

In 1956, at age 18, Burnt Murphy (yes, that is the correct spelling) was released from the Utah State Training School, Utah's institution for "mentally retarded" youth. At age 19, Murphy was charged with the rape of a 5-year-old girl and subsequently the homicide of a young woman who had been a co-resident at the state training school. In 1957, a state district court judge found Murphy incompetent to stand trial and committed him to the Utah State Hospital, the state's mental institution, until such time as he became competent. Notably, no judicial findings were made as to the nature or type of insanity or mental illness Murphy suffered from when the alleged crimes were committed.

In fact, Murphy had mild mental retardation, but for the next 15 years he was confined to the state mental hospital and received a regimen of medications, including anti-psychotics. Eventually he developed the serious side effect of tardive dyskinesia.¹

Such drugs were never indicated for his condition. It is significant that Murphy had never been diagnosed with a mental illness, only with mild mental retardation. The next judicial hearing wasn't until 1972. The '72 hearing was prompted by a letter from the hospital's superintendent and a staff psychiatrist indicating Murphy was "no longer psychotic or insane" and was competent to stand trial. After a bench trial on the rape charge held in late 1972, Murphy was found not guilty by reason of insanity and again committed to the Utah State Hospital, consistent with Utah's statutory scheme at the time, without any release date. Again, no findings were made as to the type of Murphy's "insanity" other than mental retardation. He was never tried for the alleged homicide. Review of previous court records reveal Murphy was represented by counsel, although the extent and adequacy of that representation are certainly questionable.

In 1983, I was a reasonably new state public defender when Murphy's case was assigned to me. Referral of the case came at the specific request of the newly assigned trial judge, Hon. David Dee, who had received a letter from Murphy asking for help. Murphy had now been in custody for 27 years. At the time, I had no direct experience with individuals with either mental retardation or mental illness. I quickly learned how inadequate our judicial and mental health systems were in handling criminal defendants with mental illnesses or disabilities and how those affected by either suffered at the hands of these incompetent systems.

Utah's Disability Law Center assisted me in the representation. Following a five-day hearing in 1984, the trial judge found that Murphy suffered from mild mental retardation and an acquired adult adjustment disorder, which is not surprising after 27 years in a mental hospital. The court further found the medications had made Murphy quiet and docile and that it was only after the medications were stopped because of the side effects that Murphy cried out for help. Yet Judge Dee also found that the state mental health system had no means to care for Murphy outside of an institutional setting. He reluctantly recommitted Murphy to the state hospital and invited appeal of his decision to the Utah Supreme Court. In 1988, the Utah Supreme Court, in a 14-page opinion, ordered the state of Utah to create a plan for the graduated release of Murphy to the community.² The supreme court found it untenable that Murphy had been institutionalized in the mental hospital for many more years than he would have served in the state prison.

Released in 1989 to a community group-home setting (although he was the only resident), Murphy lived quietly until his death five years later from natural causes.

During my experience, I had grown to care deeply about Murphy and the plight of those like him who faced challenges due to mental illness or being developmentally disabled. My journey and interest in the well-being of the mentally ill began with this case, and that deep-rooted interest remains to this day.

The Mental Health Working Group

In 2003, after working as a prosecutor for the U.S. Attorney's Office, I was appointed as a magistrate judge. Shortly after taking the bench, I immediately and repeatedly encountered procedural issues unique to federal mentally ill defendants. Some were in pretrial custody and some on supervised release. Most instances involved severely and persistently mentally ill persons. Problems ranged from delay in transport to decompensation while in transport or in district custody, inadequate release plans, lack of treatment records, as well as medication and medical problems. Reports of forensic examinations were routinely late in arriving and often were inadequate. There was little communication between agencies. As a result, treatment and community support were lacking, individuals suffered, costs climbed, and cases dragged on.

Two particularly difficult situations come to mind that required court action and illustrate the dilemma faced by the mentally ill within the federal criminal justice system. Charged with a serious felony, Mr. B.³ had a long history of schizophrenia and had many visible and prominent facial and body tumors. A forensic evaluation was ordered at a Bureau of Prisons (BOP) facility.⁴ Several months later, he was returned after a psychiatric determination of competency. Unfortunately, he died in custody within a few months from the cancer not addressed while he underwent forensic evaluation.

