

NATIONAL COUNCIL
MEDICAL DIRECTOR INSTITUTE

MASS VIOLENCE IN AMERICA

CAUSES, IMPACTS
AND
SOLUTIONS

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NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH

National Council Medical Director Institute

The National Council for Behavioral Health (National Council) is the largest organization of mental health and addictions treatment programs in the United States, serving 10 million adults, children and families with mental health and substance use disorders. In this capacity, it performs important organizational, educational and advocacy functions and serves as a unifying voice for its 3,000 member organizations. The National Council is committed to all Americans having access to comprehensive, high-quality, affordable care that provides every opportunity for recovery.

In 2015, the National Council Board of Directors commissioned the Medical Director Institute (MDI) to advise National Council members on best clinical practices and to address major priorities in care for mental illnesses and substance use disorders. The MDI develops policies and initiatives that serve member behavioral health organizations and their constituent clinicians and the governmental agencies and payers that support them.

The MDI is composed of medical directors of organizations who have been recognized for their outstanding leadership in shaping psychiatric and addictions service delivery and draws from every region of the country. One of the ways the MDI fulfills its charge is by developing technical documents that highlight challenges at the forefront of mental health and addictions care, providing guidance and identifying practical solutions to overcome those challenges. Topics of prior scholarly reports and white papers include “The Psychiatric Shortage — Causes and Solutions” and “Medication Matters — Causes and Solutions to Medication Non-Adherence.” This report addresses the problem of mass violence in the United States and, specifically, the extent to which mental illness is or is not contributing to this social pathology. The report was done because mass shootings are increasing in frequency and severity, and they have captured the national attention.

The Mass Violence Expert Panel Process

The MDI convened a panel of individuals with diverse expertise pertaining to mental health care and violence — including clinicians who treat individuals with mental illnesses and substance use disorders, administrators, policymakers, researchers, educators, advocates, law enforcement personnel, judges, parents and payers — for a two-day meeting focused on an in-depth review and analysis of mass violence that integrated multiple perspectives. Panel members provided input from their practical experience and research from their area of expertise, including their unique perspectives on the problem of mass violence. (See Expert Panel on page 73 for a full list of participants.)

The agenda was structured to review specific topics, vet relevant content and build consensus through discussion and debate. The meeting resulted in practical solutions that meet the test of feasibility and effectiveness based on the conclusions of the expert panel.

A technical writer and co-editors served as recorders for the proceedings, compiled the literature submissions from the panel members and drew on other sources for the background material. While we did not use a formal scoring system that weighted each publication or source of information, we synthesized what we believe are the best substantiated and consistent findings across the literature, while relying on the consensus of the panel members for areas with less empirical research.

The technical writer and co-editors completed a first draft that was circulated to all panel members. Their written comments and feedback were incorporated into a second draft. The process was repeated until the final document was completed.

The goal of this paper is to examine existing data and expertise on mass violence, provide an analysis about its causes and impacts and make recommendations to inform policy and practice for a wide range of stakeholders. These include the federal Departments of Justice and Health and Human Services and the Substance Abuse and Mental Health Services Administration; provider organizations; professional trade organizations for psychiatrists, psychologists, social workers and other behavioral health professionals; consumer and family advocacy groups; state mental health authorities; policymakers in the behavioral health arena; educators; judges; law enforcement officers; and workplace representatives.

EXECUTIVE SUMMARY

Among advanced countries, the US has a unique problem with mass violence — defined as crimes in which four or more people are killed in an event or related series of events. A substantial majority occurs by shooting. Both the rate at which mass shootings occur and the number of people killed are increasing. Frequently, in the wake of such tragedies, policymakers and the public raise the specter of mental illness as a major contributing factor.

The National Council for Behavioral Health Medical Director Institute convened an expert panel to analyze the root causes of mass violence, its contributing factors, the characteristics of perpetrators and the impacts on victims and society. The panel specifically examined the extent to which mental illness is or is not a contributing factor to this social pathology and developed recommendations for a broad range of stakeholders. A summary of their deliberations and conclusions follow.

Mass Violence Is a Rare Event

Despite the fear and public scrutiny they evoke, mass shootings are statistically rare events. Mass shootings accounted for less than two-tenths of 1 percent of homicides in the United States between 2000 and 2016. Even school shootings, the most tragic of such events, are infrequent. People are more likely to intentionally kill themselves with a gun than to be killed by a gun in a mass shooting or other type of homicide.

Perpetrators Share Certain Characteristics

While perpetrators of mass violence can be categorized with respect to motivation, the characteristics of individual perpetrators cut across demographic, sociologic, cultural and occupational groups. The characteristics that most frequently occur are males, often hopeless and harboring grievances that are frequently related to work, school, finances or interpersonal relationships; feeling victimized and sympathizing with others who they perceive to be similarly mistreated; indifference to life; and often subsequently dying by suicide. They frequently plan and prepare for their attack and often share information about the attack with others, though often not with the intended victims.

Mental Illness Plays an Important but Limited Role in Mass Violence

Incidents of mass violence — especially those that appear to be senseless, random acts directed at strangers in public places — are so terrifying and traumatic that the community responds defensively and demands an explanation. After such events, political leaders often invoke mental illness as the reason for mass violence, a narrative that resonates with the widespread public belief that mentally ill individuals in general pose a danger to others. Since it is difficult to imagine that a mentally healthy person would deliberately kill multiple strangers, it is commonly assumed that all perpetrators of mass violence must be mentally ill.

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DMS-5), provides a catalog of diverse brain-related health conditions that impair a person's normal ability to reason and perceive reality, regulate mood, formulate and carry out plans and decisions, adapt to stress, behave and relate to others in socially appropriate ways, experience empathy, modulate consumption and refrain from intentional self-injury — or various combinations of such problems. While a subset of people perpetrating mass violence has one of the more severe mental illnesses or personality disorders, many do not. Lumping all mental illness together, and then assuming that acts that seem

incomprehensible to the average person are due to mental illness, results in millions of harmless, nonviolent individuals recovering from treatable mental health conditions being subjected to stigma, rejection, discrimination and even unwarranted legal restrictions and social control.

Simplistic conclusions ignore the fact that mass violence is caused by many social and psychological factors that interact in complex ways; that many, if not most, perpetrators do not have a major psychiatric disorder; and that the large majority of people with diagnosable mental illnesses are not violent toward others.

While there is a modest link between mental illness and violence, there is no basis for the public's generalized fear of people with mental illness. Having a psychiatric diagnosis is neither necessary nor sufficient as a risk factor for committing an act of mass violence. For that reason this report has a broader range of considerations and recommendations beyond the subset of all mass violence with a link to mental illness.

While there is increasing demand to identify potential perpetrators of violence and develop preventive measures, there has been insufficient research on the root causes of the problem or resources to address them. Such causes include social alienation and social problems (including deficiencies in the educational system, poverty, discrimination, the lack of job opportunities, etc.), as well as the lack of quality and comprehensive mental health care.

Threat Assessment and Management May Help Prevent Mass Violence

Threat assessment, a term that originated in law enforcement, is a strategy to prevent violence targeted at public figures and other people who are threatened by someone. Threat assessment is no longer considered a single assessment but rather an ongoing assessment process with interventions designed to prevent violence.

A threat assessment team within a business or school is a multidisciplinary group that includes representatives from security and law enforcement, behavioral health care, human resources, legal and management, among others. Rather than examine individual characteristics, the team looks at where a person is on the pathway to violence and assesses the individual's risk factors. There are many points along that pathway at which the situation can be defused. For example, school-based teams identify the need for services and offer in-house or referral services.

Mass Violence in Schools Prompts Ill-considered Policy Decisions

Though schools are much safer than the public might believe, school shootings grab national headlines that lead to some ill-considered policy decisions. One example is the use of zero-tolerance policies in schools. The result is that students are suspended for a variety of minor misbehaviors, sometimes unnecessarily, potentially creating isolation and resentment that can lead to more and more serious, problematic behaviors.

In addition, excessive security measures include bulletproof building entrances, electronic door locks, metal detectors and panic rooms with video monitors. The use of school-shooter drills, in some cases not announced in advance, may lead students and staff to believe that an active shooting is occurring and can be psychologically traumatizing. Though some safety drills are warranted, those that evoke fear and create trauma do more harm than good.

A Communitywide Problem Demands a Communitywide Solution: The Role for Health Care Providers, Law Enforcement and the Courts

Mass violence is a communitywide problem that can't be solved by any one organization or system alone. The following play a key role.

Primary Care Providers

Primary care offers a potential opportunity to uncover, diagnose, refer and treat underlying mental disorders (e.g., conduct disorder, depression, psychosis). In response to mass violence, primary care and behavioral health teams have developed innovative ways of working together to support children and their families.

Behavioral Health Providers

Although there is a modest link between mental illness and violence, the timely availability of quality mental health treatment can be limited, especially in some areas of the country, but communities can assist in identifying the best access points. Community mental health centers and mental health treatment providers play an essential role in the systems of care for individuals with mental health symptoms, especially those with the greatest, often unmet, needs. Additionally, they play a vital role in the community response to a mass violence incident. Behavioral health providers offer support to victims and their families, to first responders and to the community at large and deliver a variety of evidence-informed, trauma-specific therapies. They play an important role in the critical incident response and command structure and leverage key relationships to support a reeling community. Sometimes they are called on to define the role that mental illness may have played in the incident.

Law Enforcement

In many parts of the country, local, state and federal law enforcement officials are being trained to respond to calls that involve people in crisis, including but not limited to those with mental illnesses. The goal is for officers to divert these individuals from the legal system by diffusing the situation, working collaboratively with their mental health colleagues and the individuals' natural supports and linking the individuals to services.

Courts

There are now more than 3,000 problem-solving courts (e.g., drug courts, mental health courts) across the country. These interdisciplinary and collaborative courts help fill gaps in psychosocial services, provide early identification and intervention with individuals who may be at risk for violence and extend the reach of an often under-resourced and overworked behavioral health treatment system. In an increasing number of states, judges can order extreme-risk protection orders resulting in the temporary removal of firearms when there are high levels of concern that gun violence could occur. The legal system across the spectrum — from family/juvenile courts to domestic violence, truancy, veterans', mental health and DWI courts — may be viewed as early interveners in identifying potential dangerousness.

Working with the Media Can Help Educate the Public

In the age of 24-hour cable news and the internet, it has become increasingly difficult to control the narrative about a mass violence event. Before many facts can be gathered, real-time speculation of the role of mental illness — by reporters, pundits and mental health professionals with little concrete information — can lead to unjust characterizations of all people with mental illness, as well as unfair speculation about the links between violence and mental illness.

But subject matter experts may have an opportunity to help educate the media and the public about mental illness by dispelling myths about mental illness and violence, providing a framework for understanding these rare but disturbing events and offering general information about mental illness treatment and services and the problems caused by lack of access to them.

Recommendations

The National Council Expert Panel on Mass Violence developed a number of specific recommendations for key stakeholders. Highlights of the recommendations follow.

General Recommendations

- Identify root causes of mass violence and develop strategies to alleviate them instead of focusing only on quick fixes downstream from the sources of the problem.
- Mental health providers and advocacy groups must acknowledge the role mental illness plays in mass violence and support efforts to prevent the subset of mass violence perpetrated by people with mental illness.

Recommendations for Health Care Organizations

- Establish multidisciplinary threat assessment and management teams that include representatives from security, human resources, legal and law enforcement.
- Implement ongoing quality improvement around the issues of violence risk assessment and threat assessment and management.
- Train staff in lethal means reduction. This is a rational strategy for lethal violence reduction and very helpful in combating suicide.
- Prepare staff for vicarious trauma and compassion fatigue. Provide resources for self-care rituals and support for staff needs.

Recommendations for Schools

- Revise zero-tolerance policies and the effects of suspensions and expulsions as they are ineffective and harmful practices. Rely instead on a well-trained multidisciplinary threat/risk assessment and management team.
- Avoid measures that create a correctional facility-like atmosphere such as bulletproof glass, armed security guards and metal detectors. More commonsense measures such as limited entry points into the school can be just as effective and cost little to implement.
- Refrain from high-stress security drills (for example, those in which students are not informed they are participating in a drill), which can themselves be traumatizing.
- Encourage an emotionally connected safe-school climate where each student can feel comfortable coming forward to a responsible adult with matters of concern.
- Emphasize and train staff in interpersonally based and emotionally supportive prevention measures that include the impact of trauma and indications for referral for mental health treatment, such as Child and Youth Mental Health First Aid, bereavement support and academic accommodations.
- Implement universal social-emotional learning and add mental health to the school health curriculum.

Recommendations for Communities for Identifying and Intervening with Higher-Risk Groups and Individuals

- Create and support broad community partnerships that include behavioral health, law enforcement, schools, the faith and medical communities, etc., to strengthen the connections among those systems that interact with individuals who have mental illnesses and addictions and may be at risk for committing violence.
- Prioritize as high risk those individuals with narcissistic and/or paranoid personality traits who are fixated on thoughts and feelings of injustice and who have few social relationships and recent stresses and those with new onset psychosis.
- Establish threat/risk assessment and management teams. These multidisciplinary teams should include representatives from mental health, security, human resources, legal and law enforcement.
- Provide training in Mental Health First Aid, which teaches skills to respond to the signs of mental and substance use disorders.

Recommendations for Judicial, Correctional and Law Enforcement Institutions

- Develop a basic educational toolkit for judges on the nuances of risk assessment, the role of trauma and the need for additional supports for individuals who may pose risks for violence.
- Involve mental health professionals in threat assessments conducted by law enforcement and implementation of red flag laws.
- Provide training in Mental Health First Aid, which teaches skills to recognize and work with individuals who have mental illnesses, for law enforcement, corrections and public safety officials.

Recommendations for Legislation and Government Agencies

- Pass legislation to increase the availability of threat assessment training at the local, state, tribal and national levels.
- Develop a payment methodology for threat assessment and management.
- Promote expansion of the Certified Community Behavioral Health Clinic (CCBHC) model because these clinics are required to provide extensive crisis response capability, and the CCBHC prospective payment model can support the development and operation of threat assessment teams.
- Enact state red flag or extreme-risk protection orders that allow the temporary removal of guns from individuals who are known to pose a high risk of harming others or themselves in the near future.
- Fully implement the existing federal background check requirement for firearms purchases.

Recommendations for Research

- Support research on the nature and factors that contribute to mass violence, including neurobiological, psychological and sociological factors.
- Support research on methods and instruments for identifying and predicting perpetrators of mass violence.
- Support research on methods of intervention and prevention of mass violence.

- Create a standardized, mandatory investigation/analysis of each mass violence incident conducted by a multiagency team lead by the Department of Justice.
- Evaluate extreme-risk protection orders in states that have enacted them to assess both the process of implementation and their effectiveness.

Recommendations for Working with the Media

- Build close working relationships with media representatives ahead of any crisis situation.
- Choose and disseminate existing guidance, such as that offered at <https://www.reportingonmassshootings.org/>, and encourage reporters to follow these guidelines.
- Train behavioral health staff who will respond to the media. Develop protocols about who should respond to what type of request and what they should say. Develop these messages well in advance of a tragic event.
- Talk about the role of treatment in helping people at risk of violence. Highlight the fact that most people with mental illnesses will never become violent. Speak to untreated or undertreated mental illness in combination with other risk factors.
- Work with the media to develop guidance for the general public on risk factors for violence. Help the public understand the importance of “see something, say something.”

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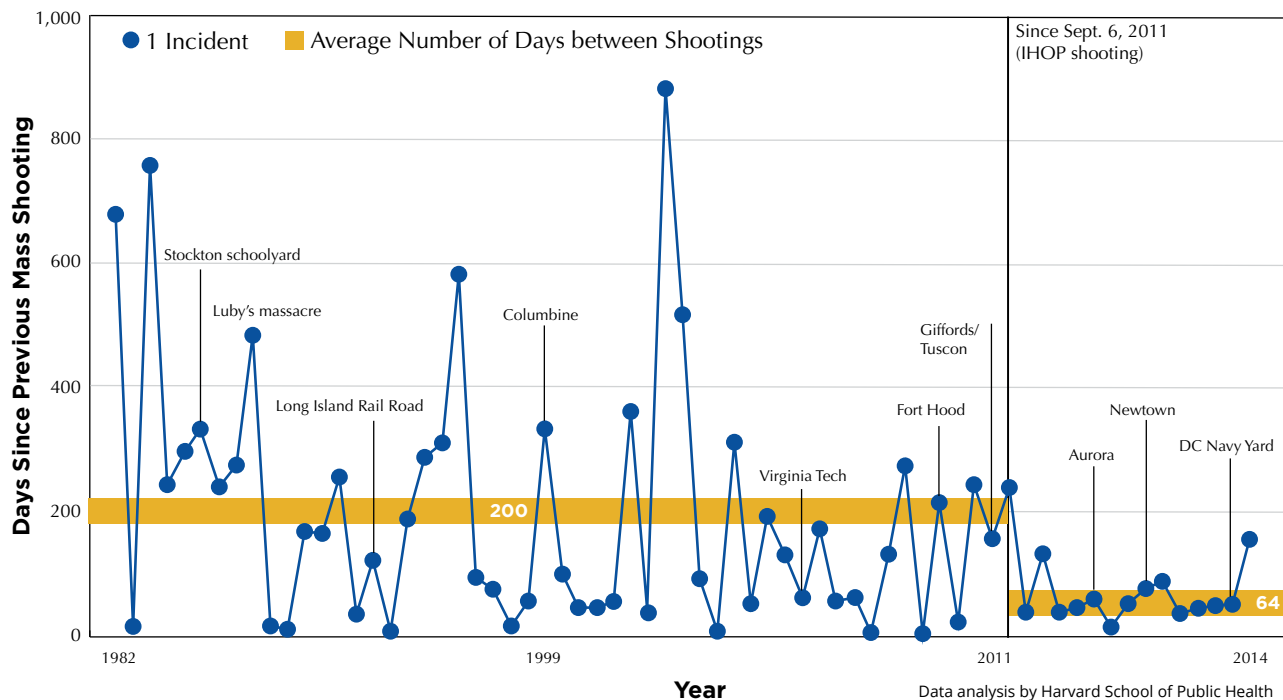
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INTRODUCTION

In the United States, the National Violent Death Reporting System produces counts of homicides by mechanism, stratified by a single victim or two or more victims. The United States has more mass violence, when defined as crimes in which four or more people are shot in an event or related series of events, than any other country in the world (Wintemute, 2015). For the states reporting for the past five years, guns were used in 82 percent of multiple victim incidents and 68 percent of single victim incidents; thus, in the United States, mass violence is often synonymous with gun violence. A large majority of the perpetrators are males who use guns to kill, act alone and ultimately either die by suicide or are killed by law enforcement officers or civilians at the scene of the attack. In some instances when officers kill the perpetrator, the perpetrators may have intentionally provoked law enforcement to kill them in a phenomenon known as “suicide by cop” or “law enforcement-assisted suicide.” In still other scenarios, the perpetrators are captured alive and subsequently tried and incarcerated or institutionalized, depending on the legal verdict.

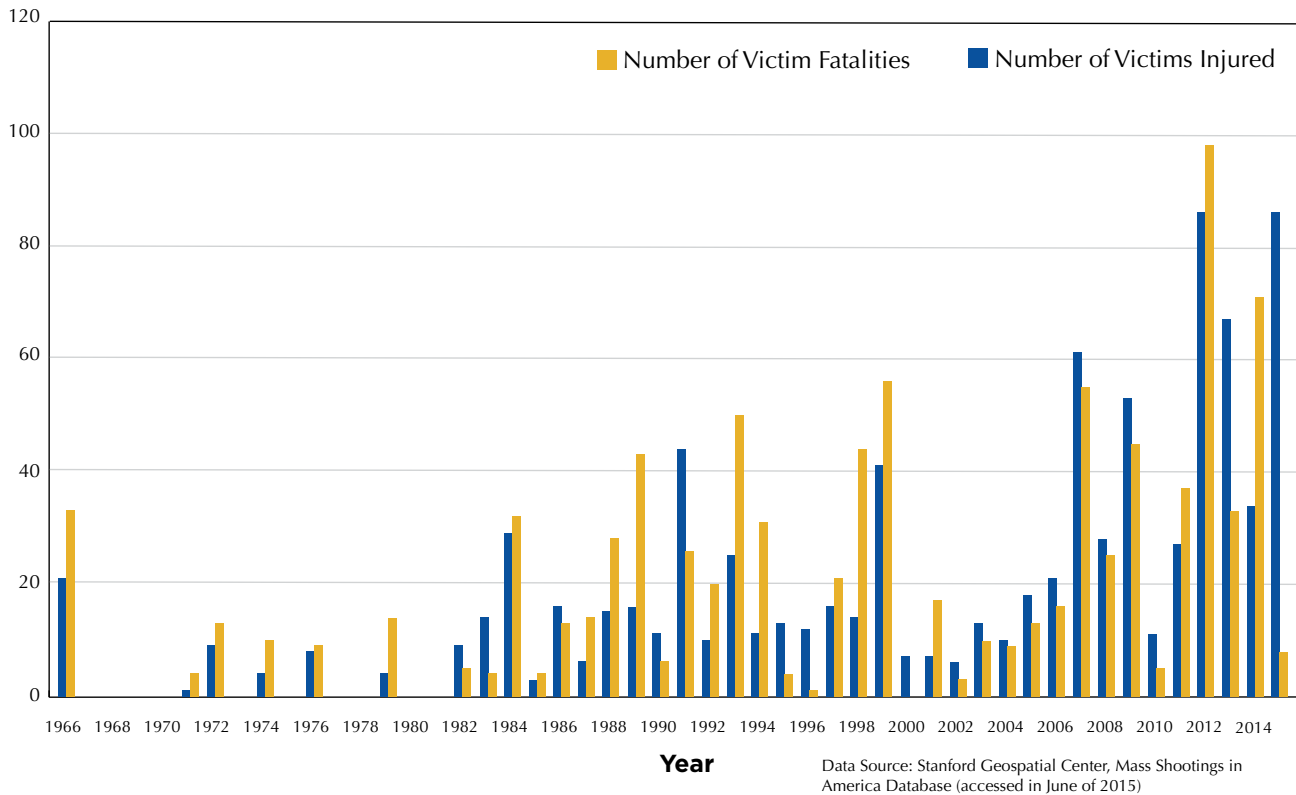
Studies indicate that the rate at which mass shootings occur has tripled since 2011. Between 1982 and 2011, a mass shooting occurred roughly once every 200 days. However, between 2011 and 2014, that rate accelerated greatly, with at least one mass shooting every 64 days (Cohen, Azrael, & Miller, 2014; Lemieux, 2014; Blair & Schweit, 2014).

