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Mental Illness and the Second Amendment Symposium Article

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Mental Illness and the Second Amendment

CLAYTON E. CRAMER

In the past, American laws seldom attempted to regulate the possession of firearms by the mentally ill. This surprising tradition has waned following a recent series of highly-publicized mass murders that were committed by persons who were identifiably mentally ill before the crime occurred. These tragedies 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 Article examines why mental health-related firearm regulations suddenly became necessary, analyzes the attendant conflicts between civil liberties and public safety, and suggests some strategies to deal with these conflicts.

ARTICLE CONTENTS

I. INTRODUCTION.....	1303
II. MENTAL ILLNESS AND MURDER IN CONTEMPORARY NEWS HEADLINES	1309
A. A BRIDGE BETWEEN EMPIRICAL STUDIES AND PUBLIC CONSCIOUSNESS	1309
B. HIGH-PROFILE MASS MURDERS LINKED TO MENTAL ILLNESS SINCE 2000.....	1310
C. THE QUESTION OF FORESEEABILITY: WHY THESE MASS MURDERS ARE CONSIDERED DISPROPORTIONATELY IMPORTANT TO PUBLIC POLICY.....	1314
III. A HISTORY OF MENTAL ILLNESS- RELATED FIREARMS REGULATION	1315
IV. CURRENT MENTAL ILLNESS- RELATED FIREARMS REGULATION	1319
A. THE FEDERAL REGULATORY SCHEME	1319
B. STATE REGULATION AND NICS REPORTING.....	1320
C. CHANGING STATE REGULATIONS AND NICS REPORTING PRACTICES IN THE WAKE OF RECENT TRAGEDIES	1322
V. DEINSTITUTIONALIZATION AND FIREARMS REGULATION FOR THE MENTALLY ILL.....	1325
A. THE SOCIETAL MOMENTUM FOR DEINSTITUTIONALIZATION	1325
B. THE CHANGED LEGAL STANDARDS RELATING TO DEINSTITUTIONALIZATION.....	1326
C. THE DEINSTITUTIONALIZATION TRANSITION: FROM STATE MENTAL HOSPITALS TO STREETS AND PRISONS.....	1329
VI. DEINSTITUTIONALIZATION’S CONSEQUENCES	1331
A. A DIFFERENT VIEW OF THE STATE	1331
B. INCREASED HOMELESSNESS AND ASSOCIATED MORTALITY RATES	1332
C. TRANSFORMED URBAN ENVIRONMENTS.....	1334
VII. THE RIGHTS OF THE MENTALLY ILL AND THE SECOND AMENDMENT: IS THERE A CONFLICT?.....	1336
VIII. NAVIGATING DUE PROCESS CONCERNS	1337
IX. CONCLUSION	1340



Mental Illness and the Second Amendment

CLAYTON E. CRAMER*

I. INTRODUCTION

It should not be surprising that severe mental illness and the commission of violent crimes, including murder, are strongly correlated in the United States.¹ Multiple studies of those charged or convicted of violent crimes in other countries have likewise found that the severely mentally ill commit a disproportionate number of such crimes.² Most

* Adjunct Faculty, College of Western Idaho. Cramer authored such books as *Armed America: The Remarkable Story of How and Why Guns Became as American as Apple Pie* and *Concealed Weapon Laws of the Early Republic: Dueling, Southern Violence, and Moral Reform*, which was cited in Justice Breyer's dissenting opinion in *McDonald v. Chicago*, 130 S. Ct. 3020, 3132 (2010). Among other articles, he co-authored Clayton E. Cramer & Joseph Edward Olson, *What Did "Bear Arms" Mean in the Second Amendment?*, 6 GEO. J.L. & PUB. POL'Y 511 (2008), which was cited in Justice Scalia's majority opinion in *District of Columbia v. Heller*, 554 U.S. 570, 588 (2008), and Clayton E. Cramer, Nicholas J. Johnson & George A. Mocsary, *"This Right Is Not Allowed by Governments That Are Afraid of the People": The Public Meaning of the Second Amendment when the Fourteenth Amendment Was Ratified*, 17 GEO. MASON L. REV. 823 (2010), which was cited in Justice Alito's majority opinion in *McDonald v. City of Chicago*, 130 S. Ct. 3020, 3039 n.21, 3041 n.25, 3043 (2010). Cramer's most recent book is *My Brother Ron: A Personal and Social History of the Deinstitutionalization of the Mentally Ill*, which combines a scholarly history of mental illness laws and the experiences of his family when his older brother suffered a schizophrenic breakdown in the 1970s. He thanks George Mocsary, Dave Hardy, Basil Copeland, Robin Roberts, Casey Smith, Cassandra Beckman Widay, Jeffrey Wisner, and Ryan Carpenter for their comments and suggestions in connection with this Article.

¹ See, e.g., Jeanne Y. Choe et al., *Perpetration of Violence, Violent Victimization, and Severe Mental Illness: Balancing Public Health Concerns*, 59 PSYCHIATRIC SERVICES 153, 161 (2008) (surveying a host of empirical studies and concluding that "violence and violent victimization are more common among persons with severe mental illness than in the general population"); 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 GEN. PSYCHIATRY 152, 155 (2009) (finding in a study of over 34,653 U.S. subjects that "people with any severe mental illness" were 2.96 times more likely to have a history of violence than the general population); 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, 39 (1978) (showing that in San Mateo County, California, mental patients were 55 times more likely to be arrested for murder than the general population in 1973; 82.5 times more likely to be arrested for murder in 1972; and 9 times more likely to be arrested for rape, robbery, aggravated assault, and burglary from 1972 to 1973); Larry Sosowsky, *Explaining the Increased Arrest Rate Among Mental Patients: A Cautionary Note*, 137 AM. J. PSYCHIATRY 1602, 1602-05 (1980) (finding that mental patients with no prior arrest record were five times more likely to be arrested for violent crimes than members of the general population).

² See, e.g., Patricia A. Brennan et al., *Major Mental Disorders and Criminal Violence in a Danish Birth Cohort*, 57 ARCHIVES GEN. PSYCHIATRY 494, 494-500 (2000) (examining all mental

national studies of prisoners in the United States report that “approximately one-quarter . . . of offenders suffer[] from mental health problems including a history of inpatient hospitalization and psychiatric diagnoses.”³ That is more than two times the rate of mental health disorders in adults in the general U.S. population.⁴

A study of Indiana murder convicts found that 18% were severely mentally ill, and suffered from “schizophrenia or other psychotic disorder, major depression, mania, or bipolar disorder.”⁵ Of these murder convicts, 5.2% were specifically diagnosed with schizophrenia,⁶ as compared to 1.1% of the overall adult U.S. population.⁷ Similarly, the Oregon Department of Corrections recently reported that 22.8% of its offenders either suffer from “severe” mental health problems or exhibit the “highest need” for treatment.⁸

Admittedly, 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 the police based on assumptions of criminal tendencies.⁹ But

hospitalization and criminal offense records for a cohort of Danish persons born between January 1, 1944, and December 31, 1947, and finding that “[a]pproximately 2.2% of the men in the cohort were hospitalized for a major mental disorder and committed 10% of the violent crimes committed by all the men in the cohort; 2.6% of the women had been hospitalized for a major mental disorder and committed 16% of the violent crimes committed by women in the cohort”); Seena Fazel et al., *Bipolar Disorder and Violent Crime: New Evidence from Population-Based Longitudinal Studies and Systematic Review*, 67 ARCHIVES GEN. PSYCHIATRY 931, 934 (2010) (explaining that Swedish bipolar disorder patients were 2.3 times more likely to be convicted of violent crimes than the general population); Seena Fazel & Martin Grann, *The Population Impact of Severe Mental Illness on Violent Crime*, 163 AM. J. PSYCHIATRY 1397, 1399–1400 (2006) (finding in a study of Swedish mental patients that schizophrenics were 6.3 times more likely to be convicted of violent crimes than untreated persons, and that individuals with “other psychoses” were 3.2 times more likely to be convicted of violent crimes); Pamela J. Taylor & John Gunn, *Homicides by People with Mental Illness: Myth and Reality*, 174 BRIT. J. PSYCHIATRY 9, 10 (1999) (gathering studies demonstrating that disproportionate rates of homicide were committed by schizophrenics in multiple European countries from as early as 1900 to as late as 1980); Cameron Wallace et al., *Criminal Offending in Schizophrenia Over a 25-Year Period Marked by Deinstitutionalization and Increasing Prevalence of Comorbid Substance Use Disorders*, 161 AM. J. PSYCHIATRY 716, 718 (2004) (noting that Australian schizophrenia patients were 3.2 times more likely to have been convicted of a violent offense than persons in a control group).

³ Robert D. Morgan et al., *Treating Offenders with Mental Illness: A Research Synthesis*, 36 LAW & HUM. BEHAV. 37, 37 (2012).

⁴ See DORIS J. JAMES & LAUREN E. GLAZE, U.S. DEP’T OF JUSTICE, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 3 (2006) (estimating that 11% of the U.S. population has a mental disorder).

⁵ See Jason C. Matejkowski et al., *Characteristics of Persons with Severe Mental Illness Who Have Been Incarcerated for Murder*, 36 J. AM. ACAD. PSYCHIATRY & LAW 74, 76 (2008) (referring to 95 persons out of a sample size of 518 persons).

⁶ See *id.* at 80 (referring to 27 persons out of a sample size of 518 persons).

⁷ *Schizophrenia*, NAT’L INST. MENTAL HEALTH, <http://www.nimh.nih.gov/statistics/1schiz.shtml> (last visited Apr. 15, 2014).

⁸ *Inmate Population Profile for 3/01/2014*, OR. DEP’T CORRECTIONS, http://www.oregon.gov/doc/RESRCH/docs/inmate_profile.pdf (last visited Mar. 18, 2014).

⁹ Amy C. Watson et al., *Police Officers’ Attitudes Toward and Decisions About Persons with*

other studies have examined violence across society at large, with one such study breaking down a sample of 10,059 people by diagnosis and self-reported violent behavior.¹⁰ The following table shows the total relative violence levels for males and females in 1997:

TABLE 1¹¹

Group	Total Number	Total Number Violent	Total % Violent	Relative to No Disorder
No disorder	7871	148	1.88%	1.00
Anxiety disorders	1444	74	5.12%	2.73
Major affective disorder or schizophrenia	408	43	10.53%	5.60
Alcohol or drug disorder	741	157	21.18%	11.27

Of particular interest is the comparison of the severely mentally ill (i.e., those placed in the “major affective disorder or schizophrenia” group) to those suffering from alcohol or drug disorders. In this study, those with alcohol or drug disorders were more likely to be violent.¹² Unsurprisingly, federal law prohibits the sale of firearms or ammunition to a person who is “an unlawful user of or addicted to any controlled substance,”¹³ and further makes it unlawful for any such person to “possess in or affecting commerce, any firearm or ammunition.”¹⁴ Other surveys of violence rate studies likewise suggest that the severely mentally ill are

Mental Illness, 55 PSYCHIATRIC SERVICES 49, 53 (2004) (concluding that police officers too often question the credibility of persons with mental illness and often exaggerate perceptions of dangerousness that escalate situations).

¹⁰ Jeffrey W. Swanson et al., *Violence and Psychiatric Disorder in the Community: Evidence from Epidemiologic Catchment Area Surveys*, in VIOLENT BEHAVIOR & MENTAL ILLNESS: A COMPENDIUM OF ARTICLES FROM PSYCHIATRIC SERVICES AND HOSPITAL AND COMMUNITY PSYCHIATRY 20, 23 (Carl C. Bell ed., 1997).

¹¹ *Id.* at 25 tbl.3.

¹² Swanson et al., *supra* note 10, at 24 tbl.2. Contrary to the popular perception that marijuana makes users mellow and alcohol makes users violent, there was only a small difference between the violence percentage for the “cannabis abuse or dependence” group (19.25%) and the “alcohol abuse or dependence” group (24.57%). Both groups were markedly less violent than individuals with “other drug abuse or dependence” (34.74%). *Id.*

¹³ 18 U.S.C. § 922(d)(3) (2012).

¹⁴ *Id.* § 922(g)(3).

disproportionately violent.¹⁵

Some contend that those suffering *only* from mental illness may not be especially violent, but that the combination of mental illness and substance abuse poses the greatest risk.¹⁶ Yet even researchers who control for substance abuse and conclude that the mentally ill are no more violent than individuals without mental illness acknowledge that “[m]ental 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.”¹⁷

Another study showed that substance abuse disorder comorbid with severe mental illness was an important part of the violence problem, and further acknowledged: “Major mental disorder without alcohol or drug abuse complications emerged as a quite rare condition in the community.”¹⁸ At the same time, this “quite rare condition . . . was significantly more common . . . among persons who reported that they had committed assaultive acts. . . . [T]he odds ratio for mental illness [alone] in the violent group exceeded 3.5.”¹⁹ Thus, while severe mental illness *alone* may not be the strongest determinant of violence, it is still a significant risk factor by itself, as well as a reliable proxy for identifying those who have a great risk of violence because of the high rates of comorbidity with substance abuse.

Others argue that the connection between mental illness and violence is illusory.²⁰ The Interfaith Disability Advocacy Coalition (“IDAC”) claims that “misconceptions about mental illness can cause discrimination and unfairly hamper the recovery of the nearly 20 percent of all adult Americans who experience a mental illness each year.”²¹ While there are many Americans with mild mental illness problems, such as depression or anxiety disorders, studies of violence and mental illness are typically

¹⁵ E.g., Frederick E. Vars & Amanda Adcock Young, *Do the Mentally Ill Have a Right to Bear Arms?*, 48 WAKE FOREST L. REV. 1, 14–16 (2013).

