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## Purpose

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has developed this resource to provide best-practice guidance for psychiatrists assessing the risk posed by a person's access to firearms. Firearms regulations both in Australia and New Zealand contain mechanisms for asking psychiatrists to provide their professional view on the risk posed (to themselves and others) by a person's access to a firearm.

Psychiatrists may be asked to provide such an opinion even if they do not practice within the forensic specialty. Any psychiatrists may find themselves with safety concerns for patients with mental health conditions who have access to firearms. For this reason, this document has been designed to support psychiatrists who may have little to no experience with firearms or violence risk assessments. While some individuals may present such low levels of risk that safety is straightforward to assess, risk can become more complex. Where risk is complex to assess and where safety is unclear, psychiatrists may seek guidance from this document. This document will also provide guidance for how to proceed when patients present a clear and unacceptable risk to themselves and others. This document also advises when it is more appropriate for a psychiatrist to refer a patient to another psychiatrist for assessment.

## Scope of the guideline

This guideline will guide psychiatrists asked to conduct assessments and address safety concerns relating to a person's access to firearms. This guideline does not comment on the regulation of firearms. This document does not comment on or guide other assessments psychiatrists may be asked to undertake, including those relating to radicalisation, lone actor grievance fuelled violence and assessments on release from prison.

It is important to note that this document is not intended to provide comprehensive guidance regarding the legal requirements within specific jurisdictions. Psychiatrists should familiarise themselves with laws applying to their jurisdiction and any reporting processes for their jurisdiction's law enforcement. If psychiatrists need further advice on compliance with the laws in their jurisdiction, they should seek advice from their Medical Indemnity Insurer or independent legal advice.

### 1 Responsibility for firearms safety

- 1.1 As part of their responsibilities, psychiatrists need to work within the [RANZCP Code of Ethics](#) to uphold the integrity of the medical profession in conducting a rigorous assessment of firearms safety. If a psychiatrist feels they are not adequately informed on firearms-related assessments or have strong ethical biases, they should refer the person to another suitably trained psychiatrist.
- 1.2 It is recommended that psychiatrists who intend to refer on their patient for a firearms risk assessment because of a lack of knowledge should in the first instance review the additional readings section of this professional practice guideline to help inform their

practice and enable them to conduct future assessments. It is important psychiatrists take responsibility for their knowledge in this way so as to not overburden forensic psychiatrists and ensure equitable access to psychiatric expertise.

- 1.3 Psychiatrists practising in specialist areas such as forensic and rural psychiatry should expect to be conducting firearms-related assessments with some regularity. As part of the responsibilities of these specialities, specialist psychiatrists should ensure they are comfortable providing assessments with at least low to moderate complexity.
- 1.4 Firearms safety is a community safety issue and as such all areas of society share a degree of responsibility for firearms safety.[1] Effective firearms safety at a community level requires collaborative and comprehensive community-based strategies.[1] Such strategies should ensure that when persons become unsafe appropriate interventions are implemented before harm occurs.
- 1.5 While psychiatrists have responsibility for specialist assessments and monitoring of those in their care or brought to their attention, law enforcement and licencing authorities have responsibility for acting on these assessments and deciding who can possess firearms, who cannot and when a firearm should be confiscated. Psychiatrists have a responsibility to take the danger posed by firearms seriously and provide considered and honest advice. Police have a responsibility to take psychiatric advice seriously and intervene when a person presents an unacceptable risk to themselves and others.
- 1.6 The firearms-using community have responsibility for their own behaviour, supporting peers to use firearms responsibly, fostering a culture of compliance and safety and for holding their peers to account. The wider community has a responsibility to support those who use firearms to stay well, encourage help-seeking and make appropriate notifications where necessary.

