Article

Firearm Laws, Patients, and the Roles of Psychiatrists

Donna M. Norris, M.D.

Marilyn Price, M.D.

Thomas Gutheil, M.D.

William H. Reid, M.D., M.P.H.

Objective: Persons with mental illness and/or substance abuse are frequently perceived by the public to be dangerous. This has resulted in an increase in state legislation restricting their ability to purchase, possess, register, obtain licensure, retain, and/or carry a firearm of any sort. The purpose of this article is to educate clinicians about the impact of firearms statutes and restrictions for their patients. Many state statutes mandate that treating psychiatrists report such gun possession to state justice or police departments. Psychiatrists may also have a statutory role in an appeals process.

Method: The firearms statutes of the 50 states, the District of Columbia, and Puerto Rico and the Federal National Firearms Act were surveyed, with particular attention paid to the ability of persons with mental illness and/or alcohol or substance abuse to obtain firearms. The results were tabulated.

Results: These statutes are not uniform. They vary in their definition of mental illness, the type and duration of gun restriction, reporting practices, the confidentiality of medical information, and the immunity of clinician reporters and appeals processes.

Conclusion: Clinicians would be wise to familiarize themselves with the provisions of the relevant statutes in their particular states. This will allow them to identify the consequences to their firearm-possessing patients, understand their own roles and obligations—if any—and better consider potential clinical and ethical issues for particular patients.

(Am J Psychiatry 2006; 163:1392–1396)

A growing trend has emerged in this country to restrict persons with mental disorders from possession, registration, licensure, retention, and/or the ability to carry a firearm if they have a history of treatment for mental illness or substance abuse (1). Just in 2004, nine additional states added persons with mental illness and/or alcohol or substance abuse to their class of prohibited persons. The definition of those who are prohibited varies significantly from persons with a history of voluntary outpatient treatment to those who are legally adjudicated mentally ill or "habitual drunkards." Regardless of the specific restrictions, the authors are alerting clinicians that they should be aware of state and federal laws that may, in some manner, impinge upon persons who are mentally ill and/or suffer from alcohol or substance abuse. Several other classes of individuals are prohibited from some form of firearm possession in the various states and, in some cases, in federal law (2, 3).

States vary according to whether or not a specific type of weapon is restricted for a particular class of persons; for example, the restriction may apply only to handguns and not to long guns, such as shotguns or rifles (3–55). State statutes also vary according to the period of time that the firearm prohibition applies, reporting practices, the confidentiality of psychiatric reports, the immunity of clinical reporters from lawsuits, and the appeals processes. Two statutes (those of California and Connecticut) mandate that treating inpatient psychiatrists report gun possession to law enforcement or judicial agencies (8, 10). Treating psychiatrists may also have a statutorily defined role in a patient's process in obtaining licensure. For example, in Massachusetts, a person who has been confined to an institution or a hospital for mental illness is restricted from gun licensure unless "the applicant submits with his application an affidavit of a registered physician attesting that such physician is familiar with the applicants' mental illness and that, in such physician's opinion, the applicant is not disabled by such an illness in a manner that should prevent such applicant from possessing a firearm" (25).

The purpose of this article is to alert clinicians that they may have additional responsibility under various firearms statutes in the United States. Each practitioner will need to review his or her own particular state statutes for clarification of the practitioner's duty and the consequences for their patients. Many online resources, such as the LexisNexis research database, can provide clinicians with the full text of each state statute.

Method

From late 2001 through February 2005, we surveyed the firearms statutes of the 50 states, the District of Columbia, and Puerto Rico, paying particular attention to the legal access to firearms by persons with mental illness and/or alcohol or substance abuse. There are various kinds of purchase requirements, both

This article is featured in this month's AJP Audio and is discussed by Dr. Appelbaum in his editorial on p. 1319.

state and federal—e.g., the "Brady bill." Under the provisions of the Brady Act (56), a background check on a prospective firearms purchaser and a 5-day waiting period are required. The Brady Act required the establishment of the National Instant Criminal Background Check System.

