
MADNESS, DEINSTITUTIONALIZATION & MURDER

By Clayton E. Cramer*

For those of us who came of age in the 1970s, one of the most shocking aspects of the last three decades was the rise of mass public shootings: people who went into public places and murdered complete strangers. Such crimes had taken place before, such as the Texas Tower murders by Charles Whitman in 1966,¹ but their rarity meant that they were shocking.

Something changed in the 1980s: these senseless mass murders started to happen with increasing frequency. People were shocked when James Huberty killed twenty-one strangers in a McDonald's in San Ysidro, California in 1984, and Patrick Purdy murdered five children in a Stockton, California schoolyard in 1989. Now, these crimes have become background noise, unless they involve an extraordinarily high body count (such as at Virginia Tech) or a prominent victim (such as Rep. Gabrielle Giffords). Why did these crimes go from extraordinarily rare to commonplace?

For a while, it was fashionable to blame gun availability for this dramatic increase. But guns did *not* become more available before or during this change. Instead, federal law and many state laws became more restrictive on purchase and possession of firearms, sometimes in response to such crimes.² Nor has the nature of the weapons available to Americans changed all that much. In 1965, *Popular Science* announced that Colt was selling the AR-15, a semiautomatic version of the M-16 for the civilian market.³ The Browning Hi-Power, a 9mm semiautomatic pistol with a thirteen-round magazine, was offered for sale in the United States starting in 1954,⁴ and advertised for civilians in both the U.S. and Canada at least as early as 1960.⁵ If gun availability does not explain the increase of mass public murders, what else might?

At least half of these mass murderers (as well as many other murderers) have histories of mental illness. Many have already come to the attention of the criminal justice or mental health systems before they become headlines. In the early 1980s, there were about two million chronically mentally ill people in the United States, with 93 percent living outside mental hospitals. The largest diagnosis for the chronically mentally ill is schizophrenia, which afflicts about 1 percent of the population, or about 1.5 percent of adult Americans.⁶ A 1991 estimate was that schizophrenia costs the United States about \$65 billion annually in direct and indirect costs.⁷

The \$19 billion in direct costs (as of 1991) included the criminal justice system dealing with a few spectacular and terrifying crimes (such as mass public shootings), and millions

of infractions, arrests, and short periods of observation.⁸ A 1999 study found that 16.2 percent of state prison inmates, 7.4 percent of federal prison inmates, and 16.3 percent of jail inmates, were mentally ill.⁹ As of 2002, about 13 percent of mentally ill state prison inmates nationwide had been convicted of murder.¹⁰ A detailed examination of Indiana murder convicts found that 18 percent were diagnosed with "schizophrenia or other psychotic disorder, major depression, mania, or bipolar disorder."¹¹

In the 1960s, the United States embarked on an innovative approach to caring for its mentally ill: deinstitutionalization. The intentions were quite humane: move patients from long-term commitment in state mental hospitals into community-based mental health treatment. Contrary to popular perception, California Governor Ronald Reagan's signing of the Lanterman-Petris-Short Act of 1967¹² was only one small part of a broad-based movement, starting in the late 1950s.¹³ The Kennedy Administration optimistically described how the days of long-term treatment were now past; newly-developed drugs such as chlorpromazine meant that two-thirds of the mentally ill "could be treated and released within 6 months."¹⁴

At about the same time, two different ideas came to the forefront of American progressive thinking: that there was a *right* to mental health treatment, and a *right* to a more substantive form of due process for those who were to be committed to a mental hospital. If there was a right to mental health treatment, then judges could use the threat of releasing patients as a way to force reluctant legislatures to increase funding for treatment.¹⁵

The notion of due process for the mentally ill was not radical. American courts have been wrestling with this question from the 1840s onward.¹⁶ While perhaps not up to the exacting standards of the American Civil Liberties Union, by the end of the nineteenth century, there was something recognizably like due process before the mentally ill were committed.¹⁷ What changed in the 1960s was the result of ACLU attorneys such as Bruce J. Ennis, who claimed that less than 5 percent of mental hospital patients "are dangerous to themselves or to others" and that the rest were improperly locked up "because they are useless, unproductive, 'odd,' or 'different.'"¹⁸

Until the 1960s, courts used a medical model when considering commitment: the government's actions were part of "the historic *parens patriae* power, including the duty to protect 'persons under legal disabilities to act for themselves.' . . . The classic example of this role is when a State undertakes to act as 'the general guardian of all infants, idiots, and lunatics.'"¹⁹ Instead, public safety alone became the legitimate basis for commitment, and with it, a more exacting standard, a bit less than is required for convicting criminal defendants.²⁰

Neither a right to treatment nor a more demanding application of due process alone was particularly destructive, but in combination they made hundreds of thousands of seriously mentally ill people homeless,²¹ where many died of exposure²² and violence.²³ They fell through the cracks, living shorter,

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more miserable lives, and often greatly degrading the quality of urban life for everyone else.²⁴ A fraction became something quite a bit more unsettling than the mentally ill person begging on the street or disrupting the public library: they became the mad mass murderers of the modern age.

