The Royal Australian & New Zealand College of Psychiatrists
Tu Te Akaaka Roa
New Zealand National Office

Your Health in Mind
Hauora hinengaro Manatuhia

The Justice Committee

The Arms Act

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Excellence and equity in the provision of mental healthcare

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ABOUT THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS

The RANZCP is the peak body representing psychiatrists in Australia and New Zealand. We are a binational college that trains doctors to become medical specialists in psychiatry. We support and enhance clinical practice, advocate for people affected by mental illness and addiction, and advise governments on matters related to mental health and addiction care.

We represent over 8,730 members, including more than 6,000 qualified psychiatrists and 2,500 trainees. Our training, policy, and advocacy work is led by expert committees of psychiatrists and subject-matter experts with academic, clinical, and service-delivery experience in mental health and addiction.

The RANZCP welcomes the opportunity to respond to the Crimes Amendment Bill 223-1 (2025). We oppose the proposed assault on the provisions for first responders. In our view, the Bill treats a system failure as an individual crime, penalising people experiencing mental health crises instead of addressing the real problem: untrained responders being sent into situations that require specialist mental health expertise.

INTRODUCTION

RANZCP supports evidence-based firearms regulation that protects public safety. However, Sections 9 and 361 of the Arms Bill contain significant flaws that will undermine both safety and equity.

Section 9(1)(i) deems people not fit and proper to hold firearms licences if they "show, or have recently shown, symptoms of a mental or physical illness."

This provision:

- Lacks empirical support - mental illness is not a reliable predictor of firearms risk
- Is operationally unclear - no definitions of "symptoms," "mental illness," or "recently shown"
- Will deter help-seeking, creating perverse safety outcomes by discouraging treatment engagement
- Enables discriminatory application, with no safeguards against racist or inequitable assessments

Section 361 requires health practitioners to "consider" reporting fitness concerns but provides no guidance on assessment, no professional protections, and no clarity on what "consider" means, resulting in risk-averse, defensive practice or inconsistent decisions.

The combined provisions rely on serial psychiatric assessments but do not consider workforce capacity or funding constraints. New Zealand is experiencing severe shortages of psychiatrists, resulting in wait times that can last for months. If these assessments become too costly or difficult to access, individuals may resort to acquiring firearms outside the official licensing process, which would heighten rather than mitigate risk.

Critically, firearms licensing is not solely a medical problem. Assessment requires diverse expertise: cultural advisors, domestic violence specialists, community safety workers, youth workers, and kaitiaki. For example, a person who assaults their partner or animal should trigger immediate removal based on demonstrated violence and victim safety - not clinical diagnosis. This is a community safety issue requiring whānau and specialist expertise, not psychiatric gatekeeping.

RANZCP RECOMMENDS:

1. Replace Section 9(1)(i) with evidence-based criteria based on demonstrated risk factors rather than the presence of symptoms:

- History of violence, threats, or concerning behaviour toward self or others
- Substance use patterns that impair judgment or increase impulsivity
- Current engagement in behaviours that pose immediate safety concerns
- Identified as high risk through validated risk assessment processes

2. Establish clear assessment frameworks developed in consultation with medical colleges and Māori health experts
3. Mandate protections against discriminatory assessments, including cultural competency training, ethnicity auditing, and community oversight
4. Provide professional liability protections for good-faith assessments
5. Clarify privacy and information-sharing provisions in Section 9(3)
6. Establish graduated response frameworks as default (not confiscation)
7. Strengthen domestic violence protections with urgent confiscation protocols
8. Require the regulator to develop and resource a community-based assessment workforce with diverse expertise, with medical professionals or psychiatrists contributing when mental health concerns genuinely warrant clinical assessment
9. If mental health criteria are retained, they should be limited to circumstances where a person is experiencing an acute psychiatric crisis requiring immediate intervention and where there is documented concern about imminent risk of harm, or where psychiatric symptoms significantly impair judgment, impulse control, or decision-making capacity in ways that affect safe firearms use, with clear timeframes for review.

