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MENTAL ILLNESS AND THE SECOND AMENDMENT

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ABSTRACT: Until surprisingly recent times, American laws seldom attempted to regulate the possession of firearms by the mentally ill. Since then, a series of highly publicized mass murders by persons who were, before the crime, identifiably mentally ill have focused attention on the question of how a free society should handle the conflict between the Second Amendment's "right of the people" and the needs of public safety. This paper examines why regulation suddenly became necessary, the conflicts between civil liberties and public safety, and suggests some strategies to deal with these conflicts.

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I. Mental Illness & Murder

It should not be surprising that severe mental illness and murder are strongly correlated, as are severe mental illness and other violent crimes. Multiple studies of those arrested in multiple countries have found that the severely mentally ill commit about 10% of all violent felonies.¹ A 1999 study of U.S. prisoners found that 16.2 percent of state prison inmates, 7.4 percent of federal prison inmates, and 16.3 percent of jail inmates, were mentally ill.² A study of Indiana murder convicts found that 18 percent were severely mentally ill, suffering from “schizophrenia or other psychotic disorder, major depression, mania, or bipolar disorder.”³ The Indiana murder convicts diagnosed with schizophrenia were 3.7 percent of the murder convicts,⁴ compared to 1.1 percent of the

¹ Arthur Zitrin, Anne S. Hardesty, Eugene I. Burdock & Ann K. Drossman, *Crime and Violence Among Mental Patients*, 133 AM. J. PSYCHIATRY 142-9 (1976) (deinstitutionalized New York City mental patients had disproportionate arrest rates for rape, burglary, and aggravated assault); Larry Sosowsky, *Crime and Violence Among Mental Patients Reconsidered in View of the New Legal Relationship Between the State and the Mentally Ill*, 135 AM. J. PSYCHIATRY 33-42 (1978) (San Mateo County, California, mental patients showed grossly disproportionate arrest rates for murder, rape, robbery, aggravated assault, and burglary; 55 times more likely to be arrested for murder than the general population in 1973; 82.5 times more likely to be arrested to be arrested for murder in 1972; nine times more likely to be arrested for rape, robbery, aggravated assault, and burglary than the general population); Larry Sosowsky, *Explaining the Increased Arrest Rate Among Mental Patients: A Cautionary Note*, 137 AM. J. PSYCHIATRY 1602-5 (1980) (even mental patients with no pre-hospitalization arrests were five times as likely to be arrested as the general population for violent crimes); H. Richard Lamb & Linda E. Weinberger, *Persons with Severe Mental Illness in Jails and Prisons: A Review*, 49 PSYCHIATRIC SERVICES 483-92 (1998); Jeanne Y. Choe, Linda A. Teplin & Karen M. Abram, *Perpetration of Violence, Violent Victimization, and Severe Mental Illness: Balancing Public Health Concerns*, 59 PSYCHIATRIC SERVICES 153-164 (Feb. 2008) (Studies in Denmark and Sweden found that psychotics are disproportionately violent offenders); Eric B. Elbogen & Sally C. Johnson, *The Intricate Link Between Violence and Mental Disorder: Results From the National Epidemiologic Survey on Alcohol and Related Conditions*, 66 ARCHIVES OF GENERAL PSYCHIATRY 152-161 (2009) (“violence and violent victimization are more common among persons with severe mental illness than in the general population.”)

² Paula M. Ditton, Bureau of Justice Statistics, *MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS* (Washington: U.S. Department of Justice, 1999), NCJ 174463.

³ Jason C. Matejkowski, Sara W. Cullen & Phyllis L. Solomon, *Characteristics of Persons with Severe Mental Illness Who Have Been Incarcerated for Murder*, 36 J. AM. ACAD. PSYCHIATRY & LAW 74, 76 (2008).

⁴ *Id.* at 80.

U.S. adult population.⁵

Studies based on arrests or prison populations are likely to suffer from sampling bias problems, as those who are mentally ill might be arrested by police based on assumptions of criminal tendencies. Other studies have compared violence of populations in the larger society, breaking down a sample of 10,059 people by diagnosis and self-reported violent behavior.⁶ The following table shows the total relative violence levels for males and females:⁷

group	total n	total n violent	total % violent	relative to no disorder
no disorder	7871	148	1.88%	1.00
anxiety disorders	1444	74	5.13%	2.73
major affective disorder or schizophrenia	408	43	10.47%	5.56
alcohol or drug disorder	741	157	21.21%	11.27

The comparison of the severely mentally ill (the “major affective disorder or schizophrenia” group) to those suffering from alcohol or drug disorders is of interest. Those with alcohol or drug disorders are even more likely to be violent, and unsurprisingly, federal law prohibits firearm or ammunition sale to “an unlawful user of or addicted to any controlled substance”⁸ or for such a person to “possess in or affecting commerce, any firearm or ammunition.”⁹

⁵ National Institute of Mental Health, SCHIZOPHRENIA (August 21, 2013), <http://www.nimh.nih.gov/statistics/1schiz.shtml>.

⁶ Jeffrey W. Swanson, Charles E. Holzer, Vijay K. Ganju, and Robert Tsutomu Jono, *Violence and Psychiatric Disorder in the Community: Evidence From Epidemiologic Catchment Area Surveys 20-23*, in *Violent Behavior & Mental Illness: A Compendium of Articles From Psychiatric Services and Hospital and Community Psychiatry* (Carl C. Bell, intro., 1997).

⁷ Derived from table 3 *Id.* at 25.

⁸ 18 USC 922(d)(3).

⁹ 18 USC 922(g)(3). Contrary to the popular perception that marijuana makes users mellow, while alcohol makes users violent, there was very little difference between violence percentages for “Cannabis abuse or dependence” (19.25 percent) and “Alcohol abuse or dependence” (24.57 percent), although both were much less than “Other drug abuse or dependence” (34.74 percent). Swanson, *op. cit.* Table 2 at 24.

While the 5.56 times ratio relative to those with “no disorder” is less than the ratios derived from arrest records, this may be an artifact of the difficulties in getting the most severely mentally ill to sit down for an research interview. Reviews of other studies suggest that the severely mentally ill are disproportionately violent.¹⁰

Some studies suggest that those suffering from mental illness in isolation may not be especially violent, but that the combination of mental illness and substance abuse is the greatest risk.¹¹ Even those who have published studies that concluded that the mentally ill are not disproportionately violent, when controlling for substance abuse, acknowledge that, “Mental disorder has a significant effect on violence by increasing people’s susceptibility to substance abuse. When first discharged, patients were twice as likely as their neighbors to be abusing substances, and alcohol and drugs raised the risk of violence for patients abusing them even more than for others.”¹² Unfortunately, it is easier to control for substance abuse in a statistical analysis package than it is in the real world. Severe mental illness *alone* may not cause violence, but still be a convenient proxy for identifying those who are at greatest risk because of comorbidity with substance abuse.

Other methods of examining the relationship between mental illness and murder demonstrate that there is a statistically significant correlation that strongly suggests a

¹⁰ Frederick E. Vars and Amanda E. Adcock, *Do the Mentally Ill Have a Right to Bear Arms?* 48:1 WAKE FOREST L.R. 14-16 (collecting studies of mental illness and violence rates).

¹¹ Eric B. Elbogen and Sally C. Johnson, *The Intricate Link Between Violence and Mental Disorder: Results From the National Epidemiologic Survey on Alcohol and Related Conditions*, 66:2 ARCHIVES OF GENERAL PSYCHIATRY 152-161 (2009).

¹² John Monahan, Henry J. Steadman, & the MacArthur Study Group, *The MacArthur Violence Risk Assessment Study Revisited: Two Views Ten Years After Its Initial Publication*, 59 PSYCH. SERVS. 147, 149 (2008).

causal relationship.¹³ Bernard E. Harcourt's examination of total institutionalization rate (prison plus mental hospital population) and murder rates from 1928 to 2000 on a national basis found an astonishingly strong negative correlation between the total institutionalization rate, and the murder rate: -0.78. As the total institutionalization rate rose, murder rates fell, and vice versa, and with a correlation so strong that any social scientist would call this an extraordinarily strong signal that there is likely a connection. Harcourt found that even when adjusting for changes in unemployment and the changing fraction of the population that was at their peak violent crime ages, the negative correlation remained strong, and did a better job of predicting both the 1960s rise and the 1990s decline in murder rates than the other models traditionally used by criminologists.¹⁴ When Harcourt used state level data for institutionalization and murder rates, and controlled for even more variables, the statistically significant negative correlation remained for forty-four states. A few states (such as Florida) showed no significant correlation between institutionalization rates and murder rates.¹⁵

Another study came to similar conclusions about the relationship between murder rates and mental illness. Steven P. Segal of UC Berkeley studied state-to-state variations in murder rates and mental health care, controlling for socioeconomic, demographic, and geographic data. He concluded that “[l]ess access to psychiatric inpatient-beds and more

¹³ The 95 percent confidence interval is commonly used as a first test of whether a relationship between variables might indicate a causal connection. Nicholas J. Johnson, David B. Kopel, George A. Mocsary & Michael P. O’Shea, FIREARMS LAW AND THE SECOND AMENDMENT: REGULATION, RIGHTS, AND POLICY ch. 13.B (Online Chapter 13 forthcoming 2013) points out that a bivariate correlation analysis might be outside the 95 percent confidence interval and yet there can still be a causal relationship.

¹⁴ Bernard E. Harcourt, *From the Asylum to the Prison: Rethinking the Incarceration Revolution*, 84 TEXAS L.R. 1766-75 (2006).

¹⁵ Bernard E. Harcourt, *From the Asylum to the Prison: Rethinking the Incarceration Revolution - Part II: State Level Analysis*, (March 2007). University of Chicago Law & Economics, Olin Working Paper No. 335; University of Chicago, Public Law Working Paper No. 155. Available at SSRN: <http://ssrn.com/abstract=970341>.

poorly rated mental health systems were associated with increases in the homicide rates of 1.08 and 0.26 per 100,000, respectively.” (Since the national average homicide rate was 5.18 per 100,000 people for 2010,¹⁶ more access to beds is clearly quite important in reducing homicide rates; “poorly rated mental health systems” matter, but not very dramatically.) An even greater difference was the variation in involuntary civil commitment (ICC) laws. “Broader ICC-criteria were associated with 1.42 less homicides per 100,000” or bit more than ¼ of the national homicide rate. In short, states where involuntary commitment of the mentally ill was relatively easy had significantly fewer murders than states where it was very hard.¹⁷

None of these studies should be surprising, especially the overrepresentation of schizophrenics among murderers, as schizophrenia’s symptoms include hallucinations and delusions. Some of the more colorful examples of schizophrenics who have committed murder include Vince Li, who beheaded and cannibalized a fellow bus passenger in Manitoba in 2008 because he believed that he was “the second coming of Jesus” and his mission was to save the Earth from extraterrestrial invasion.¹⁸

Similarly, Russell Eugene Weston, Jr., after shooting two U.S. Capitol police officers to death in 1999, explained his actions to a court-appointed psychiatrist as an attempt to

¹⁶ Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2010 on CDC WONDER Online Database, released 2012. Data are from the Multiple Cause of Death Files, 1999-2010, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on Sep 15, 2013 11:55:43 PM, ICD-10 Codes X85-Y09 (Assault).

¹⁷ Steven P. Segal, *Civil Commitment Law, Mental Health Services, and US Homicide Rates*, SOCIAL PSYCHIATRY AND PSYCHIATRIC EPIDEMIOLOGY, November 10, 2011 (September 1, 2013), <http://kendas-law.org/national-studies/commitmenthomiciderates.pdf>.

¹⁸ *Greyhound Killer Believed Man He Beheaded Was An Alien*, CBC News, May 22, 2012 (August 21, 2013), <http://www.cbc.ca/news/canada/manitoba/story/2012/05/22/mb-vince-li-schizophrenia-interview-manitoba.html>.

prevent the spread of a disease by cannibals, including the two police officers.¹⁹ Like many of the schizophrenics who become local, national, or even international headlines, Weston had a long history of mental illness well known to family, mental health workers, and police, but had not been hospitalized for any great length of time.²⁰

The NEW YORK TIMES studied 100 U.S. “rampage killers” in 2000. They found there was often plenty of advance warning related to mental illness:

Most of them left a road map of red flags, spending months plotting their attacks and accumulating weapons, talking openly of their plans for bloodshed. Many showed signs of serious mental health problems.

...

The Times’ study found that many of the rampage killers... suffered from severe psychosis, were known by people in their circles as being noticeably ill and needing help, and received insufficient or inconsistent treatment from a mental health system that seemed incapable of helping these especially intractable patients. . . .

Of the 100 murderers they studied, forty-seven “had a history of mental health problems” before committing murder, twenty had been previously hospitalized for mental illness, and forty-two had been previously seen by professionals for their mental illness.²¹

It is likely that many of the fifty-three who did not have “a history of mental health problems” were also mentally ill. (It is not particularly bizarre to assume that mass murder of complete strangers is a sign of mental illness, especially because such crimes often end in suicide or shooting by police or bystanders.) The lack of mental illness history for those fifty-three may be the result of an absence of evidence, not necessarily evidence of absence. It is entirely possible that some or even many of the fifty-three had mental illness problems that left no records because they had not come to the attention of

¹⁹ Bill Miller, *Capitol Shooter’s Mind-Set Detailed*, WASH. POST, Apr. 23, 1999.

