Your Liberty or Your Gun?

A Survey of Psychiatrist Understanding of Mental Health Prohibitors

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I. Introduction

When Justice Scalia declared in *Heller* that the Second Amendment protected an individual's right to bear arms, he excluded one group from constitutional protection: Americans living with mental illness.[1] Since 1968, federal and state laws — also known as mental health prohibitors — have explicitly tied mental health treatment to gun restrictions.[2] Federal law bans firearm possession by anyone "committed to any mental institution," a group that includes only those civilly committed by court order.[3] Some states 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]

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.

This first-of-its-kind national survey of 485 psychiatrists in nine states and the District of Columbia (D.C.) finds substantial evidence of clinicians being uninformed, misinformed and misinforming patients of their gun rights following involuntary civil commitments and voluntary inpatient admissions. Many psychiatrists have 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 commitment triggered the loss of gun rights, and the majority of psychiatrists in states with prohibitors on voluntary admissions (57.3%) and emergency holds (55.8%) were unaware that patients would lose gun rights upon voluntary admission or temporary hold.

More troublingly, while a substantial portion of surveyed psychiatrists (56%) reported that they never informed patients about any of the prohibitors, many respondents reported misinforming their patients about the laws of their state. Around 13% of respondents in states without a voluntary admissions prohibitor had incorrectly told 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 — roughly a third of them incorrectly — reported telling patients they could preserve their gun rights by permitting themselves to be voluntarily admitted for treatment, in lieu of being involuntarily committed. In those cases, patients may opt to receive inpatient treatment based on a mistaken belief that they could preserve their gun rights, raising questions of whether psychiatrists obtained full informed consent for patients' voluntary admission.

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While no study has quantified mental health prohibitors' specific impact on firearm deaths and injury, the link between mental illness and gun violence is not fully understood.[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 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, critics charge that mental health prohibitors are both over-inclusive and under-inclusive as suicide prevention polices, disqualifying low-risk individuals from gun access in some states and allowing high-risk individuals to obtain guns in others.[9] One study, for example, suggests that emergency hold prohibitors could 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]

Our surveys suggest that medical providers in state with voluntary commitment prohibitor laws may unknowingly deprive their patients of a constitutional right. While mental health prohibitors have thus far withstood constitutional challenge,[11] they implicate due process protections: Patients may be deprived unfairly of their property without informed consent, and they also may unnecessarily surrender their liberty through voluntary treatment under the belief they can preserve gun rights — even when the treating psychiatrist would not have been able to obtain an involuntary commitment court order.

States without the voluntary commitment prohibitors present patients with a stark choice: Your liberty or your gun rights? Many respondents to the survey expressed discomfort with prohibitors, characterizing them as "outmoded rubrics" that curbed patient rights and had the 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 (ERPO), that allow physicians to report medical risk factors of suicidality or dangerousness and petition for gun removal.[12]

II. Methodology

A. Mental Health Prohibitors in Targeted States

We targeted psychiatrists in ten locations with 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 — 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.[13] 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

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

Table 1: Summary of State Laws on Mental Health & Gun Rights

	Involuntary commitment prohibitor	Emergency hold prohibitor	Voluntary admission prohibitor	Diagnosis prohibitor	Gun right lost based on reporting of at-risk patients
California	Yes	Yes	No	No	Yes
Connecticut	Yes	No	Yes	No	No
D.C.	Yes	No	Yes	No	No
Florida	Yes	No	No	No	No
Illinois	Yes	No	Yes	No	Yes
Hawaii	Yes	No	No	Yes	No
New Hampshire	Yes	No	No	No	No
New York	Yes	No	No	Yes	Yes
Texas	Yes	No	No	No	No
Washington	Yes	Yes	No	No	No

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 fifty states and D.C. Therefore — while New Hampshire does not currently have a state law requiring the reporting of involuntary commitments by court order to the federal background check system — all states were coded as having a mental health prohibitor on involuntary commitments. For more details, see Appendix Figure 1.

Second, only California and Washington had mental health prohibitors associated with emergency holds. California's five-year prohibitor on gun ownership applies for patients placed on a 72-hour hold (a Section 5150 hold) and 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 comparably less restrictive provision applies for six months after a patient is detained on a 72-hour hold for evaluation or treatment. See Appendix Figure 2.

Next, three jurisdictions surveyed — Connecticut, Illinois, and D.C. — 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 D.C. and Illinois last for five years. See 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.[14] See Appendix Figure 4.

Finally, while Hawaii and D.C. allow mental health professionals to petition for extreme risk protection orders (ERPO), only California, Illinois, and New York were codified as automatically disqualifying residents from gun ownership based solely on a psychiatrist's report of their dangerousness submitted to law enforcement or a state database. See Appendix 1-4.

B. 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. 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 Appendix Figure 5.

