biases related to factors such as race, gender, age, or other extralegal factors.

The results of this qualitative analysis cannot speak to the second major claim of focal concerns theory. While some interviewees spoke of disparity within MHC or the criminal justice system generally, none of the interviewees specifically described unconscious biases or focal concerns theory as a reason for the disparity. These findings can speak to the first claim however, that decision-makers in MHC consider blameworthiness, risk to the community, and practical constraints regarding the decision. The results of these interviews suggest that MHC workgroups consider all three concerns to an extent.

Evaluations of the offender's *blameworthiness* under the focal concerns framework refers to perceptions of the offender's culpability. This can include both beliefs about the severity of the offense and the perceived intent of the offender. Blameworthiness appeared to be a concern regarding MHC admissions. Many of the interviewees referenced offense severity as a factor in admission decision. For example, while offenders who committed violent offenses were often admitted into MHC, some interviewees stated those that were particularly violent or those who used a firearm were more likely to be rejected. Similarly, intent was also considered. For example, one interviewee said there would be different considerations for an offender who accidentally got into a fight versus one who intentionally and violently attacked another individual.

Similarly, *community protection* also appeared to be a concern of MHC workgroup members. Under the focal concerns framework, *community protection* or

dangerousness refers to assessments of the defendant's likelihood of reoffending and past offenses. Some interviewees discussed how the workgroup would consider the defendants' recidivism risk as an influencing factor. Prosecutors in particular were concerned with participants reoffending and stated that as a factor that might disqualify someone from the program. Others indicated that offense history and the amount and types of offenses might similarly preclude a defendant from joining the MHC program.

Finally, MHC workgroup members also discussed factors that can be considered *practical constraints*. In the focal concerns framework, *practical constraints* assessments of resource availability or any other systemic concerns that might influence a decision. In the original conceptualization of focal concerns theory, *practical constraints* often referred to concerns about prison capacity or the ability of the defendant to serve time (Steffensmeier et al., 1998). *Practical constraints* appeared differently of course in the context of MHCs. Constraints discussed by the interviewees included concerns about whether treatment services would accept certain defendants (e.g., defendants with arson or sex offense charges), the availability of treatment services for particular diagnoses (e.g., defendants diagnosed with personality disorders or intellectual disabilities) and overall evaluations of a defendant's ability to complete the program. Therefore, overall, MHC workgroup members appear to consider the three concerns posited by focal concerns theory when choosing to accept or reject defendants into mental health court. This will be further explored in the quantitative portion of the study (see Chapter 5).

Limitations

This study shares many of the same limitations as the qualitative observations described in previous chapters. Although participants were recruited from multiple courts

across the country, they were not randomly selected. The initial recruitment process relied on a simple internet search, meaning the sample was limited to mental health courts with an online presence, such as a website or publicly listed contact information. Additionally, many courts and workgroup members were unable to participate due to time constraints, while others did not respond. As a result, self-selection bias and sampling limitations must be considered.

Beyond these sampling constraints, this study also shares the broader limitations of qualitative research discussed in the previous chapter. The data does not allow for causal conclusions regarding admission decisions. Additionally, social desirability bias may have influenced participants' responses, particularly in discussions of disparity within mental health courts. Despite these limitations, the in-depth interviews provided valuable insights that informed the qualitative survey research described in Chapter 5.

Conclusion

Chapter 3 discussed the findings of a virtual ethnographic observation of three mental health courts. While these observations provided important information regarding the operation of these courts, there was a notable gap regarding the referral and admission process. The in-depth interviews analyzed in the current chapter (Chapter 4) addressed the limitations of the previous study by directly questioning MHC workgroup members about their experiences with the MHC admission process. In addition, workgroup members also provided their experiences with disparity in their respective programs.

The primary purpose of the current study was to gain greater understanding about potential disparity within mental health court admissions. These interviews highlighted the complexity of the MHC admission process, and the various moving parts involved

and how they could lead to disparity. Admission to MHC is a multi-stage process in which candidates must first be identified, assessed for eligibility (appropriate diagnosis, risk, etc.), and ultimately accepted or rejected by the workgroup. Admissions may be also influenced by factors outside of the workgroup's control, such as a prosecutor or sentencing judge rejecting diversion, or due to the candidate deciding not to participate in mental health court. These findings suggest multiple avenues of research to better understand the admissions process of mental health courts and issues of disparity within them.

Chapter 5 describes a quantitative study using survey methods to further investigate disparity that may occur during the admission process. However, as these findings suggest, disparity can occur due to a number of reasons. Further research should investigate other issues such as mental health stigma and how that may affect the self-selection of participants into MHC programs. In addition, further research should investigate how MHC disparities can manifest at intersections with other elements of the criminal justice system. This includes at the policing level and first contact with defendants who have a mental illness, as well as how differential treatment during plea-bargaining and other pretrial processes can lead to disparity in MHC admissions further down the line. Overall, it is important to understand how defendants with mental health concerns are viewed by the criminal justice system, and how perceptions of mental illness intersect with other demographic factors.

Chapter 5: Quantitative Survey and Results

This chapter describes the final section of this mixed-methods research investigating mental health courts (MHC) and the potential disparity within MHCs. The previous two chapters described qualitative observations and in-depth interviews of MHCs. While these studies stand on their own providing useful insight into the operation of these courts, they were also instrumental for developing the vignettes and measures for the survey. The remainder of this chapter describes the rationale of the quantitative portion of the study, the methodology of the survey, and the results of the data analysis.

As an overview, this study was an experimental survey using vignettes to manipulate the characteristics (race, gender, offense type) of a hypothetical defendant being considered for an MHC program. Participants were asked to evaluate the vignette character on various measures and ultimately make a decision to recommend the defendant for an MHC court or to remain in criminal court.

Current Study and Theoretical Framework

The purpose of this study was to further investigate referral and admission decisions in MHCs. This study followed the predictions of focal concerns theory and the findings of the previous qualitative studies to investigate decision making and potential disparity within MHCs. Based on the results of the qualitative analyses, there are various explanations as to how disparity can manifest within MHCs (e.g., disparity at referral, admission decisions, greater stigma towards mental illness in minority communities, various systemic obstacles, etc.). The current study focuses on disparity as a result of differences in referral and admission decisions.

As described in greater detail in Chapter 2, focal concerns theory is a criminological theory commonly used to explain disparities in the criminal justice system. As described in Chapter 4, MHC decision-makers do appear to consider the three concerns (blameworthiness, community protection, and practical constraints) when making referral and admission decisions. Therefore, this survey will measure participants' evaluations of these three concerns in relation to the vignette character (e.g., how blameworthy the participant is, the likelihood that they will reoffend, etc.).

Also described in the literature review, classic attribution theory will be considered as an explanation for disparity and as an important component of how legal actors view mental illness in criminal defendants. As discussed in the literature review, an evaluator can attribute a certain behavior to a mixture of internal factors (e.g., the characteristics or personal choices of the individual) and external factors (e.g., situational pressures or other factors separate from the individual committing the behavior).

With regards to mental illness, there is variance in how people perceive the external versus internal nature of mental health problems. Some individuals are more likely to view mental illness as caused by a failing of the individual, while others view mental illness as more similar to a physical disease in which the individual is not at fault for contracting it (Corrigan et al., 2003; Lyndon et al., 2019). Therefore, measures of participants evaluations of the controllability, responsibility, and internal/external causes of the vignette characters behavior were also included in the survey.

Qualitative Insights

The survey described in this chapter was developed based on the findings of the qualitative analyses described in Chapters 3 and 4. The observations and interviews

influenced the content of the vignettes and the selection of measures for the survey. Observations of MHCs and interviews with workgroup members indicated that the types of offenses within these courts can be extremely varied. Offenses ranged from non-violent to violent, drug offenses, property offenses, trespassing and more. Many of those interviewed specifically indicated that there was no clear pattern in the types of offenses they would see. However, some highlighted that the victims were often family members or close relations and that court participants frequently faced additional challenges, such as housing instability and unemployment. Reflecting these findings, the vignettes (described in detail in the measures section) depict an incident involving family members while also illustrating the defendant's broader struggles.

The interviews described in Chapter 4 also highlighted the relevance of focal concerns theory, which suggests that legal decision-making is influenced by three primary factors: the blameworthiness of the defendant, the potential risk to the community, and practical constraints. Practical constraints in particular was an interesting consideration, as past literature has described this concern quite broadly, ranging from available funds to courtroom workgroup factors. In the context of MHCs, interviewees often spoke of assessing the defendant's amenability to treatment. This includes factors such as taking medication as prescribed, appearing at the designated court hearings, and overall engaging with treatment and cooperating with the court. Therefore, the practical constraints measure for this survey focused on the amenability to treatment construct. Workgroup members frequently referenced these concerns when discussing their decision-making processes, emphasizing the importance of assessing a defendant's culpability, the likelihood of reoffending, and whether they could benefit from available

treatment options. These findings reinforced the decision to incorporate measures of these focal concerns into the survey.

Research Question and Hypotheses

There were two overarching research questions for this quantitative study. First, this research attempted to answer, “do mental health court referral and admission decisions follow the predictions of focal concerns theory?” Meaning, do legal decision-makers consider blameworthiness, community protection, and practical constraints with regards to MHC admissions. Related to this, this research also attempted to answer, “do defendant demographic factors of gender and race influence mental health court admission decisions?” As previously described, research has suggested disparities in MHC participation based on race, sex, and age may exist, though this is inconclusive. These previous studies have used institutional data to identify disparities within various MHCs throughout the country. This study is taking a different approach by using hypothetical vignettes rather than institutional data. This allows for analysis of the decision-making process that legal professionals engage in rather than just the make-up of participants in an MHC at a certain period of time.

The following are the hypotheses that were tested for the current study. These hypotheses are based on the predictions of focal concerns and classical attribution theory in addition to findings of previous studies that suggest racial and gender disparities in MHC admissions (Frailing, 2011; Luskin, 2001; Snedker, 2022; Snedker et al., 2017; Steadman et al., 2005). The first hypothesis was developed based on the predictions of focal concerns theory.

H1: Participants who evaluate the defendant as less blameworthy, less of a risk to the community, and as having fewer practical constraints will be more likely to recommend the defendant for MHC.

The second hypothesis was developed based on the predictions of attribution theory.

H2: Participants who evaluate the defendant as having less control, less responsibility, and who view the cause as more situational than dispositional, will be more likely to recommend the defendant for an MHC program.

The third hypothesis was developed to test the effects of the vignette conditions on participants' diversion decisions. This was based on previous research by MHCs suggesting that there are disparities based on race and gender. In addition, based on qualitative observations and interviews, the type of offense (non-violent vs violent) is also expected to have an impact on diversion decisions.

H3: Participants who read about a White and/or female defendant will be more likely to recommend the defendant for MHC. In addition, based on findings from the qualitative studies, participants will be more likely to reject the defendant if they committed a violent offense.

Method

Sample and Participants

A power analysis was conducted using G Power software, one analysis for a linear regression and another for a logistic regression. The first power analysis was estimated with an effect size of .15, alpha of .05, and power of .95, suggesting a sample size of approximately 119 participants was needed.