John Linley Frazier was one of the first such examples. Like many other schizophrenics, he first exhibited symptoms in his early 20s. 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 it.

In October of 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."²⁵ He blindfolded them, tied them up, shot each of them, and threw them into the pool. Then he burned the house to return it back to the environment. Frazier's bizarre behavior and statements soon led to his arrest. He was found legally sane, convicted, and sentenced to life in prison.²⁶ (The legal definition of insane is considerably narrower than the psychiatric definition of insane; it also seems that juries sometimes convict even clearly insane defendants, out of fear that they might be released after being declared "cured.")

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."²⁷ In January 1989, Purdy went onto a schoolyard in Stockton, California with an AK-47 rifle, murdered five children and wounded twenty-nine others, before taking his own life.²⁸

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.²⁹

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.³⁰

Larry Gene Ashbrook was another killer who 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 their religion, then killed seven people inside, before killing himself.³¹

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.³² Only the fortuitous arrival of police, who shot Logsdon to death, prevented a larger massacre.

According to Logsdon's sister, Logsdon had a history of mental illness and alcoholism. His family contacted police over Logsdon's deteriorating mental condition and physical conditions in Logsdon's home. The police took Logsdon to a mental hospital for treatment in October 2005, concerned that he was suicidal. He was released six hours later with a voucher for a cab and a list of resources to contact.

In this case, 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.³³

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. 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." Weston explained that the two "cannibals" he had shot to death, police officers "Jacob J. Chestnut and John M. Gibson," were "not permanently deceased." Weston explained that he needed access to the satellite controller so that he could turn back time.

Before this incident, Weston had been involuntarily hospitalized for fifty-three days in Montana after threatening a neighbor, but he was then released. According to Weston's parents, he had been losing the battle with schizophrenia for two decades before he went to the Capitol.³⁴

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 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.³⁵

When I was first writing these paragraphs in April 2007, America was mourning a tragedy at Virginia Tech, where Cho Seung-Hui murdered thirty-two students and faculty before taking his own life. His psychological problems had been evident for some months before, and he was briefly hospitalized after a stalking incident. The special judge appointed to determine whether Seung-Hui should be involuntarily committed concluded that he was a danger to himself—but allowed Seung-Hui to commit himself. The next day, Seung-Hui left the hospital, and soon he was back on campus, living

in a world of paranoid schizophrenia, culminating in the largest gun mass murder in U.S. history.³⁶

Many other spectacularly horrifying crimes followed that one. Jiverly Wong murdered thirteen people before killing himself at a Binghamton, New York immigrant-assistance center in April 2009. Letters by Wong to local news media demonstrate what “Dr. Vatsal Thakkar, assistant professor of psychiatry at NYU’s Langone Medical Center” described as “major mental illness, quite possibly paranoid schizophrenia.”³⁷

Rep. Gabrielle Giffords was one of many people shot at a town hall meeting in Tucson in January 2011. The alleged shooter, Jared Lee Loughner, had a history of police contacts involving death threats, and was expelled from college for bizarre actions that clearly established that he was mentally ill. A series of disturbing web postings and YouTube videos also confirmed that Loughner’s grasp on reality was severely impaired.³⁸ Court-ordered psychiatric evaluations concluded that Loughner was suffering from schizophrenia, and was incompetent to stand trial.³⁹

Nor were these problems specific to the United States and its “gun culture” as some contend. Other nations which started down the same road toward deinstitutionalization a few years after the United States have suffered many similar mass murders.

