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NOT YOUNG GUNS ANYMORE: DEMENTIA AND THE SECOND AMENDMENT

Fredrick E. Vars

Dementia and guns can be a deadly combination. States as diverse as Texas and Hawaii have responded with diagnosis-based restrictions. This article evaluates the constitutionality, and policy wisdom, of these laws and a range of narrower and even voluntary options. Some mandatory restraints are very likely constitutional, but a diagnosis of dementia by itself may be an unconstitutional basis for mandatory gun restrictions. However, my strongest conclusion is with respect to a voluntary measure: current efforts to persuade those with dementia to voluntarily relinquish their firearms should be immediately supplemented with a system to allow such individuals to prevent their own future gun purchases. The cost of this proposal is very low and, because it is voluntary, it does not implicate the Second Amendment.

Dementia and guns can be a deadly combination. Take a recent case from England. An eighty-seven-year-old man kissed his wife of fifty-nine years, fatally shot her in the head, then “tried to shoot himself, but struggled to find the trigger after his glasses steamed up with tears.”¹ Both suffered from dementia.²

Tragedies like the one in England seem likely to be repeated in the United States. “The prevalence of dementia among individuals

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1. Rebecca Camber, *Pensioner Who Shot Dementia Wife Dead in her Care Home had Dementia Himself*, 2016 WLNR 21164048, DAILY MAIL (UK) 35 (July 12, 2016).

2. *Id.*

aged seventy-one and older was 13.9%, comprising about 3.4 million individuals in the USA in 2002.³ About thirty percent of Americans live in a household with guns.⁴ One self-selected study found that seventeen percent of dementia patients lived with a firearm in the home.⁵ Another study put the figure as high as sixty percent.⁶ Either way, it is clear that many people with dementia have access to firearms.

Dementia, a subtype of "major neurocognitive disorder," entails "significant cognitive decline" that "interfere[s] with independence in everyday activities."⁷ Difficulty managing money would reflect mild dementia; difficulty getting dressed would indicate moderate dementia; and someone with severe dementia is fully dependent.⁸ Varieties are identified by cause and include Alzheimer's disease (AD), Lewy body disease, vascular disease, and HIV infection.⁹

AD is the most common form of dementia.¹⁰ Its prevalence rises steeply with age and, though there is great variation,¹¹ mean survival after diagnosis is about ten years.¹² It is marked by a "steadily progressive, gradual decline in cognition."¹³ In one study of AD, the mean du-

3. B.L. Plassman et al., *Prevalence of Dementia in the United States: The Aging, Demographics, and Memory Study*, 29 *NEUROEPIDEMIOLOGY* 125, 125 (2007).

4. Tom W. Smith & Jaesok Son, *General Social Survey Final Report: Trends in Gun Ownership in the United States, 1972-2014*, 1 (Mar. 2014), www.norc.org/PDFs/GSS%20Reports/GSS_Trends%20Gun%20Ownership_US_1972-2014.pdf.

5. Jason K. Hsieh et al., *Firearms Among Cognitively Impaired Persons: A Cross-sectional Study*, 163 *ANN. INTERNAL MED.* 485, 486 tbl.1 (2015).

6. Karen B. Spangenberg et al., *Firearm Presence in Households of Patients with Alzheimer's Disease and Related Dementias*, 47 *J. AM. GERIATRIC SOC'Y.* 1183, 1884 (1999).

7. AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-5)* 591, 602.

8. *Id.* at 605.

9. *Id.* at 603-04.

10. *Id.* at 612.

11. See Fleur Delva et al., *Natural History of Functional Decline in Alzheimer's Disease: A Systematic Review*, 40 *J. ALZHEIMER'S DISEASE* 57, 66 (2014) ("Relatively little data are available to help physicians in clinical practice to estimate the functional evolution of AD."); Michelle Lee & Joshua Chodosh, *Dementia and Life Expectancy: What Do We Know?*, 10 *JAMDA* 466, 469 (2009) ("Based on available evidence, dementia prognostication remains a challenge and accuracy may remain an elusive goal.").

12. *DSM-5*, *supra* note 7, at 612-13.

13. *Id.* at 611.

ration of the mild phase was 5.6 years, of the moderate phase 3.5 years, and of the severe phase 3.2 years.¹⁴

Cognitive decline is one reason to be concerned about people with dementia having access to firearms. A second reason is the psychotic symptoms that are often associated with dementia.¹⁵ A third, and sometimes related, reason is behavioral disturbances like aggression.¹⁶

On the other hand, there is a constitutional right to keep and bear arms,¹⁷ which many people want strongly to exercise. Consider the following situation:

She is a ninety-year-old widow with mild Alzheimer's disease, and her son is begging her, for safety's sake, to give up something she considers essential to her independence and sense of control.

"You can't take it away from me," she told him recently. "It's all I've got."

This may sound like a classic confrontation with an elderly mother who won't give up her car. But it's in fact about a loaded .38-caliber handgun that she keeps wrapped in a scarf in her top dresser drawer in a Southern California retirement community.¹⁸

And, in fact, someone in the mild phase of dementia may be perfectly safe with a gun even if she can no longer balance her checkbook.¹⁹

In light of this, it might be surprising to learn that Texas has some of the strongest restrictions on gun possession by people with dementia.²⁰ Less surprising are the tight restrictions in Hawaii, which generally has the most restrictive gun laws in the country.²¹ As the

14. Ee Heok Kua et al., *The Natural History of Dementia*, 14 *PSYCHOGERIATRICS* 196, 199 (2014).

15. Medhat M. Bassiony & Constantine G. Lyketsos, *Delusions and Hallucinations in Alzheimer's Disease: Review of the Brain Decade*, 44 *PSYCHOSOMATICS* 388 (2003) ("The prevalence of delusions in Alzheimer's disease patients ranged from 16% to 70% (median=36.5%) in the reviewed reports, and the prevalence of hallucinations ranged from 4% to 76% (median=23%).").

