



## Alabama Law Scholarly Commons

---

Working Papers

Faculty Scholarship

---

2-2-2014

### Symptom-Based Gun Control

Fredrick E. Vars

*University of Alabama - School of Law*, fvars@law.ua.edu

Follow this and additional works at: [https://scholarship.law.ua.edu/fac\\_working\\_papers](https://scholarship.law.ua.edu/fac_working_papers)

---

#### Recommended Citation

Fredrick E. Vars, *Symptom-Based Gun Control*, (2014).

Available at: [https://scholarship.law.ua.edu/fac\\_working\\_papers/721](https://scholarship.law.ua.edu/fac_working_papers/721)

This Working Paper is brought to you for free and open access by the Faculty Scholarship at Alabama Law Scholarly Commons. It has been accepted for inclusion in Working Papers by an authorized administrator of Alabama Law Scholarly Commons.

THE UNIVERSITY OF  
**ALABAMA**  

---

**SCHOOL OF LAW**

**Symptom-Based Gun Control**

Fredrick E. Vars

*Forthcoming*, CONNECTICUT LAW REVIEW (2014)

This paper can be downloaded without charge from the Social  
Science Research Network Electronic Paper Collection:  
<http://ssrn.com/abstract=2384144>

# Symptom-Based Gun Control

Fredrick E. Vars<sup>†</sup>

In the early morning of August 8, 2013, two Newport, Rhode Island police officers responded to a harassment call from a hotel. On arrival they met with Aaron Alexis, who was obviously delusional. The police incident report states that Alexis believes that someone “has sent 3 people to follow him and keep him awake by talking to him and sending vibrations into his body” with, in Alexis’s words, “some sort of microwave machine.” Although Alexis reported not having seen any of them, he was “worried that these individuals are going to harm him.” Less than six weeks later, on September 14, Alexis legally purchased a shotgun in Virginia.<sup>1</sup> He used it two days later to kill 12 people at the Navy Yard in Washington, D.C.<sup>2</sup>

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

---

<sup>†</sup> Associate Professor, University of Alabama School of Law. Thanks to Madelon Baranoski, Caroline Harada, Ron Krotoszynski, Grace Lee, and Mike Norko for helpful comments and references. Thanks also to Carol Montgomery and Penny Gibson for excellent research assistance. The article also benefitted from comments and questions at the University of Connecticut symposium and the AALS annual meeting.

<sup>1</sup> Michael S. Schmidt, *State Law Prevented Sale Of Assault Rifle to Suspect Last Week, Officials Say*, 9/18/13 N.Y. TIMES A15.

<sup>2</sup> This was just the latest in a long string of mass shootings: “The Navy Yard shooting marks the seventh time in the past decade that a gunman has killed 10 or more people in a single incident.” Ashley Halsey III, Peter Hermann, & Clarence Williams, *DC Navy Yard rampage leaves 14 dead; alleged shooter killed, ID'd as Aaron Alexis*, 9/17/13 WASH. POST NEWS SERV.

objectively reasonable fear of harm. Psychotic symptoms obviously undermine objectivity. Furthermore, data suggest that psychotic symptoms are more closely correlated with violence than psychiatric diagnoses. And a symptom-based approach has the potential to prevent gun violence by individuals, like Alexis, who are never diagnosed or treated as mentally ill.

I propose that a police officer or mental health professional who observes an individual suffering from delusions or hallucinations should be empowered to confiscate that person's firearms and to add that person's name to the federal background check system, thus preventing firearm purchases until a successful appeal or restoration proceeding. An individual seeking to regain gun rights would need to submit evidence from a mental health professional, thereby incentivizing rather than penalizing treatment. Part I of this article describes current restrictions on gun purchases. They are generally premised on diagnosis or treatment. They leave gaps that allowed several recent mass shootings and that a symptom-based approach could fill. Part II surveys the literature on psychosis and violence and concludes that the weight of authority and most directly applicable studies find a significant positive relationship. Part III argues that my proposal is constitutional. The legal analysis also suggests another policy rationale for the proposal: a person out of touch with reality cannot be trusted to use a firearm in an objectively reasonable manner. Part IV discusses counter-arguments.

## I. CURRENT RESTRICTIONS ARE BOTH OVER- AND UNDER-INCLUSIVE

There are three basic regimes restricting gun possession by the mentally ill. Federal law sets the floor, barring firearm possession by anyone “adjudicated mentally defective” or involuntarily committed.<sup>3</sup> Although the boundaries of these terms may be unclear, serious mental disorder, insanity, or “marked subnormal intelligence” are prerequisites.<sup>4</sup> And while mental illness for civil commitment purposes is technically a legal, not medical, concept, legislatures and courts largely incorporate the definition of mental health professionals.<sup>5</sup> Thus, the federal bar rests on psychiatric diagnosis.

