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REFLECTIONS ON THE CHALLENGING PROLIFERATION OF MENTAL HEALTH ISSUES IN THE DISTRICT COURT AND THE NEED FOR JUDICIAL EDUCATION

Honorable Jessie B. Gunther

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REFLECTIONS ON THE CHALLENGING PROLIFERATION OF MENTAL HEALTH ISSUES IN THE DISTRICT COURT AND THE NEED FOR JUDICIAL EDUCATION

*Honorable Jessie B. Gunther**

I. INTRODUCTION

Maine's courts constantly deal with litigants with mental health issues. Historically, our decisions have relied on expert testimony addressing specific issues of responsibility, risk, and treatment. In recent years, by my observation, court involvement in the treatment process has increased, but the availability of expert evidence has decreased.¹ Thus, we as judges have become the ultimate decision-makers regarding litigants' mental health treatment in both criminal and civil contexts, without supporting expert testimony. In the face of this development, three interconnected issues arise.

The first issue is whether judges should even attempt to fill the void caused by lack of expert testimony. I think all judges would prefer to act only on the basis of expert information, but, as a practical matter, we cannot. The experts are not available at the courthouse and we have no choice but to use our own training and experience by default.²

The second issue, if judicial training is to compensate for an absence of expert evidence, is what type and amount of training and education should be required to achieve competency in this role. Required knowledge should probably include characteristics of mental disorders,³ the dynamics of substance abuse and domestic violence, an overview of treatment methods, and the applicability of various therapies. This list is not exhaustive. Of course, we also need to identify those areas where an expert remains essential⁴ and where we should refuse to act on our own.

The education we receive should be common to all members of the judiciary. Moreover, those appearing before the court should be informed both of the extent of our education and how we will use that education in deciding their cases. We

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1. This phenomenon is possibly due to cost factors, pro se litigants, and the pressure to use less time. These factors are not a subject of this commentary.

2. As an example, I discount arguments that frequent reconciliations disprove domestic violence. The contrary has been conclusively demonstrated in our judicial training. Cf. note 51.

3. See *infra* Section III.A.

4. A case in which I refused to rely on judicial training, *Lapointe v. Lapointe*, is on appeal to the Law Court at this writing. No. BAN-FM-3000-00122 (appeal sent to the Law Court Aug. 12, 2004) (on file with the Maine Law Review). *Lapointe v. Lapointe* is an annulment case in which the plaintiff asked me to use my domestic violence training to rebut evidence of condonation. *Id.*

must also remain aware that approaches can change. The information judges receive must be updated regularly.

The third issue raised by the increased role judges are playing in making mental health decisions is the lack of data measuring the efficacy of judicial intervention, as well as the efficacy of the alternative programs to which defendants are being sentenced. In addition to increased judicial education, courts need to evaluate particular therapeutic programs to determine whether they in fact work. As it currently stands, we make judgments without much feedback.⁵ We need reliable data, not anecdotal evidence, when deciding whether to send a defendant to an anger management program, to counseling, or to jail; whether to impose conditions on parent/child contact; or whether to include counseling in a protection from abuse order.

II. DECISIONS ADDRESSING MENTAL HEALTH TREATMENT

Maine's district courts⁶ address mental health treatment through civil commitment hearings,⁷ protection from abuse cases,⁸ bail conditions,⁹ conditions of probation,¹⁰ and the recently enacted administrative release provisions.¹¹ District court judges are directly responsible for determining competence in criminal and juvenile proceedings.¹² Specialized courts address drug and alcohol addiction at both the district and superior court levels.¹³ Some examples of the intersection between legal and mental health considerations are addressed below.

A. Criminal Prosecutions

Prosecutors bring criminal cases in an effort to hold individuals responsible for their behavior and to prevent future crimes. This task can be more difficult in cases involving the mentally ill. Legal and medical definitions of mental illness

5. An exception was a presentation at the 2004 Maine Sentencing Institute by Prof. Edward Latessa of the University of Cincinnati, who pointed out ineffective approaches with low risk offenders and promoted new approaches in that and other areas.

6. I have used district court examples because of my greater familiarity with that docket. The superior court has the primary role in criminal cases involving the insanity defense. See ME. REV. STAT. ANN. tit. 17-A, § 39 (West 1983 & Supp. 2003). Probate courts handle guardianships. See ME. REV. STAT. ANN. tit. 18-A, §§ 5-101 to 5-816 (West 1988 & Supp. 2004).

