Guns and psychiatry: what psychiatrists need to know[†]

ARTICLE

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SUMMARY

The private ownership of firearms for participation in shooting sports, subject to a rigorous process of certification by the police, is not uncommon in the UK. Primary care medical involvement in this process is currently a contentious issue. The mental health of firearms owners is clearly germane to public safety: suicide is by far the greatest concern, alongside security breaches. Homicide committed with legally held firearms is very rare: there is very little cross-over between legitimate shooting sports and crime involving firearms. The perpetrators of family annihilation and single-incident mass killings using firearms in the UK have not been known to psychiatry, although a minority have been found to be mentally disordered *post hoc*. Regarding suicidality, there is little if any difference between those at risk who own firearms and those who do not, excepting that firearm suicide attempts are highly likely to be fatal. Guidance is offered in this article on the identification of patients who own firearms, the evaluation of risks and how to manage these in practical terms.

LEARNING OBJECTIVES

After reading this article you will be able to:

- demonstrate a basic knowledge of varieties of sporting firearms and understand the differences between legitimate and criminal use of firearms in the UK
- appreciate mental health problems related to the private ownership of firearms and the risks of suicidality
- understand the role of the police in certification and how to raise concerns when a patient's access to firearms is an issue.

DECLARATION OF INTEREST

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KEYWORDS

Firearm; gun; suicide; homicide.

Shooting sports are very popular in the UK: in March 2018, 586 583 people in England and Wales held shotgun certificates (SCs), firearm certificates (FACs) or both (Home Office 2018). Certificate holders enjoy a variety of shooting sports: clay pigeon shooting, game bird shooting, wildfowling and, with rifles, target shooting. Some shooting activities such as deer stalking and pest control are crucial for farmland crop and livestock protection. Many more sporting shooters have air rifles and pistols for target shooting and small pest control: no certificate is required, except in Scotland. Despite the popularity of shooting, and therefore gun ownership, neither the General Medical Council nor the Royal College of Psychiatrists has anything specific to say about medical matters relating to patients who own firearms.

Gun control in the UK

In the UK, gun ownership is strictly controlled, much more so than in most of the rest of the world (Home Office 2016). Certificates, renewable every 5 years, must be applied for. Verified photographic evidence of identity must be provided to be granted any certificate and, for firearm certificates, two personal references are required.

Exclusion criteria

There are numerous exclusion criteria: anyone sentenced to prison for 3 years or more can never own any gun, including those for which no certificate is required, such as air guns and antiques, or ammunition. A suspended sentence of 3 months or more invokes a similar prohibition for 5 years. Furthermore, certificates may be refused on the grounds of any offence, or police intelligence that possibly indicates irresponsibility, including arrests, police call-outs and imprudent posts on social media. Domestic violence incidents are treated particularly seriously: no convictions of any kind are considered spent.

It is therefore generally considered to be the case that legitimate UK certificate holders are one of the most law-abiding sections of society.

Certificate applications

The GP's role

Firearm and shotgun certificate application forms enquire about relevant health conditions, including depression. If nothing is disclosed, police firearms

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BOX 1 Medical conditions that must be declared

- Acute stress reaction or an acute reaction to the stress caused by trauma
- Suicidal thoughts or self-harm
- Depression or anxiety
- Dementia
- Mania, bipolar disorder or a psychotic illness
- A personality disorder
- A neurological condition: e.g. multiple sclerosis, Parkinson's or Huntington's diseases, epilepsy
- Alcohol or drug misuse
- Any other mental or physical condition that might affect the safe possession of firearms or shotguns

(Home Office 2016)

enquiry officers (FEOs) then write to the general practitioner (GP) for confirmation that there are no medical issues (Box 1), and request that the GP places an encoded reminder on the patient record, indicating certification. GPs do not receive a fee for this. If the GP fails to respond to the police within 3 weeks then Home Office guidance indicates that the police should assume that there are no concerns and issue the certificate (Home Office 2016). However, several constabularies are now demanding a GP medical report before issuing a certificate, which the applicant must pay for, in addition to the fee for the certificate itself. GPs are not statutorily obliged to respond to the police. Indeed, 'conscientious objection', claiming an inability to opine on suitability for certification and malpractice indemnity concerns are escalating reasons for applicants' difficulties in obtaining their certificates. Other GPs have demanded annual fees of up to £200 from patients for their services.

