

Reforming Mental Health Law to Protect Public Safety and Help the Severely Mentally Ill

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INTRODUCTION

Murders in Newtown, Connecticut, and elsewhere have spurred public debate about reforming mental health laws. This Article pro-

poses reforms, which will better protect the public, including the severely mentally ill, while preserving the due process rights of everyone.

About 18 percent of all murders are perpetrated by persons suffering from severe mental illness. For mass attacks against strangers, the percentage is far higher. Severe mental illness also plays a major role in many other violent crimes, often through secondary effects of the illness, such as unemployment.

Absurdly, there are three times more persons with severe mental illness in jails and prisons today than there are in psychiatric hospitals. Often, the people who end up in penal institutions had previously sought mental health treatment, but could not get it. The most necessary reform, from a public safety viewpoint, is the provision of sufficient funding so that voluntary treatment is available for the severely mentally ill.

Only a small minority of severely mentally ill people is dangerously violent. For them, involuntary commitment to inpatient or outpatient programs can be life-saving for them and for other persons. Today, more than one-quarter of the current state-to-state variation in murder rates can be explained by differences among involuntary commitment laws, with broader commitment standards correlating with lower murder rates.

This Article does not recommend weakening any due process protections currently in place for involuntary commitments. The Article does recommend removing the requirement in some states that an involuntary commitment based on serious danger may only take place when the danger is “imminent.”

Nothing in the statute books matters if persons who know about an obvious danger fail to act. The killers at the Aurora movie theater and in Tucson both could have been committed under the existing laws of their states, but officials at the University of Colorado and at Pima Community College failed to inform anyone about their dangerously mentally ill ex-students.

Part I provides the definitions for the mental illnesses which are the subject of this Article. Part I also provides estimates of the numbers of people in the United States who suffer from these illnesses.

Part II examines the data about the relationship between severe mental illness and violent crime. Severe mental illness does significantly raise the odds that a person will perpetrate a violent crime. But

most often, the increased risk is not from the immediate effect of the illness itself (such as hallucinations or delusions) but rather from other factors—such as developing a substance abuse problem, or being victimized—for which the seriously mentally ill are at particularly high risk. As Part II explains, seriously mentally ill people are much more likely to be crime victims than to be crime perpetrators, and the large majority of people who are seriously mentally ill never perpetrate violent crimes.

Part III examines the data on serious mental illness and homicide, especially mass homicide. At this extreme end of the criminality spectrum, the association between untreated severe mental illness and mass murder is overwhelming. The fraction of perpetrators who are severely mentally ill is grossly disproportionate to the small percentage of the population with severe mental illness.

Part IV explains current statutory and case law about when a person may be deprived of the constitutional rights to arms, based on alleged mental illness. The federal Gun Control Act of 1968 imposes a lifetime firearms prohibition for any person who has been adjudicated mentally ill. More recently, due process protections have been somewhat improved, especially for persons who had a problem decades ago, and who have fully recovered.

Part V details the depressing results of the de-institutionalization movement of the latter part of the twentieth century. Today, prisons and jails house far more seriously mentally ill people than do mental institutions.

Part VI describes the social science research showing that broader laws on civil commitment have a large effect in reducing homicides. Part VI also explains that the number of available mental health beds (for either voluntary or involuntary treatment) is grossly insufficient. Fixing the problem will require a great deal of spending; the spending would be cost-effective in the long run, due to reduced crime and other maladies.

Part VII explains the history of constitutional standards regarding civil commitment, and recent statutory reforms in Virginia and Wisconsin. We argue that states which currently require “imminent” danger for a mental health commitment should remove the imminence requirement, but should not weaken the due process requirements for short-term or long-term commitments.

Part VIII describes the mental health issues and the commitment laws which could have been used for the perpetrators of four recent, notorious mass murders: at the Washington Navy Yard, Tucson, the Aurora theater, and Newtown. In at least two of the cases, existing state laws could have authorized a commitment, but the people who knew about the danger failed to act.

Part IX summarizes state experiences with a relatively new form of commitment: involuntary outpatient commitment (IOC). Rather than being held in a mental institution, a person may be ordered by a court to undergo outpatient treatment. For some mentally ill persons, IOC works well, and is a less restrictive alternative to inpatient commitment.

I. DEFINING THE TERMS

The standard treatise about mental disorders is the fifth edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), published by the American Psychiatric Association.¹ In DSM-5, “severe” cases have more symptoms and those symptoms are more powerful. For example, in the DSM-5’s “Clinician-Rated Dimensions of Psychosis Symptom Severity,” there are eight categories, including hallucinations,² delusions,³ and disorganized thinking, often manifested by disorganized or incoherent speech.⁴ Each symptom can range from “not present” to “severe.” In the category of delusions, the symptom is “mild” if the person feels “little pressure to act upon delusional beliefs” and is “not very bothered” by them. Delusions are “severe”

1. AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (5th ed. 2013) [hereinafter DSM-5]. Various editions of the DSM have been criticized, sometimes appropriately, for labeling non-conformity or political incorrectness as psychiatric diagnoses. Those criticisms are not relevant to this Article, which uses the DSM solely in regards to mental issues for which there is a long-standing consensus that the problem is a genuine mental disorder, such as bipolar syndrome, or schizophrenia.

2. Hallucinations are “perception-like experiences that occur without an external stimulus. They are vivid and clear, with the full force and impact of normal perceptions, and not under voluntary control.” *Id.* at 87.

Auditory hallucinations are far more common than visual ones, which are relatively rare. Dewey G. Cornell & Gary L. Hawk, *Clinical Presentation of Malingers Diagnosed by Experienced Forensic Psychologists*, 13 *LAW & HUM. BEHAV.* 375, 380–81 (1989). Among the things which can trigger auditory hallucinations is watching television, especially the news. See I. Leudar et al., *What Voices Can Do with Words: Pragmatics of Verbal Hallucinations*, 27 *PSYCHOL. MED.* 885 (1997) (analyzing various characteristics triggering hallucinations).

3. Delusions are “fixed beliefs that are not amenable to change in light of conflicting evidence The distinction between a delusion and a strongly held idea . . . depends in part on the degree of conviction with which the belief is held despite clear or reasonable contradictory evidence regarding its veracity.” DSM-5, *supra* note 1, at 87.

4. *Id.* at 88.

when the person feels “severe pressure to act upon beliefs, or is very bothered by beliefs.”⁵

Under this definition, about six percent of the U.S. population has a severe mental illness.⁶ Because this Article concentrates on public safety issues, it only addresses some severe mental illnesses. The mental illnesses most strongly associated with violent crimes are *personality disorders*.

A personality disorder is “an enduring pattern of inner experiences and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.”⁷ About 9.1 percent of the U.S. adult population has a personality disorder (although not necessarily a severe one).⁸ A majority of violent criminals have some kind of a personality disorder.⁹

The personality order definition should not be taken literally in every situation. A freedom-loving person in Stalin’s Soviet Union who persisted in reading banned books, forthrightly expressing her political opinions, worshipping in a religion not allowed by the government, and so on, might suffer the “distress or impairment” resulting from being sent to a slave labor camp.¹⁰ But such a person was not mentally disordered; indeed, such a brave person was saner, better mentally ordered, than the general population, which submitted to slavery.

Personality disorders include *paranoid personality disorder* (“pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent”),¹¹ *histrionic personality disorder* (“excessive emotionality and attention seeking”),¹² and *narcissistic personal-*

5. *Id.* at 743–44.

6. Ronald C. Kessler et al., *Prevalence, Severity, and Comorbidity of Twelve-Month DSM-IV Disorders, in The National Comorbidity Survey Replication (NCS-R)*, 62 ARCH. GEN. PSYCHIATRY 617, 619 tbl.1 (2005) (noting 1.3 percent of population with one serious disorder; 2.1 percent with two serious disorders, and 2.3 percent with three or more; using the previous edition of DSM).

7. DSM-5, *supra* note 1, at 645.

8. Mark F. Lenzenweger et al., *DSM-IV Personality Disorders, in The National Comorbidity Survey Replication*, 62 BIOLOGICAL PSYCHIATRY 553, 553 (2007).

9. Michael H. Stone, *Violent Crimes and Their Relationship to Personality Disorders*, 1 PERSONALITY & MENTAL HEALTH 138, 138–39 (2007).

10. *See generally* SIDNEY BLOCH & PETER REDDAWAY, *SOVIET PSYCHIATRIC ABUSE: THE SHADOW OVER WORLD PSYCHIATRY* (1985) (discussing various psychiatry issues in the Soviet Union).

11. DSM-5, *supra* note 1, at 649–52.

12. DSM-5, *supra* note 1, at 667–69.

ity disorder (“grandiosity . . . need for admiration, and lack of empathy”).¹³ These are classic traits of mass killers.¹⁴

Particularly associated with impulsive violent crime is *borderline personality disorder*. Some of the symptoms are:

- Problems with regulating emotions and thoughts
- Impulsive and reckless behavior
- Unstable relationships with other people.¹⁵

About 1.6 percent of the U.S. adult (18 and older) population has borderline personality disorder.¹⁶ Borderline personality disorder appears to be strongly influenced by genetics.¹⁷

Even more closely related to violent crime is *antisocial personality disorder* (ASPD). Such persons with this disorder frequently:

- Lack empathy.
- Tend to be callous, cynical, and contemptuous of the feelings, rights, and sufferings of others.
- Have an inflated and arrogant self-appraisal.
- Are excessively opinionated, self-assured, or cocky.
- Display a glib, superficial charm.¹⁸

About 1.0 percent of the U.S. adult population has antisocial personality disorder.¹⁹ Serial killer Ted Bundy was an example.²⁰

13. DSM-5, *supra* note 1, at 669–72.

14. Paul E. Mullen, *The Autogenic (Self-Generated) Massacre*, 22 BEHAV. SCI. & L. 311 (2004).

15. DSM-5, *supra* note 1, at 663–66.

16. Lenzenweger, *supra* note 8, at 556 tbl.3.

17. NAT'L INST. OF MENTAL HEALTH, BORDERLINE PERSONALITY DISORDER, available at <http://www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml> (last accessed Aug. 21, 2015).

Scientists are just beginning to understand the influence of genetics on crime. For example, a study of 153 men found that a particular genetic disorder that affects serotonin levels could explain five percent of the variance in the criminal behavior among the subjects. Wolfgang Retz et al., *Association of Serotonin Transporter Promoter Gene Polymorphism with Violence: Relation with Personality Disorders, Impulsivity, and Childhood ADHD Psychopathology*, 22 BEHAV. SCI. & L. 415 (2004). Yet a study specifically of persons with schizophrenia found no relation between the serotonin genetic disorder and homicide. Moshe Kotler et al., *Homicidal Behavior in Schizophrenia Associated with a Genetic Polymorphism Determining Low Catechol-O-Methyltransferase (COMT) Activity*, 88 AM. J. MED. GENETICS 628 (1999).

18. DSM-5, *supra* note 1, at 659–63; PsychCentral, *Antisocial Personality Disorder Symptoms*, available at <http://psychcentral.com/disorders/antisocial-personality-disorder-symptoms/> (last accessed Aug. 21, 2015).

19. Lenzenweger, *supra* note 8.

20. See generally RICHARD W. LARSEN, BUNDY: THE DELIBERATE STRANGER (1980); ANN RULE, THE STRANGER BESIDE ME (2000); Katherine Ramsland, *The Many Sides of Ted Bundy*, 22 FORENSIC EXAMINER 18 (2013) (reanalyzing data on the link between severe mental illness and increased risk of violence).

Many people with APSD also have depression. Besides frequently leading to prison, ASPD often results in difficulty holding employment due to being fired for being caught cheating. Long-term relationships are also difficult to maintain. But if persons with ASPD “are clever and do not get caught, they can be highly successful people with impressive jobs. In fact, some people with the disorder actually become model citizens as they age. It is thought that when they grapple with the limits of old age, these individuals learn to accept their limitations and have less of a need to prove their power over others.”²¹

A person’s upbringing can affect the development of personality disorders. Paul Frick’s study of preschoolers found many who could be classified as *psychopaths* (persons with a no empathy, low response to negative stimulus, and a sense of grandiosity).²² He also found that most such preschoolers who had consistent parenting eventually “grew” a conscience.²³

Much less associated with violent crime are *anxiety disorders*. An anxiety disorder differs from ordinary fear or anxiety in that it is persistent (typically for half a year or more), and it causes significant problems for the individual. Examples include panic attacks, various phobias, or post-traumatic stress.²⁴ It includes a wide variety of disorders, most of which seem unlikely to increase the risk of violent crime. For example, ranidaphobia (fear of frogs) might impair hiking, or natural history museum visits, but would not increase the probability of

21. MICHAEL T. COMPTON & RAYMOND J. KOTWICKI, RESPONDING TO INDIVIDUALS WITH MENTAL ILLNESS 153 (2007).

22. Paul J. Frick, *Using the Construct of Psychopathy to Understand Antisocial and Violent Youth*, in THE PSYCHOPATH: THEORY, RESEARCH, AND PRACTICE 343 (Hugues F. Hervé & John C. Yuille eds., 2007); see generally Mary Ellen O’Toole, *Psychopathy as a Behavior Classification System for Violent and Serial Crime Scenes*, in THE PSYCHOPATH: THEORY, RESEARCH, AND PRACTICE 303 (Hugues F. Hervé & John C. Yuille eds. 2007) (listing the 18 characteristics from the Hare Psychopathy Checklist—Revised, PCL-R). The DSM does not have a diagnosis for “psychopath,” which has a substantial overlap with the DSM’s “anti-social personality disorder.” The term “psychopath” has a well-established and clinically-valid use as a description of persons manifesting certain symptoms and behaviors. Hugues Hervé, *Psychopathy Across the Age: A History of the Hare Psychopath*, in THE PSYCHOPATH, *supra*, at 48–50; see generally Mark D. Cunningham & Thomas J. Reid, *Antisocial Personality Disorder and Psychopathy: Diagnostic Dilemmas in Classifying Patterns of Antisocial Behavior in Sentencing Evaluations*, 16 BEHAV. SCI. & L. 333 (1998) (analyzing the overlaps and the differences between psychopathology and the DSM’s anti-social personality disorder). Many people with ASPD are not psychopaths. James L. Knoll, *Clinical Framework for the Treatment Relationship*, in FRED COHEN, PRACTICAL GUIDE TO CORRECTIONAL MENTAL HEALTH AND THE LAW 8–16 (2011).

23. Paul J. Frick, *Using the Construct of Psychopathy to Understand Antisocial and Violent Youth*, in THE PSYCHOPATH, *supra* note 22, at 343.

24. See DSM-5, *supra* note 1, at 189–233.

committing violent crime. Hoplophobia (fear of gun owners)²⁵ would at least seem to reduce the risk of firearms crime.²⁶ Similarly, a person's agoraphobia (fear of being trapped, helpless, or embarrassed, in certain places, especially in public places)²⁷ may be very debilitating for the individual (e.g., the reclusive Howard Hughes²⁸), but there is little connection with criminal behavior.

Affective disorders involve long-term effects on mood. Depression is a common affective disorder.²⁹ About 6.7 percent of American adults suffer from major depressive disorder in a given year.³⁰

Another affective disorder is bipolar.³¹ Bipolar disorders involve episodes of mania (including but not limited to elevated mood and energy) and depression (depressed mood, diminished interest in pleasure, loss of energy, inability to concentrate). Sometimes bipolar disorder can make a person *psychotic*—that is, disconnected from reality. Bipolar disorder does increase the risk of violent crime, as will be detailed below. The disorder affects 5.7 million adult Americans (about 2.6%) in a given year.³²

Schizophrenia is often used as shorthand for various psychotic symptoms (also called “domains” or “features”). These include “positive symptoms” (presence of unusual things) such as delusions, hallucinations, or disorganized speech. There are also “negative symptoms” (the absence of normal things), as manifested by diminished emo-

25. See PHILIP T. NINAN & BOADIE W. DUNLOP, CONTEMPORARY DIAGNOSIS AND MANAGEMENT OF ANXIETY DISORDERS 107 (2006) (hoplophobia). Hoplophobia and ranidaphobia are examples of a *specific phobia*, and the DSM does not attempt to list every specific phobia. DSM-5, *supra* note 1, at 197–202.

26. Although it would probably elevate the risk of crime against gun owners. See Katie Mettler, *Man Shopping for Coffee Creamer at Walmart Attacked by Vigilante for Carrying Gun he was Legally Permitted to Have*, TAMPA BAY TRIB., Jan. 20, 2015 (unprovoked attack by middle-aged white man on older black man, who had handgun carry permit).

27. DSM-5, *supra* note 1, at 217–22.

28. See generally DONALD L. BARLETT & JAMES B. STEELE, HOWARD HUGHES: HIS LIFE AND MADNESS (2004) (describing Hughes' reclusive nature).

29. DSM-5, *supra* note 1, at 155–88. The greatest violence risk for depression is suicide, rather than interpersonal violent crime.

30. Kessler, *supra* note 6.

31. DSM-5, *supra* note 1, at 123–54.

32. Kessler, *supra* note 6. Percentages of adult population are calculated from U.S. Census Bureau Population Estimates for 2004, cited and detailed in NATL. INST. OF MENTAL HEALTH, THE NUMBERS COUNT: MENTAL DISORDERS IN AMERICA (2012).

tional expression or social withdrawal.³³ In addition, schizophrenia greatly impairs cognition.³⁴

Schizophrenia is extremely heterogeneous in its origin (many genetic³⁵ and environmental factors contribute to causation), in the variety of its symptoms, and in how effective various treatments are for different people.³⁶

In the United States, there are 2.4 million adults with schizophrenia, about 1.1 percent.³⁷ The age-adjusted schizophrenia rate appears to be stable. However, because more people live into old age, the total percentage of the population with schizophrenia has been increasing.³⁸

Schizophrenia certainly raises the risk of violent crime, as will be detailed in Part II, which also explains that the additional risks depend on many other variables.

Our understanding of the causes of mental illness is very incomplete. We do know that schizophrenia has a genetic component. It is not caused by bad habits or bad character. A person with schizophrenia who is hearing auditory hallucinations has no more moral culpability (zero) than does a person with Parkinson's dementia who cannot remember things. They have a biological condition, not a character flaw. The same appears to be true for bipolar disorder. Even psychop-

33. DSM-5, *supra* note 1, at 87; see generally Stanley R. Kay et al., *The Positive and Negative Syndrome Scale (PANSS) for Schizophrenia*, 13 SCHIZOPHRENIA BULL. 261 (1987) (providing foundational discussion of the Positive and Negative Syndrome Scale, PANSS).

34. Solomon Kalkstein et al., *Neurocognition in Schizophrenia*, in BEHAVIORAL NEUROBIOLOGY OF SCHIZOPHRENIA AND ITS TREATMENT 373 (Neal R. Swerdlow ed., 2010) (schizophrenia damages general intellectual functioning, attention, processing speed, executive function, learning and memory, language, visual perceptual/constructional skills, fine motor skills, and social cognition).

35. Jared W. Young et al., *Animal Models of Schizophrenia*, in BEHAVIORAL NEUROBIOLOGY OF SCHIZOPHRENIA, *supra* note 34, at 391, 412–15. Prenatal viral or bacterial infections, such as toxoplasmosis, appear to raise the risk of later development of schizophrenia. *Id.* at 443–48. So does maternal malnutrition. *Id.* at 448–50.

36. *Id.* at 392. “Diagnostically, the boundaries of the schizophrenia are less clearly marked than we once believed, expanding in some directions toward the bipolar disorders, in other toward the ‘Cluster A’ personality spectrum [Paranoid, Schizoid, and Schizotypal Personality Disorders], and in still others toward ‘pure’ genetic disorders.” Neal R. Swerdlow, *Introduction*, in BEHAVIORAL Neurobiology of Schizophrenia, *supra* note 34, at v.

37. Darrel A. Regier et al., *The De Facto Mental and Addictive Disorders Service System: Epidemiologic Catchment Area Prospective 1-Year Prevalence Rates of Disorders and Services*, 50 ARCH. GEN. PSYCHIATRY 85 (1993).