Mr. C., a severely and persistently mentally ill man and a repeat bank robber, was returned to Utah after serving his BOP sentence. He was released at the airport with no transportation, and the community corrections center where he was to reside denied him entry because he arrived two days early. As a result, he spent the night on the street and the next morning went to the same bank he last robbed, robbed it again, and then sat on a curb waiting for the police.

Although still finding my way in the federal judicial arena, albeit with some newfound authority and a bit of naiveté as to the complexities of federal mental health processes, in 2004 I called together a Mental Health Working Group of agency representatives tasked with identifying and eliminating barriers encountered by mentally ill defendants such as Mr. B. and Mr. C. The BOP, the U.S. Marshal's Service (USMS), U.S. Probation, and the Utah Federal Defenders participated. While still respecting the individual mission and independence of each agency, the group members worked diligently to identify barriers faced by the mentally ill and implemented positive procedural changes, many of which are still practiced within the district.

The Mental Health Working Group was a good start but an imperfect solution to an even larger set of problems. The unintended consequence of the group's work was identification of additional and sometimes seemingly insurmountable barriers faced by mentally ill defendants reentering the community. Barriers to successful reentry included homelessness or lack of affordable housing, lack of the ability to apply for and manage benefits even if awarded, lack of community and individual support systems, lack of transportation, isolation, lack of employment possibilities for those who could hold jobs, and serious untreated medical and dental issues. The result, as illustrat-

ed by the case of Mr. C., was suffering, recidivism, and additional costs to the public of re-incarceration.

Many of those in the Mental Health Working Group knew that the state of Utah had 10 years earlier begun effective pretrial mental health courts where the criminal cases of successful graduates were dismissed. They asked why the federal district court could not adopt and adapt a similar model for returning supervisees and others.⁵ The answer was simple: because such an approach had yet to be tried.

The RISE Mental Health Court

What to do? Once again, those interested in the plight of the mentally ill (many from the original working group) began exploring the idea of a mental health court within the District of Utah.⁶ The group decided to have a mental health court distinct from a drug court, recognizing that the severely and persistently mentally ill, even with co-occurring disorders including secondary substance abuse problems, could not likely succeed in a traditional drug court setting. Because the original Mental Health Working Group had success, I proposed to then-Chief Judge Tena Campbell the creation of both a mental health court and a drug court for consideration as pilot projects. Without hesitation, she agreed, a position consistent with our district court's view both then and now that the court should

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play a part in reducing recidivism, enhancing community safety, and improving the lot of those returning from federal prison.

It became necessary to invent something new because, according to our research, there were no other federal mental health courts. None, to our knowledge, were being considered, although other districts such as the District of Oregon, the Eastern District of Missouri, the District of Massachusetts, and the Eastern District of Pennsylvania were getting the message that reentry courts that were incorporating evidence-based practices (EBPs) were working to improve the plight of those returning to society, particularly those who were drug-addicted.

All state mental health court models, including those in Utah, were exclusively pretrial courts.⁷ The decision was made that ours would be a mix of returnees, those on diversion, and some on probation. State court staffing and hearings were visited; we consulted with our respective state counterparts, reviewed the relevant

literature, picked the brains of the originators of our state model, consulted with forensic mental health experts, and attended national trainings. After doing so, we created the most feasible model possible for the court we envisioned. For the sake of brevity, if you would like a copy of the plan, please contact my chambers.⁸

While it is understood that mental illness and/or developmental disability is not curable, it is our position that recovery is possible. We strive to provide the necessary resources, including community and medical relationships, so that participants are sufficiently stable and given the best chance of success upon termination of supervision.

We have modified the original plan over the years as the program has evolved. I will highlight a few of the modifications here. A representative from the National Alliance for Mental Illness (NAMI) has joined our professional team, giving us additional professional insight and client-based advice. Unfortunately, the BOP and USMS, for reasons relating to resources, have not been weekly members of the professional team, but there is hope for renewed participation.

