Psychiatric Evidence and Due Process in Firearms Rights Restoration

Liza H. Gold, MD, and Donna Vanderpool, MBA, JD

In the preceding article, we reviewed the current state of federal and state regulation of restoration of firearms rights, termed "relief from disability (RFD)," for those who have had those rights suspended due to mental health prohibitors. This review demonstrated that these laws vary widely and at times create situations in which firearms rights may be effectively banned indefinitely. In this article, we review due process and psychiatric evidentiary requirements in RFD hearings. The legal procedures and evidentiary standards in RFD judicial or administrative hearings also vary widely and typically do not include a current psychiatric violence or suicide risk assessment. The psychiatric and policy implications of RFD practices are also discussed in regard to mental health firearm prohibitors, restoration of gun rights, and implications for future policy regarding firearms regulations affecting those with serious mental illness.

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Restriction of firearms rights by reason of mental health prohibitors is legally referred to as a "disability;" programs that restore firearms rights are styled "relief from disability" (RFD) programs. Individuals who have had their right to possess firearms suspended for mental health reasons also have a right to have those firearms rights restored (see, e.g., *Tyler*).[1] However, the legal process of restoring gun rights that have been suspended due to mental health prohibition is not straightforward and depends on whether the legal disability was imposed by state or federal law, whether a state has a restoration or RFD program, and whether that program has been federally certified by the Bureau of Alcohol, Tobacco, Firearms, and Explosives.[2]

Moreover, relief statutes only rarely require mental health evaluations as evidence in the restoration process, which casts doubt on both the intent of the restrictions and the justification for removing them. We review current practices in RFD hearings, the psychiatric or medical evidence required (or more often not required), and the policy and evidentiary concerns that these factors raise.

Dr. Gold is Clinical Professor of Psychiatry, Georgetown University School of Medicine, Arlington, VA. Ms. Vanderpool is Vice President for Risk Management, Professional Risk Management Services, Inc., Arlington, VA. Address correspondence to: Liza H. Gold, MD, Georgetown University School of Medicine 2501 N. Glebe Road, Suite 204, Arlington, VA 22207. E-mail: lhgoldmd@gmail.com.

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Mental Illness, Firearms Regulation, and RFD Programs

The federal Gun Control Act (1968)[3] made it a crime for federally licensed firearms dealers to transfer firearms to anyone who had been "adjudicated as a mental defective or has been admitted to any mental institution."[4] This category includes individuals who have been involuntarily committed to a psychiatric institution and those found incompetent to stand trial or not guilty by reason of mental disease or defect.[5,6] State statutes may define mental health prohibitors more broadly. Although the federal government's definition does not include outpatient commitment, Florida,[7] Missouri,[8] Nevada,[9] and Virginia[10] include outpatient commitment in their statutory prohibitions.

In 1993, Congress passed legislation that created the National Instant Criminal Background Check System (NICS).[11] NICS is comprise of three databases to which federal agencies are required to submit, and states voluntarily submit, information about individuals who should be denied firearms ownership, including those with mental health prohibitors.[12] The 2007 NICS Improvement Amendment Act (NIAA)[13] required the establishment of federal programs for relief and provided grants that incentivized states to develop RFD programs.

Under the NIAA, state and federal authorities conducting RFD proceedings must receive evidence and consider the following:

> the circumstances regarding the firearms disabilities;
>
> the applicant's record, which must include, at a minimum, the applicant's mental health and criminal history records; and
>
> the applicant's reputation, developed, at a minimum, through character witness statements, testimony, and other character evidence.

In granting relief, the following findings must be made:

> The applicant will not be likely to act in a manner dangerous to public safety, and
>
> granting the relief will not be contrary to the public interest.[14]

Mental Health Evidence for RFD Hearings

The need for a current and preferably independent mental health evaluation, including risk assessment of danger to self or others, seems self-evident in an administrative or court proceeding to determine whether gun rights should be restored to an individual whose gun rights have been suspended because of a mental health prohibition. Nevertheless, applications for federal relief from federal agencies do not require a mental health assessment.[15] Similarly, most states that conduct RFD hearings do not require current mental health evaluations and even fewer specify the need for a violence or suicide risk assessment or an independent mental health assessment.