Such GP perspectives ignore the basic legal premise that the decision to grant or refuse a certificate is the responsibility of the police, not the GP. However, GPs are not yet statutorily responsible for cooperating, yet all the GP needs to do is verify that the applicant has disclosed relevant health conditions within their application, adding any not disclosed from their records.

The FEO's role

All applications and renewals for both shotgun certificates and firearm certificates trigger a home visit by an FEO, who will interview the applicant at some length, and inspect both their guns and their secure storage facilities, the latter being a condition of certification. That legal certificate holders are people of good standing who have been very carefully vetted is born out by negligible rates of certificate refusal and revocation. In the fiscal year to March 2018 there was a 2.5% refusal rate for new applications, falling to 0.25% refusal for renewals; 0.25% of certificates were revoked (Home Office 2018).

Legally held firearms

Air rifles and air pistols fire small single lead pellets and are suitable for small pest control (such as rats) and recreational target shooting. Causing serious injury or death is possible, but very rare: recorded air gun crime, such as shooting wildlife or pets, is falling. No certificate is required to own an air rifle or air pistol, except in Scotland.

Shotguns, by contrast, fire several hundred tiny balls of lead or other metal 'shot': they are used for shooting small moving targets such as clay pigeons, flying game birds (pheasants, partridges, duck, etc.) and agricultural pests such as woodpigeons and rabbits. A shotgun certificate must be granted, and all guns held registered on it.

Rifles fire a single bullet: they are used for recreational target shooting and hunting larger animals such as deer and wild boar. Smaller calibres can be used for pest control. The grant of a firearm certificate, as opposed to the shotgun certificate process, demands that the applicant show 'good reason' to own a rifle: professional needs (for instance, working as a deer manager or gamekeeper), sport recreation, firearm collection or research.

Many kinds of firearms are prohibited in the UK, including most handguns (which, like rifles, fire a single bullet), short-barrelled shotguns, which can easily be dismantled and concealed, and various automatic repeat-firing shotguns and rifles.

Crimes committed with legally held firearms are rare in the UK: guns used in the furtherance of crime are for the most part handguns, which are illegal *per se*. Many are smuggled into the country. The modification of blank firing guns such as starting pistols, the reactivation of deactivated or antique guns, and the *de novo* manufacture of ammunition for legally imported guns of obsolete calibre all feature in illegal availability (Reality Check Team 2018).

Medical issues in firearms certification

Both physical and mental disorder are of obvious relevance for gun ownership (Home Office 2016). Guidance does emphasise mental as opposed to physical disorder, despite the surprising omission of cognitive disorder apart from dementia, and developmental disorder such as attention-deficit hyperactivity disorder (ADHD) (Box 1). However, alcohol and substance misuse are, like domestic

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violence, accorded particular scrutiny. Physical disorders comprise those that affect the ability to handle a gun safely: tremor; episodes of compromise of conscious level, as in epilepsy; poor coordination or balance; lack of motor strength and manual dexterity. Conditions such as stroke and osteoarthritis, especially affecting the hands, are not uncommon in applicants, given that adherents to shooting sports tend to be older, with 63% of certificate holders in England and Wales over 50 years old, and 28% over 65 years old (Home Office 2018).

Risks associated with mental disorder

The risks conferred by mental disorder in certificate holders comprise, in summary, security breaches, suicide and homicide.

Regarding security breaches, 0.03% of registered firearms per year were lost or stolen in the UK between 2007 and 2011 (Beckford 2012): neither problem is necessarily related to mental disorder. However, the cognitive compromise of dementia may bring with it risks of security breaches, with firearms mislaid or not locked in the certificate holder's gun safe as they should be.