16. See Fredrick E. Vars, *Symptom-Based Gun Control*, 46 *CONN. L. REV.* 1633, 1640 (2014) ("Delusions appear to correlate with violence.") [hereinafter Vars, *Symptom*]. For further discussion of dementia and aggression, see *infra* 32.

17. U.S. CONST. amend. II; *D. C. v. Heller*, 554 U.S. 570, 592 (2008).

18. Dale Russakoff, *Guns in Frail Hands*, *N.Y. TIMES* (July 14, 2010), https://newoldage.blogs.nytimes.com/2010/07/14/guns-in-frail-hands/?_r=0.

19. See Carol B. Bursack, *Armed and Aging: Should Seniors be Allowed to Keep Guns?*, *AGING CARE*, <https://www.agingcare.com/articles/should-seniors-be-allowed-to-keep-guns-169994.htm> (last visited Mar. 28, 2017).

20. *Possession of Firearms by People with Mental Illness*, NAT'L CONF. OF STATE LEGISLATURES (Jan. 13, 2013), <http://www.ncsl.org/research/civil-and-criminal-justice/possession-of-a-firearm-by-the-mentally-ill.aspx>.

21. *Id.*

U.S. population ages, this problem will grow, and more states will decide how best to strike the balance between safety and liberty.

This article considers a range of responses to the combination of dementia and firearms, starting with a prohibition on gun possession triggered by a dementia diagnosis and closing with purely voluntary self-restriction. Only the most stringent restriction—mandatory diagnosis-based possession prohibition—is likely to violate the U.S. Constitution. Even an outright ban on purchase only for anyone diagnosed with dementia might survive. The constitutionality of more targeted intermediate approaches—that ban both purchase and possession—is a serious question. And it is difficult to even articulate an argument against voluntary self-restriction.

I. Diagnosis-Based Restrictions

At least two states currently prohibit gun possession by individuals diagnosed with dementia.²² Neither prohibition has been subjected to constitutional challenge. The outcome of such a challenge is uncertain,

A. The Texas Statute

Specifically, Texas law states that a person is eligible for a license to carry a handgun if the person “is not incapable of exercising sound judgment with respect to the proper use and storage of a handgun.”²³ A person is incapable if she “has been diagnosed by a licensed physician as suffering from a psychiatric disorder or condition that causes or is likely to cause substantial impairment in judgment, mood, perception, impulse control, or intellectual ability.”²⁴ A present diagnosis of “chronic dementia” constitutes “evidence that a person has a psychiatric disorder or condition.”²⁵ This provision was added to Texas law in 1999.²⁶ I have uncovered no study of the provision’s efficacy.

22. TEX. GOV'T CODE ANN. § 411.172(e)(5)(C); HAW. REV. STAT. ANN. § 134-7(c)(3).

23. TEX. GOV'T CODE ANN. § 411.172(a)(7).

24. *Id.* at § 411.172(d)(1).

25. *Id.* at § 411.172(e)(5)(C).

26. *Id.*

B. The Hawaii Statute

Hawaii bars firearm possession by anyone who “[i]s or has been diagnosed as having a significant behavioral, emotional, or mental disorders as defined by the most current diagnostic manual of the American Psychiatric Association or for treatment for organic brain syndromes.”²⁷ DSM-5 is the most current diagnostic manual and dementia is included as a “major neurocognitive disorder.”²⁸ This prohibition went into effect as part of a bundle of more restrictive gun laws in 1981.²⁹ At least one study has found a corresponding reduction in homicide rates in the 1980s.³⁰

C. Constitutionality

The Supreme Court announced an individual right to bear arms in *District of Columbia v. Heller*,³¹ but has offered little guidance as to the content and boundaries of that right. Lower courts have adopted a two-part test: (1) “whether the challenged law burdens conduct protected by the Second Amendment”³² and, if so, (2) “whether the regulation substantially burdens individual rights and how close the regulation comes to burdening the core of the Second Amendment.”³³ The first part is a threshold: if a regulation does not burden conduct protected by the Second Amendment, it obviously does not violate that Amendment.³⁴ The second part of the analysis determines the level of scrutiny: substantial burdens close to the core of the Second Amendment must pass strict scrutiny; other burdens must meet intermediate scrutiny.³⁵

27. HAW. REV. STAT. ANN. § 134-7(c)(3).

28. AM. PSYCHIATRIC ASS'N, HIGHLIGHTS OF CHANGES FROM DSM-IV-TR TO DSM-5, at 16-17 (2009).

29. See generally Joseph A. Peters et al., *Gun Crime and Gun Control: The Hawaiian Experience*, U. CHI. LEGAL F. 55, 74 (2005).

30. *Id.* (“The change in homicide rates in Hawaii during the 1980s, relative to other states that had similar homicide patterns during the 1970s, coincides with Hawaii’s implementation (in 1981) of a stricter set of regulations governing firearm permits and sales.”).

31. See generally *D.C. v. Heller*, 554 U.S. 570 (2008).

32. Angela Selvaggio & Fredrick E. Vars, “*Bind Me More Tightly Still*”: *Voluntary Restraint Against Gun Suicide*, 53 HARV. J. ON LEGIS. 671, 676 (2016) (quoting *United States v. Chovan*, 735 F.3d 1127, 1136 (9th Cir. 2013)).