Almost all states with RFD statutes require that a court or administrative agency review "medical records." However, most state statutes only vaguely indicate the type of medical records required. Only a few states such as Oregon[16] and New York[17] specify in detail the medical records that should be reviewed. Some states also require evidence of "change in condition" or "medical certification," although these states do not define these terms or specify the necessary elements of such evidence or certification. When medical certification is required, statutes rarely indicate what kind of medical professional is required to provide it.

Regardless, a review of records cannot substitute for a clinically informed risk evaluation. Of the 44 states with RFD programs, only 15 have statutes that require mental health evidence beyond the applicant's medical records and "evidence of change in condition"; of these, only 11 are federally certified (Table 1). Among the 15 states, specifications for evaluations and documentation vary considerably in regard to the required qualifications of the professional providing the evidence, the time frame within which the documentation or assessment must be provided relative to filing the petition for relief, and the points to be addressed. Of course, a court always has the discretion to order an independent psychiatric evaluation, even if one is not required as a matter of law or if petitioners provide their own evaluations.

What Happens on the Ground

Although an increasing number of people under federal and state mental health–based firearms restrictions are filing petitions for restoration of gun rights,[18] many states' RFD programs are so new that courts or administrative agencies are just beginning to hear these cases on a regular basis. Therefore, little information is available regarding how RFD hearings are conducted, how often courts request or order psychiatric evaluations, whether and how mental health evidence affects the outcomes of the hearings, and how a mental health RFD evaluation might be structured.

Some recommendations regarding RFD hearings and mental health evidence have been offered. The American Psychiatric Association (APA) has stated that the process for restoring an individual's right to purchase or possess a firearm after a disqualification relating to mental disorder should be based on adequate clinical assessment.[19] Psychiatric evaluations and testimony should be required when persons seek restoration of their firearm-related rights because psychiatrists can describe and interpret the individual's mental health history and current mental health status, and the effects of treatment and other factors on improvement or exacerbation of the person's condition.[20] The APA also indicated that an administrative or judicial body "that can weigh the right to bear arms against the considerations of public safety in making restoration determinations" should make the ultimate decision regarding restoration of firearms rights.[20]

The Consortium for Risk-Based Firearm Policy, a multidisciplinary group of legal, medical, mental

Table 1 States With Statutory Mental Health Evidence Requirements (Other Than Mental Health Records)

State and Statute	FA*	Risk Assessment[†] Specifically Required	Type of Professional Specified	Evidence Specifications	Time Limits
Delaware DE ST 11 §1448A	Yes	Yes	Medical doctor or psychiatrist licensed in DE	Certificate that person no longer has a mental disorder that "interferes with or handicaps the person from handling deadly weapons" AND Board has authority to require petitioner "undergo a clinical evaluation and risk assessment."	No
Georgia GA ST §16–11-129	No	Yes: danger to others No: danger to self	Superintendent of any mental hospital or treatment center	Optional Court may require any such person to sign a waiver authorizing the superintendent of any mental hospital or treatment center to make to the judge a recommendation regarding whether such person is a threat to the safety of others.	No
Hawaii HI ST §134–6.5	Yes	No	No	Medical documentation that petitioner is no longer adversely affected by condition that resulted in adjudication or commitment and is not likely to act in a manner dangerous to public safety.	No
Indiana IN ST §33–23-15–2	Yes	No	Psychiatrist or psychologist licensed in IN	Recent mental health evaluation.	No
Maine ME ST 15 §393	No	No	Independent psychologist or psychiatrist licensed in ME	Report specifically stating that circumstances that led to involuntary commitment have changed, that applicant is not likely to act in a manner dangerous to public safety, and that granting relief will not be contrary to the public interest. Note: State maintains list of providers willing to conduct evaluations.	No