²⁰ See Clayton Cramer, *Madness, Deinstitutionalization & Murder*, 13:1 ENGAGE (Mar. 2012) for a detailed list of such murders.

²¹ Laurie Goodstein & William Glaberson, *The Well-Marked Roads to Homicidal Rage*, N.Y. TIMES, Apr. 10, 2000.

law enforcement or mental health professionals. While family and friends are often aware of serious mental illness problems earlier than professionals, mentally ill persons sometimes estrange themselves from family and friends, making it more difficult for a forensic evaluation to locate evidence of mental illness.

Since 2000, multiple mass murder incidents have anecdotally confirmed what the NEW YORK TIMES found: people that commit random acts of mass murder are usually suffering from severe mental illness. An employee of the Postal Service, Jennifer Sanmarco, was removed from her Goleta, California workplace in 2003 because she was acting strangely, and placed on psychological disability. She moved to Milan, New Mexico, where her neighbors described her as “crazy as a loon.” “A Milan businessman said he sometimes had to pick her up and bring her inside from the cold because she would kneel down and pray, as if in a trance, for hours.” She returned to the Goleta mail sorting facility in January 2006—and murdered five employees, before taking her own life.²²

In October of 2005, the family of David W. Logsdon of Kansas City, Missouri, contacted police over Logsdon’s deteriorating mental condition. (Logsdon had a history of mental illness and alcoholism.) The police took Logsdon to a mental hospital for treatment, concerned that he was suicidal. He was released six hours later with a voucher for a cab and a list of community mental health resources to contact. It is not clear that Logsdon was sufficiently well to follow through with those resources, although funding reductions for community mental health care by Missouri government may well have

²² Martin Kasindorf, *Woman Kills 5, Self at Postal Plant*, USA TODAY, Feb. 1, 2006; Jim Maniaci, “Crazy as a Loon,” GALLUP [N.M.] INDEP., Feb. 2, 2006.

rendered the question moot.²³ In April of 2007, Logsdon beat to death a neighbor, and stole her late husband's rifle. At a nearby shopping mall, he shot and killed two people at random, wounding four others.²⁴ The remarkable and fortunate early arrival of police, who shot Logsdon to death, prevented a larger massacre.²⁵

That same month, Seung-Hui Cho murdered thirty-two students and faculty before taking his own life. That something was not right was apparent to at least some of his professors, and he was briefly hospitalized after a stalking incident. The special judge who determined whether Seung-Hui should be involuntarily committed concluded that he was a danger to himself. The next day, Seung-Hui left the hospital, and soon he was back on campus, living in a world of paranoid schizophrenia. Because he was not *involuntarily* committed to a hospital, Seung-Hui's name did not appear on the FBI's firearms background check list, and he was able to legally purchase handguns that he used in the largest gun mass murder in U.S. history.²⁶

In April 2009, Jiverly Wong murdered thirteen people at a Binghamton, New York immigrant-assistance center. Letters by Wong to local news media demonstrated what "Dr. Vatsal Thakkar, assistant professor of psychiatry at NYU's Langone Medical Center" described as "major mental illness, quite possibly paranoid schizophrenia."²⁷

In January 2011, Jared Lee Loughner opened fire on a crowd at a town hall meeting of Rep. Gabrielle Giffords and her constituents, killing six and injuring thirteen.

²³ Maria Sudekum Fisher, *Mall Gunman Planned to "Cause Havoc,"* HOUSTON CHRON., May 1, 2007; Eric Adler, *Case Points up a Crisis in Care,* KAN. CITY STAR, May 1, 2007, at A1.

²⁴ Maria Sudekum Fisher, *Mall Shooter Used Dead Woman's Home While She Was Still Inside,* TOPEKA [KANS.] CAPITAL-JOURNAL, May 3, 2007.

²⁵ Maria Sudekum Fisher, *Mall Gunman Planned to "Cause Havoc,"* HOUSTON CHRON., May 1, 2007.

²⁶ *Close the Loophole Cho Sneaked Through,* HAMPTON ROADS VIRGINIAN-PILOT, Apr. 25, 2007; Dr. Michael Welner, *Cho Likely Schizophrenic, Evidence Suggests,* ABC News, Apr. 17, 2007.

²⁷ Austin Fenner, Kirsten Fleming & Dan Mangan, *"I Am Shooting—Have a Nice Day,"* N.Y. POST, Apr. 7, 2009.

Loughner had a history of police contacts involving death threats, and was expelled from college for bizarre actions that clearly established that he was mentally ill. In spite of his frightening behavior, he was never hospitalized, even for observation – until he made himself nationally famous.²⁸ A series of disturbing web postings and YouTube videos also confirmed that Loughner’s grasp on reality was severely impaired.²⁹ Court-ordered psychiatric evaluations concluded that Loughner was suffering from schizophrenia, and was incompetent to stand trial.³⁰ Eventually, he was well enough to stand trial, and pleaded guilty to avoid the death penalty.³¹

Certainly the most disturbing of these recent mass murders was in Newtown, Connecticut. Adam Lanza had some sort of psychiatric disorder, but his childhood diagnosis of Asperger’s Syndrome is not typically associated with mass murder.³² Some reports describe Lanza as suffering from sensory integration disorder (SID), where

²⁸ Tim Steller, *Man Linked to Giffords Shooting Rampage Called “Very Disturbed,”* ARIZ. DAILY STAR, Jan. 8, 2011 (Loughner had previously made death threats and been contacted by police); *College Asked ATF About Loughner Before Rampage*, CBS NEWS, May 20, 2011 (September 15, 2013) http://www.cbsnews.com/2100-201_162-20064455.html (behavior described by school administrators as “bizarre” and “intimidating”; laughing and ranting inappropriately; ordered by the college to get a mental health evaluation before returning to campus).

²⁹ David A. Farenthold and Clarence Williams, *Tucson Shooting Suspect Jared Loughner Appears To Have Posted Bizarre Messages*, WASH. POST, Jan. 9, 2011 (September 15, 2013) <http://www.washingtonpost.com/wp-dyn/content/article/2011/01/08/AR2011010803961.html> (Loughner left “a series of postings and homemade videos that laid out a fervent, though largely incoherent, set of political views.” One quote from Loughner: “I can’t trust the current government because of the ratifications: the government is implying mind control and brainwash on the people by controlling grammar.”) Some of Loughner videos are still available: INTRODUCTION: JARED LOUGHNER (<http://www.youtube.com/watch?v=nHozZaLbqB4>, Sep. 21, 2013).

³⁰ Craig Harris & Michael Kiefer, *Judge Finds Jared Loughner Incompetent to Stand Trial*, ARIZ. STAR, May 25, 2011.

³¹ Michael Martinez & Kyung Lah, *Loughner Pleads Guilty to 19 Counts in Tucson, Arizona, Mass Shooting*, CNN, August 8, 2012.

³² Daniel C. Murrie, Janet I. Warren, Marianne Kristiansson, and Park E. Dietz, *Asperger’s Syndrome in Forensic Settings*, 1 INT’L J. FORENSIC MED. 60-61 (2002) (reviews existing studies which argue whether Asperger’s patients are disproportionately violent, but points to one study that suggests such violence is not premeditated); Barbara G. Haskins and J. Arturo Silva, *Asperger’s Disorder and Criminal Behavior: Forensic-Psychiatric Considerations*, 34 J. AM. ACAD. PSY. & LAW 376-378 (2006) (the debate about disproportionate violence remained active, but again argues that violence by Asperger’s patients was the result of inability to read social cues and narrowly focused interests).

sensory inputs overwhelm the brain.³³ There is sizable overlap between the description of SID and the sensory problems that appear to be part of schizophrenia,³⁴ enough to wonder if Lanza was edging into schizophrenia, or if Lanza’s psychiatrist was reluctant to give this devastating diagnosis until he was certain. Early reports indicate that Lanza’s mother was attempting to have him hospitalized, and his discovery of this may have provoked the crime.³⁵ Connecticut’s statute for emergency commitment does not require *imminent* danger to self or others,³⁶ but the state’s regulation do: there is a state regulatory definition of “dangerous to himself or herself or others” which includes a word that we have seen before: “the risk of *imminent* physical injury to others or self.” This regulatory definition has been the basis for several recent Connecticut Supreme Court decisions concerning involuntary commitment. While most of these cases held that *imminent* physical injury was not a requirement for involuntary commitment, these cases involved persons found not guilty of manslaughter, arson, murder, kidnapping, and other serious felonies because of mental illness, and who were now seeking release from state mental hospitals. Attempts to find recent Connecticut decisions using this non-imminent

³³ Adam Clark Estes, *Revelations About Adam Lanza’s Mental Health Still Don’t Explain the Violence*, ATLANTIC WIRE, Feb. 19, 2013 (August 24, 2013), <http://www.theatlanticwire.com/national/2013/02/revelations-about-adam-lanzas-mental-health-still-dont-explain-violence/62317/>.

³⁴ Peter Falkai, Andrea Schmitt, and Tyrone D. Cannon, *Pathophysiology of Schizophrenia*, 42, in SCHIZOPHRENIA: CURRENT SCIENCE AND CLINICAL PRACTICE (Wolfgang Gaebel, ed., 2011) (discussing dysfunction “of the cortico-cerebellar-thalamic-cortical neuronal circuit” and its role in filtering sensory information); Anthony J. Rissling and Gregory A. Light, *Neurophysical Measures of Sensory Registration, Stimulus Discrimination, and Selection in Schizophrenia Patients* 284-6, in BEHAVIORAL NEUROBIOLOGY OF SCHIZOPHRENIA AND ITS TREATMENT (Neal R. Swerdlow, ed., 2010) (discussing the relationship between sensory input processing and schizophrenia).

³⁵ Jana Winter, *Fear Of Being Committed May Have Caused Connecticut Gunman To Snap*, FOX NEWS, December 18, 2012 (September 15, 2013), <http://www.foxnews.com/us/2012/12/18/fear-being-committed-may-have-caused-connecticut-madman-to-snap/> (An acquaintance of the family reported that Adam Lanza had found out about his mother’s “petitioning the court for conservatorship and (her) plans to have him committed” and that this set him off; “[a] senior law enforcement official involved in the investigation” confirmed that Lanza’s anger over these plans was being looked at “as a possible motive.”)

³⁶ Conn. § 17a-503 (2011).

definition of danger to self or others with respect to persons not yet charged with a serious crime have been unsuccessful.³⁷

As I write this paper, America is mourning another tragedy, at the Navy Yard in Washington, D.C., where Aaron Alexis murdered twelve people before dying in a gun battle with police on September 16, 2013. In the months before, Alexis had given increasingly clear signs of serious mental illness, including paranoia, sleep disorders, and “hearing voices in his head.”³⁸ After a disturbance in a Alexis “told police in Newport, R.I., that he heard voices speaking to him through the walls of his hotel room and felt a machine sending vibrations into his body....” The conversation with the police included telling them that “he had no history of mental illness in his family and had never had any type of psychological episode....”³⁹ This does not sound like the sort of information that you would volunteer to police; it seems more likely that the police heard this bizarre paranoid statement and started to probe a bit more deeply.

³⁷ State v. March, 265 Conn. 697, 709 (2003) (“Section 17a-581-2 (a) (6) of the Regulations of Connecticut State Agencies defines “[d]anger to self or to others,” as used in General Statutes § 17a-580 (5),... as ‘the risk of imminent physical injury to others or self...’” in a case involving a defendant acquitted of manslaughter because of mental illness but involuntarily committed); State v. Harris, 890 A.2d 559, 566 (Conn. 2006) (“[I]n order to meet the regulatory standard, the board would have to find an imminent risk that the acquittee would harm himself or others.... ‘Imminent’ is defined as ‘ready to take place; esp: hanging threateningly over one’s head. . . .’” Merriam-Webster’s Collegiate Dictionary (10th Ed.1993).” in a case involving a man acquitted of arson because of mental illness but involuntarily committed.); State v. Warren, 919 A.2d 465 (Conn.App. 2007) (“defines “[d]anger to self or to others,” as used in General Statutes § 17a-580(5), as ‘the risk of imminent physical injury to others or self,’” involving a defendant found not guilty of first degree murder because of mental illness.); State v. Dyou, 53 A.3d 153, 160 (Conn. 2012) (“the defendant remained mentally ill and ‘[would pose] an imminent and substantial risk of harm to himself or others if he [were] discharged from the [jurisdiction of the] board.’” The defendant had been found not guilty because of mental illness in a kidnapping case.)

³⁸ Matt Apuzzo and Adam Goldman, *Officials: Gunman Treated For Mental Health Issues*, Associated Press, Sep. 17, 2013 (describing how law enforcement described accounts from Veterans Administration sources of Alexis’ treatment); Erica Goode, Sarah Maslin Nir, and Manny Fernandez, *Signs of Distress Multiplied on Killer’s Path to Navy Yard*, N.Y. TIMES, Sep. 19, 2013 (describing a series of incidents showing increasing paranoia and hallucinations of Alexis).

³⁹ Travis Andersen, *Navy Yard Shooter Had Odd Episode in R.I.*, Boston Globe, September 17, 2013, <http://www.bostonglobe.com/metro/2013/09/17/navy-yard-shooter-reported-hearing-voices-newport-victim-with-mass-ties-mourned/E1PkNY5nHe3euHp3sQRd8O/story.html>, last accessed December 17, 2013.

