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Preventing Dangerous Mentally Ill Individuals From Obtaining and Retaining Guns: New York’s SAFE Act

JAMES B. JACOBS & ZOE FUHR*

(March 17th]

“...consider not the what, where, or why of the Second Amendment’s limitations – but the who...” – Tyler v. Hillsdale County Sheriff’s Department et al. (6th Cir. Dec. 18, 2014)¹

“A state-wide database...will guard against the dangerous or unstable possessing guns.” Governor’s Program Bill 2013 Memorandum in Support of Secure Ammunition and Firearms Enforcement Bill²

On December 14, 2012, Adam Lanza, using one of his mother’s assault weapons, killed her and then drove from their shared home to Sandy Hook Elementary School in Newtown, Connecticut, where he murdered twenty small children and six teachers.³ Lanza’s biography was full of disturbing behaviour; in fact as a child he had been diagnosed with autism, anxiety and obsessive-compulsive disorder.⁴ Following the massacre, gun control proponents focused on prohibiting assault weapons and preventing mentally ill individuals from obtaining and retaining firearms. New York Governor Andrew Cuomo announced his determination to pass the toughest gun controls in the nation.⁵ Toward that end,

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¹ Tyler v. Hillsdale Cnty. Sheriff’s Dep’t, 775 F.3d 308, 316 (6th Cir. 2014).
² New York State, Governor’s Program Bill 2013, Memorandum in Support http://www.governor.ny.gov/sites/governor.ny.gov/files/archive/assets/documents/GPB_1_GUNS_MEMO.PDF.
invoking a “message of necessity,” he rushed the Secure Ammunition and Firearms Enforcement Act (SAFE Act) through the legislature in the middle of the night on January 15, 2013, bypassing the three-day required review period for proposed legislation.6 He signed the bill into law the next day.7 The SAFE Act expands controls over assault weapons and large capacity magazines,8 creates new gun crime offenses,9 subjects non-dealer gun transfers to background checks,10 and imposes on mental health professionals an obligation to report mentally ill and dangerous patients to the state (so-called “§ 9.46 reports”), in order to prevent the reported person from obtaining or retaining firearms.11 This article focuses on these § 9.46 reporting provisions.

It is hard to imagine much dissent from the general proposition that a mentally ill and dangerous individual should not possess a gun. However, the process of labeling some people “mentally ill” is subjective, and only a small minority of people so called are dangerous. This article considers the controversial process of identifying who is mentally ill and dangerous enough to warrant forfeiture of Second Amendment rights The Supreme Court’s decisions in District of Columbia v. Heller (2008) and McDonald v. City of Chicago (2010),12 holding that the Second Amendment guarantees an individual’s right to keep and bear arms, make this issue all the more salient. The Court stated that “nothing...should

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6 Governor Cuomo claimed “[t]he new law will limit gun violence through common sense, reasonable reforms that include addressing the risks posed by mentally ill people who have access to guns and banning high capacity magazines and lethal assault weapons.” Governor Cuomo Signs Groundbreaking Legislation That Will Give New York State the Toughest Protections Against Gun Violence in the Nation, OFFICIAL WEBSITE OF NEW YORK STATE (Jan. 15, 2013), https://www.governor.ny.gov/news/governor-cuomo-signs-groundbreaking-legislation-will-give-new-york-state-toughest-protections.
7 Id.
8 N.Y. PENAL LAW §§ 265.00; 400.00.
9 N.Y. PENAL LAW §§ 120.05(4-a); 125.26(!)(a)(a-i-a); 125.27(1)(a)(ii-a); 265.01-a; 265.01-b; 265.17; 10.00(21); 265.19; 265.45; 460.22; 400.01.
10 N.Y. GEN. BUS. LAW Art. 39-DDD, § 898.
11 N.Y. MENTAL HYG. LAW § 9.46. The SAFE Act also amended New York’s mandatory outpatient treatment law (“Kendra’s Law”), by:
- Extending the duration of an initial AOT order from six months to one year;
- Establishing procedures whereby an outpatient treatment order follows the patient from one county to another, in the event the patient moves residence;
- Requiring the county DCS to evaluate the need for extending the Assisted Outpatient Treatment Order (AOT);
- Authorizing the DCS to file a petition in the supreme or county court to renew an expiring AOT order when the subject of the AOT cannot be evaluated prior to the order’s expiration. The “appropriate” DCS is the DCS in the county where the assisted outpatient resides, even if it is not the county where the AOT order was issued. Further, the DCS in an AOT patient’s new county of residence must be notified.
See N.Y. MENTAL HYG. LAW § 9.60.
be taken to cast doubt on longstanding prohibitions on the possession of firearms by...the mentally ill."\textsuperscript{13} However, the Court did not have to consider what counts as sufficient evidence of mental illness and dangerousness to justify extinguishing a person’s Second Amendment rights, nor what process is due to such a person if he is stripped of his gun rights. It is inconceivable that either a state or the federal government could constitutionally extinguish the Second Amendment rights of any individual whom anyone accused of being mentally ill and dangerous. Presumably the justices had in mind an adjudicatory process for diagnosing mental illness and predicting future dangerousness, which includes both a reliable medical diagnosis and a reliable dangerousness prediction relevant to the patient’s capacity to responsibly possess a firearm, as well as an opportunity for the patient to challenge that diagnosis before a neutral fact finder.

New York State’s 2013 SAFE Act establishes a disarmament procedure based, in effect, on the judgment of a single mental health professional who, after even a cursory interview, can suspend an individual’s Second Amendment rights for five years.\textsuperscript{14} Specifically, a mental health professional, who need not be a mental health specialist, is required to report to a county official the name of a patient whom he or she believes “is likely to engage in conduct that would result in serious harm to self or others.”\textsuperscript{15} There is no opportunity for a hearing to challenge the classification and seek the restoration of Second Amendment rights.\textsuperscript{16} Indeed, there is no requirement that the subject of the § 9.46 report even be notified.

This article argues that the SAFE Act’s process for disarming people on the basis of a diagnosis of mental illness plus a prediction of future dangerousness cannot pass constitutional muster and that, even if it could, it is not good policy. Part I explains the SAFE Act’s requirements for reporting and disarming potentially dangerous mentally ill individuals. Part II argues that the SAFE Act’s process for suspending Second Amendment rights on grounds of mental illness and future dangerousness is unconstitutional. Part III considers the barrage of criticisms that advocates for persons suffering from mental illness have levelled against the SAFE Act’s procedures for identifying and disarming people classified as mentally ill and dangerous.

\textsuperscript{13} Heller, 554 U.S. at 626.
\textsuperscript{14} N.Y. MENTAL HYG. LAW §§ 9.46, 33.13(c)(12), 33.13(c)(15); N.Y. EXEC. LAW § 837(19); N.Y. PENAL LAW §400.02.
\textsuperscript{15} N.Y. MENTAL HYG. LAW § 9.46(b).
\textsuperscript{16} N.Y. MENTAL HYG. LAW § 9.46.
I. Understanding the SAFE Act

The SAFE Act was passed in response to the December, 2012 Sandy Hook Elementary School massacre, and sought to prevent future mass murders, by establishing a strategy for preventing mentally ill persons from committing violent crimes, and suicide. The strategy is straightforward: i) identify mentally ill individuals who are likely to engage in lethal violence in the future, ii) prevent them from obtaining firearms; or iii) disarm them if they already possess firearms. However, close consideration of the SAFE Act’s reporting provisions reveals a procedure that abrogates the Second Amendment rights of thousands of persons who have never acted violently, with or without a gun, and for whom there is no reliable basis for predicting future violence.