These amendments would align the Bill with evidence-based practice, uphold Te Tiriti obligations, and enhance rather than undermine public safety

SUMMARY OF KEY CONCERNS

RANZCP supports evidence-based firearms regulation that protects public safety. However, we have significant concerns about Section 9(1)(i) and Section 361 of the Bill:

- Section 9(1)(i) uses "symptoms of a mental or physical illness" as licensing criteria, which lacks empirical support as a predictor of firearms risk
- The provision is operationally unclear (no definitions of "symptoms," "mental illness," or "recently shown")
- Section 361 establishes health practitioner reporting obligations without providing assessment guidance or professional protections
- The combined effect will create perverse safety outcomes by deterring help-seeking behaviour
- The provisions lack safeguards to prevent discriminatory application and do not reflect Te Tiriti o Waitangi obligations

SECTION 9(1)(I): EVIDENCE-BASED CONCERNS

1. Mental illness is not a reliable predictor of violence risk

Section 9(1)(i) deems a person not fit and proper if they "show, or have recently shown, symptoms of a mental or physical illness or injury that may adversely affect their ability to safely possess firearms." This framing is inconsistent with the evidence on violence risk.

Research consistently demonstrates that mental illness alone is not a significant predictor of violence or firearms misuse. Population-level studies show that people with mental illness account for approximately 3-5% of violent acts in the community. Most people with mental illness are not violent, and the majority of violence is not attributable to mental illness.

In the New Zealand context, firearms are involved in approximately 6.1% of suicide deaths. While mental distress is a factor in many suicides, the presence of "symptoms" does not reliably predict acute risk. Effective suicide prevention requires assessment of multiple contextual factors, access to means, protective factors, and immediate crisis indicators—not merely the presence or absence of symptoms.

PPG 23 emphasises that effective risk assessment requires evaluation of: history of violence or threats, substance use patterns, domestic violence indicators, access to firearms during periods of acute distress, and protective factors including therapeutic relationships. The presence of mental health symptoms is not a meaningful risk indicator.

1.1 Substance use requires a nuanced assessment

While substance use can be a relevant risk factor in firearms assessments, it requires careful, evidence-based consideration rather than blanket exclusions. Substance use must be understood in context:

Relevant risk factors include active substance use that significantly impairs judgment or increases impulsivity, severe dependence that affects functioning and decision-making, and use during situations involving firearms access. However, past substance use, being in recovery, occasional use that does not impair functioning, or use of prescribed medications should not automatically trigger fitness concerns.

Assessment of substance use is particularly vulnerable to racialised and discriminatory judgments. Research demonstrates that Māori are more likely to be assessed as having "problematic" substance use even when usage patterns are comparable to non-Māori. What is characterised as "social drinking" in some contexts may be pathologised as "abuse" when the person being assessed is Māori. Cultural practices around alcohol and cannabis use vary significantly, and assessors unfamiliar with these contexts may inappropriately medicalise normal social practices.

The Bill should require that substance use assessments:

- Focus on current impairment and functional impact, not historical use or recovery status
- Be conducted with cultural competency and awareness of assessment bias
- Distinguish between use patterns that genuinely affect safety versus use that does not
- Recognise that people in recovery may be highly motivated to maintain safety practices
- Not conflate prescribed medication use (including opioid maintenance treatment) with problematic substance use

Without these protections, substance use provisions risk becoming another mechanism for discriminatory assessment and inequitable outcomes.

2. Operational problems with the current wording

Section 9(1)(i) lacks the operational clarity necessary for consistent regulatory decision-making:

- "Symptoms" is undefined and potentially encompasses a vast range of experiences, from transient stress responses to major psychiatric disorders. This creates uncertainty for both regulators and license holders.
- "Mental illness" is undefined in the Bill, creating ambiguity about which conditions are captured. Does this include depression, anxiety disorders, PTSD, neurodevelopmental conditions, and past episodes that have fully resolved?
- "Recently shown" has no temporal definition. This creates inconsistency in application and uncertainty for individuals with past mental health treatment.
- "May adversely affect" is entirely speculative—it requires prediction of future potential impact rather than assessment of current demonstrated risk.

