



Dangerous Minds

*Addressing violence and serious mental illness
from one judge's perspective.*

BY JUDGE TOM RICKHOFF AND ELLEN PATTERSON

HOW SHOULD THE LEGAL AND MEDICAL COMMUNITIES RESPOND TO VIOLENCE GENERATED BY MENTAL ILLNESS, AND WHAT RESOURCES ARE AVAILABLE TO PREVENT THIS VIOLENCE?

Bexar County Probate Court No. 2 Judge Tom Rickhoff suggests legislative reform to help identify those who are “manifestly dangerous mentally ill” (MDMI). The judge updated a paper written in 2006 with the rare focus on protecting the public, with current research by legal intern Ellen Patterson.

Consider one victim's perspective. She awaits a subway and leans to hear the roar of the approaching train. Suddenly an arm shoots through the crowd, pushing her onto the tracks. She is dismembered by its steel wheels. This is not a hypothetical.¹ The incidents where mentally disturbed individuals shoved innocent victims onto subway tracks increased twice as fast between 1986 and 1991 than between 1975 and 1985.² Violence, whether at the hand of the mentally ill or the intentioned criminal, is no less damaging to the victim or shocking to society. The act is even more tragic when one considers the actor probably had access to, and most likely was, noncompliant with treatment. Family and friends too often wait in horror as their ill loved one deteriorates, often because they cannot overcome the onerous substantive and procedural obstacles for obtaining legal intervention. Many justifiably conclude, based on ignorance or personal experience, that the civil commitment process is ineffective.

Take for example the case of Pauline Wilkerson, who took her schizophrenic son to the woods, ostensibly for a hike, but then helped shoot and kill him. Why? She

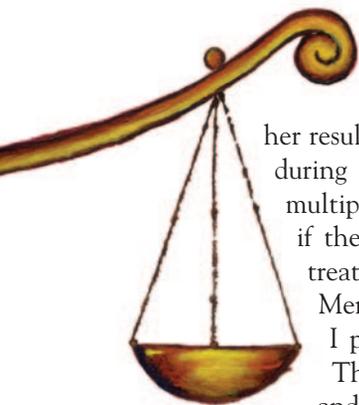
feared that he would kill her daughter and granddaughter.³ Despite her repeated attempts, her son was refused treatment. Wilkerson served

her resulting sentence, but her daughter died during the 20-year prison sentence. These multiple tragedies might have been avoided if the ill person had received immediate treatment under a Manifestly Dangerous Mentally Ill (MDMI) designation, which I propose herein for the most violent.

This could help to separate the violent and nonviolent and thus reduce the stigma for all.

Contrast these tragedies to the hopeful atmosphere pervading an informal meeting room at the Involuntary Outpatient Commitment Clinic (IOPC) in Bexar County, Texas. Patients receive court-ordered post-hospitalization services. Their issues usually involve medication or treatment. A presiding civil judge who is an expert in available treatments and knows each patient well, in collaboration with a team of professionals, designs a plan for each patient, including a weekly clinic appearance.⁴ The team—a psychiatrist, the judge, the court-appointed attorney, and the case managers—warmly greets each individual and then discusses with the patient concerns such as Medicaid and other health insurance, medications, living situations, feelings, goals, and frustrations. The patient receives appreciation for accomplishments, advice from the judge, and further interventions if necessary. Alternatively, the judge strongly admonishes the noncompliant and stands ready to order hospitalization as needed. The patient thus receives a consistent benefit from the same judge and team. Though a fledgling addition, the Bexar County IOPC has already improved hundreds of lives, arguably curbing potential violence and distress through a system of accountability and responsibility. Expanding the IOPC concept to other jurisdictions coupled with adopting an MDMI construct will save lives.⁵

While positive and effective programs such as the IOPC exist, there is still a compelling need to study and address violence in the mentally ill. First, evidence shows that the most preventable violence is committed by the mentally ill and is almost always due to refused medication.⁶ Research has shown that those suffering from schizophrenia who neglect licit medication and instead turn to self-medication with illicit drugs such as cocaine naturally have a pattern of arrests for violence significantly higher than non-cocaine users.⁷ While offenses may vary, every time a bizarre crime or mass shooting appears in the



newspaper with the line, “the motivation is unknown,” many readers translate it as, “the act was irrational, committed by a sick person.” The resulting stigma for the nonviolent is problematic.