Mass Shootings Since 2011: Every 64 Days on Average



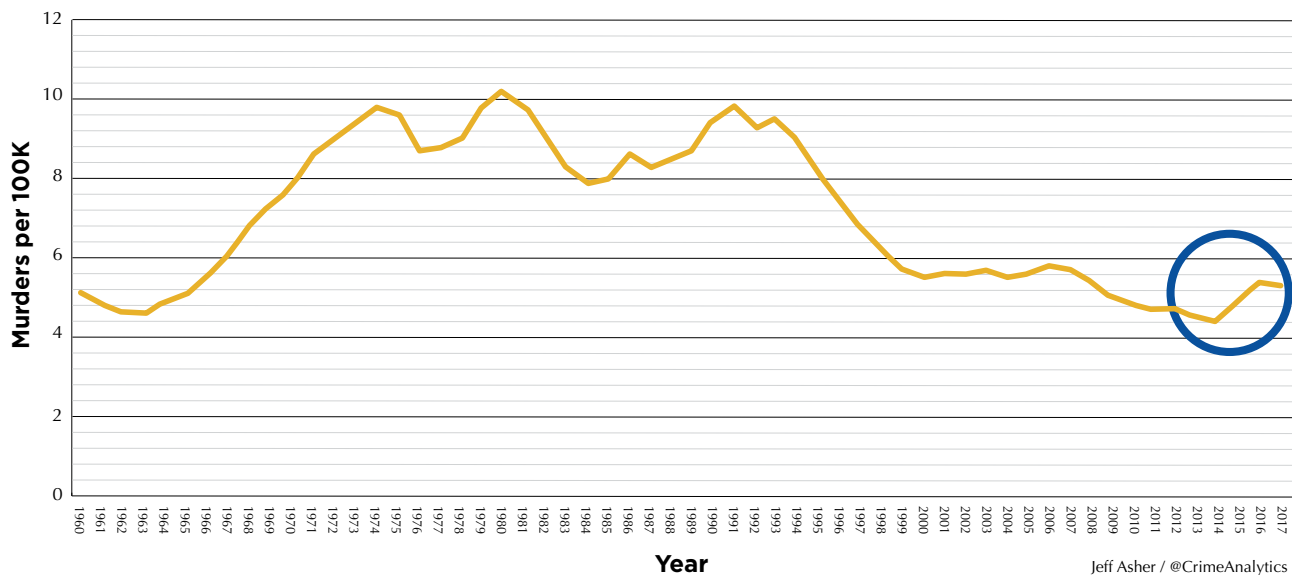
Moreover, the number killed and injured during these incidents increased as well (Stanford Mass Shootings in America, 2015).

Number of Victims of U.S. Mass Shootings, 1966–2015



And this is happening against the backdrop of an overall decline in violent crime in the United States (Asher, 2018).

Murders per 100,000 Population



While mass shootings accounted for less than one-tenth of 1 percent of homicides in the United States between 2000 and 2016 (Follman, Aronsen, & Pan, 2019; Centers for Disease Control and Prevention, 2018), mass violence evokes disproportionately greater public, media and government reaction than other forms of violence (gang, organized crime, robbery, etc.).

Mass violence occurs in various settings, including schools, universities, workplace and domestic settings and public buildings (e.g., movie theaters, shopping malls, retail stores, etc.). While each mass violence incident has its unique motivations and circumstances, the perpetrators of mass violence predominantly fall into several motivational categories: ideologically extreme individuals (e.g., terrorists); current or former disgruntled employees, students or domestic partners seeking revenge; disaffected loners; and people with mental illness (mostly psychosis, depression, posttraumatic stress disorder and substance use) whose symptoms may have played a role. These categories are useful for descriptive purposes but are not wholly precise in that there is considerable overlap among them. For example, some individuals with illnesses may be more susceptible to solicitation by extremist groups and ideologies or to becoming marginalized by society and thus disaffected, lonely and alienated. Mental illness is not the main driver of mass violence and there are many misunderstandings and much speculation about the role of mental illness.

Following events involving mass shootings, reaction predictably breaks along two lines in the United States: gun-centric — those who call for either broader use of guns or greater restrictions on specific firearms, the most common means of mass violence — and mental illness-centric — those who, blaming mass violence on mental illness, call for a series of actions that include restricting people with mental illnesses from possessing firearms and re-institutionalizing people with mental illnesses. These positions gloss over certain complexities and available data on mass violence in the United States.

People with mental illness account for a very small amount of all violent crime in the United States. However, individuals with a diagnosis of mental illness (previously diagnosed by a mental health provider) are overrepresented in the category of mass violence crimes. At the same time, policies that propose to restrict their access to firearms, or that require data on individuals receiving Social Security Disability for reasons of mental illness as part of the National Instant Criminal Background Check System (NICS), ignore the fact that there are many other risk factors for criminal violence, such as substance use, poverty, gang affiliation, employee disgruntlement, poor peer influences, etc. No single policy or program is going to address the complex problem of mass violence, so no individual intervention should be discounted for not solving the whole problem.

In the criminology literature, mental illness is not identified as one of the major factors associated with criminal recidivism. Generally, the factors associated with criminal recidivism involve antisocial personality traits, behavior, substance use and peers, as well as limited structured activity through school, work and leisure and family discord (Andrews and Bonta, 1995).

Those who attribute mass violence to mental illness often erroneously assume that psychiatric evaluation and diagnosis alone should be able to prevent such events from happening. There are two problems with this assumption. First, although researchers have identified many individual risk factors for violence in the general population and developed standardized instruments and protocols that are useful in evaluating the violence potential in people, their ability to determine exactly who will be, and when they will be, violent is still limited. Applying these risk factors in clinical settings to evaluate the potential for violence in people with mental illness is useful but not fully reliable. While there are identified risk factors for violence among those with mental illness, they are sensitive but not specific, and because of the low incidence, there is a problem of false positives. In addition, the risk assessments can

identify people at greatest risk but not when their violent actions may occur. Moreover, only a small portion of those people identified as having increased risk ever perpetrate mass violence.

The second, perhaps more important, problem is the fact that the availability of quality treatment for people in need is limited. Thus, individuals who could be treated, thereby potentially preventing an act of violence, go wanting. So, while there is increasing demand to identify potential perpetrators of violence and develop preventive measures, there have been insufficient efforts and progress toward identifying the root causes of the problem or resources to address them. Causes include social problems (including deficiencies in the educational system, poverty, discrimination, the lack of job opportunities, etc.), as well as the lack of quality and comprehensive mental health care. In this context, mass violence is the tip of an iceberg of more fundamental social problems in our country.

Terminology

“Mass violence” is a term that encompasses all physical assaults with implements to cause injury (including knives, clubs, motor vehicles, guns, assault weapons, bombs, etc.). In the context of the MDI Expert Panel Meeting, mass violence is used broadly to include a wide range of violent acts and events. While there are many means by which mass violence can be committed, much of the research presented and discussion that follows refers specifically to mass shootings, because they result in greater loss of lives and emotional impact on the public and will be so noted.

Unless otherwise specified, the term “mental illness” specifically refers to the more serious disorders in the American Psychiatric Association’s (2013) *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), including psychotic disorders (e.g., schizophrenia), mood disorders (e.g., bipolar and major depressive disorder), anxiety disorders (e.g., panic disorder), obsessive-compulsive disorder, post-traumatic stress disorder, dissociative disorders, autism spectrum disorders and developmental disabilities and dementias (e.g., Alzheimer’s disease). Substance use disorders are also considered when co-occurring with mental illnesses. While the term mental illness broadly refers to those conditions in DSM-5, it is known that only a very small number of diagnoses are actually associated with violence potential as the result of the illness itself. As will be seen, different definitions of what constitutes a mental illness yield different conclusions about the role that mental illness plays in mass violence incidents. The definitions used by different organizations and studies of mass violence are numerous and varied.

Along with mental illness, additional language around mental wellness or resilience reflects a pattern of adaptive thoughts, emotions and behaviors. Most individuals will acknowledge that they live somewhere between these two poles and where they land at any particular moment will depend on the current context and their past experiences. The fact that someone occasionally acts impulsively or angrily does not mean they have a mental illness.

SCOPE OF THE PROBLEM

How mass violence is defined affects not only the prevalence and scope of the problem, but also how one describes the characteristics of the perpetrators. Researchers have used different definitions for mass violence that consider the motivation of the perpetrator, the number of victims and the setting for the crime. Most definitions are limited to mass shootings, where there are at least three victims killed in one event, often killed indiscriminately in a public place, such as a school, concert or movie theater. Definitions also vary between mass murder (fatalities) and mass shootings (fatal and nonfatal injuries). For example:

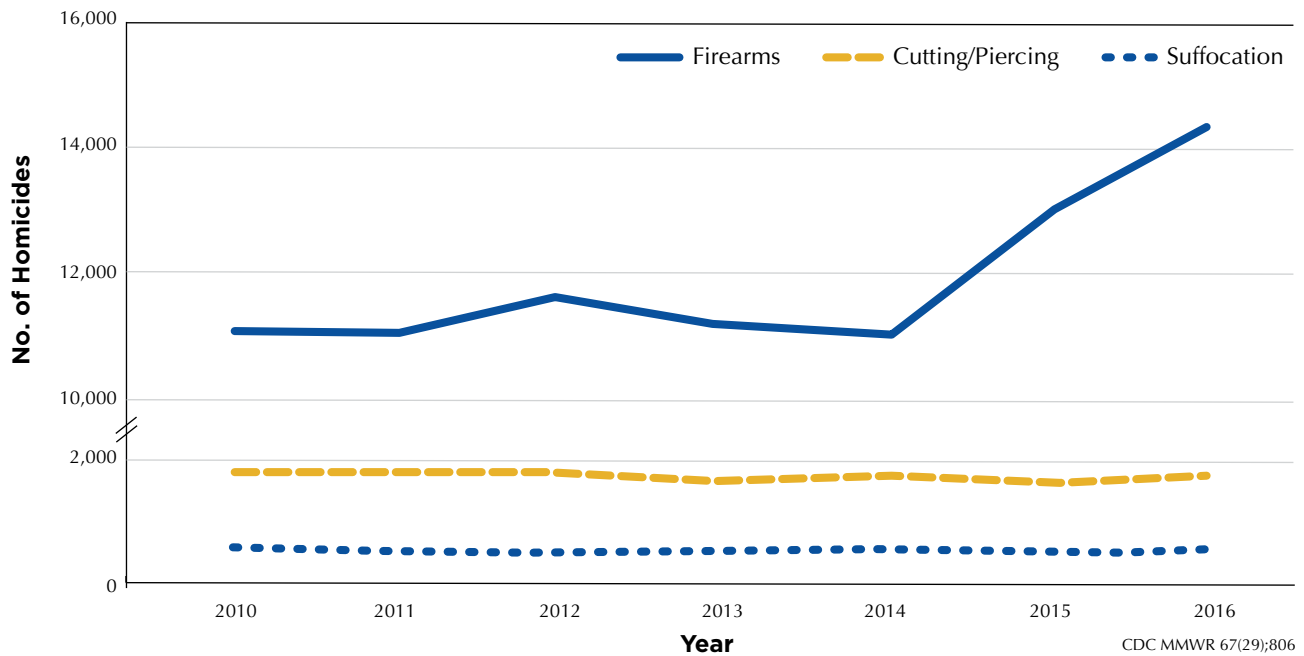
- Federal Bureau of Investigation (FBI) report, 2008: A mass murderer — versus a spree killer or a serial killer — [is one who] kills [by any method] four or more people in a single incident (not including himself), typically in a single location.
 - Shifting fatality criterion: In 2013, criterion was revised down to three or more deaths.
- Congressional Research Service report, 2013: Public mass shooting incidents [other methods excluded] occurring in relatively public places, involving four or more deaths — not including the shooter(s) — and shooters who select victims somewhat indiscriminately.
 - Motivational criteria: “The violence in these cases is not a means to an end — the gunmen do not pursue criminal profit or kill in the name of terrorist ideologies, for example.”
- Stanford Mass Shootings of America project, 2015: Mass shootings [are incidents with] three or more shooting victims (not necessarily fatalities), not including the shooter.
 - No fatality threshold — counts shooting survivors — and excludes “ordinary” street violence: “The shooting must not be identifiably gang, drug or organized crime related.”
- Mother Jones Guide to Mass Shootings in America: The perpetrator took the lives of at least four people...The killings were carried out by a lone shooter [with a few exceptions]...in a public place.
 - Excludes most family/domestic homicides: “The shooting occurred in a public place.”

The majority of definitions consider a mass violence incident to be one in which more than three or four people are killed by shooting in a single event by an individual or individuals who are not engaging in the act as part of an organized political group. In addition, these definitions do not include mass violence linked to family violence, either in the form of domestic abuse or violence with intent to kill family members.

Prevalence of Mass Violence

Overall violence in the United States is declining. As noted, data over the past 50 years show a downward trend in the homicide rate, with a slight upward tick in 2015–2016. Much of the upward trend in 2015–2016 appears to be firearms related; other methods of killing someone have remained stable over time (Pifer & Minino, 2018).

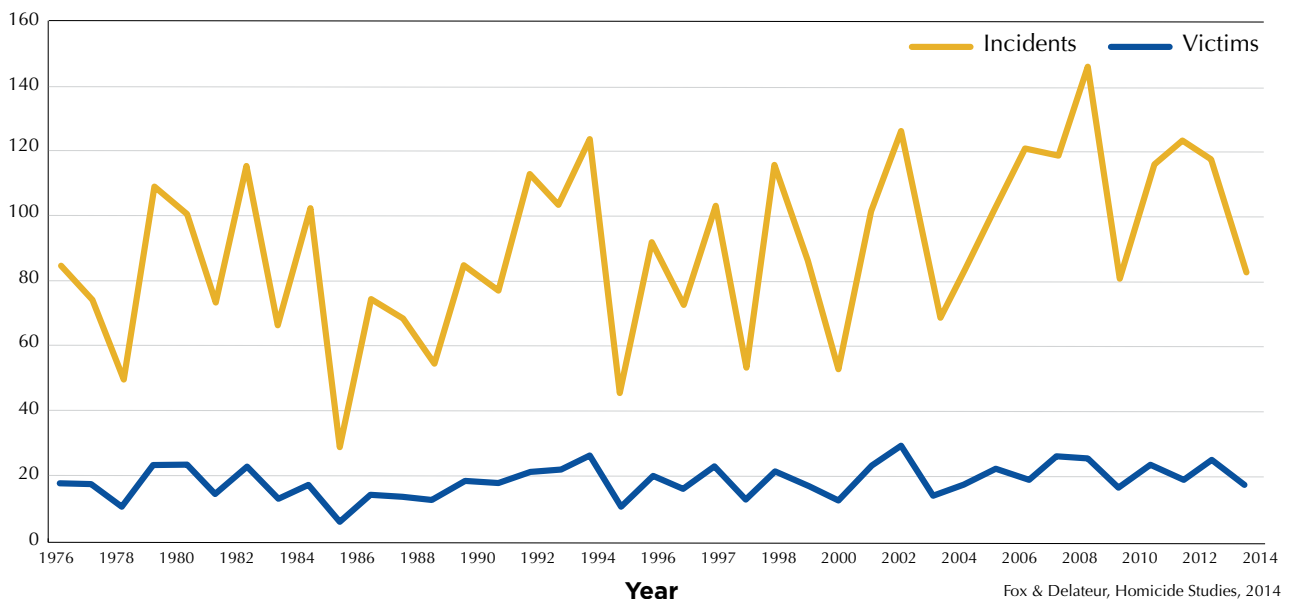
Rates of Homicide by Method 2010–2016



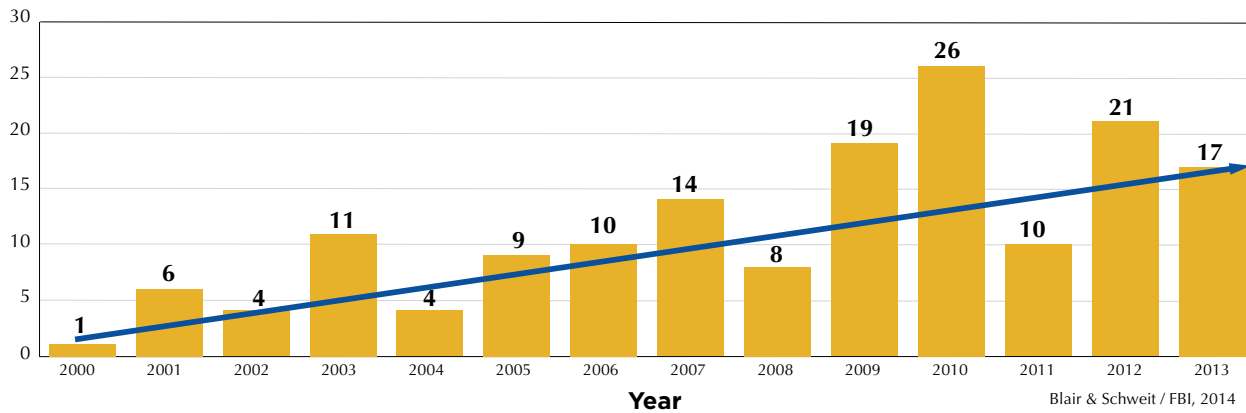
However, it is important to note that certain forms of violence that are less recognized, most notably firearm suicide, are related and often present in acts of mass violence, display strong geographic variation and have been increasing substantially in the past decade (Branas, Nance, Elliott, Richmond, & Schwab, 2004).

Research trends of mass shootings and single active shooter incidents as variously defined indicate an increase in number and frequency. In addition, the intervals between them seem to be getting shorter and the toll of injuries and deaths seems to be becoming greater. Data from Fox and DeLateur (2014), Stanford Mass Shootings in America, (2015, p. 6), Blair & Schweit (2014) and Mother Jones (based on press reports) attest to this fact.