These definitional gaps will lead to inconsistent regulatory decisions, potential legal challenges, and difficulties for health practitioners seeking to provide advice under Section 361.

Furthermore, forthcoming changes to the Mental Health Act will focus on capacity as the threshold for compulsory treatment. However, capacity assessments in that context relate to a person's ability to consent to treatment and care. A person may retain the capacity to consent to treatment while experiencing psychiatric symptoms - such as hypomania - that significantly impair impulse control, judgment, or risk assessment in ways that affect firearms safety. Any capacity-based criteria in firearms legislation must therefore be specific to firearms safety capacity, not general treatment consent capacity.

3. Perverse safety outcomes

Section 9(1)(i) will likely reduce, rather than enhance, public safety by creating a powerful disincentive for firearms license holders to seek mental health support.

If individuals know that seeking help for depression, anxiety, stress, or other mental health concerns could result in firearms license revocation, many will avoid treatment entirely. This is particularly concerning for individuals experiencing suicidal ideation—the very population where early intervention could be lifesaving.

Effective suicide prevention and violence risk management depend on early engagement with health services. Provisions that deter help-seeking undermine these goals. International evidence from jurisdictions with similar provisions demonstrates that mandatory reporting requirements and broad exclusionary criteria reduce treatment engagement among firearms owners.

This creates a paradox: the Bill aims to enhance safety but may prevent the interventions that could reduce risk.

This reinforces the need for community-based assessment models that draw on diverse expertise—cultural advisors, domestic violence specialists, youth workers, and lived-experience perspectives—rather than assuming that all assessment work can or should be conducted by medical practitioners.

Without addressing these workforce and resourcing questions, the assessment provisions in Sections 9 and 361 risk becoming operationally unworkable or creating significant inequities in access based on geography and ability to pay.

- How will rural and remote areas access assessment services?

- How will assessments be delivered equitably across geographic and socioeconomic lines?
- Who bears the cost—the regulator, the license holder, or the health system?
- What frequency of assessment is envisaged—six-monthly, annual, or triggered reviews?
- Who will conduct these assessments—specialist psychiatrists, general practitioners, or other health practitioners?

Without clear funding mechanisms, assessment costs will create barriers to licensing compliance. If assessments are prohibitively expensive or inaccessible, people will obtain or retain firearms outside the licensing system entirely - creating exactly the public safety risk the Bill aims to prevent. This creates a perverse incentive in which the regulatory burden increases risk by pushing people into unlicensed possession.

This is particularly concerning for rural and low-income communities where firearms are essential for food security, but financial barriers may be insurmountable.

Serial assessments for firearms licensing would represent a significant additional demand on an already overstretched workforce. New Zealand faces a critical shortage of psychiatrists. Wait times for psychiatric assessment extend to months in urban areas, with minimal or no coverage in many rural regions. The existing psychiatric workforce is already operating at capacity, managing acute mental health presentations, crisis interventions, and ongoing care for people with severe and persistent mental illness.

Section 361 and the assessment requirements implied by Section 9(1)(i) assume that health practitioners—particularly psychiatrists—will conduct serial or ongoing assessments to determine fitness to hold firearms licenses. This assumption is not feasible given the current workforce capacity or existing funding mechanisms.

4. Real risks versus targeted populations

Section 9(1)(i) targets people with mental illness as the primary risk group for firearms harm. However, recent mass shooting events demonstrate that the actual threats to public safety come from different sources entirely.

The 2019 Christchurch mosque attacks and the 2025 Bondi Beach shooting were not failures of mental health screening - they were failures of vetting for extremism and radicalisation. Both perpetrators obtained firearms legally and passed background checks. Neither would have been identified by Section 9(1)(i) criteria focused on mental illness symptoms. These were acts of ideologically motivated violence by individuals radicalised through online extremist networks, not people experiencing mental health crises.

