The question is difficult to answer because commitment practices vary substantially by state and locality.

Under federal law, individuals lose their firearm rights if they have been “committed to a mental institution.” In many states, commitment proceedings have 2 stages. The initial stage is a short period (eg, 3-5 days) of hospitalization for the purpose of providing emergency treatment and evaluation of whether patients meet commitment criteria; the second stage is a formal commitment hearing. These admissions are often authorized by an emergency medicine physician or mental health professional and in some states are ratified ex parte by a magistrate. These patients are discharged quite often before a formal hearing is required, so hospitalization never results in a commitment order.

Although these emergency holds are not gun-disqualifying events under federal law (because they are not, legally speaking, commitments), many states regard them as disqualifying under state law (and thereby reportable to the NICS) because they identify persons deemed by qualified clinicians to be at risk of harming themselves or others.1 Hospitalization in these situations is clearly constitutional, as is temporary removal of firearms.

We are reasonably confident that reporting these records to the NICS does not violate the due process clause or conflict with the Second Amendment so long as the period of disqualification is reasonable (eg, 5 years) and the person has a fair opportunity to seek restoration of gun rights.2 Prohibiting guns temporarily from persons subjected to short-term psychiatric detention is an expert consensus recommendation from the Consortium for Risk-Based Firearms Policy.3

Although we disagree with Kels about the constitutionality of NICS reporting after emergency hospitalization, we concur with his judgment that loss of firearm rights should ordinarily be based on more formal procedures to ensure fairness and effective reporting. One of the reasons that many states withhold gun-disqualifying mental health records from the NICS is that the informality and variability of the commitment process impedes fair and accurate reporting.

Between 2009 and 2015, the US Department of Justice provided more than $95 million in grant funding to 26 states to improve reporting of records to the NICS; efforts to incentivize accurate NICS reporting should continue.4

Kels’ letter inspires careful thought about the basis for legally restricting firearms from certain people in the interest of public safety when a constitutional right is at stake. Are the prohibiting criteria too narrow, as in the case of many who end their own lives with legally purchased firearms?

Are the rules too broad, infringing the rights of some low-risk individuals who remain prohibited from access to firearms for a lifetime due to a remote history of involuntary commitment?5 We think that a fair and effective policy must carefully balance implementation of due process standards, including rights to appeal, with evidence-based safety concerns.6

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Conflict of Interest Disclosures: The authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and reported being members of the Consortium for Risk-Based Firearm Policy.


CORRECTION

Error in Collaborator Name: In the Original Investigation entitled “Effect of Insulin Glargine Up-titration vs Insulin Degludec/Liraglutide on Glycated Hemoglobin Levels in Patients With Uncontrolled Type 2 Diabetes: The DUAL V Randomized Clinical Trial,” published in the March 1, 2016, issue of JAMA, a collaborator name contained an error: Stelios Tigkas should be corrected to Stelios Tigas. This article was corrected online.

Error in Text: In the Review entitled “Association Between Vaccine Refusal and Vaccine-Preventable Disease in the United States: A Review of Measles and Pertussis” published in the March 15, 2016, issue of JAMA, there was an error in the text. Under “Vaccine Refusal and Pertussis Outbreaks,” the article states, “The Advisory Committee on Immunization Practices currently recommends 5 DTaP doses at age 2, 4, and 6 months, at 15 to 18 months, and again at 4 to 6 years, as well as a Tdap booster in adolescence (between age 11 and 18 years) and adulthood (19 years or older).” It should state, “The Advisory Committee on Immunization Practices currently recommends 5 DTaP doses at age 2, 4, and 6 months, at 15 to 18 months, and again at 4 to 6 years, as well as a Tdap booster in adolescence (between age 11 and 12 years), or adulthood (if the adolescent dose was missed), and during every pregnancy.” This article was corrected online.


Error in Collaborator Name: Stelios Tigkas.