In eastern France, Christian Dornier, thirty-one, under treatment for “nervous depression,” murdered fourteen people in three villages.⁴⁰ He was later found not guilty by reason of insanity.⁴¹ Eric Borel, sixteen, murdered his family with a hammer and a baseball bat, then went on a shooting rampage in the nearby town of Cuers, France in September 1995. He killed twelve people besides himself.⁴² In March 2002, Richard Durn murdered eight local city officials and wounded nineteen others in Nanterre, a suburb of Paris. Durn had a master’s degree in political science and “a long history of psychological problems.” He was chronically unemployed. After his arrest, he was described as “calm but largely incoherent,” but then leaped to his death through a window.⁴³

In April 2002, nineteen-year old Robert Steinhaeuser went into a school from which he had been expelled in Erfurt, Germany and murdered eighteen people before killing himself.⁴⁴ In April 2011, Wellington Menezes de Oliveira went into a school in Rio De Janeiro, Brazil, murdering twelve children, before killing himself. His suicide note was unclear, but a police officer described de Oliveira as a “hallucinating person.”⁴⁵ Later the same month, Tristan van der Vlis went into a shopping mall in Alphen aan der Rijn, the Netherlands, and shot six people to death. In spite of very strict Dutch gun licensing laws, and van der Vlis’s history of mental illness hospitalization and suicide attempts, he had a gun license.⁴⁶

Along with the spectacular cases of public mass murder, there were many minor tragedies involving one-on-one murders, soon forgotten outside the family and friends of their victims. In 1983, the seventeen-year-old daughter of my landlord was murdered in San Francisco’s Golden Gate Park. The killer had a long history of mental problems, some of which had sent him to prison, but none of which had caused hospitalization. As so often happens, this tragedy led to another. The continuing legal battles over the killer’s sanity soon led the murder victim’s

grief-stricken father to sneak a gun into the courtroom, and open fire.⁴⁷

Edmund Emil Kemper III was a sexual sadist who killed his paternal grandparents at age fifteen, in an attempt to punish his mother. California hospitalized him until he was twenty-one, and then released him on parole in 1969. Over a bit less than a year, starting in May 1972, Kemper shot, stabbed, and strangled eight women, including his mother. (The rest of what he did is too horrifying to describe.) He repeatedly called the police to persuade them that he was the killer. Eventually, he was arrested, found legally sane, convicted, and sentenced to life in prison.⁴⁸

Herbert William Mullin was another schizophrenic whose illness arrived just as California was deinstitutionalizing its mental patients. Until 1969, just before Mullin’s 22nd birthday, it was not obvious that he was mentally ill. Mullin was persuaded to voluntarily enter Mendocino State Hospital, on California’s north coast on March 30. Six weeks later, having refused to participate in treatment programs—and under no legal obligation to remain—he left.

Mullin had trouble holding jobs, because he was “hearing voices,” which understandably frightened employers. Over several months, he was in and out of mental hospitals in California and Hawaii for brief periods, sometimes voluntarily, sometimes not. On his return to California, his behavior so scared his parents that within thirty miles of the airport, his parents stopped to call the Mountain View Police Department. Mullin was again hospitalized against his will at Santa Cruz General Hospital for a few weeks, and was again discharged, “less noisy and belligerent”—but not well.

Mullin’s parents tried to find long-term hospitalization for their son, who was clearly dangerous to others. But California’s hospitals were busily emptying out; they were not looking to take new patients. In light of Mullin’s history of voluntarily entering, then leaving mental hospitals, it might not have mattered, without an involuntary commitment.

In four months of late 1972 and early 1973, Mullin murdered thirteen people in the Santa Cruz area. Why? Mullin believed that murder prevented the San Andreas Fault from rupturing. Mullin was found legally sane and guilty of ten murders.⁴⁹

While most of these murders involved guns, there were many others that did not. Some are often completely unknown outside the community where they happened because the body count was low. In Rohnert Park, California, a thirty-three-year-old paranoid schizophrenic named Hoyt was arrested outside his mother’s home, holding a sword. Inside, his mother lay dying of sword wounds. A relative described the problem: the mental health system can do nothing until a mental patient “becomes a threat to himself or others.” Hoyt had stopped taking his medication, and there was nothing that could be done: “He’s over 18, he can’t be forced to stay on his medications until something happens. . . . Well, something has happened.”⁵⁰

In May 1998, San Francisco put twenty-one-year-old Joshua Rudiger on probation and ordered him to enter a live-in treatment center in San Francisco after shooting a former friend with a bow and arrow. Authorities knew that Rudiger was mentally ill; he had been confined to Atascadero State Hospital

for six months, diagnosed as suffering from schizophrenia and bipolar disorder—and then declared cured, and able to stand trial for the bow and arrow incident.