The Bill includes provisions banning gang members from holding firearms licences (Section 9(1)(l) and (m)). However, it contains no equivalent provisions targeting white supremacist groups or extremist organisations despite clear evidence that ideologically motivated extremism poses the primary mass shooting risk. This reveals an evidence gap: the legislation restricts populations who have not been implicated in mass shooting events (people with mental illness, gang members) while failing to adequately address the populations who have (radicalised extremists, white supremacists).

Further, the expansion of mental health-based restrictions may disproportionately criminalise tāngata whai ora (people with lived experience of mental distress) without improving public safety. Research

demonstrates that people with mental illness are far more likely to be victims of violence than perpetrators. Firearms legislation that increases surveillance and restrictions on this population without addressing actual risk factors does not align with evidence-based policy goals.

If accountability and vetting processes had been properly implemented, existing legislative frameworks could have prevented recent mass shooting events. The problem is not insufficient restrictions on people with mental illness - it is inadequate vetting for extremism, radicalisation, and ideologically motivated violence.

Section 9(1)(i) does not address any of these evidence-based risk factors. Instead, it expands restrictions on a population (people with mental illness) who are statistically more likely to experience violence than perpetrate it, while the Bill fails to adequately restrict access for the populations who have actually carried out mass shooting events in recent history.

WORKFORCE CAPACITY AND RESOURCING IMPLICATIONS

1. Firearms licensing is not solely a medical problem

While mental health may be one factor in firearms safety, effective assessment requires an understanding of contexts that extend far beyond clinical expertise:

- Community safety concerns often relate to patterns of behaviour - domestic violence, substance use in social contexts, conflicts with neighbours, mistreatment of animals – all that are better understood by those with community knowledge than by medical professionals in clinical settings
- Cultural practices and customary rights around firearms use require cultural expertise, not psychiatric assessment
- Food security and subsistence needs are practical realities understood by rural communities, kaitiaki, and whanau - not medical issues
- Youth development factors, including peer influences and maturity, are better assessed by youth workers and educators than by psychiatrists
- Domestic violence risk assessment is a specialised field distinct from psychiatric practice, requiring expertise in coercive control patterns and victim safety

For example: a person with a firearms licence who assaults their partner should trigger firearms removal based on demonstrated violence and victim safety - not on whether they meet clinical criteria for a mental health diagnosis. This is a community safety issue requiring domestic violence expertise, not a medical assessment.

Similarly, concerns about a young person’s firearms use are more appropriately assessed by those who know the youth in their community context - kaumatua, youth workers, whānau, teachers - than by a psychiatrist who sees them for a single clinical appointment.

SECTION 361: HEALTH PRACTITIONER REPORTING

1. Assessment without guidance

Section 361 requires health practitioners to "consider" notifying the regulator if they form an opinion that a firearms licence holder should not possess firearms due to their health condition. However, the Bill provides no guidance on:

- What assessment framework should be used

- What evidence threshold should inform reporting decisions
- How to balance individual rights with public safety considerations
- How to integrate cultural considerations into assessment

The requirement that health practitioners "must consider" notifying is operationally vague and legally problematic. It provides no clarity on what constitutes adequate consideration, what threshold should trigger reporting versus non-reporting, or what protections exist for either decision. The Bill is unclear whether “consideration" requires documentation, consultation with colleagues, or a formal risk assessment.

This vagueness will lead to defensive practice: practitioners will either over-report (to avoid liability if something goes wrong) or under-report (rationalising that they "considered" it but decided against it). Neither outcome serves public safety. The former overwhelms the regulator with reports that may not reflect genuine risk; the latter leaves concerning situations unreported. Both expose practitioners to legal vulnerability regardless of which decision they make.

The RANZCP PPG 23 provides this guidance for psychiatrists, but Section 361 applies to “medical practitioners, nurse practitioners, psychologists, and duly authorised officers”—many of whom will not have access to specialist psychiatric training or familiarity with firearms risk assessment frameworks.