Participants for this study were recruited from Prolific Academic. Prolific's prescreening tools were used to select participants from the United States who worked in the legal sector. Participants were compensated \$2.00 for completing the survey. A total of 232 participants were recruited through Prolific (www.prolific.com). Of these participants, 14 initially accepted the survey but then returned the survey or otherwise decided not to participate. Two of the participants were dropped because they failed two out of three attention checks. Finally, another nine participants started the survey but timed out before completion. Therefore, there were 207 cases available for the final analysis.

Measures

Vignette

After reading a short description of the study, those who consented to participate were presented one of eight randomly assigned vignettes (see Appendix C for the full text of the vignettes). These vignettes described a criminal defendant and the offense of which they were accused. The vignette further described that the defendant was showing symptoms of a potential mental illness but had not been previously diagnosed. The mental health status was kept ambiguous intentionally, as this allowed room for participants to draw their own conclusions about the mental health status of the individual. This is consistent with the findings of the qualitative study discussed in Chapter 4. While many defendants are referred to MHC already having a diagnosis, many others are diagnosed for the first time as they apply for these programs.

The eight vignettes were identical except for the manipulations of the hypothetical defendant's race, gender, and the type of offense. Therefore, this was a 2x2x2

experimental design (Race: White or Black x Gender: male or female x Offense: violent or non-violent). In addition to the nominal variable containing all eight vignette conditions, three dummy variables were created for each manipulation category (White vs. Black defendant, female vs. male defendant, non-violent vs. violent offense).

Manipulation and Attention Checks

There were three manipulation checks in the survey. Participants were asked three multiple choice questions in which they were asked to recall characteristics of the vignette character they just read about. They were asked to identify the race of the defendant (White or Black), gender of the defendant (male or female) and the offense they were accused of (took something that did not belong to them or struck a person with a bottle). In addition, three attention checks were placed throughout the survey. Respondents who failed two of the three attention checks were removed from the sample. As stated above, two participants were ultimately removed for failing these checks.

Attitudes Toward Defendant

Following the manipulation checks, participants were asked to rate the likeliness of the defendant actually experiencing a mental illness (1 = extremely unlikely, 6 = extremely likely). Participants were then asked to complete items from the social distance scale (Link et al., 1999). These six items measured how much social distance the participants desired from the vignette character (see Appendix D for full text of the measures). Reliability analysis of the current indicated high internal consistency on the social distance measures, with a Cronbach's alpha of 0.91. These items were summed to create a scale indicating overall willingness to have the defendant in the community.

Cause and Attribution Measures

Based on items used by O'Toole and Sahar (2014), participants were asked to consider eight potential factors and rate if they were a likely cause of the defendant's criminal action. Participants rated these factors on a 6-point Likert scale ranging from extremely unlikely to extremely likely. These potential factors or causes included: poverty/unemployment, mental illness, limited education, substance abuse, family problems, immoral character, peer/neighborhood pressure, and feelings of anger or revenge.

To better understand participants' attribution of the vignette character's actions, items were adapted from Mantler et al. (2003) to measure the participants' perception of the controllability, responsibility and blame of the defendant regarding their criminal actions. Participants were asked to rate their agreement with 12 items in total (four items each for controllability, responsibility and blame) on a 6-point Likert scale (strongly disagree to strongly agree). These measures were originally used to measure participants' evaluations of a vignette character's illness; therefore the wording was adapted to reference the defendant's criminal action instead (see Appendix D for full survey text). Reliability analysis of this sample indicated generally high internal consistency among the two measures. Reliability analysis indicated the responsibility items had a Cronbach's alpha of 0.76, and the control items had a Cronbach's alpha of 0.67. These items were summed to create two scales indicating participants' attribution of the defendant's control over their actions, their responsibility in committing those actions, and the blameworthiness for committing those actions.

Measures of perceived internality or locus (i.e., was the criminal action due to dispositional or situational factors) and stability (i.e. how likely is the defendant to change so they do not engage in criminal behavior again) were created for this survey. To measure internality, participants were asked to rate their agreement on two items “the cause(s) of Alex’s behavior reflect an aspect of Alex’s internal character” and “the cause(s) of Alex’s behavior reflect an aspect of the situation Alex is in” (reverse coded). To measure stability, participants were similarly asked to rate their agreement with two items, “the cause(s) of Alex’s behavior is permanent” and “the cause(s) of Alex’s behavior is something that can change over time” (reverse coded).

Factor analysis and reliability analysis indicate that these items did not perform as expected. To explore the underlying structure of these items, an exploratory factor analysis was conducted. The goal was to identify latent constructs and assess the dimensionality of these two measures. A principal component analysis approach was used for factor extraction. The number of factors was determined through a combination of Scree plot analysis and selecting factors with an Eigenvalue greater than one. Two factors were retained, accounting for 74.75% of the variance.

Factor loadings greater than 0.40 were considered meaningful. However, these factor loadings did not load onto items as expected during item development. Table 8 shows the item names, the text from the survey, and the factor loadings for these items both with no rotation applied and with Promax rotation applied. Promax rotation was chosen because the factors were theoretically expected to be related. With no rotation, factor loadings indicated a strong relationship between the stability items and the second internality item. The first stability item also loaded on to the second component along

with the first internality item, however this relationship was not as strong. With the Promax rotation applied, a clearer structure formed in which the two reverse coded items (situational and change) loaded onto the same factor, and the other items (dispositional and stable) loaded onto a second factor. Reliability analyses were conducted on these two identified factors. The combination of the reverse coded items indicated high reliability, with Cronbach's $\alpha = 0.73$. However, the other two items (dispositional and stable) did not have sufficient reliability (Cronbach's $\alpha = 0.45$).

Overall, this factor analysis shows that these items did not load as expected during the survey development (i.e., internality being one factor, and stability being a second factor). However, these items may still speak to the overall dichotomy of dispositional versus situational factors as described in attribution theory. For the current analysis, the "situational" and "change" variables were summed to create a scale capturing this dispositional versus situational construct (i.e., locus), with higher scores indicating a higher belief that the cause(s) of the defendant's behavior (i.e., their mental illness) was an internal factor. Due to their conflicting factor loadings and low reliability, the other two items (dispositional and stable) were dropped from this analysis.

Table 8. Factor Loadings for Attribution Survey Items

Variable	(The cause(s) of Alex's behavior...	No Rotation		Promax Rotation	
		Component		Component	
		1	2	1	2
dispositional	...reflect an aspect of Alex's internal character	0.23	0.85	-0.08	0.84
situational	...reflect an aspect of the situation Alex is in (reverse coded)	0.74	-0.41	0.84	0.02
stable	...is permanent	0.67	0.48	0.47	0.76
change	...is something that can change over time (reverse coded)	0.87	-0.24	0.9	0.24

Focal Concerns Measures

In addition to the blameworthiness measure above, the Perceptions of Perpetrator Blame (PPBS) scale was adapted to measure perceived blameworthiness of the defendant (Rayburn et al., 2003). This scale consists of 14 bipolar measures of various characteristics (e.g., violent to nonviolent, malicious to kind) rated on a 7-point scale with a 1 or 7 indicating high agreement with the respective adjective (e.g. 1 = very violent, 7 = very non-violent; see Appendix D for full survey measure). This measure also had high internal consistency and reliability with a Cronbach's alpha of .88. These items were standardized into z-scores and summed to create a scale indicating perceived blameworthiness of the defendant.

To measure evaluations of community risk, three items were adapted from Eno Loudon et al. (2018). On a 6-point Likert scale (1 = extremely likely, 6 = extremely unlikely) participants were asked to rate how likely they thought the participant would commit a new offense, be violent towards another person, or have their probation

revoked. These items had high internal consistency with a Cronbach's alpha of .85. To measure practical constraints, four items were created for this survey. Participants were asked similarly on a 6-point Likert scale to rate how likely they thought the defendant would: engage in mental health treatment, use the resources provided by the court, take their medication as prescribed and cooperate with the mental health court. These items also showed high internal consistency with a Cronbach's alpha of .85. The first three items were summed to create a scale indicating participants' perception of perceived risk of reoffending. The final four items were similarly summed to create a scale indicating participants' beliefs about the defendant's amenability to treatment and engaging with the court.

Mental Health Court Diversion Decision

Participants were asked to imagine that they were presented with this criminal case and had the option to recommend them for mental health court. Participants were asked if they would recommend that this defendant be diverted to an MHC program or recommend they remain in criminal court. Participants were also asked to indicate their confidence in this decision using a slider ranging from 0 to 100 (0 = not confident at all, 50 = unsure, 100 extremely confident).

Beliefs Toward Mental Illness

After making their decision, participants were asked to complete the Beliefs Toward Mental Illness (BMI) scale (Hirai & Clum, 2000). This scale is designed to assess participant's attitudes and beliefs toward mental illness. This scale consists of three subscales that capture the extent to which respondents view mental illness as dangerous, incurable, and shameful. This scale consisted of 21 items, participants were

asked to rate their agreement with these items on a 6-point Likert scale (1 = completely disagree, 6 = completely agree). The internal consistency of the three subscales was high. The shame subscale had a Cronbach's alpha of 0.88, the dangerous subscale had a Cronbach's alpha of 0.86, and the incurability subscale was the lowest with a Cronbach's alpha of 0.79. As with previous measures, these items were summed to create three subscales indicating participants' belief about the dangerousness, incurability, and shame associated with mental illness.

Participant Demographics

To conclude the survey, participants were asked to report their demographic information through a series of multiple-choice style questions. These demographic measurements included gender (male, female, or other), age, race/ethnicity (White/Caucasian, Hispanic/Latino, Black/African American, Native American/Pacific Islander, or other, with the option to select all that apply), level of education (less than high school, high school or equivalent, Bachelor's degree, Master's degree, professional degree, or doctorate), income (options ranging from less than \$25,000 to \$150,000 or more), political view (ranging from very liberal to very conservative) and political affiliation (Republican, Democrat, Independent, Green, Libertarian, or other). Participants were also asked what their current position (or last position, if retired) within the legal system was (judge, attorney, paralegal, police, administrative, other). They were also asked if they have worked as a team member of an MHC before. Finally, participants were asked if they have been diagnosed with a mental health condition.

The sample was predominantly female with 129 (62%) of the participants identifying as such. Most of the sample, 146 participants (70%), stated they were

White/Caucasian. The ages of the participants ranged from 21 to 78 with a mean age of 41. The vast majority of the sample (89.4%) had a bachelor's degree or higher. Regarding political affiliation, 95 (45.7%) identified as Democrats followed by 55 (26.4%) who identified as Republicans and 49 (23.6%) who identified as Independent. Most of the participants (82.10%) stated that they had not worked in a specialty court before. There were 23 (11.10%) participants who indicated they had worked in a specialty court other than an MHC, and 14 (6.80%) who indicated they had worked in an MHC. Seventy-four (35.6%) of the sample indicated that they either currently have a mental health diagnosis or have had a diagnosis in the past. The full descriptive statistics for the sample are displayed in Table 9. In addition, Table 10 displays the means and standard deviations of the continuous variables in addition to the correlations between the continuous variables used in this analysis.

