

## Resource Document on Mental Health Issues Pertaining to Restoring Access to Firearms

Approved by the Joint Reference Committee, February 2020

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Prepared by the Council on Psychiatry and Law

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### Introduction

Although the Second Amendment upholds the general right to bear arms in the United States, this is not an absolute right. Both federal and state laws disqualify individuals from possessing, purchasing, and transferring certain firearms. These disqualifying conditions (or "prohibitors") include felony convictions, domestic violence restraining orders, and adjudications pertaining to mental illness. As noted by Gold and Vanderpool,<sup>1</sup> the first federal laws disqualifying persons from firearm rights based on mental illness were passed in 1968, restricting transfer of specific firearms to anyone "adjudicated as a mental defective" or "committed to any mental institution."<sup>2</sup> Provisions for "relief from disability" (i.e., restoring firearm rights) were added in 1986 by the Firearms Owners Protection Act.<sup>3</sup> The Brady Act, passed in 1993, requires federally licensed firearms dealers to request background checks on any person attempting to purchase a firearm.<sup>4</sup> The Brady Act further established the National Instant Criminal Background Check System (NICS), intended to contain records of persons prohibited from receiving firearms under federal law. Prohibitive criteria include those who "[have] been adjudicated as a mental defective or committed to a mental institution."<sup>5</sup> The term "mental defective" is acknowledged by the Department of Justice as outdated.<sup>6</sup> The term is objectionable and stigmatizing but remains in federal statute. Amendments were proposed to use an alternative term of "mentally incompetent" but not passed.<sup>7</sup>

In 2007, the NICS Improvement Amendments Act (NIAA) was passed, in part to improve compliance with NICS. Included in NIAA were provisions establishing relief from mental health firearms disability.<sup>8</sup> NIAA authorized NICS Act Records Improvement Program (NARIP) grants for state infrastructure development or improvement for sending records to NICS, but to receive a NARIP grant, states were

required to maintain a relief-from-disabilities program that allowed for: (1) application for relief from disabilities under state law; (2) judicial appeal of an initial denial, and (3) removal of the person's name from the NICS database if relief were granted. As of December 31, 2018, there were over 5.6 million records reported under the mental health restriction, out of a total of 19.3 million records overall.<sup>10</sup> The available data regarding firearm usage and mental disorders, and potential impact of gun registries, was discussed in the APA's 2014 Resource Document on Access to Firearms by People with Mental Disorders,<sup>11</sup> and research and policy recommendations were set forth in the 2018 Position Statement on Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services.<sup>12</sup>

In addition to registries targeting classes of individuals as a means of restricting access to firearms for the statutorily defined list of prohibited people, a small but growing number of states have enacted risk-based gun removal laws, or gun violence restraining orders (GVROs), also called extreme risk protection orders (ERPOs). These laws, discussed at length in the 2018 Resource Document on Risk-Based Gun Removal Laws,<sup>13</sup> temporarily restrict access to firearms for persons deemed acutely dangerous to themselves or others, regardless of the reason. These laws allow individuals to initiate a temporary firearms removal based on dangerousness, not necessarily tied to a psychiatric diagnosis. As noted in the resource document, it can be a tool that can facilitate action by the clinician or others in the event that a patient presents a risk related to firearm possession. In accordance with these laws, firearms can be restricted immediately and then for a longer period after a court hearing, though the specific process varies by state. In those instances where states have initiated these laws allowing for removal of firearms, there is generally a provision for restoration of the ability to possess the firearm(s) that were removed. In addition to variations in GVROs and the relief provisions to allow restoration of firearm ownership rights, there may be other state-specific firearm restriction legislation. In New York, for example, additional mental health reporting requirements were instituted under the New York Secure Ammunition and Firearms Enforcement Act of 2013,<sup>14</sup> that can lead to firearm restrictions.