Mass shootings now dominate the media. These shootings are not merely the result of hallucination, nor impulsive, but they require planning, preparation, and execution. The perpetrators know that they and many others, who are strangers, will be killed or wounded. Because the perpetrators frequently exhibit a lack of remorse, they often suffer from both a serious mental illness and a personality disorder. To further illustrate the increase and seriousness of the MDMI, a study of 30 rampage murders in the United States and Canada (which took place between 1949 and 1998) reported that two-thirds involved mentally ill perpetrators, the majority of

tals, and the criminal and civil mental health courts continue to advance, many people fear them. These fears should be allayed with sound information made widely available, as well as extended treatment by a careful application of the MDMI construct.

Third, barriers inherent within the mental health system exist. For example, whether for fear of lawsuits or avoidance of cumbersome legal prerequisites, some psychiatrists hesitate to utilize effective measures, such as injectable medication, and inpatient or outpatient commitments. The urgency inherent in an MDMI designation would help alleviate these concerns and facilitate immediate treatment.

Fourth, psychotropic medications have serious side effects so must carefully be balanced and monitored by the court’s team to prevent patients from unilaterally dis-

Public information about mental illness must be freed from inaccuracies. For example, rather than comparing mental illness to other diseases such as diabetes or cancer, spokespersons need to emphasize that these diseases are similar in that no one wishes for them, nor are they the patients’ fault, but they must add that diseases of the brain may cause different complications in the sufferer, often resulting in misperceptions of reality, hallucinations, and sometimes harm to self or others, requiring monitoring and treatment.

cases occurring from 1985 onward.⁸ Aiming our efforts at preventative mental health measures is a more effective solution than engaging in endless gun control debate, because Texas will never disarm. We need immediate action directed at the perpetrators. Until we embrace reform, this article will become ever more relevant.

Second, historians know that violence committed by the mentally ill impacts the course of history. Consider the assassination attacks against the Roman Emperor Hadrian; Presidents Garfield, McKinley, and Reagan; Chicago Mayor Anton Cermak; Pope John Paul II; and John Lennon. Each involved a mentally ill perpetrator, who likely exhibited the same warning signs seen today. These symptoms are timeless and occurring worldwide. When a person is in need of treatment, family members and the community must be empowered to help, and our society must furnish additional resources to ensure safety for all. Resources such as the IOPC merit strengthening both financially and through enhanced public awareness. But while it is true that treatments, medications, hospi-

continuing their medications and doctor visits.

Fifth, legislators and psychiatrists who are subject to intense agenda-group pressure avoid public comment, debating behind the scenes. Their own agenda on mental health remains largely obscured.⁹ The views and interests are so charged with emotion that, but for the occasional unsung hero, there exists no principal advocate or leader in any venue. Special advocate groups comprised of the parents of mentally ill individuals and the end stakeholders in the status quo can monopolize debate by focusing on their families’ welfare, not public safety. Public safety advocates, on the other hand, often focus only on sanctions and incarceration. These problems, and society’s aversion to mental illness issues, have inhibited change. I am proposing legislative reforms that are necessary, compassionate, and safe. This decade of tragedy underscores the need for greater public awareness and action.