Table 1 Continued

State and Statute	FA*	Risk Assessment† Specifically Required	Type of Professional Specified	Evidence Specifications	Time Limits
Maryland MD ST Pub Saf §5–133.3	Yes	Yes	Board certified in psychiatry or psychology	Form stating: 1) length of time applicant has not had symptoms that cause applicant to be a danger to the applicant or others; 2) length of time that applicant has been compliant with mental illness treatment plan; 3) opinion as to whether applicant, because of mental illness, would be a danger to self if allowed to possess a firearm and reasons for the opinion; and 4) opinion as to whether applicant, because of mental illness, would be a danger to others or poses risk to public safety if allowed to possess a firearm. Note: State law provides immunity for professional in providing opinion/certification.	Form must be completed within 30 days of submission of application
Massachusetts MA ST 123 §36C	Yes	No	Licensed physician or clinical psychologist	Optional: Court may consider evidence that person no longer has the disease or condition that caused the disability or that disease or condition has been successfully treated for a period of 3 consecutive years.	No
Minnesota MN ST §624.713	No	No	Licensed medical doctor or clinical psychologist	Optional: Court may consider evidence that person no longer has the disease or condition that caused the disability or that disease or condition has been successfully treated for a period of 3 consecutive years.	No

Table 1 Continued

State and Statute	FA*	Risk Assessment† Specifically Required	Type of Professional Specified	Evidence Specifications	Time Limits
New York NY ST Ment.Hyg. §7.09 NY ADC 14 NYCRR 543.5	Yes	Yes	Qualified psychiatrist, defined as board certified or board eligible	Optional: Applicant may provide an evaluation, which should include opinion, and basis for opinion, as to whether applicant's record and reputation are such that "applicant will or will not be likely to act in a manner dangerous to public safety" and whether granting relief "would be contrary to public interest" AND "the Office reserves the right to request that the applicant undergo a clinical evaluation and risk assessment."	Psychiatric evaluation performed no earlier than 90 days before filing application
Oklahoma 21 OK ST §1290.27	Yes	No	No	Psychological or psychiatric evidence whether petitioner is a danger to self or others.	No
Oregon OR ST §166.274 OR ADC §859–300-0050	Yes	Yes	1. Licensed psychiatrist or psychologist, but not petitioner's current or previous provider 2. Optional: Letter from current mental health practitioner	1. An independent forensic mental health assessment which shall include, at a minimum, an opinion and a basis for that opinion, of petitioner's interpersonal violence and risk of self-harm. 2. Optional: Records may also include letter from petitioner's current treating mental health practitioner, if any. Letter may contain the petitioner's current medical health diagnosis, list of currently prescribed psychiatric medicines and dosage, history of compliance with medication, and any other information practitioner deems relevant to petitioner possessing a firearm.	Must be performed no more than 90 days before submission of petition

Table 1 Continued

State and Statute	FA*	Risk Assessment† Specifically Required	Type of Professional Specified	Evidence Specifications	Time Limits
Rhode Island RI ST § 11–47-63	No	Yes	Medical doctor or psychiatrist licensed in RI	Certificate that person no longer has a mental disorder "which interferes or handicaps the person from handling deadly weapons" AND "Board shall have the authority to require that the petitioner undergo a clinical evaluation and risk assessment."	No
South Carolina SC ST §23–31-1030	Yes	Yes	"Department of Mental Health" or "physician licensed in SC specializing in mental health"	Current evaluation [documented on form] presented by petitioner specifically addressing whether, due to mental defectiveness or mental illness, petitioner poses a threat to self or the safety of the public.	No
Utah UT ST §76–10-532	Yes	No	Licensed psychiatrist	Mental health evaluation to include statement regarding: 1) nature of commitment, finding, or adjudication that resulted in restriction on petitioner's ability to purchase or possess a dangerous weapon; 2) petitioner's previous and current mental health treatment; 3) petitioner's previous violent behavior, if any; 4) petitioner's current mental health medications and medication management; 5) length of time petitioner has been stable; 6) external factors that may influence petitioner's stability; 7) ability of petitioner to maintain stability with or without medication; and 8) whether the petitioner is dangerous to public safety.	Evaluation within 30 days prior to filing petition