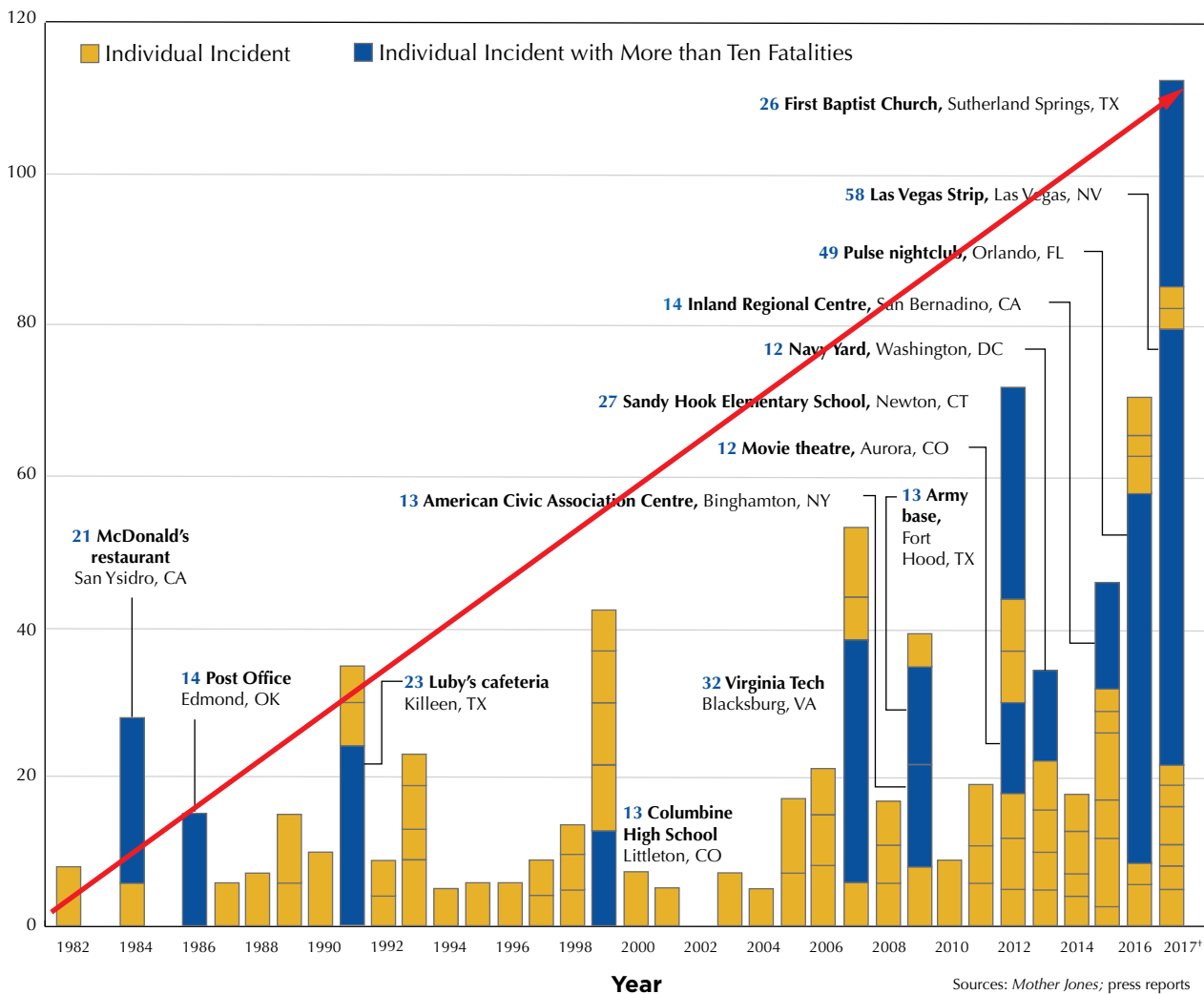
Mass Killings with Firearms in the U.S., 1976–2014



A Study of 160 Active Shooter Incidents in the United States Between 2000–2013 Incidents Annually



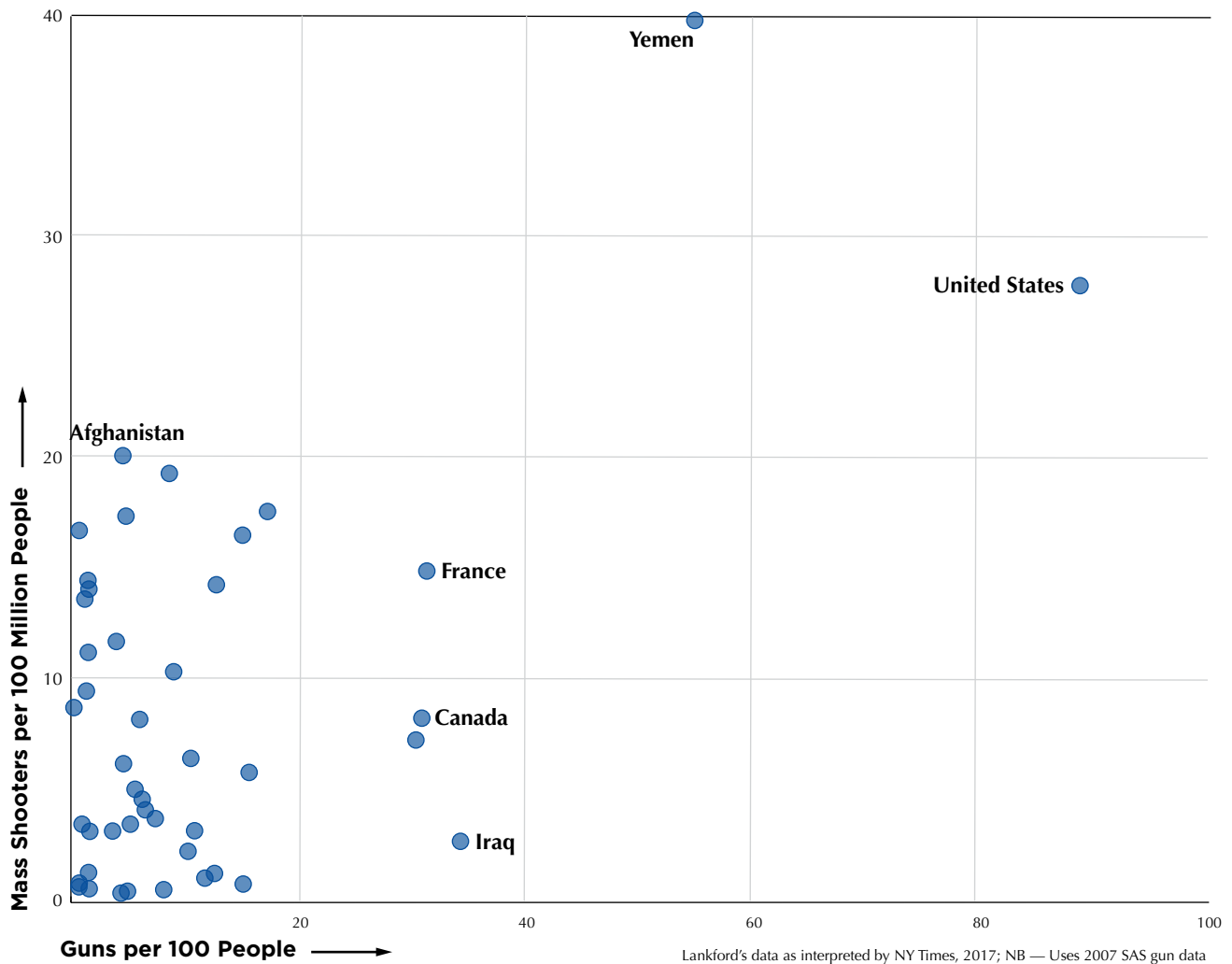
Mass Shootings



*Shootings with three or more fatalities excluding perpetrator(s). Before January 2013, with four or more fatalities. Not comprehensive. †At 6am CST, November 6

Data indicates the United States has more mass shooters and more guns per capita than other economically developed countries (Wintemute, 2015; Fisher & Keller, 2017).

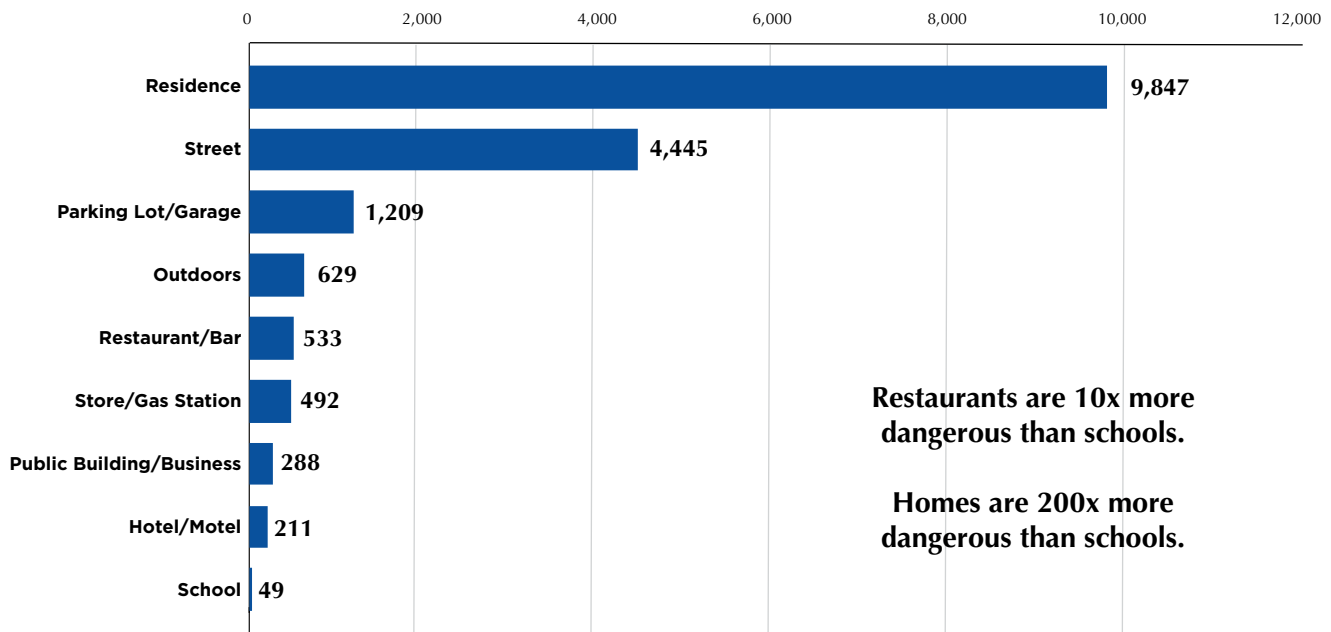
National Rates of Mass Shooting and Gun Ownership in 2007



In spite of enormous media attention focused on public mass shootings, these are rare events. Most homicides in the country are committed one at a time, often secondary to domestic violence, an interpersonal dispute or in the commission of a crime. Many of these killings are reactive or impulsive versus predatory or planned.

Even school shootings, the most tragic of such events, are a statistically rare phenomenon. For every shooting in a school, there are more than 1,600 outside of a school (Cornell, 2018a). Considering homicide in general, people are more likely to be killed in their own home or on the street. Restaurants are 10 times more dangerous than schools.

2005–2010 Homicides in 37 States



Source: FBI National Incident-Based Reporting System (NIBRS) database. Selected locations. School includes colleges. See Nekvasil & Cornell (2015) *Psychology of Violence*, 5, 236-245.

Using the definition of a mass shooting incident from the Gun Violence Archive (four or more shot and/or killed in a single event [incident], at the same general time and location, not including the shooter), there were 692 deaths and 1,803 injuries in 347 incidents in 2017. This compares to the following causes of death:

14,415	Firearm homicides 2016 (CDC, 2018)
16,617	All homicides 2017 (FBI Uniform Crime Reporting Database [UCR], 2018)
21,808	Firearm suicides 2016 (CDC, 2018)
72,287	Drug overdoses 2017 (CDC, 2018)
250,000	Medical errors (Makary, BMJ, 2016)

Suicide is a serious issue when it comes to risks related to firearms and often gets overlooked in reports related to mass violence. People are more likely to intentionally kill themselves with a gun than to be killed by a gun in a mass shooting or other type of homicide (Wintemute, 2015).

Characteristics of Mass Violence Perpetrators

While perpetrators of mass violence can be categorized with respect to motivation, as previously mentioned, characteristics of an individual perpetrator often cut across demographic, sociologic, cultural and occupational groups. A general profile emerges of males who are often hopeless, harboring grievances that are frequently related to work, finances or interpersonal relationships; who feel victimized and relate to others whom they perceive to be similarly mistreated; who are indifferent to life and often subsequently die by suicide; who plan and prepare for their attack; and who often share information about the attack with others, though often not with the intended victims. Here is where the boundaries between categories overlap. Among such individuals are those who exaggerate

and personalize slights and misfortunes, and others whose anger and fear stems from symptoms of psychosis. Still others act out of a misguided desire to end the financial/physical/mental suffering of loved ones, as well as themselves.

Numerous studies and databases provide common demographics associated with people who commit mass violence. The FBI (Blair & Schweit, 2014) identified 160 active shooter incidents, a subtype of mass violence, in the United States between 2003 and 2013 and found that:

- All but two involved single shooters.
- Seventy percent of incidents involved either a commercial or educational location.
- In at least 5–6 percent of incidents, the shooter killed family member(s) before moving to a public location.
- In only 3.75 percent of incidents, the shooter was female.
- In 56 percent of the incidents, the shooter ended the incident (e.g., suicide, stopped shooting, fleeing).
- In 40 percent of the incidents the shooter died by suicide — 84 percent of them at the site of the shootings.

Lankford (2018) found characteristics that mass shooters share:

- Male (approximately 24:1 male to female).
- Race is equally distributed by population representation for white/black.
- Attacks are often premeditated and planned.
- Weapon choice may largely reflect access, convenience, familiarity with the weapon.
- Suicidal or life indifference.
- Perceived victimization of themselves and/or a group with which they identify.
- For many, they are seeking personal notoriety and/or attention to a group or a cause.
- For many, they perceive acute social and/or situational factors that contribute to drive to attack.
- For many, they leak to others regarding their intent to attack.
- For some, narcissistic personality features (e.g., attention seeking, feeling unvalued).
- For many, they have paranoid traits (e.g., deep sense of disgruntlement, injustice) or symptoms.
- For some, they have deep empathy/identification for people perceived as similarly victimized and/or who responded to their victimization with violence.
- Psychological fixation (e.g., rumination on victimization, hopelessness, meaningless).
- High likelihood of one or more diagnosable mental illnesses.

It is important to note that the high likelihood of having more than one diagnosable mental illness defines about 18 percent of the general population — more than 40 million people in the United States — the

overwhelming majority of whom are never violent. Also, many people with mental illnesses have diagnoses such as anxiety disorder or obsessive-compulsive disorder that are not associated with violence.

In addition, Lankford notes that previous distinctions made between mass shooting attackers and suicide terrorists are less clear as more mass shooters are motivated by ideological, religious and racist considerations, and suicide terrorists rely less on bombings and specific organizational support and more on firearms as weapons capable of inflicting mass casualties. The attributes of an incident and the characteristics of the perpetrator interact in a myriad of ways to create idiosyncratic situations that are difficult to predict in advance.

The U.S. Secret Service compiled information on 28 mass attacks in public spaces during 2017 (National Threat Assessment Service, 2018). The incidents were identified and researched through open source reporting (e.g., media sources and law enforcement records); the resulting report included acts of intentional violence in public or semi-public places during which significant harm was caused to three or more people. It excluded violence related to criminal acts, failed attempts at a mass attack or spontaneous group violence. The authors found the following about the attackers:

- All were male.
- Ages ranged from 15 to 66 years old with average age of 37 years.
- Twenty-three attacks were with firearms, three with vehicles, two with knives.
- Fifteen attackers had histories of substance use disorders.
- Twenty attackers had prior criminal histories, nine with domestic charges or police responses.
- Eighteen had prior histories of violence.
- Eighteen had mental health symptoms prior to attack (one-half psychosis, one-third suicidal ideation and one-fifth depression), with seven individuals having prior known mental health treatment.
- Motives included personal grievances (13, with five of them domestic), ideology (one), racial beliefs (five).
- Five of seven attackers motivated by belief systems also had psychotic symptoms.
- Eleven exhibited a fixation with a person, activity, or beliefs with themes including personal vendettas, romantic conflicts, personal failures, perceived injustices, delusions, political ideologies, other incidents of mass violence.
- Sixteen harmed only random people, four harmed people that the attacker preselected, six harmed both random and specifically targeted individuals; all four attacks resulting in harm only to targeted individuals arose from workplace grievances; all four attacks influenced by psychotic symptoms harmed only random people.
- Eight attackers died by suicide at the scene or shortly after leaving the scene.

Recent stressors were identified in all 28 attacks. Stressors included those related to family/romantic relationships, personal problems (e.g., unstable living conditions, physical illnesses), work or social environments, contact with law enforcement and financial instability. Additional themes included the following:

Ideological or racial beliefs	7
Evidence of fixation	11
Aggressive narcissism traits	23
Threats or concerning communication	22
Had elicited concern by others	22 (13 specifically about safety)

An in-depth study of 37 incidents of targeted school violence involving 41 perpetrators, which took place in the United States from January 1974 through May 2000, found the following (Vossekuil, Fein, Reddy, Borum, & Modzeleski, 2004; Fein et al., 2004; Pollack, Modzeleski, & Rooney, 2008):

- Prior to the incidents, other people knew about the attacker's idea and/or plan to attack. In over three-quarters of the incidents, at least one person had information that the attacker was thinking about or planning the school attack. In nearly two-thirds of the incidents, more than one person had information about the attack before it occurred.
- Incidents of targeted violence at schools rarely were sudden impulsive acts.
- Most attackers did not threaten their targets directly prior to advancing the attack.
- There was no useful or accurate profile of students who engaged in targeted school violence.
- Most attackers had difficulty coping with significant interpersonal losses or personal failures. Moreover, many had considered or attempted suicide.
- Many attackers felt bullied, persecuted or injured by others prior to the attack.
- Most attackers had access to and had used weapons prior to the attack.
- Despite prompt law enforcement responses, most shooting incidents were stopped by means other than law enforcement interventions.
- In many cases, other students were involved in some capacity, some with prior knowledge of the event before it occurred.
- Most attackers engaged in some behavior prior to the incident that caused others concern or indicated a need for help.
- Few of the attackers had prior psychiatric care or formal diagnoses.

The Role of Mental Illness in Violence in General

People with mental illness account for a small amount of the overall violent behavior in our society. Swanson (1994) analyzed community-representative data from the National Institute of Mental Health's (NIMH) Epidemiologic Catchment Area surveys and found that the population's attributable risk of any violent behavior associated with serious mental illness (i.e., a DSM diagnosis of schizophrenia spectrum disorder, bipolar disorder or major depression) alone is about 4 percent.

This means that if we could eliminate the elevated risk of violence that is attributable directly to having schizophrenia, bipolar disorder or major depression, the overall rate of violence in society would go down by only 4 percent; 96 percent of violent events would still occur, because they are caused by factors other than mental illness. These other factors linked to violence include being young and male,

living in poverty, having a history of childhood abuse, being exposed to abuse and violence in the social environment, having a history of antisocial behavior beginning in childhood or adolescence and becoming involved with the criminal justice system (Swanson, McGinty, Fazel, & Mays, 2015).

Substance use disorders account for 34 percent of the risk of committing violence toward others. They can exacerbate the effects of certain kinds of psychiatric symptoms, like excessive threat perception, and expose people to toxic social factors. Overall, the best predictor of future violence is past violence (Elbogen & Johnson, 2009; Rozel, Jain, Mulvey, & Roth, 2017; Rozel & Mulvey, 2017).

The MacArthur Violence Risk Assessment Study (MVRAS) (Steadman et al., 1998) followed a cohort of more than 1,136 discharged psychiatric inpatients over one year in the community and examined the occurrence of violent behavior in relation to numerous predictors. The MVRAS found that substance use disorder comorbidity, likely a marker for poor coping, was responsible for much of the violence in these patients. Study participants who had only mental illness — that is, without substance use disorder — had no higher risk of violent behavior than their neighbors in the community, people selected at random from the same census tracts in which the patients resided.

The MVRAS's findings have often been cited as evidence that “people with mental illness are no more violent than the general public.” However, the study was not designed as a population-representative epidemiological study of the association between violent behavior and mental illness. Many of the study participants lived in disadvantaged urban neighborhoods where violent crime was relatively common. The base rates of violence among both the patients and comparison groups living in these areas were substantially higher than in the community-representative studies like the Epidemiologic Catchment Area Program of the NIMH or the National Epidemiologic Survey of Alcohol and Related Conditions (Van Dorn, Volavka, & Johnson, 2012). One interpretation of the MVRAS's finding is that social-environmental influences on violence are stronger than the effects of psychopathology and tend to wash out those effects at the population level (Swanson, McGinty, Fazel, & Mays, 2015).

The risk of violent behavior tends to fluctuate over time and recedes over the adult life course — in people who have a mental illness and in those who do not. Numerous studies have shown that violence risk in people with mental illness is generally very low but is significantly elevated at certain times in the course of a serious mental illness. This pattern is reflected in studies that focus selectively on clinical and legal settings where individuals are seen during a mental health crisis. In particular, patients seen in psychiatric emergency departments, as well as those who have been involuntarily hospitalized, and those experiencing their first episode of psychosis are at higher risk of violent behavior (Choe, Teplin, & Abram, 2008; Large & Nielssen, 2011; Brucato et al., 2019). Those with co-occurring substance use disorders, untreated psychosis, a history of oppositional defiant disorder as children or a history of antisocial personality disorder as adults are also at increased risk (Witt, van Dorn, & Fazel, 2013). (It is important to note that the U.S. Supreme Court held in *Foucha v. Louisiana* that antisocial personality disorder alone does not meet the legal definition of a mental illness.) But risk declines substantially over time, for example, in a person with a single involuntary hospitalization occurring in young adulthood (Felthous & Swanson, 2018).

Certain psychotic symptoms such as paranoid delusions and delusions or hallucinations of threat from others, command hallucinations and impulsive anger increase the risk of violence. In many cases, people with mental illnesses who engage in violent behavior are not receiving any or adequate treatment at the time of their violent acts. In most of these cases, the mentally ill perpetrators are untreated and actively symptomatic. The lack of treatment and role of symptoms should be a powerful argument for more and better mental health treatment to prevent this subset of mass violence.

Overall, while there is modest relative risk of violence associated with serious mental illness, the overwhelming majority of people with diagnosable psychiatric conditions in the community do not engage in violent acts toward others but are more likely to be victims of violence (Swanson & Belden, 2018). Further, violence risk is increased by many individual-level factors that interact in complex ways with precipitating incidents and environmental exposures over the life course. In short, there is a modest link between mental illness and violence, but there is no basis for the public's generalized fear of people with mental illness.