Rudiger never showed up at the treatment center, nor did anyone go looking for him. In one of the more disturbing understatement of the day, Carmen Bushe, the head of community services for San Francisco's Probation Department observed, "It's perhaps not necessarily a cohesive system." When Rudiger next came to the attention of police, it was for slashing the throats of four homeless people, killing one, and drinking the blood of the others.⁵¹ When arrested, Rudiger told police that he was a 2600-year-old vampire. Yet the jury concluded that he was legally sane, because he knew what he was doing, and he knew it was wrong. Rudiger was sentenced to twenty-three years to life.

Rudiger's mental problems started at age four.⁵² But others were people who made it to adulthood before mental illness appeared. Richard Baumhammers was an immigration attorney—and yet something went wrong sometime in his 20s, when he became convinced that someone had poisoned him on a trip to Europe. He "had been treated since 1993 for mental illness and had voluntarily admitted himself to a psychiatric ward at least once . . ." When the final break happened, he killed five people.⁵³ A jury found him legally sane, and convicted him of first-degree murder. The court sentenced Baumhammers to death.⁵⁴

In 1986, Juan Gonzalez was arrested for shouting threats on the street, "I'm going to kill! God told me so!" Doctors diagnosed him with a "psychotic paranoid disorder," gave him some antipsychotic medicines to take, made an appointment for outpatient treatment, and released him after two days. Within a few days he went on a rampage on the Staten Island Ferry with a sword, killing two people, and wounding nine. If not for the presence of a retired police officer who disarmed Gonzalez at gunpoint, the death toll might have been much higher.⁵⁵

Gonzalez was finally considered too dangerous to release, and the courts ordered his involuntary commitment to a mental hospital. He repeatedly contested his commitment. In March 2000, the courts granted Gonzalez unsupervised leave from the hospital, with a number of conditions on his actions for five years.⁵⁶

When *The New York Times* did a detailed study of 100 U.S. rampage killers in 2000, they pointed out that there was often plenty of warning:

Most of them left a road map of red flags, spending months plotting their attacks and accumulating weapons, talking openly of their plans for bloodshed. Many showed signs of serious mental health problems.

...

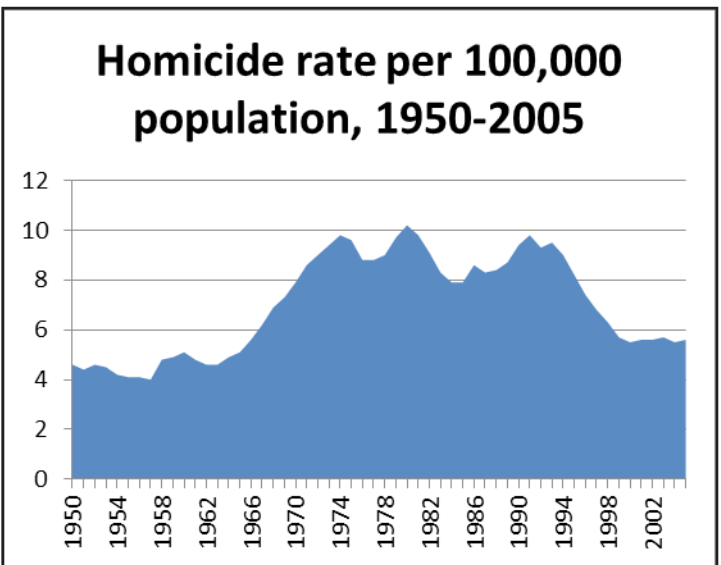
The Times' study found that many of the rampage killers... suffered from severe psychosis, were known by people in their circles as being noticeably ill and needing help, and received insufficient or inconsistent treatment from a mental health system that seemed incapable of helping these especially intractable patients. . . .

The *Times* found what it called "an extremely high association between violence and mental illness." Of the 100

rampage murderers, forty-seven "had a history of mental health problems" before committing murder, twenty had been previously hospitalized for mental illness, and forty-two had been previously seen by professionals for their mental illness. While acknowledging that mental illness diagnoses "are often difficult to pin down . . . 23 killers showed signs of serious depression before the killings, and 49 expressed paranoid ideas."⁵⁷

There is no shortage of these tragedies that have one common element: a person whose exceedingly odd behavior, sometimes combined with minor criminal acts, would likely have led to confinement in a mental hospital in 1960. After deinstitutionalization, these people remained at large until they killed. The criminal justice system then took them out of circulation (if they did not commit suicide), but this was too late for their victims.