In 2014, the name of our court was changed to the RISE (Reentry Independence through Sustainable Efforts) Behavioral Health Court so as not to further stigmatize participants. We try to no longer refer to our participants as “defendants,” “offenders,” or “inmates” for the same reason. We have included in RISE those on conditional release who potentially face a lifetime of reporting to U.S. Probation.

The eligibility requirements for program participation were also expanded to include those with traumatic brain injuries. Those convicted of sex offenses with mental illness now, when appropriate, do also participate in RISE with the intent that our court can provide the closest supervision and accountability.

Because supervisory, diversionary, and probationary periods, as well as conditional release provisions, vary greatly, we have modified our program to require an approved individual plan, created with the participant's direct involvement, to reach a set of goals. A plan is likely to include stable housing, medication compliance, treatment compliance, employment or receipt of legal-

ly authorized benefits, lack of recidivism, and positive community support and involvement. Upon achievement of an individual's goals, a recommendation may be made to terminate supervision early.

Successes, Failures, and the In Between

Allan Rice, Ph.D., our “earth father” and representative of our treatment provider, Valley Mental Health, has often taught but reemphasizes that as a court and as court professionals, we must define success differently in a mental health court setting than in a traditional court. Six months or a year of stability without re-incarceration or hospitalization can be a success story for one who has been jailed repeatedly. There are many more examples of large and small successes.

Our court of 10 participants is small due to resource restrictions. To date, it has been cost-prohibitive to have an analytical study conducted on such a small group. However, we don't judge success sole-

ly on graduation rates. Yet, our court is deemed successful by our staff, our judges, and, I believe, our participants to be an effective alternative to incarceration, which enhances the dignity of the vulnerable mentally ill population.

The following stories are illustrative of the people, problems encountered, and work done in our behavioral health court.

A.D., a previous collegiate actor and Vietnam vet, suffered from schizophrenia and had no teeth. Although on supervised release, he remained chronically homeless, was not affiliated with the U.S. Department of Veterans Affairs (VA), and was not taking previously prescribed medications. Upon entering RISE through the joint referral of his attorney and supervising probation officer, a relationship with the court and the VA ensued. In the end, A.D. graduated from our program, was stable on medications, had a Hollywood smile, and was one of the first two vets in Utah to be placed in a newly created Veteran's Foster Home. It was there that he later peacefully died from a chronic illness.

A.W. was a young man in his early 20s when he returned to Utah on supervised release. As a child, infection from undiagnosed appendicitis resulted in the amputation of one leg above the knee. As a teen, he received an accidental gunshot wound to the head resulting in severe mental and judgment impairments. Convicted of a federal felony, he entered BOP custody, during which time he continued to grow physically. He was not fitted with a new prosthetic for his leg. He hopped or crawled wherever he went. After release and once again in trouble, A.W. was referred to the RISE Behavioral Health Court. For more than a year the team tried valiantly to secure a new leg for A.W. For reasons not remembered, he was ineligible for vocational rehabilitation or Medicaid services. Ultimately, the effort failed. But for two years, he was a full participant in RISE and made lasting improvements.

About 12 years ago, J.G. was deemed incompetent to proceed on his charges of threatening a federal official. After months of hospitalization and civil commitment to a BOP facility after a finding of incompetence to proceed, he was given a conditional release, which required supervision by U.S. Probation—for up to life. J.G., like A.D., had become chronically homeless; he began using methamphetamine but had not been charged with any criminal offenses during his release period. While in RISE, housing was located for J.G. He participated in treatment and took medications as prescribed. After two years in RISE and after almost 10 years on conditional release, his conditional release was finally terminated. He still drops in for picnics and pizza with the group from time to time. Before his schizophrenia manifested, J.G. had been a promising winter Olympian.

R.L. was on supervised release after a BOP sentence. He suffered from a severe depressive disorder and chronic alcoholism. He was referred to RISE as an alternative to revocation and a return to custody. Although young, R.L. had a wife and four very young children. For months, they lived in a single room in a run-down motel. The baby slept in a dresser drawer. To deal with the inherent stresses of such a situation, R.L. would engage in further drinking—even while on anti-drinking medication. RISE assisted R.L. and his family by finding alternative housing, helped R.L. enter and complete an in-

patient alcohol program, and referred the family to community services and counseling. To this day, R.L., his wife, and his kids still drop by to say hello. R.L. has also avoided a return to custody.

