Indigent Defense, Social Workers and Suicidality in Jail

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Sandra Bland Suicide and Sandra Bland Act

Sandra Bland was a 28-year-old African American woman who was found hanged in a jail cell in Waller County, Texas, on July 13, 2015, three days after being arrested during a pretextual traffic stop. Her death was ruled a suicide by asphyxiation.

Sandra Bland suicide in jail after led to protests against her arrest, disputing cause of death, alleging violence against her, and ultimately the Texas Sandra Bland Act in 2017

County jails are required to collect information used to make a determination of mental illness or intellectual disability. A written assessment of collected information will be submitted to a magistrate and mental health expert if a potential substance abuse, mental illness or intellectual disability exists.

Suicide in jails

- Pre-trial detainees have a suicide attempt rate 8x higher than the general population
- Suicides represented an average of 6% of deaths in state prisons from 2001 to 2016
- Suicide is the leading cause of death in jails accounting for more than a third

Indigent defense

- Travis county, Texas (Austin) has a mental health court (MHC) where mentally ill offenders are diverted away from traditional courts into a friendly court seeking dismissals
- Indigent defense is provided by the 6th Amendment of the US Constitution (counsel for those who can't afford it)
- Two types of attorneys in Travis MHC – public defenders (with large staff of social workers) and private indigent attorneys (no social workers).
- Lawyer type differs by payment structure, different selection potential, and different staffing – thus this is intent to treat with suggested mechanisms

Summary of findings

- We instrument for public defense using the propensity to rate high symptoms and low functioning of the randomized therapists (leniency design)
- Public defenders with social workers have no effect on repeat offending relative to private attorneys
- Public defenders with social workers improve mental health scores by one point (four point scale)
- Public defenders with social workers **reduce** suicide attempts by 7-16%, and self-reported suicidal ideation by 1-2%
- Suicide attempt results are most precise for those with no prior offense

Introduction to Mental Health Courts

Jails and prisons are the mental health hospitals of last resort

- Inmates are 64% or up to 12 times more likely to have a mental illness than the general community (Prins, 2014)
  - 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)
  - $\sim$20 percent of inmates in our data require treatment for their mental illness
- On any given day, 7 percent of inmates with mental illness are experiencing severe symptoms such as psychosis, delusions or suicidal thoughts (Corrections Officers Receive Specialized Mental Health Training, 2020)
  - One study found a 77% prevalence rate of mental illness among inmates who attempted suicide (Goss et al. 2002)

Why are there so many mentally ill in correctional facilities?

Harcourt (2006) and Raphael and Stoll (2013) find deinstitutionalization contributed to mass incarceration

Harcourt quote, Raphael and Stoll quote

1. **Deinstitutionalization**: Residential hospitals were gradually defunded over late 20th century due to greater civil liberties for people with mentally illnesses, medical breakthroughs (e.g., lithium, SSRIs), and a push towards community-based treatment (Frank and McGuire 2010)
2. **Mass incarceration**: quintupling of prison population from the 1970s to the present (Western 2006)

People with mental illnesses got "sucked into" the growing prison population

Changing philosophies and therapeutic jurisprudence

- Mental health court (MHC) movement emerged out of inequities in the experiences among people with mental illnesses, growth in therapeutic jurisprudence and the drug court movement
- MHCs are specialty courts endogenously adopted by counties to care for the growing mentally ill population caught in criminal justice institutions

Enter mental health courts

- With **typical courts**, a defendant is booked, screened for mental illness; if convicted, goes to jail, likely receives medication to treat mental illness depending on making bail
- MHCs are **diversion** interventions (e.g., drug court, battery court) that engage defendants with mental illnesses in lieu of incarceration
- Admission into MHCs is complicated and often a variable decision-making process that involves multiple parties
- In counties with an MHC, the inmate will be redirected to a specialty court if supervisors believe mental illness contributed to offense, the defendant meets criteria and there is capacity

MHC, Indigent Defense and the Constitution

Sixth amendment guarantees US citizens right to an attorney, but the Constitution **does not** specify how this should be accomplished or financed

1. For moderately low functioning (scores of 2), **private attorneys** financed by the county. These attorneys are paid a flat rate of $750 for representing clients. As of 2018, it was 6 lawyers who do this on the side for a little extra money; they also get some extra training on mental health and the legal processes
2. For the severely impaired functioning (scores of 3), **public defenders office**. The Mental Health Public Defender Office has 4 lawyers, 6 social workers, and 2 admin staff.

