

REPORTING REQUIREMENTS AND THE NEW YORK SAFE ACT OF 2013

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Following the Sandy Hook school shooting in December of 2012, the state of New York took the increased public support for gun control measures as an opportunity to amend its existing assault weapons ban, creating the New York Secure Ammunition and Firearms (SAFE) Act of 2013. This paper focuses on the SAFE Act provision that creates a reporting requirement for mental health professionals, and compares it to existing reporting requirements for health care professionals in other contexts, including the reporting of communicable diseases, individuals considered medically unfit to drive, cases of suspected child abuse, and of pregnant women who use illegal drugs. The SAFE Act's misguided attempt at protecting public health and safety through this reporting requirement does not meet the five criteria outlined by Childress et al. (effectiveness, necessity, least infringement, benefits proportional to harms, and justifiable to the public) needed for a public health intervention that conflicts with moral considerations.

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PREFACE

Many thanks to my adviser, Dr. Lisa Parker, and to my committee members, Alan Meisel and Dr. Jack Rozel for all their help.

1.0 INTRODUCTION AND BACKGROUND

The Sandy Hook school shooting in December of 2012 killed twenty-six people, twenty of them children. Though this was not the only occurrence of fatal gun violence in recent history (the 2011 shooting of Arizona State Representative Gabrielle Giffords, or the 2012 mass shooting in an Aurora, Colorado movie theater being two other examples), the loss of life, particularly young lives, from the Sandy Hook incident resulted in increased public support for measures to address gun violence. Some proposals to reduce gun violence arose in federal and state legislatures. These proposals have included universal background checks for those seeking to purchase firearms, limiting the capacity of ammunition magazines, and assault weapons bans.

At the time of the Sandy Hook shooting, the state of New York already had an assault weapons ban in place. However, the state legislature took this increase in public support for gun control measures as an opportunity to amend that statute, creating the New York Secure Ammunition and Firearms (SAFE) Act of 2013. The part of this amendment that is my focus in this paper is the addition of a “reporting requirement” for mental health professionals: now, mental health professionals in New York are required to report the names and demographic information of “dangerous” patients to the state government. In response to this legislation, I will explore the role of the health care professional in such reporting requirements, including those that already operate in several domains of public health protection, as well as in the context of measure such as New York’s that seek to reduce gun violence.

1.1 STATEMENT OF THESIS AND PROJECT PLAN

In this paper, I will argue that the New York state statute's reporting requirement is misguided for several reasons. First, prediction of violence is not an exact science. Second, both the existence of mandatory reporting requirements, and acting in fulfillment of them, can damage the therapeutic relationship. Finally, the implementation of such a reporting requirement provides substantial opportunity for compromised patient privacy and discrimination.

In Section 2.0 of this paper, I will explain the details of the New York Secure Ammunition and Firearms (SAFE) Act of 2013. This overview will elucidate what role mental health professionals are now expected to take in helping to prevent gun violence. This legislation amended the state's existing assault weapons ban. Now, when a mental health professional determines that a person is likely to engage in conduct that would result in serious harm to self or others, she is required to report the person's name and demographic information to the New York Division of Criminal Justice Services (DCJS). As a result of the mental health professional's report, this information will be used by the DCJS to determine whether that person has an existing license to possess firearms. Then, the reported information will be used to determine whether the license will be suspended or revoked. If the person does not have a license, the reported information will be used to determine whether the individual should be considered ineligible to obtain a license in the future.

In Section 3.0 I will examine reporting requirements imposed to in other contexts. The purpose of this section is to explore the role of health care professionals in other measures intended to protect public health that involve reporting otherwise confidential information to the state. This analysis will serve as a point of comparison for the reporting role of mental health professionals in New York as envisioned by the SAFE Act. I will analyze four other situations

where reporting requirements have been instituted: when a patient has a communicable disease, when a patient is medically unfit to drive, in cases of child abuse, and drug use by pregnant women. In each of these cases, I will examine the legal requirements regarding what professionals are to report, to whom they must report, and what liberties might be limited because of these reports, as well as broader implications of implementing the reporting requirement. I will also analyze the rationale for imposing these reporting requirements and why they require the information to be reported by health care professionals.

In Section 4.0, the final part of this project, I will return to the reporting requirement imposed by the New York SAFE Act to examine the practical and ethical implications of the reporting requirement it imposes. First, I will argue that this law's focus on the mentally ill is inappropriate. Targeting a population which accounts for only a small portion of overall gun violence does not address the major perpetrators or causes of gun violence. Instead, it effectively makes scapegoats of the mentally ill. Moreover, those with mental illness continue to face social stigma because of their illness; therefore the law's focus on the mentally ill raises concern about the exacerbation of discrimination and stigmatization of those with mental illness and concern for the welfare of this already vulnerable population. Singling out a subset of the mentally ill for the potential loss of a constitutionally protected right to own a firearm may, for some, carry with it an especially weighty stigma. Moreover, in some communities and cultures within the United States being unable to own a gun may be a clearly evident mark that is stigmatizing. In any culture or community, being unable to own a legal firearm places one in the same class--or at least in the same circumstance--as those whose criminal record denies them the right to purchase a gun. The designation as unfit to own a gun is thus stigmatizing in the United States no matter the norms of one's particular community, and a reporting requirement that presents the

possibility of this designation involves health care professionals in this potentially stigmatizing enterprise.

Next, I will explore how this law requires that mental health professionals predict violence. The law therefore relies on the professional judgment of the professionals: however, violence prediction is difficult and not always accurate. The difficulty and imprecision of predicting violence opens the door for professionals' prejudicial judgments, and perhaps their concern to avoid liability, to result in injustice. Relying on an individual's best guess can be subject to that physician's personal biases and lead to unfair or arbitrary determinations regarding which patients are predicted to be violent. Fears of the consequences resulting from a failure to predict a violent action on the part of a mentally ill person may lead professionals to employ over-inclusive criteria when predicting violence. Such over-inclusion would unduly restrict the liberty of the mentally ill to own a firearm, and unduly subject mentally ill individuals to labeling and potential stigma. Thus there are important implications for the liberty and welfare interests of those with mental illness that arise when employing this, at best, inexact science.

Finally, I will examine the effect this law's reporting requirement may have on the therapeutic relationship. Both the existence of such a reporting requirement and an individual professional's acting in response to it can erode trust between the physician and patient. Patients' fears of losing their right to gun ownership, of having individual privacy compromised, or of possible discrimination may lead some mentally ill people to avoid seeking treatment that could be beneficial to them. Here too, the welfare of people with mental illness is at stake.

2.0 THE NEW YORK SAFE ACT: PROVISIONS AND INITIAL PROBLEMS

The New York Secure Ammunition and Firearms (SAFE) Act of 2013 was passed on January 15, 2013.¹ This piece of legislation marked the first change in the state's assault weapons ban in more than ten years.² The existing assault weapons ban was passed in 1994 and prohibited possession of assault weapons and large capacity ammunition feeding devices.³ The SAFE Act amends the assault weapons ban by imposing new reporting requirements on mental health professionals. These reporting requirements took effect on May 15th, 2013.

§ 9.46 of the Mental Health Act is the portion of the SAFE Act that implements this reporting requirement for mental health professionals. The text of this section reads as follows:

§ 9.46 Reports of substantial risk or threat of harm by mental health professionals.

(a) For purposes of this section, the term "mental health professional" shall include a physician, psychologist, registered nurse or licensed clinical social worker.

(b) Notwithstanding any other law to the contrary, when a mental health professional currently providing treatment services to a person determines, in the exercise of reasonable professional judgment, that such person is likely to engage in conduct that would result in serious harm to self or others, he or she shall be required to report, as soon as practicable, to the director of community services, or the director's designee, who shall report to the division of criminal justice services whenever he or she agrees that the person is likely to engage in such conduct. Information transmitted to the division of criminal justice services shall be limited to names and other non-clinical identifying information, which may only be used

¹ Bob Clark, "The SAFE Act Facts and Debates," *Olean Times Herald*, March 10, 2013, accessed March 10, 2013 http://www.oleantimesherald.com/news/article_a1a1d16c-8a65-11e2-936a-0019bb2963f4.html

² Clark, "The SAFE Act."

³ NYS Penal Law § 265.02(7)-(8).

for determining whether a license issued pursuant to section 400.00 of the penal law should be suspended or revoked, or for determining whether a person is ineligible for a license issued pursuant to section 400.00 of the penal law, or is no longer permitted under state or federal law to possess a firearm.

(c) Nothing in this section shall be construed to require a mental health professional to take any action which, in the exercise of reasonable professional judgment, would endanger such mental health professional or increase the danger to a potential victim or victims.

(d) The decision of a mental health professional to disclose or not to disclose in accordance with this section, when made reasonably and in good faith, shall not be the basis for any civil or criminal liability of such mental health professional.⁴

2.1 PROFESSIONAL JUDGMENT AND THE PREDICTION OF VIOLENCE

The SAFE Act requires that mental health professionals must use “reasonable professional judgment” to determine if a person is likely to “engage in conduct that would result in serious harm to self or others.”⁵ If the mental health professional determines that a person is likely to harm himself or others, the professional is required to report that person’s name to “the director of community services, or the director's designee, who shall report to the division of criminal justice services.”⁶

In a legal sense, “reasonable professional judgment” is both a standard of care (considered from a national rather than a local perspective).⁷ To establish this standard of care, or to evaluate its assertion as a defense, a court would consider expert testimony as to what any

⁴ New York Code, Title B Mental Health Act, §9.46

⁵ New York Code, Title B Mental Health Act, §9.46(B)

⁶ *Id.*

⁷ John Parry and Eric York Drogin, *Mental Disability Law, Evidence and Testimony: Reference Manual for Lawyers, Judges, and Mental Disability Professionals* (Chicago, ABA Publishing, 2007), 370-371.

reasonable professional would have done in similar circumstances.⁸ The professional will only be found liable when “the decision by a professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible did not base the decision on such a judgment.”⁹

By requiring the use of reasonable professional judgment, the SAFE Act, in essence, requires that the mental health professional act in the same manner as any other member of the profession would with regard to the prediction of violence. The problem with reasonable professional judgment in the prediction of violence is that professionals are only marginally better at predicting violence based on their professional clinical judgment than by chance. Lidz, Mulvey, and Gardner conducted a study to assess the accuracy of clinician prediction of violence in mental patients. Lidz et al. found that violence occurred in 53% of cases where the clinician predicted violence, while violence that occurred in 36% of cases in the comparison group where no prediction was made.¹⁰ The overall clinical accuracy was only slightly better than chance, although the prediction of violence in female patients was not better than chance.¹¹

⁸ Parry and Drogin, *Mental Disability Law*, 371.

