

Violence: Managing Major Threats

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Threat management is a multidisciplinary approach to preventing targeted violence, including mass shootings. It consists of deliberate and planned collaboration across different disciplines (eg, 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

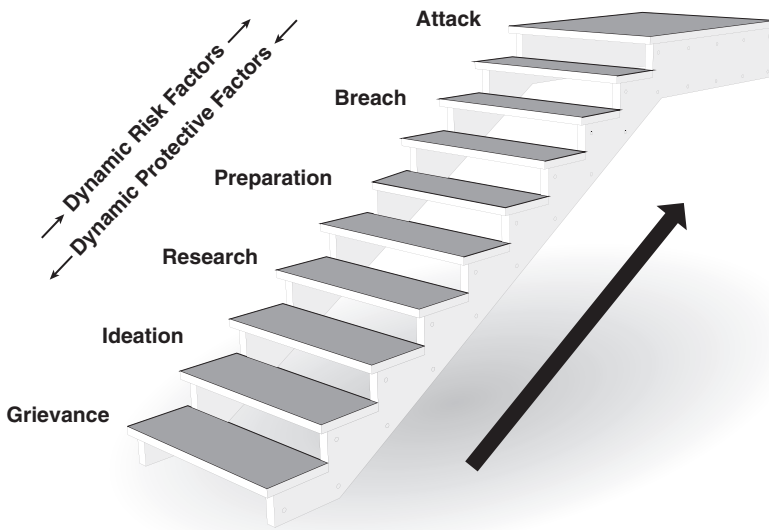


FIGURE 33.1 • Pathway to violence (15). (From Calhoun, F. S., & Weston, S. W. (2003). *Contemporary threat management: a practical guide for identifying, assessing, and managing individuals of violent intent* (p. 280). San Diego, CA: Specialized Training Services. [A practical guide series.] With permission.)

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 based 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

warrior whose actions will be remembered by others become more common (17). It should be noted that homicidal ideation and violent fantasies 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, reconnaissance, 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 dangerous 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 disinhibit 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 behavior 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 offenders who, following an initial successful attack, demonstrate increasing magnitude and decreasing thresholds to attack again when slighted.

Many clinicians may see immediate parallels 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 interviewing 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 individual 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 population. 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 psychiatric 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

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

Grievance	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?
Ideation	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 the way you have been hurt? What fantasies do you have about harming others?
Research and preparation	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?
Breach	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?

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 33.2 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.

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,

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 (52). 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

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

law enforcement are worth careful consideration by clinicians and hospital counsel alike (81,82). Although HIPAA is oft criticized for being confusing and difficult to implement, clinicians and legal advisors should reframe their legal and ethical analysis to identification of opportunities where even limited disclosure may be possible and helpful. Even when HIPAA or other factors prevent sharing of direct information with law enforcement, a professional may still be able to offer opinions to threat management teams about what behavioral factors may or may not be relevant to a case under review.

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.

REFERENCES

- Meloy, J. R. (2015). Threat assessment: Scholars, operators, our past, our future. *Journal of Threat Assessment and Management*, 2(3–4), 231–242.
- Calhoun, F. S., & Weston, S. W. (2015). Perspectives on threat management. *Journal of Threat Assessment and Management*, 2(3–4), 258–267.
- Criminal Justice Information Services Division. (2018). *2017, Crime in the US: Expanded offense*. FBI. Retrieved December 9, 2018, <https://ucr.fbi.gov/crime-in-the-u.s/2017/crime-in-the-u.s.-2017/topic-pages/expanded-offense>.
- Pew Research Center. (2013, May). *Gun homicide rate down 49% since 1993 peak; Public unaware. Pace of decline slows in past decade*. Washington, DC: Pew Research Center. Retrieved May 6, 2015, from http://www.pewsocialtrends.org/files/2013/05/firearms_final_05-2013.pdf.
- Pifer, H., & Minino, A. (2018). QuickStats: Number of homicides committed, by the three most common methods – United States, 2010–2016. *Morbidity and Mortality Weekly Report*, 67(29), 806.
- DeSilver, D. (2014). *Why timely, reliable data on mass killings is hard to find*. Washington, DC: Pew Research Center. Retrieved March 11, 2015, from <http://www.pewresearch.org/fact-tank/2014/06/17/why-timely-reliable-data-on-mass-killings-is-hard-to-find/>.
- Huff-Corzine, L., McCutcheon, J. C., Corzine, J., Jarvis, J. P., Tetzlaff-Bemiller, M. J., Weller, M., et al. (2014). Shooting for accuracy: Comparing data sources on mass murder. *Homicide Studies*, 18(1), 105–124.
- Duwe, G. A. (2005). Circle of distortion: The social construction of mass murder in the United States. *Western Criminology Review*, 6(1), 59–78.
- Follman, M., Aronsen, G., Pan, D., & Caldwell, M. *US mass shootings, 1982–2012: Data from Mother Jones' investigation*. Mother Jones. Retrieved March 11, 2015, from <http://www.motherjones.com/politics/2012/12/mass-shootings-mother-jones-full-data>.
- Schweit, K. W. (2016). *Active shooter incidents in the United States in 2014 and 2015*. Washington, DC: Federal Bureau of Investigation, US Department of Justice. Retrieved July 16, 2016, from <https://www.fbi.gov/about-us/office-of-partner-engagement/active-shooter-incidents/a-study-of-active-shooter-incidents-in-the-u.s.-2000-2013>.
- Blair, J. P., & Schweit, K. W. (2014). *A study of active shooter incidents in the United States between 2000 and 2013*. Washington, DC: Texas State University and Federal Bureau of Investigation. Retrieved September 24, 2014, from http://www.fbi.gov/news/stories/2014/september/fbi-releases-study-on-active-shooter-incidents/pdfs/a-study-of-active-shooter-incidents-in-the-u.s.-between-2000-and-2013?utm_campaign=email-Immediate&utm_content=359251.
- Lin, P.-I., Fei, L., Barzman, D., & Hossain, M. (2018). What have we learned from the time trend of mass shootings in the U.S.? *PLOS One*, 13(10), e0204722.

