Mental Illness and New Gun Law Reforms
The Promise and Peril of Crisis-Driven Policy

Jeffrey Swanson, PhD

The December 2012 tragedy in Newtown, Connecticut, transfixed the nation in a moment of shared grief for 20 small children and 6 adults who died in a merciless hail of bullets. The weeks since have brought numerous federal and state policy proposals to curb gun violence. Whether these crisis-driven reforms can help inch society toward the goal of reducing firearm-related deaths, the new laws’ broader social consequences could long outlast the memory of what happened at Sandy Hook Elementary School. Policy makers would do well to pause and think them through.

Some of the proposals deal with dangerous guns: Ban assault weapons and high-capacity ammunition magazines. That now seems like a good idea to a majority of Americans across the political spectrum. But in a nation with a constitutionally protected right to possess a firearm and an estimated 310 million firearms already in private hands, the real action in gun control is “people control”: Prohibit dangerous people from getting their hands on a gun. It is through the lens of “people control” that mental illness comes into sharp focus, both as a presumed vector of gun violence and as a categorical prohibitor of gun access.

The 1968 Gun Control Act prohibitions on the adjudicated mentally ill have remained in place long after civil commitment reforms and deinstitutionalization have run their course, radically reducing and reshaping the ranks of the involuntarily committed. The definitions are rendered blunt and indiscriminate; they leave too many at-risk people unidentifiable, while including others with largely nondangerous disorders of thought, mood, and behavior. New criteria and rules, designed to identify the small number of seriously mentally ill people who are demonstrably dangerous and to prevent them from accessing firearms, now occupy center stage in the gun policy reforms emerging at the national and state levels. But the laws are both sensible and overreaching; lawmakers need to find the right balance between public safety and civil rights as they try to sort out one from the other.

One month after the Sandy Hook shooting, New York Governor Andrew Cuomo proposed the New York Secure Ammunition and Firearms Enforcement Act of 2013; 2 days later, the same sweeping gun control measures passed both houses of the New York State legislature by a wide margin. Many of the law’s provisions are reasonable steps to improve gun safety, better regulate gun sales and licensing, enhance enforcement, and impose stricter penalties on gun law violators. The law also requires mental health professionals—psychiatrists, psychologists, social workers, and nurses—to report to local mental health authorities the names of all patients deemed likely to seriously harm themselves or others. A reported person’s name will then be checked against a database of state gun licensees; if a match is found, the gun license may be suspended and police authorized to find the person and remove the person’s firearm.

But consider what this could mean. Suppose that a college freshman is feeling depressed and having suicidal thoughts. That scenario would apply to about 1 in 10 students currently enrolled in US colleges and universities—or about 2.1 million young people. However, only a small proportion of college students with diagnosable depression receive treatment, and partly as a result of not receiving care more than 1300 of them take their own lives each year—about half using a firearm. Suicide accounted for 61% of gun-injury deaths in the United States in 2010. Now imagine that the student summons the courage to seek help at the campus health service. She discloses to a trusted counselor that she is contemplating suicide. But the counselor is now required to breach the student’s confidentiality and report her name to the authorities.

Three problems beset New York’s new reporting law for mental health professionals. The first is overidentification; the law could include too many people who are not at significant risk. The second is the chilling effect on help seeking; the law could drive people away from the treatment they need or inhibit their disclosures in therapy. The third is invasion of patient privacy; the law amounts to a breach of the confidential patient-physician relationship. Mental health professionals already have an established duty to take reasonable steps to protect identifiable persons when a patient threatens harm. However, clinicians can discharge that duty in several ways, as the situation demands, often without compromising a therapeutic relationship that depends on confidentiality. For example, the clinician could decide to see the patient more frequently or prescribe a different medication. Voluntary hospitalization is also an option for many at-risk patients.

In Maryland, 2 weeks after the Sandy Hook tragedy, a state Task Force to Study Access of Mentally Ill Individuals to Regulated Firearms submitted its report to Governor Martin O’Malley. Among the recommendations was a reporting provision even more sweeping than the one New York

Author Affiliation: Department of Psychiatry and Behavioral Sciences, Duke University School of Medicine, Durham, North Carolina.