¹⁶ See, e.g., Elbogen & Johnson, *supra* note 1, at 155 (“Individuals with severe mental illness and substance abuse and/or dependence posed a higher risk than individuals with either of these disorders alone. The highest risk was shown for dual-disordered subjects with a history of violence, who showed nearly 10 times higher risk of violence compared with subject with severe mental illness only.”).

¹⁷ John Monahan et al., *The MacArthur Violence Risk Assessment Study Revisited: Two Views Ten Years After Its Initial Publication*, 59 PSYCHIATRIC SERVICES 147, 149 (2008).

¹⁸ Jeffrey W. Swanson, *Mental Disorder, Substance Abuse, and Community Violence: An Epidemiological Approach*, in VIOLENCE AND MENTAL DISORDER: DEVELOPMENTS IN RISK ASSESSMENT 101, 111 (John Monahan & Henry J. Steadman eds., 1994).

¹⁹ *Id.*

²⁰ INTERFAITH DISABILITY ADVOCACY COALITION, GROUNDED IN FAITH: RESOURCES ON MENTAL HEALTH AND GUN VIOLENCE 2–3 (2013), available at <http://www.aapd.com/assets/grounded-in-faith.pdf>.

²¹ *Id.* at 8.

careful to distinguish the most severe illnesses from these less serious problems.²² The IDAC's claim runs contrary to the bulk of evidence concerning prevalence of severe mental health disorders.²³ It is also apparent that the IDAC is concerned about perceived connections between mental illness and violence causing stigmatization—in addition to being concerned about how such connections might derail efforts toward gun control laws aimed at the general public.²⁴

Not all mental illnesses are severe, and at least some who are suffering from severe mental illness are not necessarily a hazard to self or others. Figuring this out for any particular individual requires care and discretion, and occasionally mistakes are made in both directions, i.e., some people who are not dangerous are hospitalized, while others who are dangerous fail to be hospitalized. There are no perfect solutions to this. A society must decide where to draw the line between “too strict” and “too lax” when it comes to public safety decisions.

Other methods of examining the relationship between mental illness and murder demonstrate that there is a statistically significant correlation that strongly suggests a causal relationship.²⁵ Bernard E. Harcourt's examination of aggregate national institutionalization rates—calculated by adding the prison population to that of mental hospitals—and murder rates from 1928 to 2000 found an astonishingly strong negative correlation between the two variables: -0.78 .²⁶ As the total institutionalization rate rose, murder rates fell, and vice versa.²⁷ Harcourt urged that “including mental health data in the rate of institutionalization—rather than using prison rates only—is likely to have significant effects on the study of the

²² See *supra* Table 1.

²³ While different research yields somewhat different results, attempts to reconcile prevalence studies show that 18.5% of Americans suffer from *any* mental or substance abuse disorder, William E. Narrow et al., *Revised Prevalence Estimates of Mental Disorders in the United States*, 59 ARCHIVES GEN. PSYCHIATRY 115, 119 (2002), which is indeed IDAC's “nearly 20 percent.” Most of these disorders, however, while troubling to the sufferer, are not associated with the high violent crimes discussed earlier. See *id.* at 121 tbl.4 (noting that 5.1% suffered from “[a]ny mood disorder,” which includes bipolar disorder, and 1.0% suffered from “[s]chizophrenia/schizophreniform”). For different methods of categorizing the severity of mental illnesses, see Ronald C. Kessler et al., *Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 ARCHIVES GEN. PSYCHIATRY 617, 619 (2005) (finding in a study of 9282 respondents that 2432 (26.2%) had a disorder meeting the criteria for a twelve-month DSM mental disorder and that, among those with a disorder, 542 (22.3%) were classified as “serious”).

²⁴ INTERFAITH DISABILITY ADVOCACY COALITION, *supra* note 20, at 2, 4–6.

²⁵ The ninety-five percent confidence interval is commonly used as a first test of whether a relationship between variables might indicate a causal connection. WARREN S. BROWNER, PUBLISHING AND PRESENTING CLINICAL RESEARCH 60–61 (2d ed. 2006).

²⁶ Bernard E. Harcourt, *From the Asylum to the Prison: Rethinking the Incarceration Revolution*, 84 TEX. L. REV. 1751, 1766 (2006).

²⁷ See *id.* at 1765 (describing the aggregated institutionalized rate as an inverted plot of the homicide trend line).

relationship between confinement and crime during the twentieth century.”²⁸ Even when he adjusted for changes in unemployment and the fluctuating fraction of the population that was at peak violent crime age, the negative correlation remained strong and better predicted both the 1960s rise and the 1990s decline in murder rates than the other models traditionally used by criminologists.²⁹ In a follow-up study, where 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.³⁰ A few states—such as Florida—showed no significant correlation between institutionalization rates and murder rates.³¹

Another study came to similar conclusions about the relationship between murder rates and mental illness. Steven P. Segal of the University of California at Berkeley’s School of Social Welfare studied state-to-state variations in 2004 murder rates and mental health care, while controlling for firearms restrictions and socioeconomic, demographic, and geographic data.³² He found that less access to psychiatric inpatient beds and poorly rated mental health systems were respectively associated with increases in the homicide rates by 1.08 and 0.26 per 100,000 people.³³ Since the national average homicide rate was 5.9 per 100,000 people in 2004,³⁴ greater access to inpatient beds is clearly quite important in reducing homicide rates; poorly rated mental health systems also matter, just less dramatically. Segal also found interesting differences based on variations in involuntary civil commitment (“ICC”) laws. Broader ICC-criteria were associated with 1.42 fewer homicides per 100,000 people, which was a bit less than one-quarter of the national homicide rate.³⁵ In short, states where involuntary commitment of the mentally ill was relatively easy had significantly fewer murders than states where it was more difficult.³⁶

²⁸ *Id.* at 1773.

²⁹ *Id.* at 1767, 1771.

³⁰ Bernard E. Harcourt, *From the Asylum to the Prison: Rethinking the Incarceration Revolution Part II: State Level Analysis* 48 (Univ. of Chi. Law Sch., John M. Olin Law & Econ. Working Paper No. 335, 2007), available at <http://www.law.uchicago.edu/files/files/335.pdf>.

³¹ *Id.* at 43.

³² Steven P. Segal, *Civil Commitment Law, Mental Health Services, and U.S. Homicide Rates*, 47 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 1449, 1449–50 (2012).

³³ *Id.* at 1449.

³⁴ *Underlying Cause of Death, 1999–2010 Request*, CENTERS FOR DISEASE CONTROL & PREVENTION, <http://wonder.cdc.gov/ucd-icd10.html> (last visited Apr. 15, 2014) (group results by “ICD-10 113 Cause List”; select year “2004”; then, under ICD-10 codes, open “V01-Y89”; then select “X85-Y09”; then click “send”). In 2010, the most recent year for which data is available, the homicide rate was 5.2 per 100,000 people. *Id.* (group results by “ICD-10 113 Cause List”; select year “2010”; then, under ICD-10 codes, open “V01-Y89”; then select “X85-Y09”; then click “send”).

³⁵ Segal, *supra* note 32, at 1455–56.

³⁶ *See id.* at 1457 (finding a need for criteria facilitating early preventative intervention for people with serious mental illness).

The remainder of this Article proceeds in nine parts. Part II further sets forth the connection between mental illness and violence, and discusses the public's perception of mass murders. Parts III and IV lay out the history and current state of mental illness-related firearms regulation. Parts V and VI describe the deinstitutionalization movement and its consequences for both the mentally ill and the public. Part VII assesses whether, in current or historical context, there is a conflict between the rights of the mentally ill and the Second Amendment. Part VIII examines serious due process concerns raised by some current mental health-related regulations. Part IX concludes that reversing deinstitutionalization while ensuring that mental hospitals are humane places will serve both the mentally ill and prevent a significant amount of public violence.

II. MENTAL ILLNESS AND MURDER IN CONTEMPORARY NEWS HEADLINES

The empirical studies present persuasive evidence that there is a connection between severe mental illness and violence. While *most* severely mentally ill people are not dangerous, the popular perception of such a connection is not simply prejudice, but represents a very real difference between the severely mentally ill and the general population.

A. *A Bridge Between Empirical Studies and Public Consciousness*

The results of the empirical studies mentioned above should not take us by surprise as a society, particularly in light of the tremendous media attention given to murders committed by the severely mentally ill. Consider, for example, the Indiana study that indicated schizophrenics—whose symptoms include hallucinations and delusions—were overrepresented among murderers.³⁷ In 2008, a schizophrenic named Vince Li beheaded and cannibalized a fellow bus passenger in Manitoba because he believed that he was “the second coming of Jesus” and his mission was to save the Earth from extraterrestrial invasion.³⁸ Similarly, Russell Eugene Weston, Jr. explained to a court-appointed psychiatrist that he shot two U.S. Capitol Police officers to death in 1999 to prevent the spread of a disease by cannibals.³⁹ Like many of the schizophrenics who make local, national, or even international headlines, Weston had a long history of mental illness well known to family, mental health workers, and

³⁷ See *supra* notes 6–7 and accompanying text; see also Peter F. Liddle, *The Symptoms of Chronic Schizophrenia: A Re-examination of the Positive-Negative Dichotomy*, 151 BRIT. J. PSYCHIATRY 145, 147 (1987) (discussing the division of general symptoms of schizophrenia).

³⁸ *Greyhound Killer Believed Man He Beheaded Was an Alien*, CBC NEWS (May 22, 2012), <http://www.cbc.ca/news/canada/manitoba/greyhound-killer-believed-man-he-beheaded-was-an-alien-1.1131575>.

³⁹ Bill Miller, *Capitol Shooter's Mind-Set Detailed*, WASH. POST (Apr. 23, 1999), <http://www.washingtonpost.com/wp-srv/national/longterm/shooting/stories/weston042399.htm>.

police, but had not been hospitalized for any great length of time.⁴⁰

In 2000, the *New York Times* studied one hundred “rampage” killers in the United States.⁴¹ The study 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.⁴²

Of the one hundred murderers 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.⁴³ It is possible that many of the fifty-three who did not have a history of mental health problems were also mentally ill. The lack of mental illness history for those fifty-three may be the result of an absence of evidence, and not necessarily evidence of absence. For example, some of the individuals simply may not have come to the attention of 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.

B. *High-Profile Mass Murders Linked to Mental Illness Since 2000*

Since 2000, multiple mass murders have anecdotally confirmed what the *New York Times* found: people that commit random acts of mass murder are usually suffering from severe mental illness. In 2003, an employee of the Postal Service, Jennifer San Marco, was removed from her Goleta, California, workplace because she was acting strangely and

⁴⁰ See Clayton E. Cramer, *Madness, Deinstitutionalization & Murder*, 13 *ENGAGE* 37, 37–40 (2012), available at <http://www.fed-soc.org/publications/detail/madness-deinstitutionalization-murder> (detailing a list of murders by the mentally ill).

⁴¹ Laurie Goodstein & William Glaberson, *The Well-Marked Roads to Homicidal Rage*, N.Y. TIMES, Apr. 10, 2000, at A1.

⁴² *Id.*

⁴³ *Id.*

then placed on psychological disability.⁴⁴ San Marco moved to Milan, New Mexico, where neighbors said she “shouted furiously to herself,” “knelt in prayer at the roadside,” and “peeled off her clothes in random parking lots.”⁴⁵ One neighbor who had worked in mental health clinics for eighteen years reportedly called the police in hopes that San Marco would receive a mental health evaluation, but the police stated they lacked a record of the call.⁴⁶ San Marco returned to the Goleta mail sorting facility in January 2006 and murdered five employees before taking her own life.⁴⁷ She purchased the guns and ammunition used in the shooting from two New Mexico pawn shops—following clearance of a background check.⁴⁸

In April 2007, Seung-Hui Cho murdered thirty-two students and faculty at Virginia Tech before taking his own life.⁴⁹ Some of Cho’s professors had previously noticed that something was not right with him, including the English department’s chairman who reported to “campus police and administrators . . . her worries about Cho’s antisocial behavior and disturbingly violent writing.”⁵⁰ In 2005, Cho was detained by campus police following stalking incidents and a report that he seemed suicidal.⁵¹ Thereafter, a special judge considered whether Cho should be involuntarily committed and concluded that he was an imminent danger to himself and others.⁵² Cho was taken to a hospital and received a court-ordered medical examination, but he denied having suicidal thoughts or other concerning symptoms.⁵³ Cho was deemed free to leave the hospital and went back to live on campus in a world of paranoid schizophrenia.⁵⁴ Because he was not *involuntarily* committed to a hospital, Cho’s name did not appear on the FBI’s firearms background checklist, and he was able to purchase handguns that he used in the largest firearm mass murder in U.S. history.⁵⁵

⁴⁴ Martin Kasindorf, *Woman Kills 5, Self at Postal Plant*, USA TODAY (Feb. 1, 2006), http://usatoday30.usatoday.com/news/nation/2006-01-31-postal-shooting_x.htm.

⁴⁵ Dan Frosch, *Woman in California Postal Shootings Had History of Bizarre Behavior*, N.Y. TIMES, Feb. 3, 2006, at A19.

⁴⁶ *Id.*

⁴⁷ Kasindorf, *supra* note 44.

⁴⁸ Associated Press, *Postal Killer Believed She Was Target of a Plot*, NBC NEWS (Feb. 3, 2006), http://www.nbcnews.com/id/11167920/ns/us_news-crime_and_courts/t/postal-killer-believed-she-was-target-plot/#.U4S4-f3Fkds.

⁴⁹ Nancy Shute, *What Went Wrong?*, U.S. NEWS & WORLD REP., Apr. 30, 2007, at 42.

