Mental Health Courts and their Effects on Repeat Offending and Suicidality: Evidence from Randomized Therapists *

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Abstract

As many as 20 percent of inmates in jails reportedly suffer from a serious mental illness. In an effort to divert the mentally ill out of jails and prisons, many counties have introduced "mental health courts" which transfer defendants with mental illness symptoms into a specialty court. These courts usually place defendants on remove defendants from criminal justice constraints while awaiting disposition. Using administrative data from a large urban county's correctional complex, we use a leniency design with randomized therapists to estimate the causal effect of mental health court on criminal and health outcomes. We find that mental health court increases repeat offending by as much as 40 percent. However, we also find that mental health court improves mental health symptoms and reduces suicide attempts and suicide ideation. Using the leniency design's quasi-random assignment to a public defender versus a private attorney for all mental health court defendants, we show that public defenders are responsible for the increased mental health scores and reduction in suicidal ideation and suicide attempts.

Keywords: mental health court; diversion; recidivism; suicide; leniency design.

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1 Introduction

A significant number of individuals with mental illnesses are in jail or in prison on any given day. Consequently, jails have become the de facto mental hospital of last resort. As a result of the growth in the prison population, criminal justice now holds the sober responsibility of protecting the health and safety of its inmate population, but due to the growth in mentally ill inmates, suicide has become the most common cause of death in correctional facilities. As inmates exit these facilities, many counties have sought to address the lack of coordination and continuity of care for mentally ill offenders by investing in specialty courts which disentangle the mentally ill from criminal justice altogether. These courts are called mental health courts and exist in over 600 counties as of 2016 across the US.

Frank and McGuire (2010) note that a serious mental illness is associated with a 58% higher lifetime risk of arrest conditional on age, gender and race. They report the results of several evaluations of these courts and note that the results are mixed. The most common result appears to be a reduction in recidivism, but as the designs are often weak matching on observables, it is unclear if these declines in repeat offending are causal or merely a result of spurious unobserved selection.

We present new evidence on the causal effect of mental health courts on repeat offending, mental health symptoms and suicidal indicators using a popular design in criminal justice called the leniency design. The leniency design is also often called judge fixed effects because of the common use of randomized judges to estimate various criminal justice outcomes. Mental health courts are often too small to have randomized judges as there may be as few as one judge handling the entire docket. Instead, we use a separate form of randomized leniency – the randomization of therapists that occurs at the point of booking in a large urban correctional complex. These therapists interview each inmate and then rate the severity of their mental illness symptoms on a scale of 0 (high functioning) to 3 (lowest functioning). Because therapists show systematic tendencies to recommend mental health court, we are able to use their average propensity as an instrument for each inmate's score, allowing us to estimate the causal effect of mental health on recidivism

and health.

We show that the effect of mental health court is a mixed blessing. First, we show that random assignment of mental health court causes recidivism to increase by 47%. These effects were larger for inmates with a prior record (63% versus 38%). Because we find no differences in recidivism for public defenders versus private attorneys, we believe that the cause of the increase in repeat offending is due to mental health courts inability to incapacitate defendants awaiting trial and upon disposition. This mechanically negates any incapacitation effects from traditional adjudication.

But beyond an increase in repeat offending, we find evidence of heterogeneous effects depending on whether an inmate was assigned to a private attorney or the public defender. Public defenders have no differential impact on repeat offending, but have dramatic impacts on mental health. Conditional on returning to jails, those who had previously been assigned a public defense were less likely to attempt suicide and showed considerable improvements in their functioning. This suggests that the bulk of negative effects due to mental health courts were caused by private "wheel" attorneys.

We find that if assigned a private attorney, then compared to those individuals who had just missed qualifying for mental health court (receiving a mental health score of 1), then suicide attempts conditional on returning to jail increased. This effect is concentrated among those who have prior mental health problems. Furthermore, private attorneys do not lead to improvements in mental health. So, the overall effect of being assigned a private attorney shows no evidence of improved mental health; if anything, mental health deteriorates for this group.

These findings have implications for understanding both the causal effect of mental health courts on communities as well as whether there are differences in how communities interpret and comply with the Sixth Amendment guaranteeing counsel regardless of ability to pay. While the Sixth Amendment requires compliance in providing indigent defense, it does no specify how those benefits will be financed or sourced. We find that this matters, suggesting that through a combination of negative selection and weak incentives, private indigent attorneys perform considerably worse at helping the mentally ill than public defenders. mental health court is a mixture of costs and benefits that must be addressed

if these courts are to continue to be a first line approach to helping mentally ill defendants caught in the criminal justice system.

The following document is organized as follows. Section two discusses the history of mental healthcare, including mental health courts, in the US. The third section discusses our data and research design. The fourth section reports our findings, including heterogeneity analysis. The fifth section concludes with a discussion of the implications of our findings.

2 Background

The concentration of the mentally ill within correctional justice facilities has not always been as high as it is today. Rather, it grew as a result of the US transition of its mental healthcare towards community-based care as well as the considerable growth in arrest, sentencing and imprisonment from the 1970s to the present (Harcourt, 2006; Western, 2006; Raphael and Stoll, 2013). Some authors have suggested that this growth in jail and prison population selected on mentally ill citizens who lacked treatment options or were unable to receive it due to resource constraints. As jails and prisons began absorbing more Americans, some of this growth selected on the mentally ill. Here we discuss that history, including the growth of mental health courts and the problem of suicides in jails and prisons.

2.1 History of Mental Healthcare Within Jails and Prisons

Prior to the 1960s, the US depended intensively on state funded mental hospitals to treat severe mental illness. These hospitals were primarily staffed with custodians, in poor condition, and employed few psychiatrists. As such, there were eventual complaints about human rights violations within them, and policymakers sought to defund them. This became possible as alternatives to hospitalization became more available.

As training in mental health increased at medical schools and graduate programs, different options became available, and in 1963, President Kennedy established the first community mental health centers which improved options for treating mental health dis-

orders. Combined with the establishment of Medicare and Medicaid in the 1960s, mental healthcare expanded in the US which caused a decrease in mental health hospital populations. The creation of Section 8 housing only intensified this process as many of the mentally ill, when symptoms are severe, experience homelessness. The advent of several pharmacological breakthroughs for treating schizophrenia (Clozaril), bipolar disorder (Lithium), and depression (selective serotonin reuptake inhibitors (SSRIs)) only furthered the deinstitutionalization of US mental health hospitals and replaced it with more heterogeneous outpatient options.

But as the movement towards community based treatment for mental illness occurred, the US began its intensive war on crime. From the mid 1970s to 2000, the number of US citizens housed in correctional facilities grew from 100 individuals per 100,000 to over 500 per 100,000 (Patillo, Weidman and Western, 2004; Western, 2006). Raphael and Stoll (2013) show that the causal effect of this expansion in US imprisonment additionally caused a decline in the number of mentally ill individuals living openly in society. Torrey et al. (2014) estimates that today as much as twenty percent of inmates in jails suffer from a serious mental illness.

2.2 Mental Health Courts

The mental health court movement emerged out of recognition of inequities in the experiences of mentally ill offenders within criminal justice, along with the therapeutic jurisprudence and drug court movements (Watson et al., 2001). Admission into mental health courts is complicated and often a variable decision-making process that involves multiple parties, such as therapists, clinicians, judges, defense attorneys, and victims, all of whom represent different expertise and interests (Wolff, 2002b; Wolff and Pogorzelski, 2005). Over the last 30 years, problem-solving courts have shifted the criminal court's focus from criminal processing to therapeutic healing (Rottman and Bowman, 2014).

The first mental health courts began in Broward County, Florida in 1997 and the Psychiatric Assertive Identification and Referral (PAIR) Program in Marion County, Indiana in 1996. A Broward County circuit judge established a mental health task force which found that the mentally ill were cycling through jails. These individuals were often picked

up for low-level offenses, sat in jail untreated for days after being unable to make bond, pled guilty or no contest, released, and rearrested. This process would repeat over and over for the most severely mentally ill and became a burden on communities both in the form of using scarce criminal justice resources, as well as emergency departments.

Mental health courts were created as a diversion intervention to engage defendants with mental illnesses in treatment in lieu of incarceration (Wolff, 2002a). These courts are specialty courts adopted by counties to care for the growing mentally ill population caught in criminal justice institutions in their communities. They have grown in popularity in recent years, with over 600 county-level mental health courts across the country as of 2016, and only continue to grow.

Mental health courts receive a variation of cases, and since the criteria and capacity constraints of these courts differ by county, it is impossible to say just exactly how individuals are selected. Nonetheless, we know that these individuals differ from those in traditional adjudication based on observed and unobserved selection bias. The mere reason that a defendant has a combined criminal charge and mental illness that falls within the court's eligibility criteria is not sufficient to determine admission into the court given capacity constraints within that county. But the opposite is also true; the fact that a criminal charge and/or mental illness (of a defendant) fall outside the court's eligibility criteria is not sufficient to preclude admission. To the extent that the eligibility criteria of mental health courts are more suggestive than deterministic, selection bias can be expected (**?**). For example, particularly low-risk individuals, or those exhibiting mental illness symptoms that are misdemeanor offenders, may be offered the intervention but not necessarily be appropriate for it.

Not knowing the effect of mental health scoring of inmates, which influences the mental health court docket, as well as not knowing the source of the improved outcomes, attributes to mental health courts compromise the transportability of the intervention and its effectiveness to other settings (especially outside of jail/prison).[1] The mental health court intervention can only be expected to work for a select and specific class

[1]It is important to note that insofar as performance outcomes are driven by idiosyncratic case selection processes, then research designs such as differences-in-differences will combine heterogeneous courts which likely violate the stable unit treatment value assumption (SUTVA) assumption.

of defendants with mental illnesses. This is especially problematic when the decision rule process (i.e. mental health scoring upon entry to jail/prison) generating the mental health court class of defendants cannot be readily replicated because it relies on hard-to-measure factors, such as a clinician's/therapist's initial evaluation of an inmate (Wolff, 2002b; Wolff and Pogorzelski, 2005). Very little research has rigorously focused on the selection processes underpinning mental health courts even though such processes may influence the performance of such interventions.

mental health courts attempt to prevent criminalization and recidivism by providing critical mental health services to individuals booked in a jail/prison. But it is important to note that as each jurisdiction across the US has developed its own variation of a mental health court based on local needs and realities, these courts may experience different outcomes depending on whether specific mechanisms within the court are more effective than others. These courts handle only cases involving offenders with mental disorders, and mostly focus on misdemeanor offenses. The judge, prosecutor, defense attorney, and other court staff often have special training in and are familiar with community mental health services. Oftentimes, court staff collaborate with community providers to implement a therapeutic intervention that may include medication management, substance abuse treatment, housing, job training, and psychosocial rehabilitation, although this is mostly true only for individuals receiving public defenders via the mental health court. Overall, mental health courts aim to defer charges or jail sentences if defendants agree to participate in services. The ultimate goal of such courts is to prevent criminalization and recidivism by providing critical mental health services that such defendants would not otherwise be able to receive (Watson et al., 2001).

In general, mental health courts have several defining characteristics including: (1) a specialized docket of cases of defendants with a mental illness; (2) a collaborative and non-adversarial team comprised of a judge, prosecuting and defense attorneys, and a mental health representative; (3) a link to a local mental health system; and (4) compliance monitoring with sanctions for non-compliance (Wolff, 2002b). Clients of mental health courts may forgo criminal processing (i.e., they are not prosecuted) altogether, undergo criminal processing (i.e., they are prosecuted on criminal charges) but forgo sentencing,

or receive an alternative favorable sentence for participating and completing the mental health court program (**??**Watson et al., 2001).

The eligibility criteria for mental health courts typically require that defendants have a mental illness (serious, chronic, or persistent) and non-violent criminal charges that are most often classified as a misdemeanor (Wolff, 2002b; Wolff and Pogorzelski, 2005). Potential defendants could be referred to the mental health court by a prosecutor, defense attorney, family member, treatment provider, judge, jail personnel, police officer, and so forth (**??**). They may be screened formally by the court team or a case coordinator with mental health training with a screening protocol (Wolff, 2002b).

The confluence of all these factors on selection easily predicts variation in client pools among and between mental health courts. Variation in the client pools may occur because of eligibility requirements mandated by criminal justice personnel or the court itself, poor or inconsistent program identification or recruitment practices, mixed or variable support among team members, improper matching of services to the target population, or other forms of structural rigidities or flexibilities that restrict or expand the identification, recruitment, or selection of seemingly eligible clients. In addition, courts may use different incentives and disincentives to encourage participation in the court and, as such, introduce selection bias (Redlich et al., 2010). These motivational inducements may foster or hinder the interests of potential clients and the support from defense attorneys (Wolff, 2002b).

2.3 Suicide in Jails

Self-harm and suicide attempts in prison represent a double tragedy; as human life is in jeopardy or lost and the correctional facility failed to protect such life. There are various mental health treatment and prevention methods utilized by correctional facilities to decrease self-harm and suicide attempts. Suicide is complex, and predicting or evaluating suicide risk is even more complex (**?**). The World Health Organization explains that suicide is a serious public health problem (**?**), yet the feasibility of suicide prevention must involve many moving parts, including effective treatment of mental disorders and environmental control of risk factors (**?**).

Many factors that may influence suicide risk are varying factors between correctional

settings, including: short-term detainees, pre-trial offenders, sentenced prisoners, harsh sentencing practices, overcrowding (Huey and McNulty, 2005), purposeful activity (Leese, Thomas and Snow, 2006), times spent locked up, sanitation, sociocultural conditions, levels of stress, and access to basic health and mental health services, among other aspects. Further, after Sandra Bland's tragic suicide, which led to Texas passing its Sandra Bland Act, cells have become more suicide-resistant (i.e. without protrusions of any kind that may enable individuals to harm themselves).

Suicidal behaviors are more common among those who get imprisoned, resulting in pre-trial detainees having a suicide attempt rate of almost 8 times compared to those in the general population (Jenkins et al., 2005). The causes of suicide to persons in custody is difficult to understand since those who break the law inherently have many risk factors for suicide before, during, and after release (Pratt et al., 2006). Any combination of individual and environmental factors may account for the higher rates of suicide in correctional facilities, such as the psychological impact of arrest and incarceration, symptoms of withdrawal experienced by drug addicts, expected long prison sentences, the overall stress of being associated with prison life, poor or no access to mental health professionals or treatments, lack of formal policies and procedures to identify and manage inmates at risk of suicide, individuals with mental disorders, substance or alcohol abuse, socially isolated or socially disenfranchised individuals, among many other factors (**?**).

Environmental factors and interventions are critical to consider when assessing risk of self-harm and suicide attempt within prisons (**?**). One study found that the importance of talking with someone was helpful in decreasing self-harm and suicide attempts. For example, more time out of cell and sharing a cell with another prisoner both were discussed as helpful remedies (**?**). One case-control study from Austria identified four specific individual factors (previous suicide attempts, psychiatric diagnosis, psychotropic medication prescribed during imprisonment, and highly violent index officers) and one environmental factor (single-cell accommodation) (Fruehwald et al., 2004) that may be used to better understand who may be at risk for suicide.

Situational factors that contribute to suicide in correctional facilities are isolation or segregation cells and times when staffing is low, such as nights and weekends. Several fac-

tors affect housing assignments/arrangements within correctional facilities, such capacity, staffing, availability of appropriate facilities, and more. Housing is also widely used as a measure of supervision. For example, certain housing arrangements facilitate specific supervision from officers so that inmates are checked periodically. Also, most suicides occur by hanging in prison. Housing arrangements have a strong association with inmate suicide, especially when an inmate is placed somewhere they are unable to cope and when such housing assignments result in an inmate being inside the cell for 23 hours per day for significant periods of time (**?**). Poor social and family support, history of psychiatric illness and emotional problems, and a prior history of suicidal behavior are all common among inmate suicides. Individual stressors and vulnerabilities, resulting from bullying (Blaauw and Winkel, 2001), recent inmate-to-inmate conflicts, adverse information (Way et al., 2005), or disciplinary infractions, lead to inmates feeling hopeless, with narrowing future prospects, and loss of coping options, which ultimately leads to suicide attempts. Furthermore, as length of stay increases, so does suicide rates for long-term inmates (Frottier et al., 2002), with "lifers" having especially high-risk for suicide (**?**Liebling and Ludlow, 2016).

2.4 Mental Health Housing in our Large Urban Correctional Complex

Behavioral health and psychiatry staff review and make housing recommendations to classifications each time an assessment is completed with a patient. Recommendations for mental health housing are made primarily to ensure the safety and provide for the treatment needs of the patient. As housing options progress, they become more restrictive for the patient's and others' safety. Housing options are divided in to four categories Psychiatric Outpatient (POP), Psychiatric Inpatient (PIP), Vulnerable (VUL), and Psychiatric Intensive Care (PIC)) starting with general population and increasing in restrictiveness and monitoring.

POP describes the general population inmate unit where patients have the ability to independently manage and monitor their mental health symptoms with minimal intervention from staff including the ability to self-advocate for their needs when symptoms or situations become overwhelming. PIP describes the inmate unit where patients have

difficulty managing and monitoring mental health symptoms without support from staff. There are two housing options in PIP units: Open Psych (Open) and Psych Lockdown (PsyLD). Corrections officers have the ability to manage patients between Open and PsyLD housing. To be recommended for PIP housing, the patient must be enrolled in psychiatry services (PSY). VUL describes a cell for inmates in need of special care, support, or protection because of factors such as age, disability, or risk of abuse. Admittance to this unit requires treatment team approval. Lastly, PIC describes the inmate unit where patients are engaging in behaviors or cognitive processes that are dangerous to self. There are two housing options in PIC units: Psychiatric Observation (OBS) and Full Safety Precautions (FSP).

3 Data and Estimation

Given the heterogeneity across courts, research designs such as differences-in-differences inevitably combine many different types of treatments into a single treatment variable. Given both the endogenous adoption of courts in response to changing criminality and mental illness populations within their communities, as well as the heterogeneity problems, both the parallel trends assumption and SUTVA assumptions may be challenging assumptions to defend. As an alternative, we use administrative data from a large urban county's correctional complex using a randomized therapist design to estimate the causal effect of mental health court as well as differences between public and private representation on both repeat offending and mental health outcomes, including suicide attempts and ideation.

The design we use is sometimes referred to as the "judge fixed effects" design, but sometimes it is also referred to as a "leniency design". These terms are synonyms. As there is no variation in judges within our county, we utilize the randomization of therapists up-stream, prior to court and disposition, to identify the causal effect of mental health court and its elements. The design is only able to estimate the local average treatment for the complier population, but we believe it is nonetheless capable of revealing which mechanisms are and are not necessary to improving the lives of both the mentally ill as

well as residents within the community.

3.1 Research Design: Therapist Fixed Effects

The leniency design was first proposed by Imbens and Angrist (1994).[2] The solution to the problem of selection bias when attempting to estimate a causal effect with non-experimental data is ingenious and straightforward. Assume that an individual moves through a pipeline, but before he or she can be assigned to some treatment, the inmate must first meet with a randomly assigned decision-maker drawn from a wheel of many different decision-makers. If decision-makers are randomly assigned to each inmate, have considerable discretion in assigning treatments, and have systematic tendencies to recommend treatments, then the random assignment of decision-makers can function as a randomizing device that mimics a randomized experiment. It is called both a leniency design as well as a fixed effects design because one can estimate the causal effect using either a residualized propensity to recommend treatment for all cases excluding the one case, or one can estimate the model using a set of decision-maker fixed effects using the jackknife instrumental variables estimator (JIVE).

The design has exploded in popularity among crime economists. It has been used to study the consequences of Chapter 13 bankruptcy on future financial events (Dobbie, Goldsmith-Pinkham and Yang, 2017), racial bias among bail judges (Arnold, Dobbie and Yang, 2018), pretrial detention having higher rates of guilty pleas, conviction, recidivism and worsened labor market outcomes (Leslie and Pope, 2018; Dobbie, Goldin and Yang, 2018; Stevenson, 2018), and juvenile incarceration on high school completion and adult crime (Aizer and Doyle, 2015).