Table 1 Continued

State and Statute	FA*	Risk Assessment† Specifically Required	Type of Professional Specified	Evidence Specifications	Time Limits
West Virginia WV ST §61–7A-5	Yes	No	Licensed psychologist or psychiatrist	Certificate of mental health examination that supports that petitioner is competent and not likely to act in a manner dangerous to public safety.	Mental health examination within 30 days prior to filing

* Federally approved.
† Defined as dangerous to self or others.

health, and public health professionals, has proposed detailed model language for restoration statutes. These include recommendations for mental health RFD evaluations as a necessary part of the evidence to be considered in RFD hearings.[21,22] In addition to a review of records, they call for "an opinion of a psychiatrist or licensed clinical psychologist with a doctoral degree who has personally evaluated the petitioner" to accompany any petition for restoration. This mental health professional should be able to attest that the individual:

> is no longer symptomatic in regard to the disorder that led to the involuntary commitment;
>
> has complied with and intends to continue to comply with treatment;
>
> will adhere to treatment, if ongoing treatment is necessary, and is likely to minimize risk of relapse "so as to present a danger to self or others in the foreseeable future" (Ref. 21 p 11; Ref. 22, p 13).

Similar to the APA, the Consortium recommends that a court or other governing authority make the ultimate determination regarding restoration, based on the preponderance of all the evidence, including the mental health evidence.

A literature search identified only five peer-reviewed psychiatric publications that discuss specific statutes or procedures relating to RFD hearings and evaluations: three from Los Angeles County,[23–25] one from New York State,[26] and one from Oregon.[27] One legal article included some discussion of Virginia's RFD process.[28] Beyond these, only one relevant news media investigative report regarding RFD practices was identified.[18]

Los Angeles County, California

Simpson and Sharma[25] provide the only systematic review of the use of mental health evidence in RFD hearings and the outcomes of the hearings. California's RFD statute does not require a mental health evaluation. However, the Los Angeles County Superior Court, which hears all county resident RFD petitions, made an informal decision to have every petitioner evaluated by a forensic psychiatrist. Simpson[24] reported that of an average of six restoration petitions filed in this court each month, a judge heard and ruled upon roughly half. Of these, about 80 percent were granted. The assistant district attorney in the department could choose to oppose the

petition, and in many cases, testimony was heard, including that of the forensic psychiatrist.

The forensic psychiatrists conducting the RFD evaluations addressed the specific question under California law of whether the petitioner would be able to use firearms in a safe and lawful manner. The evaluating psychiatrists interpreted this language to include the risk of suicide and homicide and additional potential risks regarding unintentional injury. The psychiatric evaluation consisted of a review of records from the involuntary commitment precipitating the state firearms prohibition, an evaluation of the petitioner using unaided clinical judgment in the determination of risk, and, if deemed necessary, contact with collateral sources, such as family members or current treatment providers. If doubt remained about the level of risk after the clinical interview, the examiners recommended denial of the petition, unless contact with collateral sources allowed examiners to conclude that the risk was low.

In their study, Simpson and Sharma[25] reviewed Los Angeles County Superior Court RFD petitions filed or adjudicated primarily between 2005 and 2006. Of the 159 petitions identified, only 57 contained the sufficient demographic information and involved individuals who had been psychiatrically hospitalized.

Of these, only 41 cases were heard (14 petitions were withdrawn before a formal ruling had been made). Of the cases heard, the judge ruled in accordance with the recommendation of the evaluating psychiatrist in 40 of the 41.[25]

Simpson and Sharma[25] also examined the demographic and psychiatric features of the RFD petitions in regard to the outcome. Of the 57 cases identified, they found no demographic factors significantly associated with petition outcomes. The only psychiatric factor significantly correlated with examiner recommendation for nonrestoration was involuntary psychiatric detention beyond a 72-hour hold. Simpson also reported that 15 percent of the petitioners in the study worked in law enforcement or security and petitioned in an attempt to regain their former employment. All of these petitions were granted, compared with a 77 percent rate for petitioners not employed in these occupations. Simpson concluded that "employment concerns can be a significant factor" in the outcome of RFD hearings (Ref. 23, p 336).