Table 9. Descriptive Statistics of Study Sample (N = 207)

Variable	M	SD	n	% of total
Age	41.02	12.85		
Gender				
Male			75	36.20%
Female			128	61.80%
Other			3	1.40%
Prefer not to say			1	0.50%
Race				
Asian/Pacific Islander			11	5.30%
Black/African American			27	13.00%
Hispanic/Latino			19	9.20%
White/Caucasian			145	70.00%
Other			5	2.40%
Education				
High school or equivalent			22	10.60%
Bachelor's degree			80	38.60%
Master's degree			26	12.60%
Professional degree			74	35.70%
Doctorate			5	2.40%
Job				
Administrative			33	15.90%
Attorney (defense)			33	15.90%
Attorney (prosecutor)			10	4.80%
Attorney (non-criminal)			26	12.60%
Judge			3	1.40%
Paralegal			60	29.00%
Police Officer			4	1.90%
Other			28	13.50%
MHC Work Experience				
Mental health court			14	6.80%

Other specialty court	23	11.10%
Neither	170	82.10%
Income		
Less than \$25k	5	2.40%
\$25,000-\$49,999	20	9.70%
\$50,000-\$74,999	30	14.50%
\$75,000-\$99,999	43	20.80%
\$100,000-\$149,999	63	30.40%
\$150,000 or more	42	20.30%
Prefer not to say	4	1.90%
Political Party		
Republican	55	26.60%
Democrat	94	45.40%
Independent	49	23.70%
Libertarian	5	2.40%
Other	4	1.90%
Political Ideology (1=very liberal, 7 = very conservative)	2.58	1.24

Table 10. Correlations

Variable	Mean	SD	1	2	3	4	5	6	7	8	9
1. Confidence	82.32	15.35									
2. Conservative	2.58	1.24	-0.03								
3. Willingness to engage	15.85	6.82	0.06	-0.26**							
4. Perceived Control	16.27	3.03	-0.04	0.07	-0.20**						
5. Perceived Responsibility	17.33	3.08	0.02	0.19**	-0.29**	0.63**					
6. Perceived Blameworthiness	70.46	11.1	-0.01	0.15*	-0.52**	0.35**	0.42**				
7. Perceived Risk	12.94	2.73	0.04	0.22**	-0.46**	-0.46**	0.19**	0.49**			
8. Perceived Amenability	16.79	3.09	0.29**	-0.06	0.27**	-0.12	0.12	-0.23**	-0.28**		
9. Perceived Locus (Internal)	4.77	1.82	-0.15*	0.23**	-0.26**	-0.17*	-0.02	0.06	0.24**	-0.11	
10. MH Stigma	68.43	18.1	-0.09	0.37**	-0.37**	-0.08	-0.03	0.35**	0.47**	-0.11	0.29**

*indicates $p < .05$, ** indicates $p < .001$.

Results

The following section describes the descriptive statistics, preliminary analysis, and the final analysis to test the hypotheses described previously. The preliminary analyses included a series of mean comparisons through t-tests and ANOVAs, and the hypotheses in the primary analysis using a combination of binary logistic and linear regression. All statistical tests were conducted with an alpha cut-off of $\alpha = 0.05$.

Descriptive Statistics and Preliminary Analysis

Participant Opinions on Legitimacy of Defendant's Mental Illness

After reading the vignette, participants were asked to state how likely, in their opinion, that the defendant was actually experiencing issues with mental illness. As stated above, this was measured on a 6-point Likert scale (1 = extremely unlikely, 6 = extremely likely). On average, the participant sample believed that the defendant was experiencing mental illness (mean = 5.08, SD = .90). A one-way ANOVA indicated there was no significant difference in this belief between the eight vignette conditions ($p = .382$). Across all eight conditions, participants on average believed the defendant was experiencing mental illness regardless of race, gender, or offense (non-violent or violent).

Participants' Desire for Social Distance

As described above, participants were asked to state their willingness to engage in six activities with the defendant involving close social distance (e.g., moving next door, making friends, socializing with the defendant, etc.). Analysis of means indicated that participants were generally unwilling to engage in these activities with the defendant. Notably, of these six items, participants were most willing to have a group home for people like the defendant open in their neighborhoods. However, the willingness to endorse this was still low overall (mean = 3.13, SD = 1.57). See Table 10 for a breakdown of all six social distance items.

As described above, these items were summed to create a social distance scale. A one-way ANOVA analysis was conducted using this scale as the dependent variable and the randomly assigned vignette conditions as the independent variable. There was no significant difference in desired social distance between conditions ($p = .077$). Therefore,

participants were not any more or less willing to engage with the defendant based on the defendant's race, gender, or offense committed.

Table 11. Descriptive Statistics of Social Distance Items

Item	M	SD
<i>How willing are you to...</i>		
...move next door to the defendant?	2.46	1.22
...make friends with the defendant?	2.67	1.34
...spend an evening socializing with the defendant?	2.7	1.43
...start working closely with the defendant?	2.58	1.31
...have a group home for people like the defendant open in your neighborhood?	3.12	1.57
...have the defendant marry into your family?	2.29	1.32

Note: Items measured on a 1 to 6 Likert scale, 1 = completely unwilling, 6 = completely willing

Perceptions of Cause of Defendant's Behavior.

Participants were asked about eight potential causes of the defendant's behavior: poverty/unemployment, mental illness, limited education, substance abuse, family problems, peer/neighborhood pressure, and feelings of anger and revenge. Participants were asked to rate how likely that the defendant's actions were caused by these eight factors. On average, participants rated mental illness as the leading cause of the defendant's actions. This was followed by family problems, substance abuse, anger and revenge, poverty/unemployment, limited education, immoral character, and finally peer pressure. See table 11 for a breakdown of descriptive statistics for these items.

Based on the vignette, it is unsurprising that mental illness and family problems were the highest endorsed causes of the defendant's behavior, as these issues were explicitly mentioned in the vignettes. Anger and revenge were similarly also unsurprising, as based on the vignette, participants could surmise that the defendant was

feeling anger towards their family in both the non-violent and violent conditions. The lower endorsement of limited education and peer pressure was also unsurprising, as these were not factors directly mentioned in the vignette. The relatively higher endorsement of substance abuse as a cause is notable, as issues with substances were not directly mentioned in the vignettes. The relatively lower endorsement of poverty or unemployment as a cause is also notable as it was mentioned in the vignette that the defendant was sleeping in their car and on friends' couches.

Table 12. Perceptions of Likely Causes of Defendant's Actions

Item	M	SD
<i>How likely is it Alex's actions were caused by...</i>		
...poverty/unemployment	3.5	1.39
...mental illness	5.26	0.88
...limited education	3.19	1.29
...substance abuse	4.46	1.02
...family problems	4.82	1.03
...immoral character	2.9	1.31
...peer/neighborhood pressure	2.6	1.35
...anger/revenge	4.23	1.23

Note: Items measured on a 1 to 6 Likert scale, 1 = Very unlikely, 6 = Very likely

As described above, 12 items were adapted from Mantler et al. (2003) to assess the perceived controllability, responsibility, and blame of the defendant regarding the criminal actions described in the vignette. The four items for each dimension were summed to create three separate scales each with a minimum possible score of four and a maximum possible score of 24, with higher scores indicating greater levels of perceived control, responsibility, and blame. Across all three scales, participants on average

perceived that the defendant had moderately high levels of control (mean =16.29), responsibility (16.67) and blame (17.29) for their actions. Subsequent independent sample t-tests indicated that these were not significantly different across condition manipulations (Black vs White, male vs female, or non-violent vs violent).

Focal Concerns Measures

As stated previously, to measure perceived risk to the community, three items were taken from Eno Loudon et al. (2018) asking participants how likely they think the defendant would commit a new crime, be violent to someone else, or have their probation revoked. These items were subsequently summed to create a “risk to the community” scale. Scores ranged from a possible minimum of three to a possible maximum of 18. The sample averaged a score of 12.93 (SD = 2.72). An independent samples t-test indicated that participants who read a vignette involving a violent offense perceived the defendant as posing greater risk to the community $t(206) = -2.47, p < .05$. There was no significant difference based on the vignette characters' race or gender.

As described in Chapter 2, the “practical restraints” concern has various possible interpretations. Based on the results of the qualitative studies (see Chapter 3 and 4), the defendant’s amenability to treatment appeared to be a particularly pertinent practical restraint in the context of mental health courts. To measure this, four items were created for this survey that asked participants' beliefs about the likelihood of the defendant engaging in treatment and the court program. These items were subsequently summed together to create a scale with a possible minimum value of four and a possible maximum value of 24. On average, participants from this sample had a score of 12.93 (SD = 2.72). An independent samples t-test indicated that participants who read a vignette involving a

Black defendant perceived the defendant as being more amenable to treatment $t(206) = -2.14, p < .05$. There was no significant difference based on the vignette characters' gender or offense.

To measure blameworthiness, participants responded to the Perceived Perpetrator Blame Scale (Rayburn et al., 2003). These 14 items were summed to create a scale with a minimum possible score of 14 and a maximum possible score of 98. The participants in this sample scored 70.45 on average ($SD = 11.07$). An independent samples t-test indicated that participants who read a vignette involving a violent offense perceived the defendant as more blameworthy $t(206) = -2.952, p < .05$. There were no significant differences based on the vignette character's race or gender.

Belief Towards Mental Illness (BTMI)

Participants' stigma towards mental illness was measured through the BTMI scale and its three subscales (view of mental illness as dangerous, incurable, and shameful) as described previously. There were five items that measured the dangerous factor from the BTMI items. These items created a subscale with a minimum possible score of 5 and a maximum possible score of 30. On average, participants from this sample received a score of 17.24 ($SD = 5.58$). Independent samples t-tests indicated there were no significant differences in the perception of the dangerousness of mental illness based on the race or gender of the defendant. However, participants were marginally more likely to view mental illness as dangerous after reading a vignette involving a violent offense $t(202) = -1.82, p = .07$.

There were 6 items that measured participants' beliefs regarding the incurability of mental illness. These items created a subscale with a minimum possible score of 6 and

maximum possible score of 36. On average, participants received a score of 21.88 (SD = 5.32). Independent samples t-tests indicated there were no significant differences in beliefs regarding the incurability of mental illness based on the vignette conditions.

Finally, there were 10 items that measured participants' feelings of shame regarding mental illness. These items created a subscale with a minimum possible score of 10 and a maximum possible score of 60. On average, the participants from this sample received a score of 29.41 (SD = 9.42). Independent samples t-tests indicated there was no significant difference in beliefs about mental illness being shameful based on the randomly assigned vignette condition. Overall, these three factors measuring stigma towards mental illness were not affected by the vignette manipulations, indicating that these measures of mental health stigma represent the crystalized attitudes of the participants.

Final Diversion Decision and Confidence

Participants were asked their opinion on the best way to proceed with the case in the vignette, to either divert the defendant to an MHC program or to retain them in traditional court. The current sample overwhelmingly decided to divert the defendant to an MHC program. Of the 207 cases, only 11 participants decided to retain the defendant in criminal court and the remaining 196 decided to divert the defendant to the MHC program.