There is a clear statistical relationship between deinstitutionalization and murder rates. Violent crime rates rose dramatically in the 1960s, most worrisomely in the murder rate.⁵⁸



One explanation for this doubling of murder rates from 1957 to 1980 is that the Baby Boomers (the children born in the ten years after World War II) were reaching their peak violent crime years of adolescence. Some conservatives blamed the civil liberties revolution of the Warren Court for rendering the criminal justice system impotent to deal with crime, and the expansion of drug abuse by the Flower Power generation of the 1960s. This fails to answer what caused the decline in violent crime—and specifically murder—in the 1990s. This was variously ascribed to the Baby Boom Echo generation passing out of its peak violent crime years, and to increasingly tough sentencing for violent crimes.

According to Professor Bernard E. Harcourt, sociologists examining the expansion of imprisonment in the 1990s—the so-called "incarceration revolution"—missed the even more important component of institutionalization: mental hospitals. When adding mental hospital inmates to prisoners, there is an astonishingly strong negative correlation between the institutionalization rate, and the murder rate: "The correlation

between the aggregated institutionalization and homicide rates is remarkably high: -0.78.” Harcourt found that even when adjusting for changes in unemployment and the changing fraction of the population that was at their peak violent crime ages, the negative correlation remained strong—and did a better job of predicting both the 1960s rise and the 1990s decline in murder rates than other models.⁵⁹ Similar results appear when using state level data for institutionalization and murder rates, and controlling for more variables.⁶⁰

It is easy to see why the deinstitutionalization of the mentally ill would cause a rise in violent crime rates, including murder. When Massachusetts opened Worcester Hospital in the early nineteenth century, the law limited its admissions to “the violent and furious.” Dr. Samuel B. Woodward, the hospital’s first superintendent, noted that “More than half of those manifesting monomania and melancholia [roughly equivalent to paranoid schizophrenia and psychotic bipolar disorder in modern terms] are said to exhibit a propensity to homicide or suicide.”⁶¹ The opening of state asylums in Vermont in 1836 and New Hampshire in 1840 “contributed to the decline in . . . spouse and family murders during the 1850s and 1860s.”⁶² Accounts of mass murder (usually involving families killed by mentally ill members) appear often enough in this period to understand why concerns about insanity could lead to hospitalization.⁶³

Curiously, during the period before deinstitutionalization, the mentally ill seem to have been *less* likely to be arrested for serious crimes than the general population. Studies in New York and Connecticut from the 1920s through the 1940s showed a much lower arrest rate for the mentally ill.⁶⁴ In an era when involuntary commitment was relatively easy, those who were considered a danger to themselves or others would be hospitalized at the first signs of serious mental illness. The connection between insanity and crime was apparent,⁶⁵ and the society took a precautionary approach. Mentally ill persons who were not hospitalized were those not considered a danger to others. This changed as deinstitutionalization took effect.

As early as 1976, studies of deinstitutionalized New York City mental patients showed that they had disproportionate arrest rates for rape, burglary, and aggravated assault.⁶⁶ A study of San Mateo County, California mental hospital patients also showed disproportionate arrest rates for murder, rape, robbery, aggravated assault, and burglary: for murder, 55 times more likely to be arrested in 1973, and 82.5 times more likely in 1972. Mental patients were about nine times more likely to be arrested for rape, robbery, aggravated assault, and burglary than the general population of the county.⁶⁷ Even patients with no pre-hospitalization arrests were five times as likely to be arrested for violent crimes as the general population.⁶⁸ Studies in Denmark and Sweden similarly show that psychotics are disproportionately violent offenders.⁶⁹ Recent surveys in the United States also show that “violence and violent victimization are more common among persons with severe mental illness than in the general population.”⁷⁰

One recent study arguing otherwise suggests that mental illness alone is not the cause, but one of several risk factors that in combination increase violence rates. Mental illness and substance abuse seem to be an especially dangerous

combination.⁷¹ It is important to remember that even though the mentally ill are a disproportionately violent population, most of this population is primarily a threat to themselves.⁷²

Deinstitutionalization created a revolving door, in which those who committed minor crimes might be briefly held for observation, but were then again released to the community. Once a mentally ill offender ends up in the criminal justice system for the most serious crimes, such as murder or rape, sympathy for their mental illness declines quite dramatically. As some of the examples given above demonstrate, juries and judges often find people who were clearly mentally ill to be legally sane.