Some states also bar firearm possession by individuals who have been subject to voluntary commitment.<sup>6</sup> Voluntary commitment may entail a loss of liberty unlike ordinary consensual treatment. For example, a voluntarily admitted patient may not thereafter be permitted to leave at will. State statutes authorizing voluntary admission vary.<sup>7</sup> Some even expressly provide that “symptoms of mental illness,” short of a diagnosis, can suffice.<sup>8</sup> Voluntary commitment no doubt captures many people without a formal diagnosis,<sup>9</sup> but most people with psychotic symptoms are never hospitalized. In 2011, 0.8% of adults in the United States received

---

<sup>3</sup> 18 U.S.C. § 922(d)(4); Jana R. McCreary, “*Mentally Defective*” Language in the Gun Control Act, 45 CONN. L. REV. 813, 843-52 (2013).

<sup>4</sup> McCreary, *supra* note \_\_, at 843.

<sup>5</sup> Sherry F. Colb, *Insane Fear: The Discriminatory Category of “Mentally Ill and Dangerous”*, 25 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 341, 354 (1999).

<sup>6</sup> Fredrick E. Vars & Amanda Adcock Young, *Do the Mentally Ill Have a Right to Bear Arms?*, 48 WAKE FOREST L. REV. 1, 12 (2013).

<sup>7</sup> BRUCE J. WINICK, CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL 178-85 (2005).

<sup>8</sup> *E.g., id.* (citing Del. Code Ann. tit. 17, § 5123(b)).

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

inpatient mental health care.<sup>10</sup> This includes both involuntary and voluntary commitments, along with ordinary consensual treatment. In comparison, 5.1% in one general population survey reported psychotic-like experiences.<sup>11</sup> Some without a diagnosis are voluntarily committed, but many more with severe symptoms are neither diagnosed nor hospitalized.

The third regime is the most restrictive and least common. Like the federal regime, it turns on diagnosis, not symptoms. For example, Hawaii prohibits gun possession by anyone with a “significant” mental illness.<sup>12</sup> If fully enforced, this sweeping restriction could disqualify based on diagnosis and severity roughly 17-20% of the population.<sup>13</sup>

All three current regimes are premised at least in part on the belief that people with mental illness, or suspected mental illness, are dangerous. Findings are mixed, but there does appear to be an elevated risk of violence across many but perhaps not all psychiatric diagnoses.<sup>14</sup> Even the far-reaching Hawaii law is

---

<sup>10</sup> RESULTS FROM THE 2011 NATIONAL SURVEY ON DRUG USE AND HEALTH: MENTAL HEALTH FINDINGS 21 fig.2.8 (2012), at [http://www.samhsa.gov/data/NSDUH/2k11MH\\_FindingsandDetTables/2K11MHFR/NSDUHmhfr2011.pdf](http://www.samhsa.gov/data/NSDUH/2k11MH_FindingsandDetTables/2K11MHFR/NSDUHmhfr2011.pdf) (downloaded Oct. 15, 2013).

<sup>11</sup> Ramin Mojtabai, *Psychotic-Like Experiences and Interpersonal Violence in the General Population*, 41 SOC. PSYCHIATRY & PSYCHIATR. EPIDEMIOL. 183, 184 (2006).

<sup>12</sup> Haw. Rev. Stat. § 134-7.

<sup>13</sup> Ronald C. Kessler et al., *U.S. Prevalence and Treatment of Mental Disorders: 1990-2003*, 352 N. ENG. J. MED. 2515 (2005) (12-month prevalence of any “serious” or “moderate” DSM-IV disorder).

<sup>14</sup> Richard Van Dorn, Jan Volavka, & Norman Johnson, *Mental Disorder and Violence: Is There a Relationship Beyond Substance Abuse?*, 47 SOC. PSYCHIATRY PSYCHIATR. EPIDEMIOL. 487, 490 (2012). Jeffrey W. Swanson et al., *Violence and Psychiatric Disorder in the Community: Evidence from the Epidemiologic Catchment Area Surveys*, 41 HOSP. & COMM. PSYCH. 761 (1990); Bruce G. Link et al., *Real in their Consequences: A Sociological Approach to Understanding the Association Between Psychotic Symptoms and Violence*, 64 AM. SOCIOLOGICAL REV. 316, 330 (1999).

supported by research, although it disqualifies thousands of individuals who would not engage in violence with a firearm.<sup>15</sup>

The narrow federal regime also has empirical support. A leading study found that 11.5% of discharged involuntary commitment patients committed an act of violence in an initial follow-up period, as compared with 4.6% in a community control group.<sup>16</sup> Even this most limited intervention is overbroad in the sense that 88.5% of released inpatients committed no acts of violence. I am aware of no equally powerful study of voluntary commitment, but there are indications that, during hospitalization, voluntary inpatients are less violent than involuntary ones.<sup>17</sup>

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

---

<sup>15</sup> Vars & Young, *supra* note \_\_, at 16-17.