Without clear regulatory guidance, reporting decisions will be inconsistent, potentially arbitrary, and vulnerable to implicit and unconscious bias.

2. Professional liability and therapeutic relationships

Section 361 places health practitioners in a difficult position. Reporting concerns may be necessary for public safety, but it can also damage therapeutic relationships and deter future help-seeking.

The Bill does not provide professional liability protections for practitioners who make good-faith reports. This creates legal uncertainty and may result in defensive practice—either over-reporting (to avoid liability if something goes wrong) or under-reporting (to preserve therapeutic relationships).

Clear statutory protections are necessary to enable practitioners to exercise clinical judgment without fear of personal liability, while maintaining appropriate accountability for decisions that fall outside reasonable professional standards.

3. Privacy and information sharing

Section 9(3) grants the regulator broad powers to "seek and receive any information that the chief executive considers relevant" and "consider information obtained from any source." This creates potential for extensive information gathering from health records, ACC claims, pharmacy records, and other sources.

The Bill does not specify:

- What consent requirements apply
- What limitations exist on information seeking
- How privacy rights are balanced against regulatory need

- What safeguards prevent misuse of sensitive health information

Clear parameters around information gathering are necessary to maintain trust in health systems and prevent unintended consequences, such as distrust or fear of seeking help.

TE TIRITI O WAITANGI OBLIGATIONS AND EQUITABLE OUTCOMES

RANZCP is committed to Te Tiriti o Waitangi and recognises that psychiatric practice has, at times, perpetuated inequitable outcomes for Māori. Research demonstrates that Māori are more likely to be diagnosed with severe mental illness, more likely to be subject to compulsory treatment, and less likely to receive equitable care.

The Waitangi Tribunal's WAI 2575 report on mental health services documented systemic failures to uphold Te Tiriti obligations and identified institutional racism within mental health systems. These findings are directly relevant to firearms licensing provisions that rely on mental health assessments.

Without explicit safeguards, Sections 9 and 361 risk replicating existing inequities. Mental health assessments for firearms licensing must:

- Incorporate cultural safety principles and be delivered in culturally appropriate ways
- Provide access to Māori health practitioners where requested
- Enable whānau participation in assessment processes where appropriate
- Include mechanisms for monitoring outcomes by ethnicity to identify and address disparities

The Bill should explicitly require the regulator to monitor demographic patterns in licensing decisions and implement corrective measures if inequitable outcomes are identified.

FOOD SECURITY AND ESSENTIAL USE CONSIDERATIONS

For many New Zealanders—particularly in rural and remote communities—firearms are essential tools for accessing food and demonstrating manaakitanga and kaitiakitanga. This includes Māori exercising customary rights, whānau and hāpū in areas with limited access to commercial food, and low-income households for whom hunting is a significant source of food.

Firearms license revocation can therefore have material impacts on food security and whānau wellbeing. Assessment processes under Sections 9 and 361 should require consideration of:

- Whether firearms are used for subsistence hunting, or supplying kai for marae for tangihanga or for kaumatua
- What alternative food sources are available and accessible
- Whether graduated interventions could address safety concerns while preserving food access

This is consistent with a graduated response framework where the least restrictive intervention that adequately addresses risk should be preferred.

GRADUATED RESPONSES AND PROPORTIONATE INTERVENTIONS

PPG 23 emphasises graduated responses as best practice in firearms risk management. Rather than defaulting to licence revocation, regulators should consider interventions such as:

- • Temporary licence suspension with defined review timeframes
- • Modified storage requirements
- • Ammunition restrictions
- • Third-party storage arrangements
- • Conditions limiting firearm types or uses

The Bill should explicitly establish graduated response frameworks as the default approach, with full confiscation reserved for circumstances where less restrictive measures are insufficient to address demonstrated risk.

This approach better balances public safety with individual rights, reduces perverse incentives that deter help-seeking, and maintains proportionality in regulatory responses.