Participants also reported high levels of confidence in their decision on a 0-100 scale with an average score of 82.36 (SD = 15.32). An independent samples t-test indicated that there was no significant difference based on participant's diversion decision, participants had equally high confidence regardless of if they diverted the

defendant or retained them. Additional t-tests indicated that the defendant's race and offense type similarly did not have a significant effect on confidence. There was, however, a marginal effect of defendant gender on confidence. Participants reported slightly higher confidence when the participant was male (mean = 84.24) versus female (mean = 80.50), $t(206) = -1.77, p = .08$.

Primary Analysis

Hypothesis 1

To test the hypotheses for the current study, a series of binary logistic and linear regressions were conducted. The first hypothesis investigated tests the predictions of focal concerns theory.

H1: Participants who evaluate the defendant as less blameworthy, less of a risk to the community, and as having fewer practical constraints will be more likely to recommend the defendant for MHC.

A binary logistic regression was conducted to examine the impact of blameworthiness (PPB Scale), perceived risk, and perceived amenability to treatment on the MHC diversion decision. The dependent variable was coded as 0 = diverted to MHC, 1 = reject MHC diversion (i.e., remain in criminal court).

Prior to conducting the regression, the independent variables were assessed for normality and multicollinearity in addition to checking for a linear relationship between the independent variables and the log odds of the dependent variable. Histogram and Q-Q plots were made to assess normality in addition to analysis of skewness and kurtosis. Each of the independent variables approximated a normal curve. Multicollinearity was assessed using a Pearson correlation analysis between the three independent variables.

Because none of the correlation coefficients between the variables exceeded 0.7, there were no issues of multicollinearity identified. Finally, linearity between the independent variables and the log odds of the dependent variable were assessed using the Box-Tidwell procedure. An interaction term was created for each predictor and their respective natural log and included in the binary logistic regression. Because none of the interaction terms were significant, this indicated that nonlinearity was not an issue and the assumption was met.

The Chi-square test for the model was significant $\chi^2(3) = 12.41, p < .01$, indicating that the model was significantly different from the null model. The Nagelkerke R^2 value was .184, suggesting that approximately 18.4% of the variance in the MHC diversion decision is explained by the model. Higher levels of perceived blameworthiness were associated with higher likelihood of rejecting the candidate from the MHC program. Higher perceived amenability to treatment was also significantly associated with the dependent variable but suggested a decreased chance of being rejected from the MHC program. Risk was not a significant predictor in this model. See Table 12 for full test results.

Preliminary analysis of the participant demographic variables showed political ideology was a significant predictor of the MHC diversion decision. Therefore, a second binary logistic regression was included with participant political ideology as an additional control variable. The Chi-square test for the new model was significant $\chi^2(4) = 19.62, p < .001$, indicating again a statistically significant improvement over the null model. The Nagelkerke R^2 value was .289, indicating that approximately 28.9% of the variance in the MHC diversion decision is explained by the model. In this new model, the perceived

blameworthiness of the defendant was no longer a significant predictor of the dependent variable. However, perceived amenability to treatment remained a significant predictor, in which higher perceived amenability was associated with a lower likelihood of rejecting the defendant. The newly introduced variable of participant political ideology was also significant, indicating that conservative participants were more likely to retain the defendant in criminal court and accounted for the variation predicted by perceived blameworthiness.

Table 13. Binary Logistic Regression Predicting Diversion Decision

Model 1						
Predictor	B	SE	Wald	OR	95% CI for OR	p
Constant	-3.12	3.44	0.82	—	—	0.36
Blameworthiness	0.08	0.04	4.12	1.08	[1.00, 1.17]	0.04
Risk	-0.12	0.16	0.62	0.88	[0.65, 1.20]	0.43
Treatment amenability	-0.27	5.63	5.63	0.77	[0.62, 0.96]	0.02
Model 2						
Predictor	B	SE	Wald	OR	95% CI for OR	p
Constant	-3.42	3.6	0.9	—	—	0.34
Blameworthiness	0.05	0.04	1.54	1.05	[0.97, 1.13]	0.22
Risk	-0.13	0.14	0.95	0.88	[0.67, 1.14]	0.33
Treatment amenability	-0.25	0.12	4.8	0.78	[0.62, 0.97]	0.03
Conservative	0.82	0.34	5.9	2.28	[1.17, 4.42]	0.02

These same predictors were subsequently used to predict participant confidence levels in their decision. The overall regression model was statistically significant $F(4,188) = 4.99, p < .001$, indicating that the specified model was significantly different from the null model. The model explained 7.7% of the variance in participants'

confidence levels, adjusted $R^2 = .077$. Participants' perceived risk of the defendant significantly predicted their confidence levels $B = 1.03$, $t(188) = 2.18$, $p < .05$. For every one-point increase on the perceived risk scale, confidence score increased by 1.03 points on average. Perceived amenability to treatment was also a significant predictor of confidence score, $B = 1.57$, $t(188) = 4.27$, $p < .001$. For every one-point increase in perceived amenability to treatment, confidence score increased by 1.57. Perceived blameworthiness and participant political ideology did not significantly predict confidence (see Table 13 for full results)

Table 14. Multiple Linear Regression Predicting Diversion Decision Confidence

Predictor	B	SE B	β	t	p
(Constant)	43.13	11.45	—	3.77	<.001
Blameworthiness	0.01	0.12	0.004	0.05	0.96
Risk	1.03	0.48	0.18	2.18	0.03
Treatment amenability	1.57	0.37	0.31	4.27	<.001
Conservative	-0.38	0.87	-0.03	-0.43	0.67

Hypothesis 2

The second hypothesis of this study investigated the predictions of attribution theory, specifically the influence of perceived controllability, responsibility, stability, and internality of the defendant's action.

H2: Participants who evaluate the defendant as having less control, less responsibility, and who view the cause as more situational than dispositional, will be more likely to recommend the defendant for an MHC program.

Similar to the first hypothesis, a binary logistic regression was conducted to examine the impact of the attribution factors on the MHC diversion decision. The scales created for responsibility and control (adapted from Mantler et al., 2003) and participants' evaluation of the dispositional versus situational nature of the defendant's behavior were included in the model as independent variables. The dependent variable remained the MHC diversion decision as described above.

The independent variables were assessed for normality and multicollinearity in addition to checking for a linear relationship between the independent variables and the dependent variable. Histogram and Q-Q plots were made to assess normality in addition to skewness and kurtosis analysis. Each of the independent variables approximated a normal curve. Multicollinearity was assessed using a Pearson correlation analysis between the three independent variables. Because none of the correlation coefficients between the variables exceeded .7, there were no issues of multicollinearity identified. Finally, the Box-Tidwell procedure was used again to assess the linearity assumption. Again, none of the interaction terms were significant, indicating that the assumption was satisfied.

The Chi-square test for the binary logistic regression model was not significant $\chi^2(3) = 4.62, p = .20$, indicating that the model does not significantly improve prediction compared to the null model. Similar to the first hypothesis, these predictor variables were included in a linear regression to predict participants' confidence in their decision. This model was also not significant $F(3,199) = 2.16, p = .094$, indicating that the regression model was not a better predictor of participant confidence compared to the null model.

Because neither models were significant, no further analysis was conducted regarding the second hypothesis.

Hypothesis 3

The final hypothesis further investigated the issue of disparities in MHC participation based on defendant race and gender.

H3: Participants who read about a White and/or female defendant will be more likely to recommend the defendant for MHC. In addition, based on findings from the qualitative studies, participants will be more likely to reject the defendant if they committed a violent offense.

Consistent with the last two hypotheses, a binary logistic regression was conducted to investigate the effects of the vignette conditions on the MHC diversion decision. Three dummy variables were created for the three conditions (Black vs White defendant, male vs female defendant, and non-violent versus violent defendant) to serve as the primary independent variables. The dependent variable remained the MHC diversion decision as described above. Because the independent variables in this analysis are categorical, they were not assessed for normality or linearity. Multicollinearity was assessed through a series of chi-square tests of independence. These analyses were not significant, indicating there is no issue of multicollinearity between the independent variables.

The Chi-square test for the binary logistic regression model was not significant $\chi^2(3) = .98, p = .81$, indicating that the model does not significantly improve prediction compared to the null model. As was done with the previous hypotheses, these predictor variables were included in a linear regression to predict participants' confidence in their decision. This model was also not significant $F(3,203) = 1.03, p = .38$, indicating that the

regression model was not a better predictor of participant confidence compared to the null model. Therefore, defendant race, gender, nor offense type appeared to have an effect on diversion decisions. A second model was conducted to investigate the interaction effects between the three independent variables, the interaction terms were also non-significant. Because these models were not significant, no further analysis was conducted on the predictor variables.

Additional Findings

In addition to the three primary hypotheses, additional binary logistic and linear regressions were conducted for exploratory research between the measures in this survey. Because there were significant findings regarding the first hypothesis, this exploratory analysis began with the focal concerns variables (specifically blameworthiness and amenability to treatment) as dependent variables.

A multiple linear regression was conducted to investigate the effects of the three vignette conditions and participants' political ideology on perceptions of blameworthiness. The overall regression model was statistically significant $F(4, 190) = 3.36, p < .05$. The model explained 4.6% of the variance in perceived blameworthiness, adjusted $R^2 = .046$. Reading a vignette involving a violent defendant was a significant predictor of perceived blameworthiness $B = 3.74, t(190) = 2.58, p < .05$. Reading a vignette involving a violent offense resulted in, on average, a 3.74 increased score on the PPBS measure. Participant's political ideology also significantly predicted perceived blameworthiness $B = 1.25, t(190) = 2.13, p < .05$. Every one-point increase on the political ideology scale was associated with a 1.25 increase on the PPBS, indicating that conservative participants were more likely to view the defendant as more blameworthy

when holding other factors constant. There was no significant effect of the defendant's race or gender on perceived blameworthiness (see Table 14 for full results). These predictor variables were then used in a regression model predicting perceived amenability to treatment. However, the omnibus test indicated that this model was not significantly different from the null model $F(4, 194) = 1.1, p = .36$.

These results suggest a possible connection between violent offense and an increased likelihood of rejecting a defendant through perceived blameworthiness because defendants perceived as more blameworthy were more likely to be rejected, and violent defendants were seen as more blameworthy. Because there is a theoretical basis to suggest that offense type would influence perceived blameworthiness and ultimately the diversion decision, a mediation analysis was conducted. Table 15 displays the results of this analysis, suggesting that perceived blameworthiness partially mediates the relationship between reading the violent vignette condition and the decision to reject the vignette character from an MHC program.