<sup>16</sup> Henry J. Steadman et al., *Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, 55 ARCHIVES GEN. PSYCHIATRY 393, 399 tbl.5. (1998).

<sup>17</sup> Cesare Maria Cornaggia et al., *Aggression in Psychiatry Wards: A Systematic Review*, 189 PSYCHIATRY RES. 10, 17 (2011); Orestes J. Arcuni & Ghazi Asaad, *Voluntary and Involuntary Schizophrenic Patient Admissions on the Same General Hospital Psychiatric Unit*, 11 GEN. HOSP. PSYCHIATRY 393 (1989). *But see* Dale E. McNeil, *Hallucinations and Violence*, in VIOLENCE AND MENTAL DISORDER: DEVELOPMENTS IN RISK ASSESSMENT 183, 190 (John Monahan & Henry J. Steadman, eds. 1994) (“[V]iolent behavior during hospitalization has not been shown to be a good predictor of violence in the community after release.”). *Cf.* JOHN Q. LA FOND & MARY L. DURHAM, *BACK TO THE ASYLUM: THE FUTURE OF MENTAL HEALTH LAW AND POLICY IN THE UNITED STATES* 145 (1992) (suggesting that differences between voluntary and involuntary patients are diminishing); Fredrick E. Vars, *Illusory Consent: When an Incapacitated Patient Agrees to Treatment*, 87 OR. L. REV. 353 (2008) (questioning validity of consent to hospitalization).

an increased risk of violence, so Hawaii's law may be too broad.<sup>18</sup> Second, the high level of violence observed in the control group of the leading study of involuntary patients (mentioned above) suggests that restrictions broader than federal law could prevent much more violence. The same study also noted that the elevated level of violence among patients disappeared when those without substance abuse problems were excluded.<sup>19</sup> This suggests that targeting attributes other than, or in addition to, diagnosis could more efficiently reduce violence.

The most fundamental shortcoming of diagnosis- and treatment-based restrictions is that they require a diagnosis or treatment. Millions of people with mental illness are not diagnosed and do not receive treatment. In 2011, only 38.2% of people with any mental illness and 59.6% of those with serious mental illness received mental health treatment.<sup>20</sup> Even where treatment is available and taken advantage of, it may be too late for a person experiencing his first psychotic episode. Troubled individuals, like Alexis, may interact with law enforcement, and even health care providers, without receiving a diagnosis or treatment.

## II. EMPIRICAL SUPPORT FOR A SYMPTOM-BASED APPROACH

There is room for improvement beyond current diagnosis-based restrictions on gun possession. One possible approach is to focus directly on symptoms rather

---

<sup>18</sup> That is to say, too broad if the only goal is preventing violence. The stronger, and to my mind sufficient, justification for Hawaii's ban is suicide prevention. Vars & Young, *supra* note \_\_, at 19-22.

<sup>19</sup> *But cf.* Van Dorn, Volavka, & Johnson, *supra* note \_\_, at 492 tbl.2 (population-based study reporting 2.39 times greater risk of serious violence for individuals with severe mental illness alone versus 10.01 for those who also had substance use disorder---both effects were statistically significant).

<sup>20</sup> RESULTS FROM THE 2011 NATIONAL SURVEY ON DRUG USE AND HEALTH: MENTAL HEALTH FINDINGS 23 fig.2.9 (2012). [*supra* note \_\_]



than diagnosis. Delusions and hallucinations appear to have been present in a string of recent mass shootings. “Aaron Alexis [Navy Yard], Adam Lanza [Newton, Connecticut], James Holmes [Aurora, Colorado], Jared Lee Loughner [Tucson, Arizona], Seung-Hui Cho [Virginia Tech] . . . , all allegedly suffering from severe mental illness, . . . [e]ach used [legally purchased] guns to address their paranoid delusions. The number of dead from their shootings: 92, the number of wounded, well over 100.”<sup>21</sup> The data suggest that the relationship between delusions and violence is not merely anecdotal.

Delusions appear to correlate with violence. One review reported that 17 of 20 studies found a positive relationship between delusions and violence.<sup>22</sup> A 2006 study using a large dataset representative of the non-institutionalized U.S. population 18-years or older concluded that people with “psychotic-like experiences” were 5.72 times as likely as others to attack someone with an intent to injure.<sup>23</sup> “Psychotic-like experiences” included seven varieties of hallucinations and

---

<sup>21</sup> Victoria A. Brownworth, *Crazy Every Day: America's Mental Illness Epidemic*, 10/7/13 HUFFINGTON POST.