33. *Id.* at 679.

34. See *id.*

35. *Peruta v. City of San Diego*, 742 F.3d 1144, 1167 (9th Cir. 2014); Fredrick E. Vars, *Self-Defense Against Gun Suicide*, 56 B.C. L. REV. 1465, 1491 (2015) (questioning whether strict scrutiny is consistent with *Heller*).

There is an argument that a dementia gun ban falls outside the scope of the Second Amendment. The Court in *Heller* stated that its opinion recognizing an individual's right to bear arms did not call into question the longstanding prohibition on gun possession by the mentally ill.³⁶ Dementia is a mental illness. On the other hand, as discussed below, the "longstanding prohibition" referenced in *Heller* is triggered by more than just a diagnosis. There is no longstanding gun prohibition on dementia patients.³⁷ So while one court of appeals has suggested that simply targeting a high-risk population avoids Second Amendment scrutiny,³⁸ it seems much more likely that a ban on gun possession by people with dementia will be deemed to implicate the right to bear arms.³⁹

The question then becomes level of scrutiny. The key determinants again are the substantiality of the burden and its proximity to the core of the Second Amendment.⁴⁰ The "core" is the "right of law-abiding, responsible citizens to use arms in defense of hearth and home."⁴¹ A total prohibition on gun possession prevents the defensive use of firearms completely, both inside and outside the home.⁴² That is the argument for strict scrutiny. The counter-argument is that an individual with a diagnosis of dementia is not the kind of "law-abiding, responsible citizen" the Second Amendment was intended to protect.⁴³ That assertion, like the analysis under either level of scrutiny, turns on the association of dementia and violence, suicide, and gun accidents.⁴⁴ Intermediate scrutiny and strict scrutiny both focus on the strength of the government's justification for a particular gun restriction.⁴⁵

36. *Heller*, 554 U.S. at 626–27.

37. *Id.* at 675.

38. *United States v. Seay*, 620 F.3d 919, 925 (8th Cir. 2010).

39. *Heller v. D.C.*, 670 F.3d 1244, 1255 (D.C. Cir. 2011); *United States v. Reese*, 627 F.3d 792, 801 (10th Cir. 2010).

40. *Id.*

41. *Heller*, 554 U.S. at 634.

42. *Id.* at 635.

43. *See id.* at 628–29.

44. Fredrick E. Vars & Amanda Adcock Young, *Do the Mentally Ill Have a Right to Bear Arms?*, 48 WAKE FOREST L. REV. 1, 23–24 (2013) (arguing that preventing suicide is as compelling a government interest as preventing homicide); Cameron Desmond, *From Cities to Schoolyards: The Implications of an Individual Right To Bear Arms on the Constitutionality of Gun-Free Zones*, 39 MCGEORGE L. REV. 1043, 1060 (2008) ("Certainly, public safety--preventing murder, suicide, and gun-related accidents--is a compelling government interest.").

45. *See Heller*, 554 U.S. 570.

Dementia is associated with violence.⁴⁶ One long-term study (ten years) found that up to ninety-six percent of patients with dementia showed aggressive behavior over the course of their illness.⁴⁷ “Aggression was found to be positively associated with a diagnosis of dementia.”⁴⁸ Rates of aggression are significantly higher for dementia patients: one study of community dwelling elders where aggression occurred in twenty-four percent of dementia patients, but in only three percent of participants without dementia.⁴⁹ And while homicide by the elderly is rare, an association with dementia has been reported.⁵⁰

People with dementia may be at elevated risk of suicide.⁵¹ The first nationwide study of the question, from Denmark, found that dementia patients between fifty and sixty-nine years of age with hospital presentations of dementia were over eight times more likely to commit suicide, and those seventy and older three times.⁵² But the picture is far from clear. A subsequent review article concluded that: “Overall, the risk of suicide in dementia appears to be the same or less than that of the age-matched general population but is increased soon after diagnosis, in patients diagnosed with dementia during hospitalization and in Huntington’s disease.”⁵³ In short, some identifiable sub-groups of patients with dementia are at higher risk for suicide, but apparently not enough to drive up the overall rate.⁵⁴

46. Marshall B. Kapp, *The Physician’s Responsibility Concerning Firearms and Older Patients*, 25-SPG KAN. J.L. & PUB. POL’Y 159, 164 (2016) (“The correlation between dementia and firearm violence and injury has been documented.”).

47. See generally Gabriele Cipriani et al., *Violent and Criminal Manifestations in Dementia Patients*, 16 GERIATRICS & GERONTOLOGY INT’L 541 (2016).

48. Pat Gibbons et al., *A Study of Aggression Among Referrals to a Community-Based Psychiatry of Old Age Service*, 12 INT’L J. GERIATR. PSYCHIATRY 384, 384 (1997).

49. See Tracy Wharton & Bryan K. Ford, *What Is Known About Dementia Care Recipient Violence & Aggression Against Caregivers?*, 57 J. GERONTOLOGICAL SOC’Y. WORK 460, 464-65 (2014).

50. Cipriani et al., *supra* note 47, at 544-45; Stéphane Richard-Devantoy et al., *Homicide and Dementia in Older Adults: The Key Role of Dysexecutive Function*, 71 J. CLINICAL PSYCHIATRY 1402, 1402 (2010). See also Edith Greene et al., *Granny, (Don’t) Get Your Gun: Competency Issues in Gun Ownership by Older Adults*, 25 BEHAV. SCI. & L. 405, 411 (2007) (“more serious aggressive and violent acts, including self-harm and homicide, are not uncommon”).