⁹ *Id.*

¹⁰ Charles Lidz et al., “The Accuracy of Predictions of Violence to Others,” *Journal of the American Medical Association* Vol. 269 No. 8 (February 1993): 1007.

¹¹ Lidz et al., “The Accuracy of Predictions of Violence,” 1007.

2.2 SCOPE OF APPLICATION OF REPORTING REQUIREMENT

Mental health professionals are defined in the SAFE Act as defined as any physician, psychologist, registered nurse, or licensed clinical social worker.¹² As defined in the law, the term “mental health professional” presents some practical problems. First, the term does not include all the types of professionals that may encounter patients who exhibit the same symptoms fulfilling the criteria for predicting violence that then obligate other professionals to report under the SAFE Act. Licensed clinical social workers are the only type of social worker mandated to make these reports, while social workers with different credentials are excluded from making them, even though they may deal with the same types of clients and witness similar symptoms that are ostensibly predictive of future violence.¹³ The solution to this practical problem of some social workers being required and others prohibited from reporting is to include social workers of all credentials to the Act’s definition of mental health professional, thereby requiring that all report.

Additionally, the Act’s reporting requirement applies to professionals who may not conceive of themselves as “mental health professionals,” and who may have even less expertise in determining whether a patient presents a risk of future violence than trained mental health professionals. All physicians are mandated to report, whether they specialize in mental health or not. Two primary problems arise. First, the law is relying on the expertise of the professionals to predict violence. As unreliable as violence prediction is when those who specialize in mental health attempt it, physicians who specialize in other areas may be even less equipped to handle the prediction of violence.

¹² New York Code, Title B Mental Health Act, §9.46(a)

¹³ New York Code, Title B Mental Health Act, §9.46(a)

Second, many physicians may not think of themselves as mental health professionals and may not be aware that they need to report the patient themselves rather than simply referring their patient to a mental health specialist. Yet, should a patient visit his primary care physician presenting as likely to engage in conduct that will cause harm to himself or others, simply referring that patient to another mental health professional would not discharge the primary care physician's duty to report the patient's name and demographic information to the local Director of Community Services, who then reports to the Division of Criminal Justice Services.

When mental health professionals determine that, in their professional judgment, a patient is likely to do harm to self or others, they are required to submit their report via New York's Office of Mental Health website. The report form has text fields, radio buttons, and drop down menus that collect information about the professional doing the reporting, the professional's relationship to the person they are reporting, and information about the person being reported, including demographics, as well as an open text box to enter the specific reason for the report (see Figure 1).¹⁴ The information in these reports is sent to the appropriate local director of community services in the county where the patient resides, who then reviews the reports.¹⁵ If the director of community services agrees that the patient is likely to do harm to self or others, the director then sends the "non-clinical identifying information" to the New York State Division of Criminal Justice Services (DCJS) where it is used to determine whether that individual currently has a license to possess firearms.¹⁶ If the reported patient has a gun license,

¹⁴ The form for reporting is located at <https://nysafe.omh.ny.gov/>

¹⁵ New York Code, Title B Mental Health Act, §9.47

¹⁶ New York Code, Title B Mental Health Act, §9.46(b)

the non-clinical identifying information will be given to the local licensing official.¹⁷ Once the person's license is suspended or revoked, the license and any firearms must be surrendered to the local official. The time line for this process is not defined in the law, though the guidance document posted on the New York Office of Mental Health's (OMH) website states that professionals should report "as soon as is practicable."¹⁸

The potential vagueness of professionals' reports is another practical issue occasioned by this law. The New York OMH's guidance document for reports (found on the same site where reports are submitted) simply re-states the definition found in §9.01 of New York's Mental Hygiene Act that a reasonable professional judgment must be used to determine whether, "(a) a substantial risk of physical harm to the person, as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself, or (b) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior which places others in reasonable fear of serious physical harm."¹⁹ Dr. Kamin, the Chief of Clinical and Forensic Services at the Monroe County Office of Mental Health in Rochester New York, recounted one report that said, "Patient told the provider he was hoping to obtain a pistol permit." This report, for example, in no way indicated that the individual was a danger to himself or others as defined in §9.01, and is an instance of over inclusive reporting practices.

¹⁷ *Id.*

¹⁸ http://www.omh.ny.gov/omhweb/safe_act/guidance.pdf

¹⁹ New York Code, Title B Mental Health Act, §9.01



NY SAFE Act Reporting

9.46 NYS Mental Hygiene Law

*** If risk to self or others is imminent ***

Dial 911



[Help Contact Us](#)

Nov. 08, 2013

* fields with asterisk are required

Reporting Professional:

Professional's Name *
 First Name * Last Name *
 Provider Profession Type *
 : Physician : Psychologist : Psychologist (License Exempt) : Registered Nurse : LCSW
 Last 4 SSN * Date Of Birth * Phone Number * Phone Ext.
 MM/DD/YYYY
 Email Address *

Professional Relationship To Person:

Person Is Currently Hospitalized
 Hospitalized
 Treatment Team Member
 I am on the treatment team for person being reported.
 Last Seen * Treatment Relationship *
 MM/DD/YYYY

Person Being Reported:

Name *
 First * Middle Last *
 Other Name / Maiden Name
 Address
 Street *
 Street2
 Street Is Unknown
 City * New York * ZipCode *
 Postal Address Unknown
 County of Residence *

 Date of Birth or Approximate Age Social Security Number *
 Date Of Birth * MM/DD/YYYY
 Date Of Birth Unknown Social Security Number Unknown
 Gender *
 Female Male Unknown
 Race *
 White Black American Indian/ Alaskan Asian Pacific Islander Other Unknown
 Diagnosis *
 (for example: type 301.2 and a select list will appear. Either use arrows and press enter or choose with mouse)

Reason you believe the person is likely to engage in conduct that would result in serious harm to self or others including any specific threats, behaviors or actions:
 (for example: patient is found to be suicidal, has a detailed plan and is unwilling to contract for safety)
 Enter any specific threats, behaviors or actions here.

Enter Security And Submit:



(Upper and Lower Case Letters are accepted)

Figure 1. NY SAFE Act Reporting Page

3.0 ANALYSIS OF OTHER REPORTING REQUIREMENTS INTENDED TO PROTECT THE PUBLIC'S HEALTH

The amendment to the New York assault rifle ban is a measure intended to protect the public's health by reducing overall gun violence. In this section, I will examine the rationale behind other physician reporting requirements that have been enacted to protect public health. There are several frameworks that can be used for the ethical justification of a public health intervention. Nancy Kass' states that a public health intervention ought to "reduce morbidity or mortality; data must substantiate that a program...will reduce morbidity or mortality; burdens of the program must be identified and minimized; the program must be implemented fairly...and fair procedures must be used to determine which burdens are acceptable to a community."²⁰ R.E.G. Upshur's framework relies on four principles to justify a public health intervention: the prevention of harm, the least restrictive or coercive means, reciprocity, and transparency.²¹ Childress et al. outline five justificatory conditions that lawmakers and public health officials ought to take into account in order to minimize conflict between measure implemented to protect public health and the rights and interests of individuals.²² These five justificatory conditions are effectiveness,

²⁰ Nancy E. Kass, "An Ethics Framework for Public Health," *American Journal of Public Health* Vol. 91, No. 11 (November 2001): 1776.

²¹ 1. R.E.G. Upshur, "Principles for the Justification of a Public Health Intervention," *Canadian Journal of Public Health* Vol. 93, No. 2 (March-April 2002): 102.

²² James F. Childress et al., "Public Health Ethics: Mapping the Terrain," *Journal of Law, Medicine & Ethics* 30 (2002): 172.

proportionality, necessity, least infringement, and public justification.²³ These different frameworks rely on similar concepts: transparency and public justification are similar, as are effectiveness and data that substantiates a reduction in morbidity and mortality, or the minimizing of burdens and least restrictive means. In this paper, I will rely on the justificatory framework outlined by Childress et al.

If a public health protection measure is going to infringe on an individual's ethically relevant interest, such as autonomy and personal liberty, or privacy and confidentiality, this measure should be shown to be both necessary to protect the public health need and effective in doing so.²⁴ The benefits of protecting the public health ought to outweigh the potential harm, i.e. the benefit must be proportional to the potential harm to the individual or individuals affected.²⁵ Even if those first three conditions are met, the principle of least infringement should be used in order to minimize harm. Childress states, "For instance, when a policy infringes autonomy, public health agents should seek the least restrictive alternative; when it infringes privacy, they should seek the least intrusive alternative; when it infringes confidentiality, they should disclose only the amount and kind of information needed, and only those necessary to realize the goal."²⁶ Finally, when a public health measure infringes on individuals' rights or interests, the measure should be able to be justified to the public, including to those people whose rights are the ones being infringed upon.²⁷ The other four principles may be employed to proffer such a justification; however, this final principle stresses the importance of public accountability for measures enacted to protect public health and the value of transparency with regard to the

²³ Childress et al., "Public Health Ethics," 172.

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.*

rationale for implementing such public health protections. In the following examples of physician reporting requirements some are revealed to meet these justificatory conditions better than others.

