editorial

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Psychiatric illness and gun licensing

Although the majority of gun-related incidents are carried out by people not suffering from a mental illness, access to guns by some psychiatric patients is an issue because of the possibility of self-harm and, much less likely, harm to others. This article discusses the issue of guns in society and the marked differences in policy in the USA compared with other industrialised nations. The changes in gun licensing which have occurred in the UK over the past few years are considered along with the role of the medical profession in the application procedure.

Firearms and society

Most societies acknowledge the fact that licensing of firearms works to minimise gun-related crime. This is where the position of the USA is unique and intriguing. The right to keep and bear arms is enshrined in the Second Amendment of the USA Constitution. During the 1990s, firearm policy in the USA resulted in laws making legal access to guns easier. Not only is it now easier to buy a gun in the USA but there are laws in place enabling Americans to carry concealed handguns in public. The powerful pro-gun lobby in the USA argues that wider access to guns enhances public safety and the carrying of guns by the public has a deterrent effect on violent crime (Lott & Mustard, 1997). The main aim of US policy is to prevent guns falling into the wrong hands. The policy of the British government, however, has been to reduce the number of guns in circulation thereby hoping that less will be available for criminal use. Over the years there have been many amendments to UK gun licensing law, with the result that we now have the most stringent controls in the world. The statistic that the UK has approximately 400 firearm deaths per year (7 deaths per million population) as opposed to about 30 000 in the USA (106 deaths per million) suggests that the UK approach may work. Amendments to UK gun laws, however, have made interpretation and operation of the current law complicated, so that in 2002 the Home Office produced guidance to the police on firearms law (Home Office, 2002).

Dunblane and its aftermath

Gun ownership and gun control were already under scrutiny in the UK before the events of Dunblane but this incident put the issue high up on the political agenda. On 13 March 1996, 43-year-old Thomas Hamilton entered the gymnasium of Dunblane Primary School and opened fire on a class of 29 5- and 6-year-olds. One teacher and 16 children were shot dead and a further 12 children and 2 teachers were shot and injured. Hamilton then shot himself dead. He was a former Scoutmaster who had been turned down as a voluntary worker at the school. Soon after the incident Lord Cullen held a public inquiry which made many recommendations, including improvements in school security and improved vetting and supervision of adults working with children (Cullen, 1996). Cullen also recommended stricter rules on the control and use of firearms. The ruling Conservative Government at the time declined to ban handguns but such a law was passed within 3 months of the Labour party coming to power in May 1997. Lord Cullen's conclusion regarding Hamilton was that there was no evidence that he was or had been mentally ill and he used firearms which were legally held. Furthermore, Lord Cullen felt that the tragedy could not have been predicted. In tabloid journalistic terms Hamilton was deemed 'bad and not mad' but despite this the tragedy has led to scrutiny of the possible risks posed to society by people suffering from psychiatric disorder who have access to guns.

The firearm and shotgun licensing procedure

The responsibility for firearm and shotgun licensing rests with regional chief constables but in practical terms day-to-day business is devolved to a police licensing department. The UK recognises two classes of guns: firearms and shotguns. Firearms refer to handguns and rifles, and as these are deemed more lethal any certificate has to specify each individual gun. Shotguns are much more numerous in the UK and an individual can have an unspecified number of shotguns on a single certificate.

Pre-Dunblane, to apply for any gun licence an applicant had to fill out a questionnaire and answer specific questions about the presence of epilepsy or any form of psychiatric illness. Following a 1988 amendment of the

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editorial

original 1968 Firearm Act the application had to be countersigned by a member of parliament, justice of the peace, minister, doctor, lawyer, civil servant, bank officer or a person of similar standing. The countersignatory had to be resident in the UK and to have had personal knowledge of the applicant for at least 2 years. The duty of the countersignatory was to verify the facts on the form and to state that they 'knew of no reason why the applicant should not be permitted to possess a firearm'. This system posed a dilemma for doctors. A doctor could be signing in a capacity of simply knowing the person for 2 years, i.e. not necessarily knowing about health-related issues. Alternatively, a doctor could countersign a form with extensive knowledge of a person from the doctor–patient relationship. Moreover, if the applicant had declared a history of psychiatric illness it could be argued that a doctor was in some way predicting or guaranteeing future behaviour. The British Medical Association (BMA) ruled in 1996 that doctors could sign in their capacity as a person of good standing but rarely would it be the case that a doctor had sufficient knowledge of a patient to justify their judgement that a person could safely possess and control a firearm. Subsequently there was a vote taken at the BMA annual conference in June 1996 ruling that doctors should not sign applications in any capacity (Morris, 1996).