7. ME. REV. STAT. ANN. tit. 34-B, §§ 3861-3872 (West 1988 & Supp. 2004).

8. ME. REV. STAT. ANN. tit. 19-A, § 4007 (West 1998 & Supp. 2004).

9. ME. REV. STAT. ANN. tit. 15, § 1026 (West 2003). See also L.D. 357 (122nd Legis. 2005). This bill proposes an amendment to the Maine Bail Code by, in part, "[a]llowing as a condition of bail that a person enter and remain in a long-term residential facility for substance abuse." *Id.* This is in keeping with the trend toward placing the power of making mental health decisions for defendants in the hands of judges. If this becomes law, it is likely that such conditions would be imposed by a judge without the benefit of expert testimony.

10. ME. REV. STAT. ANN. tit. 17-A, § 1204(2)(a)-(d) (West 1983 & Supp. 2003).

11. *Id.* §§ 1349 to 1349-F (WESTLAW through 2004 Second Special Session of the 121st Legis.).

12. For competence proceedings involving adults, see ME. REV. STAT. ANN. tit. 15, § 101-B (West 2003), and for competence proceedings involving juveniles, see ME. REV. STAT. ANN. tit. 15, § 3318 (West 2003).

13. All but one of the drug courts are involved with criminal cases. Judge John Nivison manages a family drug court in Belfast for child protective cases, which may expand to other divisions.

are potentially incongruous,¹⁴ making the task of determining whether a mental disorder precludes a finding of responsibility very difficult. The criminal process, from arraignment through post-adjudication, is not well-adapted to treating the mentally ill, as noted in the following examples.

1. *Illustration 1: Responsibility*

Prosecutorial decisions in cases involving the mentally ill can be influenced by pressure from mental health providers. Providers occasionally request criminal proceedings in an effort to coerce hostile or unmanageable clients into conforming behavior.¹⁵ When legal action is pursued for such purposes, it can generate factually baffling prosecutions.¹⁶

An example came before me last year. The defendant and another elderly resident of a boarding home had quarreled over a can of Coke. In the course of the altercation, the defendant had thrown his walker, and it had grazed the victim, who was passing by at the time. The case was pursued at the urging of the boarding home staff, who wanted the defendant to know he could not get away with throwing things at other people. The defendant, however, seemed somewhat out of touch with the court proceedings. I accepted a negotiated plea of "no contest" and imposed a \$100 fine paid by his representative payee. The accused was insistent that he just wanted to pay and go, so I let him, despite my qualms about his mental capacity.

2. *Illustration 2: Bail or Jail*

When a defendant with a mental health disorder has been arrested, difficult release and detention issues may arise when the judge is setting bail.¹⁷ In addition to the traditional bail requirements, judges have an array of treatment options to choose from that can be ordered as bail conditions. The lack of information as to which bail conditions would be most appropriate in a given circumstance, combined with the previously noted lack of judicial education regarding mental illness, can hamper sound judicial discretion when a judge is selecting bail conditions.

I have experienced mixed results with bail conditions for treatment. DR¹⁸ had been identified as possibly incompetent through an evaluation conducted at the jail. I bailed him on charges of violating harassment orders and bail conditions, after a plan was developed through his counsel in consultation with jail per-

14. See Ellen Byers, *Mentally Ill Criminal Offenders and the Strict Liability Effect: Is There Hope for a Just Jurisprudence in an Era of Responsibility/Consequences Talk?*, 57 ARK. L. REV. 447, 455 (2004).

15. I get the sense that providers believe we let offenders hide too much behind their disorders. However, my impression is that the providers usually do not want jail time imposed on their clients, only the threat of jail. This sends a mixed message to prosecutors and, ultimately, to judges.

16. In the example that follows, we had a full house for arraignment, and the audience tittered when the prosecutor described the incident.

17. One concern with imposing bail conditions is that a violation may result in several days of incarceration. See ME. REV. STAT. ANN. tit. 15, § 1092(A) & (B) (West 2003 & Supp. 2004) (violation of conditions of release). An individual arrested for violating conditions of release cannot bail through a bail commissioner. ME. REV. STAT. ANN. tit. 15, § 1095(2) (West 2003).