13. Fein, R. A., & Vossekuil, B. (1999). Assassination in the United States: An operational study of recent assassins, attackers, and near-lethal approachers. *Journal of Forensic Sciences, 44*(2), 321–333.
14. Borum, R., Fein, R., Vossekuil, B., & Berglund, J. (1999). Threat assessment: Defining an approach to assessing risk for targeted violence. *Behavioral Sciences & the Law, 17*(3), 323.
15. Calhoun, F. S., & Weston, S. W. (2003). *Contemporary threat management: A practical guide for identifying, assessing, and managing individuals of violent intent. A practical guide series*. San Diego, CA: Specialized Training Services.
16. Poon, K.-T., & Wong, W.-Y. (2018). Stuck on the train of ruminative thoughts: The effect of aggressive fantasy on subjective well-being. *Journal of Interpersonal Violence*. doi:10.1177/0886260518812796.
17. Knoll, J. L. (2010). The “pseudocommando” mass murderer: Part I, The psychology of revenge and obliteration. *Journal of the American Academy of Psychiatry and the Law, 38*(1), 87–94.
18. Smith, C. E., Fischer, K. W., & Watson, M. W. (2009). Toward a refined view of aggressive fantasy as a risk factor for aggression: Interaction effects involving cognitive and situational variables. *Aggressive Behavior, 35*(4), 313–323.
19. Knoll, J. L. (2010). The “pseudocommando” mass murderer: Part II, The language of revenge. *Journal of the American Academy of Psychiatry and the Law, 38*(2), 263–272.
20. Lankford, A., & Madfis, E. (2018). Don't name them, don't show them, but report everything else: A pragmatic proposal for denying mass killers the attention they seek and deterring future offenders. *American Behavioral Scientist, 62*(2), 260–279.
21. Arluke, A., Lankford, A., & Madfis, E. (2018). Harming animals and massacring humans: Characteristics of public mass and active shooters who abused animals. *Behavioral Sciences & the Law, 36*, 739–751.
22. Prochaska, J. O., & Velicer, W. F. (1997). The transtheoretical model of health behavior change. *American Journal of Health Promotion, 12*(1), 38–48.
23. Knoll, J. L., & Annas, G. D. (2016). Mass shootings and mental illness. In Gold, L. H., & Simon, R. I. (Eds.), *Gun violence and mental illness* (1st ed., pp. 81–104). Arlington, VA: American Psychiatric Association Publishing.
24. Rozel, J. S., & Mulvey, E. P. (2017). The link between mental illness and gun violence: Implications for social policy. *Annual Review of Clinical Psychology, 13*(1), 445–469.
25. Huetteman, E., & Pérez-Peña, R. (2015, December 1). Paul Ryan pushes changes in mental health care after Colorado shooting. *The New York Times*. Retrieved December 2, 2015, from <http://www.nytimes.com/2015/12/02/us/obama-repeats-call-for-strict-gun-laws-after-colorado-shooting.html>.
26. Trump, D. J. (2018). *So many signs that the Florida shooter was mentally disturbed, even expelled from school for bad and erratic behavior. Neighbors and classmates knew he was a big problem. Must always report such instances to authorities, again and again!*. @realDonaldTrump. Retrieved November 26, 2018, from <https://twitter.com/realDonaldTrump/status/964110212885106689>.
27. Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 593–602.
28. Silver, J., Simons, A., & Craun, S. (2018, June). *A study of the pre-attack behaviors of active shooters in the United States between 2000 and 2013*. Washington, DC: Federal Bureau of Investigation, US Department of Justice. Retrieved from <https://www.fbi.gov/file-repository/pre-attack-behaviors-of-active-shooters-in-us-2000-2013.pdf/view>.
29. Stone, M. H. (2015). Mass murder, mental illness, and men. *Violence and Gender, 2*(1), 51–86.
30. *Analysis of recent mass shootings* (2015, August). Everytown for Gun Safety. Retrieved December 16, 2015, from <http://everytownresearch.org/documents/2015/09/analysis-mass-shootings.pdf>.
31. Vossekuil, B., Fein, R. A., Reddy, M., Borum, R., & Modzeleski, W. (2002). *The final report and findings of the Safe School Initiative: Implications for the prevention of school attacks in the United States* (p. 63). Washington, DC: U.S. Department of Education, Office of Elementary and Secondary Education, Safe and Drug-Free Schools Program and U.S. Secret Service, National Threat Assessment Center. Retrieved March 11, 2015, from https://www.secretservice.gov/data/protection/ntac/ssi_final_report.pdf.

32. Silver, J., Fisher, W., & Horgan, J. (2018). Public mass murderers and federal mental health background checks for firearm purchases. *Law & Policy, 40*(2), 133–147.
33. American Association for Emergency Psychiatry. (2018). *AAEP position statement: Evaluation of persons of concern in relation to violence, mass shootings and mental illness*. Retrieved November 26, 2018, from <https://www.emergencypsychiatry.org/position-statements>.
34. Swanson, J. W. (2011). Explaining rare acts of violence: The limits of evidence from population research. *Psychiatric Services, 62*(11), 1369–1371.
35. Steadman, H. J., Mulvey, E. P., Monahan, J., Robbins, P. C., Appelbaum, P. S., Grisso, T., et al. (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Archives of General Psychiatry, 55*(5), 393–401.
36. Choe, J. Y., Teplin, L. A., & Abram, K. M. (2008). Perpetration of violence, violent victimization, and severe mental illness: Balancing public health concerns. *Psychiatric Services, 59*(2), 153–164.
37. Brazil, I. A. (2015). Considering new insights into antisociality and psychopathy. *The Lancet Psychiatry, 2*(2), 115–116.
38. Marcus, D. K., Preszler, J., & Zeigler-Hill, V. (2018). A network of dark personality traits: What lies at the heart of darkness? *Journal of Research in Personality, 73*, 56–62.
39. Cardinale, E. M., & Marsh, A. A. (2015). Impact of psychopathy on moral judgments about causing fear and physical harm. *PLOS One, 10*(5), e0125708.
40. Swanson, J. W., Van Dorn, R. A., Swartz, M. S., Smith, A., Elbogen, E. B., & Monahan, J. (2008). Alternative pathways to violence in persons with schizophrenia: The role of childhood antisocial behavior problems. *Law and Human Behavior, 32*(3), 228–240.
41. Skeem, J., Kennealy, P., Monahan, J., Peterson, J., & Appelbaum, P. (2016). Psychosis uncommonly and inconsistently precedes violence among high-risk individuals. *Clinical Psychological Science, 4*(1), 40–49.
42. Large, M. M., & Nielssen, O. (2011). Violence in first-episode psychosis: A systematic review and meta-analysis. *Schizophrenia Research, 125*(2–3), 209–220.
43. Knoll, J. L., & Meloy, J. R. (2014). Mass murder and the violent paranoid spectrum. *Psychiatric Annals, 44*(5), 236–243.
44. Im, D. S. (2016). Template to perpetrate: An update on violence in autism spectrum disorder. *Harvard Review of Psychiatry, 24*(1), 14–35.
45. Heeramun, R., Magnusson, C., Gumpert, C. H., Granath, S., Lundberg, M., Dalman, C., & Rai, D. (2017). Autism and convictions for violent crimes: Population-based cohort study in Sweden. *Journal of the American Academy of Child & Adolescent Psychiatry, 56*(6), 491–497.e2.
46. Allely, C. S., Minnis, H., Thompson, L., Wilson, P., & Gillberg, C. (2014). Neurodevelopmental and psychosocial risk factors in serial killers and mass murderers. *Aggression and Violent Behavior, 19*(3), 288–301.
47. Allely, C. S., Wilson, P., Minnis, H., Thompson, L., Yaksic, E., & Gillberg, C. (2017). Violence is rare in autism: When it does occur, is it sometimes extreme? *The Journal of Psychology, 151*(1), 49–68.
48. White, S. G., Meloy, J. R., Mohandie, K., & Kienlen, K. (2017). Autism spectrum disorder and violence: Threat assessment issues. *Journal of Threat Assessment and Management, 4*(3), 144–163.
49. Meloy, J. R., & O'Toole, M. E. (2011). The concept of leakage in threat assessment. *Behavioral Sciences & the Law, 29*(4), 513–527.
50. Silver, J., Horgan, J., & Gill, P. (2018). Foreshadowing targeted violence: Assessing leakage of intent by public mass murderers. *Aggression and Violent Behavior, 38*, 94–100.
51. Gill, P., Silver, J., Horgan, J., & Corner, E. (2017). Shooting alone: The pre-attack experiences and behaviors of U.S. solo mass murderers. *Journal of Forensic Sciences, 62*(3), 710–714.
52. McNiel, D. E., & Binder, R. L. (1989). Relationship between preadmission threats and later violent behavior by acute psychiatric inpatients. *Psychiatric Services, 40*(6), 605–608.
53. Tversky, A., & Kahneman, D. (1973). Availability: A heuristic for judging frequency and probability. *Cognitive Psychology, 5*(2), 207–232.
54. Ropeik, D. (2010). *How risky is it really? Why our fears don't always match the facts*. New York, NY: McGraw-Hill.
55. Kahneman, D. (2013). *Thinking, fast and slow*. New York, NY: Farrar, Straus and Giroux.
56. Schneier, B. *Living in code yellow*. Fusion. Retrieved September 24, 2015, from <http://fusion.net/story/200747/living-in-code-yellow/>.
57. Langman, P. (2018). Different types of role model influence and fame seeking among mass killers and copycat offenders. *American Behavioral Scientist, 62*(2), 210–228.

