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Symptom-Based Gun Control Symposium Article

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People out of touch with reality should not have guns. This Article proposes empowering police officers to take away guns and gun rights from individuals suffering from delusions or hallucinations. This proposal is inspired by the Navy Yard shooting, but is also supported by evidence showing a correlation between these psychotic symptoms and violence. The proposal is constitutional because of this correlation and for other reasons. For example, the motivating principle behind the right to bear arms is self-defense; a criminal defendant may only invoke self-defense if he "reasonably" feared great bodily harm, and such a fear is not "reasonable" if premised on a delusion or hallucination. Hence, individuals suffering from psychotic symptoms cannot be trusted to exercise their Second Amendment rights responsibly.

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Symptom-Based Gun Control

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I. INTRODUCTION

Early in the morning on August 7, 2013, two Newport, Rhode Island, police officers responded to a harassment call at a hotel.[1] On arrival they met with Aaron Alexis,[2] who was obviously delusional. The police incident report states that Alexis believed someone had sent three people to follow him and keep him awake by talking to him and sending vibrations into his body with, in Alexis's words, "some sort of microwave machine."[3] Although Alexis reported that he had not personally seen any of these three people, he was nonetheless worried that they were "going to harm him."[4] Less than six weeks later, on September 14, Alexis legally purchased a shotgun in Virginia.[5] He used it two days later to kill twelve people at the Navy Yard in Washington, D.C.[6]

Alexis's paranoid delusions in August should have prevented him from purchasing the shotgun in September. They did not because mental health restrictions on firearm purchases are generally keyed to diagnosis or treatment, not to symptoms.[7] This is a mistake. The Second Amendment protects, first and foremost, the right to defend oneself.[8] But a valid claim

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[1] For a redacted version of the police incident report that followed this encounter, see NEWPORT POLICE DEP'T, INCIDENT REPORT: # 13-17827-OF, at 1 (2013), http://s3.documentcloud.org/documents/793545/newport-r-i-police-report.pdf.

[2] *Id*. at 2.

[3] *Id*.

[4] *Id*.

[5] Michael S. Schmidt, *State Law Prevented Sale of Assault Rifle to Suspect Last Week, Officials Say*, N.Y. TIMES, Sept. 18, 2013, at A15.

[6] Ashley Halsey III et al., *D.C. Navy Yard Rampage Leaves 14 Dead; Alleged Shooter Killed, ID'd as Aaron Alexis*, WASH. POST, Sept. 17, 2013, at A1. This was just the latest in a long string of mass shootings. *See id*. ("The Navy Yard shooting marks the seventh time in the past decade that a gunman has killed 10 or more people in a single incident.").

[7] *See infra* text accompanying notes 11–20.

[8] *See* District of Columbia v. Heller, 554 U.S. 570, 635 (2008) (protecting the right to possess a handgun in the home for immediate self-defense). *But see* William G. Merkel, *Uncoupling the Constitutional Right to Self-Defense from the Second Amendment: Insights from the Law of War*, 45 CONN. L. REV. 1809, 1818 (2013) (arguing that "the right to self-defense . . . cannot be rooted in the

of self-defense requires an objectively reasonable fear of harm.[9] Psychotic symptoms obviously undermine objectivity. Furthermore, data suggest that psychotic symptoms are more closely correlated with violence than psychiatric diagnoses.[10] And a symptom-based approach has the potential to prevent gun violence by individuals like Alexis who are never diagnosed with, or treated for, mental illness.

This Article proposes that a police officer or mental health professional who observes an individual suffering from delusions or hallucinations should be empowered to confiscate that person's firearms and to add that person's name to the federal background check system, thus preventing firearm purchases until after a successful appeal or restoration proceeding. An individual seeking to regain gun rights would need to submit evidence from a mental health professional showing his capacity to possess a firearm, thereby incentivizing rather than penalizing treatment.

Part II of this Article describes current restrictions on gun purchases. These restrictions are generally premised on diagnosis or treatment. They leave gaps that have allowed several recent mass shootings and that a symptom-based approach could fill. Part III surveys the literature on psychosis and violence and concludes that the weight of authority and most applicable studies find a significant positive relationship between the two. Part IV argues that this symptom-based proposal is constitutional. The legal analysis also suggests another policy rationale for the proposal: a person out of touch with reality cannot be trusted to use a firearm in an objectively reasonable manner. Part V discusses counter-arguments.

II. CURRENT RESTRICTIONS ARE BOTH OVER- AND UNDER-INCLUSIVE

There are three basic regimes restricting gun possession by the mentally ill. Federal law is the first regime, setting the floor by barring firearm possession by anyone who is "adjudicated as a mental defective" or involuntarily committed.[11] Although the exact boundaries of these terms may be unclear, a serious mental disorder, insanity, or "marked subnormal intelligence" are prerequisites.[12] And while mental illness for civil commitment purposes is technically a legal, not medical, concept,

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original understanding of the Second Amendment, but that it could plausibly and cogently be based on substantive due process, natural law, the Ninth Amendment, and fundamental principles of law that emerge from comparative inquiry into foreign and international law").

[9] *See infra* text accompanying notes 68–72.

[10] *See infra* Part III.

[11] 18 U.S.C. § 922(d)(4) (2012); *see* Jana R. McCreary, *"Mentally Defective" Language in the Gun Control Act*, 45 CONN. L. REV. 813, 843–52 (2013) (discussing judicial interpretations of these statutory terms).

[12] McCreary, *supra* note 11, at 843 (citing 27 C.F.R. § 478.11(a) (2010)).

legislatures and courts largely incorporate the definition applied by mental health professionals.[13] Thus, the federal bar rests on psychiatric diagnosis.