DOMESTIC AND FAMILY VIOLENCE CONSIDERATIONS

Firearms play a significant role in domestic and family violence as tools of coercive control. The presence of firearms in households experiencing family violence substantially increases the risk of lethal violence, even when firearms are not directly threatened or used.

PPG 23 addresses domestic violence in Section 9.6, noting that firearms create an "environment of fear" that may be present even without explicit threats. The Bill should strengthen protections by:

- Establishing urgent confiscation protocols where domestic violence is identified
- Requiring coordination between the regulator and specialist family violence services
- Prioritising victim safety in all assessment and decision-making processes
- Ensuring that graduated response frameworks do not compromise victim safety

RECOMMENDATIONS

RANZCP recommends the following amendments to the Arms Bill:

1. Replace Section 9(1)(i) with evidence-based criteria

Replace the current wording with criteria based on demonstrated risk factors rather than the presence of symptoms:

- • History of violence, threats, or concerning behaviour toward self or others
- • Substance use patterns that impair judgment or increase impulsivity
- • Current engagement in behaviours that pose immediate safety concerns
- • Identified as high risk through validated risk assessment processes

If mental health criteria are retained, they should be limited to circumstances where a person is experiencing acute psychiatric crisis requiring immediate intervention and where there is documented concern about imminent risk of harm, with clear timeframes for review.

2. Establish assessment guidance and standards

The Bill should require the regulator to develop and publish assessment frameworks for use under Sections 9 and 361, developed in consultation with relevant medical colleges and Māori health experts. These frameworks should:

- Specify evidence-based risk factors
- Provide operational definitions for key terms
- Incorporate cultural safety principles
- Establish graduated response protocols
- Include consideration of food security and essential use factors

3. Mandate protections against discriminatory assessments

The Bill should require:

- Cultural competency training for all staff involved in mental health-related licensing decisions
- Access to Māori health practitioners and provision for whānau participation where appropriate
- Regular auditing of licensing decisions by ethnicity and other demographic factors
- Transparent reporting of outcomes and corrective action where inequities are identified

4. Provide professional liability protections

Amend Section 361 to provide statutory protection from civil or professional liability for health practitioners who make good-faith reports in accordance with professional standards and any guidance issued by the regulator.

5. Clarify privacy and information-sharing provisions

Amend Section 9(3) to specify limitations on information gathering, consent requirements, and safeguards for sensitive health information. The Bill should balance regulatory need with privacy rights and protection of therapeutic relationships.

6. Establish graduated response frameworks

The Bill should explicitly require graduated responses as the default approach, with less restrictive interventions preferred where they adequately address identified risks. Full confiscation should be reserved for circumstances of demonstrated high risk or where graduated measures have failed.

7. Strengthen domestic violence protections

Establish urgent confiscation protocols where domestic violence is identified, require coordination with specialist family violence services, and ensure victim safety is prioritised in all decision-making processes.

CONCLUSION

RANZCP supports the aims of the Arms Bill and is committed to contributing our expertise to effective firearms regulation. However, the current drafting of Sections 9 and 361 is inconsistent with evidence-based practice and risks creating perverse safety outcomes.

Mental illness alone is not a meaningful predictor of violence risk. Regulatory provisions based on the presence of symptoms will result in poor risk assessment, operational inconsistency, and significant deterrent effects on help-seeking behaviour—the opposite of effective public safety policy.

The amendments we recommend would align the Bill with international best practice, support evidence-based risk assessment, uphold Te Tiriti obligations, and enhance rather than undermine public safety.

We welcome the opportunity to discuss these recommendations with the Committee and to provide further technical advice as needed.

Nāku noa, nā

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Appendix A: RANZCP Professional Practice Guideline 23

RANZCP Professional Practice Guideline 23: Firearm Risk Assessments (September 2023) provides comprehensive guidance for psychiatrists undertaking firearms risk assessments.

The guideline is available at: https://www.ranzcp.org/getmedia/a560e32b-1832-4759-b871-3e765d31883d/PPG-23-Firearm-risk-assements.pdf