58. King, D. M., & Jacobson, S. H. (2017). Random acts of violence? Examining probabilistic independence of the temporal distribution of mass killing events in the United States. *Violence & Victims, 32*(6), 1014–1023.
59. Towers, S., Gomez-Lievano, A., Khan, M., Mubayi, A., & Castillo-Chavez, C. (2015). Contagion in mass killings and school shootings. *PLOS One, 10*(7), e0117259.
60. Victor, D. (2018, May 11). When white people call the police on black people. *The New York Times*, A19.
61. Abo-Zena, D. M. M. (2017). Exploring the interconnected trauma of personal, social, and structural stressors: Making “sense” of senseless violence. *The Journal of Psychology, 151*(1), 5–20.
62. Johnson, K. L., Desmarais, S. L., Grimm, K. J., Tueller, S. J., Swartz, M. S., & Van Dorn, R. A. (2016). Proximal risk factors for short-term community violence among adults with mental illnesses. *Psychiatric Services, 67*(7), 771–778.
63. Swartz, M. S., Swanson, J. W., Hiday, V. A., Borum, R., Wagner, H. R., & Burns, B. J. (1998). Violence and severe mental illness: The effects of substance abuse and nonadherence to medication. *American Journal of Psychiatry, 155*, 226–231.
64. Pickard, H., & Fazel, S. (2013). Substance abuse as a risk factor for violence in mental illness: Some implications for forensic psychiatric practice and clinical ethics. *Current Opinion in Psychiatry, 26*(4), 349–354.
65. Mulvey, E. P., Odgers, C., Skeem, J., Gardner, W., Schubert, C., & Lidz, C. (2006). Substance use and community violence: A test of the relation at the daily level. *Journal of Consulting and Clinical Psychology, 74*(4), 743–754.
66. McGinty, E. E., Choksy, S., & Wintemute, G. J. (2016). The relationship between controlled substances and violence. *Epidemiologic Reviews, 38*(1), 5–31.
67. Dodge, K. A. (2006). Translational science in action: Hostile attributional style and the development of aggressive behavior problems. *Development and Psychopathology, 18*(3), 791–814.
68. Castro, B. O. D., Veerman, J. W., Koops, W., Bosch, J. D., & Monshouwer, H. J. (2002). Hostile attribution of intent and aggressive behavior: A meta-analysis. *Child Development, 73*(3), 916–934.
69. Zimbardo, P. G. (2004). A situationist perspective on the psychology of evil: Understanding how good people are transformed into perpetrators. In Miller, A. (Ed.), *The social psychology of good and evil: Understand our capacity for kindness and cruelty* (pp. 21–50). New York, NY: Guilford Press.
70. Kaney, S., & Bentall, R. P. (1989). Persecutory delusions and attributional style. *British Journal of Medical Psychology, 62*(2), 191–198.
71. Hagan, C. R., Podlogar, M. C., & Joiner, T. E. (2015). Murder-suicide: Bridging the gap between mass murder, amok, and suicide. *Journal of Aggression, Conflict and Peace Research, 7*(3), 179.
72. Warren, L. J., Mullen, P. E., & Ogloff, J. R. P. (2011). A clinical study of those who utter threats to kill. *Behavioral Sciences & the Law, 29*(2), 141–154.
73. Behavioral Analysis Unit. (2016). *Making prevention a reality: Identifying, assessing, and managing the threat of targeted attacks*. Washington, DC: Federal Bureau of Investigation, US Department of Justice. Retrieved February 27, 2017, from <https://www.fbi.gov/file-repository/making-prevention-a-reality.pdf>.
74. Simons, A., & Meloy, J. R. (2017). Foundations of threat assessment and management. In Van Hasselt, V. B., & Bourke, M. L. (Eds.), *Handbook of behavioral criminology* (pp. 627–644). Cham: Springer International Publishing. Retrieved from http://drreidmeloy.com/wp-content/uploads/2017/12/2017_FoundationsOfThreat.pdf.
75. Hughes, A. M., Gregory, M. E., Joseph, D. L., Sonesh, S. C., Marlow, S. L., Lacerenza, C. N., et al. (2016). Saving lives: A meta-analysis of team training in healthcare. *Journal of Applied Psychology, 101*(9), 1266–1304.
76. Edmondson, A. C. (2012). Teamwork on the fly. *Harvard Business Review, 90*(4), 72–80.
77. Department of Health and Human Services. (2016). Health Insurance Portability and Accountability Act (HIPAA) privacy rule and the National Instant Criminal Background Check System (NICS) 45 CFR Part 164. *Federal Register, 81*(3), 382–396.
78. Rodriguez, L. (2013). *Message to our nation's health care providers*. Retrieved January 15, 2013, from <https://www.hhs.gov/sites/default/files/ocr/office/lettertonationhcp.pdf>.

79. Werth, J. L., Welfel, E. R., & Benjamin, G. A. H. (Eds.), (2009). *The duty to protect: Ethical, legal, and professional considerations for mental health professionals*. Washington, DC: American Psychological Association.
80. Widgery, A., & Winterfield, A. (2013). Mental health professionals' duty to warn. *National Council of State Legislatures Legisbrief*, 21(1), 2.
81. Castro, J. (2015). Piercing the privacy veil: Towards a saner balancing of privacy and health in cases of severe mental illness. *Hastings Law Journal*, 66, 1769.
82. Petrila, J., & Fader-Towe, H. (2010). *Information sharing in criminal justice - Mental health collaborations: Working with HIPAA and other privacy laws*. New York, NY: Council of State Governments Justice Center. Retrieved June 4, 2017, from https://www.bja.gov/Publications/CSG_CJMH_Info_Sharing.pdf.
83. Lankford, A. (2016). Public mass shooters and firearms: A cross-national study of 171 countries. *Violence and Victims*, 31(2), 187–199.
84. Schildkraut, J., & Elsass, H. J. (2016). *Mass shootings: Media, myths, and realities. Crime, media, and popular culture*. Santa Barbara, CA: Praeger.