A Rhode Island physician may arrange for involuntary commitment if a person “is in need of immediate care and treatment” and leaving him at large “would create an *imminent* likelihood of serious harm by reason of mental disability....”⁴⁰ Oddly, the only case law immediately relevant to this provision are suits alleging that mental health facilities, by having *failed* to involuntarily commit people with serious mental illness problems, caused harm to others. There seems to be no case law involving patients involuntarily committed without sufficient cause.⁴¹ It seems likely that this dearth of case law is because physicians in Rhode Island only use this involuntary commitment capacity for extraordinarily obvious cases.

These are only the most highly publicized of such mass murders by the severely mentally ill in the United States. A comprehensive list of such tragedies since 2000 would be dozens of pages long, and include even larger mass murders committed by schizophrenics in other countries, such as Norwegian Anders Behring Breivik, who murdered 77 people and wounded 242. Breivik was found legally sane at trial, although determined to be schizophrenic by court-appointed psychiatrists.⁴²

Relative to the overall murder rate in the U.S., murders committed by the mentally ill are a small fraction, and these public mass murders that get so much media attention are a very tiny fraction indeed. Incidents “in which four or more people were killed at random by a gunman killing indiscriminately” were “less than a tenth of 1 percent” of all murders

⁴⁰ Rhode Island Code § 40.1-5-7 (2010) (emphasis added).

⁴¹ *Almonte v. Kurl*, 46 A.3d 1 (R.I. 2012) (failure to hospitalize led to patient’s suicide); *Santana v. Rainbow Cleaners*, 969 A.2d 653 (R.I. 2009) (failure to hospitalize outpatient client led to severe injuries to third party).

⁴² Mark Townsend, *Breivik Verdict: Norwegian Extremist Declared Sane and Sentenced to 21 Years*, [U.K.] *GUARDIAN*, August 24, 2012. Even those of us who follow these tragedies discover that others gathering such incidents find cases hitherto unknown to us, such as the case of Lisa Duy discussed in Jana R. McCreary, “*Mentally Defective*” *Language in the Gun Control Act*, 45 *CONN. L. R.* 813, 830 (2013). Duy’s tragedy is not at all unusual for this type of murder – only its relative obscurity is unusual.

over the last thirty years.⁴³ There is one aspect of the mass murders that renders them disproportionately important to public policy making: the question of foreseeability. Many murderers have some relationship to the victim. Where the relationship between victim and murderer is known, only 21% are strangers; most of the time, the murderer is numbered among the victim's family, friends, or acquaintances.⁴⁴ This allows members of the general society to believe, with some cause, that it is possible to avoid being a victim by picking one's friends with care, or by avoiding "bad" neighborhoods.

The category of mass murders, where there are multiple victims in a single place or across multiple locations during a brief period of time, often involve attacks on complete strangers by severely mentally ill killers. The locations of these mass murders are not normally considered high-risk locations, such as shopping malls, schools, and churches. The popular perception that you cannot avoid these tragedies creates a level of fear disproportionate to the actual risk, provoking sometimes panicked legislative actions.

II. A History of Mental Illness and Weapons Regulation

Surprisingly enough, attempts to regulate firearms possession by the mentally ill (except within the bounds of a mental hospital) appear to be quite recent. George Leib Harrison's *LEGISLATION ON INSANITY: A COLLECTION OF ALL THE LUNACY LAWS OF THE STATES...* (1884) (and as it turns out, of the territories as well) is a comprehensive collection of the laws concerning commitment, operation, and funding of state and territorial mental hospitals, running to 1119 pages. The words arms, firearms, weapon,

⁴³ Annie Linskey, *Mass Shootings Fuel Fear, Account for Fraction of Murders*, BLOOMBERG.COM, Sep. 16, 2013 (discussing the low percentage of random mass murders).

⁴⁴ FBI, *CRIME IN THE UNITED STATES 2011 (2012)*, Table 10 (total murder victims, 12,664; relationship unknown 5,558; stranger, 1,481). Note that acquaintances includes fellow gang members, the victim's drug dealer, or other members of criminal subcultures.

pistol, revolver, handgun, rifle, and shotgun appear nowhere in it.⁴⁵ Similarly, Henry F. Buswell's THE LAW OF INSANITY IN ITS APPLICATION TO THE CIVIL RIGHTS AND CAPACITIES AND CRIMINAL RESPONSIBILITY OF THE CITIZEN (1885), a comprehensive work on the law of insanity contains no discussion of regulation of arms by those who had been found mentally incompetent by the courts.⁴⁶

The earliest state law on the subject that I can find is California's 1957 statute prohibiting those previously involuntarily committed to a mental hospital from possessing a firearm.⁴⁷ Other state laws that include this goal appear in the 1960s, such as New Jersey (1966) and Illinois (1967); news accounts indicate that previously there were only local ordinances in effect, and the state laws appear to be of first impression.⁴⁸ Some of the laws, such as Georgia's 1965 statute, rely on sellers to determine whether the buyer is "mentally competent."⁴⁹ This seems a task that would be difficult for a person not

⁴⁵ George Leib Harrison, LEGISLATION ON INSANITY: A COLLECTION OF ALL THE LUNACY LAWS OF THE STATES AND TERRITORIES OF THE UNITED STATES TO THE YEAR 1883, INCLUSIVE... (1884).

⁴⁶ Henry F. Buswell, THE LAW OF INSANITY IN ITS APPLICATION TO THE CIVIL RIGHTS AND CAPACITIES AND CRIMINAL RESPONSIBILITY OF THE CITIZEN (1885).

⁴⁷ Cal. Welfare & Institutions Code § 5670 (1957), now Cal. W&I § 8100; Cal. W&I Code § 5153, now Cal. W&I § 8103.

⁴⁸ Josephine Ripley, *Shootings Trigger Gun-Law Demands*, CHRISTIAN SCIENCE MONITOR, Feb. 19, 1964, 4 (District of Columbia's handgun background check "designed to prevent the sale of handguns to persons with a record of mental illness"; "In Arlington County, Va., similar strict regulations are in force."); Times Washington Bureau, *Katzenbach Lauds N.J. Gun Bill*, [TRENTON, N.J.] SUNDAY TIMES ADVERTISER, June 5, 1966, 1:7 (New Jersey "law designed to keep firearms from the hands of ex-convicts, drug addicts and the mentally incompetent."); *N.J. Gun Law in Operation; Sniper Triggers U.S. Action*, [TRENTON, N.J.] EVENING TIMES, Aug. 2, 1966, 8 (New Jersey law "prohibits gun sales to persons convicted of crimes, narcotics addicts, alcoholics, the mentally ill, those with serious physical handicaps or illness, and members of subversive organizations."); *Stop, Frisk Bill Vetoed By Kerner*, ROCKFORD REGISTER-REPUBLIC, Aug. 4, 1967, B1 (requiring a state license to purchase firearms or ammunition; prohibited from licensing "convicted felons within five years of their conviction, narcotics addicts, mental patients confined to institutions within the previous five years and the mentally retarded."); *Gun Control Campaign Meets Ardent Foes*, CLEVELAND PLAIN DEALER, June 23, 1968, 11A (Chicago adopted April 15, 1968 a slightly more restrictive firearm registration law than Illinois that also prohibited ownership by "the mentally ill.")

⁴⁹ Marc Anderson, *State's Gun Law Called Worthless*, AUGUSTA [S.C.] CHRONICLE, Dec. 1, 1967, 1 (Concerning a 1965 state law: "We cannot hope for a pawn shop owner to judge whether a man who buys a gun is mentally competent or a felon.")

trained in medicine or psychiatry to perform while completing a transaction that might take only a few minutes to complete. One must assume that only the most obvious cases of psychosis or senility would be noticed and rejected by a seller.

Earlier than any of the state laws is the District of Columbia's 1932 Dangerous Weapons Act, which for the first time in many decades prohibited open carry of a firearm without a license.⁵⁰ This seems to be a most defective law which prohibited sales to anyone whom the seller "has reasonable cause to believe is not of sound mind."⁵¹ At the same time, while the seller was obligated to send a copy of the application for purchase to the superintendent of police, and wait "until at least forty-eight hours shall have elapsed" before transfer,⁵² there is nothing in the statute that prohibited those "not of sound mind" from *possessing* a firearm acquired outside the District, or obtained within the District other than by purchase.⁵³

While we can assume that the police would have used existing records to determine whether a person might be "not of sound mind," there seems to be no statutory definition

⁵⁰ July 8, 1932, 47 Stats. 651, ch. 465, § 4. *Cooke v. United States*, 275 F. 2d 887 (D.C.Cir. 1960) n. 3 explains the legislative history of this section's predecessors: Laws of the District of Columbia, Part II, p. 33 (1871-72) prohibited the carrying of deadly weapons; "The statute was amended after the turn of the century to make it unlawful to conceal a gun about one's person or to carry it openly with the *intent to use it unlawfully*.... CODE OF LAW FOR THE DISTRICT OF COLUMBIA, ANNO., § 855 (1910)." [emphasis in original]

⁵¹ July 8, 1932, 47 Stats. 652, ch. 465, § 7.

⁵² July 8, 1932, 47 Stats. 652, ch. 465, § 8. Later revisions of the statute making no change to the mental illness provisions: November 4, 1943, 57 Stats. 586, ch. 296; Aug. 4, 1947, 61 Stats. 743, ch. 469; June 29, 1953, 67 Stats. 93, 94, ch. 159, § 204.

⁵³ It is an interesting question whether this measure passed entirely or even primarily for the purpose of crime control. Its date of passage, July 8, 1932, is twenty days before Washington police started eviction of the "Bonus Expeditionary Force," a group of 10,000 veterans who "had 'occupied' the capital since early June" pressuring Congress to grant early payment of a bonus due them for their World War I service. Lee Nash, *HERBERT HOOVER AND WORLD PEACE* 126 (2010). Significantly, another law passed the same day as, and immediately following the Dangerous Weapons Act in Statutes at Large, provided for lending money to "any honorably discharged veteran of the World War, temporarily quartered in the District of Columbia" to return home, as long as they did so "prior to July 15, 1932." July 8, 132, 47 Stats. 654, ch. 466. Perhaps this was all coincidence; perhaps there was a desire to have a method to disarm or prosecute armed members of the B.E.F.

of this term. Would it be involuntary commitment to a mental hospital, or dementia? A search of case law from the D.C. Circuit in the period 1930 to 1940 for the term “sound mind” is more mysterious than informative.⁵⁴ The closest that these decisions come to a useful definition is tautological: “laymen may testify to sanity or insanity, since ‘the appearance and conduct of insane persons, as contrasted with the appearance and conduct of persons of sound mind, are more or less understood and recognized by every one of ordinary intelligence...’”⁵⁵

Of course, pistol licensing measures such as New York’s Sullivan Law (1911), because they provided unlimited discretion to a judge as to whether to allow an individual to possess a handgun, likely had the effect of disarming the severely mentally ill.⁵⁶ Perhaps a contributing factor to passage of the Sullivan Law was the immediately preceding New York City murder of David Graham Phillips, a socially and politically connected author, by Fitzhugh Coyle Goldsborough, a musician and poet suffering from mental illness.⁵⁷

Unfortunately, we can only presume that judges used the Sullivan Law’s discretionary issuance to prevent the mentally ill from legally acquiring pistols. New York courts have been quite reluctant to allow any independent examination of how such permits are issued.⁵⁸ A few accidental peeks inside the results of the Sullivan Law

⁵⁴ Owens v. U.S., 85 F.2d 270 (D.C.App. 1936); Ecker et al. v. Potts et al., 112 F.2d 581 (D.C.App. 1940); Railey v. Railey, 30 F.Supp. 121 (D.C.D. 1939); Thompson v. Smith, 103 F.2d 936 (D.C.App. 1939); Werner v. Frederick et al., 94 F.2d 627 (D.C.App. 1937); McDonald et al. v. Fulton Trust Co. of New York et al., 107 F.2d 237 (D.C.App. 1939); American Security & Trust Co. et al. v. Unknown Heirs at Law and Next of Kin of Mary Ann Spencer et al., 82 F.2d 456 (D.C.App. 1936).

⁵⁵ U.S. v. Witbeck, 113 F.2d 185, 187 (D.C.App. 1940) (quoting Connecticut Mutual Life Insurance Co. v. Lathrop, 111 U.S. 612, 619 (1884)).

⁵⁶ Consolidated Laws of New York, § 1897 (1916).

⁵⁷ *Phillips Dies of His Wounds*, NEW YORK TIMES, January 25, 1911.

⁵⁸ Matter of Kwitny v. McGuire, 77 AD 2d 839 (N.Y.App. 1st 1980).

process in the 1920s and 1950s suggest that there may be a good reason (well, at least good reasons for those in charge) for this reluctance to allow independent examination. Known Mafiosi were successfully receiving not just permits to possess pistols in *their homes*, but the much more difficult pistol *carry* permits.⁵⁹ We can only hope that New York State judges have been more concerned about mentally ill persons with firearms than Mafiosi with firearms.