51. Annette Erlangsen et al., *Hospital-Diagnosed Dementia and Suicide: A Longitudinal Study Using Prospective, Nationwide Register Data*, 16 AM. J. GERIATR. PSYCHIATRY 220, 220 (2008).

52. *Id.*

53. Camilla Haw et al., *Dementia and Suicidal Behavior: a Review of the Literature*, 21 INT’L PSYCHOGERIATR. 440, 440 (2009).

54. I found no studies on rates of gun accidents by dementia patients.

Do these findings mean people with dementia are not “law-abiding, responsible citizens?” Do these findings mean that a dementia gun ban is substantially related to an important government interest (as required by intermediate scrutiny)?⁵⁵ Do these findings mean that such a ban is narrowly tailored to a compelling government interest (strict scrutiny)?⁵⁶ These are difficult questions.

A diagnosis of dementia, unlike a criminal conviction,⁵⁷ does not by itself mean the individual is no longer “law-abiding.” However, a legislature could reasonably conclude that dementia patients, like eighteen- to twenty-year-olds, “tend to be relatively irresponsible.”⁵⁸

This quoted language comes from a Fifth Circuit opinion rejecting a Second Amendment challenge to a federal statute prohibiting handguns sales to persons under the age of twenty-one.⁵⁹ The court applied intermediate rather than strict scrutiny in part because Congress could reasonably believe that juveniles were less responsible than adults.⁶⁰ The Fifth Circuit also justified selecting intermediate scrutiny because the age-based prohibition was temporary.⁶¹ People are not cured of dementia, so a ban on them would not be temporary. But because dementia is progressive and all patients eventually lose the ability to use firearms responsibly, any overreach would arguably be temporary. Recall that the mild phase of dementia lasts only 5.6 years on average.⁶² Still, it must be conceded that the court had another justification: sale to young people was prohibited, but not possession, so the burden on the core of the Second Amendment was less substantial.⁶³ Parents could lawfully provide handguns to their children for their defensive use.⁶⁴

This discussion suggests that the government has an option: either ban purchase and possession by people with dementia (as does

55. *Kachalsky v. Cty of Westchester*, 701 F.3d 81, 96 (2d Cir. 2012).

56. *Kolbe v. Hogan*, 813 F.3d 160, 179 (4th Cir. 2016).

57. *United States v. Moore*, 666 F.3d 313, 319 (4th Cir. 2012).

58. *Nat’l Rifle Ass’n of Am., Inc. v. Bureau of Alcohol, Tobacco, Firearms, & Explosives*, 700 F.3d 185, 206 (5th Cir. 2012).

59. *Id.* at 211-12.

60. *Id.* at 205.

61. *Id.* at 207.

62. *Kua et al.*, *supra* note 14, at 196.

63. *NRA v. ATF*, 700 F.3d at 206 (“...these laws do not strike the core of the Second Amendment because they do not prevent 18-to-20-year-olds from possessing and using handguns ‘in defense of hearth and home.’”).

64. *Id.* at 207.

Hawaii and Texas), or ban just purchase.⁶⁵ The latter, purchase-only, restriction might be subject to intermediate scrutiny just like the eighteen- to twenty-year old purchase ban. On the other hand, the course of an individual's dementia is uncertain and it will likely be longer than three years before a mild case becomes moderate.⁶⁶ There is, therefore, a good chance that strict scrutiny would apply.

There is an even stronger chance that the first option—permanently banning both purchase and possession, including within the home—would be subject to strict scrutiny. The choice matters for both proposals because the evidence of increased risk is weighty but not overwhelming. The studies finding increased aggression and suicide rates would very likely satisfy intermediate scrutiny. Even when applying intermediate scrutiny to gun laws, “[i]t is the legislature’s job, not [the court’s], to weigh conflicting evidence and make policy judgments.”⁶⁷ On the other hand, the evidence of heightened risk could well be insufficient to meet strict scrutiny. In sum, a purchase-only ban would likely stand, but a purchase and possession ban would likely fall.

II. Narrower Approaches

A. Diagnosis-Triggered Firearm Safety Testing

There is a narrower way to use a dementia diagnosis: not to prohibit gun possession, but rather as a trigger for mandatory gun safety testing. A doctor who diagnoses dementia (or perhaps only moderate or severe cases) would be required to report that information to a state licensing authority. If a person with dementia wanted to keep their firearms, they would have a short period of time to undergo an evaluation of their ability to safely store and use a firearm. The failure to pass such a test would lead to a loss of gun rights. A person who passes would be subject to periodic retesting.

65. Another option would be to ban purchase and possession by individuals only in the moderate or severe stages of dementia. Those in the mild phase would be unaffected. Such an approach would very likely be constitutional.

66. Kua et al., *supra* note 14, at 199.

67. Kachalsky, 701 F.3d at 99; *see also* Jason T. Anderson, *Second Amendment Standards of Review: What the Supreme Court Left Unanswered in District of Columbia v. Heller*, 82 S. CAL. L. REV. 547, 592 (2009) (“It could be argued that . . . situations [involving the application of intermediate scrutiny where studies are inconclusive] suggest an appropriate opportunity for judicial deference to the legislative branch(es.)”).