<sup>22</sup> Stål Bjørkly, *Psychotic Symptoms and Violence Toward Others --- A Literature Review of Some Preliminary Finds, Part 1. Delusions*, 7 *AGGRESSION & VIOLENT BEHAV.* 617, 622 (2002). Findings on hallucinations are more evenly mixed. Stål Bjørkly, *Psychotic Symptoms and Violence Toward Others --- A Literature Review of Some Preliminary Finds, Part 2. Hallucinations*, 7 *AGGRESSION & VIOLENT BEHAV.* 605, 610 (2002). Compare, e.g., Dale E. McNeil, Jane P. Eisner, & Renée L. Binder, *The Relationship Between Command Hallucinations and Violence*, 51 *PSYCHIATRIC SERVS.* 1288, 1290 tbl.1 (2000) (finding that patients experiencing command hallucinations were 2.51 times more likely to be violent), with Angela F. Nederlof, Peter Muris, & Johannes E. Hovens, *Threat/Control-Override Symptoms and Emotional Reactions to Positive Symptoms as Correlates of Aggressive Behavior in Psychotic Patients*, 199 *J. NERVOUS & MENTAL DISEASE* 342, 346 (2011) (finding that threat but not control-override symptoms made a significant contribution to aggressive behavior).

<sup>23</sup> Mojtabai, *supra* note \_\_, at 185. The 5.72 figure reported above is higher than the median odds ratio of 2.31 reported by a recent meta-analysis. Kevin Douglas, Laura S. Guy, & Stephen D. Hart, *Psychosis as a Risk Factor for Violence to Others: A Meta-Analysis*, 135 *PSYCH. BULLETIN* 679, 691 (2009). As explained below in the text, there are reasons for present purposes to prefer the 2006 population-based study to an amalgam of different types of studies.

delusions.<sup>24</sup> Hearing voices, seeing visions, and paranoid ideations were the most strongly associated with violence.<sup>25</sup> Disarming every person afflicted by psychotic-like symptoms would be admittedly overbroad: one attacker would be correctly disarmed for every 14.5 sufferers who would not attack another.<sup>26</sup>

The study reports that 70% of the individuals with psychotic-like experiences had not received mental health care in the past year.<sup>27</sup> This strongly suggests that disqualification based on diagnosis misses many people whose symptoms put them at relatively high risk for violence. And even if treatment had been sought, “it is quite likely that only a minority of these experiences would be identified as clinically significant symptoms and only a small proportion of the individuals with these experiences would be identified as cases of psychotic disorders by clinicians.”<sup>28</sup>

A very similar study of Japanese adolescents broadly confirms the findings of the 2006 study, although the observed effects were smaller. Overall, those who suffered from psychotic-like experiences were about twice as likely as others to

---

<sup>24</sup> *Id.* at 189 appdx.A.

<sup>25</sup> *Id.* at 187 tbl.2.

<sup>26</sup> *Id.* at 184 (5.1% reported psychotic-like experiences); *id.* at 185 (1.5% overall reported attacking another).

<sup>27</sup> *Id.* at 185.

<sup>28</sup> *Id.* at 187. One might be concerned that police officers under my proposal---like the hypothetical clinicians---would also miss the symptoms. But the study authors do not question clinicians’ ability to identify the symptoms, only that the symptoms would be deemed “clinically significant” or evidence of “psychiatric disorders.” Police officers also should be able to identify symptoms, which is all my proposal requires.

engage in interpersonal violence.<sup>29</sup> The effect remained statistically significant for paranoia and hearing voices even after controlling for other variables.<sup>30</sup>

An early comparable study from Israel measured weapon use directly and concluded that “those who score high on threat/control-override symptoms [are] much more likely than those who score low to have engaged in fighting and weapon use.”<sup>31</sup> This result held even after controlling for diagnosis and other psychotic symptoms, as well as a host of other variables.<sup>32</sup> Indeed, the study concluded that “the threat/control-override symptoms have primacy over diagnostic distinctions in explaining violence.”<sup>33</sup> (A very recent study confirmed the significance of threat delusions, but not those involving control-override.<sup>34</sup>) One implication is that symptom-based gun control has the potential to prevent more gun violence than diagnosis-based regulation.<sup>35</sup>

---

<sup>29</sup> Yoshihiro Kinoshita et al., *Psychotic-Like Experiences Are Associated with Violent Behavior in Adolescents*, 126 SCHIZOPHRENIA RESEARCH 245, 248 tbl.1 (2011).