In the ’60s this country hospitalized 600,000 mentally ill patients but now provides beds to fewer than 40,000.¹⁰ With this discharge rate more than 90 percent, often

without an enforceable treatment plan, who should be surprised by today's tragic headlines? Effectively, there exists a revolving-door system now run by psychiatrists, created by the Legislature, and maintained by ministerial judges.¹¹ One dangerously mentally ill person can easily cost millions of dollars cycling through a lifetime of commitments. If we dedicated with similar fervor the same amount of resources that we currently use to fight terrorism, we would be well on our way to better helping the mentally ill and making this country far safer. For example, while body scans and removal of shoes by millions may be necessary to deter one terrorist, similar monies could be effectively spent on awareness campaigns, treatments, and programs for mental illness, aimed at the MDMI, the prime resource users.

We can certainly agree that in every group, there exist individuals who monopolize our care, resources, and attention because of an identified propensity for violence. This is no less true for the mentally ill, and thus we should consider identifying and distinguishing them from those 80 percent or greater who are nonviolent. We need the public to know the MDMI term beyond its present limited use within state hospital systems. A bright line rule might not be the easiest of solutions; however, doctors and judges must identify telltale signs of serious and imminent harm to self or others. The single most important predictor of violent behavior is a history of violent behavior.¹² We must begin a discussion and create a workable matrix that identifies the violently mentally ill. If doctors are required to complete a risk analysis, on the record for the court, behaviors cannot be ignored. For example, social media posts levying threats against the public are one warning sign—and should be taken seriously. Another key indicator is a history of acting upon delusions, threats, and refusing medication. Grave decompensation coupled with command hallucinations to kill and records of escalating violent acts naturally are the predictors of violence. Once a person is identified as MDMI, then cooperative, closed-loop information sharing by the courts, police, and doctors would help each system better deal with problems when they arise.¹³

Public information about mental illness must be freed from inaccuracies. For example, rather than comparing mental illness to other diseases such as diabetes or cancer, spokespersons need to emphasize that these diseases are similar in that no one wishes for them, nor are they the patients' fault, but they must add that diseases of the brain may cause different complications in the sufferer, often resulting in misperceptions of reality, hallucinations, and sometimes harm to self or others, requiring monitoring and treatment. Also, the National Alliance on Mental Illness (NAMI) features an instructive state-

ment: "treating individuals with major psychiatric disorders markedly reduces episodes of violent behavior."¹⁴ The types of treatment mentioned by NAMI include IOPC, conservatorships, and conditional release.¹⁵ I would add that inpatient hospitalizations and compelled medications, when appropriate, are also integral to recovery.

Advocacy groups are fond of mentioning that the overall likelihood of violence in individuals with mental illnesses is low. However, one Finnish study in 1996 reported that having schizophrenia increased the likelihood of homicidal recidivism in individuals more than 25 times the average for the normal population.¹⁶ Advocacy groups will also note that "the amount of violence committed by people with schizophrenia is small, and only 1 percent of the U.S. population has schizophrenia ... By comparison 2 percent of the U.S. general population without psychiatric disorders engages in any violent behavior in any one year period."¹⁷ Rather than focus on defending all individuals with mental illnesses, these statistics bear out the very premise of my proposal, that the MDMI are in fact an identifiable group.

Indeed, I support advocacy for the mentally ill, until it infringes on the public's corresponding right to safety. The two are not mutually exclusive. I think we can all agree that freedom without treatment translates to freedom to be miserably ill, often homeless, and a danger to all. For example, those dangerously ill with anosognosia¹⁸ often cannot function without intense inpatient treatment, enforced medication, and extended commitments. Naturally, if psychiatrists are empowered to direct injectable medications, this power must be balanced by the patient's needs, family input, medical peer review, and finally, discretionary judicial oversight.

Mentally ill individuals are also statistically at a vastly higher risk as victims of a crime, suicide, and homelessness, all contributing to the stigma.¹⁹ Alcohol and drug abuse is a common form of self-medication to many who suffer from mental illness, and compounds the problem.²⁰

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The behaviors of these unfortunate and neglected individuals are a partial result of their release from full-time care since the '60s, society's slowness to embrace these widespread effective reforms,²¹ and our current "no plan" releases. As a result of these failures and the existing stigma, many patients with diagnosable disorders are unlikely to independently seek help.