Suicide is, numerically, by far the biggest concern in certification, and clearly associated with mental disorder, regardless of the method utilised to achieve completion. There were 5821 suicides in the UK in the year to March 2017 (Office for National Statistics 2018a); regarding method, firearm suicide statistics are enclosed within the category 'other', which includes death by sharp object, falling from a height, placing oneself in front of a vehicle, etc. The most recent statistics specifically recording firearm suicide were reported in 2011, when 1.8% of UK suicides were by firearm, a total of 106, or less than 1 in 50 (https://www.gunpolicy.org/firearms/region/united-kingdom). A tiny minority of those who died, 2, were women (https://www.gunpolicy.org/firearms/region/united-kingdom). Unfortunately, suicide attempts by firearm are likely to be fatal, with considerable trauma for all concerned.

Regarding homicide in the UK, rates of which have been showing a decrease, in the year to March 2017 there were 615, or 10 per million population (Office for National Statistics 2018b). Of 32 homicides committed with a firearm, only two were perpetrated with a legally held gun. Nevertheless, firearm homicides whether with legal or illegal guns are very newsworthy, and their ramifications often result in consequences for those with legitimate shooting interests. It is generally accepted that there is no direct association between homicide and mental disorder (McGinty 2016), as opposed to the case for suicide (Simon 2016).

Suicide risk and firearms

The risk of completing suicide with a firearm is essentially influenced by the factors attaching to completed suicide via any other means. Male gender, mental disorder of any kind, unemployment, living alone, alcohol and substance misuse and, above all, a history of suicidal gestures, attempts or aborted suicide incidents are all well-recognised in this regard. Depression (rarely delusional) and personality problems, with long-standing tendencies to dysfunctional thinking, emoting, relating to others and behaving, may all figure. Disinhibition and impulsivity, whether through alcohol or substances, or as features of personality, can be crucial and unpredictable. Dementia, associated with so many emotional and behavioural symptoms, is a potential risk factor from a number of perspectives, such as the hopelessness that may accompany insight, paranoia, and impulsivity and disinhibition.

In any individual, whether suffering from a recognised mental disorder or not, current crises involving losses of any kind, bereavement and relationship breakdown, especially in the context of a dearth of social and family support, create fertile ground for the often-momentary desperation that can lead to suicide. Indeed, the impulsive and evanescent nature of suicidal feelings, which can come and go within minutes rather than hours, utilising whatever is to hand, offers a plausible explanation for the quite astonishing, in the UK context, US firearms death statistics. In the USA there is very little in the way of gun control, with no requirement to store firearms securely.

Since the commencement of this millennium, not far short of half a million Americans have died by shooting, and three-quarters of those were suicides (Gold 2016).

Nevertheless, despite the non-availability of legal handguns in the UK, and the relative difficulty of killing oneself with a 'long gun' (the American term for shotgun or rifle) as opposed to a handgun, alongside low numbers of gun suicides, UK FEOs still, quite rightly, take suicide risk very seriously. Conversations with FEOs identify a particular risk when a certificate holder receives a diagnosis of serious or terminal illness, a situation potentially affording the opportunity for effective intervention (D. Coutts, personal communication, 2019).

Multiple homicide: family annihilation and autogenic massacre/single-incident mass killing

Again, the situation in the USA is markedly different from that in the UK, and for the same reasons: ubiquitous availability of firearms and lack of gun control. Incidents of multiple homicide remain

BOX 2 Examples of single-incident mass killings in the UK

Birmingham, 1978

Barry Williams (aka Harry Street) was a single 34-year-old foundry worker, living with his parents and legally possessing a semi-automatic pistol. Following disputes with and threats to his neighbours, he killed three of them and two unrelated individuals; he wounded another two. He shot at several more people, including children, but fortunately missed. On conviction, he was detained under the Mental Health Act 1959, having been diagnosed with schizophrenia. He was conditionally discharged by a mental health review tribunal in 1994 but was recalled in 2013. During police investigation subsequent to his having harassed neighbours in 2013, he was found in possession of a home-made bomb, home-made bullets and three handguns.