What is especially interesting about the increase in concern about the mentally ill being in possession of firearms from the 1960s onward, and suggesting that deinstitutionalization had something to do with it, is the relationship between violent crime and mental illness before deinstitutionalization. Certainly in the early days of the state mental hospital system, the potential for the mentally ill to commit crimes of violence was widely understood. When Massachusetts opened Worcester Hospital in the early nineteenth century, the law limited its admissions to “the violent and furious.” Dr. Samuel B. Woodward, who was Worcester Hospital’s first superintendent, noted that, “More than half of those manifesting monomania and melancholia [roughly equivalent to paranoid schizophrenia and psychotic bipolar disorder in modern terms] are said to exhibit a propensity to homicide or suicide.”⁶⁰ The opening of state asylums in Vermont in 1836 and New Hampshire in 1840 “contributed to the decline in such spouse and

⁵⁹ David Critchley, *THE ORIGIN OF ORGANIZED CRIME IN AMERICA: THE NEW YORK CITY MAFIA, 1891-1931*, 285 n. 81 (2009); Thomas A. Reppetto, *AMERICAN MAFIA: A HISTORY OF ITS RISE TO POWER* 105 (2004); Sid Feder and Joachim Joesten, *THE LUCIANO STORY* 53-54 (1994) (examples of 1920s Mafiosi receiving pistol carry permits under the Sullivan Law); Jay S. Albanese, *ORGANIZED CRIME IN OUR TIMES* 141-2 (2011) (concerning the 1957 Apalachin, New York Mafia leadership meeting that police accidentally discovered); Edward Behr, *PROHIBITION: THIRTEEN YEARS THAT CHANGED AMERICA* 240-1 (1996) (many of the Mafiosi had pistol carry permits issued by New York and New Jersey authorities).

⁶⁰ Herbert Goldhamer and Andrew W. Marshall, *PSYCHOSIS AND CIVILIZATION: TWO STUDIES IN THE FREQUENCY OF MENTAL DISEASE* 40-41 (1953).

family murders during the 1850s and 1860s.”⁶¹ Accounts of mass murder (usually involving family members) appear often enough in this period to understand why insanity could lead to hospitalization.⁶²

Yet during the period before deinstitutionalization, the mentally ill seem to have been *less* likely to be arrested for crimes than the general population. Studies in New York and Connecticut from the 1920s through the 1940s showed a much lower arrest rate for the mentally ill.⁶³ This is no surprise; those who were severely mentally ill were much more likely to be hospitalized before they became dangerously violent.

III. Current Law

The U.S. Gun Control Act of 1968 (as subsequently amended) makes firearms possession unlawful for anyone “adjudicated as a mental defective” or who has been “committed to a mental institution.” Federal regulation further defines these terms:

Adjudicated as a mental defective. (a) A determination by a court, board, commission, or other lawful authority that a person, as a result of marked subnormal intelligence, or mental illness, incompetency, condition, or disease:

- (1) Is a danger to himself or to others; or
- (2) Lacks the mental capacity to contract or manage his own affairs.

⁶¹ Randolph A. Roth, *Spousal Murder in Northern New England, 1776-1865*, 72, in *OVER THE THRESHOLD: INTIMATE VIOLENCE IN EARLY AMERICA* (Christine Daniels and Michael V. Kennedy, eds., 1999).

⁶² See Laurel Thatcher Ulrich, *A MIDWIFE’S TALE: THE LIFE OF MARTHA BALLARD, BASED ON HER DIARY, 1785-1812* 291-306 (1991) and James W. North, *THE HISTORY OF AUGUSTA, FROM THE EARLIEST SETTLEMENT TO THE PRESENT TIME...* 208-14 (1870), for detailed accounts of the 1806 Purrinton murders, in which James Purrinton used a knife to murder his wife and seven of his eight children (one survived the attack), then committed suicide. Disturbingly similar is the case of William Beadle, of Wethersfield, Connecticut. In 1782, Beadle murdered his entire family (wife and four children) by knocking them unconscious with an ax, then slitting their throats. He then killed himself by firing two pistols at his head, simultaneously. Steven Mintz, *MORALISTS AND MODERNIZERS: AMERICA’S PRE-CIVIL WAR REFORMERS* 6 (1995); Royal Ralph Hinman, *A CATALOGUE OF THE NAMES OF THE EARLY PURITAN SETTLERS OF THE COLONY OF CONNECTICUT...* 165-7 (1852). Beadle was protecting them from ensuing poverty, his capital having been destroyed by the Revolution. George Simon Roberts, *HISTORIC TOWNS OF THE CONNECTICUT RIVER VALLEY* 153-6 (1906).

⁶³ Phil Brown, *THE TRANSFER OF CARE: PSYCHIATRIC DEINSTITUTIONALIZATION AND ITS AFTERMATH* 133-7 (1985); Thomas M. Arvanites, *The Mental Health and Criminal Justice Systems: Complementary Forms of Coercive Control*, 138-41, in *SOCIAL THREAT AND SOCIAL CONTROL* (Allen A. Liska, ed., 1992).

(b) The term shall include—

- (1) A finding of insanity by a court in a criminal case; and
- (2) Those persons found incompetent to stand trial or found not guilty by reason of lack of mental responsibility pursuant to articles 50a and 72b of the Uniform Code of Military Justice, 10 U.S.C. 850a, 876b....

Committed to a mental institution. A formal commitment of a person to a mental institution by a court, board, commission, or other lawful authority. The term includes a commitment to a mental institution involuntarily. The term includes commitment for mental defectiveness or mental illness. It also includes commitments for other reasons, such as for drug use. The term does not include a person in a mental institution for observation or a voluntary admission to a mental institution.⁶⁴

One important and interesting provision of the NICS Improvement Act of 2007 required states, as a condition of receiving funds for improving record provision to NICS, to implement relief from firearms disabilities programs. This requires states to provide such a firearms disability relief through “a State court, board, commission, or other lawful authority” if “the person's record and reputation, are such that the person will not be likely to act in a manner dangerous to public safety and that the granting of the relief would not be contrary to the public interest....”⁶⁵ Similar provisions apply to federal agencies or courts submitting firearms disability records based on mental illness or incompetence.⁶⁶

Federal law concerning mental illness and firearms possession is of course supreme, and if vigorously enforced, would render state laws on the subject moot. Federal law, while supreme in its authority, is necessarily limited in its practical enforcement. Except in fairly limited circumstances (e.g., an attempt to purchase a firearm from a licensed dealer), a person disqualified by federal law from firearms possession is unlikely to be arrested or prosecuted. State law is where most prosecutions take place, because state

⁶⁴ 27 C.F.R. 478.11 (April 1, 2013).

⁶⁵ H.R. 2640: NICS Improvement Amendments Act of 2007, 110th Congress, § 105(2). Minnesota is among those providing such relief under Minn. Stats., § 624.713, subd. 4 (2012).

⁶⁶ *Id.* at § 101(c)(2)(a).

and local police provide most criminal law enforcement within the United States.

One 2007 survey found that fifteen states had no laws prohibiting firearms possession by the mentally ill (as defined by the federal standard); twelve states only prohibited the mentally ill from obtaining a license to carry a concealed weapon; the remaining thirty-five (plus the District of Columbia) prohibited, in varying degrees or for varying periods, the mentally ill from possessing at least some categories of firearms. Usually this is a prohibition on handguns, but sometimes, a prohibition on any category of firearm.⁶⁷

Fourteen states that do not impose a firearms disability on the severely mentally ill sounds like a somewhat serious matter, but this actually understates the severity of the problem. Even states that have mental illness firearms disability laws often do not supply this disqualifying information to the National Instant Criminal Background Check System (NICS), which performs firearms background checks for gun dealers, or assists state law enforcement agencies in doing so. A 2000 General Accounting Office report on the completeness of the records used by NICS found that only 41 records had been submitted by a total of six states for “mental defectives.”⁶⁸ (This included not only those involuntarily committed for mental illness, but also those found mentally incompetent for other reasons.) As of April 30, 2007, NICS had received 138,766 “disqualifying mental health records” from the Veterans Administration, *one* record from the Department of Defense, and 167,903 records from twenty-two of the fifty states. (The other twenty-

⁶⁷ Joseph R. Simpson, *Bad Risk? An Overview of Laws Prohibiting Possession of Firearms by Individuals With a History of Treatment for Mental Illness*, 35 J. AM. ACAD. PSYCHIATRY LAW 3:333. There is a discrepancy between the text at 333 and Table 1 at 334-5. I have relied on Table 1 at least in part because some states for which I have researched the code match Table 1, although not the text summary at 333. States not prohibiting possession of a firearm by the involuntarily committed or adjudicated: Alaska, Colorado, Idaho, Kansas, Kentucky, Louisiana, Maine, Mississippi, Montana, New Hampshire, New Mexico, South Dakota, Tennessee, Texas, Vermont, Wyoming.

⁶⁸ General Accounting Office, *GUN CONTROL: OPTIONS FOR IMPROVING THE NATIONAL INSTANT CRIMINAL BACKGROUND CHECK SYSTEM* 7 (2000).

eight states had submitted no mental illness disqualifier records at all.) Of those 167,903 records, 92 percent were from Michigan and Virginia. The most populous state, California, had submitted a total of 27 records.⁶⁹

Complicating our understanding of how severe this problem is, states have the discretion to submit records under the “Denied Persons File” instead of the “Mental Defective File,”⁷⁰ apparently in the interests of protecting patient privacy. Still, it appears that most of those ineligible under federal law are not yet being reported to NICS. It should therefore be no surprise that NICS rejects an astonishingly low number of firearms purchases for mental illness. In 2005, NICS received close to 8.3 million firearms transfer applications, of which 131,916 were rejected⁷¹ (although about 33 percent of these rejections were reversed on appeal).⁷² Only 1956 applications were rejected specifically because of either mental illness or other mental incompetence.⁷³ (As mentioned previously, the “Denied Persons File” provides a way for states to disqualify a person without specifying mental illness, and at least some of the 12,914 rejections for “Other prohibitions” likely are in this category.)⁷⁴

A few states perform their own background checks, using the state’s own records as

⁶⁹ *Id.* at 11. Department of Veterans Affairs submits mental disqualification records when they have assigned a fiduciary to manage an individual’s financial affairs because he “lacks the mental capacity to manage his or her own financial affairs regarding disbursement of funds without limitation, and is either rated incompetent by VA or adjudged to be under legal disability by a court of competent jurisdiction.” Congressional Research Service, SUBMISSION OF MENTAL HEALTH RECORDS TO NICS AND THE HIPAA PRIVACY RULE, 2-3 (2013). As might be expected, there is some dispute as to whether all such cases are appropriately reported to NICS; the Social Security Administration has no similar rule for whom a fiduciary manages financial benefits. *Id.* at 3.

⁷⁰ *Id.* at 11.

⁷¹ Michael Bowling, Gene Laurer, Matthew J. Hickman, Devon B. Adams, Bureau of Justice Statistics, BACKGROUND CHECKS FOR FIREARMS TRANSFERS, 2005, 2 (November 2006).

⁷² *Id.* at 5.

⁷³ *Id.* at 2, 5 (0.5 percent of 66,705 FBI rejections and 3.0 percent of 65,211 state and local agency rejections).

⁷⁴ *Id.* at 2, 5 (4.5 percent of 66,705 FBI rejections and 15.2 percent of 65,211 state and local agency rejections).

well as the resources of NICS – but do not necessarily submit mental health disqualifying records to NICS. One consequence of keeping the cards close to the chest is that a state may successfully block a mentally ill person from buying a firearm *in that state*, but such a person taking up residence in another state is not blocked from purchase. The new state of residence does not have access to the previous state’s mental illness records, nor does NICS. One example of where submitting records to NICS makes a real difference is Virginia, which started submitting mental health disqualifier records in November of 2003. Three years later, Virginia’s records had prevented not only sixty purchase attempts in Virginia, but 378 purchase attempts in other states.⁷⁵

For those wondering if or how the Virginia Tech Massacre fits into Virginia’s 2003 change in procedure: it does not. The killer, Seung-Hui Cho, was not involuntarily committed to a hospital, in spite of concern by mental health professionals and the special judge who presided over the hearing that Cho was an imminent threat to himself.⁷⁶ Because of differences in how federal and Virginia law define firearms disability with respect to mental illness, Cho’s purchases were in violation of federal law, but not clearly in violation of Virginia law.⁷⁷ The ambiguity of whether court-ordered outpatient treatment qualified as “involuntary commitment” under Virginia law would appear to be why Cho’s handgun purchases were allowed by the background check, and not reported to the national background check system. (This ambiguity was corrected by executive order of Governor Kaine in the days following the murders.)⁷⁸

Clearly, improved reporting of mental health disqualifiers to NICS would reduce

⁷⁵ *Id.* at 11-12.

⁷⁶ MASS SHOOTINGS AT VIRGINIA TECH APRIL 16, 2007 REPORT OF THE REVIEW PANEL 56 (2007).

⁷⁷ *Id.* at 71-72.

⁷⁸ *Id.* at 72-73.

firearms purchases by those prohibited by federal law. In response to recent tragedies, federal financial assistance, and encouragement from the U.S. Department of Justice,⁷⁹ there has been a dramatic increase in the number of states that now submit mental incompetence records to NICS in the intervening years, or are preparing to do so.

In the case of New Jersey, the roadblock to submission appears to have been the courts. The New Jersey courts recently announced that they had submitted “nearly 413,000 records to the New Jersey State Police to forward to federal authorities” for addition to NICS. At least part of what made this possible was a revision to state law “clarifying that disclosure of mental health records does not violate privacy laws.”⁸⁰ But along with these 413,000 records of involuntary commitments, “Information about thousands of individuals who voluntarily seek admission to mental health treatment facilities also will be submitted for inclusion on the NICS using the existing infrastructure at no additional cost,”⁸¹ even though the federal definition specifically excludes voluntary commitments from the federal disability.⁸² This inclusion of voluntary commitments creates a serious due process problem.

