

REFLECTIONS ON JUDGING IN A MENTAL HEALTH COURT AND CHALLENGES BEYOND THE COURTROOM DOORS

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In 1995, former Illinois Supreme Court Justice Mary Ann McMorrow spoke at the investiture of a group of new judges. She began her remarks by underscoring the honor and the responsibility of being a judge: “For most of us, being a judge is really living out our dream come true. Our becoming a judge signifies our desire to devote ourselves to the pursuit of justice and to service to others.” She concluded by reminding the audience:

As judges, we look beyond the legal formalities of a particular dispute—to remain aware of the human dilemma that underlies almost every case brought before us, and, always within the bounds of our authority, try to resolve the problems presented to us in a manner that satisfies both the legal and the human aspects of the case. Let us not forget that the law is first and foremost about human beings and their problems.

I became a judge in 1995, and at no time in my twenty-one years on the bench have Justice McMorrow’s observations resonated with me more than in my work with mental health and the criminal justice system. As any judge who has presided over a criminal courtroom can attest, mental illness poses unique challenges to the justice system, challenges which the traditional model of criminal justice is poorly-suited to confront. These problems are not new, but only in the past several decades have we begun to see problem-solving courts that are specifically tailored to address this human dilemma. The research regarding the effectiveness of these courts is promising, yet it is clear that there is still much progress that can and must be made. As I reflect on my personal experiences working with mental health courts over the past fourteen years, it is my sincere hope and expectation that we can continue to adapt our practices as our understanding of mental illness evolves.

The American Psychiatric Association has recently reported that there are 2,000,000 incarcerations of persons with serious mental illness each year.¹ The prevalence of serious mental illness in the United States prisons

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is significantly higher than in the general population.² The statistics were proportionally just as alarming fourteen years ago in 2002, when I first had the opportunity to consider the connection between mental health and our criminal justice system. How did this happen? In the 1950s, persons with serious mental illnesses were for the most part confined to state psychiatric hospitals or asylums. The conditions in those facilities were deplorable and demanded a solution. When President John F. Kennedy was elected in 1961, he made mental illness one of his priorities. In what was to be his last piece of legislation,³ President Kennedy signed the Community Mental Health Act of 1963.⁴ His vision, to be realized through that legislation, was to build community mental health centers to provide comprehensive treatment and services to persons with mental illnesses outside of institutions.⁵ The problem, though, was that only one half of the proposed facilities were ever built, and those that were built were underfunded.⁶ Most of the psychiatric hospitals closed, and in the absence of appropriate

1995, was appointed a Circuit Judge by the Illinois Supreme Court in 1998, and won election and was retained in 2004 and 2010. She served as Presiding Judge of the Criminal Division and the Mental Health (Therapeutic Intervention Program) Court in the 17th Circuit, and chaired the community-wide task force that created the problem-solving court. In 2003, she was elected Chief Judge and served until her assignment to the Appellate Court in May 2007. She served as Presiding Justice of the Second Appellate District from August 2008 to December 2010.

Justice Zenoff chaired the Specialty Courts Committee of the Illinois Conference of Chief Judges, which issued a comprehensive report on mental health courts and drug courts in Illinois. She was named National Co-Chair of the Judges' Leadership Initiative for Criminal Justice and Mental Health Issues in 2007 and has contributed to the Chief Justice Initiative and the Judges' Guide to Mental Health Jargon. Justice Zenoff has also participated in the Criminal Justice/Mental Health Transformation Initiative project convened by the Illinois Department of Human Services Division of Mental Health. She currently serves as Chairman of the Illinois Supreme Court Special Advisory Committee for Justice and Mental Health Planning and Chair of the Advisory Board for the Illinois Center of Excellence for Behavioral Health and Justice. She is a member of the Leadership Council for the Kennedy Forum Illinois. She has been recognized by the Illinois House of Representatives for her service in helping to implement initiatives designed to improve the criminal justice system. Justice Zenoff has testified in Washington, D.C. before the United States Senate Judiciary Subcommittee on Human Rights and the Law at a hearing entitled "Human Rights at Home: Mental Illness in our Jails and Prisons."