18. I have omitted case citations and individual names for privacy reasons.

sonnel.¹⁹ DR was placed in a living situation in the Waterville area that we understood was to be supervised. Unfortunately, however, DR is now among the missing. A warrant is outstanding for his arrest, despite his questionable competence, for the original charges and a new charge of violating conditions of release.

By contrast, a continuance without bail but with directions for treatment was effective with JH. JH was discharged from the Bangor Mental Health Institute (BMHI) after two months of involuntary commitment, only to face a charge of assault that arose at the time of his admission to BMHI, when he hit a nurse in the Eastern Maine Medical Center examining room. The initial Title 15 evaluation, done while he was hospitalized, found incompetence.²⁰ Before the second stage evaluation,²¹ the attorneys and JH's caseworker negotiated a continuance. Eventually, the case was dismissed by the prosecutor after community support services had been successful in maintaining JH for six months.

3. Illustration 3: Post-Adjudication

Historically, courts have utilized probation to achieve compliance with mental health treatment conditions following conviction.²² In 2003, the Maine Legislature supplemented the courts' options for mandating mental health services by adding the administrative release provision to Maine's Criminal Code.²³ An example of the courts' ability to mandate such services can be found in paragraph 16 of the current probation form and paragraph 7 of the administrative release form:

[C]omplete (evaluation and) counseling and treatment as an (outpatient/inpatient) (at _____ or a similar facility) as directed by [your probation officer] for (substance abuse) (sexual offender) (psychological) (domestic abuse) (certified batterer's intervention) (anger management) (medical) (_____) issues and sign any releases²⁴

The court has the option of revoking probation for failure to comply with treatment conditions, although that option is often not exercised. For example, JM was a probationer residing in a boarding home maintained by his mental health

19. A number of jails are associated with various types of projects that develop pretrial release plans. Volunteers of America covers the Penobscot County Jail.

20. Counsel from the commitment hearing was appointed to defend the criminal action, and was able to obtain evaluation during hospitalization. See ME. REV. STAT. ANN. tit. 15, § 101-B(1) (West 2003) (authorizing the district court to order a defendant to participate in a mental health evaluation to determine competency to stand trial). This was fortunate, as, generally speaking, getting an unstable defendant and the evaluator together can be a difficult task.

21. See ME. REV. STAT. ANN. tit. 15, § 101-B(2) (West 2003) (requiring a mandatory follow-up examination if the preliminary examination showed the defendant may suffer from a mental disease or defect or if further observation is required).

22. ME. REV. STAT. ANN. tit. 17-A, § 1204(2-A) (West 1983 & Supp. 2003). Subsection 4 of § 1204 authorizes referral for evaluation to the Department of Behavioral and Developmental Services for an assessment of a probation condition requiring psychiatric treatment or counseling. It requires notice to the Department when treatment or counseling is ordered. This provision, which has been in existence since 1997, is rarely used, in my experience. It is not incorporated in the administrative release provision of ME. REV. STAT. ANN. tit. 17-A, § 1349, *et seq.* (West Supp. 2004).

23. ME. REV. STAT. ANN. tit. 17-A, § 1349-C (West Supp. 2004).

24. District Court Probation Form CR-1223, Rev. 10/03; District Court Administrative Release Form CR-113, Rev. 7/04.

service provider.²⁵ The home was designed specifically for JM, but contained other residents as well. JM had faced multiple prosecutions for assault and threats directed at staff and fellow residents²⁶ and was placed on probation after several convictions in 2003. The conditions required him to “[f]ollow treatment recommendations, including MEDICATION compliance, of treating MH workers.” JM’s probation was revoked last summer after three new assault convictions.²⁷ With individuals as mentally ill as JM, new criminal conduct is usually the key to revocation. In contrast, revocation is often sought for the failure to pursue substance abuse, sexual offender, or batterer’s intervention counseling, which courts may perceive as more in the control of the offender.