This idea is based on current and proposed approaches to driving. Older drivers have a relatively high rate of driving fatalities.⁶⁸ Because dementia can affect one's ability to drive, California and Pennsylvania require doctors to report a diagnosis of dementia.⁶⁹

One concern with mandatory physician reporting is that patients who want to keep firearms will become reluctant to seek needed medical care or to disclose symptoms that might call into question cognitive capacity.⁷⁰ This is a legitimate concern, but would need to be weighed against the risk of gun misuse. A second drawback of this approach is expense. Every state already conducts driving tests, so the burden of additional testing there is merely incremental. Most states do not require handgun or firearm licenses, and very few mandate specific training.⁷¹ Testing for firearm safety skills would therefore necessitate significant costs.

On the other hand, if the test was well designed and an appeal process was available, this approach would be almost perfectly targeted to disqualify only those who are unable to responsibly possess a firearm. Its constitutionality is almost beyond question.

B. Current Federal Law

Federal statute prohibits gun possession by anyone "who has been adjudicated as a mental defective or who has been committed to a mental institution."⁷² A mere diagnosis of dementia is obviously insufficient to fall within either category, but it can be relevant to both.

Federal regulation defines "a mental defective" to be a person who as a result of "mental illness, incompetency, condition, or disease" is either a danger to himself or others or lacks the mental capacity to manage his own affairs.⁷³ Many people with moderate or severe dementia may meet that standard, but only those who have been determined to do so by "a court, board, commission, or other lawful authority" (*i.e.*, "adjudicated") will be disqualified from gun possession.⁷⁴

68. Older Drivers, INS. INFO. INST., 2002, at 1 WL 1049001.

69. *Id.* at 5; Maureen Cleary, *Driving with Dementia: the Necessity of a Comprehensive Reporting Scheme*, 24 ELDER L. J. 151, 158 (2016).

70. Cleary, *supra* note 69, at 166.

71. 18 U.S.C. § 922(g)(4) (2012).

72. *Id.*

73. 27 C.F.R. § 478.11 (2014).

74. *Id.*

Thus, having executed a power of attorney is not disqualifying, but being subject to guardianship is.⁷⁵

Commitment to a mental institution is merely one variety of mental-defect adjudication. “Civil commitment statutes differ by state, but all states require the following two criteria for commitment: (1) the respondent must have a mental illness and (2) the respondent must be a danger to self or others as a result of that mental illness.”⁷⁶ Mental illness is one type of mental defect, and, in most states, dementia qualifies as a mental illness for purposes of civil commitment.⁷⁷ The dangerousness prong for civil commitment can also convert a mental illness into a sufficiently serious mental defect to justify gun disqualification.⁷⁸

Courts have pretty consistently upheld the federal mental health provisions.⁷⁹ This should not be surprising given the aforementioned dicta from *Heller*: “nothing in our opinion should be taken to cast doubt on longstanding prohibitions on the possession of firearms by . . . the mentally ill.”⁸⁰ Some courts rely on the *Heller* dicta with no further analysis.⁸¹ Other courts have reached the same conclusion ap-

75. *Petramala v. U.S. Dept. of Justice*, No. CV 10–2002–PHX–FJM, 2011 WL 3880826, at *2 (D. Ariz. Sept. 2, 2011), *aff’d*, 481 Fed. Appx. 395 (9th Cir. 2012). The Obama administration has proposed an expansion of the “mentally defective” prohibitor for certain individuals receiving government benefits on the basis of mental disabilities. SOCIAL SECURITY ADMINISTRATION, 20 C.F.R. Part 421, Docket No. SSA-2016-0011, Implementation of the NICS Improvement Amendments Act of 2007, <https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10424.pdf>.

76. Stephanie A. Evans & Karen L. Salekin, *Involuntary Civil Commitment: Communicating with the Court Regarding “Danger To Other,”* 38 L. & HUM. BEHAV. 325, 325 (2014).

77. “Alzheimer’s disease is not only the most common disease affecting the mental state of older people, it is the most common justification for the initial civil commitment of older people who had never previously suffered from a mental disorder.” Arlene S. Kanter, *Abandoned But Not Forgotten: The Illegal Confinement of Elderly People in State Psychiatric Institutions*, 19 N.Y.U. REV. L. & SOC’Y. CHANGE 273, 280 (1991/1992). *But see* *In re Helen E.F.*, 814 N.W.2d 179 (Wis. 2012). For an argument in favor of allowing short-term civil commitment of individuals with dementia, see Caroline N. Harada & Fredrick E. Vars, *Last Resort of Individuals with Dementia Threatened*, 60 J. AM. GERIATRIC SOC’Y. 2185 (2012).

78. Harada, *supra* note 77.

79. *Petramala*, 2011 WL 3880826, at *2 (Other courts have reached the same conclusion applying heightened scrutiny); *United States v. Johnson*, No. CR15–3035–MWB, 2016 WL 212366 (N.D. Iowa Jan. 19, 2016) (magistrate), *aff’d*, 2016 WL 614727 (N.D. Iowa Feb. 16, 2016). The outlier is *Tyler v. Hillsdale County Sheriff’s Dept.*, 775 F.3d 308 (6th Cir. 2014), which was limited to the commitment prong and which has been vacated pending rehearing en banc.

80. *Heller*, 554 U.S. at 626.