38. Heinz Häfner, *Are Mental Disorders Increasing Over Time?* 18 PSYCHOPATHOLOGY 66, 66 (1985) (“Except for age-related changes, we do not seem to have become more ill than the generation of our parents, but more pessimistic.”); CLAYTON E. CRAMER, *MY BROTHER RON: A PERSONAL AND SOCIAL HISTORY OF THE DEINSTITUTIONALIZATION OF THE MENTALLY ILL* 27–28 (2012) (summarizing evidence for and against rising schizophrenia rates).

athy appears have to have a strong genetic basis, perhaps related to a neurochemical disorder in the processing of negative stimuli.³⁹

When we see a person with Down's syndrome, or Alzheimer's, we recognize that we are fortunate not to have their illness, and we try to help; we do not blame them for having an illness. The same should be true for the mental illnesses, including schizophrenia, which are primarily biochemical in origin. This does not mean that people with schizophrenia, or Down's syndrome, or Parkinson's dementia, never have any responsibility for their actions; people can still make choices. But we can recognize that sometimes, the ability to discern the right choice may be gravely impaired by conditions beyond an individual's moral power to control.

II. DATA AND STUDIES ON CRIME AND THE SERIOUSLY MENTALLY ILL

According to one study, 46 percent of Americans will have a psychiatric disorder at least once during their lifetimes.⁴⁰ This does not mean that 46 percent of Americans should be put in mental hospitals, or that they are dangerous to themselves or others. The definitions of mental/personality disorders have expanded greatly since the early twentieth century. Likewise, there is much greater awareness of physical disorders and diseases, some of which are quite subtle.

In this Article, we focus on a much smaller set of mental disorders, and among them, we primarily address severe cases. But the 46 percent figure is still useful, since it is a reminder that if someone has a problem—such as a phobia about large social events, or moderate depression—there is nothing wrong with going to a mental health professional to get help. One of the most significant barriers to mental health treatment has been the stigma associated with mental illness. There is no stigma associated in going to the doctor when you think you may have a kidney disorder, and there should likewise be no

39. Robert D. Hare, *Forty Years Aren't Enough: Recollections, Prognostications, and Random Musings*, in *THE PSYCHOPATH: THEORY, RESEARCH, AND PRACTICE* 14 (Hugues F. Hervé & John C. Yuille eds., 2007). Another influence may be extreme prenatal malnutrition. Richard Neugebauer et al., *Prenatal Exposure to Wartime Famine and Development of Antisocial Personality Disorder in Early Adulthood*, 282 *JAMA* 455 (1999) (reporting the results of a study on Netherlands males born 1944-46. During part of this time, a Nazi blockade on food supplies was in effect. Severe maternal malnutrition during the first or second semesters of pregnancy increased the odds ratio of anti-social personality disorder by 2.5 times).

40. Ronald C. Kessler et al., *Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 *ARCH. GEN. PSYCHIATRY* 593 (2005).

stigma in seeking treatment when you think you may have a mental disorder.

A. The seriously mental ill as crime victims

When we examine the data on serious mental illness and violent crime, it is clear that the problem of victimization is far larger than the problem of perpetration. A Swedish study found that the severely mentally ill are five times more likely to be murdered.⁴¹ A Chicago study found persons with severe mental illness eleven times more likely to be the victim of a violent crime.⁴² In Los Angeles, the data indicate that a person with schizophrenia is much more likely to be a crime victim than a crime perpetrator.⁴³ National U.S. data show that persons with mental disabilities are at far greater risk of being victimized by violent criminals.⁴⁴

The precise reasons for the higher victimization rate have not been delineated by social science. One reason may be that the symptoms of mental illness sometimes impair a person's situational awareness, so that he is less alert about a risky situation. Or if the person's symptoms are apparent to others, he may be identified as an easy target. Further, serious mental illness often leads to lower socioeconomic status, because of unemployment, less educational attainment, lower-paying jobs, and so on; thus the seriously mentally ill person may be unable to afford to live anywhere except in a high-crime neighborhood, where everyone is at greater risk. At the extreme end of the spectrum, the seriously mentally ill person may become homeless, with all of the attendant risks of being victimized.

So although this Article is primarily about reducing crime *by* the seriously mentally ill, the largest crime-reductive effect of implementing our proposals to help the seriously mentally ill would likely be in

41. Casey Crump et al., *Mental Disorders and Vulnerability to Homicidal Death: Swedish Nationwide Cohort Study*, 2013 BRIT. MED. J. 346 (2013) (finding 4.9-fold overall risk increase; 9-fold if in conjunction with substance abuse; without substance abuse, 3.2 for personality disorders, 2.6 for depression, 2.2 for anxiety disorders, and 1.8 for schizophrenia).

42. Linda A. Teplin et al., *Crime Victimization in Adults with Severe Mental Illness: Comparison with the National Crime Victimization Survey*, 62 ARCH. GEN. PSYCHIATRY 911, 911, 913 (2005) (controlling for income and other demographic variables).

43. J.S. Brekke et al., *Risks for Individuals with Schizophrenia who are Living in the Community*, 52 PSYCHIATRIC SERV. 1358 (2001) (three-year study of 172 persons with schizophrenia in Los Angeles).

44. ERIKA HARRELL, UNITED STATES DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, CRIME AGAINST PERSONS WITH DISABILITIES, 2009-2011 tbl.3 (2012).

reducing the number of crimes perpetrated *against* the seriously mentally ill.

B. Studies of serious mental illness and crime

Before looking at the research on serious mental illness and violent crime, some caveats are appropriate. First, not all crimes committed by mentally ill persons may be related to the mental illness.⁴⁵ Diabetics commit crime, but that does not mean that diabetes itself makes people into criminals. Or imagine a person who has a severe phobia about riding in elevators. The person robs someone in a park. The particular mental illness and the crime would have nothing to do with each other. Similarly, if a violent criminal has borderline personality disorder and also has schizophrenia (e.g., auditory hallucinations), the borderline personality may well be related to the crime, while the schizophrenia may or may not be.

A crucial variable is how a person responds to symptoms of mental illness. For example, a person might have a quite severe case of persistent hallucinations. Yet the person is also aware that the hallucinations are not real. Such persons are less likely to act violently because of the hallucinations.⁴⁶

Several large-scale studies have indicated that serious mental illness is a risk factor for violence. A 1990 study by the National Institute of Mental Health (NIMH) found that in a one-year period, the prevalence of violence (very broadly defined) was 12 percent among persons with schizophrenia, bipolar disorder, or major depression, and 7 percent for persons who had these disorders but no substance abuse. In contrast, the violence rate for the general population without mental or substance disorders was two percent.⁴⁷ The lifetime violence

45. The closest link would be that a crime was directly caused by symptoms of mental illness. A small-scale study of 143 mentally ill criminals (with 429 crimes among them) found only 17 percent their crimes directly caused by symptoms. Jillian K. Peterson et al., *How Often and how Consistently do Symptoms Directly Precede Criminal Behavior Among Offenders with Mental Illness?* 38 *LAW & HUM. BEHAV.* 439 (2014). As the authors point out, the mentally ill have many problems related to secondary or tertiary effects of their illnesses. *Id.* at 440. This will be examined further, in text *infra*.

46. A girlfriend of one of the authors long ago suffered from simple schizophrenia. She knew the voices that kept her awake yelling, "Kill yourself," were not real. Because of this, she was able to voluntarily admit herself to a mental hospital.

47. 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* 20–24 (1997). Because the study came from a large sample of more than 10,000 voluntary participants, the data may underrepresent the relative violence levels of persons suf-

rate (including self-reported minor and non-criminal violence) was 15 percent for the general population, 33 percent for serious mental illness alone, and 55 percent for serious mental illness plus substance abuse.

This lifetime rate includes periods when a person might not have serious mental illness or substance abuse. These rates are also calculated without regard to whether or not a person was receiving treatment for mental illness or substance abuse. The 1990 study also showed that risks were higher for mentally ill people in categories which are independently associated with higher risk of violence (young, male, low socioeconomic status) and therefore lower for persons not in those categories.

Subsequently, the MacArthur Violence Risk Assessment Study (MVRAS) followed about a thousand acute psychiatric patients after their hospital discharge, for a period of one year. For patients who did *not* have substance abuse problems, their violence rate was no higher than that of people who lived in similar neighborhoods and were not substance abusers—although the base violence rate was fairly high in itself (18 percent), since the discharged patients tended to live in high-crime, low-income neighborhoods.⁴⁸ Also, the persons studied had all received inpatient psychiatric treatment in the previous 20 weeks, which might have lowered their violence risk.

In contrast to the discharged patients without substance abuse issues, 31 percent of the discharged patients who did abuse substances had at least one violent incident during the subsequent year.

fering from severe mental illness. People suffering from paranoid schizophrenia, for example, are almost certainly less likely to participate in a voluntary survey; their delusions may have convinced them that the questioner works for the CIA, the KGB, or is an alien in human disguise.

48. Henry J. Steadman et al., *Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, 55 ARCH. GEN. PSYCHIATRY 393, 398 tbl.4, 401 (1998). The MacArthur study looked at combinations of characteristics, which indicated whether persons were especially likely or unlikely to commit violence. Some of the results were surprising. For example, one combination for low violence, was low psychopathy, few prior arrests, no recent violence, hospital admission had been voluntary, and “symptom activation” was “high.” JOHN MONAHAN ET AL., *RETHINKING RISK ASSESSMENT: THE MACARTHUR STUDY OF MENTAL DISORDER AND VIOLENCE* 100 fig.5.2 (2001). In other words, active symptoms actually reduced violence risks in this group. The highest-risk group (58.5 percent violence rate during the study period) was the combination of psychopathy, having been the victim of serious child abuse, being an alcohol or drug abuser, and the reason for the hospital admission was *not* suicide risk. *Id.* Overall, the single strongest factor for high risk was the score on the Hare Psychopathy Checklist—Screening Version. *Id.* at 108. But no “given variable constituted the cause of violence, even for a subgroup of patients.” *Id.* at 142. Rather, it was “the accumulation of risk factors, no one of which is either necessary or sufficient for a person to behave aggressively toward others.” *Id.*

The combination of mental illness with substance abuse can be particularly lethal. A Finnish study found that for females, a schizophrenia diagnosis was associated with a five- or six-fold increase in the risk of perpetrating a homicide. In contrast the diagnosis of alcoholism plus antisocial personality disorder increased the odds by forty- to fifty-fold.⁴⁹ An Australian study found that schizophrenics with substance abuse had an odds ratio of 7.7 for being convicted of a violent crime, compared to schizophrenics without substance abuse; for this latter group had a violent crime odds ratio of 2.5:1 compared to the general population.⁵⁰ Between 20 and 50 percent of persons with schizophrenia have a substance abuse disorder, and substance abuse is also elevated in persons with various other mental illnesses.⁵¹

Another study surveyed over 32,000 U.S. households. It found lower violence than the 1990 NIMH study, partly because of narrower definitions, and also because the U.S. crime rate has decreased greatly since 1990. That study found a 10 percent annual violence rate for substance abuse plus serious mental illness, 2.9 percent for serious mental illness alone, and 0.8 percent for persons with neither substance abuse nor serious mental illness.⁵²

Substance abuse by itself (not necessarily in conjunction with mental illness) increases the risk for violence by seven to nine times.⁵³

49. Markku Eronen et al., *Mental Disorders and Homicidal Behavior in Finland*, 53 ARCH. GEN. PSYCHIATRY 497 (1996). Epidemiologists often report their results as an “odds ratio” or as “relative risk.” Let’s suppose that there are two groups that are perfectly identical in all respects, except that people in Group 1 frequently drive at least 20 miles an hour above the speed limit, and the people in Group 2 rarely or never do so. A study investigates whether there was a particular “outcome” (an automobile accident) in a given period (let’s say the driving study covered a two-year period). During the two-year period, only one percent of Group 2 (non-speeders) had an auto accident, while twenty percent of Group 1 (frequent heavy speeders) had an accident. Then the “relative risk” for speeding and accidents would be 20. The “odds ratio” formula is more complicated; the odds ratio for speeding and accidents is 24.75. Relative risk and odds ratios of less than 2 are often ignored, as not being strong enough to demonstrate a relationship.

50. 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, 721–22 (2004). “Most convictions for violent offenses were for robbery with violence and inflicting actual or grievous bodily harm.” *Id.* at 724. During the 25 years studied, “8.2% of all subjects with schizophrenia, and 13.0% of male subjects with schizophrenia, were convicted of a violent offense.” *Id.* at 724.

51. Anders Tengström et al., *Schizophrenia and Criminal Offending: The Role of Psychopathy and Substance Use Disorders*, 31 CRIM. JUST. & BEHAV. 367, 372–73 (2004) (summarizing prior research).

52. Richard Van Dorn et al., *Mental Disorder and Violence: Is There a Relationship Beyond Substance Use?* 47 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 487, 490 (2012).

53. Seena Fazel et al., *Schizophrenia and Violence: Systematic Review and Meta-Analysis*, 6 PLOS MED. Aug. 2009, at 1.

A meta-analysis (literature review and synthesis) of twenty previous studies estimated that persons with schizophrenia and substance abuse were about as likely to be violent as persons who are substance abusers but do not have schizophrenia.⁵⁴ The study did not account for whether these non-schizophrenics had other mental illnesses.

The result is consistent with a study of over 34,000 persons in the United States (including controls who were not mentally ill), finding that “severe mental illness alone did not predict future violence; it was associated instead with historical (past violence, juvenile detention, physical abuse, parental arrest record), clinical (substance abuse, perceived threats), dispositional (age, sex, income), and contextual (recent divorce, unemployment, victimization) factors.”⁵⁵ In other words, the same factors that are associated with greater violence in the general population.

While previous studies had found a powerful criminogenic interaction between substance abuse and schizophrenia, another study found that the effect of substance abuse on serious violence was rendered nonsignificant in the final model when controlling for age, PANSS positive symptoms,⁵⁶ childhood conduct problems, and recent victimization.⁵⁷ Likewise, although psychopaths have a very high rate of alcohol abuse, it does not appear to raise their already-high risk of violent recidivism.⁵⁸

Further, the study found that by far the highest rate of serious violence (9 percent in a six-month period) was not for persons with the most extreme symptoms; rather, violence was greatest among

54. *Id.*

55. 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 ARCH. GEN. PSYCHIATRY 152 (2009).

56. “Positive and Negative Syndrome Scale.” Positive symptoms of schizophrenia include hallucinations, delusions, or disorganized thought. Negative symptoms include social withdrawal, low emotional responsiveness, or catatonia. See Kay et al., *supra* note 33, at 261.

57. Jeffery W. Swanson et al., *A National Study of Violent Behavior in Persons with Schizophrenia*, 63 ARCHIVES GEN. PSYCHIATRY 490, 490 (2006).

58. Marnie E. Rice & Grant T. Harris, *Psychopathy, Schizophrenia, Alcohol Abuse, and Violent Recidivism among Mentally Disordered Offenders*, 18 INT’L J. L. & PSYCHIATRY 333 (1995); cf. Stephen Porter & Sasha Porter, *Psychopathy and Violent Crime*, in THE PSYCHOPATH, *supra* note 22, at 287, 289 (summarizing studies showing high crime risks for re-offending by criminally-convicted psychopaths, compared to non-psychopaths, and also showing larger risks for psychopathic ex-patients at mental institutions, compared to other ex-patients). It should be noted that the majority of psychopaths who are released from penal institutions do not recidivate, and of those that do, the recidivism is almost always within two or three years after release. Stephen C.P. Wong & Grant Burt, *The Heterogeneity of Incarcerated Psychopaths: Differences in Risk, Need, Recidivism, and Management Approaches*, in THE PSYCHOPATH, *supra*, at 461–62 (summarizing studies).

those who were high in positive symptoms (e.g., delusions, hallucinations) while being *low* in negative symptoms (e.g., emotional flatness, social withdrawal).⁵⁹

The importance of factors other than mental illness alone is also demonstrated by a four-state study of psychiatric inpatients and outpatients, based on perpetration of violence in the previous year. The study considered three risk factors: substance abuse, violent victimization history (after age 16),⁶⁰ and exposure to violence in the person's current neighborhood. If the mentally ill person had one risk factor, the violence rate was close to that of the general population (which includes substances abusers, and persons with undiagnosed mental illnesses). If the mentally ill person had two risk factors, the probability of violence doubled. When all three risk factors were present, 30 percent of this group perpetrated violence.⁶¹

Stated another way, persons who suffer from serious mental illness, but who grew up in a healthy family environment (e.g., not violently victimized by family members), developed self-control and coping skills (no substance abuse), and who are able to maintain gainful employment (better able to afford living in a non-violent neighborhood) often seem to escape whatever crime-causing effects mental illness might have. Unfortunately, this subset of the seriously mentally ill is far from a majority of the group. So it seems that one important way in which serious mental illness may lead to violence is that it leads to other problems, which themselves seem to increase violence.

As one literature review put it, "The weight of the evidence to date" shows that "a statistical relationship does exist between schizophrenia and violence."⁶² But the relationship is much more complex than just the immediate effects of the disorder itself.

For bipolar disorder, a meta-analysis of eight previous studies, in conjunction with a study of forty years' of data from Sweden, deter-

59. Swanson et al., *supra* note 57, at 496. The violence rate was one percent for people who were low in both positive and negative symptoms. It was three percent for people who were high in both positive and negative symptoms, or were low positive and high negative. *Id.*

60. The study found that victimization during childhood did not have an association with violence as an adult, unless the child victim was also re-victimized after age 16. Jeffrey W. Swanson et al., *The Social-Environmental Context of Violent Behavior in Persons Treated for Severe Mental Illness*, 92 AM. J. PUB. HEALTH 1523, 1528 (2002). If so, the person was more likely to be violent than were persons who had only been victimized after age 16. *Id.*

61. *Id.* at 1529.

62. Elizabeth Walsh et al., *Violence and Schizophrenia: Examining the Evidence*, 180 BRIT. J. PSYCHIATRY 490, 494 (2002). Also, "only a small proportion of societal violence can be attributed to persons with schizophrenia." *Id.*

mined that the violence risk ratio was 1.3 for persons without substance abuse, compared to the general population; this is not a large enough ratio on which to base policy choices. However, for persons with bipolar disorder coupled with substance abuse, the risk increased to 6.4.⁶³

Antisocial personality disorder is associated with a particularly large increase (12.8) in violence risks.⁶⁴

So what percentage of total violent crime is related to mental illness? “Population-attributable crime” answers the question “How much less crime would there be if the particular group were not present?” For example, in the United States in 2013, there were 7,120,525 arrests for any type of crime. Males accounted for 5,249,466 of these arrests.⁶⁵ So the population-attributable crime of males is 74 percent. This obviously does not mean that all of the crimes perpetrated by males were caused by the fact that the perpetrator was male. Population-attributable crime figures provide information that people with a particular characteristic are perpetrating crime at a disproportionate rate, but the figures do not mean that the characteristic is the cause of all their crime.

With that caveat, the population-attributable figures are: for psychoses (loss of connection with reality; often a symptom of schizophrenia, but sometimes a symptom of another mental disorder) 2-10 percent of violence;⁶⁶ for personality disorders, about 11 percent of violent crimes, and 29 percent of repeat offenses;⁶⁷ and for substance abuse (which could be in conjunction with a mental illness), 24.7 percent.⁶⁸

Again, this does not mean that a symptom of mental illness always precipitated the crime. Indeed, a study of patients who had been released after acute psychiatric hospitalization found that patients who continued to have delusions after release were not more violent

63. 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) (studying persons discharged at least two times from Swedish hospitals with a bipolar diagnosis, and covering 1973–2004; using government data for violent crime convictions).

64. Rongqin Yu et al., *Personality Disorders, Violence, and Antisocial Behavior: A Systematic Review and Meta-Regression Analysis*, 26 J. PERSONALITY DISORDERS 775, 784 (2012).

65. FBI, CRIME IN THE UNITED STATES, tbl.33 (2013).

66. Fazel, *supra* note 53, at 5; see also Seena Fazel & Martin Grann, *The Population Impact of Severe Mental Illness on Violent Crime*, 163 AM. J. PSYCHIATRY 1397 (2006) (in Sweden, 5.2 percent for violent crime by persons with schizophrenia and “other psychoses”).