Differences between public and private defenders

- Public defenders are salaried; private indigent defense attorneys are paid a flat fee per client
- Public defenders employee **two social workers for every one lawyer**
- Private defenders have **no social workers**
- All remaining differences are selection, potentially related to payment structure or low demand for their day job

Data and research design

Data Description

Travis County Texas Correctional Complex (2016-2019)

- Universe of bookings (n>40,000 reduced to 31,000 using selection criteria)
- Inmate ID (unique) & booking ID (unique case/event) allows us to measure recidivism (we use only misdemeanors)
- Administrative data including offense type (felony, misdemeanor), demographics, mental health, charges, suicide attempt, suicide ideation, etc.

Raw data shows signs of selection bias (see summary statistics below)

Worried sources of bias

- Collider bias based on our data only having repeat offenders (see graph)
- Conditional independence violated due to unobserved selection therapists witness (we have none of their records)
- We check for issues raised by collider structure in the data
- We estimate our LATE of public defenders and social workers on suicidality using 2SLS and unbiased jackknife IV estimator (UJIVE)
- We present some evidence that monotonicity and exclusion hold

Instrumental variables

1. Independence – director of inmate mental health has explained they use a random number generator to assign therapists to inmates which we check with balance
2. SUTVA – the assignment of an inmate to one inmate cannot change suicidality potential outcomes of another inmate (no spillover from instrument assignment)
3. Exclusion – randomized therapist during assessment can have indirect or direct effect on suicidality except via assignment to public defend and social workers
4. Non-zero first stage – relationship between instrument and assignment to public defender and social workers
5. Monotonicity – if therapist A always rates an inmate as low functioning with high symptoms more than therapist B (they do not change places in strictness)

Collider bias and sample selection

- Pearl (2009), Morgan and Winship (2014), Schneider (2020) and Imbens (2020) say directed acyclic graphs (DAG) can help us develop designs that avoid "collider bias"
- Collider bias is caused by controlling for a "collider" variable, or selecting on a sample that is itself a collider in some chain of causal effects (Schneider 2020)