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² *Id.*

⁵³ *Id.*

⁵⁴ *Id.*; see Michael Welner, *Cho Likely Schizophrenic, Evidence Suggests*, ABC NEWS (Apr. 17, 2007), <http://abcnews.go.com/Health/VATech/cho-schizophrenic-evidence-suggests/story?id=3050483&singlePage=true> (reporting that a forensic psychiatrist “believe[d] the evidence strongly supports that Cho had paranoid schizophrenia”).

⁵⁵ Josh Horwitz, *Expanding Background Checks Necessary, but Not Enough*, HUFFINGTON POST (Jan. 7, 2014), <http://www.huffingtonpost.com/josh-horwitz/expanding->

In April 2009, Jiverly Wong murdered thirteen people at a Binghamton, New York, immigrant assistance center before also killing himself.⁵⁶ Letters from Wong to local news media demonstrated what Dr. Vatsal Thakkar, assistant professor of psychiatry at New York University's Langone Medical Center, described as "major mental illness, quite possibly paranoid schizophrenia."⁵⁷

In January 2011, Jared Lee Loughner opened fire on a crowd at a public meet-and-greet with Congresswoman Gabrielle Giffords and her constituents, killing six and injuring thirteen.⁵⁸ Loughner had a history of incidents with police and was expelled from college for bizarre actions.⁵⁹ Despite his frightening behavior, he apparently was never hospitalized—even for observation—until he made himself nationally infamous.⁶⁰ A series of disturbing web postings and *YouTube* videos also confirm that Loughner's grasp on reality was severely impaired.⁶¹ Court-ordered psychiatric evaluations concluded that Loughner suffered from schizophrenia and was incompetent to stand trial.⁶² Eventually, he was well enough to stand trial and pleaded guilty to avoid the death penalty.⁶³

background-check_b_4554161.html; Editorial, *Close the Loophole Cho Sneaked Through*, VIRGINIAN-PILOT (Apr. 25, 2007), <http://hamptonroads.com/node/255931>.

⁵⁶ Austin Fenner et al., "I Am Shooting—Have a Nice Day"—*Shocking Letter Reveals Spree Killer's Paranoia*, N.Y. POST, Apr. 7, 2009, at 7.

⁵⁷ *Id.* (internal quotation marks omitted).

⁵⁸ Jacques Billeaud, *Loughner Pleads Not Guilty*, TULSA WORLD, Jan. 25, 2011, at A5.

⁵⁹ Brian Skoloff & Jacques Billeaud, *Arizona Shooting Suspect Spiraled into Madness*, GAZETTE (Montreal, Can.), Mar. 28, 2013, at A14; Tim Steller, *Man Linked to Giffords Shooting Called "Very Disturbed"*, ARIZ. DAILY STAR (Jan. 8, 2011), http://azstarnet.com/news/local/crime/man-linked-to-giffords-shooting-rampage-called-very-disturbed/article_91db5db4-1b74-11e0-ba23-001cc4c002e0.html.

⁶⁰ See Tim Steller, Sr. Reporter: *Tucson Hospital Says Loughner Wasn't a Patient*, ARIZ. DAILY STAR (May 9, 2011, 10:00 AM), http://azstarnet.com/news/blogs/senior-reporter/sr-reporter-tucson-hospital-says-loughner-wasn-t-a-patient/article_050f92b2-7a68-11e0-b623-001cc4c03286.html (noting, contrary to previous reports, that no prior records existed of Loughner being hospitalized for his mental health problems); *College Asked ATF About Loughner Before Rampage*, CBS NEWS (May 20, 2011) <http://www.cbsnews.com/news/college-asked-atf-about-loughner-before-rampage/> (noting that Loughner's college administrators ordered him to get a mental health evaluation before returning to campus and described his behavior as "bizarre" and "intimidating").

⁶¹ David A. Fahrenthold & Clarence Williams, *Tucson Shooting Suspect Jared Loughner Appears to Have Posted Bizarre Messages*, WASH. POST (Jan. 9, 2011), <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." *Id.* In one of his *YouTube* videos, Loughner stated: "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." *Id.* Some of Loughner's videos are still available on the Internet. *Classitup10, Introduction: Jared Loughner*, YOUTUBE (Dec. 15, 2010), <http://www.youtube.com/watch?v=nHoaaLbqB4>.

⁶² Craig Harris & Michael Kiefer, *Judge Finds Jared Loughner Incompetent to Stand Trial*, AZCENTRAL (May 25, 2011), <http://www.azcentral.com/news/articles/2011/05/25/20110525gabriel-giffords-shot-jared-loughner-competency-hearing.html>.

⁶³ Michael Martinez & Kyung Lah, *Loughner Pleads Guilty to 19 Counts in Tucson, Arizona*,

James Holmes, a neurosciences graduate student at the University of Colorado, open fired in a movie theater on the night of July 20, 2012, killing twelve and injuring fifty-eight others.⁶⁴ Holmes's problems were serious enough for his psychiatrist at the medical school, Dr. Lynne Fenton, to break doctor-patient confidentiality and alert the police, who took no action.⁶⁵ Because Dr. Fenton broke doctor-patient confidentiality to contact the police, it is reasonable to assume that Holmes "communicated to [her] a serious threat of imminent physical violence against a specific person or persons."⁶⁶ This exception to doctor-patient confidentiality outlines the only way Dr. Fenton could disclose Holmes's threat to law enforcement, and yet the police's failure to commit Holmes to a seventy-two-hour treatment and evaluation period suggests that they believed he was not "an imminent danger to others."⁶⁷

Certainly, the most disturbing of these recent mass murders occurred in December 2012 in Newtown, Connecticut. Adam Lanza had some sort of psychiatric disorder, but his childhood diagnosis of Asperger's Syndrome⁶⁸ is not typically associated with violent crime.⁶⁹ Some reports describe Lanza as suffering from sensory integration disorder ("SID"), where sensory inputs overwhelm the brain.⁷⁰ There is sizable overlap between the description of SID and the sensory problems that appear to be part of schizophrenia⁷¹—enough to wonder if Lanza was edging into

Mass Shooting, CNN (Aug. 8, 2012), <http://www.cnn.com/2012/08/07/us/arizona-loughner-plea/>.

⁶⁴ *Colo. Shooting Suspect James Holmes' Lawyers: He's Mentally Ill*, CBS NEWS (Aug. 9, 2012), <http://www.cbsnews.com/news/colo-shooting-suspect-james-holmes-lawyers-hes-mentally-ill/>.

⁶⁵ *Id.*

⁶⁶ COLO. REV. STAT. § 13-21-117 (2013).

⁶⁷ *Id.* § 27-65-105.

⁶⁸ Alice Park, *Don't Blame Adam Lanza's Violence on Asperger's*, TIME (Mar. 11, 2011), <http://time.com/19957/adam-lanzas-violence-wasnt-typical-of-aspergers/>.

⁶⁹ See Daniel C. Murrie et al., *Asperger's Syndrome in Forensic Settings*, 1 INT'L J. FORENSIC MENTAL HEALTH 59, 61 (2002) (noting the existence of an intense debate about "whether Asperger's patients are truly more prone to violence," but observing that the vast majority of those diagnosed do not commit violent crimes); Press Release, Interagency Autism Coordinating Comm., Statement of the Interagency Autism Coordinating Committee (IACC) Related to the Sandy Hook Tragedy (Dec. 21, 2012), available at http://iacc.hhs.gov/news/press_releases/2012/iacc_sandy_hook_statement_122112.pdf ("There is no scientific evidence linking [autism spectrum disorder] with homicides or other violent crimes."). But see Barbara G. Haskins & J. Arturo Silva, *Asperger's Disorder and Criminal Behavior: Forensic-Psychiatric Considerations*, 34 J. AM. ACAD. PSYCHIATRY & L. 374, 378 (2006) ("Violent behavior among children, adolescents, and even adults with [Asperger's] is not uncommon.").

⁷⁰ Adam Clark Estes, *Revelations About Adam Lanza's Mental Health Still Don't Explain the Violence*, THE WIRE (Feb. 19, 2013), <http://www.thewire.com/national/2013/02/revelations-about-adam-lanzas-mental-health-still-dont-explain-violence/62317/>.

⁷¹ See Peter Falkai et al., *Pathophysiology of Schizophrenia*, in SCHIZOPHRENIA: CURRENT SCIENCE AND CLINICAL PRACTICE 31, 42 (Wolfgang Gaebel ed., 2011) (discussing "dysfunction "of the cortico-cerebellar-thalamic-cortical neuronal circuit" and its role in filtering sensory information); Anthony J. Rissling & Gregory A. Light, *Neurophysiological Measures of Sensory Registration, Stimulus Discrimination, and Selection in Schizophrenia Patients* 284–46, in BEHAVIORAL

schizophrenia or if Lanza's psychiatrist was reluctant to diagnose this devastating illness until he was certain of it. Early reports indicated that Lanza's mother was attempting to have him hospitalized and this may have provoked the crime.⁷²

Americans have recently mourned yet 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, 2013.⁷³ In the months before, Alexis had given increasingly clear signs of serious mental illness, including paranoia, sleep disorders, and "hearing voices" in his head.⁷⁴

These highly publicized incidents only represent a few of the mass murders committed in the United States by persons with signs of severe mental illness. A comprehensive accounting of such tragedies since 2000 would be dozens of pages long. During this same period, even larger mass murders have been committed by the mentally ill in other countries, such as Norwegian Anders Behring Breivik, who murdered 77 people and wounded 242.⁷⁵

C. *The Question of Foreseeability: Why These Mass Murders Are Considered Disproportionately Important to Public Policy*

Relative to the overall murder rate in the United States, murders committed by the mentally ill amount to a small fraction, and the public mass murders that receive so much media attention are an especially tiny

NEUROBIOLOGY OF SCHIZOPHRENIA AND ITS TREATMENT 283, 284–86 (Neal R. Swerdlow, ed., 2010) (discussing the relationship between sensory input processing and schizophrenia); *see also* Andrew Solomon, *The Reckoning: The Father of Sandy Hook Killer Searches for Answers*, NEW YORKER (Mar. 17, 2014), http://www.newyorker.com/reporting/2014/03/17/140317fa_fact_solomon?currentPage=all (noting that Adam Lanza's father now suspects that his son's Asperger's Syndrome may have "veiled" or "mask[ed]" schizophrenia).

⁷² Jana Winter, *Fear of Being Committed May Have Caused Connecticut Gunman to Snap*, FOX NEWS (Dec. 18, 2012), <http://www.foxnews.com/us/2012/12/18/fear-being-committed-may-have-caused-connecticut-madman-to-snap/> (reporting that Adam Lanza found out about his mother "petitioning the court for conservatorship and (her) plans to have him committed," and that "[a] senior law enforcement official involved in the [Sandy Hook] investigation confirmed that Lanza's anger at his mother over plans for 'his future mental health treatment' [was] being looked at as a possible motive").

⁷³ Ashley Halsey III & Peter Hermann, *Day of Deaths and Dread in the Nation's Capital*, BOS. GLOBE, Sept. 17, 2013, at A1.

⁷⁴ Erica Goode et al., *Signs of Distress Multiplied on Killer's Path to Navy Yard*, N.Y. TIMES, Sept. 20, 2013, at A1; *see also* Brigid Schulte et al., *Chances to Intervene in Navy Yard Shooter's Problems Missed for Years by Various Groups*, WASH. POST, Sept. 22, 2013, at A1 (describing law enforcement accounts from Veterans Administration sources concerning Alexis's treatment).

⁷⁵ Mark Townsend, *Breivik Verdict: Norwegian Extremist Declared Sane and Sentenced to 21 Years*, THE GUARDIAN (Aug. 24, 2012), <http://www.theguardian.com/world/2012/aug/24/breivik-verdict-sane-21-years>. Breivik was found legally sane at trial, although determined to be schizophrenic by court-appointed psychiatrists.

portion. Over the past thirty years, “incidents in which four or more people were killed at random by a gunman killing indiscriminately” make up “less than a tenth of 1 percent” of all murders.⁷⁶ Only one aspect of the mass murders renders them disproportionately important to public policy making: the question of foreseeability. Many murderers have some relationship to the victim. Of situations where the relationship between victim and murderer is known, only twenty-one percent of victims are strangers to their murderer.⁷⁷ This allows members of the general public 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.

Mass murders, defined as killings with 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.⁷⁸ The locations of these mass murders are not normally considered high-risk locations, as they include shopping malls, schools, and churches. The popular perception that you cannot avoid these tragedies creates a level of fear disproportionate to the actual risk, sometimes provoking panicked legislative actions.

III. A HISTORY OF MENTAL ILLNESS-RELATED FIREARMS 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 L. Harrison’s *Legislation On Insanity* provides a comprehensive collection of nineteenth-century laws concerning the commitment, operation, and funding of state and territorial mental hospitals.⁷⁹ The words arms, firearms, weapon, pistol, revolver, handgun, rifle, and shotgun appear nowhere within its 1119 pages. Similarly, Henry F. Buswell’s *The Law of Insanity in Its Application to the Civil Rights and Capacities and Criminal Responsibility of the Citizen*, a comprehensive work on the law of insanity from the same period, contains no discussion of regulation of arms by those who had been found mentally incompetent by the courts.⁸⁰

⁷⁶ Annie Linskey, *Mass Shootings Fuel Fear, Account for Fraction of Murders*, BLOOMBERG (Sept. 16, 2013), <http://www.bloomberg.com/news/2013-09-17/mass-shootings-fuel-fear-account-for-fraction-of-murders.html>.

