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BRIEFS

from THE NATIONAL CENTER FOR STATE COURTS

The National Landscape of Mental Health Treatment Courts: Survey Findings and Emerging Trends

A new national survey highlights how mental health treatment courts are expanding across the United States, and why clearer standards, stronger data collection, and sustained funding are needed to guide their growth.

By Kendall Friend & Lisa M. Williams

As of 2022, an estimated 618 mental health treatment courts (MHTCs) — specialized court programs that connect justice-involved individuals with serious mental health needs to treatment, supervision, and support services as an alternative to traditional case processing — were located across the country. That number marked a 26% increase in just three years (between 2019 and 2022).[1] But the guidance supporting these courts has remained stagnant for over a decade.

Primary sources of MHTC-specific guidance consist of publications and training developed by the Council of State Governments Justice Center in partnership with the Bureau of Justice Assistance.[2] One of the most widely used resources is *Developing a Mental Health Court: An Interdisciplinary Curriculum*, a national training initiative published in 2013 and accompanied by a facilitator handbook that provides guidance on court design, team composition, target populations, and program implementation.[3] These materials were

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developed through collaboration among researchers and practitioners and were intended to translate research and field experience into guidance for courts. However, while these materials serve as foundational guidance, they are not regularly updated. This gap has been made apparent by the frequent requests received at the National Center for State Courts (NCSC) for updated MHTC best practices and training.[4]

Nevertheless, the broader Adult Treatment Court Best Practice Standards — which provide guidance for adult treatment courts — were updated as recently as January 2026.[5] Although these standards provide important guidance for treatment courts generally, they are not tailored to the distinct needs of MHTCs. And while MHTC teams often rely on these standards in the absence of mental health–specific guidance, they nevertheless find themselves facing complex and unresolved questions:

- How should the target population be defined and assessed based on mental health diagnoses? For example, should MHTCs focus on individuals with serious mental illness (SMI) that significantly affects daily functioning, treatment engagement, or justice involvement, and if so, how should those criteria be determined?
- Which behavior-modification strategies and clinical services are appropriate for individuals with SMI?
- How should courts determine stabilization and readiness for graduation?

These issues surface repeatedly in technical assistance requests and in statewide training discussions, underscoring consistent gaps in evidence-informed guidance. This guidance would help courts identify and refer appropriate individuals for MHTC participation; coordinate alternative responses, such as diversion, community-based treatment, or case management; make informed decisions; and focus limited resources on interventions with demonstrated benefits.

> As of 2022, an estimated 618 mental health treatment courts were located across the country — a 26% increase in just three years.

STATE STATUTORY FRAMEWORKS FOR MENTAL HEALTH TREATMENT COURTS

Across the country, legislatures recognize the judiciary's role in addressing behavioral health needs, as seen in the expansion and modernization of MHTC-oriented statutes in states such as Missouri, Georgia, and Michigan:

- **2025:** Missouri authorizes broad judicial authority to create MHTCs that connect participants to treatment and supervision.[6] However, it leaves many operational details, such as eligibility criteria, team composition, data collection, and performance measures, to local discretion.
- **2024:** Georgia authorizes courts to create MHTC divisions, outlining foundational elements, including planning groups, eligibility considerations, and collaborative partnerships with treatment providers.[7]
- **2022:** Michigan formally incorporates MHTCs into the state's broader problem-solving court framework, reflecting an evolution from local innovation toward system-level coordination.[8] However, even within this structured framework, courts retain discretion over screening practices and service delivery models, highlighting challenges with fidelity to evidence-based practices.

While these statutes differ in structure and scope, they collectively illustrate both the growth of MHTCs and — given the variety of programming approaches and the broad discretion afforded courts — the need for clear, evidence-based standards to guide expansion. Without clear, evidence-based standards, MHTCs may risk unintended harm — a particular concern given that court creation seems to be surpassing the development of formal guidance.

NATIONAL SURVEY INSIGHTS

To gain insight into the current state and territory structures, standards, and practices for MHTCs, NCSC surveyed 55 U.S. state and territory statewide treatment court coordinators, who oversee various treatment courts in each state, including MHTCs, on screening participants, engaging community partners, and how states and territories fund, govern, and support MHTCs. With 42 states and territories responding, a 76% response rate, the survey results indicate 90% of respondents have mental health courts (38). Twenty-eight states and territories reported fewer than 25 MHTCs, and 10 reported between 26 and 50. NCSC ▸

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conducted followup interviews to better understand MHTC challenges and successes and to identify what specific supports and guidance MHTCs need moving forward.

Most MHTCs draw from multiple funding sources. The most common are local district, county, or municipal funds (62%); federal grants (56%); state general revenue budget funds (51%); local grants, foundations, trusts, or donors (44%); and legislative funds (31%). All four states without MHTCs identified funding as a barrier to developing these court programs.