DAG showing plausible causal effects

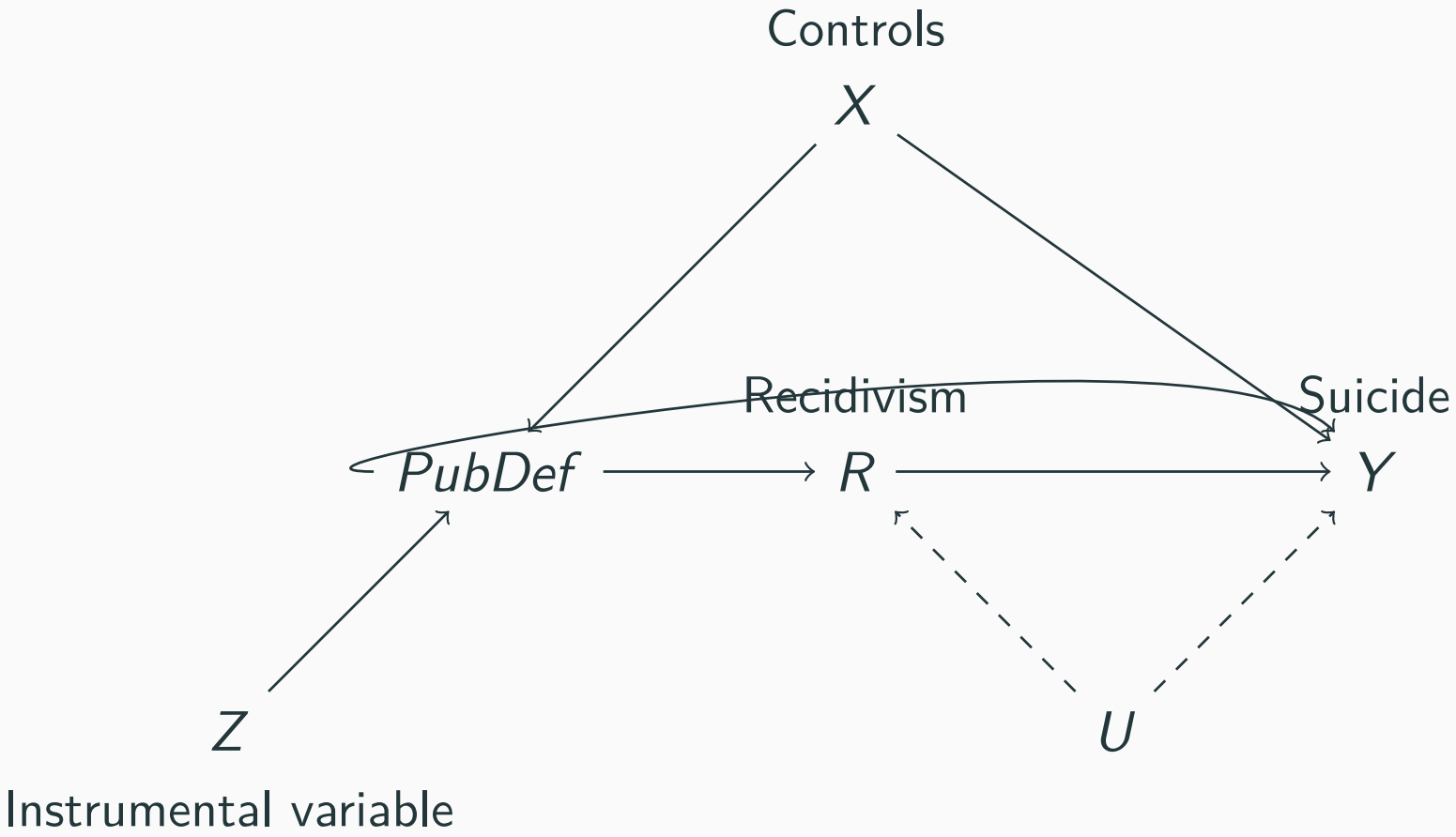


Figure 1: DAG showing sample based collider bias connecting public defense to suicides and mental health scores

Implications of DAG for our study

- When there is **an effect** on recidivism, don't examine suicide due to collider bias

$$PubDef \rightarrow \boxed{\not{R}} \qquad U \rightarrow \not{Y}$$

- When there is **no effect** on recidivism, examining suicide is permissible as there is no collider bias

$$PubDef \rightarrow \not{Y}$$

- We need that public defenders do not cause recidivism relative to private indigent defense attorneys otherwise the sample is a collider and we have to move to bounds (Knox, Lowe and Mummolo 2020)

Randomized assignment to therapists

- Each inmate is randomly assigned a therapist who interviews them for 15 minutes within 36 hours of booking
- Therapists assign a score (0-3) measuring the severity of mental and behavioral health symptoms as it relates to their **functioning** (important)
  - Inmates with no (0) or mild (1) functioning related symptoms skip MHC and are assigned to typical courts
  - Inmates with moderate (2) symptoms are assigned to private indigent defense attorneys (paid for by the county) in MHC
  - Inmates with severe (3) symptoms are assigned to MHC public defenders office
- After therapists score the inmate, he is assigned to a court and the therapist never sees them again (i.e., no therapy) which ensures exclusion holds in the data

Calculating the residualized leave-one-out mean

1. Regress observed *PubDef* onto a vector of time controls (day of year time fixed effects)
2. Calculate the residual, $\widetilde{D}_{dkt}$, from this regression
3. Use the residualized public propensity to recommend public defense rate to calculate the therapist recommendation instrument $\widetilde{Z}_{cl}$ as a leave-one-out mean rate of Public defense recommendation associated with each randomly assigned therapist l and inmate c

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

2SLS estimating equations

$$PubDef_{dct} = \widetilde{Z}_{cl} + X_{dct} + \tau_t + \varpi_{dct} \quad (2)$$

$$Y_{dct} = \delta \widehat{PubDef}_{dct} + X_{dct} + \tau_t + \varepsilon_{dct} \quad (3)$$

where Y is the outcome of interest (e.g., repeat offending, suicide), *PubDef* is an indicator equalling 1 if the inmate was assigned to the public defender and 0 if the private indigent defense attorney; X are pre-court controls; τ_t are time fixed effects; $\widetilde{Z}$ is the residualized "leave-one-out-mean" average assignment to mental health court and errors are at the end of each equation.