Some States Require Licenses to Carry Firearms or to Carry Concealed Firearms

The full text of the firearms statutes of each state, the District of Columbia, and Puerto Rico and the Federal National Firearms Act—which regulates access to firearms for persons with mental illness, alcohol abuse, and drug abuse—were obtained by referencing the particular states' web sites. We summarized the various restrictions for persons with mental illness and drug abuse according to the following topics: mental illness, drug abuse, alcohol abuse, the presence of a "mental health database," and the specifics of each state's law. These mental health databases contain mental health information that has been submitted by the courts and/or by mental health treatment facilities and are usually a repository for data from the state criminal justice system. In most jurisdictions, law enforcement authorities have access to these mental health data and can use them to determine legal access to firearms. Currently, 22 states maintain a mental health database. Each state's regulations are individualized in the manner in which they restrict the possession of firearms. Some states restrict individuals who have mental illness only, whereas others restrict individuals with drug and/or alcohol abuse only; still others have broadened the restrictive regulations to include all of these categories together or in some other designated combination (data supplement 1; available at http://ajp.psychiatryonline.org). Some states have established a database that is maintained by either the department of mental health or the state law enforcement agency.

Firearms can generally be divided into two major categories: handguns and long guns. For the purposes of this article, we use the term "firearm" to include "any weapon which will, or is designed to, or may readily be converted to expel a projectile by the action of an explosive" (3). Handguns can be held or fired with one hand (e.g., a revolver), whereas long guns, such as rifles or shotguns, require two hands to hold or fire. The sale and possession of handguns are particularly well regulated because handguns can be concealed and are involved in a majority of crimes in which a firearm is used (3). Long guns are used much less frequently in crime and are subject to less regulation than handguns. However, for the purposes of tabulation of the firearms statutes, we considered any restriction—whether it be the purchase, possession, registration, ability to obtain licensure, retention, and/or the carrying of any class of firearm that identifies persons with mental illness and/or alcohol or substance abuse as prohibited individuals.

We designated three categories of statutory restrictions. Category I refers to mentally ill persons, including those legally adjudicated as mentally ill, under guardianship, involuntarily committed, not guilty by reason of insanity, and/or incompetent to stand trial, as well as individuals who have been treated for a mental disorder, either as inpatients or outpatients. The commentary section of the table (data supplement 1) gives more details about the specific state law prohibitions. However, the full state's statute should be reviewed for completeness, especially since revisions in the law occur regularly.

Category II includes statutes that have restrictions for individuals with alcohol disorders, regardless of the nature and level of specific impairment. Some laws in this category are limited to those convicted of alcohol-related offenses, such as driving while intoxicated; others include individuals who are addicted or are habitually intoxicated or are chronic alcohol abusers. Still other statutes restrict individuals who have been in treatment for alcohol-related problems.

Category III includes statutes that have restrictions for individuals with drug abuse disorders, regardless of the nature and level of the specific impairment. This category includes laws that restrict or eliminate from consideration individuals who have been convicted of a drug-related crime and/or have received drug abuse treatment.

Results

The survey results tabulated in data supplement 1 and data supplement 2 include prohibitions of firearm licensure for persons with mental illness. Forty-three states, the District of Columbia, and Puerto Rico have prohibitions for persons with mental illness. Thirty-six states and Puerto Rico have prohibitions for drug abuse. Thirty-one states, the District of Columbia, and Puerto Rico have prohibitions for alcohol abuse. Twenty states and the District of Columbia have databases tracking individuals with mental illness.

Discussion

The firearms statutes are not uniform; they vary considerably in ownership and/or carry restrictions on the manner in which restricted individuals are defined. Prohibited persons range in various states from those who receive outpatient psychiatric treatment to persons who have been civilly committed to treatment or found not guilty by reason of insanity. Some statutes restrict individuals with a history of alcohol or substance abuse (with different criteria for inclusion in this restricted class). Others have no restrictions; therefore, the federal laws provide the only restrictions prohibiting the sale of firearms to those with a specifically defined history of mental illness and substance abuse. In states with less-restrictive statutes, federal law supersedes state statutes. The Federal Gun Control Act (2) "prohibits the transfer of any firearm to any person who…is an unlawful user of or addicted to any controlled substance, has been adjudicated as a mental defective or committed to a mental institution." Although we cannot provide an exhaustive review of each state's statute, the following summary will illustrate the variability.