B. Civil Proceedings: Family Matters

Maine statutes governing protection from abuse cases²⁸ and parent-child contact in cases of domestic abuse²⁹ explicitly authorize the court to mandate mental health services. Judges are also becoming increasingly involved as managers in child protection cases.³⁰ After a child is removed from a home, the parents and the Department of Health & Human Services (DHHS) are responsible for developing and pursuing a reunification plan;³¹ reunification plans almost always include mental health treatment. Resolution of the mental disorder is not the goal of the protective proceeding, however. The aim of the proceeding is to resolve the legal issue of whether the child is in jeopardy, and the two may not be the same.³² Mental illness in and of itself does not preclude being a competent parent.

In parental rights cases, courts are also confronted with the task of determining if any risk of harm to a child arises from a parent’s mental or emotional condition. Pretrial motions may be filed to compel disclosure of mental health treatment, usually opposed by the party whose records are sought.³³ Evaluation may

25. State v. JM, No. BAN-CR-03-568 (Bang. Dist. Ct. Mar. 14, 2003) (docket on file with the Maine Law Review).

26. In a demonstration of unintended consequences, a bail condition of no contact with a co-resident victim resulted in the victim being removed from the home, not the defendant.

27. Probation imposed in BAN-CR-03-568 (conviction of assault, 3/14/03), revoked as to three days, 8/28/03 (new conviction, criminal threatening, BAN-CR-03-2454; other charges BAN-CR-03-2309, criminal mischief, and BAN-CR-03-3467, criminal threatening, dismissed); revoked as to seven days, 12/5/03, concurrent with assault conviction, BAN-CR-03-4571. JM also served three days in October 2003 for criminal threatening and terrorizing, without revocation.

28. See ME. REV. STAT. ANN. tit. 19-A, § 4007(1)(H) (West 1998).

29. See *id.* § 1653(6)(B)(3).

30. The June 14, 2004 judicial education presentation, “Child Protection Matters—Partnership for Permanency,” presented by Judge Nancy S. Salyers of Chicago, advocated active judicial monitoring of these cases. Nancy S. Salyers, Presentation at a Child Protection Training Session, Bangor, Maine (June 14, 2004).

31. ME. REV. STAT. ANN. tit. 22, § 4041 (West 2005). A reunification plan sets specific goals that the parent(s) must accomplish for reunification, usually accompanied by a statement of services to be provided. The recent case of *In re Jazmine L.*, 2004 ME 125, 861 A.2d 1277, notes the problem of plans not changing with changed circumstances.

32. See, e.g., *In re Jazmine L.*, 2004 ME 125, 861 A.2d 1277; *In re Dakota P.*, 2005 ME 2, 86 A.2d 280.

33. ME. R. CIV. P. 35(a). Maintaining a level of privacy presents problems when opposing parties receive copies of each other’s mental health evaluations. Ten years ago I had a case, *VL v. KL*, in which a child protective evaluation of the father was widely circulated by the mother in their subsequent divorce. Any discovery or evaluation order should include a non-disclosure provision.

be requested separately or through appointment of a guardian ad litem.³⁴ If a parent has a mental disorder, ongoing judicial monitoring may become an issue for the final decree.³⁵ I am reluctant to stay involved in parental rights cases post-judgment, but I have required a parent to sign a release so that the other parent can confirm continuing therapy or medication compliance as a condition of allowing visitation.³⁶ If the parties agree to judicial monitoring, I have continued the guardian's role or appointed a Special Master to manage visitation and other disputes.³⁷

III. EXPERTISE OR EVIDENCE ON MENTAL HEALTH ISSUES

Aberrant behavior may not be the result of a mental disorder,³⁸ although the untrained observer may assume that it is. Diagnosing is as much an art as a science and does not have the certainty legal minds prefer, as noted in the section that follows.

A. A Primer on Mental Disorders

The common medical authority for identifying mental disorders is the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR), now in its fourth edition.³⁹ The DSM-IV-TR is organized into five categories, Axis I through Axis V.⁴⁰ Most judges have generalized knowledge of the conditions described in Axis

34. ME. REV. STAT. ANN. tit. 19-A, § 1507(3)(B)(4) (West 2004). Most guardian ad litem motions are, however, addressed by the case management officers. ME. FAM. R. III(A)(1). No legal standard exists for the mental health evaluations, and often the results are presented second-hand through the guardian's report. The recent case of *In re Guardianship of K-M*, 2005 ME 8, 866 A.2d 106, provides an excellent discussion of ordering an examination in a guardianship case.

