Threat management is a multidisciplinary approach to preventing targeted violence, including mass shootings. It consists of deliberate and planned collaboration across different disciplines (e.g., law enforcement and investigation) to prevent targeted violence from occurring. Unlike traditional psychiatric approaches, threat management looks beyond the scope of diagnoses and symptoms to look at criminogenic and contextual factors. The field, now built on over 25 years of research, both complements and informs our own work in clinical care of behavioral emergencies (1,2). For both threat management and emergency psychiatry, all threats must be taken seriously.

**TARGETED VIOLENCE**

Targeted violence encompasses all attacks that are contemplated, planned, and/or enacted toward a specific individual or group and is neither spontaneous or random. Targeted violence includes most homicides, as well as mass shootings, vehicle attacks, bombings, arson, and other attacks intended to injure large numbers of people. Most targeted violence homicides in the United States happen within small groups or dyads—a bar fight, domestic violence, a drug deal gone bad—and by definition are intentionally directed to a specific target, chosen by who they are or their membership in a class. Contrary to popular perceptions, the US homicide rate has decreased significantly over the past 30 years (3,4). There has been an uptick in homicides in 2015 to 2016 that is specifically attributable to firearms and which is not reflected in homicides by other means such as stabbing or strangulation (5).

Mass shootings or attacks account for only about 1% of all homicides but also appear to be occurring with increased frequency (9-12). Mass shootings can be defined in a number of different ways leading to confusion about the varying interpretations of different data sets (6-8). Mass shootings also appear to be distinctly more common in the United States than in other economically developed nations (83,84).

Collectively, this grouping is called targeted violence. Threat management is a specialized approach to managing targeted violence that can be extremely useful to psychiatric emergency service (PES) professionals. Its models, techniques, and tools are informative whether the target is one or many and even when there is no specific target at all.

**THE PATHWAY TO VIOLENCE**

The conceptualization of a pathway to violence is central to threat management. This model describes how persons of concern rarely, if ever, snap; rather, they follow a pathway beginning with grievance, transitioning to thoughts of violence and contemplation of a target, evolving to preparation and, ultimately, to attack. This pathway to violence often takes days, weeks, or even years which provide an extended window of opportunity for identification, investigation, and intervention (13-15). This model is summarized in Figure 33.1.

Conceptually, grievance is the first step on the pathway to violence. As risk factors accumulate and protective factors weaken, fixation intensifies and people progress up the stairway toward an attack. The goal is to disrupt and...
divert a person before they reach the attack stage. People at highest risk may be those who are already at or near the top of the staircase or who seem to be moving upwards more quickly. Threat management embraces using either criminal justice or mental health interventions as needed because each given person of concern transits the pathway in a unique and distinct manner. Careful clinical judgment is always essential for no model can truly countenance the subtleties of all human behavior. What follows are brief descriptions of each stage primarily upon the Calhoun and Weston version of the pathway to violence (15).

Grievance
Grievance, in the context of threat management, is the idea that one has been wronged and treated unjustly by another, an organization, or the world writ large. All people encounter frustrating situations by circumstance or the acts of others; most let the frustrations effervesce away. Some people ruminate on these slights, be they real or imagined. They let the feelings fester and grow and, increasingly, to become a central part of their self-perception. In a psychiatric interview, this is a person who readily identifies how their problems or adverse experiences are attributable to a person or parties. Persistent rumination itself may be harmful to the individual in other psychological ways (16). The clinician should be especially wary of the person who readily catalogs the numerous slights and offenses of their lives (so called “grievance collectors”) and those who, often through characterological pathology, seek repeatedly to create situations where they can claim injustices against themselves (“grievance creators.”)

Ideation
Ideation is the pivot from “I’ve been harmed by others” to “I will harm them back.” It is the beginning of the progression toward an attack. It may be marked by increased empathy with others who engage in violence and shifting from a viewpoint of passive victimization to embracing a proactive position that, by harming others, the person of concern can somehow address the injustices they have suffered. Although persons of concern may be cognizant of the fact that the world may view their actions as immoral or illegal, they often perceive themselves as the one who is just. Increased fixation on how the target or the world deserves the intended harm becomes more common. Themes of entitlement are common and perhaps a predisposing risk factor as well. Fantasies about being an avenging, righteous

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warrior whose actions will be remembered by others become more common (17). It should be noted that homicidal ideation and violent fanta- sies are not uncommon and, in and of themselves, not necessarily concerning. The therapeutic space is often used as a safe way to express those urges so as not to act on them; the critical nuance is when they evolve from fantasy to intent (18).

Research and Preparation
At this stage, the person of concern moves beyond simple contemplation of an act of violence to planning and exploration of how they might attack their target. It may include the development of an operational plan or merely readiness to act when the opportunity arises by carrying a weapon. It can include surveillance, reconnaiss- ance, or probing the security of the target. It may be accompanied by increased fixation on and fantasies about how they will be perceived during or after their attack. This phase may include acquisition and practice with weapons, costuming and dress, and interest in how their message will be conveyed and portrayed (19). Often, this may include communications which become leakage through varying social media or interpersonal connections (20).

Breach
Breach is the pivot from the preparation to dan- gerous action. It may include “walk throughs” or rehearsals, probes of security such as bringing a weapon to a setting where they know they should not have one, or a verbal altercation or threat toward their intended target. Actions to strengthen commitment toward the final act are common including sabotage of their own personal resources and protective factors; examples include dropping out of treatment, distancing themselves from personal relationships, and even destroying their own home or apartment. Some assailants may escalate substance use, knowing it will dis- inhibit them while others may shift to abstinence to increase their focus and dexterity. It can also include cruelty to animals as a form of practice or fixating into commitment, such as killing the family dog before killing the family itself (21).

Attack
This is the final stage and is the act or attempt to physically injure the target. Successful attacks, especially when consequences (natural, logical, or legal) do not occur, may reinforce aggressive behav- ior in the person of concern. A history of violence is one of the best predictors of future violence. It is not uncommon to see persistently violent offend- ers who, following an initial successful attack, demonstrate increasing magnitude and decreasing thresholds to attack again when slighted.

Many clinicians may see immediate par- allels between the pathway to violence and the stages of change (22). Grievance is similar to precontemplation. Ideation and research are similar to contemplation. Planning and breach correlate to determination or commitment. And, of course, action corresponds to attack. The correlation of the models invites the use of motivational interviewing methodology in interview, assessment, and development of strategies for the person of concern to change their behavioral pathway. Just as substance users are often ambivalent about their use, ambivalence can be common in potential assailants up to the moment of attack. Motivational interview- ing techniques and strategy may be helpful by creating an alliance with the person of concern, building understanding through exploration and empathy, and ultimately helping the individ- ual move toward changing their behaviors. Some possible interview questions are provided in Table 33.1.

THE CASE FOR THE ROLE OF EMERGENCY PSYCHIATRY
In most cases, psychiatric illness has little to do with gun violence or with mass shootings (23,24). Examined purely statistically, the rates of mental illness among perpetrators of violence is lower than the rate of mental illness in the general pop- ulation. Nonetheless, after many high-profile events, there is often an immediate ascription of blame to mental illness from pundits and policy makers (25,26). In American adults, the prevalence of a prior diagnosis of mental illness is 25% and the lifetime prevalence approaches 55% (27). In comparison, a study from the FBI Behavioral Analysis Unit looked closely at recent mass shooting offenders and identified psychiat- ric illness in only 25% of offenders (28). A long- term study looking at a century of data on mass murderers found a rate of 25% for mental illness
as well (29). And, notably, although psychotic illnesses play a substantial role in general violence risk, they accounted for only a minority of these active assailants in both studies. Some studies, have found lower rates of mental illness in mass shooting offenders: only 17% in school shooters, only 11% in other shooters, and one study found that only 4.7% of mass shooters in public locations had a psychiatric history severe enough to disqualify them from legally acquiring a firearm (ie, involuntary commitment, found incompetent to stand trial, or not guilty by reason of insanity) (30,31,32).

Although it is rarely stated explicitly, the implication is that if psychiatric services were better, somehow the person at risk would have been identified and helped (or hospitalized—not that they are mutually exclusive) prior to the attack. Thus, one could argue, emergency psychiatry is the linchpin: if, as suggested, these offenders were seriously mentally ill, then certainly if they had only been brought to a PES in time and been treated or admitted, then such tragedies would not occur. Emergency psychiatry is involved in the discussion about mass shootings because we were invited. It is an issue squarely in the lane of emergency health professionals. No studies have ever suggested that people with mental illness never engage in such violence and so the role of emergency psychiatry is to identify and stabilize those at risk.

In response to the debate, the American Association for Emergency Psychiatry (AAEP) issued a position statement about the role of mental illness in violence and mass shootings (33). It recognizes both that the role of mental illness in violence and mass violence is often exaggerated and that psychiatrists and emergency psychiatrists have an important role to play both in the evaluation and care of people at risk and in the ongoing public dialogue about appropriate public policy remedies for this issue. Anchored to the mission of promoting evidence-based and compassionate care for people with behavioral emergencies, it endeavors to mitigate stigma and risk alike through application of science and collaboration with other stakeholders. And, by including the idea of collaboration across disciplines, the AAEP position statement is compatible with and complements threat management. The core recommendations of the position statement are summarized in Table 33.2.