Connecticut, unsurprisingly, after the Newtown tragedy, “is creating a database of individuals who are disqualified from owning a gun for mental health reasons.”⁸³ Unlike New Jersey, news coverage indicates that they are conforming to the federal

⁷⁹ Statement of Rachel L. Brand, Department of Justice... BEFORE THE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM SUBCOMMITTEE ON DOMESTIC POLICY, UNITED STATES HOUSE OF REPRESENTATIVES, LETHAL LOOPHOLES: DEFICIENCIES IN STATE AND FEDERAL GUN PURCHASE LAWS 10-11 (May 10, 2007), <http://www.justice.gov/olp/pdf/guns07a.pdf>.

⁸⁰ David Levinsky, *413,000 NJ Mental Health Records Submitted For Gun Checks*, BURLINGTON COUNTY [N.J.] TIMES, Aug. 27, 2013.

⁸¹ *Id.*

⁸² 27 C.F.R. 478.11 (April 1, 2013).

⁸³ Jenny Wilson, *State Announces Initiative To Improve Mental Health Reporting To NICS*, HARTFORD [CONN.] COURANT, May 8, 2013.

requirements, including only those who have been involuntarily committed, and those “who have been found incompetent to stand trial or not guilty due to insanity.”⁸⁴ State officials report that they have already found disqualifying records not previously submitted to NICS.⁸⁵

Pennsylvania also submitted more than 600,000 mental disqualifying records to NICS in January of 2013, records not previously provided by the state police.⁸⁶ Complicating this decision is that about 70 to 75 percent of these records are “302” commitments. The federal government was, at least report, reviewing whether 302 commitments qualify as involuntary commitments under federal regulations.⁸⁷ In 1996, the federal government concluded that 302 commitments were *not* involuntary commitments for purposes of firearms disability.⁸⁸

Since 2008, when state law changed to clarify that this did not violate the privacy rights of patients, Maine has wanted to submit mental health disqualifiers to NICS. A lack of resources has prevented court officials from processing approximately 5000 records to find how many qualify as involuntary commitments.⁸⁹

Massachusetts Governor Patrick, in the aftermath of the Newtown tragedy, sought legislative approval to submit mental health disqualifier records from public psychiatric

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ Theresa Katalinas, *PA Mental Health Records Included in Gun Check Database* (August 31, 2013), <http://phoenixville.patch.com/groups/politics-and-elections/p/pa-mental-health-records-included-in-gun-check-databad17af9fb13>.

⁸⁷ Moriah Balingit, *Pa. Sends Mental Health Data For Gun Checks*, PITTSBURGH POST-GAZETTE, Jan. 19, 2013; Penn. Stats. § 7302 (allows for involuntary commitment for observation for up to 120 hours based on a doctor’s belief that a patient “is severely mentally disabled and in need of immediate treatment.” There is no court hearing or other due process requirement.).

⁸⁸ Lawrence L. Duchnowski, Bureau of Alcohol, Tobacco, and Firearms, to Jon Pushinsky, Sep. 4, 1996 (August 31, 2013), <http://princelaw.files.wordpress.com/2013/02/atf-determination-302-violates-due-process.pdf>.

⁸⁹ Robert Long, *How Does Maine Balance Public Safety And Gun Rights Of Mentally Ill?* BANGOR [ME.] DAILY NEWS, Jan. 18, 2013.

facilities to NICS. Mental health advocacy organizations, such as the National Association for the Mentally Ill, opposed it, because “An all-encompassing database reinforces stigma and labels, and creates fear.”⁹⁰ Very true, but as discussed in part I of this paper, this fear has a very real factual basis. Other opponents seemed to misunderstand that such records were only for involuntary commitments, and not for outpatient or voluntary inpatient treatment: “[Professor James Alan Fox] added that banning gun possession for people who go to psychiatrists ‘would only discourage people from getting treatment.’”⁹¹

IV. Deinstitutionalization & Firearms Regulation For The Mentally Ill

It is a bit startling that regulation of firearms possession by the mentally ill is so recent – until we examine the history of how American society has handled the problem of mental illness. Until the 1960s, those with severe mental illness problems were hospitalized fairly readily, sometimes for periods of months and then released, sometimes forever, depending on how well they responded to treatment.⁹²

Under the best of conditions, state mental hospitals were not good environments for the mentally ill, but in retrospect, they may have been the best of the available poor alternatives. Today, we have switched to what seems like the worst of the poor choices: life on the street for many; death from exposure and disease for some; jail or prison for some; tragic headlines for a few who become national news stories.

The desire for a more humane approach led to deinstitutionalization of the mentally

⁹⁰ Lee Hammel, *Mental Health Is A Factor In Trying To Reduce Mass Killings*, WORCESTER NEWS & TELEGRAM, Feb. 24, 2013.

⁹¹ *Id.*

⁹² Clayton E. Cramer, *MY BROTHER RON: A PERSONAL AND SOCIAL HISTORY OF THE DEINSTITUTIONALIZATION OF THE MENTALLY ILL* 77 (2012).

ill in the 1960s and the 1970s. In the period immediately after World War II, state mental hospitals were often dreadful, barbarous places, at least in part because of funding problems because of the Depression and World War II. Another factor was that state mental hospitals cared for the senile elderly and syphilitic insane, creating severe crowding in what were often custodial institutions, and not very nice ones at that.⁹³ Until the introduction in 1954 of the first antipsychotic medication, chlorpromazine, the choice for how to manage patients who were a danger to self or others was a straitjacket, electroconvulsive therapy (“shock treatment”), or a prefrontal lobotomy.⁹⁴

Unfortunately a perfect storm of public policy emerged in the period between the end of World War II and 1980 as multiple movements collided to produce the deinstitutionalization movement, which became very nearly the antithesis of humane treatment of the mentally ill. Good intentions were not in short supply, but good intentions were not enough. The emerging dynamic psychiatry movement dominated the profession and the newly formed National Institute of Mental Health. Through these institutions, dynamic psychiatry promoted a model that had worked well with soldiers suffering from combat fatigue, but was completely inappropriate for the utterly inapposite civilian psychotic population.⁹⁵

Other movements rapidly collided with ultimately disastrous results. The emerging counterculture distrusted authority and middle-class values, and soon had its partisans in the establishment.⁹⁶ Civil libertarians insisted on a very strict standard of due process that

⁹³ *Id.* at 43-44 (2012) (describing the evolution of state mental hospitals and due process).

⁹⁴ *Id.*, at 48-49, 55 (describing how chlorpromazine changed the situation for violent patients).

⁹⁵ *Id.*, at 51-58.

⁹⁶ *Id.*, at 66-75.

was substantially at variance with the American tradition of civil commitment law.⁹⁷ *Lessard v. Schmidt* (E.D.Wisc. 1972) struck down Wisconsin's involuntary commitment statute because it provided insufficient notice to the patient of the proceedings involving her, and failed to provide an opportunity to have a lawyer represent her interests.⁹⁸ Perhaps more important than the easily correctable flaws in the statute, the *Lessard* decision rejected the traditional *parens patriae* role of government to look out for the interests of the patient.⁹⁹ Going a bit further, *Addington v. Texas* (1979) replaced the traditional preponderance of evidence standard for involuntary commitment with a requirement for "clear and convincing evidence" of mental illness. The Court's reasoning was that involuntary commitment involved both the deprivation of liberty and the stigma associated with mental illness.¹⁰⁰ In *Vitek v. Jones* (1980), the Court imposed due process requirements before a state could transfer a *convicted felon* from a prison to a mental hospital because of the stigmatizing effect of being labeled mentally ill. The prisoner was still within his original sentence; there was no additional deprivation of liberty associated with the transfer.¹⁰¹

At the same time, psychiatrists and judges with the best of intentions insisted that the state had a duty to provide treatment as a condition of holding mental patients.¹⁰² In some cases, the goal was openly stated: the threat to release mental patients would be a stick to force legislatures to spend the required money to provide treatment, instead of simply

⁹⁷ *Id.*, at 105-123.

⁹⁸ *Lessard v. Schmidt*, 349 F.Supp. 1078, 1083 (E.D.Wisc. 1972).

⁹⁹ *Id.*, at 1085.

¹⁰⁰ *Addington v. Texas*, 441 U.S. 418, 420, 421 (1979).

¹⁰¹ *Vitek v. Jones*, 445 U.S. 480, 492, 493, 494, 495 (1980).

¹⁰² David L. Bazelon, *The Right to Treatment: The Court's Role*, 20:5 *Hospital and Community Psychiatry* 129 (May 1969) (defending his decision in *Rouse v. Cameron*, 373 F.2d 451 (D.C.App. 1966) (holding that a mental patient held against his will because of his dangerousness must be either treated or released)).

warehousing the mentally ill.¹⁰³ Whatever the pragmatic arguments for this might be, it was a dramatic change in the American legal tradition. In *O'Connor v. Donaldson* (1975), the Court ruled that a mental patient held against his will must be either treated or released. In this case, the patient had refused treatment.¹⁰⁴ Chief Justice Burger's concurrence pointed out how dramatic a change this was and gave a very prescient warning: "[T]he idea that States may not confine the mentally ill except for the purpose of providing them with treatment is of very recent origin, and there is no historical basis for imposing such a limitation on state power.... It may be that some persons in either of these categories, and there may be others, are unable to function in society and will suffer real harm to themselves unless provided with care in a sheltered environment."¹⁰⁵

Civil libertarians who had previously demanded treatment of the mentally ill as an obligation of the state changed their argument. Now they insisted that patients had a right to refuse treatment (thus destroying the justification for holding mental patients against their will). Among the more astonishing of these decisions comes from the Massachusetts Supreme Judicial Court. A schizophrenic minor with a history of criminal behavior refused medical treatment in a mental hospital, against the advice of the psychiatrist. The minor's parents had consented to this treatment because of their concern for the well-being of their son. The Massachusetts high court concluded that the parents did not have the authority to give such consent, but that the courts, a disinterested

¹⁰³ Morton Birnbaum, *The Right to Treatment*, 46 AMERICAN BAR ASSOCIATION JOURNAL, 499, 502-3 (May, 1960) (Birnbaum's argument for such a right to treatment was not based on any recognizable Constitutional provision, but simply that if this "right to treatment were to be recognized and enforced, it will be shown that the standard of treatment in public mental institutions probably will be raised....").

¹⁰⁴ *O'Connor v. Donaldson*, 422 U.S. 563, 577 (1975) ("A State cannot constitutionally confine... a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends....")

¹⁰⁵ *O'Connor v. Donaldson*, 422 U.S. 563, 583-5 (1975) (Burger, J., conc.)

party, could substitute their judgment for that of the parents. The decision concluded that the court must substitute its judgment for what the minor might have decided had he been sane. But what would the minor have decided if he were sane?¹⁰⁶ “The likelihood of improvement or cure enhances the likelihood that an incompetent patient would accept treatment, but it is not conclusive.” A mentally incompetent person, if he had been sane, *might* decide that sanity is preferable to insanity, but this was by no means certain.¹⁰⁷ The net effect was that where states had at least an obligation to provide care for the severely mentally ill, if they were held involuntarily, were now strongly encouraged to provide no care at all.

In addition, some of the suits against really deplorable state mental hospitals (one initiated at the request of the hospital’s director) dramatically increased the operating costs, strongly encouraging states to deinstitutionalize. *Wyatt v. Stickney* (M.D.Ala. 1972) ruled, not too terribly surprisingly, that patients enjoyed a constitutional right to send sealed mail,¹⁰⁸ but it also decided that there was a constitutional right to a specific number of clerical support staff per patient.¹⁰⁹ The exact clause upon which this constitutional right was founded seems to have not made it into this decision. Nor does it appear in the preceding decision which referred to a right to treatment that is “constitutionally required.”¹¹⁰ The net effect of *Wyatt* was to both micromanage state mental hospitals and dramatically increase their operating costs.

Soon, state mental hospitals were emptied of many of their patients – from 559,000 in

¹⁰⁶ *Guardianship Of Roe Matter Of*, 421 N.E.2d 40, 52, 383 Mass. 415, 435, 436 (1981) (held that the state hospital psychiatrists and father of a mentally ill minor did not have authority to overrule minor’s decision to refuse antipsychotic drugs).

¹⁰⁷ *Id.*, at 448, 449.

¹⁰⁸ *Wyatt v. Stickney*, 344 F.Supp. 373, 379 (M.D.Ala. 1972).

¹⁰⁹ *Id.* at 383.

¹¹⁰ *Wyatt v. Stickney*, 325 F.Supp. 781, 784, 785 (M.D.Ala. 1971).

1955, to 110,000 in 1990¹¹¹ – a period when the U.S. population rose by 50 percent.¹¹² To be fair, some of this dramatic reduction was because of Medicare’s willingness to pay private nursing homes to care for the elderly senile, but not to reimburse state mental hospitals for it.¹¹³ This created an economic incentive for states to move what had been a large portion of their patients to private nursing care (where death rates were higher, perhaps because of aggressive cost-cutting by these profit-making institutions).¹¹⁴ The introduction of antibiotics for treatment of syphilis after World War II also gradually eliminated the syphilitic insane at about this time, who had been between 6 and 22 percent of the mental hospital patients during the twentieth century.¹¹⁵

While California was a leader in the deinstitutionalization of the mentally ill, it was not completely unusual: it experienced a 67 percent decline in non-elderly state mental hospital patients between 1955 and 1977, as deinstitutionalization increasingly returned the mentally ill to community-based mental health treatment facilities. In practice, because so many of the severely mentally ill refused to accept treatment in a voluntary setting, deinstitutionalization returned them not so much to the community, as to park benches, the lobbies of public buildings, and alleys.¹¹⁶ Astonishingly enough, one recent critic of the increasing incarceration rates of the mentally ill ascribed failure of the

¹¹¹ David Mechanic and David A. Rochefort, *Deinstitutionalization: An Appraisal of Reform*, 16:1 ANNUAL REVIEW OF SOCIOLOGY 301 (1990).