While half of the responding states and territories report that MHTCs are authorized by statute, governance and oversight models vary widely. According to respondents, these responsibilities are distributed among state judiciaries, administrative offices of the courts, and departments of mental health or substance use services — either at the local level or through a partnership with a given state or territory's department of justice. All responding states and territories reported screening for legal eligibility (charges, level, history), criminogenic risk, and needs (including treatment), though specific screening tools and processes vary due to differing requirements and local court discretion. Most states and territories screen MHTC candidates for eligibility at multiple points, including pretrial (87%), post-plea (76%), and post-sentence (53%). Most also accept misdemeanor and felony charges (82%). Fewer states and territories accept only felonies (16%) and only misdemeanors (3%). In addition, 5% accept civil commitment cases.

All 38 responding states and territories with MHTCs reported partnerships with local mental health treatment providers. Additional partnerships include peer support organizations/providers (71%), community behavioral health boards (63%), and employment assistance (58%). About half of states and territories with MHTCs partner with the local health department (53%), housing agencies (50%), and MHTC graduate alumni (47%). Some also partner with civil legal assistance organizations (26%). Figure 1 illustrates MHTC partnerships.

MHTC teams are consistently staffed by legal and treatment professionals, with community-based service liaisons (community providers, employment assistance, health and housing organizations, etc.) participating less frequently.

As Figure 2 shows, all responding MHTC teams include judges, and nearly all include defense and prosecuting attorneys (97%) and probation officers (95%). Most MHTC teams also include case managers (87%) and local treatment providers (84%). Other common team members include behavioral health court liaisons (50%), peer supports (39%), and court coordinators (21%). The breadth of partnerships and representation on MHTC teams reflects a strong community-based commitment to serve individuals with mental health diagnoses involved in the criminal justice system.

KEY SUBSTANTIVE FINDINGS: BEST PRACTICES, THE MEANING OF SUCCESS, AND CHALLENGES

The majority of responding states and territories (54%) have developed their own treatment court best practice standards, with eight of those (21%) reporting MHTC standards that include additional information beyond the Adult Treatment Court Best Practice Standards. However, according to respondents, most do not provide clear guidance specific to SMI, such as adaptation to eligibility criteria, approaches to substance testing, and how to assess stability in MHTCs.

Traditional treatment courts identify and track recidivism as a measure of success.[9] However, MHTC teams are increasingly shifting their definition of success for individuals with SMI to include more complex clinical and social outcomes, including stabilization, connection to treatment, community supports, and reduction in symptoms. Follow-up interviews highlight the importance of structuring teams and services around participant needs, with individualized phase progression as a more meaningful indicator of improvement than completion of rigid program requirements. For individuals living with SMI, full treatment completion within a 12- to 24-month program timeframe may not be realistic.

The survey results and follow-up interviews point to a consistent set of challenges facing states and territories in supporting MHTCs: lack of data, inconsistent funding, unclear substance testing protocols, and difficulty identifying when a participant is ready to graduate, due to the lack of clear program completion benchmarks that are present in other treatment court type — for example, completion of treatment or substance-free timeframes in courts devoted to serving individuals with substance use diagnoses.

NEXT STEPS FOR COURT LEADERSHIP

Judiciary and administrative leaders are uniquely positioned to drive progress and lead change in court and community responses to mental health issues. Key opportunities for action include:

1. Advancing Statewide Standards and Certification Frameworks

With at least half of states and territories already authorizing or requiring MHTCs, state judicial branch leadership

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Figure 1. COMMUNITY PARTNERS OF MENTAL HEALTH TREATMENT COURTS
NOTE: SELF-REPORTED 2026 SURVEY RESPONSES (38 STATES AND TERRITORIES), WITH MOST REPORTING A COMBINATION OF PARTNERS