⁷⁷ See *Crime in the United States 2011: Expanded Homicide Data Table 10*, FED. BUREAU INVESTIGATION, <http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2011/crime-in-the-u.s.-2011/tables/expanded-homicide-data-table-10> (last visited Mar. 16, 2014) (indicating that of the 12,664 total murder victims in 2011, 5558 had an unknown relationship with their murderer and 1481 were strangers to their murderer).

⁷⁸ DAVID LESTER, *MASS MURDER: THE SCOURGE OF THE 21ST CENTURY* 11 (2004).

⁷⁹ GEORGE L. HARRISON, *LEGISLATION ON INSANITY: A COLLECTION OF ALL THE LUNACY LAWS OF THE STATES AND TERRITORIES OF THE UNITED STATES* (Phila., Globe 1884).

⁸⁰ HENRY F. BUSWELL, *THE LAW OF INSANITY IN ITS APPLICATION TO THE CIVIL RIGHTS AND*

The earliest state law on the subject that I could find is a 1957 California statute prohibiting any “mental patient in any hospital or institution or on parole from any hospital or institution” from possessing a firearm.⁸¹ Other restrictive state laws appeared in the 1960s, such as New Jersey in 1966⁸² and Illinois in 1967;⁸³ news accounts suggest that previously there were only local ordinances in effect, and the state laws appear to be the first of their kind.⁸⁴ Some of these early laws, such as South Carolina’s 1965 statute, relied on sellers to determine whether the buyer was “mentally competent.”⁸⁵ This would be a difficult task for a person not trained in medicine or psychiatry to perform while completing a transaction that otherwise might take only a few minutes. One must assume that only the most obvious cases of psychosis and senility would be noticed and rejected by a seller.

Appearing 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.⁸⁶ This law prohibited sales to anyone whom the seller “ha[d] reasonable cause to believe is not of sound mind.”⁸⁷ The law seems functionally defective because there was nothing in the statute that prohibited those “not of sound mind” from *possessing* a firearm that was acquired outside of the District or obtained within the District by means other than a purchase.⁸⁸

CAPACITIES AND CRIMINAL RESPONSIBILITY OF THE CITIZEN (Bos., Little Brown 1885).

⁸¹ CAL. WELF. & INST. CODE § 5670 (1957) (current version at CAL. WELF. & INST. CODE § 8100 (West 2013)).

⁸² See 1966 N.J. Laws 484 (making a firearms seller guilty of a misdemeanor “where the seller has reason to believe the person is of unsound mind”).

⁸³ See 1967 Ill. Laws 2599–600 (“A person commits the offense of unlawful sale of firearms when he knowingly . . . [s]ells or gives any firearm to any person who has been a patient in a mental hospital within the past 5 years . . .”).

⁸⁴ See *Katzenbach Lauds N.J. Gun Bill*, SUNDAY TIMES ADVERTISER (Trenton, N.J.), June 5, 1966, at 1, 7 (reporting that New Jersey’s “pioneering law” was the “nation’s most comprehensive gun control”); *Stop, Frisk Bill Vetoed by Kerner*, ROCKFORD REG.-REPUBLIC (Rockford, Ill.), Aug. 4, 1967, at B1 (quoting Illinois’s governor as saying its new law was a “strong beginning”); see also *Gun Control Campaign Meets Ardent Foes*, CLEVELAND PLAIN DEALER, June 23, 1968, at 11A (reporting that on April 15, 1968, Chicago adopted a slightly more restrictive firearm registration law than Illinois that prohibited ownership by “the mentally ill”).

⁸⁵ S.C. CODE ANN. § 54-578 (1965); see also Marc Anderson, *State’s Gun Law Called Worthless*, AUGUSTA CHRON. (Augusta, Ga.), Dec. 1, 1967, at 1 (stating, with respect to a 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”).

⁸⁶ D.C. CODE § 116d (Supp. V 1939). *Cooke v. United States* explains the legislative history of this section’s predecessors. 275 F.2d 887, 889 n.3 (D.C. Cir. 1960). In 1871, a law in the District prohibited the carrying of deadly weapons. *Id.* “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.*” *Id.* (emphasis added).

⁸⁷ D.C. CODE § 116g.

⁸⁸ 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 District police started

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 of this term. Would it require involuntary commitment to a mental hospital, a diagnosis of dementia, or something else? A search of D.C. Circuit cases in the period between 1930 and 1940 for the term “sound mind” is more mysterious than informative, and largely yields decisions relating to trusts and estates law.⁸⁹ 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.’”⁹⁰

Of course, pistol-licensing measures, such as New York’s Sullivan Law of 1911, likely had the effect of disarming the severely mentally ill because they provided unlimited discretion to a judge as to whether to allow an individual to possess a handgun.⁹¹ A few accidental peeks inside the results of the Sullivan Law process in the 1920s and 1950s suggest that there may have been political dimensions to the permit issuance process, at

eviction of the “Bonus Expeditionary Force,” a group of ten thousand veterans who “had ‘occupied’ the capital since early June” to pressure Congress to grant early payment of a bonus due to them for their World War I service. HERBERT HOOVER AND WORLD PEACE 126 (Lee Nash ed., 2010). Significantly, another law passed the same day as, and immediately following, the Dangerous Weapons Act, which 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.” H.R.J. Res. 462, 72nd Cong., 47 Stat. 654 (1932). Perhaps this was all coincidence, but perhaps there was a desire to have a method to disarm or prosecute armed members of the Bonus Expeditionary Force.

⁸⁹ See, e.g., *Ecker v. Potts*, 112 F.2d 581, 581 (D.C. Cir. 1940) (noting appellant’s argument that the testatrix was not of “sound mind”); *McDonald v. Fulton Trust Co.*, 107 F.2d 237, 238 (D.C. Cir. 1939) (noting the division of courts on the issue of whether a trust will be terminated “when some of its purposes are not yet fulfilled, but all the beneficiaries are of full age and sound mind”); *Thompson v. Smith*, 103 F.2d 936, 939 (D.C. Cir. 1939) (noting testimony that the decedent was “of sound mind”); *Werner v. Frederick*, 94 F.2d 627, 628 (D.C. Cir. 1937) (noting the plaintiffs’ assertion that the decedent was not “of sound mind” at the time a will was executed); *Owens v. United States*, 85 F.2d 270, 271 (D.C. Cir. 1936) (noting that the jury returned a verdict finding the defendant to be of “sound mind”); *Am. Sec. & Trust Co. v. ex rel. Spencer*, 82 F.2d 456, 456 (D.C. Cir. 1936) (quoting a portion of the decedent’s will where she stated she was “of sound mind”); *Railey v. Railey*, 30 F. Supp. 121, 122 (D.D.C. 1939) (noting the defendant’s argument that the decedent was of “sound mind”).

⁹⁰ *United States v. Witbeck*, 113 F.2d 185, 187 (D.C. Cir. 1940) (quoting *Conn. Mut. Life Ins. Co. v. Lathrop*, 111 U.S. 612, 619 (1884)).

⁹¹ 1911 N.Y. Laws ch. 195, sec. 1, § 1897 (current version at N.Y. PENAL LAW §§ 265.01(1), 265.20(a)(3) (McKinney 2013)). A contributing factor to the passage of the Sullivan Law was the murder of David Graham Phillips, a socially and politically connected author, in New York City by Fitzhugh Coyle Goldsborough, a musician and poet suffering from mental illness. Peter Duffy, *100 Years Ago, the Shot That Spurred New York’s Gun-Control Law*, CITY ROOM (Jan. 23, 2011), <http://cityroom.blogs.nytimes.com/2011/01/23/100-years-ago-the-shot-that-spurred-new-yorks-gun-control-law/>; see also *Phillips Dies of His Wounds*, N.Y. TIMES, Jan. 25, 1911, at A1 (announcing Phillips’s death).

least at the beginning. Known Mafiosi were successfully receiving not just permits to possess pistols in *their homes*, but the much more difficult pistol carry permits.⁹² We can only hope that New York State judges have been more concerned about mentally ill persons with firearms than Mafiosi with firearms.

Given the increased concern from the 1960s onward regarding the possession of firearms by the mentally ill, it is especially interesting to consider the relationship between violent crime and mental illness *before* that period of 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.”⁹³ Dr. Samuel B. Woodward, Worcester Hospital’s first superintendent, noted, “More than half of those manifesting monomania and melancholia are said to exhibit a propensity to homicide or suicide.”⁹⁴ Accounts of mass murder—usually involving family members—appear often enough in this period to understand why insanity could lead to hospitalization.⁹⁵ The opening of state asylums in

⁹² See JAY S. ALBANESE, ORGANIZED CRIME IN OUR TIMES 141–42 (2011) (reviewing the 1957 Appalachian, New York, Mafia leadership meeting that police accidentally discovered); EDWARD BEHR, PROHIBITION: THIRTEEN YEARS THAT CHANGED AMERICA 240–41 (1996) (stating that many of the Mafiosi had pistol carry permits issued by New York and New Jersey authorities); DAVID CRITCHLEY, THE ORIGIN OF ORGANIZED CRIME IN AMERICA: THE NEW YORK CITY MAFIA, 1891–1931, at 285 n.81 (2009) (describing how a New York mafia member used someone else’s address to obtain a pistol permit); SID FEDER & JOACHIM JOESTEN, THE LUCIANO STORY 52–54 (1954) (providing examples of 1920s Mafiosi receiving pistol carry permits); THOMAS A. REPPETTO, AMERICAN MAFIA: A HISTORY OF ITS RISE TO POWER 105 (2004) (noting that a New York mafia member was able to produce “a pistol permit signed by a state supreme court justice” when stopped by the police).

⁹³ HERBERT GOLDHAMER & ANDREW W. MARSHALL, PSYCHOSIS AND CIVILIZATION: TWO STUDIES IN THE FREQUENCY OF MENTAL DISEASE 39 (1953).

⁹⁴ *Id.* at 40–41. In modern terminology, the disorders mentioned are the rough equivalents of schizophrenia and depression, respectively. The term “monomania” was used for a variety of psychiatric conditions in the nineteenth century, leading to criticisms that it should perhaps be narrowed in its meaning. See R.L. PARSONS, *Nomenclature of Psychiatry*, 56 MED. & SURGICAL REP. 718 (1887) (“Monomania had been employed to indicate many different conditions of mental disease . . . [at least one doctor] had come to use the term paranoia as a substitute for that of monomania with satisfaction . . .”).

⁹⁵ See, e.g., JAMES W. NORTH, THE HISTORY OF AUGUSTA, FROM THE EARLIEST SETTLEMENT TO THE PRESENT TIME 335–37 (1870) (providing detailed accounts of the 1806 Purrinton murders, in which James Purrinton used a knife to murder his wife and seven of his eight children before committing suicide); LAUREL THATCHER ULRICH, A MIDWIFE’S TALE: THE LIFE OF MARTHA BALLARD, BASED ON HER DIARY, 1785–1812, at 291–306 (1991) (same). The case of William Beadle, of Wethersfield, Connecticut, is disturbingly similar. ROYAL RALPH HINMAN, A CATALOGUE OF THE NAMES OF THE EARLY PURITAN SETTLERS OF THE COLONY OF CONNECTICUT 165–67 (1852). In 1782, Beadle murdered his wife and four children by knocking them unconscious with an ax, then slitting their throats. *Id.* at 166. He then killed himself by firing two pistols at his head, simultaneously. *Id.* Beadle’s alleged motive was to protect them from ensuing poverty, his capital having been destroyed by the Revolution. GEORGE SIMON ROBERTS, HISTORIC TOWNS OF THE CONNECTICUT RIVER VALLEY 153–55 (1906).

Vermont in 1836 and New Hampshire in 1840 “contributed to the decline in such spouse and family murders during the 1850s and 1860s.”⁹⁶

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.⁹⁷ This is no surprise; those who were severely mentally ill were much more likely to be hospitalized before they became dangerously violent.⁹⁸

IV. CURRENT MENTAL ILLNESS-RELATED FIREARMS REGULATION

A. *The Federal Regulatory Scheme*

The Gun Control Act of 1968⁹⁹ makes firearms possession unlawful for anyone “adjudicated as a mental defective” or who has been “committed to a mental institution.”¹⁰⁰ 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.

(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.

....

⁹⁶ Randolph A. Roth, *Spousal Murder in Northern New England, 1776–1865*, in *OVER THE THRESHOLD: INTIMATE VIOLENCE IN EARLY AMERICA* 65, 72 (Christine Daniels & Michael V. Kennedy eds., 1999).

⁹⁷ PHIL BROWN, *THE TRANSFER OF CARE: PSYCHIATRIC DEINSTITUTIONALIZATION AND ITS AFTERMATH* 133 (1985); *cf.* Thomas M. Arvanites, *The Mental Health and Criminal Justice Systems: Complementary Forms of Coercive Control*, in *SOCIAL THREAT AND SOCIAL CONTROL* 131, 139 (Allen A. Liska ed., 1992) (“[E]vidence that suggests that the mentally ill are being arrested more often since deinstitutionalization.”).

⁹⁸ BROWN, *supra* note 97, at 140.

⁹⁹ 18 U.S.C. §§ 921–28 (2012).

¹⁰⁰ *Id.* § 922.

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.¹⁰¹

Federally licensed firearms dealers must use the National Instant Criminal Background Check System (“NICS”) to perform background checks on prospective firearm purchasers.¹⁰² The NICS Improvement Amendments Act of 2007 requires states to contribute criminal records and records of certain mental health-related adjudications or commitments to NICS as a condition to receiving federal funds.¹⁰³ The Act also requires states to provide relief from disability-derived firearms restrictions 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.”¹⁰⁴ Similar provisions apply to federal departments or agencies that make mental health-related adjudications or commitments.¹⁰⁵

Assuming its constitutionality, federal law concerning mental illness and firearms possession is, of course, supreme and—if vigorously enforced—would render state laws on the subject moot. But 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. Most prosecutions take place under state law because state and local police provide most criminal law enforcement within the United States.