¹¹² U.S. Census Bureau, *Historical National Population Estimates: July 1, 1900 to July 1, 1999* (August 31, 2013), <http://www.census.gov/population/estimates/nation/popclockest.txt>.

¹¹³ Michael J. Dear and Jennifer R. Wolch, LANDSCAPES OF DESPAIR: FROM DEINSTITUTIONALIZATION TO HOMELESSNESS 65-66, 140-2 (1987); Margaret W. Linn and Shayna Stein, *Nursing Homes as Community Mental Health Facilities*, 267-71, in HANDBOOK ON MENTAL HEALTH POLICY IN THE UNITED STATES (Rochefort, ed., 1989).

¹¹⁴ Gerald N. Grob, THE MAD AMONG US: A HISTORY OF THE CARE OF THE AMERICA'S MENTALLY ILL 265-7, 289-90 (1994); Gerald N. Grob, FROM ASYLUM TO COMMUNITY: MENTAL HEALTH POLICY IN MODERN AMERICA 267-9 (1991).

¹¹⁵ Massachusetts State Board of Insanity, FIFTEENTH ANNUAL REPORT OF THE STATE BOARD OF INSANITY OF THE COMMONWEALTH OF MASSACHUSETTS 45 (1914); Grob, *supra* note 72, 124-7, 166.

¹¹⁶ Dear and Wolch, *supra* note 71, at 65-66, 140-2.

deinstitutionalized mentally ill to receive treatment to a shortage of community mental health centers, homelessness, loss of Medicaid benefits while jailed, substance abuse problems, and stigma that prevents the mentally ill from obtaining jobs.¹¹⁷ While many of these are certainly factors, she somehow missed what is often the most basic problem of all: a refusal of the severely mentally ill to recognize that they are in need of treatment. Hallucinations and delusions are quite capable of transforming the rest of our society into zombies or monsters from another planet. Why go to zombies for mental health treatment?

Millions of unsupervised and untreated mental patients returned to the streets. There was little in the way of either theoretical or practical regulation of firearms access by the mentally ill. Sometimes surprisingly large Social Security disability checks went to persons with hallucinations and delusions. The question is not why the period from 1980 to the present have been awash in these random acts of mass murder, disproportionately committed by people with very serious mental illness problems: the question is why we as a society have been so lucky? The number of mass murders could have been much higher.

The answer is the incarceration revolution of the 1990s, where many states dramatically increased sentences for violent crimes. This locked up many of the mentally ill in prison. This prevented what might have been a far more serious murder problem (although at very substantial costs to mentally ill prisoners). Harcourt's work demonstrates that while the mentally ill from the 1990s forward were not being *hospitalized* much, they were still being locked up in jails and prisons – and that is why

¹¹⁷ Christina Canales, *Prisons: The New Mental Health System*, 44:5 CONN. L.R. 1726-7 (2012).

murder rates fell.¹¹⁸

V. The Rights of the Mentally Ill & the Second Amendment: Is There A Conflict?

There are several different ways to approach this question, but first it is important to recognize that absolutist positions, while intellectually satisfying, have little to do with the U.S. Constitution. As Justice Scalia's opinion in *D.C. v. Heller* (2008) reminds us, "There seems to us no doubt, on the basis of both text and history, that the Second Amendment conferred an individual right to keep and bear arms. Of course the right was not unlimited, just as the First Amendment's right of free speech was not, see, *e.g.*, *United States v. Williams*,... (2008)."¹¹⁹ At other times the Court has reminded us that no matter how strongly worded the guarantees of the Bill of Rights may seem, "The law is perfectly well settled that the first 10 amendments to the constitution, ... were not intended to lay down any novel principles of government, but simply to embody certain guaranties and immunities which we had inherited from our English ancestors, and which had, from time immemorial, been subject to certain well-recognized exceptions, arising from the necessities of the case."¹²⁰

How did the United States get along for a century and a half with no need for firearms disability laws for the mentally ill? Certainly, firearms were not in short supply in early America, and with the exception of blacks and Indians, the only substantial firearms regulations were those *requiring* widespread gun ownership and sometimes requiring the

¹¹⁸ Harcourt, *supra* notes 6 and 7.

¹¹⁹ *D.C. v. Heller*, 128 S.Ct. 2783, 2799 (2008).

¹²⁰ *Robertson v. Baldwin*, 165 U.S. 275, 281 (1897) (holding that legal enforcement of a seaman's contract to work for a certain period of time did not violate the Thirteenth Amendment's forbidding of slavery or involuntary servitude).

carrying of firearms.¹²¹ Nor can the dramatic and tragic increase in murder by the mentally ill be ascribed to changes in gun regulation, which have generally become *more* restrictive over this period.¹²² Nor can it be attributed to the sudden availability of high-capacity semiautomatic weapons. The Colt AR-15, a semiautomatic version of the U.S. Army's M-16, has been available with 30 round magazines for ownership by private citizens since at least 1965.¹²³ Thirteen round semiautomatic pistols have been advertised for sale since at least 1954.¹²⁴ Semiautomatic pistols with detachable magazines have been offered for sale to private citizens since at least 1918.¹²⁵

VI. Deinstitutionalization's Consequences

The evidence from Harcourt's work statistically supports what a depressing drumbeat of news stories tells us: these tragedies are a consequence of a well-intentioned effort in the 1960s and 1970s to improve conditions of the mentally ill by emptying state mental hospitals. Some of this was simply a consequence of legislative miscalculation and a failure to correct the mistakes. However, the judiciary constitutionalized what had

¹²¹ Generally, see Clayton E. Cramer, *ARMED AMERICA: THE REMARKABLE STORY OF HOW AND WHY GUNS BECAME AS AMERICAN AS APPLE PIE* (2006) (demonstrating that gun ownership was extremely widespread through at least 1840).

¹²² Federal laws: Gun Control Act of 1968, Pub. L. No. 90-618 (1968) (prohibited felons from possessing firearms or ammunition); Brady Handgun Control Act, Pub. L. 103-159 (1993) (required waiting periods and background checks for handgun purchases); Violent Crime Control and Law Enforcement Act of 1994, Pub. L. No. 103-322 (prohibited certain categories of semiautomatic weapons); Gun Ban for Individuals Convicted of a Misdemeanor Crime of Domestic Violence, Pub. L. 104-208, 18 U.S.C. 922(g)(9) (1996) (prohibited those convicted of domestic violence misdemeanors from possessing a firearm). Representative state and local laws prohibiting semiautomatic detachable magazine weapons and high capacity magazines: Robert-Roos Assault Weapons Control Act of 1989, Cal. Penal Code § 12276; N.J. Stat. Ann. §§ 2C:39-1 to -15, :43-6 to -7, :58-5, :58-12 to -14 (West 1982 & Supp. 1991); New York City Local Law 78 (1991) (prohibiting possession of assault weapons and high capacity magazines), *cited in* *Richmond Boro Gun Club, Inc. v. City of New York*, 97 F.3d 681, 683 (2d Cir. 1996).

¹²³ Paul Wahl, *Now You Can Buy a Hot Combat Rifle for Sport*, *POPULAR SCI.*, Feb. 1965, at 171.

¹²⁴ *All The World Admires Browning* (advertisement), *LIFE*, Sept. 27, 1954, at 4.

¹²⁵ *Our Duty* (advertisement), *POPULAR SCIENCE MONTHLY*, Nov. 1918, at 108 (asking civilian customers of Colt to be patient, because all manufacturing capacity is currently in use for government contracts to defeat the Hun).

formerly been the realm of state legislative decision making. Here was a radical transformation of the traditional understanding of the duty of the state to which Chief Justice Burger alluded in his concurring opinion in O'Connor:

[T]he States are vested with the historic *parens patriae* power, including the duty to protect 'persons under legal disabilities to act for themselves.' ... The classic example of this role is when a State undertakes to act as "the general guardian of all infants, idiots, and lunatics."¹²⁶

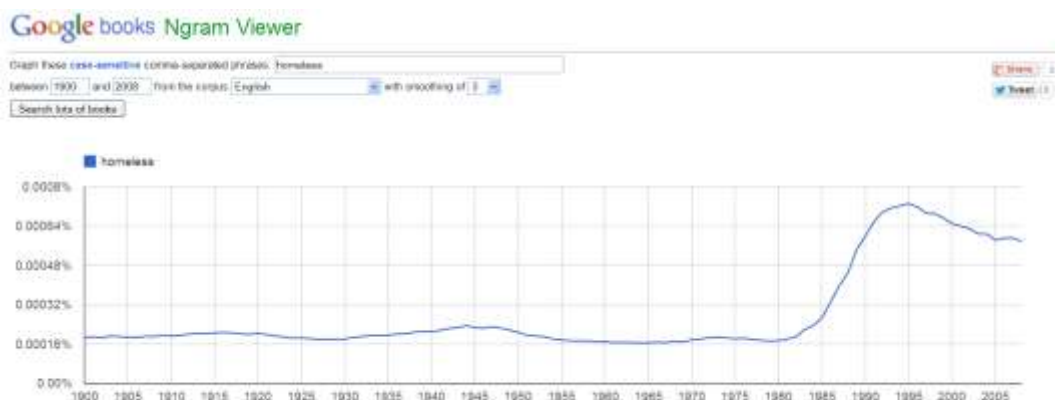
In this role, state governments were assumed to be looking out for the best interests of the mentally ill, and thus the traditional preponderance of evidence standard was considered sufficient for involuntary commitment. Civil libertarians zealously insisted, largely based on theoretical models that often denied that mental illnesses such as schizophrenia even existed,¹²⁷ that a much more demanding standard be used, preferably "beyond a reasonable doubt."¹²⁸ While intellectually satisfying, the intervening decades have demonstrated the negative consequences of deinstitutionalization for the mentally ill, and not just with respect to crime rates.

Homelessness in America was not even on the radar of the general public before 1980. A plot of references to the word "homeless" in published works reveals a startling increase several years after deinstitutionalization was fully implemented in the late 1970s:

¹²⁶ O'Connor v. Donaldson, 422 U.S. 563, 583-5 (1975) (J. Burger, conc.)

¹²⁷ Cramer, MY BROTHER RON, *supra* note 61, at 68-74 (quoting Thomas Szasz and R.D. Laing concerning the non-existence of schizophrenia); at 111, 115 (concerning how legal advocates for strict standards knew nothing of mental illness except what they had read from Szasz). See *Thomas Szasz in Conversation with Alan Kerr*, 21 PSYCHIATRIC BULLETIN 39-44 (1997) for Szasz's proud description of how he completed his psychiatric residency without ever having any contact with psychotic patients, and how after he was drafted into the Navy he went through the motions of being a psychiatrist: "The servicemen didn't want to be in the Navy and played the role of mental patient. I didn't want to be in the Navy and played the role of military psychiatrist: My job was to discharge the men from the Service as 'neuropsychiatric casualties'."

¹²⁸ Addington v. Texas, 441 US 418, 421 (1979) (appellant had requested at trial that the court use "beyond a reasonable doubt" as the standard of proof for involuntary commitment).



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Nor is this simply an artifact of increased discussion; studies of the homeless from the 1980s through the present found that the homeless were disproportionately mentally ill,¹³⁰ and where attempts were made to determine causality, the mental illness usually preceded homelessness.¹³¹ While there were differences in methodology across different studies,

¹²⁹ Google Ngram plot for word “homeless” in works published in English 1900-2008, http://books.google.com/ngrams/graph?content=homeless&year_start=1900&year_end=2008&corpus=15&smoothing=3&share= last accessed September 1, 2013.

¹³⁰ Dear and Wolch, *supra* note 71, at 175-6; Levine and Haggard, *Homelessness as a Public Mental Health Problem*, in Rochefort, *supra* note 71, at 294-9, 306; Bachrach, *The Homeless Mentally Ill and Mental Health Services*, 16-19, in *THE HOMELESS MENTALLY ILL: A TASK FORCE REPORT OF THE AMERICAN PSYCHIATRIC ASSOCIATION* (H. Richard Lamb, ed., 1984) (40 percent of 179 homeless men and women in a Philadelphia shelter found to have “major mental disorders,” with one-third diagnosed as schizophrenic, and one-fourth with substance abuse problems; study of 78 Boston shelter residents in 1983 found 40 percent had major mental disorders, and 51 percent had less severe psychiatric problems; the 9 percent without mental disorders were largely spouses and children dependent on the 91 percent); Shirley N. Harris, Carol T. Mowbray, and Andrea Solarz, *Physical Health, Mental Health, and Substance Abuse Problems of Shelter Users*, 19 *HEALTH AND SOCIAL WORK* 37-45 (Feb. 1994) (study of homeless shelter residents found that only 26.0 percent had been previously hospitalized for psychiatric problems, although 4.8 percentage of those requested to participate declined because “psychiatric distress too severe” and 29.0 percent declined for various reasons including “they did not want any records made on themselves” (which may well indicate paranoia); Pamela J. Fischer, Sam Shapiro, William R. Breakey, *et al.*, *Mental Health and Social Characteristics of the Homeless: A Survey of Mission Users*, 76 *AM. J. PUB. HEALTH* 519, 521 (37 percent of homeless were diagnosed as suffering a mental disorder compared to 18 per cent of household males); *Id.* at 522 (“One-third of the homeless had a previous psychiatric hospitalization compared to only 5 percent of male householders...”); Cheryl Zlotnick, Tammy Tam, and Kimberly Bradley, *Long-Term and Chronic Homelessness in Homeless Women and Women With Children*, 25:5 *SOCIAL WORK IN PUBLIC HEALTH* 470, 472-4, 478 (50.6 percent of homeless women (n=2938) surveyed in 1996 National Survey of Health Assistance Providers and Clients had mental health problems within the previous year).