The Role of Mental Illness in Mass Violence

Incidents of mass violence — especially those that appear to be senseless, random acts directed at strangers in public places — are so terrifying and traumatic that the community demands an explanation and the incidents often provoke a defensive response from mental health advocates. After such events, political leaders often invoke mental illness as the reason for mass violence, a narrative that resonates with the widespread public belief that mentally ill individuals in general pose a danger to others. Since it is difficult to imagine that a mentally healthy person would deliberately kill multiple strangers, it is commonly assumed that all perpetrators of mass violence must be mentally ill. And when mental illness becomes the accepted putative reason for mass violence, the conclusion follows that restricting the liberty of people with mental illnesses — even removing them from the community — or preventing them from owning guns are solutions. This simplistic conclusion ignores the facts that mass violence is caused by several different social and psychological factors that interact with each other in complex ways, that many if not most perpetrators do not have a diagnosable mental illness and that the large majority of people with diagnosable mental illnesses are not violent toward others.

However, rather than being sympathetic to the plight of people who are mentally ill, the public discourse about mass violence and “mental illness” often dehumanizes them. In reality, mental illness is a highly elastic clinical term that can mean many things but is often used without definition in the mass violence narrative. In considering the role of mental illness in mass shootings, it is important that it be clearly defined.

As the following table demonstrates, the degree of increase depends on how mental illness is defined in a particular study. Studies looking at signs or stressors report much higher rates than studies requiring an actual diagnosis.

LIKELIHOOD OF “MENTAL ILLNESS”	
4.7%	NICS-disqualifying mental illness PMSs (Silver et al 2018)
11%	Evidence of prior MH “concerns” (Everytown, 2015)
17%	Pre-incident dx (diagnosis), school shooters (Vossekuil/SSI 2004)
25%	Pre-incident diagnosis of any kind, AS (Silver/BAU, 2018)
28%	Evidence of MI, ISIS-influenced (Gill & Corner, 2017)
55%	Lifetime risk, DSM-IV Disorder, all of USA (Kessler, 2006)
59%	“Signs of serious mental illness” (Duwe, 2007)
61%	Documented hx (history) extremely depressed (Vossekuil/SSI 2004)
62%	Mental Health “stressor,” AS (Silver/BAU, 2018)
78%	History of suicidal ideation &/or attempt (Vossekuil/SSI 2004)

In a study of the pre-attack behaviors of 63 active shooters (Silver, Simons, & Craun, 2018), the FBI found that 16 (25 percent) had a confirmed diagnosis of mental illness, including mood disorder, anxiety, psychosis, personality disorder and autism. The researchers were unable to determine a psychiatric history for 37 percent of their sample but concluded that “declarations that all active shooters must simply be mentally ill are misleading and unhelpful.” In part, this is because if efforts at reducing mass violence are only focused on people with mental illness, they may miss those who are acutely distressed and perhaps more likely to commit violence. Many of those who are acutely distressed could be helped with mental health services.

Of the individuals who kill three or more people, it appears that about 60 percent (Follman, Aronsen, & Pan, 2019) have evidence of some sort of unspecified psychological distress, even if they do not meet formal diagnostic criteria.

Corner & Gill (2015) and Gruenewald, Chermak, & Freilich (2013) found that mass casualty offenders/lone actor terrorists are significantly more likely to have a mental disorder than group actors. Thirty-two percent of lone actors have evidence of mental illness, compared to 3 percent of group actors. The greater the isolation of the individual in terms of co-offenders/social network, the greater the likelihood of mental illness.

While individuals diagnosed with mental illness only account for 4 percent of all violent crime in the United States, a higher portion of perpetrators of mass homicides are mentally ill in comparison to perpetrators of other types of violence.

Having any diagnosis is not the same as having a diagnosis that is associated with a greater likelihood of mass violence. The American Psychiatric Association’s DSM-5 provides a very broad catalog of diverse brain-related health conditions that impair a person’s normal ability to reason and perceive reality, regulate mood, formulate and carry out plans and decisions, adapt to stress, behave and relate to others in socially appropriate ways, experience empathy, modulate consumption and refrain from intentional self-injury — or various combinations of such problems. Almost all of these mental illnesses have no increased risk of violence, unlike a diagnosis of severe personality disorder that is applied to a remorseless killer whose compulsive, aberrant behavior manifests in willfully destroying others.

In addition, there is a difference between mental illness and urgent emotional distress (e.g., a person with a mental illness like schizophrenia, bipolar disorder or psychotic depression whose delusional thoughts impel them to violence, in contrast to a disgruntled employee who is fired and becomes so enraged that they seek violent revenge). When such different meanings of mental illness are conflated in the public discussion — and people act on the basis of their fears — the result is that millions of harmless individuals recovering from treatable mental health conditions can be subjected to stigma, rejection, discrimination and even unwarranted legal restrictions and social control.

However, the absence of a prior documented diagnosis of mental illness is not a guarantee that one does not exist. There has been limited retrospective research on the mental health status of mass violence perpetrators, which likely underestimates the proportion that may have suffered from a mental illness and the role the illness may have played, or not, in their crime. In addition to the lack of efforts to determine whether perpetrators may have had histories of mental illness, the fact that they often go unrecognized and untreated adds to further underestimation, especially in young people who may not have been diagnosed yet.

Apart from establishing a diagnosis, there is the question of whether the symptoms of the person’s illness caused the violent behavior in question. Correlation is not causation — even when a person who commits mass violence is found to have a diagnosable mental illness, it is not clear that mental illness

was the precipitating factor in the crime. Having a psychiatric diagnosis is neither necessary nor sufficient a risk factor for committing an act of mass violence.

In the same way as motivation for a crime must be established in law enforcement, the way in which symptoms of mental illness contribute to violent behavior must be determined on a case-by-case basis. Unless we define the specific conditions and symptoms referred to and posit some causal model for how these problems could motivate violent behavior, it is difficult to meaningfully characterize the role that various kinds of psychopathology could play in acts of mass violence. Merely to assert that “all mass violence perpetrators are mentally ill” is an empty and misleading statement.

Of course, there are particular violent acts with a clear connection to a psychiatric condition — for example, a multiple-casualty shooting by a person with acute paranoid schizophrenia manifested in persecutory delusions and homicidal command hallucinations. Another example would be a perpetrator with compelling nihilistic delusions and suicidal thoughts who kills his family and/or others before ending his own life or dying in a “suicide by cop.” In the instances of disgruntled employees, one violent perpetrator might have had a pre-existing “intermittent explosive disorder” and was thus predisposed to violence while another, because of particular circumstances, may have been especially impacted by their termination.

The stereotype of an individual with a severe and persistent mental illness such as schizophrenia, where schizophrenia is the sole factor contributing to mass violence, is unfounded. At the same time, perpetrators of mass violence, specifically, are more likely to suffer from mental illness (whether it has been diagnosed or not) and usually are receiving no or inadequate treatment.

IDENTIFYING HIGH-RISK PERSONS

It is important to recognize that mass violence is a rare event, difficult to characterize, which makes it virtually impossible to predict (Swanson, 2011) but still preventable. Mass shootings accounted for less than two-tenths of 1 percent of homicides in the United States between 2000 and 2016 (Follman, Aronsen, & Pan, 2019; Centers for Disease Control and Prevention, 2018). Much research has gone into identifying risk factors for violence and assessment of threat. From this, research protocols and instruments for assessing risk of violence have been developed and usefully applied. While these instruments are valid at the group or population level, they are limited in their ability to identify specific individuals who are truly positive for risk and determine when they might act with sufficient precision. Studies reveal that the relevant characteristics of mass violence perpetrators are many and shared by large numbers of people who will not commit acts of mass violence.

Perpetrators of mass violence may share some characteristics but are a sufficiently heterogeneous group that models relying on profiles will almost certainly result in high rates of both false negative and false positive identifications. In addition, many of the risk factors for violence apply to individuals in the population with and without mental illness. Mass shooters who bear diagnoses of mental illness, whether schizophrenia or bipolar disorder or simply symptoms of urgent emotional distress, also commonly exhibit putative risk factors for violence shared by nonmentally ill people, such as poverty, substance use disorders, prior violent criminal conduct, recent stressors and nondelusional belief systems that may trigger violence.

Profiling is especially problematic when the suggestion is made to screen all people with mental health problems to prevent rare acts of serious violence. The danger is that those who are identified as being at risk of violence, rather than being given priority access to treatment and becoming eligible for intensive services, will instead be discriminated against, deprived of their liberty and subject to social control, whether through arrest and incarceration or involuntary inpatient or outpatient commitment. In addition, when only people with mental illnesses are profiled, many others who might commit violence are missed. Nonetheless, improving behavioral health treatment access, quality and patient engagement will likely prevent some violent episodes and, therefore, these strategies emerge as important public health interventions.

While there has been substantial research and a body of evidence for violence risk assessment and prediction, current methods still have significant limitations. Nevertheless, research in this important area continues, and existing methods of threat assessment and management are valuable and have become an important part of efforts to help prevent incidents of mass violence.

Threat Assessment and Management

Threat assessment, a term that originated in law enforcement, is a strategy to prevent violence targeted at public figures and other people who are threatened by someone. The term “behavioral threat assessment” is sometimes used to distinguish this approach from a more general security assessment. Over time, the meaning of the term has evolved. Most important, threat assessment is no longer considered a single assessment, but rather an ongoing assessment process with interventions designed to prevent violence.

A threat assessment team within a business or school is a multidisciplinary group that includes representatives from security and law enforcement, behavioral health care, human resources, legal and management, among others (see more about threat assessment teams in the section “Mass Violence in Schools,” which follows). The threat assessment model recognizes that violence is a multi-determined phenomenon, arising from the interaction of three sets of variables: static and dynamic individual

factors, static and dynamic environmental factors and situational factors or triggers (Fein, Vossekuil, & Holden, 1995).

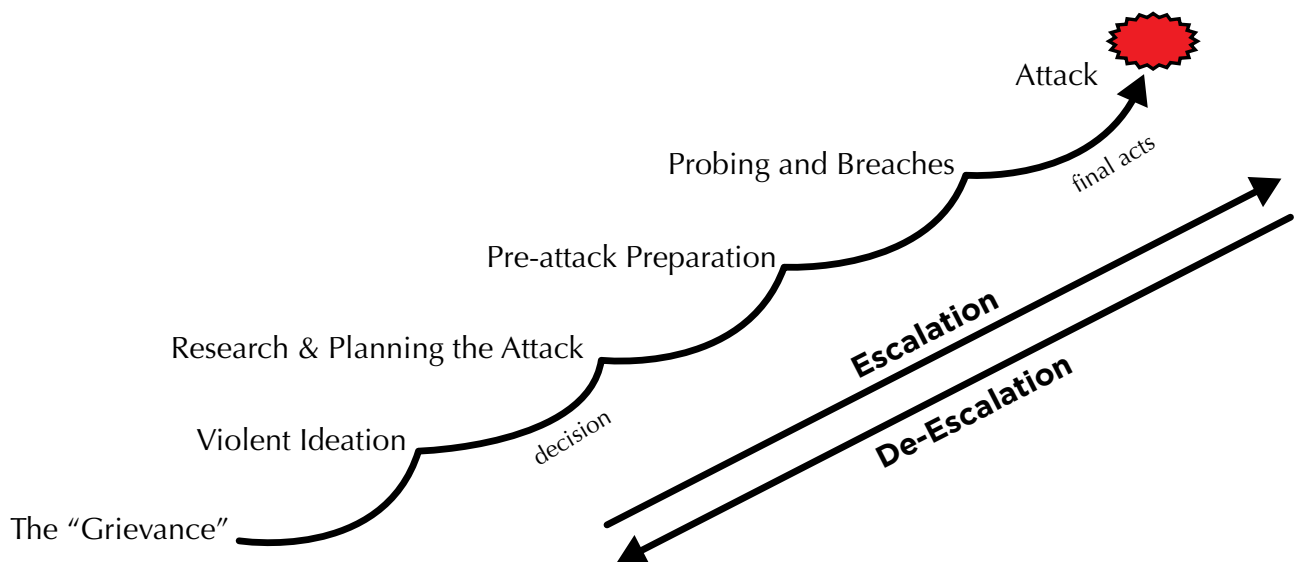
In many threat assessment situations, those assessing risk do not meet the person being assessed or do a clinical, face-to-face evaluation. They look at social media, written documents, oral communications, direct reports/observations from individuals other than the assumed perpetrator and other documentation of behavior. Then they must determine what to do with that information. Threat assessment and management is often effective in preventing violence but is a longer process and takes more resources than the ineffective single-point-in-time clinical risk assessment.

Instead of focusing on static traits and features of individuals, threat assessment teams focus on trajectories or pathways of individuals across key dimensions (e.g., motive and intent, ability and means, intensity of fixation, suicidal intent or indifference to personal outcome) (Fein et al., 2004). Trajectories or pathways can also be driven, shaped or disrupted by social and situational factors.

Factors can contribute to risk (e.g., identification with ideological, religious or deviant social subcultures that provide reasons for mass violence) or diminish risk (e.g., observations or incidents that prompt assessment and/or interventions). Approaches that use operational threat assessment methods to assess the trajectory (pathway) of a potential attacker toward or away from executing an attack also lend themselves to evidence-based (or potentially evidence-based) prevention and interdiction strategies within a public health model (Meloy, Hoffmann, Guldinann, & James, 2012).

Calhoun & Weston (2003) conceptualized one pathway to violence related to workplace violence that can be applied in other settings. Two key takeaways: First, all targeted or intended violence begins with a grievance and escalates when the person cannot deal with their urgent emotional distress. And second, there are many points in which the situation can be defused. That is part of what a threat assessment team does.

The Pathway to Violence **Pathway to Workplace Targeted or Intended Violence**



Adapted with permission from F.S. Calhoun and S.W. Weston (2003). *Contemporary threat management: A practical guide for identifying, assessing and managing individuals of violent intent*. © 2003 F.S. Calhoun and S.W. Weston. All rights reserved.

IDENTIFYING HIGH-RISK PERSONS

Threat assessment examines behaviors, rather than diagnoses. It examines a set of specific individual factors that do not change over time and that are not affected by intervention or interdiction. These include criminal background, drug and weapons history, history of child abuse or other victimization, individual and family violence, bullying, suicide attempts, etc. Dynamic individual factors that change over time and are amenable to intervention or interdiction include current drug use, weapons possession, untreated psychotic symptoms, personal capacity for resilience, etc.

A common dynamic individual factor is a perception of injustice — the idea that the person has been treated unfairly and no one cares. The grievance or sense of injustice is often associated with a sense of hopelessness and grandiosity, revenge or fanatical beliefs and an adverse response to authority and identification with violent perpetrators. Unemployment, lack of social support, emotional disconnection, suicidal and homicidal ideation and mental illness, especially substance use disorder, can all play a role in precipitating mass violence.

Environmental factors include the presence of available victims, lack of family and community supports, access to weapons, a culture of violence, a high-conflict situation and an absence of constraints.

Situational factors include acute and chronic stressors. In their study of 63 active shooters, Silver, Simons, & Craun (2018) found that in the year preceding the attack, active shooters typically experienced an average of 3.6 stressors; those whose primary stressors were related to mental health accounted for 62 percent. This indicates that the active shooter appeared to be struggling with (most commonly) depression, anxiety, paranoia, etc., in daily life in the year before the attack. Although these stresses were present, it was unclear if these symptoms were sufficient to warrant a formal diagnosis of mental illness. Other stressors included finances, jobs and interpersonal relationships, abuse of drugs and alcohol, caregiving responsibilities, conflicts at school and with family members and sexual stress or frustration.

TABLE 1: Stressors

STRESSORS	NUMBER	%
Mental health	39	62
Financial strain	31	49
Job related	22	35
Conflicts with friends/peers	18	29
Marital problems	17	27
Abuse of illicit drugs/alcohol	14	22
Other (e.g., caregiving responsibilities)	14	22
Conflict at school	14	22
Physical injury	13	21
Conflict with parents	11	18
Conflict with other family members	10	16
Sexual stress/frustration	8	13
Criminal problems	7	11
Civil problems	6	10
Death of friend/relative	4	6
None	1	2

Schouten (2003) developed the mnemonic FINAL to describe the situational factors that may drive a person to the edge of violence:

- **F**inancial
- **I**ntoxication
- **N**arcissistic injury
- **A**cute or chronic illness
- **L**osses

Factors that inhibit the risk for violence include the availability of mental health treatment and receptivity to its use, family and other social supports and spiritual beliefs, among other influences.

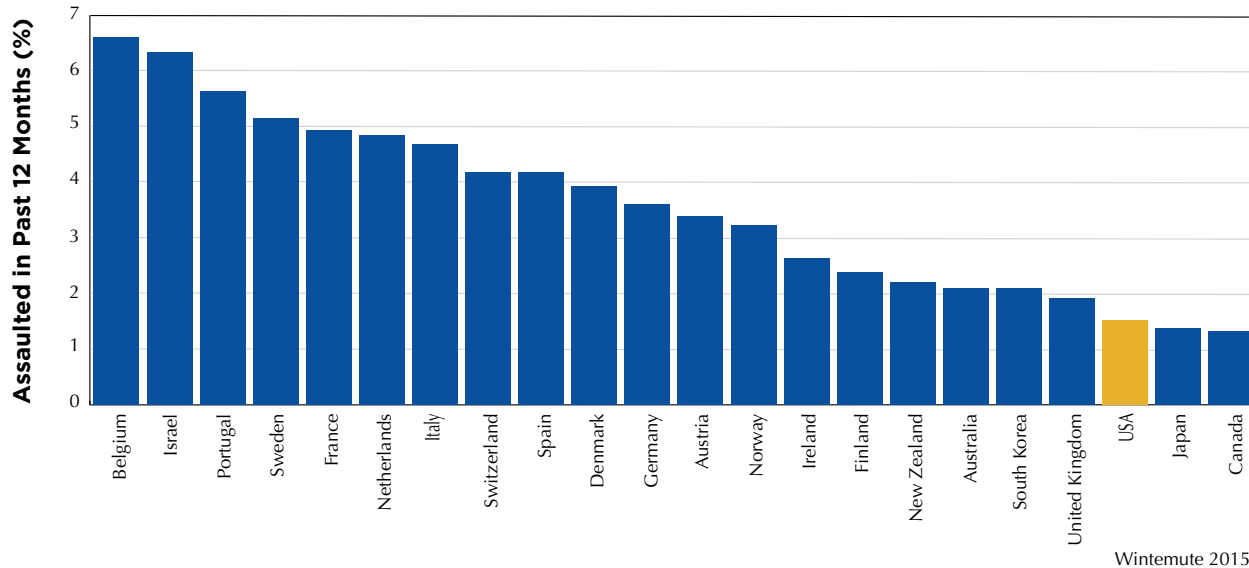
While being in a high-risk group increases the probability of mass violence, the positive predictive value is still limited to “if” and “when.” There are certain process variables that must be examined. These include the following (Association of Threat Assessment Professionals, 2006):

- Approach behavior (e.g., does the person go near the target; do they attempt to contact the target?).
- Evidence of escalation.
- Fantasy rehearsal.
- Actively violent state of mind.
- Command hallucinations to harm specific individuals.
- Diminishing inhibitions.
- Inability to pursue other options.
- Obsession.
- Diminished protective inhibitions.
- Sense of inevitability (apocalyptic vision).
- Pre-attack or ritual preparation (e.g., suicide note).
- Recent acquisition or preparation with firearms.
- Subject’s response to assessment and inquiries.

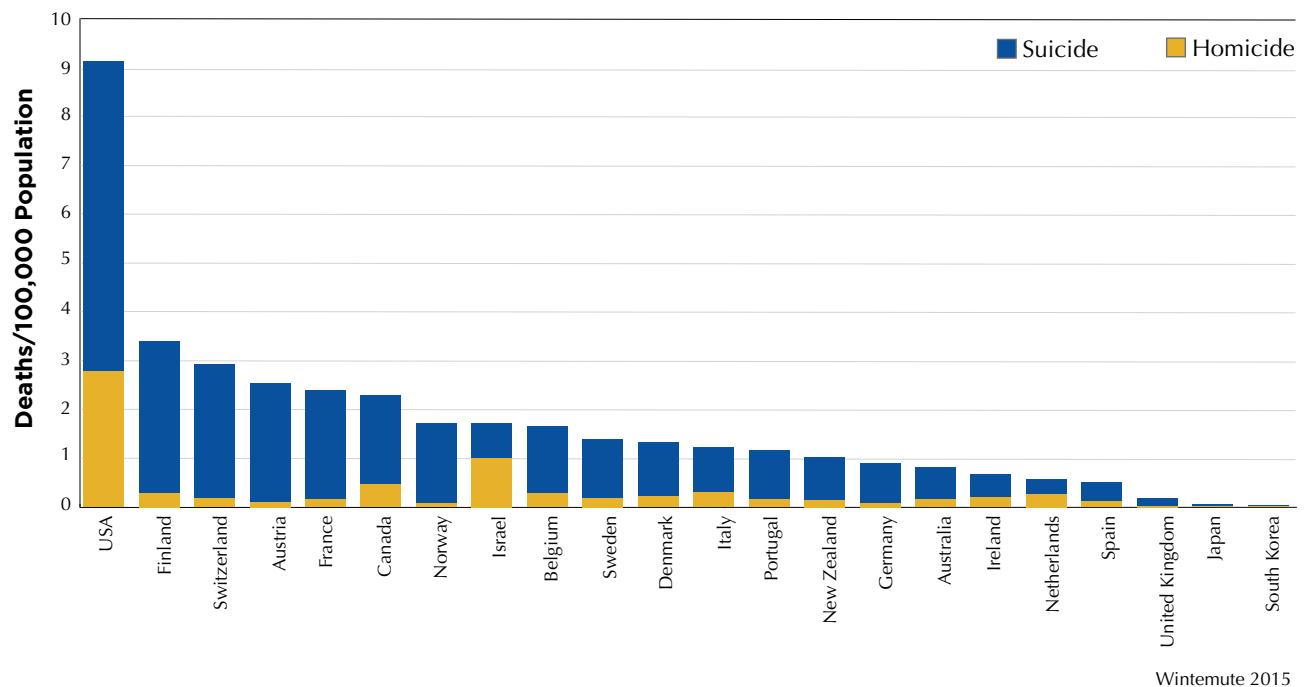
METHODS OF MASS VIOLENCE

Individuals committing mass violence, regardless of their motivation, can employ a variety of means: knives, hammers, motor vehicles, poisons, arson, bombs and firearms. Although, individuals in the United States are less likely to be assaulted than those in other countries, when individuals in the United States become violent, the violence is often more lethal than in other countries because it more often involves firearms (Wintemute, 2015).