Most of the applications use randomized judges, but there are exceptions such as

[2]In this classic instrumental variables paper decomposing IV estimates into the local average treatment effect, the authors write "Suppose applicants for a social program are screened by two officials. The two officials are likely to have different admission rates, even if the stated admission criteria are identical. Since the identity of the official is probably immaterial to the response, it seems plausible that Condition 1 [independence] is satisfied. The instrument is binary so Condition 3 is trivially satisfied. However, Condition 2 [monotonicity] requires that if official A accepts applicants with probability $P(0)$, and official B accepts people with probability $(P1) > P(0)$, official B must accept any applicant who would have been accepted by official A. This is unlikely to hold if admission is based on a number of criteria. Therefore, in this example we cannot use Theorem 1 to identify a local average treatment effect nonparametrically despite the presence of an instrument satisfying Condition 1 [independence]"

Joseph J. Doyle (2007, 2008) who use randomized case workers to estimate the causal effect of removal from the home and placement into foster care on future adult outcomes, such as crime and teen pregnancy. This is the first project, though, that uses randomized therapists to assign individuals into any type of treatment. We use it for mental health courts because in our setting, therapists are used to score the severity of each inmate's mental illness. As these therapists never meet with the inmate again, the exclusion restriction is trivially satisfied. And since therapists are randomly assigned, it also trivially meets the independence assumption.

What is also intriguing about our context, though, is that this county uses both a public defender's office as well as a "wheel" of private attorneys who moonlight providing indigent defense. Inmates are assigned to either/or if the inmate's score exceeds a particular threshold. Since therapists are randomized, this ensures that both the observed and unobserved inmate characteristics are assigned to mental health court, or public defense, independent of an inmate's potential outcomes.

The way in which this assignment occurs is explained as follows. Upon booking, inmates in this correctional complex are met by an officer who makes a cursory check about whether an inmate has any signs or history of mental illness. This decision is based on such questions as whether the individual has a history of mental illness, has ever taken medication, or whether the officer believes the person is showing signs of mental illness. If any of these criteria are met, the officer recommends that the inmate meet with the therapist who will evaluate their symptoms. A large number of inmates are believed to suffer from some form of mental illness and thus are redirected to a randomized therapist. At any point in time, the correctional complex employs approximately 60 therapists. The vast majority of these therapists are clinical social workers and professional counselors. Their interest in working for the correctional complex is sometimes due to the generous benefits of the county, as well as seeking the hours needed for licensure in the state.

Using a structured survey as well as their own professional judgment, therapists rate the severity of the inmate's symptoms on a scale of 0 to 3, with 3 being the most severe and lowest functioning score evaluation possible. Inmates with a 0 (no symptoms) or 1 (mild symptoms) do not meet criteria for the county mental health court and so remain on the

normal track into traditional adjudication. Inmates with a 2 (moderate symptoms) are assigned to a private attorney appointed by the court for indigent defense. These private attorneys are paid a nominal flat fee of $750 which does not vary with the number of hours devoted to the defendant's case. Inmates with a 3 (severe symptoms) are perceived as unusually low functioning and are redirected to the county public defender's office who are salaried.

Public and private defenders differ with regards to the resources that each bring to a case, as well as potentially with regards to unobserved selection. Public moonlighting attorneys flat fee of $750 is financed by the county. Six lawyers perform this service. They receive extra mental health training for this work. The Mental Health Public Defenders office, on the other hand, employees four lawyers, six social workers and two administration staff. This office provides resources other than indigent defense, though. Social workers, for instance, help defendants receive disability and housing, as well as other social services.

3.2 Our setting: Large Urban Correctional Complex

County jails around the nation have become frequent temporary homes for millions of individuals suffering from mental illness or a substance use disorder thanks to gaps in health coverage, limited access to behavioral health care and many more reasons (for Substance Abuse Treatment, 2005). In most states, there is at least one jail or prison that houses more mentally ill individuals than the largest psychiatric hospital in the area (Torrey et al., 2014). Approximately 20 percent of the inmate population at our large urban correction complex requires treatment for mental illness.[3] On any given day, approximately seven percent of inmates with mental illness are experiencing severe symptoms such as psychosis, delusions or suicidal thoughts. The jail is a highly sensitive and unusual work environment that requires extensive training and a very unique skill set. It is incumbent upon the large urban county's Sheriff's office to make every effort possible to ensure our employees are equipped to serve this vulnerable population (Corrections Officers Receive Specialized Mental Health Training).

[3]We have chosen note to name our county until we have had a chance to show our results to the agency. But we can say that this is one of the largest counties in the state.

The purpose of the Misdemeanor Mental Health Diversion Docket is to provide court supervision for defendants diagnosed with mental illness who have entered an agreement with the State to have their criminal case dismissed after a period of treatment and stability. Defendants are released on personal bond with conditions that are agreed to by the State and are supervised by specialized pretrial service officers. Defendants report monthly until their case is dismissed. The eligibility criteria includes: mental health diagnosis, pending misdemeanor offense, and approval by prosecution (Misdemeanor Mental Health Diversion Docket). For our county, eligibility criteria includes the defendant is also experiencing significant challenges due to mental health, intellectual, or developmental disabilities.

The County Mental Health Public Defender office is operated in connection with County Justice Planning. The County Mental Health Public Defender (MHPD) Office began in April 2007 to serve the needs of persons with mental illness in the criminal justice system. The staff includes a director, three full time attorneys, four social workers, three caseworkers, and three support staff (Mental Health Public Defender). The social and case workers are also available to assist private court appointed attorneys. Referrals are made for a variety of social services. Follow-up case management services are also provided (Mental Health Public Defender).

Our empirical data is from a large urban county's correctional complex administrative records on every inmate they saw between 2016 and 2019. This urban county is home to over 1.2 million residents. These data were collected as routine mental and physical health assessments on inmates.[4] We have over 31,501 observations who were screened for mental illness from administrative data which include information on each inmate's offense type (felony, misdemeanor), demographics, mental health records, charges, suicide attempt, suicide ideation, and more. A unique inmate ID and unique booking ID is utilized for each inmate.

We begin with a sample of over 40,000 unique inmate bookings. But we do not use all of these because we were informed that the only way in which the randomization was violated was in instances where a therapist would endogenously select a client who he or

[4]Institutional review board (IRB) approval was granted from Baylor University in April 2019.

she had seen before. As this automatically selects on individuals who are reoffending, this can create issues for our randomization. We investigated the degree to which this may be occurring by comparing the distribution of clinician assignment against a randomized simulation. This is shown in Appendix Figure 8.1. As can be seen, there are fewer singleton visits (40,808 versus 35,974) than would occur at random, and more multiple visits than would be predicted in our simulation. Thus in order to eliminate all such instances where randomization may not occur, we use only those instances where a therapist-client match was unique. This drops our sample from 40,808 to 31,501.

3.3 Descriptive Statistics

Table 1 reports summary statistics for our sample for our typical court group and our mental health court. These courts differ considerably along observable dimensions. The mental health court, for instance, has fewer White and Hispanic inmates, and more Black inmates. There are fewer males in mental health court, and individuals tend to be about 2.5 years older. Individuals in mental health court typically have more priors. They also are more likely to have received mental health treatment prior to this visit.

3.4 Instrumental Variable Calculation

The correctional complex randomly assigns therapists. We construct a residualized leave-one out mean measure of each therapist's tendency to recommend scores greater than 1 (i.e., mental health court assignment) as an instrument for a therapist's own score for a particular inmate. This design, called the "therapist fixed effects," has proven popular over the last several years in criminal justice, but we are the first to use this leniency design with randomized therapists. First, we show that there is considerably strong relationships between a therapist's average tendency to recommend mental health court and their judgment on any inmate's own symptom level. Given the wide discretion that therapists have in making rulings, this is not surprising to the degree that any portion of a recommendation is due to subjective professional judgment. Many therapists, in other words, have "tendencies" when making judgments about an inmate's presentation of symptoms. Some tend to consistently see symptoms regardless of an inmate's pre-

sentation, whereas others are considerably less likely to recommend mental health court, ceteris paribus. This random variation in therapists creates a natural experiment in which inmates are randomly assigned across mental health court and traditional adjudication independent of presenting symptoms.[5] Our estimating equations are:

$$
\begin{aligned}
Y_{dct} &= \delta \widehat{mentalhealthcourt}_{dct} + \gamma X_{dct} + \varepsilon_{dct} && (1) \\
mentalhealthcourt_{dct} &= \beta \widetilde{Z}_{cl} + \psi X_{dct} + \varpi_{dct} && (2)
\end{aligned}
$$

Following Arnold, Dobbie and Yang (2018); Aizer and Doyle (2015), though, we construct the residualized leave-one-out using the following steps. First, we regress observed mental health court indicator variable onto a vector of time controls (day of year time fixed effects). This was done as a balancing act between having enough power within each fixed effects to estimate parameters, and wanting to restrict identification to periods in time that control for both seasonality and scheduling. Next, we calculate the residual, $\tilde{D}_{dkt}$, from this regression. Finally, we use the residualized mental health court propensity rate to calculate the therapist recommendation instrument $\tilde{Z}_{cl}$ as a leave-one-out mean rate of mental health court recommendation associated with each randomly assigned therapist l and inmate c.

To calculate the leave-one-out mean, we use the following formula which is the same as used by Aizer and Doyle (2015) and others.

$$
\begin{aligned}
\widetilde{Z}_{cl} &= \left(\frac{1}{n_l - n_c}\right)\left(\sum_{k=0}^{n_l} \widetilde{D}_{dkt} - \sum_{k \in \{c\}} \widetilde{D}_{dkt}\right) \\
&= \frac{1}{n_l - 1} \sum_{k \neq c}^{n_l - 1} \widetilde{D}_{dkt} && (3)
\end{aligned}
$$

We overlaid the residualized leave-one-out with the share of individuals assigned to

[5]Our design controls for differences across mental health housing arrangements in both defendant characteristics and leniency of therapists and officers. In robustness checks, we also present results using a non-residualized version of our therapist leniency measure controlling for housing-by-time fixed effects and find very similar results.

mental health court and present it in Figure 3. As can be seen, there is a strong correlation between the average tendency of a therapist to recommend mental health court and whether they do the own-case. Furthermore, there is a large spread in recommendation rates in the first place ranging from -0.5 (normalized) to 0.5.[6]

Table 2 shows the strength of the first stage. A one point change in the leave-one-out mean is associated with a 0.9 increase in probability of recommending mental health scores.

Key to our identification strategy, though, is that the instrument is balanced across observable inmate characteristics. To the degree that it is, we have some ad hoc evidence that unobservables may also be. In Table 3, we present a table of inmate characteristics across the distribution of the residualized leave-one-out-mean instrumental variable with p-values on differences in means for the bottom tercile of the instrument, as well as the difference between top and bottom. For the most part, the data is balanced. When it is not, for instance for number of offenses per book, the magnitude differences are trivial (1.51 vs 1.56). It is probable that at least one difference can be significant, though, so it's noteworthy that these are effectively small zeroes.

Finally, in Table 4, we present evidence on the independence of the instrument from inmate characteristics. The observable difference between inmates in mental health court and those in traditional adjudication is stark, which we saw also in Table 1. But once we construct the instrument, the differences shrink to small zeroes, most of which are not statistically significant.

In our two-stage least-squares (2SLS) results, we use our predicted therapist leniency measure as an instrumental variable for whether the defendant is assigned mental health court.

[6]We also present evidence for systematic differences in Figure 1 and Figure 2, which show effect sizes on therapist fixed effects as well as the distribution of t-statistics. There is considerable variation in effect sizes, consistent with what is shown in Figure 3, as well as evidence for a strong first stage.

4 Results

We examine two main types of outcomes: recidivism and mental health. But within each, we look at several dimensions of these variables. For instance, for recidivism, we examine whether an inmate re-entered the correctional complex (our definition of reoffending), whether they did so within a year of booking, the number of times they committed another offense, the days to returning, and whether the next offense was a felony. For mental health, we have three measures: the booking score upon re-entry, whether a suicide attempt was recorded upon re-entry, and whether the inmate expressed any suicidal ideations upon re-entry.

We present results for our main specification of the returns to mental health court in Table 5. Note that our mental health court variable is an indicator as to whether the inmate had a score of 2 or 3, and thus measures both the return to private and public defense attorneys combined. Any heterogeneity in returns, though, will necessarily create complications for interpretations. But we explore these heterogeneities in subsequent analysis.

It is noteworthy that in Table 5, the 2SLS results differ so considerably from that of the OLS results. Comparisons between these two are not warranted, though, since OLS is a biased estimate of the ATE, whereas 2SLS is a consistent estimate of the LATE. Nevertheless, we find using 2SLS that mental health assignment increases recidivism by almost 50%. The effect on recidivism within a year of booking is roughly the same, and the number of future offenses is around 1.3. More concerning, though, is the effect that mental health court has on felonies. Conditional on returning to jail, there's a 13% increase in the likelihood that the returning offenses is a felony. This suggests that mental health court is not only not blocking repeat offending, but something inherent to it is worsening the offense since our entire sample is misdemeanor offenses.

We suspect that the reason for this increase in repeat offending is due, not so much to mental health court as an intervention, so much as mental health court releasing offenders on personal bond and seeking dismissal. By disentangling defendants from the criminal justice system, it necessarily negates any incapacitation effects associated with traditional

adjudication. This is concerning given that Frank and McGuire (2010) note that the mentally ill have considerably higher rates of arrest than others.

But, interestingly, the effects on health itself are mixed. Conditional on returning, individuals assigned to mental health court experience a 0.5 reduction in the severity of their mental health score. Recall that mental health symptoms are ranked on a 0-3 scale. Thus this is a non-trivial reduction conditional on re-offending. This is unfortunately the only good news, though, because individuals randomly assigned to mental health court show a 4-5% increase in suicide attempts and almost a 1% increase in suicidal ideation.

4.1 Heterogeneity analysis

In order to better understand this unusual combination of perverse effects, we examined different specifications both along inmate characteristics and defender characteristics. First, we divided our sample into two groups: those with a prior offense and those without. We find that for the most part, the perverse effects remain, though there are still important differences between new offenders and repeat offenders. Repeat offenders, for instance, are almost twice as likely to reoffend than those without a prior offense, suggesting that perhaps the negation of the incapacitation effect is more severe for those who show a higher propensity to commit offenses in the first place. Repeat offenders commit 2.2 more offenses over the course of the sample as opposed to 0.8. And the likelihood they commit an offense is also more than twice that of those without a criminal offense. Interestingly, though, the returns to mental health scores in reducing future mental health scores is higher for those without a prior offense than those with one. Both groups have comparable increases in suicide risk, but those without a prior offense are considerably more precise.

In Table 6, we examine differences by prior treatment for mental illness. One way to interpret these specifications is that mental health court has been assigned to those who previously had been receiving help for their mental illness and those who had not. Interestingly, all of the positive and significant effects of mental health care are concentrated among the inmates who had never received treatment for their mental illness in the past. It is also this group, though, that saw improvements in mental health scores upon

re-entry, but who also shows signs of increased suicidality. Table 7 repeats this analysis for those individuals suffering from economic hardship and finds that none of the perverse effects originate from those who are homeless or unemployed. Rather, the effects we find are concentrated among those who are not homeless and who are employed.

Next, we analyze the effects of being assigned a public defender or a private attorney from the wheel. Table 8 shows the differences between these groups on observables. There are more people in our "wheel" group than our public defense group because severe symptoms are less common in this correctional complex. After that, though, most of the differences are the same with some exceptions. Public defenders on average have clients whose mental health scores improve upon re-entry, for instance.

Table 9 shows the strength of the first stage. As can be seen, once we construct the instrument, there is no longer any unique effect of observable characteristics. Tables 10 and 11 present evidence that our instrument is balanced. Across the distribution of the residualized leave-one-out-mean instrumental variable, the mean characteristics of inmates remains virtually the same. The only significant difference is that those with the highest recommendation rate are different from those with the lowest (0.42 versus 0.38), but the effects are only significant at the 10% level. Observable individual covariates are also independent of the residualized leave-one-out-mean as well (Table 11).

In Table 12, we re-examine all of the outcomes shown in Table 5, only this time the treatment variable is a public defender and the control is a private attorney from the wheel. Insofar as recidivism is a product of the court, and not attorney type, then there should be no difference between these two groups. We do not find significant differences from public and private attorneys which suggests that the most likely reason that mental health court increases repeat offending is due to the negation of the incapacitation effect which is common to both attorney types.

But once we examine mental health outcomes, we begin to see stark differences between the two types of attorneys. In fact, it appears that most of the returns to mental health scores is driven by the public defender. Being assigned a public defender instead of a private attorney, holding constant observable and unobservable characteristics of the inmate, causes one's mental health score to improve by approximately one point. This

effectively means that conditional on returning, those who had been assigned to mental health court the first time show only moderate symptoms upon returning, and thus they appear to be more functioning.

Public defenders also appear to reduce suicidality among returning inmates, unlike the main effect we found which had been positive. Being assigned the public defender causes suicidal attempts to fall between 12-16% and suicidal ideation to fall more than 1 point. We also extended our earlier analysis to examine subsamples – those with and without prior offenses, those with and without prior treatment of mental illness, and those in and not in economic distress. We are hesitant to draw much from this heterogeneity analysis, though, given the sample size falls considerably with each subsetting of the data. Nevertheless, we find that public defenders improve mental health scores roughly the same regardless of prior offense. In Table 12, we also examine whether public defenders differentially improve the mental health of those with or without treatment for mental illness. We find that the aforementioned gains in mental health, measured as either improvements in mental health scores or reductions in suicide, are concentrated among those individuals who had previously received treatment for mental illness. This is noteworthy because our earlier finding that suicidality had increased for those assigned to mental health court, which suggests that the deterioration was due to the wheel assignment, and not the public defender assignment. In fact, the effects essentially cancel out for ideation, and are much larger in absolute value for the public defender regressions than they had been in Table 5 for the mental health court treatment variable as a whole. We will examine this in greater detail when we compare the wheel to those who just barely missed criteria for mental health court as a result of the tendencies of their therapist.

Finally, we examined the returns to a public defender depending on whether the inmate was homeless or jobless. We find that the negative effects observed appear to be concentrated as well as among those who are not homeless and who are employed. As these are also the individuals most likely to have received treatment, it appears that the benefits of public defenders select primarily on the relatively better off in general.

Given what we found when comparing the public defenders to the private "wheel" attorneys, we sought to study the efficacy of being assigned a wheel attorney to those

inmates who just barely missed the criteria for mental health court with a score of 1. As before, the first stage is strong. But, covariates are much less balanced (Table 17) than we had found in earlier subsamples. Thus, we caution the reader to not make too much of this analysis as idiosyncratic factors in the correctional complex which are poorly understood may in fact be causing an imbalance between the marginal cases.

First, we find that when we compare those who just barely made it into mental health court and those who missed, the wheel attorneys cause recidivism to increase by between 16 and 29%. The number of future offenses is smaller than what we had previously found, though, but conditional on returning, the wheel defendants are more likely to come in having committed a felony than those in traditional adjudication. We suspect that as none of these results had been significant when comparing the wheel to public defenders, the most likely explanation is again the negation of the incapacitation effect associated with traditional adjudication, though the increase in felony probabiities is worrisome.

The improvements in mental health, on the other hand, is considerably weaker. We find almost no evidence that mental health scores improve relative to those whose symptoms had been just below the minimum criteria needed for eligiblity into mental health court. This suggests that the bulk of the returns to mental health court had been on those with the most severe symptoms, since it is those with the most severe symptoms who receive public defender representation. Assignment to the wheel also has no effect on whether suicidality increases, which suggests perhaps it is an issue of power in the control group that was responsible for the positive effect found earlier when evaluating the mental health court effect more generally.