UJIVE

- Common to see people estimate models using UJIVE as well as 2SLS
- Even though model is just identified with residualized leave-one-out-mean, the instrument is multi-dimensional in the number of clinicians and with weak instruments, this creates finite sample bias
- We also use LASSO to select strongest instruments and shrink weaker ones, but results don't change
- Our results don't change when estimating either UJIVE or LASSO, so I present 2SLS because of data visualization

Indigent defense: Public defender vs Private attorneys

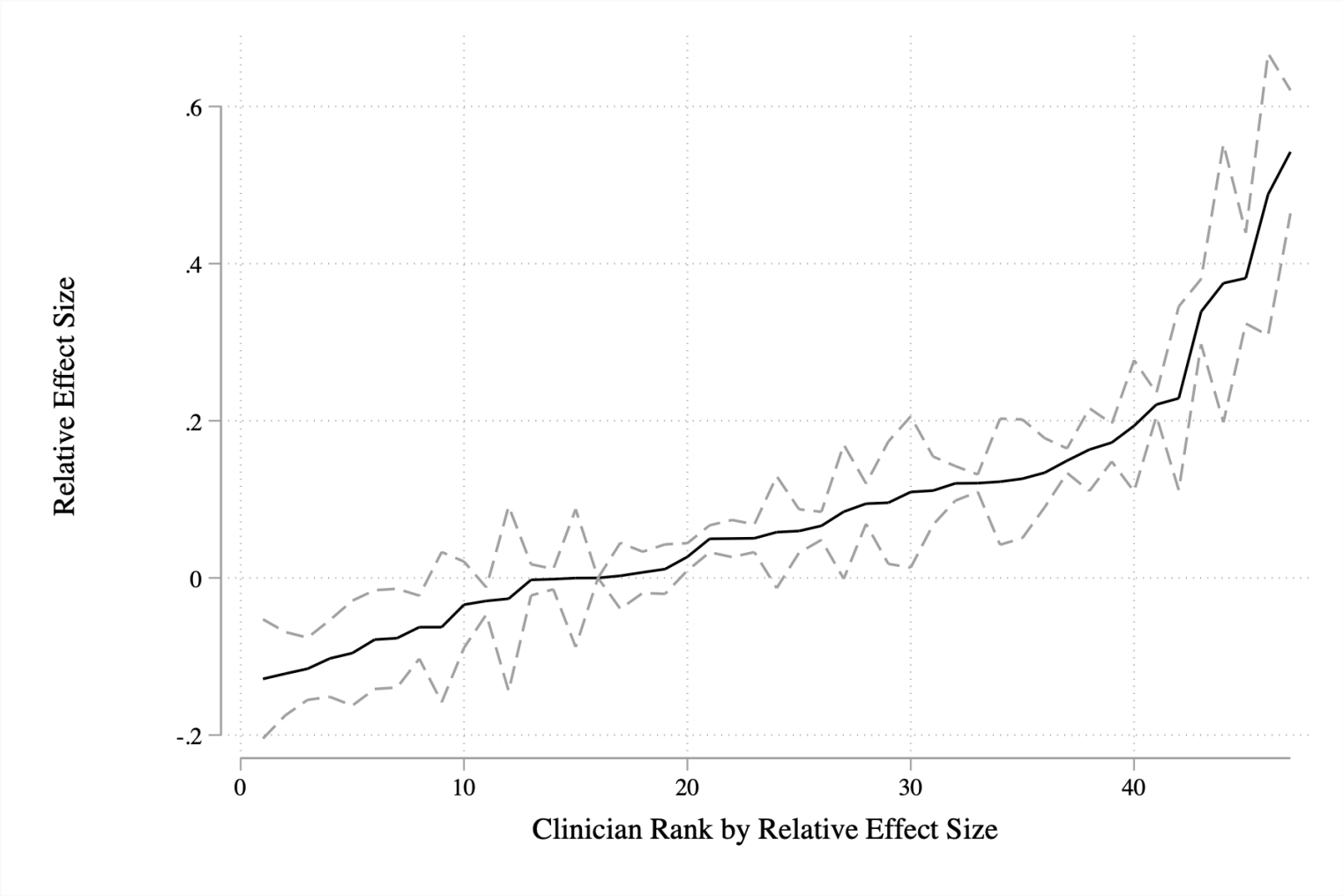
Table 1: Descriptive Statistics by Public Defender Assignment