New York

New York uses an administrative process for consideration of relief petitions. New York's Office of Mental Health (OMH) relief process does not require that evidence considered include independent psychiatric examinations. Applicants have the option of providing a psychiatric evaluation performed no earlier than 90 days before the date of the relief request by a licensed, board-certified or board-eligible psychiatrist. Regardless of whether the applicant submits a psychiatric evaluation, OMH is allowed to request that applicants undergo a clinical evaluation and risk assessment with an OMH selected examiner.

Fisher *et al.*[26] reported that after the initiation of the RFD program, OMH recruited forensic psychiatry fellowship training programs to provide clinical evaluations and risk assessments. These authors described the practice at one forensic fellowship program. They noted that practices may vary at other New York programs, but indicated they believed that the methods they described are typical of other New York state academic forensic programs.

Fisher *et al.* described using a structured professional judgment approach to risk assessment. The evaluation includes record review, a psychiatric interview, and clinical judgment supplemented with a structured clinical assessment tool. Psychiatric evaluators prepare a report, including an opinion required by regulations, as to whether the applicant's "record and reputation are such that the applicant will or will not be likely to act in a manner dangerous to public safety and whether or not the granting of relief would be contrary to public interest" (Ref. 26, p 343).

A committee of three individuals appointed by OMH, including a senior forensic psychiatrist, an attorney from the Attorney General's office, and a patient advocate, reviews the psychiatrist's report and other evidence presented and makes the determination as to whether to grant the petition. Fisher *et al.* stated that the committee will take into account the forensic psychiatric clinical risk assessment but is not bound by the psychiatric opinions.[26] Denied petitions may be reviewed *de novo* in civil court; however, no data are available regarding how often the decision to grant relief concurs with the psychiatric opinions or how often those denied relief take their petitions to civil court.

Oregon

Oregon uses a preexisting administrative agency, the Psychiatric Security Review Board (PSRB), to conduct the state's firearms restoration hearings. The PSRB is an independent state agency established in 1977 with five appointed and statutorily defined board members: an attorney, a psychiatrist, a psychologist, an individual familiar with probation and parole, and a lay citizen.[29] The PSRB was created to supervise and manage treatment of Oregon's insanity acquittees. The PSRB's board members' mental health expertise, their familiarity with conducting contested cases, and its record in public safety led the Oregon State Legislature to designate the PSRB as the state's mental health gun relief authority. The PSRB began hearing RFD petitions in 2010.[27]

Oregon's current process includes notification of the district attorney and law enforcement agencies in the county where the petitioner resides and in which the mental health determination was made, the Oregon Health Authority, and known victims, if any. Both the district attorney and the Oregon Health Authority may be parties to the hearing, which is open to the public, and both written and oral testimony is received. Should a petition be denied, Oregon statutes allow for judicial review of the denial.

Oregon's RFD program has some of the most specific and stringent evidentiary requirements of any state. Most notably, Oregon requires that an independent forensic psychiatric assessment be performed by a nontreating, licensed psychiatrist or psychologist, no more than 90 days before the submission of the petition for relief. This assessment must include an opinion, and a basis for this opinion, of the petitioner's risk of interpersonal violence and self-harm. In addition to a review of the records, the assessment includes a clinical interview, psychological test results, diagnostic impressions, and a conclusion regarding the petitioner's risk to public safety if firearms privileges are restored.[27]

The Oregon PSRB has received about 20 requests for relief applications since 2011, but received only 11 petitions. Two petitions were incomplete and so were not heard. The board has conducted only 10 relief hearings through June 2017 (Britton J, personal communication, June 2017). All petitioners had been prohibited because of a history of involuntary commitment. The hearings resulted in one continuation, which was reheard, and thus approval for 10 petitions granting relief; one petition was denied. In the three hearings held before 2014, petitioners testified on their own behalf, "answered questions from the board, called several good character witnesses, and submitted letters of support and evidence of employment and other accomplishments to support their petition for relief" (Ref. 27, p 328).