81. *E.g.*, *Petramala*, 2011 WL 3880826, at *2; *United States v. McRobie*, No. 08–4632, 2009 WL 82715, at *1 (4th Cir. Jan. 14, 2009) (per curiam); *United States v.*

plying heightened scrutiny.⁸² A possible outlier is the recent Sixth Circuit decision in *Tyler v. Hillsdale County Sheriff's Department*.⁸³ That opinion purports to affirm only an as-applied challenge to the commitment prong under intermediate scrutiny, but did so in terms that arguably reach more broadly.⁸⁴

Federal law impacts only a tiny fraction of people with dementia.⁸⁵ Data on adult guardianship is spotty, but one best estimate is 1.5 million active cases nationally.⁸⁶ One study of guardianships and conservatorships in Kansas showed that nearly sixty percent were based on developmental disabilities, whereas only sixteen percent were premised on an "aging related disability."⁸⁷ In contrast, there are estimated to be at least five million people with age-related dementia in the United States.⁸⁸ Plainly, the vast majority of people with dementia are not under guardianship.⁸⁹ Recent civil commitment numbers are hard to find. In 1980, there were 306,468.⁹⁰ Commitments based on dementia alone likely constitute a small fraction.⁹¹

Murphy, 681 F. Supp. 2d 95, 103 (D. Me. 2010); *United States v. Roy*, 742 F. Supp. 2d 150, 152 (D. Me. 2010).

82. See Johnson, 2016 WL 212366. See also Fredrick E. Vars & Amanda Adcock Young, *Do the Mentally Ill Have a Right To Bear Arms?*, 48 WAKE FOREST L. REV. 1, 17, 22 (2013) (predicting that "most courts would likely conclude that the federal restriction is substantially related to the important government interest[s] in curbing gun violence" and gun suicide).

83. *Tyler v. Hillsdale Country Sheriff's Dept.*, 837 F.3d 678 (6th Cir. 2014) (en banc).

84. *Tyler*, 837 F.3d at 686. For this point and a more general critique of the majority opinion's reasoning in *Tyler*, see Fredrick E. Vars, *The Sixth Circuit Moves the Second Amendment Target*, 68 ALA. L. REV. ONLINE 1 (2016).

85. See Greene, *supra* note 50, at 408 ("[T]he vast majority of cognitively and functionally impaired persons (including those with dementia) do not receive a formal adjudication attesting to this fact, nor have they been committed to a mental institution.").

86. Brenda K. Uekert & Richard Van Duizend, *Adult Guardianships: A "Best Guess" National Estimate and the Momentum for Reform*, FUTURE TRENDS IN STATE COURTS 2011 107, 109, (Carol R. Flango, Amy M. McDowell, Charles F. Campbell, & Neal B. Kauder, eds. 2011).

87. Colleen Colton et al., *Volunteer Guardians: Possible, Practical and Professional*, Reaching New Heights in Law and Aging Partnerships 2004 Joint Conf. (Nov. 11-14, 2004).

88. FAQ INSTITUTE FOR DEMENTIA RESEARCH & PREVENTION, <http://idrp.pbr.edu/faq.htm> (last visited Mar. 28, 2017).

89. *Id.*; Colton, *supra* note 87.

90. John Monahan & Saleem Shah, *Dangerousness and Commitment of the Mentally Disordered in the United States*, 15 SCHIZOPHRENIA BULL. 541, 549 (1990).

91. Commitments for schizophrenia and bipolar disorder, for example, are probably much more common. In Belgium in 1998, only 2.2% of civil commitments involved dementia. Hans Joachim Salize & Harald Dressing, *Epidemiology of Involuntary Placement of Mentally Ill People Across the European Union*, 184 BRIT. J. PSYCHIATRY 163, 167 (2004).

C. Relaxing the Mental Illness Requirement

Under Indiana law, a police officer may seize firearms from an individual if the police officer believes that person is “dangerous.”⁹² If a search warrant is required to effect the seizure, the police officer can obtain one by showing probable cause exists to believe that the individual is “dangerous” and in possession of a firearm.⁹³ This might appear to eliminate the mental illness requirement completely, but, unless the danger is imminent, “dangerousness” requires either “a mental illness that may be controlled by medication” or “a propensity for violent or emotionally unstable conduct.”⁹⁴ Because dementia cannot be “controlled” by medication,⁹⁵ a history of violent or unstable conduct would almost certainly be required for someone with dementia to lose their firearms under this regime.

California has an analogous regime that authorizes a “temporary emergency gun violence restraining order” for individuals who present “an immediate and present danger of causing personal injury” with a firearm.⁹⁶ A one-year restraining order requires a “significant” rather than “immediate” danger.⁹⁷ No mental illness is required in California either for short-term or longer-term gun confiscation.⁹⁸

I have proposed an alternative approach that would revoke gun rights not because a person seems “dangerous” based on past behavior, but because the person is experiencing symptoms that make gun ownership dangerous.⁹⁹ Whatever they may have done or not

92. IND. CODE ANN. § 35-47-14-3(a) (West 2016).

93. *Id.* at § 35-47-14-2(1)(A).

94. *Id.* at § 35-47-14-1(2)(A).

95. Dementia medications appear to delay slightly the progression of the disease, but do so with potentially significant side effects. William James Deardorff et al., *The Use of Cholinesterase Inhibitors Across All Stages of Alzheimer’s Disease*, 32 DRUGS & AGING 537, 537 (2015). The behavioral and psychological symptoms of dementia are arguably the most relevant to firearm safety and for them there are no approved medications. See H. Karl Greenblatt & David J. Greenblatt, *Use of Antipsychotics for the Treatment of Behavioral Symptoms of Dementia*, J. CLINICAL PHARMACOLOGY 1048, 1048 (2016) (“There are currently no FDA-approved treatments specifically for behavioral and psychological symptoms of dementia.”); see also Rajesh R. Tampi & Deena J. Tampi, *Efficacy and Tolerability of Benzodiazepines for the Treatment of Behavioral and Psychological Symptoms of Dementia: A Systematic Review of Randomized Controlled Trials*, 29 AM. J. ALZHEIMER’S DISEASE & OTHER DEMENTIAS 565, 565 (2014) (“Available data, although limited, does not support the routine use of benzodiazepines for the treatment of [behavioral and psychological symptoms of dementia].”).