When we split the sample in Table 20 and 21, for the first time we find evidence that mental health courts harm those who had previously been treated or identified with a mental illness. These individuals, for instance, were more likely to reoffend at all or within a year and were more likely to attempt suicide upon return. Given that the wheel attorneys have weak incentives to assist defendants given the low flat fee paid to private attorneys, this may suggest that there are unobservable transfers such as signing up individuals for disability and other social services that play the most significant role in mental health improvements associated with mental health court. Table 21, on the other hand,

shows no systematic differences when evaluating economic circumstance. Surprisingly, those who are unemployed actually experience worsened mental health scores as a result of being assigned the wheel relative to traditional adjudication.

5 Discussion

The causal effect of mental health court on defendants is complex. When dismissal and personal bond are used, and longterm treatment cannot be enforced, then mental health court increases repeat offending. The most likely reason being a negation of the incapacitation effects. But, there is some evidence that mental health improves, too. Though suicidality worsens as a result of mental health court assignment, therapist measures of mental health functioning improves.

This puzzling outcome is best explained by the heterogenous returns to public versus private defense. Across the board, public defenders cause considerable improvements in mental health relative to that of private "wheel" attorneys. Their mental health scores improve by almost a full point, which suggests that their functioning has improved since daily functioning is the main reason that a therapist assigns a 3 instead of a 2. But perhaps even more hopeful is the effect that public defense has on suicidality. Both suicidal ideation and suicide attempts fall drastically as a result of being assigned to a public defender instead of the private "wheel" attorneys in our sample. This may be a result of several factors. For one, public defenders have more staff, which include numerous social workers and administrative staff. Social workers work very hard to sign defendants up for disability, as well as other social support services. They also help defendants meet the criteria needed for dismissal. And since they do not have differential recidivism rates, this suggests that the higher rates of recidivism observed as a consequence of mental health court assignment are due, not by the resources or investments made in inmates by court attorneys, but a feature of the court itself – most likely the negation of the incapacitation effect.

There are several implications of this study. For one, it suggests that counties who adopt mental health courts should seek to provide resources to defendants who are most

at risk. Some of the largest returns to mental health court, for instance, are concentrated towards the relatively more well off. We find that mental health court on average improves the lives of those who had previously been treated for mental illness, though exceptions to this can be found (such as for those with moderate symptoms). But the more significant effect we find is with regards to the dependence on a wheel system. A wheel system that pays a nominal flat fee dilutes incentives to provide high quality defense along two dimensions. First, because the fee is low, it is likely primarily appealing to those whose law firms have low demand. Conversations with officials suggest there is some truth to this. Lawyers with low demand are likely lower quality lawyers, suggesting that the wheel negatively selects on the pool of potential attorneys. Public defenders, on the other hand, are often considered to be driven by altruism, at least in part.

A second difficulty that wheel attorneys face has to do with the lack of incentives to exert effort on a case. Because an attorney faces a flat fee, there is no incentive to exert marginal effort. This combined with the fewer resources that wheel attorneys often have can lead to lower quality representation despite the fact that private attorneys often see the relatively less severe cases. This has implications for state's compliance with the Sixth Amendment, because it is possible to meet the letter of the law without meeting the spirit of the law.

The high burden of mentally ill within the criminal justice system has caused counties to experiment with a variety of programs, including mental health courts. These courts are likely to become even more interesting to counties if jurisdictions seek to shift resources away from police departments and towards social services. We find that the mechanisms used matter a lot. Absent efforts to incapacitate defendants while awaiting trial, mental health courts can have a perverse effect of increasing repeat offending. Reliance on a wheel system, which is very common across the country, may also be sub-optimal given the higher returns to using public defenders.

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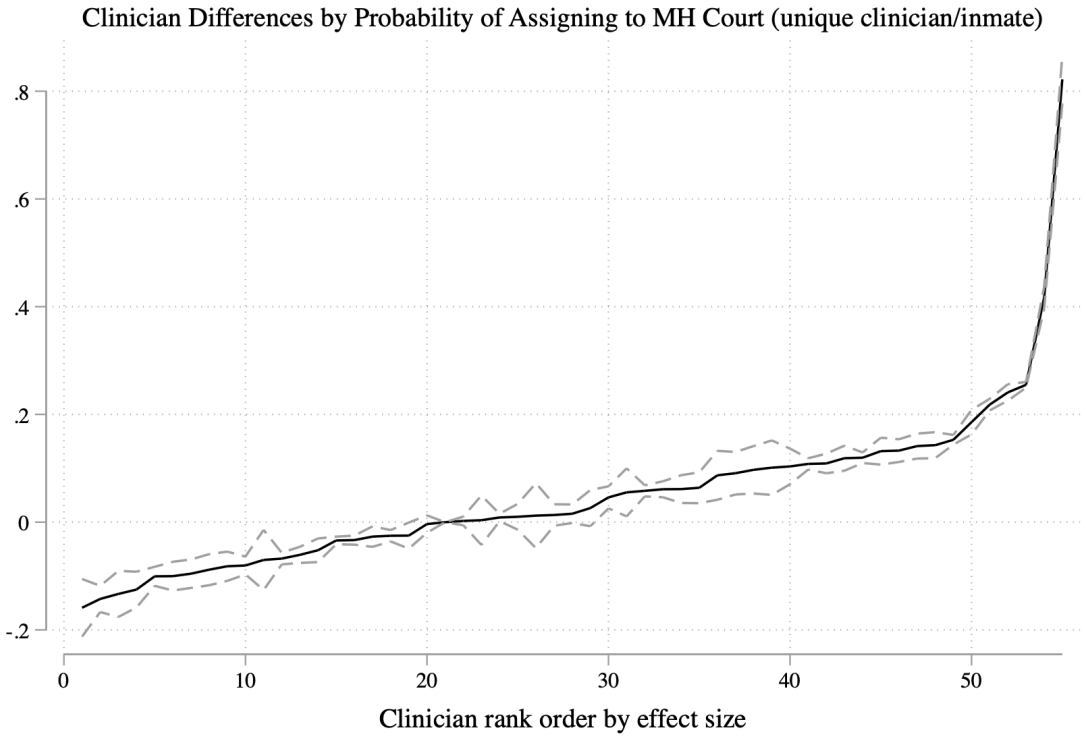


Figure 1 Clinician fixed effects with unique clinician sample for individuals assigned to mental health court

6 Tables and Figures

7 Appendix

Table 1 Descriptive Statistics by MH Court (unique clinician/inmate) Assignation

	Typical Court	Mental Health Court
Mental Health Needs		
None	0.754	0.000
Mild	0.246	0.000
Moderate	0.000	0.822
Severe	0.000	0.178
Outcomes		
Recid after current booking	0.322	0.454
Recid within 1 year	0.411	0.516
Count of future recidivism	0.573	0.928
Days to recidivism	244.321	218.646
Next offense felony	0.091	0.127
Next booking mental health score improves	0.104	0.453
Suicide attempt in next booking	0.019	0.047
Suicide ideation in next booking	0.002	0.006
Inmate Characteristics		
White	0.763	0.726
Asian	0.014	0.009
Black	0.223	0.263
Race other	0.001	0.001
Hispanic	0.302	0.210
Male	0.718	0.643
Age at booking	33.362	35.929
Prior offense w/in 365 days	0.296	0.391
Number of offenses per booking	1.522	1.607
First time in jail	0.062	0.018
Prior treatment	0.110	0.131
Prior medications	0.103	0.122
Prior hospitalization	0.050	0.099
Homeless	0.032	0.052
Jobless	0.070	0.070
Clinician Characteristics		
Clinician Male	0.150	0.188
Clinician White	0.793	0.852
Clinician Black	0.137	0.072
Clinician Hispanic	0.065	0.069
Observations	26,279	5,222

Table 2 First Stage Regressions for MH Court (unique clinician/inmate)

	Residualized Leave-Out		Clinician Fixed Effects
	(1)	(2)	(3)
Z: Clinician's Leave-Out Mean Mental Health Score Rate	0.963***	0.897***	
	(0.017)	(0.024)	
Asian		-0.044**	-0.044**
		(0.019)	(0.019)
Black		0.005	0.006
		(0.006)	(0.006)
Race other		0.093	0.095
		(0.077)	(0.077)
Hispanic		-0.047***	-0.047***
		(0.009)	(0.010)
Male		-0.046***	-0.046***
		(0.007)	(0.008)
Age at booking		0.002***	0.002***
		(0.000)	(0.000)
Prior offense w/in 365 days		0.052***	0.053***
		(0.011)	(0.011)
Number of offenses per booking		0.009***	0.009***
		(0.002)	(0.002)
First time in jail		-0.055***	-0.049***
		(0.009)	(0.011)
Prior treatment		-0.016	-0.010
		(0.012)	(0.014)
Prior medications		-0.021*	-0.017
		(0.011)	(0.011)
Prior hospitalization		0.141***	0.143***
		(0.014)	(0.016)
Homeless		0.043**	0.046**
		(0.018)	(0.019)
Jobless		-0.029**	-0.025*
		(0.013)	(0.015)
Time fixed effects	Yes	Yes	Yes
Anderson-Rubin F-test	11.23	15.76	
Anderson-Rubin p-values	0.0015	0.0002	
Observations	31,498	31,498	31,501

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 3 Instrument v. Inmate Characteristics for MH Court (unique clinician/inmate)

	Bottom Tercile	Middle Tercile	Top Tercile	Middle v. Bottom P-Value	Top v. Bottom P-Value
Z: Clinician's Leave-Out					
Mean Mental Health Score Rate	-0.082	-0.017	0.099	(0.001)	(0.000)
Inmate Characteristics					
Asian	0.013	0.013	0.013	(0.976)	(0.935)
Black	0.224	0.237	0.227	(0.326)	(0.781)
Race other	0.001	0.001	0.001	(0.468)	(0.199)
Hispanic	0.300	0.285	0.277	(0.156)	(0.163)
Male	0.721	0.715	0.682	(0.684)	(0.065)
Age at booking	33.219	33.751	34.393	(0.178)	(0.014)
Prior offense w/in 365 days	0.288	0.335	0.313	(0.325)	(0.343)
Number of offenses per booking	1.511	1.542	1.556	(0.407)	(0.045)
First time in jail	0.083	0.053	0.028	(0.296)	(0.034)
Prior treatment	0.115	0.110	0.116	(0.900)	(0.892)
Prior medications	0.111	0.101	0.107	(0.806)	(0.969)
Prior hospitalization	0.050	0.055	0.071	(0.858)	(0.440)
Homeless	0.031	0.036	0.040	(0.720)	(0.543)
Jobless	0.072	0.072	0.065	(0.973)	(0.929)

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 4 Test of Randomization for MH Court (unique clinician/inmate)

	(1) Mental Health Court	(2) Z: Mental Health Court
Asian	-0.040*	0.005
	(0.020)	(0.005)
Black	0.002	-0.003*
	(0.006)	(0.001)
Race other	0.077	-0.018
	(0.081)	(0.015)
Hispanic	-0.050***	-0.004*
	(0.009)	(0.002)
Male	-0.057***	-0.013**
	(0.009)	(0.005)
Age at booking	0.002***	0.000***
	(0.000)	(0.000)
Prior offense w/in 365 days	0.052***	-0.001
	(0.011)	(0.002)
Number of offenses per booking	0.010***	0.001***
	(0.002)	(0.000)
First time in jail	-0.089***	-0.039***
	(0.012)	(0.012)
Prior treatment	-0.016	-0.000
	(0.012)	(0.008)
Prior medications	-0.033**	-0.014**
	(0.014)	(0.007)
Prior hospitalization	0.159***	0.020***
	(0.014)	(0.004)
Homeless	0.047**	0.005
	(0.019)	(0.009)
Jobless	-0.044**	-0.017
	(0.017)	(0.015)
Time fixed effects	Yes	Yes
F-test	32	5
Observations	31,501	31,498

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 5 Assignation to MH Court (unique clinician/inmate) and Recidivism Outcomes

	OLS results		2SLS results		2SLS by Prior Offense	
	(1)	(2)	(3)	(4)	(5)	(6)
Recid after current booking	0.132***	0.110***	0.490***	0.469***	0.379***	0.630***
	(0.012)	(0.009)	(0.146)	(0.119)	(0.121)	(0.123)
Recid within 1 year	0.104***	0.112***	0.467***	0.513***	0.537***	0.490***
	(0.011)	(0.011)	(0.100)	(0.104)	(0.146)	(0.091)
Count of future recidivism	0.355***	0.304***	1.334***	1.336***	0.844***	2.201***
	(0.039)	(0.033)	(0.411)	(0.352)	(0.278)	(0.472)
Days to recidivism	-26.506***	-20.246***	77.978	62.346	91.316	39.332
	(8.050)	(7.859)	(77.913)	(59.704)	(73.013)	(57.136)
Next offense felony	0.036***	0.032***	0.127***	0.136***	0.093***	0.213***
	(0.005)	(0.005)	(0.041)	(0.036)	(0.031)	(0.054)
Next booking mental health score improves	0.350***	0.355***	0.496***	0.519***	0.602***	0.428***
	(0.024)	(0.024)	(0.077)	(0.080)	(0.086)	(0.100)
Suicide attempt in next booking	0.028***	0.023***	0.048*	0.044**	0.050***	0.033
	(0.005)	(0.005)	(0.025)	(0.019)	(0.019)	(0.025)
Suicide ideation in next booking	0.004***	0.004***	0.008***	0.008***	0.008**	0.008
	(0.001)	(0.001)	(0.003)	(0.003)	(0.003)	(0.006)
Time fixed effects	Yes	Yes	Yes	Yes	Yes	Yes
Baseline controls	No	Yes	No	Yes	Yes	Yes
Subsample					No prior offense	Prior offense

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 6 Assignation to MH Court (unique clinician/inmate) and Heterogeneity in Outcomes

	Prior treatment		Prior medications		Prior hospitalization	
	(1) No	(2) Yes	(3) No	(4) Yes	(5) No	(6) Yes
Recid after current booking	0.460***	0.347	0.464***	0.273	0.472***	0.228
	(0.117)	(0.230)	(0.117)	(0.190)	(0.119)	(0.360)
Recid within 1 year	0.489***	0.784	0.502***	0.440	0.517***	0.188
	(0.098)	(0.627)	(0.101)	(0.344)	(0.103)	(0.620)
Count of future recidivism	1.358***	0.519	1.367***	0.414	1.366***	0.106
	(0.351)	(0.412)	(0.350)	(0.378)	(0.351)	(0.595)
Days to recidivism	54.960	548.944	52.755	749.755	54.459	-233.071
	(57.970)	(1186.035)	(57.522)	(1291.764)	(57.706)	(269.026)
Next offense felony	0.134***	0.158	0.136***	0.110	0.134***	0.242
	(0.037)	(0.169)	(0.037)	(0.140)	(0.037)	(0.236)
Next booking mental health score improves	0.522***	1.772	0.515***	1.384	0.527***	0.792
	(0.065)	(7.842)	(0.066)	(5.497)	(0.071)	(1.121)
Suicide attempt in next booking	0.036**	0.210	0.034**	0.282	0.042**	0.237
	(0.018)	(0.150)	(0.017)	(0.190)	(0.018)	(0.207)
Suicide ideation in next booking	0.008***	0.017	0.007**	0.035	0.009***	0.009
	(0.003)	(0.033)	(0.003)	(0.049)	(0.003)	(0.043)
Time fixed effects	Yes	Yes	Yes	Yes	Yes	Yes
Baseline controls	Yes	Yes	Yes	Yes	Yes	Yes

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 7 Assignation to MH Court (unique clinician/inmate) and Heterogeneity in Outcomes

	Homeless		Jobless	
	(1) No	(2) Yes	(3) No	(4) Yes
Recid after current booking	0.468***	0.230	0.457***	0.354
	(0.118)	(0.327)	(0.118)	(0.420)
Recid within 1 year	0.509***	0.498	0.501***	1.129
	(0.102)	(0.565)	(0.101)	(1.794)
Count of future recidivism	1.336***	0.778	1.318***	0.879
	(0.348)	(0.710)	(0.350)	(1.026)
Days to recidivism	59.629	8.300	60.872	-274.060
	(57.076)	(445.845)	(58.338)	(361.136)
Next offense felony	0.141***	-0.161	0.140***	-0.323
	(0.038)	(0.179)	(0.038)	(0.326)
Next booking mental health score improves	0.520***	80.044	0.535***	-0.996
	(0.075)	(4843.045)	(0.074)	(2.754)
Suicide attempt in next booking	0.043**	0.003	0.045**	0.020
	(0.019)	(0.151)	(0.019)	(0.180)
Suicide ideation in next booking	0.008**	0.027	0.007**	0.116
	(0.003)	(0.100)	(0.003)	(0.099)
Time fixed effects	Yes	Yes	Yes	Yes
Baseline controls	Yes	Yes	Yes	Yes

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 8 Descriptive Statistics by Public Defender (unique clinician/inmate) Assignation

	Wheel	Public Defender
Mental Health Needs		
None	0.000	0.000
Mild	0.000	0.000
Moderate	1.000	0.000
Severe	0.000	1.000
Outcomes		
Recid after current booking	0.445	0.495
Recid within 1 year	0.511	0.536
Count of future recidivism	0.904	1.038
Days to recidivism	222.642	202.020
Next offense felony	0.129	0.117
Next booking mental health score improves	0.431	0.547
Suicide attempt in next booking	0.051	0.030
Suicide ideation in next booking	0.006	0.004
Inmate Characteristics		
White	0.731	0.704
Asian	0.009	0.011
Black	0.259	0.284
Race other	0.001	0.001
Hispanic	0.218	0.177
Male	0.630	0.702
Age at booking	35.653	37.204
Prior offense w/in 365 days	0.379	0.449
Number of offenses per booking	1.597	1.654
First time in jail	0.019	0.014
Prior treatment	0.140	0.087
Prior medications	0.129	0.089
Prior hospitalization	0.103	0.080
Homeless	0.055	0.042
Jobless	0.073	0.052
Clinician Characteristics		
Clinician Male	0.185	0.200
Clinician White	0.841	0.903
Clinician Black	0.079	0.042
Clinician Hispanic	0.074	0.045
Observations	4,294	928

Table 9 First Stage Regressions for Public Defender (unique clinician/inmate)

	Residualized Leave-Out		Clinician Fixed Effects
	(1)	(2)	(3)
Z: Clinician's Leave-Out Mean Mental Health Score Rate	0.635***	0.619***	
	(0.152)	(0.150)	
Asian		0.034	0.036
		(0.055)	(0.056)
Black		0.009	0.012
		(0.015)	(0.014)
Race other		-0.074	-0.076
		(0.143)	(0.142)
Hispanic		-0.034**	-0.030*
		(0.015)	(0.015)
Male		0.038***	0.037***
		(0.011)	(0.012)
Age at booking		0.001**	0.002**
		(0.001)	(0.001)
Prior offense w/in 365 days		0.035***	0.031**
		(0.013)	(0.012)
Number of offenses per booking		0.005	0.004
		(0.005)	(0.005)
First time in jail		0.054*	0.059*
		(0.031)	(0.031)
Prior treatment		-0.145***	-0.133***
		(0.036)	(0.038)
Prior medications		0.059	0.054
		(0.037)	(0.040)
Prior hospitalization		0.049*	0.049*
		(0.025)	(0.025)
Homeless		-0.003	-0.016
		(0.029)	(0.029)
Jobless		-0.003	-0.002
		(0.016)	(0.017)
Time fixed effects	Yes	Yes	Yes
Adjusted F-test			
Observations	5,215	5,215	5,222

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 10 Instrument v. Inmate Characteristics for Public Defender (unique clinician/inmate)