Virginia

Virginia's federally certified RFD program, like those in many states,[18] specifies only that "treatment records" be considered in coming to the findings that the petitioner "will not be likely to act in a manner dangerous to public safety" and that "the granting of the relief would not be contrary to the public interest."[10] Individuals in Virginia with a history of involuntary commitment seeking to have their firearms rights restored must file a petition with the general district court in their jurisdiction of residence. The Commonwealth's Attorney is given a copy of the petition, and a hearing is scheduled if requested by either party. A Virginia attorney describing the RFD process stated, "The applicant will have a full opportunity to explain to a neutral decision-maker all the circumstances underlying the commitment and the strides made since that time; the court will then have the opportunity to consider other evidence and testimony as appropriate" (Ref. 28, p 358), and will then make a determination.

This attorney concluded, "Virginia's firearm rights restoration proceeding affords adequate procedural safeguards to keep at-risk individuals from lawfully possessing firearms in Virginia . . ." (Ref. 28, p 357–8). However, the investigative report described Virginia's RFD hearings as "often relatively brief, sometimes perfunctory" and stated, "In case after case . . . judges made decisions without important information about an applicant's mental health."[18]

Virginia, like most states, does not collect statistics on the number of RFD petitions filed or their outcomes. The investigation found that in 2009, 21 people had their firearms rights restored. In 2010, judges considered approximately 40 restoration applications and restored firearms rights to 25 petitioners. Of denied applications, "many were turned down for technical reasons, like filing in the wrong jurisdiction or failing to show up for a hearing."[18] The article cited only one case in which a judge ruled against a petitioner because he failed to provide documentation from a mental health provider.

The investigators concluded that in Virginia, "Doctors' declarations clearly influenced judges."[18] However, although some Virginia judges insisted on seeing a doctor's note, others did not. One successful petitioner, who reported his hearing lasted about five minutes, had brought a note from his psychiatrist, but told investigators, "The judge did not even ask to see it."[18] When medical evidence was reviewed, documentation usually consisted of a short note from a treating general practitioner at the request of the petitioner. None of the Virginia physicians who wrote letters on behalf of their patients, when contacted, reported conducting a risk assessment of the patient.

Discussion

The current status of RFD statutes and procedures presents a confused and contradictory set of mental health and legal difficulties. First, the mental health prohibitors that bar individuals who have been involuntarily committed, found incompetent to stand trial, or found not guilty by reason of insanity from access to firearms are based on an assumption that these adjudications bear some relationship to an increased risk of firearms violence. Despite the popular misconception that individuals with serious mental illness are dangerous, most are not violent. The current mental health firearms prohibitors reflect and reinforce stereotypical assumptions about mental illness and violence.[30,31]

Only 3 to 5 percent of all violent incidents in the United States are attributable to serious mental illness,[32] and only a small fraction of all violent incidents involving those with serious mental illness also involve firearms.[33,34] Most individuals who pose a danger to others by virtue of possession of firearms do not have a history of mental illness and are not captured by the mental health prohibitors. Steadman and colleagues[35] found that only 8 to 10 percent of individuals with evidence of psychopathology and impulsive angry behavior and who carried firearms have been psychiatrically hospitalized, and only a small fraction of those were involuntarily hospitalized.

Because the mental health prohibitors are not evidence based, they are ineffective in decreasing firearms morbidity and mortality, regardless of whether considering increased risk to others or increased risk of suicide. Adjudicated mental health records constitute the second largest category, about 30 percent, of all records in the NICS database.[36] Nevertheless, between November 1998 and June 2017, mental health prohibitors accounted for only 0.18 percent of all federal denials of firearms purchases.[37] The most significant association between mental illness and firearms is suicide; ~50 percent of all suicides in the United States are committed with firearms.[38,39]

Second, assuming that the mental health prohibitors represent effective policy interventions that decrease gun violence, logic dictates that the legal restoration process should include a mental health evaluation that assesses a petitioner's current mental status and risk of danger to self and others. Maine requires the report of an independent psychologist or psychiatrist,[40] and Oregon specifies that an applicant must have an independent forensic mental health assessment.[16] Otherwise, only 6 of the 15 states that require more than the provision of medical records explicitly require a mental health evaluation. The same number of states also have statutes that incorporate an explicit reference to a risk assessment, defined for purposes of this discussion as a mental health assessment of level of risk of danger to self or others. Of these six, only Maryland,[41] Oregon,[16] and South Carolina[42] specify evaluation of risk of harm to self, the statistically most likely risk associated with a history of mental illness and access to a firearm.[43,44]