### PSYCHIATRIC ILLNESS AND THE PATHWAY TO VIOLENCE

In threat management, a mental illness is relevant in as much as it either facilitates a person of concern’s progression up the pathway to violence or slows down that progression. It is always an assessment based on the individual, their experience of the illness, and within the context of

#### TABLE 33.1 Interview Questions to Explore Progress Along the Pathway to Violence

<table>
<thead>
<tr>
<th>Grievance</th>
<th>Who has wronged you in your life? What experiences have you had where others have wronged you? What makes it difficult to forgive people who have wronged you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideation</td>
<td>You have described a number of ways others have hurt you; what can you do to set things right? Do you ever want to hurt people they way you have been hurt? What fantasies do you have about harming others?</td>
</tr>
<tr>
<td>Research and preparation</td>
<td>How would you attack this person (when, where, how)? What has kept you from attacking this person so far? What would be the most effective way to take care of the person who wronged you?</td>
</tr>
<tr>
<td>Breach</td>
<td>What is the closest you have gotten to attacking them? What has kept you from attacking them so far? What is your “go-ahead” condition to attack them?</td>
</tr>
</tbody>
</table>
other risk and protective factors. Extrapolating population-level, nomothetic research to understand individual level and idiographic behavior is challenging and fraught with inaccuracy and risk (34). Mental illness is relatively uncommon in people who engage in violence, including severe violence (35,36). There is no psychiatric illness or symptom which, in and of itself, necessary or sufficient as a risk factor for targeted violence. When psychiatric illness is present in a person at risk for violence, early identification, appropriate treatment, and careful follow-up can be essential to reducing the risk of attack or necessity for criminal justice involvement.

Perhaps it will turn out in future studies that the risk for engaging in mass violence intersects not with severe mental illness but with moderate mental illness. That is, the broad and severe impairment that typifies severe mental illness may be substantially incompatible with the capacity to plan and carry out a complex plan of attack. There are some disorders which may be seen more frequently in state or trait in individuals who engage or attempt to engage in planned and intentional violence which warrant additional discussion.

### Psychopathy

Psychopathy, as an intersection of antisocial and narcissistic personality, is often seen as an important risk factor for violence in general and targeted violence in particular (37,38). As with all risk factors, it is neither necessary nor sufficient in and of itself. However, the presence of psychopathy in a person who is contemplating targeted violence or otherwise at risk for violence may be at risk for greater magnitude or severity due to the lack of moral inhibitions against violence (39). Although oft debated, psychopathy is not currently recognized as a psychiatric disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM).

### Psychosis and Paranoia

Major psychotic disorders, especially schizophrenia and bipolar I, are often associated with violence especially earlier in the course of illness,

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**TABLE 33.2 Recommendations From the American Association for Emergency Psychiatry (33)**

1. All threats of violence must be taken seriously and receive a psychiatric evaluation within the capacity of the facility.
2. Optimal use of emergency and general psychiatric services will not eliminate community violence or mass shootings because of the limited role psychiatric illness plays in such events; however, when such cases do arise and are clinically identified, every reasonable clinical intervention should be considered.
3. Recognizing that violence is often multifactorial, consultation and collaboration amongst professionals (including health care and law enforcement) should be used to support multidisciplinary assessment and intervention including accessible psychiatric treatment.
4. Emergency department and PES decision-making should reflect clinically appropriate, ethical, and legal practices.
5. Care of violent and threatening patients is challenging and PES and ED programs should provide staff wellness resources to support optimal team performance.
6. The science of violence and firearm injury prevention is an actively developing science. Clinicians should consider violence an essential element of continuing education and the AAEP will prioritize relevant education and training for the membership.
7. Understanding concerns about media-related contagion, communications by healthcare providers or hospital spokespersons relating to such events should adhere when possible to best practices (www.reportingonmassshootings.org) including avoiding glamorizing the assailant or attack, using behavioral health experts to explain the science, and explaining that violence and mass shootings are complex with multiple causes.

AAEP, American Association for Emergency Psychiatry; ED, emergency department; PES, psychiatric emergency service.
with comorbid substance use, when resistant to treatment and when acutely symptomatic (40-42). Recent data have suggested that mental illness is uncommon in people who engage in mass shootings, and psychotic illnesses in particular are uncommon within that subset (28). There is also a frequent pattern of suspiciousness, mistrust, and alienation that is seen in people who engage in planned violence and which seems to suggest, at least, the trait of psychosis and persecutory and paranoid ideology (43).

**Autism Spectrum**

Several high-profile active shooters have been identified as having autism spectrum features. In general, autism is not significantly linked to violence, especially once attention-deficit/hyperactivity disorder (ADHD) and conduct disorder are controlled for (44,45). However, it has been suggested that features of autism, including persistence and planning, limited emotional reciprocity, and elevated risk of being psychologically abused or bullied by others (none of which are the exclusive domain of autism), may facilitate planned violence in some people already otherwise predisposed to engage in more extreme violence (46,47). Notably, although most experienced mental health professionals can readily discern autism spectrum from schizophrenia or antisocial personality and psychopathy, professionals in other disciplines may confuse the symptoms and the diagnoses. This may undermine the success of a threat management intervention plan constructed without the input of a mental health professional who can recognize the differences and help adapt the plan accordingly (48).

**LEAKAGE AND THREATS**

A threat is when a person of concern expresses intent to harm the target in a way that the target is aware of the danger; leakage is when that information is directed to or through a third party (49). Leakage and threats are a sensitive but nonspecific risk factor for engaging in serious violence; studies often identify leakage or threats in 80% or more of serious attacks including mass shootings and school attacks (28,31,50,51). Threatening behavior as a cause for admission is also a strong risk factor for inpatient violence (32). Numerous PES evaluations occur because a person has leaked or threatened a desire to harm others.

After a highly publicized event such as a mass shooting, PESs often receive an influx of people flagged as potential risks for similar acts. The initial response of many clinicians is exasperation and a sense that others are overreacting. Indeed, people are more likely to categorize a person as being at risk if they have just been thinking about a highly risky event (53,54). Apophenia—a tendency to see threatening patterns in behavior which are not actually present is a known reaction to fear and stress (55,56). However, clustering of mass shootings does occur after highly publicized events so there likely is an increased probability of encountering a person at risk for engaging in a major attack amid the flurry of other referrals (57-59). Although it may be frustrating to be seeing an increased number of persons who may or may not have made a bona fide threat, it is important to evaluate each threat and each threatener carefully. Threats and leakage are a sensitive but not a specific risk factor for future violence.

Consider four basic categories of the potential threats and threateners seen in the PES, especially after highly publicized violent events: pseudothreateners, hoaxers, hotheads, and bona fide threats.

**Pseudothreatening Outliers**

This category includes people with no intent to threaten or harm but behavior is awkward, intimidating, or disruptive enough to provoke anxiety in others. These may be people with autism spectrum disorders or schizotypy, people with an unexpectedly loud or disruptive tone or merely people who are engaging in benign activities who are misperceived because of stereotype or prejudice (60). Although PES clinicians should in no way pathologize a target of stereotype or stigma, some of these persons may show developmental or personality features, communication disorders, or other issues that, if not previously identified, may benefit from clinical intervention or support.

**Hoaxers and Trolls**

The concept of instrumental or sadistic threats is well understood and, while possibly exacerbated in an era of social media and electronic communication, has been present for some time. These
threats are often anonymous but are occasionally traced back to the perpetrator. They are made without any intent to actually harm the target physically but merely to intimidate that person or disrupt operations of a facility (eg, anonymous bomb threats to a school). Clinicians may identify conduct disorder or personality disorder in these persons; treating comorbid mood or substance use disorders may decrease their risk for future antagonistic behavior as will, of course, natural consequences for criminal conduct.

**Hotheads**

This category impulsively makes menacing or threatening statements when upset or angry without sustained (or any) intent to carry out attack. Intermittent explosive disorder, other impulse control disorders, mania, or substance use may be identified and may benefit from targeted treatment including education on coping skills.

**Bona Fide Threats**

This is the most concerning category: a person contemplating or moving toward an attack with real intent to harm others. This category may or may not have treatable psychopathology, but, if and when present, such illness should be treated aggressively.

**ALL THREATS MUST BE TAKEN SERIOUSLY**

Conceptually, the premise that all threats must be investigated and all threateners evaluated for clinical needs is cardinal. As discussed above, threats and a history of violence are critical risk factors to consider in the evaluation of violence; threats and leakage are a highly sensitive risk factor for future violence. Additionally, acute stressors and losses including romantic or personal relationships, employment and financial security, medical illness, and housing have all been associated with risk of violence in people with and without mental illness and across the spectrum of violence types (28,31,46,61,62). Substance use and intoxication has been widely recognized as a potent risk factor for violence and also is significant both for people with and without other mental illness (63-66). People who perceive the world as an inherently dangerous or threatening place automatically believe neutral actions of others are intentionally harmful or demeaning to them, or have other features of a hostile attribution bias have significant risk for violence (67,68). Similarly, external attributional style including an inability to take personal responsibility and blaming others for their own shortcomings or failures is at elevated risk for violence—and this may come out in the aforementioned paranoid or persecutory delusional pattern (69,70). Finally, suicidality and hopelessness may also be a risk factor for violent behavior (as the opposite is true as well); notably, many mass shooters either kill themselves or expect to be killed in their attacks (71,72). Consider the mnemonic in Table 33.3 as a useful tool.

**ATTACKS, TARGETS, AND AGGRESSORS**

Targeted violence is a complex, dynamic problem, both in the colloquial and the scientific sense of those terms. Effective interventions themselves will also need to be complex and nuanced—and to move beyond the traditional concept of merely

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**TABLE 33.3 All THREATS Must Be Taken Seriously**

| T  | Threats and leakage about violence toward others |
| H  | History of violence toward others, especially the identified target |
| R  | Recent stressors or losses (financial, relationship, medical, employment, housing) |
| E  | Ethanol or other drug abuse |
| A  | Agitated or annoyed easily (hostile attributional style) |
| T  | Takes no responsibility for actions (external attributional style) |
| S  | Suicidal or hopeless |
disrupting or stopping the attack through admission (or arrest) of the person of concern or warning of the target.