Under the second regime, some states also bar firearm possession by individuals who have been subject to voluntary commitment.[14] Voluntary commitment may entail a loss of liberty, unlike ordinary consensual treatment. For example, a voluntarily admitted patient may not thereafter be permitted to leave at-will. State statutes authorizing voluntary admission vary.[15] Some even expressly provide that "symptoms of mental illness," short of a diagnosis, can suffice.[16] Voluntary commitment no doubt captures many people without a formal diagnosis,[17] but most people with psychotic symptoms are never hospitalized (rightly or wrongly). In 2011, 0.8% of adults in the United States received inpatient mental health care.[18] This included both involuntary and voluntary commitments, along with ordinary consensual treatment. By comparison, one study found that 5.1% of the general population reported psychotic-like experiences within a twelve-month period.[19] This illustrates that while some people may be voluntarily committed without a diagnosis, many more with severe symptoms are neither diagnosed nor hospitalized.

The third regime is the most restrictive and least common. Like the federal regime, it turns on diagnosis, not symptoms. For example, Hawaii prohibits gun possession by anyone with a "significant" mental illness.[20] If fully enforced, this sweeping restriction could disqualify roughly 17% to 20% percent of the overall population based on diagnosis and severity.[21]

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[13] Sherry F. Colb, *Insane Fear: The Discriminatory Category of "Mentally Ill and Dangerous*," 25 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 341, 354 (1999).

[14] Fredrick E. Vars & Amanda Adcock Young, *Do the Mentally Ill Have a Right to Bear Arms?*, 48 WAKE FOREST L. REV. 1, 12 (2013).

[15] *See* BRUCE J. WINICK, CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL 178–85 (2005) (listing various state statutes relating to voluntary commitment).

[16] *See, e.g.*, DEL. CODE. ANN. tit. 16, § 5123(a) (2012) (authorizing a psychiatrist to admit a person who has "symptoms of a mental condition" for observation, diagnosis, or care); *id*. (referring to a Delaware statute regarding voluntary admission, which requires persons with "symptoms of mental illness" to obtain a letter from a doctor recommending hospitalization).

[17] *But cf*. Donald H. Stone, *The Benefits of Voluntary Inpatient Psychiatric Hospitalization: Myth or Reality?*, 9 B.U. PUB. INT. L.J. 25, 30 (1999) ("The psychiatrist should use the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV* to ensure the patient is admitted with more than just a suspicion of mental illness." (footnote omitted)).

[18] U.S. DEP'T OF HEALTH & HUMAN SERVS., CTR. FOR BEHAVIORAL HEALTH STATISTICS & QUALITY, RESULTS FROM THE 2011 NATIONAL SURVEY ON DRUG USE AND HEALTH: MENTAL HEALTH FINDINGS 21 (2012).

[19] Ramin Mojtabai, *Psychotic-Like Experiences and Interpersonal Violence in the General Population*, 41 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 183, 184 (2006).

[20] HAW. REV. STAT. § 134-7(c)(3) (2013).

[21] *See* Ronald C. Kessler et al., *Prevalence and Treatment of Mental Disorders, 1990 to 2003*, 352 NEW ENG. J. MED. 2515, 2518 (2005) (comparing two studies of mental disorders and reporting that "serious" disorders were prevalent in 5.3% to 6.3% of the population, while "moderate" disorders were prevalent in 12.3% to 13.5% of the population).

All three current regimes are premised at least in part on the belief that people with mental illness, or suspected mental illness, are dangerous. Findings are mixed, but there does appear to be an elevated risk of violence across many, but perhaps not all, psychiatric diagnoses.[22] Even the far-reaching Hawaii law is supported by research, although it disqualifies thousands of individuals who would not engage in violence with a firearm.[23]

The narrower approach of some states—disqualifying both voluntary and involuntary psychiatric inpatients—has stronger support. A leading study found that 11.5% of individuals discharged from inpatient psychiatric care perpetrated an act of violence against others during an initial follow-up period, as compared with 4.6% in a community control group.[24] Yet even this level of intervention is overbroad in the sense that 88.5% of released individuals who received inpatient treatment committed no acts of violence. The federal regime has the strongest support. A follow-up study using the same dataset found that involuntary admission status was a significant risk factor for violence.[25]

My primary question is not whether existing diagnosis- and treatment-based restrictions should be retained, but whether they can be supplemented. The aforementioned studies contain several reasons to think that adding differently targeted measures makes sense. First, it

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[22] *See* Bruce G. Link et al., *Real in Their Consequences: A Sociological Approach to Understanding the Association Between Psychotic Symptoms and Violence*, 64 AM. SOC. REV. 316, 323–24 (1999) (finding that "fighting and weapon use is substantially and significantly elevated among people with psychotic and bipolar disorder," but that people diagnosed with major depression or anxiety disorders are no more likely than the general public without mental illness to engage in violence); Jeffrey W. Swanson et al., *Violence and Psychiatric Disorder in the Community: Evidence from the Epidemiologic Catchment Area Surveys*, 41 HOSP. & COMMUNITY PSYCHIATRY 761, 765 (1990) (explaining a study that showed "[t]he prevalence of affective disorder was three times higher among respondents who were violent," and that "[t]he same was true for the prevalence of schizophrenia," but that "the difference was less pronounced for the prevalence of anxiety disorder"); Richard Van Dorn et al., *Mental Disorder and Violence: Is There a Relationship Beyond Substance Use?*, 47 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 487, 490 (2012) (showing that all classifications of mental illness . . . elevate violence risk compared to those with no disorders").

[23] *See* Vars & Young, *supra* note 14, at 16–18 (referencing a study finding that persons with serious mental illness were 3.5 times more likely to report violent behavior than those without mental illness, yet arguing that the Hawaii statute nonetheless suffers from being overbroad).

[24] Henry J. Steadman et al., *Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, 55 ARCHIVES GEN. PSYCHIATRY 393, 399 tbl.5 (1998). As discussed shortly, see *infra* note 28 and accompanying text, this effect actually appears to be attributable to the comorbidity of psychiatric illness and substance abuse.