To prevent dangerous mentally ill persons from obtaining or retaining guns, the SAFE Act imposes on mental health professionals reporting obligations that go far beyond prior New York State and federal laws. The Act requires mental health professionals, using “reasonable professional judgment,” to report the names of patients “likely to engage in conduct that would result in serious harm to self or others.” The term “mental health professionals” includes physicians, psychologists, registered nurses and licensed clinical social workers. There is no requirement that reporting mental health professionals use risk assessment instruments, or justify their diagnosis and prediction, to a neutral fact finder. There is no opportunity for the person labelled mentally ill and dangerous by a single mental health professional to dispute the diagnosis and prediction.

When a mental health professional believes that a patient “is likely to engage in conduct that would result in serious harm to self or others,” she must send a “§ 9.46 report” to the county director of community services (DCS), summarizing the reasons for her assessment. If the county DCS agrees

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18 N.Y. MENTAL HYG. LAW § 9.46(b).
19 The duty to report does not apply just to health care professionals who treated the patient for mental health issues.
20 The SAFE Act amended New York’s Mental Hygiene Law by adding § 9.46, which imposes mandatory reporting requirements on mental health professionals.
21 Directors of Community Services are appointed pursuant to N.Y. MENTAL HYG. LAW § 41.09(a), by charter governments. Directors are not required to be psychiatrists. If a director is not a physician he or she must designate a physician to “conduct examinations on behalf of such director.” N.Y. MENTAL HYG. LAW § 41.09(b).
22 The § 9.46 report is submitted via the SAFE Act’s Integrated Reporting System (ISARS) portal. The ISARS reporting form can be found at https://nysafe.omh.ny.gov. It requires the mental health professional to explain why he or she believes that the patient is likely to engage in conduct that would result in serious harm to his or her self or others, including any specific threats, behaviors or actions.
with the report, based solely on the mental health professional’s summary, the DCS must pass the reported-individual's name on to the New York State Division of Criminal Justice Services (DCJS). DCJS receives only non-clinical identifying information such as date of birth, race, sex, social security number, and address. The reported person’s name and identifying data must be added to a DCJS database of individuals disqualified for five years from obtaining or retaining a firearms license and from possessing a firearm. Violation of this disqualification is a Class A misdemeanor. The existence of this database should prevent a person from obtaining a license to purchase or possess a handgun. Since the SAFE Act requires private (i.e. non-dealer) firearm transfers to be processed by a licensed dealer who must submit the purchaser’s name to the state police for a background check, an individual whose name is in the database should not be able to obtain a firearm. Of course, “off-the-books” transfers remain possible; the extent of compliance with the SAFE Act’s universal firearms background checking requirements remains to be seen.

The SAFE Act machinery is meant to identify and disarm licensed gun owners who have been the subject of a § 9.46 report. DCJS checks the name of anyone who is the subject of a § 9.46 report against a database of all individuals who have ever applied for a firearms license in any New York State county. If a license is pending, the county firearms licensing officer will be instructed to reject it. If there is a match, DCJS notifies the state police, who will determine whether the reported person currently holds a firearms license; if so, the relevant county firearms licensing official is instructed to suspend or revoke the license and to order the revoked licensee to surrender her firearms. A serious limitation of this

23 N.Y. MENTAL HYG. LAW § 9.46(b).
24 Id.
25 N.Y. MENTAL HYG. LAW §§ 9.46, 33.13(c)(12), 33.13(c)(15); N.Y. EXEC. LAW § 837(19).
26 N.Y. PENAL LAW § 400.00(17).
27 N.Y. PENAL LAW § 265.00(10) defines “licensing officer” “in the city of New York [as] the police commissioner of that city; in the county of Nassau the commissioner of police of that county; in the county of Suffolk [as] the sheriff of that county except in the towns of Babylon, Brookhaven, Huntington, Islip and Smithtown, the commissioner of police of that county; for the purposes of section 400.01 of this chapter [as] the superintendent of state police; and elsewhere in the state [as] a judge or justice of a court of record having his office in the county of issuance.”
28 N.Y. PENAL LAW § 400.00(11)(b). See In re Douglas L.B. 983 N.Y.S. 2d 772 (Otsego Cnty. Ct., 2014). The Otsego County Court, as the pistol-licensing officer, received notification from the New York State Police necessitating review of Mr. Douglas’s pistol license after he was reported under the SAFE Act’s mental health provisions. The Court suspended his license on a temporary basis and scheduled a hearing to review Mr. Douglas’ pistol license. State officials have said that they do not know how many guns have been seized through this process. Janine Kava of DCJS explained that local officials are not required to tell the state what actions the have taken. See James T. Mulder, SAFE Act: State Identifies 278 Mentally Unstable People to Lose their Guns, SYRACUSE.COM, Dec. 2, 2014, available at http://www.syracuse.com/news/index.ssf/2014/12/guns_confiscated_from_about_20_people_in_cny_too_mentally_unstable_to_have_weapo.html.
strategy is that, except in New York City, a license is required only for possession of a handgun. Thus, the reporting machinery will not identify a reported person who possesses a rifle or shotgun, except for assault weapons, which, pursuant to the SAFE Act, must also be registered. If the reported person does not voluntarily surrender her guns, the police are authorized to seize them. Licensees may seek to challenge the revocation of their license before their county licensing officer. Even if a judge exercises his or her discretion not to revoke the license, this will not expunge the licensee’s 9.46 classification.

Disarming a recalcitrant gun owner may prove difficult. The person subject to the surrender order might take steps to hide all or some of his firearms, perhaps by transferring them to a relative or friend for safe keeping. Rather than seeking a search warrant, the police department will probably first dispatch an officer to persuade the firearms licensee to surrender his or her firearms. The officer will explain that the person’s firearm’s license has been revoked (on account of a physician or therapist’s report) and that, consequently, it is no longer lawful for the licensee to possess a firearm. The reported person might (falsely) claim not to have a firearm or (falsely) claim to have sold the firearm to someone whose name the patient has forgotten or never knew. He or she may admit having one firearm, but withhold information about others, and refuse the officer’s request to have “a look around.” Without a search warrant, the officer cannot search the house.