## **2 Links between mental illness and gun violence**

- 2.1 Public perceptions that those with mental health conditions pose a risk of violence to society are well documented. Media reporting of shootings involving perpetrators with a mental health condition has been shown to increase the public perception that people with mental health conditions are dangerous.[2] Given the increased lethality of gun violence, public concerns about access to firearms by those who may pose higher risks are understandable.
- 2.2 It is important to note that studies consistently show that the risk of violence associated with having a mental health condition is modest and not high enough to have predictive validity.[2-4] A more useful consideration is how mental health conditions interact with other risk factors such as substance use, problems with behavioural regulation and aggressive impulses and a history of trauma.[2, 4]
- 2.3 For those who have mental health conditions and access to firearms the greatest danger they pose is to themselves.[2] Firearms are involved in 5.3% of deaths by suicide in Australia (in 2020) and 6.1% of deaths by suicide in New Zealand (in 2016).[5, 6] Firearms are a particularly prevalent method of death by suicide amongst men and in regional, rural and remote communities.[5-7]
- 2.4 Violent incidents involving people with mental health conditions and firearms are thankfully rare in Australia and New Zealand. Incidents such as the Port Arthur Massacre and the 2019 Christchurch Shooting in New Zealand are horrific events, and every effort should be taken to prevent similar events in the future. However, it needs to be recognised that many people that commit acts of violence with firearms do not experience any mental health conditions.[3] Those people that do commit acts of violence with a firearm and had a mental health condition were often not found to have a condition significant enough that would have disqualified them from firearms ownership prior to committing the act of violence.[3]

### **3 Privacy, confidentiality, and the clinical relationship**

- 3.1** In most circumstances, psychiatrists should maintain strict confidentiality of discussions with their patients and any carers, family and whānau where consulted. This is outlined in principle 4.1 of the [RANZCP Code of Ethics](#) ('Psychiatrists shall instil confidence in patients that whatever information they reveal will not be used improperly or shared').<sup>[8]</sup> However, it is recognised that at times it is in the public good to breach this confidentiality where the immediate safety of others is in jeopardy. These disclosures are permitted under principle 4.4 of the RANZCP Code of Ethics ('A breach of confidentiality may be justified where there are public-interest considerations, to protect the safety of the patient or other people').<sup>[8]</sup>
- 3.2** Psychiatrists should be aware that a disclosure of this kind is likely to affect the clinical relationship.<sup>[9]</sup> Psychiatrists need to consider these consequences against the possible consequences if a disclosure is not made.
- 3.3** When a psychiatrist is conducting a firearms-related assessment, the clinical relationship normally present with the patient may be impacted due to the psychiatrist's change in role as an assessor rather than a treating professional. In an assessor role, psychiatrists should still take care to only disclose the information that is necessary and relevant to the assessment to preserve a degree of privacy. Where disclosure is mandatory, this should be done in line with principle 4.6 of the Code of Ethics ('If required to disclose clinical information, such as by subpoena, psychiatrists shall limit such disclosure to what is necessary').<sup>[8]</sup>

### **4 Assessing risks in a polarised environment**

- 4.1** For many people, firearms can be a politically, emotionally, and culturally charged subject. Some members of the community may be fearful of firearms and view privately owned firearms as an unreasonable danger to communities. For others, firearms possession holds deep cultural, ideological, and political importance. They likely view themselves and fellow firearm owners as law-abiding and highly responsible and fear being painted with the same brush as irresponsible firearm owners or violent individuals. Psychiatrists may find themselves holding strong personal opinions along these lines or fear reprisal from applicants or community members if their recommendations don't match community attitudes.<sup>[9]</sup>
- 4.2** Before assessing a person, a psychiatrist should consider their personal opinions and take steps to remove personal opinions as much as possible from their assessment. Psychiatrists may wish to consult with supervisors or trusted colleagues about an assessment to ensure the assessment is as objective as possible. Psychiatrists are encouraged to limit the assessment to areas covered by their medical expertise about how a person's mental state does or does not present an unreasonable danger to themselves and others if they possessed a firearm.

### **5. Conducting risk assessments for licencing purposes**

- 5.1** Although all psychiatrists are familiar with assessing the risks of suicide and violence, they may have little experience in assessing an individual's safety to possess a firearm. Some aspects of firearm risk assessments may fall outside the scope of what medical opinions a psychiatrist can provide such as if the applicant is a 'fit and proper person'. Psychiatrists should limit their recommendations to areas where their medical training and expertise allow them to comment on the nature and treatment of identified mental health conditions.
- 5.2** Psychiatrists can only conduct a risk assessment of a person at the current time in their life, their current mental state and based upon collateral information available to them in that assessment. Psychiatrists cannot make an assessment based on hypothetical circumstances or collateral information that was not provided or was not accessible.