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*.



FERPA permits the non-consensual disclosure of PII from “education records” for health and safety emergencies and judicial orders.

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 Services' Office for Civil Rights HIPAA web site at <http://www.hhs.gov/ocr/privacy>.





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To cite this article: Amy Barnhorst & John S. Rozel (2021) Evaluating threats of mass shootings in the psychiatric setting, *International Review of Psychiatry*, 33:7, 607-616, DOI: [10.1080/09540261.2021.1947784](https://doi.org/10.1080/09540261.2021.1947784)

To link to this article: <https://doi.org/10.1080/09540261.2021.1947784>



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Published online: 16 Jul 2021.



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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.

ARTICLE HISTORY

Received 24 March 2021

Accepted 22 June 2021

KEYWORDS

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,

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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 heterogeneous 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 be 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).

Table 1. Investigate all THREATS³.

T	Threats, leakage, or other statements of intent to harm made currently or recently
H	History of violence, especially with the identified target or in an escalating pattern
R	Recent stressors (relationships, finances, housing, employment, health, victimization)
E	Ethanol / other drug intoxication, current or frequently present
A	Agitated / annoyed easily (Hostile Attributional Style)
T	Takes no responsibility (External Attributional Style)
S	Suicidality, increasing hopelessness
S	Symptomatic psychiatric illness currently or frequently present
S	Specific target / access / means identified

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

Table 2. Threat assessment professional organisations.

Association of Threat Assessment Professionals (USA)	https://www.atapworldwide.org
Canadian association of threat assessment professionals	https://catap.ca/
Asia Pacific Association of Threat Assessment Professionals	https://www.apatap.org/
African Association of Threat Assessment Professionals	https://afatap.africa/
Association of European Threat Assessment Professionals	https://www.aetap.eu/

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 (Petrila & 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.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

Amy Barnhorst, MD, is funded by the State of California through the UC Firearm Violence Research Centre. John S. Rozel, MD, MSL, is partially funded through the Department of Homeland Security Office of Targeted Violence and Terrorism Prevention.

References

- Alathari, L., Drysdale, D., Driscoll, S., Ed, M., Blair, A., Carlock, A., Cotkin, A., Johnston, B., Foley, C., Mauldin, D., McGarry, J., Nemet, J. (2019). *Protecting America's schools: A U.S. secret service analysis of targeted school violence* (p. 35). U.S. Secret Service, Department of Homeland Security. https://www.secretservice.gov/sites/default/files/2020-04/Protecting_Americas_Schools.pdf
- American Psychological Association. (2019). *One-third of US adults say fear of mass shootings prevents them from going to certain places or events* [Press release]. <http://www.apa.org/news/press/releases/2019/08/fear-mass-shooting>
- Behavioral Analysis Unit. (2016). *Making prevention a reality: Identifying, Assessing, and managing the threat of targeted attacks*. Federal Bureau of Investigation, US Department of Justice. <https://www.fbi.gov/file-repository/making-prevention-a-reality.pdf>
- Booty, M., O'Dwyer, J., Webster, D., McCourt, A., & Crifasi, C. (2019). Describing a "mass shooting": The role of databases in understanding burden. *Injury Epidemiology*, 6(1), 47. <https://doi.org/10.1186/s40621-019-0226-7>
- Brucato, G., Appelbaum, P. S., Hesson, H., Shea, E. A., Dishy, G., Lee, K., Pia, T., Syed, F., Villalobos, A., Wall, M. M., Lieberman, J. A., & Girgis, R. R. (2021). Psychotic symptoms in mass shootings v. mass murders not involving firearms: Findings from the Columbia mass murder database. *Psychological Medicine*, 1–9. Advance online publication. <https://doi.org/10.1017/S0033291721000076>
- Butterfield, F. (2000). Hole in gun control law lets mentally ill through. *New York Times*. <https://www.nytimes.com/2000/04/11/us/hole-in-gun-control-law-lets-mentally-ill-through.html>
- Calhoun, F. S., & Weston, S. W. (2003). *Contemporary threat management: A practical guide for identifying, assessing, and managing individuals of violent intent*. Specialized Training Services.
- Campbell, S., Yablon, A., & Mascia, J. (2018). Red flag laws: Where the bills stand in each state. The Trace. <https://www.thetrace.org/2018/03/red-flag-laws-pending-bills-tracker-nra/>
- Caspi, A., Houts, R. M., Ambler, A., Danese, A., Elliott, M. L., Hariri, A., Harrington, H., Hogan, S., Poulton, R., Ramrakha, S., Rasmussen, L. J. H., Reuben, A., Richmond-Rakerd, L., Sugden, K., Wertz, J., Williams, B. S., & Moffitt, T. E. (2020). Longitudinal assessment of mental health disorders and comorbidities across 4 decades among participants in the Dunedin birth cohort Study. *JAMA Network Open*, 3(4), e203221–e203221. <https://doi.org/10.1001/jamanetworkopen.2020.3221>
- Fatal Injury Data. Web-based Injury Statistics Query and Reporting System (WISQARS). Centers for Disease Control and Prevention. Published July 1, 2020. Accessed May 1, 2021. <https://www.cdc.gov/injury/wisqars/fatal.html>
- Corner, E., Gill, P., Schouten, R., & Farnham, F. (2018). Mental disorders, personality traits, and grievance-fueled targeted violence: The evidence base and implications for research and practice. *Journal of Personality Assessment*, 100(5), 459–412. <https://doi.org/10.1080/00223891.2018.1475392>
- Fein, R. A., Vossekuil, B. (1998). *Protective intelligence and threat assessment investigations: A guide for state and local law enforcement officials* (NCJ 170612; p. 65). U.S. Department of Justice, Office of Justice Programs. http://www.secretservice.gov/ntac/PI_Guide.pdf
- Follman, M., Aronsen, G., & Pan, D. (2020). *US Mass Shootings, 1982-2020: Data from Mother Jones' investigation*.
- Gavaghan, C. (2007). Dangerous patients and duties to warn: A European human rights perspective. *European journal of health law*, 14(2), 113–130. <https://doi.org/10.1163/092902707x205016>
- Grinshteyn, E., & Hemenway, D. (2016). Violent death rates: The US compared with other high-income OECD countries, 2010. *The American Journal of Medicine*, 129(3), 266–273. <https://doi.org/10.1016/j.amjmed.2015.10.025>
- Grinshteyn, E., & Hemenway, D. (2019). Violent death rates in the US compared to those of the other high-income countries, 2015. *Preventive Medicine*, 123, 20–26. <https://doi.org/10.1016/j.ypmed.2019.02.026>
- Gutiérrez-Lobos, K., Wagner, E., Schmidl-Mohl, B., & Schmid-Siegel, B. (2000). Wrapped in silence: Psychotherapists and confidentiality in the courtroom. *International Journal of Offender Therapy and Comparative Criminology*, 44(1), 33–45. <https://doi.org/10.1177/0306624X00441004>
- Herman, P., Marimow, A. (2013). Navy Yard shooter Aaron Alexis driven by delusions. *The Washington Post*. https://www.washingtonpost.com/local/crime/fbi-police-detail-shooting-navy-yard-shooting/2013/09/25/ee321abe-2600-11e3-b3e9-d97fb087acd6_story.html
- Hills B. R. (2020) The cat is already out of the bag: Resolving the circuit split over the dangerous patient exception to the Psychotherapist–Patient Privilege. *University of Baltimore Law Review*, 49(2/3):153–182. <https://scholarworks.law.ubalt.edu/ublrl/vol49/iss2/3/>
- Hudson, J. (2011). What we know about Jared Lee Loughner. *The Atlantic*. <https://www.theatlantic.com/politics/archive/2011/01/what-we-know-about-jared-lee-loughner/342711/>