Failing to obtain voluntary compliance, the police will have to obtain a warrant to search the person’s house, but a judge might well find that the fact that a person holds a firearms license does not establish probable cause for a warrant to search an entire house. Even if a warrant is granted, the police may have to conduct a comprehensive search of the person’s property (i.e., the kind of intrusive search

31 There is no formal court process governing such a hearing, the authors understand that they are sometimes held in chambers, other times the licensee may provide the judge with a letter from a psychiatric expert attesting to their mental stability and lack of dangerousness. If a license is reinstated, only those pistols listed on the permit will be returned to the individual, any other firearms seized by police will not be.
32 While the SAFE Act makes sales and non-monetary gun transfers between private parties subject to a background check, transfers between immediate family members are exempt. N.Y. Gen. Bus. Law, Art. 39-DDD, § 898.
likely to provoke outrage from gun owners, patients, rights groups and civil libertarians). Indeed, a search like that might exacerbate a mentally ill person’s distress and instability.33

Disarming the revoked licensee might take considerable time (weeks, perhaps months)34 during which the reported person might commit a crime, suicide or mass murder. Even if the revoked licensee relinquishes his firearms, perhaps transferring them to a family member or friend for safekeeping,35 he will not necessarily be rendered incapable of crime, suicide or mass murder. He might retrieve his guns, unlawfully obtain another gun from a black market seller or from a private seller willing to ignore the SAFE Act’s requirement that private sales be processed through a licensed firearms dealer.36

II. The SAFE Act’s Constitutionality

In Heller and in McDonald,37 the Supreme Court’s majority said that the individual’s Second Amendment right to keep a firearm at home for self defense is not inconsistent with disqualifying people from firearms possession on grounds of mental illness.38 In those cases, however, the Court had no occasion to consider who can make such a mental illness diagnosis and future violence prediction and, most critically, what process for predicting a mentally ill person’s risk of future dangerousness would satisfy the Second Amendment (and the Fifth and Fourteenth Amendments’ due process requirement). The challenge is formidable given the enormous pool of people who could be defined as

33 Testimony of Beth Haroules, on behalf of the New York Civil Liberties Union before the Senate Standing Committee on Mental Health and Developmental Disabilities, concerning the implementation and impact of the mental health requirements in the NY SAFE Act, at 7. (May 31, 2013).
34 Eric Neblung, PhD, President of the New York State Psychological Association, argued at the Senate Hearing that § 9.46 does “nothing” to allow a mental health provider to take immediate action to deal with a dangerous mental health patient, as the provision is not designed to allow clinicians to breach confidentiality in a way that will allow them to take the “necessary, direct, and immediate steps that will simultaneously help a dangerous patient and protect society from that patient,” instead requiring the mental health professional to make a report “that must work its way relatively slowly through a bureaucracy.” See Neblung’s oral testimony at the May 31, 2013 Senate Hearing.
35 In the case of Lois Reid, one of the Montgomery plaintiffs, while her firearm license was suspended following a § 9.46 report, the police permitted her husband to retain physical possession of their co-registered handguns at a property owned by the couple. See Montgomery v. Cuomo No.6:14-cv-06709 (W.D.N.Y. Dec. 17, 2014), at ¶256.
38 Heller, 554 U.S. at 626.
potential candidates for extinction of Second Amendment rights on grounds of mental illness. (Approximately, fifteen percent of adults receive mental health care in the United States each year.)

The federal Gun Control Act of 1968 made it unlawful for a person who has ever been adjudicated as a mental defective or committed to an institution on account of mental illness to purchase a firearm. This is a lifetime prohibition. Under federal law, it is a crime to transfer a firearm to a person whom the transferor knows to have been found mentally ill and dangerous in either of these ways. The 1986 Firearms Owners Protection Act established a “relief from disabilities” program whereby individuals prohibited from possessing firearms can petition the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) to have his or her gun purchasing rights restored. The applicant has to establish that he or she “will not be likely to act in a manner dangerous to public safety and that the granting of the relief would not be contrary to the public interest.” A denial of relief is subject to judicial review. The key point is that, according to federal law, an individual’s right to keep and bear arms cannot be extinguished on grounds of mental illness unless that person has, pursuant to a court hearing, been civilly committed to a mental hospital or been declared mentally defective. By contrast, the SAFE Act offers no opportunity for an individual to be heard and to challenge the mental illness classification. It does not even require that the subject of a § 9.46. report be notified.

42 A restoration petition must include: (i) statements from at least three references; (ii) written consent for the ATF to examine copies of various records pertaining to the applicant, including medical records; and (iii) a statement from the entity that had adjudicated the individual mentally defective or ordered mental hospital commitment, attesting that the person no longer suffers from the condition on which the adjudication or commitment was predicated.
43 The federal rights restoration program attracted Congressional criticisms because it cost too much to administer. In 1992 Congress ceased funding the program and the Bureau of Alcohol, Tobacco, Firearms and Explosives stopped accepting restoration petitions. The Supreme Court foreclosed federal appellate review when it ruled in United States v. Bean, 537 U.S. 71, 123 S. Ct. 584, 154 L. Ed. 2d 483 (2002), that the ATF’s inaction did not amount to an “administrative denial of relief” within the meaning of the FOPA. After Bean, a person who had ever been adjudicated mentally defective or involuntarily committed to a mental institution was, in effect, barred for life from purchasing a firearm from a federal licensed firearms dealer. 18 U.S.C. § 925(c) authorized U.S. Circuit courts to hear appeals from agency denial of a petition for restoration of the right to purchase firearm. Even though the program was essentially terminated after Congress stopped funding it, the BATF regulations still prescribed the application procedures for obtaining relief. See 28 C.F.R § 25.10 (2005).
After *Heller* and *McDonald*, extinguishing Second Amendment rights pursuant to a court’s civil commitment or adjudication of mental defectiveness has been subjected to constitutional challenge. In 2014, the Sixth Circuit struck down a Michigan statute, which forfeited an individual’s Second Amendment rights for life, without a restoration procedure, if at any time in the past that individual had been involuntarily committed to a mental hospital. 44 The Sixth Circuit held:

“It is certain that there is a non-zero chance that a previously institutionalized person will commit gun violence in the future, but that is true of all classes of persons... the government... has offered not an iota of evidence that prohibiting the previously institutionalized from possessing guns serves its compelling interests.”45

The First Circuit has also held that Second Amendment rights cannot be extinguished without a due process hearing at which the respondent can contest their mentally ill and dangerous classification.46 In *United States v. Rehlander*, 47 a Maine resident was subject to several involuntary temporary hospitalizations on account of ‘suicidal impulses’.48 He was released after a court found that the state had not met the burden of proving mentally illness and dangerousness necessary for permanent commitment.49 (The trial judge found that although Rehlander needed treatment, he did not pose a risk of serious harm.50) Nevertheless, Rehlander’s emergency hospitalization resulted in automatic revocation of his firearms license.51 Twenty months later, he was apprehended and indicted for felony possession of a firearm without a license.52 He challenged the indictment on the ground that revocation of his firearms license violated the Second and Fourteenth Amendments. In overturning the conviction, the First Circuit held that Rehlander had been “permanently deprived of the right to bear arms based solely on procedures suitable for temporary hospitalization under emergency conditions....nothing in those procedures provided an advance adversary proceeding to test whether the subject was mentally