[25] Henry J. Steadman et al., *A Classification Tree Approach to the Development of Actuarial Violence Risk Assessment*, 24 LAW & HUM. BEHAV. 83, 88 tbl.1 (2000). *But cf.* JOHN Q. LA FOND & MARY L. DURHAM, BACK TO THE ASYLUM: THE FUTURE OF MENTAL HEALTH LAW AND POLICY IN THE UNITED STATES 145 (1992) (suggesting that differences in the levels of dangerousness between voluntary and involuntary patients are diminishing); Fredrick E. Vars, *Illusory Consent: When an Incapacitated Patient Agrees to Treatment*, 87 OR. L. REV. 353, 355, 364 (2008) (questioning validity of consent to hospitalization).

appears that not every diagnosis carries an increased risk of violence, so Hawaii's law may be too broad.[26] Second, the high level of violence observed in the community control group of a leading study of inpatients, mentioned above,[27] suggests that restrictions broader than those under federal law could prevent much more violence. The same study also noted that the elevated level of violence across all inpatients disappeared when those with substance abuse problems were excluded.[28] This suggests that targeting attributes other than, or in addition to, diagnosis could more efficiently reduce violence.[29]

The most fundamental shortcoming of diagnosis and treatment-based restrictions is that they require a diagnosis or treatment. Millions of people with mental illness are not diagnosed and do not receive treatment.[30] In 2011, only 38.2% of people with any mental illness and 59.6% of those with serious mental illness received mental health treatment.[31] Even where treatment is available and taken advantage of, it may be too late for a person experiencing his first psychotic episode. Troubled individuals like Alexis may interact with law enforcement, and even health care providers, without receiving a diagnosis or inpatient treatment.

III. EMPIRICAL SUPPORT FOR A SYMPTOM-BASED APPROACH

There is room for improvement beyond current diagnosis- and treatment-based restrictions on gun possession. One possible approach is to focus directly on symptoms. Delusions and hallucinations appear to have been present in a string of recent mass shootings, including those in the Navy Yard,[32] Aurora,[33] and Tucson.[34] The data suggest that the

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[26] That is to say, the law is too broad if the only goal is to prevent violence toward others. The stronger, and to my mind, sufficient justification for Hawaii's ban is suicide prevention. *See* Vars & Young, *supra* note 14, at 19–20 (observing that states with low household gun ownership rates have lower suicide figures than states with high household gun ownership rates).

[27] *See supra* text accompanying note 24.

[28] Steadman et al., *supra* note 24, at 400. *But cf*. Van Dorn et al., *supra* note 22, at 492 (reporting that, by comparison to the general population, the risk of serious violence was 2.39 times greater in individuals with severe mental illness alone, while the risk was 10.01 times greater for individuals who also had a substance use disorder).

[29] Substance abuse problems can rise to the level of psychiatric disorder, AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 481 (5th ed. 2013), but generally do not subject individuals to involuntary hospitalization, *see, e.g.*, ALA. CODE § 22-52-1.1(1) (2013) ("Mental illness, as used herein, specifically excludes the primary diagnosis of epilepsy, mental retardation, substance abuse, including alcoholism, or a developmental disability."); *id*. § 22-52-10.4 (listing "mental illness" as prerequisite for involuntary commitment).

[30] U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 18, at 25.

[31] *Id*. at 23.

[32] *See supra* text accompanying notes 1–6.

[33] Erica Goode et al., *Before Gunfire, Hints of "Bad News,"* N.Y. TIMES, Aug. 27, 2012, at A1.

relationship between delusions and violence is not merely anecdotal.

Delusions appear to correlate with violence. One review reported that seventeen of twenty studies found a positive relationship between delusions and violence.[35] A 2006 study using a large dataset representative of the non-institutionalized U.S. population eighteen years or older concluded that people with "psychotic-like experiences" were 5.72 times more likely than others to attack someone with an intent to seriously injure.[36] "Psychotic-like experiences" included seven varieties of hallucinations and delusions.[37] Hearing voices, seeing visions, and paranoid ideations were the most strongly associated with violence.[38] Yet disarming every person afflicted by psychotic-like symptoms would be admittedly overbroad: one attacker would be correctly disarmed for every 13.5 sufferers who would not attack another.[39]

The 2006 study reported that seventy percent of the individuals with psychotic-like experiences had not received mental health care in the past year.[40] This strongly suggests that disqualification based on diagnosis misses many people whose symptoms put them at relatively high risk for violence. And even if treatment had been sought, "it is quite likely that only a minority of these experiences would be identified as clinically significant symptoms and only a small proportion of the individuals with these experiences would be identified as cases of psychotic disorders by a

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[34] Joseph Schuman, *Jared Lee Loughner Trial: Judge Grants Doctors More Time to Restore Accused's Mental Fitness*, HUFFINGTON POST (Feb. 6, 2012), http://www.huffingtonpost.com/2012/02/06/jared-lee-loughner-trial-mental-competency_n_1258397.html.

[35] Stål Bjørkly, *Psychotic Symptoms and Violence Toward Others—A Literature Review of Some Preliminary Findings: Part 1. Delusions*, 7 AGGRESSION & VIOLENT BEHAV. 617, 622 (2002); *cf.* Stål Bjørkly, *Psychotic Symptoms and Violence Toward Other—A Literature Review of Some Preliminary Findings: Part 2. Hallucinations*, 7 AGGRESSION & VIOLENT BEHAV. 605, 610 (2002) (demonstrating that findings on hallucinations are more evenly mixed). *Compare* Dale E. McNiel et al., *The Relationship Between Command Hallucinations and Violence*, 51 PSYCHIATRIC SERVS. 1288, 1290 (2000) (finding that patients experiencing command hallucinations to hurt others were 2.51 times more likely to be violent), *with* Angela F. Nederlof et al., *Threat/Control-Override Symptoms and Emotional Reactions to Positive Symptoms as Correlates of Aggressive Behavior in Psychotic Patients*, 199 J. NERVOUS & MENTAL DISEASE 342, 346 (2011) (finding that threat but not control-override symptoms made a significant contribution to aggressive behavior).