3.1 REPORTING REQUIREMENTS RELATED TO COMMUNICABLE DISEASES

The 10th Amendment of the United States Constitution allows states to enact laws to regulate actions pertaining to the health, safety, morals, and general welfare. This “police power” is the constitutional basis for state governments’ enactment of laws that can require physicians and other professionals to report communicable diseases to public health agencies.²⁸

The types of diseases that are reportable, and the agencies responsible for receiving the report vary by state.²⁹ The person who has the duty to report is also state-specific, but most states impose that duty on physicians. In addition to the disease, physicians generally have to report the patient’s name and demographic information. Interest in preventing and limiting the spread of some kinds of communicable diseases is the rationale behind this type of reporting requirement. The limited compromise of some individuals’ privacy involved in reporting those individuals to state authorities has benefits for the population as a whole. This collection of data means that public health education and prevention efforts can be focused on the geographic areas and people that need them most. Required reporting of the names and locations of individuals with designated diseases to government agencies helps a state protect the health of the public in two

²⁸ Lawrence O. Gostin, *Public Health Law: Power, Duty, Restraint*, (Berkeley and Los Angeles, CA: University of California Press, 2000), 117.

²⁹ Gostin, *Public Health Law*, 118.

ways. First, having the name and demographic information of infected individuals can ensure that those individuals receive the appropriate medical treatment, which may help prevent those individuals from spreading the disease. Second, the reporting requirement facilitates the collection of data. Amassing accurate data, in turn, allows public health officials to determine the sources of outbreaks and to track the spread of the diseases and to allocate the limited resources to the geographic areas or populations most in need.³⁰

Even though the reporting of certain communicable disease to the government by physicians is required by law, and has been established as a proper exercise of the police power.³¹ However, it is not without ethical concern. Mandating that physicians are required to report communicable diseases can place the public health official's duty to the community as a whole in opposition to the physician's duty to the individual patient. A public health official might defend the necessity of the reporting requirement by citing the importance of gathering these data in order to appropriately tailor treatment and prevention efforts, as well as a collective responsibility to the whole population.³² But a physician might see her duty to report as a violation of her patient's confidentiality and a source of mistrust within the therapeutic relationship. In addition to the intrinsic problem of violating confidentiality, patients may be less likely to seek medical care if they realize that their sensitive information may be reported to the government and that this information may be used to track down those that the patient may have infected, thereby exposing them to possible negative social consequences.³³ However, in spite of the mistrust that such a reporting requirement potentially creates within the therapeutic

³⁰ *Id.* at 120.

³¹ *Id.* at 50-51.

³² *Id.* at 119.

³³ *Id.* at 120.

relationship, placing the reporting burden on physicians is an effective way for a state to further its interest in protecting the health of its inhabitants by gathering the names and demographic information of infected individuals for use by public health officials.

The reporting of HIV is one case that has been a particular source of ethical concern. HIV/AIDS is itself stigmatizing both in itself, and because it is associated with stigmatizing behaviors such as intravenous drug use, and sexual behavior, particularly between two men. Because of this, the required reporting of cases of HIV infection attracted particular ethical and legal scrutiny.³⁴ Attempts to craft policy that satisfies the state's interest in protecting public health through tracking diseases can be at odds with individual civil liberties, and the civil liberties of many of those with HIV are especially vulnerable. Those using illegal substances or engaging in illegal or socially stigmatized sexual behaviors are at risk of forfeiting some civil liberties or having their ethical rights infringed through discrimination by others. When HIV infection serves as a marker of those stigmatizing behaviors, having ones HIV+ status reported increases the risk of incurring those negative consequences. Thus, the required reporting of the names of people who have been diagnosed with HIV introduces fears of compromised privacy, discrimination, and misuse of the information. When collected in computerized databases, this information has the potential to be hacked into and leaked, or otherwise abused, either by the government that collected it or by other parties. Some of these fears have already been realized: for example, one Florida health official gave the names of people infected with HIV to a dating service.³⁵ In another case of a state government's arguably unethical overreaching, the Illinois legislature passed a law that required the names of people in the state's AIDS database to be

³⁴ Ronald Bayer, "Stigma and the ethics of public health: Not can we but should we," *Social Science and Medicine* Vol. 67 (2008): 464.

³⁵ Gostin, *Public Health Law*, 120.

cross-referenced with the database of health care licenses in order to ensure that no individuals with health care licenses were infected with AIDS.³⁶

This latter measure fails the test of being either effective or necessary to avoid the continued licensing of health care professionals who have HIV. The cross-referencing would not effectively discover all those professionals who have HIV, as not all those infected may have sought testing and treatment; moreover some may not have seroconverted at the time of testing. Nor is the cross-referencing necessary to discover infected health care professionals. Finally, and most importantly, the discovery of infected health care professionals is not necessary to minimize the risk of transmitting HIV to patients, which is the apparent rationale for conducting the cross-referencing. Instead, use of “universal precautions” to avoid infection is an alternative means of preventing transmission. This is more effective, and since it involves less intrusion into individual privacy than cross-referencing, it is also a less restrictive alternative.

In the case of HIV reporting, there have been attempts to use a less restrictive means to prevent unethical compromises of privacy, as happened in Florida, or discrimination, as happened in Illinois. The chief attempt was the use of unique identifiers rather than names in the surveillance of individuals with HIV. The Centers for Disease Control (CDC) conducted a study of the effectiveness of using unique identifiers in the reports, rather than the names of the individuals.³⁷ Although this attempt was less restrictive in terms individual privacy, it was found that using a unique identifier was not as effective for the purpose of surveillance as using names

³⁶ *Id.*

³⁷ *Id.*

because the records in the databases using unique identifiers were found to be incomplete and difficult to match.³⁸

3.2 REQUIREMENTS TO REPORT MEDICAL UNFITNESS TO DRIVE

Driving is an activity that has the potential to cause harm to other drivers, pedestrians, and others on the road. Because of the inherent risk that is taken when a person drives, the state has an interest in protecting public health by regulating drivers. Some of these safety precautions include age restrictions, licensing requirements, and even the exclusion of some people with certain medical conditions from holding a driver's license.

There are medical conditions that can make driving difficult or dangerous: cataracts, glaucoma, and macular degeneration pose a risk to drivers who have them as they can result in reduced vision. Other conditions also have the potential to make driving dangerous such as stroke, sleep apnea, or taking some medications as these can cause cognitive limitations, or arthritis and muscle weakness which can cause motor skills deficits.³⁹ When people who have these (and other) conditions attempt to drive, there is a risk of injury or death that is posed to both the driver and others on the road. The State of California Department of Motor Vehicles (DMV) found that drivers who were known to the DMV as having reportable medical conditions

³⁸ *Id.*

³⁹ Eby and Molnar, *2008 North American License Policies Workshop Proceedings*, (Washington D.C.: AAA Foundation for Traffic Safety, 2008), 40.

have a crash rate significantly higher than the general driving population.⁴⁰ Drivers with mental impairments have a crash rate that is 2.3 times higher than the general driving population.⁴¹ Drivers with physical impairments crash rate is 2.2 times greater the general driving population.⁴² These two groups have much higher crash rates than even the “high risk” group of males under 25 years of age, who have a crash rate 1.7 times that of the general driving population, and are typically singled out for this increased risk through increased car insurance premiums.⁴³

Because of the danger, and increased risk of accidents, that these conditions pose to drivers, their passengers, and others on the road, many states seek to protect public health and safety by preventing those who are medically unfit to drive from obtaining a driver’s license. This end is furthered by laws that either require or allow physicians to report to the state any patient who has medical conditions that would result in impaired or dangerous driving. Although unsafe driving may be detected by family and friends before a physician is consulted, the law likely chooses the physician as the required reporter because there is a specific list of conditions that the law requires to be reported and the physician is the one with the state-recognized credentials to diagnose these conditions. Further, physicians may be considered to have more objective measure for assessing fitness to drive than are available to lay people simply observing their fellows. Finally, physicians’ judgment may be considered to be less biased by irrelevant considerations: neighbors, friends, or family may let interpersonal conflicts, grudges, or personal

⁴⁰ State of California Department of Motor Vehicles, *Medical Conditions and Other Factors in Driver Risk*, Report to the Legislature of the State of California in accord with Senate Bill 335, Chapter 985, 2000 Legislative Session, (Sacramento, CA: May 2001), 3.

⁴¹ *Medical Conditions and Other Factors in Driver Risk*, 9.

⁴² *Id.*

⁴³ *Id.*

biases either affect their judgment of another's driving ability, or lead them to falsely or maliciously report their fellows.

Pennsylvania is an example of a state that requires physicians to report when they judge one of their patients is medically unfit to drive. Pennsylvania's statute lists certain conditions, such as failure to meet the vision standards or seizure disorders, as triggering the reporting requirement.⁴⁴ If a patient has one of the listed conditions, the physician is required to report the name, date of birth, and address in writing to the Pennsylvania Department of Transportation (PennDOT) within ten days.⁴⁵

But when requiring a physician to report medically unfit drivers to the state, the question of whether driving has the legal status of a privilege or a right comes into play. If driving is a right, then due process--likely in the form of a hearing--must be exercised when the right is going to be restricted, limited, or revoked. One argument in support of considering driving a right because the Supreme Court has found interstate travel is a fundamental right.⁴⁶ However, this argument has been rejected by courts. So long as there are other means of interstate travel available, the existence of barriers to any specific mode of transportation does not violate the right to interstate travel.⁴⁷ This holds whether that barrier is the requirement of medical fitness to drive in order to maintain a driver's license, or the high cost of a plane ticket.

⁴⁴ Pennsylvania Code § 83.6

⁴⁵ Pennsylvania Code § 83.6

⁴⁶ As noted by the court in *Miller v. Reed*, no.97-17006 US 9th. Cir. (1999): "The Supreme Court has recognized a fundamental right to interstate travel. *Attorney General of New York v. Soto-Lopez*, 476 U.S. 898, 903, 106 S.Ct. 2317, 90 L.Ed.2d 899 (1986) (Brennan, J., plurality opinion)."