- Hunter, L. Y., Ginn, M. H., Storyllewellyn, S., & Rutland, J. (2020). Are mass shootings acts of terror? Applying key criteria in definitions of terrorism to mass shootings in the United States from 1982 to 2018. *Behavioral Sciences of Terrorism and Political Aggression*, 1–30. <https://doi.org/10.1080/19434472.2020.1762108>
- Ilic, A., & Frei, A. (2019). Mass murder and consecutive suicide in Switzerland: A comparative analysis. *Journal of Threat Assessment and Management*, 6(1), 23–37. <https://doi.org/10.1037/tam0000121>
- Johnson, R., Persad, G., & Sisti, D. (2019). The Tarasoff rule: The implications of interstate variation and gaps in professional training. *Focus (American Psychiatric Publishing)*, 17(4), 435–442. <https://doi.org/10.1176/appi.focus.17402>
- Kadooka, Y., Okita, T., & Asai, A. (2016). Ethical obligations in the face of dilemmas concerning patient privacy and public interests: The sasebo schoolgirl murder case. *Bioethics*, 30(7), 520–527. <https://doi.org/10.1111/bioe.12249>
- Karp, A. (2018). Estimating global civilian-held firearms numbers (Briefing Paper No. 9). *Small Arms Survey*. <http://www.smallarmssurvey.org/fileadmin/docs/T-Briefing-Papers/SAS-BP-Civilian-Firearms-Numbers.pdf>
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry*, 62(6), 593–602. <https://doi.org/10.1001/archpsyc.62.6.593>
- Knoll, J. L., & Meloy, J. R. (2014). Mass murder and the violent paranoid spectrum. *Psychiatric Annals*, 44(5), 236–243. <https://doi.org/10.3928/00485713-20140502-07>
- Langman, P. (2009). Rampage school shooters: A typology. *Aggression and Violent Behavior*, 14(1), 79–86. <https://doi.org/10.1016/j.avb.2008.10.003>
- Langman, P. (2018). Different types of role model influence and fame seeking among mass killers and copycat offenders. *American Behavioral Scientist*, 62(2), 210–228. <https://doi.org/10.1177/0002764217739663>
- Lankford, A. (2016). Public mass shooters and firearms: a cross-national study of 171 countries. *Violence and Victims*, 31(2), 187–199. <https://doi.org/10.1891/0886-6708.VV-D-15-00093>
- Lankford, A., & Cowan, R. G. (2020). Has the role of mental health problems in mass shootings been significantly underestimated? *Journal of Threat Assessment and Management*, 7(3-4), 135–156. <https://doi.org/10.1037/tam0000151>
- Large, M., Smith, G., & Nielssen, O. (2009). The epidemiology of homicide followed by suicide: a systematic and quantitative review. *Suicide & Life-Threatening Behavior*, 39(3), 294–306. <https://doi.org/10.1521/suli.2009.39.3.294>
- Leach, M. M. (2009). International ethics codes and the duty to protect. In J. L. Werth, Jr., E. R. Welfel, & G. A. H. Benjamin (Eds.), *The duty to protect: Ethical, legal, and professional considerations for mental health professionals* (pp. 41–58). American Psychological Association. <https://doi.org/10.1037/11866-004>
- Medical Directors' Institute. (2019). *Mass violence in America: Causes, impacts & solutions*.
- Meloy, J. R., & O'Toole, M. E. (2011). The concept of leakage in threat assessment. *Behavioral Sciences & The Law*, 29(4), 513–527. <https://doi.org/10.1002/bsl.986>
- Metzl, J. M., Piemonte, J., & McKay, T. (2021). Mental illness, mass shootings, and the future of psychiatric research into American gun violence. *Harvard Review of Psychiatry*, 29(1), 81–89. <https://doi.org/10.1097/HRP.0000000000000280>
- Mulheron, R. P. (2010). *Medical negligence: Non-patient and third party claims*. Ashgate.
- Mullen, P. E. (2004). The autogenic (self-generated) massacre. *Behavioral Sciences & the Law*, 22(3), 311–323. <https://doi.org/10.1002/bsl.564>
- Mulvey, E. P., Odgers, C., Skeem, J. L., Gardner, W., Schubert, C., & Lidz, C. (2006). Substance use and community violence: A test of the relation at the daily level. *Journal of Consulting and Clinical Psychology*, 74(4), 743–754. <https://doi.org/10.1037/0022-006X.74.4.743>
- NCSL (2010). *NCSL staff research; Edwards, Griffin Sims*. Database of State Tarasoff Laws.
- NCSL (2018). *Mental health professionals' duty to warn*. <https://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx>
- Petrila, J., Fader-Towe, H. (2010). *Information Sharing in Criminal Justice—Mental Health Collaborations: Working with HIPAA and Other Privacy Laws*. Council of State Governments Justice Center. https://www.bja.gov/Publications/CSG_CJMH_Info_Sharing.pdf
- Phelan, J. C., Sinkewicz, M., Castille, D. M., Huz, S., Muenzenmaier, K., & Link, B. G. (2010). Effectiveness and outcomes of assisted outpatient treatment in New York State. *Psychiatric Services*, 61(2), 137–143. <https://doi.org/10.1176/ps.2010.61.2.137>
- Rahman, T., Hartz, S. M., Xiong, W., Meloy, J. R., Janofsky, J., Harry, B., & Resnick, P. J. (2020). Extreme overvalued beliefs. *Journal of the American Academy of Psychiatry and the Law Online*, 48(3):319–326. <https://doi.org/10.29158/JAAPL.200001-20>
- Rodriguez, L. (2013). *Message to Our Nation's Health Care Providers*. <http://www.hhs.gov/ocr/office/lettertonationhcp.pdf>
- Rozel, J. S., & Mulvey, E. P. (2017). The link between mental illness and firearm violence: Implications for social policy and clinical practice. *Annual Review of Clinical Psychology*, 13(1), 445–469. <https://doi.org/10.1146/annurev-clinpsy-021815-093459>
- Rozel, J. S., & Zacharia, M. Z. (2021). Risk management in the emergency department: Liabilities, duties, and EMTALA. In L. S. Zun, K. Nordstrom, & M. P. Wilson (Eds.), *Behavioral emergencies for healthcare providers*. (pp. 441–450). Springer International Publishing. https://doi.org/10.1007/978-3-030-52520-0_44
- Scarry, E. (2011). *Thinking in an emergency*. (1st ed.). W.W. Norton & Co.
- Schildkraut, J., Gruenewald, J., Gilliam, M., & Novak, M. (2020). Framing mass shootings as a social problem: A comparison of ideologically and non-ideologically motivated attacks. *Aggression and Violent Behavior*. Advance online publication. <https://doi.org/10.1016/j.avb.2020.101533>