35. In the divorce of *JM v. KM*, the guardian ad litem recommended that the divorce decree mandate post-judgment psychological evaluation of the father, with five particular tests, including the Hare Psychopathy checklist (not a universally accepted tool), prior to parent-child contacts. No. BAN-FM-02-19 (Bangor Dist. Ct. May 17, 2004) (on file with the Maine Law Review).

36. TS v. NT, No. BAN-FM-99-179 (Bangor Dist. Ct., pending request for further modification).

37. NB v. CC, No. BAN-DV-96-329 (Bangor Dist. Ct. Feb. 17, 2005).

38. See DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, AMERICAN PSYCHIATRIC ASSOCIATION xxxi (4th ed., text revision, 2000) [hereinafter DSM-IV-TR]. According to the DSM-IV-TR:

[E]ach of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability or important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. *Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of dysfunction in the individual, as described above.*

Id. (emphasis added).

39. *Id.*

40. *Id.* at 27-37.

I, such as schizophrenia, bipolar disorder, and major depression. District court judges frequently hear testimony regarding conditions described in Axis II, which covers personality disorders and mental retardation,⁴¹ because personality disorders are common components in allegations of jeopardy. Personality disorders are fixed, maladaptive patterns of behavior that are very difficult to treat. Medication is largely an ineffective means of treating a personality disorder, although it may relieve some symptoms.⁴² Furthermore, not all individuals with the same mental health diagnosis have the same characteristics, and, conversely, symptoms often overlap.⁴³

Perhaps the most famous legal construct related to mental disorders is the legal definition of insanity. The term "insanity," however, is nowhere to be found in the index of the DSM-IV-TR.⁴⁴ The exculpatory defense of insanity originated in *M'Naghten's Case*.⁴⁵ The House of Lords articulated the first modern concept of legal insanity as follows:

To establish a defense on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.⁴⁶

The legal standard for insanity has undergone a variety of revisions since the *M'Naghten* test, including the "irresistible impulse" test, the *Durham* test, and most recently the test of the American Law Institute's Model Penal Code section 4.01.⁴⁷ The Model Penal Code's broader formulation of insanity enables the jury

41. *Id.* at 28-29. The DSM-IV-TR describes a personality disorder as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment." *Id.* at 685. The DSM-IV-TR furthermore notes that "[o]nly when personality traits are inflexible and maladaptive and cause significant functional impairment or subjective distress do they constitute Personality Disorders." *Id.* at 686. The remaining categories in the DSM-IV-TR include Axis III, medical conditions, Axis IV, psychosocial and environmental stressors, and Axis V, the Global Assessment of Functioning (GAF) Scale. *Id.* at 29-34.

42. Enough experts have testified to these propositions in my courtroom that I accept them as true. The experts include John Lorenz, Ph.D., Diane Tennies, Ph.D., David Booth, Ph.D., Jonathan Siegel, Ph.D., and Bruce Saunders, Ph.D. I have never had an expert testify to the contrary.

43. DSM-IV-TR, *supra* note 38, at xxxi. When several core features of a particular diagnosis present themselves, but individual characteristics do not give rise to any one subcategory, a description of "NOS," meaning "Not Otherwise Specified," is given. A diagnosis followed by "NOS" does not put the principal diagnosis in doubt. For first commitments, where diagnoses are still being refined when involuntary commitment hearings are held, we often see "Psychotic Disorder NOS" rather than depression, schizoaffective disorder, or bipolar disorder. *See id.* at 343.

44. DSM-IV-TR, *supra* note 38, at 937.

45. 8 Eng. Rep. 718 (H.L. 1843).

46. Timothy S. Hall, *Mental Status and Criminal Culpability after Atkins v. Virginia*, 29 U. DAYTON L. REV. 355, 356 (2004) (quoting *M'Naghten's Case*, 8 Eng. Rep. 718, 722 (H.L. 1843)).