B. *State Regulation and NICS Reporting*

One 2007 survey found that four states had no laws prohibiting firearms possession by the mentally ill; twelve states prohibited the mentally ill from obtaining a license to carry a concealed weapon only; and

¹⁰¹ 27 C.F.R. § 478.11 (2013).

¹⁰² 18 U.S.C. § 922(t); *see also* *National Instant Criminal Background Check System*, FED. BUREAU OF INVESTIGATION, <http://www.fbi.gov/about-us/cjis/nics> (last visited Apr. 30, 2014) (describing the functions of NICS).

¹⁰³ Pub. L. No. 110-180, §§ 102–103, 121 Stat. 2559, 2564–68.

¹⁰⁴ *Id.* § 105, 121 Stat. at 2569–70.

¹⁰⁵ *Id.* § 101(c)(2)(A).

the remaining thirty-four states (plus the District of Columbia) prohibited, in varying degrees or for varying periods, the mentally ill from possessing firearms.¹⁰⁶ In some jurisdictions, this is a prohibition on handguns, but in others, it is a prohibition on any category of firearm.¹⁰⁷

That sixteen states allow the severely mentally ill to purchase, receive, or possess firearms is alarming, 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 NICS. 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.¹⁰⁸ The other twenty-eight states had submitted no mental illness disqualifier records at all. Of the 167,903 records that were submitted, ninety-two percent were from Michigan and Virginia.¹⁰⁹ The most populous state, California, had submitted a total of twenty-seven records.¹¹⁰

Further complicating this severe problem, states have the discretion to submit records under the “denied persons file” instead of the “mental defective file,” if, for example, there are concerns regarding patient privacy.¹¹¹ This option allows states to disqualify a person without specifying a reason or turning over mental health records to NICS.¹¹² It should therefore be no surprise that NICS rejects an astonishingly low number of firearms purchases for mental illness. In 2010, NICS received approximately 10.4 million firearms transfer applications, of which 152,850 were rejected.¹¹³ Only 5879 applications were rejected

¹⁰⁶ 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 & L. 330, 333 (2007).

¹⁰⁷ *Id.*

¹⁰⁸ *Lethal Loopholes; Deficiencies in State and Federal Gun Purchase Laws: Hearing Before the Subcomm. on Domestic Policy of the H. Comm. on Oversight and Government Reform*, 110th Cong. 138 (2007) [hereinafter *Lethal Loopholes Hearing*] (statement of Rachel L. Brand, Assistant Att’y Gen. for Legal Policy, Department of Justice).

¹⁰⁹ *Id.*

¹¹⁰ *Id.* The Department of Veterans Affairs submits mental disqualification records when it has 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.” EDWARD C. LIU ET AL., CONG. RESEARCH SERV., R43040, SUBMISSION OF MENTAL HEALTH RECORDS TO NICS AND THE HIPAA PRIVACY RULE 3 (2013), available at <http://www.fas.org/sgp/crs/misc/R43040.pdf>. 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 when a fiduciary manages financial benefits. *Id.* at 3.

¹¹¹ *Lethal Loopholes Hearing*, *supra* note 108, at 11.

¹¹² *Id.*

¹¹³ RONALD J. FRANSEN ET AL., BUREAU OF JUSTICE STATISTICS, NCJ 238226, BACKGROUND CHECKS FOR FIREARMS TRANSFERS, 2010—STATISTICAL TABLES, at 4 tbl.2 (2013). Of the 2010 rejections, 36,672 (24%) were appealed, and 12,275 (33.5%) of the appeals were reversed. *Id.* at 7

specifically due to mental illness or disability.¹¹⁴ Because the “denied persons file” provides a way for states to disqualify a person without mentioning mental illness, at least some of the 20,667 rejections for “other prohibitions” might be attributable to such conditions.¹¹⁵

A few states perform their own background checks, using the state’s own records as well as the resources of NICS, but do not necessarily submit mental health disqualifying records to NICS.¹¹⁶ One consequence is that a state may successfully block a mentally ill person from buying a firearm *in that state*, but the person may take up residence in another state and not be blocked from purchasing firearms.¹¹⁷ The new state of residence does not have access to the previous state’s mental illness records, nor does NICS.¹¹⁸ One example where submitting records to NICS made a real difference is that of Virginia, which started submitting mental health disqualifier records in November 2003.¹¹⁹ Three years later, Virginia’s records had prevented not only sixty purchase attempts in that same state, but also 378 purchase attempts in other states.¹²⁰

C. *Changing State Regulations and NICS Reporting Practices in the Wake of Recent Tragedies*

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, despite concerns by the special judge who presided over the hearing that Cho was an imminent threat to himself and others.¹²¹ Cho was ordered, however, to engage in outpatient treatment.¹²² 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.¹²³ The ambiguity of whether court-ordered outpatient treatment qualified as “involuntary commitment” under Virginia law

tbl.6.

¹¹⁴ See *id.* at 6 tbl.4 (reflecting the combined figure of 1.8% of 72,659 FBI rejections and 5.7% of 80,191 state and local agency rejections).

¹¹⁵ See *id.* (reflecting the combined figure of 0.3% of 72,659 FBI rejections and 25.5% of 80,191 state and local agency rejections).

¹¹⁶ *Background Checks for Guns: What You Need to Know*, NBC NEWS (Apr. 10, 2013), http://usnews.nbcnews.com/_news/2013/04/10/17689167-background-checks-for-guns-what-you-need-to-know?lite.

¹¹⁷ *Lethal Loopholes Hearing*, *supra* note 108, at 139.

¹¹⁸ *Id.*

¹¹⁹ *Id.*

¹²⁰ *Id.*

¹²¹ VA. TECH REVIEW PANEL, MASS SHOOTINGS AT VIRGINIA TECH 48, 56 (2007), available at <http://www.washingtonpost.com/wp-srv/metro/documents/vatechreport.pdf>.

¹²² *Id.* at 48.

¹²³ *Id.* at 71–72.

would appear to be why Cho's handgun purchases were allowed by the background check and not reported to NICS. Note that this ambiguity was corrected by an executive order from Governor Kaine in the days following the murders.¹²⁴

Improved reporting of mental-health disqualifiers to NICS would reduce firearms purchases by those prohibited by federal law. In response to recent tragedies, federal financial assistance, and encouragement from the Department of Justice,¹²⁵ there has been a dramatic increase in the number of states that now submit mental incompetence records to NICS or are preparing to do so.

In 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.¹²⁶ 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.”¹²⁷ But along with these 413,000 records of involuntary commitments, “[i]nformation 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,”¹²⁸ even though the federal definition specifically excludes voluntary commitments from the federal disability.¹²⁹ This inclusion of voluntary commitments creates a serious due process problem, because these voluntary commitments are indistinguishable from the involuntary commitments when NICS must decide whether to reject a firearm purchase.

Unsurprisingly, after the Newtown tragedy, Connecticut “is creating a database of individuals who are disqualified from owning a gun for mental health reasons.”¹³⁰ Unlike New Jersey, news coverage indicates that the state is conforming to the federal requirements by only including those who have been involuntarily committed and those “who have been found incompetent to stand trial or not guilty due to insanity.”¹³¹ State officials

¹²⁴ *Id.* at 72–73.

¹²⁵ See *Lethal Loopholes Hearing*, *supra* note 108, at 137–38 (explaining federal “outreach efforts” to encourage increased state reporting).

¹²⁶ David Levinsky, *413,000 NJ Mental Health Records Submitted for Gun Checks*, BURLINGTON COUNTY TIMES (Aug. 27, 2013), http://www.burlingtoncountytimes.com/news/local/burlington_county_times_news/nj-mental-health-records-submitted-for-gun-checks/article_2b01c264-3fd8-5b03-8c77-1482d55ed2a3.html.

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ See 27 C.F.R. § 478.11 (2013) (“The term [commitment] does not include a person in a mental institution for observation or a voluntary admission to a mental institution.”).

¹³⁰ Jenny Wilson, *Banned List for Owning Guns; State Creating Database for Better Reporting; Mental Health*, HARTFORD COURANT, May 8, 2013, at A1.

¹³¹ *Id.*

report that they have already found disqualifying records not previously submitted to NICS.¹³²

Pennsylvania also submitted more than 600,000 disqualifying mental health records to NICS in January 2013—records not previously provided by the state police.¹³³ Complicating this decision is that about seventy to seventy-five percent of those records were “302 Commitments.”¹³⁴ The 302 Commitment is “the shortest and most common type of involuntary mental health commitment.”¹³⁵ Recently, the ATF acknowledged that it is “reviewing whether Pennsylvania’s 302 commitment is a federal prohibition under federal law.”¹³⁶ The emergency nature of a 302 Commitment is posited on concern that the subject is an imminent threat to self or others, and the short-term nature of the commitment (120 hours)¹³⁷ limits the damage that such a commitment does to a subject’s rights. It seems like a reasonable balancing of the individual’s rights and the state’s desire to protect both others and the subject of the commitment. However, the submission of a 302 Commitment to NICS, which deprives an individual of the right to keep and bear arms for years in the future, is neither emergency in nature (because it will take days for that information to become operative in the NICS database), nor temporary in its consequences (because it will deprive an individual of the right to bear arms for years). It seems unlikely that a long-term commitment or deprivation of fundamental rights would be so readily tolerated by the federal courts without a more formal procedure.

Maine amended its state law in 2008 to clarify that allowing state agencies to “releas[e] information about involuntarily committed individuals” did not violate the privacy rights of patients.¹³⁸ Maine has since wanted to submit mental health disqualifiers to NICS, but a lack of resources has prevented court officials from processing approximately 5000 records to find out how many qualify as involuntary commitments.¹³⁹

¹³² *Id.*

¹³³ Moriah Balingit, *Pa. Sends Mental Health Data for Gun Checks*, PITTSBURGH POST-GAZETTE, Jan. 19, 2013, at A1.

¹³⁴ *Id.*; see also 50 PA. CONS. STAT. ANN. § 7302 (West 2014) (allowing for involuntary commitment for up to 120 hours of observation based on a doctor’s belief that a patient “is severely mentally disabled and in need of immediate treatment”). Pennsylvania’s 302 Commitment statute does not provide individuals with any advance notice or opportunity for a hearing, but the Third Circuit has held that the statute satisfies procedural due process requirements in light of the “emergency situation” and “short-term commitment.” *Benn v. Universal Health Sys.*, 371 F.3d 165, 174 (3d Cir. 2004).

¹³⁵ Balingit, *supra* note 133.

¹³⁶ *Id.* (internal quotation marks omitted).

¹³⁷ 50 PA. CONS. STAT. ANN. § 7302(d).

¹³⁸ Robert Long, *How Does Maine Balance Public Safety and Gun Rights of Mentally Ill?*, BANGOR DAILY NEWS (Jan. 18, 2013), <http://bangordailynews.com/2013/01/18/politics/how-does-maine-balance-public-safety-and-gun-rights-of-mentally-ill/>.

¹³⁹ *Id.*

In the aftermath of the Newtown tragedy, Governor Deval Patrick of Massachusetts sought legislative approval to submit mental health disqualifier records from public psychiatric facilities to NICS.¹⁴⁰ Mental health advocacy organizations, such as the National Alliance on Mental Illness of Massachusetts, opposed the bill, because “[a]n all-encompassing database reinforces stigma and labels, and creates fear.”¹⁴¹ This may be very true, but as discussed in Part I of this Article, that fear has a very real factual basis.¹⁴² Other opponents of the Massachusetts proposal misunderstood that such records were only for involuntary commitments, and not for outpatient or voluntary inpatient treatment. For example, Professor James Alan Fox stated that “banning gun possession for people who go to psychiatrists ‘would only discourage people from getting treatment.’”¹⁴³

The Newtown tragedy has certainly given strong impetus to states to submit involuntary commitment and other mental illness disqualifying records to NICS. Some are doing what the law requires and carefully separating voluntary from involuntary commitments. Other states are opening up a can of worms by failing to make that distinction. This both violates the rights of persons who voluntarily enter a mental hospital for treatment and may discourage persons who are severely depressed, but are reluctant to risk the loss of firearms rights.

V. DEINSTITUTIONALIZATION AND FIREARMS REGULATION FOR THE MENTALLY ILL

A. *The Societal Momentum for Deinstitutionalization*

It may seem a bit startling that regulation of firearms possession by the mentally ill has only occurred in relatively recent times, until we examine the history of how American society has handled the problem of mental illness. Until the 1960s, individuals 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.¹⁴⁴ Under the best of conditions, state mental hospitals were not good environments for the mentally ill. But today, we have switched to even worse alternatives: life on the street for many; death from exposure

¹⁴⁰ Lee Hammel, *Mental Health Factor in Trying to Reduce Mass Killings*, WORCESTER TELEGRAM & GAZETTE, Feb. 24, 2013, at A1.

¹⁴¹ *Id.* (internal quotation marks omitted).

¹⁴² See *supra* Part I (discussing the correlation between mental health and violence).

¹⁴³ Hammel, *supra* note 140.