- Silva, J. R., & Greene-Colozzi, E. A. (2019). Fame-seeking mass shooters in America: Severity, characteristics, and media coverage. *Aggression and Violent Behavior, 48*, 24–35. <https://doi.org/10.1016/j.avb.2019.07.005>
- Silva, J. R., Capellan, J. A., Schmuhl, M. A., & Mills, C. E. (2021). Gender-based mass shootings: An examination of attacks motivated by grievances against women. *Violence Against Women*. Advance online publication. <https://doi.org/10.1177/1077801220981154>
- Silver, J., Fisher, W., & Horgan, J. (2018). Public mass murderers and federal mental health background checks. *Law & Policy, 40*(2), 133–147. <https://doi.org/10.1111/lapo.12102>
- Silver, J., Simons, A., Craun, S. (2018). *A study of the pre-attack behaviors of active shooters in the United States between 2000 and 2013*. Federal Bureau of Investigation, US Department of Justice. <https://www.fbi.gov/file-repository/pre-attack-behaviors-of-active-shooters-in-us-2000-2013.pdf/view>
- Skeem, J. L., & Mulvey, E. (2019). What role does serious mental illness play in mass shootings and how should we address it? *Criminology & Public Policy, 19*(1), 85–108. <https://doi.org/10.1111/1745-9133.12473>
- Skeem, J. L., Schubert, C., Odgers, C., Mulvey, E. P., Gardner, W., & Lidz, C. (2006). Psychiatric symptoms and community violence among high-risk patients: A test of the relationship at the weekly level. *Journal of Consulting and Clinical Psychology, 74*(5), 967–979. <https://doi.org/10.1037/0022-006X.74.5.967>
- Soulier, M. F., Maislen, A., & Beck, J. C. (2010). Status of the psychiatric duty to protect, circa 2006. *The Journal of the American Academy of Psychiatry and the Law, 38*(4), 457–473.
- Stone, M. H. (2015). Mass Murder, Mental Illness, and Men. *Violence and Gender, 2*(1), 51–86. <https://doi.org/10.1089/vio.2015.0006>
- Swanson, J. W. (1996). Mental disorder, substance abuse, and community violence: An epidemiological approach. In J. Monahan & H. J. Steadman (Eds.), *Violence and Mental Disorder: Developments in Risk Assessment*. (pp. 101–136). University of Chicago Press.
- Swanson, J. W., Easter, M. M., Robertson, A. G., Swartz, M. S., Alanis-Hirsch, K., Moseley, D., Dion, C., & Petrila, J. (2016). Gun violence, mental illness, and laws that prohibit gun possession: Evidence from two Florida Counties. *Health Affairs Project Hope, 35*(6), 1067–1075. <https://doi.org/10.1377/hlthaff.2016.0017>
- Swanson, J. W., Swartz, M. S., Borum, R., Hiday, V. A., Wagner, H. R., & Burns, B. J. (2000). Involuntary outpatient commitment and reduction of violent behaviour in persons with severe mental illness. *British Journal of Psychiatry, 176*(4), 324–331. <https://doi.org/10.1192/bjp.176.4.324>
- Swanson, J., Norko, M., Lin, H., Alanis-Hirsch, K., Frisman, L., Baranoski, M., Easter, M., Robertson, A., Swartz, M., & Bonnie, R. (2017). Implementation and effectiveness of Connecticut's risk-based gun removal law: does it prevent suicides? *Law & Contemporary Problems, 80*, 179–208.
- Tarasoff v. Regents of University of California, 551 P. 2d 334 (Cal Supreme Court 1976).
- Warren, L. J., Mullen, P. E., & Ogloff, J. R. P. (2011). A clinical study of those who utter threats to kill. *Behavioral Sciences & The Law, 29*(2), 141–154. <https://doi.org/10.1002/bsl.974>
- Warren, L. J., Mullen, P. E., Thomas, S. D. M., Ogloff, J. R. P., & Burgess, P. M. (2008). Threats to kill: A follow-up study. *Psychological Medicine, 38*(4), 599–605. <https://doi.org/10.1017/S003329170700181X>
- Wintemute, G. J., Beckett, L., Kass, P. H., Tancredi, D., Studdert, D., Pierce, G., Braga, A. A., Wright, M. A., & Cerdá, M. (2017). Evaluation of California's Armed and Prohibited Persons System: study protocol for a cluster-randomised trial. *Injury Prevention: Journal of the International Society for Child and Adolescent Injury Prevention, 23*(5), 358–358. <https://doi.org/10.1136/injuryprev-2016-042194>
- Wintemute, G. J., Pear, V. A., Schleimer, J. P., Pallin, R., Sohl, S., Kravitz-Wirtz, N., & Tomsich, E. A. (2019). Extreme risk Protection orders intended to prevent mass shootings: A case series. *Annals of Internal Medicine, 171*(9), 655–658. <https://doi.org/10.7326/M19-2162>
- Zeoli, A. M. (2018). *Multiple Victim Homicides, Mass Murders, and Homicide-Suicides as Domestic Violence Events*. Battered Women's Justice Project. <https://www.preventdvgunviolence.org/multiple-killings-zeoli-updated-112918.pdf>
- Zeoli, A. M., & Paruk, J. K. (2020). Potential to prevent mass shootings through domestic violence firearm restrictions. *Criminology & Public Policy, 19*(1), 129–145. <https://doi.org/10.1111/1745-9133.12475>



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

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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-naïve 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

Table 46.1 Situations when firearm access may be explored in ED and PES settings

Suicidal or homicidal ideations, threats, or plans
Self-injury physical violence or related ideations, threats, or plans
Domestic or intimate partner violence
Substance use
Dementia and other progressive or acute cognitive issues
Anger issues
Any accidental injury in the home, especially involving children

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 46.2 General questions about firearms and weapons

<p>How many guns are in your home? How do you store guns in your home? Why are guns important to you? What did you buy them for? Have those reasons changed over time? How hard is it for you to get your hands on a gun (in your neighborhood/family/community)? Do you have a gun or any other weapon with you now? When you get in fights, what kind of weapons have you used? 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)? When there are fights at home, how often are guns brandished, used, or threatened with, implicitly or explicitly? What weapons do you have access to? Which would you use in [this situation]? 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? How did you learn how to use that weapon? What do you do to practice with it? Has the frequency with which you carry a weapon increased recently? Are there weapons at home that you have moved recently (e.g., from the attic to the bedside table)? Where do your parents keep their guns? How are they secured?</p>

Table 46.3 AEIOU: A weapons use mnemonic

Domain	What we are trying to learn
Access	How difficult is it for the patient to obtain a firearm for impulsive or deliberate violence?
Experience	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.
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.
Operational plan	Impulsive use is concerning; detailed and specific plans are also concerning.
Unconcerned with consequences and suicidality	Suicidality and homicidality have similar risk factors, and the presence of one can significantly increase the risk of the other.