- 5.3** Risk assessments are best provided where the psychiatrist knows the applicant well, has previous or existing treatment relationship with them, and is in the position to provide ongoing monitoring of the applicant's level of risk. If an applicant is not a patient of the psychiatrist, if they lack the capacity to monitor the applicant on an ongoing basis or the applicant is not well known to the psychiatrist, they should make note of these factors in their report.
- 5.4** While extensive research exists attempting to understand risk factors for violent behaviour and many tools have been developed to conduct risk assessments such as the Historical Clinical Risk Management-20 (HCR-20), none of these tools or research enables psychiatrists to predict violent behaviour.[10] A risk assessment should in no way be taken as a prediction, psychiatrists may wish to make this clear in their recommendations.
- 5.5** Psychiatrists are only responsible for providing advice and recommendations for consideration. Decisions regarding who should and should not own firearms are made by police enforcing regulations legislated by governments.
- 5.6** It is possible for a mentally healthy person to experience a rapid deterioration of their mental health if exposed to trauma, adverse life events or after developing problems with substance use.[9] Applicants also have a vested interest in having their application approved. Some applicants may be reluctant to reveal information they feel may jeopardise their application.[11] Psychiatrists should make clear in their recommendations that their recommendations are based on the applicant's mental state at the time and based on the information provided to them.
- 5.7** If the applicant has a history of mental illness which could pose a greater risk to themselves or others if they possessed firearms, a range of factors should be considered in their assessment. In addition to assessing their current mental state, psychiatrists should assess any plans for ongoing treatment, how the applicant has approached previous and current treatment, how the applicant handles periods of low mood, distress, symptoms of a mental health condition, the applicant's impulsivity, how frequently the applicant experiences concerning incidents and if the applicant shows an intention to continue with their current treatment[11], whether they attend their appointments with mental health professionals as well as continuing to correctly take any prescribed medication. Psychiatrists should also consider applicant access to support networks such as social circles, the firearm-using community, family and whānau with whom the applicant feels comfortable discussing their mental health.[11].

## **6. Managing risks presented by existing patients**

- 6.1** Once a psychiatrist becomes aware of a patient's access to firearms this should form an ongoing layer of assessment and management in the clinical situation. This will be most relevant for patients at risk of suicidal ideation, patients with poor impulse control, grievances against family, former friends, workplaces or institutions, neurological conditions such as dementia or those who frequently experience concerning incidents or are experiencing significant relationship issues with intimate partners.[11] The friends and family/whānau of a person can be an effective source of monitoring and support for patients. Patients should be encouraged to discuss their firearms access and how it relates to their mental health with friends, those in the firearms-using community and family/whānau so they can encourage a patient to seek help when needed and make appropriate notifications if safety concerns escalate.
- 6.2** Patients with access to firearms are often aware that psychiatrists and other mental health professionals have the power to make recommendations that their firearms be confiscated/licence suspended.[12] This can make them reluctant to disclose mental health conditions to those around them or seek help. They may understate the level of distress or symptoms of a mental health condition they experience out of fear their firearms will be confiscated.[12] Patients should be given valid assurance that single instances of low mood and lower-level symptoms are highly unlikely to lead to reporting or police confiscation.[11]

Patients should be made aware that even if they present with more concerning symptoms, reporting to police and confiscation are not the first response and alternative measures can be considered where appropriate.[11]

- 6.3 If patients are presenting for help and are willing to engage with treatment and discuss their thoughts, this indicates a level of personal responsibility and a likelihood they can manage low-level symptoms without the need for intervention.[11]
- 6.4 A patient's identified areas of concern may also change over time. Symptoms of a mental health condition may reduce so significantly that the condition no longer presents a concern. If patients abstain from substance use or cease dangerous behaviours for long periods of time psychiatrists may accept that these factors no longer need to be considered when conducting an assessment. A patient may also develop new risks such as concerning substance use or risky behaviours which will create new concerns the psychiatrist will need to monitor during their relationship with the patient.
- 6.5 Where appropriate, a patient's family and whānau should be involved in decision-making and ongoing support systems for the patient. Family and whānau will be able to provide support and monitoring to a much greater extent than a psychiatrist will be able to. Family and whānau should also be informed about what they should do if their support becomes ineffective, if a patient's condition worsens and who to notify if they become concerned for the safety of themselves, the patient, and others. For further information please see [Professional Practice Guideline 20: Information sharing with families/whānau/carers](#)
- 6.6 Some patients may pose serious concerns relating to their access to firearms and require timely intervention. All jurisdictions in Australia and New Zealand have circumstances in which psychiatrists must report such individuals to the police so they can make a determination about confiscating their firearms and/or suspending their licence. When making a report psychiatrists should consider how a patient may react to the confiscation and inform police of potential dangers to police, the patient, those around the patient and the general public so police can take appropriate action.