⁴⁷ As the court in *Miller v. Reed* states: "See *Monarch Travel Servs., Inc. v. Associated Cultural Clubs, Inc.*, 466 F.2d 552, 554 (9th Cir.1972) ("A rich man can choose to drive a limousine; a poor man may have to walk. The poor man's lack of choice in his mode of travel may be

It seems most reasonable to consider driving is not a legal right, but a privilege that is granted only to individuals that satisfy certain requirements imposed by the state: being of a certain age, being licensed, following the driving laws, and being medically fit to drive. Keeping unsafe drivers off the road is a public health concern. The motivation behind state laws that require physicians to report patients who are medically unfit to drive is that the need for safety outweighs an individual's need to drive.

Ethically speaking, whether driving is legally considered a privilege or a right is less important than its social role. For many people, restricting their ability to drive legally restricts their ability to participate in many common aspects of daily life. Losing the ability to drive can restrict a person's ability to pursue employment, necessary activities such as buying groceries or keeping medical appointments, as well as the ability to socialize and otherwise enjoy life. Because restricting driving impedes the pursuit of so many activities and thus has negative consequences for an individual's well-being, these consequences must be proportional to the health risks continued driving would impose. This balancing of potential harms is critical both in determining which conditions should trigger the reporting requirement and in demanding that physicians use due care when diagnosing such conditions in individuals. Restricting driving is perhaps both necessary and the only effective means of preventing a particular range of risks on the road; however, all drivers (as well as pedestrians, bicyclists, and others) incur some risk when taking to the road. As evidenced by no-fault insurance schemes that are implemented in some states, there is a recognition that risk reduction is an appropriate goal with regard to the

unfortunate, but it is not unconstitutional.”); *City of Houston v. FAA*, 679 F.2d 1184, 1198 (5th Cir.1982) (“At most, [the air carrier plaintiffs’] argument reduces to the feeble claim that passengers have a constitutional right to the most convenient form of travel. That notion, as any experienced traveler can attest, finds no support whatsoever in [the Supreme Court's right of interstate travel jurisprudence] or in the airlines' own schedules.”).”

regulation of driving and the risks it presents. Reporting requirements put in place to remove drivers from the road who are especially risky due to medical conditions should similarly reflect a goal of risk reduction, and thus require a balancing of the potential harms prevented and imposed by reporting and removing such individuals.

3.3 REQUIRED REPORTING OF CHILD ABUSE

Mandatory physician reporting in cases of suspected child abuse is a relatively recent legal requirement. The diagnosis of “battered child syndrome” arose out of work done in the early 1960s by Kempe, Silverman, Steele, and Drogemeuller.⁴⁸ The work of Kempe et al. also pointed out physician reluctance to question patients around the subject of child abuse. Once battered child syndrome had been defined, and the problem of physician reluctance to report child abuse came to light, there came a push for model legislation that would require the reporting of maltreatment of children.⁴⁹ Legislation that required reporting of suspected maltreatment was specifically intended to induce physicians to report injuries that they might not have otherwise acknowledged as possible abuse.⁵⁰

The legal requirements for reporting suspected child abuse, much like the requirements for reporting individuals with communicable diseases and patients who are medically unfit to drive, are different in each state. Most laws require reporting to the individual state’s designated

⁴⁸ Kalichman, Seth C. “Mandatory Child Abuse Reporting Laws: Origins and Evolution,” in *Mandated Reporting of Suspected Child Abuse: Ethics, Law & Policy (2nd Ed.)*. (Washington D.C.: American Psychological Association, 1999), 10.

⁴⁹ Kalichman, “Mandatory Child Abuse Reporting Laws,” 10-11.

⁵⁰ *Id.* at 38

child protection services when the physician (or other designated party) has “reason to believe” or “reasonable cause to suspect” that maltreatment is happening.⁵¹ What is considered maltreatment also varies by state. Statutes can focus on vague signs/symptoms using broad terms such as “mental injury” or “psychological impairment.”⁵² Other statutes have a narrower focus on physical symptoms such as bruises, burns, or fractures or on specific acts such as incest, molestation, or rape.⁵³ In every state, all professionals who are required to report suspected maltreatment are provided protection from civil and criminal liability associated with reporting.⁵⁴

Originally, such laws targeted physicians in primary care and emergency medicine, under the rationale that those physicians would be the most likely to encounter a child whose injuries were incurred through abuse.⁵⁵ Physicians objected to being singled out by these reporting laws, and also cited concerns about protecting patient privacy and confidentiality, and maintaining trust in the physician-patient relationship. In 1964 the American Medical Association (AMA) stated, “This is a social problem in which the physician plays but a part...To compel reporting by the physician alone may single him out unwisely. Knowing of this requirement, the parent or guardian may, for his own protection, put off seeking medical care.”⁵⁶ Rather than this argument reducing or eliminating state laws that require the reporting of suspected abuse, by the 1970s the laws were expanded to include other health care professionals, social service workers, teachers, and in some states even commercial film developers.⁵⁷

⁵¹ *Id.* at 29-30.

⁵² *Id.* at 29.

⁵³ *Id.* at 29.

⁵⁴ *Id.* at 24.

⁵⁵ *Id.* at 23.

⁵⁶ *Id.* at 23.

⁵⁷ *Id.* at 23-24.

The AMA's concern that compulsory reporting of suspected abuse to state child protective services would cause parents to avoid seeking medical attention for their children is understandable: patient confidentiality is highly valued for both intrinsic and instrumental reasons. Patient confidentiality is the basis of trust in the physician-patient relationship; without that trust, patients will not reveal sensitive information that can be crucial for proper diagnosis and care. Moreover, parents' fear of having their child taken away--whether by mistake or because of actual abuse--as well as their fear of being prosecuted and stigmatized as a child abuser is a strong incentive for parents to avoid the person who would report suspected abuse to the government. However, in this context, the welfare of children and families remains the most important consideration in the eyes of the legislatures. Since the implementation of these laws, the number of reports of suspected abuse has steadily increased, and even exceeded the abilities of states' resources to intervene.⁵⁸

The requirement to report suspected child abuse, at least in theory, seems to fulfill the requirement that this public health protection measure--one that appropriately infringes on inappropriately wielded parental powers and liberties--is effective in reducing future abuse. Further, the requirement seems to balance the potential harms and benefits appropriately, thereby satisfying the requirement of proportionality. In practice, to minimize the harms of reporting or misreporting abuse, those charged with reporting, and subsequently investigating, must not abuse their respective authority. In other words, those reporting suspected abuse must exercise professional judgment in determining whether physical injuries or psychological responses truly indicate potential abuse. They must not allow their personal biases toward or against any particular parents to influence their judgments of what they observe in the child. They must

⁵⁸ *Id* at 38.

recognize that the goal of the reporting requirement is to protect children from abuse while minimally affecting family structure and relationships, and parental authority. Those investigating reports must act with similarly restricted motives and humility, while taking actions necessary to determine whether suspected abuse is truly abuse and whether (and what) intervention is warranted.

Legally, before parents are deprived access to their children, a civil or criminal court case is initiated by a child welfare caseworker. The Child Welfare Information Gateway on the U.S. Department of Human Services website outlines the basic process of taking a case of child abuse and neglect to court: before initiating a court proceeding to remove the child, the caseworker must consider whether the child is in clear danger of significant harm, and whether there is a way that the child's safety could be maintained by providing help to the family instead of initiating court proceedings for removal.⁵⁹ This final provision seeks to fulfill the "least restrictive alternative" requirement. With a court proceeding comes due process: parents generally have right to notice of the court proceeding, a contested fact-finding hearing.⁶⁰ Other particularities can vary by state or be dependent on whether the trial is civil or criminal: some states afford parents right to a lawyer, and if it is criminal proceeding, parents may have the right to confrontation, cross-examination, and a jury trial.⁶¹

In terms of the necessity of the reporting requirement, the state has a strong interest in protecting children from abuse so that those children will grow up to be productive members or society. That the number of reports has exceeded the states' capacity to intervene demonstrates

⁵⁹ "The Court System and Child Abuse and Neglect," Child Welfare Information Gateway, accessed November 10th, 2013.

https://www.childwelfare.gov/pubs/usermanuals/courts_92/courtsc.cfm

⁶⁰ "The Court System and Child Abuse and Neglect."

⁶¹ *Id.*

the possible necessity of this measure. The public justification requirement is also fulfilled: the state must justify itself to the specific parents in a public court proceeding.

3.4 REPORTING OF ILLEGAL DRUG USE BY PREGNANT WOMEN

The state's interest in protecting fetuses, and the children they will become, from the harms of illegal drug use by pregnant women is another area where public health concerns clash with the patient's interests and rights that are undermined by reporting requirements imposed on physicians. Abusing drugs while pregnant poses risk to both the pregnant woman and her fetus. How to balance the bodily autonomy of the woman and the state's interest in encouraging healthy pregnancies has proved to be difficult for many state legislatures.

In the absence of criminal laws that specifically refer to drug use during pregnancy, prosecutors in some states have taken creative approaches when charging women who abuse illegal drugs while pregnant. Some have charged women with possession of a controlled substance, delivering drugs to a minor, or child abuse and neglect.⁶² Women in many states who have appealed their convictions under these different laws were successful in all states except South Carolina. In the 1997 case, *Whitner v. South Carolina*, the state supreme court found that a viable fetus is recognized as a person under the state's criminal child endangerment statute, and therefore drug abuse while pregnant could constitute child abuse.⁶³

⁶² Dailard and Nash. "State Responses to Drug Abuse Among Pregnant Women," *The Guttmacher Report on Public Policy* (December 2000): 3.

⁶³ Dailard and Nash. "State Responses to Drug Abuse Among Pregnant Women," 3.