	Wheel	Public Defender
Outcomes		
Suicide attempt in next booking	0.051	0.030
Suicide ideation in next booking	0.006	0.004
Next booking mental health score improves	0.431	0.547
Recid after current booking	0.445	0.495
Recid within 1 year	0.511	0.536
Count of future recidivism	0.904	1.038
LOS	13.712	26.880
Days to recidivism	222.642	202.020
Next offense felony	0.129	0.117
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

Systematic “biases” in first-time screeners”

- Assessment is brief and one-time event
- Imagine rating mental illness symptoms was like a blood test – then there’d be no variation in assessment
- As therapists see on average same types, without bias there would be no variation in recommendations
- But we do not find this – therapists appear to disagree, caused likely by discretion and “tendencies”

Visualizing therapist fixed effects



Visualizing residualized leave-one-out mean

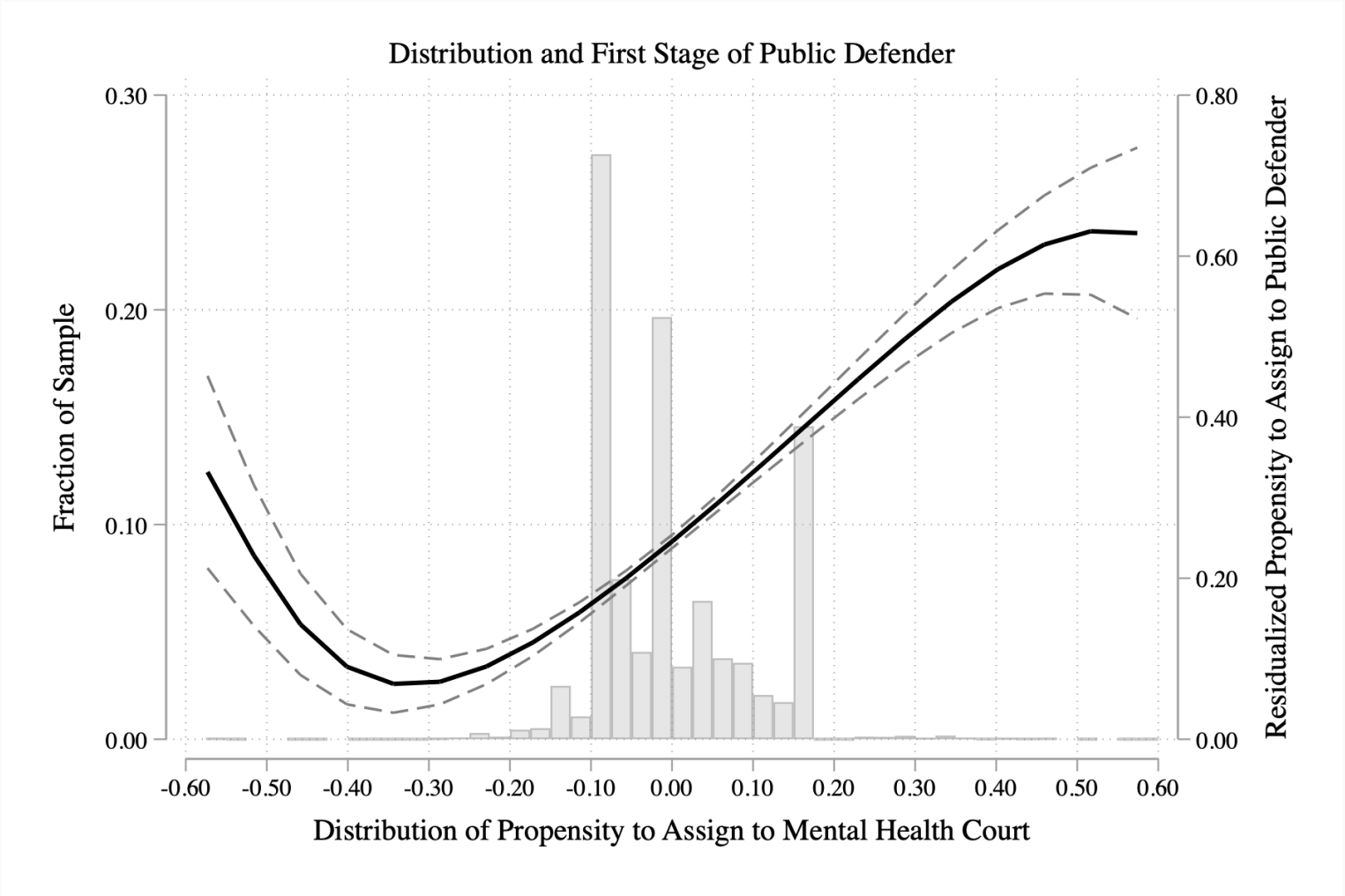


Table 2: Instrument v. Inmate Characteristics for Public Defender

	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	-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.
* $p<0.10$, ** $p<0.05$, *** $p<0.01$

Strength of first stage

Table 3: First Stage Regressions for Initial Assessment of Most Severe Mental Health Rating

	(1)	(2)
Z: Clinician's Leave-Out Mean Mental Health Score	0.635***	0.619***
	(0.152)	(0.150)
Kleibergen-Paap F	17.3653	17.1609
Time Fixed Effects	Yes	Yes
Baseline Controls	No	Yes
Observations	5,215	5,215

We report the first stage results of a linear probability model with outcome of interest being the initial assessment of an inmate's mental health being most severe as opposed to moderately severe. The propensity to assign the most severe score is estimated using data from other cases assigned to the clinician following the procedure described in the text. Column (1) shows the results by controlling only for day-of-week-month fixed effects, whereas Column (2) also