<sup>30</sup> *Id.* at 249 tbl.3.

<sup>31</sup> Bruce G. Link et al., *Real in their Consequences: A Sociological Approach to Understanding the Association Between Psychotic Symptoms and Violence*, 64 AM. SOCIOLOGICAL REV. 316, 325 (1999). The “threat/control-override symptoms subscale” asked how often the subject felt that (1) “your mind was dominated by forces beyond your control?” (2) “thoughts were put into your head that were not your own?” and (3) “there were people who wished to do you harm?” *Id.* at 330 Appdx.A

<sup>32</sup> *Id.* at 326 tbl.3.

<sup>33</sup> *Id.* at 329. Accord Bruce G. Link & Ann Stueve, *Psychotic Symptoms and the Violent/Illegal Behavior of Mental Patients Compared to Community Controls*, in VIOLENCE AND MENTAL DISORDER: DEVELOPMENTS IN RISK ASSESSMENT 137, 154 tbl.7 (John Monahan & Henry J. Steadman, eds. 1994) (reporting that patient variable lost statistical significance in predicting weapon use when psychotic symptom variable, which was highly significant, was introduced into regression model).

<sup>34</sup> Jeremy W. Coid et al., *The Relationship Between Delusions and Violence*, JAMA PSYCHIATRY E1, E5 (Mar. 6, 2013). Delusions of being spied on, persecution, and conspiracy were significantly associated with violence, although the study suggests that the anger produced by such delusions was a mediating cause of violence. *Id.* at E4. Note that Alexis experienced precisely these types of delusions.

<sup>35</sup> See also Bruce G. Link et al., *The Violent and Illegal Behavior of Mental Patients Reconsidered*, 57 AM. SOC. REV. 275, 283 tbl.1 (1992).

It should be noted that other studies question the relationship between delusions and violence.<sup>36</sup> All four of these cited studies (including the leading study funded by the MacArthur Foundation) examined highly selected groups as opposed to populations. This is an important distinction. Take for example the MacArthur study: it followed released psychiatric inpatients. In all likelihood, the subjects were therefore just below a maximum risk threshold at the time of release. It may well have been an artifact of sample selection, not lack of causation, that those with and without psychotic symptoms were equally safe.<sup>37</sup> The population studies (although far from perfect) are therefore more persuasive for present purposes.

### III. CONSTITUTIONALITY OF A SYMPTOM-BASED APPROACH

#### A. *Second Amendment*

As I have elsewhere argued, there are at least three possible Second Amendment tests for mental health gun regulations: reasonableness, intermediate scrutiny, and something close to strict scrutiny.<sup>38</sup> The data cited above almost certainly clear the low “reasonableness” hurdle because people with delusions or hallucinations are more dangerous than others. On the other hand, strict scrutiny would likely be fatal: a measure that disarms one attacker for every 14.5 harmless

---

<sup>36</sup> E.g., Paul S. Appelbaum et al., *Violence and Delusions: Data From the MacArthur Violence Risk Assessment Study*, 157 AM. J. PSYCHIATRY 566 (2000); Olivier F. Colins et al., *Psychotic-Like Symptoms as a Risk Factor of Violent Recidivism in Detained Male Adolescents*, 201 J. NERVOUS & MENTAL DISEASE 478 (2013); Jeffrey Swanson et al., *Violent Behavior Preceding Hospitalization Among Persons with Severe Mental Illness*, 23 LAW & HUMAN BEHAV. 185 (1999); Eduardo Henrique Teixeira & Paulo Dalgarrondo, *Violent Crime and Dimensions of Delusion: A Comparative Study of Criminal and Noncriminal Delusional Patients*, 37 J. AM. ACAD. PSYCHIATRY LAW 225 (2009).

<sup>37</sup> Pamela J. Taylor, *Psychosis and Violence: Stories, Fears, and Reality*, 53 CAN. J. PSYCHIATRY 647 (2008) (concluding after reviewing literature that “there is consistent evidence of a general association between delusions and violence”; dismissing on other grounds “dissenting studies”).

<sup>38</sup> Vars & Young, *supra* note \_\_, at 4-11.

sufferers is probably not “narrowly tailored.” The outcome under intermediate scrutiny---which has apparently become the consensus standard<sup>39</sup>---is uncertain. However, courts apply intermediate scrutiny only if the restriction “substantially burdens Second Amendment rights.”<sup>40</sup> And while prohibiting gun purchases by a large subset of the population would seem to be a substantial burden and therefore clear this threshold, there are good arguments to the contrary.