Hungerford, 1987

Michael Ryan legally possessed exemplars of several classes of firearms that are now prohibited. He shot and killed his mother and 14 other people, wounded 15 people and finally killed himself, for no apparent reason. He was an unemployed 27-year-old who lived with his mother and had strong interests in military and 'survivalist' media.

Monkseaton, 1989

Robert Sartin, a 22-year-old single clerk, took his father's firearms (to which, legally, he should not have had access), killing one person and wounding another 16 before being arrested. He was diagnosed with schizophrenia and found not fit to plead. Several years later he became fit to plead, and on conviction he was detained under the Mental Health Act 1983.

Dunblane, 1996

Thomas Hamilton, a 43-year-old single unemployed shopkeeper, legally possessed a number of firearms, including handguns, which are now prohibited. He shot and killed 16 primary school children, 5- and 6-year-olds, and their teacher, and wounded another 16 people before killing himself. He was well-known to the police, having been investigated for various allegations, some involving children. He was disbarred as a Scout leader, his attempts to set up his own boys' club had been thwarted and he was known to have made formal complaints about perceived interference from the authorities, on which he also blamed the failure of his shop.

Cumbria, 2010

Derek Bird, a 52-year-old separated taxi driver, legally held shotguns and rifles. Following a series of personal reversals, culminating in threats to other taxi drivers, he killed 12 people, beginning with his twin brother and his solicitor, wounded another 11 people and then killed himself.

Northumberland, 2010

One month after the Bird shootings, in an arguably 'copycat' incident, Raul Moat, a 37-year-old unemployed man recently released from prison (and therefore unable to possess any firearm legally), shot and wounded his former partner and killed her new partner. He shot and blinded a police officer. He later shot and killed himself.

Durham, 2013

Michael Atherton, a 42-year-old taxi driver, killed his partner, her sister and the sister's daughter, and wounded his stepdaughter before killing himself. He legally held firearms but had a history of domestic abuse incidents and was known to the police, who had confiscated but returned his guns following a threat to kill himself in 2008. It would appear that he was drunk when the family annihilation took place, in the context of an escalating argument.

Surrey, 2014

John Lowe, an 82-year-old single man, killed a female friend and her daughter, allegedly during an argument. He legally held firearms, although there was police intelligence to the effect that he had allegedly made threats to kill the previous year: his guns had been confiscated but were later returned.

thankfully extremely rare in the UK and are not necessarily perpetrated with guns. Perpetrators are almost exclusively male, tending to be isolated and dysfunctional individuals who perceive the world and those around them as oppressive (Mullen 2004). A current crisis may precipitate the act, but sometimes there is nothing obvious immediately before it. The UK incidents outlined in Box 2 illustrate the general lack of any known association of multiple gun homicide with mental disorder and the difficulty in applying heuristics in any preventive capacity. Unless stated, none of these perpetrators were known to psychiatric services.

Who has firearms?

It is of obvious importance to be aware when a patient holds a shotgun or firearm certificate or has other access to firearms. This information can be drawn from a number of sources within the process of taking a traditional comprehensive psychiatric history. The patient's occupational history is crucial: most farmers, for instance, possess firearms, as will gamekeepers and those in gun-related occupations, such as registered firearms dealers, gun-shop assistants, rifle- and gunsmiths, shooting instructors, clay-shooting ground employees and sporting agents. Many people are employed in related branches of the shooting sports industry, for instance by cartridge and sports clothing and equipment manufacturers and working-dog breeders and trainers. Serving, ex-military and some police personnel, and country dwellers in general, are more likely to have experience of, and interest in, shooting sports.

Some individuals have access to firearms but do not hold a certificate, for instance those who run or supervise 'cadet forces', where rifle shooting may be a standard activity. Other people will have friends or relations who shoot: apart from a formal occupational history, firearms information may flow from a proper appraisal of the patient's hobbies and interests. Again, access to firearms does not necessarily involve personal certification: many people borrow guns to pursue their sport with family members and friends or at a clay-shooting ground.