Security professionals often discuss the idea of hardening the target: this is a concept which extends the traditional idea of warning and adds some degree of counseling or provision of resources to potential targets. If the target is an organization, especially one with its own security resources, this could take the form of adding security professionals, surveillance for threats, countersurveillance to disrupt or block stalking or pursuit, or simply relocation of the target from the zone of danger (eg, paid leave). As clinical professionals, PES providers may also consider helping the target, especially if the target is an individual person. Although law enforcement colleagues may be able to provide essential counseling in situational awareness or even self-defense training to a potential target, attending to the psychological needs of the individual or linkage to appropriate victim advocacy services may be helpful as well. Targets of workplace threats or violence can be linked to Employee Assistance Programs; the impact of threats or violence can be significant, and Critical Incident Stress Management or similar interventions for impacted individuals or teams should be considered.

Although our role as clinicians is often focused on the person of concern (ie, identifying and treating contributing psychiatric illnesses), this concept of aiding the aggressor to decrease their risk may not be identified as a priority by others involved in threat management. It should not be neglected as doing so may both decrease the risk of harm to the current (or future) targets but can also improve the quality of life and well-being of the person of concern.

COLLABORATION: AD HOC AND INTENTIONAL

Psychiatry, acting alone, will often struggle to fully and effectively evaluate a threat. In part, this is due to many risk factors extending beyond mere diagnosis and symptoms. In part, this is due to many elements of data relevant to assessment often being unavailable to evaluating clinicians in a PES. Input from collateral and coordination with law enforcement is often necessary to mitigate violence risk. This is not to say that PES clinicians should be routinely involving law enforcement, but rather to suggest that such collaboration and coordination of efforts may be ethical, legal, and even clinically optimal for the person of concern. This may be a particular concern when assessment and treatment as usual are expected to yield foreseeably unsatisfactory results.

Threat management, as a multidisciplinary approach to an interdisciplinary problem, integrates subject matter and operational expertise to identify effective strategies and tactics to disrupt attacks before they happen. Categories of interventions include blocking the attack, hardening the target and altering target behavior, and intervening with the person of concern (73). Threat management draws expertise and evidence from behavioral sciences, law enforcement, law and risk management, intelligence, operational security, and other fields; it uses an investigative and preventive mindset to derail attacks before they occur (74). Arguably, with expertise in violent behavior management and legal aspects relating to commitment and duties to third parties, emergency psychiatrists and emergency medicine physicians can be especially effective team members.

Collaboration may occur ad hoc when a person of concern is identified by law enforcement and brought to a PES for evaluation or the PES team identifies a person of concern and reaches out to law enforcement for collaboration. Ideally, established teams exist on an ongoing basis, working closely together through actual cases and role plays, with explicitly defined roles and processes (75). Of course, many ongoing teams begin when the same professionals find themselves working through similar cases repeatedly and opt to shift from a reactive to a proactive stance (76).

The Health Insurance Portability and Accountability Act of 1996 Privacy (HIPAA) regulations specifically permit sharing of information to prevent intentional and severe violence when doing so is within the ethical standards of the professional or the applicable jurisdictional laws (77,78). Jurisdictional and professional standards vary and evolve over time; the prudent practitioner would be well served in attending to their nuances (79,80). Resources providing guidance in the ethical and legal sharing of information with
CONCLUSION

Violence risk is one of the most common and concerning chief complaints in the PES. Our clinical evaluations can benefit from integrating threat management principles into our direct work and by developing collaborative threat management processes through ad hoc cooperation or the development of formal and informal teams. Although only a minority of violence is attributable to psychiatric illness, psychiatric emergency professionals have valuable expertise nurtured from their experience with high-risk patients, familiarity with legal issues including commitment and duties to third parties, and through their comfort working with complex cases and relationships. Although media coverage may falsely portray mass violence as psychiatric issue, the increasing frequency of mass violence is also creating a growing need for effective collaboration between emergency psychiatry and other threat management professionals.

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Family Educational Rights and Privacy Act
A Guide for First Responders and Law Enforcement

What is FERPA?
The Family Educational Rights and Privacy Act (FERPA) is a Federal law that protects the privacy of student education records. The law applies to all educational institutions and agencies (termed “schools” below) that receive funds under any U.S. Department of Education program. FERPA gives parents certain rights with respect to their children's education records. These rights transfer to the student when he or she reaches the age of 18 or attends a postsecondary institution. Students to whom the rights have transferred are “eligible students.”

FERPA protects the rights of parents or eligible students to:
- inspect and review education records;
- seek to amend education records;
- consent to the disclosure of information from education records, except as specified by law.

What information can schools provide to law enforcement?

Generally, schools may disclose personally identifiable information (PII) from students’ education records to outside parties, including local law enforcement, only if the parent or the eligible student has provided prior written consent. “Education records” are defined as those records that are directly related to a student and maintained by a school or a party acting for the school, and include student records such as transcripts, disciplinary records, immunization records, and other similar records.

However, there are exceptions to the definition of “education records.” One of these exceptions is for school “law enforcement unit (LEU) records.” These records are defined as records that are (1) created by a LEU; (2) created for a law enforcement purpose; and (3) maintained by the LEU. These records are not protected under FERPA and can be disclosed according to school policy or as required by law. Education records that are in the possession of the LEU do not lose their status as education records and must continue to be protected under FERPA.
Discussed below are some relevant exceptions to FERPA’s general consent rule that permit the non-consensual disclosure of PII from education records to law enforcement agencies:

**Schools may non-consensually disclose designated “directory information” to law enforcement agencies.**

This is permitted if the school has provided notice to parents and eligible students of PII from student education records that the school has designated as directory information and if the parents and eligible students have not opted out of directory information disclosures. Directory information is information from an education record that would not generally be considered harmful or an invasion of privacy if disclosed and may include items such as name, address, telephone listing, and participation in sports.

**Schools may non-consensually disclose PII from education records in connection with a health or safety emergency.**

When an articulable and significant threat exists – anything from an active shooter to a hazardous weather event to a chemical spill – school officials are permitted to disclose PII from education records to appropriate parties, such as law enforcement, in order to protect the health and safety of students or other individuals. Schools are allowed to share this information only during the period of the emergency, and they have to meet certain recordkeeping requirements.

**Schools may non-consensually disclose PII from education records in order to comply with a judicial order or a lawfully issued subpoena.** Prior notification to parents and students is generally required, though there are some exceptions for law enforcement subpoenas where the court or issuing agency has ordered that the existence or contents of the subpoena or the information furnished in response to the subpoena not be disclosed.

**Questions about FERPA?**

Email the U.S. Department of Education’s Family Policy Compliance Office with questions about FERPA at FERPA.Customer@ed.gov. You may also contact your legal counsel for advice.
Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule: A Guide for Law Enforcement

What is the HIPAA Privacy Rule?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule provides Federal privacy protections for individually identifiable health information, called protected health information or PHI, held by most health care providers and health plans and their business associates. The HIPAA Privacy Rule sets out how and with whom PHI may be shared. The Privacy Rule also gives individuals certain rights regarding their health information, such as the rights to access or request corrections to their information.

Who must comply with the HIPAA Privacy Rule?

HIPAA applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically (e.g., billing a health plan). These are known as covered entities. Hospitals, and most clinics, physicians and other health care practitioners are HIPAA covered entities. In addition, HIPAA protects PHI held by business associates, such as billing services and others, hired by covered entities to perform services or functions that involve access to PHI.

Who is not required to comply with the HIPAA Privacy Rule?

Many entities that may have health information are not subject to the HIPAA Privacy Rule, including:

- employers,
- most state and local police or other law enforcement agencies,
- many state agencies like child protective services, and
- most schools and school districts.

While schools and school districts maintain student health records, these records are in most cases protected by the Family Educational Rights and Privacy Act (FERPA) and not HIPAA. HIPAA may apply however to patient records at a university hospital or to the health records of non-students at a university health clinic.
Under what circumstances may a HIPAA covered entity disclose PHI to law enforcement?

A HIPAA-covered entity may disclose PHI to law enforcement with the individual’s signed HIPAA authorization.

A HIPAA covered entity also may disclose PHI to law enforcement without the individual’s signed HIPAA authorization in certain incidents, including:

- To report PHI to a law enforcement official reasonably able to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public.

- To report PHI that the covered entity in good faith believes to be evidence of a crime that occurred on the premises.

- To alert law enforcement to the death of the individual, when there is a suspicion that death resulted from criminal conduct.

- When responding to an off-site medical emergency, as necessary to alert law enforcement to criminal activity.

- To report PHI to law enforcement when required by law to do so (such as reporting gunshots or stab wounds).

- To comply with a court order or court-ordered warrant, a subpoena or summons issued by a judicial officer, or an administrative request from a law enforcement official (the administrative request must include a written statement that the information requested is relevant and material, specific and limited in scope, and de-identified information cannot be used).

- To respond to a request for PHI for purposes of identifying or locating a suspect, fugitive, material witness or missing person, but the information must be limited to basic demographic and health information about the person.

To respond to a request for PHI about an adult victim of a crime when the victim agrees (or in limited circumstances if the individual is unable to agree). Child abuse or neglect may be reported, without a parent’s agreement, to any law enforcement official authorized by law to receive such reports.