includes the inmate baseline controls as shown in Table 1. Each column gives the corresponding clinician and inmate robust two-way clustered standard errors in parentheses. Robust (Kleibergen-Paap) first stage F reported (which is equivalent to the effective F-statistic of Montiel Olea and Pflueger (2013) in this case of a single instrument).
* $p<0.10$, ** $p<0.05$, *** $p<0.01$

Monotonicity tests

Table 4: Frandsen, Lefgren, Leslie (2020) Test of Joint Null of Exclusion and Monotonicity

Outcome	FLL P-Value
Suicide attempt in next booking	0.000
Suicide ideation in next booking	1.000
Next booking mental health score improves	0.267
Recid after current booking	0.000
Recid within 1 year	0.018
Count of future recidivism	0.000
LOS	0.126
Days to recidivism	0.002
Next offense felony	0.001

This table presents results from the test proposed in Frandsen, Lefgren, and Leslie (2020) for the joint null hypothesis that the monotonicity and exclusion restrictions hold. A failure to reject the null implies that we cannot reject the hypothesis that the monotonicity and exclusion restrictions jointly hold. This test was implemented in Stata via the package testjfe (Frandsen, 2020).

Table 5: Average Montonicity for Initial Assessment of Most Severe Mental Health Rating

	Male	Female	Black	White	Hispanic	Age $<$ 25	Age $>$ 45
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
[t]2.3Z: Clinician's Leave-Out Mean Mental Health Score	0.562***	0.766***	0.899***	0.547***	0.556***	0.598**	0.568***
	(0.164)	(0.152)	(0.179)	(0.147)	(0.200)	(0.254)	(0.170)
Observations	3,355	1,860	1,371	3,790	1,097	1,031	1,219
Time Fixed Effects	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Controls	Yes	Yes	Yes	Yes	Yes	Yes	Yes

This table reports the first stage results by subsamples as listed in the column headers, which serves as informal evidence of average monotonicity if the estimate significant across all subsamples. * p$<$0.10, ** p$<$0.05, *** p$<$0.01