The basic mental health laws in this country have not undergone dramatic change since the '60s. Attempts at legislative reform have brought mixed results.²² We must reform the judge-created gatekeeper rule for involuntary commitment that requires one to be a very serious danger to self or others, and which for evidence is entirely reliant on the subjective judgment of psychiatrists. If a team can grasp an individual's violence risk potential and identify the MDMI earlier, effective treatment will result. Allowing the mentally ill to choose the timing and duration of treatment when they are incapable of doing so is inhumane. Legislation I have drafted and proposed in cooperation with former state Sen. Jeff Wentworth, now a judge, includes requirements to:

1. Fingerprint every patient committed who has been identified as MDMI. Closed-loop identification could better prepare emergency rooms or first responders in serving these individuals. The police now have hand-held fingerprint identifiers with instant results.
2. Establish DNA mouth swabbing for the MDMI, with restricted access to this information.²³ Ironically, such an approach may defend against a false accusation.
3. As in California, require all psychiatrists to report patients who make credible threats to kill.²⁴ Doctors should ask those patients who, what, where, when, and why and then report this information to the appropriate local law enforcement.
4. No one identified as MDMI should be allowed to own weapons. Stringent screening processes should have access to the MDMI database. Before the present system was implemented,²⁵ the mentally ill could walk out of the hospital after discharge to a gun shop, lie on all of the forms (because mental health history could not then be verified), and wait the required time for their gun and ammo.²⁶ Our system should also enable immediate state action for families of the mentally ill who cannot effectively disarm them. Additionally, law enforcement should be well aware of an individual's MDMI status upon their arrival.
5. All persons involuntarily committed will need a Social Security payee until they stabilize.
6. The MDMI who suffer from homicidal command hallucinations must be identified on a national level. In addition, after initial screening, if diag-

nosed as MDMI, their inpatient treatment must be long and intense. If released as outpatients, current technology should be used to monitor their whereabouts. Similar precautionary, intense follow-up programs as are used with chronic pedophiles released from prison could be used.

7. Juveniles diagnosed with mental illness identified as MDMI deserve a plan and must be monitored longer. In Texas in 2010, youth completing the Texas Youth Commission's Mental Health Treatment Program demonstrated a reduction in risk by 38 percent for rearrest for a felony or misdemeanor and a reduction by 89 percent for re-incarceration when compared to those who did not.²⁷ Adults deserve a similar program, with emphasis on intense supervision for medication compliance.
8. Mentally ill patients in major cities who are frequently hospitalized, jailed, or detoxed need to be identified and then institutionalized and given free medication upon their release. Studies show that this system could save communities millions.²⁸ The present "least restrictive setting" must give way to more controlled monitoring and enforced medication.²⁹ For example, one violent patient in San Antonio, Texas, still in her 20s, was committed 81 times involuntarily. She generated endless hand-wringing meetings amongst naive professionals. What rational system would release her?
9. Finally, we need specialized criminal mental health courts for sufferers committing crimes. These courts currently exist in 43 states.³⁰ The approximately 300 mental health courts in the United States divert qualifying offenders from the mainstream criminal justice system.³¹ These courts must have a role in labeling the MDMI within constitutional limits.

Sadly, in jurisdictions without mental health courts or reasonable commitment processes, many acute-care, violent patients are allowed to depart from hospital confinement after two weeks of treatment with a handful of medications, which they could disregard, and seek a shelter or bridge underpass or land in jail.³² But the cost of care of the incarcerated mentally ill eclipses the cost of maintaining the general prison population without serious mental illnesses or co-occurring disorders. It has been estimated that mentally ill inmates cost \$130 a day to incarcerate rather than \$80,³³ or about \$400 to \$500 per day in a state psychiatric facility.³⁴ Costs can easily top \$2.5 million for a lifetime of care.³⁵

