Violence 201: Integrating Threat Management into Clinical Practice

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@ViolenceWonks
Disclosures

- No payments or gifts from pharma/industry or other ACCME-defined commercial interests since 2007
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- I receive payments from government agencies, nonprofit organizations, and non-healthcare businesses, for consultation, training, and expert witness work
2018 AAEP Position Statement on Mass Shootings & Mental Illness

www.emergencypsychiatry.org

• All threats of violence must receive a psychiatric evaluation within the capacity of the facility
• Psychiatric evaluation and tx will have limited impact
• Consultation & Collaboration
• Clinically, ethically, & legally appropriate decision making
• Staff support and care
• Continued study, learning, and development
• Evidence based messaging and communication
Key points

• Try to stay left of bang
• Individualized assessments and interventions
• Disrupt risk factors, support protective factors
• Never worry alone
• Threat management is a tool towards treatment and threat management teams are allies in care
Left of Bang
Brian

• From the outpatient team:
  • 14M being evaluated for autism spectrum
  • Elaborate homicidal fantasies disclosed to psychologist

• From the school:
  • Fake email from a new parent to school leadership: “What do you do to keep students safe from shootings?”

• From law enforcement:
  • Mimicry in apparel, social media handles relating to Columbine
  • Favoriting social media posts on accessing firearms

• Community ER: “he says he was joking,” not psychotic or suicidal, no indication for admission and is sent home
STRONGER THAN HATE
Beware the shiny object

-Stephanie Leite, PsyD
**Violence & Mass Shootings: Likelihood of “mental illness”**

- 4%  
  Violence attributable to mental illness (Swanson 1996)

- 17%  
  Any non-SUD Axis I in murder def's (Martone 2013)

- 4.7%  
  NICS-disqualifying mental illness PMSs (Silver et al 2018)

- 11%  
  Evidence of prior MH “concerns” (Everytown 2015)

- 17%  
  Pre-incident dx, school shooters (Vossekuil/SSI 2002)

- 25%  
  Evidence of SMI, 100+ yrs of MM (Stone 2015)

- 25%  
  Pre-incident diagnosis of any kind, AS (Silver/BAU 2018)

- 28%  
  Evidence of MI, ISIS-influenced (Gill & Corner 2017)

- 40%  
  Prior dx in targeted school attacks (USSS/NTAC 2019)

- 55%  
  Lifetime risk, DSM-IV Disorder, all of USA (Kessler 2006)

- 59%  
  “Signs of serious mental illness” (Duwe 2007)

- 62%  
  Mental Health “Stressor,” AS (Silver/BAU 2018)
Layers of Mental Illness

• Symptoms
• Diagnoses, current or past
• Current, significant impairment
• If I saw this person in the psychiatric emergency service, would I
  • Recommend outpatient, partial, inpatient?
  • Involuntary commitment?
• Would this person meet criteria for involuntary outpatient commitment? Long term state hospitalization?
• Not competent to stand trial?
• Guilty but mentally ill? (Illness impacts)
• Not guilty by reason of insanity? (Illness overrides)
A multidisciplinary threat assessment team, in conjunction with the appropriate policies, tools, and training, is the best practice for preventing future tragedies.

Protecting America’s Schools
U.S. Secret Service, 2019
Behavioral Threat Assessment and Management

- Using diverse teams of subject matter and operational experts to recognize and reduce violence risk before attacks happen

- **Evidence based** identification, investigation, prevention and follow up (case management*)

- Focus is on behavior, communication, risk factors; not profiling by diagnosis, religion, ethnicity, politics, etc.

- Diverse teams reduce discrimination and systemic bias

- Mitigation of harm is the absolute goal
Behavior.
Communication.
Ideation.

Not profiling.
Not profiling.
Not profiling.
Not profiling.
“You have to collect the dots before you can connect the dots.”  Jeff Pollard
We can be good at prevention without needing to be good at prediction

(Simons & Meloy, 2017)
As many as 80% of assailants leak or threaten (Lankford et al 2019, Mitchell 2019 et al, Meloy & O'Toole 2011)

A threat is a communication to a target of intent to do harm.