¹³¹ Judith A. Stein and Lillian Gelberg, *Homeless Men and Women: Differential Associations Among Substance Abuse, Psychosocial Factors, and Severity of Homelessness*, 3:1 *EXPERIMENTAL AND CLINICAL PSYCHOPHARMACOLOGY* 75, 76, 77 (collecting studies on the percentage of mentally ill homeless: “Most

making exact comparisons questionable, and trend analysis statistically meaningless,¹³² even analysts who believed that deinstitutionalization had been a positive step agreed that the dramatic expansion of the homeless population in the 1980s was because large numbers of mentally ill persons were either released from mental hospitals, or were never committed.¹³³

Deinstitutionalization-induced homelessness was not only tragic for those living on the streets; it was a tragedy for those dying on them as well. At the same that deinstitutionalization was in full swing, hypothermia deaths in America were on the rise. In 1974, the death rate was 0.164/100,000 people. By 1979, the death rate had doubled to 0.322/100,000. Hypothermia death rates continued to rise, peaking at 0.411/100,000 in 1989, before dropping back below 0.2/100,000 in the late 1990s.¹³⁴ Not every person who died of hypothermia was mentally ill, but a detailed study of hypothermia deaths in Washington, DC in the years 1972-82 found that one-third were severely malnourished, with “most discovered in abandoned buildings or vehicles. Four-fifths had not been reported missing. One-half had high blood ethanol levels.”¹³⁵ It is difficult to read these characteristics, which sound suspiciously like those of mentally ill homeless people in America, and not suspect that the increase in hypothermia death rates was partly because

data indicate that the prevalence of mental illness is about 20% to 30%... a survey of homeless people in Chicago... found almost 25% had been in mental hospitals for at least 48 hr. Nearly one half had high levels of depression, and one fourth showed some signs of psychotic thinking.. [I]ncidence of mental illness is found with a high frequency in well-designed studies.”); *Id.* at 77 (citing “Belcher (1991) found that 35% of his sample of persons released from state mental hospitals became homeless.”)

¹³² Rael Jean Isaac and Virginia C. Armat, *MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL* 4-6 (1990).

¹³³ H. Richard Lamb, *Introduction*, xiii, in *THE HOMELESS MENTALLY ILL: A TASK FORCE REPORT OF THE AMERICAN PSYCHIATRIC ASSOCIATION* (H. Richard Lamb, ed., 1984).

¹³⁴ Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1979-1998. CDC WONDER On-line Database, compiled from Compressed Mortality File CMF 1968-1988, Series 20, No. 2A, 2000 and CMF 1989-1998, Series 20, No. 2E, 2003, ICD-9 E901.

¹³⁵ Nicholas Rango, *Exposure-Related Hypothermia in the United States: 1970-79*, 74:10 AM. J. OF PUBLIC HEALTH, 1159-60 (October, 1984).

of deinstitutionalization.

Along with homelessness and its destructive effects on the mentally ill, homelessness led to a hard to measure, but nonetheless obvious decline in the quality of life for the rest of the society. Public libraries became, in many urban areas, day shelters for the mentally ill. This should be no surprise to anyone living in big cities over the last thirty years. What is surprising is how, even in the early 1980s, when the problem of homelessness was still being blamed on “Reaganomics” rather than deinstitutionalization, the public library problem was recognized as primarily caused by mental illness. A 1981 New York Times article detailed how public libraries around the country were dealing with what the article called “problem patrons”:

The Library of Congress in Washington has recently been patronized by a man wearing a yellow plastic wastebasket over his head, an elderly woman who sped to the stacks of telephone books in search of someone who had put a curse on her, a woman who smelled so foul she cleared one whole section of the main reading room, and a man the librarians came to call Robin Hood. He wore a quiver of arrows, and spent his time at the microfilm screen reading *The Los Angeles Times*.¹³⁶

In 2007, Chip Ward, assistant director of the Salt Lake City public library system, wrote a devastating account of how the mentally ill homeless changed the library environment. While incorrectly blaming deinstitutionalization on the Reagan Administration, his first-hand account leaves no question as to the severity of the mental illness afflicting many of those he saw:

Ophelia sits by the fireplace and mumbles softly, smiling and gesturing at no one in particular. She gazes out the large window through the two pairs of glasses she wears, one windshield-sized pair over a smaller set perched precariously on her small nose. Perhaps four lenses help her see the invisible other she is addressing. When her “nobody there” conversation disturbs the reader seated beside her, Ophelia turns, chuckles at the woman’s discomfort, and explains, “Don’t mind me, I’m dead. It’s okay. I’ve been dead for some time now.” She pauses, then adds reassuringly, “It’s not

¹³⁶ Gregory Jaynes, *Urban Librarians Seek Ways To Deal With “Disturbed Patrons,”* NEW YORK TIMES, Nov. 24, 1981.

so bad. You get used to it.” Not at all reassured, the woman gathers her belongings and moves quickly away. Ophelia shrugs. Verbal communication is tricky. She prefers telepathy, but that’s hard to do since the rest of us, she informs me, “don’t know the rules.”

Margi is not so mellow. The “[obscenity deleted] Jews” have been at it again she tells a staff member who asks her for the umpteenth time to settle down and stop talking that way. “Communist!” she hisses and storms off, muttering that she will “sue the boss.” Margi is at least 70 and her behavior shows obvious signs of dementia. The staff’s efforts to find out her background are met with angry diatribes and insults. She clutches a book on German grammar and another on submarines that she reads upside down to “make things right.”

Mick is having a bad day, too. He hasn’t misbehaved but sits and stares, glassy-eyed. This is usually the prelude to a seizure. His seizures are easier to deal with than Bob’s, for instance, because he usually has them while seated and so rarely hits his head and bleeds, nor does he ever soil his pants. Bob tends to pace restlessly all day and is often on the move when, without warning, his seizures strike. The last time he went down, he cut his head. The staff has learned to turn him over quickly after he hits the floor, so that his urine does not stain the carpet.¹³⁷

A friend, Norma Kennemer, worked at the main branch of the Santa Rosa, California public library in the 1980s and 1990s. She was awash in similar stories of mentally ill homeless people who would urinate in the corners of the library, make frightening noises, sleep at the tables, and generally create an environment that would have been grounds for at least expulsion, if not arrest and commitment, in any American public library in 1960. The library staff was obligated to work with such “patrons” until their actions became clearly criminal. She recounted what happened when she observed that one of these mentally ill patrons was sitting at a table with his pants down to his knees. Her supervisor was obligated by library rules to attempt to first resolve the problem without the police. He approached this exposed “patron” and diplomatically asked, “Sir, are you appropriately attired for the library?”

Why was it necessary for librarians to take such a kid glove approach? Attempts to resolve behavioral problems led to lawsuits, such as happened in Morristown, New Jersey. The behavior and offensive smell of a homeless person named Kreimer led to the

¹³⁷ Chip Ward, *America Gone Wrong: A Slashed Safety Net Turns Libraries into Homeless Shelters*, AlterNet, April 2, 2007 (September 1, 2013), <http://www.alternet.org/story/50023/>.

adoption of a code of conduct, prohibiting loitering, “unnecessary staring,” following others around the library, and requiring those using the library to conform to community standards of cleanliness. The ACLU filed suit against this allegedly discriminatory code. At trial, Judge Sarokin ruled that the rules were discriminatory, and the ban on annoying other patrons violated Kreimer's right to freedom of speech:

The greatness of our country lies in tolerating speech with which we do not agree; that same toleration must extend to people, particularly where the cause of revulsion may be of our own making. If we wish to shield our eyes and noses from the homeless, we should revoke their condition, not their library cards.¹³⁸

Wiser heads prevailed on appeal: the Court of Appeals concluded that the rules were not unconstitutional, and reversed Sarokin's decision.¹³⁹ Nonetheless, the cost of fighting this suit was substantial, with Morristown paying \$230,000 to Kreimer as a settlement for this violation of his rights — and by the time they were finished, Morristown had spent more than one million dollars.¹⁴⁰ The cost of fighting such lawsuits by the ACLU certainly discouraged codes of conduct.

The problems of urban life degradation were not limited to libraries, nor would you need to enter a library to research these problems. In the 1990s, I had occasion to visit the University of California San Francisco's Hastings Law School library, which was located in the area called the Tenderloin, a rough area just north of Market Street. Homelessness was widespread in San Francisco, but especially concentrated in the Tenderloin. While mental illness was not the only cause, it did not require professional training to conclude that many of the homeless on the streets were showing signs of

¹³⁸ Kreimer v. Bureau of Police for Town of Morristown, 765 F. Supp. 181, 183 (D.N.J., 1991) ; John Cichowski, *Some Riders Wear Suits, Some File Them*, [BERGEN COUNTY, N.J.] RECORD, March 15, 2005.

¹³⁹ Kreimer v. Morristown, 958 F.2d 1242 (3d Cir. 1992).

¹⁴⁰ Cichowski, *op cit.*

psychosis. One consequence of this was the smell of urine on the sidewalks was overpowering, to the point that I had to hold my nose to avoid nausea. There was a shortage of public restrooms at least partly because businesses were reluctant to allow non-patrons to use their facilities. Why were they reluctant? Because many of the homeless were dirty, smelly, and behaved in ways that were frightening to both their customers and employees. Sometimes that fear was not prejudice, but a realistic appraisal based on past experiences.

San Francisco was an especially obvious example, but throughout the last three decades, I have visited dozens of large American cities, and seen this same depressing degradation (and one that was not present until the late 1970s). Obviously mentally ill homeless people lived under conditions of personal filth, either unable to access shower and laundry facilities, or unconcerned about the need for it.

The purpose of this disparate list of social tragedies, many far removed from the problem of mass murder should be obvious: the decision to replace American law's traditional view of the proper role of government in caring for those suffering severe mental illness problems with an absolutist and novel notion of due process has produced a flood of social problems. Because deinstitutionalization took place over a period of more than a decade, and in different states in different years, the muddy water rose slowly. Because the common origin of these social problems were not immediately obvious, it was easy to see each wave as coming from a separate storm.

One wave did rise rapidly, widespread homelessness starting in the late 1970s, but it was largely ignored in the popular media until it could be used as a political bludgeon,

characterized as a result of “Reaganomics.”¹⁴¹ Yet as we have seen, as early as 1983, social scientists studying the homelessness problem knew that the homeless were disproportionately, and in some samples almost entirely, mentally ill. The unwillingness to draw connections to the just completed and radical social experiment of deinstitutionalization was more about partisan politics than about sensible public policy.

VII. Solutions

There is strong case for states prohibiting those who are severely mentally ill from possession of firearms. While such laws will not disarm all the severely mentally ill, like all laws, they do not need to work perfectly to be worthwhile: they only need to work at the margins to be worth passing and enforcing. The exact definition of “severely mentally ill” is something of a definitional problem. The federal standard codified in 27 C.F.R. 478.11 contains more than sufficient due process protections, and might be considered an appropriate choice by the fifteen states that do not currently prohibit firearms possession by the mentally ill or mentally incompetent.

On the other hand, New York State’s recent SAFE Act is clearly deficient in due process. It requires “physicians, psychologists, registered nurses, and licensed clinical social workers” to report to county mental health officials any individual “for whom they are providing mental health treatment is ‘likely to engage in conduct that will cause serious harm to self or others.’”¹⁴² If the county mental health official agrees with the report, he is obligated to inform the state government agency that licenses firearms

¹⁴¹ Ward, *op. cit.*

¹⁴² New York State Office of Mental Health, *New York Secure Ammunition and Firearms Enforcement Act (NY SAFE Act), Guidance Document 1-2* (September 1, 2013), http://www.omh.ny.gov/omhweb/safe_act/guidance.pdf.

ownership, who will then notify “the appropriate local licensing official, who must suspend or revoke the license as soon as practicable.”¹⁴³ This involves immediate surrender of the firearms license and all firearms.¹⁴⁴

This would seem a clear violation of existing precedents concerning due process. A plethora of decisions by the U.S. Supreme Court have recognized that due process requires “an adversary hearing before an independent decisionmaker.”¹⁴⁵ The gun owner accused enjoys no right to a hearing of any sort, much less an adversary hearing before the county mental health official who is the independent decisionmaker. Even in a time of war, “due process demands that a citizen held in the United States as an enemy combatant be given a meaningful opportunity to contest the factual basis for that detention before a neutral decisionmaker.”¹⁴⁶ A U.S. citizen seized in time of war on a foreign battlefield enjoys this protection. Why should a U.S. citizen accused of mental instability not enjoy at least the same opportunity to contest his loss of rights?

