Your Liberty or Your Gun? A Survey of Psychiatrist Understanding of Mental Health Prohibitors

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Introduction

When Justice Scalia declared in *Heller* that the Second Amendment protected an individual's right to bear arms, he excluded an important group from constitutional protection: Americans living with mental illness.[1] Since 1968, a group of laws known as mental health prohibitors have explicitly tied mental health treatment to gun restrictions.[2] The federal prohibitor bans firearm possession by anyone "committed to any mental institution," a group that includes only those civilly committed by court order.[3] Some state prohibitors go further, restricting gun ownership for people who voluntarily admit themselves for inpatient treatment or who are detained via an emergency hold (a typically 72-hour involuntary hospitalization of a person deemed to present a danger to themselves or others).[4] Hawaii restricts gun rights based on mere diagnosis of "a significant behavioral, emotional, or mental disorder."[5]

No study has quantified mental health prohibitors' specific impact on firearm deaths and injury, and the link between mental illness and gun violence is complex.[6] Studies suggest that people with serious mental illness are only slightly more likely to be violent than the general population, though certain mental health conditions like active psychosis are associated with an elevated risk of violence.[7] Research does indicate a strong association between firearm access, mental illness, and suicide.[8] However, some charge that mental health prohibitors are both over-inclusive and under-inclusive as suicide prevention policies, disqualifying low-risk individuals from gun access in some states and allowing high-risk individuals to obtain guns in others.[9] For instance, evidence suggests that emergency hold prohibitors may prevent suicide among high-risk individuals, but states like Connecticut restrict gun rights based on voluntary admissions (arguably a lower risk group) and not emergency holds.[10]

By conditioning gun rights on medical treatment, some states grant mental health providers a near-unilateral power to constrain a patient's Second Amendment rights. Yet no studies to date have explored how mental health professionals understand these laws, or their clinical and ethical role in informing patients about how their treatment implicates gun rights. Given informed consent's vital role in the ethical practice of medicine and the high stakes of psychiatric decision-making around hospitalization, we sought to explore psychiatrists' knowledge of prohibitor laws through a first-of-its kind national survey.

The survey revealed substantial evidence of clinicians being uninformed and misinformed, and misinforming patients of their gun rights following involuntary civil commitments and voluntary inpatient admissions. Many psychiatrists had inaccurate and incomplete knowledge of their state's mental health prohibitors. A significant percentage of psychiatrists (36.9%) did not understand that an involuntary civil

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The Journal of Law, Medicine & Ethics, 48 S2 (2020): 155-163. © 2020 The Author(s)
DOI: 10.1177/1073110520979417

commitment triggered the loss of gun rights, and the majority of psychiatrists in states with prohibitors on voluntary admissions (57.3%) were unaware that patients would lose gun rights upon voluntary admission.

More troublingly, while a substantial portion of surveyed psychiatrists (56%) reported never informing patients about any of the prohibitors, many reported misinforming their patients about their state's laws. Around 13% of respondents in states without a voluntary admissions prohibitor had incorrectly informed a patient they could lose gun rights by voluntarily admitting themselves for inpatient treatment. There was also evidence that psychiatrists used gun rights to negotiate "voluntary" commitments with patients: 15.9% of respondents reported telling patients they could preserve their gun rights by permitting themselves to be voluntarily admitted for treatment, in lieu of being involuntarily committed. Many of the respondents who reported negotiating over gun rights practiced in voluntary admissions prohibitor jurisdictions; in those cases, patients may opt to receive inpatient treatment based on a false belief that they could preserve their gun rights. While the scope of a psychiatrist's ethical duty to inform patients is unclear, these cases raise questions of whether psychiatrists obtained full informed consent for patients' admission.

Our surveys suggest that medical providers in states with voluntary admission prohibitor laws may unknowingly deprive their patients of a constitutional right, implicating due process protections. Patients may be deprived unfairly of the use of their property without informed consent, and, in some jurisdictions, patients whose cases do not meet the legal standard for involuntary commitment may be improperly induced into institutionalization in order to preserve gun rights. Yet, to date, most psychiatrists receive no formal or mandatory training around these laws.

States without voluntary admission prohibitors therefore present some patients with a stark choice: Your liberty or your gun rights? Indeed, many respondents to the survey expressed discomfort with the potential impact of the prohibitors on patient rights, as well as their potential to dehumanize patients, compromise the therapeutic relationship, and chill mental health treatment. Respondents expressed more support for risk-based gun removal laws, like discretionary Extreme Risk Protection Orders (ERPOs), that allow physicians to report medical risk factors of suicidality or dangerousness and petition for gun removal.[11]

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Methodology

Mental Health Prohibitors in Targeted States

We targeted psychiatrists in 10 jurisdictions in four broad categories of state mental health prohibitors: (1) states that only had the federal prohibitor on civil commitments ("involuntary commitment prohibitor"); (2) states that had prohibitors on patients admitted under emergency holds ("emergency hold prohibitor"); (3) states that had prohibitors for voluntary admissions ("voluntary admission prohibitor"); and (4) states with a mental health prohibitor based on a patient diagnosis ("diagnosis prohibitor").

Mental health prohibitors tie medical treatment — for example, an involuntary hold, a civil commitment, voluntary admission, or diagnosis — to an automatic loss of gun rights. Notably, while involuntary commitments implicate individual rights *during hospitalization* such as patient liberty and bodily autonomy, access to firearms is the exceptional right restricted *after* civil commitment.[12] These laws are distinct from other gun control laws concerning mental health, such as ERPOs, which may allow mental health professionals to report to law enforcement officials or directly petition a court for gun removal from violent or suicidal patients. Table 1 details the coding of each juris-

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Table 1
Summary of State Laws on Mental Health and Gun Rights

	Involuntary commitment prohibitor	Emergency hold prohibitor	Voluntary admission prohibitor	Diagnosis prohibitor
California	Yes	Yes	X	X
Connecticut	Yes	X	Yes	X
DC	Yes	X	Yes	X
Florida	Yes	X	X	X
Illinois	Yes	X	Yes	X
Hawaii	Yes	X	X	Yes
New Hampshire	Yes	X	X	X
New York	Yes	X	X	Yes
Texas	Yes	X	X	X
Washington	Yes	Yes	X	X

diction's law for the survey analysis, differentiated by slight nuances that merit brief discussion.

First, of the states targeted, Florida, New Hampshire, and Texas *only* had a mental health prohibitor for court-ordered involuntary commitments. The federal mental health prohibitor on involuntary commitments facially applies in all 50 states and DC Therefore — while New Hampshire does not currently have a state law requiring the reporting of involuntary commitments by court order for background checks — all states were coded as having a mental health prohibitor on involuntary commitments. For more details, see Online Appendix Figure 1.

Second, only California and Washington had mental health prohibitors associated with emergency holds. Crucially, California's five-year prohibitor on gun ownership only applies for patients placed on a 72-hour hold (a Section 5150 hold) and then subsequently admitted for further treatment, as well as Section 5250 holds (14 days) that must be approved by a court. California also bars individuals from gun ownership *for life* if they are held on a 5150 and subsequently admitted more than once in a year. Washington's provision applies for six months after a patient is detained on a 72-hour hold for evaluation or treatment. See Online Appendix Figure 2.

Next, three jurisdictions surveyed — Connecticut, Illinois, and DC — prohibit, for a period of time, firearm ownership for residents who voluntarily admitted themselves for inpatient treatment. Connecticut's prohibitor lasts for six months after the patient is released from their voluntary admission, while the prohibitors in DC and Illinois last for five years. See Online Appendix Figure 3.

Hawaii and New York were classified as states whose prohibitors are triggered on the mere diagnosis of a mental health condition. New York's diagnosis prohibitor requires residents seeking firearm licenses to disclose whether or not they have "ever suffered any mental illness," which can result in an applicant's rejection. Additionally, New York psychiatrists are *required* to report patients they determine are "likely to engage in conduct that would result in serious harm to self or others." In practice, these reports are allegedly "rubber-stamped" and automatically lead to revocation of a patient's right to own a gun for five years.[13] See Online Appendix Figure 4.