67. Yu, *supra* note 64, at 784.

68. Martin Grann & Seena Fazel, *Substance Misuse and Violent Crime: Swedish Population Study*, 328 BRIT. MED. J. 1233, 1234 (2004).

in the following year than were other released patients. Surprisingly, the study even found that people with “threat/control override” delusions (who “believe that people are seeking to harm them or that outside forces are controlling their minds”) were at no greater risk of perpetrating violence than were persons with non-delusional schizophrenia. The authors emphasized that sometimes delusions do precipitate crime—they just do not seem to do so more than does schizophrenia in general.⁶⁹ A subsequent study reported that threat/control override did not affect the frequency of violence, but was associated with more severe violence.⁷⁰

More generally, a study of former defendants in the mental health court in Minneapolis found that symptoms of the illness were *not* part of the cause of 65 percent of the crimes for which the prisoners were presently incarcerated.⁷¹ As discussed *supra*, mental illness may set in motion a series of problems (low socioeconomic status, leading to exposure to violence), which may subject the individual to other environmental factors which increase crime risk.

The above figures are for violence in general. As a practical matter, violent crime statistics are dominated by assault. For example, in the United States in 2013, there were estimated to be 1,163,146 major violent crimes. Of these, aggravated assaults comprised sixty-two percent, robbery thirty percent, rape seven percent, and homicide one percent.⁷² Thus, if the homicide rate doubled, or if homicide never occurred, the effect on the total violent crime rate would be small.

As noted above, the large majority of crime by the mentally ill does not appear to be immediately caused by psychotic symptoms.⁷³ But in a study of schizophrenic homicide offenders, psychotic symptoms *did* directly cause “a significant majority” of the killings.⁷⁴ Yet there was an exception: for persons who also had antisocial personality disorder, delusions did not increase the risk. Persons with ASPD were much more likely to attack non-relatives.⁷⁵

69. Paul S. Appelbaum et al., *Violence and Delusions: Data from the MacArthur Violence Risk Assessment Study*, 157 AM. J. PSYCHIATRY 566, 571 (2000).

70. Thomas Stompe, et al., *Schizophrenia, Delusional Symptoms, and Violence: The Threat/Control-Override Concept Reexamined*, 30 SCHIZOPHRENIA BULL. 31, 39 (2004).

71. Peterson et al., *supra* note 45, at 444.

72. FBI, CRIME IN THE UNITED STATES, VIOLENT CRIME (2013).

73. See *supra* text accompanying notes 45–70.

74. C.C. Joyal et al., *Characteristics and Circumstances of Homicidal Acts Committed by Offenders with Schizophrenia*, 34 J. PSYCHOL. MED. 433 (2004).

75. *Id.*

A meta-study found that persons with schizophrenia perpetrate homicide at a rate 20 times greater than the general population—although only one in 300 persons with schizophrenia kills someone.⁷⁶ As a literature view of mental illness and violence observed, “Odds are substantially higher when homicide is considered as the violence outcome.”⁷⁷

In other words, serious mental illness’s greatest effect in increased violent crime is in substantially greater homicide. This does not negate the importance of paying attention to other factors—such as substance abuse or victimization—which may have independent or synergistic effects in increasing the risks of all types of violent crime, including homicide, by persons with serious mental illness.

C. Incarceration Data

While we are a long way from fully understanding the relationship between serious mental illness and violent crime, we know one thing for certain: arrest and incarceration rates for the mentally ill are very disproportionate to the number of seriously mentally ill persons.

A study of all prisoners in Indiana who had been convicted of homicide found that 19 percent had severe mental illness.⁷⁸ Research in other nations has found between 5.3 and 17.9 of homicides to be perpetrated by the severely mentally ill.⁷⁹

The Oregon Department of Corrections reports that 22.8 percent of its prisoners suffer from “severe” mental health problems or from

76. Fazel, *supra* note 7, at 7.

77. Jeffrey W. Swanson et al., *Mental illness and reduction of gun violence and suicide: bringing epidemiologic research to policy*, 25 ANN. OF EPIDEMIOLOGY 366 (2015). The article also stated that risks for any violence are unusually high for first-episode psychosis. *Id.* One reason why violence risks for a person’s first psychotic episode may be so high is that the perpetrators “tend to be young adults whose symptoms may go untreated for an extended period before contact with a mental health treatment provider who could intervene.” *Id.* Just as mental illness has a greater relation to homicide than to violent crime in general, so does substance abuse. Between 45 and 80 percent of homicide offenders were drinking. John M.W. Bradford, David M. Greenberg & Gregory G. Motayne, *Substance Abuse and Criminal Behavior*, 15 PSYCHIATRIC CLINICS OF N. AM. 605 (1992).

78. Jason Matejkowski et al., *Characteristics of Persons with Severe Mental Illness Who Have Been Incarcerated for Murder*, 36 J. AM. ACAD. OF PSYCHIATRY & L. 74, 76 (2008) (out of 518 homicide offenders, 95 had severe mental illness; of the mentally ill for whom the treatment history was known, 43 percent had never been treated, or had only been treated once); see generally D.E. Wilcox, *The Relationship of Mental Illness to Homicide*, 6 AM. J. FORENSIC PSYCHIATRY 3 (1985) (among 71 persons convicted of non-vehicular homicides in Contra Costa County, California, in 1978-80, percent of homicides perpetrated by persons with schizophrenia, 49 of the 71 had serious mental disorders which affected the crime).

79. E. FULLER TORREY, *THE INSANITY OFFENSE: HOW AMERICA’S FAILURE TO TREAT THE SERIOUSLY MENTALLY ILL ENDANGERS ITS CITIZENS* 145, 213–18 (2008).

the next category: “highest need” for treatment.⁸⁰ Thirty percent of prisoners in the Cook County, Illinois, jail are mentally ill.⁸¹

A literature review of studies of prisoners in the United States found that “approximately one-quarter (25%) of offenders” suffer “from mental health problems including a history of inpatient hospitalization and psychiatric diagnoses.”⁸²

A Bureau of Justice Statistics study reported that while 10 percent of the U.S. population had a mental health disorder (anything in the DSM) in the past year, 64 percent of local jail inmates, 56 percent of state prison inmates, and 45 percent of federal prison inmates had such a disorder.⁸³

Looking specifically at some particular symptoms of severe mental illness, 11.8 percent of state prison inmates suffer from psychotic symptoms such as delusions.⁸⁴ This includes 7.9 percent suffering from hallucinations.⁸⁵

Federal prisoners were less likely to have these conditions: 7.8 and 4.6 percent respectively. This may be a consequence of the fact that the federal prison system consists primarily of persons convicted of drug sales offenses; mental illness may impair a person’s ability to operate a business, including an illegal business such as drug sales.

In city or county jails, 17.5 percent of prisoners suffer delusions, with 13.7 percent experiencing hallucinations.⁸⁶

The above data are consistent with other studies, which have found that the percentage of the population which is incarcerated for serious violent crimes consists disproportionately of persons who are seriously mentally ill.⁸⁷

80. OREGON DEPARTMENT OF CORRECTIONS, INMATE POPULATION PROFILE FOR 12/01/2013, available at http://www.oregon.gov/doc/RESRCH/docs/inmate_profile.pdf (last accessed Aug. 21, 2015).

81. Adam Geller, *Jails Struggle with Mentally Ill Inmates*, HUFFINGTON POST (July 14, 2014), available at http://www.huffingtonpost.com/2014/07/14/mentally-ill-prisoners_n_5586065.html (last accessed Aug. 21, 2015).

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

83. U.S. DEP’T OF JUSTICE, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 3 (2006).

84. *Id.* at 2.

85. *Id.*

86. *Id.*

87. Seena Fazel & John Danesh, *Serious Mental Disorder in 23000 Prisoners: A Systematic Review of 62 Surveys*, 359 THE LANCET 545 (2002) (analyzing 62 surveys across 12 countries published between 1966 and 2001 shows that for imprisoned persons, 3.7 percent had psychotic illnesses, 10 percent major depression, 47 percent antisocial personality disorder and 65 percent a personality disorder; for women, the figures were 4 percent psychotic, 12 major depression, 21

Obviously it would not make sense as a violent crime prevention strategy to force every alcoholic into treatment (including confined inpatient treatment) simply because a minority of them are violent. The same is true for persons with schizophrenia, affective disorders, and other mental illnesses. The vast majority of persons with serious mental illness, like the vast majority of persons with substance abuse problems, never commit violent crimes.⁸⁸

III. MASS MURDERS AND PSYCHOSIS

A study of 30 adult mass murderers and 34 adolescent (19 years old or younger) mass murderers found a very high rate of serious mental illness among the adults. Of the adults, 40 percent were psychotic at the time of the mass murder, and another 27 percent “exhibited behaviors suggestive of psychosis.”⁸⁹ As explained previously, “psychosis” is a loss of contact with reality; it usually includes false beliefs about what is taking place or who one is (delusions), or seeing or hearing things that aren’t there (hallucinations).

Even compared to other mass murderers, the adults suffering from psychosis were far more dangerous. They killed almost twice as many people per incident as did the non-psychotics, and were much more likely to attack strangers. Indeed, in all of the incidents in which all of the targets were complete strangers, the killer was psychotic.⁹⁰

percent antisocial personality disorder, and 42 percent any personality disorder.); H. Richard Lamb & Linda E. Weinberger, *Persons with Severe Mental Illness in Jails and Prisons: A Review*, 49 PSYCHIATRIC SERVICES 483 (1998) (6 to 15 percent of persons in jail, and 10 to 15 percent of persons in prison have severe mental illness); 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 (1978) (higher arrest rates for violent and non-violent crimes for 301 former state mental hospital patients in San Mateo County, California); Larry Sosowsky, *Explaining the Increased Arrest Rate Among Mental Patients: A Cautionary Note*, 137 AM. J. PSYCHIATRY 1602 (1980) (in previously-cited study, arrest rate for serious violent crimes for ex-patients with no pre-admission arrests was five times greater than for the general county population); Linda A. Teplin, *The Prevalence of Severe Mental Disorder Among Urban Jail Detainees: Comparison With the Epidemiologic Catchment Area Program*, 80 AM. J. PUB. HEALTH 663 (1990) (studying male jail inmates; schizophrenia rate three times greater than in general population, after controlling for demographics); Arthur Zitrin et al., *Crime and Violence Among Mental Patients*, 133 AM. J. PSYCHIATRY 142 (1976) (in two-year periods before admission and after release from Bellevue Hospital, patients had a higher arrest rate than the general population).

88. Jeffrey W. Swanson, *Mental Disorder, Substance Abuse, and Community Violence: An Epidemiological Approach*, in VIOLENCE AND MENTAL DISORDER: DEVELOPMENTS IN RISK ASSESSMENT 101–36 (John Monahan & Henry J. Steadman eds., 1994).

89. J. Reid Meloy et al., *A Comparative Analysis of North American Adolescent and Adult Mass Murderers*, 22 BEHAV. SCI. & L. 291, 297 (2004).

90. *Id.* at 300.

Further, the majority of adults and adolescents appeared to have narcissistic, antisocial, paranoid and/or schizoid personality disorders.⁹¹ Notably, “In virtually all cases of adult and adolescent mass murder, psychiatric treatment was either unavailable or underutilized.”⁹²

Mass murders are very atypical but highly publicized crimes in America. *USA Today* has constructed an online database of mass murders (incidents with more than four dead victims) since 2006. In seven years, these incidents totaled more than 900 deaths,⁹³ or about 0.7 percent of all U.S. murders.⁹⁴ Mass murders fit into four categories:

- family murders;
- public murders;
- mass murders resulting from a robbery or burglary; and
- other.

The 36 public mass murders since 2006 have received significant attention. Yet the family mass murders are much more common: 117 since 2006 (and many of which do not involve firearms). The mass murders as parts of robberies or burglaries incidents are almost as common as the public mass murders: 31 cases, but almost unknown outside the town where they take place.⁹⁵

Public mass murders receive enormous publicity. The far more typical murders in the U.S. involve only one or two dead victims. Unless involving someone famous, the fatal acts are seldom considered worthy of news coverage outside the community in which they are perpetrated.

Mass murders are distinct outliers from the average murder in the United States. Nonetheless, thoughtful actions that state legislators take to deal with the public mass murder cases can also prevent some of the hundreds of individual murders and tens of thousands of other

91. *Id.* at 297. Schizoid Personality Disorder is long-term detachment from social relationships, coupled with very limited emotional range in communicating with other people. DSM-5, *supra* note 1, at 652–55.

92. Meloy, *supra* 89, at 304. The same is true for homeless people who are mentally ill. See generally E. FULLER TORREY, NOWHERE TO GO: THE TRAGIC ODYSSEY OF THE HOMELESS MENTALLY ILL (1988); CRAMER, MY BROTHER RON, *supra* note 38.

93. *Explore the Data on U.S. Mass Killings Since 2006*, USA TODAY, available at <http://www.usatoday.com/story/news/nation/2013/09/16/mass-killings-data-map/2820423/> (last accessed Aug. 21, 2015).

94. FBI, CRIME IN THE UNITED STATES, tbl.1, (2012).

95. *Id.* at 20.

violent felonies committed each year by severely mentally ill offenders.

It is therefore worth considering how current state mental health laws and their enforcement have failed the citizens. As is typical with other mass murderers,⁹⁶ the killers at the Aurora theater, Sandy Hook Elementary, Tucson, and the Washington Navy Yard had given clear signs of serious mental illness problems to police, family, or mental health workers. Unfortunately, state commitment laws and practice failed the victims in all four incidents, as will be explained in Part VIII.

Besides the just-cited examples, there are many other cases of notorious multiple homicides where the perpetrator was recognized well in advance of the crime as mentally ill, and in need of treatment. These include John Linley Frazier,⁹⁷ Patrick Purdy,⁹⁸ Laurie Wasser-

96. Laurie Goodstein & William Glaberson, *The Well-Marked Roads to Homicidal Rage*, N.Y. TIMES, Apr. 10, 2000 at A1; CENT. FL. INTELLIGENCE EXCH., ACTS OF VIOLENCE ATTRIBUTED BY BEHAVIORAL AND MENTAL HEALTH ISSUES (2013) (study of mass shooters from Jan. 2011 to May 2013; 79 percent “demonstrated signs of continuous behavioral health issues and mental illness”).

97. John Linley Frazier first exhibited symptoms of schizophrenia in his early twenties. Fixated on ecology, after a traffic accident he became convinced that God had given him a mission to rid the Earth of those who were altering the natural environment. Frazier’s mother and wife recognized how seriously ill he was, and tried to obtain treatment for him, but he refused. In October 1970, Frazier warned them that “some materialists might have to die” in the coming ecological revolution. The following Monday, Frazier murdered “Dr. Victor M. Ohta, his wife, their two young sons, and the doctor’s secretary.” DONALD T. LUNDE, MURDER AND MADNESS 49–52 (1976).

98. Patrick Purdy, a mentally ill drifter, used his Social Security Disability payments to buy guns, while having a series of run-ins with the law. After one suicide attempt in jail in 1987, a mental health evaluation concluded that he was “a danger to his health and others.” *Gunman ‘Hated Vietnamese’*, PRESCOTT COURIER, Jan. 19, 1989, at 2. In January 1989, Purdy went onto a schoolyard in Stockton, California with a Kalashnikov rifle, murdered five children and wounded twenty-nine others, before taking his own life. *Slaughter in a School Yard*, TIME, Jan. 30, 1989, at 29.

man Dann,⁹⁹ Buford Furrow,¹⁰⁰ Larry Gene Ashbrook,¹⁰¹ David W. Logsdon,¹⁰² Russell Eugene Weston, Jr.,¹⁰³ and Jennifer Sanmarco.¹⁰⁴

99. Federal prosecutors held back for a few days from indicting Laurie Wasserman Dann in May 1988 for a series of harassing and frightening phone calls—and in those few days, she went on a rampage, killing one child in an elementary school, wounding five children and one adult, and distributing poisoned cookies and drinks to fraternities at Northwestern University. She had a history of odd behavior going back at least two years, riding the elevator in her apartment building for hours on end. *Police Still Unraveling Trail Left by Woman in Rampage*, N.Y. TIMES, May 22, 1988, at 16.

100. Buford Furrow was a member of a neo-Nazi group in Washington State. Conflicts with his wife led her to take him to a mental hospital, where he threatened suicide and “shooting people at a nearby shopping mall.” He threatened nurses with a knife. At trial, he told the judge about his mental illness problems and suicidal/homicidal fantasies. The judge refused to hospitalize Furrow, sending him to jail instead. Released within a few months, Furrow went to Los Angeles in August 1999, where he acted out the fantasy that he had earlier told the court: he shot up a Jewish community center, wounding five people, and murdering an Asian-American mail carrier nearby. Jaxon Van Derbeken et al., *L.A. Suspect Dreamed of Killing: History of Erratic Behavior, Ties to Neo-Nazi Group*, S.F. CHRON., Aug. 12, 1999, at A1.

101. Larry Gene Ashbrook gave plenty of warning, writing letters to local papers referring “to encounters with the CIA, psychological warfare, assaults by co-workers and being drugged by police.” Neighbors had long noticed his bizarre behavior—exposing himself in response to laughter that he thought (incorrectly) was directed at him. In September 1999, he went into a Fort Worth, Texas Baptist Church. He screamed insults about the worshippers’ religion, then killed seven people inside before killing himself. Jim Yardley, *Deaths in a Church: The Overview; An Angry Mystery Man who Brought Death*, N.Y. TIMES, Sept. 17, 1999; *Tapes, Letters Reveal Gunman’s Chilling Actions, Thoughts*, CNN, Sept. 17, 1999.

102. In April 2007, David W. Logsdon of Kansas City, Missouri, beat to death a neighbor, Patricia Ann Reed, and stole her late husband’s rifle. At the Ward Parkway Center Mall, he shot and killed two people at random, wounding four others. Only the fortuitous arrival of police, who shot Logsdon to death, prevented a larger massacre. Maria Sudekum Fisher, *Mall Shooter Used Dead Woman’s Home While She Was Still Inside*, TOPEKA CAPITAL-JOURNAL, May 3, 2007. According to Logsdon’s sister, Logsdon had a history of mental illness and alcoholism. *Id.* His family contacted police over Logsdon’s deteriorating mental condition and physical conditions in Logsdon’s home. *Id.* The police took Logsdon to a mental hospital for treatment in October 2005, concerned that he was suicidal. *Id.* He was released six hours later with a voucher for a cab and a list of resources to contact. *Id.* The problem was not that the law prevented Logsdon from being held. Instead, Logsdon’s early release was because of a shortage of beds in Missouri public mental hospitals. In addition, Missouri in 2003 had eliminated mental health coordinator positions in its community mental health centers as a cost-cutting measure. See Eric Adler, *Case Points up a Crisis in Care*, KAN. CITY STAR, May 1, 2007, at A1; Maria Sudekum Fisher, *Mall Gunman Planned to “Cause Havoc,”* HOUS. CHRON., May 1, 2007.

103. After Russell Eugene Weston, Jr., shot two police officers at the U.S. Capitol in 1999, he explained to the court-appointed psychiatrist that he needed to do it because “Black Heva,” the “most deadliest disease known to mankind,” was being spread by cannibals feeding on rotting corpses. Bill Miller, *Capitol Shooter’s Mind-Set Detailed*, WASH. POST, Apr. 23, 1999 at A1. He needed to get into the Capitol “to gain access to what he called ‘the ruby satellite,’ a device he said was kept in a Senate safe.” *Id.* Weston explained that the two “cannibals” he had shot to death, police officers Jacob J. Chestnut and John M. Gibson, were “not permanently deceased.” *Id.* Weston explained that he needed access to the satellite controller so that he could turn back time. *Id.* Before this incident, Weston had been involuntarily hospitalized for fifty-three days in Montana after threatening a neighbor, but he was then released. *Id.* According to Weston’s parents, he had been losing the battle with schizophrenia for two decades before he went to the Capitol. *Id.*

104. An employee of the Postal Service, Jennifer Sanmarco was removed from her Goleta, California, workplace in 2003 because she was acting strangely, and placed on psychological

IV. LEGAL STANDARDS FOR DEPRIVATION OF THE RIGHT TO KEEP AND BEAR ARMS

When the Second Amendment was ratified in 1791, and then made enforceable against the states by the ratification of the Fourteenth Amendment in 1868, there were no laws against firearms possession by the mentally ill. The first such laws did not appear until after 1930, when the Uniform Firearms Act (a model law adopted by some states) forbade delivery of a pistol to a person of “unsound mind.”¹⁰⁵

The federal Gun Control Act of 1968 made possession of a firearm or ammunition a federal felony for anyone “who has been adjudicated as a mental defective or who has been committed to a mental institution.”¹⁰⁶

By regulation, this is defined to mean “A determination by a court, board, commission, or other lawful authority that a person, as a result of marked subnormal intelligence, or mental illness, incompetence, condition, or disease: (1) is a danger to himself or others; [or] (2) Lacks the mental capacity to contract or manage his own affairs.”¹⁰⁷ Further: “Committed to a mental institution” means:

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.¹⁰⁸

The Supreme Court’s decision in *District of Columbia v. Heller* expressly recognized the constitutionality of mental illness restrictions: “nothing in our opinion should be taken to cast doubt on longstanding prohibitions on the possession of firearms by . . . the mentally

disability. She moved to Milan, New Mexico, where her neighbors described her as “crazy as a loon.” “A Milan businessman said he sometimes had to pick her up and bring her inside from the cold because she would kneel down and pray, as if in a trance, for hours.” She returned to the Goleta mail sorting facility in January 2006—and murdered five employees, before taking her own life. Martin Kasindorf, *Woman Kills 5, Self at Postal Plant*, USA TODAY, Feb. 1, 2006; Jim Maniaci, *Crazy as a Loon*, GALLUP [N.M.] INDEP., Feb. 2, 2006.