	Bottom Tercile	Middle Tercile	Top Tercile	Middle v. Bottom P-Value	Top v. Bottom P-Value
Z: Clinician's Leave-Out					
Mean Mental Health Score Rate	-0.088	-0.020	0.107	(0.000)	(0.000)
Inmate Characteristics					
Asian	0.010	0.009	0.009	(0.717)	(0.679)
Black	0.279	0.256	0.253	(0.069)	(0.003)
Race other	0.001	0.001	0.002	(0.365)	(0.768)
Hispanic	0.202	0.227	0.202	(0.248)	(0.795)
Male	0.643	0.639	0.649	(0.976)	(0.892)
Age at booking	36.445	35.793	35.523	(0.372)	(0.133)
Prior offense w/in 365 days	0.380	0.372	0.421	(0.706)	(0.082)
Number of offenses per booking	1.606	1.581	1.637	(0.820)	(0.467)
First time in jail	0.025	0.018	0.011	(0.434)	(0.174)
Prior treatment	0.176	0.118	0.098	(0.420)	(0.363)
Prior medications	0.163	0.112	0.092	(0.451)	(0.380)
Prior hospitalization	0.136	0.089	0.073	(0.413)	(0.339)
Homeless	0.062	0.050	0.045	(0.658)	(0.688)
Jobless	0.090	0.074	0.045	(0.745)	(0.293)

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 11 Test of Randomization for Public Defender (unique clinician/inmate)

	(1) Mental Health Court	(2) Z: Mental Health Court
Asian	0.030	-0.006
	(0.054)	(0.008)
Black	0.004	-0.007**
	(0.014)	(0.003)
Race other	-0.067	0.011
	(0.144)	(0.017)
Hispanic	-0.035**	-0.002
	(0.015)	(0.004)
Male	0.040***	0.004
	(0.011)	(0.003)
Age at booking	0.001**	-0.000
	(0.001)	(0.000)
Prior offense w/in 365 days	0.036***	0.003
	(0.013)	(0.003)
Number of offenses per booking	0.005	0.000
	(0.005)	(0.001)
First time in jail	0.041	-0.018
	(0.031)	(0.012)
Prior treatment	-0.141***	-0.014
	(0.041)	(0.018)
Prior medications	0.046	-0.004
	(0.037)	(0.012)
Prior hospitalization	0.048**	0.001
	(0.024)	(0.008)
Homeless	-0.007	-0.005
	(0.029)	(0.010)
Jobless	-0.014	-0.018
	(0.018)	(0.013)
Time fixed effects	Yes	Yes
F-test	6	2
Observations	5,222	5,215

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 12 Assignation to Public Defender (unique clinician/inmate) and Recidivism Outcomes

	OLS results		2SLS results		2SLS by Prior Offense	
	(1)	(2)	(3)	(4)	(5)	(6)
Recid after current booking	0.053***	0.024	0.123	-0.016	0.056	-0.257
	(0.020)	(0.019)	(0.182)	(0.145)	(0.114)	(0.276)
Recid within 1 year	0.029	0.023	0.006	-0.064	-0.010	-0.198
	(0.022)	(0.023)	(0.156)	(0.143)	(0.118)	(0.273)
Count of future recidivism	0.135*	0.043	0.700	0.278	0.243	0.132
	(0.082)	(0.083)	(0.589)	(0.469)	(0.255)	(1.086)
Days to recidivism	-20.884*	-18.330	29.171	-17.727	-3.769	12.697
	(12.060)	(11.705)	(90.727)	(77.893)	(135.021)	(126.284)
Next offense felony	-0.011	-0.020*	0.034	-0.020	0.039	-0.098
	(0.010)	(0.010)	(0.083)	(0.075)	(0.058)	(0.146)
Next booking mental health score improves	0.115***	0.136***	0.964***	0.981***	1.060***	1.021**
	(0.036)	(0.037)	(0.274)	(0.249)	(0.304)	(0.415)
Suicide attempt in next booking	-0.020***	-0.016***	-0.158**	-0.122**	-0.095**	-0.198
	(0.006)	(0.006)	(0.064)	(0.060)	(0.041)	(0.140)
Suicide ideation in next booking	-0.002	-0.002	-0.019**	-0.014*	0.005	-0.065***
	(0.003)	(0.003)	(0.008)	(0.008)	(0.009)	(0.022)
Time fixed effects	Yes	Yes	Yes	Yes	Yes	Yes
Baseline controls	No	Yes	No	Yes	Yes	Yes
Subsample					No prior offense	Prior offense

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 13 Assignation to Public Defender (unique clinician/inmate) and Heterogeneity in Outcomes

	Prior treatment		Prior medications		Prior hospitalization	
	(1) No	(2) Yes	(3) No	(4) Yes	(5) No	(6) Yes
Recid after current booking	0.011	0.778	0.033	0.990	0.034	0.702
	(0.115)	(0.734)	(0.119)	(0.862)	(0.121)	(0.642)
Recid within 1 year	-0.028	0.752	-0.016	1.013	0.011	0.758
	(0.110)	(0.895)	(0.109)	(1.074)	(0.110)	(0.886)
Count of future recidivism	0.281	0.730	0.318	0.970	0.348	0.972
	(0.411)	(1.120)	(0.409)	(1.194)	(0.415)	(0.967)
Days to recidivism	-28.812	-2560.919	-17.018	49.104	-33.053	-79.582
	(71.714)	(32823.913)	(78.772)	(636.080)	(70.464)	(287.655)
Next offense felony	-0.042	-0.151	-0.029	-0.076	-0.033	-0.116
	(0.067)	(0.294)	(0.068)	(0.263)	(0.065)	(0.246)
Next booking mental health score improves	0.903***	-6.008	0.904***	-4.811	0.875***	-7.145
	(0.223)	(24.778)	(0.222)	(23.310)	(0.226)	(24.786)
Suicide attempt in next booking	-0.085*	0.486	-0.075	0.592	-0.090*	0.267
	(0.049)	(0.504)	(0.048)	(0.574)	(0.049)	(0.326)
Suicide ideation in next booking	-0.013**	0.051	-0.013**	0.060	-0.012**	0.040
	(0.006)	(0.087)	(0.006)	(0.095)	(0.006)	(0.066)
Time fixed effects	Yes	Yes	Yes	Yes	Yes	Yes
Baseline controls	Yes	Yes	Yes	Yes	Yes	Yes

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 14 Assignation to Public Defender (unique clinician/inmate) and Heterogeneity in Outcomes

	Homeless		Jobless	
	(1) No	(2) Yes	(3) No	(4) Yes
Recid after current booking	-0.032	0.169	-0.063	-0.396
	(0.116)	(0.507)	(0.113)	(0.550)
Recid within 1 year	-0.065	0.287	-0.074	0.609
	(0.114)	(0.773)	(0.121)	(1.066)
Count of future recidivism	0.224	0.261	0.140	-1.600
	(0.403)	(0.862)	(0.392)	(1.631)
Days to recidivism	-29.522	-701.198	-23.106	-30.442
	(68.549)	(1482.588)	(76.675)	(357.661)
Next offense felony	-0.025	-0.013	-0.007	0.374
	(0.066)	(0.181)	(0.068)	(0.426)
Next booking mental health score improves	0.945***	-1.189	0.925***	0.309
	(0.220)	(1.415)	(0.219)	(1.039)
Suicide attempt in next booking	-0.119**	-0.021	-0.107**	-0.004
	(0.053)	(0.165)	(0.054)	(0.255)
Suicide ideation in next booking	-0.013**	0.076	-0.018**	-0.101
	(0.007)	(0.077)	(0.008)	(0.079)
Time fixed effects	Yes	Yes	Yes	Yes
Baseline controls	Yes	Yes	Yes	Yes

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 15 Descriptive Statistics by MH Score 1s vs. 2s (unique clinician/inmate) Assignation

	0	1
Mental Health Needs		
None	0.000	0.000
Mild	1.000	0.000
Moderate	0.000	1.000
Severe	0.000	0.000
Outcomes		
Recid after current booking	0.368	0.445
Recid within 1 year	0.445	0.511
Count of future recidivism	0.671	0.904
Days to recidivism	241.022	222.642
Next offense felony	0.107	0.129
Next booking mental health score improves	0.327	0.431
Suicide attempt in next booking	0.040	0.051
Suicide ideation in next booking	0.003	0.006
Inmate Characteristics		
White	0.772	0.731
Asian	0.010	0.009
Black	0.217	0.259
Race other	0.001	0.001
Hispanic	0.244	0.218
Male	0.626	0.630
Age at booking	34.474	35.653
Prior offense w/in 365 days	0.326	0.379
Number of offenses per booking	1.538	1.597
First time in jail	0.045	0.019
Prior treatment	0.197	0.140
Prior medications	0.192	0.129
Prior hospitalization	0.098	0.103
Homeless	0.038	0.055
Jobless	0.085	0.073
Clinician Characteristics		
Clinician Male	0.193	0.185
Clinician White	0.849	0.841
Clinician Black	0.061	0.079
Clinician Hispanic	0.082	0.074
Observations	6,454	4,294

Table 16 First Stage Regressions for MH Score 1s vs. 2s (unique clinician/inmate)

	Residualized Leave-Out		Clinician Fixed Effects
	(1)	(2)	(3)
Z: Clinician's Leave-Out Mean Mental Health Score Rate	0.945***	0.890***	
	(0.032)	(0.034)	
Asian		-0.011	-0.011
		(0.051)	(0.051)
Black		0.036***	0.036***
		(0.012)	(0.012)
Race other		0.218*	0.220*
		(0.115)	(0.114)
Hispanic		-0.017	-0.016
		(0.017)	(0.017)
Male		-0.003	-0.002
		(0.011)	(0.011)
Age at booking		0.001***	0.001***
		(0.000)	(0.000)
Prior offense w/in 365 days		0.039***	0.039***
		(0.011)	(0.011)
Number of offenses per booking		0.006	0.005
		(0.005)	(0.005)
First time in jail		-0.053*	-0.053*
		(0.027)	(0.029)
Prior treatment		-0.020	-0.019
		(0.030)	(0.033)
Prior medications		-0.135***	-0.134***
		(0.025)	(0.024)
Prior hospitalization		0.145***	0.146***
		(0.015)	(0.016)
Homeless		0.118***	0.116***
		(0.022)	(0.022)
Jobless		0.013	0.013
		(0.023)	(0.023)
Time fixed effects	Yes	Yes	Yes
Adjusted F-test			
Observations	10,747	10,747	10,748

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 17 Instrument v. Inmate Characteristics for MH Score 1s vs. 2s (unique clinician/inmate)

	Bottom Tercile	Middle Tercile	Top Tercile	Middle v. Bottom P-Value	Top v. Bottom P-Value
Z: Clinician's Leave-Out Mean Mental Health Score Rate	-0.142	-0.005	0.147	(0.000)	(0.000)
Inmate Characteristics					
Asian	0.010	0.009	0.010	(0.403)	(0.799)
Black	0.225	0.244	0.233	(0.063)	(0.657)
Race other	0.001	0.001	0.001	(0.613)	(0.357)
Hispanic	0.245	0.225	0.231	(0.059)	(0.478)
Male	0.630	0.636	0.617	(0.642)	(0.495)
Age at booking	34.323	35.375	35.138	(0.024)	(0.049)
Prior offense w/in 365 days	0.317	0.371	0.354	(0.028)	(0.029)
Number of offenses per booking	1.508	1.587	1.591	(0.005)	(0.003)
First time in jail	0.067	0.017	0.021	(0.004)	(0.010)
Prior treatment	0.257	0.148	0.117	(0.233)	(0.058)
Prior medications	0.247	0.143	0.111	(0.246)	(0.057)
Prior hospitalization	0.126	0.102	0.073	(0.677)	(0.193)
Homeless	0.057	0.043	0.034	(0.613)	(0.232)
Jobless	0.127	0.065	0.049	(0.140)	(0.053)

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 18 Test of Randomization for MH Score 1s vs. 2s (unique clinician/inmate)

	(1) Mental Health Court	(2) Z: Mental Health Court
Asian	-0.005	0.006
	(0.051)	(0.004)
Black	0.034***	-0.003
	(0.011)	(0.003)
Race other	0.195	-0.026
	(0.119)	(0.023)
Hispanic	-0.020	-0.004
	(0.017)	(0.004)
Male	-0.010	-0.008*
	(0.012)	(0.004)
Age at booking	0.002***	0.000
	(0.000)	(0.000)
Prior offense w/in 365 days	0.041***	0.001
	(0.011)	(0.004)
Number of offenses per booking	0.008*	0.003**
	(0.005)	(0.001)
First time in jail	-0.093***	-0.045***
	(0.031)	(0.015)
Prior treatment	-0.044	-0.027*
	(0.034)	(0.016)
Prior medications	-0.164***	-0.032*
	(0.034)	(0.017)
Prior hospitalization	0.171***	0.028***
	(0.018)	(0.010)
Homeless	0.126***	0.009
	(0.021)	(0.011)
Jobless	-0.018	-0.034
	(0.032)	(0.022)
Time fixed effects	Yes	Yes
F-test	40	5
Observations	10,748	10,747

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 19 Assignation to MH Score 1s vs. 2s (unique clinician/inmate) and Recidivism Outcomes

	OLS results		2SLS results		2SLS by Prior Offense	
	(1)	(2)	(3)	(4)	(5)	(6)
Recid after current booking	0.079***	0.050***	0.288***	0.159**	0.160**	0.153
	(0.014)	(0.010)	(0.107)	(0.073)	(0.079)	(0.114)
Recid within 1 year	0.064***	0.057***	0.205**	0.144*	0.216*	0.066
	(0.014)	(0.012)	(0.085)	(0.076)	(0.112)	(0.094)
Count of future recidivism	0.237***	0.166***	0.797***	0.501**	0.382**	0.711
	(0.043)	(0.035)	(0.293)	(0.207)	(0.178)	(0.454)
Days to recidivism	-18.073*	-16.147*	83.344	31.124	27.293	63.098
	(10.497)	(9.210)	(81.658)	(54.092)	(63.767)	(62.308)
Next offense felony	0.023***	0.016***	0.091**	0.066*	0.042	0.120
	(0.007)	(0.006)	(0.043)	(0.039)	(0.036)	(0.080)
Next booking mental health score improves	0.102***	0.116***	0.227	0.250*	0.320**	0.170
	(0.019)	(0.018)	(0.154)	(0.151)	(0.143)	(0.214)
Suicide attempt in next booking	0.011**	0.010**	0.005	0.026	0.035	0.002
	(0.005)	(0.005)	(0.029)	(0.024)	(0.025)	(0.046)
Suicide ideation in next booking	0.003***	0.003***	0.001	0.003	0.005	-0.006
	(0.001)	(0.001)	(0.003)	(0.004)	(0.007)	(0.009)
Time fixed effects	Yes	Yes	Yes	Yes	Yes	Yes
Baseline controls	No	Yes	No	Yes	Yes	Yes
Subsample					No prior offense	Prior offense

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 20 Assignation to MH Score 1s vs. 2s (unique clinician/inmate) and Heterogeneity in Outcomes

	Prior treatment		Prior medications		Prior hospitalization	
	(1) No	(2) Yes	(3) No	(4) Yes	(5) No	(6) Yes
Recid after current booking	0.114	0.301**	0.127	0.283**	0.130*	0.476***
	(0.078)	(0.120)	(0.079)	(0.126)	(0.075)	(0.181)
Recid within 1 year	0.065	0.597***	0.087	0.462**	0.100	0.714**
	(0.073)	(0.229)	(0.074)	(0.226)	(0.073)	(0.284)
Count of future recidivism	0.441*	0.516*	0.472**	0.442	0.462**	0.698*
	(0.233)	(0.271)	(0.231)	(0.272)	(0.220)	(0.386)
Days to recidivism	25.508	91.401	24.073	204.192	27.045	-394.497
	(56.052)	(95.034)	(56.420)	(214.855)	(54.103)	(1246.411)
Next offense felony	0.071	0.025	0.074	0.029	0.060	0.190***
	(0.050)	(0.051)	(0.049)	(0.054)	(0.044)	(0.069)
Next booking mental health score improves	0.279*	-0.026	0.269*	-0.033	0.288**	131.209
	(0.147)	(0.649)	(0.147)	(1.444)	(0.142)	(16679.668)
Suicide attempt in next booking	0.001	0.194***	0.001	0.236***	0.021	0.187*
	(0.023)	(0.066)	(0.022)	(0.070)	(0.023)	(0.099)
Suicide ideation in next booking	0.001	0.017	0.002	0.016	0.002	0.010
	(0.004)	(0.014)	(0.004)	(0.015)	(0.004)	(0.015)
Time fixed effects	Yes	Yes	Yes	Yes	Yes	Yes
Baseline controls	Yes	Yes	Yes	Yes	Yes	Yes

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 21 Assignation to MH Score 1s vs. 2s (unique clinician/inmate) and Heterogeneity in Outcomes

	Homeless		Jobless	
	(1) No	(2) Yes	(3) No	(4) Yes
Recid after current booking	0.140*	0.406	0.138*	0.290**
	(0.072)	(0.308)	(0.074)	(0.143)
Recid within 1 year	0.109	1.021	0.097	0.829***
	(0.073)	(0.795)	(0.068)	(0.296)
Count of future recidivism	0.458**	0.824	0.470**	0.400
	(0.207)	(0.594)	(0.214)	(0.332)
Days to recidivism	30.301	-36.794	37.613	-155.859
	(52.587)	(356.290)	(58.077)	(134.466)
Next offense felony	0.068	-0.005	0.065	0.054
	(0.042)	(0.131)	(0.043)	(0.109)
Next booking mental health score improves	0.263*	41.162	0.288*	-0.643**
	(0.157)	(704.710)	(0.147)	(0.319)
Suicide attempt in next booking	0.016	0.232	0.011	0.247***
	(0.024)	(0.169)	(0.023)	(0.089)
Suicide ideation in next booking	0.001	0.027	0.002	0.020
	(0.004)	(0.036)	(0.004)	(0.019)
Time fixed effects	Yes	Yes	Yes	Yes
Baseline controls	Yes	Yes	Yes	Yes

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

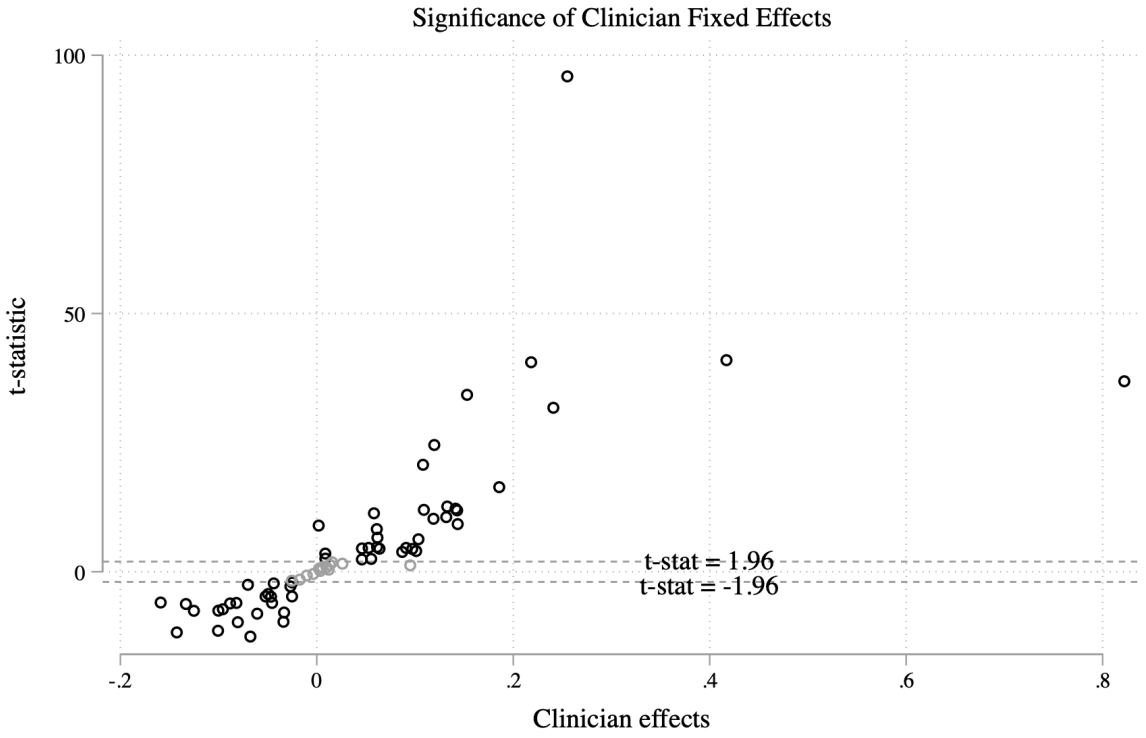


Figure 2 Distribution of t-statistics on individual therapist fixed effects for unique clinician sample for individuals assigned to mental health court