First, the proposed restriction on gun purchases is targeted and temporary. Experiencing delusions or hallucinations serious enough to come to the attention of a police officer would disqualify an individual only until the individual shows that they are no longer suffering from psychotic symptoms and are receiving appropriate mental health treatment. A comparable Indiana statute disqualifies “dangerous” individuals for 180 days, with an opportunity thereafter to apply for a restoration of gun rights.<sup>41</sup> Applying the Indiana constitution, an appellate court held that this statute did not impose a “material burden” on the right to bear arms.<sup>42</sup> A restriction with the possibility of immediate appeal and restoration is obviously less burdensome.

The second argument that this proposal does not amount to a substantial burden on Second Amendment rights derives from the purpose of the Amendment.

---

<sup>39</sup> *United States v. Lahey*, No. 10–CR–765 (KMK), 2013 WL 4792852, at \*15 (S.D.N.Y. Aug. 8, 2013).

<sup>40</sup> *Id.*

<sup>41</sup> *Redington v. State*, 992 N.E.2d 823, 834 (Ind. App. 2013).

<sup>42</sup> *Id.* at 833-34.

The animating principle of the right to bear arms is self-defense.<sup>43</sup> The Court in *Heller* and again in *McDonald* struck down restrictions on handgun possession because handguns are “overwhelmingly” favored by the public for self-defense.<sup>44</sup> The popularity of handguns is a relatively recent phenomenon.<sup>45</sup> Pistols represented only a small fraction of firearms owned by early Americans.<sup>46</sup> This is significant because it demonstrates that the Court, despite Originalist rhetoric in *Heller*, interprets the Second Amendment through the lens of present circumstance.

One thing that has changed since ratification of the Second Amendment is the definition of self-defense under almost every state’s criminal law. “Generally, both at common law and under modern state penal codes, a criminal defendant charged with homicide or assault and battery may invoke self-defense to justify the use of physical force against another when the defendant ‘reasonably’ believes that at the time such force was used, he was in imminent danger of losing his life or suffering great bodily harm at the hands of such other.”<sup>47</sup>

---

<sup>43</sup> See *McDonald v. City of Chicago*, 130 S. Ct. 3020, 3036 (2010) (explaining that “individual self-defense is the central component of the Second Amendment right”).

<sup>44</sup> *Id.* at 3036 (quoting *District of Columbia v. Heller*, 554 U.S. 570, 628 (2008)).

<sup>45</sup> “The proportion of households owning handguns has risen since 1959 from thirteen percent to about twenty-four percent.” Marian Wright Edelman & Hattie Ruttenberg, *Legislating for Other People’s Children: Failing To Protect America’s Youth*, 7 STAN. L. & POL’Y REV. 11, 13 (Winter, 1995-1996).

<sup>46</sup> See Clayton E. Cramer & Joseph Edward Olson, *Pistols, Crime, and Public: Safety In Early America*, 44 WILLAMETTE L. REV. 699, 706 (2008) (“One analysis of all Plymouth Colony probate inventories through the 1670s found that, of 339 listed firearms, 13% were pistols . . .”).

<sup>47</sup> John F. Wagner Jr., *Standard for Determination of Reasonableness of Criminal Defendant’s Belief, For Purposes of Self-Defense Claim, That Physical Force Is Necessary—Modern Cases*, 73 A.L.R.4th 993 sec. 2 (1989 rev. 2011). One could argue that self-defense may be broader for purposes of the Second Amendment than it is under criminal law. To the contrary, “nothing in *Heller* purports to alter the way the states have defined self-defense.” *State v. Warmus*, 967 N.E.2d 1223, 1237 ¶47 (Ohio App. 2011).

Through the early nineteenth century, reasonableness was wholly subjective. If the defendant actually felt threatened, then actions in self-defense were not criminal, even if no reasonable person would have felt threatened in the same situation. Thus, *M'Naughten* states: “if under the influence of his delusion he supposes another man to be in the act of attempting to take away his life, and he kills that man, as he supposes, in self-defence, he would be exempt from punishment.”<sup>48</sup>

In the mid-nineteenth century, jurisdictions began requiring objective reasonableness.<sup>49</sup> Significantly, one cause for this movement may have been increasing access to handguns.<sup>50</sup> Because handguns were easier to use and more deadly, their use in self-defense needed to be further circumscribed. Honest but unreasonable mistakes were no longer tolerated when the stakes escalated dramatically. The rule quoted above from *M'Naughten* has been reversed in the vast majority of jurisdictions: “But if that honest belief is the product of a delusion or a misperception of a threat—where someone without similarly impaired cognitive abilities or misapprehensions would sense no danger—a defendant lacks legal

---

<sup>48</sup> *M'Naughten's Case*, 8 Eng. Rep. 718, 723 (H.L. 1843). *Accord* *Coleman v. State*, 320 A.2d 740 (Del. 1974).