105. Carlton F.W. Larson, *Four Exceptions in Search of A Theory: District of Columbia v. Heller and Judicial Ipse Dixit*, 60 HASTINGS L.J. 1371, 1376–77 (2009).

106. 18 U.S.C. § 922(g)(4) (2014). There is a parallel provision making the transfer of firearms or ammunition to such a person into a felony. 18 U.S.C. § 922(d)(4) (2014).

107. 27 C.F.R. § 478.11 (2015).

108. *Id.*

ill.”¹⁰⁹ The Court described such prohibitions as “presumptively lawful.”¹¹⁰

A. What is a commitment?

1. Federal standards on short-term involuntary commitment

Federally, there is a circuit split regarding short-term involuntary commitments. In the 2012 case of *United States v. Rehlander*, the First Circuit held that the “commitment” which triggers a lifetime gun ban under 18 U.S. Code section 922(g)(4) does not include a short involuntary hospitalization. The First Circuit explained the arms rights deprivation would be permissible if it were “a temporary suspension of the right to bear arms pending further proceedings. It could also be different if section 922 permitted one temporarily hospitalized on an emergency basis to recover, on reasonable terms, a suspended right to possess arms on a showing that he no longer posed a risk of danger.”¹¹¹

In contrast, the Fourth Circuit in the 1999 *United States v. Midget* upheld the application of 922(g)(4) to short involuntary commitments, which had no judicial authorization.¹¹² However, *Midget* dates from a period when some lower federal courts, including the Fourth Circuit, labored under the misunderstanding that ordinary American citizens had no Second Amendment rights.¹¹³ Accordingly, it is not strong authority in the era following *Heller* and *McDonald*, in which the Supreme Court has instructed that the Second Amendment is not a “second-class right” which can be “singled out for special—and specially unfavorable—treatment.” Rather, the same “body of rules” gov-

109. *District of Columbia v. Heller*, 554 U.S. 570, 626 (2008); *see also McDonald v. Chicago*, 561 U.S. 742, 786 (2010) (*Heller* “does not cast doubt” on laws against gun possession by the mentally ill).

110. *Id.* at 626–27 n.26. The phrase “presumptively lawful” does not mean that the presumption is irrebuttable. Further, if a new restriction on the mentally ill is not of the same type as previous “longstanding” restrictions, there might not be any presumption of lawfulness; the government would bear the burden of proving it constitutional, as is always the case when heightened scrutiny is involved.

111. *United States v. Rehlander*, 666 F.3d 45, 48 (1st Cir. 2012).

112. *United States v. Midget*, 198 F.3d 143, 147 (4th Cir. 1999).

113. *District of Columbia v. Heller*, 554 U.S. 570, 624 n.24 (2008) (criticizing lower courts which “overread” the Supreme Court’s 1939 *United States v. Miller*, and whose “erroneous reliance” on their misinterpretation of *Miller* led them to “nullify” the Second Amendment); *Id.* at 638 n.2 (Stevens, J., dissenting) (citing the Fourth Circuit’s *United States v. Johnson*, 497 F.2d 548, 550 (4th Cir. 1974) as among the decisions which interpreted *Miller* as denying Second Amendment rights to anyone who is not in a militia).

erns the Second Amendment as “the other Bill of Rights guarantees” that have been incorporated.¹¹⁴

Interpreting the federal statute, the Nebraska Supreme Court took the modern approach in *Gallegos v. Dunning*.¹¹⁵ Joseph Gallegos was a veteran with post-traumatic stress disorder (PTSD) and depression, and whose marriage was ending in divorce. He voluntarily went to a veteran’s hospital for treatment. During intake, he explained that he had homicidal and suicidal thoughts, but would not act on them because of his religious beliefs.¹¹⁶ A physician at the hospital filed a petition to the state Mental Health Board (MHB), asking that Gallegos be kept at the hospital. The MHB ordered Gallegos held for one week, and scheduled a hearing for him in the middle of that week. At the hearing, Gallegos asked for and was granted a 90-day continuance, so that he could voluntarily undergo treatment. He did so, and was later discharged. The MHB petition was dismissed. His treating physician’s records stated that Gallegos was no longer a danger to himself or others.

Several years later, Gallegos sought to purchase a handgun, and register it with his county sheriff, as required by state law. The registration request was denied, because Gallegos’s voluntary treatment had been reported to the FBI’s National Instant Check System (NICS), the national database of “prohibited persons.”

Like the Fifth and Eighth Circuits, the Nebraska Supreme Court looked to state law to determine what was a “formal commitment.”¹¹⁷ The state Mental Health Board had never made a finding by clear and convincing evidence that Gallegos was dangerous, which was what Nebraska law required for a formal commitment. Accordingly, Gallegos was not prohibited from possessing a firearm under 18 U.S.C. § 922(g)(4), and the sheriff was ordered to allow Gallegos to register his gun.

In Colorado, when a person has been involuntarily held for 72-hour observation or short-term treatment (up to three months), the person’s name is sent to the FBI’s National Instant Criminal Background Check System as having been committed against his will. After three years, Colorado removes that person from the prohibited per-

114. *McDonald v. Chicago*, 561 U.S. 742, 778–80 (2010).

115. *Gallegos v. Dunning*, 277 Neb. 611 (2009).

116. *Id.* at 612.

117. *Id.* at 614 (citing *United States v. Giardina*, 861 F.2d 1334 (5th Cir. 1988); *United States v. Hansel*, 474 F.2d 1120 (8th Cir. 1973)).

sons list if he has not been subject to additional commitment orders or outpatient treatment orders.¹¹⁸ The submission of the records for the 72-hour observational holds is inconsistent with the approach in *Rehlander* and *Gallegos*.

2. State standards on commitment

Some states have firearms restrictions which are more severe than federal law. In Virginia, a voluntary commitment is treated the same as an involuntary commitment. As a result, the person who voluntarily commits himself forfeits the right to arms. This has the unfortunate consequence of discouraging people from seeking treatment.¹¹⁹

The Pennsylvania Superior Court upheld a lower court's determination that a person had been involuntarily committed, within the meaning of state law, when he went to a mental health facility, and was then detained there for four days under a physician's order because of his suicidal thoughts.¹²⁰

In California, a person can be held for up to 72 hours, based on the order of a government employee or a physician.¹²¹ This automatically results in a five-year loss of the right to keep and bear arms, even if the intake physician at a facility discharges the person immediately. The only way for a person's gun rights to be restored before the end of the five years is to bring a section 8103 hearing in court, where the government must then prove by a preponderance of the evidence that the plaintiff is still dangerous. The California intermediate court of appeals upheld this system against a challenge brought under the Second and Fourteenth Amendments.¹²²

A more positive attitude towards due process is followed by Minnesota. Firearms disqualifications for mental health reasons must be

118. C.R.S. § 13-9-123 (2010).

119. Robert Luther, III, *Mental Health and Gun Rights in Virginia: A View from the Battlefield*, 40 N.E. J. ON CRIM. & CIV. CONFINEMENT 345, 349 (2014).

120. *J.C.B. v. Penn. State Police*, 35 A.3d 792 (Pa. Super. Ct. 2012). Pennsylvania's "302" commitments are not a "formal commitment" for purposes of federal law, according to the ATF. Letter from Lawrence Duchnowski, Special Agent in Charge, Dep't of Treasury, Bureau of Alcohol, Tobacco, and Firearms, to Jon Pushinsky, Attorney (Sept. 4, 1996) (on file with author). Nevertheless, about 70 to 75 percent of the mental health records which Pennsylvania transmits to the federal government are for 302 commitments. Moriah Balingit, *Pa. Sends Mental Health Data for Gun Checks*, PITTSBURGH POST-GAZETTE, Jan. 19, 2013. New Jersey is likewise submitting voluntary admissions to the NICS database, in contravention of the federal regulation. David Levinsky, *413,000 NJ Mental Health Records Submitted for Gun Checks*, BURLINGTON COUNTY TIMES, Aug. 27, 2013.

121. CAL. WELF. & INST. CODE § 5150 (West 2014).

122. *People v. Jason K.*, 188 Cal. App. 4th 1545, 116 Cal. Rptr. 3d 443 (2010).

based on a commitment hearing which had full due process, and which resulted in the finding of certain specific conditions.¹²³

B. Restoration of Rights

The federal Gun Control Act of 1968 was a much more severe law than its state predecessors. Previous state laws had typically imposed prohibitions only for a period of years (rather than lifetime) for convicted criminals, or had only imposed bans for certain felonies (rather than for all felonies, including non-violent ones), or had only applied to handguns, rather than all guns. Or a state's gun licensing system might leave the licensing authority with some discretion to issue a license to a convicted person, depending on the licensor's evaluation of the circumstances.¹²⁴

The consequences of the federal lifetime ban were certainly anomalous. Weld County, Colorado, Sheriff John Cooke recalled one elderly citizen in his county who, around 2013, had been forbidden to buy a gun, because in the 1950s, the then teenager had been convicted of vehicular homicide. The senior citizen thought it strange that he was allowed to have a driver's license and drive in public (using the type of instrument which had led to an innocent person's death) yet he was forbidden to possess a firearm (an instrument which he had never misused), even at home.

The severity of the federal system of a lifetime bans was mitigated by a process for the restoration of firearms rights. A convicted felon could petition the federal Bureau of Alcohol, Tobacco and Firearms (BATF), and the Bureau would have discretion to restore rights, taking into account all the circumstances about the person. Unfortunately, the restoration of rights system was only for convicted felons (who could try to prove that they had gone straight), and was not available to persons in other prohibited categories (such a person who had briefly been mentally ill decades ago, and had been fine for a very long time).

A federal district court ruled this system to be an Equal Protection violation, because it "in effect creates an irrebuttable presumption that one who has been committed, no matter what the

123. MINN. STAT. § 624.713-1(3) (2014). Subdivision 4 provides a process for the restoration of rights.

124. C. Kevin Marshall, *Why Can't Martha Stewart have a Gun?*, 32 HARV. J.L. & PUB POL'Y 695 (2009).

circumstances, is forever mentally ill and dangerous.”¹²⁵ The case went to the Supreme Court.¹²⁶ Before the Supreme Court ruled, Congress enacted the Firearm Owners’ Protection Act of 1986, which made restoration of rights potentially available for all classes of prohibited persons, not just for convicted felons.¹²⁷

Having fixed the restoration system in 1986, Congress then broke it in 1992, with an appropriations rider that forbade BATF to spend money processing rights restoration applications.¹²⁸ The defunding via appropriations has continued ever since.¹²⁹

The Supreme Court refused to do anything about the problem. In the 2002 case *United States v. Bean*, the Court ruled that Bean had no standing to challenge the Bureau’s refusal to process his restoration of rights petition; the Bureau’s permanent “inaction” was not the same as a “denial.” There being no final agency “action,” Bean had no standing to raise a Due Process challenge to the deprivation of his statutory right to consideration of his rights restoration petition.¹³⁰

C. The 2007 NICS Improvement Amendment Act

The Virginia Tech murders in 2007 finally spurred Congress to begin to fix the broken system. The NICS Improvement Amendment Act offered states grants to do a better job of providing their records (e.g., of mental health commitments) to the FBI’s National Instant Criminal Background Check System (NICS). One of the conditions for the grants was that the states had to have a restoration process for all types of prohibited persons.¹³¹ The federal government would then

125. *Galiato v. Dep’t of the Treasury*, 602 F. Supp. 682, 689 (D.N.J. 1985).

126. *U.S. Dep’t of the Treasury v. Galiato*, 477 U.S. 556 (1986).

127. Firearm Owners’ Protection Act, Pub. L. No 99-308, 100 Stat. 449 (1986), amending 18 U.S.C. § 925(c). See 27 C.F.R. § 478.144(e) (stating that rights restoration for a commitment allowed only if “a court, board, commission, or other lawful authority” has held the individual “to have been restored to mental competency, to be no longer suffering from a mental disorder, and to have had all rights restored”).

128. Treasury, Postal Service, and General Government Appropriations Act, Pub. L. No. 102-393, 106 Stat. 1732 (1993). The defunding was passed at the urging of the Violence Policy Center, a gun prohibition organization.

129. Consolidated Appropriations Act, Pub.L. No. 113-76, 128 Stat. 5, 57 (2014).

130. *United States v. Bean*, 537 U.S. 71, 75-76 (2002).

131. National Instant Background Check System Improvement Amendment Act of 2007, Pub. L. No. 110-180, 121 Stat. 2559 (2008) (“[I]f the person’s record and reputation are such that the person would 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.”).

treat a state restoration of rights as equivalent to the restoration contemplated in 18 U.S.C. § 925(c).¹³²

However, not all states have implemented rights restoration. One, which has not, is Michigan. Clifford Tyler had been involuntarily committed for one month, while undergoing a divorce. He was discharged, and remained mentally healthy for the next 28 years. Yet he was unable to purchase a firearm, so he brought suit in federal court for the restoration of his rights. The Sixth Circuit panel ruled (in a decision that has since been granted en banc review) that strict scrutiny is the norm in Second Amendment cases, and that, as applied to Tyler, the lifetime federal gun prohibition based on involuntary commitments was unconstitutional.¹³³

As of 2007, there were slightly under 300,000 disqualifying mental health records in the NICS database.¹³⁴ By the end of 2013, there were over 3.2 million such records.¹³⁵ In 2014, the NICS system denied 90,885 attempted purchases; of these, 3,557 were for mental health adjudications.¹³⁶

D. Limitations on what gun control can accomplish

It is possible that background checks, which include mental health records, might temporarily stop a mentally ill person from acquiring a

132. The federal government has not promulgated regulations for minimum standards for rights restoration. However, ATF says that its policies for what makes a mental health restoration process compliant with the NICS Improvement Act are as follows: the restoration program must be formally established by statute, regulation, or administrative order; it must allow petitions by persons who are disqualified under 18 U.S.C. § 922(g)(4); there must be a board, commission, or other lawful authority that will consider petitions, but it may not grant petitions arising from a commitment in a different states; the applicant must have the opportunity to present evidence; that there must be an independent decision maker; there must be a proper record; there must be findings that the individual is not likely be a danger to self or others, and that granting the relief is not contrary to the public interest; there must be judicial review in which the court may but is not required to defer to the findings below; and the state must inform NICS when restoration is granted. GAO, SHARING PROMISING PRACTICES AND ASSESSING INCENTIVES COULD BETTER POSITION JUSTICE TO ASSIST STATES IN PROVIDING RECORDS FOR BACKGROUND CHECKS 46–48 (2012).

133. Tyler v. Hillsdale Cnty. Sheriff's Dept. 775 F.3d 308, 343–44 (6th Cir. 2014), *reh'g en banc granted, opinion vacated* 775 F.3d 308 (6th Cir. 2015).

134. Swanson, *supra* note 77. The increase came mostly from a dozen states; many other states have contributed few additional records. GAO, *supra* note 11 at 9.

135. FBI, NATIONAL INSTANT CRIMINAL BACKGROUND CHECK SYSTEM (NICS) OPERATIONS 2013 12 (2013), *available at* <http://www.fbi.gov/about-us/cjis/nics/reports/2013-operations-report> (last accessed Aug. 21, 2015).

136. These figures are derived from subtracting the 1998–2013 cumulative denial figures (provided in *id.*) from the same figures for 1998–2014, which are provided in FBI, FEDERAL DENIALS: REASONS WHY THE NICS SECTION DENIES NOVEMBER 30, 1998 - DECEMBER 31, 2014, *available at* http://www.fbi.gov/about-us/cjis/nics/reports/federal_denials.pdf (last accessed Aug. 21, 2015).

firearm which would be used in a crime; it is also possible that some such individuals might not be able to acquire a substitute firearm from a black market source, or by theft. It is unrealistic, however, to expect that any laws on gun acquisition would stop mass killers.

“Tighter restrictions on gun purchasing— for example, eliminating multiple gun sales and closing the gun-show loophole—may help reduce America’s gun violence problem generally, but mass murder is unlike most other forms of violent conflict,” wrote criminologist James Alan Fox, a professor at Northeastern University who has tracked mass shootings. “Mass killers are determined, deliberate and dead-set on murder. They plan methodically to execute their victims, finding the means no matter what laws or other impediments the state attempts to place in their way. To them, the will to kill cannot be denied.”¹³⁷ This is consistent with the surprising finding that while crimes perpetrated by psychopaths include many unplanned, impulsive incidents, for homicide by psychopaths, 93 percent were planned.¹³⁸ The Sandy Hook attack was by no means the first mass murder committed with stolen guns. It was not even the first such attempt *that week*.¹³⁹

V. PUTTING THE SERIOUSLY MENTALLY ILL IN PRISONS AND JAILS RATHER THAN IN MENTAL INSTITUTIONS

In 1939, a comparative study of 18 European nations resulted in the declaration of “Penrose’s Law”: that there is an inverse relationship between the number of persons in mental institutions and the number of persons in penal institutions.¹⁴⁰ It is not an ironclad rule

137. See Ed Komenda & Jackie Valley, *What Now? Three Mass Shootings in a Week Leave Communities Wondering how to React*, LAS VEGAS SUN, June 15, 2014.

138. Stephen Porter & Sasha Porter, *Psychopathy and Violent Crime*, in THE PSYCHOPATH 290 (Hugues Hervé & John C. Yuille eds., 2007). Psychopaths perpetrate about half of all murders of police officers. A.J. PINIZZOTTO & E.F. DAVIS, FED. BUREAU OF INVESTIGATION, KILLED IN THE LINE OF DUTY: STUDY OF SELECTED FELONIOUS KILLINGS OF LAW ENFORCEMENT OFFICERS (1992).

139. *Oregon Mall Gunman Identified, Used Stolen Gun In Rampage, Police Say*, CLEVELAND PLAIN DEALER, Dec. 12, 2012 (reporting Jacob Tyler Roberts stole the AR-15 used in the Clackamas Mall shooting). Adam Lanza’s recklessly irresponsible mother was planning on buying him a firearm for Christmas, so if he had just waited a few weeks, he would not even have had to steal her guns.

140. Lionel Sharples Penrose, *Mental Disease and Crime: Outline of a Comparative Study of European Statistics*, 18 BRIT. J. MED. PSYCHOL. 1 (1939).

under all circumstances, but it has held up well in various studies of subsequent decades.¹⁴¹

Today, absurdly, “the United States has three times more individuals with severe mental illnesses in prison than in psychiatric hospitals.”¹⁴² By the mid-1990s, the largest institutional provider of mental health services in the United States was not a state or private psychiatric hospital, but the Los Angeles County Jail.¹⁴³

The criminal justice system is not designed for this situation. Not surprisingly, even with the best of intentions, the results are terrible. Penal institutions often fail to provide “even minimally appropriate mental health services for prison inmates.”¹⁴⁴

When in prison, mentally ill inmates are much more likely to be the victims of sexual assault. In a study covering a six-month period, one in twelve male mentally ill prison inmates was a sexual assault victim, compared to one in thirty-three inmates who were not mentally ill; the disparity is even greater for mentally ill female prison inmates.¹⁴⁵

A. Deinstitutionalization

One reason that the mentally ill are in prisons and jails rather than in mental institutions is the deinstitutionalization movement, which began in the 1960s.