## **7 Assessments of Aboriginal and Torres Strait Islander peoples and Māori**

- 7.1 When conducting assessments of first nations peoples or managing their risk as a patient, psychiatrists need to consider additional factors. These additional factors in no way imply a greater level of risk presented by Aboriginal and Torres Strait Islander peoples and Māori. These additional factors are considered to ensure risk assessments are culturally safe and do not disempower Aboriginal and Torres Strait Islander people and Māori but are inclusive of their culture and ways of living.
- 7.2 Historically firearms regulations have been used to unfairly confiscate firearms from Aboriginal and Torres Strait Islander peoples and Māori.[13, 14] Health professionals have played roles in government policy to deny Aboriginal and Torres Strait Islander peoples and Māori their rights and even to take their children from them. Factors such as these have led to some Aboriginal and Torres Strait Islander peoples and Māori having difficulty trusting governments or health professionals. For more information please see [Position statement 42: Acknowledging the Stolen generations](#).
- 7.3 Aboriginal and Torres Strait Islander peoples and Māori may be reluctant to disclose the extent of their mental health condition if they feel they are not in a culturally safe environment.[15, 16] Psychiatrists should take steps to ensure their practice is culturally safe and factors unique to Aboriginal and Torres Strait Islander peoples and Māori are considered when undertaking assessments or managing patient risk. Please see [Position Statement 105: Cultural Safety](#) for more information on cultural safety.
- 7.4 Aboriginal and Torres Strait Islander peoples and Māori may need firearms to fulfil cultural obligations like hunting or land management, in some areas it may also be a necessary part of how they access food. A report leading to confiscation may have additional impacts on these people's mental health and should be considered as part of an assessment.

- 7.5** Psychiatrists in New Zealand should also be aware of their obligations under Te Tiriti o Waitangi (Treaty of Waitangi). Any assessments need to be conducted in a way that aligns with tikanga principles. The treaty entitles Māori to live in their own way and exercise tino rangatiratanga (self-determination). These entitlements may be infringed upon by an unreasonable firearms confiscation. For more information on Te Tiriti please see [Position Statement 107: Recognising the significance of Te Tiriti o Waitangi](#).
- 7.6** First nations people may have additional sources of support and monitoring within their communities such as elders, those with kinship commitments and whānau. Psychiatrists may wish to ask first nations patients if it would be appropriate for these groups to provide them with support to keep themselves and others safe.

## **8 Assessments of young people**

- 8.1** Young people in both Australia and New Zealand are capable of applying for firearms licences/permits before the age of 18. Young people may also have access to firearms within their household even if they are not licenced to own them such as firearms owned by a parent. Psychiatrists should not assume a young person does not have access to firearms solely due to their age.
- 8.2** Modern neuroscience has shown that the brain continues to develop after the age of 18 and finishes between the ages of 25 and 30.[17] During this period a young person's reasoning and ability to control impulses and emotions are still developing.[17] A young person may have a reduced capacity to manage impulses and emotions and be more susceptible to negative influences which may increase their risk. Young people are also more susceptible to risk-taking behaviours and the influence of peers who may encourage risk-taking behaviour.[17]
- 8.3** Psychiatrists seeking to manage or assess a young person's risk regarding firearms should ensure they have considered the young person from a developmental perspective. While developmental risks are likely to reduce over time as the brain develops, they can cause a young person to behave differently than an older adult in similar circumstances.[17]