Table 6: Effects of Initial Assessment of Most Severe Mental Health Rating on Recidivism Outcomes

	OLS results		2SLS results			
	(1)	(2)	(3)	(4)	(5) No Prior Offense	(6) Prior Offense
[t]2.2Recid 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)
			[-0.283, 0.458]	[-0.311, 0.279]	[-0.174, 0.265]	[-1.494, 0.506]
[t]2.2Recid 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)
			[-0.400, 0.293]	[-0.437, 0.199]	[-0.245, 0.180]	[-1.529, 0.507]
[t]2.2Count 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)
			[-0.501, 1.901]	[-0.677, 1.324]	[-0.273, 0.710]	[-2.876, 5.006]
[t]2.2LOS	13.442***	12.344***	16.056	17.292	10.626	19.776
	(1.905)	(1.648)	(15.244)	(14.792)	(10.486)	(26.409)
			[-9.105, 58.977]	[-4.222, 58.885]	[-6.545, 31.837]	[-23.087, 224.003]
[t]2.2Days 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)
			[-118.927, 229.537]	[-144.483, 153.767]	[-242.925, 235.386]	[-330.825, 332.529]
[t]2.2Next 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)
			[-0.151, 0.202]	[-0.171, 0.132]	[-0.079, 0.146]	[-0.866, 0.251]
Time fixed effects	Yes	Yes	Yes	Yes	Yes	Yes
Baseline Controls	No	Yes	No	Yes	Yes	Yes

This table reports the ordinary least squares and two-stage least squares estimates of the impact of a clinician's initial assessment of a most severe mental health rating on inmates' subsequent mental health. The outcome variables of interest are given in each row along with the corresponding estimates of the impacts of an initial assessment of a most severe mental health rating. Two-stage least squares specifications instrument for severe mental health rating using a clinician leniency measure that is estimated using data from other cases assigned to a clinician as described in the text. We include day-of-week-month fixed effects for all specifications and baseline controls for Columns (2) and (4)-(6). The clinician and inmate robust two-way clustered standard errors are shown in parentheses. For the IV estimates, confidence intervals based on inversion of the Anderson-Rubin test are shown in brackets. * $p<0.10$, ** $p<0.05$, *** $p<0.01$

Table 7: Effects of Initial Assessment of Most Severe Mental Health Rating on Health Outcomes

	OLS results		2SLS results			
	(1)	(2)	(3)	(4)	(5) No Prior Offense	(6) Prior Offense
2.25Suicide 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)
			[-0.325, -0.053]	[-0.290, -0.035]	[-0.186, -0.027]	[-1.390, 0.003]
2.25Suicide 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)
			[-0.037, -0.003]	[-0.033, -0.000]	[-0.011, 0.021]	[..., -0.042]
2.25Next booking mental health score	0.115***	0.136***	0.964***	0.981***	1.060***	1.021**
	(0.036)	(0.037)	(0.274)	(0.249)	(0.304)	(0.415)
			[0.518, 1.619]	[0.577, 1.575]	[0.638, 1.707]	[0.520, 3.451]
Time fixed effects	Yes	Yes	Yes	Yes	Yes	Yes
Baseline Controls	No	Yes	No	Yes	Yes	Yes

This table reports the ordinary least squares and two-stage least squares estimates of the impact of a clinician's initial assessment of a most severe mental health rating on inmates' subsequent mental health. The outcome variables of interest are given in each row along with the corresponding estimates of the impacts of an initial assessment of a most severe mental health rating. Two-stage least squares specifications instrument for severe mental health rating using a clinician leniency measure that is estimated using data from other cases assigned to a clinician as described in the text. We include day-of-week-month fixed effects for all specifications and baseline controls for Columns (2) and (4)-(6). The clinician and inmate robust two-way clustered standard errors are shown in parentheses. For the IV estimates, confidence intervals based on inversion of the Anderson-Rubin test are shown in brackets. * $p<0.10$, ** $p<0.05$, *** $p<0.01$

Table 8: Initial Assessment of Most Severe Mental Health Rating and Heterogeneity in Outcomes