141. Pål Hartvig & Ellen Kjelsberg, *Penrose’s Law Revisited: the Relationship Between Mental Institution Beds, Prison Population and Crime Rate*, 63 *NORD. J. PSYCHIATRY* 51 (2009) (Norway 1930–2004); B.D. Kelly, *Penrose’s Law in Ireland: an Ecological Analysis of Psychiatric Inpatients and Prisoners*, 100 *IR. MED. J.* 373 (2007) (Ireland 1963–2003); Miklós Péter Kalapos, *Penrose’s Law: Reality or Fiction? Mental Health System and the Size of Prison Population - International Overview*, 150 *ORVOSI HETILAP* 1321 (2009).

142. Robert D. Morgan et al., *Treating Offenders with Mental Illness: A Research Synthesis*, 36 *LAW & HUM. BEHAV.* 37, 37 (2012); E. FULLER TORREY ET AL., *TREATMENT ADVOCACY CENTER, MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES* (2010).

143. Likewise, in Colorado, the largest housing facility for the mentally ill is the Denver City & County Jail. Over 500 jail inmates (about twenty percent of total inmates) there are mentally ill; at the state psychiatric hospital in Pueblo, there are about 400 inmates, most of whom are there by court order. *TREATMENT ADVOCACY CENTER, THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY* 35 (2014). The county Sheriffs, who are in charge of the county jails in every Colorado county, described the increase in mentally ill inmates as the “top problem facing sheriffs statewide. By default, we’ve become the mental health agencies for the individual counties.” *Id.* See Kristin Jones, *Untreated: Steep Costs for Mentally ill Inmates*, *ROCKY MOUNTAIN PBS I-NEWS*, May 11, 2014.

144. Morgan, *supra* note 142.

145. Nancy Wolff et al., *Rates of Sexual Victimization in Prison for Inmates with and without Mental Disorders*, 58 *PSYCHIATRIC SERV.* 1087 (2007) (studying 7,582 inmates in a mid-Atlantic state prison system, consisting of 12 prisons for men and one for women).

As of the early nineteenth century, anyone could arrest the “furiously insane.” Then, the Sheriff would hold them until a court could make a decision about long-term institutionalization.¹⁴⁶ Someone who was obviously mentally ill stood a good chance of being diverted into the mental health system—such as it was back then—before placing himself or others at serious risk. The opening of state mental hospitals in Vermont (1836) and in New Hampshire (1840) reduced family murder rates.¹⁴⁷

Legitimate concerns about abuse of power led states to increasing formalization of the commitment process, especially for long-term commitment. Ohio was an early example, in 1824.¹⁴⁸ By the latter half of the nineteenth century, the laws required due process in every state but Maine.

The exact mechanisms varied. Some states mandated a jury trial, while others relied on panels of experts (“commissions of lunacy”). The general rule was that a person could not be locked up for more than a short time without some legal process; in practice, there were situations in which due process was not followed.¹⁴⁹ Because commitment was a civil procedure, the civil law standard of proof applied: was there a preponderance of evidence that a person was mentally ill, and would benefit from hospitalization?

By the early 1960s, most states relied on emergency commitment procedures, which provided a mechanism for hospitalizing persons believed to be a danger either to themselves or to others, or in need of treatment to prevent an irretrievably bad situation. The justification for allowing emergency hospitalization based only on a determination by a doctor or police officer was simple: the risk of leaving such a

146. ALBERT DEUTSCH, *THE MENTALLY ILL IN AMERICA: A HISTORY OF THEIR CARE AND TREATMENT FROM COLONIAL TIMES* 419–20 (2d ed. 1949).

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

148. 29 Acts of a General Nature, Enacted, Revised and Ordered to be Reprinted, At the First Session of the Twenty-Ninth General Assembly of the State of Ohio 224 (1831) (1824 session law authorizing justices of the peace to accept applications by relatives or any overseer of the poor for commitment, with an inquest of seven jurors to return a verdict).

149. HENRY F. BUSWELL, *THE LAW OF INSANITY IN ITS APPLICATION TO THE CIVIL RIGHTS AND CAPACITIES AND CRIMINAL RESPONSIBILITY OF THE CITIZEN* 25–36 (Little, Brown & Co., 1885). Spot checking of the complete collection of all state laws in GEORGE LEIB HARRISON, *LEGISLATION ON INSANITY: A COLLECTION OF ALL THE LUNACY LAWS OF THE STATES AND TERRITORIES OF THE UNITED STATES TO THE YEAR 1883, INCLUSIVE* (1884), confirms Buswell’s claim; see also Isham G. Harris, *Commitment of the Insane, Past and Present, in the State of New York*, 7 *N.Y. STATE J. MED.* 487 (1907) (detailed account of the increasing formalization of the commitment procedure in that state).

person unrestrained exceeded the temporary loss of the patient's liberty, especially because the commitment was supposed to be short-term. But some state laws provided for extensions without due process, and a few, such as Maine, had no time limit for an emergency commitment.¹⁵⁰

Some emergency commitment procedures were too easy. A variety of movements and concerns converged in the 1960s and 1970s to destroy less humane practices of caring for the mentally ill.¹⁵¹ Today, however, the situation has gone too far the other way.

B. Dealing with serious mental illness on a post-hoc basis in the criminal justice system is fiscally wasteful

Mental health hospitals are quite expensive. Michigan's state system spends over 260,000 per bed annually.¹⁵² In Virginia, the cost is \$214,000 per year.¹⁵³ A "forensic hospital" (for persons found not guilty by reason of insanity, and for similar persons) is even more expensive; St. Elizabeth Hospital in Washington, D.C., spends about \$328,000 per patient-year.¹⁵⁴ To add capacity, there would have to be extensive spending on construction costs, since many former mental hospitals have been torn down or converted to other uses.¹⁵⁵

Outpatient treatment is expensive too—\$44,000 for a full year of outpatient treatment for each patient in Virginia.

Because mental hospitals or quality outpatient treatment cost a lot of money, there is reluctance by state legislatures to appropriate sufficient funds. But having to pay for the criminal justice system to deal with mentally ill homicide perpetrators costs a lot of money too. The average U.S. criminal justice system cost for murder in 2013 dollars was \$461,208.¹⁵⁶ As for homicide perpetrators who are mentally

150. ALEXANDER D. BROOKS, *LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM* 751-52 (1974).

151. See generally CRAMER, *MY BROTHER RON*, *supra* note 38, at chs. 7, 9, 13-15 (discussing the various movements that came together, sometimes unwittingly).

152. Dominic A. Sisti, Andrea G. Segal & Ezekiel J. Emanuel, *Improving Long-term Psychiatric Care: Bring Back the Asylum*, 313 *JAMA* 243, 244 (2015).

153. Annys Shin, *She Fought for Patients' Rights, Then She Was Put in a Hospital Against Her Will*, *WASH. POST*, Jan. 31, 2015.

154. Sisti et al., *supra* note 152, at 244.

155. Shin, *supra* note 153.

156. Matt DeLisi et al., *Murder by Numbers: Monetary Costs Imposed by a Sample of Homicide Offenders*, 21 *J. FORENSIC PSYCHIATRY & PSYCHOL.* 501, 507 (2010) (costing \$426,255 in 2008). The 2013 figure is based on the 2008 figure, adjusted for inflation by the U.S. Inflation Calculator.

ill, almost all will be indigent; the taxpayer will have to pay for public defenders.

Based on the data in Part II, one can estimate that around 2,500 murders and non-negligent manslaughters are committed annually by severely mentally ill offenders. (Slightly under 20 percent of total homicides.)¹⁵⁷ This means that states are spending about \$1.2 billion a year before sending the offender to prison.

The costs of incarceration after conviction are substantial. Colorado currently spends \$32,335 per year per inmate. A mentally sane murderer who spends 30 years in prison will cost \$1,004,982 in 2013 dollars.¹⁵⁸ However, states are required to provide mental health services for prisoners. (This does not mean that they always do so.) Mentally ill inmates are more expensive to care for than sane inmates. Pennsylvania several years ago found that mentally ill prisoners cost \$51,100 per year, nearly twice as much as sane prisoners (\$28,000 a year).¹⁵⁹ Nationally, the estimated annual prison costs for mentally ill murderers are about \$3.7 billion.

The costs of dealing with mental illness post-hoc in the criminal justice system do not end when the prisoner is released. Ex-prisoners with serious mental illness are two to three times more likely to recidivate than other prisoners.¹⁶⁰ So in the long run, greater spending up-front to make treatment more available can partly be paid for via long-term savings in the criminal justice system.

Further, early investment in treatment will increase tax revenue in the long run. When fewer people are killed or injured, they can remain engaged in their on-going productive activities, thus helping the economy for everyone, and paying taxes.¹⁶¹

When we consider the costs to *victims*, such as lost earnings, medical care, pain and suffering, and so on, it seems clear that expensive mental health treatment up-front is a net cost savings to society.

157. FBI, *Crime in the United States 2012*, tbl.16 (2013).

158. *Budget Hearing Before Colorado Dep't of Corrections*, (2012) (statement of Tom Clements) (prison costs of \$970,060 in 2011 dollars). The 2013 equivalent calculated with U.S. Inflation Calculator.

159. Lynne Lamberg, *Efforts Grow to Keep Mentally Ill Out of Jails*, 292 JAMA 555 (2004).

160. Jacques Baillargeon et al, *Psychiatric Disorders and Repeat Incarcerations: The Revolving Prison Door*, 166 AM. J. PSYCHIATRY 103 (2009).

161. One promising initiative is Maryland's planned Center for Excellence on Early Intervention for Serious Mental Illness. It aims to help people in early stages of psychosis, before they deteriorate further. Jonathan Pitts, *New Maryland Mental Health Initiative Focuses on Identifying and Treating Psychosis*, BALT. SUN, Oct. 21, 2013.

Besides that, treatment will help some people with mental illness achieve self-sufficiency, and contribute to society in many ways.¹⁶² The sooner, the better. Early and consistent treatment for schizophrenia can prevent further deterioration.¹⁶³

Currently, the needed mental hospital beds are not available. Since 1955, the number of available mental hospital beds per capita has declined by 95 percent; it has reached a per capita low not seen since 1850.¹⁶⁴ In the United Kingdom, there are 60 mental hospital beds per 100,000 seriously mentally ill persons. In the United States, there are about 11. The National Alliance on Mental Illness argues that at least 50 beds for 100,000 should be the minimum level of availability in the United States.¹⁶⁵

Given that there are about 2.2 million persons in prisons or jails¹⁶⁶ and that a very large fraction of those prisoners are seriously mentally ill,¹⁶⁷ NAMI's proposal for creating about 250,000 new beds, in public or private hospitals, does not seem unreasonable. The taxpayers are already paying the costs for incarcerating lots of mentally ill people after a violent crime was committed. Today, we really no longer have "deinstitutionalization"; rather we have "transinstitutionalization," with people who should have been in mental hospitals ending up in prisons and jails. Having sufficient mental hospitals available might help many of these people avoid ending up in prison after seriously injuring or killing someone.

In short, building more mental health treatment centers is a crucial element of mental health reform, from a crime reduction perspective.

162. The social costs of unemployment resulting from schizophrenia are estimated to be \$32.4 billion. E.Q. Wu et al, *The Economic Burden of Schizophrenia in the United States in 2002*, 66 J. CLINICAL PSYCHIATRY 1122 (2005).

163. Ming T. Tsuang et al., *The Treatment of Schizotaxia*, in EARLY CLINICAL INTERVENTION AND PREVENTION IN SCHIZOPHRENIA 294 (William S. Stone et al. eds., 2004); Tejal Kaur & Kristin S. Cadenhead, *Treatment Implications of the Schizophrenia Prodrome* in BEHAVIORAL NEUROBIOLOGY, *supra* note 34, at 97, 98 (citing studies).

164. E. FULLER TORREY ET AL., TREATMENT ADVOCACY CTR., NO ROOM AT THE INN: TRENDS AND CONSEQUENCES OF CLOSING PUBLIC PSYCHIATRIC HOSPITALS, tbl. 2 (2012) (citing for 1831–1980, A.L. Stroup & R.W. Manderscheid, *The Development of the State Mental Hospital System in the United States: 1840-1980*, 87 J. WASH. ACAD. SCI. 59 (1988)).

165. NAT'L ALLIANCE ON MENTAL ILLNESS, GRADING THE STATES 2009: A REPORT ON AMERICA'S HEALTH CARE SYSTEM FOR ADULTS WITH SERIOUS MENTAL ILLNESS 33 (2009).

166. LAUREN E. GLAZE & DANIELLE KAEBLE, U.S. DEPT' OF JUSTICE, BUREAU OF JUSTICE PROGRAMS, CORRECTIONAL POPULATIONS IN THE UNITED STATES 2 (2013).

167. *Id.*

VI. MENTAL HEALTH TREATMENT IS HIGHLY EFFECTIVE IN REDUCING HOMICIDE

University of Chicago Law Professor Bernard Harcourt has published two time-series studies using national and state level data to investigate the relationship of mental illness and murder.¹⁶⁸ These studies demonstrate a statistically significant relationship between the total institutionalization rate (the rate of criminal justice prisoners plus mental hospital inmates) and murder rates. As the total institutionalization rate rose, murder rates fell, and vice versa.¹⁶⁹

During the 1970s, as states emptied out their mental hospitals, murder rates rose. People seeking voluntary treatment had a harder time getting it. Involuntary commitment of the dangerously and severely mentally ill also becomes more difficult.¹⁷⁰ The reduction in murder rates in the 1990s occurred partly because states were giving longer sentences to violent criminals, which means that many mentally ill offenders now were going to prison for a long stretch. Unfortunately, many went to prison *after* they had committed a violent felony against someone else.¹⁷¹ It would have been better if they had been sent to a mental hospital for months or years before perpetrating a violent crime, rather than sentenced to a long term in state prison after the crime.

University of California at Berkeley Social Work Professor Steven P. Segal examined the influence of mental health care on variations in state-to-state murder rates. He too found strong evidence that deinstitutionalization has substantially contributed to the murder problem. A startling 27 percent of the state-to-state variation in murder rates can be explained by differences in the strictness of involuntary commitment laws, with easier commitment correlating with lower murder rates. This state-to-state difference is more important than the availability of psychiatric inpatient beds (which explains 20 percent of

168. A time-series study follows a single population or location through a period of time, assessing changes in behavior or symptoms. In contrast, cross-sectional studies compare different populations at a particular point in time.

169. Bernard E. Harcourt, *From the Asylum to the Prison: Rethinking the Incarceration Revolution*, 84 TEX. L. REV. 1751, 1766–75 (2006); Bernard E. Harcourt, *From the Asylum to the Prison: Rethinking the Incarceration Revolution—Part II: State Level Analysis* (Univ. of Chicago Law & Economics, John M. Olin Working Paper No. 335, 2007), available at <http://ssrn.com/abstract=970341> (last accessed Aug. 21, 2015)

170. Other factors, of course, contributed to this development, but total institutionalization rate explains at least part of the change in murder rates than do other factors.

171. Harcourt, TEX. L. REV., *supra* note 169; Harcourt, Working Paper, *supra* note 169.

the state-to-state variation), and more important than the quality of state mental health care systems.¹⁷²

One benefit of inpatient treatment is that the patient can receive antipsychotic medication. There is considerable research demonstrating that medication, including “second-generation antipsychotics” such as clozapine, risperidone, olanzapine, and quetiapine reduce aggressive behavior.¹⁷³ For some of these, injectable versions which require only a shot every two weeks (or less often), rather than a daily pill(s), are now available, and they improve patient medication adherence.¹⁷⁴ Of course medication can work in outpatient treatment as well, provided that the patient follows the course of medication.¹⁷⁵

In 1990, the U.S. Supreme Court ruled that a prison inmate could be medicated with antipsychotics without consent, based on a determination by an administrative hearing.¹⁷⁶ The decision emphasized the importance of the state’s interest in maintaining prison safety.

172. Steven P. Segal, *Civil Commitment Law, Mental Health Services, and US Homicide Rates*, 47 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 1449 (2011), available at <http://kendas-law.org/national-studies/commitmenthomiciderates.pdf> (last accessed Aug. 21, 2015).

173. Seena Fazel, Johan Zetterqvist, Henrik Larsson, Niklas Långström, Paul Lichtenstein, *Antipsychotics, Mood Stabilisers, and Risk of Violent Crime*, 384 LANCET 1206 (2014) (showing a 45 percent lower violent crime rate when 82,647 Swedish patients took medications from 2006 to 2009); Peter F. Buckley, *The Role of Typical and Atypical Medications in the Management of Agitation and Aggression*, 60 J. CLIN. PSYCHIATRY 52 (1999); Jan Volavka, Julie Magno Zito, Jozsef Vitrai & P. Czobar, *Clozapine Effects on Hostility and Aggression in Schizophrenia*, 13 J. CLIN. PSYCHOPHARMACOLOGY 287 (1993); Peter F. Buckley, Stephen G. Noffsinger, Douglas A. Smith, Debra R. Hrouda & James L. Knoll, IV, *Treatment of the Psychotic Patient who is Violent*, 26 PSYCHIATRIC CLINICS OF N. AM. 231 (2003); Maurizio Fava, *Psychopharmacologic Treatment of Pathologic Aggression*, 20 PSYCHIATRIC CLINICS OF N. AM. 427 (1997); J.W. Swanson, M.S. Swartz & E.B. Elbogen, *Effectiveness of Atypical Antipsychotic Medications in Reducing Violent Behavior among Persons with Schizophrenia in Community-based Treatment*, 30 SCHIZOPHR. BULL. 3 (2004); Jeffrey W. Swanson et al., *Comparison of Anti-Psychotic Medication Effects on Reducing Violence in People with Schizophrenia*, 193 BRIT. J. PSYCHIATRY 37 (2008) (violence was reduced from 16 percent of persons to 9 percent; no reduction for persons with childhood conduct problems). The mechanism by which these medications reduce positive symptoms of schizophrenia appears to be in “blunting the intrusion of aberrant cortical activity into consciousness.” Neal R. Swerdlow, *Integrative Circuit Models and Their Implications for the Pathopsychologies and Treatments of the Schizophrenias*, in BEHAVIORAL NEUROBIOLOGY OF SCHIZOPHRENIA AND ITS TREATMENT 555, 567–68 (Neal R. Swerdlow ed., 2010). (“constraining the chaos created by reverberating misinformation.” The effect is often to make hallucinations milder and easier to ignore, and to make delusions “less complex and systematic.”)

174. See, e.g., Serdar Dursun, *An Atypical Long-Acting Injectable Antipsychotic: Implications for Pharmacotherapy of Schizophrenia*, 19 J. PSYCHOPHARMACOLOGY 3 (Supp. 5, Sept. 2005).

175. Jeffrey W. Swanson, Marvin S. Swartz & Eric Elbogen, *Effectiveness of Atypical Antipsychotic Medications in Reducing Violent Behavior Among Persons With Schizophrenia in Community-Based Treatment*, 30 SCHIZOPHRENIA BULL. 3 (2004).

176. *Washington v. Harper*, 494 U.S. 210, 212 (1990); see also COHEN, PRACTICAL GUIDE TO CORRECTIONAL MENTAL HEALTH 7-41 to 7-62 (analyzing *Harper* and related cases).

Courts have also allowed nonconsensual medication in other institutional settings, such as mental hospitals, if there is “imminent danger.”¹⁷⁷ Some courts, such as in Colorado have gone further, and allowed involuntary medication if there is an imminent risk of irreversible deterioration.¹⁷⁸ Other courts allow forced medication when the patient lacks the ability to make an informed decision about treatment, but this non-emergency decision requires an independent judicial determination.¹⁷⁹

Medication is often helpful in reducing psychoses and the “positive” symptoms of schizophrenia. But it does not reduce the “negative” symptoms. Nor does it help more than a little with impaired cognition.¹⁸⁰

177. See, e.g., *Rogers v. Okin*, 738 F.2d 1 (1st Cir. 1984) (“[I]f a patient poses an imminent threat of harm to himself or others, and only if there is no less intrusive alternative to antipsychotic drugs, may the Commonwealth invoke its police powers without prior court approval . . .”); *Davis v. Hubbard*, 506 F. Supp. 915, 934 (N.D. Ohio 1980) (“Given the significant invasion of fundamental interests that the forced use of psychotropic drugs represents, the risk of danger which the State has a legitimate interest in protecting against must be sufficiently grave and imminent to permit their coerced use. The focus must therefore be in the first instance on the existence of danger, not merely the remote possibility, to others, since it is this which justifies the coercive power of the State.”).

