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Please cite this publication as follows:

Bryant, R. (2019) Commentary - guns and psychiatry: what psychiatrists need to know. BJPsych Advances. ISSN 2056-4678 (Print), 2056-4686 (Online). (In Press)

Link to official URL (if available):

<https://www.cambridge.org/core/journals/bjpsych-advances>

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## Commentary

In this issue, Professor Ann Mortimer examines 'guns and psychiatry' and focuses on what psychiatrists need to know. The article provides a clear exposition of the background to gun control in the UK and the licencing processes employed by police forces. Professor Mortimer makes some important points concerning the complexities around firearms licencing, for example in terms of the omission of certain cognitive disorders from the Home Office list of medical conditions.

To grant or deny a member of the public the right to own and use a firearm is one of the most onerous decisions that the police are required to make: it falls squarely within the realm of a 'wicked problem'. The Home Office provides guidance to police forces on how to implement statute and the College of Policing also advises on the risk factors to be considered: these include the medical and mental health of the applicant (College of Policing, 2016). Although the police carry out their licencing duties effectively, mistakes can and do happen, as illustrated at a recent inquest into the deaths of Christine and Lucy Lee in 2014 (killed by an individual using legally held shotguns returned to him by local police). There have also been highly critical national reports on firearms licencing with Her Majesty's Inspectorate of Constabulary concluding in 2015 that the way that police forces managed firearms licencing risk was 'unsatisfactory'. Improvements have been made since 2015, but problems remain. For example, it is unfortunately not the case that a home visit is always undertaken for renewals (as stated in Professor Mortimer's article), as many police forces have now adopted renewal interviews by phone.

It is probably true that firearms certificate holders are, as Professor Mortimer claims, 'one of the most law abiding sections of society' but there is little research to corroborate this. Professor Mortimer's personal reflection that she finds '[...] that most certificate holders are extremely reluctant to disclose low mood, or indeed any mental health problem, for fear of confiscation of their firearms and revocation of their certificates' suggests the police are right to remain vigilant about simply assuming the ongoing 'trust worthiness' of certificate holders. Professor Mortimer also points to a 2.5% refusal rate in 2017/18 for new applications as a signifier of 'good standing'. However, this conflates the figures for firearms (2.2%) and shotguns (2.9%). There are many more shotgun certificates issued than firearms. When the two percentages are combined it means that there were approximately 1000 'unsuitable' people in England and Wales attempting to gain the right to hold a gun licence in 2017/18 (based on Home Office, 2018).

Although it is correct (as the author claims) that the majority of crimes involving firearms involve illegally held handguns, underlying trends are also important. Whilst handguns remained relatively stable as a proportion during the last 10 years (at about 43%) shotguns increased from 6% to 10% (ONS, 2019). Further, in terms of illegal firearms discharges during the 2017/18 reporting period, shotguns actually accounted for a greater proportion than handguns (NABIS, personal communication, 2019).

The medical profession clearly has an important role to play in assisting police decision-making. GPs and psychiatrists provide police with factual information concerning relevant medical conditions. However, it is for the police to assess any mental health information provided alongside crime, intelligence and other reports available to them (and often them alone). Medical practitioners are not expected to offer advice on the suitability of their patient to own a gun, but to work with police so that the latter are able to make an informed decision. Professor Mortimer makes this point in the 'The GPs role' section, but I felt some other parts of the article 'muddled the waters'. A fundamental difference between the roles of psychiatrists and police in the licencing process is that latter will be expected to adopt an 'investigative mindset'. Example 2 in the 'high risk' section of Professor

Mortimer's paper illustrates why this is important. The assumption in the example is that the situation is resolved through the cooperation of the patient's brother. However, in cases like this the police will also risk assess non medically related factors such as: are there a spare set of keys to the safe? The patient's psychiatrist should also not, in my view, become involved in giving advice on the storage of a certificate holder's guns (as appears to be the case with the 'medium risk' advice offered).

Professor Mortimer argues that '[t]he risks conferred by mental disorder in certificate holders comprise, in summary, security breaches, suicide and homicide.' In terms of homicide, as readers of this journal will appreciate, most people with mental health issues do not act violently, with or without a weapon. The article's emphasis on suicide as a risk is understandable, from a patient care perspective. However, there are significant dangers to the public from guns being lost, stolen, misused or used to frighten and control others (the simple existence of weapon in a house may be intimidatory). Mental health is clearly a risk factor for a number of these dangers. The National Ballistics Intelligence Service (NABIS) report that during the 2017/18 period 430 firearms were recorded on the NABIS database as having been stolen, with 305 of these being shotguns (NABIS, personal communication, 2019). In 2016 the MP Jo Cox was shot using a modified rifle stolen from someone who held it legally.

In general terms, is unclear to me if the 'low', 'medium' and 'high risk' categories described by the author refer to dangers to the patient (e.g. suicide), to others (e.g. intimidation of a partner of the gun-holder) or a medical practitioner (the reference to 'significant personal risk'). Indeed, I have misgivings surrounding any firearms risk assessment carried out by non-police and particularly if it leads to actions such as a patient being advised by their psychiatrist to 'cease their access to firearms'. In these litigious times (Birks et al., 2018) even the most well-intentioned medical professional can find their interventions challenged *post hoc*.

## References

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