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44 *See also* Tyler v. Hillsdale Cnty. Sheriff’s Dep’t., 775 F.3d 308 316 (6th Cir. 2014).
45 *Id.* at 342.
46 *United States v. Nathan Rehlander*, 666 F.3d 45 (1st Cir. 2012).
47 *Id.*
48 *Id.* at 47. Rehlander was involuntarily commitment under Maine’s ex parte temporary hospitalization procedure. This procedure requires an application by a health or law enforcement officer, supported by a certifying medical examination. The application must be endorsed by a judge or justice of the peace, who can confirm that the correct procedure has been followed: Me. REV. STAT. tit. 34-B, § 3863(1)-(3).
49 *Rehlander*, 666 F.3d at 47.
50 *Id.*
51 *Id.*
52 *Id.*
ill or dangerous [and] no effective post-hospitalization means to recover the right to bear arms if the subject had in fact never been mentally ill or dangerous.”53 The Court said further that:

“Although the right established in Heller is a qualified right, the right to possess arms (among those not properly disqualified) is no longer something that can be withdrawn by government on a permanent and irrevocable basis without due process. Ordinarily, to work a permanent or prolonged loss of a constitutional liberty or property interest, an adjudicatory hearing, including the right to offer and test evidence if facts are in dispute, is required. It is evidently doubtful that a [temporary commitment hearing] provides the necessary process for a permanent deprivation (Emphasis added).54

A court applying the test adopted in Rehlander to New York’s SAFE Act would have to reach the same conclusion. The SAFE Act provides no process for challenging a determination that an individual is mentally ill and dangerous, and like Maine, provides no procedure for restoring an individual’s Second Amendment rights.55 No matter how stable the reported-person’s conduct may be going forward, for the next five years he will be treated as irrefutably too dangerous to acquire a gun.56

The SAFE Act’s deficiencies are illuminated by comparison with California’s law for disarming mentally ill and dangerous persons.57 California’s law provides that an individual may be deprived of his right to possess or purchase a gun for five years, if he communicates to a licensed psychotherapist a “serious threat of physical violence against a reasonably identifiable victim or victims[.]”58 That is the

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53 Id. at 50.
54 Id. at 48.
55 N.Y. C.P.L.R. § 530.14. While the SAFE Act does not provide any mechanism for challenging the DCS’s decision to report someone, it may be possible for a patient to do so by bringing an Art. 78 proceeding. Under N.Y. C.P.L.R. 217, such a proceeding must be brought within four months of the date of the final decision (which may be problematic given the SAFE Act does not require that notice be given to the reported person. Actions based on unconstitutionality are not subject to this time limit; instead they are subject to a three-year statutory limitation period from the date of the wrong. New York’s Executive Law §837(19) contemplates such a proceeding, provided that DCS must destroy the reported names of patients and non-clinical identifying information after the five year period, or if “pursuant to a proceeding brought under Article Seventy-Eight of the Civil Practice Law and rules determining that an individual is eligible for a license pursuant to section 400.000 of the Penal Law and otherwise permitted to possess a firearm.”
56 The Second Circuit rejected a Second Amendment attack on the SAFE Act’s assault weapons ban, observing that the ban left people with opportunity to protect themselves with a very large number of other semi-automatic firearm models. New York State Rifle & Pistol Ass’n v. Cuomo, 804 F.3d 242 (2d Cir. 2015). By contrast, the SAFE Act’s provisions for disarming people reported as mentally ill and dangerous under § 9.46 completely extinguish that person’s ability to possess a firearm at home for a five year period.
57 CAL. WELF. & INST. §§ 8100, 8103.
58 CAL. WELF. & INST. § 8100(b)(1).
same reporting standard that applied in New York before the SAFE Act.59 The California law states that once the licensed psychotherapist notifies the police of the patient’s threat, the police must notify the patient that, on account of the report, she is prohibited from possessing a firearm.60 The person must also be notified that she has a right to a court hearing to challenge the firearms prohibition.61 At the hearing, the state “bears the burden of showing by a preponderance of evidence that the reported person would not be likely to use firearms in a safe and lawful manner.”62

Anomalously, New York affords a due process hearing for an individual whose gun rights are forfeited due to involuntary commitment to a mental hospital, a commitment which itself requires an adversarial court hearing. Upon release from the hospital, the previously committed person may petition the Commissioner of Mental Health for relief “where the person’s record and reputation are such that the person is not likely to act in a manner contrary to public safety.”63 By contrast, an individual whose gun rights are extinguished on account of a § 9.46 report is not authorized to petition the Commissioner for relief.

Montgomery v. Cuomo et al.,64 pending in the New York District Court (Western District) as of November 2015, is the first constitutional challenge to the SAFE Act’s procedures for disarming an individual whom a mental health professional reports as mentally ill and dangerous.65 It was filed as a

59 N.Y. MENTAL HYG. LAW § 33.13(6).
60 CAL. WELF. & INST. § 8100(b)(2)(A). The notice will be sent by certified mail (return receipt requested) and states the date when the prohibition commences and ends.
61 CAL. WELF. & INST. § 8100(b)(2)(B).
63 N.Y. MENTAL HYG. LAW §§7.09(J), 13.09(g).
class action on behalf of five named plaintiffs. All five plaintiffs are middle-aged persons without any history of violence. Two are physically disabled. The plaintiffs challenge the SAFE Act on Second, Fourth, Fifth and Fourteenth Amendment grounds. Their principal arguments are that the SAFE Act: i) extinguishes Second Amendment rights without due process; ii) fails to provide notice that their names have been added to a database that stigmatizes them as mentally ill and dangerous, and; iii) allows the information in the database to be accessed by state agencies. According to the complaint, “[t]he State is already or is on the verge of being in a position of unprecedented and unparalleled power to widely abuse patient privacy rights in its drive to trample individual Second Amendment freedoms, along with multiple other civil liberties including due process, equal protection, freedom from searches and seizures, and taking of property.”

Montgomery, a navy veteran and retired police detective, held a pistol permit for nine years. On the day in question, he went to Eastern Long Island Hospital’s emergency room complaining about insomnia and depression. The nurse’s notes stated that Montgomery had no thoughts of hurting himself or others. A second evaluator at the hospital said that the patient denied suicidal or homicidal ideation and that “there was no evidence of any psychotic process, mania, or OCD symptoms. Insight, judgment, impulse are good.” Thus, Montgomery was discharged within 48 hours. His “Discharge Summary” said that he was experiencing stress “in the setting of buying a new home and selling the old one.” Nevertheless, hospital personnel submitted a § 9.46 report erroneously stating that Montgomery had been involuntarily committed. A week later, the State Police notified the Suffolk County Clerk’s Office that Montgomery was prohibited from possessing a firearm. The Suffolk County Sheriff’s Department seized Montgomery’s four firearms and suspended his pistol license.