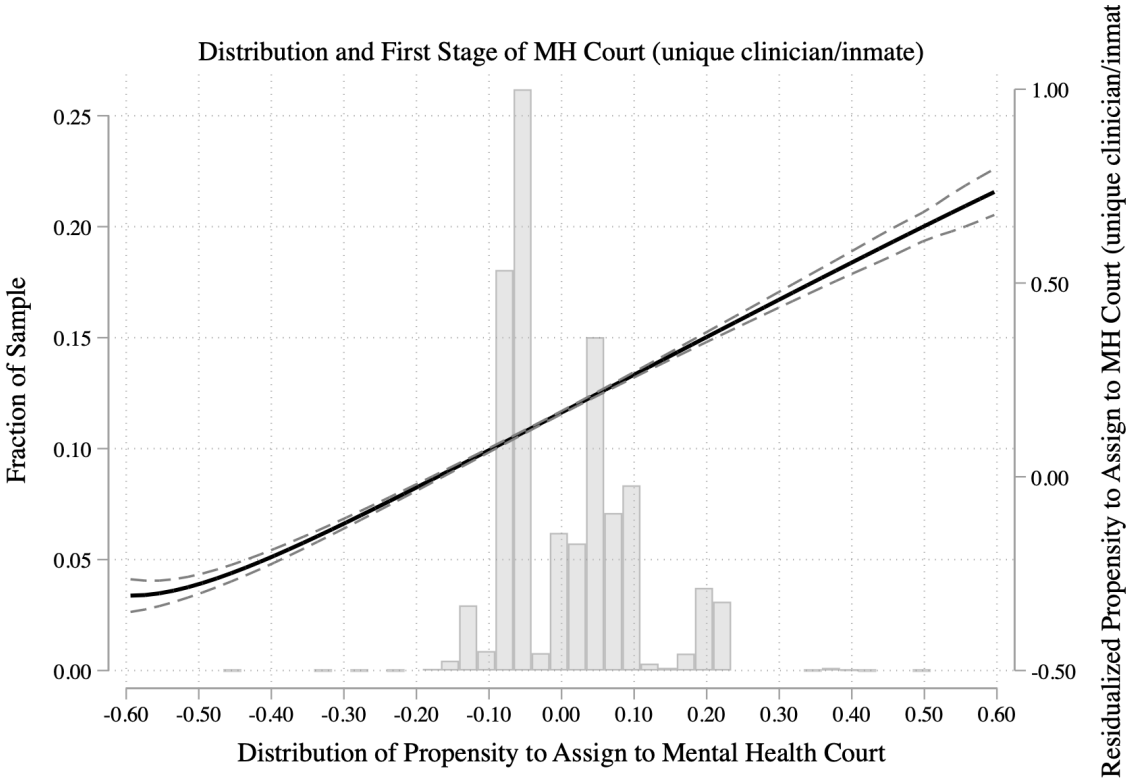


Figure 3 Smoothed fan regression of residualized leave one out against the share of individuals assigned to mental health court

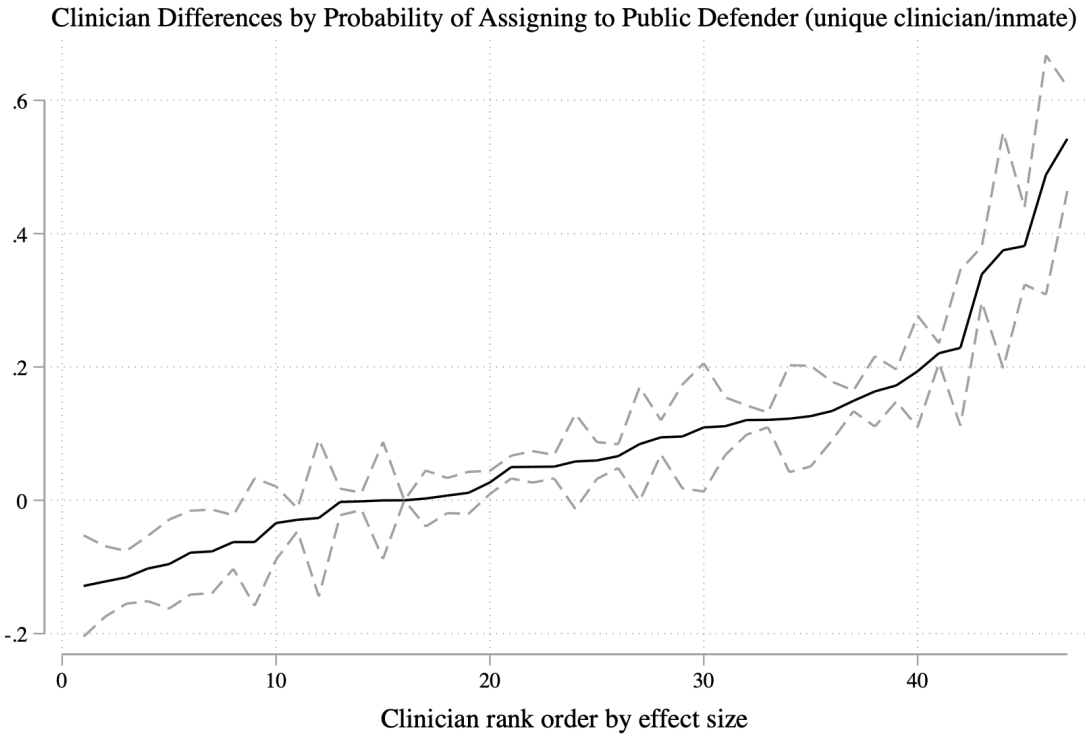


Figure 4 Clinician fixed effects with unique clinician sample for individuals assigned to public defender

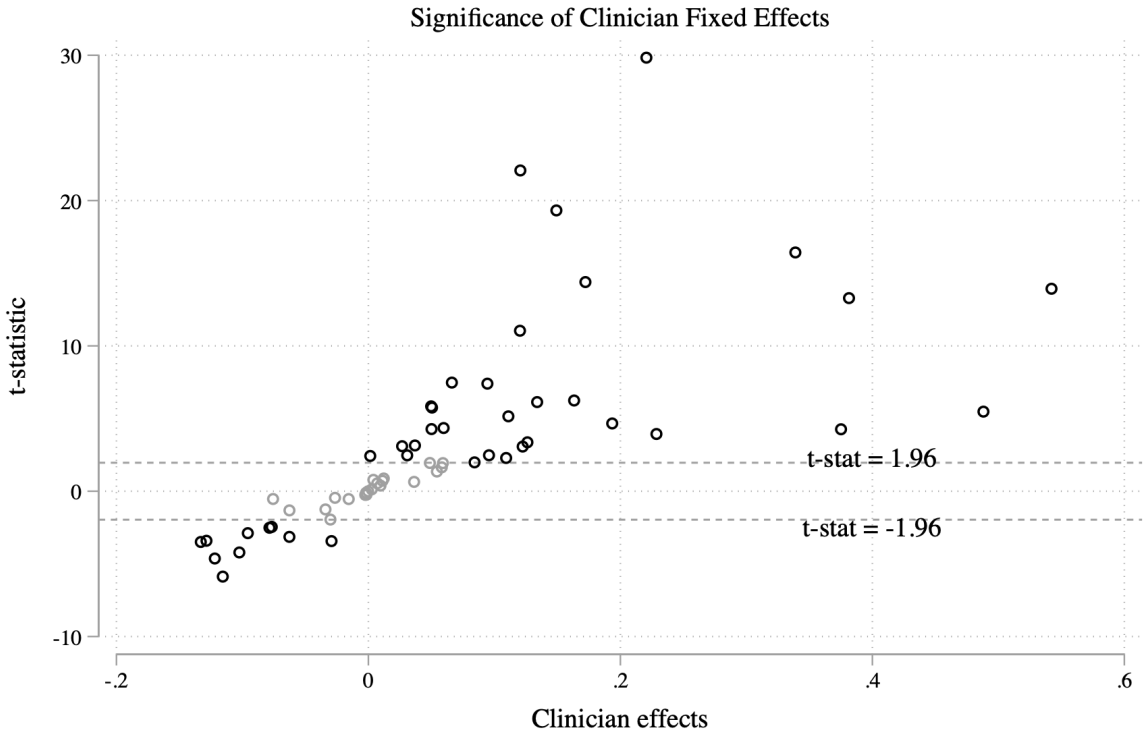


Figure 5 Distribution of t-statistics on individual therapist fixed effects for unique clinician sample for individuals assigned to public defender

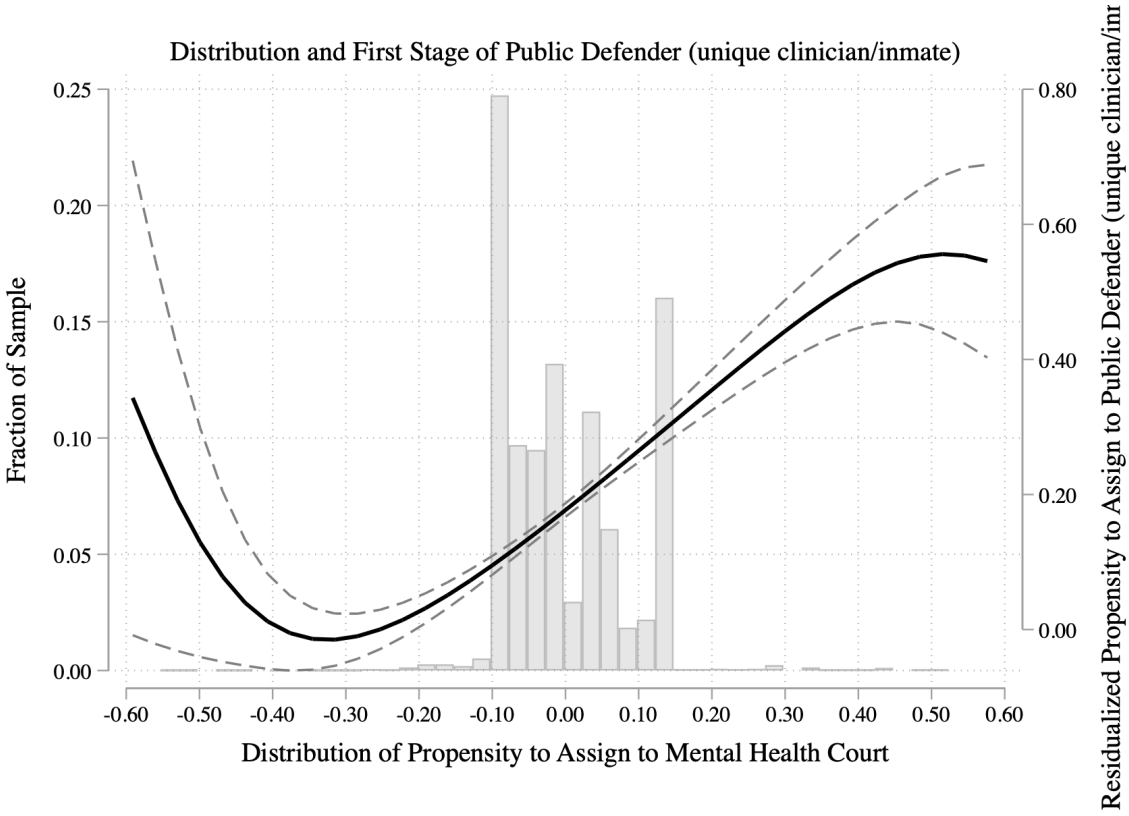


Figure 6 Smoothed fan regression of residualized leave one out against the share of individuals assigned to public defender

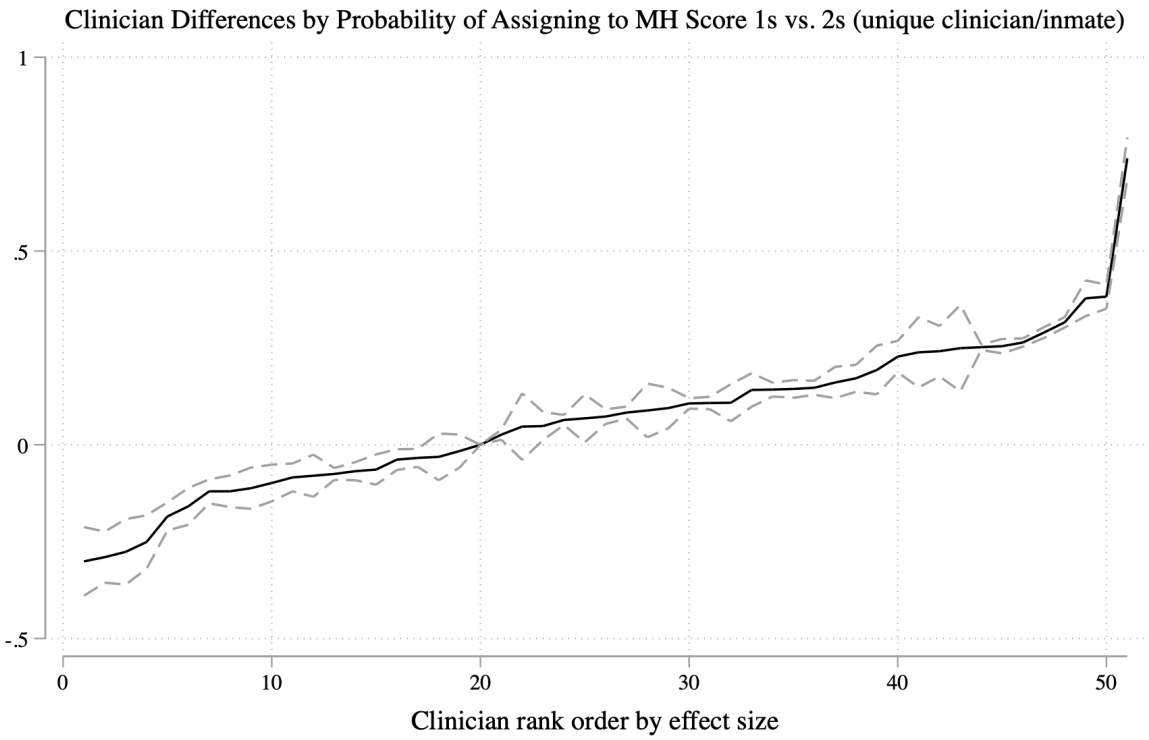


Figure 7 Clinician fixed effects with unique clinician sample for 1s vs 2s

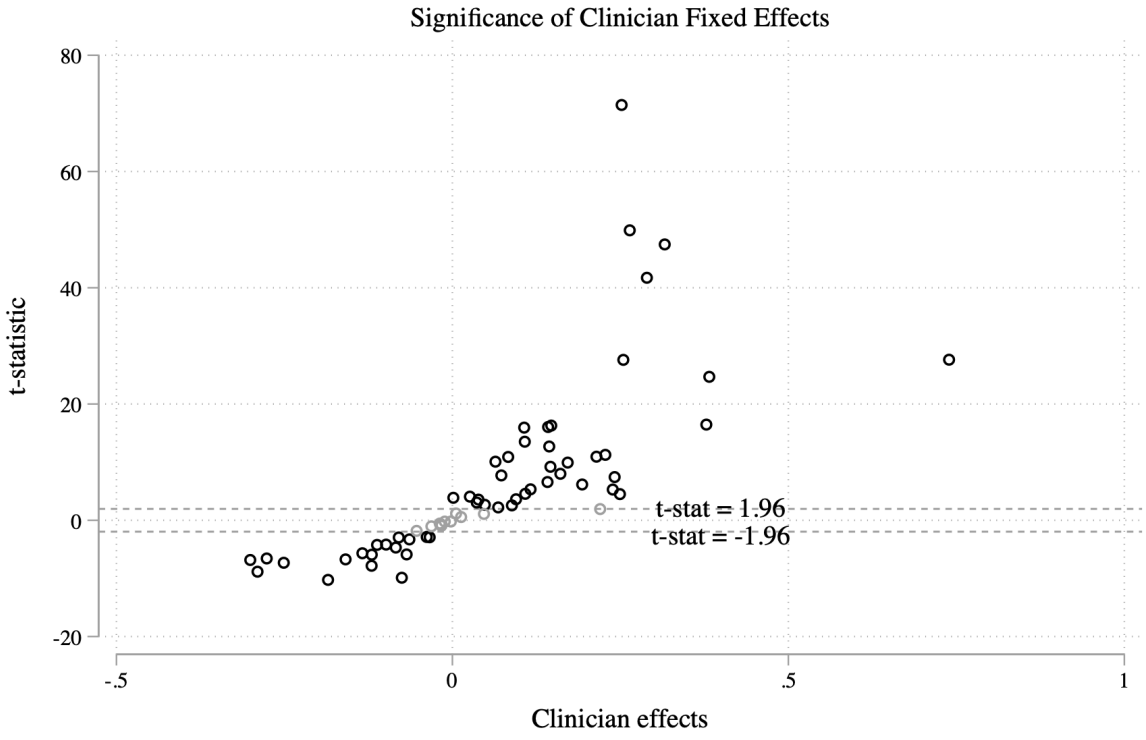


Figure 8 Distribution of t-statistics on individual therapist fixed effects for unique clinician sample for 1s vs 2s