This remains an area where inconsistencies in existing laws and the right to an adversarial hearing remain, and not just in the New York SAFE Act. For example, California Family Code § 6389(a) prohibits person subject to a protective order from owning or possessing a firearm.¹⁴⁷ Such protective orders may be issued *ex parte*,¹⁴⁸ precluding a gun owner subject to such an order from advance notice or an adversarial hearing before such an order takes effect. The usual justification for *ex parte* orders is

¹⁴³ *Id.*

¹⁴⁴ *Id.*

¹⁴⁵ *Vitek v. Jones*, 445 US 480, 485 (1980) (requiring independent decisionmaker).

¹⁴⁶ *Hamdi, v. Rumsfeld*, 542 US 507, 509 (2004)

¹⁴⁷ Cal. Family Code § 6389(a) (“A person subject to a protective order, as defined in Section 6218, shall not own, possess, purchase, or receive a firearm or ammunition while that protective order is in effect.”)

¹⁴⁸ Cal. Family Code § 6218 (“Protective order” means an order that includes any of the following restraining orders, whether issued *ex parte*, after notice and hearing, or in a judgment...”)

that delay may result in irreparable harm to one or more parties. There are unquestionably many circumstances where failure to disarm a party in a domestic violence dispute has led to murder. It is not at all difficult to imagine circumstances where such a firearms prohibition could easily lead to murder of the person disarmed. Yet the risk of irreparable harm was certainly plausible in the Hamdi case, and much greater harm than in any common domestic violence case, yet this was not sufficient reason to ignore Hamdi's right to an adversarial hearing concerning his deprivation of liberty.

There is no opportunity for the gun owner to cross-examine witnesses against him or present opposing evidence – contrary to existing precedent involving revocation of welfare benefits¹⁴⁹ or of parole.¹⁵⁰ As Justice Scalia's opinion in *Crawford v. Washington* (2004) observes, there is a right to cross-examine the statements of not just sworn witnesses, but “An accuser who makes a formal statement to government officers bears testimony in a sense that a person who makes a casual remark to an acquaintance does not.”¹⁵¹ There is a very real risk that a gun owner might be disarmed simply because of a misunderstanding or malicious falsehood, and with no opportunity to correct or counter such errors.

There is no opportunity under the New York SAFE Act for a gun owner to receive

¹⁴⁹ *Goldberg v. Kelly*, 397 US 254, 259 (1970) (discussing the right of “personal appearance of the recipient before the reviewing official, for oral presentation of evidence, and for confrontation and cross-examination of adverse witnesses.”)

¹⁵⁰ *Morrissey v. Brewer*, 408 US 471, 486, 487 (1972) (“At the hearing the parolee may appear and speak in his own behalf; he may bring letters, documents, or individuals who can give relevant information to the hearing officer. On request of the parolee, a person who has given adverse information on which parole revocation is to be based is to be made available for questioning in his presence.”)

¹⁵¹ *Crawford v. Washington*, 541 US 36, 51 (2004). *Id.* at 42-53 provides a history of the abuses of the denial of the right to cross-examine witnesses, and why the Sixth Amendment's guarantees are such an essential part of due process.

notice of a hearing before this deprivation of liberty. Yet the Supreme Court has repeatedly held that due process includes prior notice of a hearing that deprives one of liberty. This right of “adequate notice” is even required when the deprivation of liberty is only the transfer from a prison to a mental hospital.¹⁵² When a convict’s parole is to be revoked, he has a right to advance notice of such a hearing.¹⁵³ A welfare recipient enjoys the right to a hearing *before* revocation of welfare benefits.¹⁵⁴ Welfare benefits can hardly be placed in the same category of fundamental rights as an enumerated right to possess an arms for self-defense.

It is curious that the advocates of an exacting and absolutist due process requirement for involuntary commitment have shown so little interest in challenging this law. The SAFE Act does not even give the gun owner the opportunity to demand a hearing where the state must demonstrate by even a preponderance of evidence that his possession of firearms is a danger to public safety. There does not even seem to be a provision for a gun owner to challenge this decision after the fact.

There is a strong case for states to submit mental incompetence records to NICS so that persons who are disabled from firearms ownership by federal law may not move across state lines and suddenly become able to buy guns. To avoid rendering NICS data misleading, it is imperative that states only submit records that conform to federal law. As we saw with Pennsylvania’s submission of involuntary commitment records that do not appear to conform to due process requirements, it is important that NICS make sure

¹⁵² *Vitek v. Jones*, 445 US 480, 485 (1980)

¹⁵³ *Morrissey v. Brewer*, 408 US 471, 486, 487 (1972) (“[T]he parolee should be given notice that the hearing will take place and that its purpose is to determine whether there is probable cause to believe he has committed a parole violation. The notice should state what parole violations have been alleged.”)

¹⁵⁴ *Goldberg v. Kelly*, 397 US 254, 261 (1970) (“Under all the circumstances, we hold that due process requires an adequate hearing before termination of welfare benefits, and the fact that there is a later constitutionally fair proceeding does not alter the result.”)

that records submitted by the states conform to federal law.

All of these gun control related measures are good – but they will do nothing for the 32.3 percent of U.S. murders committed with non-guns.¹⁵⁵ Nor will background checks do any good for murders committed by mentally incompetent persons who *steal* guns, as has been the case in at least three recent mass murders.¹⁵⁶ Even the most optimistic of gun control advocates will usually admit that black market gun transactions will continue to exist, even if at a reduced level, no matter how strict the regulatory measures in effect. Nor will background checks make a difference for persons who were mentally competent when they purchased a firearm, but became mentally ill or suffered a senile dementia decline. Finally, there is reason to wonder if mandatory firearms background checks actually do anything at all.¹⁵⁷

There is, however, something that has been demonstrated to make a difference: restore our mental hospital system – and make it more humane and more transparent this time. (There are some additional improvements, such as involuntary outpatient commitment that provide an intermediate step between today’s “let them die of exposure” approach and hospitalization. Involuntary outpatient commitment compels persons who are severely mentally ill to participate in outpatient treatment as a condition of not being

¹⁵⁵ FBI, CRIME IN THE UNITED STATES 2011, Table 7.

¹⁵⁶ Richard A. Serrano and Alana Semuels, *Suspect In Massacre Tried To Buy Rifle Days Before, Sources Say*, LOS ANGELES TIMES, Dec. 15, 2012 (Adam Lanza was unable to legally buy a rifle, so he stole murder weapon from his mother); Maria Sudekum Fisher, *Mall Shooter Used Dead Woman’s Home While She Was Still Inside*, TOPEKA [KANS.] CAPITAL-JOURNAL, May 3, 2007 (Logsdon murdered neighbor to steal her late husband’s rifle); *Oregon Mall Gunman Identified, Used Stolen Gun In Rampage, Police Say*, Cleveland Plain Dealer, Dec. 12, 2012 (Jacob Tyler Roberts had stolen the AR-15 used in the Clackamas Mall shootings).

¹⁵⁷ Clayton E. Cramer, *Background Checks and Murder Rates*, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2249317 (unpublished paper examining statistical evidence of effect of existing mandatory state background check laws on murder rates using interrupted time series analysis; concludes that there is no statistically significant effect on murder rates).

involuntarily hospitalized.)¹⁵⁸

As Harcourt's work strongly suggests, hospitalization reduces murder rates.¹⁵⁹ This is not surprising: it is far easier to prevent inmates in locked wards from getting guns, knives, and other deadly weapons, than it is to prevent the mentally incompetent from doing so in a free society – no matter how strict our firearms regulatory system might be. As Segal's work demonstrates,¹⁶⁰ not only is ease of involuntary commitment a statistically significant determinant of murder rates, so is mental hospital bed availability, and the quality of the mental health care system. This should also not be surprising.

If reducing murder rates were the *only* consequence of correcting the disastrous mistake of deinstitutionalization, it might be justifiable for that reason alone. But that is not the only social gain from reversing course on the failure of deinstitutionalization. Many of the mentally ill who end up in jail and prison, especially after they have committed a serious felony, would be hospitalized earlier in the process, before they have done as much damage to others. There is general agreement that a mental hospital, even a locked ward, is a better place to treat someone than the hospital ward of a prison.

Reducing deaths from exposure must certainly qualify as a public good; for all the faults of the old state mental hospitals, patients did not freeze to death in them, or regularly die of malnutrition, tuberculosis, or the other diseases that so often kill homeless people in America. To the extent that mentally ill homeless people delay seeking medical care, this increases medical costs compared to a system where it is probable that their medical problems will be identified and treated early.

¹⁵⁸ Cramer, *supra* note 61, 190-195.

¹⁵⁹ Harcourt, *supra* notes 6 and 7.

¹⁶⁰ Segal, *supra* note 8.

There are substantial if diffuse costs to our society right now associated with homelessness: cleaning up city sidewalks; police patrols to keep homelessness disorder problems “under control,” businesses running off homeless people who are scaring off paying customers; public libraries that must act as referees between the regular patrons and sometimes scary mentally ill visitors; both public and privately funded facilities providing shelters of last resort.

One of the frequent criticisms of reversing deinstitutionalization is that it is going to take a lot of money: to rebuild now abandoned mental hospitals, and to hire psychiatrists, nurses, and other workers to staff them. This is very true. But our current system is spending astonishing amounts of money right now dealing with the consequences of *not* institutionalizing the severely mentally ill.

Mental hospitals cost money. So do trials of mentally ill offenders. Determining the costs of murder trials is surprisingly difficult, because so much of the published research is driven by attempts to prove that capital murder trials cost more than non-capital murder trials. Trying to find raw data without the ideological motivations is hard.

An estimate of costs in murder cases in Clark County, Nevada for the years 2009-2011 determined that public defender costs *alone* for capital murder trials averaged \$229,800; for non-capital murder trials, \$60,100.¹⁶¹ It seems quite believable that including prosecution costs, time spent operating the courts, investigating the crime, as well as the inevitable appeals, that a non-capital murder trial can easily cost the government \$500,000, especially because mentally ill defendants are almost always

¹⁶¹ Terance D. Miethe, University of Nevada, Las Vegas, *Estimates of Time Spent in Capital and Non-Capital Murder Cases: A Statistical Analysis of Survey Data from Clark County Defense Attorneys*, Feb. 21, 2012, <http://www.deathpenaltyinfo.org/documents/ClarkNVCostReport.pdf>.

indigent, and thus receive public defenders. A capital murder case, of course, will be substantially more expensive because ardent opponents of the death penalty litigate every point, valid or not, for decades on end.

The United States had 12,664 murders in 2011.¹⁶² If 11 percent of those murders were by severely mentally ill offenders (a reasonable guess based on the Indiana murder convict data discussed *supra* note 3), that is \$633 million spent on trials that will often be preventable. Moreover, the costs of incarceration after conviction are substantial. Colorado is a pretty typical state; it currently spends \$32,335 per year per inmate. A mentally sane murderer who spends thirty years in prison will cost \$970,060 (in 2011 dollars).¹⁶³ Multiplied by 1266 murders per year, this is a bill for \$1.228 billion in current and accrued costs. However, states are required to provide mental health services for prisoners. Mentally ill inmates are more expensive for states to care for than sane inmates. Pennsylvania several years ago found that mentally ill prisoners cost \$51,100/year; sane prisoners, \$28,000/year.¹⁶⁴ If a similar cost differential applies nationally, the incarceration bill is \$2.241 billion a year in current and future costs. Trial costs plus current and future incarceration costs total \$2.874 billion per year, or \$2.27

¹⁶² FBI, CRIME IN THE UNITED STATES 2011, Table 7.

¹⁶³ Tom Clements, Colorado Department of Corrections, Budget Hearings, January 5, 2012, 2, http://www.state.co.us/gov_dir/leg_dir/jbc/2011-12/corhrg.pdf.

¹⁶⁴ Lynne Lamberg, "Efforts Grow to Keep Mentally Ill Out of Jails," *Journal of the AMA* 292:5 [August 4, 2004] 555-6. Cost estimates for more recent years for different states show considerable difference: Mississippi's cost for 2011 was \$49.68 per day, or \$18,133 per year, Mississippi Legislature, Joint Committee on Performance Evaluation and Expenditure Review, Report #557, *Mississippi Department of Corrections' FY 2011 Cost Per Inmate Day*, <http://www.peer.state.ms.us/557.html> (October 20, 2013); North Carolina averaged \$27,747 per year, North Carolina Department of Public Safety, *Cost of Supervision for fiscal year ending June 30, 2011*, <http://www.doc.state.nc.us/dop/cost/> (October 20, 2013); Iowa averaged \$81.17 per day, or \$29,627 per year, Pat Curtis, *Average cost for each Iowa prison inmate: \$81.17 a day*, RADIO IOWA, Oct. 23, 2012, <http://www.radioiowa.com/2012/10/23/average-cost-for-each-iowa-prison-inmate-81-17-a-day/> (Oct. 20, 2013).

million per year per murder.

If involuntary commitment of those with serious mental illness problems even prevented 300 murders a year (or 21 percent of the murders by mentally ill offenders) it would save taxpayers at least \$681 million per year for incarceration. That would pay for a lot of mental health services. Victim costs are not included in these estimates; it seems likely that anyone present at any of the recent mass murders would have gladly paid more taxes to hospitalize mentally ill persons before they opened fire.

Finally, there is one other reason to admit that deinstitutionalization was a mistake: the mentally ill homeless are parents, children, friends, siblings – often too violent for family or friends to shelter – but still people who deserve humane care, even if we cannot cure them. No one should be sleeping on a steam grate, eating out of a trash can, or wondering if they will survive the night. Not now. Not in our country.