Firearm Restrictions Related to Mental Illness, Alcohol, and Drug Abuse

Each state defines, in a multifactorial manner, people identified as having mental illness and/or alcohol or substance abuse who have or have not received some form of firearms restrictions or are allowed legally to own some type of firearm (data supplement 1). States such as Colorado, Idaho, New Mexico, Vermont, and New Hampshire do not define a prohibited population for gun possession and thus are governed only by federal statute. However, in some states, the specific definition of prohibited persons goes beyond federal restrictions.

For example, Pennsylvania and states with similar statutes narrowly limit restrictions to people who have "been adjudicated as an incompetent or who have been involuntarily committed to a mental institution for inpatient care and treatment…or have been convicted of driving under the influence of alcohol or controlled substance…on three or more separate occasions within a 5-year period" (42).

In Texas, the general gun statutes permit individuals to carry guns on their persons and in their car if the guns are not concealed or otherwise prohibited, such as in a government building or a place where alcohol is sold. This state provides a very detailed description of "prohibited persons," which includes those with specific diagnoses, such as schizophrenia, delusional disorder, bipolar disorder, chronic dementia, dissociative identity disorder, intermittent explosive disorder, and antisocial personality disorder. For Texas, the length of time a restriction will be in place is 5 years, i.e., after involuntary psychiatric hospitalization, inpatient or residential substance abuse treatment, a diagnosis of alcohol or drug dependence, or diagnosis by a licensed physician that the person suffers or has suffered from a psychiatric disorder (48).

In Hawaii, any person is restricted from handgun licensure who is described by the following:

> Is or has been under treatment or counseling for addiction to, abuse of, or dependence upon any dangerous, harmful, or detrimental drug, intoxicating compound as defined…has been acquitted of a crime on the grounds of mental disease, disorder, or defect…or is or has been diagnosed as having a significant behavioral, emotional or mental disorder as defined by the most current diagnostic manual of American Psychiatric Association or the treatment for organic brain syndrome. (15) [The term "mental defect" is a legal term of art referring to conditions such as mental retardation and dementia.]

Mental Health Data Banks

Twenty states, the District of Columbia, and Puerto Rico maintain records of persons with mental illnesses that can be used to assess the eligibility of firearms purchases or licensure (data supplement 1 and data supplement 2). The states vary according to the type of information retained and how information is collected. In California, those who have been admitted to a psychiatric hospital (public or private) and designated a danger to themselves or others must be reported to the local law enforcement agency by an attending health care professional (8). In Massachusetts, the reporting requirement is limited to public hospital admissions and does not include private hospitals (25).

In states in which databases are maintained, an application for such things as firearms purchase or licensure to carry firearms may trigger state agency access to the mental health records. Law enforcement agencies may also use this information to seize or confiscate firearms from persons who appear to pose a risk of injury to others and sometimes to themselves (10).

In Arizona, the courts provide data about mental health to the Department of Public Safety that can be used to enforce the state's firearms laws (6). In Colorado, courts are required to report data on those found to be incapacitated or ordered committed for drug, alcohol, or mental health treatment to the National Instant Criminal Background Check System (9).

State Authority and the Physician's Role

Psychiatrists may have a role in the process by which their patients apply for permission to purchase, possess, or transfer a handgun, as well as in the appeals process for those with mental illness and/or alcohol or drug abuse. In states such as Massachusetts, for example, an applicant who "has been confined to any hospital or institution for mental illness" may be considered for firearms licensure if he or she

> submits with his [or her] application an affidavit of a registered physician attesting that such a physician is familiar with the applicant's mental illness and that in such physician's opinion the applicant is not disabled by such an illness in a manner that should prevent the applicant from possessing a firearm, rifle, or shotgun, is or has been under treatment for or confinement for drug addiction or habitual drunkenness, unless such applicant is deemed to be cured of such condition by a licensed physician. (25)

In other states, such as Rhode Island, a restricted person must wait 5 years from the date of "being pronounced cured by competent medical authority" before he or she may present an affidavit to the effect that "he or she is a mentally stable person and a proper person to possess firearms" (44). The legal standard of "cure" may make physicians uncomfortable because it is not in keeping with the relapsing and remitting course of many psychiatric disorders. The issue of "cure," moreover, does not clarify potential legal liability for a patient's future acts.

