COMMENTARY

Guns, Violence, and Mental Health: Did We Close the State Mental Hospitals Prematurely?

by Douglas A. Kramer, MD, MS and Johan Verhulst, MD

We grieve Sandy Hook as we continue to grieve Aurora, and shudder because we know there will be a “next time.”

During the 23 years I practiced psychiatry in Wisconsin, I (DK) saw many patients in the emergency department whom I judged to be more psychotic and more dangerous than either Adam Lanza or James Holmes appears to have been before the horrors for which we now know their names. Not once was I able to prevail on Crisis Intervention for the county to approve admission of any of those patients to the excellent state mental hospital less than 9 miles away. Instead, outpatient treatment at Community Mental Health Center (CMHC) was mandated. This was because of limited funding and the limited number of inpatient beds available for seriously mentally ill patients—even ones who displayed definite signs of dangerousness.

Politicians are discussing bans on the sale of certain types of guns, magazines, and ammunition. President Obama has focused on the expansion of background checks for certain types of gun sales. There is discussion of infringing on the basic relationship between psychiatrist and patient and relaxing the privacy of mental health records with respect to interested government agencies. Even the US Supreme Court [Jaffee v Redmond, 1996] understood the chilling effect this would have on mental health treatment: “For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.”

These proposed initiatives are mostly desperate efforts to find a patch to replace a mental health system we dismantled—most importantly, the system of state mental hospitals.

As of this writing, more than 150 days have elapsed since a young man with likely significant psychiatric illness did something all of us consider unthinkable. More than 150 days since he walked into an elementary school and murdered 20 children and 6 staff members after killing his mother. In public discourse, the problem has been defined in 2 terms: “gun violence,” and “serious mental illness.” Most proposed solutions in the medical literature focus almost exclusively on the first component.1,2

There is a long tradition in the US of operating institutions for the care of persons with serious mental illness.3 The Society of Friends began admitting patients to the Pennsylvania Hospital in 1752. The Commonwealth of Virginia established the Public Hospital for Persons of Insane and Disordered Minds in 1768. The Government Hospital for the Insane, now known as St Elizabeth’s Hospital, opened in 1855. Virtually every state had one or more state mental hospitals by the mid-20th century.

Is it possible that we as a society care less for the plight of the seriously mentally ill than we did 100 or more years ago? Is homelessness an answer for those suffering individuals? Is incarceration with minimal mental health treatment an ethical solution? When the jails in our most populous counties become our largest public mental health facilities, we definitely have a problem—a problem we created—in how we respond to serious mental illness.3

Borrowing from the movie Field of Dreams, “If you build it, they will come;” we may simply need to build it, and build it, and build it, until a public mental hospital system exists where the seriously mentally ill may come for treatment. Good treatment for serious mental illness must be hospital-based and of sufficient duration to be effective. Outpatient treatment is for people of sufficiently sound mind to make decisions regarding their own health and treatment.

As dramatized in One Flew Over the Cuckoo’s Nest, 1 (JV) observed that long-term psychiatric hospitalization may lead to paternalism and abuse of power. Our current appreciation of the importance of informed consent and patient empowerment can not only help avoid such dangers but also inspire a truly humane and therapeutic hospital environment.

Firearm violence and mental health

In addition to the 28 killed and 2 injured in the Sandy Hook tragedy, other recent mass shootings include 33 dead, 23 wounded at Virginia Tech; 6 dead, 14 injured in Tucson; and 12 killed, 58 injured in Aurora. In each of these cases, it appears that the shooter was seriously mentally ill. CDC statistics for firearm deaths in 2010 show 19,390 suicides, 11,062 homicides, and 950 unintentional and law enforcement deaths.4

Every firearm death is tragic. For the approximately 20,000 suicides by firearms annually, the CDC estimates that 45% are primarily the result of “mental health” problems, and 31% are the result of “intimate partner” problems. This means that at least 76% of suicides are broadly mental health-related.5 With respect to violence toward others, 13% of people with a serious mental illness reported having committed assaultive acts during the previous year.6

The majority of homicides, including those involving firearms, are not committed by persons who are psychotic or suffering from a severe psychiatric disorder. Nevertheless, a statistical analysis based on the Swedish national registers for all hospitalizations and all criminal convictions indicated that in a 5-year period, about 1 in 20 violent crimes were committed by patients with severe mental illness.7 Many more offenders are in a temporary state of rage or despair.8

There are indications, however, that mass violence events are committed by people in the midst of an episode of serious psychiatric disorder. This cannot be known for certain in every instance because perpetrators of mass violence often do not survive the event, and many have not previously seen a psychiatrist. These tragedies involve many factors: an untreated seriously mentally ill person; in unimaginable distress; with relatively easy access to military style weapons; and illegal psychoactive drugs; living in a society with substandard treatment of the seriously mentally ill; largely due to society’s unwillingness to adequately fund public mental health; in a culture increasingly lacking in cohesive societal responsiveness.9

History of public mental health

Until the final third of the 20th century, the states operated mental hospitals where psychiatric care was provided for people with severe mental illness. In 1955, the nation’s capacity for mental health care in public institutions exceeded 558,000 beds, equivalent to 1,060,000 beds today. By 1994, this capacity had dropped to 72,000 beds.10 There are 4 reasons for the decline:

1. Beginning in 1954, more effective treatment became available, primarily medication for severe psychiatric illnesses such as schizophrenia and bipolar disorder. Medication allowed many patients.
to be discharged from state mental hospitals.
2. Many persons with severe mental illnesses are now found in correctional facilities. A recent estimate was 321,000.13
3. Another large group of seriously mentally ill persons is found among the 3.5 million Americans who experience homelessness annually.14
4. The CMHC program was never able to provide the intensity of care available in the state mental hospitals. Federal funding for CMHCs evaporated and more patients entered the world of corrections and homelessness since there were no public hospitals to which to return.

**Current status of the seriously mentally ill**

Without the availability of public mental health beds, seriously mentally ill patients often enter a downward spiral of despair, social isolation, unemployment, poverty, homelessness, malnutrition, disease, substance abuse, and victimization by violence.

Thomas Insel, Director of the NIMH, testified in January 2013 that the delay from the start of an episode of serious mental illness to contact with a professional is 5 years on average.15 It is possible that episodes of violence like those cited at the beginning of this essay were committed by young men in the early stages of schizophrenia or bipolar disorder—which would have increased the likelihood that they would not have yet come to the attention of the mental health system. Five years of deterioration; suffering; access to alcohol and illegal drugs; going without humane care and treatment; deterioration of family, social, and community relationships; potential access to firearms; and increased risk of violent behavior. Five years on average in the United States of America!

**Our recommendations**

1. Revitalize the state mental hospital system to readily provide safety, evaluation, and treatment before an act of violence has occurred.
2. Lower the threshold for legal commitment, with appropriate civil safeguards to protect patients and potential victims.
3. Develop a transitional system of “partial hospitalization” to facilitate a carefully managed return to the community

**References**


*Members of the Research Committee, Group for the Advancement of Psychiatry.*

**U.S. Psychiatric and Mental Health Congress**

**Psych Congress is the nation’s largest independent educational conference** for psychiatrists, primary care physicians, psychiatric nurses, psychologists, and other health care professionals who seek to increase their knowledge, confidence, and abilities pertaining to mental health disorders.  

- **Las Vegas, NV—September 30 - October 3, 2013**
  - 91+ Exhibitors and Sponsors
  - 85+ Educational Sessions
  - Up to 30 CME/CE Credits

Visit www.psychcongress.com and experience the Psych Congress Network.