Survey Design

The thirteen-question survey, hosted online over Yale's Qualtrics platform, assessed: (1) if and how psychiatrists communicated with their patients about firearm ownership; (2) their understanding of their state's mental health prohibitors through a series of yes-or-no questions; (3) whether they informed patients when they could lose gun rights; (4) whether they ever used a mental health prohibitor to negotiate for voluntary admission, as opposed to an involuntary commitment; and (5) their attitudes toward ERPOs and reporting at-risk patients to law enforcement. In order to assess

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whether responses changed based on awareness of the gun violence crisis, the survey also randomly assigned respondents to a primed or unprimed condition in which the primed subjects were reminded of the firearm suicide epidemic at the beginning of the survey. Participants could submit additional comments in an optional text box. Full survey questions are included in Online Appendix Figure 5.

Survey Recruitment

Depending on the state, a large range of mental health professionals and state actors can petition for involuntary commitments or emergency holds. These include law enforcement, nurses, social workers, psychologists, and emergency medicine providers. We opted to survey only psychiatrists and psychiatric residents because they are the individuals that typically file for commitments.

Participants who were emailed were randomly selected from those listed for the 10 targeted jurisdictions in the American Psychiatric Association (APA) member directory.[14] As a recruitment incentive, respondents had the option to compete to win a pair of Apple AirPods. Between March 11, 2020 and April 7, 2020, individual emails were sent to 5,110 psychiatrists and psychiatric residents.

The survey received 516 anonymized responses — 485 from the targeted states — for a response rate of 10.1%.

SURVEY LIMITATIONS

The low response rate could lead to a non-representative sample. As such, the survey results should not be construed to completely capture the entire population of American psychiatrists. Additionally, the implementation of each state's prohibitor varies from state-to-state, and so while the literal application of a prohibitor would results in gun rights being limited, the laws had differing practical effect in certain jurisdictions. For example, in California, the law — which is triggered only if the patient is admitted *after* an emergency hold — could have been plausibly interpreted by respondents as not being an emergency hold prohibitor *per se*.

Results

Initial Communication with Patients Regarding Firearms

Table 2 reports the practicing jurisdictions of respondents: (1) 107 responses from jurisdictions with prohibitors solely on involuntary commitments; (2) 120 responses from jurisdictions with prohibitors on emergency holds; (3) 185 responses from jurisdictions with prohibitors on voluntary admissions; and (4) 73 responses from jurisdictions with diagnosis prohibitors. An overwhelming majority of respondents — 94.6% — had a patient who had been involuntarily committed. State-specific summaries of responses to each question are available in Online Appendix Figure 7.

A little over half of respondents — 53% — reported that they "often" or "always" asked patients about firearms. A few added in the optional textbox that they were child or adolescent psychiatrists, and therefore they were less likely to ask patients about gun ownership. Only 7% of psychiatrists reported "never" or "rarely" asking patients about firearms, frequently cit-

Table 2

Practicing Jurisdiction, Commitment Activity, and Firearm Communications

State	Number of Respondents	Percent of Total Respondents
California	51	10.5%
Connecticut	82	16.9%
District of Columbia	39	8.0%
Florida	38	7.8%
Hawaii	28	5.8%
Illinois	64	13.2%
New Hampshire	19	3.9%
New York	45	9.3%
Texas	50	10.3%
Washington	69	14.2%
Does respondent routinely ask patients if they own firearms?		
Yes	459	94.6%
No	26	5.4%
Has respondent ever had a patient who was involuntarily committed?		
Never	7	1.4%
Rarely	27	5.6%
Sometimes	194	40.0%
Often	117	24.1%
Always	140	28.9%

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ing that they did not believe the question was necessary unless the patient reported they were homicidal or suicidal. A Washington psychiatrist remarked that they "only assess if patients have access to guns if they express suicidal ideation. Most of my patients are the worried, high-functioning [type] in private practice." An Illinois psychiatrist submitted that: "I am not a good survey participant since my patient cohort is not as ill or violent as would require these considerations." Another Washington psychiatrist echoed: "If a patient has never had suicidal ideation or [has] not for many years, I don't ask about whether they have firearms."

There was no statistically significant difference for survey responses between the unprimed group and the group primed with the question regarding the suicide epidemic.

Psychiatrist Knowledge of Mental Health Prohibitor Laws

Table 3 details the proportion of respondents who inaccurately responded to questions concerning their jurisdictions' prohibitors. Notably, respondents both overestimated and underestimated the force of their state prohibitors, indicating an urgent need for psychiatrist education and training. Underlying estimates can be found in Online Appendix Figures 7 and 8.

First, while the federal prohibitor applies in all states, over a third of total respondents (36.9%) inaccurately responded that an involuntary court-ordered commitment did not trigger the loss of gun rights. Notably, the majority of psychiatrists in New Hampshire (57.9%) and Texas (54%) — two states with more relaxed gun control laws — underestimated the force of an involuntary commitment on gun rights.

Second, the majority of respondents in states with emergency hold and voluntary admission prohibitors underestimated the force of their states' laws, mistakenly reporting that those interventions *did not* lead to the loss of gun rights. Roughly 57% of participants in locations with voluntary admission prohibitors believed that a patient's voluntary admission to inpatient treatment would not trigger the loss of gun rights. A slight majority of respondents in Illinois (57.8%) — which has some of the strictest gun laws in the nation — correctly construed the law. But the vast majority of respondents in DC (87.2%) and a slight majority of respondents in Connecticut (54.9%) believed that voluntary inpatient treatment had no impact on gun rights. Notably, eight percent of respondents in jurisdictions without voluntary admission prohibitors mistakenly reported that voluntary admission would result in a loss of gun rights.

Likewise, while the majority of participants in states *without* emergency hold prohibitors correctly understood that a temporary hold did not trigger a loss of gun rights, the majority of respondents in Washington and California (roughly 56%) inaccurately reported that an emergency hold did not trigger the loss of gun rights for patients. (As California's emergency hold law is only triggered after the initial 72-hour period, a robustness check was performed on the results where California was not classified as an emergency hold state — in those circumstances, 71.0% of Washington respondents inaccurately interpreted the law). The majority of California respondents, however, understood the law as an emergency hold prohibitor (64.7%). Washington psychiatrists may have been less aware of the law as their emergency hold prohibitor was only enacted in May of 2019, less than one year before the survey.[15]

Finally, a significant percentage of psychiatrists without a diagnosis prohibitor (43.2%) overestimated the force of their state law, mistakenly reporting that patients could lose their gun rights based on the force

Table 3

Share of Jurisdiction Respondents with Mistaken Beliefs about Prohibitors

	Jurisdiction With Prohibitor Law	Jurisdiction Without Prohibitor Law
Inaccurate Response on Involuntary Commitment Prohibitor	36.9%	–
Inaccurate Response on Emergency Hold Prohibitor	55.8%	25.2%
Results if California is not classified as an emergency hold state	71.0%	30.0%
Inaccurate Response on Voluntary Admission Prohibitor	57.3%	8.3%
Inaccurate Response on Diagnosis Prohibitor	39.7%	43.2%

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https://doi.org/10.1177/1073110520979417 Published online by Cambridge University Press

of their diagnosis. However, in Hawaii and New York, states with codified diagnosis prohibitors, roughly 60% of respondents correctly understood that their diagnosis of serious mental disorder could trigger the revocation of gun rights. In Hawaii, with its explicit statutory prohibitor, 67.9% of respondents correctly answered the diagnosis question; in New York, 55.6% understood that a diagnosis could result in revocation of gun rights. Some New York psychiatrists reported confusion about the SAFE system, noting that "[w]e use the SAFE act reporting system but we never know what happens afterwards." Another psychiatrist wrote:

> I fill out SAFE ACT paperwork for all patients who are psychiatrically admitted to hospital. My understanding was that this paperwork (which I highly doubt is every really reviewed by a human) merely places [patient] on a list such that their requests to purchase a gun are more redflagged or more carefully vetting — NOT that they cannot ever permanently buy a gun.