Percent of Population Assaulted Annually by Nation



Death Rates from Suicide and Homicide by Nation



U.S. homicide rates are seven times higher than in other high-income countries, driven by a gun homicide rate that is 25 times higher (Grinshteyn & Hemenway, 2016). An adult in the United States is seven times more likely to commit suicide with a firearm than an adult in another country. The U.S. homicide rate by firearm is greater than the rate in the next seven countries combined.

These statistics clearly reflect the greater access to firearms in the United States. Estimates of the number of guns in the United States vary from slightly more than 300 million (Azrael, Hepburn, Hemenway, & Miller, 2017) to more than 600 million (Owens, 2016), but even using a middle-of-the-road estimate of just fewer than 400 million, the United States has more total guns than the next 24 countries combined (Karp, 2018).

393,000,000
civilian-owned firearms in USA
(Small Arms Survey, 2018)

2. India	10. Turkey	18. Iran
3. China	11. France	19. Saudi Arabia
4. Pakistan	12. Canada	20. South Africa
5. Russian Federation	13. Thailand	21. Colombia
6. Brazil	14. Italy	22. Ukraine
7. Mexico	15. Iraq	23. Afghanistan
8. Germany	16. Nigeria	24. Egypt
9. Yemen	17. Venezuela	25. Philippines

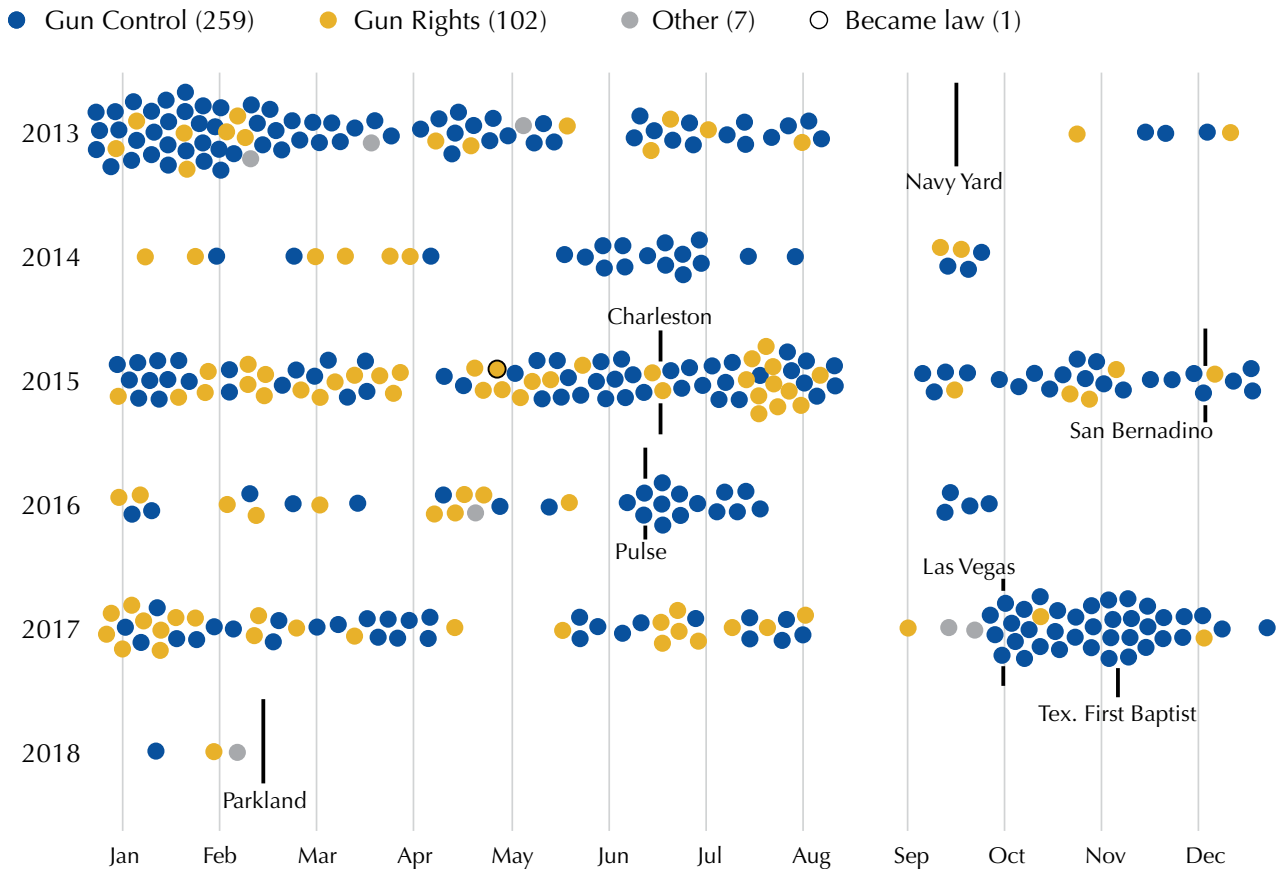
The rights of individuals in the United States to own guns, protected by the Second Amendment to the U.S. Constitution, has been upheld in two recent U.S. Supreme Court decisions. *District of Columbia v. Heller*, 554 U.S. 570 (2008), held that the Second Amendment guarantees an individual's right to possess a firearm unconnected with service in a militia and to use that arm for traditionally lawful purposes, such as self-defense within the home. *McDonald v. Chicago*, 561 U.S. 742 (2010), extended *Heller* to states and municipalities.

Heller made clear that Second Amendment rights are not unlimited (e.g., prohibitions on possession of guns by those charged with a felony are still valid); it held that permitted firearms are those “in common use at the time.” Some observers believe this would still protect the use of assault-style weapons and high-capacity magazines [common use test discussed in *Heller* at 128 S. Ct. 2815 (2008)]. As of 2017, eight U.S. states had laws banning high-capacity magazines, limiting the number of rounds to 10 or 15. California passed Proposition 63 in 2016, banning the possession of high-capacity magazines holding more than 10 rounds. On appeal, the federal courts stayed the new law as the state failed to show how this law did not violate the Second Amendment or the property rights of owners of previously legal goods. Shooters in mass violence events obtain their guns legally and illegally, suggesting that no single restriction will prohibit all forms of gun violence.

Currently, the Brady Bill, P.L. 103-159 (1993), passed in the wake of the attempted assassination of President Ronald Reagan, forbids anyone who is “adjudicated a mental defective,” or has been involuntarily committed, from owning or possessing a firearm. As noted, because the vast majority of people with mental illnesses are not violent, this provision and the language used to characterize the population has generated pushback, including from the mental health advocacy community. In addition, it is common for mass violence perpetrators to obtain their firearms from family members who would not be covered by this restriction.

Frequently, in the wake of mass shootings, a spate of new legislation is introduced, both to regulate guns and to protect gun rights. To date, legislation enacted at the state level has surpassed that at the national level. Since the Sandy Hook Elementary School shootings of 20 children and six staff in Newtown, Connecticut, of all the gun control and guns rights legislation introduced in Congress, the only one to pass was a limited measure called the Federal Law Enforcement Self-Defense and Protection Act of 2015, which declares that a federal law enforcement official is allowed to carry federally issued firearms during a furlough (Britzky, Canipe, & Witherspoon, 2018).

Gun Access Bills Introduced in Congress since 2013



(Axios, interpreting ProPublica data, 2/19/18)

Often, in the wake of a mass shooting, calls are made to reinstate the federal assault weapons ban. Fox and DeLateur (2014) studied the impact of the federal assault weapons ban, which was in effect from 1994 to 2004, and found that assault rifles were used in fewer than 25 percent of shootings and that the initial rate of mass shootings continued to increase at the same rate both while the ban was in place and after it ended. While their findings indicate that banning assault rifles alone is unlikely to significantly change the rate of mass shootings, a reduction in fatalities from mass shooting may be a more actionable goal.

TABLE 2: Mass Shootings and the Federal Assault Weapon Ban (1994–2004)

TIME PERIOD	INCIDENTS		VICTIMS	
	TOTAL	AVERAGE	TOTAL	AVERAGE
1976–1994	335	17.6	1,536	80.8
1995–2004	193	19.3	876	87.6 ←
2005–2011	144	20.6	699	99.9

Source: Supplementary Homicide Reports, 1976–2011.

TABLE 3: Weapons Used in Mass Shootings

TYPE OF FIREARM	n	%
Assault weapons	35	24.6 ←
Semiautomatic handguns	68	47.9 ←
Revolvers	20	14.1
Shotguns	19	13.4
Total	142	100.0

Source: Mother Jones database of mass shootings 1982–2012.

Fox DeLauter, HS 2014

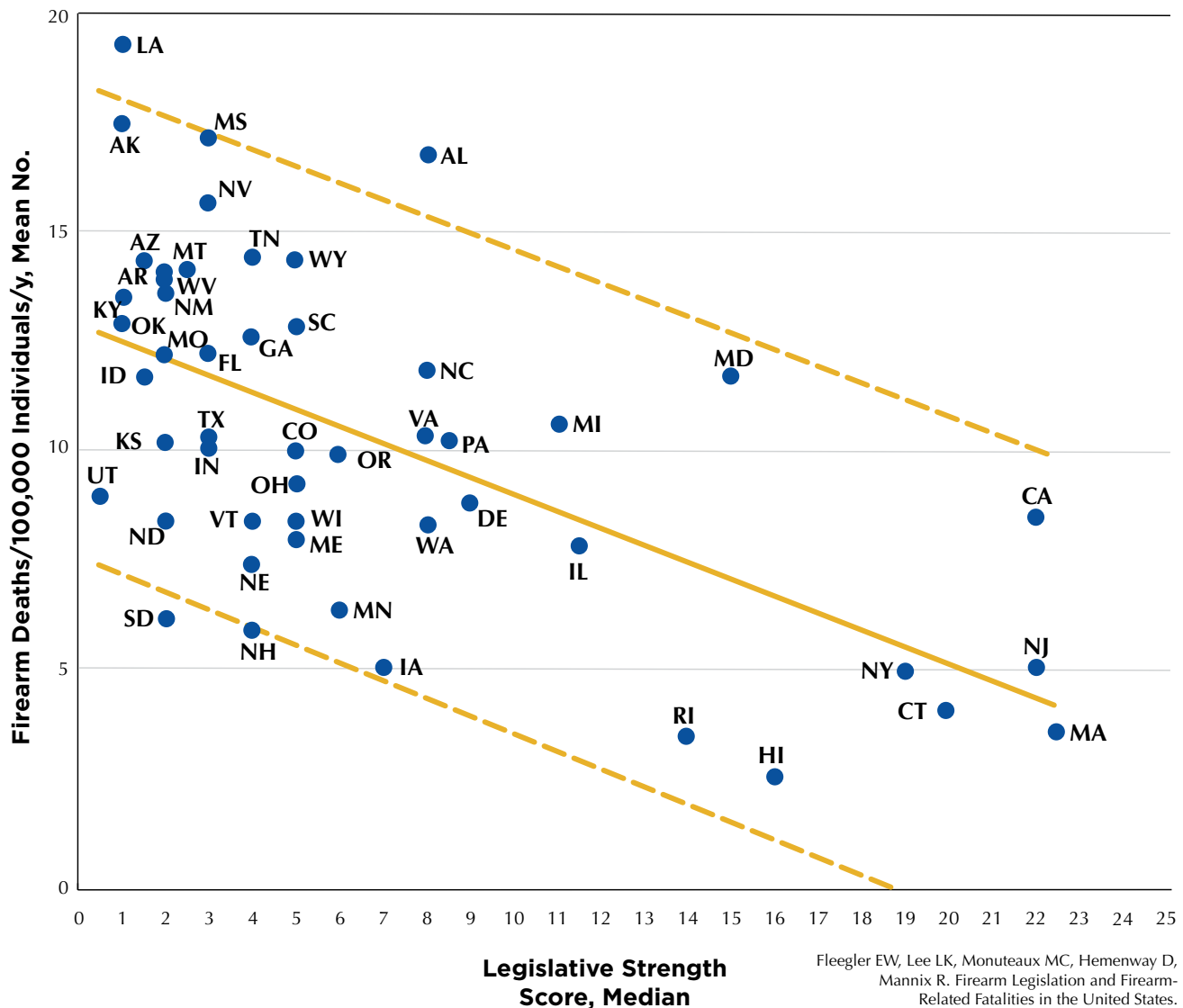
Furthermore, although the use of assault weapons in mass shootings was lower during the assault weapons ban (DiMaggio et al., 2019), there is differing data about the relative danger of assault rifles versus other weapons used in mass shootings. Some observers believe there is more lethality with assault weapons (de Jager et al., 2018), while others believe this is not the case (Sarani et al., 2018).

Part of the problem in studying gun violence is the dearth of good information. The Centers for Disease Control and Prevention (CDC) and the FBI's UCR program have no highly reliable, standardized and centralized data set for tracking firearms crime, shootings, injuries and deaths. The National Institutes of Health awarded only three major grants to study gun violence between 1973 and 2012 (Masters, 2016). Stark and Shah (2017) found that federal funding for firearms injuries research was about one percent compared to that expected for other causes of morbidity and mortality. In addition to funding limitations, the small amount of funded research on gun violence is due to bureaucratic impediments and political factors.

Because there is no single solution to mass violence, studies of the impact of putative solutions can be misleading. The RAND Corporation's 2018 systematic review and meta-analysis of gun policy in the United States found "little persuasive evidence for the effects of most policies on most outcomes" (RAND Corp., n.d.). Researchers reviewed 9,382 studies, 72 of which addressed mass shootings. There were inconclusive findings on background checks, assault-style weapons and high-capacity magazine bans, license/permit requirements, child access laws, minimum purchase age, concealed-carry laws and waiting periods. There was no useful research on stand-your-ground laws, lost/stolen gun reporting, gun sales reporting/recording, gun surrenders by prohibited possessors, gun-free zones or prohibitions for mental illness.

However, there are studies of these individual interventions in combination that show the impact on mass violence involving guns. Fleeger et al. (2013) used an overall legislative strength-of-gun-control law summary score for each of the 50 states that, when compared to each state's homicide rate overall, showed lower homicide rates associated with a higher score of legislative strength of gun control laws.

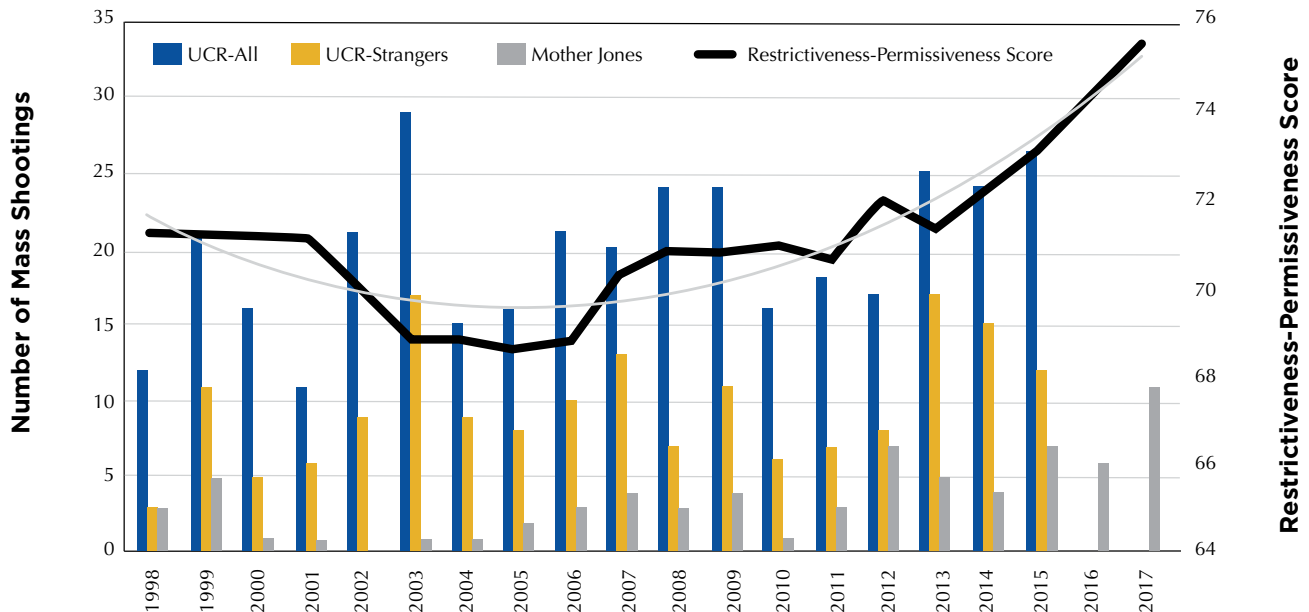
Rates of Firearm Deaths Compared to Firearm Restrictions by State



In a similar vein, Reeping et al. (under review) examined the restrictiveness or permissiveness of state gun laws and compared them to mass shooting events between 1998 and 2017. Restrictiveness refers to such things as restrictions for open carry in government buildings and banning loaded gun permits in schools, while permissiveness includes such items as recognizing out-of-state permits, the use of lifetime permits and permitless carry. The restrictiveness score was created using ratings from “The Traveler’s Guide to State Laws” published annually from 1998 to 2007.

The researchers used mass shootings as defined in the FBI’s UCR database and those recorded by Mother Jones and reached two key conclusions. First, they found that state laws regarding gun ownership have become much more permissive over time. Second, they found that those states with more permissive gun laws tended to have more mass shootings (Branas & Rozel, 2018).

Number of Shootings in FBI UCR (1998–2015) and Mother Jones (1998–2017) Data and State Restrictiveness-Permissiveness Score

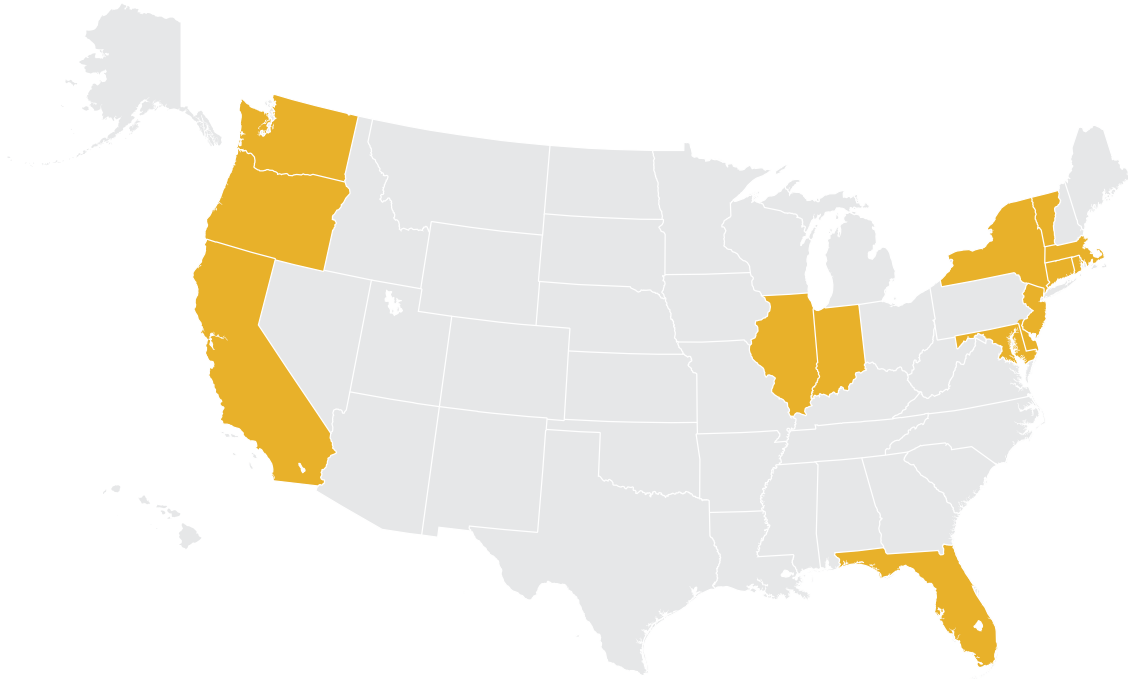


On average, for every 10-unit increase in firearms permissiveness, there was an 11 to 13 percent increase in the rate of mass shootings. The researchers caution that their study measured correlation and not causation. It is unclear what came first — the restrictive/permissive gun laws or mass shootings. And if the laws do have an impact, more research is needed about which laws and what the specific impact might be. Comparing this score to the rate of mass shootings for each state showed stricter state firearms laws are associated with fewer mass shootings after adjusting for multiple population factors.