[36] Mojtabai, *supra* note 19, at 184, 185; *cf.* Kevin S. Douglas et al., *Psychosis as a Risk Factor for Violence to Others: A Meta-Analysis*, 135 PSYCHOL. BULL. 679, 691 (2009) (finding the median odds ratio for hallucinations/delusions to be 2.31, lower than the 5.72 figure from the population-based study). As will be explained, see *infra* text accompanying notes 49–53, there are reasons for present purposes to prefer the 2006 population-based study to an amalgam of different types of studies.

[37] Mojtabai, *supra* note 19, at 189.

[38] *Id.* at 187 tbl.2.

[39] This figure is based on data from the 2006 study. *See id.* at 184 ("Psychotic-like experiences were reported by 5.1% of adults in the community."); *id.* at 185 (finding that 1.5% of participants reported attacking someone with the intent of hurting that person). The full underlying calculation is on file with the author.

[40] *Id.* at 185.

clinician."[41]

A very similar study of Japanese adolescents broadly supports the findings of the 2006 study, although the observed effects were smaller. Overall, those who suffered from psychotic-like experiences were about twice as likely as others to engage in interpersonal violence.[42] The effect remained statistically significant for paranoia and hearing voices even after controlling for other variables.[43]

An early comparable study from Israel measured weapon use directly and concluded that "those who score high on threat/control-override symptoms [are] much more likely than those who score low to have engaged in fighting and weapon use."[44] This result held even after controlling for diagnosis and other psychotic symptoms, as well as a host of other variables.[45] Indeed, the study concluded that "the threat/control-override symptoms have primacy over diagnostic distinctions in explaining violence."[46] (A very recent study confirmed the significance of threat delusions, but not those involving control-override.[47]) One implication is that symptom-based gun control has the potential to prevent more gun violence than diagnosis-based regulation.[48]

It should be noted that other studies question the relationship between delusions and violence.[49] All four of these other studies—including the

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[41] *Id*. at 187. One might be concerned that, under my proposal, police officers would also miss the symptoms. But the study authors do not question clinicians' ability to identify the symptoms, only that the symptoms would be deemed "clinically significant" or evidence of "psychotic disorders." *Id*. Police officers also should be able to identify symptoms, which is all this proposal requires.

[42] Yoshihiro Kinoshita et al., *Psychotic-Like Experiences Are Associated with Violent Behavior in Adolescents*, 126 SCHIZOPHRENIA RES. 245, 248 tbl.1 (2011).

[43] *Id*. at 249 tbl.3.

[44] Link et al., *supra* note 22, at 325; *see id*. at 330 (stating that the "Threat/Control-Override Symptoms Subscale" asked how often the subject felt that (1) "your mind was dominated by forces beyond your control?" (2) "thoughts were put into your head that were not your own?" and (3) "there were people who wished to do you harm?").

[45] *Id*. at 326 tbl.3.

[46] *Id*. at 329; *see also* Bruce G. Link & Ann Stueve, *Psychotic Symptoms and the Violent/Illegal Behavior of Mental Patients Compared to Community Controls*, *in* VIOLENCE AND MENTAL DISORDER: DEVELOPMENTS IN RISK ASSESSMENT 137, 154 tbl.7 (John Monahan & Henry J. Steadman eds., 1996) (reporting that the patient variable lost statistical significance in predicting weapon use when the psychotic symptom variable, which was highly significant, was introduced into a regression model).

[47] Jeremy W. Coid et al., *The Relationship Between Delusions and Violence: Findings from the East London First Episode Psychosis Study*, 70 JAMA PSYCHIATRY 465, 466 (2013). Delusions of being spied on, persecution, and conspiracy were statistically significant in being associated with violence, although the study suggests that the anger produced by such delusions was a mediating cause of violence. *Id*. at 468. Note that Alexis experienced precisely these types of delusions. *See supra* text accompanying notes 3–4.

[48] *See* Bruce G. Link et al., *The Violent and Illegal Behavior of Mental Patients Reconsidered*, 57 AM. SOC. REV. 275, 283 tbl.1 (1992) (charting the percentage of patients engaging in violent or illegal behavior based on patient status and type of behavior).

[49] *See, e.g.*, Paul S. Appelbaum et al., *Violence and Delusions: Data from the MacArthur Violence Risk Assessment Study*, 157 AM. J. PSYCHIATRY 566, 566 (2000) ("To demonstrate that delusions can

leading study funded by the MacArthur Foundation—examined highly selected groups as opposed to populations. This is an important distinction. Take, for example, the MacArthur study: it included individuals who were recently released from civil commitment.[50] Because dangerousness is a prerequisite for continued involuntary hospitalization[51] and because there is tremendous pressure to release inpatients as soon as possible,[52] many subjects likely were just below a maximum risk threshold at the time of release. It may well have been an artifact of sample selection, not lack of causation, that those with and without psychotic symptoms were equally safe.[53] The population studies, although far from perfect, are therefore more persuasive for present purposes.

IV. CONSTITUTIONALITY OF A SYMPTOM-BASED APPROACH

A. *Second Amendment*

As I have elsewhere argued, there are at least three possible Second Amendment tests for mental health gun regulations: reasonableness, intermediate scrutiny, and something close to strict scrutiny.[54] The data cited above almost certainly clear the low "reasonableness" hurdle because it is reasonable for the legislature to conclude that people with delusions or hallucinations are more dangerous than others. On the other hand, strict scrutiny would likely be fatal: a measure that disarms one attacker for

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precipitate violence, however, is not to say that delusional persons are necessarily more violent than persons with other mental illnesses, or even than their neighbors in the general population."); Olivier F. Colins et al., *Psychotic-Like Symptoms as a Risk Factor of Violent Recidivism in Detained Male Adolescents*, 201 J. NERVOUS & MENTAL DISEASE 478, 482 (2013) (concluding that "by identifying detained youths with delusions in general or [paranoid delusions] or [threat/control override delusions] in particular, clinicians are likely to identify youths with a low risk for committing repetitive violent crimes"); Jeffrey Swanson et al., *Violent Behavior Preceding Hospitalization Among Persons with Severe Mental Illness*, 23 LAW & HUM. BEHAV. 185, 201 (1999) (finding that paranoid symptoms and psychoticism were not significantly associated with violence, and further suggesting that addressing the problems of substance abuse and poor social environments could best prevent violence by severely mentally ill persons); Eduardo Henrique Teixeira & Paulo Dalgalarrondo, *Violent Crime and Dimensions of Delusion: A Comparative Study of Criminal and Noncriminal Delusional Patients*, 37 J. AM. ACAD. PSYCHIATRY L. 225, 225 (2009) ("[C]ontrary to current beliefs, delusional patients who are frightened or who have other negative affects associated with delusional ideas appear to commit fewer violent acts . . . .").