47. *See* JOSHUA DRESSLER, *CASES AND MATERIALS ON CRIMINAL LAW* 619-26 (3d ed. 2003). Section 4.01 of the Model Penal Code, titled "Mental Disease or Defect Excluding Responsibility," provides as follows:

(1) A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law.

to consider both the volitional and the cognitive impairments of the defendant.⁴⁸

States may vary, of course, in their individual definitions and “tests” to arrive at a legal standard for insanity. Maine statutes establish that “mental disease or defect” means:

[o]nly those severely abnormal mental conditions that grossly and demonstrably impair a person’s perception or understanding of reality. An abnormality manifested only by repeated criminal conduct or excessive use of alcohol, drugs, or similar substances, in and of itself, does not constitute a mental disease or defect.⁴⁹

The State of Maine provides other “legal” definitions relating to mental disorders, such as the civil commitment statute, which defines a “mentally ill person” as “a person having a psychiatric or other disease which substantially impairs his mental health, including persons suffering from the effects of the use of drugs, narcotics, hallucinogens or intoxicants, including alcohol, but not including mentally retarded or sociopathic persons.”⁵⁰ More statutory guidance can be found in a definition of “psychotic condition” from the Interstate Compact on Mental Health, adopted by Maine in 1993:

“Psychotic condition” means any disease, illness or condition commonly referred to by the medical profession . . . as any disorder characterized by psychotic tendencies or manic-depressive behavior or schizophrenia or other similar condition that, without the administration of medical treatment, including the use of psychotropic drugs, would constitute a danger to the patient or to others and would result in a patient being gravely disabled.⁵¹

B. Judicial Education

Judicial education in Maine regarding mental health issues and the efficacy of alternative treatment programs is presently haphazard. As noted, judges absorb “expertise” in child protective hearings, sentencing hearings, and during family matters cases involving parenting disputes. After enough professionals have said the same thing about a given disorder, or about best parenting practices, the information becomes part of the judge’s background knowledge—a form of on-the-job training. Additionally, with the possible exception of the newest judges, all Maine judges have had some domestic violence training.⁵² Many judges have had train-

(2) As used in this Article, the terms “mental disease or defect” do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct.

Id. at 1012.

48. *Id.* at 623.

49. ME. REV. STAT. ANN. tit. 17-A, § 39(2) (West Supp. 2003).

50. ME. REV. STAT. ANN. tit. 34-B, § 3801(5) (West 1988). Robert Gallon, Ph.D., who does examinations for BMHI commitments, and I have discussed informally the unhelpfulness of the word “sociopathic,” which is not a DSM-IV-TR construct. My impression is that the statute intends to exclude personality disorders, but I have not had to rule directly on that point.

51. ME. REV. STAT. ANN. tit. 34-B, § 11001(1)(H) (West 2004).

52. For example, a comprehensive session was held in September 2001 entitled “Enhancing Judicial Skills in Domestic Violence Cases.” Breakout sessions included: “Observations and Commentary Regarding Victim and Perpetrator Behavior” and “Fact-Finding: How to Get the Right Information.” The subtitle of the session indicated that faculty would also review factors considered to be important indicators of dangerousness or lethality. An earlier training provided a publication of the Association of Family and Conciliation Courts, “Domestic Violence Visitation Risk Assessment,” published, I believe, in 1999.

ing on substance abuse,⁵³ including all of the juvenile drug court judges, who met for multi-day training sessions when the juvenile drug courts were introduced in 1999.⁵⁴ Finally, most Maine judges have attended sessions on the effects of trauma on children.

Nonetheless, the group training opportunities for Maine judges are limited, with many topics fighting for consideration.⁵⁵ Although individual judges attend programs addressing different aspects of mental health pathology and treatment and file reports, no regular programs on the subject of mental health issues are scheduled.⁵⁶ Thus, with the exception of domestic violence training and some issues regarding substance abuse, no common background exists among judges in Maine regarding mental health disorders or the efficacy of alternative treatment plans.⁵⁷

This kind of judicial education—picked up through listening to expert testimony and scattered conferences and presentations—has its dangers. Moreover, it fails to provide all judges with the same background and does not ensure that their education is of the highest quality and derived from the latest data.⁵⁸ This creates the risk that litigants will be treated inconsistently, and it threatens the integrity of the system as a whole. Another danger lies in the fact that such training tends to be

53. For example, between September 20 and 23, 2004, Justice Andrew Mead attended a National Judicial College course on “Co-Occurring Substance Abuse and Mental Disorders,” and later filed a report. See *infra* note 55.