Some states use the concepts of the remission and stabilization of mental illness or substance abuse in their statutes and impose more clinically based expectations on the clinical documentation needed. For handgun licensure in Oklahoma, a physician is asked to certify that a person is no longer disabled by any mental or psychiatric illness or that the person has been stabilized with medication for 10 or more years (40). With respect to inpatient treatment for substance abuse, the patient may wait for 3 years or may obtain a certifying statement from a licensed physician that he or she has been free from substance abuse for the preceding 12 months.

One purpose for restricting legal access to firearms is the prevention of violent crime. Mentally ill persons are often one focus of firearms legislation, a fact that appears to reflect public concern about the possibility of an increased risk of violence in that population (57–60). Although there is an ongoing discussion and sometimes a debate in medicine, law, social sciences, and public safety

regarding the uncertain relationship between violence and mental illness, the literature highlights the complexity involved in assessing risk (61–72).

More recent research strongly suggests a relationship among major mental illness, substance abuse, and violence; individuals with serious mental illness who are comorbid for substance abuse have the greater risk for violence (61–64). However, the relationship is complex, particularly when one tries to assess individual risk (61–72). This finding might well raise some question about whether or not it is scientifically valid or reliable to deny firearm purchase and licensure solely on the basis of some vague and generic impression of "mental illness." Public perception and emphasis on preventing tragedy, of course, are separate matters.

In the United States, 25% of adults own a firearm of some kind, and some 40% of all adults live in a residence that contains a firearm (73–77). This article has reviewed the various state laws and federal statutes governing access to firearms by persons who have mental illnesses and problems with substance abuse, some of which suggest procedural roles for psychiatrists and other physicians. We note the wide variation in these statutes and suggest that each clinician first be aware of any mandatory reporting requirements and then decide the extent to which he or she wishes to become involved in the mental-health-related aspects of firearm possession.

A complete discussion of risk assessment is beyond the purview of this article (78). Nevertheless, we recommend that a psychiatrist who is asked to evaluate or certify his or her patient for a firearms application be certain that he or she understands the question being asked. Is it answerable? What is the role of a clinical response to a legal issue? Does the psychiatrist appreciate the dual agency associated with being both evaluator and treating clinician (79)?

With firearm licensure statutes present in all 50 states, the District of Columbia, and Puerto Rico, it is likely that a psychiatrist will be asked at some point in his or her career to provide a certificate or to perform an assessment for a firearm-related matter. A clinician must be cognizant of the professional responsibility inherent in this assessment. Many clinicians may not fully appreciate the ramifications of accepting such requests or evaluations, which may appear simplistic on their surface.

Received Jan. 25, 2005; revision received April 7, 2005; accepted May 13, 2005. From the Program in Psychiatry and the Law, Beth Israel/Deaconess Hospital, Massachusetts Mental Center, Harvard Medical School, Boston; the Department of Psychiatry and Human Behavior, Brown Medical School, Providence, R.I.; and the Department of Psychiatry, University of Texas Health Science Center, San Antonio, Tex. Address correspondence and reprint requests to Dr. Norris, 25 Shattuck St., Boston, MA 02115; Dmnorris@aol.com (e-mail).

The authors thank the members of the Program in Psychiatry and the Law, the APA Council on Psychiatry and the Law, and the Subcommittee on Firearms and Mentally Ill Persons. The latter includes the following: Arthur Berg, M.D., Howard Zonana, M.D., Kamlyn Haynes, M.D., and Susan Kelly, M.D.

The views expressed in this article are the sole responsibility of the authors. The statute review and summaries should not be construed as a reliable legal review or as an indication of what may be legal or illegal in any individual situation or jurisdiction.