<sup>49</sup> Richard Singer, *The Resurgence of Mens Rea: II-Honest but Unreasonable Mistake of Fact in Self Defense*, 28 B.C. L. REV. 459, 480 (1987).

<sup>50</sup> *Id.* at 488.

grounds to assert self-defense.”<sup>51</sup> More succinctly, “[b]y definition, a reasonable person is not one who hears voices due to severe mental illness.”<sup>52</sup>

A person who is unable to make an objectively reasonable determination regarding the appropriateness of self-defense has a relatively weak claim for Second Amendment protection. The Amendment first and foremost protects self-defense. Precisely in response to the danger of guns, the overwhelming majority of jurisdictions now allow self-defense only when it is both subjectively *and* objectively reasonable. People suffering from delusions or hallucinations cannot be trusted to limit their self-defensive actions to circumstances where doing so is objectively reasonable. Restricting their access to firearms therefore infringes less upon Second Amendment rights.<sup>53</sup>

One familiar form of counter-argument is the slippery slope. If delusional people have lesser Second Amendment rights, what about people with drinking or anger problems or simply below average intelligence? Such people may not be capable of being objectively reasonable in their use of firearms. To categorically exclude them from Second Amendment protection would go too far. But one need not slide down the slope: a possible response to this concern is history. Restrictions on gun possession by the mentally ill have been described favorably by the Court as

---

<sup>51</sup> *State v. Bellinger*, 278 P.3d 975, 987 (Kan. App. 2012).

<sup>52</sup> *People v. Jefferson*, 14 Cal. Rptr. 3d 473, 481 (Cal. App. 3d Dist. 2004). *Accord* *Com. v. Hinds*, 927 N.E.2d 1009, 1015 (Mass. 2010); *State v. Walden*, 932 P.2d 1237, 1242 (Wash. 1997).

<sup>53</sup> As noted above, a parallel argument under Indiana’s state constitution prevailed in *Redington v. State*, 992 N.E.2d 823, 833-34 (Ind. App. 2013).



“longstanding.”<sup>54</sup> There are no longstanding prohibitions based on intoxication, anger, or intelligence.

If, despite these arguments to the contrary, the burden on Second Amendment rights is deemed to be great enough to clear the threshold, then my proposal might trigger intermediate scrutiny. Is the measure substantially related to an important government interest? The answer could well turn on emphasis. People with delusions are much more prone to violence. But the vast majority of people with delusions are not violent, and only a tiny fraction will misuse firearms. Whether a particular court would be swayed by the heightened risk or the massive overbreadth is difficult to predict.<sup>55</sup>

### *B. Due Process*

Under my proposal, a police officer or mental health professional would provide a written notice to the affected individual explaining the basis for suspension of gun rights and the process to appeal or to seek restoration. The individual would be entitled to an evidentiary hearing where they would have the burden to show that they were not in fact suffering from delusions or hallucinations (appeal) or that they were but have since been found to be symptom-free by a mental health professional and to be receiving appropriate treatment (restoration).

---

<sup>54</sup> District of Columbia v. Heller, 554 U.S. 570, 626 (2008).

<sup>55</sup> Cf. Vars & Young, *supra* note \_\_, at 17-19. In his contribution to this symposium, Professor O’Shea suggests that the political party affiliation of a judge’s appointing President may help predict the judge’s position in Second Amendment cases. [\*\*\*INSERT CITATION]

Appeals would have to be filed within 90 days; motions for restoration could be filed at any time. Gun rights would be suspended during the process.

This scheme would not violate due process. Given the exigency of the situation and the threat to health and safety, no predeprivation hearing is required.<sup>56</sup> “[W]here a State must act quickly, or where it would be impractical to provide predeprivation process, postdeprivation process satisfies the requirements of the Due Process Clause.”<sup>57</sup> Protecting public health and safety is an interest of paramount importance which has long justified summary deprivation of property.<sup>58</sup> For the same reasons, suspension of gun rights during the postdeprivation process should be allowed. Placing the burden of proof on the individual is appropriate because that individual will be in the best position to produce relevant evidence.<sup>59</sup> Furthermore, requiring certification from a mental health professional may induce some individuals who want their gun rights restored to go into treatment or at least to submit to evaluation. This would be a significant policy advantage over current diagnosis- and treatment-based restrictions that may actually discourage beneficial treatment.<sup>60</sup>

#### IV. POLICY COUNTER-ARGUMENTS

---

<sup>56</sup> Hightower v. City of Boston, 693 F.3d 61, 84-85 (1st Cir. 2012).

<sup>57</sup> *Id.* at 84 (quoting Gilbert v. Homar, 520 U.S. 924, 930 (1997)).