Table 15. Multiple Linear Regression Predicting Blameworthiness

Predictor	B	SE B	β	t	p
(Constant)	67.05	2.08	—	32.18	<.001
Black defendant	-1.08	1.45	-0.05	-0.74	0.46
Male defendant	-1.66	1.45	-0.08	-1.14	0.26
Violent defendant	3.74	1.45	0.18	2.58	0.01
Conservative	1.25	0.59	0.15	2.13	0.03

Table 16. Mediation Analysis

IV -> DV						
Predictor	B	SE	Wald	OR	95% CI for OR	p
Violent defendant	0.223	0.622	0.129	1.25	[.37, 4.23]	0.72
Constant	-2.99	0.46	42.74	0.05	-	<.001
IV -> M -> DV						
Violent defendant	0.1	0.69	0.02	1.11	[.29, 4.28]	0.88
Blameworthiness	0.08	0.03	5.41	1.08	[1.01, 1.15]	0.02
Constant	-8.6	2.49	11.93	0	-	<.001

Although perceived risk was not a significant predictor of MHC diversion decisions, it was a significant predictor of decision confidence. Therefore, another model was tested to analyze the effects of vignette conditions and participant political ideology on perceived risk. The overall regression model was statistically significant $F(4, 196) = 3.80, p < .01$, indicating that the specified model was significantly different from the null model. The model explained 5.3% of the variance in perceived risk, adjusted $R^2 = .053$. Participants who read a vignette involving a violent defendant perceived the defendant as posing greater risk on average, $B = .762, t(196) = 2.08, p < .05$. Participants' political ideology was also a significant predictor, $B = .48, t(196) = 3.21, p < .05$, indicating that more conservative participants were more likely to view the defendant as riskier holding all other variables constant (see Table 16 for full results).

Table 17. Multiple Linear Regression Predicting Perceived Risk

Predictor	B	SE B	β	t	p
(Constant)	11.48	0.53	—	21.8	<.001
Black defendant	0.02	0.37	0.004	0.06	0.96
Male defendant	-0.2	0.37	-0.04	-0.54	0.59
Violent defendant	0.76	0.37	0.14	2.08	0.04
Conservative	0.48	0.15	0.22	3.21	0.002

Although they were not part of the original hypotheses, measures of desired social distance and stigma towards mental illness (BTMI scale) were included in the survey as potentially important factors. A binary logistic regression was conducted using the social distance scale and the three BTMI scales as predictors of MHC diversion. The Chi-square test for the binary logistic regression model was marginally significant $\chi^2(2) = 5.67, p = .059$. Analysis of the individual predictor variables indicated that mental health stigma was a marginally significant predictor of rejecting the defendant from an MHC program. Increased stigma towards individuals with mental illness was marginally associated with increased likelihood to reject the defendant and to retain them in traditional criminal court.

Because the introduction of political ideology as a control variable had a significant impact on the diversion decision, subset analyses were conducted to see if the significance of the primary predictor variables differed based on political affiliation. A dummy variable was created from the political party variable, with any participant who identified as republican or libertarian coded as a 1, democrats, independent, and those who reported that they identified with some other party were coded as 0. Three binary logistic regressions were conducted to test the three hypotheses again. However, for these

models, subsamples were analyzed to compare conservatives and non-conservatives to identify whether political ideology moderated the effects of the predictor variables.

Similar to the models used in the primary analysis, attribution measures (locus, responsibility, and control) were not significant predictors of the MHC diversion decision across both conservative and non-conservative subsamples. Vignette conditions (defendant race, gender, and offense type) also remained non-significant across both subsamples. However, there were notable differences across the two subsamples regarding the focal concerns predictors.

For the conservative subsample, the binary logistic regression predicting diversion decision based on perceived blameworthiness, risk, and treatment amenability was overall non-significant, $\chi^2(3) = 5.89$, $p = .12$. The three predictors had no significant impact on conservative respondents' diversion decision. The chi-square test for the non-conservative sub-sample (democrat, independent, other), however, was significant and therefore an improvement over the null model, $\chi^2(3) = 11.06$, $p < .05$. The Nagelkerke R^2 of .404 indicates that the model explained about 40.4% of the variance in non-conservatives' diversion decision. Higher perceived risk and perceived treatment amenability were both associated with a decreased likelihood of rejecting the defendant from MHC. Perceived blameworthiness, unlike the full sample, was not a significant predictor for the non-conservative subsample. See Table 17 for a full breakdown of results and odds ratios.

Table 18. Binary Logistic Regression Predicting Diversion Decision

<i>Conservative Participants</i>						
Predictor	B	SE	Wald	OR	95% CI for OR	p
Constant	-5.67	4.26	1.77	—	—	<.01
Blameworthiness	0.07	0.05	1.95	1.07	[0.97, 1.17]	0.16
Risk	0.03	0.18	0.03	1.03	[0.73, 1.46]	0.86
Treatment amenability	-0.11	0.12	0.86	0.9	[0.71, 1.13]	0.73
<i>Other Participants</i>						
Constant	9.62	7.08	1.84	—	—	0.18
Blameworthiness	0.14	0.11	1.87	1.15	[0.94, 1.42]	0.17
Risk	-0.97	0.46	4.44	0.38	[0.16, 0.94]	0.04
Treatment amenability	-0.81	0.33	6.07	0.9	[0.37, 4.23]	0.01

Discussion

The purpose of this study was threefold. The primary goal was to investigate the issue of disparities in mental health courts based on defendant race and gender (Cosden et al., 2003; Frailing, 2011; Hiday et al., 2005; Luskin, 2001). It was hypothesized that disparities could occur due to biases, conscious or unconscious, that occur during the referral and admission stages of MHC participant recruitment. It was further hypothesized that these disparities could be explained by the predictions of focal concerns and classic attribution theory. Therefore, the second and third purpose of this study was to test the predictions of these two theories, both to determine if these factors (perceived risk, blameworthiness, control, disposition, etc.) influenced the diversion decision and if these factors mediated the relationship between the vignette conditions and diversion decision.

Starting with the third hypothesis, the results showed there was no significant impact of the vignette conditions on diversion decisions. Therefore, indicating that defendant race and gender does not impact the diversion decision. Surprisingly, the offense type (non-violent versus violent) also did not have an effect on the diversion decision. This is surprising due to the findings of the qualitative interviews described in Chapter 4, in which MHC professionals stated that violent crimes were more heavily scrutinized. It was expected that violent defendants would be more likely to be diverted because of the potential risk. Ultimately, however, there was no significant effect.

It is also important to note that participants in this study overwhelmingly chose to divert the vignette character to a MHC program. Of the 207 cases in this analysis, only 11 of the participants chose to reject the defendant and retain them in traditional criminal court. This is not necessarily surprising, as some of the professionals interviewed (see Chapter 4) remarked that they tried to admit anyone that they could, or that the MHC would give almost anyone a chance if they were interested in joining. Therefore, it may be worthwhile for future research to focus on how diversion can occur in areas outside of the referral and admission stages.

Hypothesis 1 and 2 investigated the predictions of focal concerns and attribution theory respectively. Hypothesis 1 was slightly supported as both perceived blameworthiness and amenability to treatment had a significant effect on participants' diversion decisions. As expected by the predictions of the theory, defendants who were perceived as more blameworthy received the harsher punishment of being retained in criminal court rather than being diverted to the MHC program. Therefore, blameworthiness did appear to be a factor in participant decision making. The measure

for practical constraints, amenability to treatment, also had a significant impact on participants' diversion decision. Participants who were perceived as more likely to engage in treatment and cooperate with the court were more likely to be diverted to the mental health court. However, perceived risk was not a significant predictor of the diversion decision. It is unknown why perceived risk did not have a significant effect on this decision. Descriptive observations of the individual items indicated that participants did believe, in general, that the defendant was at least slightly likely to commit a new offense, be violent towards someone else, or have their probation revoked. It is possible participants believed this risk would be mitigated regardless if they were under the supervision of the mental health court or the criminal court. Future research should further investigate how legal professionals view the potential risk of MHC participants.

Factors of attribution theory (controllability, responsibility, and locus) were tested as part of the second hypothesis. These factors were also found to not be significant predictors of the diversion decision. It was expected that participants who perceived the defendant as being more responsible for their actions, having more control over their actions, and viewed the cause as dispositional rather than situational, would be more likely to reject the defendant from the MHC program. As was described in the measures section, the items created for this survey intended to measure stability and locus did not perform as expected, therefore it is difficult to interpret the lack of significant findings. It is of course possible that these factors have no influence on the diversion decision, or there could be issues with the measurements used in the current study.

The findings of this study offer valuable insights into the factors influencing diversion decisions in mental health courts (MHC), although some results were

unexpected. First, the lack of significant impact of vignette conditions (defendant race and gender) on diversion decisions contradicts prior research that highlights racial and gender disparities within the criminal justice system. Even more surprising was the non-significance of offense type (non-violent versus violent) on diversion decisions. These findings suggest that, within the controlled environment of this study, participants may have been more focused on the defendant's mental health needs rather than demographic characteristics. However, the absence of an effect for offense type is particularly surprising, given the qualitative evidence from MHC professionals who indicated that violent offenses are more heavily scrutinized. This discrepancy may reflect a divergence between stated professional attitudes and actual decision-making processes in a controlled experimental setting.

The overwhelming preference for diversion to MHC, with only 11 out of 207 participants opting for traditional criminal court, further underscores the commitment to rehabilitation within MHC contexts. This aligns with qualitative interviews where professionals expressed a desire to admit almost any defendant who demonstrated interest in treatment. Even though the majority of the participants did not, and had not worked in an MHC setting, it seems they still had this commitment to rehabilitation. This finding raises the possibility that future research should explore other stages of the diversion process, such as post-admission compliance and retention, to better understand where disparities might emerge.

Regarding the first hypothesis, the significant effects of perceived blameworthiness and amenability to treatment support the predictions of focal concerns theory. Defendants perceived as more blameworthy faced higher likelihoods of retention

in traditional court, consistent with the theory's emphasis on moral evaluations. Conversely, those seen as more amenable to treatment were more likely to be diverted, highlighting the importance of practical constraints in decision-making. However, the non-significant effect of perceived risk is puzzling. Descriptive data suggests participants did view the defendant as at least slightly likely to reoffend or violate probation, suggesting they did view the vignette character as posing a recidivism risk. However, this perception of risk may have been mitigated by the supervision provided in either court setting. This finding warrants further investigation into how risk perception interacts with court supervision models.

In addition, political ideology was included as a control variable and proved to be an impactful predictor of diversion decisions. An additional analysis was conducted in which subsets of the data (conservative versus non-conservative respondents) were examined independently and compared in a binary logistic regression. This additional analysis indicated that focal concerns measures (perceived blame, risk, and treatment amenability) were not significant predictors for conservative participants. For non-conservative participants, higher perceived risk and treatment amenability were associated with a lower likelihood of rejecting the defendant from the MHC program. However, it is important to note that the already limited number of cases in which participants rejected the defendant was split across these subsets. More research with larger sample sizes is necessary for more conclusive findings.

These findings also have important theoretical implications for focal concerns theory more broadly. Research regarding focal concerns has received criticism in the past for various reasons, but a prominent critique has focused on research methodology

(Hartley et al., 2007; Lynch, 2019). These criticisms highlight that focal concerns researchers often use defendant-level data in their analysis. For example, blameworthiness may be operationalized as offense severity, assuming that more violent offenses are perceived as more blameworthy. Similarly, risk to the community may be operationalized as criminal history, assuming that legal decision-makers will view defendants with a prior record as greater risk. While these may be understandable assumptions and measures for defendant-level and secondary data, these methods do not capture decision-makers' perceptions of these concerns (i.e., how blameworthy or risky decision-makers perceive the defendant as). While the use of vignettes and self-report measures may have their own drawbacks (discussed further in the limitations section), the current study provides a more direct measure of decision-makers' perceptions of blameworthiness, risk, and practical constraints.