Third, even if all the states and the federal government were to incorporate a requirement for a forensic mental health evaluation as part of the evidence needed to restore firearms rights, no standards for a relief for firearms disability examination (i.e., a competency to possess firearms examination), are available. In 1968, Rotenberg and Sadoff wrote, "competence to possess firearms. . .is an uncharted area in which much research needs to be done" (Ref. 45, p 842–3). Despite the passage of 50 years and the staggering toll of gun violence, specific data regarding the factors necessary to conclude that individuals with a history of involuntary commitment do or do not pose a danger to the public, or more likely to themselves, if access to firearms is restored or denied, are not available. Informative outcome data relative to RFD hearings are also not available.

To date, the only specific models for a standardized RFD evaluation have been proposed by the authors[46] and Pirelli *et al.*[47] These reflect that, absent hard data, general principles of psychiatric risk assessment need to be adapted, as far as possible, to the specific legal and clinical circumstances associated with firearms competency.[48,49] Such adaptations impose additional complexities, because the data under-

lying risk assessment methodology are based on specific clinical and forensic populations and on repeated evaluations of level of risk over time.[48] Conclusions in RFD evaluations would therefore be extrapolated from risk assessment data that may have varying degrees of relevance to RFD populations in general and, in any single case, specifically.

Fourth, assuming that courts and administrative agencies accept the logic of including current mental health risk assessments as a standard element of the evidence considered in RFD hearings, such assessments should be provided by appropriately trained mental health professionals. Finding such professionals presents significant challenges. Most administrative agencies and courts are not likely to have the option of accessing a postgraduate forensic psychiatric training programs, as in New York[26] or a preexisting board that already included forensically trained clinicians, as does Oregon's PSRB.[27]

In addition, many psychiatrists and psychologists receive little or no formal training in violence risk assessment, particularly in civil contexts.[50–52] Many physicians are unsure of how to assess a patient for certification for carrying firearms or are uncomfortable doing so, despite legislation in some states that requires physician certification.[53–55] Pierson *et al*. found, "physicians' beliefs about their capability to assess the physical competence of patients to carry concealed weapons were not significantly related to their actual signing of those permits" (Ref. 55, p 2453).

In the absence of training or comprehensive standards, "physicians may choose whether to sign off on such permits guided as much by their own views about gun ownership as by any standard" (Ref. 55, p 2252), a view echoed by Candilis *et al.*[56] Goldstein *et al.*[54] found that the only consistent predictor for a physician's beliefs regarding competency to carry a concealed weapon was if the physician was male and personally owned a gun.[54]

Finally, the involvement of physicians and mental health professionals inevitably raises considerations of liability for a "competency to bear firearms" evaluation. As Appelbaum observed, "Although the involvement of mental health professionals in these evaluations may be helpful to the ultimate decision-makers, clinicians have understandable concerns about the risk of liability, adverse publicity, and sanctions should their decisions turn out to be wrong" (Ref. 57, p 5). Regardless of medical specialty, there are no physician training programs or standards for the assessment of competency to carry firearms.[58,59] To date, only Maryland provides immunity for professionals providing RFD opinions.

Conclusion

The lack of specificity in RFD standards and the lack of guidance in how to fulfill them have resulted in widely differing evidentiary requirements in demonstrating a petitioner's current state of mental health beyond provision of medical records. Current RFD statutes reflect and embody the contradictory policies that characterize both our ineffective regulation of firearms and the stigma of violence associated with mental illness. An equitable RFD process should be based on development of "workable models of judicial authority informed by clinical expertise" (Ref. 60, p 1234). Research is needed to support and inform policy regarding mental health prohibitors, restoration of firearms rights, and the development of clinical training to assist mental health professionals who are called upon to provide firearms competency evaluations.

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