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1. Dr. Altha Stewart, Associate Professor, Department of Psychiatry, and Director, Center for Health in Justice-Involved Youth, University of Tennessee Health Science Center, Presider, Keynote Address at the National Stepping Up Summit, Washington D.C. (April 18, 2016).
2. Henry J. Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 PSYCHIATRIC SERVICES 761, 761–65 (2009).
3. Vic DiGravio, *The Last Bill JFK Signed—And the Mental Health Work Still Undone*, WBUR's COMMON HEALTH (October 23, 2013, 10:03 AM) <http://commonhealth.wbur.org/2013/10/community-mental-health-kennedy>.
4. Community Mental Health Act of 1963, Pub. L. No. 88-164, 77 Stat. 282.
5. *Kennedy's Vision for Mental Health Never Realized*, USA TODAY (Oct. 20, 2013) <http://www.usatoday.com/story/news/nation/2013/10/20/kennedys-vision-mental-health/3100001/>.
6. DiGravio, *supra* note 3.

community treatment facilities, persons with serious mental illnesses ended up in our jails and prisons in disproportionate numbers.⁷ Once released from incarceration, these individuals, many of whom had co-occurring substance use disorders, were likely to reoffend and end up back in custody.⁸ De-institutionalization was a social disaster. Trans-institutionalization took its place. This phenomenon has been labeled the “revolving door syndrome,”⁹ the “criminalization of the mentally ill,”¹⁰ and, as former Surgeon General David Satcher referred to it, a “silent epidemic.” Related issues of homelessness, health problems, the lack of affordable housing, and lack of job skills and employment contributed to the crisis.

Winnebago County, Illinois, which is ninety miles northwest of Chicago, was not immune to this crisis. In 2002, I was serving as the Presiding Judge of the 17th Judicial Circuit’s Criminal Division. I could not help but note the disproportionate numbers of persons with serious mental illnesses in our criminal courtrooms. Our jail was overcrowded. We were desperately looking both for the underlying reasons for these problems and the solutions. A local leader in the behavioral health field, Frank Ware, who was the CEO of Janet Wattles Mental Health Center,¹¹ helped shine a light on these issues for our circuit. He informed us that persons with serious mental illnesses were cycling in and out of our jail, that they accounted for much of our jail overcrowding, and that they were overrepresented in our justice system. On behalf of the circuit, I convened and led a seventy-person community-wide Task Force to study the problem and come up with solutions. Frank Ware and his staff at Janet Wattles were willing and welcome partners.

The Task Force worked collaboratively for eighteen months, learning about innovative diversion programs for persons with serious mental illnesses who had come in contact with the justice system. One of those innovations was a mental health court. At that time, there were only two or three mental health courts in Illinois, and not many more across the nation.

7. *Id.*

8. Roger H. Peters et al., *Co-Occurring Substance Use and Mental Disorders in the Criminal Justice System: A New Frontier of Clinical Practice and Research*, 38 *PSYCHIATRIC REHABILITATION J.* 1, 1 (2015).

9. See DEREK DENCKLA & GREG BERMAN, CENTER FOR COURT INNOVATION, *RETHINKING THE REVOLVING DOOR: A LOOK AT MENTAL ILLNESS IN THE COURTS* 4 (2001).

10. Mark R. Munetz and Patricia A. Griffin, *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*, 57 *PSYCHIATRIC SERV’S* 544, 544 (2006).

11. Janet Wattles Center merged with the Rosecrance Health Network (Rosecrance formerly focused solely on addiction treatment) on September 1, 2011. ROSECRANCE, *Our History*, <http://www.rosecrance.org/who-we-are/our-history/> (last visited May 5, 2016).

The first one had opened in 1997 in Broward County, Florida.¹² We were interested, though, as these courts appeared to represent an effective and innovative approach to traditional criminal case processing, a different way to “do justice.” The Task Force drafted protocols for each stakeholder which had contact with a person with a mental illness, such as law enforcement, the State’s Attorney, the Public Defender, corrections personnel, and judges. We also designed a mental health court for our community.