Rather than using the criminal law to attack the problem of drug use during pregnancy, other states have taken it as a matter of civil law and have chosen to expand child welfare laws to include prenatal drug exposure.⁶⁴ In seven states, health care professionals are required to report to the state when a pregnant woman shows evidence of drug use or if a newborn tests positive for drug exposure.⁶⁵ Since the prenatal exposure to drugs is considered by the states to be a matter of child welfare, such reports go to the local child protective services. These reports are then used as evidence during child welfare proceedings.

Ethical concerns arise when requiring physicians to report drug use in pregnant women to the state. A primary concern is that women's knowledge of such a requirement, and then physicians acting in fulfillment of the requirement, affects women's seeking of prenatal care. Poland, Dombrowski, Ager, and Sokol, for example, conducted a survey of women's attitudes toward laws that punish pregnant women who use illegal drugs, and found that women would "go underground" and eschew treatment for fear of having their drug use detected, in order to avoid the subsequent incarceration, or loss of their children.⁶⁶ Additionally, requiring a breach of confidentiality by drug testing and reporting damages women's trust in their physicians and the health care system as a whole by compromising the confidentiality and interpersonal trust that grounds the physician-patient relationship. The cost of this loss of trust can create small obstacles in effective prenatal care such as women failing to give a complete and accurate medical history, or large obstacles such as women avoiding prenatal care altogether.

⁶⁴ *Id.*

⁶⁵ *Id.* at 5.

⁶⁶ Marilyn L. Poland et al, "Punishing pregnant drug users: enhancing the flight from care," *Drug and Alcohol Dependence* Vol. 31, Issue 3 (February 1993): 199.

One of the seven states that mandates reporting, Kentucky, has addressed the concern about testing without women's knowledge by requiring the physician to give women notice of the testing.⁶⁷ This aspect of the Kentucky statute attempts to minimize the potential harm to pregnant women's interest by allowing them to "protect" themselves from the intrusion of testing and its consequences. It also satisfies to some degree the requirement that the intervention is transparent to the public. Nevertheless, it imposes a condition on seeing prenatal care and giving birth within a health care system, which may otherwise endanger the welfare of fetus, pregnant woman, and newborn.

Further, the Kentucky law allows physicians the discretion to decide whether or not to report to the state.⁶⁸ Allowing physician discretion in reporting introduces the possibility for personal bias, arbitrariness, and risk of unjust application of the reporting requirement. This bias can be seen in the fact that poor women and women of color are more often screened for drugs, in spite of the fact that illegal drug use occurs at a similar rate in all women, regardless of race or class.⁶⁹

Finally, the Kentucky law does not allow the drug test results to be used in a criminal proceeding.⁷⁰ This final provision seems most directly designed to tailor the statute to afford the benefit of fetal protection while limiting the risks imposed on the individual pregnant woman. In this regard, the provision seeks to implement the least restrictive alternative of the fetal protection measure. The question remains, however, as to whether even Kentucky's version of

⁶⁷ Dailard and Nash. "State Responses to Drug Abuse Among Pregnant Women," 5.

⁶⁸ *Id.*

⁶⁹ Carolyn S. Carter, "Prenatal Care for Women Who Are Addicted: Implications for Gender-Sensitive Practice," *Affilia* 17:299 (2002): 305, doi 10.1177/0886109902173003.

⁷⁰ Dailard and Nash. "State Responses to Drug Abuse Among Pregnant Women," 5.

this type of legislation is effective in preventing drug use in pregnant women, since fear of the negative consequences causes women who use drugs to avoid treatment.⁷¹

Requiring physicians to report the drug use of pregnant women to the state under the guise of promoting child welfare highlights tension between the bodily autonomy of women and the state's interest in encouraging healthy pregnancies and births. In extreme cases such as South Carolina's *Whitner* decision, any behavior that could be seen to "endanger" the fetus makes the woman subject to criminal liability and potentially undermines the woman's right to choose an abortion.⁷² The singling out of some behaviors--e.g. illicit substance use--while ignoring the potential risks to fetuses presented by other behaviors--e.g. vigorous exercise or use of herbal products--is viewed by some commentators as reflecting racist and classist biases in the implementation of the South Carolina legislation and in the context of other laws that focus on illicit drug use while ignoring other potentially harmful behaviors.⁷³ Finally, that the reporting requirement was often applied to economically disadvantaged women or women of color seeking prenatal care in public clinics or through the emergency department, rather than to middle and upper class women who went to private physicians, leads some commenters to identify race and class bias on the part of the medical profession in implementing the requirements.

The state has an interest in protecting fetuses and children, but the required reporting of pregnant women who use illegal drugs does not meet the threshold of being an effective, proportional, and necessary infringement on a woman's autonomy and personal liberty in the name of public health. If the goal is to prevent pregnant women from endangering their fetuses through drug use, reporting to the state in order to remove the child from the woman's custody

⁷¹ Poland et al., "Punishing pregnant drug users," 199.

⁷² Dailard and Nash. "State Responses to Drug Abuse Among Pregnant Women," 6.

⁷³ Carter, "Prenatal Care for Women Who are Addicted," 306.

creates incentive for the drug-addicted woman to avoid prenatal care. This is both ineffective and dangerous for both the woman and the fetus. Testing and reporting is not the only possible intervention: instead of prosecuting the woman, or removing the child once it is born, the state could satisfy its interest in promoting healthy pregnancy by expanding access to drug treatment programs for pregnant women.

4.0 PRACTICAL AND ETHICAL IMPLICATIONS OF THE REPORTING REQUIREMENT FOUND IN THE SAFE ACT

The required reporting for health care professionals in the contexts previously reviewed constitutes measures designed to protect public health and safety (in the case of physicians reporting communicable diseases and medical unfitness to drive). In the cases of various professionals' required reporting of suspected child abuse and physicians' reporting of substance using pregnant women, the measure are designed to protect the welfare of especially vulnerable members of society: children and potential children (fetuses). In contrast, the reporting requirement component of the New York SAFE Act ostensibly seeks to protect public health by focusing on and regulating the behavior of a vulnerable population: the mentally ill. In this section, employing the five criteria used to assess other reporting requirements, as well as other considerations, I will analyze whether this focus on the mentally ill is an ethically appropriate measure that furthers the law's intended effect of reducing overall gun violence.

4.1 PEOPLE WITH MENTAL ILLNESS AS A VULNERABLE POPULATION

Despite substantial progress in recognizing mental illness as a medical condition, rather than a moral failing, and despite ever increasing understanding of the biological components of mental

health conditions and their symptoms, individuals with mental illness still face stereotyping, prejudice, and discrimination that are associated with their stigmatizing condition.

Stigma against mental illness is part of the reason that the mentally ill are a vulnerable population. Vulnerability is at its heart “susceptibility to harm.”⁷⁴ This susceptibility to harm can come from many different sources, for example race, poverty, physical weakness, or mental illness. These conditions affect how an individual is treated by society and may affect how individuals are able to respond to (or defend against) maltreatment. Three crucial components contributing to vulnerability are individual capacities (e.g. physical strength or weakness), lack or availability of support (e.g. situations of discrimination or protection), and community resources (e.g. protection by authorities or resources to engage in self-protection).⁷⁵ Vulnerability of various types, or due to different causes, can be exacerbated by stigma and discrimination associated with those causes (e.g. the stigma associated with physical defect or mental illness).⁷⁶ With the decreased access to housing and jobs and scarce community resources for treatment and support of people with mental illness, as well as the illness itself and self-stigma potentially hindering an individual’s capacity to handle these difficulties and interact with society, mental illness is certainly a source of vulnerability and people with mental illness are a vulnerable population.

The stigma of mental illness manifests in two ways: public stigma, the effect of negative attitudes about mental illness and treatment held by the public, and self-stigma, the internalized effect of these attitudes resulting in the same negative attitudes held by the person with the

⁷⁴ David Mechanic and Jennifer Tanner, “Vulnerable People, Groups, and Populations,” *Health Affairs* 26, No. 5 (2007), 1220.

⁷⁵ Mechanic and Tanner, “Vulnerable People,” 1222.

⁷⁶ *Id.* at 1224.

stigmatized condition.⁷⁷ Public stigma and self-stigma may interact, with the public stigma serving to amplify self-stigma.⁷⁸ Both types of stigma can have negative effects on individuals who have mental illness.

Stigmatizing representations of people with mental illness occur in the media. Some of these include the representation of people with mental illness as homicidal maniacs, the presentation of those with mental illness as having childlike perceptions of the world, or that their depiction as rebellious free spirits.⁷⁹ Stigmatizing attitudes the general public holds about mental illness include that it is similar to drug addiction, prostitution, and criminality; that mental illness is something the individual has control over and is responsible for; and that help or treatment is not deserved.⁸⁰ Stigmatizing views of mental illness are pervasive, and can even occur in mental health professionals.⁸¹

There are four major stereotypes that have negative consequences for individuals with mental illness: “(1) People with mental illness are dangerous and should be avoided. (2) People with mental illness are to blame for their disabilities that arise from weak character. (3) They are incompetent and require authority figures to make decisions for them. (4) They are viewed as childlike and profit from parental figures to care for them.”⁸² These four stereotypes depict the mentally ill as either dangerous or incompetent.

⁷⁷ Jonathan W. Kanter et al., “Depression Self-Stigma: A New Measure and Preliminary Findings,” *The Journal of Nervous and Mental Disease* Vol. 196, No 9 (September 2008): 663.

⁷⁸ *Id.*

⁷⁹ Patrick W. Corrigan and David L. Penn, “Lessons from Social Psychology on Discrediting Stigma,” *American Psychologist* Vol. 54, No. 9 (September 1999): 766.

⁸⁰ Corrigan and Penn, “Lessons from Social Psychology,” 766.

⁸¹ *Id.* at 765.