54. ME. REV. STAT. ANN. tit. 15, § 3312(3)(A)(4) (West 2003).

55. At our most recent education program, the Tri-State Conference, March 16-18, 2005, held with judges from Vermont and New Hampshire, the focus was on high-conflict divorces (including those involving mental health issues), with other topics on child support, juvenile drug issues, business valuations, and tax issues in divorce.

56. Reports of seminars are circulated through the Judicial Education Committee, which Justice Paul Rudman chaired until very recently. This office maintains information on each judge’s particular CJE.

57. In addition to expert testimony, the case management officers (CMOs) have materials on the developmental stages of children, which they have passed on to judges somewhat randomly. For example, CMO Jordan gave me a very helpful “Developmental Table of Children’s Experience of Divorce,” which cites the following sources: James Bray, *Psychosocial Factors Affecting Custodial and Visitation Arrangements*, 9 BEH. SCI. & L. 419 (1991); WILLIAM F. HODGES, *INTERVENTIONS FOR CHILDREN OF DIVORCE: CUSTODY, ACCESS, AND PSYCHOTHERAPY* (John Wiley & Sons, Inc. 1986); JUDITH WALLERSTEIN & SANDRA BLAKESLEE, *SECOND CHANCES: MEN, WOMEN, AND CHILDREN A DECADE AFTER DIVORCE* (Tickner & Fields 1990); JUDITH WALLERSTEIN & JOAN BERLIN KELLY, *SURVIVING THE BREAKUP: HOW PARENTS AND CHILDREN COPE WITH DIVORCE* (Basic Books 1980). I do not know where the table itself came from. It includes reactions, common problems, prevention, and recommended custody/visitation arrangements for various age groups.

58. By contrast, some states have set up coordinating commissions for judicial education to address and coordinate judicial education on all issues, including issues of mental health. See, e.g., The Coordinating Commission for Judicial Department Education, *available at* <http://www.courts.mo.gov/osca/index.nsf/0689b8c101eb734c8625655007e179d/58c3056d6b8c693d86256e8c00750a25?OpenDocument> (last accessed Apr. 10, 2005). Other states have begun publishing newsletters for judges and have set up hotlines that judges can call for information about psychiatric disorders, the availability of local mental health services, and other topics. See, e.g., Liz Lipton, *Judges Educate Colleagues About Mental Illness*, 37(9) PSYCHIATRIC NEWS 8 (May 3, 2002) *available at* <http://pn.psychiatryonline.org/cgi/content/full/37/9/8> (referencing the efforts of the Law and Psychiatry Institute of the North Shore-Long Island Jewish Health System in New York State to provide these services to judicial officers financed in part by a grant from the New York legislature). [The author is particularly indebted to the Law Review staff, as previously noted, for this information, and for that in the following two notes.]

invisible to the litigants and off the record. Ongoing training and education for judges is critical if we are to avoid these dangers and succeed in this new judicial role, a role that enables and sometimes requires us to order individuals to attend counseling or alternative treatment programs.⁵⁹

Whatever the training, judicial education must still defer to any available expert evidence. The modest knowledge that might come from our limited education must always yield to qualified testimony.

IV. CONCLUSION: IMPROVING THE WORK PRODUCT

Our current caseload requires greater familiarity with definitions of mental disorders, the available modes of treatment, and the professionals who administer them. To effectively administer this caseload and the increasing demands placed on judges to order therapeutic measures for partners, parents, and criminal offenders, we need a common education. That education should include information about the following:

- mental disorders as medicine defines them and the law accounts for them;
- substance abuse and its interaction with mental health and legal issues;
- the developmental needs of children and their significance in the law;

59. In its discussion of “problem-solving courts,” a report published by the National Center for State Courts cites “ongoing training and education for judge and staff in domestic violence dynamics” as a key component of successful domestic violence courts; similarly, it cites “continuing interdisciplinary education” as critical to the success of drug courts. PAMELA M. CASEY & DAVID B. ROTTMAN, *PROBLEM-SOLVING COURTS: MODELS AND TRENDS 4-7* (National Center for State Courts, 2003). Although my discussion is not confined to Maine’s specialty or problem-solving courts, the importance of judicial education regarding broader, psychosocial concerns of defendants in any type of hearing or court proceeding remains.