While reporting indicates that SAFE Act reports are *not* reviewed by a human, most reports are placed in a database barring state residents from obtaining a fire-

Table 4

Informed Consent for Involuntary and Voluntary Commitments

Informed patients they will lose gun rights if involuntarily committed	**Total (485 respondents)**	
Never	60.0%	
Rarely	17.9%	
Sometimes	7.0%	
Often	10.5%	
Always	4.5%	
TOTAL	**100.0%**	
Informed patients they will lose rights if voluntarily admitted	**No Voluntary Admission Prohibitor (300 respondents)**	**Voluntary Admission Prohibitor (185 respondents)**
Never	86.7%	62.7%
Rarely	7.3%	15.1%
Sometimes	1.3%	5.9%
Often	3.7%	9.2%
Always	1.0%	7.0%
TOTAL	**100.0%**	**100.0%**
Have suggested to patients they can preserve rights through voluntary admission, versus involuntary commitment	**No Voluntary Admission Prohibitor (300 respondents)**	**Voluntary Admission Prohibitor (185 respondents)**
Never	83.0%	85.9%
Rarely	9.3%	5.4%
Sometimes	2.0%	1.1%
Often	5.3%	7.6%
Always	0.3%	0.0%
TOTAL	**100.0%**	**100.0%**

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arm license for five years. New Yorkers on the list must petition a court to have their gun permit restored.

Many participants expressed frustration that they did not understand their state's gun laws, indicating a need for further medical school and on-the-job training. One respondent from Illinois noted that, while they asked about guns as part of safety assessments: "I do not know anything about gun rights and mental health in [I]llinois. My answers were essentially guess[es]." A psychiatrist in New York wrote that "I was not aware till this very year that involuntary admission results in revoking of rights to possess firearms." Five separate psychiatric residents opined that they had received no education or training on firearms or gun rights; one DC respondent reported guessing on all questions and that "[t]o date (latter half of my first year of residency) I have received little to no instruction on local firearms laws and the effect of mental health hospitalizations on ability to purchase firearms."

Informed Consent & Coercive Bargaining Over Gun Rights

Table 4 summarizes the percentage of psychiatrists that informed patients about the mental health prohibitors, categorized by whether or not the respondent worked in a voluntary admission prohibitor jurisdiction. The survey indicates that psychiatrists' mistaken beliefs about gun laws lead them to communicate misinformation to patients about their rights. Some respondents indicated they may have induced patients into "voluntary" inpatient treatment based on misinformation: in voluntary admission prohibitor jurisdictions, 14.1% of respondents reported at times falsely suggesting to patients they could preserve gun rights through a voluntary admission, instead of being involuntarily committed.

The majority of surveyed psychiatrists (56%) reported never informing patients about either their state's voluntary admission or involuntary commitment prohibitor. And while psychiatrists manifestly should not misinform patients, it is troubling that 62.7% of respondents in voluntary admission prohibitor jurisdictions indicated that they never inform patients that voluntary admissions will result in a loss of constitutional rights. While the scope of psychiatrist's ethical duty to disclose is unclear, failing to describe the full consequences of voluntary admission may be inconsistent with obtaining informed consent to treatment, particularly if the psychiatrist reasonably believes it will impact patient decision-making. This is particularly concerning for certain patients, such as members of law enforcement, who may carry a firearm as part of their job, since loss of firearm access could affect their employment. Indeed, Florida law contemplates this scenario by requiring patients to sign a court-reviewed consent form waiving their gun rights upon voluntary admission where physicians assert that they would have filed a petition for involuntary commitment if the person had not ultimately agreed to voluntary hospitalization.[16]

Some respondents stressed that involuntary commitments and emergency holds were life-or-death decisions, where discussing gun rights would be inappropriate and counterproductive. As one Florida psychiatrist commented, "[w]hen patient is brought to ER voluntarily or involuntarily, we don't get into discussing their [g]un rights… There are so many other priorities." One New Hampshire respondent stated that "there are more important issues than gun rights when people need involuntary level of psychiatric care" and a New York psychiatrist commented that "this is emergency room medicine, and assessment of risk is the predominant concern." A California psychiatrist elaborated:

> [W]hen committing a patient to the ER/inpatient unit, the situation must be acute and imminently serious by its nature. Later consequences of such a decision, [e]ffects on the patient's ability to own or possess a gun, or other unfortunate negative [e]ffects on their future (stigma, job prospects, etc.) are not on the forefront of the psychiatrist's mind … If a patient came into the ER bleeding out, and sending him/her into surgery in an attempt to save that patient's life means he or she may not possess a gun for a 5 or 10 year period or longer, as physicians, the hope is we decide to save the life at hand …

Still other psychiatrists worried that informing patients of a loss of gun rights could result in violence. A psychiatrist working at a Connecticut Veterans Administration hospital commented "my concern would be that it would just make them upset and not want to go at all and then get agitated, and possibly aggressive, which puts staff at risk of harm."

In states with *no* voluntary admission prohibitor, a significant percentage of respondents — 13.3% — reported on at least one occasion misinforming patients they could lose gun rights by admitting themselves for inpatient treatment. Such misinformation could deter patients from inpatient treatment on a mistaken belief they could lose gun rights.

Finally, many psychiatrists reported using the threat of an involuntary commitment — and subsequent loss of gun rights — to encourage patients to voluntarily

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admit themselves. 15.9% of respondents reported having suggested to patients, at least once, that they could preserve their gun rights by avoiding an involuntary commitment through a voluntary admission. Some respondents indicated they leveraged Second Amendment rights to induce a voluntary admission *based on misinformation*: 14.1% of respondents in voluntary admission prohibitor jurisdictions reported falsely telling patients that a voluntary admission would not impact their rights. In those cases, vulnerable patients may have decided to voluntarily forgo their liberty under a mistaken belief they could preserve their gun rights.

Some respondents reported changing treatment decisions in order to *preserve* their patients' gun rights. In Connecticut — where 18.3% of respondents reported telling patients they should voluntarily admit themselves to preserve access to firearms — respondents may have negotiated with patients over gun rights before 2013, when the state's voluntary admissions prohibitor went into effect. One Connecticut psychiatrist commented: "Prior to law change I … informed [p]atients that by admitting themselves voluntarily they preserved the right to own firearm." After the law change, another Connecticut psychiatrist reported occasionally recommending an emergency hold over a voluntary admission "so that a patient whose work requires firearm access (e.g. law enforcement) may obtain treatment and continue to retain their firearm." Two California psychiatrists also reported that "public defenders push off 5250 involuntary hold certification hearings to avoid patients from being found by the court to need commitment which then makes buying a gun a felony for five years."

Psychiatrist Feedback on Mental Health Prohibitors

In supplementary comments, psychiatrists expressed concern that mental health prohibitors were overly stigmatizing and could chill treatment; however, many respondents also expressed frustration that they had no case-by-case basis of safely disarming violent or suicidal patients. Respondents were generally supportive of ERPO laws, as long as they were flexible and not mandatory: The average respondent *would* use an ERPO for gun removal at least "sometimes" if they were available to them (see Online Appendix Figure 9 for details).