⁸² Watson and Corrigan, “The Impact of Stigma on Service Access and Participation: A Guideline Developed for the Behavioral Health Recovery Management Project,” 5. Accessed June 19th, 2013. <http://www.bhrm.org/guidelines/stigma.pdf>

Stigma causes harm to people with mental illness. Being labeled a “mental patient” can result in prejudice and discrimination.⁸³ Attempting to avoid this label can result in the individual with mental illness choosing not to adhere to treatment regimens, particularly because some treatments have discernable side effects, or not to pursue treatment at all.⁸⁴ Because of these labels and stigma, people with mental illness have a more difficult time finding housing and employment.⁸⁵ This discrimination combined with self-stigma (the result of internalizing the negative attitudes about mental illness prevalent in society) can cause shame, low self-esteem, and demoralization.⁸⁶

The physician reporting requirement of the SAFE Act is a policy that reinforces the stereotype of mentally ill people as dangerous and the stereotype of them as incompetent and in need of parent-like authority figures to make their decisions for them. Requiring mental health professionals to report their patients’ words and actions to the state and allowing the state, based on a single report, to decide whether the individual should be permitted a gun license, places both the physician and the state into a parental role of overseeing people with mental illness. The reporting requirement and subsequent state intervention with regard to gun ownership assumes that individuals with mental illness are not competent, in effect making a determination of competence based largely on the nature of a single interaction where the mental health professional determines a likelihood of imminent harm. It restricts or removes decision-making ability from the person with mental illness without a particular determination of the person’s

⁸³ Patrick W. Corrigan, “How Clinical Diagnosis Might Exacerbate the Stigma of Mental Illness,” *Social Work* Vol. 52, No. 1 (January 2007): 31.

⁸⁴ Corrigan, “How Clinical Diagnosis Might Exacerbate the Stigma of Mental Illness,” 31.

⁸⁵ Corrigan, “How Clinical Diagnosis Might Exacerbate the Stigma of Mental Illness,” 32.

⁸⁶ *Id.*

capacity to make a competent decision about purchasing, owning, storing, and discharging a firearm.

Buchanan and Brock argue that competence should be decision-relative--that is that competence should be considered to be the capacity to undertake a specific task rather than a global determination.⁸⁷ Determining competence then should be determining “a particular person’s capacity to perform a particular decision-making task at a particular time under specified conditions.”⁸⁸ In the case of mental illness and gun ownership, perhaps this determination should be made at the time when a mental health professional determines a patient likely to harm himself or others; at that time the patient may not be competent to make a decision about owning and using a firearm. But mental illness is not a static condition; symptoms and episodes can be intermittent and an individual with mental illness can demonstrate the capacities of communication, understanding, reasoning, and possessing a set of values that are the constitutive components of competence⁸⁹ to make decisions about owning and using a gun.

The notion of people with mental illness being dangerous and violent is a stereotype that is perpetuated by the media.⁹⁰ The reporting component added to the SAFE Act similarly perpetuates the stereotype that people who have a mental illness are dangerous and violent *because of* that mental illness. The primary goal of New York’s assault weapons ban is to reduce gun violence. Including a physician reporting requirement in legislation intended to prevent gun violence insinuates that the people that physicians must report are major contributors to overall

⁸⁷ Allen Buchanan and Dan W. Brock, “Deciding for Others,” *The Millbank Quarterly* Vol. 64, Supplement 2 (1986): 22-23.

⁸⁸ Buchanan and Brock, “Deciding for Others,” 23.

⁸⁹ Buchanan and Brock, “Deciding for Others,” 25-26.

⁹⁰ Bernice A. Pescosolido, et al., “The Public’s View of the Competence, Dangerousness, and Need for Legal Coercion of Persons with Mental Health Problems,” *American Journal of Public Health* Vol. 89, No 9 (September 1999): 1341.

gun violence. If those to be reported are not major contributors to the problem, then reporting them is not an effective measure in reducing the problem.

4.2 PEOPLE WITH MENTAL ILLNESS AS PERPETRATORS AND VICTIMS OF VIOLENCE

In order to determine whether targeting gun ownership among the mentally ill is a reasonable measure to substantially reduce gun violence--indeed one that warrants singling out a vulnerable population for treatment that may exacerbate its vulnerability--one criterion that must be satisfied is that of being an effective measure. To determine the measure's potential effectiveness, in turn, it is important to determine whether people with mental illness are perpetrating a substantial portion of gun violence, so that taking a measure to prevent their doing so would substantially reduce such violence. In 2008, Choe et al. reviewed empirical studies of both perpetration of violence committed by people with mental illness, and their victimization by violence in the United States since 1990. This study encompasses violence of all kinds, not only gun violence. However, since gun violence is a subset of all violence, these numbers are still important. Choe et al. estimated that approximately 6% of adults in the United States have a severe mental illness.⁹¹ Analyzing studies that used the Epidemiologic Catchment Area data, Choe et al. determined that of all people with severe mental illness, 7-8% had perpetrated violence, while

⁹¹ Jeanne Choe et al., "Perpetration of Violence, Violent Victimization, and Severe Mental Illness: Balancing Public Health Concerns," *Psychiatric Services* Vol. 58, No. 2 (February 2008): 153, doi: 10.1176/appi.ps.59.2.153.

only 2% of people without any diagnosed mental disorder had perpetrated violence.⁹² Individuals with a severe mental illness are slightly more likely to perpetrate violence than those without any diagnosis of mental illness, however individuals with a severe mental illness constitute only 6% of the overall population; therefore in absolute numerical terms, it seems that those with mental illness may not be responsible for a substantial portion of acts of violence.

In epidemiologic terms, the percentage of attributable risk is the proportion of incidences of a disease in an exposed population that is due to the exposure. The attributable risk of mental illness to the perpetration of violence is 2%.⁹³ This means that out of all people who have a mental illness (the exposed population), the number who commit violence that is attributable to their mental illness, and not other risk factors, is 2%. To put that attributable risk percentage into perspective, age and gender are much stronger predictors of violence: males who are 24 years old and younger account for approximately 40% of arrests for serious violent crimes, including murder, non-negligent homicide, forcible rape, robbery, and aggravated assault.⁹⁴ In spite of this much stronger association of sex and age with the perpetuation of violence, there are not mandatory reporting requirements being written with young men in mind.

Given that those with mental illness are associated with such a small proportion of violence, including gun violence, singling them out to limit their access to firearms seems an ineffective measure to substantially reduce gun violence. Given the social costs--for example, in terms of potential effect on the therapeutic relationship (discussed below) and on stigmatization of the mentally ill (discussed above)--the measure seems to lack both effectiveness and

⁹² Choe et al., “Perpetration of Violence, Violent Victimization, and Severe Mental Illness,” 161.

⁹³ *Id.*

⁹⁴ *Id.*

proportionality. Furthermore, given the goal of reducing gun violence and the relatively small role that people with mental illness play in perpetrating it, the measure seems unnecessary.

Rather than posing a significant threat of causing violence, individuals with severe mental illness are far more likely to be the victims of violence. The 2005 study by Teplin et al. using data from the National Crime Victimization Survey found that of all people with a mental illness, 25% had been the victims of violence, while only 3% of the general population were victims of violence.⁹⁵ This disparity shows the magnitude of the mischaracterization of people with mental illness as more likely to commit violence, when in reality they are far more likely to be the victims of violence. Those with mental illness are thus vulnerable in two senses: they are vulnerable to being stigmatized and are disproportionately vulnerable to being victims of violence. When laws such as the New York SAFE Act target the mentally ill, rather than effectively reducing gun violence, the law instead serves to perpetuate negative stereotypes and misunderstanding of mental illness and the risks the ill present to others.

4.3 PREDICTION OF VIOLENCE

The accurate and fair implementation, and the potential effectiveness, of the reporting requirement of the New York SAFE Act relies on the ability of mental health professionals to predict violence in their patients, however prediction of violence is not possible in most cases, particularly cases where the individual who commits the violence does not seek help from a mental health professional. This difficulty in reliably predicting violence coupled with the legal

⁹⁵ Linda A. Teplin et al., “Crime Victimization in Adults with Severe Mental Illness,” *Archives of General Psychiatry* Vol. 62, No. 8 (August 2005): 920, doi 10.1001/archpsyc.62.8.911

demand to do so creates potential for clinicians to be over-inclusive in identifying their patients as “likely to engage in conduct that would result in serious harm to self or others.”⁹⁶ The incentives created by the reporting requirement would seem to lead clinicians to err on the side of identifying someone as dangerous.

Concerns about being held liable for failure to identify a patient who goes on to perpetrate violence would create an incentive for clinicians to use over-inclusive criteria or to be expansive in their professional judgment of patients’ dangerousness. The SAFE Act does attempt to ameliorate this concern with a provision that states, “The decision of a mental health professional to disclose or not to disclose in accordance with this section, when made reasonably and in good faith, shall not be the basis for any civil or criminal liability of such mental health professional.”⁹⁷ However, in spite of not being held legally liable, a wish to avoid guilt or feelings of responsibility that could arise from failing to predict a specific instance of violence could also lead a clinician to prefer erring on the side of over-inclusiveness.

The Lidz et al. study assessing the accuracy of clinicians’ prediction of violence in mental patients found that violence occurred in 53% of cases where the clinician predicted violence, compared to the 36% of cases in the comparison group in which no prediction of violence had been made.⁹⁸ The overall accuracy in violence prediction was better than chance, although the prediction of violence in female patients was not better than chance.⁹⁹ Because the exercise of professional clinical judgment does not ensure the accuracy of a prediction of

⁹⁶ New York Code, Title B Mental Health Act, §9.46(b)

⁹⁷ New York Code Title B Mental Health Act, §9.46(d)

⁹⁸ Charles Lidz et al., “The Accuracy of Predictions of Violence to Others,” *Journal of the American Medical Association* Vol. 269 No. 8 (February 1993): 1007.

⁹⁹ Lidz et al., “The Accuracy of Predictions of Violence,” 1007.

violence,¹⁰⁰ over-inclusive reports on the part of the mental health professionals in New York would be an understandable attempt to ensure that those few patients who will actually go on to commit gun violence are prohibited from having a gun license in spite of the social costs of such “false positive” judgments for the majority of reported patients who will not go on to commit violence.