The second hypothesis, which tested attribution theory, yielded non-significant results for controllability, responsibility, and locus of control. This may reflect measurement issues, as noted in the measures section, where items intended to assess stability, and locus did not perform as expected. Alternatively, it is possible that these factors are genuinely less influential in MHC diversion decisions compared to focal concerns. Future studies could refine the measurement tools or explore alternative theoretical frameworks to better understand the role of attribution in this context.

Overall, these findings suggest that while certain focal concerns—such as blameworthiness and amenability to treatment—shape diversion decisions, demographic factors and attributional judgments may play a less significant role than anticipated. These results contribute to the growing body of literature on mental health courts and

highlight key areas for future investigation, particularly regarding the mechanisms underlying risk assessment and the long-term impacts of diversion decisions. Of particular note is the need for research that explicitly considers the political orientation of the participants. While originally included as a control variable, participants' political ideology proved to be an important predictor of MHC diversion. Future research could include more detailed scales to investigate this relationship through the lens of right-wing-authoritarianism and social dominance orientation measures.

Limitations

While this study provides valuable insights into the decision-making processes of mental health court (MHC) professionals, several limitations should be acknowledged. First, the use of a vignette-based methodology, while useful for controlling variables and isolating specific factors, may not fully capture the complexities of real-world diversion decisions. In practice, MHC professionals likely consider a broader array of factors, including case-specific details, personal interactions with defendants, and organizational constraints that were not represented in this study. As was made clear in the qualitative interviews, these admission decisions are often made after multiple meetings with the defendant and across several weeks. While participants in this study made their decision in a matter of minutes after reading a short vignette. Additionally, decision-making in actual MHC settings may be influenced by institutional policies, resource availability, and external pressures that were not accounted for in the controlled survey environment.

Second, although efforts were made to develop valid measures for key theoretical constructs, some of the attribution theory measures—particularly those assessing stability and locus—did not perform as expected. This raises concerns about whether these

constructs were accurately assessed, potentially contributing to the null findings regarding attributional judgments. Future research should refine these measures, perhaps incorporating established scales from previous studies or using qualitative methods to better understand how MHC professionals conceptualize these attributions in their decision-making processes.

Another limitation concerns the sample composition. The study relied on self-reported responses from legal professionals in the United States, but it is unclear to what extent their responses reflect their actual decision-making behavior. Social desirability bias may have influenced participants to respond in a way that aligns with best practices or ethical guidelines rather than their true decision-making tendencies. Given the sensitivity of topics related to race, gender, and criminal justice, it is possible that participants underreported the extent to which these factors influence their judgments. Therefore, it is important that future research continues to use secondary and institutional data to investigate disparity in real-world criminal justice systems.

Additionally, the overwhelming preference for diversion in this study raises questions about generalizability. While qualitative interviews suggested that MHC professionals strive to admit as many eligible participants as possible, it is unclear whether this strong preference for diversion reflects actual practices across different jurisdictions. Some MHCs may have stricter admission criteria or face constraints that limit their ability to divert defendants, which was not accounted for in this study. Future research should explore whether these findings hold across diverse court settings, particularly in jurisdictions with varying policies regarding eligibility and resource allocation.

Finally, while this study focused on the referral and admission stages of the MHC process, disparities may emerge at later stages, such as compliance monitoring, sanctioning, or program completion. The current study does not account for potential biases that could arise after a defendant has been admitted to the program. Future research should take a more longitudinal approach to examine whether disparities in MHC outcomes occur over time and identify factors that contribute to successful program completion.

Despite these limitations, the findings of this study provide an important contribution to the understanding of decision-making in MHCs and offer a foundation for future research aimed at improving equity and effectiveness in diversion programs. Future research using a vignette approach could include other manipulations not present in the current study. For example, future studies could include diagnosis type as a condition to see if different diagnoses and/or comorbidities (e.g., with substance abuse or personality disorders) affect perceptions of blame, risk, and treatment amenability. Additionally, future research could explore how the defendant's behavioral presentations such as expressed remorse, cooperation with law enforcement, or prior treatment engagement—affects diversion decisions. Investigating the role of contextual factors, such as judicial discretion, courtroom culture, and available treatment resources, may also provide deeper insight into the real-world applicability of these findings. Finally, the continued incorporation of qualitative methods, such as interviews or case studies, is important to help contextualize the decision-making process in ways that quantitative methods alone may not capture. This approach offers a more holistic understanding of how MHC professionals navigate these complex judgments.

Conclusion

This study contributes to the growing body of research on mental health courts (MHCs) by examining the factors that influence diversion decisions, with a particular focus on disparities related to race and gender, as well as the theoretical frameworks of focal concerns and attribution theory. While the results did not indicate significant disparities based on race or gender, they did highlight the importance of perceptions of blameworthiness and amenability to treatment in shaping diversion decisions. These findings suggest that while demographic factors may not play as large a role in the initial diversion decision as expected, legal decision-makers are still influenced by subjective assessments of a defendant's moral culpability and potential for rehabilitation.

Methodologically, this study highlights the importance of using direct measures of judicial decision-making factors rather than relying solely on secondary data sources. The findings provide support for aspects of focal concerns theory but offer less evidence for the role of attribution theory in MHC diversion decisions. However, limitations regarding measurement validity and the use of vignette-based methodology suggest that further refinement of theoretical models and research designs is necessary in addition to the continued use of institutional data to investigate disparities within the criminal justice system.

Beyond theoretical implications, this study has practical relevance for policymakers and practitioners involved in MHCs. Understanding that perceptions of blameworthiness and amenability to treatment influence diversion decisions may help inform training initiatives aimed at reducing potential biases in judicial decision-making. Furthermore, the overwhelming preference for diversion in this study suggests that MHC

professionals may be broadly supportive of expanding access to these programs. Future research should explore whether this preference aligns with real-world practices, particularly in jurisdictions where admission criteria and resource constraints may create additional barriers to entry.

In sum, this study provides a foundation for further exploration of decision-making in MHCs, particularly regarding the interplay between subjective perceptions, theoretical frameworks, and policy implementation. Future research should continue to refine measurement approaches, explore additional contextual factors, and examine longitudinal outcomes to assess the long-term impact of diversion decisions. By doing so, scholars and practitioners can work toward ensuring that MHCs operate in a manner that is both equitable and effective in addressing the needs of individuals with mental illness in the criminal justice system.

Chapter 6: General Discussion and Conclusion

This dissertation investigated the decision-making processes within mental health courts (MHCs), particularly in how it can contribute to disparities in admission decisions. Using a mixed-methods approach, the research integrated qualitative observations, in-depth interviews with MHC professionals, and an experimental survey to explore the role of race, gender, and offense type in diversion decisions. The findings contribute to both theoretical and practical understandings of legal decision-making in MHCs and have implications for policy and future research.

Summary of Key Findings

Across the three studies, multiple factors were examined to determine their influence on MHC admissions. The qualitative observations provided insight into how MHCs operate, highlighting the collaborative nature of decision-making and the therapeutic goals of these courts in comparison to traditional criminal courts. In addition, these observations demonstrated how focal concerns theory manifest in the context of MHCs and how these evaluations could lead to disparities within these programs. Observations of termination hearings suggested that MHC professionals consider the severity of violations, likelihood of continued violations, and access to resources as important factors when deciding to retain or remove a participant.

While not a primary focus of the current study, these observations also highlighted differences in the functions between the three observation sites. Most notably, the smaller size of the Thurston County MHC allowed for longer and more meaningful interactions between the participants and the courtroom workgroup. This contrasts with Washoe and Sacramento County programs which had much larger

caseloads. These hearings were more focused on efficiently processing the court docket rather than longer status hearings. While conclusions cannot be drawn from this qualitative data alone, it is important to consider how the time allotted for each participant during MHC hearings may influence outcomes.

The in-depth interviews with MHC professionals provided insight into the admission process, revealing that objective criteria such as offense type and mental health diagnosis play a role, subjective evaluations—including perceived blameworthiness and treatment amenability—also significantly impact decisions. Some professionals acknowledged the potential for biases, but most emphasized their commitment to fairness in admissions. These interviews also highlighted MHC professionals' goals of providing treatment and avenues of rehabilitation for their participants. Interviewees also stated issues of stigma among other legal professionals and especially among defendants themselves. Many professionals described a persistent skepticism among traditional court actors, as well as reluctance among defendants to self-identify as needing mental health services, both of which can act as barriers to MHC participation.

The experimental survey tested the findings of the qualitative studies in a controlled setting, manipulating defendant race, gender, and offense type to assess their influence on diversion decisions. The results did not indicate significant disparities based on race or gender, contradicting some prior research on criminal justice disparities. In addition, attributional measures (locus, stability, and controllability) similarly did not have an effect on diversion decisions. However, perceived blameworthiness and treatment amenability emerged as significant predictors of diversion decisions, supporting the predictions of focal concerns theory. Violent defendants were also, on

average, perceived as more blameworthy, coinciding with qualitative findings that suggested greater scrutiny is placed on defendants with more violent offenses.

In addition, participants' political ideology was found to have a significant effect on diversion decisions, indicating that long-held beliefs about crime and how to address it may have the strongest predictive power of these factors. In fact, concerns of blameworthiness and treatment amenability became nonsignificant predictors in a subset analysis of conservative respondents. Finally, it is important to note, survey respondents overwhelmingly decided to divert the vignette character to the MHC program. This coincided with the qualitative findings which suggested that workgroups attempt to admit any participant who seems eligible and gives defendants the chance to participate in the court.

Theoretical Implications

This research extends focal concerns theory by applying it to MHC decision-making. While prior research has often inferred blameworthiness and risk perceptions from case characteristics such as offense severity or prior criminal history, this study directly measured these perceptions through an experimental vignette survey and self-report of perceptions. The findings indicate that while blameworthiness and treatment amenability significantly influence MHC admission decisions, the expected impact of perceived risk was not observed. This suggests that MHC decision-makers may weigh the potential benefits of rehabilitation more heavily than the risks of recidivism, or view MHC programs as still exerting a sufficient amount of control over risky defendants. In addition, participant race and gender did not influence these factors as the theory would predict, though it is possible social desirability concerns influenced participant responses.

The study also tested attribution theory but found limited evidence for its explanatory power in this context. While it was hypothesized that perceptions of controllability, responsibility, and locus of causality would influence diversion decisions, these factors were not significant predictors. This may be due to measurement limitations or a genuine lack of impact in MHC settings, warranting further exploration in future research.

Practical and Policy Implications

The findings have several implications for MHC policy and practice. First, the strong influence of perceived blameworthiness and treatment amenability suggests that judicial training and decision-making frameworks should emphasize structured assessments to minimize subjective biases. Ensuring that eligibility criteria and decision-making guidelines are transparent and standardized may help reduce disparities in admissions.