With the incentives offered to states to update their NICS database input, and with the growing number of GVRO laws being enacted, individuals with mental illness may encounter firearms restrictions more frequently. The American Psychiatric Association has previously elucidated its position on firearms access and mental illness in the updated position statement from 2018.<sup>12</sup> Nevertheless, with the evolving legal landscape, psychiatric input may be requested by individuals restricted by these various forms of legislation, or by government agencies administering registries or relief processes. Because the relevant statutes are often unclear as to what information should be offered by a psychiatrist, this resource document is intended to offer guidance to the general psychiatrist in this role. This resource document is not intended to take a position on firearm policy or the interpretation of the Second Amendment.

### **Important Considerations for General Psychiatrists**

General psychiatrists who are asked by patients to assess their fitness (i.e., suitability) for firearm possession may be uncertain about how to proceed. No one-size-fits-all rule applies to such requests, particularly as statutes vary. The assessment provided by a treating psychiatrist is typically one part of a review of an individual's application for relief, along with history and data collected from other sources

by the ultimate decision makers. The referral question and the associated federal or state statutes should be reviewed, and the psychiatrist may wish to consider the following factors before undertaking the task.

### ***Knowledge, Time, and Resource Limitations***

Although psychiatrists are familiar with assessing acute risk for suicide and violence, training and experience vary, and many have little experience with the particular task of assessing an individual's safety with a firearm. Some may feel that this task is beyond the scope of psychiatric expertise. Others may feel comfortable opining about patients they know well but wary of requests from new patients, particularly those who seek them out expressly for a firearm "clearance letter." Still others may feel comfortable assessing risk in the short-term (i.e., hours to days), but not for a lengthy or indefinite period of time.

In general, psychiatrists who feel unequipped or uncomfortable with assessing fitness to possess firearms should not perform such assessments. This resource document and other available forensic texts<sup>15,16</sup> can familiarize psychiatrists with assessing risk, and consultation with experts in one's local jurisdiction can also be useful. However, psychiatrists should not hesitate to tell a patient that assessing fitness to possess firearms is a highly specialized evaluation. If a psychiatrist does not feel they have the requisite knowledge and expertise, referral to a forensic psychiatrist with skills in this area is appropriate. Even experienced forensic psychiatrists might determine that they are not sufficiently knowledgeable to conduct these assessments, or they may simply determine that they do not feel that an opinion on the matter should be offered.

If the psychiatrist does agree to perform an evaluation of an individual's fitness to possess a firearm, it is also reasonable to place limits on the scope of the assessment. Patients should understand that no psychiatrist can certify that an individual is safe to possess a firearm under all circumstances for an unlimited time frame, nor do psychiatrists have particular expertise in assessing an individual's skill in safely operating a firearm. The psychiatrist should make clear that any opinion, if given, would be limited only to the impact of an individual's mental illness on violence and/or suicide risk and likely only in the near term. As such, the psychiatrist should acknowledge that the nature and level of risk may change in the future based on dynamic factors such as treatment adherence, psychosocial stressors and supports, and substance use, which may further limit the ability to give a broad opinion regarding firearm possession.

### ***Liability Considerations***

Evaluations about fitness to possess firearms are likely to raise questions about the psychiatrist's legal liability in the event that a patient misuses a firearm to cause harm to self or others. Alternatively, psychiatrists may fear a lawsuit in the event that they "deny a patient's Second Amendment rights" by opining that firearm possession would carry significant risk. Many psychiatrists may therefore decline to conduct firearm safety evaluations. Others may be open to the task, provided that they are appropriately shielded from liability for their opinions.

Unfortunately, laws prohibiting firearm possession based on dangerousness or mental health histories do not consistently address the procedural and evidentiary issues raised in restoration proceedings, including the possibility of psychiatrist liability in providing a clinical letter of support to restore the firearm. Currently, this is largely uncharted legal territory, and psychiatrists who perform assessments regarding fitness to possess a firearm do so without any explicit protection from civil suits. Therefore, clinicians who are concerned about their risk of liability should consider consultation with their malpractice carrier, hospital attorney, and/or other legal experts in the local jurisdiction prior to undertaking an evaluation.