## **9. Additional factors for consideration**

- 9.1** Members of rural and agricultural communities are more likely to possess firearms than patients in urban areas. Psychiatrists practising in rural or agricultural communities may wish to ask patients if they have access to firearms as a routine part of initial consultations.
- 9.2** For some patients, firearms ownership is an important part of their identity and enables them to participate in social activities within the firearms-using community like target shooting and hunting. For these patients, firearms confiscation may have a more significant impact on their wellbeing and social connections than others.[11] Psychiatrists should identify if confiscation is likely to have such an impact and factor that into their assessment when working with these patients. Some studies have also shown that using messaging culturally consistent with the patient's views on firearms can make them more receptive to discussions about their firearms.[18]
- 9.3** When a person's firearm is confiscated this may have a significant reputational impact and be embarrassing or humiliating for the person. Even after access is restored, they may continue to be seen as dangerous or unstable by others due to the stigma around mental health conditions. If firearm use is a required part of a person's job, confiscation may have a negative impact on their career and affect their ability to work. Psychiatrists should identify if confiscation is likely to have such an impact. If appropriate, psychiatrists may wish to work with the person to discuss how to disclose the confiscation to friends, colleagues, and managers to minimise any negative impact on their reputation and wellbeing.

- 9.4** Where possible, psychiatrists should discuss their assessments/reports with the person it is regarding before its submission. This allows the psychiatrist to preserve a trusting relationship with the person and allows the person to prepare for any impact that may result from the assessment/report's submission. Discussion of the report's contents is not encouraged if the psychiatrist believes the patient may attempt to use their firearms to harm themselves or others before the firearms can be confiscated.
- 9.5** Firearms owners are a diverse cohort and should not be considered homogenous. Some firearms owners are highly social in their firearms ownership, participating in target shooting, hunting and other firearms-related communities while others such as farmers use their firearms in isolation. Some firearms owners view their firearms simply as a tool for necessary tasks or hobbies while others place a strong political and ideological importance on firearms ownership which may form part of their identity.
- 9.6** Psychiatrists have a responsibility to be observant of behaviours in people in their care that could amount to coercive control of their partners. Coercive control may take many forms and may be related to underlying psychopathology. By their very nature weapons can be a powerful tool of coercive control in domestic and family violence and do not need to be used directly against another person to be harmful. Perpetrators of domestic and family violence may use the firearm in indirect ways other than brandishing, discharging, directly threatening or shooting someone.[19] Perpetrators may place the firearm where it is easily and frequently seen, make unprompted remarks about possessing the firearm or take the firearm for a shooting activity as a means of creating an environment of fear and intimidation.[19] Perpetrators may take these actions in response to a perceived provocation, or argument or if someone is considering taking an action the perpetrator objects to. Just knowing that a perpetrator has a firearm can create this environment of fear without perpetrators taking action to use it in a coercive way.[19] Psychiatrists need to be aware that firearms, in this context, are weapons and a powerful form of coercion.
- 9.7** When conducting a risk assessment, psychiatrists should not lose sight of their primary task of assessing the safety of the person rather than the firearm. The significant lethality of firearms can make it understandable for psychiatrists to fixate on the firearm and the danger it poses. An excessive focus on the risk posed by the firearm may result in the assessing psychiatrist losing sight of how the same individual may also be capable of violence by other methods. While the focus of these risk assessments is regarding firearms, psychiatrists should ensure their risk assessment takes account of a person's risk for violence generally.

### **Additional reading**

- Harvard School of Public Health. [Harvard Injury Control Research Centre](#)
- University of Nebraska-Lincoln. [Challenging the Political Assumption That "Guns Don't Kill People, Crazy People Kill People!"](#)
- Cambridge University. [Guns and Psychiatry: what psychiatrists need to know](#)
- Samuel HG Diprise Adams. [Mental health first aid for firearm owners: Addressing the elephant in the room](#)

### **Jurisdictional information**

- New Zealand Police. [Health practitioner requirements](#)
- Victoria Police. [Quick Guide \(Firearms\): Information for the Role of the Health Professional](#)
- New South Wales Police. [Mental Health Section 79 Notification Form](#)
- Queensland Police. [Health and Weapons Information Booklet](#)
- SA Health. [Firearms notifications- Mandatory reporting by health professionals](#)
- Tasmania Police. [Firearms and Health Professionals](#)

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This information is intended to provide general guidance to practitioners and should not be relied on as a substitute for proper assessment with respect to the merits of each case and the needs of the patient. The RANZCP endeavours to ensure that information is accurate and current at the time of preparation but takes no responsibility for matters arising from changed circumstances, information or material that may have become subsequently available.



## REVISION RECORD

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