D.S. had a low IQ and went to prison on a six-year sentence as a very young man. He returned to Utah having had a schizophrenic break while in prison and with a significantly reduced IQ after receiving head injuries during prison assaults. D.S. had loving, supportive parents but remained housebound due to anxiety. Since joining

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RISE, D.S. now enjoys associating with our group and walking his dog. He has visited an independent living center and is working toward participation in its activities. In short, his quality of life has risen dramatically. These are but a few of the successful individuals helped by the RISE program.

Conclusion

Although the RISE courts were approved as single-year pilot projects, the issue of sustaining them has never been revisited. Rather, the District of Utah, with full support of its judiciary, U.S. Probation, the U.S. Attorney, and the Utah Federal Defender, has initiated another pioneering effort called Assisted Re-entry to the Community (ARC). ARC is a districtwide initiative to further the goals of reducing recidivism, increasing public safety, reducing costs, and enriching the lives of those so vulnerable in even more and differing ways.

Presiding over the RISE Behavior Health Court has been the most rewarding aspect of my tenure as a magistrate judge. I feel judges have the responsibility to apply the law on the front end to effect justice, but we have an equal moral and ethical obligation to use our power on the back end to benefit our citizens and our communities.

A behavioral health court is doable—in your district. I urge you to consider it. ☺



Judge Brooke C. Wells was appointed as a U.S. magistrate judge in 2003. In addition to her regular criminal and civil dockets, she presides over two specialized courts, the RISE Behavioral Health and Drug Courts. She can be reached by email at ut-decf_wells@utd.uscourts.gov. She is grateful for those who have assisted in the creation of the Mental Health Court. Among those professionals deserving of recognition for their vision and work are David Christensen, (chief, USP), Kevin McKenna (USP), Karan Pace (USP), John Warner (USP), Meriska Holt (USP), Bob Steele (AUFDF), Georgette Leventis (UFD investigator), and Allan Rice, Ph.D. (Valley

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Endnotes

¹Tardive dyskinesia is characterized as “involuntary, choreiform, athetoid, or rhythmic movements (lasting at least a few weeks) of the tongue, jaw, or extremities developing in association with the use of neuroleptic medication for at least a few months.” AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 736 (4th ed., 2000).

²*State v. Murphy*, 760 P.2d 280, 281 (Utah 1988).

³For the interests of privacy, all participant names have been abbreviated.

⁴As there are no BOP facilities in the district of Utah, forensic evaluations are generally conducted out of district.

⁵According to our treatment providers, persons with persistent

and severe mental illness have a life span of 10 years less than those without such mental illness.

⁶At about the same time in 2004, other interested federal professionals from the same agencies began to talk about a drug court model for the district. We knew of Judge Anne Aiken's Oregon federal drug court program and of Utah state court models. Also in 2004, through the initiative of Anrico Del Ray (USP), the Utah federal district court became a partner in a federal-state collaboration eventually known as UDOWD (Utah Defendant/Offender Work Force Development). The resulting task force and advisory board consisted of state, federal, and local law enforcement members including the Utah Department of Corrections, and state agency representatives (Department of Vocational Rehabilitation, Department of Work Force Services, and Division of Child Support Recovery Services), as well as community representatives from the LDS Church and Catholic Community Charities. This mission of UDOWD was to identify and remove barriers to employment faced by state and federal prison returnees.

⁷In 2004, the Thornburg Memo still advised the actions of the U.S. Department of Justice and local U.S. attorneys as to resolution of federal criminal cases. Federal prosecutors, including those in the District of Utah, were required to accept pleas of guilty only to the highest provable offense in a specific case, thus eliminating diversions except in extraordinary circumstances.

⁸Feel free to contact us at utdefc_wells@utd.uscourts.gov.



THIS IS OUR ELEMENT.



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