Leakage is the communication to a third party of an intent to do harm.
Lately, I’ve been having uncontrollable cravings for venison
Individualized assessment, individualized interventions

Dr. Vancbromicin
@BromoSouthern

As a resident it can take only about 2.5 seconds to go from “what a nice day” to “I want to punch everyone in the face”
Availability heuristic drives service utilization

1. **Pseudothreatening Outliers** – no intent to threaten or harm but behavior is awkward enough to provoke anxiety in others
2. **Comedians** – no intent to harm, made threatening statement as a joke
3. **Hoaxers & Trolls** – sadistic provocation of others’ anxieties with negligible intent to carry out any attack
4. **Hotheads** – Impulsively makes menacing or threatening statements when upset or angry without intent to carry out attack
5. **Posers/explorers** – Want to take on the appearance or identity of a person intending or capable of violence
6. **Real Deals** – Somebody who is contemplating or acting towards an attack with real intent
Not every risk factor will be useful
Investigate all **THREATS**\(^3\) (Barnhorst & Rozel 2021)

- **T** Threats, leakage, or other statements of intent to harm
- **H** History of violence, especially with the identified target
- **R** Recent stressors (relationships, $$$, housing, work, health, vic)
- **E** Ethanol / other drug intoxication or recent use
- **A** Agitated/annoyed easily (Hostile Attributional Style)
- **T** Takes no responsibility (External Attributional Style)
- **S** Suicidality, increasing hopelessness
- **S** Symptomatic psychiatric illness, especially psychosis
- **S** Specific target, access, means, plan
Personality Disorders & Spectrums

- Antisocial
- Narcissistic
- Borderline
- Paranoid
- Obsessive-compulsive

- Meta-constructs
  - Psychopathy (Antisocial + Narcissistic)
  - Querulous (Paranoid + Obsessive-Compulsive)

(Fazel et al 2021; Lowenstein et al 2016; Sarkar 2019; Newhill et al 2009; Fox & Delisi 2019; Linden 2020; Carroll 2012)
“We are better; you are worse”

“You are different, wrong, and imminently dangerously to me”
Medical issues and violence risk

**Serious pain**
- Acute or chronic
- Undertreated
- Altered subjective experience of pain

**Affects the brain**
- TBI
- Delirium
- Dementia
- Progressive sensory issues
- Disorientation
- COVID19 related hypoxia / neuro-inflammation

**Causes strain**
- Bad news / prognosis
- Failure to get disability
- Not getting a wanted rx/letter/etc
- Fired from clinic
- Medically unexplained symptoms
What do we do with a POI in clinical psychiatry?

- **Assess**, (and possibly admit) as comprehensively as possible, including collateral and bio / psycho / social / spiritual & social determinants of health needs
- **Build rapport** with patient and those who care for them
- **Care for them** – treating what we can, amplifying strengths, and bringing resources supports into their lives
- **Document our understanding** – and share that within the boundaries of the law
- **Evaluate again** – neither threat management nor psychiatric treatment is ever a one-and-done
Path to Intended* Violence
(Adapted from Calhoun & Weston 2003/2016)

Grievance
Ideation
Research
Preparation
Breach
Attack

→ Dynamic Risk Factors
← Dynamic Protective Factors
Stages of Change
(Prochaska 1997)

Precontemplation

Contemplation

Determination

Action
Path to Intended* Violence
(Adapted from Calhoun & Weston 2003/2016)

Interventions, Tools, & Options
- Grievance
- Ideation
- Research
- Preparation
- Breach
- Attack

Dynamic Risk Factors ➔
Dynamic Protective Factors ←
Not everybody makes it to the top
How can I help?

- An illness that can be treated
- A legitimate grievance that can be addressed
- An error that can be apologized for
- A psychosocial stressor that I can mitigate
- A strength I can amplify
- A protective factor I can add or reinforce
- Soft landings & supported exits
- Promote connection
How can I hurt?

• Acting out of bias
• Ignore concerns – ignore the dots
• Blame / punish reporters
• Punish / Push away
• Zero tolerance
• Scare / alienate
• Hard landings / fast exits
We need to understand the environment we face and how others view it. Then build relationships at the personal, organizational and national level.

Relationships are the intermediate objectives to most goals.

Gen. Stanley McChrystal
Organic teams

- Who are you solving problems with?
- Who else in your institution?
- Which EDs, crisis teams, counselors, etc.?
- Who else in your community?

- Trust
- Diversity
- Collaborative mindset and track record
- Common vision and purpose
- Subject matter expertise
When law enforcement comes knocking...

- We should always listen – there is a good chance they have collateral information we will never learn of otherwise
- “This sounds important. I may not be able to say much but I will do what I can to get it to the right treatment provider.”
- We can ask questions and offer hypotheticals as long as we are not leading
- HIPAA allows information sharing with LE to prevent acts of violence
- It’s hard to argue against applying the HIPAA emergency exception when you are in the ED
Suggested readings & references


• The Sandy Hook Promise “Tomorrow’s News” video is at https://youtu.be/ZvRQ1StsYGw