The rise in judicial intervention in mental health areas has to some extent coincided with the emergence over the past decade of problem-solving courts and the concept of “therapeutic justice.” *See id.*; *see generally* *JUDGING IN A THERAPEUTIC KEY: THERAPEUTIC JURISPRUDENCE AND THE COURTS* (Bruce J. Winick & David B. Wexler eds., 2003); The Honorable Gerald W. Hardcastle, *Adversarialism and the Family Court: A Family Court Judge’s Perspective*, 9 U.C. DAVIS J. JUV. L. & POL’Y 57 (2005). Indeed, national institutions such as the Conference of Chief Justices and the Conference of State Court Administrators have embraced problem-solving courts as a promising way to resolve disputes involving “psychosocial problems as well as legal issues.” CASEY & ROTTMAN, *supra*, at 1. In fact, the Maine Judicial Branch is in the process of adding behavioral/mental health courts to its roster of specialized courts as a way of addressing the prevalence of mental health issues in criminal cases. CRIME & JUSTICE DATA BOOK, 2004 MAINE CRIMINAL JUSTICE COMMISSION & MAINE STATISTICAL ANALYSIS CENTER 3-6. The *Crime & Justice Data Book* is an annual publication of the Maine Criminal Justice Commission that compiles statistics and data for the stated purpose of keeping governmental entities abreast of trends and existing conditions in the criminal justice system. *Id.* *See also* ME. REV. STAT. ANN. tit. 5, § 3358(1) (West 1999) (establishing the Maine Criminal Justice Commission and charging it with the task of “monitor[ing] and evaluat[ing] the State’s criminal justice system on an ongoing basis and . . . provid[ing] recommendations regarding changes in that system to the appropriate state departments and the Legislature”). Given the national trend toward increasing the number of problem-solving courts, a trend replicated here in Maine, it is imperative that judges be properly, uniformly, and consistently educated, and that reliable studies be conducted on the efficacy of *all* court-ordered mental health treatment and other alternative treatment programs.

- issues of anger and domestic violence and their relationship to the law; and
- the efficacy of alternative treatment programs and mental health intervention.⁶⁰

This curriculum should also be summarized and made available to litigants, so that they can anticipate where judicial familiarity with a subject can be assumed (or perhaps needs to be contradicted).

Judges should also have some grasp of the role of the various professionals and experts mentioned in the statutes who work in the field: psychiatrists, who are medical doctors;⁶¹ psychologists and psychological examiners;⁶² substance abuse counselors, including alcohol and drug counseling aides, certified drug and alcohol counselors, and licensed alcohol and drug counselors;⁶³ social workers, including licensed clinical social workers, licensed master social workers, and licensed social workers;⁶⁴ and professional counselors, including licensed professional counselors and licensed clinical professional counselors.⁶⁵ Not all may qualify as "experts" all of the time under the statutes, and judges should be kept abreast of which specialists qualify as experts in which contexts.

This judicial education should be regularly updated, and a committee or task force should be charged with reviewing data on the effectiveness of various modes of treatment ordered by the courts.⁶⁶ Judges should be kept informed of what works and what does not. The ultimate objective of the training is to help us understand the evidence we receive and its legal significance. It should not be the evidence itself. We need to stay humble and know our limitations. Our field is law, not medicine or social work. We will do best when litigants bring the evidence in, without expecting us to supply it.

60. There does appear to be some movement in this direction. In its latest report, the Maine Criminal Justice Commission indicated its intention to keep track of the impact problem-solving courts are having on the administration of justice: "Problem-solving courts offer the Judiciary a new model to complement their overall system. Over time, this annual report intends to track and monitor the number of cases entering these courts, and the impact they are having on the overall system." *CRIME & JUSTICE DATA BOOK*, *supra* note 58, at 3-6. This is a laudatory goal, but data also needs to be gathered across the spectrum of cases—not just in the specialized, problem-solving courts—to determine the efficacy of mental health treatment in different contexts.

61. *WEBSTERS II NEW COLLEGE DICTIONARY* 893 (1999). For physician licensing, see *ME. REV. STAT. ANN.* tit. 32, § 3270, *et seq.* (West 1999).

62. *See ME. REV. STAT. ANN.* tit. 32, § 3811 (West 1999).

63. *See id.* § 6203.

64. *See id.* § 7001-A.

65. *See id.* § 13858.

66. *See supra* note 59 and accompanying text.