178. *People v. Medina*, 705 P.2d 961, 974 (Colo. 1985) (allowing involuntary administration of a medication if “in the absence of the proposed treatment the patient will likely constitute a continuing and significant threat to the safety of himself or others in the institution. . . . [T]here may be emergency situations requiring a physician or other professional person to override the patient’s refusal of antipsychotic medication in order to protect the patient from inflicting immediate and serious harm on himself, to protect others from a similar danger, or to prevent the immediate and irreversible deterioration of the patient due to a psychotic episode”).

179. See, e.g., *Rogers v. Comm’r Dep’t of Mental Health*, 458 N.E.2d 308, 321–23 (Mass. 1983) (allowing administration without prior court approval “only if a patient poses an imminent threat of harm to himself or others, and only if there is no less intrusive alternative to antipsychotic drugs,” or to prevent the “immediate, substantial, and irreversible deterioration of a serious mental illness.”; in other circumstances, a court hearing must be held for there to be a “substituted judgment decision”); *Rivers v. Katz*, 67 N.Y.2d 485, 496-98 (1986) (“an emergency situation, such as when there is imminent danger to a patient or others in the immediate vicinity”; or when patient lacks ability to make an informed decision, judicial hearing is required, with de novo consideration of the facts, and the state having burden of proof by clear and convincing evidence); *Steele v. Hamilton Cnty. Cmty Mental Health Bd.*, 90 Ohio St. 3d 176, 183–86 (2000) (noting that the state’s “police power” may be used for involuntary medication only when there is an “imminent” risk of harm by or to the patient; *parens patriae* power may be used for forced medication in other circumstances “when the patient lacks the capacity to make an informed decision regarding his/her treatment.”).

180. Dennis H. Kim & Stephen M. Stahl, *Antipsychotic Drug Development*, in *BEHAVIORAL NEUROBIOLOGY OF SCHIZOPHRENIA AND ITS TREATMENT* 123, 125 (Neal R. Swerdlow ed., 2010). *But see* Sololmon Kalkstein, Irene Hurford, & Ruben C. Gur, *Neurocognition in Schizophrenia*, *CURRENT TOPICS IN BEHAVIORAL NEUROSCIENCE* 373, 386 (2010) (stating that atypical anti-psychotics improve social cognition. Nicotine improves cognition for persons with schizophrenia. This may explain why so many people with schizophrenia smoke.); Deanna M. Barch, *Pharmacological Strategies for Enhancing Cognition in Schizophrenia*, *BEHAVIORAL NEUROBIOLOGY*, *supra*, at 23, 51–60; David L. Braff, *Prepulse Inhibition of the Startle Reflex: A Window on the Brain of Schizophrenia*, in *BEHAVIORAL NEUROBIOLOGY*, *supra*, at 349, 357–58.

Personality disorders, including antisocial personality disorder, cannot be treated by medication, except to the extent that they are producing psychotic symptoms. Dealing with personality disorders requires therapy. Of course all forms of serious mental illness usually also require therapy, not medication alone.

Further, anti-psychotics often have side effects, including raising cardiovascular and metabolic risk (e.g., of a heart attack) by causing weight gain.¹⁸¹

An essential crime-reductive reform of mental illness policy is providing much greater access to treatment, including inpatient hospitalization. Many people voluntarily seek treatment, and too many are turned away due to insufficient resources. Creating the increased capacity will require substantially greater government spending of taxpayer dollars, and greater charitable contributions. The long-run benefits will mitigate the cost to government, and result in a net savings to society.

VII. CIVIL COMMITMENT SHOULD NOT REQUIRE “IMMINENT” DANGER

In Parts VII-IX of this Article, we make the case for involuntary commitment to mental hospitals, and for involuntary commitment to outpatient programs—even in circumstances when a mentally ill person is not “imminently” dangerous. Our proposals would be futile, however, unless there were simultaneously greater financial support to increase bed availability. Addressing the problem of mental illness and crimes requires either higher taxes, or cuts in government spending on other things, or both.

A. The *Lessard* case and the imminence standard

In some jurisdictions, civil commitments are allowed only if there is an “imminent danger” The most important source of the imminent danger standard is the 1972 Wisconsin federal district court case *Lessard v. Schmidt*. *Lessard* defined “imminent danger” as “based upon a finding of a recent overt act, attempt or threat to do substantial harm to oneself or another.” *Lessard* did not expressly say that the danger

181. Jonathan M. Meyer, *Antipsychotics and Metabolics in the Post-CATIE Era*, BEHAVIORAL NEUROBIOLOGY OF SCHIZOPHRENIA, *supra* note 180 23, 23–42 (Neal R. Swerdlow ed., 2010).

would have to be immediate, but many later decisions following *Lessard* did.¹⁸²

The *Lessard* case transformed involuntary commitment law. The case lasted four years, and went to the U.S. Supreme Court twice.¹⁸³ Plaintiff Alberta Lessard, a school teacher, had been running through her apartment complex “shouting that the communists were taking over the country that night.”¹⁸⁴

She had refused to accept new pedagogical techniques for teaching reading, and thus lost her job as an elementary school teacher, and also her position training teachers at Marquette University.¹⁸⁵ She was convinced that “Richard Nixon’s goons” were after her. (Nixon did illegally spy on people,¹⁸⁶ although there is no evidence that he illegally spied on her.)

On the evening when her behavior brought her to the attention of police, she was dangling from the windowsill of her apartment building. In the four decades since she was first taken into custody, she was hospitalized more than a hundred times because of her paranoid delusions and behavior.¹⁸⁷ Her long history of hospitalizations strongly indicates that she was severely mentally ill; her well-documented record plainly shows that she was not a danger to others, but she was a danger to herself, as evidenced by dangling from the windowsill.

There were several significant rules that *Lessard* and similar cases created:

182. *Lessard v. Schmidt*, 349 F. Supp. 1078, 1093–94 (E.D. Wis. 1972).

183. “In *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D.Wisc.1972), the first consideration of this case, this court held that the Wisconsin civil commitment procedures did not provide adequate due process rights to those who were committed and ordered numerous safeguards be instituted, including adequate notice, the right to counsel, availability of the privilege against self-incrimination, and a speedy hearing. The Supreme Court vacated and remanded the case because the judgment entered did not meet the specificity requirements for injunctive orders of Fed.R.Civ.P. 65(d). *Schmidt v. Lessard*, 414 U.S. 473 (1974). In *Lessard v. Schmidt*, 379 F. Supp. 1376 (E.D.Wisc.1974), this court entered a specific judgment in accordance with the prior opinion. The Supreme Court again vacated and remanded, this time ‘for further consideration in light of *Huffman v. Pursue, Ltd.*, 420 U.S. 592, 95 S.Ct. 1200, 43 L.Ed.2d 482 (1975).” *Lessard v. Schmidt*, 413 F. Supp. 1318, 1319 (E.D. Wis. 1976).

184. E. FULLER TORREY, *THE INSANITY OFFENSE: HOW AMERICA’S FAILURE TO TREAT THE SERIOUSLY MENTALLY ILL ENDANGERS ITS CITIZENS* 76–78 (2008).

185. For all we know, she was right in refusing. Modern international comparisons regarding reading comprehension scores of U.S. students are very unimpressive.

186. See generally AMERICAN CIVIL LIBERTIES UNION, *WHY PRESIDENT RICHARD NIXON SHOULD BE IMPEACHED* (1973); David Cole, *Reviving the Nixon Doctrine: NSA Spying, the Commander-in-Chief, and Executive Power in the War on Terror*, 13 WASH. & LEE J. CIVIL RTS. & SOC. JUST. 1 (2006).

187. *Alberta Lessard*, MILWAUKEE JOURNAL-SENTINEL (Dec. 9, 2011), available at <http://www.jsonline.com/multimedia/video/?bctid=1318733908001> (last accessed Aug. 21, 2015).

1. Involuntary commitment procedures, even though done in the interest of a person who may be mentally ill,¹⁸⁸ may not ignore due process requirements. Due process includes the right to be notified of a timely hearing,¹⁸⁹ and the right to be represented by counsel.¹⁹⁰
2. A mentally ill person had a right to the least restrictive alternative available, meaning that if there is some other method of treating a patient that does not involve involuntary hospitalization, the less restrictive alternative must be used.¹⁹¹
3. The preponderance of evidence standard traditionally used in civil commitment proceedings is insufficient. *Lessard* required proof beyond a reasonable doubt.¹⁹²
4. To justify the deprivation of liberty, an involuntary commitment required proof of dangerousness “based upon a finding of a recent overt act, attempt or threat to do substantial harm to oneself or another,” which *Lessard* considered to be “a finding of imminent danger to oneself or others. . . .”¹⁹³

Lessard led other courts to strike down many existing civil commitment laws.¹⁹⁴ *Lessard*'s concern about the stigma of involuntary

188. *Lessard*, 349 F. Supp. at 1084 (“State commitment procedures have not, however, traditionally assured the due process safeguards against unjustified deprivation of liberty that are accorded those accused of crime. This has been justified on the premise that the state is acting in the role of *parens patriae*, and thus depriving an individual of liberty not to punish him but to treat him.”).

189. *Id.* at 1092 (“Notice of the scheduled hearing, ‘to comply with due process requirements, must be given sufficiently in advance of scheduled court proceedings so that reasonable opportunity to prepare will be afforded,’ and it must set forth the basis for detention with particularity.”).

190. *Id.* at 1097–98 (“There seems to be little doubt that a person detained on grounds of mental illness has a right to counsel, and to appointed counsel if the individual is indigent.”).

191. *Id.* at 1095 (quoting *Shelton v. Tucker*, 364 U.S. 479 (1960) (“Even if the standards for an adjudication of mental illness and potential dangerousness are satisfied, a court should order full-time involuntary hospitalization only as a last resort. A basic concept in American justice is the principle that ‘even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgment must be viewed in the light of less drastic means for achieving the same basic purpose.’”).

192. *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.”).

193. *Id.* at 1093–94.

194. Samuel R. Bagenstos, *The Past and Future of Deinstitutionalization Litigation*, 34 CARDOZO L. REV. 1, 22–24 (2012). (“*Lessard*'s least restrictive alternative principle, in particular, was extremely influential.”).

commitment¹⁹⁵ became one of the rationales for the U.S. Supreme Court's 1979 *Addington v. Texas* decision, which required "clear and convincing" proof for involuntary civil commitment.¹⁹⁶ "Clear and convincing" is about halfway in-between the traditional "preponderance" standard, and *Lessard's* "reasonable doubt" rule.

We support the due process improvements since the early 1970s, except for the requirement that the danger be imminent.

When courts struck down commitment laws for including danger that was not imminent, they would point back to *Lessard's* requirement for imminent and substantial danger.¹⁹⁷ Some courts after *Lessard* upheld existing state commitment laws in a particular case only because the state was able to reasonably argue that the patient "would be dangerous to others 'in the immediate future.'"¹⁹⁸ Not all courts agreed that involuntary commitment required imminence, with some state supreme courts accepting "a showing of a substantial risk of serious harm."¹⁹⁹

The effect of *Lessard* and social changes in the 1970s was to strongly discourage involuntary commitment except where a patient was an imminent danger to self or others. Many of the severely men-

195. *Lessard*, 349 F. Supp. at 1089 ("Evidence is plentiful that a former mental patient will encounter serious obstacles in attempting to find a job, sign a lease or buy a house. One commentator, noting that 'former mental patients do not get jobs,' insisted that, '[i]n the job market, it is better to be an ex-felon than ex-patient.'").

196. *Addington v. Texas*, 441 US 418, 425-26 (1979) ("[I]t is indisputable that involuntary commitment to a mental hospital after a finding of probable dangerousness to self or others can engender adverse social consequences to the individual. Whether we label this phenomena 'stigma' or choose to call it something else is less important than that we recognize that it can occur and that it can have a very significant impact on the individual.").

197. *E.g.*, *Suzuki v. Yuen*, 617 F.2d 173, 178 (9th Cir. 1980) ("We agree that the danger must be imminent to justify involuntary commitment.") (The decision does not define imminent, but the language quoted from *Lessard* strongly suggests an immediate danger, as evidenced by immediately preceding actions or threats.).

198. *People v. Lane*, 581 P.2d 719, 722 (Colo. 1978) (upholding a continuing involuntary commitment based on previous violent criminal behavior); *People v. Howell*, 586 P.2d 27, 30 (Colo. 1978) (distinguishing the instant case from *Lessard* because Howell had a long history of violent criminal convictions and had been found not guilty by reason of insanity for murder.).

199. *In re Harris*, 654 P.2d 109, 112 (Wash. 1982) (upholding an involuntary commitment statute that did not require immediate danger); *Hatcher v. Wachtel*, 269 S.E. 2d 849, 852 (W.Va. 1980) (quoting the New Jersey Supreme Court, "The risk of danger, a product of the likelihood of such conduct and the degree of harm which may ensue, must be substantial within the reasonably foreseeable future. On the other hand, certainty of prediction is not required and cannot reasonably be expected."); *State v. Krol*, 68 N.J. 236, 260 (1975) ("Commitment requires that there be a substantial risk of dangerous conduct within the reasonably foreseeable future."); *Commonwealth v. Nassar*, 380 Mass. 908, 917 (1980) ("'Immediacy'" is linked to the requirement of an enhanced standard of proof in the sense that the forecast of events tends to diminish in reliability as the events are projected ahead in time . . . We may accept, further, that in the degree that the anticipated physical harm is serious—approaches death—some lessening of a requirement of 'imminence' seems justified.")

tally ill, as long as the dangers their mental illness caused were not immediate, were now free to continue a path downward. The broad reading of *Lessard* by some courts seriously aggravated the problem of violence by the severely mentally ill, and also the risk to the severely mentally ill from suicide, violence, homelessness, and exposure-related deaths.²⁰⁰

B. State Laws Reforms Allowing Involuntary Commitment with Due Process, but without a Finding of “Imminent” Danger

1. Virginia

In the aftermath of the mass murder spree at Virginia Tech in April 2007, the Virginia legislature revised its commitment law so that “imminent” dangerousness was no longer required for law enforcement to take a person to a “licensed mental health facility in lieu of arrest.”²⁰¹ Virginia now allows emergency hospitalization if “any responsible person, treating physician” or the magistrate himself:

has probable cause to believe that any person (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information²⁰²

Whereas some states require *imminent* danger, Virginia’s only requires danger “in the near future.” At the same time, Virginia still requires specific evidence, not merely a hunch: “as evidenced by recent behavior causing, attempting, or threatening harm.”²⁰³

200. One effect of the change was that large numbers of mentally ill people in Wisconsin “died with their rights on,” as Wisconsin Mental Health Institute psychiatrist Darold Treffert wrote. Darold A. Treffert, *The Macarthur Coercion Studies: A Wisconsin Perspective*, 82 MARQ. L. REV. 759, 775 (1999). The Portland *Oregonian* newspaper was able to identify at least ninety-four Oregon mentally ill residents over a 3½ year period that they believed could be fairly attributed to a failure of Oregon’s public mental health system. Some starved themselves to death while family, police, and social workers looked on, by law prohibited from intervening. Michelle Roberts, *Free to Die*, PORTLAND OREGONIAN (Dec. 30, 2002).

201. Richard J. Bonnie, James S. Reinhard, Philip Hamilton & Elizabeth L. McGarvey, *Mental Health System Transformation After the Virginia Tech Tragedy*, 28 HEALTH AFFAIRS 800 (2009).

202. VA. CODE, § 37.2-808(A) (2013).

203. VA. CODE, § 37.2-808(A) (2013).

2. Wisconsin

After twelve years of discussion, the Wisconsin Legislature added what became known as the “fifth standard” for involuntary commitment. Like many other states, Wisconsin already had four basic commitment standards: imminent danger to others;²⁰⁴ imminent danger to self;²⁰⁵ substantial probability of physical injury,²⁰⁶ or “gravely disabled” because “unable to satisfy basic needs for nourishment, medical care, shelter or safety without prompt and adequate treatment.”²⁰⁷

Wisconsin added a fifth standard, allowing involuntary commitment

if a lack of treatment will cause deterioration of a person’s mental and physical health, or cause him or her to suffer severe mental, emotional, or physical harm resulting in loss of independent functioning or loss of control over thoughts and actions, and if the person is incapable of understanding the advantages and disadvantages of accepting treatment and its alternatives.²⁰⁸

A lawsuit challenged the new law. A person suffering from schizophrenia, identified in court documents as Dennis H., was committed at the request of his father, a physician. Dennis H. was refusing to eat or drink, and had already suffered kidney failure as a result of a previous episode. The Wisconsin Supreme Court upheld the new “fifth standard.” Dennis H. was not in *imminent* danger because of his condition, but it was clear that his mental illness made it likely that he would deteriorate to a point where he was at risk if no treatment were given.²⁰⁹

Most of the Wisconsin Supreme Court’s decision focused on whether the fifth standard was clearly unconstitutional. The Wisconsin Supreme Court affirmed a traditional view of the state’s duty towards the mentally ill: “The state has a well-established, legitimate interest under its *parens patriae* power in providing care to persons unable to care for themselves”²¹⁰

204. WIS. STAT. § 51.20(1)(a)(2.b) (1995).

205. WIS. STAT. § 51.20(1)(a)(2.a) (1995).

206. WIS. STAT. § 51.20(1)(a)(2.c) (1995) (“[I]mpaired judgment, manifested by evidence of a pattern of recent acts or omissions, that there is a substantial probability of physical impairment or injury to himself or herself.”).

207. WIS. STAT. § 51.20(1)(a)(2.d) (1995).

208. WIS. STAT. § 51.20(1)(a)(2.e) (1995).

209. *Wisconsin v. Dennis H.*, 647 N.W.2d 851, 855 (Wis. 2002); Eve Bender, *Wisconsin Court Rejects Attempt To Narrow Commitment Law*, 37 PSYCHIATRIC NEWS 24, 33 (2002).

210. *Wisconsin v. Dennis H.*, *supra* note 209, at 855.

We are not arguing that every state should follow the Wisconsin model. Our narrower point is that people who are dangerously mentally ill, but not imminently so, can be placed into treatment, and this is not unconstitutional.

And most importantly, statutes mean little if there are not enough psychiatric beds available. Remember Ms. Lessard? In the quarter-century after she won her case, she tried several times to check herself into a Wisconsin state hospital for treatment. She was turned away because of a shortage of beds. “They said I wasn’t sick enough,” she explained.²¹¹

VIII. CIVIL COMMITMENT AND FOUR NOTORIOUS MASS MURDERS

This Part examines the role that civil commitment laws could or could not have played in the prevention of four notorious crimes: at the Washington Navy Yard, Newtown, Tucson, and Aurora. In the latter two cases, state laws were in place, which could have allowed the commitment of the perpetrators, based on circumstances a few weeks before the killings. But the responsible and aware government officials did not take action by filing the necessary petitions. This Article’s proposals for expanded inpatient and outpatient commitment will be of little value unless people who know about specific dangers speak up.

A. Rhode Island Law and the Navy Yard Murders

About a month before Aaron Alexis shot to death twelve people at the Navy Yard in Washington, D.C., he “told police in Newport, R.I., that he heard voices speaking to him through the walls of his hotel room and felt a machine sending vibrations into his body. . . .” Alexis was convinced that others in the hotel intended to harm or control him through these vibrations. The conversation with the police included him telling them that “he had no history of mental illness in his family and had never had any type of psychological epi-

211. Jeffrey L. Geller, *The Right to Treatment*, in PRINCIPLES AND PRACTICE OF FORENSIC PSYCHIATRY 121, 126 (Richard Rosner ed., 1994) (citing *Mental-Illness Ruling Hinders Patients*, DULUTH NEWS TRIB. (Aug. 28, 2000)). Dr. Dobbins had a similar experience, attempting to check herself into a mental hospital shortly after the beginning of a psychotic episode, and being turned away because she was not “admit material.” The psychoses soon became much worse, and caused considerable problems. DOBBINS, *supra* note *.

sode. . . .”²¹² This disclosure does not sound like the sort of information that would typically be volunteered to police.

