Mass Shootings and Psychiatric Deinstitutionalization, Here and Abroad

Dimitrios Pagourtzis, the student accused of shooting 10 people to death at a Texas high school in May 2018, was on the honor roll. His pre-AP language arts teacher, Valerie Martin, described him as bright, and “quiet, but he wasn’t quiet in a creepy way.” His football teammate Tyler Ray admired his commitment to summer workouts and his family’s commitment to attending his games.1 By many accounts, Pagourtzis was an active participant in the civic and cultural institutions of Santa Fe, supported by a caring community of family and friends.

Yet, in the wake of such atrocities, observers now instinctively begin to comb the suspect’s mental health history for signs of disorder. In this case, we have discovered his Facebook page, where a photo of a t-shirt reading “Born to Kill” appeared. Although this image should be enough to raise suspicions about an adolescent’s psychological development, when placed in context, it may not have been enough to commit Pagourtzis to psychiatric services, neither voluntarily nor involuntarily, even if these services were widely available.

THE CLAI M

Too often, gun rights advocates point to the flaws of the mental health system as the cause of mass gun violence. Consider President Trump’s response to the February 14 massacre at Marjory Stoneman Douglas High School. He said that psychiatric hospitals should be reopened to prevent more carnage: “You know in the old days we had mental institutions, had a lot of them, and you could nab somebody like this.”2 Trump was referring to the closure of psychiatric hospitals during deinstitutionalization—the result of ideological, economic, and political factors—which began in the 1960s, peaked in the 1970s and 1980s, and continues today.

Is deinstitutionalization to blame for the regularity of mass shootings in America? Deinstitutionalization occurred not only here but also across other high-income democracies. Major international organizations, such as the World Health Organization, have supported the reduction of hospital psychiatry.3 Comparing cross-national data of mass shootings—typically defined as four or more fatalities—with the decline of inpatient psychiatric capacity offers little evidence to support this association.

THE FACTS

Although the United States has reduced its supply of inpatient psychiatric care more than other countries, it is not an outlier in this regard. According to a standard test of statistical outliers, the bed rate in the United States (0.21) falls well within the range of inliers (−0.71, 2.25).4 Nor does the United States appear to bias the distribution downward. Furthermore, the outcomes of American deinstitutionalization may appear different from that of other countries, but the factors that caused it are not particularly unique. Around the world, the postwar expansion of social insurance programs (here, the enactment of Medicare, Medicaid, and the expansion of disability benefits), combined with the welfare retrenchment of the late 1970s and 1980s, incentivized public asylum to depopulate. Moreover, the legal and social movements that advocated the civil rights of people with mental illnesses were often just as active elsewhere as they were in America. Indeed, many prominent leaders of these international movements were based abroad (e.g., R. D. Laing, David Cooper,

Franco Basaglia). Finally, the same pharmaceutical companies that promoted the clinical use of psychotropic medications in the United States did so in other countries as well. The first of these medications (chlorpromazine), in fact, was developed by a French company (Rhône-Pouilenc).

Where the United States does appear to be truly exceptional, however, is in the frequency and number of casualties of mass shootings. A comparative study of mass shootings in the United States versus Australia, Canada, China, England, Finland, France, Germany, Mexico, Norway, and Switzerland from 2000 to 2014 revealed that the United States had more episodes—and more casualties—than the other countries combined.5 Though Americans make up less than 5% of the world’s population, 31% of the gunmen involved in mass shootings were American.6

Other countries occasionally experience mass shootings, too. If high psychiatric bed capacity were related to mass shootings, nations with low bed count would have more shootings and those with high bed count would have fewer shootings. In reality, those with high rates of inpatient psychiatric capacity are not the

ABOUT THE AUTHORS

Isabel M. Perera is with the Department of Medical Ethics and Health Policy and the Department of Political Science at the University of Pennsylvania, Philadelphia. Dominic A. Sisti is with Department of Medical Ethics and Health Policy at the Perelman School of Medicine at the University of Pennsylvania. Correspondence should be sent to Isabel M. Perera, Department of Medical Ethics and Health Policy, Perelman School of Medicine at the University of Pennsylvania, 423 Guardian Drive, Philadelphia, PA 19104-4884 (e-mail: iperera@upenn.edu). Reprints can be ordered at http://www.ajph.org by clicking the “Reprints” link.