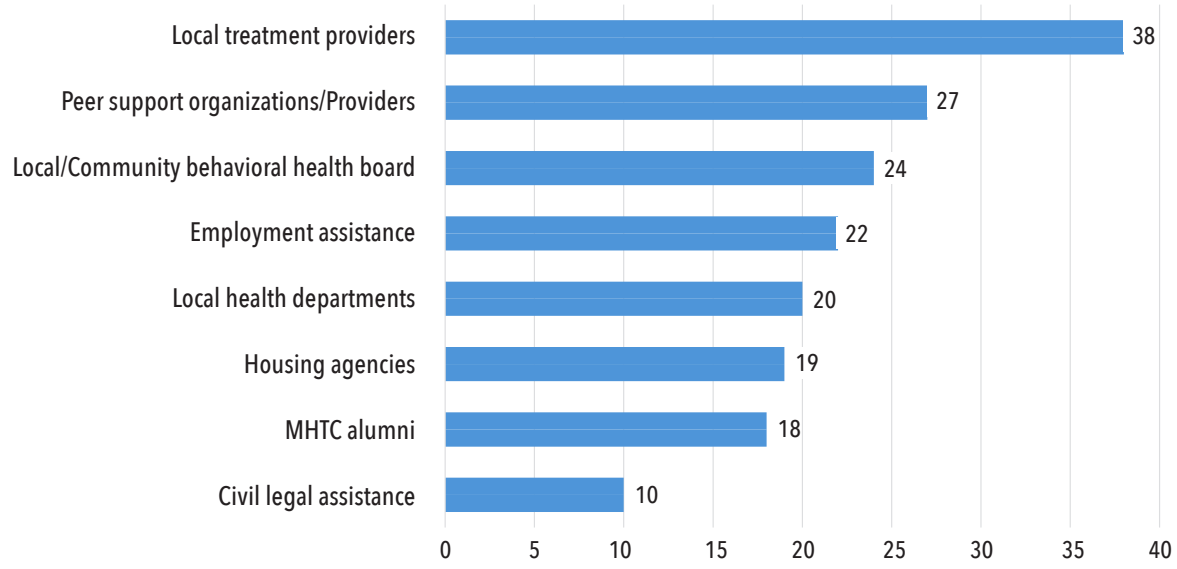
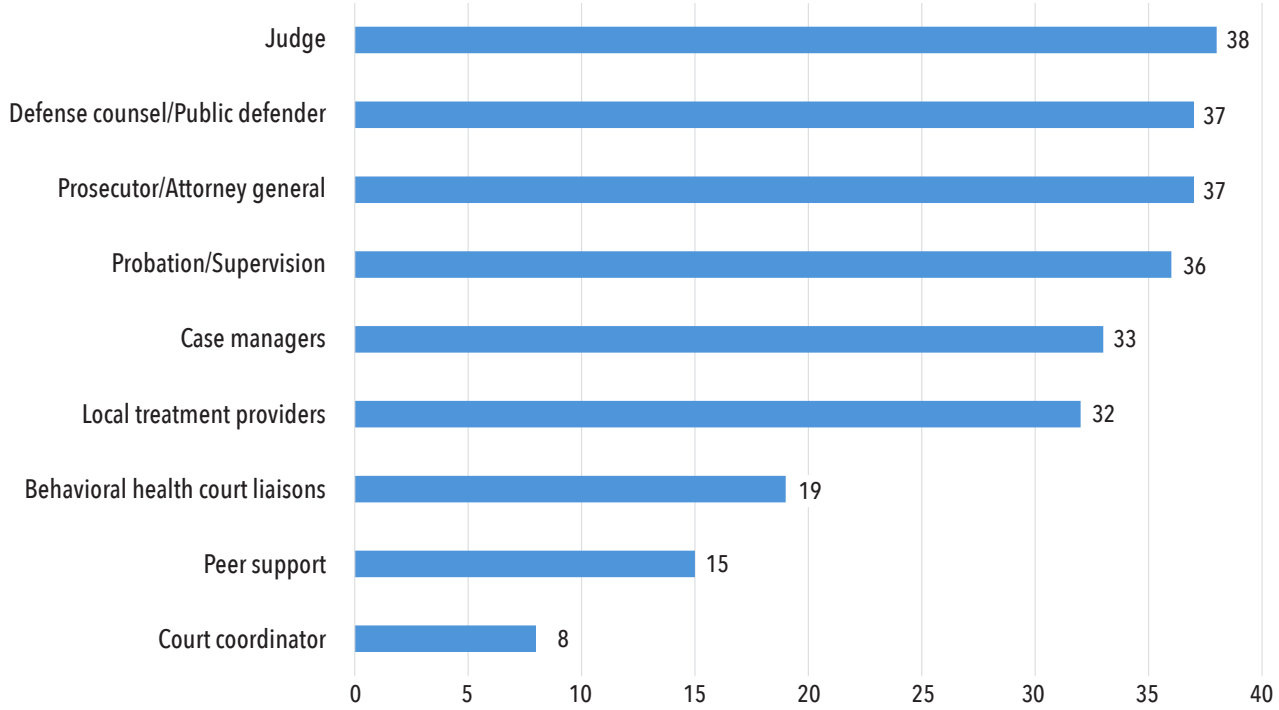


Figure 2. MENTAL HEALTH TREATMENT COURT TEAM MEMBERS



is well-positioned to endorse statewide standards or certification processes to ensure consistency, fidelity to evidence-based practices, and alignment with legislative intent.

2. Aligning Funding Advocacy with Statutory Responsibility

State and territory judicial leaders can position MHTCs as core judicial infrastructure, warranting stable appropriations rather than discretionary or short-term funding.

3. Prioritizing Statewide Data Collection

A nationwide lack of MHTC data, particularly regarding the services participants need and the referrals courts receive, limits the field's ability to demonstrate impact.[11] State and territory court judicial leaders can play a critical role by championing statewide data collection and reporting practices that capture key elements.

4. Advocating for Local Change

Local judicial leaders can build sustainable community partnerships with local mental health providers; press for frequent, ongoing training ▸

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for court professionals on SMI and trauma-informed practices; and stress the unique needs of MHTCs.

By collaborating across branches and working with local jurisdictions, leaders can influence development and adherence to best-practice standards, strengthen data collection and reporting, and advocate for local change to help ensure adequate funding for MHTCs at all levels.

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3 *Id.*
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