Many psychiatrists worried that prohibitor laws discriminated against their patients, and could disincentivize them from seeking treatment. One Connecticut psychiatrist stated "patients may not be honest about their mental health if they fear they will lose privileges like gun ownership." Another Connecticut psychiatrist called the mental health prohibitors "outmoded rubrics" that curbed patient rights, and a third lamented that "[g]un laws are excessively focused on the mentally ill." A Washington psychiatrist stated that "if American laws/society value the right to own guns, then individuals with mental illness's rights to own guns should have similar protections." Gun laws, commented one military psychiatrist from Texas, "tend to be concrete and draw clean lines but psychiatric symptoms and behaviors associated with diagnosis are anything but concrete and linear … it would severely compromise trust/rapport in patients who value their gun rights but are afraid/concerned [seeking treatment] will result in the loss of their firearm rights." In contrast to studies showing that access to guns are strongly associated with suicidality,[17] another Texan respondent stated:

> In my opinion, whether an individual has a gun or not doesn't matter. If they are motivated to kill themselves and have the urge to do so, they will find a way to do it … I was NOT aware that firearms could be restricted based off of involuntary commitments, holds, or even voluntary admission to the hospital. This would highly dissuade a number of patients' inpatient hospitalization.

However, another New York psychiatrist responded that, while he felt it was wrong that patients were mental illness were "singled out … if they represent a small proportion of those who may use firearms against others or, more likely, themselves, it seems egregious to not take steps to mitigate against risk once we are aware of it."

While respondents generally rejected the one-size-fits-all mental health prohibitors, psychiatrists, primarily from Texas and Florida, did indicate support for discretionary gun removal laws for at-risk patients, like ERPOs. Florida's ERPO law does not allow psychiatrists to directly petition for gun removal, while Texas has no ERPO law.[18] A Texan psychiatrist stated:

> Texas doesn't enforce removing guns. I even had a patient tell me point blank he was going to use his gun to shoot himself. Not only was he sent home from ER, even after wife said he was at danger, but also cops let him keep his firearms. This state doesn't take away firearms for involuntary holds, and no one would enforce it. It's a huge travesty.

Another Texan called it a "problem" that "[a]uthorities will not intervene when a violent, psychotic patient

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with a recent involuntary commitment is buying guns and making threats." A Florida psychiatrist reported being concerned for their safety:

> Though I have notified local law enforcement re: concern about certain patients and firearms, the firearms are usually not removed from them (in Florida); including somebody who was involuntary hospitalized for threatening to shoot a healthcare provider.

A Florida psychiatrist who reported being a "firm believer" in the Second Amendment commented that "there are rare times when it would be very appropriate to have someone's gun rights infringed. I wish this option existed."

Conclusion

This study indicates that many psychiatrists are ignorant of federal prohibitor laws and those of their state, causing them to mislead and misinform patients about the consequences of voluntary psychiatric treatment. Our results have profound implications not only for gun rights, but for liberty rights. In some cases, psychiatrists may inappropriately induce a patient's institutionalization through voluntary admission by threatening the loss of their Second Amendment rights from involuntary commitment, even though an involuntary commitment order would never have been issued. In other cases, vulnerable patients may unwittingly forfeit a constitutional right by obtaining voluntary treatment (and at times this forfeiture might be caused by psychiatrists' mistaken assurance that voluntary treatment would not trigger a loss of rights). Vulnerable patients may also fail to seek voluntary treatment because they were misinformed by their psychiatrist that they would lose their gun rights as a result.

This study reveals an urgent need for psychiatrist training on mental health prohibitor laws and recommended best practices when those laws impact patient treatment. However, the results may also call into question the general wisdom of state prohibitor laws as policy. It may be unrealistic to expect psychiatrists to stay appraised of the patchwork and ever-changing morass of state prohibitor laws, and even more unrealistic to expect medical professionals to engage in the delicate rights-balancing analysis that is usually reserved for courts. Flexible policies based on individual patient risk assessment, such as discretionary ERPO laws, may better equip providers to disarm at-risk firearm owners with mental illness.

Editor's Note

Additional materials for this article can be found in the Online Appendix.

Note

The authors do no have any conflicts of interest to disclose.

Acknowledgment

The authors would like to thank Zachary Shelley for excellent research assistance.

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15. Sen. Patty Kuderer, Press Release, *Governor Signs Legislation to Reduce Suicide by Firearms* (May 7, 2019).
16. Fla. Stat. § 790.065(2)(a)(4)(b)(II) (West 2020).
17. Baumann, *supra* note 8.
18. Fla. Stat. §790.401, et seq. (West 2020).

The Journal of Law, Medicine & Ethics, 48 S2 (2020): 155-163. © 2020 The Author(s)

Your Liberty or Your Gun? A Survey of Psychiatrist Understanding of Mental Health Prohibitors

Cara Newlon, Ian Ayres, and Brian Barnett

APPENDIX

Figure 1

Summary of State Law for States with Mental Health Prohibitors Solely on Involuntary Civil Commitments

	Prohibitor based on involuntary commitment	State prohibitor based on an emergency hold	State prohibitor on voluntary admissions	State prohibitor on diagnosis
Florida	Yes	No	No	No
New Hampshire	Yes	No	No	No
Texas	Yes	No	No	No

Federal law prohibits possession of a firearm or ammunition by anyone who has been "adjudicated as a mental defective" or involuntarily "committed to any mental institution."[1] However, states are not required to report data on involuntary commitments by court order to the National Instant Criminal Background Check System (NICS), and states vary in their statutory codes respecting involuntary commitments. For purposes of this paper, three states were surveyed with mental health prohibitors *solely* based on involuntary commitments: Florida, New Hampshire, and Texas.

In Florida, state law requires the Florida Department of Law Enforcement (FDLE) to compile and maintain a database of persons who are prohibited from purchasing a firearm based on court records of involuntary commitments.[2] Florida has an additional provision including those "voluntarily" admitted for inpatient treatment in the definition of "committed [involuntarily] to a mental institution" for purposes of the prohibitor if: 1) a physician asserts that he or she would have filed a petition for involuntary commitment if the person had not agreed to go voluntarily; 2) the patient has been notified that they may lose their gun rights and still gone forward with the treatment; and 3) a court has reviewed the certification.[3] Patients must then sign a form that states the following:

> "I understand that the doctor who examined me believes I am a danger to myself or to others. I understand that if I do not agree to voluntary treatment, a petition will be filed in court to require me to receive involuntary treatment. I understand that if that petition is filed, I have the right to contest it. In the event a petition has been filed, I understand that I can subsequently agree to voluntary treatment prior to a court hearing. I understand that by agreeing to voluntary treatment in either of these situations, I may be prohibited from buying firearms and from applying for or retaining a concealed weapons or firearms license until I apply for and receive relief from that restriction under Florida law."[4]

As the voluntary admission law is, by all accounts, rarely enforced — and amounts to an involuntary commitment in practice — Florida was coded as a state with a mental health prohibitor solely on involuntary commitment.[5]

In Florida, a mental health provider *may* (but is not required to) report persons to law enforcement if they have specifically threatened to cause serious bodily injury or death to a readily available person and the mental health provider believes that "the patient has the apparent intent and ability to imminently or immediately carry out such threat."[6] Law enforcement can then seek voluntary surrender of firearms or ammunition for 24 hours if they take that person into custody for an involuntary examination, or petition a court for an extreme risk protection order (ERPO) up to but not exceeding one year.[7] However, a psychiatrist's report does not independently or automatically lead to the revocation of the right to own a firearm.

https://doi.org/10.1177/1073110520979417 Published online by Cambridge University Press

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In New Hampshire, there is no law that requires the reporting of mental health information to NICS. In 2016, the legislature actually included a provision as part of their Medicaid expansion bill that prohibited "any person, organization, department or agency from submitting the name of any person to NICS on the basis that the person has been committed to a mental institution, except pursuant to a court order issued following a hearing in which the person participated and was represented by an attorney."[8] That portion of the law was repealed in 2018. New Hampshire has mandatory reporting requirements only for licensed psychotherapists (generally only psychologists) where a patient has communicated a "serious threat of physical violence" against a reasonably identifiable victim or victims.[9] However, at time the survey was conducted, New Hampshire had no ERPO law on the books to allow law enforcement to petition for firearm removal.[10S]

Finally, Texas has a statute that mandates reporting of patients to NICS who have been court-ordered to receive inpatient mental health services or placed in the long-term care of a residential facility.[11] Psychiatrists in Texas *may* disclose information to law enforcement if they determine that there is a "probability of imminent physical injury by the patient to the patient."[12] However, law enforcement are only allowed to seize a firearm for 15 days if someone is taken into custody of an inpatient mental health facility — there are no longer-term extreme risk protection orders.[13] Like Florida, a psychiatrist's report to law enforcement does not automatically trigger the loss of firearms.