What should the psychiatrist do?

Low risk – collaborate with the patient

Awareness of a patient's access to firearms adds a vital extra layer to risk assessment and management in the clinical situation. Nevertheless, patients, and indeed their families, may be able to give valid assurances that they are able to maintain their own and other people's safety. It is important to recognise and to respect this.

Speaking from both professional and personal experience, I find 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. That the patient has presented, is seeking help and is willing to engage is evidence of the

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taking of personal responsibility, an attitude appropriate to any certificate holder. Furthermore, most police forces would not consider a single episode of low mood or anxiety, if not accompanied by suicidal ideation and if able to be subsumed under the rubric of adjustment disorder, a reason to refuse or revoke a certificate. It is far more important that the patient should access effective treatment and recover their mental health. Assessing the ability of a patient to give valid assurances about safety is a matter of clinical judgement, an integral part of psychiatric practice. I have found the question 'What do you usually do when things go wrong?' of immense importance in exploring any individual's coping strategies, robustness and resilience.

Medium risk – advise the patient to stop access to guns

However, should the psychiatrist conclude that the risk exceeds that which can be addressed by reassurance, then the patient should be advised to cease their access to firearms. Consent should be asked to contact relatives or others who have loaned or given access to firearms, asking that this temporarily go into abeyance. If the patient has their own certificate, firearms and gun safe, they should be advised to lodge their firearms elsewhere, until all are satisfied that it is appropriate for them to take possession once more. There is a standard form to fill in, notifying the police of firearms change of address: most people who own firearms will know other people who own firearms and who will oblige. The form does not require a reason to be given for the change of address. The psychiatrist should follow up with the patient that they have implemented their recommendations in this regard.

High risk – contact the police firearms department

Should exigent risks present, then the psychiatrist is entitled to breach confidentiality without the patient's consent, notifying the local police firearms department of the clinical situation. Clearly, in an ideal world the psychiatrist's apprehensions should be put to the patient and consent asked for. However, psychiatrists may feel that to do so would put them at significant personal risk, given the lethality of firearms. It is of course possible to have a confidential conversation with an experienced FEO without identifying the patient in question. Indeed, such conversations may be had in any situation where a psychiatrist requires some practical guidance, leaving aside the urgent high-risk variety. Again, the decision on what action to take subsequently lies firmly with the police, not the psychiatrist: firearms may be seized immediately, for instance, if the risk is perceived as very high.

Example 1

A psychiatrist saw a young man who was involved with his partner in child protection proceedings, for the purpose of composing a court report. These parents had previously abducted their newly born baby, who was suffering a drug withdrawal state, from the hospital. Asked about his hobbies and interests, the man disclosed that he enjoyed 'rough shooting' with his father, a shotgun certificate holder and shotgun owner. When later asked what he would do if the judge ordered that the baby be adopted, the man said 'I think I'll get him!'. The psychiatrist wrote to the court, suggesting that the man's father was visited by an FEO and advised that his son should not access his firearms under any circumstances: the court made this order, immediately.

Example 2

A psychiatrist saw a severely depressed middle-aged man, referred to the out-patient clinic by his GP. During the evaluation of premorbid personality it was disclosed that the patient was a shotgun certificate holder and had contemplated suicide. The psychiatrist explored the issue and was told that the patient's brother also held a shotgun certificate and had space in his gun safe. The psychiatrist asked for and was given permission to telephone the patient's brother, who, having been very concerned, thanked the psychiatrist for the call and agreed to lodge the patient's firearms until advised to return them.

Example 3

A young farmer facing a number of very serious legal and family difficulties placed the muzzles of his loaded shotgun into his mouth and was contemplating pulling the trigger when he was interrupted by the unexpected arrival of a shooting friend. This led to an urgent GP appointment and psychiatric evaluation. The psychiatrist immediately telephoned the police firearms team, strongly suggesting that all firearms be removed straight away, which they were. The patient's shotgun certificate was revoked. The patient made an excellent recovery in due course and was able to resume his shooting interests through the legal loan of a firearm from his friend when required.