[50] Appelbaum et al., *supra* note 49, at 567.

[51] O'Connor v. Donaldson, 422 U.S. 563, 575 (1975).

[52] *See* Ira D. Glick et al., *Inpatient Psychiatric Care in the 21st Century: The Need for Reform*, 62 PSYCHIATRIC SERVICES 206, 206 (2011) (lamenting the "current model of ultrashort inpatient hospitalization" and advocating for a new model of psychiatric care).

[53] *See* Pamela J. Taylor, *Psychosis and Violence: Stories, Fears, and Reality*, 53 CAN. J. PSYCHIATRY 647, 651 (2008) (concluding after reviewing literature that "there is consistent evidence of a general association between delusions and violence," and dismissing "dissenting studies" on other grounds).

[54] Vars & Young, *supra* note 14, at 3.

every 13.5 harmless sufferers is probably not "narrowly tailored." The outcome under intermediate scrutiny—which has apparently become the consensus standard[55]—is uncertain. However, courts apply intermediate scrutiny only if the restriction "substantially burdens Second Amendment rights."[56] And while prohibiting gun purchases by a large subset of the population would seem to be a substantial burden and therefore clear this threshold, there are good arguments to the contrary.

First, the proposed restriction on gun purchases is targeted and temporary. Experiencing delusions or hallucinations serious enough to come to the attention of a police officer would disqualify an individual only until the individual shows that he is no longer suffering from psychotic symptoms and is receiving appropriate mental health treatment. A comparable Indiana statute disqualifies "dangerous" individuals for 180 days, with an opportunity thereafter to apply for a restoration of gun rights.[57] Applying the Indiana Constitution, an appellate court held that this statute did not impose a "material burden" on the right to bear arms.[58] A restriction with the possibility of immediate appeal and restoration is obviously less burdensome.

The second argument that this proposal does not amount to a substantial burden on Second Amendment rights derives from the purpose of the Amendment. The animating principle of the right to bear arms is self-defense.[59] In *District of Columbia v. Heller*[60] and *McDonald v. City of Chicago*,[61] the U.S. Supreme Court struck down restrictions on handgun possession because handguns are "overwhelmingly" favored by the public for self-defense.[62] Widespread ownership of handguns is a relatively recent phenomenon.[63] Pistols represented only a relatively small fraction

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[55] *See* United States v. Chovan, 735 F.3d 1127, 1138 n.5 (9th Cir. 2013) ("The majority of courts have applied an intermediate scrutiny test."); Stacey L. Sobel, *The Tsunami of Legal Uncertainty: What's a Court to Do Post-*McDonald*?*, 21 CORNELL J.L. & PUB. POL'Y 489, 513 (2012) ("Most courts have found that intermediate scrutiny or its equivalent is the proper standard to apply to Second Amendment challenges to § 922(g)(9) and similar statutes.").

[56] *Chovan*, 735 F.3d at 1138.

[57] IND. CODE §§ 35-47-14-6(b), 35-47-14-8(a) (2013); *see also* Redington v. State, 992 N.E.2d 823, 834 (Ind. Ct. App. 2013) (noting that a person can petition for the return of firearms 180 days after the firearms are seized).

[58] *Redington*, 992 N.E.2d at 834.

[59] *See* McDonald v. City of Chicago, 130 S. Ct. 3020, 3036 (2010) (explaining that "individual self-defense is 'the *central component*' of the Second Amendment right" (quoting District of Columbia v. Heller, 554 U.S. 570, 599 (2008))).

[60] 554 U.S. 570.

[61] 130 S. Ct. 3020.

[62] *Id.* at 3036 (quoting *Heller*, 554 U.S. at 628).

[63] *See* Marian Wright Edelman & Hattie Ruttenberg, *Legislating for Other People's Children: Failing to Protect America's Youth*, 7 STAN. L. & POL'Y REV. 11, 13 (1995) (noting an increase in "[t]he proportion of households owning handguns" and that the number "has risen since 1959 from thirteen percent to about twenty-four percent").

of firearms owned by early Americans.[64] This is significant because it demonstrates that the Court, despite Originalist rhetoric in *Heller*, interprets the Second Amendment through the lens of present circumstance.[65]

One thing that has changed since ratification of the Second Amendment is the definition of self-defense under almost every state's criminal law:

> Generally, both at common law and under modern state penal codes, a criminal defendant charged with homicide or assault and battery may invoke self-defense to justify the use of physical force against another when the defendant "reasonably" believes that at the time such force was used, he was in imminent danger of losing his life or suffering great bodily harm at the hands of such other.[66]

Through the early nineteenth century, reasonableness was wholly subjective. If the defendant actually felt threatened, then actions in self-defense were not criminal, even if no reasonable person would have felt threatened in the same situation. Illustratively, *M'Naghten* states: "if under the influence of his delusion he supposes another man to be in the act of attempting to take away his life, and he kills that man, as he supposes, in self-defense, he would be exempt from punishment."[67]

In the mid-nineteenth century, jurisdictions began requiring objective reasonableness.[68] Significantly, one cause for this movement may have been the development of affordable revolvers.[69] Because revolvers were

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[64] *See* Clayton E. Cramer & Joseph Edward Olson, *Pistols, Crime, and Public: Safety in Early America*, 44 WILLAMETTE L. REV. 699, 706 (2008) ("One analysis of all Plymouth Colony probate inventories through the 1670s found that, of 339 listed firearms, 13% were pistols . . . ."). On the other hand, pistols may have been used more frequently than their numbers would suggest. *See id*. ("54.5% of lead projectiles recovered from Plymouth Colony digs were pistol ammunition.").