Corresponding Author: Jeffrey Swanson, PhD, Department of Psychiatry and Behavioral Sciences, Duke University School of Medicine, Box 3071 Med Ctr, Durham, NC 27701 (jeffrey.swanson@duke.edu).

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would soon enact: “All verbal or physical actions threatening suicide or serious violence toward a reasonably identifiable victim or victims should be reported to local law enforcement. Mandated reporting should apply to psychiatrists, psychologists, physicians, social workers, addiction treatment counselors, educators, case managers, and probation agents.” Even teachers would be required to report students who engage in “verbal or physical actions threatening suicide or serious violence [to others].”

Governor O'Malley rejected the task force’s particular recommendation for a broad reporting requirement in the initiatives he proposed, perhaps for the same reasons expressed by some psychiatrists with serious concerns about New York’s reporting law. According to Paul S. Appelbaum, “such a requirement ‘represents a major change in the presumption of confidentiality that has been inherent in mental health treatment.’” He added, “The prospect of being reported to the local authorities, even if [patients] do not have weapons, may be enough to discourage patients with suicidal or homicidal thoughts from seeking treatment or from being honest about their impulses.” Still, Appelbaum and other mental health experts are on record as supporting in principle a statute “allowing firearms to be removed from persons in emergency situations, when the risk of violence is heightened, whether or not they have a mental disorder.”

Indiana’s law authorizing gun seizure from “dangerous persons” is an example. Without resorting to mandated reporting for mental health professionals, the law provides a discretionary avenue for clinicians to involve law enforcement in removing guns from a person deemed at risk of violence—irrespective of psychiatric diagnosis or civil commitment criteria.

While stepping back from the prospect of reporting the names of possibly suicidal psychotherapy patients, Governor O’Malley did propose a change in the gun-disqualifying reporting requirement for involuntarily committed patients—a change that perhaps goes too far in the other direction. That provision, if enacted, would require reporting to the federal background check database the names of people involuntarily committed for danger-to-others concerns but not danger to self. The idea behind having a less stringent civil-commitment reporting requirement for people who might hurt themselves but not others was undoubtedly well intentioned: Not to stigmatize people with depression, infringe on their privacy, and chill their desire to seek help, all in a rush to enact stricter gun control. Avoiding those adverse consequences of reporting is presumably why Governor O’Malley rejected the New York–style provision that his task force had recommended. Do not the same problems arise in reporting danger-to-self commitments?

They are not the same. Equating the two is to lose sight of a crucial distinction between the context of a therapeutic encounter in which the law has not intruded—an encounter governed by the norms of confidentiality, patient autonomy, clinical judgment, and care—and a very different context in which the law has already breached the clinical relationship to render a judgment of dangerousness in a judicial proceeding—a proceeding governed by police powers, legal rights, and due-process requirements for overriding a person’s liberty. Here the problems of overidentification, the chilling effect, and the breach of confidentiality are moot: the individual already has been hospitalized against his or her will.

A rule ensuring that any future gun background check would deny a firearm to a formerly involuntarily committed patient who had threatened another’s life but not deny a firearm to a similar patient who had threatened his or her own life is a rule that lacks reason and fairness. Both of these categories of civilly committed dangerous individuals are already prohibited by federal law from purchasing a gun. From a public health perspective, neither of these individuals should possess a gun while they remain dangerous, and both should have an expedient opportunity for legal restoration of gun rights at the point they are deemed no longer dangerous. How best to provide such an opportunity for restoration—what federal law mandates as “relief from disabilities”—is a serious policy challenge that states must face in their renewed efforts to fill the background check databases with more and more mental health records. Developing workable models of judicial authority informed by clinical expertise, and finding the balance between safety and rights in the difficult decision to restore gun rights to mentally ill individuals who have lost those rights, is a task that perhaps cannot be accomplished on a tragedy-driven timeline measured in weeks.