Mental Illness, Guns and Dangerous Patients

written by Richard Leslie | April 3, 2018

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It seems that every time there is a mass shooting event, followed by an outcry for gun control legislation (and school safety), there is also a discussion about the "mentally ill" and whether limitations should be placed upon their ability to legally own or possess guns. Media discussions are filled with references to the "mentally ill" without clearly defining what is meant by the term "mentally ill." With respect to reports to the FBI's National Instant Criminal Background Check System (NICS), those who have been adjudicated a danger to self or others in an involuntary commitment proceeding must be reported by certain entities or persons. Those "mentally ill" persons are therefore not entitled to buy or possess guns. But after all of the media discussion following the recent Florida school shooting, what would be the result of a poll question that asked the public "should a mentally disordered patient be allowed to possess a gun?"

Mental health practitioners understand that people who are being treated for mental and emotional problems span a wide spectrum – the overwhelming majority posing no threat or likelihood of committing acts of violence toward self or others. For the many practitioners who deal with patients who seek reimbursement from insurance companies and managed care plans of various types, the diagnosis and treatment of a mental disorder is required in order to be entitled to reimbursement by the insurer or other payer – whether private or governmental. Many practitioners of various licensures believe that the pressure to specify diagnoses for patients early in the therapeutic process has transformed their practices (and professions) unnecessarily toward the sickness, illness, or medical model. Prior to the reality of widespread reimbursement for psychotherapists, there was no need to quickly identify and specify a DSM diagnosis, if at all – depending upon the treatment philosophy (e.g., family systems therapy, narrative therapy, etc.) of the particular practitioner.

This reality sometimes raises the question of whether practitioners in private practice should explore with patients the pros and cons of the patient paying "out of pocket" rather than relying on the health insurance company's reimbursement. Such a discussion would necessarily include the topics of privacy, confidentiality, the amount of coverage, and the nuanced explanation that in order for reimbursement to occur, it will be necessary to designate a particular mental disorder that is being treated. Such a discussion must be done with care, since a careless job might lead a patient to later allege, among other things, that the practitioner talked the patient out of utilizing his/her coverage for the practitioner's convenience – to the economic detriment of the patient. Some practitioners have shaped their practices to avoid patients who depend upon insurance reimbursement or other payers, thus eliminating oversight and review and the need to quickly assign a mental disorder to the patient. Such selectivity of clientele is not always possible or desired.

The often thorny issue for psychotherapists of all licensures is how to deal with dangerous patient situations once the practitioner has determined that a patient poses a serious danger of violence against a readily identifiable other (or a determination of dangerousness based upon a similar standard). Once that determination is made, the practitioner must act in a manner that is consistent with state law (statutory and case law). I have previously written about the dangerous patient issue and the so-called "duty to warn" in California, first established by the "Tarasoff decision" by the California Supreme Court. The actual duty enunciated in the landmark 1976 decision was that the therapist must use reasonable care to protect the intended victim against the serious danger of violence – it did not create an actual "duty to warn." As the Court states, the discharge of the duty may call for the therapist to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.

The content of a warning made by a mental health practitioner to an intended victim can become an issue. Generally, I have advised that the warning be clear and concise – and that the practitioner reveal only that amount of information necessary to accomplish the purpose. My concern was to protect confidentiality in accordance with the sentiments expressed by the Court in the Tarasoff decision. In a 1991 California appellate court decision involving the Menendez brothers, accused of killing their parents, that court ruled that the content of a "Tarasoff warning" may include any of the patient's statements to the therapist that the therapist reasonably believes are necessary to disclose to the victim in order to convince the victim of the extent and seriousness of the danger. In that case, one of the brothers admitted to the murder during a therapy session, and that information was later disclosed by the therapist when making the warning.

In some cases, the patient may inform the therapist that a particular person is threatening violence against the patient or a third party. Therapists sometimes think that the usual duty or right to take certain actions applies to such situations. Since the patient is not threatening harm to others, it is the patient who must decide on the appropriate course of action for the patient to take. The therapist may discuss various options that the patient could pursue, but the dangerous patient exception to confidentiality relates to situations where the patient is the one who presents the danger to others (or self).

What if a practitioner asks whether he/she should return a gun that the practitioner had taken from the patient at the patient's request? Whether the practitioner should take the weapon in the first place is a question that can be debated, although in most circumstances, such action is either unnecessary or unwise. I think of the scenario, however, where the failure to take and temporarily hold a gun that was surrendered by the dangerous patient could result in liability exposure if the patient leaves and shortly thereafter commits an act of violence with the gun. Should the facts ultimately emerge as to the refusal of the therapist or counselor to accept and hold/store the gun, the practitioner could be vulnerable – especially if judged after the fact of a mass shooting and in the midst of intense publicity and scrutiny.

If the therapist decides to return the gun when the patient makes such a request, it can be inferred that the therapist has made the determination that the patient is no longer a serious danger of violence. The

risks involved with such a determination should be apparent. I would advise a therapist in such a situation (hopefully rare) to not act rashly and to refer the patient to another practitioner (preferably a psychiatrist) for an evaluation of mental status and dangerousness. Finding a practitioner willing to make such a determination, in light of recent events, might be difficult. While the gun cannot be held by the therapist indefinitely, perhaps it can be kept by the therapist until a corroborating professional opinion is obtained and treatment is terminated. It can be argued (in appropriate cases) that since the patient voluntarily sought therapy, readily communicated the threatened behavior to the therapist, voluntarily surrendered the gun, and was thereafter in an improved mental state (no longer a danger), return of the gun was both reasonable and warranted.

On a lighter note, I have previously written about the call I once received from a therapist who told me that the patient who was scheduled for a session later that week had just called and told the therapist that when he comes to treatment in a few days he is going to kill (shoot) the therapist. The therapist asked, “What is my duty?” My response was “cancel your appointment.” Further discussion revolved around whether the therapist should notify the police of the threat and the identity and whereabouts of the patient. Of course, termination of treatment, and the manner in which the termination could be implemented, was also a topic for discussion.