<sup>58</sup> *Id.* at 84-85.

<sup>59</sup> *Id.* at 87.

<sup>60</sup> T.B. Cole, *Efforts to Prevent Gun Sales to Mentally Ill May Deter Patients from Seeking Help*, 298 JAMA 503 (2007).

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

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

Another related counter-argument to my proposal is that psychotic symptoms are a bad proxy. If dangerousness is the concern, then bar gun possession based on an assessment of dangerousness. That was the approach adopted in New York following the Newtown, Connecticut school shooting. New York now authorizes revocation of gun privileges based on a mental health professional's assessment of

dangerousness with no explicit diagnosis requirement.<sup>61</sup> Indiana had earlier authorized law enforcement officers to confiscate firearms based on dangerousness with or without a diagnosis of mental illness.<sup>62</sup>

Assessing dangerousness, like making a diagnosis, arguably does require real mental health expertise. Presumably as a result, New York limits this power to mental health professionals. This may be sound public policy as far as it goes, although clinical assessments of dangerousness are notoriously unreliable.<sup>63</sup> One additional problem is that it does not go far enough. The New York law would not have stopped Alexis from buying the fatal shotgun. No mental health professional assessed Alexis and found him dangerous. This is more than an anecdote. Literally millions of Americans with mental illness are not receiving mental health treatment. Some of them are psychotic and many come in contact with law enforcement.

Indiana has made the right choice in empowering police officers to sometimes curb gun rights. However, Indiana's choice of standard may not be optimal. Dangerousness is difficult to define, let alone assess, even by trained experts. There is real potential for police abuse of such a discretionary authority. But even assuming reliable assessment free from abuse, a *per se* rule regarding delusions and

---

<sup>61</sup> N.Y. McKinney's Mental Hygiene Law § 9.46. California has very recently adopted a similar provision, barring gun possession by any individual who makes a serious threat to a psychotherapist. Patrick McGreevy & Melanie Mason, *Brown vetoes gun-control bills*, L.A. TIMES (Oct. 11, 2013).

<sup>62</sup> George F. Parker, *Application of a Firearm Seizure Law Aimed at Dangerous Persons: Outcomes From the First Two Years*, 61 PSYCHIATRIC SERVS. 478 (2010).

<sup>63</sup> Mitzi Dorland & Daniel Krauss, *The Danger of Dangerousness in Capital Sentencing: Exacerbating the Problem of Arbitrary and Capricious Decision-Making*, 29 LAW & PSYCHOL. REV. 63, 85-86 (2005); Henry J. Steadman, *From Dangerousness to Risk Assessment of Community Violence: Taking Stock at the Turn of the Century*, 28 J. AM. ACAD. PSYCHIATRY LAW 265, 269-70 (2000).

hallucinations, along the lines suggested herein, may be a useful supplement to dangerousness. A psychotic individual may not appear immediately dangerous, but is probably still unable to be objectively reasonable in using a firearm.

A final counter-argument is that the federal background check system is too porous to make a difference. No background check is required for private sales, which make up a substantial portion of gun transactions. One might therefore expect mental health restrictions on purchases from licensed dealers to have little or no effect. However, recent empiricism suggests that this is not the case. “In those with a gun-disqualifying mental health record, risk of violent criminal offending declined significantly after Connecticut began reporting gun-disqualifying mental health records to the [federal background check system].”<sup>64</sup> The cost of switching to a private sale apparently deters some gun purchases. Of course, expanding the background check system would maximize the effectiveness of my proposal, but the proposal is likely to have a positive impact in the meantime.

\* \* \*

Most delusions are harmless and invisible.<sup>65</sup> Some of the more serious ones will come to the attention of the police. If they do, then the officer should suspend gun rights. This proposal would likely have prevented Alexis from purchasing the shotgun used in the Navy Yard shooting. It is grounded in empirical work showing

---

<sup>64</sup> Jeffrey W. Swanson et al., *Preventing Gun Violence Involving People with Serious Mental Illness*, in REDUCING GUN VIOLENCE IN AMERICA: INFORMING POLICY WITH EVIDENCE AND ANALYSIS 45 (Daniel W. Webster & Jon S. Vernick, eds., 2013).

<sup>65</sup> Jeffrey Swanson & Marvin Swartz, *The Navy Yard Shooting and Mental Illness*, INTERNAL MEDICINE NEWS (Sept. 20, 2013).

that psychotic symptoms can predict violence better than diagnosis does. And there is an additional constitutional argument for this symptom-based approach derived from principles of self-defense. A person suffering from delusions or hallucinations cannot be trusted to use a firearm defensively in an objectively reasonable fashion.

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