Deinstitutionalization played a substantial role in the dramatic increase in violent crime rates in America in the 1970s and 1980s. People who might have been hospitalized in 1950 or 1960 when they first exhibited evidence of serious mental illness today remain at large until they commit a serious felony. The criminal justice system then usually sends these mentally ill offenders to prison, not a mental hospital.

The result is a system that is bad for the mentally ill: prisons, in spite of their best efforts, are still primarily institutions of punishment, and are inferior places to treat the mentally ill. It is a bad system for felons without mental illness problems, who are sharing facilities with the mentally ill, and are understandably afraid of their unpredictability. It is a bad system for the victims of those mentally ill felons, because in 1960, a mentally ill person was much more likely to have been hospitalized before victimizing someone else. It is a bad system for the taxpayers, who foot the bill for expensive trials and long prison sentences for the headline tragedies, and hundreds of thousands of minor offenses, instead of the much less expensive commitment procedures and perhaps shorter terms of treatment.

Deinstitutionalization of the mentally ill was one of the truly remarkable public policy decisions of the 1960s and 1970s, and yet its full impact is barely recognized by most of the public. Partly this was because the changes did not happen overnight, but took place state-by-state over two decades, with no single national event. While homelessness received enormous public attention in the early 1980s, the news media’s reluctance to acknowledge the role that deinstitutionalization played in this human tragedy meant that the public safety connection was generally invisible to the general public. The solution remains unclear, but recognizing the consequences of deinstitutionalization is the first step.

Endnotes

1 See generally GARY M. LAVERGNE, *A SNIPER IN THE TOWER: THE CHARLES WHITMAN MURDERS* (1997).

2 Federal laws: Gun Control Act of 1968, Pub. L. No. 90-618 (1968) (prohibited felons from possessing firearms or ammunition); Brady Handgun Control Act, Pub. L. 103-159 (1993) (required waiting periods and background checks for handgun purchases); Violent Crime Control and Law Enforcement Act of 1994, Pub. L. No. 103-322 (prohibited certain categories of semiautomatic weapons); Gun Ban for Individuals Convicted of a Misdemeanor Crime of Domestic Violence, Pub. L. 104-208, 18 U.S.C. 922(g)(9) (1996) (prohibited those convicted of domestic violence

- misdeemeanors from possessing a firearm). Representative state and local laws prohibiting semiautomatic detachable magazine weapons and high capacity magazines: Robert-Roos Assault Weapons Control Act of 1989, CAL. PENAL CODE § 12276; N.J. STAT. ANN. §§ 2C:39-1 to -15, :43-6 to -7, :58-5, :58-12 to -14 (West 1982 & Supp. 1991); New York City Local Law 78 (1991) (prohibiting possession of assault weapons and high capacity magazines), cited in *Richmond Boro Gun Club, Inc. v. City of New York*, 97 F.3d 681, 683 (2d Cir. 1996).
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- 5 *Browning 9mm Hi-Power Automatic* (advertisement), POPULAR MECHANICS, Sept. 1960 at 70; *Do You Know This Pistol?* (advertisement), POPULAR MECHANICS, Aug. 1962, at 26.
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- 11 *Id.* at 76.
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- 13 JOINT COMM'N ON MENTAL ILLNESS & HEALTH, ACTION FOR MENTAL HEALTH: FINAL REPORT OF THE JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH xv-xvi (1961).
- 14 Message from the President of the United States Relative to Mental Illness and Mental Retardation, Feb. 5, 1963, reprinted in HENRY A. FOLEY & STEVEN S. SHARFSTEIN, MADNESS AND GOVERNMENT: WHO CARES FOR THE MENTALLY ILL? 166-7 (1983), quoted in RAELEEN ISAAC & VIRGINIA C. ARMAT, MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL 77-78 (1990).
- 15 Morton Birnbaum, *The Right to Treatment*, 46 A.B.A. J. 499 (May 1960); David L. Bazelon, *The Right to Treatment: The Court's Role*, 20 HOSP. & COMMUNITY PSYCHIATRY 129-130 (May 1969).
- 16 *In re Oakes*, 8 Law Rep. 122 (Mass. 1845); *Hinchman v. Richie*, Brightly 143 (C.P. Phila. 1849); [An American Citizen], *The Hinchman Conspiracy Case*, in LETTERS TO THE NEW YORK HOME JOURNAL (Philadelphia: Stokes & Brother, Arcade, 1849); Paul S. Appelbaum & Kathleen N. Kemp, *The Evolution of Commitment Law in the Nineteenth Century: A Reinterpretation*, 6 LAW & HUM. BEHAV. 345-7 (1982).
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