That is not to say there is no agreement on certain measures aimed at addressing gun injuries and deaths in America. Barry et al. (2018) found a series of evidence-based measures that have wide support, including among 75 percent of gun owners. They include the following:

1. Conducting universal background checks before purchase of a firearm.
2. Allowing the Bureau of Alcohol, Tobacco, Firearms and Explosives to suspend a dealer's license if more than 20 guns are unaccounted for on audit.
3. Implementing permitting and competence testing for concealed carry.
4. Requiring states to report people to the NICS when they are involuntarily committed.
5. Removing firearms from a person subject to a domestic violence temporary restraining order.
6. Allowing families to petition for the temporary removal of firearms.

For any gun measures to succeed, they must have broad popular support. They should be supported by empirical evidence and be designed to adequately balance public safety with individual rights. A pertinent example is the federal law allowing for temporary gun removal court orders in cases of domestic violence. This was broadly accepted at least in part because it involves due process and the gun removal is temporary with a clear process for return.



Fourteen states have passed risk-based firearms removal laws (Frizzell & Chien, 2019) that are known by different names, including a risk warrant law, gun violence restraining order, extreme-risk protection order, lethal violence protective order, security temporary order of protection or red flag law. However, they all share common elements, including:

1. Civil court order for gun removal (non-criminalizing).
2. Targeting individuals who possess firearms and are known to pose a high risk of harming others or themselves in the near future.
3. Criteria for gun removal that do not require that the person have a diagnosis of mental illness or any gun-disqualifying record.
4. Authorizing police to search for and remove firearms
 - a. Initial warrant based on probable cause of imminent harm
 - b. Subsequent court hearing (e.g., within two weeks) requires state to show clear and convincing evidence of ongoing risk.
5. Limiting the duration of gun removal, typically 12 months.

For example, the Marjorie Stoneman Douglas High School Public Safety Act, F.S. 790.401, was passed just over one month after the Parkland, Florida, shooting. It provides that law enforcement can petition the court to temporarily remove and prohibit the purchase of firearms when an individual poses “significant danger to themselves or others, when they may not be legally prohibited from purchasing or possessing a firearm.” The statute sets forth the filing process as well as factors for the circuit court to consider.

Descriptive information on the implementation of Connecticut's risk warrant gun removal law, GS § 29-38c (1999–2013), found the following (Swanson et al., 2017):

Characteristics of gun removal cases: (N=762)

- Average number of guns removed per case: 7 guns
- Gender: 92 percent male
- Age: mean 47 years
- Mental health or substance use treatment record: 46 percent
- Arrest leading to conviction in year before or after: 12 percent
- Risk of harm to self: 61 percent
- Calls to police come from family/acquaintance: 49 percent of cases
- Transported to Emergency department/hospital: 55 percent

Every 10 to 20 gun-removal actions is equal to one life saved, often from self-harm (Swanson et al., 2017). Although the risk-based gun removal laws in Connecticut and Indiana were both enacted in the aftermath of highly publicized mass shootings, data indicate that they are most often used in response to concerns about suicide risk, not violence toward others.

Gun removal measures should be temporary, for temporary risk, and not based on any single criteria like mental illness. Gun removal measures must meet all constitutional requirements of due process. Effective gun measures should promote positive behavior, not simply sanction negative behavior (Kapoor et al., 2018).

VENUES OF MASS VIOLENCE

Mass violence is perpetrated in numerous venues. These include office buildings and other workplace settings, vehicles of mass transportation, shopping malls, public streets, concert arenas, cinemas, restaurants, college campuses and grade schools. All are vulnerable venues that lend themselves to such mayhem and can only be hardened (further protected) at the risk of restricting personal freedoms; installing expensive and intrusive security systems (e.g., metal detectors, surveillance cameras, barricades); or eliminating access to weapons to specific risk groups.

The question of security best practices is beyond the scope of our expertise and we believe ultimately is best addressed by identifying and alleviating the root causes of violence among perpetrators. (In the case of people with mental illness, this would entail providing effective, comprehensive treatment.) However, schools have been a particularly vulnerable and painful venue for violence because of their defenselessness, the youth of potential victims and the large numbers gathered in educational settings. Consequently, the remainder of this section will focus on schools.

Though schools are much safer than the public might believe, school shootings grab national headlines, leading to some ill-considered policy decisions that are addressed below. Creating safe and supportive environments and conducting threat assessment and management can help make schools even safer.

Mass Violence in Schools

Media attention to school shootings has generated a misperception that schools are dangerous places. On the contrary, shootings are much more prevalent outside of schools in places such as restaurants, stores and residences. A study by Nekvasil, Cornell, & Huang (2015) at the University of Virginia using FBI homicide data examined the locations of homicides in 37 states over six years and found that schools, including colleges, are one of the safest places in the United States, compared to other locations. A person is 10 times more likely to be murdered in a restaurant than in a school. This applies to shootings and mass shootings, as well as homicides in general.

Despite their statistical rarity, school shootings shock the nation. They cause widespread trauma for victims and their families, perpetrators' families, first responders and whole communities. The fear of school shootings has led to an overemphasis on expensive school security measures; at the same time, schools have shortages of mental health professionals whose services have the potential to prevent violence both in schools and in the broader community by helping troubled youth.

Policy Mistakes

One example of mistaken policy that has created detrimental downstream consequences is the use of zero-tolerance policies for threats in school (American Psychological Association Zero Tolerance Task Force, 2008). There was an increase in zero-tolerance policies in the wake of the 1999 Columbine shooting, expanding from a no-guns policy to include such things as no nail clippers, plastic utensils, finger-pointing, jokes, drawings or rubber band shooting. The result is that students are suspended for all sorts of minor misbehavior. Often these youth have to present back to school with a doctor's note or some type of safety medical clearance. This can result in youth being sent to an emergency room, with emergency room providers needing to sort out a complex situation and attesting to the fact that the youth is safe to discharge and return to school.

Many studies have found negative outcomes to suspension (Fabelo et al., 2011; Morgan, Salomen, Plotkin, & Cohen, 2014; Noltemeyer, Ward, & Mcloughlin, 2015). Students who are suspended often fall behind in their classes, even if their work is sent home. They may return to school feeling alienated and rejected, and rather than improve their behavior, they are more likely to misbehave and be suspended again. They are at increased risk of dropping out of school. These conclusions have prompted a national movement away from the use of school suspension.

In addition, school suspension has a disproportionate impact on minority students, who are often suspended at higher rates than white students (Fabelo et al., 2011; Losen & Martinez, 2013). Racial disparities in suspensions are seen across the country. Minority students are generally suspended for less serious, more subjective offenses, like disorderly conduct or disrespect, rather than more serious offenses such as drug possession or weapons possession, which were the original basis for zero tolerance.

A burgeoning industry of school security leads to what some consider to be excessive security measures, including bulletproof building entrances, electronic door locks, metal detectors and panic rooms with video monitors and ventilation systems. All are expensive, and, when money is tight, student support services and preventive interventions suffer.

A final practice that has grown in the wake of school shootings is the use of school-shooter drills. Although fire drills are conducted in a calm and low-key manner, shooting drills have become increasingly dramatic. Some involve student roleplaying, with students made up to look like they have been shot. Students are taught to attack armed shooters with anything they have at hand. In some cases, drills are not announced in advance and there are situations where deception is used so that students, and sometimes staff, are led to believe that an active shooting is occurring, rather than a drill. Though some safety drills are warranted, those that evoke fear and create trauma do more harm than good (Schonfeld, Rossen, & Woodard, 2017; Rich & Cox, 2018).

The goal is to prevent shootings and not simply prepare for them. To that end, many school systems around the country are focused on creating a safe and supportive school environment and establishing threat assessment and management teams. Both are lynchpins in violence prevention initiatives.

A Safe, Supportive School Environment

A safe, supportive school environment is one in which students forge connections with adults and create positive ties with their peers. Key elements include:

- Respect and emotional support within educational institutions.
- Positive adult (teachers, advisors) role models.
- Constructive communication between adults and students.
- Equivalent attention to emotional needs as to academic needs.
- Bullying prevention.

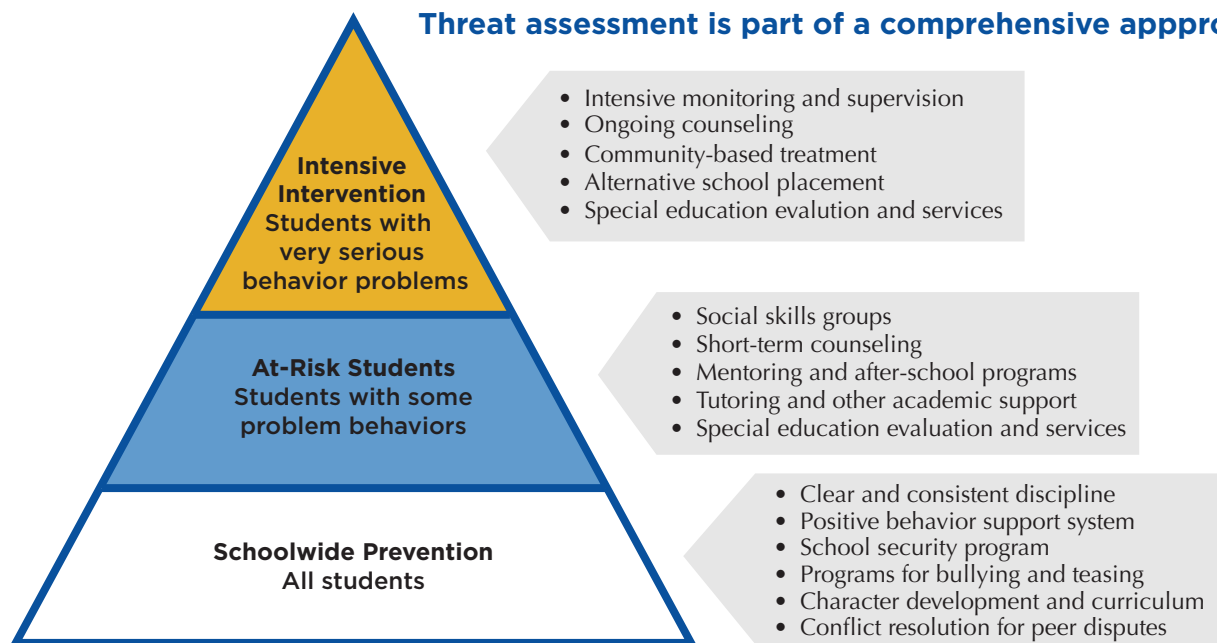
Breaking the code of silence is critical. Students should feel safe reporting their concerns about their fellow classmates, which assumes the school has procedures in place to handle these concerns (see discussion of threat assessment in the next section). They must be willing to seek help for themselves or others. Every student must feel that he or she has a trusting relationship with at least one adult in a position of responsibility at their school. Research reveals that these kinds of trusting relationships can be formed but usually are not (Williams, Horgan, & Evans, 2016; The Federal Commission on School Safety, 2018; Pollack, Modzeleski, & Rooney, 2008).

Students who feel that they are in a safe school and have an adult they can go to are more likely to report a potentially threatening situation (Pollack, Modzeleski, & Rooney, 2008). They will become an upstander rather than standing by. This requires that staff be trained to properly respond to students who provide them with information about a threatening or disturbing situation, as well as to deal with actual threats. Research in Virginia schools found that students are the most frequent reporters of a student's threat to harm someone (Cornell et al., 2016).

Threat Assessment and Management in Schools

Threat assessment is a strategy to prevent violence by identifying and assisting troubled individuals about their potential for violence. The FBI, Secret Service and U.S. Department of Education recommended a threat assessment approach nearly 20 years ago (O'Toole, 2000; Vossekuil, Fein, Reddy, Borum, & Modzeleski, 2004). Threat assessment must be adapted for schools, recognizing developmental issues in young people and the social context of the school. Unlike threat assessment for protecting public figures, school threat assessment must recognize the overarching goal of helping all students to be successful in their education and development.

In school settings, threat assessment is a problem-solving approach to violence prevention that involves assessment and intervention with students who have threatened or pose a threat of violence in some way (Cornell et al., 2018b). The threat assessment team *identifies* threats made by students, as well as indicators that a student poses a threat in the absence of an explicit threat; *evaluates* the seriousness of the threat and the danger it poses to others, recognizing that all threats are not the same; *intervenes* to reduce the risk of violence; and *follows up* to assess the intervention results. In the most serious cases, protective action is taken.



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The goal of school-based teams is to identify needs for services and either offer them in house or make referrals to outside providers when indicated. Students who make a threat are waving a red flag to indicate that they have encountered a problem they do not know how to solve. Threat assessment teams are problem solvers. The problems they encounter might involve mental health concerns or they might involve special or general education needs. Often, a student is experiencing conflicts in social competence and conflict resolution. So, school counselors, school psychologists and social workers are often involved. In the most serious cases, the school resource officer plays an essential role in the threat assessment and management process. As with adults, the goal of threat assessment and management with students is prevention and, where appropriate, getting people the help they need.

The composition of a school threat assessment team will vary depending on school staffing patterns. A typical school threat assessment team draws upon school administration (principal or assistant principal), mental health (school counselor, psychologist, social worker) and law enforcement or security (Cornell, 2018b). Teachers, school nurses and other professional staff may be included. Each school should have a threat assessment team, although a districtwide team can be a valuable resource in the most complex or challenging cases. A school-based team will have firsthand knowledge of the students, be able to respond quickly and can carry out preventive actions and monitor their effectiveness. Collaboration with law enforcement is critical so that authorities can avoid overreaction to cases that do not rise to the level of a criminal offense and can be resolved with counseling and school discipline, and, yet, react appropriately to more serious cases that merit law enforcement intervention.

Based on work done by the U.S. Secret Service National Threat Assessment Center on enhancing school safety, threat assessment is predicated on a set of key principles (Fein et al., 2004):

1. Targeted violence is the end result of an understandable, and often discernible, process of thinking and behavior.
2. Targeted violence stems from an interaction among the individual, the situation, the setting and the target.
3. An investigative, skeptical, inquisitive mindset is critical to successful threat assessment.
4. Effective threat assessment is based upon facts, rather than on characteristics or traits.
5. An integrated systems approach should guide threat assessment inquiries and investigations.
6. A central question in a threat assessment inquiry or investigation is whether a *student poses a threat, not whether the student has made a threat* [emphasis original].

A threat assessment model specifically designed for schools was developed at the University of Virginia in 2001 (Cornell et al., 2004). This model uses a decision tree to guide school-based teams in an assessment of student threats that emphasizes the distinction between transient threats that are not serious and can be easily resolved as student misbehavior and a smaller number of substantive threats that merit protective action and require a more extended safety plan (Burnette, Datta, & Cornell, 2017). Five controlled studies compared schools using this model with control group schools (either using a different model of threat assessment or not using threat assessment). In brief, these studies found that schools using the Virginia Student Threat Assessment Guidelines had lower rates of school suspension, less bullying and student aggression and more positive perceptions of school environment and safety, as reported by teachers and students (Cornell, 2018b).

A randomized controlled trial found that schools using threat assessment (compared to a waitlist control group of schools not using threat assessment) were less likely to suspend students or transfer them to another school and more likely to use counseling services and parent involvement in resolving student threats (Cornell, Allen, & Fan, 2012). However, there were too few incidents of threats being carried out to compare the two groups of schools. (Studies of threat assessment in Virginia schools have been unable to examine the impact on school homicides or serious injuries because no such incidents have occurred during any of the study time periods.)

Following the Sandy Hook shooting, Virginia schools mandated that all K-12 public schools use a threat assessment approach. A statewide assessment (Cornell et al., 2018) found that, across 1,865 threat cases from 785 schools, 97.7 percent of threats were not attempted and less than 1 percent were carried out, with no serious injuries. Also, 84 percent of the students who made the threats continued in their original school. Notably, there were no statistically significant differences in suspension rates for white and minority students (Cornell, Maeng, Huang, Shukla, & Konold, 2018).

School administrators, employers and others may feel caught between a rock and a hard place: at risk of litigation for failing to respond to potential threat and prevent harm, but also for violating the rights of students and employees. Mass violence has given rise to personal injury lawsuits seeking damages for wrongful death, nonfatal injuries and the economic and emotional harms flowing from them. Lawsuits resulting from these tragedies are rooted in fundamental legal principles of duty to take reasonable care to guard against known or reasonably foreseeable hazards. Defendants in such suits have included employers, school districts and officials, law enforcement, mental health professionals and even the parents of perpetrators. In these cases, plaintiffs allege that the defendants had an obligation to act to prevent the harm from occurring and negligently failed to do so.

While the potential for such suits causes justifiable concern, many school officials and others also worry that they may be sued for disability discrimination, or violation of federal or state statutes, such as the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA) (see text box, Clarifications on HIPAA and FERPA). These concerns are often exaggerated, as both HIPAA and FERPA provide multiple exceptions for the disclosure of otherwise-protected information to protect the person of concern or others.

With that in mind, the safest course is to behave in a reasonable fashion that responds to known or foreseeable harm and adheres to legal requirements. This can include:

1. Developing policies and procedures that address the risks of potential harm and managing them.
2. Training employees on these policies and procedures, including periodic retraining.
3. Applying the policy and procedures and following up.
4. Establishing multidisciplinary threat assessment and management teams.
5. Practicing the application of the policies and procedures.
6. Educating team members and others in the organization as to the actual requirements of statutes such as HIPAA and FERPA.
7. Keeping track of cases for future reference and reviewing how they were handled for quality improvement purposes.

It is important to note that merely having policy and procedures in place is not sufficient to protect against liability. Indeed, unless staff are trained on the policy and procedures, and they are actually applied, their existence may be used to show that the defendant knew of the risks but was negligent in failing to follow its own rules.

Recognizing and Responding to Trauma in the Wake of a School Shooting

Multiple reactions follow school shootings, including shock, outrage and grief when deaths occur. Such a crisis is often followed by a cascade of unexpected secondary losses and stressors. For example, after a school shooting, there may be a drop in school enrollment when students who have experienced trauma transfer out or even students who were not traumatized seek a school that is less impacted by the recovery from the event and more focused on academic pursuits. Prospective students and families often opt to go to a different school. Budgets are based on the number of students attending the school and if the budget drops after enrollment drops, schools may feel the need to cut support services to save money, just at a time when students need this help. Tax bases may drop, too, as property values diminish due to the violence occurring within the neighborhood.

Crisis events uncover prior trauma or loss, even if it is unrelated to the event. Research reveals that trauma and loss are common, but provider training addressing these issues is often not sufficient to meet the need. One out of 20 young people experiences the death of a parent and nine out of 10 experience the death of a close relative by the time they complete high school. However, fewer than 10 percent of educators receive any training on how to support grieving children and youth, which is the main factor limiting their ability and willingness to provide support (Schonfeld & Demaria, 2016).

In a study on the effects of the September 11, 2001, terrorist attacks on New York City schoolchildren (Hoven et al., 2005), one in four students surveyed six months later met the criteria for one or more probable psychiatric disorders, including posttraumatic stress disorder, major depressive disorder, separation anxiety and general anxiety disorders, panic attacks and agoraphobia. Based on a survey of 8,000 students, 87 percent had at least one trauma symptom that was continuing six months later. More important, the vast majority who self-reported their symptoms also reported they had neither sought nor received mental health treatment, even though there was free mental health counseling available in the school.

This means that individual treatment services in isolation are not enough to address the broad range of needs for supportive and therapeutic services after a traumatic event like a school shooting. A school response should not be limited to only providing individual services outside of the classroom. Teachers, school administrators and staff can have a profound impact by providing compassionate support in their daily interactions with students, in addition to identifying those who may benefit from additional mental health services. This more comprehensive and trauma-informed approach requires both training and adequate resources.

Training in providing compassionate support after a trauma has not been a priority in teacher preparation coursework nor in professional development. Such training is often sought in the wake of a school shooting, but so-called “just-in-time-training” is far from ideal, since school staff will also be deeply impacted personally by these events and therefore often overwhelmed themselves and less able to focus on learning new skills (Sandy Hook Advisory Commission, 2015). Prior to any major event, they need to learn about the impact of trauma and bereavement on young people and their learning, practical strategies for providing Psychological First Aid and brief supportive services and indications for referral for mental health services. Given that these skills can be used to support young people who are struggling with personal and family crisis events, they are critical for educators and will be valuable even in the absence of a school shooting.

Preparedness involves not just preparing to respond but also preparing to recover. Too little attention is paid to the time needed to recover, which may take years and the timeframe for federal funding is not aligned with this need. In addition, the amount of funding is often less than the scope of the need. Recovery funding mechanisms should, therefore, be harmonized with the duration and extent of need (Sandy Hook Advisory Commission, 2015).