¹⁴⁴ See CLAYTON E. CRAMER, MY BROTHER RON: A PERSONAL AND SOCIAL HISTORY OF THE DEINSTITUTIONALIZATION OF THE MENTALLY ILL 77 (2012) (“There *were* patients who entered public mental hospitals, and stayed there for life [M]any others . . . were released within a year.”) (emphasis added).

and disease for some; jail or prison for others; and tragic headlines for a few who become national news stories.¹⁴⁵

The desire for a more humane approach led to deinstitutionalization of the mentally 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 caused by the Great Depression and World War II.¹⁴⁶ State mental hospitals also cared for the senile elderly and syphilitic insane, creating severe crowding in what were often unpleasant custodial institutions.¹⁴⁷ Until the introduction in 1954 of the first antipsychotic medication, chlorpromazine, the first choices for managing a patient who posed a danger to self or others were a straitjacket, electroconvulsive therapy (“shock treatment”), or a prefrontal lobotomy.¹⁴⁸

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 nearly became the antithesis of humane treatment of the mentally ill.¹⁴⁹ Good intentions were not in short supply, but good intentions were not enough. The emerging psychiatry movement dominated the profession and the National Institute of Mental Health was formed.¹⁵⁰ Through these institutions, psychiatry promoted a model that had worked well with soldiers suffering from combat fatigue, but was completely inappropriate for the civilian psychotic population.¹⁵¹

B. *The Changed Legal Standards Relating to Deinstitutionalization*

Other movements rapidly collided, ultimately with disastrous results. The emerging counterculture distrusted authority and middle-class values, and soon had its partisans in the establishment.¹⁵² Civil libertarians insisted on a very strict standard of due process that was substantially at odds with the American tradition of civil commitment law.¹⁵³ In *Lessard v. Schmidt*,¹⁵⁴ a federal district court struck down Wisconsin’s involuntary commitment statute for two reasons.¹⁵⁵ First, it failed to provide the patient with sufficient notice of her proceedings and an opportunity to have a lawyer represent her interests.¹⁵⁶ Second, and perhaps more importantly, it

¹⁴⁵ *Id.* at 51.

¹⁴⁶ *Id.* at 76.

¹⁴⁷ *Id.* at 77.

¹⁴⁸ *Id.* at 48–49, 55.

¹⁴⁹ *Id.* at 51, 57.

¹⁵⁰ *Id.* at 54.

¹⁵¹ *Id.* at 51.

¹⁵² *Id.* at 66–75.

¹⁵³ *Id.* at 105–23.

¹⁵⁴ 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated on other grounds*, 414 U.S. 473 (1974).

¹⁵⁵ *Id.* at 1103.

¹⁵⁶ *Id.* at 1093, 1099.

rejected the traditional *parens patriae* role of government to watch over the interests of the patient¹⁵⁷ and required that the government prove beyond a reasonable doubt that a person was “mentally ill and dangerous.”¹⁵⁸

Backing away from *Lessard*'s use of the standard of proof for criminal convictions, the U.S. Supreme Court in *Addington v. Texas*¹⁵⁹ replaced the traditional preponderance of evidence standard for involuntary commitment with a requirement for “clear and convincing evidence” of mental illness.¹⁶⁰ The Court reasoned that involuntary commitment involved both the deprivation of liberty and the stigma associated with mental illness.¹⁶¹ In *Vitek v. Jones*,¹⁶² the Court ruled that due process requirements must even be satisfied before a convicted felon is transferred from a prison to a mental hospital.¹⁶³ The prisoner in the case was still within his original sentence, yet the Court explained that “involuntary commitment [would be] more than a loss of freedom from confinement” for him because it subjects individuals to involuntary psychiatric treatment and stigmatization.¹⁶⁴

At the same time, some commentators insisted that the state had a duty to provide treatment as a condition of holding certain mental health patients.¹⁶⁵ In some cases, the goal was openly stated: the threat to release mental patients would force legislatures to spend the requisite money to provide treatment, instead of simply warehousing the mentally ill.¹⁶⁶

¹⁵⁷ See *id.* at 1085 (explaining that the “American innovation [of *parens patriae*] resulted in total, and perhaps permanent, loss of liberty”).

¹⁵⁸ See *id.* at 1095 (“The argument for a stringent standard of proof is more compelling in the case of a civil commitment in which an individual will be deprived of basic civil rights and be certainly stigmatized by the lack of confidentiality of the adjudication. We therefore hold that the state must prove beyond a reasonable doubt all facts necessary to show that an individual is mentally ill and dangerous.”).

¹⁵⁹ 441 U.S. 418 (1979).

¹⁶⁰ *Id.* at 427.

¹⁶¹ *Id.* at 429.

¹⁶² 445 U.S. 480 (1980).

¹⁶³ *Id.* at 493–94.

¹⁶⁴ *Id.* at 492, 494.

¹⁶⁵ See, e.g., David L. Bazelon, *The Right to Treatment: The Court's Role*, 20 HOSP. & COMMUNITY PSYCHIATRY 129–30 (1969) (defending his decision in *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966), which found that a person who is involuntarily committed following acquittal of a crime by reason of insanity must either be treated within a reasonable amount of time or released). More recently, the Supreme Court recognized that the lone penological goal of incapacitation could be appropriate in some situations, for “it would be of little value to require treatment as a precondition for civil confinement of the dangerously insane when no acceptable treatment existed.” *Kansas v. Hendricks*, 521 U.S. 346, 366 (1997).

¹⁶⁶ See Morton Birnbaum, *The Right to Treatment*, 46 A.B.A. J. 499, 502–03 (1960) (arguing for “the recognition and enforcement of the legal right of a mentally ill inmate of a public mental institution to adequate medical treatment for his mental illness”). 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 [would] be shown that the standard of treatment in public mental institutions probably [would] be raised.” *Id.* at 499.

Whatever the pragmatic arguments for this might be, it represented a dramatic change in the American legal tradition. In *O'Connor v. Donaldson*,¹⁶⁷ the Court held that “[a] finding of ‘mental illness’ alone” does not justify holding a mental patient against his will and that release is required if the patient is “dangerous to no one and can live safely in freedom.”¹⁶⁸ While the Court did not reach the specific question of whether the state must provide treatment during involuntary commitments,¹⁶⁹ Chief Justice Burger reflected on the developing movement in that area in his concurrence:

[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 [who do not acknowledge their illness or cooperate with treatment] . . . are unable to function in society and will suffer real harm to themselves unless provided with care in a sheltered environment.¹⁷⁰

Civil libertarians also furthered a campaign insisting that patients have a right to refuse treatment.¹⁷¹ Among the more astonishing decisions embracing this rationale comes from the Massachusetts Supreme Court.¹⁷² Against the advice of a psychiatrist, a schizophrenic minor with a history of criminal behavior refused antipsychotic medication at a state hospital.¹⁷³ The minor’s father sought contingent authority to authorize this treatment out of concern for the well-being of his son.¹⁷⁴ Under the circumstances, the court found that the approach to treatment would require a “substituted judgment determination.”¹⁷⁵ This determination involves a court substituting its judgment for what the minor might have decided to do had

¹⁶⁷ 422 U.S. 563 (1975).

¹⁶⁸ *Id.* at 575.

¹⁶⁹ *Id.* at 573.

¹⁷⁰ *Id.* at 582–84.

¹⁷¹ E. Fuller Torrey & Mary Zdanowicz, Op-Ed, *Why Do Severely Mentally Ill Go Untreated?*, BOS. GLOBE, Aug. 1, 1998, at A11. It is worth noting that in prison settings, the U.S. Supreme Court has recognized that the state can “treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate’s medical interest.” *Washington v. Harper*, 494 U.S. 210, 227 (1990).

¹⁷² *See In re Guardianship of Roe*, 421 N.E.2d 40, 43 (Mass. 1981) (holding that state hospital psychiatrists and the father of a mentally ill minor did not have authority to overrule the minor’s decision to refuse antipsychotic medication).

¹⁷³ *Id.* at 44.

¹⁷⁴ *Id.* at 50.

¹⁷⁵ *Id.*

he been sane.¹⁷⁶ But what would the minor have decided if he were sane? As the same court explained in a later decision, “The likelihood of improvement or cure enhances the likelihood that an incompetent patient would accept treatment, but it is not conclusive.”¹⁷⁷ A mentally incompetent person, if he had been sane, *might* decide that sanity is preferable to insanity, but this is by no means certain.¹⁷⁸ As a result, states that had at least an obligation to provide care for the severely mentally ill, if they were held involuntarily, could face competing pressures to provide no care at all.

In addition, some of the lawsuits initiated against deplorable state mental hospitals dramatically increased their operating costs, and further encouraged states to deinstitutionalize. For example, in *Wyatt v. Stickney*¹⁷⁹ a federal district court ruled, not too surprisingly, that patients enjoy a constitutional right to send sealed mail.¹⁸⁰ But the court also decided that there was a constitutional right to a specific number of clerical support staff per patient.¹⁸¹ The net effect of *Wyatt* was to both micromanage local mental hospitals and dramatically increase their operating costs.

C. *The Deinstitutionalization Transition: From State Mental Hospitals to Streets and Prisons*

Soon, state mental hospitals were emptied of many of their patients—from 559,000 in 1955 to 110,000 in 1990¹⁸²—during a period when the U.S. population rose by fifty percent.¹⁸³ 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.¹⁸⁴ This created an economic incentive for states to move a large portion of their patients to private nursing care (where death rates

¹⁷⁶ *Id.* The court noted that its decision was confined to non-emergency situations and that an individual’s right to refuse treatment could be overridden if necessary to prevent harm to the patient or others. *Id.* at 59.

¹⁷⁷ *Rogers v. Comm’r of Dep’t of Mental Health*, 458 N.E.2d 308, 319 (Mass. 1983).

¹⁷⁸ *Id.*

¹⁷⁹ 344 F. Supp. 373 (M.D. Ala. 1972).

¹⁸⁰ *Id.* at 379.

¹⁸¹ *Id.* at 383.

¹⁸² David Mechanic & David A. Rochefort, *Deinstitutionalization: An Appraisal of Reform*, 16 ANN. REV. SOC. 301, 301 (1990).

¹⁸³ *Historical National Population Estimates: July 1, 1900 to July 1, 1999*, U.S. CENSUS BUREAU, <http://www.census.gov/population/estimates/nation/popclockest.txt> (last updated June 28, 2000).

¹⁸⁴ MICHAEL J. DEAR & JENNIFER R. WOLCH, LANDSCAPES OF DESPAIR: FROM DEINSTITUTIONALIZATION TO HOMELESSNESS 65–66, 140–42 (1987); Margaret W. Linn & Shayna Stein, *Nursing Homes as Community Mental Health Facilities*, in HANDBOOK ON MENTAL HEALTH POLICY IN THE UNITED STATES 267, 270–71 (David A. Rochefort ed., 1989).

were higher, perhaps because of aggressive cost-cutting by these profit-making institutions).¹⁸⁵ The introduction of antibiotics for the treatment of syphilis after World War II also gradually eliminated the syphilitic insane, who had accounted for between six and twenty-two percent of mental hospital patients during the twentieth century.¹⁸⁶

While California was a leader in the deinstitutionalization of the mentally ill, its experience was not completely unusual. California saw a 67% 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.¹⁸⁷ 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.¹⁸⁸ One recent critic of the growing incarceration rate for the mentally ill argued that it could be remedied by addressing four key problems: (1) homelessness; (2) the frequent failure to reapply for Medicaid benefits following prison release; (3) substance abuse disorders; and (4) stigmatization.¹⁸⁹ While these factors may certainly contribute to the mentally ill's failure to receive proper treatment, the most basic problem of all should not be discounted: refusal by the severely mentally ill to recognize that they are in need of treatment.

As 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, Social Security disability checks went to persons with hallucinations and delusions.¹⁹⁰ For example, it appears that Patrick Purdy's Social Security disability checks paid for the weapons that he used for the first of the schoolyard massacres in 1989.¹⁹¹ The question is not why the period from 1980 to the present has been awash in these random acts of mass murder, disproportionately committed by people with very serious mental illnesses.

¹⁸⁵ See GERALD N. GROB, FROM ASYLUM TO COMMUNITY: MENTAL HEALTH POLICY IN MODERN AMERICA 267–69 (1991) (demonstrating financial restrictions on state mental health hospitals); GERALD N. GROB, THE MAD AMONG US: A HISTORY OF THE CARE OF AMERICA'S MENTALLY ILL 266 (1994) [hereinafter GROB, THE MAD AMONG US] (illustrating the patient shift to private nursing care).

¹⁸⁶ GROB, THE MAD AMONG US, *supra* note 185, at 124–25; MASS. STATE BD. OF INSANITY, FIFTEENTH ANNUAL REPORT OF THE STATE BOARD OF INSANITY OF THE COMMONWEALTH OF MASSACHUSETTS 45 (1914).

¹⁸⁷ DEAR & WOLCH, *supra* note 184, at 65–66, 140–42.

¹⁸⁸ *Id.*

¹⁸⁹ Christina Canales, Note, *Prisons: The New Mental Health System*, 44 CONN. L. REV. 1725, 1727 (2012).

¹⁹⁰ See, e.g., *Johnson v. Astrue*, 493 F. Supp. 2d 652, 655, 657 (W.D.N.Y. 2007) (defining hallucinations and delusions as impairments for the purposes of qualifying for Social Security disability income).

¹⁹¹ Glen Morgan, *The Assault Rifle Controversy*, 3 J. POL. & SOC. 21, 24 (1991).

Arguably, the question should instead be: why have we as a society been so lucky? Given these circumstances, the number of mass murders could potentially have been much higher.

The answer is the advent of the incarceration revolution, which began in the late twentieth century and caused prison populations to “skyrocket[.]”¹⁹² Many dangerous mentally ill individuals that may have been institutionalized in another era were imprisoned. 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 hospitalized much, they were still being incapacitated via jails and prisons¹⁹³ — which is why murder rates fell.