Montgomery’s case is not a straightforward SAFE Act case, because he was erroneously reported as having been involuntarily committed. Nevertheless, it demonstrates the problems that

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67 Id. at ¶ 141-314.
68 Id. at ¶ 2-3.
69 Id. at ¶ 139.
70 Id. at ¶ 154-55, 160.
71 Id. at ¶ 143.
72 Id. at ¶ 146.
73 Id. at ¶ 147.
74 Id. at ¶ 153.
75 Id. at ¶ 166.
76 Id. at ¶ 153.
77 Id. at ¶ 168.
78 Id. at ¶ 171-74.
inhere in evaluating a patient’s risk of dangerousness in an emergency room setting where patients are briefly interviewed by nurses and doctors who have never seen them before. The long wait time that non-urgent patients frequently experience in an emergency room might itself exacerbate stress and result in unruly conduct. Moreover, some emergency room patients may exaggerate their distress in order to be seen more quickly. Even though a patient is discharged within hours, a risk-averse hospital staffer may file a § 9.46 report in order to protect against criticism if the patient were to cause harm after being discharged.\textsuperscript{79} It is hard to see how a court could uphold this scheme under any level of constitutional scrutiny.\textsuperscript{80}

III. Policy Objections to the SAFE Act’s Reporting Requirements

Not only are the SAFE Act’s reporting requirements on thin constitutional ice, they have also drawn significant criticisms from advocates for the mentally ill for several reasons, including:\textsuperscript{81} i) it will stigmatize mentally ill people generally and those in the database particularly by equating mental illness with violence; ii) it will deter mentally ill people from seeking treatment and/or continuing treatment; iii) it will undermine the therapeutic relationship; iv) it subjects mental health professionals to confusing and conflicting reporting requirements, and; v) it constitutes a significant administrative burden on counties.

Stigmatizing Mental Illness and the Mentally Ill.

Many mental health care specialists dispute the assumption that mental illness causes violent behaviour.\textsuperscript{82} Indeed, they insist that people suffering from mental illness are more likely to be victims

\textsuperscript{79} Over 92% of § 9.46 reports in the first sixty days after the launch of the procedure came from hospitals (primarily hospital emergency rooms and psychiatric units). Only 5% came from outpatient providers, and “an insignificant number” from private practitioners.

\textsuperscript{80} Since \textit{Heller} and \textit{McDonald}, federal courts have been applying intermediate scrutiny in cases challenging various gun controls. \textit{See, e.g.}, New York State Rifle & Pistol Ass’n v. Cuomo, 804 F.3d 242 (2d. Cir. 2015).

\textsuperscript{81} On May 31, 2013, more than four months after the SAFE Act was enacted, the New York State Senate Standing Committee on Mental Health and Developmental Disabilities held a hearing on the New York SAFE Act’s mental health reporting provisions. The following mental health associations and organizations gave testimony: New York State Psychiatric Association, New York Association of Psychiatric Rehabilitation Services, Coalition of Behavioural Health Agencies, Conference of Local Mental Hygiene Directors, Urban Justice Center Mental Health Project, New York State Psychological Association, New York Nurses’ Association, New York Civil Liberties Union, and MHA-NYC Center for Policy.

\textsuperscript{82} The MacArthur Foundation’s comprehensive study of mental disorder and violence found that mental illness by itself is not a strong predictor of future violence. \textit{John Monahan et al., Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence} (2001).
than perpetrators of violence. According to the Executive Director of the National Alliance on Mental Illness New York City:

“There is a strong belief that people with serious mental illness are dangerous and are responsible for a significant amount of the violence in this country. The vast majority of Americans with mental health conditions are not violent. According to a 2006 American Journal of Psychiatry study, only 5% of violent crimes – defined by the FBI as murders, robberies, rapes, and aggravated assaults – can be attributed to people with mental illness. The remaining 95 per cent of violent crimes are committed by individuals without mental health problems. If we are seeking to address the problem of violence in America, we must look elsewhere. Associating violence with people with mental illness serves to exacerbate stigma. Stigma isolates individuals and their families, makes them feel ashamed and to blame, and prevents them from seeking treatment when needed.  

Contrary to the assumption underlying the SAFE Act, people who seek mental health treatment, even people diagnosed with a mental illness, are not, as a group, more dangerous than those in the general population and certainly not more dangerous than drug and alcohol abusers, gang members, perpetrators of domestic violence, and persons convicted of violent misdemeanors or felonies before age 18. New York State, like all other states, has procedures for civilly committing mentally ill people

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83 Wendy Brennan, Executive Director, NAMI-NYC Metro, Testimony at NYU Langone Medical Center; New York State’s SAFE Act: What Does it Mean for Medical Health Providers and their Patients?, May 1, 2013 (transcript available at http://www.naminycmetro.org/LinkClick.aspx?fileticket=y3CYMgiZg9Q=&tabid=37).

84 See John Monahan, A Jurisprudence of Risk Assessment: Forecasting Harm among Prisoners, Predators and Patients, 92 VA. L. REV. 391 (2006); Guns, Public Health and Mental Illness: An Evidence-Based Approach for State Policy, CONSORTIUM FOR RISK-BASED FIREARM POLICY, (2013), available at http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-gun-policy-and-research/publications/GPHMI-State.pdf; Jennifer L. Skeem & John Monahan, Current Directions in Violence Risk Assessment, 20 CURRENT DIRECTIONS IN PSYCHOLOGICAL SCIENCE 38 (2011); Jeffrey W. Swanson et al., Mental Illness and Reduction of Gun Violence and Suicide: Bringing Epidemiologic Research to Policy, 25 ANNALS OF EPIDEMIOLOGY 366 (2015). See also MONAHAN ET AL., supra note 8283 (concluding that mental illness by itself is not a strong predictor of future violence). Under federal law, 18 U.S.C. § 922(g)(3), (8) and (9), persons who have been classified as an unlawful user of or addicted to any controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802); persons who are subject to restraining orders; and persons who have been convicted in any court of a misdemeanor crime of domestic violence; are prohibited from possessing firearms. 18 U.S.C. § 922 (2014). The New York Civil Liberties Union (NYCLU) also criticized the SAFE ACT on the ground that youths, as young as eleven, are being inappropriately reported under § 9.46. Moreover, according to the NYCLU:
when a court finds that they are likely to cause serious harm to self or others.\textsuperscript{85} These procedures require a judicial determination after an adversarial hearing at which the respondent has a right to counsel.\textsuperscript{86} In addition, there are expedited procedures for emergency mental illness commitments, but those are limited to 15 days and typically include procedural protections, unlike the SAFE Act.\textsuperscript{87} The SAFE Act assumes a population of mentally ill people too dangerous to possess firearms, but not dangerous enough to be committed to a mental hospital.

The Consortium for Risk-Based Firearm Policy\textsuperscript{88} and the American Psychiatric Association recommend focusing firearm disarmament efforts on evidence-based assessments of risk of dangerousness rather than subjective predictions based on fleeting contact with a patient.\textsuperscript{89} They urge disarming persons who have exhibited prior episodes of violence (e.g., conviction for a violent misdemeanor, being subject to a temporary domestic violence restraining order), or who have documented incidents of loss of control while intoxicated (e.g., convicted of two or more DWI or DUls in

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\textsuperscript{85} N.Y. MENTAL HYG. LAW § 9.39(a); see also Rights of inpatients in New York State Office of Mental Health Psychiatric Centers, NEW YORK STATE OFFICE OF MENTAL HEALTH (Feb. 2010), https://www.omh.ny.gov/omhweb/patientrights/inpatient_rts.htm.