The murder of strangers by individuals with mental illness is a statistically rare and unpredictable event.¹⁰¹ The mass killings of strangers, such as those in the Sandy Hook school shooting, are behind the public support for gun control measures such as the SAFE Act. Nevertheless, it is this event’s unpredictability of this type of event that presents a critical problem for the implementation of the SAFE Act’s reporting requirement. Nielssen et al. found that in the majority of stranger homicides the perpetrator of violence had never been treated with medication or admitted to the hospital, and was not known to their local mental health services.¹⁰² If a person is not known to the professionals providing mental health services, those professionals have no opportunity to even attempt to assess the likelihood of committing violence.

The SAFE Act’s reliance on the idea that people with mental illness are inherently violent and that mental health professionals have the ability to accurately predict violence is part of the legacy of the 1968 Gun Control Act.¹⁰³ That legislation prohibited any person who had been

¹⁰⁰ Jeffrey W. Swanson et al., “Preventing Gun Violence Involving People With Serious Mental Illness,” in *Reducing Gun Violence in America: Informing Policy with Evidence and Analysis*, ed. Daniel W. Webster and Jon S. Vernick. (Baltimore: The Johns Hopkins University Press, 2013), 35.

¹⁰¹ Olav Nielssen et al., “Homicide of Strangers by People with a Psychotic Illness,” *Schizophrenia Bulletin* Vol. 37, Issue 3 (May 2011): 577, doi:10.1086/599247.

¹⁰² Nielssen et al., “Homicide of Strangers by People with a Psychotic Illness,” 577.

¹⁰³ Swanson, “Preventing Gun Violence Involving People with Serious Mental Illness,” 35.

involuntarily committed or “been adjudicated as a mental defective” from purchasing firearms.¹⁰⁴ Although there has been reform of the civil commitment process and deinstitutionalization of people with mental illness since that legislation passed in 1968, the law has continued to exclude people with mental illness from purchasing guns. This continued exclusion is evident in the background check instituted by the 1994 Brady Violence Prevention Act.¹⁰⁵ The law has been relying on the idea that people who are involuntarily committed to psychiatric institutions are at an increased risk for committing violence once released.

The historical connection of involuntary commitment to the exclusion of mentally ill people from obtaining a gun license is overbroad and does not target the correct population. Before civil commitment reform began in 1969, involuntarily committing a person effectively rested with the discretion of the judge.¹⁰⁶ This requisite exercise of discretion meant that there may have been people involuntarily committed, and thus excluded from gun ownership, without them presenting any risk of committing violence. The present criteria that one must present a danger to self or others in order to be involuntarily committed were introduced as a response to this judicial discretion. The criteria are meant to safeguard individual liberty, balance such liberty against the state interest in protecting its citizens, and limit the number of people admitted into state institutions.¹⁰⁷ However, the present dangerousness criteria effectively leave the liberty of the mentally ill individual in the hands of the mental health professional who is conducting the

¹⁰⁴ Swanson, “Preventing Gun Violence Involving People with Serious Mental Illness,” 35.

¹⁰⁵ *Id.*

¹⁰⁶ William H. Fisher and Thomas Grisso, “Commentary: Civil Commitment Statutes--40 Years of Circumvention,” *The Journal of the American Academy of Psychiatry and the Law* Vol. 38, No.3 (2010): 365.

¹⁰⁷ *Id.*

risk assessment, but the professional's exercise of professional judgment in applying these criteria can be affected by social, political, and economic factors.¹⁰⁸

Measures to ensure community treatment, as well as earlier and continued treatment of psychosis may help to prevent homicides overall,¹⁰⁹ but treatment is not prediction. Many people who would benefit from treatment make the decision not to participate in treatment, or do not completely adhere to prescribed treatments.¹¹⁰ Some individuals with mental illness may choose not to seek treatment because of the stigma associated with having a mental illness. If participating in mental health treatment labels a person as a “mentally ill” or as a “mental patient” and if especially in the current social and legal climate these labels in turn lead to that person with being considered potentially dangerous, the degree of stigmatization only increases. It is reasonable for individuals to consider this social stigma and the discrimination that can follow when deciding whether or not to pursue diagnosis and treatment.¹¹¹

Reducing the stigma associated with mental illness could lead to an increase in people who have mental illness choosing to seek treatment. Requiring physicians to report their patients' thoughts and actions to the state government enshrines in law the incorrect association of violence with mental illness. This legislation could have the opposite effect from that intended because the implementation of a reporting requirement creates more incentive for individuals with mental illness not to seek treatment. The majority of people with mental illness are not likely to commit violence, however in the majority of those rare and unpredictable cases of

¹⁰⁸ *Id.* at 365.

¹⁰⁹ Nielssen et al., “Homicide of Strangers by People with a Psychotic Illness,” 578.

¹¹⁰ Patrick Corrigan, “How Stigma Interferes with Mental Health Care,” *American Psychologist* Vol. 59 No. 7 (October 2004): 614.

¹¹¹ Watson and Corrigan, “The Impact of Stigma on Service Access and Participation,” 2.

stranger homicides committed by people with mental illness, those perpetrators had not been seeking treatment.

4.4 IMPLICATIONS FOR THE RIGHT TO BEAR ARMS

The Second Amendment states that a “well regulated militia, being necessary to the security of a free State, the right of the people to keep and bear arms, shall not be infringed.” Being explicitly stated in the constitution, gun ownership is a right and not a privilege. However, simply because it is a right does not mean it can never be regulated or limited. Keeping guns out of the hands of the mentally ill is a limitation of the right to bear arms that is supported by the Supreme Court. In the case *District of Columbia v. Heller*, the Court found that a specific handgun ban was too limiting on the right to bear arms, but they stated, “nothing in our opinion should be taken to cast doubt on longstanding prohibitions on the possession of firearms by felons or the mentally ill...”¹¹² In the eyes of the Court, laws that prohibit people with mental illness from obtaining a gun are presumptively lawful, and so New York’s physician reporting requirement in the SAFE Act is not in violation of the Second Amendment.

Although the SAFE Act is free from legal scrutiny in that sense, whether creating a physician reporting requirement that is the basis for taking away such a right is an ethically appropriate measure is another matter. The SAFE Act requires a mental health professional to report to the state when a patient is likely to harm himself or others. This report is then reviewed

¹¹² Lawrence E. Rosenthal and Adam Winkler, “The Scope of Regulatory Authority Under the Second Amendment,” in *Reducing Gun Violence in America: Informing Policy with Evidence and Analysis*, ed. Daniel W. Webster and Jon S. Vernick. (Baltimore: The Johns Hopkins University Press, 2013), 226.

by the state to determine whether the individual ought to be prohibited from having a gun license. Aside from other issues such as the potential to create distrust in the doctor-patient relationship, and the inappropriate focus on the mentally ill, allowing a single interaction with a mental health professional to be the empirical basis for the removal of a constitutionally protected right is a harsh policy.

Before a felon is prohibited from exercising his right to bear arms, there is a trial, an advocate for the accused, and the opportunity for an appeal process that occurs before his status as a felon is cemented. Individuals with mental illness get no such process under the SAFE Act. Instead, their very personal interaction with the mental health professional meant to be helping them is subsequently used by the state to take away their right of gun ownership without the additional protections afforded those accused of crimes. From the patient's perspective, this medico-legal response to his seeking medical care could seem an especially onerous attack on his right in a vulnerable moment. From the perspective of mental health professionals, the difficulty in predicting violence can put them in the situation of preferring to be more inclusive, to sacrifice specificity in their judgments out of fear of being inadequately sensitive to the state-imposed goal of detecting risk of violence. Mental health professionals are, in effect, forced to play a key role in a process that may deny someone a constitutionally protected right.

4.5 COMPARISON OF THE SAFE ACT'S REPORTING REQUIREMENT TO OTHER CONTEXTS

The SAFE Act's reporting requirement at first seems quite similar to the reporting requirement in the case of child abuse: parents are afforded the right to raise their children how they see fit, until

they abuse the child. In the case of child abuse, the physician's report is reviewed by a state entity that then decides whether the right to raise their children ought to be taken away from the parents. However, one key difference is that laws around child abuse take away a right in order to protect a vulnerable population while the SAFE Act is taking away the right of a vulnerable population in the name of public safety in spite of evidence to the contrary showing that there is little public safety risk. An additional difference is that parents are to be deprived of their child only after actually acting in an unethical and illegal manner. In contrast, the SAFE Act's reporting requirement may result in a mentally ill person being deprived of her gun ownership right without ever having acted in an inappropriate manner. It is the mere risk of such action that grounds the deprivation.

When a public health intervention is in conflict with a moral consideration, the first condition enumerated by Childress et al. is whether that intervention is going to be effective in protecting public health.¹¹³ In the case of reporting requirements for communicable diseases, the reported information is effectively used in disease tracking and tailoring of prevention efforts to the correct populations in the service of the goal of preventing the spread of communicable diseases. The necessity of gathering the reported information to the effectiveness of the intervention was demonstrated when the use of unique identifiers rather than names was unsuccessfully attempted.¹¹⁴ In the case of medical unfitness to drive, the reporting requirement is effective in preventing drivers whose medical conditions pose a risk of car accident that is approximately two times greater than the risk of crash in the general driving population from

¹¹³ Childress et al., "Public Health Ethics," 172.

¹¹⁴ Gostin, *Public Health Law*, 120.

maintaining a driver's license.¹¹⁵ For cases of suspected child abuse, reporting is effective in removing children from harmful situations, though false reports ("false positives") result in over-inclusive removal of children from their parents and many cases of child abuse remain undetected and unreported. Nevertheless, the extreme vulnerability of children to abuse, and the requirement that some empirical evidence of actual abuse (not mere risk of future abuse) as the basis for reports, may warrant the implementation of reporting requirements for cases of suspected child abuse. But the reporting requirement in the case of pregnant women who take illegal drugs is not an effective measure to prevent the harm that can occur to both the woman and her fetus from using illegal drugs. Instead, it creates the incentive for pregnant women who use illegal drugs to avoid prenatal care altogether¹¹⁶, which does nothing to remove the danger.