The Therapeutic Intervention Program Court or “TIP Court” opened in February 2005. Our program represented a therapeutic, non-adversarial approach to handling criminal cases involving persons with serious mental illnesses. It was thought that by treating participants’ mental illnesses and the underlying problems that brought them into the criminal justice system, the participants under court monitoring could make positive lifestyle changes while back out in the community. It was also thought that this would reduce the likelihood of participants reoffending, thus enhancing public safety. Entry into our mental health court was voluntary at either the pre-adjudicatory or post-adjudicatory phase of the criminal proceedings, after an assessment and diagnosis of a serious mental illness, such as schizophrenia or depression. A multi-disciplinary team of legal and treatment professionals provided services to the participants. Medication and treatment for the participants’ mental illnesses and any co-occurring substance use disorders were integral parts of the services. The team also provided ancillary or “wrap around” services, such as assistance with housing, life skills, and employment training. Another important aspect of the program was the participants’ regular status appearances before the judge presiding in the mental health court in order to closely monitor their progress. Although I had been elected Chief Judge in our circuit by the time that our TIP Court opened, I incorporated that assignment into my Chief Judge duties as I felt a commitment and responsibility to help assure a positive start for the program.

One of the challenges I faced was how to preside in a non-adversarial setting. In my criminal court assignments, I spoke only to the attorneys standing before the bench representing their clients. Most of the time, there was no direct interaction with the defendants themselves. If I changed my approach in our mental health court, what would be the effect? At the time, I did not realize how key the role is that the judge plays in a problem-solving court, a role that was fundamentally different from any other judicial assignment. While little research was available then, the Council of

12. NICOLE L. WATERS ET AL., NATIONAL CENTER FOR STATE COURTS, MENTAL HEALTH COURT CULTURE: LEAVING YOUR HAT AT THE DOOR (Nov. 2009).

State Governments Justice Center,¹³ the GAINS Center,¹⁴ and the Bureau of Justice Assistance convened several national meetings where speakers shared their experiences working with mental health courts. At those meetings, I learned that judges in problem-solving courts were encouraged not to be detached “referees” as in traditional criminal courtrooms, but to engage the participants directly through regular and frequent court appearances.

I decided to try that approach. At every court appearance, I spoke with each participant in an effort to inspire confidence and trust and develop a rapport to encourage compliance with the treatment and program requirements. Although their attorneys and behavioral health counselors were present, I often asked the participants themselves to tell me in their own words how they were doing. I heard about their struggles with symptoms of their mental illnesses. They told me of the side effects of prescribed medications, their difficulties with daily living tasks, and the stigma they felt because of their mental illnesses and addictions. That was in addition to their difficulties making the required meetings with their counselors, doctors, and the probation officers on the TIP team. While relating their difficulties and, at times, their relapses with drugs and psychiatric crises, most participants were not ready to give up, and they saw the TIP Court as their lifeline. Their stories and their struggles touched me personally, and I redoubled my efforts at being encouraging, respectful, fair, attentive, caring, and knowledgeable about their challenges and progress, while still holding them accountable for their behavior.

The TIP team supported my efforts both at staffings held before court appearances and in their individual work with the participants. I used graduated incentives (such as applause or calling a participant’s case earlier in the docket) and graduated sanctions (such as writing an essay or sitting in the jury box through other participants’ cases) as recommended by the TIP team to assist in the process. Our hope was that eventually the participants

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13. “The Council of State Governments Justice Center is a national nonprofit organization that serves policymakers at the local, state, and federal levels from all branches of government. The Justice Center provides practical, nonpartisan advice and consensus-driven strategies—informed by available evidence—to increase public safety and strengthen communities.” Press Release, Council of State Governments Justice Center, CSG Justice Center Announces New Leadership of Judges’ Initiative to Address the Overrepresentation of People with Mental Illnesses in the Criminal Justice System (April 24, 2008) (on file with author).
 14. The GAINS Center for Behavioral Health and Justice Transformation provides technical assistance and support to professionals working in the fields of behavioral health and criminal justice, and to recipients of Substance Abuse and Mental Health Services Administration-funded grant programs that address behavioral health and criminal justice issues.

could and would take charge of their own recovery. Our “watchword” and guide, coined by Frank Ware, was “See the Person, not the Illness.”