[65] For further scholarship in this vein, see generally Reva B. Siegel, *Dead or Alive: Originalism as Popular Constitutionalism in* Heller, 122 HARV. L. REV. 191 (2008).

[66] John F. Wagner Jr., Annotation, *Standard for Determination of Reasonableness of Criminal Defendant's Belief, for Purposes of Self-Defense Claim, that Physical Force Is Necessary—Modern Cases*, 73 A.L.R. 4th § 2, at 993 (1989). One could argue that self-defense may be broader for purposes of the Second Amendment than it is under criminal law. To the contrary, "nothing in *Heller* purports to alter the way the states have defined self-defense." State v. Warmus, 967 N.E.2d 1223, 1237 (Ohio Ct. App. 2011).

[67] *See* M'Naghten's Case, (1843) 8 Eng. Rep. 718 (H.L.) 723.

[68] *See* Richard Singer, *The Resurgence of Mens Rea: II-Honest but Unreasonable Mistake of Fact in Self Defense*, 28 B.C. L. REV. 459, 484–86 (1987) ("If the first half [of the nineteenth] century saw little development or analysis of the self defense question, the second half began with an explosion of statutes, case law, and treatise writing which rapidly established the proposition, in a majority of states, that only a reasonable mistake as to the need to use deadly force would result in a self defense verdict, and that the unreasonably mistaken actor would suffer as a murderer.").

[69] *See* Improvement in Fire-Arms, U.S. Patent No. X9430 (issued Feb. 25, 1836) (describing the "revolving gun" invented by Samuel Colt of Hartford, Connecticut).

easier to use and more deadly, their use in self-defense needed to be further circumscribed.[70] Honest but unreasonable mistakes were no longer tolerated when the stakes escalated dramatically. The rule quoted above from *M'Naghten* has been reversed in the vast majority of jurisdictions: "But if that honest belief is the product of a delusion or a misperception of a threat—where someone without similarly impaired cognitive abilities or misapprehensions would sense no danger—a defendant lacks legal grounds to assert self-defense."[71] More succinctly, "[b]y definition, a reasonable person is not one who hears voices due to severe mental illness."[72]

A person who is unable to make an objectively reasonable determination regarding the appropriateness of self-defense has a relatively weak claim for Second Amendment protection. The Amendment first and foremost protects self-defense.[73] Precisely in response to the danger of guns, the overwhelming majority of jurisdictions now allow self-defense only when it is both subjectively *and* objectively reasonable.[74] People suffering from delusions or hallucinations cannot be trusted to limit their self-defensive actions to circumstances where doing so is objectively reasonable. Restricting their access to firearms therefore infringes less upon Second Amendment rights.[75]

One familiar form of counter-argument is the slippery slope. If delusional people have lesser Second Amendment rights, what about people with drinking problems, anger problems, or simply below average intelligence? Such people may not be capable of being objectively reasonable in their use of firearms. To categorically exclude them from Second Amendment protection would go too far. But one need not slide down the slope: a possible response to this concern is history. Restrictions on gun possession by the mentally ill have been described favorably by the Court as "longstanding."[76] There are no longstanding prohibitions based on intoxication, anger, or intelligence.

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[70] *See* Singer, *supra* note 68, at 488 (explaining that the introduction of the gun, which is deadly at greater ranges than knives or swords, may have moved courts to adopt a reasonableness test).

[71] State v. Bellinger, 278 P.3d 975, 987 (Kan. Ct. App. 2012).

[72] People v. Jefferson, 14 Cal. Rptr. 3d 473, 481 (Ct. App. 2004); *accord* Commonwealth v. Hinds, 927 N.E.2d 1009, 1015 (Mass. 2010) (declining to "interpret reasonable provocation as the subjective experience of provocation by a person whose anxiety has resulted in paranoia.").

[73] District of Columbia v. Heller, 554 U.S. 570, 635 (2008).

[74] Wagner, *supra* note 66, § 3, at 997–1006 (collecting cases).

[75] As noted above, a parallel argument under Indiana's Constitution prevailed in *Redington v. State*. *See* 992 N.E.2d 823, 834–35 (Ind. Ct. App. 2013) ("Indeed, the Act seeks to keep firearms from individuals it deems 'dangerous' if and when they present a risk of personal injury to either themselves or other individuals. On that score, we also observe that, as discussed below, the State bears the burden of proving that the individual is 'dangerous' by a heightened clear and convincing evidence standard. We therefore conclude that the Act does not place a material burden upon the core value of Redington's right to defend himself and accordingly that the Act is not unconstitutional as applied to Redington." (citation omitted)).

[76] *Heller*, 554 U.S. at 626.

If, despite these arguments to the contrary, the burden on Second Amendment rights is deemed to be great enough to clear the threshold, then my proposal might trigger intermediate scrutiny. Is the measure substantially related to an important government interest? The answer could well turn on emphasis. People with delusions are much more prone to violence. But the vast majority of people with delusions are not violent, and only a tiny fraction will misuse firearms. Whether a particular court would be swayed by the heightened risk or the massive overbreadth is difficult to predict.[77]

B. *Due Process*

Under my proposal, a police officer or mental health professional would provide a written notice to the affected individual explaining the basis for suspension of gun rights and the process to appeal or to seek restoration. The individual would be entitled to an evidentiary hearing where he would have the burden to show that he was not in fact suffering from delusions or hallucinations, or that he was, but have since been found to be symptom-free by a mental health professional and to be receiving appropriate treatment. Appeals would have to be filed within 90 days; motions for restoration could be filed at any time. Gun rights would be suspended during the process.