Previously, Alexis likely would have been taken into custody for psychiatric evaluation. Charles Krauthammer today writes a political column for the *Washington Post*, but 35 years ago, Dr. Krauthammer worked as an emergency room psychiatrist at Massachusetts General Hospital. He described of what would have happened if Alexis had been presented in the emergency room with the above symptoms:

Were he as agitated and distressed as in the police report, I probably would have administered an immediate dose of Haldol, the most powerful fast-acting antipsychotic of the time.

This would generally have relieved the hallucinations and delusions, a blessing not only in itself, but also for the lucidity brought on that would have allowed him to give us important diagnostic details—psychiatric history, family history, social history, medical history, etc. If I had thought he could be sufficiently cared for by family or friends to receive regular oral medication, therapy and follow-up, I would have discharged him. Otherwise, I’d have admitted him. And if he refused, I’d have ordered a 14-day involuntary commitment.²¹³

Why didn’t police take Alexis into custody for evaluation? Rhode Island’s emergency commitment statute contains a very important word that severely limits a modern emergency room psychiatrist’s options. A Rhode Island physician may arrange for involuntary commitment when a person “is in need of immediate care and treatment” if leaving him at large “would create an *imminent* likelihood of serious harm by reason of mental disability. . . .”²¹⁴

If Alexis had been committed, then by Rhode Island law, he would have had to wait at least five years to purchase a firearm, as well as provide “an affidavit issued by competent medical authority to the effect that he or she is a mentally stable person and a proper per-

212. Travis Andersen, *Navy Yard Shooter Had Odd Episode in R.I.*, BOSTON GLOBE (Sept. 17, 2013).

213. Charles Krauthammer, *The Real Navy Yard Scandal*, WASH. POST (Sept. 19, 2013).

214. R.I. GEN. LAWS § 40.1-5-7 (2010) (emphasis added). Oddly, the only Rhode Island case law immediately relevant to this provision involves suits alleging that mental health facilities, by having *failed* to involuntarily commit people with serious mental illness problems, caused harm to others. There seems to be no case law involving patients involuntarily committed without sufficient cause. See *Almonte v. Kurl*, 46 A.3d 1, 13 (R.I. 2012) (finding that a failure to hospitalize led to patient’s suicide); see also *Santana v. Rainbow Cleaners*, 969 A.2d 653, 655 (R.I. 2009) (finding that a failure to hospitalize outpatient client led to severe injuries to third party).

son to possess firearms.”²¹⁵ This would not have guaranteed that he could not have obtained a firearm illegally, but if he had been treated, then perhaps he would not have murdered twelve people.

B. Pima Community College fails to inform law enforcement about a known and serious danger

Arizona has good laws for temporary civil commitment, but a state college recklessly failed to inform law enforcement about the danger posed by a former student.

On January 8, 2011, U.S. Rep. Gabrielle Giffords (D-Ariz.) was holding a town hall meeting at a supermarket in Tucson. Jared Lee Loughner approached, and opened fire with a handgun, killing six people, and wounding nineteen, including Congresswoman Giffords.

Loughner had a history of police contacts involving death threats,²¹⁶ and was suspended from Pima Community College for bizarre actions and threats that strongly suggested that he was mentally ill. He was told that he could not return unless he received a mental health evaluation.²¹⁷ If the college had looked, it also would have found a series of disturbing web postings and YouTube videos confirming that Loughner’s grasp on reality was severely impaired.²¹⁸

In the aftermath of the shootings, Pima College’s director of contracts and risk management, Mark Dworschak, argued that the college had an obligation to do more than just tell Loughner to seek help: “Arizona has one of the most lenient criteria for a commitment procedure which, having read the police reports, should have been initiated. . . . You don’t dump them as (another official) suggests.”²¹⁹

Arizona uses the “clear and convincing evidence” language from *Addington v. Texas* (1979), but Arizona has no requirement for “imminent” danger. Rather, if “the proposed patient, as a result of mental disorder, is a danger to self, is a danger to others, is persistently or acutely disabled or is gravely disabled and in need of treatment, and is

215. R.I. GEN. LAWS, § 11-47-6 (2010).

216. Tim Steller, *Man Linked To Giffords Shooting Rampage Called “Very Disturbed”*, ARIZ. DAILY STAR (Jan. 8, 2011), available at http://azstarnet.com/news/local/crime/article_91db5db4-1b74-11e0-ba23-001cc4c002e0.html (last accessed Aug. 21, 2015).

217. *Tucson shooting suspect’s school releases records*, USA TODAY (Apr. 16, 2011), available at <http://usatoday30.usatoday.com/news/nation/2011-04-16-loughner-records.htm> (last accessed Aug. 21, 2015).

218. Steller, *supra* note 216.

219. Associated Press, *Emails Document Loughner’s Outbursts at College*, NATIONAL PUBLIC RADIO (May 20, 2011).

either unwilling or unable to accept voluntary treatment,” he can be ordered into either an inpatient or outpatient treatment program.²²⁰

Court-ordered psychiatric evaluations after the shooting concluded that Loughner was suffering from schizophrenia, and was incompetent to stand trial.²²¹ After months of medication and therapy, Loughner recovered enough to be tried, and pleaded guilty, accepting a life sentence. He was legally mentally ill, but not so much so that he was not responsible for his actions. He had even researched the death penalty before his attack.²²²

The Pima College administration recognized that there was something seriously wrong, but made no effort to have Loughner hospitalized, or even to inform law enforcement. Merely suspending him from school meant that he was no longer Pima College’s problem. He purchased the handgun on November 30, 2010, *after* he was suspended from Pima College. A few weeks later, he was the problem of many others.²²³

If Loughner had been involuntarily committed, and later released, Arizona law would have prohibited him from possessing a firearm, unless he successfully petitioned an Arizona court to restore his rights.²²⁴

C. The University of Colorado fails to alert law enforcement to well-known and grave danger

Colorado has two complementary systems for 72-hour commitments. One procedure is for “imminent danger.” It is Colo. Rev. Stats. § 27-65-105. The other procedure does not require that the “danger” be imminent, but is requires more judicial process. It is C.R.S. § 27-65-106.

220. ARIZ. REV. STAT. § 36-540 (2011).

221. Craig Harris & Michael Kiefer, *Judge Finds Jared Loughner Incompetent to Stand Trial*, ARIZ. STAR (May 25, 2011), available at <http://www.azcentral.com/news/articles/2011/05/25/20110525gabriel-giffords-shot-jared-loughner-competency-hearing.html> (last accessed Aug. 21, 2015).

222. Ashley Powers & Michael Muskal, *Jared Lee Loughner Sentenced to Life for Tucson Shootings*, L.A. TIMES, Nov. 8, 2012, available at <http://articles.latimes.com/2012/nov/08/nation/la-na-jared-loughner-20121109> (last accessed Aug. 21, 2015); *Jared Loughner pleads guilty to Tucson shootings, avoids death penalty*, NBC NEWS, (Aug. 7, 2012).

223. Michelle Price, *Emails Document Loughner’s Outbursts at College*, ASSOCIATED PRESS (May 19, 2011), available at <http://www.foxnews.com/us/2011/05/20/emails-document-loughners-outbursts-college/> (last accessed Aug. 21, 2015) (reporting emails that show “[a] campus police officer wanted to expel Jared Lee Loughner after he caused an outburst in a math class in June 2010, but a dean said she wasn’t ready to do so and expressed concerns about Loughner’s due-process rights, according to one of the notes”).

224. ARIZ. REV. STAT. §§ 13-925, 36-540 (2011).

After a 72-hour commitment, 90-day commitments can be authorized (and renewed) by a court; the individual will have an attorney and the opportunity to present evidence.

When there is an “imminent danger,” the process to order a 72-hour commitment for a mental health evaluation is that a certified peace officer, as well as certain other professionals (e.g., doctors, nurses, social workers) can file an affidavit with a court setting forth the facts supporting a 72-hour hold. If the affidavit contains the requisite facts, then the court is required to order that the person be taken into custody for an evaluation.²²⁵

Besides applying to a person who presents an “imminent danger to others or to himself or herself,” the statute can also be used for persons who are “gravely disabled.”²²⁶

James Holmes’ threats, which were communicated to his psychiatrist around May 2012, were real, but they may not have been sufficiently “imminent.” His crime did not take place until late July.

Nor did Holmes did meet the statutory definitions of “gravely disabled.” He was not unable or unwilling “to provide himself or herself with the essential human needs of food, clothing, shelter, and medical care.” There is no indication that he was having trouble feeding himself, taking care of other basic needs, and so on.

Nor did he meet the second definition of “gravely disabled”—to be a person “who lacks judgment . . . to the extent that his or her health or safety is significantly endangered and lacks the capacity to understand that this is so.”²²⁷ His intricate booby trapping of his apartment and planning of the crime suggest a person of considerable intelligence and foresight. Nothing indicated that he lacked “the capacity to understand” the risk to his own safety (e.g., being shot by police or by a victim) of his attack. Rather, he actively worked to reduce those risks.

To reduce the police risk, he set music playing very loudly in his apartment, apparently hoping that a complaint would draw the police to open the door, and set off the huge quantity of explosives he had rigged. With first responders converging in the chaotic aftermath of the bombing, there would be a distraction away from the Aurora theater.

225. COLO. REV. STAT. § 27-65-105 (2010).

226. COLO. REV. STAT. § 27-65-105 (2010).

227. COLO. REV. STAT. § 27-65-102(9)(a) (2010).

The place where Holmes chose his mass casualty attack was a theater with a posted “no guns” policy, so Holmes was able to reduce the risk of being shot by a victim. There are a significant number of mass shootings which have ended sooner than the attacker wished because someone shot the attacker or drew a gun on him.²²⁸ One took place at the Sister Marie Lenahan Wellness Center in Darby, Pennsylvania, in July 2014. A psychiatric outpatient killed his caseworker and wounded his psychiatrist. He was then shot by the psychiatrist, Dr. Lee Silverman, who had a concealed handgun, in violation of the hospital’s no-guns policy. The District Attorney said that the attacker had been intending a mass shooting.²²⁹

As for the third Colorado definition of “gravely disabled,” it would fit many mentally ill persons, but not Holmes. As applied in Colorado, “gravely disabled” includes chronic schizophrenia, chronic affective disorder, chronic delusional disorder, and chronic mental disorder with psychotic features.²³⁰ Holmes may have had these illnesses, but as of 2013 the Colorado statute further required that such a person must have been hospitalized “at least twice during the last thirty-six months.”²³¹ Holmes had never been hospitalized. The requirement was removed in 2014.

So Holmes could not have been committed for 72 hours based upon an affidavit from certain professionals, as is allowed by C.R.S. § 27-65-105.

Yet he could have been committed under section 106, which does not require “imminent” danger. Under section 106, any person (not just particular types of professionals) may petition a court for a mental health evaluation of an individual.²³² The statute allows the petition

228. See David Kopel, *Arming the Right People Can Save Lives*, L.A. TIMES (Jan. 15, 2013), <http://articles.latimes.com/print/2013/jan/15/opinion/la-oe-kopel-guns-resistance-nra-20130115>. This article identifies lesser known instances of thwarted violence, including “Pearl High School in Mississippi; Sullivan Central High School in Tennessee; Appalachian School of Law in Virginia; a middle school dance in Edinboro, Pa.; Players Bar and Grill in Nevada; a Shoney’s restaurant in Alabama; Trolley Square Mall in Salt Lake City; New Life Church in Colorado; Clackamas Mall in Oregon (three days before Sandy Hook); Mayan Palace Theater in San Antonio (three days after Sandy Hook).”

229. Meg Wagner, *Pennsylvania Patient Who Allegedly Killed Caseworker, Shot Doctor Had 39 More Bullets, Intended Mass Shooting: DA*, (N.Y.) DAILY NEWS (July 25, 2014), available at <http://www.nydailynews.com/news/national/penn-psychiatric-center-shooting-suspect-abusive-ex-wife-article-1.1880052> (last accessed Aug. 21, 2015).

230. Nat’l Alliance on Mental Illness Arapahoe/Douglas Counties, *Involuntary Commitment and Emergency Services in Our Community of Arapahoe and Douglas Counties for Persons Who Are Gravely Disabled* (Dec. 18, 2008).

231. COLO. REV. STAT. § 27-65-102(9)(b)(II) (2010) (current version at § 27-65-102 (2014)).

232. COLO. REV. STAT. § 27-65-106 (2010).

based on allegations that the individual is “gravely disabled” or is “a danger to others or to himself.” The statute does not require that the danger be “imminent.” The Petition for Evaluation is available online.²³³

Unlike in the professional affidavit statute (section 105), the court is not required to order the evaluation. The court makes its own decision. The proceeding may be *ex parte*.

Once a person has been detained for 72 hours for evaluation under either statute, the treating facility may file a certification which authorizes the facility to hold the person for up to three months for involuntary short-term treatment. The certification must be filed with a court, and the court must immediately appoint an attorney to represent the individual. The individual and his attorney may at any time petition the court for the individual’s release. The standard for involuntary treatment is that the individual is “gravely disabled” or “is a danger to others or to himself or herself.” Again, “imminent” danger is *not* required.²³⁴

How could section 106 (discretionary court-ordered hold, no requirement for imminence) have been used for James Holmes?

Holmes’s psychiatrist, Dr. Lynn Fenton broke doctor/patient confidentiality when she warned the Threat Assessment Team at the University of Colorado that Holmes had been talking about killing a lot of people.²³⁵ Violating patient confidentiality is generally illegal in Colorado, with one important exception.²³⁶ Under the “Tarasoff rule,” psychiatrists and other mental health workers have a duty to warn threatened persons based on conversations with a patient.²³⁷

The Tarasoff rule requiring disclosure when a patient poses a “foreseeable danger” was created in California in 1976, and has been

233. Petition for Evaluation *available at* <http://www.colorado.gov/cs/Satellite?blobcol=url data&blobheadername1=Content-Disposition&blobheadername2=ContentType&blobheader value1=inline%3B+filename%3D%22Petition+for+Evaluation+and+Motion+and+Order+of+ Screening.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=Mungo Blobs&blobwhere=1251742447393&ssbinary=true> (last accessed Aug. 21, 2015)

234. COLO. REV. STAT. § 27-65-107 (2010).

235. John Ferrugia, *CU Psychiatrist Called Threat Team About James Holmes*, 7NEWS DENVER, (Aug. 2, 2012, *available at* http://www.thedenverchannel.com/news/call7-investigators/james-holmes-cu-psychiatrist-was-concerned-he-spoke-fantasized-about-killing-people-sources-say?hpt=JU_bn5) (last accessed Aug. 21, 2015).

236. COLO. REV. STAT. § 12-43-218(1) (2010).

237. The rule was announced in *Tarasoff v. Regents of the University of California*, 17 Cal. 3d 425, 431 (1976), and has been adopted almost everywhere in the U.S. See Randy Borum & Marisa Reddy, *Assessing Violence Risk in Tarasoff Situations: A Fact-Based Model of Inquiry*, 19 BEHAV. SCI. & L. 375, 376 (2001).

adopted in one form or another almost everywhere in the U.S. The details of the rule vary among the states, with some states requiring an “identifiable victim” before a therapist must alert authorities.²³⁸ Dr. Fenton’s actions suggest that she recognized a Tarasoff duty to warn. Colorado’s statute imposes the duty to warn only when “the patient has communicated to the mental health provider a serious threat of imminent physical violence against a specific person or persons, including those identifiable by their association with a specific location or entity.”²³⁹

Dr. Lynne Fenton’s efforts indicated she perceived Holmes to be at least level 4 of the University of Colorado’s Behavioral Evaluation and Threat Assessment (BETA) matrix: “High Risk.”²⁴⁰

The University of Colorado Police asked Dr. Fenton if she wanted to place a 72-hour hold on Holmes, and she declined, apparently in part because Holmes was withdrawing from the University.²⁴¹ Given that Holmes’ defense in his criminal trial was based entirely on an insanity plea, it seems likely that if Holmes had been given a 72-hour evaluation, evidence of his severe and very dangerous mental condition would have been apparent.

The problems in Arizona and Colorado were not weaknesses in the statutes, but the failure of state higher education officials to take the appropriate steps regarding a known and dangerously mentally ill student.

D. Connecticut Law and Newtown

In the aftermath of the horrific December 2012 mass murder at Sandy Hook Elementary School, the question on everyone’s minds was: *Why?* People wanted to know what prompted Adam Lanza to murder first his mother, then twenty elementary school children and six adults at the elementary school he had attended long ago.

238. John M. Greene, Adjunct Clinical Faculty, Stanford Univ. Dep’t of Psychiatry, *Lecture: Psychiatrist Duties: Tarasoff* (Aug. 3, 2006), available at <http://forensicpsychiatry.stanford.edu/Files/Tarasoff%20Greene.htm> (last accessed Aug. 21, 2015).

239. COLO. REV. STAT. § 13-21-117(2)(a) (2014).

240. *Did CU Officials Consider James Holmes ‘High Risk’ For Violence?*, 7NEWSDENVER (Aug. 16, 2012), available at <http://www.thedenverchannel.com/news/31363132/detail.html> (last accessed Aug. 21, 2015).

241. Ferrugia, *supra* note 235.

Adam Lanza had a psychiatric disorder known as Asperger's Syndrome,²⁴² a diagnosis not associated with premeditated violence. Violence by persons suffering from Asperger's Syndrome is often related to a loss of temper, inability to read social cues, and narrowly-focused interests that lead to inappropriate behavior. Premeditated mass murder is not only atypical, but Lanza's case may be the first such instance.²⁴³

Lanza suffered from a sensory integration disorder (SID), where sensory inputs overwhelm the brain.²⁴⁴ There is sizable overlap between the description of SID and the sensory problems that appear to be part of schizophrenia.²⁴⁵ Some of his symptoms in pre-school overlap with symptoms of schizophrenia: "smelling things that are not there" and "excessive hand washing."²⁴⁶ Lanza's father later speculated that Asperger's "veiled a contaminant." Namely, "I was thinking it could mask schizophrenia."²⁴⁷ Was Lanza's psychiatrist reluctant to give this devastating diagnosis until he was certain? The final report of the Connecticut State Police indicates changes in behavior before the murders. He stopped playing Dance Dance Revolution in a local theater lobby about a month before, and exhibited signs of increasingly

242. In the DSM, Asperger's is diagnosed under the category of Autism Spectrum Disorder. See AMER. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 50–53 (5th ed. 2013); Andrew Solomon, *The Reckoning: The Father of the Sandy Hook Killer Searches for Answers*, THE NEW YORKER, Mar. 17, 2014, at 36, available at <http://www.newyorker.com/magazine/2014/03/17/the-reckoning> (last accessed Aug. 21, 2015).

243. Barbara G. Haskins & J. Arturo Silva, *Asperger's Disorder and Criminal Behavior: Forensic-Psychiatric Considerations*, 34 J. AM. ACAD. PSYCHIATRY & L. 374, 376–78 (2006) (showing that persons with Asperger's Syndrome are disproportionately violent, but noting that the violence may be related to co-occurring conditions, such as bipolar disorder, in some patients); Daniel C. Murrie, et al., *Asperger's Syndrome in Forensic Settings*, 1 INT'L J. FORENSIC MENTAL HEALTH 59, 60–61 (2002) (existing studies are mixed, and have small samples, but on the whole they suggest that Asperger's patients are disproportionately violent).

244. Adam Clark Estes, *Revelations about Adam Lanza's Mental Health Still Don't Explain the Violence*, Atlantic Wire (Feb. 19, 2013), available at <http://www.theatlanticwire.com/national/2013/02/revelations-about-adam-lanzas-mental-health-still-dont-explain-violence/62317/> (last accessed Aug. 21, 2015). See also Stephen J. Sedensky, III, State's Attorney, District of Danbury, REPORT OF THE STATE'S ATTORNEY FOR THE JUDICIAL DISTRICT OF DANBURY ON THE SHOOTINGS AT SANDY HOOK ELEMENTARY SCHOOL AND 36 YOGANANDA STREET, NEWTOWN, CONNECTICUT ON?DECEMBER 14, 2012 34–35 (concerning "sensory issues.").

245. 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, *Neurophysical Measures of Sensory Registration, Stimulus Discrimination, and Selection in Schizophrenia Patients*, in BEHAVIORAL NEUROBIOLOGY OF SCHIZOPHRENIA AND ITS TREATMENT 283, 284–86 (Neal R. Swerdlow ed., 2010) (discussing the relationship between sensory input processing and schizophrenia).