Example 4

A man presented for an experimental treatment for depression. History-taking revealed that he had access to firearms through volunteer involvement

MCQ answers
1 d 2 c 3 b 4 b 5 d

BOX 3 UK certification requirements for guns in private ownership

The following lists are not exhaustive

Guns that may legally owned without a certificate

- Low-powered air rifles and air pistols (except in Scotland)
- Blank-firing starting pistols
- Antique (obsolete) guns

Guns that require a certificate

- Shotguns (shotgun certificate)
- Rifles (firearm certificate)

Illegal guns

- Handguns
- Self-loading or pump-action rifles or shotguns

with military services, but no shotgun certificate, firearm certificate or firearms of his own. He told the psychiatrist that if the new treatment did not work he was intent on taking his own life. The psychiatrist explored the preferred method in some detail and put it to the patient that it may be necessary for his suicidal ideation to be shared with the military authorities. The patient strenuously denied that he would shoot himself, since this would bring the military into disrepute, a consequence that was abhorrent to him. The psychiatrist rather reluctantly decided to respect the patient's assurances and proceeded with the new treatment, while putting adequate monitoring in place. The patient made a good recovery and his military volunteering continued.

And finally… the psychological benefits of shooting sports

A survey by the British Association for Shooting and Conservation (2015) identified a number of positive benefits to psychological well-being emanating from engagement with shooting sports. Of the 1400 people questioned, 95% stated that shooting was important for their personal well-being, making on average 20 new friends through the activity; 77% said that their social life would suffer without shooting. The top three reasons for taking part in shooting sports were enjoyment, exercise and relaxation.

Conclusions

Shooting sports using legally held firearms (Box 3) is a growth area in the UK, with many potential benefits for psychological well-being, social interaction and healthy outdoor physical exercise. Those allowed to own firearms are carefully vetted, including for relevant mental disorder, by the police. Psychiatrists will inevitably encounter certificate-holding patients, given the popularity of shooting sports, and should be aware who they are. Suicidality is the most consequential area of risk relevant to legal ownership of firearms. Nonetheless, presenting for treatment is a major step in the right direction.

Suicide risk can be mitigated by temporary removal of access to firearms, with or without formal police involvement. Psychiatrists should feel able to approach their local firearms enquiry officers (FEOs) in confidence and maintaining patient anonymity, if in need of guidance.

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MCQs

Select the single best option for each question stem

1 A depressed patient discloses suicidal ideation: you are aware that she enjoys target and vermin shooting with her air rifles and pistols. You should:
a ask the police firearms department to revoke her certificates
b urgently suggest to the police that her firearms are seized
c ask her to give her gun-safe keys to her husband
d enquire about the nature of the ideation, intent, plan or method considered
e do nothing, since suicidal intentions come and go very quickly

2 The perpetrators of firearm multiple homicide in the UK, including criminals and terrorists:
a are often known to psychiatric services
b tend to begin by killing strangers, and later kill family, friends and colleagues
c may not present any obvious trigger, such as an argument
d prefer legal firearms to any other method
e can be reliably identified by police intelligence.

3 Legitimate shooting sports in the UK do not include:
a driven game-bird shooting
b target shooting with a handgun
c clearing a rat infestation with an air rifle
d shooting woodpigeons at the request of a farmer whose pea seedlings they are eating
e deer stalking.

4 Factors recognised as increasing the risk of self-harm include:
a owning antique firearms
b relationship breakdown
c owning an air rifle
d owning a gun dog
e deer stalking and wildfowling.

5 In the UK, the decision to grant and renew firearm certificates and shotgun certificates is made by:
a the British Association for Shooting and Conservation
b the applicant's GP
c an independent chief constable of a neighbouring police force
d the chief constable of the applicant's constabulary, whose powers are delegated to their firearms enquiry officers and managers
e the applicant's psychiatrist, if any.