This scheme would not violate due process. Given the exigency of the situation and the threat to health and safety, no predeprivation hearing is required.[78] "[W]here a State must act quickly, or where it would be impractical to provide predeprivation process, postdeprivation process satisfies the requirements of the Due Process Clause."[79] Protecting public health and safety is an interest of paramount importance which has long justified summary deprivation of property.[80] For the same reasons, suspension of gun rights during the postdeprivation process should be allowed. Placing the burden of proof on the individual is appropriate

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[77] *Cf.* Vars & Young, *supra* note 14, at 17–19 (discussing the lack of uniformity among empirical studies with respect to the relationship between mental illness and violence, as well as the concern that using intermediate scrutiny in Second Amendment cases would disarm many harmless mentally ill persons). In his contribution to this Symposium, Professor O'Shea suggests that the political affiliation of a judge's appointing President may help predict the judge's position in Second Amendment cases. Michael P. O'Shea, *The Steepness of the Slippery Slope: Second Amendment Litigation in the Lower Federal Courts and What It Has to Do with Background Recordkeeping Legislation*, 46 CONN. L. REV. 1381, Part IV.E (2014).

[78] *See* Hightower v. City of Boston, 693 F.3d 61, 84–85 (1st Cir. 2012) (rejecting the appellant's claim "that due process required that a hearing take place before her license could be revoked" because the "predeprivation process provided . . . was constitutionally adequate when considered in conjunction with the available postdeprivation process").

[79] *Id.* at 84 (quoting Gilbert v. Homar, 520 U.S. 924, 930 (1997)) (internal quotation marks omitted).

[80] *Id.* at 84–85.

because that individual will be in the best position to produce relevant evidence.[81] Furthermore, requiring certification from a mental health professional may induce some individuals who want their gun rights restored to go into treatment or at least to submit to evaluation. This would be a significant policy advantage over current diagnosis- and treatment-based restrictions that may actually discourage beneficial treatment.[82]

V. POLICY COUNTER-ARGUMENTS

What I have described as the fundamental shortcoming of the diagnosis-based approach—requiring a diagnosis—could be alternatively described as its greatest virtue. Mental health professionals are trained to make accurate diagnoses and thus to ensure that only those who actually have disorders are barred from gun possession. Allowing police officers to disqualify people because they suspect delusions or hallucinations requires them to act beyond their expertise.

There are at least two responses. First, it is relatively easy to identify an active delusion or hallucination, so the police would not need the formal mental health training needed to diagnose mental illness. Alexis's fear of a microwave attack demonstrates that there will be easy cases, even if police may sometimes be unsure whether a strange belief is in fact based in reality. Second, even if one concedes that law enforcement will not do as well as mental health professionals in identifying delusions and hallucinations, a flawed assessment by law enforcement is better than failing to prevent tragic violence. As mentioned above, vast numbers of people with mental health problems do not receive treatment.[83] To wait for them to get psychiatric care is to roll the dice on what they will do in the meantime.

Giving mental health professionals the power to take away guns and gun rights is arguably objectionable for a different reason: the potential "chilling effect" on the therapeutic relationship. One recent study found that imposing a mandatory duty on psychologists to warn others about threats posed by patients corresponded to a nine percent increase in teen suicides.[84] The study's author suggests that teens may have been less

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[81] *See id*. at 87 (suggesting that the Massachusetts legislature could have reasonably placed the burden of proof on the aggrieved individual because he would be in the best place to present relevant evidence as to the suitability requirement).

[82] *See* Thomas B. Cole, *Efforts to Prevent Gun Sales to Mentally Ill May Deter Patients from Seeking Help*, 298 JAMA 503, 504 (2007) (discussing the NICS Improvement Act of 2007, and suggesting that the Act's push to enter mental health-related information into a federal database "may make some patients uneasy" about pursuing treatment due to the stigma that is sometimes associated with being labeled mentally ill).

[83] *See supra* text accompanying note 31.

[84] Griffin Edwards, Tarasoff*, Duty to Warn Laws, and Suicide*, 34 INT'L REV. L. & ECON. 1, 5 (2013).

willing to disclose suicidal thoughts to their therapists when the teens knew that such disclosures might not remain confidential.[85] Whether such a substantial chilling effect would materialize in the gun context is an important consideration in evaluating my proposal. Limiting the proposal to police officers would eliminate this concern.

Another related counter-argument to my proposal is that psychotic symptoms are a bad proxy. If dangerousness is the concern, then bar gun possession based on an assessment of dangerousness. That was the approach adopted in New York following the Newtown, Connecticut, school shooting.[86] New York now authorizes revocation of gun privileges based on a mental health professional's assessment of dangerousness with no explicit diagnosis requirement.[87] Indiana had earlier authorized law enforcement officers to confiscate firearms based on dangerousness with or without a diagnosis of mental illness.[88]

Assessing dangerousness, like making a diagnosis, arguably does require real mental health expertise. Presumably, as a result, New York limits this power to mental health professionals.[89] This may be sound public policy as far as it goes, although clinical assessments of dangerousness are notoriously unreliable.[90] One additional problem is that

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[85] *Id*. at 7.

[86] *See* Michael Ollove, *States Tackle Mental Illness and Gun Ownership*, PEW CHARITABLE TRUSTS (Mar. 21, 2013), http://www.pewstates.org/projects/stateline/headlines/states-tackle-mental-illness-and-gun-ownership-85899461407 (reporting that "New York was the first state to adopt new gun control measures in the aftermath of the December shooting massacre at Sandy Hook Elementary School in Newtown, Conn." by passing legislation with the "most expansive language in the United States for keeping gun ownership from people with mental illness" and only requiring mental health professionals to tell local officials that they believe a patient is likely to hurt himself or others, rather than requiring a court determination).