### ***Performing Evaluations in a Polarized Context***

Guns are undoubtedly a politically, emotionally, and culturally charged subject, and psychiatrists themselves may hold personal opinions that could influence their clinical judgment in fitness to possess firearm evaluations. For example, some psychiatrists may feel that individuals with mental illness are unfairly stigmatized by laws restricting their access to firearms, particularly when the scientific evidence shows that only a small amount of gun violence is attributable to mental illness.<sup>11,17</sup> They may feel pressure to certify that individuals are safe to possess a firearm, both from the individual in question and from broader societal norms that hold gun rights as inalienable. Conversely, psychiatrists may feel that stricter gun controls are warranted in general, and such a belief could influence their objectivity when considering a particular individual's case.

Before undertaking an evaluation regarding fitness to possess firearms, psychiatrists should carefully consider their personal opinions about guns and decide whether they are able to perform an objective assessment. Consultation with a supervisor or trusted colleague can be helpful in this endeavor. If the psychiatrist decides to proceed with the evaluation, they should, of course, adhere to the main tenets of forensic psychiatry ethics: striving for objectivity, truth-telling, and respect for persons.<sup>18</sup>

### ***Impact on the Therapeutic Relationship***

When asked by a patient to perform an evaluation related firearm safety and fitness to possess a firearm, psychiatrists may consider the impact of such an assessment on the therapeutic relationship. In fact, forensic psychiatry texts have historically warned clinicians against wearing “two hats” with a patient—as both treater and evaluator in a legal context—in part because of the potential negative impact on the treatment relationship.<sup>19</sup> For example, if the psychiatrist opines that gun possession is unsafe for a patient, will the patient become angry and stop treatment? Or worse, will the patient threaten the psychiatrist and/or others with harm if unhappy with the outcome of the evaluation?

One could argue that these considerations are not unique to firearm safety evaluations; they also occur when psychiatrists are asked to opine, for example, about a patient's ability to work or the necessity of emotional support animals. These are not considered ethical breaches, and in fact, some administrative bodies (e.g., Social Security) give weight to the treating clinician's views as someone who knows the patient best. However, given how closely and strongly held an individual's beliefs about gun rights can be, firearm evaluations are particularly fraught with complexity. Psychiatrists should carefully consider at the outset the potential clinical impact of agreeing to perform an evaluation

regarding firearm possession rights for a patient. The setting of the evaluation may be relevant, depending on whether it occurs in an emergency room, during a brief inpatient hospitalization, in a long-term outpatient setting, or outside a clinical setting altogether. A frank discussion with the patient prior to the evaluation can be helpful. For example, the psychiatrist can explore how the patient would feel and react if permission for firearm possession were denied, and the patient can be invited to consider the pros and cons of having a treater (vs. an independent evaluator) perform the assessment. Payment for the evaluation could be another source of potential problematic bias, and it would be important for the evaluating psychiatrist to be aware how financial incentives may impact impartiality. Involving the patient in such a discussion, as well as carefully documenting this interaction, may be useful in mitigating the negative therapeutic impact of a firearm risk assessment.

### ***Consultation with and Referral to Subspecialists***

Because of the complex clinical and legal factors outlined above, many general psychiatrists might prefer to refer the patient to another psychiatrist, such as a forensic psychiatrist, or even to another clinician with expertise in firearm safety assessment, rather than performing the evaluation themselves. Psychiatrists should not hesitate to choose this path if necessary. However, in some practice settings, general psychiatrists may not have ready access to an appropriate referral. In addition, patients may not be able to afford the fees associated with such an evaluation, which is likely not covered by health insurance. In these cases, informal consultation with an attorney or psychiatrist with relevant experience may be helpful. However, if psychiatrists decide to undertake firearm safety evaluations, the following section of this document can help guide the assessment.

### **Assessments of Individual's Suitability to Possess a Firearm**

As discussed earlier, psychiatrists vary in training and experience with suicide and violence risk assessment, and especially with firearm safety considerations. Psychiatrists should only offer assessments to the extent they have a reasonable basis to believe that they are qualified. In some instances, when the patient lies at one of the extremes of the risk spectrum, the level of risk may be more obvious. Most patients, however, will likely fall somewhere in between the extreme high and low ends of the risk spectrum. In these cases, two possible approaches to assessment can be identified. One approach is to provide only a limited statement that indicates: (1) what the patient is currently in treatment for and (2) whether the symptoms are stable. No risk prediction or risk analysis is offered in this approach.