For More Information

This is a summary of the relevant provisions and does not include all requirements that are found in the HIPAA Privacy Rule. For complete information, please visit the U.S. Department of Health and Human Service’s Office for Civil Rights HIPAA web site at http://www.hhs.gov/ocr/privacy.
Evaluating threats of mass shootings in the psychiatric setting

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Evaluating threats of mass shootings in the psychiatric setting

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ABSTRACT

Psychiatrists may encounter patients at risk of perpetrating mass shootings or other mass violence in various settings. Most people who threaten or perpetrate mass violence are not driven by psychiatric symptoms; however, psychiatrists may be called upon to evaluate the role of mental illness plays in the risk or threat, and to treat psychiatric symptoms when present. Regardless of whether psychiatric treatment is likely to reduce symptoms or the potential for violence, the psychiatrist should collaborate closely with law enforcement, potential targets, and other agencies involved to mitigate risk. Such communications are governed by various privacy laws and duties to third parties. Additional measures, like protective orders, may be a means of restricting the subject’s access to firearms.

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Mass shootings; firearms; mental illness; red flag laws; violence; forensic psychiatry; gun violence

Intro, epi and definitions

In the last two decades, mass shootings have become a rare but traumatic part of American life. In 2019, there were 10 heavily publicised public mass shootings (in which three or more people were killed) that took the lives of 73 Americans and injured 112 more (Follman et al., 2020). It is the seemingly random public mass shootings of strangers that are widely reported in the media, despite the fact that they comprise less than 1% of firearm deaths in the United States (Follman et al., 2020; CDC, 2020). Public mass shootings inspire fear because of the perception they could strike anyone in places once considered safe like churches, malls and schools. One-third of Americans reported avoiding certain places because of fear of such incidents (American Psychological Association, 2019).

Mass shootings are the most common form of mass violence in the United States. This is due, at least in part, to the extraordinarily large amount of firearms in civilian hands in the U.S., amounting to approximately 46% of the all civilian-owned firearms in the world. The U.S. has more privately-owned firearms than the next thirty-nine countries combined (Karp, 2018). The abundance of firearms leads to disproportionate burdens of mass shooting casualties as well as smaller scale assaults and homicides, and suicides (Grinshteyn & Hemenway, 2016, 2019; Lankford, 2016). However, many of the considerations for psychiatric evaluation of people suspected of planning to carry out mass shootings apply to mass attacks with other weapons such as knives, explosives or vehicles.

Quantitative reports of mass shootings are inconsistent because researchers and agencies use different data sources and different criteria. Datasets diverge on setting (some exclude incidents occurring in homes; some include only incidents in public places), types of injuries (e.g. firearm injuries vs. injuries incurred in fleeing vs. non-firearm attacks), source (e.g. FBI Crime Reports vs. media reports), and thresholds of the number of people injured or killed to count as a case. Some datasets expressly exclude terrorist acts, but a substantial minority (43%) of these mass violence incidents may have social, political, or ideological motivation, be intended to influence large groups of people, or otherwise qualify as a terrorist act (Hunter et al., 2020). Domestic violence incidents are also frequently excluded from datasets,
though there is mounting evidence that intimate partner violence and violent misogyny play a role in many of these incidents (Silva et al., 2021; Zeoli & Paruk, 2020). Because of the variations in definitions and data sources, the datasets never overlap completely and at times can verge on being mutually exclusive (Booty et al., 2019).

These heterogenous datasets make discerning trends amongst mass shooters challenging. However, some common motivations emerge: political or religious ideology, vengeance for longstanding grudges, psychosis (Langman, 2009; Schildkraut et al., 2020). A subset of mass shooters admire prior mass shooters and are seeking similar notoriety for themselves (Langman, 2018; Silva & Greene-Colozzi, 2019). Revenge for a central grievance is often seen as the first step towards engaging in targeted violence (Calhoun & Weston, 2003; Fein & Vossekuil, 1998).

While many of these characteristics are identified as commonalities among mass shooters in hindsight, they are common traits among the general population and lack the specificity they would need to be predictive. Additionally, they are not mutually exclusive and often multiple motivations co-exist.

If identifiable, motivations can be useful in identifying an appropriate intervention. An attack planned because of delusional beliefs could benefit from psychiatric treatment; an attack motivated by political extremism may benefit better suited for a deradicalization approach. Just as in every aspect of medicine: while broad commonalities may provide useful schema for guiding evaluation and formulation, assessment should be adaptive and treatment planning should be individualised.

The majority of public mass shooters do not have a pre-existing psychiatric diagnosis, and amongst those that do, psychosis is an infrequent factor (Silver et al, 2018). Nonetheless, there have been a number of well-publicised mass shootings perpetrated by people with overt psychotic symptoms. The DC Navy Yard shooter had reported that he was being controlled by “extremely low frequency electromagnetic waves” that were coming in through the walls of his hotel room and preventing him from sleeping (Herman and Marimow, 2013). A woman with a diagnosis of schizophrenia and previous hospitalisations opened fire in the lobby of a television station that she believed was broadcasting stories about her sex life (Butterfield, 2000). The man who shot Gabriel Giffords at a campaign event, believed that the US government was faking space flights and printing counterfeit currency (Hudson, 2011).

Regardless of whether mental illness plays a role, psychiatrists faced with such cases have a variety of tools at their disposal to mitigate the risk of public violence, to treat any contributory mental illness, and to minimise personal liability. The approach includes a thorough psychiatric assessment, treatment for any underlying contributing mental illness, close collaboration with law enforcement agencies, communication with potential targets if appropriate (schools or workplaces), and removal of access to firearms.

### Psychiatric assessment and treatment

Psychiatrists may encounter patients at risk of perpetrating mass violence in the outpatient, emergency, or inpatient setting. Patients may present because of direct and overt threats or because of subtle but concerning statements. Leakage – a statement or indication of violent intent by the patient to a third party – is common in people who engage in mass violence and often a cause for referral for psychiatric evaluation (Meloy & O'Toole, 2011). The violent intent may be the reason for presentation or simply an issue revealed during an otherwise routine assessment. In crisis or emergency settings, these evaluations may be initiated by law enforcement bringing the patient in on an involuntary hold for dangerousness, at times in the absence of overt psychiatric symptoms or history.

In such cases with both a criminal justice and a mental health component, there may be unrealistic expectations of threat reduction by the different parties. Law enforcement teams may erroneously believe that mental health holds will allow for indefinite detention and loss of access to firearms, or expect that psychiatric treatment will cure the patient of any underlying violent tendencies. Mental health professionals may not be familiar with the level of evidence required to arrest and bring charges in various jurisdictions, and the amount of time needed for a complete investigation. In such cases, it is important to consider the timeframes and potential efficacy of interventions from various agencies working on the case, and keep open lines of communication to ensure public safety.

### Understanding the role of psychiatric illness in mass shootings

It should be emphasised that most general violence is not attributable to mental illness or people with mental illness (Swanson, 1996). Amongst people with
mental illness, symptoms drive acute risk, not the presence of a diagnosis itself; similarly, current and recent intoxication drive risk in substance users (Mulvey et al., 2006; Skeem et al., 2006).

The view that mental illness is a central risk factor for mass shootings is not substantiated by most available research, and is driven by public misperception and stigma (Metzl et al., 2021; Rozel & Mulvey, 2017; Skeem & Mulvey, 2019). A majority of studies indicate that overt psychiatric illness is present in less than half of mass shooters. In one of the more robust studies from the FBI, only 25% of mass shooters had an identified psychiatric illness and only a quarter of those had evidence of psychosis (Silver, Simons, et al., 2018). More common factors were longstanding grievance, recent loss, and behavioural problems at school or in the workplace (Silver, Simons 2018; National Threat Assessment Centre).

Thus, a person at risk of committing a mass shooting may not present for overt psychiatric symptoms, but instead for acute psychosocial stressors, threats, or indirect statements of intent to kill others – common chief complaints in acute psychiatric settings and risk factors for engaging in violence (Alathari et al., 2019; Silver, Simons, et al., 2018). It is possible that many mass shooters meet the diagnostic criteria for personality disorders, but there is little recorded diagnostic data to support this. Low rates of diagnosed personality disorders or other psychiatric illness in mass shooters may be due to lack of information about assailants and low rates of access to psychiatric evaluation (Lankford & Cowan, 2020). Given the relatively high baseline rates (55-85% in some studies) (Caspi et al., 2020; Kessler et al., 2005) of psychiatric diagnoses in the United States, the question becomes not whether a potential perpetrator of mass violence has a mental illness, but whether the symptoms of the illness cause the violence, and if there is a potential, plausible way for the mental health system to mitigate said risk of violence.

**Grievances, paranoia, and entitlement**

The pathway to targeted violence often begins with a grievance or a grudge: a person perceives they have been wronged and clings to and fixates upon the perceived wrong (Calhoun & Weston, 2003; Corner et al., 2018; Stone, 2015). People with paranoid tendencies, ranging from subsyndromal traits to overt psychotic illness or personality disorder frequently perceive threat or harm from the environment around them. These traits and disorders are frequently seen in people who plan or carry out mass shootings and other types of targeted violence (Knoll & Meloy, 2014; Mullen, 2004). A fixation on the belief that one has been wronged by others and loss of insight may progress at varying rates and may be influenced by peers and social interactions which reinforce such beliefs (Rahman et al., 2020). These features are more common than formal psychotic symptoms or diagnosis, which are present in only a small minority mass shootings and mass murders (Brucato et al., 2021; Silver, Simons, et al., 2018).

**Suicide risk**

A substantial number of mass shootings end in a suicide, suicide by cop, or attempted suicide (Medical Directors’ Institute, 2019). People who made serious threats of violence towards others are more likely to die of suicide than to complete a homicide (Warren et al., 2008; Warren et al., 2011). Homicides followed by suicides are of significant concern, especially in cases with a nexus with intimate partner violence (Ilic & Frei, 2019; Large et al., 2009; Zeoli, 2018). As such, any evaluation of violence risk should also include a thoughtful evaluation of suicide risk. It has been widely noted that many of the risk factors for imminent violence overlap with those for suicide.