Figure 2

Summary of State Law for States with Prohibitors Based on Emergency Holds

	Prohibition based on involuntary commitment	State prohibition based on an emergency hold	State prohibition on voluntary admissions	State prohibition on diagnosis
California	Yes[14]	Yes[15]	No	No
Washington	Yes[16]	Yes[17]	No	No

Psychiatric emergency hold laws permit involuntary admission to a health care facility of a person with an acute mental illness *without a court order*. The process of obtaining an emergency hold — and the procedural protections afforded to patients — vary greatly from state to state. Only California and Washington have mental health prohibitors associated with temporary emergency holds.

In California, patients can be involuntarily committed to a mental health facility under a 72-hour hold (a Section 5150 hold), a 14-day hold (a Section 5250 hold), a second additional 14-day hold (a Section 5260 hold) and a 30-day hold after completion of the initial Section 5250 14-day hold (Section 5270.51 hold).[18] Under a Section 5150 hold, a member of law enforcement, staff member at an evaluation facility designated by the county, or "other professional person designated by the country" may — upon probable cause that a person presents a danger to themselves or others — detain the patient for evaluation and treatment for a maximum of 72 hours (excluding Saturdays, Sundays, and holidays).[19] California's statutory firearm ban *only is initiated* if a person is admitted to a facility for inpatient treatment under Section 5151 and 5152 after the initial Section 5150 hold. That means California's five-year emergency hold prohibitor applies only if the emergency holds lasts longer than the initial 72 hours.

California's gun prohibitor based on an emergency hold can also be indefinite: If a patient has been taken into a 5150 hold and admitted for treatment "one or more times within a period of one year," they are barred from "owning, possessing, controlling, receiving, or purchasing a firearm *for the remainder of his or her life*."[20] The statute *also* requires that medical facilities inform patients that they are prohibited from "owning, possessing, controlling, receiving, or purchasing any firearm" for a period of time, and inform patients that they can request a hearing from the court.[21]

California psychiatrists are required by law to report patients to law enforcement who exhibit "a serious threat of physical violence" against another, also known as a "Tarasoff Warning."[22] State law bars anyone who has been

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the subject of a Tarasoff report from purchasing or possessing a firearm for five years after the report.[23] If a person wishes to own a firearm, they may petition superior court for a finding that they can use firearms in a safe and lawful manner.

Washington state's emergency hold prohibitor law is comparably less restrictive than California's. In Washington, any "designated crisis responder" — including psychiatrists, psychologists, physician assistance, nurse practitioners, and social workers[24] — who receives information that a person presents an imminent likelihood of serious harm can cause a person to be taken into emergency custody for 72 hours (excluding Saturdays, Sundays, and holidays). Individuals who have been detained for 72-hour evaluation and treatment under Section 71.05.153 and Section 71.05.150 of the Washington Code — but not subsequently involuntarily committed — "may not have in his or her possession or control any firearm for a period of six months after the date that the person is detained."[25] Upon discharge, the designated crisis responder must inform the patient orally and in writing that he is prohibited from possessing or controlling any firearm and that he must surrender any firearms that he or she possesses.

Washington psychiatrists are under a mandatory duty to warn or take reasonable protections where patients communicate an actual threat of physical violence against a reasonably identifiable person.[26] A law enforcement officer can then petition for an extreme risk protection order that lasts up to one year.[27] However, a psychiatrist's report does not independently result in the revocation of the right to own a firearm.

Figure 3

Summary of State Laws for States with Prohibitors Based on Voluntary Admissions to Inpatient Treatment

	Prohibition based on involuntary commitment	State prohibition based on an emergency hold	State prohibition on voluntary admissions	State prohibition on diagnosis
Connecticut	Yes[28]	No	Yes[29]	No
DC	Yes[30]	No	Yes[31]	No
Illinois	Yes[32]	No	Yes[33]	No

Three states — Connecticut, Illinois, and Maryland — and the District of Columbia have some firearm prohibition on patients who have been voluntary admitted to inpatient treatment. Of those jurisdictions, Maryland was excluded from the survey recruitment as its prohibitor only applied to a narrow category of patients voluntarily admitted to inpatient treatment (only if they have been "voluntarily admitted for more than 30 consecutive days to a facility").[34]

As of October 1, 2013, Connecticut law places a six-month statutory prohibitor on firearm and ammunition purchase or possession on patients who have been voluntarily admitted to a psychiatric hospital.[35] The statute specifically excludes those who were admitted solely for substance abuse issues. While Connecticut bars patients from accessing guns who have been voluntarily admitted for inpatient treatment, patients who have been admitted through an emergency hold — a physician's emergency certificate (PEC) — have no prohibition on firearm access. This has been described as a "huge gap in policy" and Connecticut Senator John McKinney that the legislature was not aware the prohibitor wouldn't cover PECs when the law was passed.[36]

Connecticut allows, but does not require, psychiatrists to report patients to law enforcement who present an imminent risk of personal injury to themselves or others.[37] Law enforcement can then petition the state for an ERPO that lasts up to a year.[38] However, a report by a psychiatrist does not automatically lead to the revocation of gun rights.

In the District of Columbia, no person or organization can access or control a firearm unless they pass a DC background check and hold a valid registration certificate.[39] The District's mental health prohibitions pertain to

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those registration certificates. Like Connecticut, DC's prohibition does not apply to 48-emergency holds under Section 21-521,[40] but does for firearm registration applicants who have been voluntarily admitted to a mental health facility within the past five years.[41] Mental health providers in DC *may* report patients to law enforcement that present a "substantial risk of imminent and serious physical injury" to themselves or others.[42] They additionally can petition for the removal of firearms for up to one year via DC's ERPO law.[43]

In Illinois — implemented as part of the Firearm Owners Identification Card (FOID) Act, which requires every Illinois citizen to obtain a license before they purchase or possess firearms or ammunition — a person in Illinois cannot lawfully possess or be sold a firearm if they have been voluntarily admitted "within the past 5 years."[44] The statute excludes treatment that was voluntary and solely for an alcohol abuse disorder and no other secondary substance abuse disorder or mental illness.[45]

In addition to a five-year firearm prohibitor for patients who have been voluntarily admitted to inpatient treatment, Illinois has extensive reporting requirements. Clinicians must report any patients whom they believe pose a "clear and present" danger to themselves, another person, or the community to the DHS within 24 hours.[46] Clear and present danger is defined as a person who: communicates a serious threat of physical violence against a reasonable identifiable victim or poses a clear and imminent risk of harm to himself; herself, or another person; or 2) demonstrates threatening physical or verbal behavior, such as violent, suicidal, or assaultive threats, actions or other behavior.[47] Law enforcement can then revoke an owner's FOID card.[48]

Figure 4

Summary of State Laws for States with Prohibitors Based on a Diagnosis to Inpatient Treatment

	Prohibition based on involuntary commitment	State prohibition based on an emergency hold	State prohibition on voluntary admissions	State prohibition on diagnosis
Hawaii	Yes[49]	No	No	Yes[50]
New York	Yes[51]	No	No	Yes[52]

Hawaii has some of the most restrictive gun prohibitions in the country pertaining to mental health. Their current mental health prohibitors bars anyone "diagnosed as having a significant behavioral, emotional, or mental disorders as defined by the most current diagnostic manual of the American Psychiatric Association."[53] The statute also bars those under treatment or counseling for substance abuse or addiction.[54] Psychiatrists in Hawaii must disclose mental health information of persons seeking a firearm to law enforcement in response to requests for such information.[55] Mental health professionals can also petition for gun removal for up to one year under Hawaii's ERPO law.[56]