96. CAL. PENAL CODE § 18125 (2016).

97. *Id.* at § 18175(b)(1).

98. *Id.* at §§ 18125, 18175.

99. Vars, *Symptom*, *supra* note 16, at 1638-1642.

done in the past, people suffering from delusions or hallucinations should not have access to firearms. There are three main advantages of this symptom-based approach: (1) it would permit gun seizure before, rather than after, dangerous symptoms produce injury; (2) because the presence of psychotic symptoms is more objective than predictions of dangerousness based on propensities, police discretion and potential abuse would be narrower than in Indiana; and, related, (3) police could therefore be trusted to make these judgments rather than waiting for a court order, as in California.¹⁰⁰

These advantages may be particularly important in the context of dementia. In one study of fourteen elderly psychiatric patients who attempted or committed homicide, ten had a diagnosis of dementia, eight of the attacks were precipitated by delusions, but only two patients had a history of violence.¹⁰¹ An individual suffering from delusions without prior violence may not seem "dangerous" and therefore may not lose gun rights in Indiana or California, but would under my proposal. One example of a patient from the study illustrates: a seventy-eight-year-old man with Alzheimer's tried to strangle his wife because he had a delusion that she was having an affair.¹⁰² The marriage had not previously been violent.¹⁰³

The Indiana and California statutes are likely constitutional.¹⁰⁴ Indeed, the Indiana regime has already survived a state constitutional challenge.¹⁰⁵ And at least one commentator has argued that the California regime passes federal constitutional muster.¹⁰⁶ The common denominator is that, by expressly targeting dangerous individuals, these measures are narrowly tailored to the state's compelling interest in reducing gun fatalities and injuries.¹⁰⁷ Connecticut has a similar statute

100. To be sure, court approval may be quite expeditious by, say, having a judge rule over the phone.

101. Stephen B. Ticehurst et al., *Homicidal Behaviour in Elderly Patients Admitted to a Psychiatric Hospital*, 3 *DEMENTIA* 86, 89-90 (1992).

102. *Id.* at 88 (Case 10).

103. *Id.*

104. *Redington v. State*, 992 N.E.2d 823, 845 (Ind. Ct. App. 2013).

105. *Id.*

106. Lauren Paglini, *How Far Will the Strictest State Push the Limits: The Constitutionality of California's Proposed Gun Law under the Second Amendment*, 23 *AM. U. J. GENDER SOC'Y. POL'Y & L.* 459 (2015).

107. *Redington*, 992 N.E.2d at 834 ("The Act seeks to keep firearms from individuals it deems 'dangerous' if and when they present a risk of personal injury to either themselves or other individuals."); Paglini, *supra* note 106, at 482 ("The bill narrowly aims at seizing firearms from only those who are proven as a significant threat to themselves or others.")

and enough experience applying it to evaluate how well it is tailored.¹⁰⁸ One study estimates “approximately [one] averted suicide for every [ten] to [eleven] gun seizure cases.”¹⁰⁹ That is a very good fit, certainly much closer than existing federal law.¹¹⁰

My proposal is arguably less narrowly tailored. I have elsewhere defended its constitutionality on the ground that it is targeted to symptoms that are demonstrably dangerous and imposes only a temporary burden.¹¹¹ In addition, I have argued that this proposed limitation on gun rights is perfectly consistent with the Second Amendment’s core purpose of self-defense.¹¹² A valid self-defense claim requires objective reasonableness, which a delusional or hallucinating individual is incapable of exercising.¹¹³ The progressive and incurable nature of dementia strengthens the case for constitutionality.¹¹⁴ Some demented individuals with delusions may be harmless today, but they will eventually lose the ability to use firearms responsibly.¹¹⁵ As argued above, any erroneous deprivation will therefore be only temporary.

III. Voluntary Restriction

The right to bear arms is waivable, so voluntary self-restriction presents no serious constitutional concerns.¹¹⁶ This is already taking place, with doctors counseling dementia patients and families to restrict firearm access.¹¹⁷ Even so, many people with dementia have access to firearms: as noted above, one study found that sixty percent of households with a demented family member had firearms.¹¹⁸ But even

108. Jeffrey W. Swanson et al., *Implementation and Effectiveness of Connecticut’s Risk-Based Gun Removal Law: Does It Prevent Suicides?*, L. & CONTEMP. PROBS. 1, 23 (forthcoming).

109. *Id.*

110. Fredrick E. Vars & Amanda Adcock Young, *Do the Mentally Ill Have a Right To Bear Arms?*, 48 WAKE FOREST L. REV. 1, 22 (2013) (providing a very rough estimate that “the federal restriction denies gun rights to about 450 former patients who would not use a firearm to commit suicide for every gun suicide it prevents”).

111. Vars, *Symptom*, *supra* note 16, at 1643.

112. *Id.* at 1643-45.

113. *Id.* at 1634.