References

1. Cannon A: Guns and the mentally ill. US News and World Report, April 1, 2002, p 22
2. Federal Gun Control Act, 18 USC § 922 (1968), et seq
3. US Department of Justice Survey of State Procedures Related to Firearm Sales Midyear 2003. Aug 2004 NCJ 203701
4. Ala Code § 13A-11-50 (2004), Criminal Code, Chapter 11, et seq
5. Alaska Stat § 11.61.190 (2004), et seq; 18.65.710, et seq
6. Ariz Rev Stat Ann § 13.905 (2004), et seq; 13.3101, et seq
7. Ark Stat Ann § 5-73-103 (2003), et seq
8. Cal Welf & Inst Code § 8100–8105 (2004), et seq
9. Col Rev Stat § 12-26.1-101 (2004), 18-12-101, et seq; 24-33.5-424
10. Conn Gen Stat § 29-27 (2003), et seq; 53-202 et seq; 53a-211 et seq; 17a-500 et seq
11. Del Code Ann title xi § 1441 (2004), et seq; title xxii § 904A
12. DC Code Ann § 22-4502 (2004), et seq; 22-4505–4507
13. Fla Stat § 790.001 (2004), et seq; 493.6115 (2003)
14. Ga Code Ann § 16-11-123 (2004), et seq; 16-11-174, et seq
15. Haw Rev Stat § 134-1 (2003), et seq
16. Idaho Code § 18-310 (2003); 18-3302, et seq
17. Ill Rev Stat 430:65 (2004), et seq; 720:5/24-1, et seq; 725:5/112A-14
18. Ind Code Ann § 35-47-1-5 (2004), et seq
19. Iowa Code § 702.7 (2003), et seq; 724.1, et seq
20. Kansas Stat Ann § 21:4201 (2003), et seq; 75–7b17, et seq
21. Ky Rev Stat Ann § 237.110 (2004), et seq; 527.040, et seq
22. La Rev Stat Ann § 14:95 (2004), et seq; 40:1379.1, et seq
23. Me Rev Stat Ann, title 15 § 393 (2003), et seq; 17A.1052, et seq
24. Md Pub Safety Code Ann § 5-101 (2004), et seq; 5-118, et seq
25. Mass Gen L ch 140 § 129B (2004), et seq; 269-10
26. Mich Comp Laws Ann § 28.422 (2004), et seq; 750.222, et seq
27. Minn Stat § 609.66 (2003), et seq; 609.165, et seq; 624.71, et seq
28. Miss Code Ann § 45-9-101 (2004), 97-37-1, et seq
29. Mo Rev Stat § 471.090 (2004)
30. Mont Code Ann § 45-8-321 (2004)
31. Neb Rev Stat § 28-1201 1991, et seq; 69–2401, et seq
32. Nev Rev Stat § 202.253 (2004), et seq; 202.360, et seq
33. N H Rev Stat Ann § 159:1 (2004), et seq
34. NJ Rev Stat § 2C:39-1 (2004), et seq; 2C:58-1, et seq
35. NM Stat Ann § 30-7-2 (2004), et seq
36. NY Law Crim Proc § 265.00 (2004), et seq; 400.00, et seq
37. NC Gen Stat § 14-269.7 (2004), et seq; 14-402, et seq
38. ND Cent Code § 62.1-01-01 (2004), et seq
39. Ohio Rev Code Ann § 2933.11 (2004), et seq
40. Okla Stat title 21 § 1271.1 (2004), et seq
41. Or Rev Stat § 166.170 (2004), et seq
42. 18 Pa Cons Stat § 6101 (2004), et seq
43. PR Laws Ann title 25 § 412 (2002), et seq; 427, et seq
44. RI Gen Laws § 11-47-2 (2004), et seq
45. SC Code Ann § 16-23-10 (2003), et seq; 23-31-110, et seq
46. SD Codified Laws § 16-23-10 (2004), et seq; 23-31-110, et seq
47. Tenn Code Ann § 39-17-1301 (2004), et seq
48. Tex Penal Code Ann § 46.01 (2004), et seq
49. Utah Code Ann § 53-5-704 (2004), et seq; 76-10-501, et seq
50. Vt Stat Ann § 13-4004 (2004), et seq
51. Va Code Ann § 18.2-279 (2004), et seq; 76-10-501, et seq
52. Wash Rev Code Ann § 9.41.010 (2004), et seq