New York's prohibitor on diagnosis is more nuanced than the Hawaii law. First, to obtain a gun license in the state of New York, a person must disclose whether or not he or she has "ever suffered any mental illness" to the licensing authority, which can result in the denial of a license.[57] As part of the SAFE Act, any "mental health professional" — including physicians, psychologists, nurses, and clinical social workers — are also *required* to report to the New York Director of Community Services if they determine that a person they are treating is "likely to engage in conduct that would result in serious harm to self or others."[58] That information is then intended to be reviewed by the New York Department of Criminal Justice Services for the purpose of determining if the person is ineligible or eligible to possess a firearm. In practice, however, a report begins an "automatic process that results in revocation of a patient's right to bear arms."[59] All reports are effectively "rubber-stamp[ed]" and patients are placed in a no-gun list for the following five years. In 2014, the database had reportedly ballooned to roughly 34,500 individuals prohibited from accessing firearms.[60]

https://doi.org/10.1177/1073110520979417 Published online by Cambridge University Press

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Survey Language

Figure 5

Survey Language

The survey began with filtering questions to identify the participants' current location and ensure that participants were 18 or older and psychiatrists or psychiatric residents:

1. Are you 18 years of age or older? (Y/N)
2. Are you a psychiatrist or psychiatric resident? (Y/N)
3. In what state do you currently practice medicine? [Drop down menu to select state].

Participants were then directed to answer the following questions:

1. As a psychiatrist, have you ever had a patient who was involuntarily committed? (Y/N)
2. Do you routinely ask patients with mental health conditions if they own firearms? (Likert Scale: 1 (never) to 5 (always))
   a. Question 2 was randomized for 50% of the participants as follows: As you may be aware, firearm suicide claims the lives of over 22,000 Americans every year. Do you routinely ask patients if they own firearms? (Likert Scale: 1 (never) to 5 (always))
   b. If participants answered "rarely" or "never" for either version of the question, a contingent question appeared: What factors might make you refrain from asking patients with mental health conditions if they own firearms? A) Believe that it interferes with their second amendment rights; B) Concerned it could damage relationship with patient; C) Don't find it necessary unless patient is reporting they are suicidal or homicidal; D) I have never thought to ask; E) Other._____
3. Is it your understanding that in [state] patients *who are involuntarily committed (by a court)* lose their right to purchase or possess a gun? (Y/N)
4. Is it your understanding that in [state] patients *who are admitted on an emergency hold* lose their right to purchase or possess a gun? (Y/N)
5. Is it your understanding that in [state] patients *who are voluntarily admitted to inpatient treatment* lose their right to purchase or possess a gun? (Y/N)
6. Is it your understanding that in [state] patients *who are diagnosed with a serious mental disorder* can lose their right to purchase or possess a gun? (Y/N)
7. Do you inform patients that they will lose the right to purchase or possess a firearm if they are involuntarily committed by court order? (Likert Scale: 1 (never) to 5 (always))
8. Do you inform patients that they will lose the right to purchase or possess a firearm if they are voluntarily admitted for inpatient treatment? (Likert Scale: 1 (never) to 5 (always))
9. Have you suggested to patients that they can preserve their right to purchase or possess firearms if, instead of being involuntarily committed by court order or emergency hold, they allow themselves to be voluntarily admitted? (Likert Scale: 1 (never) to 5 (always))
10. Do patients ever raise questions about what will happen to their gun rights if they are involuntarily committed or voluntarily admitted to inpatient treatment? (Likert Scale: 1 (never) to 5 (always))
11. Have you reported a patient to a state database or law enforcement in [state] because they present a danger to themselves or others? (Likert Scale: 1(never) to 5 (always))
12. Do you inform patients that they may lose their right to purchase or possess a firearm due a report by you? (Likert Scale: 1 (never) to 5 (always))
13. If extreme risk protection order (ERPO) reporting — also known as "red flag" petitioning in cases where patients present a risk of harm to themselves or others — was optional for psychiatrists, how often would you petition for firearm removal from a patient? (Likert Scale: 1 (never) to 5 (always))
14. Optional: Is there anything else related to this survey or mental health and gun rights that you'd like us to know? [OPTIONAL TEXT BOX]
15. Optional: Please let us know one or two additional emails of other mental health professionals who might be interested in completing this survey: [OPTIONAL TEXT BOX]

https://doi.org/10.1177/1073110520979417 Published online by Cambridge University Press