For the SAFE Act, the effectiveness is questionable. As in the case of pregnant women and illegal drug use, the existence of the reporting requirement for mental health professionals creates the incentive for individuals to avoid treatment in order to avoid being reported and be able to keep or obtain gun licenses. Additionally, the reporting requirement cannot be effective in reducing overall gun violence when people with mental illness who commit violence make up only a tiny proportion of overall violence.

The next step is to consider necessity, or whether the goal of the public health intervention can only be achieved through this particular measure.¹¹⁷ The reporting requirement is necessary for the effective tracking of communicable diseases, for removing licenses from medically unfit drivers, and for protecting children from abuse. The reason for this necessity is that only medical professionals (or in the case of child abuse, other professionals named in

¹¹⁵ *Medical Conditions and Other Factors in Driver Risk*, 9.

¹¹⁶ Marilyn L. Poland et al, "Punishing pregnant drug users," 199.

¹¹⁷ Childress et al., "Public Health Ethics," 172.

statutes who have similar contact with children) have reliable access to evidence of the need for a public health intervention. In the case of drug use by pregnant women, taking the less coercive, or less restrictive, step of offering a drug treatment program may invalidate the necessity of reporting her to the state to face a criminal or civil child removal proceeding. For the reporting requirement in the SAFE Act, if the measure were actually an effective way of substantially reducing gun violence, the reporting requirement could be similarly necessary (though perhaps not the least infringing) as the effective tracking of communicable diseases or removing driver's licenses from the medically unfit, though perhaps would still not be the least infringing alternative.

The next consideration is, therefore, whether this is the policy presents that the most minimal infringement on the relevant ethical interests.¹¹⁸ In the case of communicable diseases, the least restrictive alternative is one that uses only the amount of sensitive information that is absolutely necessary to identify infected cases in order to achieve the goal of reducing the spread of communicable disease while still protecting privacy as maximally as possible, given the countervailing interest. For medically unfit drivers, removal of the driver's license infringes on liberty, but, depending on the specific condition, there may be no treatment or less restricting compromise that would make driving with their condition any less dangerous to others on the road. In the case of reporting suspected child abuse, due process proceedings should prevent actual removal of children from their parents until the abuse is proved in court.

In the case of the reporting requirement in the SAFE Act, there is no similar due process protection as there is in the case of child abuse. Once the determination is made by the state that an individual is no longer allowed a gun license, that decision will stand for five years, provided

¹¹⁸ Childress et al., "Public Health Ethics," 172.

that there are no subsequent reports to start the five year time period over again. Unlike some of the conditions cited in cases of medical unfitness to drive which take away the physical ability to safely operate a car, mental illness does not permanently render and individual unable to make a reasonable decision about safely owning a gun. Less restrictive alternatives that would achieve the goal of reducing gun violence without restricting the liberty of people with mental illness could include different gun control measures that would target all gun owners (and not just a stigmatized group), such as the use of mandatory gun safes, or restrictions on how many rounds a single clip could hold.

The next necessary condition is proportionality. For an intervention to be proportional, the public health benefits must outweigh the moral considerations, including the individual interests and rights that are infringed.¹¹⁹ Effectively preventing the spread of communicable disease outweighs the harm of having personal information disclosed to public health officials, so long as that information is not used in a discriminatory manner and the information is kept as private as possible. Keeping medically unfit drivers from posing excessive danger to others on the road outweighs the harm of restricting those individuals' personal liberty, particularly if possession of a drivers' license is considered a privilege, not a right. (To minimize the harm to individuals caused by restricting their driving privilege, alternate means of transportation should be available to enable them to continue to function within society.) The state's interest in protecting children from harm outweighs the right of parental autonomy when that autonomy is exercised to harm their children. The state's interest in protecting potential children is more complicated. Although a woman's liberty does not extend to the right to use illegal drugs, saying that the state's interest in protecting fetuses is a more weighty consideration than a woman's

¹¹⁹ Childress et al., "Public Health Ethics," 172.

liberty and right to control her body in this case could lead to negative consequences for a woman's right to choose abortion. The reporting requirement can be a proportional response in the interest of protecting the health of the fetus, but only if such reporting was actually an effective way to reduce substance abuse by pregnant women. Given that this effectiveness is the best doubtful, and given that the reporting requirement may lead women to avoid prenatal care and thus risk their own and their fetuses' health in other ways, the reporting requirement cannot meet the criterion of being proportional.

As for the reporting requirement in the SAFE Act, the primary moral considerations being infringed include the liberty of individuals who have mental illness to have a gun license, as well as the privacy of those with mental illness (and attendant risks of discrimination and stigma) and the trustworthiness of their therapeutic relationship. Does the probable benefit of reducing overall gun violence outweigh the infringement of liberty and the compromise of trust? If people with mental illness were responsible for the majority of gun violence, the answer might be yes. But since they are not, and the positive effect of substantial reduction in gun violence will not actually be achieved by this measure, the negative effects of further stigmatizing an already vulnerable population outweigh that hypothetical good.

Finally, there is the responsibility to justify these measures that infringe on moral considerations to the public. The privacy infringement caused by the reporting requirement in the case of communicable diseases can be justified to the public by demonstrating the effectiveness of disease prevention measures that come from the collected data. The liberty infringement of reporting of medically unfit drivers can similarly be justified to the public by showing that, in spite of the inherent risks involved in driving, the road is safer for everyone when especially unsafe drivers are prevented from driving. Reporting of suspected child abuse is also justifiable in spite

of the privacy and liberty infringements because of the importance of protecting a vulnerable population from harm. But in the case of the SAFE Act’s reporting requirement, the justifications of taking liberty away from an already stigmatized group are on shaky ground: targeting individuals with mental illness is based on the incorrect assumptions and faulty logic--namely, that mental illness makes a person violent and therefore people with mental illness must be responsible for the majority of violence. Unfortunately, this view is likely shared by a large part of the any given legislator’s constituents, and so they might agree with such justification. But this action is not justifiable to the people being targeted with this measure.

Table 1. The Different Reporting Requirements and the Five Justificatory Conditions

	Effective in Protecting Public Health	Necessary for Achieving the Goal	Least Infringement of Moral Consideration	Proportional Harms and Benefits	Justifiable to Both the Public and Individuals
Reporting Individuals with Communicable Diseases	Yes. Allows prevention efforts to be appropriately tailored.	Yes. Using non-name based identifiers not as effective.	Yes. Less restrictive than locking up people with communicable disease, more effective than identifiers.	Yes. As long as non-discriminatory and kept as private as possible.	Yes. Preventing disease important to everyone.
Reporting the Medically Unfit to Drive	Yes. Removes licenses from population with 2x more accidents.	Yes. Relying on self-restriction not as effective.	Yes. As long as other forms of transport are available.	Yes. Removing high risk population from road outweighs inconvenience.	Yes. Reduces number of car accidents.
Reporting Cases of Suspected Child Abuse	Yes. Reporting ideally leads to child’s removal from context of abuse.	Yes. Physicians were historically unwilling to report.	Yes. Due process should protect against false accusations	Yes. Parental autonomy does not extend to child abuse.	Yes. Especially important to protect vulnerable population.

<p>Reporting Illegal Drug Use by Pregnant Women</p>	<p>No. Drives drug using pregnant women underground.</p>	<p>No. Ineffectiveness removes necessity.</p>	<p>No. Less restrictive to offer drug treatment.</p>	<p>No. Fetal welfare does not outweigh autonomy and privacy/trust.</p>	<p>No. Drug using pregnant women need help, not incarceration.</p>
<p>Reporting Mentally Ill Individuals Considered Likely to Commit Violence</p>	<p>No. Targeted population not responsible for significant portion of gun violence.</p>	<p>No. Ineffectiveness removes necessity.</p>	<p>No. Less infringing to regulate gun use by all owners than to target gun ownership right of one group.</p>	<p>No. Increase in stigma and removal of a right not proportional to infinitesimal reduction in gun violence.</p>	<p>No. Justification for targeting mentally ill based on incorrect assumptions.</p>

5.0 CONCLUSION

The new reporting requirement for mental health professionals in the New York SAFE Act is a misguided attempt to reduce gun violence. For this reporting requirement to be warranted, it would need to be both effective and necessary, which, contrary to fact, would depend on people with mental illness perpetrating a large portion of overall gun violence and the ability of mental health professionals to accurately predict violence. This difficulty in prediction combined with the small number of people who have a mental illness and also commit violence renders this approach to reducing overall gun violence ineffective, while at the same time reinforcing negative stereotypes about people with mental illness. Because of the high social costs of reinforcing these stereotypes, the reporting requirement's burdens are not proportional to its potential benefits. Further, there are less restrictive alternatives that would serve to reduce overall gun violence by targeting all gun owners, without making scapegoats of the mentally ill. Overall, due to the ineffectiveness of this measure, it is not able to be justified, particularly to those individuals that it affects.

Would a reporting requirement similar to the one found in the SAFE Act have prevented the tragedy at Sandy Hook? According to the final report by Connecticut's State Attorney, "It is known that the shooter had significant mental health issues that affected his ability to live a normal life and to interact with others...As an adult he did not recognize or help himself deal with those issues. What contribution this made to the shootings, if any, is unknown as those

mental health professionals who saw him did not see anything that would have predicted his future behavior...Investigators however, have not discovered any evidence that the shooter voiced or gave any indication to others that he intended to commit such a crime himself.”¹²⁰

¹²⁰ Office of the State’s Attorney, Judicial District of Danbury, Stephen J. Sedensky III, State’s Attorney, *Report of the State’s Attorney for the Judicial District of Danbury on the Shootings at Sandy Hook Elementary School and 36 Yogananda Street, Newtown, Connecticut on December 14, 2012*, (November 25, 2013), 3. Accessed December 5th, 2013.
http://www.ct.gov/csao/lib/csao/Sandy_Hook_Final_Report.pdf

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