\textsuperscript{86} Under New York’s civil commitment laws, a person may not be held for more than forty-eight hours, unless within that period the original physician’s finding has been confirmed after examination by another physician (who must be a member of the psychiatric staff of the hospital). N.Y. MENTAL HYG. LAW § 9.39. At the time of emergency admission, the patient must be served with written notice of his status and rights as a patient. \textit{Id.} At any time after admission, the patient, any relative, friend, or the mental hygiene legal services may give notice to the director of any hospital of a request for a court hearing on the question of need for immediate observation, care, and treatment. \textit{Id.} A hearing must be held as soon as practicable, and no more than five days after such a request is received. \textit{Id.} The SAFE Act provides less due process than N.Y. law provides for extinguishing the Second Amendment rights of mentally ill persons who have been judicially adjudicated incompetent or involuntarily committed. See N.Y. PENAL LAW § 265.01(6) which provides that a person is guilty of a criminal possession of a weapon in the fourth degree when that person has been “certified not suitable to possess a rifle or shotgun, as defined in subdivision sixteen of section 265.00, and refuses to yield possession of such rifle or shotgun upon the demand of a police officer”; N.Y. PENAL LAWS § 265.00(16), which defines “certified not suitable to possess a self-defense spray device, a rifle or shotgun” to mean “that the director or physician in charge of any hospital or institution for mental illness, public or private, has certified to the superintendent of state police or to any organized police department of a county, city, town or village of this state, that a person who has been judicially adjudicated incompetent, or who has been confined to such institution for mental illness pursuant to judicial authority, is not suitable to possess a self-defense spray device . . . or a rifle or shotgun.” (emphasis added).

\textsuperscript{87} See N.Y. MENTAL HYG. LAW § 9.39.

\textsuperscript{88} The Consortium for Risk-Based Firearm Policy includes leading researchers, practitioners, and advocates in gun violence prevention and mental health from across the United States. In March 2013, members of the Consortium met for a two-day conference. The conference resulted in a commitment to advance evidence-based gun violence prevention policy recommendations through the Consortium.

\textsuperscript{89} See Guns, Public Health and Mental Illness, supra note \textsuperscript{8485}, at 2.
a period of five years or convicted of two or more misdemeanour crimes involving a controlled substance in a period of five years). This proposal to add a behavioural predicate as a pre-requisite for suspending Second Amendment rights has great merit.

Deterring People Suffering from Mental Illnesses from Seeking or Continuing Treatment.

New York City’s Veterans’ Mental Health Coalition, comprised of 800 member organizations serving an estimated 15,000 veterans of combat in Iraq and Afghanistan, predicted that the SAFE Act would deter veterans suffering from post-traumatic stress disorder and other psychological problems from seeking mental health services. The U.S. Department of Veteran Affairs announced that, as a federal agency it is not required to comply with state law, and will not voluntarily comply with the SAFE Act’s reporting requirements because “[f]ederal laws safeguarding the confidentiality of veterans’ treatment records do not authorize VA mental-health professionals to comply with this NY State law.” According to the Director of Public Policy at the NYS Mental Health Association, “[t]here is a chilling effect on people getting care, and we’re particularly concerned about veterans . . . [because] we have a hard enough time getting veterans in for PTSD. Veterans are a prime example of someone [sic] who would have a disincentive to go.

The New York State Catholic Conference and New York State Psychiatric Association (NYSPA) also expressed concern that the wide net cast by the SAFE Act’s standard of “likely to engage in conduct that would cause serious harm to self or others” will discourage individuals from seeking needed mental

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90 Id. at 8.
91 A RAND Corporation study found that more than one in five veterans suffer from post-traumatic stress disorder (PTSD) or major depression, rates two to four times higher than the general population for major depression, and eight times higher for PTSD. See RAND CENTER FOR MILITARY HEALTH AND POLICY RESEARCH, INVISIBLE WOUNDS OF WAR: PSYCHOLOGICAL AND COGNITIVE INJURIES, THEIR CONSEQUENCES, AND SERVICES TO ASSIST RECOVERY (Terri Tanielian & Lisa H. Jaycox eds., 2008), available at http://www.rand.org/content/dam/rand/pubs/monographs/2008/RAND_MG720.pdf.
92 Paul Appelbaum, Director of Law, Ethics, and Psychiatry at Columbia University, has expressed a similar view, "Lots of people, because of the stigma associated with mental illness, don’t want anybody to know that they’re in treatment .... They don’t use their insurance coverage. They pay out of pocket, so their employer and their insurer won’t know. They may not even tell their spouse. The SAFE Act reporting provisions may be enough to scare them away forever.” See Paul Adams, Will Gun Laws Hurt the Mentally Ill? BBC News, Mar. 29, 2013,http://www.bbc.com/news/world-us-canada-21890032.
93 See id.
health treatment, due to fear of being reported.\textsuperscript{95} Therefore, the Catholic Conference has supported amending the SAFE Act to require reporting only where a patient poses an imminent danger to self or others.\textsuperscript{96} This would be a sensible amendment and would help mitigate the current wording’s over-inclusiveness.

\textbf{Undermining the Therapeutic Relationship.}

The SAFE Act’s reporting procedures may also erode trust between therapist and patient. Rather than encouraging the belief that the therapist’s interests are fully aligned with those of the patient, the SAFE Act places the therapist in something of a policing role. Indeed, should an ethical therapist warn patients, before encouraging them to fully disclose their emotional state and symptoms, that they, the therapist, are required to report them to the state if they deem them at risk of causing harm to themselves or others, and that such a report will be practically certain to result in the abrogation of their Second Amendment rights?

The NYSPA has emphasized the damage, which the SAFE Act may cause to the integrity and effectiveness of the therapeutic relationship:

“...psychiatry recognizes that the duty of confidentiality may yield to public health and safety concerns when a psychiatrist concludes that a patient presents a serious and imminent risk of harm to self or others. In that situation, a psychiatrist may elect to breach confidentiality in order to prevent injury or possible death. However, such breach is only justified when the disclosure is made to either the potential victim, if identifiable, or to law enforcement to attempt to prevent potential harm or injury. In addition, after any potential danger has been averted, law enforcement should work with the treating psychiatrist to decide if the patient should be brought to a hospital emergency room for evaluation to determine whether inpatient care and treatment is required. The critical element here is that the disclosure may prevent the possible harm or injury either by notifying appropriate individuals or law enforcement authorities who


\textsuperscript{96} Id.
are able to take immediate action, including bringing the patient in for psychiatric evaluation. Without this element – disclosure to prevent harm or injury – the breach of confidentiality would not be warranted."97

The NYSPA also argued that the SAFE Act will weaken the psychiatrist-patient relationship by mandating disclosure of confidential information absent exigent circumstances:

[P]sychiatry is unique among medical specialities in that patients’ disclosure of their inner thoughts and feelings including angers, hostilities and resentments, is often essential to the treatment of mental illness. If patients do not feel secure that the information they provide to the psychiatrist will be kept confidential, they may be reluctant to enter into treatment or continue with on-going treatment. In this regard, the mandatory reporting requirements of the SAFE Act may dissuade individuals from pursuing needed treatment precisely because they feel that their confidences will not be kept confidential."98