Ultimately, schools can help prevent violence by ensuring that students are successful academically and in their interpersonal relationships. Investing in universal social and emotional curriculum may be one way to support prosocial behavior and emotional well-being. However, this investment can be challenging in schools without adequate staff-to-student ratios and an emphasis on high academic standards and behavioral expectations in lieu of social and emotional learning.

Helping Families Heal

Family members of those who are victims of mass violence experience a wide range of emotions that run the gamut of loss and grief to trauma. They are grieving the loss of someone to whom they didn't say goodbye and traumatized by the way in which they died. They are likely dazed and confused and initially may want to withdraw rather than talk to providers. They may have little recall for what is discussed in bereavement counseling, so written materials can be helpful.

It is also important for providers to remember that those who have experienced this kind of loss likely have an altered perception of the world and their safety and are often hypervigilant. This means they may have difficulties establishing trusting relationships with treatment providers. Some will want to work out their grief by speaking to the media, but others will need to be protected from the constant glare. As future tragedies strike, even years after an event, their trauma may be retriggered, as seen in the recent suicides of two students who were survivors of the Parkland shooting and the suicide of a father of a Sandy Hook victim.

Families of perpetrators go through the same reactions, but they bear an additional layer of scrutiny. They may be barraged by the press; blamed by the media, public officials and other families; and have legal concerns to address. But they may also be grieving the loss of a loved one and left to wonder what, if anything, they could have done. Often, their concerns are brushed aside.

“Something Was Broken”

Sue Klebold remembers her son Dylan, one of the two Columbine High School shooters, as “the young cherub with the golden curls and the blue eyes.” He could read “Stuart Little” at the age of four and was a loving brother. Three days before the April 20, 1999, shooting that left 12 students and one teacher dead and another 24 individuals injured, the 17-year-old senior attended his high school prom. He had been accepted at four colleges. Three days later he would be dead of a self-inflicted gunshot wound.

To this day, Sue is not sure what prompted Dylan and his friend, Eric Harris, to plan to kill everyone in the school. Fourteen months before his death, Dylan and Eric got in trouble for stealing something from a parked van, but they were released early from a diversion program. At 17, he was sometimes moody and Sue found out after his death that he drank alcohol, but she’s not aware that he used drugs (none were reported in the toxicology report). He did not have a diagnosed mental illness.

Years after his death and long after the police report came out, Sue discovered that Dylan had written in his journal when he was 15 that he was in agony and wanted to die. He wrote that he wanted to get a gun and that he was cutting himself. “I never saw signs of those, but we found it in his writings,” Sue says.

Sue now says she believes, “Something was broken. Something was not right in Dylan’s thinking. He had lost access to whatever tools he had of self-governance and reason, logic and concern.”

Everyone from the public to the media to the governor blamed the shooting on poor parenting and Sue says she has had trouble forgiving herself. “I believe now that I could have done things differently,” she says. “I could have listened differently. I could have asked different questions. And I really believe that his participation, at least, could have been prevented.” She noted that neither his teachers nor his friends suspected he was capable of this level of violence.

For Sue, the concept of “life indifference” or suicidality on the part of active shooters rings true. She has become a vocal suicide prevention advocate who believes that every citizen should have some type of suicide prevention training and that everyone should be trained in Mental Health First Aid. Because mass violence is a rare event, she notes, the goal is not to prevent a shooting but to help people who are suffering.

She also believes, “We can’t back away from the conversation of how mental ‘unwellness’ intersects with violence. I don’t think we should be afraid of having that conversation,” Sue says, while acknowledging the need to put some boundaries around the discussion so as not to unfairly characterize all mental illness as linked to violence, which would increase stigma for those with mental health problems.

Ultimately, Sue believes we must get quiet and listen to one another. “I think we have lost our ability to do that,” she says. The goal, as community members, family members and adults in our youth’s lives is not to make them feel better, but simply to help them feel — to identify their feelings and learn how to respond. “We might save their lives,” Sue says.

A PUBLIC HEALTH MODEL OF PREVENTION

Mass violence, to the limited extent that it is due to mental illness, may best be prevented by providing competent and comprehensive mental health care to the American population (a situation that doesn't currently exist) and, in this context, adopting a public health model of prevention:

- **Universal:** A public education campaign to help identify people of concern (e.g., “see something, say something”).
- **Selective:** Measures to assess and intervene with people with specific identified warning signs — but no history of past significant violence, communication of threat or evidence of planning — and access to weapons capable of inflicting mass casualties.
- **Indicated:** Measures to contain, assess and intervene with people with past histories of threatened or actual significant violence, specific warning signs that include communications of threat and evidence of planning/practice and access to weapons capable of inflicting mass casualties.

It is important to note that most of the people who pose a risk of violence are not hidden from view. In the right kind of organizational setting — whether community, workplace, health care or educational venues — people exhibit signs with what they say, do and how they behave that reveal their distress or propensities. Some of them overtly threaten violence, recruit accomplices, talk about their violent acts and clearly need help. But there's a broader pool of people who are in urgent emotional distress. They might have a mental illness, but their distress may be circumstantial, caused by a domestic dispute, a setback or disappointment in their job, financial duress or a combination of events. In such conditions there are interventions that can defuse the situation and move people off the pathway to violence well before they show up with a gun (Rozel, 2018). And while it may not be possible to precisely determine if and when their suspected untoward behavior might emerge, creating within an organization a place where a person who sees something can say something and know that their concerns will be acted on is a powerful public health intervention. It also becomes an important basis for getting information about who might cause harm.

The goal is to minimize exposure to traumatic events and maximize protective factors. This involves teaching resilience and helping young people learn how to regulate their emotions and considering investments in home visiting programs, parental supports, maternal leave policies and access to high-quality preschools. It means helping strengthen a young person's coping skills, teaching parents to model nonviolent behavior and educating their children on positive ways to deal with stressful events. It means creating healthy communities in places that too often are racked by poverty, violence and substance use. Incorporating the pediatric medical home, which can serve as a hub for so-called “medical neighborhoods,” can address social determinants of health and promote affiliative childhood/family/community experiences over adverse ones. Several evidence-based social and emotional learning curricula exist that can aid schools and ultimately communities in this vital endeavor (Macklem, 2014).

Opportunities for Prevention

Despite the gravity of the problem and increasing public concern, there is little research available regarding the efficacy of violence prevention interventions. This is in part due to the relatively rare occurrence of mass violent events, but more so the result of limitations in research funding. The increased public demand for stemming this growing and disturbing problem should move government to action but has yet to do so. In the absence of coordinated policy-driven action, individuals and communities have pursued opportunities for prevention and, in doing so, helped promote resilience and relieve emotional distress. Several examples of such prevention efforts follow.

“See something, say something.”

The concept of “see something, say something” is predicated on the belief that often individuals demonstrate red flags in their behavior and the individuals most trained to recognize and address those flags are not the individuals most likely to see them. The so-called “bystander problem” was discussed in Williams, Horgan, & Evans (2016), who examined a program in Bethesda, Md., that was designed to encourage students to report concerning behavior. When they surveyed the young people who participated in the program, none indicated that they would report a friend who said they were about to engage in a violent act. The bystanders said they were afraid they’d be wrong, they didn’t want to get their friend in trouble, or they didn’t want to be a target of their friend’s anger. Other studies have found greater bystander willingness to report and have found that school environment is associated with student willingness to seek help for threats of violence (Millspaugh, Cornell, Huang, & Datta, 2015; Eliot, Cornell, Gregory, & Fan, 2010).

Silver, Simons, & Craun (2018) found similar results. Even though the active shooters they studied showed four to five concerning behaviors that bystanders observed, only 41 percent reported their concerns to law enforcement. Eighty-three percent of bystanders communicated their concerns directly to the active shooter, who would try to allay the bystander’s concerns. Each subject of concern had more than one contact whose behavior (talked to the subject, reported to police, etc.) was noted. The researchers concluded that more needs to be done to help bystanders understand that their concerns will elicit a caretaking rather than a punitive approach (Pollack, Modzeleski, & Rooney, 2008; The Federal Commission on School Safety, 2018). School shootings have been averted because a student or someone else reported the threat (Daniels et al., 2007; Madfis, 2014; Daniels & Bradley, 2011; Daniels et al., 2010; Esserman, n.d.).

Community Intervention Programs

Programs like Community Connect at Boston Children’s Hospital bring together a broad segment of the community — including local police departments, public schools, mental health professionals and members of the faith community — to provide resources for families at risk (Ellis & Abdi, 2017). Program members refer cases of children, adolescents and young adults who are at risk of involvement in the criminal justice system, for whatever reason, and an effort is made to first identify the needs of the individual and family and then coordinate how those needs can be met. The goal of all participants, including those from law enforcement, is to help avoid involvement in the criminal justice system.

In 2015, President Obama issued task forces on Countering Violent Extremism that examined three cities. Part of what was developed was an organized approach through the Department of Homeland Security, but also, many communities came to understand that open dialogue and conversation, as well as the building of safety networks, would help families and friends know where to turn if concerns about behavior arose (The White House, 2015).

Mental Health First Aid is an eight-hour training that prepares the average person to identify someone in distress from mental illness, provide them with reassurance and get them assistance. Early identification and treatment of mental illness reduces the risk for violence.

A Role for Treatment Providers

Behavioral health treatment providers have key roles to play in preventing and responding to incidents of mass violence. Engaging clinicians in these activities requires sensitivity to their concerns in a number of key areas.

Prevention

Behavioral health clinicians working with patients who may be at risk for violence may have concerns that need to be addressed. First and foremost, they are potential victims of violence, an occupational hazard. In this context violence prevention becomes a workplace safety goal. In addition, they may also be worried about damaging the therapeutic alliance with patients if they report their concerns, and, conversely, they may fear repercussions if they don't.

Clinicians may also wrongly believe they can't act on their concerns because of HIPAA, which protects patient privacy. But, in fact, providers can pass along information to law enforcement, family members of the patient or others when they feel such action is warranted to protect personal safety (see the text box, Clarifications on HIPAA and FERPA). The FERPA protects students' educational records (their health records are covered by HIPAA) and federal restrictions on disclosure of information related to alcohol and drug abuse treatment records are governed by 42 CFR Part 2. Clinicians and school officials need to be educated about their rights and responsibilities under these regulations.

Clarifications On Federal Regulations Related to Confidentiality

For HIPAA, when a provider believes in good faith that a warning to law enforcement, family members of the patient or others is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others, the privacy rule allows the provider, consistent with applicable law and standards of ethical conduct, to alert those people whom the provider believes are reasonably able to prevent or lessen the threat (45 CFR Sec. 164.512(j)). They may notify the family to watch for symptoms, even if harm is not imminent (45 CFR 164.510(b)(2)).

Under 42 CFR Part 2 § 2.63 confidential communications may be disclosed pursuant to “(a) A court order under the regulations in this part may authorize disclosure of confidential communications made by a patient to a part 2 program in the course of diagnosis, treatment, or referral for treatment only if: (1) The disclosure is necessary to protect against an existing threat to life or of serious bodily injury, including circumstances which constitute suspected child abuse and neglect and verbal threats against third parties.”

The FERPA (20 U.S.C. § 1232g; 34 CFR Part 99) is a federal law that protects the privacy of student education records. The law applies to all schools receiving funds under an applicable program of the U.S. Department of Education. FERPA gives families certain rights with respect to their child's education records. However, there are areas in which a school has the right to disclose information to specified officials for evaluation purposes (e.g., concerns of violence risk). After the Virginia Tech shooting, the U.S. Department of Education issued brochures with clarifications on FERPA that explicitly recognized that school authorities can disclose names and other identifying information to protect the health or safety of others (https://www2.ed.gov/policy/gen/guid/fpco/ferpa/safe_schools/index.html). The clarification also acknowledged that school authorities may have personal knowledge of a student that is not part of the educational record and therefore can be disclosed at the authority's discretion. This is important because there is a widespread misperception that FERPA prevents school authorities from sharing information about a threatening student.

In some situations, clinicians are required to breach confidentiality.

Tarasoff Duty to Protect

“When a therapist determines, or pursuant to the standards of his profession, should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger.” “[T]he judgment of the therapist in diagnosing emotional disorders and in predicting whether a patient presents a serious danger of violence is comparable to the judgment which doctors and professionals must regularly render under accepted rules of responsibility.”

This rule, which has spread to many states and has been modified or rejected in others, originated in the California Supreme Court’s decision in *Tarasoff v. Regents of the University of California* (17 Cal.3d 425 [1976]). In *Tarasoff*, a patient told his psychotherapist that he intended to kill an unnamed but readily identifiable woman. Subsequently, the patient killed the woman. Her parents then sued the psychotherapist for failing to warn them or their daughter about the danger. The therapist notified the police, who contacted the patient and also notified his supervisor, who reprimanded the therapist for violating confidentiality and threatened to fire him for any further violation of confidentiality. The California Supreme Court rejected the psychotherapist’s claim that he owed no duty to the woman because she was not his patient, holding that if a therapist determines or reasonably should have determined “that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger.”

Under the Anglo-American legal system, individuals who cause harm to others may be held liable and required to pay damages if the injury caused was reasonably foreseeable (i.e., a reasonable person in similar circumstances would understand that the behavior in question was likely to cause injury). A fundamental tenet of personal injury law in this system is that Person A cannot be held responsible for harm caused by another person (the actor, Person B) unless a special relationship exists between A and B. *Tarasoff* and its progeny reconfirmed this principle but limited foreseeability to situations in which there is an actual threat of violence to a specific person or a reasonably identified person. The primary significance of this line of cases is the requirement that under such circumstances, therapists may be obligated to breach confidentiality.

The *Tarasoff* duty to protect others only applies to specifically identified or readily identifiable individuals. The *Tarasoff* case does not contemplate duties that may arise toward groups of people. Duties to third parties vary highly across states and even across time as new cases are decided and statutes enacted; because subsequent cases in other states have broadened or narrowed the duty or specify how it can be met, the reader is advised to discuss the legal duty in their state with their legal advisor.

Finally, ideological and philosophical beliefs about an individual’s rights and personal autonomy versus the safety and best interests of society may influence providers’ actions regarding violence surveillance and prevention.

Mental health advanced directives, including Ulysses contracts, can aid in preventing mass violence during times of exacerbation of mental illness. In a Ulysses contract, a person documents their agreement to have their guns temporarily removed if their clinicians decide their risk of using them to harm themselves or others has become significant. Research shows that 46 percent of psychiatric patients would willingly agree to a seven-day delay or judicial review limit on firearms access (Vars, McCullum, Smith, Shelton, & Cropsey, 2017). The psychiatric advance directive, which offers instruction for men-

tal health treatment and authorizes someone as a health care proxy, might be especially important for young adults transitioning into college, a time when mental illnesses often are exacerbated.

Response

Community mental health treatment providers play a vital role in the wake of a mass violence incident. They provide support to victims and their families, to first responders and to the community at large. Sometimes they are called on to define the role that mental health may have played in the incident. Those seeking to provide a leadership role or consulting role to schools and school systems after major events should have training and experience in systems-level consultation in the aftermath of such events and experience in working with and in school settings. Otherwise, to be of optimal assistance, they should seek consultation from individuals or groups that have this experience. It is critical that providers understand their role in a communitywide response. Lessons learned from past events shed some light on how best to prepare.

- Establish relationships in the community early on to foster trust and support in the aftermath of a tragic event. Attempting to establish relationships in the aftermath of an event can be challenging.
- Be responsive, but not intrusive. It is easy to get overinvolved and to want to be everything to everyone. Go with invitation as a guest of the institution that owns the incident. Support, but don't take over.
- Have identified sources of funding in place so providers can spend their time responding and not fundraising.
- Have a plan to coordinate volunteers; they may come from all over the country and will need to be managed effectively.
- Have a plan to coordinate and credential clinicians. Ensuring community mental health centers have certified clinicians on staff and a process to disseminate information/support to others is essential to meet the needs of the community.
- Understand your place in the critical incident command structure. Leverage key relationships to remain involved when and where you are needed.
- Remember that disaster response is a marathon, not a sprint. Don't underestimate the level of need or the duration of these events.
- Prioritize. Start with the people who need your help the most. Be aware that those who need your help may not be the ones who seek it, so be prepared to identify them and reach out. Go to them, rather than waiting for them to come to you.
- Be flexible. Whatever is anticipated about the way the community response will look will undoubtedly change. Things are quite fluid on the ground. One phrase that was helpful to hear, for instance, in the response by psychiatrists in the early days of the Sandy Hook tragedy was that they would benefit by providing "therapy by walking around," as people gathered in the town in large groups.
- Understand that those in the community who have experienced previous trauma (e.g., veterans) may be triggered by a mass violence incident. Be prepared for an increase in need across the behavioral health care system.
- Support staff early and often. Be aware of vicarious trauma and compassion fatigue and have plans to address them.

- Address gaps in care by reaching out to organizations that are not typically at the table. Include business leaders, the faith community, youth, mental health consumers and law enforcement. Collaborate with local crisis providers.
- Consider providing Mental Health First Aid training to all staff, including receptionists, human resources personnel and security staff and to members of the community the agency serves.
- Remember that health center staff can themselves be a target of violence and prepare them for how to respond.
- Be prepared for an onslaught of media. Know who in your organization or broader mental health system is authorized to speak with the press. If you are tasked with this role, have talking points about mental illness and violence, your state's commitment laws and your state's gun laws at the ready. A resource such as "Responding to a High-Profile Tragic Incident Involving a Person with a Serious Mental Illness" (NASMHPD and CSG Justice Center, 2010) can help. See more in "Recommendations for Working with the Media," later in this paper.

Community mental health providers have a role to play both in violence risk assessments of individual clients and as part of multidisciplinary threat assessment teams. Violence risk assessment differs from threat assessment and management. The most fundamental difference is that the latter focuses on whether a given individual poses a risk of harm to a specific target, whereas the former focuses on the likelihood of violence, in general. Other ways in which they differ include those listed in the following table (Meloy & Hoffman, 2014):

THREAT ASSESSMENT AND MANAGEMENT	VIOLENCE RISK ASSESSMENT
Investigative approach	Clinical assessment approach
Ongoing process	Single point-in-time assessment
Includes non-clinicians — police, lawyers, etc.	Clinicians only
More resource intense	Less resource intense
Includes interventions	Does not include interventions

Unfortunately, many clinicians are not adequately trained in violence risk assessment and very few are trained in threat assessment and management. Clinicians must have access to responsive threat assessment and management for persons who are experiencing intense emotional crisis but who do not meet criteria for involuntary hospitalization or treatment.

Liability fears may prevent providers from being involved in broader threat assessment approaches. But the time has long since passed when providers can deny their role in assessing risk for violence. The goal is not for community providers to play the only role in identifying and addressing risk for violence but to be a critical part of integrated, comprehensive community-based care for individuals at elevated risk for committing a violent act (Rozel, Jain, Mulvey, & Roth, 2017).

The behavioral health system needs to be able to respond quickly to struggling or distressed youth and adults who could be experiencing mental health problems. However, access to care and treatment can be challenging. Although 76 percent of Americans think mental health is just as important as physical health, we are experiencing a crisis in access to care. One in four Americans have had to choose between getting mental health treatment and paying for daily necessities and 96 million have had to wait more than a week for mental health services.

But inroads to increasing such access have been expanding, such as services that help consult primary care providers around behavioral health issues. Private practitioners who are not part of a mental health system may need further training and outreach to address these complex areas of concern. Specialized services include programs designed to work with youth who are experiencing a first episode of psychosis and their families.

The federal Interdepartmental Serious Mental Illness Coordinating Committee recognized the need to increase access to care when it released its initial report (Interdepartmental Serious Mental Illness Coordinating Committee, 2017). Among its recommendations were the following:

- Define and implement a national standard for crisis care.
- Prioritize early identification and intervention for children, youth and young adults.
- Maximize the capacity of the behavioral health workforce.
- Expect serious mental illness and serious emotional disturbance screening to occur in all primary care settings.
- Make screening and early intervention among children, youth, transition-age youth and young adults a national expectation.
- Make trauma-informed, whole-person health care the expectation in all our systems of care for people with serious mental illnesses and serious emotional disturbances.

Finally, any efforts at prevention and early intervention must include activities that help reduce stigma. Many people can benefit from mental health services in times of urgent emotional distress without being diagnosed as having a mental illness. It must be understood that mental illness is treatable in the same way that acute and chronic medical conditions are treatable and, likewise, that recovery is possible.

A Role for Primary Care Providers

The belief among primary care clinicians (in family medicine, internal medicine, pediatrics and obstetrics and gynecology) is that 40 percent of the problems they encounter in their practice are behavioral health and psychiatric in nature. This is important in all age groups but particularly among young people. Half of all lifetime cases of mental illness begin by age 14 and three-quarters begin by age 24 (Kessler et al., 2005). The average delay between onset of symptoms and their diagnosis and treatment is eight to 10 years (NAMI, n.d.) and, yet, there is a nationwide shortage of child and adolescent psychiatrists and other mental health professionals. Primary care providers are often the first to detect mental illness and offer a potential opportunity to diagnose, refer and treat underlying mental disorders (e.g., conduct disorder, depression, psychosis). However, primary care clinicians are ill prepared to fulfill this opportunity. In addition, there are numerous barriers to enhancing mental health care in the primary care setting.