53. W Va Code § 61-7-2 (2004), et seq
54. Wis Stat § 175.30 (2003), et seq; 941.20, et seq
55. Wyo Stat § 6-8-101 (2004), et seq
56. Brady Act 18 USC § 922 (s1–s6)
57. Link BG, Phelan JC, Bresnahan M, Stueve A, Pescosolido BA: Public conceptions of mental illness: labels, causes, dangerousness, and social distance. Am J Public Health 1999; 89: 1328–1333
58. Kimhi R, Barak Y, Gutman J, Melamed Y, Zohar M, Barak I: Police attitudes toward mental illness and psychiatric patients in Israel. J Am Acad Psychiatry Law 1998; 26:625–630
59. Corrigan P, Thompson V, Lambert D, Sangster Y, Noel JG, Campbell J: Perceptions of discrimination among persons with serious mental illness. Psychiatr Serv 2003; 54:1105–1110
60. Corrigan PW, Watson AC, Warpinski AC, Gracia G: Implications of educating the public on mental illness, violence, and stigma. Psychiatr Serv 2004; 55:577–580
61. Wallace C, Mullen PE, Burgess P: Criminal offending in schizophrenia over a 25-year period marked by deinstitutionalization and increasing prevalence of comorbid substance use disorders. Am J Psychiatry 2004: 161:716–727
62. Beck J: Delusions, substance abuse and serious violence. J Am Acad Psychiatry Law 2004; 32:169–172
63. Robbins PC, Monahan J, Silver E: Mental disorder, violence and gender. Law Hum Behav 2003; 27:561–571
64. Walsh E, Gilvarry C, Samele C, Harvey K, Manley C, Tattan T, Tyrer P, Creed F, Murry R, Fahy T, The UK700 Group: Predicting violence in schizophrenia: a prospective study. Schizophr Res 2004; 67:247–252
65. Buckley PF, Hrouda DR, Friedman L, Noffsinger SG, Resnick PJ, Camlin-Shingler K: Insight and its relationship to violent behavior in patients with schizophrenia. Am J Psychiatry 2004; 161: 1712–1714
66. Monahan J, Steadman HJ, Appelbaum PS, Robbins PC, Mulvey EP, Silver E, Roth LH, Grisso T: Developing a clinically useful actuarial tool for assessing violence risk. Br J Psychiatry 2000; 176; 307–311
67. Grisso T, Davis J, Vesselinov R, Appelbaum PS, Monahan J: Violent thoughts and violent behavior following hospitalization for mental disorder. J Consult Clin Psychol 2000; 68:388–398
68. Monahan J: Violence prediction: the past twenty and the next twenty years. Crim Justice Behav 1996; 23:107–120
69. Hiday VA, Swanson JW, Schwartz MS, Borum R, Wagner HR: Victimization: a link between mental illness and violence? Int J Law Psychiatry 2001; 24:559–572
70. Appelbaum PS, Robbins PC, Monahan J: Violence and delusions data from the MacArthur Violence Risk Assessment Study. Am J Psychiatry 2000; 157:566–572
71. Binder RL: Are the mentally ill dangerous? J Am Acad Psychiatry Law 1999; 27:189–201
72. Steadman HJ, Mulvey EP, Monahan J, Robbins PC, Appelbaum P, Grisso T, Roth L, Silver E: Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. Arch Gen Psychiatry 1998; 55:393–401
73. Kellerman AL, Rivara FP, Rushforth NB, Banton JG, Reay DT, Francisco JT, Locci AB, Prodzinsky J, Hackman BB, Somes G: Gun ownership as a risk factor for homicide in the home. N Engl J Med 1993; 329:1084–1091
74. Center for Gun Policy and Research and the National Opinion Research Center: National Gun Policy Survey. Baltimore, Johns Hopkins University Center for Gun Policy and Research, National Opinion Research Center, 1997
75. Cook PJ, Ludwig J: Guns in America: Results of a Comprehensive National Survey on Firearms Ownership and Use. Washington, DC, Police Foundation, 1996
76. Kellermann AL, Rivara FP, Somes G, Reay DT, Francisco JT, Banton JG, Prodzinsky J, Fligner C, Hackman BB: Suicide in the home in relation to gun ownership. N Engl J Med 1992; 327: 467–472
77. NRA/ILA: Gun Laws: US DOJ Letter on Interstate Firearms Transport. www.nraila.org/GunLaws
78. Appelbaum P, Gutheil T: Clinical Handbook of Psychiatry and the Law, 2nd ed. Baltimore, Williams & Wilkins, 1991
79. Strasburger LH, Gutheil TG, Brodsky A: On wearing two hats: role conflict in serving as both psychotherapist and expert witness. Am J Psychiatry 1997; 154:448–456