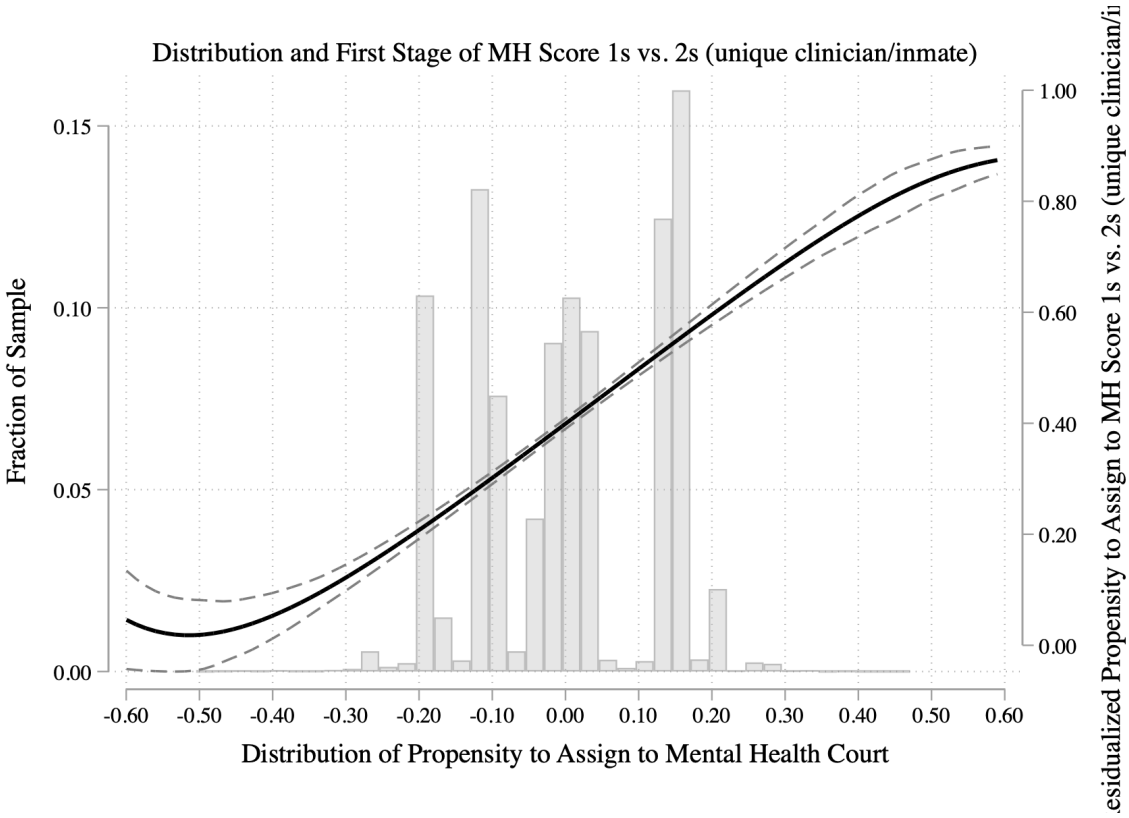


Figure 9 Smoothed fan regression of residualized leave one out against the share of individuals with 1s vs 2s

Table 22 Descriptive Statistics by Mental Health Court Assignation

	Typical Court	Mental Health Court
Mental Health Needs		
None	0.732	0.000
Mild	0.268	0.000
Moderate	0.000	0.754
Severe	0.000	0.246
Outcomes		
Recid after current booking	0.421	0.671
Recid within 1 year	0.519	0.720
Count of future recidivism	1.229	3.888
Days to recidivism	193.055	125.354
Next offense felony	0.119	0.139
Next booking mental health score improves	0.095	0.323
Suicide attempt in next booking	0.028	0.063
Suicide ideation in next booking	0.003	0.008
Inmate Characteristics		
White	0.744	0.694
Asian	0.012	0.011
Black	0.243	0.294
Race other	0.001	0.001
Hispanic	0.298	0.189
Male	0.737	0.691
Age at booking	33.761	37.121
Prior offense w/in 365 days	0.396	0.632
Number of offenses per booking	1.557	1.630
First time in jail	0.051	0.010
Prior treatment	0.118	0.143
Prior medications	0.111	0.136
Prior hospitalization	0.058	0.117
Homeless	0.044	0.075
Jobless	0.079	0.083
Clinician Characteristics		
Clinician Male	0.155	0.188
Clinician White	0.791	0.855
Clinician Black	0.136	0.063
Clinician Hispanic	0.068	0.074
Observations	32,449	9,912

Table 23 First Stage Regressions for Mental Health Court

	Residualized Leave-Out		Clinician Fixed Effects
	(1)	(2)	(3)
Z: Clinician's Leave-Out Mean Mental Health Score Rate	0.896***	0.792***	
	(0.038)	(0.040)	
Asian		-0.007	-0.007
		(0.037)	(0.036)
Black		0.000	0.002
		(0.009)	(0.009)
Race other		0.033	0.037
		(0.073)	(0.074)
Hispanic		-0.072***	-0.071***
		(0.010)	(0.011)
Male		-0.052***	-0.052***
		(0.009)	(0.010)
Age at booking		0.003***	0.003***
		(0.000)	(0.000)
Prior offense w/in 365 days		0.150***	0.150***
		(0.018)	(0.019)
Number of offenses per booking		0.005**	0.005**
		(0.002)	(0.002)
First time in jail		-0.055***	-0.045***
		(0.012)	(0.016)
Prior treatment		-0.047**	-0.040*
		(0.020)	(0.021)
Prior medications		-0.025*	-0.016
		(0.014)	(0.013)
Prior hospitalization		0.185***	0.185***
		(0.014)	(0.016)
Homeless		0.040***	0.045***
		(0.013)	(0.012)
Jobless		-0.048***	-0.045***
		(0.012)	(0.014)
Time fixed effects	Yes	Yes	Yes
Adjusted F-test			
Observations	42,357	42,357	42,361

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 24 Instrument v. Inmate Characteristics for Mental Health Court

	Bottom Tercile	Middle Tercile	Top Tercile	Middle v. Bottom P-Value	Top v. Bottom P-Value
Z: Clinician's Leave-Out					
Mean Mental Health Score Rate	-0.111	-0.009	0.118	(0.000)	(0.000)
Inmate Characteristics					
Asian	0.011	0.013	0.011	(0.449)	(0.823)
Black	0.254	0.262	0.249	(0.417)	(0.604)
Race other	0.001	0.001	0.000	(0.293)	(0.145)
Hispanic	0.282	0.269	0.266	(0.566)	(0.448)
Male	0.743	0.719	0.716	(0.177)	(0.159)
Age at booking	33.714	34.703	35.225	(0.099)	(0.018)
Prior offense w/in 365 days	0.423	0.472	0.459	(0.029)	(0.293)
Number of offenses per booking	1.559	1.571	1.592	(0.767)	(0.059)
First time in jail	0.062	0.048	0.015	(0.525)	(0.012)
Prior treatment	0.113	0.165	0.094	(0.402)	(0.794)
Prior medications	0.109	0.154	0.087	(0.462)	(0.722)
Prior hospitalization	0.054	0.098	0.063	(0.277)	(0.753)
Homeless	0.041	0.071	0.041	(0.259)	(0.962)
Jobless	0.076	0.104	0.059	(0.485)	(0.731)

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 25 Test of Randomization for Mental Health Court

	(1) Mental Health Court	(2) Z: Mental Health Court
Asian	-0.005	0.003
	(0.037)	(0.006)
Black	-0.003	-0.004***
	(0.010)	(0.001)
Race other	0.015	-0.023
	(0.075)	(0.020)
Hispanic	-0.076***	-0.005*
	(0.010)	(0.003)
Male	-0.062***	-0.012***
	(0.010)	(0.005)
Age at booking	0.003***	0.001***
	(0.000)	(0.000)
Prior offense w/in 365 days	0.155***	0.006*
	(0.017)	(0.003)
Number of offenses per booking	0.006**	0.001*
	(0.002)	(0.000)
First time in jail	-0.094***	-0.049***
	(0.012)	(0.016)
Prior treatment	-0.046**	0.001
	(0.018)	(0.011)
Prior medications	-0.033**	-0.011
	(0.016)	(0.008)
Prior hospitalization	0.205***	0.025***
	(0.014)	(0.006)
Homeless	0.047***	0.009
	(0.017)	(0.010)
Jobless	-0.064***	-0.020
	(0.018)	(0.020)
Time fixed effects	Yes	Yes
F-test	56	3
Observations	42,361	42,357

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 26 Assignation to Mental Health Court and Recidivism Outcomes

	OLS results		2SLS results		2SLS by Prior Offense	
	(1)	(2)	(3)	(4)	(5)	(6)
Recid after current booking	0.251***	0.168***	0.503***	0.433***	0.373***	0.476***
	(0.014)	(0.010)	(0.133)	(0.116)	(0.129)	(0.113)
Recid within 1 year	0.202***	0.184***	0.479***	0.500***	0.543***	0.470***
	(0.011)	(0.010)	(0.101)	(0.110)	(0.153)	(0.099)
Count of future recidivism	2.661***	2.088***	4.101***	3.637***	1.118**	5.557***
	(0.261)	(0.212)	(1.242)	(1.143)	(0.434)	(1.765)
Days to recidivism	-68.549***	-45.344***	-56.202	-40.063	27.976	-67.408**
	(5.823)	(4.824)	(51.763)	(35.518)	(54.961)	(28.492)
Next offense felony	0.021***	0.005	0.064**	0.063**	0.095**	0.039
	(0.005)	(0.005)	(0.029)	(0.027)	(0.037)	(0.026)
Next booking mental health score improves	0.228***	0.244***	0.284***	0.309***	0.473***	0.226**
	(0.024)	(0.024)	(0.085)	(0.090)	(0.096)	(0.096)
Suicide attempt in next booking	0.036***	0.023***	0.065	0.053**	0.073***	0.037
	(0.006)	(0.004)	(0.043)	(0.025)	(0.025)	(0.033)
Suicide ideation in next booking	0.005***	0.005***	0.008**	0.007**	0.009**	0.006
	(0.001)	(0.001)	(0.004)	(0.003)	(0.004)	(0.006)
Time fixed effects	Yes	Yes	Yes	Yes	Yes	Yes
Baseline controls	No	Yes	No	Yes	Yes	Yes
Subsample					No prior offense	Prior offense

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 27 Assignation to Mental Health Court and Heterogeneity in Outcomes

	Prior treatment		Prior medications		Prior hospitalization	
	(1) No	(2) Yes	(3) No	(4) Yes	(5) No	(6) Yes
Recid after current booking	0.413***	0.461	0.415***	0.426	0.434***	0.071
	(0.112)	(0.399)	(0.113)	(0.315)	(0.115)	(0.568)
Recid within 1 year	0.479***	0.807	0.484***	0.565	0.506***	-0.077
	(0.105)	(0.753)	(0.107)	(0.408)	(0.109)	(0.928)
Count of future recidivism	3.926***	-4.725	3.729***	0.254	3.944***	-14.249
	(1.153)	(6.806)	(1.168)	(1.231)	(1.136)	(20.754)
Days to recidivism	-42.958	-239.780	-44.364	-113.825	-40.965	2009.284
	(35.573)	(385.027)	(35.517)	(127.470)	(34.901)	(26638.824)
Next offense felony	0.055**	0.268	0.058**	0.204	0.059**	0.344
	(0.026)	(0.297)	(0.027)	(0.202)	(0.027)	(0.393)
Next booking mental health score improves	0.330***	-0.344	0.333***	-0.284	0.319***	-1.219
	(0.078)	(1.444)	(0.082)	(0.758)	(0.082)	(6.139)
Suicide attempt in next booking	0.036	0.496	0.037	0.417	0.043*	0.667
	(0.024)	(0.376)	(0.024)	(0.263)	(0.025)	(0.699)
Suicide ideation in next booking	0.009**	-0.010	0.008**	-0.004	0.009***	-0.042
	(0.003)	(0.030)	(0.003)	(0.031)	(0.003)	(0.051)
Time fixed effects	Yes	Yes	Yes	Yes	Yes	Yes
Baseline controls	Yes	Yes	Yes	Yes	Yes	Yes

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 28 Assignation to Mental Health Court and Heterogeneity in Outcomes

	Homeless		Jobless	
	(1) No	(2) Yes	(3) No	(4) Yes
Recid after current booking	0.429***	0.223	0.426***	-0.229
	(0.114)	(0.305)	(0.115)	(0.857)
Recid within 1 year	0.497***	0.362	0.498***	0.028
	(0.109)	(0.392)	(0.108)	(1.318)
Count of future recidivism	3.656***	1.337	3.876***	-26.378
	(1.145)	(1.474)	(1.141)	(36.555)
Days to recidivism	-39.154	-214.690	-39.396	-1155.028
	(35.805)	(169.751)	(35.465)	(4316.772)
Next offense felony	0.065**	-0.099	0.063**	-0.020
	(0.028)	(0.212)	(0.027)	(0.505)
Next booking mental health score improves	0.323***	0.254	0.334***	-1.222
	(0.088)	(0.264)	(0.081)	(6.246)
Suicide attempt in next booking	0.048*	0.197	0.051**	0.478
	(0.026)	(0.166)	(0.025)	(0.469)
Suicide ideation in next booking	0.006**	0.059	0.006*	0.130
	(0.003)	(0.091)	(0.003)	(0.166)
Time fixed effects	Yes	Yes	Yes	Yes
Baseline controls	Yes	Yes	Yes	Yes

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 29 Descriptive Statistics by Public Defender Assignation

	Wheel	Public Defender
Mental Health Needs		
None	0.000	0.000
Mild	0.000	0.000
Moderate	1.000	0.000
Severe	0.000	1.000
Outcomes		
Recid after current booking	0.644	0.755
Recid within 1 year	0.699	0.780
Count of future recidivism	3.425	5.302
Days to recidivism	136.279	96.858
Next offense felony	0.147	0.115
Next booking mental health score improves	0.302	0.378
Suicide attempt in next booking	0.071	0.042
Suicide ideation in next booking	0.008	0.006
Inmate Characteristics		
White	0.700	0.674
Asian	0.008	0.020
Black	0.291	0.305
Race other	0.001	0.000
Hispanic	0.201	0.152
Male	0.686	0.707
Age at booking	36.471	39.107
Prior offense w/in 365 days	0.595	0.748
Number of offenses per booking	1.625	1.648
First time in jail	0.012	0.005
Prior treatment	0.158	0.097
Prior medications	0.149	0.097
Prior hospitalization	0.125	0.090
Homeless	0.080	0.060
Jobless	0.091	0.059
Clinician Characteristics		
Clinician Male	0.188	0.187
Clinician White	0.842	0.895
Clinician Black	0.073	0.034
Clinician Hispanic	0.078	0.061
Observations	7,469	2,443

Table 30 First Stage Regressions for Public Defender

	Residualized Leave-Out		Clinician Fixed Effects
	(1)	(2)	(3)
Z: Clinician's Leave-Out Mean Mental Health Score Rate	0.497***	0.487***	
	(0.164)	(0.158)	
Asian		0.201**	0.194**
		(0.094)	(0.092)
Black		-0.002	-0.001
		(0.017)	(0.016)
Race other		-0.078	-0.079
		(0.171)	(0.171)
Hispanic		-0.047***	-0.046***
		(0.016)	(0.017)
Male		-0.003	-0.004
		(0.018)	(0.018)
Age at booking		0.003***	0.003***
		(0.001)	(0.001)
Prior offense w/in 365 days		0.117***	0.116***
		(0.015)	(0.015)
Number of offenses per booking		-0.000	-0.001
		(0.005)	(0.005)
First time in jail		0.039	0.049
		(0.032)	(0.030)
Prior treatment		-0.139***	-0.135***
		(0.039)	(0.036)
Prior medications		0.031	0.032
		(0.039)	(0.041)
Prior hospitalization		0.052**	0.055**
		(0.024)	(0.025)
Homeless		-0.006	-0.009
		(0.021)	(0.021)
Jobless		-0.024*	-0.012
		(0.013)	(0.012)
Time fixed effects	Yes	Yes	Yes
Adjusted F-test			
Observations	9,907	9,907	9,912

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 31 Instrument v. Inmate Characteristics for Public Defender

	Bottom Tercile	Middle Tercile	Top Tercile	Middle v. Bottom P-Value	Top v. Bottom P-Value
Z: Clinician's Leave-Out					
Mean Mental Health Score Rate	-0.097	-0.023	0.116	(0.000)	(0.000)
Inmate Characteristics					
Asian	0.011	0.011	0.011	(0.987)	(0.680)
Black	0.310	0.289	0.284	(0.087)	(0.000)
Race other	0.001	0.000	0.001	(0.221)	(0.702)
Hispanic	0.173	0.204	0.190	(0.000)	(0.025)
Male	0.684	0.695	0.694	(0.311)	(0.795)
Age at booking	37.426	37.222	36.716	(0.579)	(0.240)
Prior offense w/in 365 days	0.655	0.617	0.625	(0.113)	(0.240)
Number of offenses per booking	1.638	1.603	1.651	(0.119)	(0.995)
First time in jail	0.013	0.015	0.003	(0.711)	(0.019)
Prior treatment	0.162	0.205	0.062	(0.555)	(0.093)
Prior medications	0.156	0.196	0.056	(0.570)	(0.073)
Prior hospitalization	0.133	0.169	0.048	(0.548)	(0.093)
Homeless	0.085	0.104	0.036	(0.574)	(0.167)
Jobless	0.105	0.121	0.022	(0.610)	(0.044)

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 32 Test of Randomization for Public Defender

	(1) Mental Health Court	(2) Z: Mental Health Court
Asian	0.203**	-0.003
	(0.096)	(0.007)
Black	-0.005	-0.006**
	(0.016)	(0.002)
Race other	-0.074	0.007
	(0.173)	(0.017)
Hispanic	-0.046***	0.003
	(0.016)	(0.003)
Male	-0.001	0.004
	(0.018)	(0.003)
Age at booking	0.003***	-0.000
	(0.001)	(0.000)
Prior offense w/in 365 days	0.116***	-0.002
	(0.015)	(0.004)
Number of offenses per booking	-0.000	0.000
	(0.005)	(0.001)
First time in jail	0.019	-0.042**
	(0.031)	(0.019)
Prior treatment	-0.142***	-0.005
	(0.042)	(0.019)
Prior medications	0.016	-0.030**
	(0.040)	(0.014)
Prior hospitalization	0.055**	0.006
	(0.022)	(0.007)
Homeless	-0.006	0.001
	(0.022)	(0.009)
Jobless	-0.032*	-0.018
	(0.017)	(0.012)
Time fixed effects	Yes	Yes
F-test	10	.
Observations	9,912	9,907

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 33 Assignation to Public Defender and Recidivism Outcomes

	OLS results		2SLS results		2SLS by Prior Offense	
	(1)	(2)	(3)	(4)	(5)	(6)
Recid after current booking	0.112***	0.042***	0.011	-0.077	0.130	-0.200
	(0.018)	(0.014)	(0.126)	(0.098)	(0.110)	(0.126)
Recid within 1 year	0.083***	0.058***	-0.110	-0.152	0.043	-0.220
	(0.015)	(0.015)	(0.117)	(0.112)	(0.111)	(0.150)
Count of future recidivism	1.899***	0.973***	0.324	-1.102	0.660	-2.282
	(0.370)	(0.313)	(2.725)	(2.280)	(0.532)	(3.401)
Days to recidivism	-39.500***	-28.206***	102.758	37.404	14.262	48.633
	(7.296)	(5.700)	(69.089)	(44.641)	(81.817)	(51.316)
Next offense felony	-0.032***	-0.038***	-0.007	-0.036	0.062	-0.079
	(0.006)	(0.006)	(0.071)	(0.064)	(0.062)	(0.076)
Next booking mental health score improves	0.076***	0.111***	0.825***	0.756***	0.927***	0.726***
	(0.025)	(0.023)	(0.196)	(0.167)	(0.230)	(0.180)
Suicide attempt in next booking	-0.029***	-0.025***	-0.144*	-0.045	-0.093**	-0.010
	(0.007)	(0.006)	(0.082)	(0.062)	(0.037)	(0.098)
Suicide ideation in next booking	-0.002	-0.002	-0.019**	-0.008	-0.001	-0.015
	(0.001)	(0.002)	(0.009)	(0.009)	(0.014)	(0.013)
Time fixed effects	Yes	Yes	Yes	Yes	Yes	Yes
Baseline controls	No	Yes	No	Yes	Yes	Yes
Subsample					No prior offense	Prior offense

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 34 Assignation to Public Defender and Heterogeneity in Outcomes