Additionally, the overwhelming preference for diversion in the experimental study suggests that MHC professionals and other legal decision-makers may be generally supportive of expanding access to these programs. However, disparities may still emerge in later stages of the MHC process, such as compliance monitoring, sanctioning, or program termination. Future research should investigate these later stages to identify potential points of inequity.

The qualitative findings offered valuable insight into the functioning of mental health courts (MHCs) and the perceptions held by courtroom workgroup members regarding their respective programs. The first study facilitated cross-site comparisons among three courts, revealing notable differences in both the duration and quality of

interactions between participants and the courtroom workgroup. In particular, the smaller docket sizes in Thurston County appeared to allow for longer, and potentially more therapeutic, engagements with participants. However, despite having shorter individual hearings, Sacramento similarly had fewer violations. This indicates that even in more brief interactions between the workgroup and the participants, there was perhaps an increase in the quality of interactions that appeared to have been more therapeutic in nature. While such differences are influenced by structural factors including court size, caseload, and available resources, MHCs may wish to explore strategies for enhancing the frequency and depth of participant interaction—such as increasing the number of calendars held each week or reducing the number of participants seen per calendar. Even in resource-constrained settings, workgroup members should endeavor to engage meaningfully with participants, acknowledging their experiences and challenges both within and beyond the court program.

In addition, it is important to consider how types of interventions can contribute to positive interactions with the workgroup. Thurston County often required participants to contact their care coordinators daily by phone until their next hearing after a violation even for first time or minor infractions. Other mental health courts should consider this approach rather than simply giving the participant a warning for minor violations. Requiring this communication is a simple way to increase accountability of the participant in addition to creating more interactions with workgroup members which can facilitate building trust and rapport with participants.

Study two provided insight into workgroup members' perspectives regarding disparity in their programs. Approximately half of those interviewed stated they had not

noticed any issues of disparity, and some of those described their program's efforts to track admission rates in addition to graduation, termination, and even sanction application across factors such as race, gender, sexual orientation, and age. Mental health courts should continue tracking participant demographic data or adopt this practice if not already doing so to promote transparency, identify potential inequities, and support efforts toward more equitable outcomes for all participants.

Some of those interviewed indicated that prosecutors and judges outside of the mental health court may be reluctant to divert defendants to these programs due to misunderstandings of mental health struggles or concerns about MHCs being too lenient. Relatedly, some interviewed also indicated that there may be a lack of awareness about their respective MHC programs among potential referral sources such as private defense attorneys or the general community. Therefore, education efforts within the legal system and the broader public can help ensure that eligible individuals are appropriately referred to mental health courts, enhance understanding of the challenges faced by individuals with mental illnesses, and build broader support for these programs as a valuable alternative within the justice system.

Others also indicated that mental health stigma from the participants themselves may result in disparity. These professionals stated that minority defendants may be less likely to join these programs simply because of the name of the court. Participants may fear being labeled as mentally ill or may distrust mental health services based on cultural stigma or past negative experiences with institutional systems. As a result, mental health courts should consider strategies to reduce stigma, such as providing clear, respectful explanations of the program's purpose and benefits, engaging culturally competent staff,

and exploring alternative program names or descriptions that emphasize recovery and support rather than diagnosis.

In relation to stigma, several interviewees suggested that participants may exhibit resistance to engaging with mental health courts (MHCs) due to mandated medication compliance. Some interviewees expressed empathy toward this reluctance, citing the often severe side effects associated with psychotropic medications. Existing scholarship has raised ethical concerns regarding compulsory medication as a condition of program participation (Hughes & Peak, 2012); however, such mandates remain a common component of MHC requirements. In light of these concerns, MHCs may benefit from incorporating the recommendations of Hughes and Peak, which emphasize the importance of affording participants greater agency in their treatment plans, including the autonomy to accept or decline medication.

Finally, this research highlights the importance of integrating qualitative and quantitative approaches in legal decision-making studies. The qualitative findings provided context for understanding decision-makers' reasoning, while the experimental survey allowed for the systematic testing of key variables. Future studies should continue to use mixed-methods designs to gain a more comprehensive understanding of MHC operations.

Limitations and Future Directions

While this research provides valuable insights, several limitations should be acknowledged. The vignette-based experimental design, while useful for isolating specific factors, may not fully capture the complexities of real-world decision-making. Additionally, the study relied on self-reported judgments, which may not always align

with actual behavior in courtroom settings. Future research should incorporate case file reviews or observational studies of real MHC decision-making to validate these findings. In addition, future research should continue to analyze institutional data in addition to studies that directly measure decision-maker perceptions such as the current study.

The measurement of attributional constructs also posed challenges. Some scales, particularly those assessing stability and locus of control, did not perform as expected. Future studies should refine these measures or explore alternative ways of capturing attributional reasoning in MHC contexts.

Another important area for future research is the role of political ideology in MHC decision-making. The survey findings indicated that political orientation was a significant predictor of diversion decisions, suggesting that broader ideological beliefs may influence perceptions of blameworthiness, risk, and treatment potential. Further research should investigate this relationship using more detailed measures of political attitudes, such as right-wing authoritarianism or social dominance orientation.

Lastly, while this dissertation focused on the referral and admission stages of the MHC process, disparities may also occur in later phases, such as compliance monitoring and program completion. Similar vignette style studies framed around sanction or termination decisions is an avenue for future research. In addition, a longitudinal approach that follows defendants throughout their participation in MHC programs would provide deeper insights into how disparities evolve over time.

Conclusion

This dissertation advances the understanding of decision-making in mental health courts by integrating qualitative and quantitative methodologies to examine disparities in

admissions. While the findings do not support the hypothesis that race and gender directly influence diversion decisions, they underscore the importance of perceived blameworthiness and treatment amenability in shaping these outcomes. The study contributes to theoretical debates on focal concerns and attribution theory, highlighting the need for further refinement of these models in the context of specialty courts. Practically, these findings emphasize the importance of structured decision-making tools and standardized criteria in MHC admissions. They also point to the need for continued research on how political ideology and broader systemic factors shape diversion decisions. By addressing these issues, future research can help ensure that MHCs operate in a manner that is both equitable and effective in addressing the needs of individuals with mental illness within the criminal justice system.

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Appendix A: Definitions of Codes and Subcodes

Communication: Cases with a therapeutic intervention code received this subcode if the participant was instructed to increase the amount of contact with the workgroup or increase the level of communication (e.g., required to meet in-person instead of calling).

Communication issues: Violation hearings received this this subcode if at least one of the violations included an issue of remaining in contact with workgroup members they were expected to meet or check-in with.

Community service: Cases with a punitive intervention code received this subcode if the participant was ordered to complete community service hours.

Concerning behavior: Violation hearings received this subscode if at least one of the violations included participant exhibiting symptomatic behaviors or being combative towards treatment or courtroom staff.

Coordinating with treatment providers: Cases with a therapeutic intervention code received this subcode if the court instructed the participant to speak with their treatment provider to ask about changes to medication or other treatment.

Extend program time: Cases with a punitive intervention code received this subcode if the participant's graduation date was delayed as a response to their violation.

Failure to follow sanction: Violation hearings received this subcode if at least one of the violations included the participant failing to complete a sanction for a previous violation.

Increased care: Cases with a therapeutic intervention code received this subcode if the court increased the participant to a higher level of treatment such as moving to an in-patient facility or a sober-living environment

Increased court appearances: Cases with a punitive intervention code received this subcode if the participant was required to attend MHC hearings more often (e.g., every week instead of every two weeks).

Increased drug testing: Cases with a therapeutic intervention code received this subcode if the participant was instructed to increase their level of substance testing (e.g., from random testing to everyday testing).

Jail: Cases with a punitive intervention code received this subcode if the participant was ordered to turn themselves into the jail in response to their violation.

Missed court: Violation hearings received this subcode if at least one of the violations included missing a scheduled court hearing.

New criminal charge: Violation hearings received this subcode if at least one of the violations included a new criminal charge.

No intervention: Cases received this code when the courts response to a violation was to not impose an intervention or excuse the violation.

Participant removed: The judge decided to remove the participant from the MHC program,

Participant retained: The judge decided to let the participant remain in the MHC program.

Punitive intervention: Cases received this code when at least one response to a violation involved an intervention focused on punishment or deterrence.

Reflective essays: Cases with a therapeutic intervention code received this subcode if the participant was instructed to write or journal about the violation and how to prevent it in the future.

Set termination hearing: Cases with a punitive intervention code received this subcode when the response was to schedule a termination hearing to formally discuss if the participant would remain in the program.

Status hearing: Cases received this code when the workgroup gave an update on the participant with no pressing issues to discuss (e.g., violation, sanction, termination).

Termination hearing: Cases received this code when the purpose of the hearing was to discuss if a participant would be removed from the program.

Testing violation: Violation hearings received this subcode if at least one of the violations included: missing a scheduled substance test, a diluted test, or a positive result for substances not allowed in the program.

Therapeutic intervention: Cases received this code where at least one response to a violation involved an intervention focused on treatment or rehabilitation.

Treatment violation: Violation hearings received this subcode if at least one of the violations included: not taking medication as prescribed, missing an appointment with a treatment provider.

Violation hearing: Cases received this code when the workgroup discussed a participant's non-compliance with the mental health court and its rules.

Voluntary removal: The participant asked to leave the program and to return to traditional court.

Warning: Cases with a therapeutic intervention code received this subcode if the response was to inform the participant about the violation and the expectations with no further intervention.

Appendix B: Interview Questionnaire

Opening

1. Could you explain your role in the Mental Health Court and give a description of your time there?
 - a. Did you receive any special training, whether voluntary or required, when joining this workgroup?
 - b. How did you find yourself in this court? Did you elect to be involved or were you selected?
2. What would you say is the overall goal and philosophy of the mental health court program?
3. For Judge Wren: What do you think are the major changes you have seen over your time in the MHC?

Admissions

4. How are defendants identified and selected for the program?
 - a. At what point in the process are defendants diverted to MHC? (i.e., after arrest, after initial hearing, etc.)?
5. Is there a standardized process for diverting/accepting people into the court? Or is it discretionary or a case by case basis?
 - a. Who makes this decision?
 - b. How difficult would you say it is to get accepted into the program?
 - c. When you discuss a case as a team, have there been disagreements on whether or not someone should be admitted? How is that resolved and what are the disagreements over?
6. What factors might prevent someone from being accepted into the court?
 - a. Does the type of offense matter? Would someone convicted of a violent offense still have the option of going into mental health court?
 - b. Is there a pattern of types of offenses you see in this population?
 - c. Do you have to identify the nexus between the offense and the diagnosis?
 - d. Is there every a question or consideration of “why did this person commit this offense?”
7. Do defendants ever choose not to enter the program or leave part way through? Do they give indication as to why?
 - a. Is mental health stigma an issue?

Sanctions/in the program

8. What is expected of clients in the program? What do they have to do?
9. What kind of services are available to participants?
 - a. What factors go into suggesting a client for in-patient or out-patient treatment?
10. What is your response to non-compliance among participants?
11. What are sanctions like? How do you decide when they are necessary? How do you decide what they should be?
 - a. What would you say are the goals of the sanctions?
 - b. When do you decide on rehabilitative vs punitive sanctions?
12. Do you use incentives in addition to sanctions? If so, what are the incentives?
 - a. What is the goal of incentives? Is it different from sanctions?