The results were mostly positive. Winnebago County saw fewer re-arrests, resulting in cost savings due to the decreased number of jail days served by TIP Court participants. The number of hospitalizations dropped as well. Beyond that, the impact on the lives of the participants was profound. At our first graduation, one of the participants commented:

My life has undergone a shift from the constant unwellness [*sic*] of most of the previous decade to a life worth living The constant responsibility to appear before the judge, and meet with various [mental health case managers] were the essential first step.

Another graduate shared:

The whole TIP team has watched, helped and guided me through my recovery Because of this program, I feel like I finally have my life back.

I could not help but be heartened. I wanted to know more about what worked and what could be improved, as well as how the TIP team and I could be most effective. Research results for mental health courts, however, would not be available until years later, beginning in 2010,¹⁵ so our approach then, while informed, was mostly intuitive.

Yet, even with mostly anecdotal information, in the ten years since the TIP Court opened in the 17th Judicial Circuit, the number and types of problem-solving courts grew exponentially as a response to the persistence and seriousness of the revolving door syndrome and silent epidemic. Nationally, there are now more than 350 mental health courts.¹⁶ Other types of problem-solving courts, such as drug courts, have been in existence much longer than mental health courts, and they number over 3,400.¹⁷ In Illinois, there are currently sixty-three drug courts, twenty-five mental health courts, and seventeen veteran’s courts.¹⁸ During these ensuing years, “evidence-based practices,” or tested interventions with measurable positive outcomes, have become available and are being used by many of these

15. Carol Fidler, *Toward a New Understanding of Mental Health Courts*, JUDGES’ J., Spring 2015, at 9.

16. Henry J. Steadman et al., *Criminal Justice and Behavioral Health Care Costs of Mental Health Court Participants: A Six-Year Study*, 65 PSYCHIATRIC SERVICES 1100, 1100–01 (2014).

17. NATIONAL INSTITUTE OF JUSTICE, *Drug Courts*, <http://www.nij.gov/topics/courts/drug-courts/pages/welcome.aspx> (last visited May 5, 2016).

18. ILLINOIS CENTER OF EXCELLENCE, *Problem-Solving Courts*, <http://www.illinoiscenterofexcellence.org/data/printer-friendly-courts.cfm> (last visited May 5, 2016).

courts to enhance their effectiveness.¹⁹ For example, some courts now use integrated dual disorder treatment for persons with both a mental illness and a co-occurring substance use disorder. Simply stated, this allows for both conditions to be treated at the same time and place.²⁰ Significant work has been done by Dr. Fred Osher on the development of a risk-needs-responsivity model integrated with behavioral health factors to aid mental health courts in predicting recidivism and formulating appropriate treatment levels for participants.²¹ Dr. Douglas Marlowe's research regarding drug courts is also widely known, and it informs current court practice.²² Among his findings are that the judge is a "key component" in a drug court, and that intense and regular interaction with that judge accounts for enhanced performance, especially for high-risk participants.²³

The emerging published research substantiates that defendants in mental health courts have lower rates of re-offending and fewer jail days compared to those in traditional courts.²⁴ That coincides with our experience with participants in the TIP Court. What has been surprising, however, is another finding: mental illness is no longer considered a risk factor for criminal conduct, or, in other words, the primary cause or reason that persons with mental illnesses end up in the criminal justice system.²⁵ It *is*, however, an important factor affecting their ability to respond to interventions to change their criminal behavior.²⁶ This has caused those studying mental health courts to question the premise on which many of the early mental health courts were based: treatment engagement for persons with mental illnesses leads to better mental health and to improved public safety outcomes.²⁷

While the research to date has shown that mental health courts are effective, it may not be for all of the reasons that we have presumed. In thinking about what other aspects of mental health courts might account for

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19. See SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, *Evidence-Based Practices Web-Guide*, <http://www.samhsa.gov/ebp-web-guide> (last visited May 5, 2016).
 20. Fred C. Osher & Lial L. Kofoed, *Treatment of Patients with Psychiatric and Psychoactive Substance Abuse Disorders*, 40 PSYCHIATRIC SERV'S 1025, 1025 (1989).
 21. FRED OSHER ET AL., COUNCIL OF STATE GOVERNMENTS JUSTICE CENTER, ADULTS WITH BEHAVIORAL NEEDS UNDER CORRECTIONAL SUPERVISION: A SHARED FRAMEWORK FOR REDUCING RECIDIVISM AND PROMOTING RECOVERY (2012).
 22. Douglas B. Marlowe, J.D., Ph.D., is the Chief of Science, Law & Policy for the National Association of Drug Court Professionals.
 23. Douglas B. Marlowe et al., *The Judge is a Key Component of Drug Court*, 4 DRUG CT. REV. 1, 25–26 (2004).
 24. Fislser, *supra* note 15, at 10.
 25. *Id.* at 11.
 26. *Id.*
 27. *Id.* at 10.