**Identification of treatment targets**

The priority of psychiatric assessment in clinical settings is to identify treatable psychiatric illnesses, even those which may not appear to directly contribute to violence risk. The alleviation of suffering is a fundamental ethical value of clinical work, and to whatever degree identified psychopathology may contribute to the risk, treatment may help mitigate the risk.

As a secondary goal, identification of other dynamic or modifiable risk factors for violence should be identified and, when possible, interventions offered. These may be psychosocial risk factors (such as homelessness, employment or financial stressors), medical concerns (directly or indirectly contributing to violence risk), or even personality or cognitive issues (such as rigid or inflexible thinking). To be clear, any identified psychiatric illness that is amenable to treatment may and should be a valid target for intervention, but violence is complex, and broad awareness and individualised intervention to address multiple risk factors – psychopathology, environment, sociopolitical issues, and others – is vital (Corner et al., 2018).
The THREATS3 mnemonic incorporates frequent and significant risk factors for mass shootings and other types of mass violence. As a general practice, any person evaluated who has made direct threats or leakage or any person with a history of violence and any of the remaining elements may warrant heightened scrutiny (Table 1).

<table>
<thead>
<tr>
<th>Table 1. Investigate all THREATS³.</th>
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<tbody>
<tr>
<td>T Threats, leakage, or other statements of intent to harm made currently or recently</td>
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<tr>
<td>H History of violence, especially with the identified target or in an escalating pattern</td>
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<tr>
<td>R Recent stressors (relationships, finances, housing, employment, health, victimization)</td>
</tr>
<tr>
<td>E Ethanol / other drug intoxication, current or frequently present</td>
</tr>
<tr>
<td>A Agitated / annoyed easily (Hostile Attributional Style)</td>
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<tr>
<td>T Takes no responsibility (External Attributional Style)</td>
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<tr>
<td>S Suicidality, increasing hopelessness</td>
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<tr>
<td>S Symptomatic psychiatric illness currently or frequently present</td>
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<tr>
<td>S Specific target / access / means identified</td>
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The THREATS3 mnemonic incorporates frequent and significant risk factors for mass shootings and other types of mass violence. As a general practice, any person evaluated who has made direct threats or leakage or any person with a history of violence and any of the remaining elements may warrant heightened scrutiny (Table 1).

**Level of care**

In cases in which psychosis or a treatable mental illness is driving the potential for violence but involuntary hospitalisation is unfeasible, court-ordered outpatient treatment, also known as assisted outpatient treatment (AOT), has shown potential to reduce violence. Studies in New York and North Carolina showed that people with serious mental illness who were court-ordered to treatment had reductions in violent acts by around 50% (Phelan 2010; Swanson 2000).

These studies looked at community violence not incidents of mass violence, and the subjects were people with a diagnosed serious mental illness. Thus, the results may not translate well to acts of mass violence in which the person may be more commonly driven by a desire for revenge or a non-delusional ideology of hate. Nonetheless, in some cases, AOT may be a useful tool for psychiatric providers. While it is legally available in nearly all states, the details of the orders and the degree of implementation varies highly between and within states.

When serious threats of violence are encountered in a new patient, or newly revealed in an established patient, acute psychiatric admission may be indicated to support further investigation of the threats or leakage, identification of risk factors amenable to intervention, and clarification of possible targets who may need to be warned. For outpatients, this may be damaging to an established therapeutic alliance. However, with high stakes of public safety, it may be prudent to err on the side of caution and admit for a more detailed evaluation.

**Other clinical considerations: consultation and documentation**

A brief evaluation in a PES or a new referral to an outpatient clinic may not afford the time or resources for fully evaluating, formulating, and mitigating violence risk. Fatigue and time pressure can impair the emergency psychiatrist’s ability to provide a thorough and thoughtful evaluation and to identify the flexible and compassionate interventions that may be needed (Scarry, 2011).

The mantra of “never worry alone” is ubiquitous in forensic and emergency psychiatry. At a minimum, this may consist of formal or informal consultation with a seasoned colleague and coordination with others involved in the care of the patient. When possible, a formal second opinion may be prudent, or in the outpatient setting, a referral made to a PES for further evaluation.

The medical record should convey the content of an evaluation, the formulation of the patient, and the judgement and decision-making process of the clinician. Careful documentation may also serve to mitigate liability in as much as reflect the appropriate judgement of the clinician (Rozel & Zacharia, 2021). Elements to consider in documentation (beyond traditional elements of a psychiatric evaluation) include detailed information about putative targets, access to firearms and other weapons, experience or history with weapons, and a detailed discussion of the identification and mitigation of risk factors and the reinforcement of protective factors. Documenting consultation may be helpful but caution should be taken when documenting consultation with the hospital’s or physician’s legal advisor, as it may contain privileged information.

**Reducing access to firearms**

**Firearm prohibitions**

While the motives for mass violence may be difficult to ameliorate (or even identify), restricting access to firearms is a crucial component of risk reduction in cases where mass shootings are threatened. In the United States, many firearm restrictions are aimed at people with mental health histories, while others target those who have made specific threats. However, mental-health based prohibitions appear to lack the
sensitivity and specificity to be effective mechanisms of violence prevention (Swanson et al., 2016). Research indicates that the likelihood of a mass shooter having a psychiatric illness severe enough to disqualify them from firearm access was less than 5% (Silver, Fisher, et al., 2018).

The Gun Control Act of 1968 prohibits anyone “committed to a mental institution” from owning or purchasing a firearm. However, this prohibition does not apply to people on emergency psychiatric holds; it is activated only at the time of a hearing before a judge or hearing officer who certifies their civil commitment in a court of law. Thus an emergency psychiatric hold or admission to a psychiatric facility will not necessarily result in a firearms prohibition. Additionally, while a certified commitment may make any firearms the person already owns now illegal, most states besides California lack comprehensive registries of owners, and few have protocols to remove illegally owned guns from a person’s possession (Wintemute et al. 2017).

Other prohibitory criteria include mental health conservatorships, findings of incompetency to stand trial, pleas of not guilty by reason of insanity, convictions on felony charges, and court-ordered outpatient treatment. Patients who have experienced one of these disqualifying events will, in theory, have their names uploaded to the federal NICS database. Then, at the time they attempt purchase from a federally licenced dealer, their background check would show they were prohibited and the sale would be denied. However, millions of names of prohibited persons are missing from the federal database. Additionally, in twenty-eight states (Giffords), background check are not required on private sales, so this system of preventing access to firearms is imperfect.

**Protective orders**

Depending on the target of the threat and the jurisdiction, various protective orders may be available to restrict contact with the threatened parties, prohibit firearm possession, or both.

Many mass shooting incidents are at least in part incidents of domestic or intimate partner violence, and a domestic violence protective order (DVPO) is a potential mechanism of both protection and firearm prohibition. Federal law prohibits respondents to an active DVPO from owning or purchasing a firearm. Some states require an order in full effect (not an ex-parte or emergency order) before firearm prohibitions are enacted, though some allow for firearm removal and prohibition with an order before hearing (Zeoli and Paruk, 2020).

Clinicians are generally not able to petition for DVPOs on behalf of their patients, but in cases where there is concern for overlapping domestic and mass violence, they can provide resources and assistance to patients who wish to file a DVPO.

Many states also have workplace or school protective orders to address threats of violence that are not directed at an intimate or domestic partner. These are applicable in cases in which there has been violence or a credible threat of violence directed at an employer or co-worker, or in the workplace. In most states, the employer can petition on behalf of an at-risk employee. These orders prohibit contact between the parties, and in some states can prohibit the respondent from owning or purchasing a firearm. As with DVPOs, clinicians cannot petition for a workplace protective order on behalf of the threatened party (unless they were the employer whose workplace was at risk), but may be able to advise affected parties of the option.

Extreme Risk Protection Orders (ERPOs), also known as “red flag laws”, are available in nineteen states and the District of Columbia (Campbell, et al. 2018). They provide a way to remove any firearms and ammunition currently in the possession of the subject, and prohibit them from purchasing more for a time period in the future (usually six months to a year). ERPOs generally do not require any mental health history nor any criminal activity, only an imminent risk of harm to self or others.

In most states, family members and law enforcement can petition for these orders, though in Maryland, Washington DC, and Hawaii, certain healthcare providers can also petition. In California, teachers and employers can petition. ERPOs are focussed on removing access to firearms and do not include the stay away or no-contact orders that may be part of other protective orders. They are focussed on violence risk, not mental health history, and do not include a provision for mandatory psychiatric treatment. However, one study in Connecticut found that they did serve as a bridge to mental health services for about 15% of respondents. This study also identified a substantial reduction in suicide risk based on the use of ERPOs, again highlighting the intersection between violence risk and suicide risk (Swanson et al., 2017).

In situations in which a patient owns or has intent to purchase a firearm, the evaluating psychiatrist may wish to consider discussing such an order with the
involved law enforcement agency or concerned family member.

One case series of California’s ERPO looked at 21 orders filed out of concern for mass shootings, in which 52 firearms were removed. Though it’s unknown what would have happened without the orders, there were no acts of firearm violence or suicide perpetrated by any of the respondents in the subsequent year (Wintemute et al., 2019), indicating it may be an effective intervention in cases of mass shooting threats. While many states passed ERPO laws in direct response to mass shootings, the majority of these orders have actually been used in cases where there was concern for suicide (Swanson et al., 2017). However, given the number of public mass shooting perpetrators who ultimately take their own lives, there may be overlap between risks.

Collaboration with law enforcement

Many of these cases will have both a legal and a mental health component, thus it is important to consider both aspects of intervention, and keep open lines of communication between agencies working on the case.