13. At what point do you consider removing a participant from the program? What goes into that decision?
14. What qualities do you see in participants who are ultimately successful in the program?
 - a. What qualities do you see in participants who struggle, or who ultimately drop out of the program?
15. What do you think MHC in general is doing well, how can it improve?
 - a. Do you think there are any notable barriers right now that affect the efficacy of the court? Getting people admitted? What would you like to see in the future of mental health courts?
16. Previous research has indicated there may be discrepancies in MHC and other specialty courts based on race, gender, age, and other demographic variables. Have you had any experiences like this or noticed any discrepancies?
17. Anything else you'd like to add that I haven't asked about?

Appendix C: Vignettes

Non-Violent Condition

Alex, a 23-year-old (White/Black) (male/female) (pictured below), was arrested after arriving uninvited to a family gathering at a relative's house. Relatives reported that Alex, who had been estranged from (his/her) family due to arguments and erratic behavior, had been sleeping in (his/her) car or on friends' couches. Witnesses said Alex had seemed increasingly unstable, expressing feelings of exclusion. At the gathering, (he/she) questioned relatives about not being invited and became agitated when told (he/she) wasn't welcome. The situation escalated when Alex attempted to take items, including expensive kitchenware and a handbag, stating (he/she) "needed these things." After attempts to calm (him/her) failed, the police were called.

When officers arrived, Alex appeared confused and defensive, insisting (he/she) "had to be there" and muttering about feeling "left out" and "alone." (He/She) struggled to explain (his/her) actions and seemed unaware of their seriousness. The district attorney has recommended charges of theft and trespassing. Friends and family report Alex has shown signs of possible mental illness, including unstable mood, paranoia, and disorganized thinking, but (he/she) has never been diagnosed or treated. Recently, Alex has become increasingly withdrawn and struggled with daily routines.

The community has a Mental Health Court, which offers probation and treatment as an alternative to incarceration. In discussing this option with (his/her) attorney, Alex expressed hesitation, admitting (he/she) was unsure if it was "the right path" and didn't fully understand the program. However, (he/she) also showed interest because it would keep (him/her) out of jail. As you consider this scenario, please reflect on Alex's actions, the importance of addressing mental health concerns, and whether diversion to mental health court is appropriate. Factors to consider include the safety of the community, the resources required for treatment, and Alex's ability to complete the program.

Violent Condition

Alex, a 23-year-old (White/Black) (male/female) (pictured below), was arrested after arriving uninvited to a family gathering at a relative's house. Relatives reported that Alex, who had been estranged from (his/her) family due to arguments and erratic behavior, had been sleeping in (his/her) car or on friends' couches. Witnesses said Alex had seemed increasingly unstable, expressing feelings of exclusion. At the gathering, (he/she) questioned relatives about not being invited and became agitated when told (he/she) wasn't welcome. The situation escalated when (his/her) sibling, Jamie, confronted (him/her), an argument escalated, and Alex struck Jamie with a glass bottle, causing serious injuries that required medical attention.

When officers arrived, Alex appeared confused and defensive, insisting (he/she) "had to be there" and muttering about feeling "left out" and "alone." (He/She) struggled to explain (his/her) actions and seemed unaware of their seriousness. The district attorney

has recommended charges of aggravated assault and trespassing. Friends and family report Alex has shown signs of possible mental illness, including unstable mood, paranoia, and disorganized thinking, but (he/she) has never been diagnosed or treated. Recently, Alex has become increasingly withdrawn and struggled with daily routines.

The community has a Mental Health Court, which offers probation and treatment as an alternative to incarceration. In discussing this option with (his/her) attorney, Alex expressed hesitation, admitting (he/she) was unsure if it was “the right path” and didn’t fully understand the program. However, (he/she) also showed interest because it would keep (him/her) out of jail. As you consider this scenario, please reflect on Alex’s actions, the importance of addressing mental health concerns, and whether diversion to mental health court is appropriate. Factors to consider include the safety of the community, the resources required for treatment, and Alex’s ability to complete the program.

Appendix D: Survey Measures

Initial evaluation of defendant's mental health

1. In your opinion, how likely do you think it was that the defendant (Alex) was actually experiencing mental illness? (1- Extremely unlikely to 6-Extremely likely).

Social Distance Measure

2. Please indicate your willingness to engage in the following activities (1- Completely willing to 6-completely unwilling).
 - a. Move next door to the defendant?
 - b. Make friends with the defendant?
 - c. Start working closely with the defendant?
 - d. Have a group home for people like the defendant open in your neighborhood?
 - e. Please select "completely willing"
 - f. Have the defendant marry into your family?

Cause of defendant's behavior

3. In your opinion, how likely is it that Alex's actions were caused by... (1- Extremely unlikely to 6- Extremely likely).
 - a. poverty/unemployment
 - b. mental illness
 - c. limited education
 - d. substance abuse
 - e. family problems
 - f. immoral character
 - g. peer/neighborhood pressure
 - h. feelings of anger and revenge

Locus/Control/Stability measure

4. Please indicate your level of agreement with the following statements. **The cause(s) of Alex's behavior...**(1- Strongly agree to 6- Strongly disagree).
 - a. Reflect an aspect of Alex's internal character
 - b. Is something that Alex can manage
 - c. Is permanent
 - d. Is something Alex CANNOT regulate
 - e. Is something that can change over time
 - f. Reflect an aspect of the situation Alex is in

Risk/Amenability to treatment measures

5. In your opinion, how likely is Alex to...(1- Extremely unlikely to 6- Extremely likely)
 - a. Commit a new offense
 - b. Be violent towards someone else
 - c. Have their probation revoked
 - d. Engage in mental health treatment
 - e. Please select "moderately unlikely"

- f. Use the services and resources given to them by the court
- g. Take mental health medication as prescribed
- h. Cooperate with the mental health court

Attribution: Control measure

6. Please indicate your agreement with the following statements (1- Strongly disagree to 6- Strongly agree).
- a. The defendant's actions were under their personal control
 - b. It was something that the defendant did that led to the criminal offense
 - c. The defendant could NOT have prevented their actions
 - d. The defendant had NO control over the causes that led to the offense

Attribution: Responsibility measure

7. Please indicate your agreement with the following statements (1- Strongly disagree to 6- Strongly agree).
- a. The defendant is responsible for their actions
 - b. The defendant is accountable for their actions
 - c. The defendant's actions are NOT a result of their own negligence
 - d. The defendant should NOT be held personally liable for their actions

Attribution: Blameworthiness measure

8. Please indicate your agreement with the following statements (1- Strongly disagree to 6- Strongly agree).
- a. The defendant is to blame for their actions
 - b. It is their own fault that the defendant is facing a criminal charge
 - c. The defendant does NOT deserve what happened to them
 - d. The defendant should NOT feel guilty for their actions
 - e. Please select "somewhat agree"

Perception of Perpetrator Blameworthiness scale

9. Rate the defendant on the following characteristics (Binary measure 1 to 7)
- a. violent - nonviolent
 - b. gentle - forceful
 - c. maniacal - sane
 - d. good nature - vicious
 - e. malicious - kind
 - f. blameless - blameworthy
 - g. fault - faultless
 - h. harmful - harmless
 - i. hurtful - innocuous
 - j. responsible - irresponsible
 - k. careful - reckless
 - l. conscientious - careless
 - m. reliable - unreliable
 - n. dependable - undependable

Belief Towards Mental Illness scale

10. Select the option that best reflects your agreement towards the statement (1- completely disagree to 6- completely agree)
- a. A mentally ill person is more likely to harm others than a normal person.

- b. Mental disorders require a much longer period of time to be cured than would other general diseases.
- c. It may be a good idea to stay away from people who have psychological disorders because their behavior is dangerous.
- d. The term “psychological disorder” makes me feel embarrassed.
- e. A person with a psychological disorder should have a job with minor responsibilities.
- f. Mentally ill people are more likely to be criminals than non-mentally ill people.
- g. Psychological disorders are recurrent.
- h. I am afraid of what my boss, friends, and others would think if I were diagnosed as having a psychological disorder.
- i. Individuals diagnosed as mentally ill will suffer from its symptoms throughout their life.
- j. People who have once received psychological treatment are likely to need further treatment in the future.
- k. It might be difficult for mentally ill people to follow social rules such as being punctual or keeping promises.
- l. I would be embarrassed if people knew that I dated a person who once received psychological treatment.
- m. I am afraid of people who are suffering from psychological disorders because they may harm me.
- n. A person with a psychological disorder is less likely to function well as a parent.
- o. I would be embarrassed if a person in my family became mentally ill.
- p. I do not believe that psychological disorders are ever completely cured.
- q. Mentally ill people are unlikely to be able to live by themselves because they are unable to assume responsibilities.
- r. Most people would not knowingly be friends with a mentally ill person.
- s. The behavior of people who have psychological disorders is unpredictable.
- t. Psychological disorders are unlikely to be cured regardless of treatment.
- u. I would not trust the work of a mentally ill person assigned to my work team.

Demographic questions

- 11. What is your gender?
 - a. Male
 - b. Female
 - c. Other (please specify)
 - d. Prefer not to say.
- 12. What is your age? (fill in)
- 13. What is your race/ethnicity? (Select all that apply)
 - a. White/Caucasian
 - b. Hispanic/Latino
 - c. Black/African American
 - d. Native American/American Indian

- e. Asian/Pacific Islander
 - f. Other (please specify)
14. What is your level of education?
- a. Less than a high school diploma
 - b. High school or equivalent
 - c. Bachelor's degree
 - d. Master's degree
 - e. Professional degree (e.g., JD, MD, DDS)
 - f. Doctorate
 - g. Other (please specify)
15. What is your current (or last position if retired) profession within the legal system?
- a. Judge
 - b. Attorney (defense)
 - c. Attorney (prosecution)
 - d. Paralegal
 - e. Police officer
 - f. Administrative position
 - g. Other (explain)
 - h. I do not/have not worked in the legal system.
16. Are you currently working as a team member of a Mental Health Court or have you worked as a team member of a Mental Health Court in the past?
- a. Yes, I currently work/have worked in a Mental Health Court
 - b. No, but I have worked on another specialty court docket (Drug Court, Veterans Court, etc.)
 - c. No, I haven't worked on a mental health court or specialty court.
17. What was your total household income before taxes during the past 12 months?
- a. Less than \$25,000
 - b. \$25,000 - \$49,999
 - c. \$50,000 - \$74,999
 - d. \$75,000 - \$99,999
 - e. \$100,000 - \$149,999
 - f. \$150,000 or more
 - g. Prefer not to say.
18. How would you describe your political view? (1- Very liberal, 3- Moderate, 5- Very conservative)
19. What is your political affiliation?
- a. Republican
 - b. Democrat
 - c. Independent
 - d. Green
 - e. Libertarian
 - f. Other (please specify)
20. Are you currently diagnosed, or have you ever been diagnosed with a mental health condition?

- a. No
- b. Yes (What is/was the diagnosis? Leave blank if you prefer not to say)