NYSPA therefore proposes that the SAFE Act be amended to require reporting only when the therapist concludes that there is a serious and imminent danger to the patient or others; and that, when a patient must be reported, the warning should be communicated directly to those in danger or to the appropriate local law enforcement agency, not to DCJS.99 According to NYPSA, these amendments would provide a more expeditious and targeted strategy for protecting potential victims. They would also significantly reduce the number of patients whose Second Amendment rights are extinguished.100

98 Id.
99 Assemblyman Gary Pretlow’s (D-Mount Vernon) proposed amendment to the SAFE Act (A6233-A) embodied these proposals. It would permit, but not mandate, disclosure and reporting when a treatment professional concludes that the patient poses a serious and imminent danger to self or others. The bill provides that, in addition to submitting the report to the local director of community services, the therapist should warn those endangered or the local police. It also provides that, absent malice or intentional misconduct, no criminal or civil liability should attach either to the decision to report or the decision not to report. So far, this bill has had no traction. See The Implementation and Impact of the SAFE Act Mental Health Requirements: Hearing Before the S. Standing Comm. on Mental Health and Developmental Disabilities, Leg., 236th Sess. 3 (NY. 2013) (testimony of Glenn Martin, President of the NY State Psychiatric Association).
100 Id.
Confusing and Burdensome Reporting Requirements.

The Medical Society of the State of New York (MSSNY) complained that the SAFE Act subjects its members to multiple and inconsistent reporting requirements. Health care professionals’ working for an Office of Mental Health (OMH) or in an Office for People with Disabilities (OPWDD) licensed or operated facility have for years been required to report threats of violence to the police or to named victims if they perceive that the patient poses a “serious and imminent threat to the health and safety of self or others.” Now, the SAFE Act requires them to report to the state a patient whom they believe is “likely to engage in conduct that would result in serious harm”:

We are concerned that the existence of two standards will cause significant confusion among health care professionals and could result in the reporting of persons who do not pose a serious and imminent threat to society. MSSNY supports an amendment to the SAFE Act, which would assure that only those who present a “serious and imminent threat to self or others” are reported. Moreover, MSSNY supports an amendment to the Act, which would clearly do away with the private right of action, which will result in litigation over the question of whether the reporter exercised reasonable professional judgment in the exercise of their duty. MSSNY seeks an amendment which would assure that the decision of a mental health professional to disclose or not to disclose, if exercised without malice or intentional misconduct, shall not be the basis for any civil or criminal liability.

102 Section 33.13(6) of the New York Mental Hygiene Law authorized, but did not mandate disclosure in such circumstances. See N.Y. MENTAL HYG. LAW § 33.13(6).
103 Under that standard, only psychiatrists and psychologists working in facilities licensed or operated by the OMH and the OPWDD were authorized (not mandated) to release information to warn possible victims or law enforcement officials in the event a patient presents a serious and imminent risk of harm to self or others. See N.Y. MENTAL HYG. LAW § 33.13(6).
104 MSSNY’S 2014 Legislative Program, Medical Society of the State of New York, at 12, https://www.mssny.org/Documents/GA%20%20Advocacy%20Matters%20%20Testimony/MSSNY_LegislativeProgram2014.pdf. The NYSPA noted that: “At the same time, however, psychiatry recognizes that the duty of confidentiality may yield to public health and safety concerns when a psychiatrist concludes that a patient presents a serious and imminent risk of harm to self or others. In that situation, a psychiatrist may elect to breach confidentiality in order to prevent injury or possible death. However, such breach is only justified when the
The NYSPA has also complained that the SAFE Act’s reporting requirement conflicts with the federal Health Insurance Portability and Accounting Act (HIPAA), which permits disclosure of health information to law enforcement or to a potential victim, without patient authorization, only when a patient poses a threat that is both serious and imminent to health or safety. By contrast, the SAFE Act imposes a broader reporting requirement that, in some cases, would violate HIPPA.

Both the NYSPA and the New York State Nurses Association objected to the SAFE Act placing diagnostic and prediction responsibilities on registered nurses, which exceed nurses’ expertise and which might expose them to the risk of civil liability and professional discipline.

disclosure is made to either the potential victim, if identifiable, or to law enforcement to attempt to prevent potential harm or injury. After any potential danger has been averted, law enforcement should work with the treating psychiatrist to decide if the patient should be brought to a hospital emergency room for evaluation to determine whether inpatient care and treatment is required. The critical element here is that the disclosure may prevent the possible harm or injury either by notifying appropriate individuals or law enforcement authorities who are able to take immediate action, including bringing the patient in for psychiatric evaluation. Without this element – disclosure to prevent harm or injury – the breach of confidentiality would not be warranted.” See New York State Psychiatric Association, NYSPA Issues Press Release on SAFE Act Reporting Requirements, NEW YORK STATE PSYCHIATRIC ASSOCIATION, http://www.ny psych.org/index.php?option=com_content&view=article&id=41:Safe-act-press-release&catid=20:site-content.


106 45 C.F.R. § 164.512(j).

107 In opposition to the SAFE Act, the Shooters Committee on Political Education (SCOPE) initiated a campaign in June 2015. Among other arguments, SCOPE insisted that seizure of guns without an opportunity for a hearing violates the constitution. SCOPE encouraged citizens (whether gun owners or not) to file Freedom of Information requests with state police to obtain records of § 9.46 report, if any, about themselves. See Dave McKinley, SAFE Act Opponents Launch FOIL Campaign, WGRZ.COM (Jun. 9, 2015), http://www.wgrz.com/story/news/2015/06/09/urges-people-to-learn-if-theyve-been-reported-under-mental-hygiene-law/28759511/. These FOIL requests highlight the potential for the SAFE Act to violate patient’s privacy by including them in a database of firearms ineligible persons that is subject to disclosure under the state’s Freedom of Information Law. A person who is publicly disclosed as having been included in a database of persons too mentally unstable to be permitted to own a firearm would be vulnerable to stigma and discrimination. This lack of privacy protection stands in stark contrast to New York State’s law protecting the identity of firearms licensees, who are able to claim an exemption from having their identity as a firearms’ licensee disclosed: § 400.00(5)(c).


Administrative Cost Frustrates Individualized Assessment

The NYS Conference of Local Mental Hygiene Directors (CLMHD), representing the Directors of Community Services from 57 counties and the City of New York, criticized the SAFE Act for imposing on counties the burden of reviewing tens of thousands of mental health professionals’ reports, a responsibility that requires the counties to hire hundreds, perhaps more than a thousand new employees. The CLMHD claimed that hospitals have adjusted to the SAFE by adopting an automatic referral system, which does not make individualized assessments of patients. According to CLMHD’s counsel, state-operated psychiatric centers alone filed 1000 new reports in April 2014.