	Prior treatment		Prior medications		Prior hospitalization	
	(1) No	(2) Yes	(3) No	(4) Yes	(5) No	(6) Yes
Recid after current booking	-0.127	0.393	-0.118	0.290	-0.105	0.145
	(0.088)	(0.694)	(0.087)	(0.692)	(0.091)	(0.697)
Recid within 1 year	-0.218**	0.371	-0.221**	0.344	-0.183*	0.032
	(0.107)	(0.556)	(0.102)	(0.611)	(0.109)	(0.578)
Count of future recidivism	-1.324	0.572	-1.340	1.575	-1.134	-0.714
	(2.402)	(3.555)	(2.378)	(3.475)	(2.420)	(4.282)
Days to recidivism	43.389	-29.167	47.050	-100.224*	45.749	-30.247
	(46.043)	(87.724)	(47.622)	(52.464)	(47.272)	(78.176)
Next offense felony	-0.061	0.226	-0.059	0.332	-0.060	0.313
	(0.071)	(0.386)	(0.073)	(0.484)	(0.073)	(0.509)
Next booking mental health score improves	0.823***	-0.341	0.820***	-0.636	0.807***	-0.433
	(0.180)	(0.437)	(0.177)	(0.410)	(0.173)	(0.500)
Suicide attempt in next booking	-0.026	-0.508*	-0.022	-0.613**	-0.039	-0.487*
	(0.067)	(0.303)	(0.066)	(0.304)	(0.065)	(0.261)
Suicide ideation in next booking	-0.009	-0.159	-0.009	-0.164	-0.009	-0.208
	(0.010)	(0.112)	(0.010)	(0.109)	(0.010)	(0.136)
Time fixed effects	Yes	Yes	Yes	Yes	Yes	Yes
Baseline controls	Yes	Yes	Yes	Yes	Yes	Yes

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 35 Assignation to Public Defender and Heterogeneity in Outcomes

	Homeless		Jobless	
	(1) No	(2) Yes	(3) No	(4) Yes
Recid after current booking	-0.096	0.843	-0.113	2.054
	(0.089)	(1.993)	(0.087)	(5.013)
Recid within 1 year	-0.172	0.617	-0.187*	1.667
	(0.110)	(1.392)	(0.111)	(4.188)
Count of future recidivism	-0.944	-3.972	-0.856	-6.781
	(2.342)	(7.885)	(2.382)	(12.404)
Days to recidivism	38.546	-92.173	40.564	-241.908
	(43.083)	(661.560)	(45.422)	(939.376)
Next offense felony	-0.032	-0.450	-0.033	-0.391
	(0.060)	(0.646)	(0.061)	(0.778)
Next booking mental health score improves	0.778***	-31.313	0.750***	-0.489
	(0.169)	(1971.284)	(0.166)	(4.275)
Suicide attempt in next booking	-0.038	-0.395	-0.037	-0.393
	(0.061)	(0.591)	(0.064)	(0.864)
Suicide ideation in next booking	-0.005	-0.415	-0.012	-0.092
	(0.007)	(0.700)	(0.009)	(0.455)
Time fixed effects	Yes	Yes	Yes	Yes
Baseline controls	Yes	Yes	Yes	Yes

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 36 Descriptive Statistics by MH Score 1s vs. 2s Assignation

	MH Score 1	MH Score 2
Mental Health Needs		
None	0.000	0.000
Mild	1.000	0.000
Moderate	0.000	1.000
Severe	0.000	0.000
Outcomes		
Recid after current booking	0.498	0.644
Recid within 1 year	0.582	0.699
Count of future recidivism	1.733	3.425
Days to recidivism	175.856	136.279
Next offense felony	0.136	0.147
Next booking mental health score improves	0.275	0.302
Suicide attempt in next booking	0.053	0.071
Suicide ideation in next booking	0.003	0.008
Inmate Characteristics		
White	0.741	0.700
Asian	0.009	0.008
Black	0.250	0.291
Race other	0.001	0.001
Hispanic	0.240	0.201
Male	0.663	0.686
Age at booking	34.981	36.471
Prior offense w/in 365 days	0.460	0.595
Number of offenses per booking	1.582	1.625
First time in jail	0.035	0.012
Prior treatment	0.193	0.158
Prior medications	0.188	0.149
Prior hospitalization	0.104	0.125
Homeless	0.051	0.080
Jobless	0.089	0.091
Clinician Characteristics		
Clinician Male	0.200	0.188
Clinician White	0.847	0.842
Clinician Black	0.061	0.073
Clinician Hispanic	0.085	0.078
Observations	8,701	7,469

Table 37 First Stage Regressions for MH Score 1s vs. 2s

	Residualized Leave-Out		Clinician Fixed Effects
	(1)	(2)	(3)
Z: Clinician's Leave-Out Mean Mental Health Score Rate	0.659***	0.606***	
	(0.176)	(0.163)	
Asian		-0.000	-0.003
		(0.041)	(0.042)
Black		0.018	0.020*
		(0.011)	(0.011)
Race other		0.113	0.115
		(0.133)	(0.132)
Hispanic		-0.040***	-0.039***
		(0.013)	(0.013)
Male		-0.002	-0.000
		(0.010)	(0.010)
Age at booking		0.002***	0.002***
		(0.000)	(0.000)
Prior offense w/in 365 days		0.111***	0.108***
		(0.013)	(0.013)
Number of offenses per booking		0.003	0.002
		(0.003)	(0.003)
First time in jail		-0.074**	-0.058*
		(0.029)	(0.029)
Prior treatment		-0.062**	-0.054*
		(0.028)	(0.029)
Prior medications		-0.129***	-0.120***
		(0.022)	(0.019)
Prior hospitalization		0.175***	0.167***
		(0.017)	(0.017)
Homeless		0.118***	0.114***
		(0.018)	(0.018)
Jobless		0.008	0.016
		(0.022)	(0.018)
Time fixed effects	Yes	Yes	Yes
Adjusted F-test			
Observations	16,169	16,169	16,170

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 38 Instrument v. Inmate Characteristics for MH Score 1s vs. 2s

	Bottom Tercile	Middle Tercile	Top Tercile	Middle v. Bottom P-Value	Top v. Bottom P-Value
Z: Clinician's Leave-Out Mean Mental Health Score Rate	-0.140	-0.001	0.137	(0.000)	(0.000)
Inmate Characteristics					
Asian	0.008	0.008	0.009	(0.738)	(0.527)
Black	0.263	0.277	0.268	(0.105)	(0.926)
Race other	0.001	0.001	0.001	(0.624)	(0.887)
Hispanic	0.226	0.215	0.225	(0.368)	(0.650)
Male	0.670	0.681	0.669	(0.457)	(0.944)
Age at booking	35.024	36.082	35.903	(0.008)	(0.079)
Prior offense w/in 365 days	0.487	0.541	0.539	(0.006)	(0.001)
Number of offenses per booking	1.562	1.617	1.626	(0.026)	(0.012)
First time in jail	0.049	0.014	0.010	(0.008)	(0.001)
Prior treatment	0.253	0.167	0.111	(0.401)	(0.041)
Prior medications	0.244	0.161	0.105	(0.399)	(0.037)
Prior hospitalization	0.140	0.123	0.078	(0.837)	(0.170)
Homeless	0.078	0.064	0.051	(0.758)	(0.326)
Jobless	0.141	0.071	0.057	(0.153)	(0.083)

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 39 Test of Randomization for MH Score 1s vs. 2s

	(1) Mental Health Court	(2) Z: Mental Health Court
Asian	0.005	0.008
	(0.042)	(0.007)
Black	0.019	0.001
	(0.011)	(0.003)
Race other	0.109	-0.007
	(0.134)	(0.018)
Hispanic	-0.039***	0.002
	(0.013)	(0.004)
Male	-0.005	-0.005*
	(0.011)	(0.003)
Age at booking	0.002***	0.000*
	(0.000)	(0.000)
Prior offense w/in 365 days	0.113***	0.003
	(0.014)	(0.004)
Number of offenses per booking	0.003	0.001
	(0.003)	(0.001)
First time in jail	-0.105***	-0.051***
	(0.031)	(0.016)
Prior treatment	-0.078**	-0.026
	(0.029)	(0.016)
Prior medications	-0.143***	-0.023*
	(0.026)	(0.013)
Prior hospitalization	0.196***	0.034**
	(0.018)	(0.013)
Homeless	0.129***	0.019**
	(0.019)	(0.009)
Jobless	-0.007	-0.024
	(0.032)	(0.026)
Time fixed effects	Yes	Yes
F-test	23	5
Observations	16,170	16,169

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 40 Assignation to MH Score 1s vs. 2s and Recidivism Outcomes

	OLS results		2SLS results		2SLS by Prior Offense	
	(1)	(2)	(3)	(4)	(5)	(6)
Recid after current booking	0.148***	0.084***	0.260**	0.124*	0.165**	0.078
	(0.015)	(0.009)	(0.113)	(0.075)	(0.079)	(0.102)
Recid within 1 year	0.116***	0.095***	0.182*	0.126	0.225**	0.051
	(0.012)	(0.010)	(0.103)	(0.094)	(0.109)	(0.104)
Count of future recidivism	1.697***	1.203***	1.661	0.673	0.354	1.039
	(0.216)	(0.169)	(1.428)	(1.115)	(0.320)	(2.129)
Days to recidivism	-39.342***	-25.588***	34.481	6.858	-3.044	24.953
	(8.972)	(6.879)	(73.572)	(40.912)	(54.878)	(42.665)
Next offense felony	0.012**	0.000	0.071**	0.054*	0.061**	0.053
	(0.006)	(0.006)	(0.032)	(0.029)	(0.028)	(0.050)
Next booking mental health score improves	0.027	0.048***	0.052	0.047	0.213	-0.059
	(0.019)	(0.017)	(0.181)	(0.163)	(0.144)	(0.176)
Suicide attempt in next booking	0.018***	0.011**	0.020	0.042	0.057*	0.025
	(0.006)	(0.004)	(0.055)	(0.029)	(0.030)	(0.050)
Suicide ideation in next booking	0.005***	0.005***	0.005	0.008	0.003	0.011*
	(0.001)	(0.001)	(0.004)	(0.005)	(0.007)	(0.006)
Time fixed effects	Yes	Yes	Yes	Yes	Yes	Yes
Baseline controls	No	Yes	No	Yes	Yes	Yes
Subsample					No prior offense	Prior offense

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

Table 41 Assignation to MH Score 1s vs. 2s and Heterogeneity in Outcomes

	Prior treatment		Prior medications		Prior hospitalization	
	(1) No	(2) Yes	(3) No	(4) Yes	(5) No	(6) Yes
Recid after current booking	0.083	0.229*	0.096	0.201	0.113	0.181
	(0.077)	(0.124)	(0.077)	(0.131)	(0.078)	(0.202)
Recid within 1 year	0.074	0.338*	0.090	0.257	0.115	0.154
	(0.097)	(0.173)	(0.098)	(0.169)	(0.097)	(0.237)
Count of future recidivism	0.553	0.032	0.629	-0.284	0.686	-1.156
	(1.308)	(0.996)	(1.293)	(1.059)	(1.213)	(1.762)
Days to recidivism	5.178	-9.790	6.697	-14.911	7.176	-85.078
	(45.135)	(49.593)	(45.477)	(42.008)	(42.489)	(98.452)
Next offense felony	0.060*	0.045	0.066*	0.031	0.056*	0.124
	(0.036)	(0.061)	(0.037)	(0.055)	(0.032)	(0.080)
Next booking mental health score improves	0.095	0.015	0.085	0.027	0.078	0.116
	(0.173)	(0.245)	(0.174)	(0.242)	(0.163)	(0.507)
Suicide attempt in next booking	0.018	0.223***	0.021	0.227***	0.042	0.152
	(0.030)	(0.072)	(0.028)	(0.069)	(0.028)	(0.102)
Suicide ideation in next booking	0.008*	0.009	0.009*	-0.001	0.011**	-0.030
	(0.005)	(0.019)	(0.005)	(0.017)	(0.005)	(0.022)
Time fixed effects	Yes	Yes	Yes	Yes	Yes	Yes
Baseline controls	Yes	Yes	Yes	Yes	Yes	Yes

Data is from a large county correctional complex.

Time fixed effects include day-of-week-month fixed effects.

Clinician and inmate two-way clustered standard errors shown in parentheses.

* p<0.10, ** p<0.05, *** p<0.01

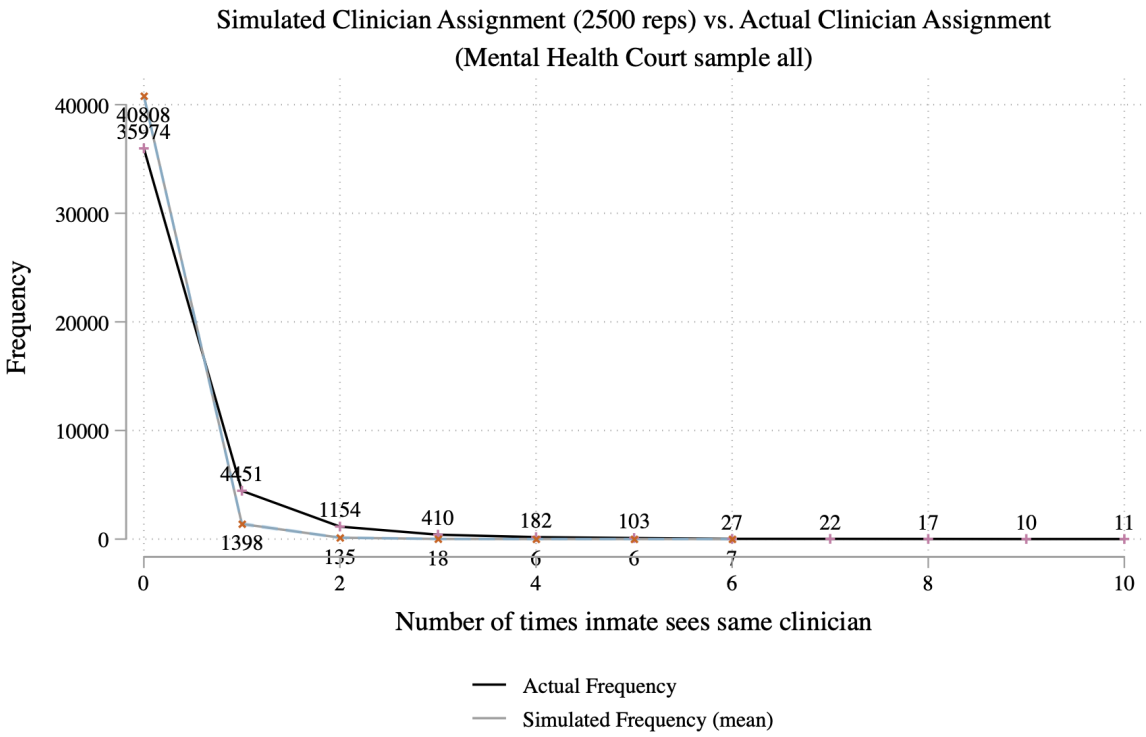


Figure 10 Simulated Clinician Assignment Compared to Actual Assignment

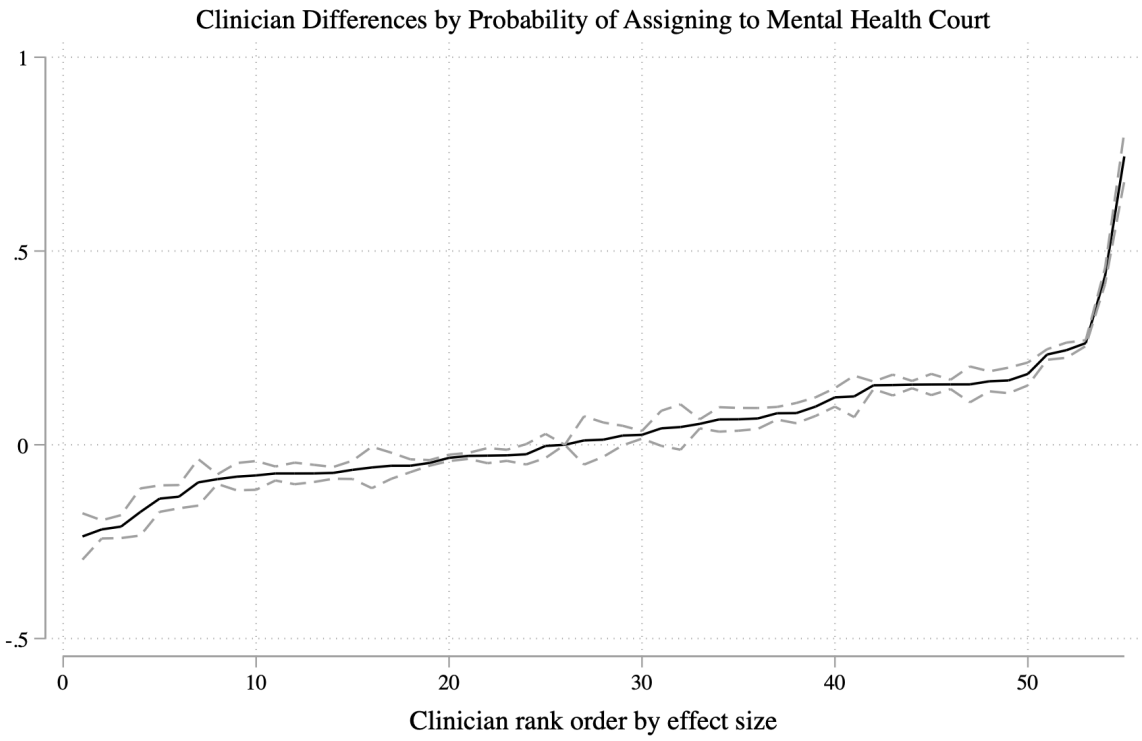


Figure 11 Clinician fixed effects with full sample for mental health court assignment

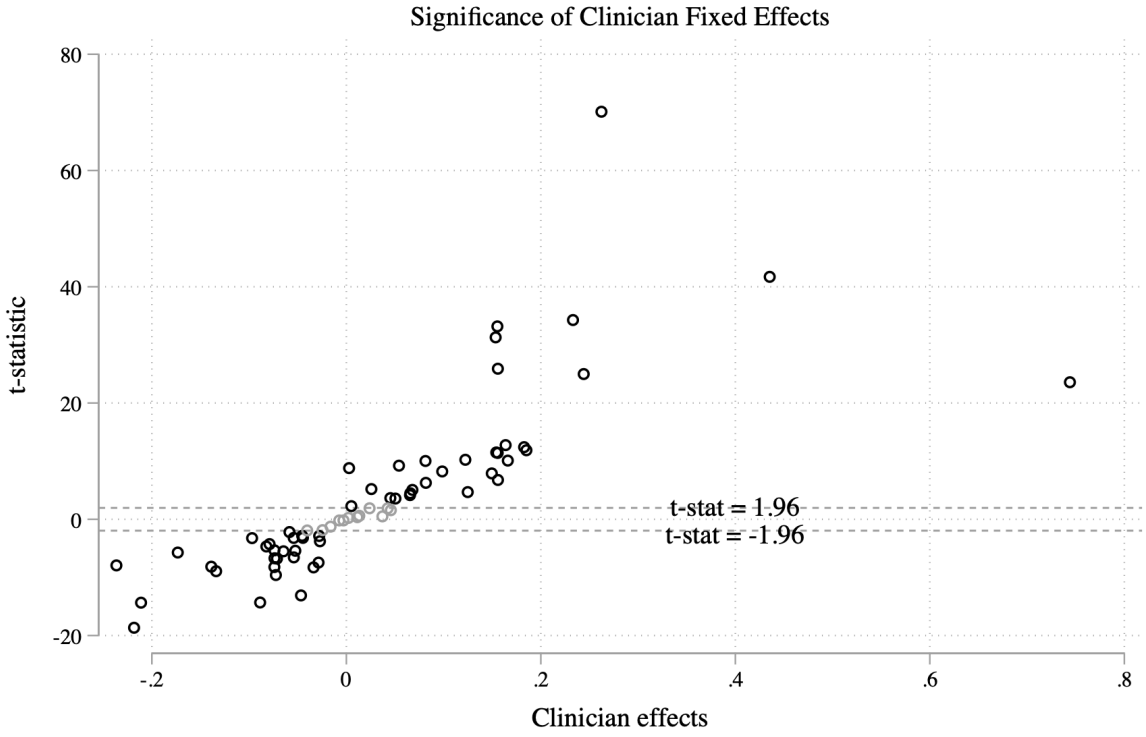


Figure 12 Distribution of t-statistics on individual therapist fixed effects for full sample