Developing formal threat management teams can be a critical step and can be done following established best practices for communities and medical centres. (Behavioral Analysis Unit, 2016; Medical Directors’ Institute, 2019). Working across silos is an essential element of effective threat management and building a network of colleagues involved in threat work can be critical to successfully and safely resolving cases, expanding resources, and supporting training.

Cross jurisdictional challenges

In the United States, threat cases often cross state lines and thus may exceed the resources or authority of local law enforcement to investigate or intervene. This is especially true for threats made on social media and cyberstalking. The Tips Line of the Federal Bureau of Investigation may often be the best resource in such cases that transcend local law enforcement jurisdictions (http://www.fbi.gov/tips or 1-800-225-5324 [800-CALLFBI]). Internationally, resources will vary substantially based upon nation and region. It is critical to identify a point of contact who has a leadership or investigatory role with whom to establish ongoing communication.

Duties to third parties

Privacy concerns

Within the United States, communication with law enforcement to prevent violence is a permitted disclosure under the Health Insurance Portability and Accountability Act (HIPAA) (Rodriguez, 2013). HIPAA explicitly allows for disclosure if a patient makes a “serious and imminent threat” of violence and such a disclosure “is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others” and “is to a person(s) reasonably able to prevent or lessen the threat.” The US Department of Health and Human Services states, “HIPAA expressly defers to the professional judgment of health professionals in making determinations about the nature and severity of the threat to health or safety posed by a patient.” Extensive guidance is available on appropriate information sharing and building collaborative relationships within the framework of HIPAA (Pettrila & Fader-Towe, 2010).

Thus, in the case of a patient who poses a risk for public violence, it is appropriate and allowable to communicate with law enforcement about clinical progress, court hearings and discharge plans. Releasing a patient under investigation without alerting the investigating or legal authorities could result in a bad outcome that could have been mitigated by sharing the information about their release. Ongoing communication may also allow law enforcement time to gather evidence for an arrest, file an ERPO petition and remove firearms, or plan for further surveillance or outreach.

It is not clear if threats made by a patient to attack third parties, when made within the context of mental health treatment, can be used for criminal prosecution. The matter of whether therapist-patient privilege includes threatening communications, and the specific question of whether those communications are admissible in criminal court, has been considered in a number of Federal Circuit Courts with varied outcomes (Hills 2017). Note that the purpose of warning under the Tarasoff doctrine is generally interpreted to
support the overarching goal of protection, not prosecution. Further, some laws on threatening communications require that they be heard by the putative target or that they be made in non-privileged contexts (e.g., on social media) to be criminal. That said, in some cases criminal justice referral may be appropriate or necessary; proactive consultation with legal counsel is advised.

In addition to communications with law enforcement, potential targets should be notified if possible. Such a communication would be to “a person(s) reasonably able to prevent or lessen the threat”, and therefore an allowable disclosure under HIPAA.

Whereas HIPAA permits such a disclosure, in most of the United States, there is a duty to warn or protect a potential victim under specific circumstances: if a patient communicates to a psychotherapist a threat of serious harm to an identifiable victim. Based on a famous lawsuit in California, Tarasoff v. Regents of the University of California, these laws are often collectively referred to as the Tarasoff Duty. Such rules may protect the therapist from civil liability for negligence if the therapist makes reasonable efforts to protect or warn the potential victim in such a case.

Duties to third parties vary substantially across jurisdictions and professions with each state approaching the issue in its own distinct way (Johnson et al., 2019; NCSL, 2018). Whether the duty is to warn or protect (or both) depends on the jurisdiction. Interpreting and applying these rules across state lines may be especially complex given the interstate variations which may be a particular challenge for professionals who work across state lines via telehealth or who work near a state border. Law enforcement are frequently involved in either case. This duty is regardless of any psychiatric contribution to the potential for violence (NCSL 2010; Soulier 2010).

Legal and ethical standards for duties to potential victims vary substantially across nations (Leach, 2009). Most European and economically developed countries appear to have some sort of duty to warn – with the possible exception of Austria which has statutes which protect therapeutic communications absolutely (Gavaghan, 2007; Gutiérrez-Lobos et al., 2000; Mulheron, 2010). Japan has no statute creating such a duty and appears not to have court rulings establishing such a duty (Kadooka et al., 2016).

When possible, psychiatrists can consult with available legal advisers who have the expertise in complex duty to third party cases. Depending upon the clinical context, risk management consultants or even malpractice insurance providers – which may be the only readily available expert for consultation for private practice professionals – may also be useful resources. Such consultation can provide aid in deciding between the alternatives of facing litigation for breach of confidentiality versus failure to warn of threats with potential for serious harm.

While legal duties to third parties, if any, are often limited to warning or protecting a target, in some situations it may be reasonable to explore helping the target if possible. Being a target of a threat is not just about physical security; it is also a stressful, frightening, and isolating experience. Linking targets to social services, victim advocacy, local law enforcement who may be able to assist with charges or restraining orders, counselling, and other resources may be beneficial. This may be an unrealistic undertaking, however, and can foster novel conflicts of interest for patient care.

**Conclusion**

Most people who threaten or perpetrate mass violence are not driven by psychiatric symptoms. Nonetheless, psychiatrists are commonly involved when people make overt threats to harm others or whose actions raise such concerns. Decisions about emergency holds or involuntary admissions should be made conservatively when there is a risk of danger to third parties. Though rare, delusions or other psychotic symptoms may drive violence potential; in others, symptoms like depression or anxiety may be related to the problem, though not causal. In either case, standard psychiatric treatment should be provided when indicated.

In cases of mass shooting threats not likely to respond to psychiatric treatment, protective orders may be a mechanism of both reducing the risk to the victim. In some jurisdictions, such orders may also be a way to remove the patient’s access to firearms. Protective orders, civil commitment standards and firearm prohibitions will vary by country and jurisdiction.

Even more so than in other cases, communication with collaborating agencies is of paramount importance when public violence is threatened. In the emergency and inpatient setting, law enforcement may be the party initiating the psychiatric evaluation. However, in the outpatient setting, the provider may have to involve them when allowable by privacy policy. Generally, disclosures of PHI to law enforcement or a potential target are permitted to lessen a threat, and there may be instances where disclosures to third parties are mandated. Threat assessment teams are a
multi-disciplinary approach that help coordinate psychiatric and legal efforts.

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The Gun Talk: How to Have Effective Conversations with Patients and Families About Firearm Injury Prevention

John S. Rozel, Layla Soliman, and Abhishek Jain

Introduction

In fairness, few people present for clinical services identifying firearm ownership as their chief complaint. Nonetheless, firearms access is associated with a number of significant medical and social issues that may intersect with an emergency department (ED) or a psychiatric emergency service (PES), including suicide, homicide, assault, domestic violence, accidental injury, and shootings of law enforcement officers [1–5]. Some patients may present with emergencies that are obviously gun-related, such as injuries from firearms, threats of suicide, or aggression with a firearm. Others, however, may present with complaints that only indirectly raise questions regarding firearm safety, such as a history of an underlying psychiatric or substance use disorder, impulsivity in a juvenile, or cognitive impairment in an elderly person [6, 7]. In what may be a clinical presentation for a very different issue, clinicians may need to tactfully open a dialogue about firearm safety.

Recent legal minefields and controversies further complicate this delicate conversation. For example, in 2010, during routine health screening at a well-child visit, a pediatrician asked a parent about firearms at home. The family refused to answer, the conflict escalated, and the family was ultimately “fired” from the practice. The family went to a local chapter of a firearm advocacy group who, in turn, lobbied for legislation colloquially known as the “Docs vs. Glocks law” [8]. This law – formally, the Firearm Owner’s Privacy Protection Act of 2011 – made inquiries about firearms a sanctionable disciplinary issue for licensed professionals. After numerous court cases and appeals, the most recent ruling struck down the law.

The United States has substantially more firearms than any other country with proportionately elevated risks for firearm suicides and homicides, including mass shootings [9–11]. Highly publicized incidents of firearm violence are often followed by periods of increased firearm sales, increased concealed carry permit applications, increased stock prices for firearm manufacturers, and decreased firearm regulation [12–14].

Thus, firearms are ubiquitous, potentially quite dangerous, and unlikely to be subject to significantly increased restrictions anytime in

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the foreseeable future. Nonetheless, when appropriate, health-care providers can play an important role in effectively and appropriately discussing firearm access with patients and their families [15–17]. Additionally, while evaluation of firearm access is only one aspect of violence and suicide risk assessment, it can be a vital component [18].

As clinical research continues and many legal considerations remain unresolved, in this chapter, we consider a practical approach to help providers engage patients regarding firearm safety, specifically by identifying and bridging cultural gaps through nonjudgmental interactions and the use of motivational interviewing. Embracing the concept of relative risks and harm reduction, an approach emphasizing safer storage, removal when possible (especially in the context of suicide and violence risk), and preservation of clinician-patient rapport is highlighted. We summarize the following: why clinicians should care about firearms, firearm access and ownership, recognizing and understanding gun culture, current clinical practices, initial screening for firearm access, using therapeutic approaches to encourage safer storage, and documentation.

Why Clinicians Should Care About Firearms

While gun ownership is a hot-button political issue and may not immediately be thought of as a health-care issue, firearm-related morbidity and mortality has a significant impact on the health-care system. Clinician knowledge of firearm prevalence and availability can play an important role in the overall care of a patient.

Over the previous few years, firearms have annually accounted for 10,000–12,000 homicides, 20,000–22,000 suicides, and 50,000–80,000 injuries [19, 20]. US firearm suicide rates are ten times as high, and homicide rates are 25 times as high as other developed countries [10]. Accidental and sublethal injuries with firearms occur with significant frequency; however, quantifying the full impact is challenging due to inconsistent reporting and coding standards [21, 22]. Nonetheless, studies show firearm injuries are extremely costly to the health-care system and disproportionately impact youth, minority, and uninsured populations [23]. Estimated annual costs for medical treatment of firearm injuries are as high as $2.8 billion with the majority of those costs absorbed by Medicare and Medicaid [23–25]. Furthermore, patients who survive often face frequent readmissions, lifelong disability, medical expenses, and elevated risks of subsequent violent injury or death [26, 27].