C. Survey Recruitment

Depending on the state, a large range of mental health professionals and state actors can petition for involuntary commitments or emergency holds, including law enforcement, nurses, social workers, psychologists, and emergency medicine providers. However, we opted to survey only psychiatrists and psychiatric residents, who usually file for commitments. Survey recruitment emails are included in Appendix Figure 6.

The survey protocol was assessed and approved by Yale's Institutional Review Board (IRB). Participants were randomly selected and emailed individually from the 10 targeted jurisdictions through the American Psychiatric Association (APA) member directory. The survey was also sent to 40 colleagues of the co-authors, as well as the Yale Psychiatry Residency Program, and 47 psychiatrists obtained through snowball sampling. As a recruitment incentive, respondents had the option to compete to win a pair of Apple AirPods. All participants received a follow-up email. 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%.

III. Results

A. 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 Appendix Figure 7.

Table 2: Practicing Jurisdiction, Commitment Activity and Firearm Communications

State	**Respondents**	**Percentage of 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%
Have they ever had a patient who was involuntarily committed?		
No	26	5.4%
Yes	459	94.6%
Do they routinely ask patients if they own firearms?		
Never	7	1.4%
Rarely	27	5.6%
Sometimes	194	40.0%
Often	117	24.1%
Always	140	28.9%

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 citing 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 not a statistically significant difference between responses from primed (concerning suicide epidemic) and unprimed groups. See Appendix Figure 10.

B. Psychiatrist Knowledge of Mental Health Prohibitor Laws

Table 3 details the proportion of respondents who incorrectly responded to questions concerning their jurisdiction's 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 Appendix Figure 7 and 8.

Table 3: Share of Jurisdiction Respondents with Mistaken Beliefs about Prohibitors

	Jurisdiction Has Prohibitor	Jurisdiction Does Not Have Prohibitor
% Wrong About Involuntary Commitment Prohibitor	36.9%	-
% Wrong About Emergency Hold Prohibitor	55.8%	25.2%
% Wrong About Voluntary Admit Prohibitor	57.3%	8.3%
% Wrong About Diagnosis Prohibitor	39.7%	43.2%

First, while the federal prohibitor applies in all states, over a third of total respondents (36.9%) incorrectly 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 controls — 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 state's 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 the D.C. (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 triggered the loss of gun rights for patients. The majority of respondents in California correctly responded (64.7%), but only 29% of respondents in Washington did so. Washington psychiatrists may not have been 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 of their diagnosis. However, in Hawaii and New York, states with have 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 firearm 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 D.C. 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."

C. 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. Troublingly, 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.

Table 4: Informed Consent for Involuntary and Voluntary Commitments

Informed patients they will lose gun rights if involuntarily committed by court order	No Prohibitor	Involuntary Commitment Prohibitor
Never	0.0%	60.0%
Rarely	0.0%	17.9%
Sometimes	0.0%	7.0%
Often	0.0%	10.5%
Always	0.0%	4.5%
Total	0.0%	100.0%

Informed patients they will lose gun rights if voluntarily admitted for treatment	No Voluntary Admission Prohibitor	Voluntary Admission Prohibitor
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%

Suggested to patients they will preserve gun rights via voluntary admission	No Voluntary Admission Prohibitor	Voluntary Admission Prohibitor
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%

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 in jurisdiction with voluntary admission prohibitors that 62.7% of respondents indicate that they never inform patients that voluntary admissions will result in a loss of constitutional rights. While the scope of psychiatrist's duty to warn 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 decisionmaking. Indeed, Florida law contemplates this scenario by requiring patients to sign a court-reviewed consent forms 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 been convinced to go voluntarily.[16] Certain patients, such as members of law enforcement, may have to carry a firearm as part of their job, and loss of firearm access would be more than an inconvenience.

Some respondents stressed that involuntary commitments and emergency holds were life-or-death situations, 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 and not let the patient

bleed out because of laws that regulate their right to own or possess a gun determine that life and death decision."

Still other psychiatrists worried that informing patients of potentially losing 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 may have deterred 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 admit themselves. 15.9% 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 amended their mental health prohibitor to cover voluntary admissions. One Connecticut psychiatrist commented: "Prior to law change I have 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."

D. 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 Appendix Figure 9 for details).[16]

Many psychiatrists worried that prohibitor laws discriminated against their patient, and could disincentivize patients 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." While most studies show 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 patient's 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. 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 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."

IV. Conclusion

This study indicates that many psychiatrists are ignorant of their state's and federal prohibitor laws, causing them to mislead and misinform patients about the consequences of voluntary medical treatment. The survey 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 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). In other cases, vulnerable patients may fail to seek voluntary treatment because they were misinformed by their psychiatrist that doing so would forfeit their firearm rights.

This paper demonstrates that there is an urgent need for psychiatrist training on mental health prohibitor laws and recommended best practices when those laws impact patient treatment. However, the survey 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 physicians to engage in the delicate rights-balancing analysis usually reserved for courts. Flexible policies based on patient risk assessment, such as discretionary ERPO laws, may better equip mental health providers to safely petition for firearm removal from suicidal or homicidal patients.

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