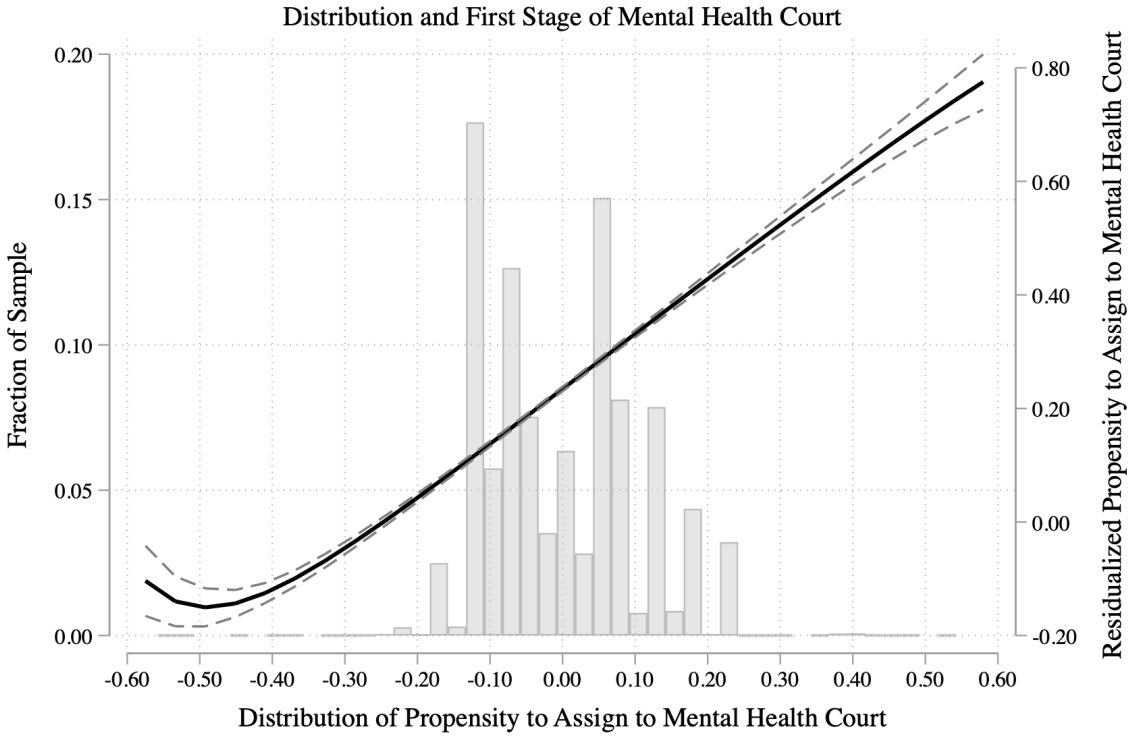


Figure 13 Smoothed fan regression of residualized leave one out against the share of individuals in mental health court

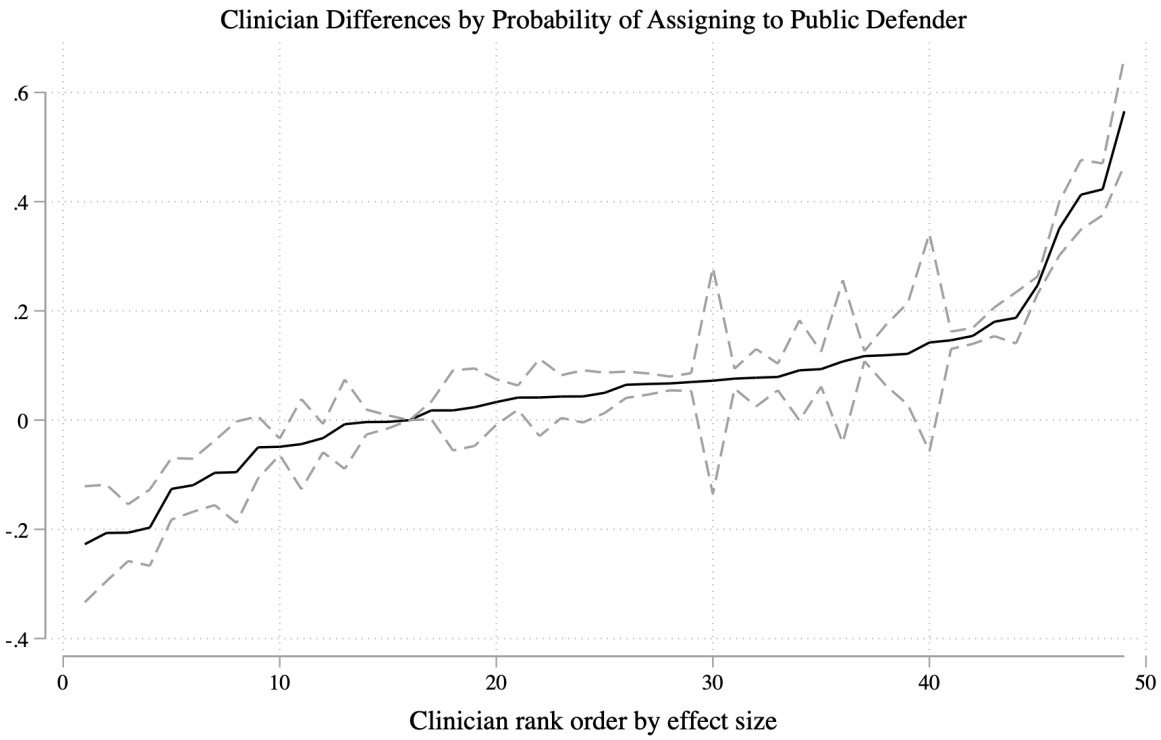


Figure 14 Clinician fixed effects with full sample for public defender assignment

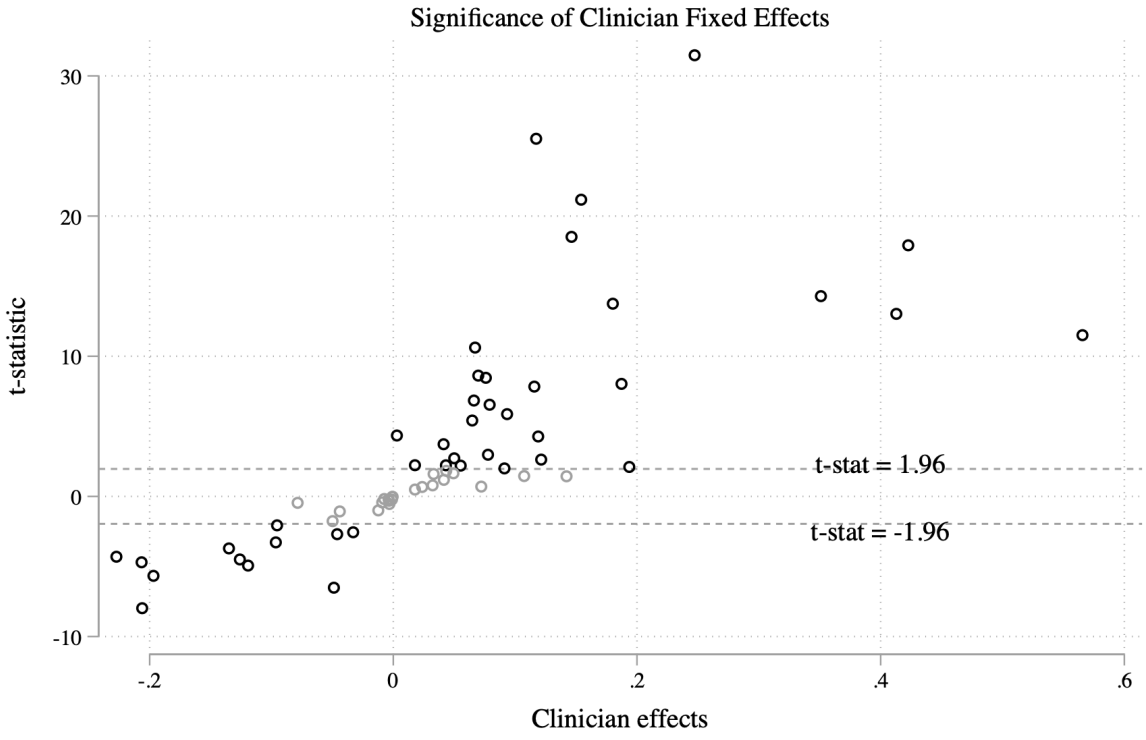


Figure 15 Distribution of t-statistics on individual therapist fixed effects for full sample for public defender assignment

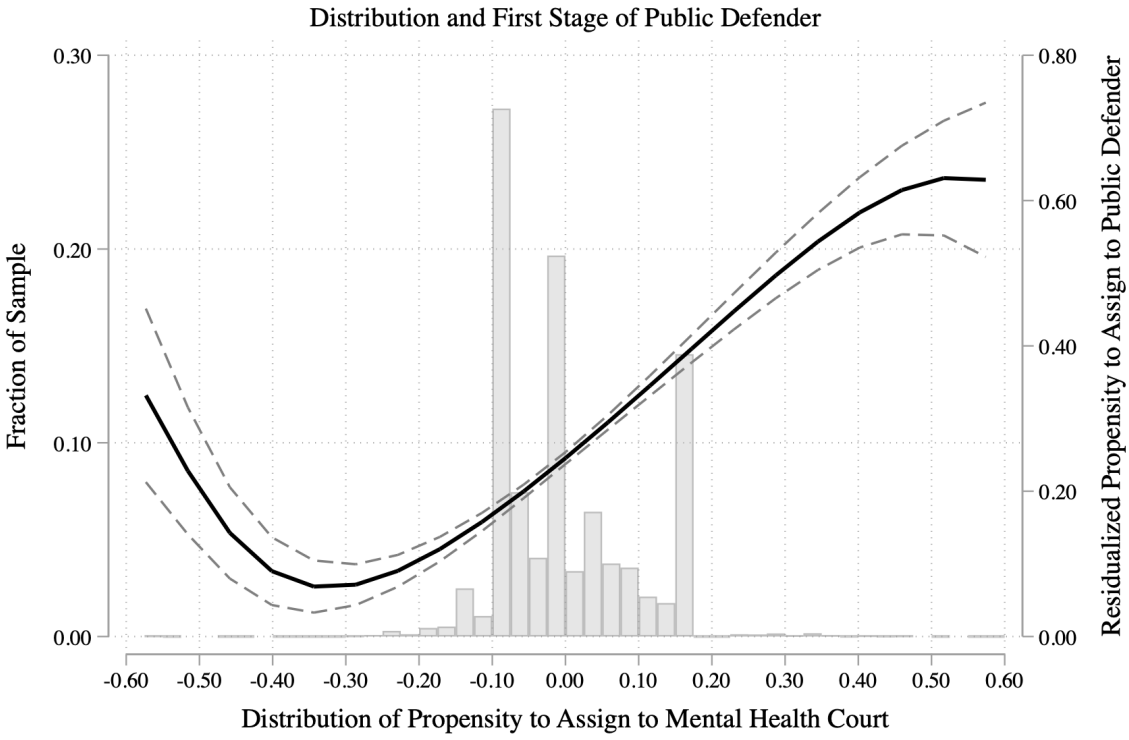


Figure 16 Smoothed fan regression of residualized leave one out against the share of individuals with public defender assignation

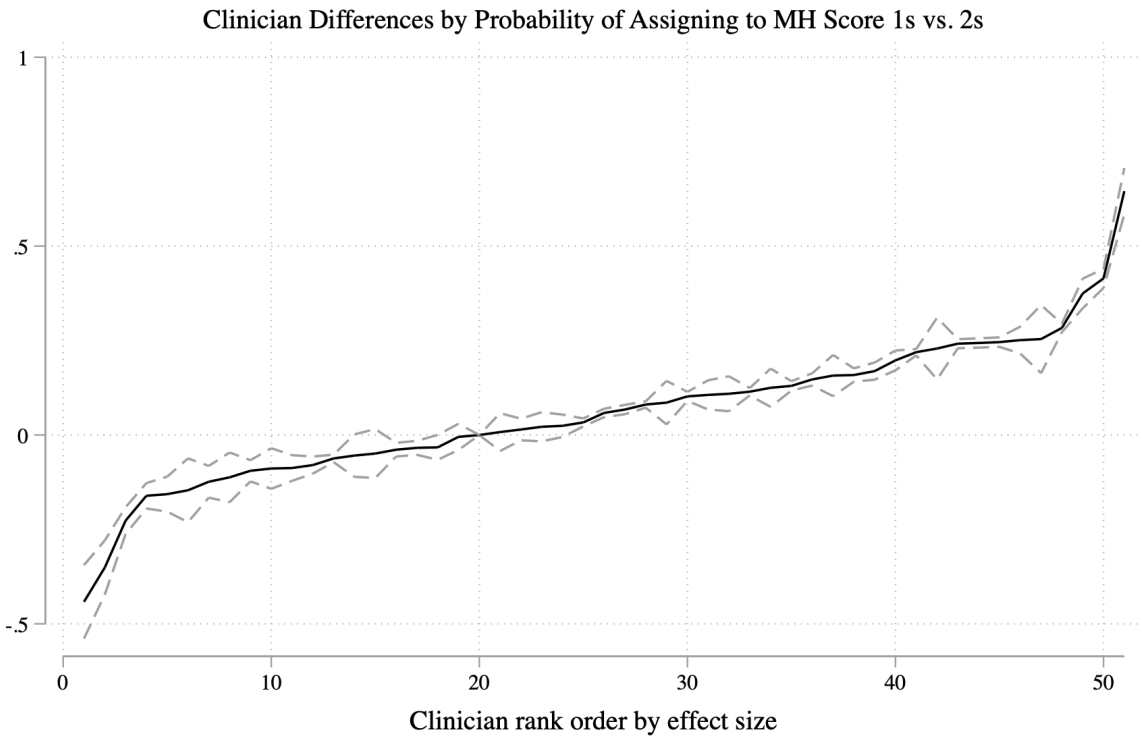


Figure 17 Clinician fixed effects with full sample for 1s vs 2s

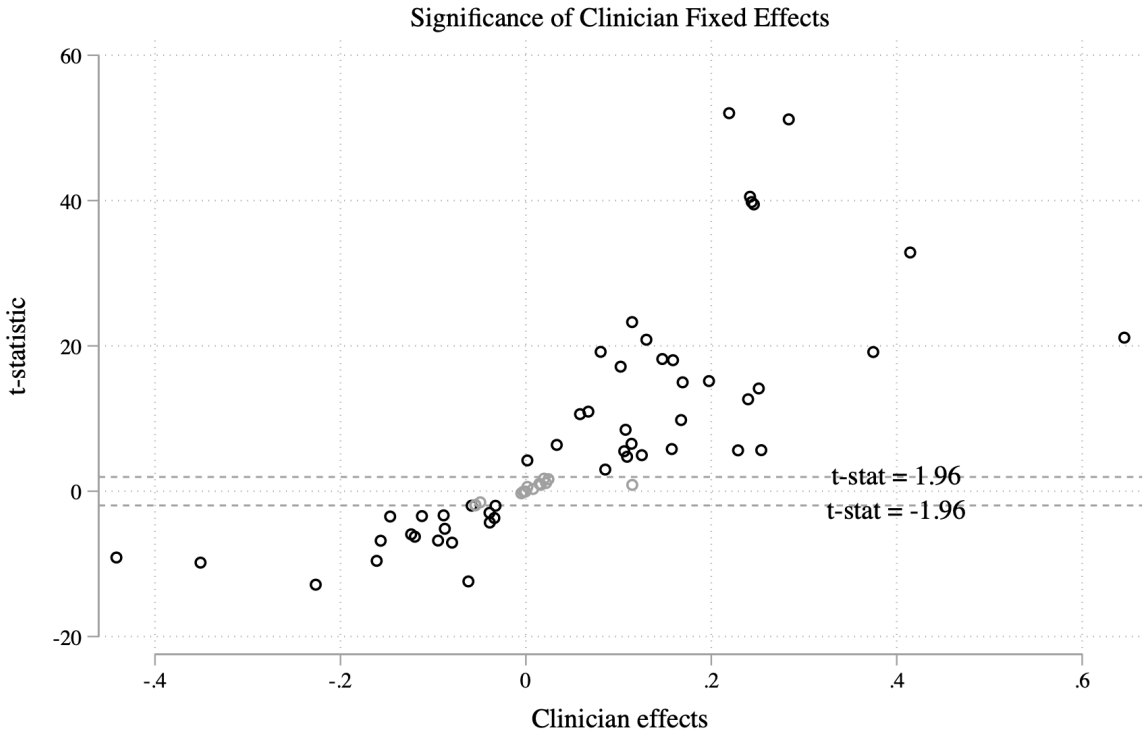


Figure 18 Distribution of t-statistics on individual therapist fixed effects for full sample for 1s vs 2s

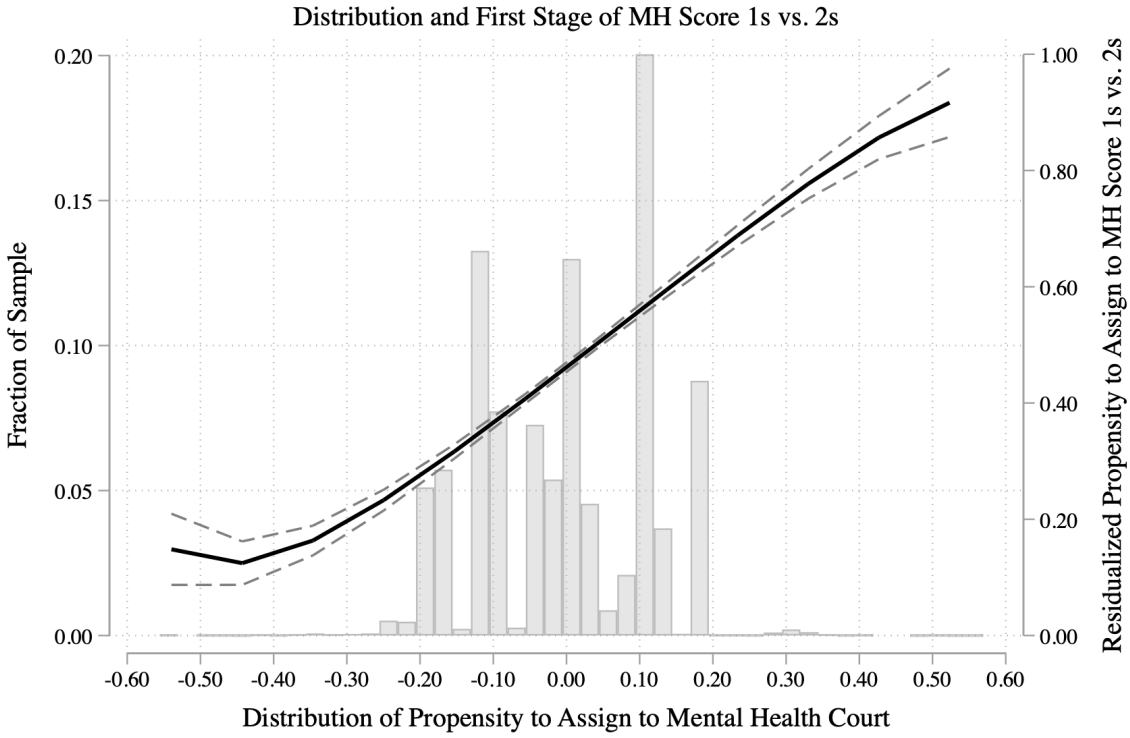


Figure 19 Smoothed fan regression of residualized leave one out against the share of individuals with 1s vs 2s