their success, one important part of the explanation appears to be related to the principles of “procedural justice.”²⁸ According to Yale law professor Tom Tyler, procedural justice is the perceived fairness of court procedures and interpersonal treatment.²⁹ His research has demonstrated that there is a strong link between an individual’s perceptions of the fairness of the proceedings and his or her future behavior.³⁰ The more confidence a person has in the fairness of the process, the more likely that person is to comply with court orders.³¹ The salient components of procedural justice are: voice, or giving participants the opportunity to tell their side of the story; neutrality and transparency about the rules and how decisions are made; respect, or viewing each person as important and treating him or her courteously; and trust, sincerity, and compassion on the part of the decision maker.³² These were the principles that I tried to use, albeit intuitively, when I presided in the TIP Court. Today, judges presiding in mental health courts are educated about these principles and are strongly encouraged to adhere to them. It is rewarding for me to know that these principles may have made a difference both in motivating the participants to complete the program’s requirements and in giving them hope that they could disengage from the justice system.

When I began my work on the appellate bench in 2007, I passed the torch of presiding over the 17th Judicial Circuit’s mental health court to another judge and redirected my efforts toward improving the quality and consistency of problem-solving courts both nationally and throughout Illinois. I felt that a judge’s role must extend beyond the courtroom doors, for with the privilege and the dream of wearing a black robe comes the responsibility to help accomplish needed changes beyond our courtrooms. One of the first steps I took was to accept the invitation in 2008 to become the national co-chair of the Judges’ Leadership Initiative (JLI) for Criminal Justice/Mental Health Issues.³³ JLI provides resources to judges who have taken leadership roles in criminal justice/mental health issues in their communities. We have worked on creating benchbooks, benchcards, videos, and other tools for judges presiding in mental health courts. We have also collaborated with the American Psychiatric Association Foundation to create a Psychiatric Leadership Group, which partners with

28. *Id.* at 11–12.

29. Tom R. Tyler, *Procedural Justice and the Courts*, 44 COURT REV. 26, 26 (2007).

30. KEVIN BURKE AND STEVE LEBEN, AMERICAN JUDGES ASSOCIATION, PROCEDURAL FAIRNESS: A KEY INGREDIENT IN PUBLIC SATISFACTION 5 (2007).

31. Fislser, *supra* note 15, at 12.

32. Tyler, *supra* note 29, at 30.

33. Judge Steven Leifman, Associate Administrative Judge, Criminal Division, Eleventh Judicial Circuit of Florida, is the other co-chair of JLI. Judge Leifman is also the Chair of the Supreme Court of Florida Task Force on Substance Abuse and Mental Health Issues in the Courts.

judges to sponsor educational seminars and workshops on behavioral health and the criminal justice system. Most recently, we have supported the “Stepping Up Initiative,” which was launched in 2015 by the National Association of Counties, the Council of State Governments Justice Center, and the American Psychiatric Association Foundation. The initiative encourages counties across the nation to develop strategies to reduce the prevalence of persons with mental illnesses being held in jails.

Many communities have recognized the unique challenges that mental illness poses to the justice system. In a very real sense, this is a human rights issue. In 2009, Senator Richard Durbin’s Senate Subcommittee on Human Rights and the Law held hearings for the first time on a national topic: “Human Rights at Home: Mental Illness in our Jails and Prisons.” I accepted the invitation to testify and spoke about the stigma attached to mental illness, the need for expanding funding for mental health courts and diversion programs, and the urgency of providing continuity of care for those with mental illnesses released from our jails and prisons. I underscored the need for improved screening and mental health services in our jails. Other speakers shared their own experiences and assessments. The significance of the hearings was not only in the substance of what was discussed and proposed, but also in the fact that they were held at all. The United States Senate set the bar high by focusing on “human rights” when discussing mental illness and incarceration.