Table 46.4 PHASES mnemonic for advanced firearm users and violence risk

Domain	What we are trying to learn
Proximity change	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.
Hatefulness and hostility	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.
Acquisition despite exclusion	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.
Substance use	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.
Escalating purchases	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.)
Suicidality and hopelessness	Presence of suicidality and hopelessness can increase violence risk

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).

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 46.5 “May I offer some suggestions?”

Safer: Secure the firearm more safely in the home	Somewhere else: Store the firearm at another safe location	Sold: Sell, exchange, or transfer the firearm legally
Mechanical and “smart” trigger locks Gun safes Separated from ammunition	At work (if permitted by employer) Rental storage locker With a safe friend or relative	Licensed firearm dealers Community buyback programs Pawnshops

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.

References

1. Anestis MD, Houtsma C. The association between gun ownership and statewide overall suicide rates. *Suicide Life Threat Behav.* 2018;48(2):204–17.
2. Anglemeyer A, Horvath T, Rutherford G. The accessibility of firearms and risk for suicide and homicide victimization among household members: a sys-

- tematic review and meta-analysis. *Ann Intern Med.* 2014;160(2):101–10.
3. Zeoli AM, Malinski R, Turchan B. Risks and targeted interventions: firearms in intimate partner violence. *Epidemiol Rev.* 2016;38(1):125–39.
 4. Miller M, Azrael D, Hemenway D. Firearm availability and unintentional firearm deaths. *Accid Anal Prev.* 2001;33(4):477–84.
 5. Swedler DI, Simmons MM, Dominici F, Hemenway D. Firearm prevalence and homicides of law enforcement officers in the United States. *Am J Public Health.* 2015;105(10):2042–8.
 6. Branas CC, Han S, Wiebe DJ. Alcohol use and firearm violence. *Epidemiol Rev.* 2016;38(1):32–45.
 7. Rozel JS, Mulvey EP. The link between mental illness and gun violence: implications for social policy. *Annu Rev Clin Psychol.* 2017;13(1):445–69.
 8. Tomazic M. *Docs v. Glocks: restricting doctor's professional speech in the name of firearm owner privacy – Wollschlaeger v. governor of Florida.* *Am J Law Med.* 2015;41(4):680–3.
 9. Lankford A. Public mass shooters and firearms: a cross-national study of 171 countries. *Violence Vict.* 2016;31(2):187–99.
 10. Grinshteyn E, Hemenway D. Violent death rates in the US compared to those of the other high-income countries, 2015. *Preventive Medicine.* 2019;123:20–6.
 11. Karp A. *Estimating Global Civilian-Held Firearms Numbers. Small Arms Survey, Geneva.* 2018. Available from: <http://www.smallarmssurvey.org/fileadmin/docs/T-Briefing-Papers/SAS-BP-Civilian-Firearms-Numbers.pdf>.
 12. Gopal A, Greenwood BN. Traders, guns, and money: the effects of mass shootings on stock prices of firearm manufacturers in the U.S. *Plos One.* 2017;12(5):e0177720.
 13. Studdert DM, Zhang Y, Rodden JA, Hyndman RJ, Wintemute GJ. Handgun acquisitions in California after two mass shootings. *Ann Intern Med.* 2017;166(10):698–706.
 14. Luca M, Malhotra DK, Poliquin C. The impact of mass shootings on gun policy. *Harv Bus Sch NOM Unit Work Pap* [Internet]. 2016 [cited 2016 Jul 16];(16–126). Available from: http://papers.ssrn.com/sol3/Papers.cfm?abstract_id=2776657.
 15. Betz ME, Wintemute GJ. Physician counseling on firearm safety: a new kind of cultural competence. *JAMA.* 2015;314(5):449–50.
 16. Wintemute GJ, Betz ME, Ranney ML. Yes, you can: physicians, patients, and firearms. *Ann Intern Med.* 2016;165(3):205–13.
 17. Betz ME, Wintersteen M, Boudreaux ED, Brown G, Capoccia L, Currier G, et al. Reducing suicide risk: challenges and opportunities in the emergency department. *Ann Emerg Med.* 2016;68(6):758–65.
 18. Rozel JS, Jain A, Mulvey EP, Roth LH. *Psychiatric assessment of violence.* In: Sturmey P, editor. *The Wiley handbook of violence and aggression.* Chichester: Wiley; 2017. p. 697–709.
 19. Wintemute GJ. The epidemiology of firearm violence in the twenty-first century United States. *Annu Rev Public Health.* 2015;36(1):5–19.
 20. Fowler KA, Dahlberg LL, Haileyesus T, Annett JL. Firearm injuries in the United States. *Prev Med.* 2015;79:5–14.
 21. Thiels CAD, Zielinski MD, Glasgow AEM, Habermann EB. The relative lack of data regarding firearms injuries in the United States. [Letter]. *Ann Surg.* 2018;268(6):e55–6.
 22. Jacoby SF, Kollar LMM, Ridgeway G, Sumner SA. Health system and law enforcement synergies for injury surveillance, control and prevention: a scoping review. *Inj Prev.* 2018;24(4):305–11.
 23. Peek-Asa C, Butcher B, Cavanaugh JE. Cost of hospitalization for firearm injuries by firearm type, intent, and payer in the United States. *Inj Epidemiol.* 2017;4(1):20.
 24. Spitzer SA, Staudenmayer KL, Tennakoon L, Spain DA, Weiser TG. Costs and financial burden of initial hospitalizations for firearm injuries in the United States, 2006–2014. *Am J Public Health.* 2017;107(5):770–4.
 25. Gani F, Sakran JV, Canner JK. Emergency department visits for firearm-related injuries in the United States, 2006–14. *Health Aff (Millwood).* 2017;36(10):1729–38.
 26. Kalesan B. The cost of firearm violence survivorship. *Am J Public Health.* 2017;107(5):638–9.
 27. Rowhani-Rahbar A, Zatzick D, Wang J, Mills BM, Simonetti JA, Fan MD, et al. Firearm-related hospitalization and risk for subsequent violent injury, death, or crime perpetration: a cohort study. *Ann Intern Med.* 2015;162(7):492.
 28. Duwe G. The patterns and prevalence of mass murder in twentieth-century America. *Justice Q.* 2004;21(4):729–61.
 29. Ingraham C. There are now more guns than people in the United States [Internet]. *The Washington Post WonkBlog.* 2015 [cited 2016 Jul 5]. Available from: <https://www.washingtonpost.com/news/wonk/wp/2015/10/05/guns-in-the-united-states-one-for-every-man-woman-and-child-and-then-some/>.
 30. Ladapo JA, Elliott MN, Kanouse DE, Schwebel DC, Toomey SL, Mrug S, et al. Firearm ownership and acquisition among parents with risk factors for self-harm or other violence. *Acad Pediatr.* 2016;16(8):742–9.
 31. Miller M, Hepburn L, Azrael D. Firearm acquisition without background checks: results of a national survey. *Ann Intern Med.* 2017;166(4):233–9.
 32. Fabio A, Duell J, Creppage K, O'Donnell K, Laporte R. Gaps continue in firearm surveillance: evidence from a large U.S. city Bureau of Police. *Soc Med.* 2016;10(1):13–21.
 33. Mueller DG, Frandsen R. Trends in firearm background check applications and denials. *J Public Aff.* 2017;17(3):n/a–n/a.
 34. Roskam K, Chaplin V. The gun violence restraining order: an opportunity for common ground in the