This editorial was accepted September 5, 2018.

doi: 10.2105/AJPH.2018.304764
least violent. When the data were adjusted for population size, three countries had more mass shootings per person than the United States between 2000 and 2014: Norway, Finland, and Switzerland—countries where the population size can inflate the per-capita effect of one or two lethal events, such as the 2011 terror attacks by Anders Breivik in Norway where there were 77 fatalities, 69 of which were caused by gunshot. Norway and Switzerland have among the highest levels of inpatient psychiatric capacity in the Organization for Economic Co-operation and Development (Norway = 1.14; Switzerland = 0.92 psychiatric beds per 1000). Moreover, nations with fewer psychiatric beds per person tended also to have fewer mass shootings (e.g., Canada, Australia, England).

Although many countries replaced asylums with generous community care systems, high access to outpatient treatment does not appear to explain cross-national differences in mass gun violence. In fact, the volume of outpatient mental health visits and day treatment sessions is rather high in some of the countries with higher rates of violence (32336 and 722 per 100 000, respectively, in Finland; and 44208 and 11779 per 100 000 in Norway). Compare this to the United Kingdom, which has lower rates of violence, yet a lower volume of community treatment (3335 mental health visits and 1035 day treatment sessions per 100 000). These data suggest that there is no obvious relationship between the degree and nature of deinstitutionalization and the prevalence of mass shooters and shootings.

Instead, consider the fact that the United States has the highest rates of civilian-held firearms in the world: 120.4 per 100 000. The next highest country on the list (Yemen) has less than half that rate (52.8 per 100 000). Two countries have rates that surpass 25% of the American rate (Finland = 32.4 per 100 000 and Canada = 34.7 per 100 000). The permissiveness of US federal law in this area helps to explain the facility of access. Constitutional provisions and Supreme Court rulings have shifted the regulation of firearms to states—of which only a fraction require a permit, license, or registration for the purchase of firearms. Other countries impose at least one of these regulations on prospective gun owners. Many have banned semiautomatic assault weapons, and in many others, legal purchases are limited to sporting rifles and shotguns. These regulations stand in stark contrast to the United States, where federal laws permit the sale of a range of weapons that increase the lethality of firearms, such as semiautomatic assault weapons, 0.50 caliber sniper rifles, and large-capacity ammunition magazines.

A DIFFERENT APPROACH

There is no doubt that America’s mental health system needs significant repair. The United States needs more psychiatric hospital capacity to take care of individuals who have serious mental illnesses, who fail to thrive in the community, and who often end up homeless or in correctional settings. Incidentally, the president’s comments ignored the astronomical, and internationally exceptional, increase in mass incarceration that followed psychiatric deinstitutionalization. Although those de-carcerated from mental institutions (often elderly White women) differed demographically from those now incarcerated in penal institutions (often young Black men), many prisons have become the new asylums. However, reopening psychiatric institutions for the purpose of preventing mass shootings is misguided, especially given that firearms—particularly highly lethal assault weapons—continue to be so easily available.

Isabel M. Perera, PhD, MA
Dominic A. Sisti, PhD, MBE

CONTRIBUTORS

Both authors contributed equally to this editorial.

ACKNOWLEDGMENTS

I. M. Perera acknowledges the support of the Brocher Foundation and the Horowitz Foundation for Social Policy. D. A. Sisti acknowledges the support of the Thomas Scattergood Behavioral Health Foundation.

CONFLICTS OF INTEREST

The authors have no conflicts of interest to report.

REFERENCES