Although research has shown that problem-solving courts are effective, the rapid expansion of such courts throughout Illinois gave rise to a need for further study. To that end, in 2010, the Illinois Supreme Court created the Special Advisory Committee for Justice and Mental Health Planning. I was honored to be invited to chair the committee and have done so for the past six years. The committee is comprised of twenty-four judges from across the state who either preside over or have expertise in problem-solving courts. The Supreme Court charged the committee with numerous responsibilities, including pursuing statewide strategic planning, developing educational programs for judges, assessing the need for rule changes, investigating the efficient use of resources, and making recommendations regarding problem-solving courts to the Supreme Court in these areas. In 2013, the Supreme Court also charged the committee with collaborating with the Administrative Office of the Illinois Courts to develop both standards and an application and certification process for all problem-solving courts in Illinois. To draft the standards for Illinois courts, the committee studied the National Drug Court Best Practice Standards as well

as the standards in other states. The Supreme Court adopted the committee's proposed Standards at its November 2015 term.³⁴ The purpose was to bring uniformity, accountability, and administrative oversight to all problem-solving courts in the state. Our challenge was to see that the Standards embodied evidence-based practices, principles of procedural justice, due process, and access to justice. With their adoption, no Illinois judge will have to intuit how to preside in a problem-solving court.

Two other examples of working beyond the courtroom doors are my involvement with the Illinois Center of Excellence for Behavioral Health and Justice and the Kennedy Forum Illinois.³⁵ The Center of Excellence provides evidence-based training, coordination, and implementation assistance related to justice-involved individuals with mental health and/or substance use disorders in order to create problem-solving courts and other alternatives to incarceration throughout the state. It collaborates with over twenty entities to engage in national and statewide discussions, leverage resources, and keep Illinois courts and communities up-to-date on trends and research. The Center of Excellence opened in 2012, and I have been honored to serve as chair of its Advisory Board. As explained at the opening ceremonies by Dr. Anderson Freeman of the Illinois Department of Human Services Division of Mental Health: "This intergovernmental partnership makes a strong statement about the power of collaboration in creating a good outcome even while resources are limited."³⁶ Importantly, the mission of the Kennedy Forum Illinois is to end stigma against mental health and substance use disorders by changing both attitudes and practices. As a member of the Leadership Council since the Kennedy Forum was launched in Illinois in 2014 with the support of former Congressman Patrick Kennedy, our work has involved implementing many new programs and visible initiatives, such as the "On the Table" annual community discussions about mental illness and addiction. We are also working to advance integration and coordination of behavioral health care into the general primary care medical system.

In 2002, the phenomena of the revolving door syndrome and criminalization of the mentally ill meant that I was continually seeing human beings in my courtroom with seemingly insurmountable problems: mental illness and addiction. Traditional forms of case processing had failed. Our goal was to change the way that our system responded—or had

34. The Standards are posted on the Illinois Supreme Court website at http://illinoiscourts.gov/Probation/Problem-Solving_Courts/P-SC_Standards_2015.pdf.

35. More information about the Kennedy Forum Illinois is available at <http://thekennedyforumillinois.org/>.

36. Press Release, Illinois Center of Excellence for Behavioral Health and Justice Formal Opening (June 7, 2012) (on file with author).

not responded—to address their problems. I was privileged to be part of the collaborative process of creating a mental health court and then to preside over that court. It was both challenging and rewarding to promote a therapeutic atmosphere, an environment in which participants were motivated to take charge of their own recovery, graduate from our program, and find hope that their lives could begin anew without involvement in the criminal justice system. As I reflect on my courtroom experience, I am even more convinced that the principles of procedural justice played a key role in creating that environment. They affirmed the dignity of the persons in our mental health court while at the same time affirming the integrity of our justice system. My work outside the courtroom doors has also been rewarding in that it has allowed me to work with others who share the passion and commitment to transform how we “do justice.” Much progress has been made. Nevertheless, there is still far more to be done to accomplish the goals that President Kennedy articulated over fifty years ago, to change how persons with mental illnesses and addictions are treated in our society.