Lord Cullen criticised the countersignature system arguing that the procedure was essentially negative, i.e. the less the countersignee knew of an applicant the less difficulty he/she may have in supporting the application. Cullen recommended that the system should be replaced, with two referees each completing a report. Such a model is now in place for firearms certificates. An applicant completes the form quoting the names of two referees. The applicant is interviewed by the police and there is a home visit to inspect security arrangements for the storage of guns. The referees can be from any background or occupation but must be of 'good character and honest'. The referee verifies the details on the application form and is asked to comment on the general character and background of an applicant. The referee is not required to guarantee future good behaviour. At the current time the countersignature system is still in place for shotgun certificates but this may change with a recent Home Office consultation paper on firearm policy (Home Office, 2004). Current guidance advises that for a shotgun licence doctors may act as referees but they should act in a personal rather than a professional capacity and as such should not request a fee.

The role of medical information in the granting of certificates

Lord Cullen considered a proposal that general practitioners should provide a mandatory report for a person applying for a gun licence. He rejected this stating that 'I am entirely satisfied that general practitioners cannot reliably assist in the identification of those who pose a risk of violence and those who do not'. Cullen rejected a proposal for mandatory psychiatric or psychological assessments for similar reasons (Cullen, 1996). Any system, however, which does not use medical information in the gun licensing process is arguably flawed. To quote Dr Laslo Antal, a general practitioner in Liverpool, 'a general practitioner cannot see into the future but they can see into the past' (Warden, 1996). Currently an applicant gives permission for the police to approach their general practitioner at any time. A general practitioner would not be approached as a matter of course but only if concerns were raised by the application form, the reports from the referees, the interview or the home visit. Presumably, psychiatrists or other specialists could also be approached in a manner rather like the sharing of responsibility between primary and secondary care in advising the Driver and Vehicle Licensing Agency regarding fitness to drive. The guidance to the police emphasises that doctors should be asked for factual information only and should not be asked for opinions, endorsement of an application or its opposition. Doctors, however, would be open to oppose granting of a licence to an applicant but they would be expected to justify this. There does not appear to be a requirement for a gun licence holder to notify the police should they develop a psychiatric condition, as is the case with a driving licence. Doctors, however, can approach the police at any time if they have concerns about a patient who is known to have access to a gun, although the General Medical Council rules concerning breach of confidentiality apply.

Common reasons for refusal or revocation of a firearm certificate

The most common reason for refusing an application is that the case for wanting access to a gun is not good enough. Less common reasons for refusal are for 'intemperate habits' and 'unsound mind'. Intemperate habits can refer to a history of alcohol or drug misuse or aggressive/antisocial behaviour, particularly in a domestic setting. This is particularly important as domestic shootings are common in the USA, suggesting that the availability of a gun in the home can turn an argument into a homicide. In *Guidance to the Police* the subject of unsound mind is described as 'a particularly difficult and sensitive area' (Home Office, 2002). There is no definition of unsound mind but chief officers are advised to be alert to reports from doctors of depression, suicidal tendencies, emotional instability, unpredictable behaviour or being subject to the 1983 Mental Health Act presently or in the past. The guiding principle as suggested to the Cullen Inquiry by the Royal College of Psychiatrists is 'common sense rather than (spurious) scientific grounds'.

It is harder to obtain a firearm/shotgun licence now than in the recent past, with refusal of applications rising from 1% in 1994 to 3.5% in 2000. Applicants can appeal against refusals/revocations to the Crown Court in England and Wales or to a sheriff in Scotland. Doctors may be called to submit reports or be cited to appear in person but they should be mindful of the submission to

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the Cullen Inquiry by Professor David Cooke, forensic psychologist, who stated that 'It is impossible to predict with certainty who might be unsafe with a gun' (Morris, 1996). Such an opinion seems intuitively sensible but there is a danger of the police viewing applications from people with any history of contact with psychiatric services with increasing conservatism. This would be in line with the acceptance of society that minimising risk takes priority over personal rights, although the loss or refusal of a firearm certificate may have far-reaching implications if a gun is required for occupational reasons as may be the case for gamekeepers and farmers.

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Declaration of interest

None.

editorial

References

CULLEN, Lord (1996) *The Public Inquiry into the Shootings at Dunblane Primary School on 13 March 1996*. London: The Stationery Office.

HOME OFFICE (2002) *Firearms Law. Guidance to the Police*. London: The Stationery Office.

HOME OFFICE (2004) *Control on Firearms. A Consultation Paper*. Home Office Communications Directorate. London: The Stationery Office.

LOTT, J. R. & MUSTARD, D. B. (1997) Crime, deterrence, and right to carry concealed handguns. *Journal of Legal Studies*, **26**, 1–68.

MORRIS, A. M. (1996) Firearm legislation and the Cullen inquiry. *BMJ*, **313**, 374–375.

WARDEN, J. (1996) Doctors may have to countersign gun applications. *BMJ*, **313**, 379.

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