246. Sedensky, *supra* note 244, at 34.

247. Solomon, *supra* note 242.

antisocial behavior in the preceding year.²⁴⁸ These *might* be evidence of the onset of depression, which is associated with schizophrenia.²⁴⁹

Connecticut's statutes concerning involuntary commitment do not require *imminent* danger. The provision for detention by a police officer for emergency commitment requires "a person has psychiatric disabilities and is dangerous to himself or herself or others or gravely disabled, and in need of immediate care and treatment. . . ." ²⁵⁰ The definition of "'dangerous to himself or herself or others' means there is a substantial risk that physical harm will be inflicted by an individual upon his or her own person or upon another person."²⁵¹

However, the Connecticut statute is undermined by a regulation created by the Connecticut executive branch. The state regulation defining "dangerous to himself or herself or others" includes a word previously seen: "the risk of *imminent* physical injury to others or self."²⁵²

The statute has been the basis for several recent Connecticut Supreme Court decisions concerning involuntary commitment. The cases involved persons found not guilty of manslaughter, arson, murder, kidnapping, and other serious felonies because of mental illness, and who were now seeking release from state mental hospitals. Most of these cases held that *imminent* physical injury was not a requirement for involuntary commitment.²⁵³

Lanza had very serious mental problems, and refused treatment and medication.²⁵⁴ Committing him on the basis of likely violence

248. Sedensky, *supra* note 244.

249. Samuel G. Siris, *Depression in Schizophrenia*, in CONTEMPORARY ISSUES IN THE TREATMENT OF SCHIZOPHRENIA 155, 156 (Christian L. Shriqui & Henry A. Nasrallah eds., 1995).

250. CONN. GEN. STAT. § 17a-503(a) (2010).

251. CONN. GEN. STAT. § 17a-495(a) (2009).

252. CONN. PSYCHIATRIC SECURITY REVIEW BD., GENERAL OPERATIONS AND PROCEDURES § 17a-581-2(a)(6) (1993).

253. *See* State v. Dyous, 53 A.3d 153, 160 (Conn. 2012) ("the defendant remained mentally ill and '[would pose] an imminent and substantial risk of harm to himself or others if he [were] discharged from the [jurisdiction of the] board.'" The defendant had been found not guilty because of mental illness in a kidnapping case.); State v. Harris, 890 A.2d 559, 566 (Conn. 2006) ("[I]n order to meet the regulatory standard, the board would have to find an imminent risk that the acquittee would harm himself or others. . . . 'Imminent' is defined as 'ready to take place; esp: hanging threateningly over one's head. . . . 'Merriam-Webster's Collegiate Dictionary (10th Ed.1993)'""); State v. March, 265 Conn. 697, 709 (2003) ("Section 17a-581-2(a)(6) of the Regulations of Connecticut State Agencies defines '[d]anger to self or to others,' as used in General Statutes § 17a-580 (5), . . . as 'the risk of imminent physical injury to others or self'""); State v. Warren, 919 A.2d 465, 468, 470 (Conn. App. Ct. 2007) (defining "'danger to self or to others,'" as used in General Statutes § 17a-580(5), as "'the risk of imminent physical injury to others or self,'" involving a defendant found not guilty of first degree murder because of mental illness).

254. The State's Attorney reported that:

In the late 1990s he was described as having speech and language needs. At that time he was also being followed medically for seizure activities. In preschool his conduct

would not appear to have been supported by his prior history. If his mother had so chosen, it is possible that he could have been committed based on a separate criterion: his being “gravely disabled” due to his inability to care for himself.²⁵⁵

IX. INVOLUNTARY OUTPATIENT COMMITMENT

Involuntary outpatient commitment (IOC) is a program in which a mentally ill person might be “forced to undergo mental health treatment or care in an outpatient instead of an institutional setting.” The goal is to provide both a less restrictive and less expensive alternative for persons who have severe mental illness, and who might be successfully treated outside of a locked facility. Involuntary inpatient commitment can remain as the backup for persons who are unwilling or unable to use outpatient treatment.²⁵⁶

included repetitive behaviors, temper tantrums, smelling things that were not there, excessive hand washing and eating idiosyncrasies. In 2005, the shooter was diagnosed with Asperger’s Disorder and was described as presenting with significant social impairments and extreme anxiety. It was also noted that he lacked empathy and had very rigid thought processes He had no learning disability It was reported that his school issues related to his identified emotional and/or Pervasive Developmental Disorder (PDD) spectrum behaviors. His high level of anxiety, Asperger’s characteristics, Obsessive Compulsive Disorder (OCD) concerns and sensory issues all impacted his performance to a significant degree, limiting his participation in a general education curriculum. Tutoring, desensitization and medication were recommended. It was suggested that he would benefit by continuing to be eased into more regular classroom time and increasing exposure to routine events at school.

The shooter refused to take suggested medication and did not engage in suggested behavior therapies.

. . . .
[I]t is unknown, what contribution, if any, the shooter’s mental health issues made to his attack on SHES. Those mental health professionals who saw him did not see anything that would have predicted his future behavior.

Sedensky, *supra* note 244, at 34–35.

255. See CONN. GEN. STAT. § 17a-495(a) (“[G]ravely disabled” means that a person, as a result of mental or emotional impairment, is in danger of serious harm as a result of an inability or failure to provide for his or her own basic human needs such as essential food, clothing, shelter or safety and that hospital treatment is necessary and available and that such person is mentally incapable of determining whether or not to accept such treatment because his judgment is impaired by his psychiatric disabilities.”); see also *id.* § 17a-497 (a)–(b) (commitment decision to be made by a probate judge, or if respondent so requests, by a three-judge panel); *id.* § 17a-498(c)(1), (3) (“clear and convincing evidence standard”; certificates from at least two examining physicians required; at least one of the physicians must be a psychiatrist).

256. Ingo Keilitz, *Legal Issues in Mental Health Care: Current Perspectives* 363, 368–89, in HANDBOOK ON MENTAL HEALTH POLICY IN THE UNITED STATES (David A. Rochefort ed., 1989); Robert D. Miller, *Involuntary Civil Commitment to Outpatient Treatment*, in PRINCIPLES & PRACTICE OF FORENSIC PSYCHIATRY 116, 116–17 (Richard Rosner ed., 2d ed. 2003) (noting that before the 1980s, involuntary outpatient commitment was unstructured, and was almost always in the context of a judge granting someone a conditional release from inpatient custody. Beginning in the mid-1980s, state legislature enacted statutes to regularize outpatient commitment, and to allow such commitment for persons who were not already inpatients).

A. The first states

North Carolina's 1984 law allowed a court to order IOC for persons who were not an imminent danger, but were "in need of treatment . . . to prevent further disability or deterioration which would predictably result in dangerousness."²⁵⁷ North Carolina's goal appears not to have been to widen the power of the government over mentally ill persons, but to narrow it, by substituting involuntary outpatient commitment for hospitalization.²⁵⁸ By the early 1990s, IOC had also been tried in Iowa, Ohio, Tennessee, and the District of Columbia.

In North Carolina, IOC appears to have made little difference, perhaps because the courts rarely used use the new procedure. In addition, community mental health professionals were reluctant to treat involuntary patients. Many of them lacked knowledge of how to use IOC.²⁵⁹

Tennessee appears to have been something of a success, at least as measured by what fraction of patients subject to IOC orders were showing up for follow-up appointments with clinicians.²⁶⁰

In Iowa, a five-year retrospective study found that IOC patients did much better, with reduced hospital and emergency room treatment, compared to a matched set of control subjects not subject to IOC.²⁶¹

B. New York

New York State tried the experiment next, starting with a trial program at New York City's Bellevue Hospital in 1994. The results were sufficiently positive to justify expanding the program.²⁶² One spur to expansion came on January 3, 1999, when 29-year-old Andrew Goldstein, who had schizophrenia, pushed Kendra Webdale in front of an oncoming subway train in midtown Manhattan, killing her. The victim was an aspiring writer from upstate New York. As her brother

257. N.C. GEN. STAT. § 122C-263(d)(1)(c) (2009).

258. Bruce J. Winick, Ken Kress & Michael L. Perlin, *Therapeutic Jurisprudence and Outpatient Commitment Law: Kendra's Law as Case Study*, 9 PSYCHOL., PUB. POL'Y & L. 183, 187-89 (2003).

259. *Id.* at 189.

260. Miller, *supra* note 256, at 117.

261. Marvin S. Swartz & Jeffrey W. Swanson, *Involuntary Outpatient Commitment, Community Treatment Orders, and Assisted Outpatient Treatment: What's in the Data?*, 49 CAN. J. PSYCHIATRY 585, 587 (2004).

262. Sally L. Satel, *Real Help for the Mentally Ill*, N.Y. TIMES (Jan. 7, 1999), available at <http://www.nytimes.com/1999/01/07/opinion/real-help-for-the-mentally-ill.html> (last accessed Aug. 21, 2015).

explained, “She was the kind of person who would have helped the kind of person who did this.”²⁶³

Webdale was not the first person murdered in this way; the crime was not even the first murder by a mental patient pushing someone under a New York subway train. An escapee from a state psychiatric hospital had done something similar in 1995.²⁶⁴ But unlike the 1995 perpetrator, Goldstein had a long history of hospitalization followed by release. Even by the existing standards, Goldstein should have been subject to involuntary commitment. He had repeatedly sought hospitalization, only to be turned away.²⁶⁵ Again, this shows that increased funding for mental hospital beds is essential.

Goldstein had been hospitalized five times in 1998, and was released only three weeks before killing Webdale.²⁶⁶ Shortly before the subway incident, Goldstein stopped taking his medications because of the side effects.²⁶⁷

Goldstein provided a shocking example, particularly in ending the life of such a sympathetic victim. The *New York Times* published editorials calling for the state to take a more active role in caring for the deinstitutionalized mentally ill.²⁶⁸ Gov. George Pataki signed the bill providing for an involuntary outpatient commitment law in August 1999.²⁶⁹ It took effect three months later.²⁷⁰

263. Robert D. McFadden, *New York Nightmare Kills a Dreamer*, N.Y. TIMES (Jan. 5, 1999), available at <http://www.nytimes.com/1999/01/05/nyregion/new-york-nightmare-kills-a-dreamer.html> (last accessed Aug. 21, 2015).

264. Amy Waldman, *Woman Killed in a Subway Station Attack*, N.Y. TIMES (Jan. 4, 1999), available at <http://www.nytimes.com/1999/01/04/nyregion/woman-killed-in-a-subway-station-attack.html> (last accessed Aug. 21, 2015).

265. Michael Winerip, *Bedlam on the Streets*, N.Y. TIMES (May 23, 1999), available at <http://www.nytimes.com/1999/05/23/magazine/bedlam-on-the-streets.html> (last accessed Aug. 21, 2015).

266. Metro News Briefs: New York, *Hospital Stay Revealed For Man in Train Killing*, N.Y. TIMES (Mar. 31, 1999), available at <http://www.nytimes.com/1999/03/31/nyregion/metro-news-briefs-new-york-hospital-stay-revealed-for-man-in-train-killing.html> (last accessed Aug. 21, 2015).

267. N. R. Kleinfeld & Kit R. Roane, *Subway Killing Casts Light On Suspect's Mental Torment*, N.Y. TIMES (Jan. 11, 1999), available at <http://www.nytimes.com/1999/01/11/nyregion/subway-killing-casts-light-on-suspect-s-mental-torment.html> (last accessed Aug. 21, 2015).

268. *After Kendra Webdale's Death*, N.Y. TIMES (Jan. 8, 1999), available at <http://www.nytimes.com/1999/01/08/opinion/after-kendra-webdale-s-death.html> (last accessed Aug. 21, 2015).

269. *A Signature for 'Kendra's Law'*, N.Y. TIMES (Aug. 28, 1999), available at <http://www.nytimes.com/1999/08/28/nyregion/a-signature-for-kendra-s-law.html> (last accessed Aug. 21, 2015).

270. N.Y. STATE OFFICE OF MENTAL HEALTH, *KENDRA'S LAW: FINAL REPORT ON THE STATUS OF ASSISTED OUTPATIENT TREATMENT 1* (2005).

The definition of eligibility for Assisted Outpatient Treatment (AOT)—as New York called its IOC program— was written with an apparent awareness of the battles the New York Civil Liberties Union had fought to prevent involuntary commitment. The care in drafting paid off; a series of challenges to the law failed to strike it down.²⁷¹

The criteria were specific, and appear to have been written with the “compelling governmental interest” and “narrowly tailored” requirements of strict scrutiny in mind. Criteria included a history of non-adherence to treatment where such failure had “been a significant factor in his or her being in a hospital, prison or jail at least twice within the last 36 months,” or has “resulted in one or more acts, attempts, or threats of serious violent behavior towards self or others within the last 48 months.”²⁷²

The law also included many other changes intended to improve the provision of mental health services to outpatients, as would be necessary to take care of an increased number of patients who would be subject to it.

In AOT’s first four years, 10,078 persons in New York State were referred to the program for potential inclusion. Of that number, mental health officials filed 4,041 petitions seeking AOT status, and 3,766 of those petitions were granted.²⁷³ The numbers suggest that mental health officials took care to make appropriate use of the program for patients, since more than half of the referrals did not lead to AOT.

Research showed that persons subject to AOT became somewhat better off in terms of functioning and self-care. In addition, the percentage of AOT patients who threatened suicide fell from 15 percent at the start to 8 percent by the first six-month renewal. Notably, the percentage of physically harming others also fell from 15 percent to 8 percent, with comparable improvements in the categories “Threaten Physical Harm,” “Damage or Destroy Property,” and “Verbally Assault Others.” Substantial reductions also took place in “hospitalization, homelessness, arrest and incarceration” thanks to AOT.²⁷⁴

271. Erin O’Connor, *Is Kendra’s Law a Keeper? How Kendra’s Law Erodes Fundamental Rights of the Mentally Ill*, 11 J.L. & Pol’y 313, 334–36 (2002).

272. N.Y. STATE OFFICE OF MENTAL HEALTH, *supra* note 773, at 2. For persons participating in AOT, the arrest rate declined from thirty percent to five percent. *Id.*

273. *Id.* at 7.

274. *Id.* at 16–19. This is not to say that Kendra’s Law has been completely successful. See O’Connor, *supra* note 271, at 358–59, 364–67.

C. Other States

Success in New York was sufficiently clear that other states followed suit, with Florida passing an IOC law in 2004. A pilot program in Seminole County reduced by 43 percent the number of days mentally ill persons spent in a hospital, and numbers of days incarcerated by 72 percent, saving about \$14,000 per patient over an 18-month period.²⁷⁵

Studies across the industrialized world found that IOC patients were less likely to be hospitalized, half as likely to be involved in acts or threats of violence, far less likely to be victims of crime (23.5 percent of patients within a year versus 42.4 percent of patients in the control group), and enjoyed improved quality of life.²⁷⁶ A review of all English-language published studies of IOC concluded that IOC was most effective with patients suffering from psychotic disorders who were subject to IOC orders for six months or more.²⁷⁷

In several states, a factor that seems to have contributed to the limited use of IOC was that mental health professionals did not know about the program, or did not know how to use it. Perhaps not surprisingly, a 2001 survey concerning involuntary commitment (both inpatient and outpatient) found that large numbers of psychiatrists did not fully understand the commitment laws of the states in which they practiced. In general, they erred on the side of believing the law to be narrower than it actually was. Especially with respect to IOC, error

275. Rosanna Esposito, Valerie Westhead & Jim Berko, Letter, *Florida's Outpatient Commitment Law: Effective but Underused*, 59 *PSYCHIATRIC SERVICES* 328 (2008).

Colorado law provides for outpatient treatment orders for those found incompetent to stand trial, as well as for involuntary civil commitment with the option of having the treatment done on an outpatient basis. *COLO. REV. STAT. § 16-8.5-111(2)(a)* (2008) (“As a condition of bond, the court may require the defendant to obtain any treatment or habilitation services that are available to the defendant, such as inpatient or outpatient treatment at a community mental health center or in any other appropriate treatment setting, as determined by the court.”); *Id.* § 27-65-107(c)(6) (“The respondent for short-term treatment or his or her attorney may at any time file a written request that the certification for short-term treatment or the treatment be reviewed by the court or that the treatment be on an outpatient basis.”).

276. Swartz & Swanson, *supra* note 261, at 588–89.

277. *Id.* at 585. Unsurprisingly, IOC was effective only if community mental health services were available. Such programs are no panacea; a one-year follow-up study in North Carolina found that “few patients in any group did well on measures of compliance with medication, appointments kept and absence of disruptive symptoms.” However, patients subject to IOC did much better than patients who had been involuntarily committed or who had been held for 72-hour observation. Those who had been involuntarily committed were likely the most severely ill. The IOC patients may have done better because they experienced less severe problems. *Id.* at 586–87.

rates were quite high, with only 53 percent of psychiatrists correctly answering questions about whether IOC was allowed.²⁷⁸

IOC can work best when it is structured like probation: there is a supervisor assigned to the patient, and the supervisor is responsible for meeting with the patient from time to time, conducting home visits, and monitoring whether the patient is complying with the treatment program.²⁷⁹

IOC is not an alternative to involuntary inpatient commitment. Rather it is a relatively lower cost complement, appropriate for severely mentally ill patients who are willing and able to stay on their medications.²⁸⁰ That does not mean it is cheap; the data indicate that it only works “when more intensive services are provided, obviating its use as an inexpensive remedy.”²⁸¹

CONCLUSION

Much can be done to reduce not only the tiny fraction of U.S. murders that are random acts of mass killing, but also the rest of the 18-19 percent of homicides by the severely mentally ill that get no national attention.

One important change legislators in some states can make is to recognize that waiting for a mentally ill person to become an *imminent* danger to self or others is waiting too long. By the time a person with severe mental illness is an imminent danger, he is on the verge of murder or other major violent crime. The costs of waiting are enormously high: in blood, suffering, autopsies, inquests, trials, and prison cells.

Earlier intervention will, in the long run, greatly lower the societal costs of severe mental illness. Early treatment may be the differ-

278. Robert A. Brooks, *Psychiatrists' Opinions About Involuntary Civil Commitment: Results of a National Survey*, 35 J. AM. ACAD. PSYCHIATRY & L. 219, 223–24 (2007).

279. Christian A. Piccolo, Note, *Falling through the Cracks: The Need for Enhanced Supervision in the Involuntary Outpatient Civil Commitment Setting*, 54 VILL. L. REV. 309, 314, 335–36 (2009). Cf. Jennifer Eno Loudon et al., *Supervision Practices in Specialty Mental Health Probation: What Happens in Officer-Probationer Meetings?*, 36 L. & HUMAN BEHAV. 109 (2012) (finding that probation officers who specialize in supervising the mentally ill use probationer interaction strategies which, compared to standard probation work, pay more attention to general mental health, and rely less on threats).

280. One study (not specifically about IOC) found that 74 percent of persons with schizophrenia discontinued medication within 18 months. Jeffrey A. Lieberman et al., *Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia*, 353 NEW ENG. J. MED. 1209 (2005); see also Cara R. Rabin & Steven J. Siegel, *Antipsychotic Dosing and Drug Delivery*, in BEHAVIORAL NEUROBIOLOGY, *supra* note 245, at 141, 151, 153 (citing similar studies). Nonadherence to medication increases the risk of relapse five-fold. *Id.* at 153–54.

281. Swartz & Swanson, *supra* note 261, at 590.

ence for some between lifelong disability and a healthy measure of economic and personal self-sufficiency. It is scandalous that so many severely mentally ill people who voluntarily seek treatment are turned away, and that so many of them therefore end up in jails or prisons.

Mere suspicion of mental illness does not justify taking away someone's rights. People suffering from minor emotional or psychological problems do not pose a genuine threat, under normal conditions. Nor, for that matter, do the majority of persons with severe mental illness. Yet the evidence is very clear that a subset of persons with severe mental illness pose a very real danger of violence.

Narrow and carefully written statutory reforms can make involuntary commitment to inpatient or outpatient treatment available when necessary to protect the public from persons whose severe mental illness creates a serious risk of violence. However, mental health professionals must work alongside others involved in the process (law enforcement, judges, lawyers, and social workers) to proactively solve the problems of severe mental illness and criminal violence. Prevention is cheaper than punishment. Statutory improvements, though, are empty gestures unless backed up by necessary funding for mental health treatment. Appropriate funding will provide a large net gain to society over the long run.