It should be noted that most firearm violence is personal (an altercation between a small number of people, usually two), whereas mass shootings, though devastating and frequently publicized, are actually quite rare in the United States (accounting for significantly less than 1% of firearm homicide incidents) and are even more rare in other developed nations [9, 28].

Firearm Access and Ownership

An estimated 270–350,000,000 firearms are in civilian hands in the United States [11, 29]. Of particular concern to clinicians may be that, according to recent evidence, households with more risk factors for violence and suicide are more likely to own firearms [30]. Furthermore, 18 states currently allow some firearm purchases or transfers without background checks. Recent research suggests that at least 22% are transferred privately in this manner [31], and another study approximates that 20% of firearms carried or owned by criminal offenders had been lawfully acquired [32]. Thus, the lack of universal background checks allows people – who may otherwise be stopped from purchasing possessing firearms from a licensed dealer (i.e., history of involuntary admission, severe substance use, certain felonies, permanent restraining orders) – to purchase firearms [33]. Additionally, most states do not have a process to confirm removal or actively remove firearms from a newly prohibited owner [34].

Accidental injuries and risk from firearm storage in homes with children can also be a significant concern. In one study of homes with children and firearms, more than two-thirds of the chil-
dren knew where the firearm was stored, and one-third had handled the firearm without the parents’ knowledge or permission [35]. In a laboratory study of children who had received firearm safety training, most located a hidden firearm in less than 15 minutes, and a third tried to fire the weapon; this was despite parents’ near-unanimous belief that their children would not engage in such conduct [36]. One recent survey of licensed firearm dealer practices identified that education about suicide and domestic violence risk was provided in less than 10% of transactions and trainings offered to firearm purchasers [37].

Recognizing and Understanding Gun Culture

As with other culturally sensitive subjects (e.g., reproductive health, substance use, etc.), basic awareness of varying attitudes, behaviors, and beliefs surrounding gun ownership in the United States may help clinicians empathize and “meet the patient where they are.” Firearm ownership in contemporary America is often a cultural issue with distinct political, social, and religious differences between owners and nonowners that impacts ownership, use, and storage [26, 38]. Additionally, there is significant heterogeneity of beliefs among firearm owners themselves, including about firearm policy [39]. The role of culture in driving these factors and legislative responses has been recognized for nearly 50 years and continues to play a major role in the public policy landscape [40]. It is important for clinicians to understand that there are distinct cultures and subcultures of firearm owners, and these can play a significant role in clinical interactions, such as how people perceive firearm risks and potential opportunities for counseling [41]. Similarly, reasons for owning firearms vary significantly – with two-thirds indicating ownership is for protection – while others indicate ownership is for hunting, sport shooting, collecting, or work [42]. A gun-naive clinician may not even realize cultural differences at play in their interactions with a patient or family until they have inadvertently damaged their rapport.

The authors are not aware of any controlled study of firearm ownership among doctors. There is some evidence that firearm-owning physicians are less likely to support safety counseling [43]. Clinical training about firearm issues is often limited to a “checklist” approach to asking about access [44]. This puts physicians, especially those without the personal experience of owning firearms, using firearms, or growing up in a “gun household,” at a disadvantage in recognizing and working across the potential cultural divide. Specific continuing education and nonclinical exposure to firearms (e.g., going with a friend or colleague from hospital security to a firearm range) could be helpful means of addressing knowledge gaps.

Of concern, some groups recommend that firearm owners refuse to answer clinical questions about firearms, lie about ownership or storage, or challenge physicians with implied threats of litigation [45]. Training on firearm safety provided by dealers can also be quite limited, and seldom is delivered to other household members; few salespeople offer guidance on safer storage practices, and only 15% of purchasers or trainees receive any material about suicide risk [46, 47]. Reassuringly, most patients and most firearm owners, including those in ED settings, are open to inquiries or counseling if they are approached in a deliberate, respectful way [48].

Current Clinical Practices

Any time there is concern of suicide or violence risk, exploring access to lethal means, such as firearms, should be considered a prudent step [49, 50]. In fact, the Joint Commission recently advised screening for suicide risk in numerous settings (including emergency settings) with the included proviso that, for those at risk of suicide, access to firearms and other lethal means be assessed and removal or improved security be advised [51]. Additionally, the unfettered ability to screen and counsel about firearm access and storage has been identified as a major public health priority by a number of professional medical organizations [52]. That said, the nuances and
optimal clinical approaches – beyond the broad advisory to explore access to firearms and counsel safe storage and removal – remains a matter of ongoing discussion, education, and research.

In the emergency setting, screening for firearm access and counseling about firearm safety may be considered when direct clinical concerns for suicide, homicide, or aggression emerge in a patient, particularly one who may be discharged to the community. Other clinical situations may also alert the clinician to explore firearm access (Table 46.1). It is important to highlight that although firearm access is appropriate to explore in the context of mental illness and that active symptoms of mental illness can increase the risk of both suicide and violent behavior, mental illness is more strongly linked with suicide and accounts for only a small portion of violence in the community [7]. It should also be noted that in and of itself, firearm access is not a robust risk factor and may not be an ideal target for intervention in the absence of pertinent risk factors.

Initial Screening for Firearm Access

Because inquiries about firearm access can lead to resistance, clinicians need to approach questioning sensitively. Similar to asking about other sensitive topics such as sexual behavior or substance use, phrasing matters [53]. First, timing is critical; broaching the topic before there is good clinical engagement can be off-putting. Embedding questions about firearm access into a list of other health survey type of questions may or may not be effective depending on the individual.

Optimally, look for an opportunity or an invitation to ask. Statements by a patient or family like “What can I do to keep myself/my child/my spouse safe?” or “How do I get through this illness?” may provide a good opportunity. Clinicians can respond with something like “Well, one thing to consider is doing everything we reasonably can to prevent something impulsive happening; may I ask you if there are any guns at home?”

Asking permission to ask is often a helpful strategy to diffuse resistance and encourage engagement. It may help to use prefatory statements as well. For example:

- “You initially came to our ED because you made some statements about wanting to kill yourself while you were drinking. Both of those issues raise some concerns about firearms. May I ask you some questions about your guns?”
- “You have an illness that can sometimes cause problems with emotions, decisions, and your sense of hope. Whenever this occurs, I am concerned about suicide and aggression as a risk, no matter how unlikely. You are too important to take chances with. May we talk about your access to guns?”

Note that the use of a gentle assumption – accepting the likely presence of firearms in the home – can be less stigmatizing than a question like “Are you a gun owner?” Additional suggested phrasing for questions about firearm access are listed in Table 46.2. Note that it is often preferable to ask about the firearms in the home rather than firearms that are owned; many households have only one or two “gun owners” but many people in the household.

A useful mnemonic to guide initial screening for risks related to weapon access for people with an elevated risk for violence is AEIOU (see Table 46.3). It is a helpful way to explore general firearm access and for other weapons as well.

For people with more extensive experience or access to firearms, some additional questions may be helpful. Firearms are complex tools, and while some basic functionality can be attained by

<table>
<thead>
<tr>
<th>Table 46.1 Situations when firearm access may be explored in ED and PES settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal or homicidal ideations, threats, or plans</td>
</tr>
<tr>
<td>Self-injury physical violence or related ideations, threats, or plans</td>
</tr>
<tr>
<td>Domestic or intimate partner violence</td>
</tr>
<tr>
<td>Substance use</td>
</tr>
<tr>
<td>Dementia and other progressive or acute cognitive issues</td>
</tr>
<tr>
<td>Anger issues</td>
</tr>
<tr>
<td>Any accidental injury in the home, especially involving children</td>
</tr>
</tbody>
</table>
almost anybody, the impact of their use in skilled and experienced hands can be substantially greater. Consider the PHASES mnemonic for people with advanced access or knowledge about firearms (see Table 46.4).

### Table 46.2 General questions about firearms and weapons

<table>
<thead>
<tr>
<th>Question</th>
<th>What we are trying to learn</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many guns are in your home?</td>
<td>Access: How difficult is it for the patient to obtain a firearm for impulsive or deliberate violence?</td>
</tr>
<tr>
<td>How do you store guns in your home?</td>
<td></td>
</tr>
<tr>
<td>Why are guns important to you? What did you buy them for?</td>
<td>Experience: How much experience do they have with handling firearms?</td>
</tr>
<tr>
<td>How hard is it for you to get your hands on a gun (in your neighborhood/community)?</td>
<td></td>
</tr>
<tr>
<td>Do you have a gun or any other weapon with you now?</td>
<td></td>
</tr>
<tr>
<td>When you get in fights, what kind of weapons have you used?</td>
<td>Ideation and intent: How much thought, fantasy, or intent a person has about firearm use for violence can suggest fixation, a major risk factor for violence.</td>
</tr>
<tr>
<td>Were they “opportunistic weapons” (e.g., picking up a 2 x 4 lying on the ground) or something you carried for that purpose (e.g., a gun or knife)?</td>
<td></td>
</tr>
<tr>
<td>When there are fights at home, how often are guns brandished, used, or threatened with, implicitly or explicitly?</td>
<td></td>
</tr>
<tr>
<td>What weapons do you have access to? Which would you use in [this situation] ?</td>
<td></td>
</tr>
<tr>
<td>I don’t know much about guns. Would you please describe it to me so I can have a better idea of what we are talking about?</td>
<td></td>
</tr>
<tr>
<td>How did you learn how to use that weapon? What do you do to practice with it?</td>
<td></td>
</tr>
<tr>
<td>Has the frequency with which you carry a weapon increased recently?</td>
<td></td>
</tr>
<tr>
<td>Are there weapons at home that you have moved recently (e.g., from the attic to the bedside table)?</td>
<td></td>
</tr>
<tr>
<td>Where do your parents keep their guns? How are they secured?</td>
<td></td>
</tr>
</tbody>
</table>