Another approach is to provide a more expanded and focused evaluation of the person's mental state and its relationship to the risk of firearms misuse both with regard to violence towards others and suicide. When undertaking such an assessment, psychiatrists should take into account a patient's or evaluatee's environment, as well as the personal, interpersonal, and social meaning of their illness and, if the individual had their prior firearm removed (e.g., due to an involuntary commitment or under a GVRO) and is now seeking restoration, the psychiatrist should explore the issues that led to the firearm removal. The psychiatrist should be able to compile a thorough longitudinal history of the patient's symptoms of mental illness, participation in and response to treatment, patterns of substance use, and

violent or self-injurious behavior. Evidence of equivocal motivation for continued engagement in treatment or likelihood of relapse is an important consideration. Relevant records should be obtained and reviewed; if not, the assessment should indicate how available information was limited, e.g., restricted to patient report and current presentation.

When writing a report grounded in this more expanded approach, the event(s) leading to loss of gun rights should be acknowledged. For example, if the individual became disqualified from firearm possession due to an involuntary commitment, the circumstances leading to commitment would be described, including symptoms of mental illness present at that time. If the individual had their guns removed under a GVRO when they were in crisis, the circumstances of that crisis would be explained. The following areas should then be described:

- (1) Nature of the relationship between the psychiatrist-evaluator and the individual;
- (2) Nature and the extent of the assessment and review of any written documents to help provide context to the assessment;
- (3) Whether the evaluatee has a mental illness or intellectual or developmental disability;
- (4) Whether there is a history of alcohol or substance use disorder, and if so, and explanation of the relationship between alcohol or substance use and the evaluatee's history of violence toward others and history of suicides;
- (5) Whether the individual is currently in treatment, including substance use treatment, or receiving mental health services or other supports;
- (6) If in treatment, the pattern of adherence to treatment recommendations;
- (7) Current symptoms;
- (8) Stability, and need for ongoing treatment to maintain stability;
- (9) Explanation of relationship of current presentation to the context of the event leading to loss of gun rights;
- (10) Risk factors for future self-harm or harm to others, and, if possible, a general estimate of the risk category into which the person falls compared with the general population given present circumstances (i.e., lower, higher or average risk).

Should a recommendation regarding access to firearms be made, particularly if in support of restoring access to firearms, the limitations of such a recommendation should be clearly articulated. It should be understood that risk assessment is not the same as prediction. Risk assessment seeks to identify relevant risk factors and mitigators, and then determine an estimate of risk category. Given the nature of risk assessment, some individuals considered low risk for violence may eventually commit violent acts, while some individuals considered high risk never do so, and the same is true related to suicide risk. In addition, risk level is not static; it changes as circumstances change. For example, should the evaluatee end treatment, symptoms recur, substance use relapse occurs, or an adverse life event is experienced, risk level might increase. Risk assessment is most accurate in the short term, but restoration of access to firearms, once granted, is not time limited and potentially occurs without the benefit of an ongoing treatment relationship that might provide opportunities to clinically intervene should risk level change. As a result of these limitations, if an opinion regarding risk of firearm possession is to be offered, it may be preferable to offer only a clearly delineated opinion about

whether the individual's present mental state confers additional current risk of firearm possession, with the stated caveat that risk level changes as life circumstances change.

Caution should be taken in opining on long-term risk, recognizing that the level of risk is likely to fluctuate over time as circumstances change. As discussed earlier, should an evaluator have any reservations about speaking to the presence or absence of risk as related to firearms access, they should not attempt to provide a risk assessment. Ultimately, the goal is to provide factual information about mental health treatment and the person's mental health status to inform the administrative or judicial body charged with making the final decision about whether to restore firearms rights to the individual. In doing so the psychiatrist provides meaningful clinical information, without engaging in long-term risk prediction or assessing more than the psychiatrist feels qualified to provide.

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