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Figure 6

State-by-State Results Breakdown

	California	Connecticut	District of Columbia	Florida	Hawaii	Illinois	New Hampshire	New York	Texas	Washington	**Total**
N	51	82	39	38	28	64	19	45	50	69	**485**
	%	%	%	%	%	%	%	%	%	%	**%**
Ever committed a patient											**485**
No	7.8%	3.7%	7.7%	2.6%	10.7%	6.3%	5.3%	6.7%	6.0%	1.4%	**5.4%**
Yes	92.2%	96.3%	92.3%	97.4%	89.3%	93.8%	94.7%	93.3%	94.0%	98.6%	**94.6%**
Routinely ask patients if they own firearms											
Never	3.9%	1.2%	5.1%	0.0%	0.0%	1.6%	5.3%	0.0%	0.0%	0.0%	**1.4%**
Rarely	5.9%	6.1%	15.4%	0.0%	10.7%	6.3%	0.0%	4.4%	4.0%	2.9%	**5.6%**
Sometimes	45.1%	41.5%	20.5%	31.6%	28.6%	50.0%	36.8%	37.8%	50.0%	40.6%	**40.0%**
Often	19.6%	20.7%	28.2%	26.3%	25.0%	23.4%	15.8%	31.1%	22.0%	27.5%	**24.1%**
Always	25.5%	30.5%	30.8%	42.1%	35.7%	18.8%	42.1%	26.7%	24.0%	29.0%	**28.9%**
Believe that patients involuntarily committed (court-ordered) lose gun rights											
No	15.7%	42.7%	48.7%	47.4%	46.4%	20.3%	57.9%	40.0%	54.0%	24.6%	**36.9%**
Yes	84.3%	57.3%	51.3%	52.6%	53.6%	79.7%	42.1%	60.0%	46.0%	75.4%	**63.1%**
Believe that patients committed on an emergency hold lose gun rights											
No	35.3%	78.0%	66.7%	84.2%	71.4%	59.4%	94.7%	71.1%	86.0%	71.0%	**70.1%**
Yes	64.7%	22.0%	33.3%	15.8%	28.6%	40.6%	5.3%	28.9%	14.0%	29.0%	**29.9%**
Believe that patients voluntarily admitted to inpatient treatment lose gun right											
No	86.3%	54.9%	87.2%	92.1%	75.0%	42.2%	100.0%	91.1%	96.0%	97.1%	**78.6%**
Yes	13.7%	45.1%	12.8%	7.9%	25.0%	57.8%	0.0%	8.9%	4.0%	2.9%	**21.4%**
Believe that patients diagnosed with a serious mental disorder lose gun rights											
No	62.7%	56.1%	53.8%	47.4%	32.1%	37.5%	84.2%	44.4%	50.0%	75.4%	**54.2%**
Yes	37.3%	43.9%	46.2%	52.6%	67.9%	62.5%	15.8%	55.6%	50.0%	24.6%	**45.8%**
Informed patients they will lose rights if involuntarily committed											
Never	39.2%	62.2%	82.1%	57.9%	64.3%	48.4%	73.7%	80.0%	66.0%	49.3%	**60.0%**
Rarely	15.7%	15.9%	10.3%	10.5%	14.3%	29.7%	15.8%	11.1%	14.0%	29.0%	**17.9%**
Sometimes	11.8%	9.8%	2.6%	7.9%	10.7%	4.7%	5.3%	0.0%	8.0%	7.2%	**7.0%**
Often	17.6%	9.8%	5.1%	18.4%	10.7%	7.8%	5.3%	4.4%	12.0%	11.6%	**10.5%**
Always	15.7%	2.4%	0.0%	5.3%	0.0%	9.4%	0.0%	4.4%	0.0%	2.9%	**4.5%**
Informed patients they will lose rights if voluntarily committed											
Never	78.4%	53.7%	92.3%	86.8%	78.6%	56.3%	100.0%	88.9%	88.0%	89.9%	**77.5%**
Rarely	7.8%	13.4%	5.1%	7.9%	10.7%	23.4%	0.0%	8.9%	8.0%	5.8%	**10.3%**
Sometimes	3.9%	9.8%	2.6%	0.0%	3.6%	3.1%	0.0%	0.0%	2.0%	0.0%	**3.1%**
Often	5.9%	13.4%	0.0%	5.3%	7.1%	9.4%	0.0%	2.2%	2.0%	2.9%	**5.8%**
Always	3.9%	9.8%	0.0%	0.0%	0.0%	7.8%	0.0%	0.0%	0.0%	1.4%	**3.3%**
Suggested to patients they can preserve rights if voluntary committed											
Never	72.5%	81.7%	97.4%	76.3%	96.4%	84.4%	84.2%	95.6%	86.0%	78.3%	**84.1%**
Rarely	13.7%	6.1%	2.6%	7.9%	3.6%	6.3%	5.3%	4.4%	10.0%	13.0%	**7.8%**
Sometimes	2.0%	1.2%	0.0%	7.9%	0.0%	1.6%	0.0%	0.0%	0.0%	2.9%	**1.6%**
Often	11.8%	11.0%	0.0%	7.9%	0.0%	7.8%	10.5%	0.0%	4.0%	4.3%	**6.2%**
Always	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.4%	**0.2%**
Patients raise questions about gun rights											
Never	41.2%	47.6%	82.1%	36.8%	57.1%	43.8%	42.1%	75.6%	62.0%	46.4%	**52.6%**
Rarely	37.3%	26.8%	12.8%	31.6%	35.7%	28.1%	47.4%	22.2%	22.0%	40.6%	**29.7%**
Sometimes	0.0%	1.2%	0.0%	10.5%	3.6%	3.1%	0.0%	2.2%	6.0%	0.0%	**2.5%**
Often	21.6%	23.2%	5.1%	21.1%	3.6%	23.4%	10.5%	0.0%	10.0%	13.0%	**14.8%**
Always	0.0%	1.2%	0.0%	0.0%	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	**0.4%**
Have reported a patient to a state database or law enforcement as dangerous											
Never	31.4%	54.9%	46.2%	36.8%	53.6%	46.9%	52.6%	35.6%	44.0%	33.3%	**43.1%**
Rarely	13.7%	22.0%	23.1%	23.7%	21.4%	34.4%	26.3%	24.4%	28.0%	31.9%	**25.4%**
Sometimes	13.7%	2.4%	7.7%	10.5%	7.1%	9.4%	10.5%	22.2%	2.0%	7.2%	**8.7%**
Often	31.4%	19.5%	23.1%	21.1%	14.3%	7.8%	10.5%	15.6%	22.0%	24.6%	**19.6%**
Always	9.8%	1.2%	0.0%	7.9%	3.6%	1.6%	0.0%	2.2%	4.0%	2.9%	**3.3%**
Inform patients they may lose their rights due to your report											
Never	39.2%	58.5%	87.2%	55.3%	67.9%	51.6%	84.2%	68.9%	76.0%	72.5%	**63.9%**
Rarely	37.3%	20.7%	7.7%	18.4%	14.3%	32.8%	15.8%	6.7%	16.0%	21.7%	**20.6%**
Sometimes	0.0%	6.1%	0.0%	2.6%	3.6%	0.0%	0.0%	8.9%	4.0%	0.0%	**2.7%**
Often	17.6%	13.4%	2.6%	15.8%	14.3%	10.9%	0.0%	13.3%	4.0%	2.9%	**9.9%**
Always	5.9%	1.2%	2.6%	7.9%	0.0%	4.7%	0.0%	2.2%	0.0%	2.9%	**2.9%**
Would use ERPO for firearm removal from a patient											
Never	2.0%	2.4%	5.1%	10.5%	0.0%	0.0%	5.3%	4.4%	10.0%	1.4%	**3.7%**
Rarely	15.7%	34.1%	28.2%	21.1%	32.1%	15.6%	26.3%	17.8%	18.0%	31.9%	**24.3%**
Sometimes	27.5%	12.2%	28.2%	23.7%	25.0%	21.9%	21.1%	24.4%	24.0%	14.5%	**21.0%**
Often	43.1%	37.8%	23.1%	28.9%	32.1%	43.8%	42.1%	35.6%	44.0%	43.5%	**38.4%**
Always	11.8%	13.4%	15.4%	15.8%	10.7%	18.8%	5.3%	17.8%	4.0%	8.7%	**12.6%**

https://doi.org/10.1177/1073110520979417 Published online by Cambridge University Press

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Figure 7

Summary of Physician Understanding of Gun Laws (N = 485)

Believe that patients involuntarily committed (court-ordered) lose gun rights	Correct	Incorrect
No	0.0%	36.9%
Yes	63.1%	0.0%
Total	63.1%	36.9%

Believe that patients committed on an emergency hold lose gun rights	Correct	Incorrect
No	56.3%	13.8%
Yes	10.9%	19.0%
Total	67.2%	32.8%

Believe that patients voluntarily admitted to inpatient treatment lose gun rights	Correct	Incorrect
No	56.7%	21.9%
Yes	16.3%	5.2%
Total	73.0%	27.0%

Believe that patients diagnosed with a serious mental disorder lose gun rights	Correct	Incorrect
No	48.2%	6.0%
Yes	9.1%	36.7%
Total	57.3%	42.7%

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Figure 8

Reporting Questions

	Mean
Have reported a patient to state database or law enforcement (Likert Scale 1-5)	2.15
Have informed patients they may lose rights due to your report (Likert Scale 1-5)	1.67
Would use ERPO for firearm removal from a patient (Likert Scale 1-5)	3.32

Figure 9

Statistical Analysis of the Framed Question

Variable	(1) Unframed Mean/SE	(2) Framed Mean/SE	t-test p-value (1)-(2)
Routinely ask patients if they own firearms	3.722	3.746	0.790
	[0.062]	[0.065]	
Informed patients they will lose rights if involuntarily committed	1.701	1.930	0.037**
	[0.073]	[0.082]	
Informed patients they will lose rights if voluntarily committed	1.469	1.471	0.979
	[0.068]	[0.064]	
Suggested to patients they can preserve rights if voluntary committed	1.282	1.328	0.531
	[0.052]	[0.051]	
Patients raise questions about gun rights	1.714	1.902	0.053*
	[0.064]	[0.072]	
Have reported a patient to a state database or law enforcement as dangerous	2.021	2.270	0.028**
	[0.079]	[0.082]	
Inform patients they may lose their rights due to your report	1.614	1.730	0.250
	[0.072]	[0.070]	
Would use ERPO for firearm removal from a patient	3.299	3.336	0.706
	[0.072]	[0.068]	
Ever committed a patient	0.971	0.922	0.017**
	[0.011]	[0.017]	
Believe that patients involuntarily committed (court-ordered) lose gun rights	0.614	0.648	0.447
	[0.031]	[0.031]	
Believe that patients committed on an emergency hold lose gun rights	0.307	0.291	0.700
	[0.030]	[0.029]	
Believe that patients voluntarily admitted to inpatient treatment lose gun right	0.232	0.197	0.340
	[0.027]	[0.026]	
Believe that patients diagnosed with a serious mental disorder lose gun rights	0.436	0.480	0.334
	[0.032]	[0.032]	
N	241	244	
F-test of joint significance (p-value)			0.125
F-test, number of observations			485