### Table 46.3 AEIOU: A weapons use mnemonic

<table>
<thead>
<tr>
<th>Domain</th>
<th>What we are trying to learn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>How difficult is it for the patient to obtain a firearm for impulsive or deliberate violence?</td>
</tr>
<tr>
<td>Experience</td>
<td>How much experience do they have with handling firearms? Increased experience may increase risk of dangerous use or suicide. Tactical experience can certainly increase the magnitude and severity of any violent use.</td>
</tr>
<tr>
<td>Ideation and intent</td>
<td>How much thought, fantasy, or intent a person has about firearm use for violence can suggest fixation, a major risk factor for violence.</td>
</tr>
<tr>
<td>Operational plan</td>
<td>Impulsive use is concerning; detailed and specific plans are also concerning.</td>
</tr>
<tr>
<td>Unconcerned with consequences and suicidality</td>
<td>Suicidality and homicidality have similar risk factors, and the presence of one can significantly increase the risk of the other.</td>
</tr>
</tbody>
</table>

### Table 46.4 PHASES mnemonic for advanced firearm users and violence risk

<table>
<thead>
<tr>
<th>Domain</th>
<th>What we are trying to learn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proximity change</td>
<td>Has the person made their firearms more readily accessible, i.e., moved them from a closet to their bedside table or their person? Are they carrying more frequently? Suggest increased perceived risk in the environment.</td>
</tr>
<tr>
<td>Hatefulness and hostility</td>
<td>Extremist/racist ideology or hate group affiliation may be associated with a lower threshold for violence. Hostile attributional style is a broad risk factor for ease of provocation into violence.</td>
</tr>
<tr>
<td>Acquisition despite exclusion</td>
<td>Obtaining a firearm despite being legally excluded and failing to relinquish firearms when required both demonstrate willingness to defy major laws about safe firearm use.</td>
</tr>
<tr>
<td>Substance use</td>
<td>Substance use in general, and especially while handling firearms, is a major risk factor for violence and suicide because of impaired judgement and affect regulation.</td>
</tr>
<tr>
<td>Escalating purchases</td>
<td>Purchasing more firearms at a time with decreased frequency or with increasing caliber may suggest preparation to attack others. (N.B., large purchases of ammunition may simply reflect a typical response to bona fide market scarcity.)</td>
</tr>
<tr>
<td>Suicidality and hopelessness</td>
<td>Presence of suicidality and hopelessness can increase violence risk</td>
</tr>
</tbody>
</table>

Motivational Interviewing and Therapeutic Approaches to Encourage Safer Storage

Traditional approaches to counseling about firearm removal may be less effective than hoped. In a 2-year study of depressed adolescents at high risk for suicide, most firearm-owning families either did not remove the firearm after counseling or returned the firearm to the home while the ado-
lescent was still at risk; one in six homes without a firearm acquired one during the period of the study [54]. In a study of adults involuntarily committed for suicidality or homicidality with access to a firearm who received extensive counseling and initially removed the firearms from the home, one-third of those reassessed within 2 years had reacquired access to firearms [55].

We highlight motivational interviewing (MI) as one helpful strategy in building alliance and moving people toward positive change [56]. MI has traditionally been used to engage patients regarding substance abuse but has also shown promise in early studies looking at means restriction in suicide prevention by counseling people at risk for suicide about the removal of dangerous implements including firearms [57]. Our ultimate goals are continued engagement and safer storage. Similar to the language used in reproductive health, consider framing storage options as safer storage, not safe storage, as any storage can potentially be breached [58, 59].

Motivational interviewing uses four basic stages – engaging, focusing, evoking, and planning – to help patients move through the Stages of Change toward a successful modification of behavior. Engaging means creating a meaningful clinical alliance with patients and families so that we understand their reasons for coming to the ED and PES and our role in helping them with that issue. Focusing allows us to make that subtle transition to exploring their firearm ownership, current practices for handling and storage, and our reasons for concern. The next step is helping the patient or family recognize the importance for change and what risks may be entailed with continued unsafe access to firearms. Finally, planning is the process of getting the patient and family to commit to safer storage, develop specific plans, and optimally create a plan to follow up and confirm removal. If, during a conversation, the clinician notices increased resistance, it is likely prudent to return to the engagement stage.

Long-term change is difficult to achieve and intimidating to contemplate. Clinicians should consider appealing to acuity concerns; no matter how chronic the illness or behavior, there is a reason that the patient is in the PES at this time. Note that many patients and families have had the firearm for many years (and, perhaps, never needed it for self-defense); that risk is stable. This is the acute phase of an illness that undermines rational decisions, hope, and impulse control. It is reasonable to make temporary changes in behavior to assure one’s well-being. If the removal of the firearm becomes a “new normal” or newly tolerated habit, that may not be the worst outcome.

Once a patient or family member is engaged and willing to consider options for safer storage, first explore what ideas they may have. If they are open to your input, consider offering solutions as outlined in Table 46.5. Ultimately, removal is the safest intervention but may also be the option the person is most resistant to. To continue the safer sex metaphor, removal, like abstinence, may be highly effective but also less likely to be taken seriously or adhered to by the patient. Partial movement toward the goal of safety is preferable to frank refusal or false assurances of compliance. Of note, firearm theft from automobiles is quite common, and storage of firearms in vehicle should not be recommended [60]. It is important to note that there are a lot of ways to hurt and kill people without firearms. Clinicians must not assume that because there are no firearms, there is no risk. Do not forget to explore other types of weapon access, and do not lose sight of the fact that weapon access alone is not a meaningful risk factor or target for intervention in the absence of suicidality, aggression, or other risk factors.

<table>
<thead>
<tr>
<th>Table 46.5</th>
<th>“May I offer some suggestions?”</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safer:</strong> Secure the firearm more safely in the home</td>
<td><strong>Somewhere else:</strong> Store the firearm at another safe location</td>
</tr>
<tr>
<td><strong>Mechanical and “smart” trigger and chamber locks</strong></td>
<td><strong>At work (if permitted by employer)</strong></td>
</tr>
<tr>
<td><strong>Gun safes</strong></td>
<td><strong>Rental storage locker</strong></td>
</tr>
<tr>
<td><strong>Separated from ammunition</strong></td>
<td><strong>With a safe friend or relative</strong></td>
</tr>
<tr>
<td><strong>Sold:</strong> Sell, exchange, or transfer the firearm legally</td>
<td><strong>Licensed firearm dealers</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Community buyback programs</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Pawnshops</strong></td>
</tr>
</tbody>
</table>
Documentation

In the event of adverse outcomes, a well-crafted medical record accurately reflecting clinical events and clinician decision-making is important. At the same time, the pace and volume of many ED and PES settings make extensively detailed documentation challenging. Ideally, documentation should clearly reflect patient or family responses to inquiries about firearm access, what role access plays in clinical decision-making (if any), what guidance (if any) was given to the patient or family, and how they appeared to receive such information.

Examples
We talked to Mr. and Mrs. Smith about Mr. Smith’s depression and the fact that firearms access increases his risk of completed suicide. We recommended removal of firearms to a safe location. Mr. Smith reported that hunting with his brother is one of the few things that still gives him pleasure. He agreed to have his brother take possession of his rifle for now and continues to assess this issue with his therapist and intensive outpatient team. Though he does not currently meet criteria for involuntary commitment and is not actively suicidal, we remain concerned for his safety and encouraged him to find other outlets while he gets treatment for this acute depressive episode.

Miss Jones presented with symptoms of PTSD and passive death wish. She keeps a handgun for personal protection. Though she has a chronically elevated risk of suicide due to traumatic past, ongoing suicidal ideation, and past attempts, she does not currently meet criteria for involuntary commitment and declined voluntary admission. She declines our recommendation to remove the gun from her home. We have talked to her mother, who has no immediate safety concerns. We provided both the patient and her mother with our recommendation and the rationale, as well as alternatives for safer storage, such as mother keeping the gun locked in a combination safe in her room. These were also declined. We referred the patient for partial hospitalization programming and advised the treatment team in that clinic of the situation and recommendations.

In the event of involuntary commitment of a person who owns firearms, clinicians should consider how and when to inform patients and family members about potential restrictions on firearm access. And, of course, the clinicians should assure that they themselves have a reasonable understanding of such restrictions and rules. It may be appropriate for such a dialogue to be handled by an inpatient team or even by law enforcement involved in the commitment process depending on the context.

Use of prepared and vetted educational information for patients and families about firearm safety may be considered. The information may be better received if it targets specific high-risk situations or groups such as homes with children, acute psychiatric illness, or cognitive decline and dementia. Information that is provided to all ED patients – such as standard language in discharge instructions – may diminish any sense of stigmatization or being singled out. It also runs the risk of being information that is easily disregarded if it is embedded in long and detailed handouts.

Conclusion

Firearms are ubiquitous, are legally protected, and contribute to substantial morbidity, mortality, and health-care costs. Various ED and PES presentations – including aggression and suicidality – can raise concerns about a patient’s gun access. Being able to navigate potential cultural barriers surrounding guns can help clinicians engage in constructive dialogues about strategies and safer storage with patients and their families. With appropriate therapeutic approaches, clinicians may be able to help mitigate risk of firearm-related injuries and death.

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