VI. DEINSTITUTIONALIZATION’S CONSEQUENCES

A. *A Different View of the State*

The previous discussion alludes to many recent tragedies being the consequence of a well-intentioned effort to improve conditions for the mentally ill by emptying state mental hospitals. Some of this was simply a consequence of legislative miscalculation and a failure to correct mistakes. But there was also a radical abrogation of the traditional duty of the state, which Chief Justice Burger described 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.’”¹⁹⁴

Traditionally, state governments were assumed to be looking out for the best interests of the mentally ill, and thus the preponderance of evidence standard was considered sufficient for involuntary commitment.¹⁹⁵ Civil libertarians zealously insisted, largely based on theoretical models that often denied that mental illnesses such as schizophrenia even existed,¹⁹⁶ that a much more demanding standard be

¹⁹² Harcourt, *supra* note 30, at 3.

¹⁹³ Harcourt, *supra* note 26, at 1773.

¹⁹⁴ *O’Connor v. Donaldson*, 422 U.S. 563, 583 (1975) (Burger, C.J., concurring) (citations omitted) (quoting *Hawaii v. Standard Oil Co.*, 405 U.S. 251, 257 (1972)).

¹⁹⁵ See, e.g., *State v. Turner*, 556 S.W.2d 563, 566 (Tex. 1977) (“In future cases of civil commitment the jury should be instructed that the burden is upon the State to prove by a preponderance of the evidence the statutory prerequisites to commitment.”).

¹⁹⁶ See CRAMER, *supra* note 144, at 68–74, 111, 115 (reviewing arguments by Szasz and Laing concerning the non-existence of schizophrenia and explaining how lawyers advocating for stricter standards, as a matter of civil liberties, knew nothing about mental illness except for what they had read from Szasz); see also Alan Kerr, *Interview: Thomas Szasz*, 21 PSYCHIATRIC BULL. 39, 41 (1997) (including Szasz’s proud description of how he completed his psychiatric residency without ever

used for involuntary commitment, preferably “beyond a reasonable doubt.”¹⁹⁷

B. *Increased Homelessness and Associated Mortality Rates*

While this approach is superficially appealing, 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.¹⁹⁸

This is not simply an artifact of increased discussion; studies of the homeless from the 1980s through the present have found that the homeless are disproportionately mentally ill.¹⁹⁹ Where attempts were made to determine causality, the mental illness was usually found to have preceded

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.’”).

¹⁹⁷ *Addington v. Texas*, 441 U.S. 418, 421 (1979) (indicating that the appellant had requested at trial that the court use “beyond a reasonable doubt” as the standard of proof for involuntary commitment).

¹⁹⁸ GOOGLE BOOKS NGRAM VIEWER, <https://books.google.com/ngrams> (last visited Apr. 15, 2014) (search “homeless” between “1900” and “2000” from the corpus “English” with a smoothing of “3”).

¹⁹⁹ DEAR & WOLCH, *supra* note 184, at 175–76; *see also* Leena L. Bachrach, *The Homeless Mentally Ill and Mental Health Services*, in *THE HOMELESS MENTALLY ILL: A TASK FORCE REPORT OF THE AMERICAN PSYCHIATRIC ASSOCIATION* 16–19 (H. Richard Lamb ed., 1984) (reporting that 40% of 179 homeless men and women in a Philadelphia shelter were found to have “major mental disorders,” with one-third diagnosed as schizophrenic and one-fourth diagnosed as having substance abuse problems, and further that 40% of 78 Boston shelter residents had major mental disorders, 51% had less severe psychiatric problems, and the remaining 9% were largely dependent spouses and children); Irene Shifren Levine & Loretta K. Haggard, *Homelessness as a Public Mental Health Problem*, in *HANDBOOK ON MENTAL HEALTH POLICY IN THE UNITED STATES*, *supra* note 184, at 293, 294–99, 306 (noting that the mentally ill are at a high risk of becoming homeless and that “[h]omelessness is in part a public mental health problem”); Pamela J. Fischer et al., *Mental Health and Social Characteristics of the Homeless: A Survey of Mission Users*, 76 AM. J. PUB. HEALTH 519, 521–22 (1986) (explaining that in one study 37% of homeless persons were diagnosed as suffering a mental disorder compared to 18% of household males, and that “[o]ne-third of the homeless had a previous psychiatric hospitalization compared to only 5 percent of male householders”); Shirley N. Harris et al., *Physical Health, Mental Health, and Substance Abuse Problems of Shelter Users*, 19 HEALTH & SOC. WORK 37 (1994) (summarizing a study of homeless shelter residents that found that only 26% had been previously hospitalized for psychiatric problems, although 4.8% of those requested to participate declined because their “psychiatric distress [was] too severe” and 29% declined for various reasons, including that they “did not want any records made on themselves”); Cheryl Zlotnick et al., *Long-Term and Chronic Homelessness in Homeless Women and Women with Children*, 25 SOC. WORK IN PUB. HEALTH 470, 472–74, 478 (2010) (illustrating that 50.6% of homeless women surveyed in a 1996 National Survey of Health Assistance Providers and Clients had reported mental health problems within the previous year).

homelessness.²⁰⁰ While there were differences in methodology across different studies, making exact comparisons questionable and trend analysis statistically meaningless,²⁰¹ 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 never committed.²⁰²

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 time that deinstitutionalization was in full swing, hypothermia deaths in America were on the rise. In 1974, the death rate was 0.164 per 100,000 people.²⁰³ By 1979, the death rate had doubled to 0.322 per 100,000.²⁰⁴ Hypothermia death rates continued to rise, peaking at 0.4 per 100,000 in 1985, before dropping back below 0.2 per 100,000 in the late 1990s.²⁰⁵ Not every person who died of hypothermia was mentally ill, but a detailed study of hypothermia deaths in Washington, D.C. from 1972 to 1982 found that one-third were severely malnourished, four-fifths were never reported missing, one-half had high blood ethanol levels, and most were found in abandoned buildings or vehicles.²⁰⁶ It is difficult to consider these population 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 attributable to deinstitutionalization.

²⁰⁰ See Judith A. Stein & Lillian Gelberg, *Homeless Men and Women: Differential Associations Among Substance Abuse, Psychosocial Factors, and Severity of Homelessness*, 3 EXPERIMENTAL & CLINICAL PSYCHOPHARMACOLOGY 75, 76–77 (1995) (“Most data indicate that the prevalence of mental illness is about 20% to 30%. For instance, 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.” (citations omitted)).

²⁰¹ See RAELE JEAN ISAAC & VIRGINIA C. ARMAT, *MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL* 4–6 (1990) (comparing the statistical analysis of the homeless population from various sources, including the U.S. Census and a study financed by the U.S. Department of Agriculture).

²⁰² H. Richard Lamb, *Foreword* to *THE HOMELESS MENTALLY ILL: A TASK FORCE REPORT OF THE AMERICAN PSYCHIATRIC ASSOCIATION*, *supra* note 199, at xiii.

²⁰³ Nicholas Rango, *Exposure-Related Hypothermia Mortality in the United States, 1970–79*, 74 AM. J. PUB. HEALTH 1159, 1159 (1984).

²⁰⁴ *Id.*

²⁰⁵ *Compressed Mortality, 1979–1998 Request*, CENTERS FOR DISEASE CONTROL & PREVENTION, <http://wonder.cdc.gov/ucd-icd10.html> (last visited Apr. 15, 2014) (group results by “ICD Chapter”; select year “1985”; then, under ICD-9 codes, open “E901”; then click “send”; repeat previous steps for year “1998”).

²⁰⁶ Rango, *supra* note 203, at 1160.

C. *Transformed Urban Environments*

Along with 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 society. In many urban areas, public libraries became day shelters for the mentally ill. This should be of no surprise to anyone who has lived in a big city during the last thirty years. What is surprising, however, is how early the connection between the public library problem and mental illness was recognized. In 1981, a *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*.²⁰⁷

A friend of mine, Norma Kennemer, worked at the main branch of the Santa Rosa, California public library in the 1980s and 1990s. She shared 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 this hypercautious approach? Because attempts to resolve behavioral problems could lead to lawsuits—which was precisely the experience in Morristown, New Jersey. The behavior and offensive smell of a homeless person named Kreimer led to the adoption of a code of conduct, which prohibited loitering, “unnecessary staring,” and following others around the library, and also requiring library patrons to conform to community standards of

²⁰⁷ Gregory Jaynes, *Urban Librarians Seek Ways To Deal With “Disturbed Patrons,”* N.Y. TIMES, Nov. 24, 1981, at A16.

cleanliness.²⁰⁸ Kreimer filed suit against this allegedly discriminatory code, seeking punitive and compensatory damages “stemming from his ejection from the library.”²⁰⁹ At trial, Judge H. Lee 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.²¹⁰

Wiser heads prevailed on appeal. The Third Circuit concluded that the rules were not unconstitutional and reversed Sarokin’s decision.²¹¹ 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 it was finished, Morristown had spent more than one million dollars.²¹² The cost of fighting such lawsuits may certainly discourage codes of conduct in these public spaces.

* * *

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 was 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. Yet social scientists studying the homelessness problem knew as early as 1984 that the homeless were disproportionately, and in some samples predominantly, mentally ill.²¹³ The unwillingness to draw connections to the just-completed and radical social experiment of

²⁰⁸ *Kreimer v. Bureau of Police for Morristown*, 765 F. Supp. 181, 183–84 (D.N.J. 1991), *rev’d*, 958 F.2d 1242 (3d Cir. 1992).

²⁰⁹ *Kreimer*, 958 F.2d at 1248–49.

²¹⁰ *Kreimer*, 765 F. Supp. at 183.

²¹¹ *Kreimer*, 958 F.2d at 1246.

²¹² John Cichowski, *Some Riders Wear Suits, Some File Them*, THE RECORD (Bergen County, N.J.), Mar. 15, 2005.

²¹³ See *supra* note 199 and accompanying text.

deinstitutionalization was more about partisan politics than about sensible public policy.

VII. THE RIGHTS OF THE MENTALLY ILL AND THE SECOND AMENDMENT: IS THERE A CONFLICT?

There are several different ways to approach the question of whether there is a conflict between the Second Amendment and the rights of the mentally ill. But first, it is important to recognize that absolutist positions, while politically satisfying and less analytically complicated, have little to do with the U.S. Constitution.

As Justice Scalia's opinion in *District of Columbia v. Heller* 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."²¹⁴ 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 ten 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.²¹⁵

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 carrying of firearms.²¹⁶ 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.²¹⁷ Nor can it be attributed to the

²¹⁴ 554 U.S. 570, 595 (2008).

²¹⁵ *Robertson v. Baldwin*, 165 U.S. 275, 281 (1897).

²¹⁶ See generally CLAYTON E. CRAMER, *ARMED AMERICA: THE REMARKABLE STORY OF HOW AND WHY GUNS BECAME AS AMERICAN AS APPLE PIE* 1–16, 30–38 (2006); see also Nicolas J. Johnson, *Firearms Policy and the Black Community: An Assessment of the Modern Orthodoxy*, 45 CONN. L. REV. 1491, 1516–18 (2013) (detailing a post-Civil War movement for the right for black “freedmen” to keep and bear arms).

²¹⁷ See, e.g., 18 U.S.C. § 922(g)(1) (2012) (prohibiting felons from possessing firearms or ammunition); *id.* § 922(g)(9) (prohibiting those convicted of domestic violence misdemeanors from possessing a firearm); *id.* § 922(r) (prohibiting certain categories of semiautomatic weapons); *id.* § 922(t)(1) (requiring waiting periods and background checks for handgun purchases); CAL. PENAL

sudden availability of high-capacity semiautomatic weapons. For example, the Colt AR-15, a semiautomatic version of the U.S. Army's M-16, has been available with thirty-round magazines for ownership by private citizens since at least 1965.²¹⁸ Additionally, thirteen-round semiautomatic pistols have been advertised for sale since at least 1954.²¹⁹ Semiautomatic pistols with detachable magazines have been offered for sale to private citizens since at least 1918.²²⁰

The lack of apparent conflict for most of our history appears to have been because most persons whose mental illness problems were considered to be a public safety concern were hospitalized. After hospitalization, in most states into the 1960s, these persons were deemed legally incompetent and were unable, for example, to obtain a driver's license, vote, or manage their financial affairs.²²¹ A person confined to a mental hospital might have been able to make a constitutional argument that denial of his right to keep and bear arms violated either the Second Amendment or the various state constitution analogs. But it seems most unlikely that, until the civil rights revolution of the late twentieth century, any court or lawyer would have taken such a claim seriously. The severely mentally ill were (as today) a tiny fraction of the population, and the legal distinctions that treated them differently seem to have produced only occasional and very limited efforts at protecting their civil rights.

VIII. NAVIGATING DUE PROCESS CONCERNS

There is a strong case for states to prohibit the severely mentally ill from possessing firearms. Granted, crafting an exact definition for "severely mentally ill" presents a challenge. The federal standard for being "adjudicated as a mental defective," codified in 27 C.F.R. § 478.11, arguably contains sufficient due process protections, as it requires a specific finding of dangerousness or incompetence by a court, board, commission, or other lawful authority.²²² This standard might be

CODE § 30605(a) (West Supp. 2012) (criminalizing possession of certain assault weapons); *see also* *Richmond Boro Gun Club, Inc. v. City of New York*, 97 F.3d 681, 683 (2d Cir. 1996) (discussing a local law that "criminalizes the possession or transfer of certain assault weapons and ammunition feeding devices within the city").

²¹⁸ Paul Wahl, *Now You Can Buy a Hot Combat Rifle for Sport*, POPULAR SCI., Feb. 1965, at 171, 171.