114. *Id.*

115. See Kua et al., *supra* note 14, at 197.

116. Fredrick E. Vars, *Self-Defense Against Gun Suicide*, 56 B.C.L. REV. 1465, 1494-97 (2015).

117. Mario F. Mendez, *Dementia and Guns*, 44 J. AM. GERIATRICS SOC’Y 409, 409-10 (1996).

118. Spangenberg, *supra* note 6 (another study found a much lower percentage (17%), but with a self-selected sample); Hsieh, *supra* note 5, at 486 tbl.1.

if that number were zero, there would be a gaping loophole: in the vast majority of states, someone with dementia can legally purchase a gun.¹¹⁹

This loophole can have tragic consequences. In 2005, a sixty-five-year-old Oklahoma man walked into the Hominy Diner during the lunch rush and fatally shot a young waitress three times: once in the mouth and twice in the back.¹²⁰ He had purchased the 9 mm handgun earlier that same day.¹²¹ A few years before that, the man had won a citizen-of-the-year in the town for his volunteer work.¹²² At the time of the crime, he suffered from dementia.¹²³

Individuals ought to be able to close this loophole themselves, by waiving their right to purchase a firearm.¹²⁴ Specifically, either in hard-copy or through a secure website, people diagnosed with dementia should be able to opt to have their names added to the federal background check system, thereby preventing future gun purchases from licensed dealers. This option could prevent homicides, like the one in Oklahoma, but also suicides and gun accidents.

I have elsewhere established that many people overall would self-restrict gun purchases in this way, with especially high sign-up rates among the mentally ill.¹²⁵ In one study, forty-six percent of two hundred people seeking psychiatric care said they would give up their ability to immediately purchase a gun.¹²⁶ This option should be particularly appealing for someone diagnosed with dementia. With dementia, cognitive decline to a mental state unsafe for gun possession will eventually occur in every patient who lives long enough.¹²⁷ So while a person with depression may never become suicidal, a person with dementia at some point will not understand the risks of gun

119. See generally Greene, *supra* note 50.

120. Sheila Stogsdill, *Man gets Life Sentence for Shooting in Diner*, NEWSOK (July 18, 2007), <http://newsok.com/article/3085584>.

121. *Id.*

122. *Id.*

123. *Id.*

124. Fredrick E. Vars, *The Sixth Circuit Moves the Second Amendment Target*, 68 ALA. L. REV. ONLINE 1 (2016).

125. Fredrick E. Vars et al., *Willingness of Mentally Ill Individuals To Sign Up for a Novel Proposal To Prevent Firearm Suicide*, SUICIDE & LIFE-THREATENING BEHAV. (Oct 3, 2016); Ian Ayres & Fredrick E. Vars, *Libertarian Gun Control* 13-15 (2016).

126. Fredrick E. Vars et al., *Willingness of Mentally Ill Individuals to Sign Up for a Novel Proposal to Prevent Firearm Suicide*, SUICIDE LIFE-THREATENING BEHAV. (Oct. 3, 2016).

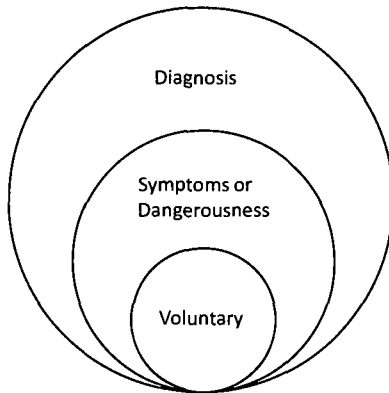
127. DSM-5, *supra* note 7, at 611.

use and abuse. Removing guns from the equation should appeal to many with early stage dementia.

IV. Conclusion

The measures discussed above can be conceptualized as follows, from the narrowest, voluntary approaches to the broadest, diagnosis-based prohibitions.

FIGURE 1



Each circle can be subdivided. The narrowest possible approach is to leave gun access up to individual choice. A slightly broader, still voluntary, approach is to allow individuals to waive their gun purchase rights.

Such voluntary approaches are unobjectionable but will never eliminate all risks. Some people who are no longer safe with firearms insist on keeping them. Just recall the ninety-year-old widow in the introduction.¹²⁸

The current federal approach represents a small expansion outward from purely voluntary measures. It reduces risk, but only for a tiny fraction of people with dementia. The middle circle goes broader, to incorporate dangerousness and symptom-based approaches. Mandatory firearm safety testing triggered by a dementia diagnosis is a funnel with a wider top, but only those who fail an objective test of

128. Russakoff, *supra* note 18.

their gun safety abilities will be deprived of firearms. These reach modestly further and do not raise serious constitutional issues.

On the other hand, a ban on gun purchase and possession by anyone diagnosed with dementia (the outermost circle) may well violate the Second Amendment. Trimming back such a ban to prohibit purchase but not possession could arguably tip the scales in favor of constitutionality.

In sum, legislatures are generally free to address the problem of dementia and guns. How to strike the balance between liberty and safety is particularly challenging in this context. Many older people want to keep their firearms even as they descend further into dementia, but at some point, the risk of harm becomes too great.

V. Recommendations

I recommend that current efforts to persuade those with dementia to voluntarily relinquish their firearms be immediately supplemented with a system to allow such individuals to prevent their own future gun purchases. The cost of this proposal is very low and, because it is voluntary, it does not implicate the Second Amendment.

Similarly, I recommend adding to current federal law new restrictions based on dangerousness and symptoms. Such restrictions are focused narrowly on people with substantially heightened risk of gun misuse.

I am ambivalent about the next step: mandatory doctor-reporting coupled with firearm safety testing. The start-up cost of such a program, plus the potentially negative impact on the doctor-patient relationship, is weighty. On the other hand, a well-designed test could disqualify just the right people.

The diagnosis-based restrictions in Texas and Hawaii strike me as too broad. There are connections between dementia and violence and suicide, but the relationships are not as strong as with civil commitment, for example. Many people with mild dementia can be responsible with firearms.