“Some DCS are receiving reports that appear to be made by someone other than the [Mental Health Professional] treating the patient. This might be a person designated by the hospital to make such reports or, in some cases, by a computer-generated report. Technically such a report is neither made by an MHP who is currently treating the subject nor is it based on reasonable professional judgment. we have been advised that the State has taken the position that all persons admitted to a State Psychiatric Center meet the criteria of 9.46 simply by virtue of their admission, and for at least some period of time, all such admitted persons were apparently being reported en mass by computer generated reports not based

therapists in private practice. Prior to the SAFE Act, only psychiatrists and psychologists who work at facilities licensed or operated by either the Office of Mental Health (OMH) or Office for Persons with Developmental Disabilities (OPWDD) were required to report patients who pose an imminent threat to an identifiable person.

"Initial discussions regarding this new provision of law with hospitals across the State indicate that it is their belief that all admissions to psychiatric units (whether voluntary or involuntary) require a report pursuant to 9.46 to be filed with the DCS or designee. The most recent available hospital data show over 210,000 psychiatric discharges in the year 2010 alone. This will likely translate into over 200,000 reports to be received, evaluated, and passed on to DCS from hospitals alone; and this number does not include the numerous others who might meet the 9.46 criteria who are not admitted to hospitals and whose names will be reported to the DCS or designee by practitioners in other settings, such as outpatient clinics and private practices.” Regarding the Local Director of Community Services (DCS) duty to receive and investigate reports from mental health practitioners pursuant to Mental Hygiene Law 9.46 in the “NY SAFE Act”, New York State Conference of Local Mental Hygiene Directors, 2013, http://www.clmhd.org/img/uploads/file/Safe_Act_9_46_Memo_CLMHD_LH(1).pdf.

The NYS Office of Mental Health has acknowledged that many psychiatric patients were automatically referred to county officials. Benjamin Rosen, a spokesperson for the OMH explained that: “[b]etween March 16, 2013 and May 6, 2013, while OMH was building a reporting portal for state psychiatric hospitals, reports were initiated based on admissions to state psychiatric hospitals, although mental health professionals had the ability to prevent reports from being forwarded for those persons who did not meet NY SAFE Act criteria”. Skinner supra note 9495.

on the reasonable professional judgment of a treating clinician as the statute
requires.\textsuperscript{113}

The SAFE Act calls for subjective predictions of future firearms misuse. Mental health professionals
are likely to report patients about whom they have \textit{any concern}, since the consequences of failing to
report someone who subsequently engages in violence may be dire for victims as well as for the mental
health professional’s career. According to the Chair of the American Psychiatrist Association’s
Committee on Judicial Action, mental health professionals are unlikely to take the risk of not reporting a
patient: “[i]f my patient acts on their impulses in a horrendous way, what happens when everyone starts
pointing fingers at me?”\textsuperscript{114} Moreover, DCS review is bound to be a rubber stamp, since the reviewer will
not have met or talked to either the therapist or the patient or even had access to the patient’s file, and
is therefore unlikely to second-guess the reporting mental health professional.\textsuperscript{115}

By October 2014, just over 18 months after the NYS’s reporting requirement took effect, over
40,000 names had been added to the database,\textsuperscript{116} approximately 2,000 reports per month.\textsuperscript{117} The
number of people being reported to the database each month is roughly equivalent to the number of
New York suicides (1,637) and homicides (671) combined for an entire year.\textsuperscript{118}


\textsuperscript{114} Appelbaum notes that the widow of one of the victim’s of the July 20, 2012 massacre in Aurora Colorado filed a
lawsuit against Lynne Fenton, M.D., the University of Colorado psychiatrist who treated James Holmes, the
gunman See Adams \textit{supra} note \textsuperscript{9293}.

\textsuperscript{115} The New York Times reports that so many patients’ names are reported to DCSs (approx. 500 per week
statewide) that the DCS review has become a rubber stamp. From March 16, 2013 until Oct 3, 2014, health care
professionals reported 41,427 patients to DCSs. The DCSs forwarded 40,678 names to DCJS. The Commissioner of
Mental Hygiene for Dutchess County admitted that while, at first, he had carefully scrutinized every name sent to
him through the SAFE Act, he then realized he was just “a middleman” and it was unlikely he would ever meet or
examine any of the patients. He began simply checking off the online boxes, sometimes without even reviewing
the narrative about a patient “every so often I read one just to be sure...I am not going to second guess. I don’t see
the patient. I don’t know the patient.” See Anemona Hartocollis, \textit{Mental Health Issues Put 34,500 on New York’s
34500-on-new-yorks-no-guns-list.html.

\textsuperscript{116} Id.

\textsuperscript{117} It is reported that the database grows by a rate of approximately 750 people per week. See \textit{NY State Police
police-receive-900-freedom-of-information-requests/.

\textsuperscript{118} See \textit{NEW YORK STATE DEPARTMENT OF HEALTH, DIVISION OF INFORMATION AND STATISTICS, ANNUAL REPORT OF VITAL STATISTICS:
NEW YORK STATE 2013, TABLE 33A: DEATHS AND DEATH RATES * BY SELECTED CAUSES AND RACE NEW YORK STATE – 2013 (2013),
IV. Conclusion

The SAFE Act aims to prevent mentally ill and dangerous individuals from committing mass murder, like the Sandy Hook Elementary School massacre, by preventing them from obtaining or retaining firearms. To this end, the Act imposes a mentally ill and dangerous reporting requirement on every mental health professional, regardless of whether they are a therapist or specialist in mental illness, much less specialized in behavioral risk prediction. Section 9.46 reports have already resulted in the five-year suspension of the Second Amendment rights of more than thirty thousand people who have never, and will never engage in violent acts. By penalizing and stigmatizing people suffering from psychological and emotional problems, the SAFE Act will likely deter some people from seeking treatment and others from speaking frankly with medical staff.

The SAFE Act's logic ignores the fact that the constitution guarantees an individual right to keep and bear arms. It assumes that it is justifiable to extinguish that right in order to prevent some speculative number of gun incidents. Following the same logic, it would be justifiable to disarm the whole population in order to reduce firearms injuries. However, the Constitution, as interpreted by the Supreme Court in *Heller* and *McDonald*, has precluded such a policy choice.

It is hard to believe that New York State would allow other constitutional rights to be abrogated this casually. Imagine a state politician advocating the criminalization of hate speech in order to reduce fights and inter-group conflict. Consider the civil liberties furor that would be provoked by a proposal that voters show identity documents in order to prevent fraud.

The SAFE Act authorizes the forfeiture of Second Amendment rights on the basis of the crudest type of impressionistic risk prediction. Section 9.46’s reporting process ignores the existence of evidence-based risk assessment instruments. Moreover, the reported individual is not entitled to any due process, or even to notice, before being stripped of his rights. The legislation demonstrates bias against and stereotyping of the "mentally ill".

Admittedly, there are circumstances where public safety requires that the state disarm a mentally ill individual. But the circumstances need to be carefully limited, with recognition that it is a constitutional right at stake. A person should only be disarmed if he has expressed a credible threat to harm himself or another and, even then, there must be an opportunity to challenge his classification. There should also be a procedure for regaining one's suspended rights after a substantial period of time has passed without any violent conduct; five years is certainly too long.