In 1968, while I was working for legal aid, a client called while he was traveling to the LBJ ranch and said, "I need to kill Lyndon Johnson because he raped my daughter." I had him removed by the civil mental health

unit and reported to Secret Service. He called the next day and said, “Do you know where I am? I am in a mental institution.” Decades later, I found myself calling the same mental health docket he cycled through. One day, two convicted pedophiles appeared for release. One was walking a child off school grounds when stopped and the other was at a school performing a dangerous act. Neither knew the children. I could not sleep if I signed their releases. But the doctors concluded that they were no longer a danger once medicated, so they were released without my order. I resigned that duty and now advocate for this legislation. Mental illness and violence will continue its costly toll worldwide; however, embracing effective reforms will help eliminate the suffering and costs and address the needs of each individual. **TBJ**

NOTES

1. During the writing of this paper, another commuter-train pushing death occurred in Los Angeles, California, perpetrated by a person long known to be mentally ill who reportedly was not taking her medication.
2. E. Fuller Torrey, *The Sanity Offense* 167. (W.W. Norton & Company, Inc., 2012).
3. *Id.* at 22.
4. My colleague Judge Spencer wisely appointed Oscar Kazen as a civil associate judge, as the statute places mental health administration solely with her.
5. Bexar County also has several county-city funded programs that provide treatment and ongoing services for individuals suffering from mental illness and/or substance abuse issues that are in crisis. The Restoration Center Addiction Services has saved the county approximately \$50 million over five years, and the count of homeless people living downtown has been reduced by 60 percent. Leon Evans, President and C.E.O., Center for Health Care Services, Address to NAMI National Conference, San Antonio, Tex. (June 28, 2013).
6. See Torrey, *supra* note 2, at 118-120, reporting that in one study, 21 out of 65 patients released from an Ohio state psychiatric hospital were arrested within six months of release; psychotropic medication had been prescribed upon their discharge, but the residents failed to take their medication. Another study of almost 2,000 individuals with schizophrenia demonstrated that those who were nonadherent with medications were twice as likely to commit violent acts and also twice as likely to be arrested, rehospitalized, or victimized by criminal acts.
7. See, e.g., Helen Dermatis, Ph.D., et al, Schizophrenic Patients and Cocaine Use: Antecedents to Hospitalization and Course of Treatment, *Substance Abuse*, Vol. 19, No. 4, 169 (1998), available at <http://link.springer.com/article/10.1023%2FA%3A1021477312621#page-1>.
8. See Torrey, *supra* note 2, at 147.
9. Both the legal field and psychiatry attempt to predict behavior, and they are subjective, inexact disciplines. As an example, it was not until 1973 that psychiatrists voted to remove homosexuality as a psychiatric disorder in the DSM rubric.
10. See *Diseases of the Mind: Highlights of American Psychiatry Through 1900*, U.S. National Library of Medicine, National Institutes of Health, available at <http://www.nlm.nih.gov/hmd/diseases/early.html>; see also Sue Abderholden, *Changes in Mental Health System*, Council on Crime and Justice, available at <http://www.crimeandjustice.org/councilinfo.cfm?PID=55>.
11. See Torrey, *supra* note 2, at 222.
12. *Id.* at 157.
13. Every policeman’s car computer should alert when law enforcement is sent to an incident by a known perpetrator.
14. See *New Study Confirms Treatment Reduces Violence in Individuals with Major Psychiatric Disorders by Half*, NAMI website, (May 14, 1998), available at http://www.nami.org/Content/ContentGroups/Press_Room1/1998/May_1998/New_Study_Confirms_Treatment_Reduces_Violence_in_Individuals_with_Major_Psychiatric_Disorders_by_Hal.htm.