	Prior treatment		Prior medications		Prior hospitalization	
	(1) No	(2) Yes	(3) No	(4) Yes	(5) No	(6) Yes
[t]2.3Suicide 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)
[t]2.3Suicide 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)
[t]2.3Next 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)
Time fixed effects	Yes	Yes	Yes	Yes	Yes	Yes
Baseline controls	Yes	Yes	Yes	Yes	Yes	Yes

This table explores the heterogeneity in effects on whether an inmate admitted to having prior treatment, prior medications, or prior hospitalization. The outcome variables of interest are given in each row along with the corresponding two-stage least squares estimates of the impacts of an initial assessment of a most severe mental health rating. We include day-of-week-month fixed effects and baseline controls, and the clinician and inmate robust two-way clustered standard errors are shown in parentheses. * $p<0.10$, ** $p<0.05$, *** $p<0.01$

Table 9: UJIVE Results for Initial Assessment of Most Severe Mental Health Rating and Suicidality Outcomes

	Clinician Fixed Effects			
	(1)	(2)	(3)	(4)
			No Prior Offense	Prior Offense
[t]2.3Suicide attempt in next booking	-0.138***	-0.102***	-0.145	0.447
	(0.033)	(0.035)	(0.097)	(0.394)
[t]2.3Suicide ideation in next booking	-0.024**	-0.020	-0.023	0.142
	(0.011)	(0.013)	(0.041)	(0.111)
[t]2.3Next booking mental health score improves	0.791***	0.894***	-0.574**	-0.339*
	(0.232)	(0.280)	(0.246)	(0.184)
Time fixed effects	Yes	Yes	Yes	Yes
Baseline controls	No	Yes	Yes	Yes

This table reports the Unbiased Jacknife Instrumental Variables (UJIVE) estimates of the impact of a clinician's initial assessment of a most severe mental health rating on inmates' subsequent mental health and criminality. The outcome variables of interest are given in each row along with the corresponding estimates of the impacts of an initial assessment of a most severe mental health rating. We include day-of-week-month fixed effects for all specifications and baseline controls for Columns (2) and (4)-(6). The clinician and inmate robust two-way clustered standard errors are shown in parentheses. * $p<0.10$, ** $p<0.05$, *** $p<0.01$

Table 10: IVLASSO Results for Initial Assessment of Most Severe Mental Health Rating and Suicidality Outcomes

	Clinician Fixed Effects			
	(1)	(2)	(3) No Prior Offense	(4) Prior Offense
[t]2.3Suicide attempt in next booking	-0.076*	-0.076*	-0.056**	-0.184**
	(0.045)	(0.045)	(0.026)	(0.075)
[t]2.3Suicide ideation in next booking	-0.022***	-0.022***	-0.009**	-0.049***
	(0.004)	(0.004)	(0.004)	(0.004)
[t]2.3Next booking mental health score improves	0.592**	0.592**	0.540***	0.583***
	(0.232)	(0.232)	(0.164)	(0.182)
Time fixed effects	Yes	Yes	Yes	Yes
Reduced controls	No	Yes	Yes	Yes

This table reports the Instrumental Variables LASSO (IVLASSO) estimates of the impact of a clinician's initial assessment of a most severe mental health rating on inmates' subsequent mental health and criminality. The outcome variables of interest are given in each row along with the corresponding estimates of the impacts of an initial assessment of a most severe mental health rating. We include day-of-week-month fixed effects and baseline controls for all specifications; however, the IVLASSO procedure penalizes the controls as well as the instruments and can penalize them to zero as discussed in the text. The clinician and inmate robust two-way clustered standard errors are shown in parentheses. * $p<0.10$, ** $p<0.05$, *** $p<0.01$

Discussion

Design elements are important

- Public defenders are relatively more impactful at decreasing suicidality and improving mental health conditional on reentry
- It's possible this is driven not by lawyer type (bc no recidivism result) but perhaps bc of social workers who only work with lawyers
- Contemporary US debates, like "Defund the Police", predict shifting of resources away from police to community resources could be coming, and one can imagine MHC being a candidate
- Figuring out which elements work is essential if we are going to change our handling of mental illness within the criminal justice system