The value displayed for t-tests are p-values.
The value displayed for F-tests are p-values.
Standard errors are robust.
***, **, and * indicate significance at the 1, 5, and 10 percent critical level.

https://doi.org/10.1177/1073110520979417 Published online by Cambridge University Press

APPENDIX
References

1. 18 U.S.C. § 922(d)(4) (2020).
2. Fla. Stat. § 790.065(2)(a)(4) (West 2020).
3. Fla. Stat. § 790.065(2)(a)(4)(b)(II) (West 2020)
4. *Id.*
5. J. Staletovich, "Florida Law Is Supposed to Keep Guns from the Violent and Mentally Ill. It's Not Working," *Miami Herald*, February 23, 2018, *available at* <https://www.miamiherald.com/news/local/article201835374.html> (last visited September 29, 2020).
6. Fla. Stat. § 394.4615 (West 2020).
7. Fla. Stat. § 394.463(2)(d)(1) (West 2020); Fla. Stat. § 790.401 et seq. (West 2020).
8. N.H. Rev. Stat. Ann. § 126-A:5(XXX)(e) (repealed 2018).
9. N.H. Rev. Stat. Ann. § 329-B:29 (West 2020).
10. However, an ERPO law did pass through the New Hampshire House in January of 2020. See H. Ramer, "NH House Passes Red-Flag Gun Bill," *Associated Press*, January 8, 2020.
11. Tex. Gov't Code Ann. § 411.0521(a) (West 2020).
12. Tex. Health & Safety Code Ann. § 611.004 (West 2020).
13. Tex. Code Crim. Proc. Ann. art. 18.191 (West 2020).
14. California's state statutory prohibitor on involuntary commitments includes: 1) any person who "has been adjudicated by a court of any state to be a danger to others as a result of a mental disorder or mental illness;" 2) has been adjudicated to be a "mentally disordered sex offender," and 3) any person who has been placed "under conservatorship by a court … because the person is gravely disabled as a result of a mental disorder or impairment of chronic alcoholism." In California, Britney Spears — who is currently under a conservatorship — would likely not be able to purchase a gun. Cal. Welf. & Inst. Code §§ 8103(a)(1)-(e)(1) (West 2020).
15. California's prohibition on firearm purchase, possession, and access lasts for a period of five years. Cal. Welf. & Inst. Code §§ 8103(f)(1)(A)-(C) (West 2020).
16. Washington specifies that the following individuals must have their information submitted to the NICs background check system: 1) a person is committed by court order under Section 71.05.240 (involuntary treatment for 14 days); 2) a person committed under Section 71.05.320 (treatment for an adult lasting 90 or 180 days); 3) a person committed under Section 71.34.740 (an involuntary commitment hearing for a minor), or 4) Section 71.34.750 (involuntary treatment for a minor for 180 days). Wash. Rev. Code Ann. § 9.41.047 (West 2020).
17. Wash. Rev. Code Ann. § 71.05.182 (West 2020).
18. Cal. Welf. & Inst. Code § 5150 (West 2020); Cal. Welf. & Inst. Code § 5250 (West 2020); Cal. Welf. & Inst. Code § 5260 (West 2020); Cal. Welf. & Inst. Code § 5270.15 (West 2020).
19. Cal. Welf. & Inst. Code § 5150(a) (West 2020).
20. Cal. Welf. & Inst. Code § 8103(f)(1)(B) (West 2020) (emphasis added).
21. Cal. Welf. & Inst. Code § 8103(f)(2)(B)(3) (West 2020).
22. Cal. Civ. Code § 43.92 (West 2020).
23. Cal. Welf. & Inst. Code § 8100(b).
24. *See generally* Wash. Rev. Code Ann. § 71.05.160 (West 2020).
25. Wash. Rev. Code Ann. § 71.05.182(1) (West 2020). *See also* Wash. Rev. Code Ann. § 71.05.153 West 2020); Wash. Rev. Code Ann. § 71.05.150 (West 2020).
26. Wash. Rev. Code Ann. § 71.05.120 (West 2020).
27. Wash. Rev. Code Ann. § 7.94.030 (West 2020).
28. Conn. Gen. Stat. § 29-36l(d)(2) (West 2020) (establishing the state process for submitting information on prohibited persons to NICs).
29. Conn. Gen. Stat. § 29-38b(a) (West 2020).
30. The District of Columbia has no federal reporting to NICs. However, the District of Columbia prohibits access to registration certificates for those who have been involuntarily committed by a mental facility by a court as defined in the federal regulations. *See generally* D.C. Code §§ 7-2502.03(a)(6)(A)(1)-5 (West 2020).
31. D.C. Code § 7-2502.03(a)(6)(A)(1) (West 2020).
32. In Illinois, the Department of State Police and the Department of Human Services must coordinate to submit to NICs information on those judicially committed involuntarily for purposes of background checks. 430 Ill. Comp. Stat. 65/3.1(e)(2) (West 2020).
33. 720 Ill. Comp. Stat. Ann. 5/24-3.1 (West 2020) (outlawing possession).
34. Md. Pub. Safety Code § 5-133(b)(9) (West 2020).
35. Conn. Gen. Stat. § 29-38b(a) (West 2020).
36. A. Becker, "Post-Newtown Gun Law Has a Mental Health Loophole, Critics Say," *CT Mirror*, February 14, 2014, *available at* <https://ctmirror.org/2014/02/14/gun-law-has-a-mental-health-loophole-critics-say/> (last visited September 29, 2020).
37. Conn. Gen. Stat. § 52-146c (West 2020).
38. Conn. Gen. Stat. § 29-38c (West 2020).
39. D.C. Code Ann. §§ 7-2502.01, 7-2502.06(a) (West 2020).
40. D.C. Code Ann. § 21-521 (West 2020).
41. D.C. Code Ann. § 7-2502.03(a)(6)(A)(1) (West 2020).
42. D.C. Code Ann. § 7–1203.03 (West 2020).
43. D.C. Code Ann. § 7-2510.01 et seq. (West 2020).
44. 720 Ill. Comp. Stat. Ann. 5/24-3.1(a)(4) (West 2020).
45. *Id.*
46. 405 Ill. Comp. Stat. Ann. 5/6-103.3 (West 2020).
47. 430 Ill. Comp. Stat. 65/1.1 (West 2020).
48. 430 Ill. Comp. Stat. Ann. 65/8 (West 2020).
49. *See generally* Haw. Rev. Stat. § 334-60.5 (West 2020).
50. Haw. Rev. Stat. § 334-60.5(c)(3) (West 2020).

https://doi.org/10.1177/1073110520979417 Published online by Cambridge University Press

APPENDIX
References (continued)

51. N.Y. Penal Law § 400.00(1)(j) (McKinney 2019).
52. *Id.* § 400.00(1)(i).
53. Haw. Rev. Stat. § 334-60.5(c)(3) (West 2020).
54. *Id.* § 334-60.5(c)(1).
55. Haw. Rev. Stat. Ann. § 134-3.5 (West 2020).
56. Haw. Rev. Stat. Ann. § 134-61 et seq. (West 2020).
57. N.Y. Penal Law § 400.00(i) (McKinney 2019).
58. N.Y. Mental Hy. Law § 9.46(b) (McKinney 2019).
59. M. Gamsin, Student Note, "The New York Safe Act: A Thoughtful Approach to Gun Control, or a Politically Expedient Response to the Public's Fear of the Mentally Ill?" *Southern California Law Review* 88 (2015): 16, 30.
60. A. Hartocollis, "Mental Health Issues Put 34,500 on New York's No-Guns List," *New York Times*, October 19, 2014, *available at* <https://www.nytimes.com/2014/10/19/nyregion/mental-reports-put-34500-on-new-yorks-no-guns-list.html> (last visited September 29, 2020).

https://doi.org/10.1177/1073110520979417 Published online by Cambridge University Press