²¹⁹ *See, e.g., All the World Admires Browning*, LIFE, Sept. 27, 1954, at 4, 4 (advertising a Browning automatic pistol).

²²⁰ *See, e.g., Our Duty*, POPULAR SCI. MONTHLY, Nov. 1918, at 108, 108 (advertising Colt weapons to civilian customers and asking them to be patient because all manufacturing capacity was currently being used to satisfy government contracts for the military's effort in World War I).

²²¹ ALEXANDER D. BROOKS, LAW, PSYCHIATRY, AND THE MENTAL HEALTH SYSTEM 820–22 (1974).

²²² 27 C.F.R. § 478.11 (2013); *see supra* text accompanying note 101 (presenting the regulation's complete text).

considered an appropriate choice for the sixteen states that do not currently prohibit firearms possession by the mentally ill or mentally incompetent.²²³

In contrast, New York State's SAFE Act²²⁴ 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 [that] is 'likely to engage in conduct that will cause serious harm to self or others.'"²²⁵ If the county mental health official agrees with the report, he must inform the state government agency that licenses firearms ownership, who will then notify "the appropriate local licensing official, who must suspend or revoke the license as soon as practicable."²²⁶ This involves immediate surrender of the firearms license and all firearms.²²⁷

The revocation of a firearms license might be considered stigmatizing, but stigma alone is not sufficient to raise a due process objection. As the Supreme Court has pointed out in *Paul v. Davis*,²²⁸ due process considerations under the Fourteenth Amendment requires some liberty or property interest to be at risk.²²⁹ The requirement that such persons must surrender all firearms involves both a property interest (the firearm as a material and presumably valuable object) and a liberty interest (the right to keep and bear a firearm for self-defense).

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."²³⁰ The gun owner accused under the SAFE Act enjoys no right to a hearing of any sort, much less an adversary hearing before the county mental health official who is the independent decision maker.²³¹ 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

²²³ See *supra* note 106 and accompanying text.

²²⁴ 2013 N.Y. Laws Ch. 1.

²²⁵ N.Y. STATE OFFICE OF MENTAL HEALTH & N.Y. STATE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, NEW YORK SECURE AMMUNITION AND FIREARMS ENFORCEMENT ACT (NY SAFE ACT) GUIDANCE DOCUMENT 1 (2013) [hereinafter NY SAFE ACT GUIDANCE DOCUMENT], available at http://www.omh.ny.gov/omhweb/safe_act/guidance.pdf.

²²⁶ *Id.* at 2.

²²⁷ *Id.*

²²⁸ 424 U.S. 693 (1976).

²²⁹ *Id.* at 711–22. For an example of state supreme courts that have recognized both a liberty and property interest in a concealed handgun license through state guarantees of a right to keep and bear arms, see *Kellogg v. City of Gary*, 562 N.E.2d 685, 694–95 (Ind. 1990) and *Caba v. Weaknecht*, 64 A.3d 39, 63–64 (Pa. Commw. Ct. 2013).

²³⁰ *Vitek v. Jones*, 445 U.S. 480, 485 (1980).

²³¹ See NY SAFE ACT GUIDANCE DOCUMENT, *supra* note 225, at 1–2 (failing to require notice or a hearing before a person can be deprived of his or her property).

a neutral decisionmaker.”²³² 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? As indicated, there is also no opportunity under the New York SAFE Act for a gun owner to receive *notice* of a hearing before being deprived of his or her liberty. Yet the Supreme Court has repeatedly held that due process includes prior notice of a hearing that deprives one of liberty.²³³ This right of “adequate notice” is even required when the deprivation of liberty is only the transfer from a prison to a mental hospital.²³⁴ When a convict’s parole is to be revoked, he has a right to advance notice of such a hearing.²³⁵ A welfare recipient enjoys the right to a hearing *before* revocation of welfare benefits.²³⁶

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 a person subject to a protective order from owning or possessing a firearm.²³⁷ Such protective orders may be issued *ex parte*,²³⁸ precluding a gun owner from advance notice or an adversarial hearing before the order takes effect. The usual justification for *ex parte* orders is 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. The justification for disarming a person without due process is that there is risk to life and limb if he is not disarmed.

But there is no opportunity for the gun owner to cross-examine witnesses against him or present opposing evidence—contrary to existing

²³² *Hamdi v. Rumsfeld*, 542 U.S. 507, 509 (2004).

²³³ *See, e.g.*, *Goss v. Lopez*, 419 U.S. 565, 579 (1975) (discussing how, in accordance with due process, students facing interference with a protected property interest “must be given *some* kind of notice and afforded *some* kind of hearing”); *Armstrong v. Manzo*, 380 U.S. 545, 550 (1965) (“[A]s to the basic requirement of notice itself there can be no doubt”); *Mullane v. Cent. Hanover Trust Co.*, 339 U.S. 306, 313 (1950) (“Many controversies have raged about the cryptic and abstract words of the Due Process Clause but there can be no doubt that at a minimum they require that deprivation of life, liberty or property by adjudication be preceded by notice and opportunity for hearing appropriate to the nature of the case.”).

²³⁴ *Vitek*, 445 U.S. at 485.

²³⁵ *See Morrissey v. Brewer*, 408 U.S. 471, 486–87 (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.”).

²³⁶ *See Goldberg v. Kelly*, 397 U.S. 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.”).

²³⁷ CAL. FAM. CODE § 6389(a) (West 2013).

²³⁸ *Id.* § 6218.

precedent involving revocation of welfare benefits²³⁹ or of parole.²⁴⁰ As Justice Scalia's opinion for the Court in *Crawford v. Washington*²⁴¹ observed, not only is there a right to cross-examine the statements of sworn witnesses, but also "[a]n 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."²⁴² There is a 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.

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 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 the gun owner to challenge this decision after the fact.

Pennsylvania's system poses a different issue. There is a strong case for states to submit mental incompetence records to NICS. But to avoid rendering NICS data misleading, it is imperative that states only submit records that conform to federal law. While Pennsylvania's 302 involuntary commitment has been upheld as conforming to due process requirements, it is because 302 commitments are emergency and temporary in nature.²⁴³ If a 302 commitment is reported to NICS, the agency would prohibit the person reported from possessing or purchasing firearms or ammunition in the indefinite future, a deprivation of both liberty and property that is neither emergency nor temporary.

IX. CONCLUSION

All of these gun control-related measures are good, but they will do nothing for the 32.3% of murders that are committed without guns.²⁴⁴ Nor

²³⁹ See *Goldberg*, 397 U.S. at 259 (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").

²⁴⁰ See *Morrissey*, 408 U.S. at 487 ("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.").

²⁴¹ 541 U.S. 36 (2004).

²⁴² *Id.* at 51. The *Crawford* Court additionally provided a history of the abuses of the denial of the right to cross-examine witnesses and a discussion of the importance of the Sixth Amendment's guarantees. *Id.* at 42-53.

²⁴³ *Benn v. Universal Health Sys.*, 371 F.3d 165, 174 (3d Cir. 2004).

²⁴⁴ *Crime in the United States 2011: Expanded Homicide Data Table 7*, FED. BUREAU OF INVESTIGATION, <http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2011/crime-in-the-u.s.-2011/tables/expanded-homicide-data-table-7> (last visited Mar. 30, 2014).

will they do anything for murders committed by mentally incompetent persons who *steal* guns, as has been the case in at least two recent mass murders,²⁴⁵ or who buy them on the black market.²⁴⁶ Nor will background checks make a difference for persons who were not mentally ill when they purchased a gun. There is also reason to wonder whether mandatory firearms background checks actually do anything at all.²⁴⁷

There is, however, something that has been demonstrated to make a difference: restoring our mental hospital system—and making it more humane and more transparent this time. This can be accompanied by involuntary outpatient commitment, which compels participation in outpatient treatment as a condition of not being involuntarily hospitalized.²⁴⁸

As Harcourt's work strongly suggests, hospitalization reduces murder rates.²⁴⁹ This is not surprising. It is far easier to prevent inmates in locked wards from getting weapons than it is to prevent the mentally incompetent from doing so in a free society. As Segal's work demonstrates,²⁵⁰ not only is ease of involuntary commitment a statistically significant determinant of murder rates, but so are 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. That is not, however, the only social gain from reversing course on the failure of deinstitutionalization.

Reducing deaths from exposure should 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

²⁴⁵ See, e.g., Maria Sudekum Fisher, *Mall Shooter Used Dead Woman's Home While She Was Still Inside*, TOPEKA CAPITAL-J. (May 3, 2007), http://cjonline.com/stories/050307/kan_167236210.shtml (recounting how Logsdon murdered his neighbor to steal her late husband's rifle); Richard A. Serrano & Alana Semuels, *Suspect in Massacre Tried to Buy Rifle Days Before, Sources Say*, L.A. TIMES (Dec. 15, 2012), <http://articles.latimes.com/2012/dec/15/nation/la-na-nn-sandy-hook-gunman-tried-to-buy-rifle-days-before-20121215> (noting that Adam Lanza was unable to legally buy a rifle, so he stole murder weapon from his mother).

²⁴⁶ See Lauren Dake, *Oregon Gun Hearing Emotionally Charged*, THE BULLETIN (Feb. 7, 2014), <http://www.bendbulletin.com/home/1763154-151/oregon-gun-hearing-emotionally-charged#> (discussing that proposed legislation in Oregon to expand background checks on gun sales is a "reasonable step" but that felons do not care if "we pass one more law").

²⁴⁷ See generally Clayton E. Cramer, *Background Checks and Murder Rates* (Oct. 31, 2013) (unpublished manuscript), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2249317 (examining statistical evidence of effect of existing mandatory state background check laws on murder rates using interrupted time series analysis and concluding that there is no statistically significant effect on murder rates).

²⁴⁸ CRAMER, *supra* note 144, at 190–95.

²⁴⁹ Harcourt, *supra* note 26, at 1766–73.

²⁵⁰ Segal, *supra* note 32, at 1457.

other diseases that so often kill homeless people in America. Major mental illness is associated with a seven to twenty-four year decrease in lifespan.²⁵¹

Reversing deinstitutionalization will have an economic cost, that of rebuilding and staffing the now abandoned mental hospitals. 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 prosecutions of mentally ill offenders. The average U.S. criminal justice system cost for murder in 2008 dollars was \$426,255.²⁵² In 2014 dollars, that would be \$464,817.²⁵³ It seems likely that these costs will be borne by the state because mentally ill defendants are frequently indigent, and thus receive public defenders. The United States had 12,664 murders in 2011.²⁵⁴ If eighteen percent of those murders were by severely mentally ill offenders—a reasonable guess based on the Indiana murder convict data discussed above²⁵⁵—that is \$1.015 billion spent on trials that could often have been 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.²⁵⁶ A mentally sane murderer who spends thirty years in prison will cost \$970,060 in 2011 dollars. Multiplied by 2279 murders per year, this is a bill for \$2.21 billion in current and accrued costs. However, states are required to provide mental health services for prisoners.²⁵⁷ Mentally ill inmates are more expensive for states to care for than sane inmates.²⁵⁸ Several years ago, Pennsylvania found that mentally ill prisoners cost

²⁵¹ Edward Chesney et al., *Risks of All-Cause and Suicide Mortality in Mental Disorders: A Meta-Review*, 13 *WORLD PSYCHIATRY* 153, 158 (2014).

²⁵² Matt DeLisi et al., *Murder by Numbers: Monetary Costs Imposed by a Sample of Homicide Offenders*, 21 *J. FORENSIC PSYCHIATRY & PSYCHOL.* 501, 507 (2010).

²⁵³ Calculated with U.S. Inflation Calculator, <http://www.usinflationcalculator.com/> (last visited Mar. 24, 2014) (insert “2008” in the first box, “426,255” in the second box, then click “calculate”).

²⁵⁴ *Crime in the United States 2011: Expanded Homicide Data Table 8*, FED. BUREAU OF INVESTIGATION, <http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2011/crime-in-the-u.s.-2011/tables/expanded-homicide-data-table-8> (last visited Mar. 30, 2014).

²⁵⁵ See *supra* text accompanying note 5.

²⁵⁶ See COLO. DEP’T OF CORRECTIONS, BUDGET HEARING 2 (2012), available at http://www.tornado.state.co.us/gov_dir/leg_dir/jbc/2011-12/corhrg.pdf (noting that Colorado’s daily cost of incarceration was \$88.59 per offender, and that the comparable average for other reporting states was \$76.23 per offender).

²⁵⁷ *Know Your Rights: Medical, Dental and Mental Health Care*, ACLU NAT’L PRISON PROJECT 6, https://www.aclu.org/files/images/asset_upload_file690_25743.pdf (last updated Nov. 2005) (“The Eighth Amendment requires that prison officials provide a system of ready access to adequate mental health care.”).

²⁵⁸ See Lynne Lamberg, *Efforts Grow to Keep Mentally Ill Out of Jails*, 292 *JAMA* 555, 555 (2004) (indicating that, according to speakers at a forum, it costs communities more to put mentally ill people behind bars than it does to treat them).

\$51,100 per year and sane prisoners \$28,000 per year.²⁵⁹ If a similar cost differential applies nationally, the incarceration bill is \$4.03 billion a year in current and future costs. In light of these figures, trial costs plus current and future incarceration costs would total \$6.24 billion per year.

If involuntary commitment of those with serious mental illness problems even prevented 455 murders a year (or twenty percent of the murders by severely mentally ill offenders) it could save taxpayers \$547 million per year for trials and incarceration, perhaps less, depending on the number of plea bargains. 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 trashcan, or wondering whether he will survive the night. Not now. Not in our country.

²⁵⁹ *Id.*