[87] N.Y. MENTAL HYG. LAW § 9.46(b) (McKinney 2013). California has recently adopted a similar provision, barring gun possession by any individual who makes a serious threat to a psychotherapist. *See* Patrick McGreevy & Melanie Mason, *Brown Kills New Limits on Gun Sales*, L.A. TIMES, Oct. 11, 2013, at A1 ("[T]he Governor accepted a bill prohibiting gun ownership by people who make serious threats to psychotherapists").

[88] IND. CODE §§ 35-47-14-2 to -3 (2013); *see also* George F. Parker, *Application of a Firearm Seizure Law Aimed at Dangerous Persons: Outcomes From the First Two Years*, 61 PSYCHIATRIC SERVS. 478, 478 (2010) (studying early data relating to firearm seizures under the Indiana statute and concluding that seizures rarely resulted from psychosis, but instead were connected to a risk of suicide).

[89] *See* N.Y. MENTAL HYG. LAW § 9.46 (allowing only "mental health professional[s]" under the meaning of that section to report a patient as dangerous if the patient is likely to act in a way that would harm himself or others).

[90] *See* Mitzi Dorland & Daniel Krauss, *The Danger of Dangerousness in Capital Sentencing: Exacerbating the Problem of Arbitrary and Capricious Decision-Making*, 29 LAW & PSYCHOL. REV. 63, 85–86 (2005) (discussing the "high level of inaccuracy" when mental health professionals predict dangerousness and noting that it is very difficult to truly test accuracy because "there is no way of knowing how many times a particular expert was right or wrong in his or her predictions of future dangerousness"); Henry J. Steadman, *From Dangerousness to Risk Assessment of Community Violence: Taking Stock at the Turn of the Century*, 28 J. AM. ACAD. PSYCHIATRY & L. 265, 269–70 (2000) (similar).

it does not go far enough. The New York law would not have stopped Alexis from buying the fatal shotgun. No mental health professional assessed Alexis and found him dangerous. This is more than an anecdote. Literally millions of Americans with mental illness are not receiving mental health treatment. Some of them are psychotic and many come in contact with law enforcement.

Indiana has made the right choice in empowering police officers to sometimes curb gun rights. However, Indiana's choice of standard may not be optimal. Dangerousness is difficult to define, let alone assess, even by trained experts. There is real potential for police abuse of such a discretionary authority. But even assuming reliable assessment free from abuse, a per se rule regarding delusions and hallucinations, along the lines suggested herein, may be a useful supplement to dangerousness. A psychotic individual may not appear immediately dangerous but is probably still unable to be objectively reasonable in using a firearm.

A final counter-argument is that the federal background check system is too porous to make a difference. No background check is required for private sales, which make up a substantial portion of gun transactions.[91] One might therefore expect mental health restrictions on purchases from licensed dealers to have little or no effect. However, recent experience suggests that this is not the case. "In those with a gun-disqualifying mental health record, risk of violent criminal offending declined significantly after Connecticut began reporting gun-disqualifying mental health records to the [federal background check system]."[92] The cost of switching to a private sale apparently deters some gun purchases. Of course, expanding the background check system would maximize the effectiveness of my proposal, but the proposal is still likely to have a positive impact in the meantime.

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[91] *See* Stephen Davis & Bryan Polcyn, *Guns for Sale: No Background Check Required*, FOX6NOW.COM (Nov. 7, 2013), http://fox6now.com/2013/11/07/guns-for-sale-no-background-check-required/ ("Over the past 15 years, the FBI has processed more than 100-million criminal background checks on potential gun buyers. But those checks only apply to the sale of guns through a federally licensed firearms dealer. Don't want a background check? No problem. Just buy from a private seller instead."); *Universal Background Checks & the Private Sale Loophole Policy Summary*, LAW CENTER TO PREVENT GUN VIOLENCE (Aug. 21, 2013), http://smartgunlaws.org/private-sales-policy-summary/ ("The most dangerous gap in federal firearms laws today is the 'private sale' loophole. Although federal law requires licensed firearms dealers to perform background checks on prospective purchasers and maintain records of all gun sales, unlicensed 'private' sellers do not have to do either. An estimated 40% of all firearms sold in the U.S. are transferred by unlicensed 'private' sellers.").

[92] Jeffrey W. Swanson et al., *Preventing Gun Violence Involving People with Serious Mental Illness*, *in* REDUCING GUN VIOLENCE IN AMERICA: INFORMING POLICY WITH EVIDENCE AND ANALYSIS 33, 45 (Daniel W. Webster & Jon S. Vernick eds., 2013).

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Most delusions are harmless and invisible.[93] Some of the more serious ones will come to the attention of the police. If they do, then the officer should suspend gun rights. This proposal would likely have prevented Alexis from purchasing the shotgun used in the Navy Yard shooting. It is grounded in empirical work showing that psychotic symptoms can predict violence better than diagnosis does. And there is an additional constitutional argument for this symptom-based approach derived from principles of self-defense. A person suffering from delusions or hallucinations cannot be trusted to use a firearm defensively in an objectively reasonable fashion.

Prevention, however, comes with a price. Many who would never misuse a firearm will have their access to guns curtailed. Whether this approach would ultimately survive legal scrutiny may be an open question, but it would appear a promising enough policy direction to warrant further consideration.

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[93] Jeffrey Swanson & Marvin Swartz, *The Navy Yard Shooting and Mental Illness*, CLINICAL PSYCHIATRY NEWS (Sept. 20, 2013), http://www.clinicalpsychiatrynews.com/index.php?id=2407&cHash=071010&tx_ttnews[tt_news]=216831 (explaining that post-*Heller*, the United States faces the difficult task of trying to keep guns out of the hands of certain "dangerous people"; that "we often don't know who the dangerous people are (until it's too late), and the people that we might assume to be dangerous (say because they have a mental illness) mostly are not"; and that psychiatrists' predictions of gun violence "aren't much better than a coin toss" so "reducing gun violence in the tiny proportion of mentally ill individuals at risk is a vexing challenge").