15. See Ken Duckworth, M.D., *The Virginia Tech Tragedy: Distinguishing Mental Illness from Violence*, NAMI website, (April 18, 2007), available at http://www.nami.org/Content/ContentGroups/Press_Room1/2007/April6/The_Virginia_Tech_Tragedy_Distinguishing_Mental_Illness_from_Violence.htm.
16. Torrey, *supra* note 2, at 157.
17. See Duckworth, *supra* note 15.
18. Defined as a lack of awareness of one’s mental illness.
19. See Torrey, *supra* note 2, at 164.
20. See, e.g., Dermatis *supra* note 7, at 169.
21. See, e.g., Duckworth, *supra* note 15.
22. See, e.g., Kristen Beronia, et al, U.S. Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans, Department of Health and Human Services website, available at http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm#content; see also California’s Lanterman-Petris-Short Act, Cal. Welf & Inst. Code, sec. 5000 et seq., July 1, 1972.
23. Indeed, the U.S. Supreme Court on June 3, 2013, upheld the police practice of taking DNA samples from people who have been arrested but not convicted of a crime, ruling that it amounts to the 21st century version of fingerprinting.
24. See *Mental Health Professionals’ Duty to Protect/Warn*, National Conference of State Legislatures website, (January 2013), available at <http://www.ncsl.org/issues-research/health/mental-health-professionals-duty-to-warn.aspx>; see also *Tarasoff v. The Regents of the Univ. of Cal.*, 551 P.2d 334 (Cal. 1976).
25. See 18 U.S.C. § 922(d), relating to restrictions on previously committed persons to access to firearms.
26. But see Tex. Gov’t Code §411.172, relating to restrictions in Texas on concealed weapons carried by previously committed persons.
27. Texas Youth Commission, 2010 Annual Review of Agency, Treatment Effectiveness, (Dec. 2010), available at http://www.tjcd.texas.gov/about/Annual_Treatment_Effectiveness_Review2010.pdf.
28. See, e.g., Allen J. Frances, M.D., *Prison or Treatment for the Mentally Ill*, *Psychology Today* (March 2013), available at <http://www.psychologytoday.com/blog/saving-normal/201303/prison-or-treatment-the-mentally-ill>; see also Kirk Mitchell, *Drug aid program benefits mentally ill prisoners*, *Denverpost.com* (2009) available at http://www.denverpost.com/breakingnews/ci_13284304?source=rss.
29. I am suggesting a more controlled, family atmosphere for psychiatric institutions, with modern treatments.
30. E. Lea Johnston, *Theorizing Mental Health Courts*, 89 Wash. U.L. Rev. 519 (2012).
31. *Id.* at 519, 521.
32. The number of jail admissions involving people with SMIs (serious mental illnesses) has been estimated to be around 804,000 annually, and these individuals tend to stay incarcerated longer than “others charged with similar crimes.” See Dale E. McNeil, Ph.D. & Renee L. Binder, M.D., *Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence*, 164 Am. J. Psychiatry 1395 (2007). The most common SMIs in the prison population include schizophrenia, bipolar disorder, and major depression, and these illnesses are classified by the American Psychiatric Association in a DSM-IV-TR rubric. See also *Psychiatric Disorders; Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV), All Psyche Online, <http://allpsych.com/disorders/dsm.html>.
33. C.M. Miller & A. Fantz, *Special “psych” jails planned*, *Miami Herald* (Nov. 2007) available at http://consensusproject.org/media/special_psych_jails_planned_1. The article cites that some reasons for the higher cost include increased activity in the courts, increased need for evaluations by social workers and physicians, and costs of medications administered. In regard to recidivism, a 2010 study of the Los Angeles County Jail showed that 90 percent of mentally ill inmates are repeat offenders, with 31 percent having been incarcerated 10 or more times. See also E.F. Torrey, et al., *More Mentally Ill Persons are in Jail and Prisons than Hospitals: A Survey of the States*, Treatment Advocacy Center and National Sheriffs Association (2010).
34. See Torrey, *supra* note 2, at 90.
35. Figures based on best estimate as stated in e-mail exchange by Associate Judge Lin Morrisett, Tarrant County, Tex., and using per diem state hospital figures of the San Antonio State Hospital (June 5, 2013).



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