- gun violence debate section I. *Dev Ment Health Law*. 2017;36:1–22.
35. Baxley F, Miller M. Parental misperceptions about children and firearms. *Arch Pediatr Adolesc Med*. 2006;160(5):542–7.
 36. Jackman GA, Farah MM, Kellermann AL, Simon HK. Seeing is believing: what do boys do when they find a real gun? *Pediatrics*. 2001;107(6):1247–50.
 37. Hemenway D, Rausher S, Violano P, Raybould TA, Barber CW. Firearms training: what is actually taught? *Inj Prev J Int Soc Child Adolesc Inj Prev*. 2019;25(2):123–8.
 38. Utter GH, True JL. The evolving gun culture in America. *J Am Comp Cult*. 2000;23(2):67–79.
 39. comments KP. Among gun owners, NRA members have a unique set of views and experiences [Internet]. Pew Research Center. 2017 [cited 2017 Sep 15]. Available from: <http://www.pewresearch.org/fact-tank/2017/07/05/among-gun-owners-nra-members-have-a-unique-set-of-views-and-experiences/>.
 40. Hofstadter R. America as a gun culture. *Am Herit*. 1970;21(6):4.
 41. Braman D, Kahan DM, Grimmelmann J. Modeling facts, culture, and cognition in the gun debate. *Soc Justice Res*. 2005;18(3):283–304.
 42. Parker K, Horowitz J, Igielnik R, Oliphant B, Brown A. America's complex relationship with guns: an in-depth look at the attitudes and experiences of U.S. adults [Internet]. Washington, D.C.: Pew Research Center; 2017 Jun [cited 2017 Jun 26]. Available from: <http://assets.pewresearch.org/wp-content/uploads/sites/3/2017/06/22135403/Guns-Report-FOR-WEBSITE-PDF-6-21.pdf>.
 43. Becher EC, Cassel CK, Nelson EA. Physician firearm ownership as a predictor of firearm injury prevention practice. *Am J Public Health*. 2000;90(10):1626–8.
 44. Puttagunta R, Coverdale TR, Coverdale J. What is taught on firearm safety in undergraduate, graduate, and continuing medical education? A review of educational programs. *Acad Psychiatry J Am Assoc Dir Psychiatr Resid Train Assoc Acad Psychiatry*. 2016;40(5):821–4.
 45. Ammoland. What to do when your doctor asks about your guns [Internet]. [AmmoLand.com](http://www.ammoland.com). Shooting Sports News. 2015 [cited 2016 Mar 6]. Available from: <http://www.ammoland.com/2015/06/what-to-do-when-your-doctor-asks-about-your-guns/>.
 46. Rowhani-Rahbar A, Lyons VH, Simonetti JA, Azrael D, Miller M. Formal firearm training among adults in the USA: results of a national survey. *Inj Prev*. 2018;24(2):161–5. <https://doi.org/10.1136/injury-prev-2017-042352>. Epub 2017 Jul 11.
 47. Sanguino SM, Dowd MD, McEnaney SA, Knapp J, Tanz RR. Handgun safety: what do consumers learn from gun dealers? *Arch Pediatr Adolesc Med*. 2002;156(8):777–80.
 48. Betz ME, Azrael D, Barber C, Miller M. Public opinion regarding whether speaking with patients about firearms is appropriate: results of a National Survey. *Ann Intern Med*. 2016;165(8):543–50.
 49. Pinals DA, Appelbaum PS, Bonnie R, Fisher CE, Gold LH, Lee L-W. American Psychiatric Association: position statement on firearm access, acts of violence and the relationship to mental illness and mental health services: APA position statement on firearm access. *Behav Sci Law*. 2015;33(2–3):195–8.
 50. Simon RI. Gun safety management with patients at risk for suicide. *Suicide Life Threat Behav*. 2007;37(5):518–26.
 51. Patient Safety Advisory Group. Detecting and treating suicide ideation in all settings. *Sentin Event Alert* [Internet]. 2016 Feb 24 [cited 2017 Oct 15];(56). Available from: https://www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf.
 52. Weinberger SE, Hoyt DB, Lawrence HC, Levin S, Henley DE, Alden ER, et al. Firearm-related injury and death in the United States: a call to action from 8 health professional organizations and the American Bar Association. *Ann Intern Med*. 2015;162(7):513–6.
 53. Shea SC. My favorite tips for uncovering sensitive and taboo information from antisocial behavior to suicidal ideation. *Psychiatr Clin North Am*. 2007;30(2):253–9.
 54. Brent DA, Baugher M, Birmaher B, Kolko DJ, Bridge J. Compliance with recommendations to remove firearms in families participating in a clinical trial for adolescent depression. *J Am Acad Child Adolesc Psychiatry*. 2000;39(10):1220–6.
 55. Sherman ME, Burns K, Igelzi J, Raia J, Lofton V, Toland D, et al. Firearms risk management in psychiatric care. *Psychiatr Serv*. 2001;52(8):1057–61.
 56. Miller WR, Rollnick S. *Motivational interviewing: helping people change*. 3rd ed. New York: Guilford Press; 2013. 482 p. (Applications of motivational interviewing).
 57. Britton PC, Bryan CJ, Valenstein M. Motivational interviewing for means restriction counseling with patients at risk for suicide. *Cogn Behav Pract*. 2016;23(1):51–61.
 58. Shenassa ED, Rogers ML, Spalding KL, Roberts MB. Safer storage of firearms at home and risk of suicide: a study of protective factors in a nationally representative sample. *J Epidemiol Community Health* 1979-. 2004;58(10):841–8.
 59. Ollam D. Safe to armed in seconds. In Las Vegas, Nevada; 2011 [cited 2017 Sep 30]. Available from: https://www.youtube.com/watch?v=3SVMT_zNlGA.
 60. Hemenway D, Azrael D, Miller M. Whose guns are stolen? The epidemiology of Gun theft victims. *Inj Epidemiol*. 2017;4(1):11.