Chief among these is a lack of adequate training in behavioral health and a resulting ambivalence and discomfort in dealing with mental disorders. In addition, time constraints and poor payment models discourage treatment of mental health problems in the primary care setting. Primary care providers may also lack access to mental health specialty resources — two-thirds of primary care clinicians reported difficulty accessing psychiatric services, more than double the percentage that report difficulty referring to any other specialty (National Council Medical Director Institute, 2017). Further, young people and their families may be reluctant to seek care from the specialty sector. Administrative barriers and limited

information exchange between primary care and mental health specialty providers also act as constraints on serving young people with behavioral health needs in the primary care sector.

In response, primary care and behavioral health teams have developed innovative ways of working together to support young people and their families (Coffey, Vanderlip, & Sarvet, 2017). These range from developing formal consultation and collaboration protocols to locating staff in the same facility with access to the same health records. One such example is Project ECHO, a telehealth model that bridges the gap in health care for rural and underserved communities. Project ECHO is a collaborative model of both education and consultation aimed at providing specialty care to primary care physicians serving patients with mental illnesses. In another model, several states have developed consultative services for primary care and pediatric practices where a child psychiatrist can be consulted directly using telehealth services (e.g., Massachusetts MCPAP and Michigan's MC3). These innovative ways of care delivery can be effective in meeting the mental health needs of children and adolescents; however, funding mechanisms — alternative to fee for service — are needed to sustain this level of support.

To facilitate the integration of behavioral and mental health care into primary care, the model of “collaborative care,” in which mental health providers are embedded in primary care settings, was developed by Katon and Unützer (Katon, Unützer, Wells, & Jones L, 2010). The medical community has strongly advocated for these important approaches. Health care organizations and individual clinicians are encouraged to advocate on both state and national levels for policies that promote social and emotional health and increased access to mental health care.

Courts and Law Enforcement Working with Youth

Although not all perpetrators of mass violence had behavioral challenges as youth, sometimes there is an overlap. Community partnerships connecting law enforcement with mental health are a potential avenue for therapeutic intervention and possible prevention of mass violence by at-risk youth. Some programs work directly with children and adolescents to help prevent violence and head off youth from becoming involved in the juvenile justice system. For instance, the Child Development-Community Policing (CD-CP) program in New Haven, Connecticut, began as a partnership between the Yale Child Study Center and the New Haven Department of Police Service in 1991. The program, whose goal is to respond to young people and families exposed to violence, serves as a model for law enforcement/mental health partnerships around the country.

In CD-CP communities, mental health professionals respond 24 hours a day, seven days a week to police calls involving child victims or witnesses to violence. Police, mental health professionals, child protective services and other providers work together to help reestablish safety, security and well-being in the immediate wake of violent events. In the CD-CP model, clinicians and officers interrupt a trajectory that frequently leads to increased risk of psychiatric problems, academic failure, encounters with the criminal justice system and perpetuation of violence. They set young people and their families on a path to recovery.

In Cambridge, Mass., the mission of Safety Net is to “foster positive youth development, promote mental health, support safe school and community environments and limit youth involvement in the juvenile justice system through coordinated prevention, intervention and diversion services for Cambridge youth and families.” The program is a collaboration among the Cambridge Police and County District Attorney's Office, the Cambridge Police Department Youth and Family Services Unit, Cambridge Health Alliance, Department of Human Services and Cambridge Public Schools.

Together, the partners conduct outreach to families to develop an action plan that is tailored to meet the unique needs of the child. Services include connections to mental health services, home visits, juvenile diversion programs and help navigating the legal system. In addition, since 2007, all Cambridge public schools and city youth programs have had an assigned Youth Resource Officer who helps reduce juvenile delinquency through prevention, early intervention and diversion programs (Haas & Barrett, 2014).

North Carolina's School Justice Partnership (SJP) program began as a local effort but is now being rolled out statewide. Chief district court judges convene stakeholders from schools, law enforcement, the court system and the community to establish policies and procedures through a memorandum of understanding to address student misconduct within the school system and community rather than by automatic referral to the justice system. The goal is to help reduce in-school arrests, out-of-school suspensions and expulsions, which can set youth on a path into the school-to-prison pipeline. A single suspension can triple the likelihood that a student will enter the juvenile justice system and confinement in a juvenile facility increases the risk that a youth will be rearrested as an adult (School Justice Partnership North Carolina, n.d.).

SJP programs use evidence-based discipline strategies for minor, nonviolent offenses that keep kids in school and improve academic achievement. In North Carolina, Texas and Connecticut, SJP programs show an overall decrease in referrals to juvenile court, a decrease in referrals of youth of color to juvenile court and an increase in graduation rates (School Justice Partnership North Carolina, n.d.). However, there is no evidence that these programs reduce mass violence.

IMPACT ON COURTS AND LAW ENFORCEMENT

Problem-solving courts (e.g., drug courts, mental health courts) and law enforcement have become an extension of and, in some cases, an entrée into, the mental health system. These efforts are described in this section.

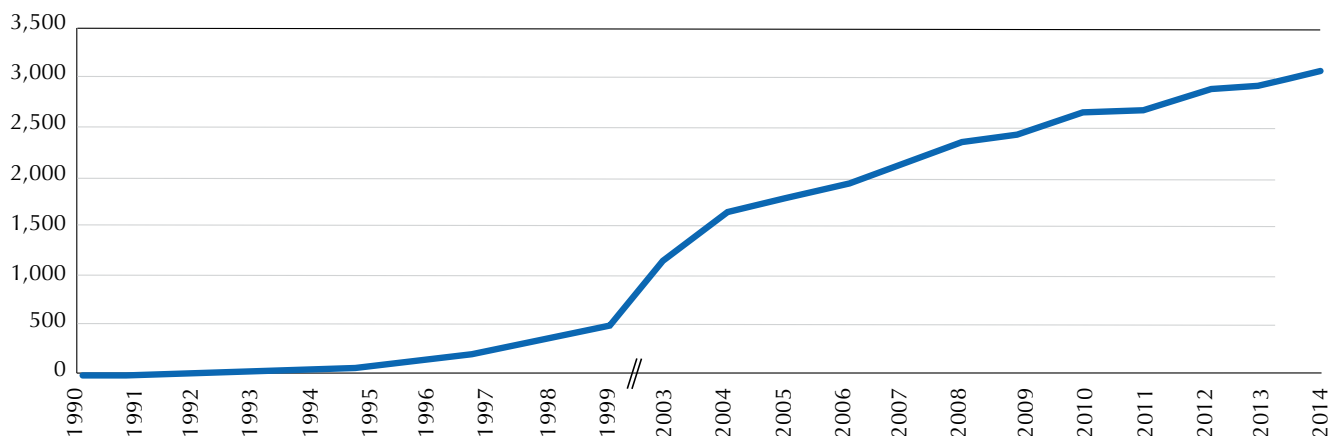
Therapeutic Jurisprudence in Problem-solving Courts

According to the Bureau of Justice Statistics, “problem-solving courts were created to address underlying problems that result in criminal behavior” (Strong, Rantala, & Kyckelhahn, 2016). These interdisciplinary and collaborative courts help fill gaps in psychosocial services, provide early identification and intervention with individuals who may be at risk for violence and extend the reach of an often under-resourced and overworked behavioral health treatment system.

Since the first drug treatment court was founded in Miami-Dade County, Florida, in 1989, the concept of “therapeutic jurisprudence” has taken hold in problem-solving courts around the country. Therapeutic jurisprudence is “a multidisciplinary examination of how law and mental health interact.” And, more significantly, it is the explicit recognition that what happens in a courtroom, including the behavior and decision of the judge, can have significant positive effects on a defendant’s mental health and can work to decrease the risk of recidivism. It was developed in the 1980s by Professors David Wexler and Bruce Winick as an academic approach to mental health law (Winick & Wexler, 2003).

Today, the range of problem-solving courts includes not only drug and mental health courts, but also domestic violence courts (misdemeanor and felony), veterans’ courts, DWI courts, homeless courts, girls’ courts, community reentry courts and truancy courts, among others. The civil legal system has its own array of collaborative problem-solving courts that include juvenile dependency/child welfare courts and safe babies’ courts. There are now more than 3,000 problem-solving courts around the country. For example, Michigan currently has 185 problem-solving courts and legislation recently passed to fund juvenile mental health courts statewide (Cook, 2018). In addition, courts of general jurisdiction have become more interested in using alternative sentencing models and diversion.

Number of Drug Courts by Year in the United States, 1989–2014



Source of data: National Drug Court Institute,, “Painting the Current Picture: A National Report on Drug Courts and Other Problem-Solving Courts in the United States.” (2016), Table 3 (<http://www.nadcp.org/sites/default/files/2014/Painting%20the%20Current%20Picture%202016.pdf>)

Problem-solving courts evolved from the realization that many criminal courts had become revolving doors for individuals with mental and substance use disorders and trauma histories who might be better served in treatment. Along the way, judges that serve in problem-solving courts have become first responders and crisis interveners. The courts themselves help fill gaps in services for individuals who need mental and substance use disorder treatment, serving, in essence, as an offramp to the criminal justice system.

TABLE 4: Point of entry into problem-solving courts, by type of court, 2012

TYPE OF COURT	PRE-PLEA OR AT CASE FILING	POST-PLEA	POST-SENTENCE OR POST-RELEASE ^a	JUDICIAL ORDER	OTHER ^b
All courts	35.5%	66.1%	35.7%	8.5%	2.4%
Drug	27.1	73.9	44.5	2.1	0.9
Mental health	44.1	73.1	41.1	3.7	0.7
Family	43.3	16.1	12.1	60.7	10.7
Youth specialty	49.5	54.3	11.7	3.2	6.4
Hybrid DWI/drug ^c	24.0	85.4	40.1	1.6	0.5
DWI	14.7	68.4	41.2	2.3	1.1
Domestic violence	72.8	39.1	14.6	15.9	2.0
Veterans	46.3	81.0	27.3	2.5	3.3
Tribal wellness	29.2	83.3	54.2	16.7	0.0
Other ^d	49.2	45.8	36.7	7.5	4.2

Note: detail may be more than 100% because multiple responses were allowed. Percentages based on 96.6% response rate.

^aIncludes entry after violation or revocation of parole.

^bIncludes acceptance on a case-by-case basis, post-referral from outside agency, entry after child adjudicated dependent, and after admitting to impaired ability to care for a child.

^cHandles alcohol- or drug-dependent offenders also charged with a driving offense.

^dIncludes other courts not shown

Source: Bureau of Justice Statistics, Census of Problem-Solving Courts, 2012.

Problem-solving courts share common goals and objectives, which include being led by a judicial officer who applies the social science of therapeutic jurisprudence. Unlike traditional courts of general jurisdiction, this model includes a specialized docket. Although court models may differ, common fidelities include individual clinical assessments, treatment planning and court oversight, typically from a diversionary approach.

Using the best evidence-based practices, problem-solving courts are trauma-informed and culturally sensitive. Judges act as conveners for a broad group of community stakeholders, including those from the behavioral health care system, who come together to develop treatment plans that are person-centered, trauma-informed and strengths-based. Most courts use an incentive/sanction approach, with the goals of improving public safety, increasing positive health outcomes and reducing recidivism.

Through a collaboration of trained stakeholders and court staff, the impact of childhood trauma, adverse childhood experiences and/or identification of emotional disorders for youth and/or adults are typically reviewed to evaluate not only treatment needs, but also matters of risk and accountability. The legal system across the spectrum — from family/juvenile courts to domestic violence, truancy, veterans'

mental health and DWI courts — may be viewed as early interveners in the identification of potential dangerousness (Shauhin, 2007).

The legal system across the spectrum — from family/juvenile courts to domestic violence, truancy, veterans' mental health and DWI courts — may be viewed as early interveners in the identification of potential dangerousness (Shauhin, 2007).

Law Enforcement Training and Co-responder Models

In many parts of the country, local, state and federal law enforcement officials are being trained in how to respond to calls that involve people with serious mental illnesses. They are trained in how to identify mental health problems, respond appropriately and de-escalate a situation that may lead to violence. Programs include Mental Health First Aid, Crisis Intervention Team (CIT) training and motivational interviewing. There are currently nearly 3,000 Mental Health First Aid instructors with the public safety designation. They have trained 200,000 officers to date (including patrol, intake, corrections, warrant, court staff, etc.) in about 500 departments nationwide.

The goal is for officers to work collaboratively with an individual and with their partners in mental health to defuse a situation and find help for a person who may not belong in the criminal justice system. For example, in Pittsburgh, law enforcement officers have access to a mobile app that links them with mental health crisis resources and also walks them through an appropriate response to a person who may be experiencing a mental health crisis.

More formal collaborations include the Community Mental Health Liaison program in Missouri, in which master's-level clinicians with community mental health centers work directly with law enforcement. In this co-responder model, every law enforcement officer in Missouri has access to these clinicians, who can help an officer assess a person and refer them to appropriate treatment. This moves the intervention upstream and helps the person avoid coming into contact with the criminal justice system.

Mobile crisis teams in many communities and states develop a liaison with law enforcement. Less formally, mental health center staff may ride along with local law enforcement. This makes them available should police encounter a mental health crisis situation.

In Massachusetts, a specialized law enforcement training at the academy level fostered numerous multi-agency collaborations to help police be better equipped to manage crises, all while co-responder, CIT and innovative diversion strategies were being developed across the state.

Involuntary Commitment

Civil commitment is a legal mechanism to treat patients regarded as mentally ill and potentially dangerous, even over their objection. This is most commonly done by admitting patients to mental hospitals or the psychiatric units of general hospitals. In addition, many states have statutes providing for involuntary outpatient commitment, which may be an option for someone who has severe mental illness and is thought to be at serious risk for violence or harm to themselves but does not require hospitalization. Swartz et al. (2010), a study of New York State's Kendra's Law, found that with the appropriate resources devoted to community treatment, involuntary outpatient commitment for a narrowly defined population can reduce hospitalization and length of stay, increase receipt of psychotropic medication and intensive case management services and promote greater engagement in outpatient services. Yet, court-ordered treatment is not a total solution — some individuals at risk for violence will not meet the mental health criteria and court-ordered care does not mean full adherence. Moreover, the cumbersome legal process that is warranted and the time constraints on mental health providers have resulted in this mechanism being underused.

Others argue that voluntary treatment is always preferred (Beauchamp & Childress, 2013; Saks, 2017). Involuntary inpatient commitment may not be the panacea some would hope for if the person cannot be held beyond the initial several days that a court order allows. Civil commitment, whether inpatient or outpatient, is a complicated intervention and it is not clear that it could be an approach to a mass shooter, or even firearms violence in general, though it could be helpful where mental illness is present and there is a clear risk of harm to self or others (Pinals, 2016).

MEDIA AND MASS VIOLENCE

Since the first highly publicized American mass violence event in the 1960s — the Texas Clock Tower shootings in 1966 — the media has played a critical and sometimes controversial role in how these events are viewed and filtered and the social and policy mandates proposed to prevent them. The following section is based on information provided to the Expert Panel on Mass Violence by Stephen Fried, author, investigative journalist and adjunct faculty at the Columbia University School of Journalism.

Media coverage may be problematic for several reasons:

- Media portrayals of the role of mental illness as a cause of violence are exaggerated (McGinty, Webster, Jarlenski, & Barry, 2014).
- Media portrayals of the violence/mental illness intersection drive stigma.
- Overstating the role that mental illnesses play in mass shootings further increases harmful stigma (Clement et al., 2015; Siltan, Flannelly, Milstein, & Vaaler, 2011).
- It has been suggested that media coverage of mass shootings can be correlated with tactical mimicry (imitating techniques) and temporal clustering (increased frequency after an index event) (Jetter & Walker, 2018; Towers, Gomez-Lievano, Khan, Mubayi, & Castillo-Chavez, 2015).

As soon as expanded live coverage was added to traditional reported and edited stories in print, radio and television, conversations began about how mental illness was portrayed and discussed by reporters and pundits, the experts who were consulted to comment on points (for which there is substantial debate in the unfolding mental health literature) and how media coverage could lead to contagion. These dynamics have become increasingly challenging with the proliferation of 24-hour cable news and the internet — much of which goes out immediately live — and the reduction of some traditional reporting staffs. While these changes affect all news coverage, they are especially challenging for the coverage of mental illness, in general, and the coverage of emergencies that may or may not involve mental illness, in particular. Before many facts can be gathered, real-time speculation of the role of mental illness — by reporters, pundits and mental health professionals with little concrete information — can create problems and lead to unjust characterizations of all people with mental illness, as well as unfair speculation about the links between violence and mental illness.

In critiquing the media, however, it is important to differentiate between live interviews on television and produced, edited pieces in print, online and for radio and television broadcast. It is also important to note the irony that while there is more discussion than ever about mental illness in national and local media during mass violence events (and suicides of well-known people), there is often a paucity of coverage the rest of the time. The scant coverage is sometimes shaped by ideological bias about the nature of mental illness and the fields that are charged with understanding and treating it. Rather than an emphasis on a spectrum of mental well-being, often biased views support an “us vs. them” dichotomous approach.

When a mass violence event unfolds, reporters look for credible sources. They might reach out to a local mental health provider, a provider agency, the state mental health authority or an organization such as the American Psychiatric Association or the American Psychological Association. Some of these organizations provide media training to their staff and members so they know who should respond and what they prefer their initial and ongoing response to be. Typically, after any event involving mass casualty, the initial response is one of sympathy and shared solidarity.

But subject matter experts may have an opportunity to help educate the media and the public about mental illness. Even if the perpetrator does turn out to have mental illness, experts can use their airtime to provide a framework for understanding these rare but disturbing events and offer some general information about mental illness treatment and services and the problems caused by lack of access to them. They can also attempt to dispel myths about how common it is for mental illness to lead to violence. Further, experts can provide valuable information to the community about mental health resources that may be available to help deal with resulting trauma in the aftermath of a significant violent incident.

Some organizations have prepared position statements on such hot-button topics as firearms and mental illness (see Resources Appendix for examples) that allow them to speak with a clear and consistent message.

Often, factual distinctions can impact decisions about whether and how to speak to the media. For example, the perpetrator may be a person with no known mental health history, a person with a known or newly revealed mental health history (treated privately or within the public system) or a person with a vague mental health history. Clearly, providers have confidentiality limitations, including HIPAA and 42 CFR Part 2, if the perpetrator has been in their care. However, journalists are not bound by HIPAA, patients and their families are allowed to break confidentiality in speaking to the press and the question of whether or not a caregiver should have broken confidentiality in a case where a patient made violent threats is a fair subject for coverage.

Clinicians also are bound by the ethics of their profession, which stipulate that they should not break the confidentiality of their patients (without their informed permission). They also should not speculate on diagnoses for people on the public stage about whom they have no direct knowledge (as detailed in the “Goldwater Rule,” promulgated by the American Psychiatric Association after a public figure questioned how a psychiatrist could opine on his diagnosis without having a formal professional role or examination to do so). Even with these ethical standards, some mental health professionals will speak out. Although these individuals might not be speaking on behalf of their profession, since they are credentialed and have expertise, journalists and the public will likely interpret their personal opinions as an authoritative position on certain mental health issues. This can lead to the dissemination of potentially biased or false information and potentially add to the confusion around mental health stereotypes, patients with mental illnesses and the mental health profession.

As news about a mass shooting event unfolds, response from the mental health community will change over time. While the initial focus may be on the shooter and the victims, the ongoing response will focus on the needs of the broader community. Here, mental health organizations can be a significant resource. Many have amassed materials for dealing with the aftermath of a traumatic event. For example, the American Academy of Child and Adolescent Psychiatry has prepared information for schools to help young people who may be exposed to violent extremism. Other sources of information include the Substance Abuse and Mental Health Administration’s Disaster Technical Assistance Center; the National Child Traumatic Stress Network; the American Academy of Pediatrics, which has policies, recommendations and resources, including a coping and adjustment to disasters webpage; the Coalition to Support Grieving Students; and the National Center for School Crisis and Bereavement. See the Appendices for additional information.

Working with Reporters

Studies of reporting on mass violence show that the biggest differences in how stories are covered include whether or not the killer survived the incident, the ethnicity of the killer and the age and ethnicity of the victims. In a recent study, Silva & Capellan (2019) found the following:

“The most common mass public shooting characteristics include perpetrators that are middle-aged, white and nonideological, as well as incidents that have relatively low victim rates, occur most commonly in the workplace and only involve handguns. Despite this, the media highlights mass public shootings involving perpetrators that are younger, Middle Eastern and ideological, as well as incidents involving higher victim rates, in non-workplace settings, with a combination of weapons.”

There are few formal guidelines for media coverage of mass shooting events. The ones that do exist (see <https://www.reportingonmassshootings.org/>, created by SAVE — Suicide Awareness Voices of Education) are largely based on recommendations for reporting on suicide (a more common event than a mass shooting) and they are voluntary and subject to wide interpretation. These guidelines emphasize making sure the perpetrator(s) are not glamorized and advocating that the victims, police and other first responders get the media’s attention. Following these guidelines is easier said than done, of course, especially when the biggest open questions are: Who did the killing, how and why?

Just as in suicide situations, guidelines emphasize the need to not sensationalize the acts or perpetrators. Suicide reporting guidelines sometimes insist the means of suicide not be reported at all for fear of contagion; mass shooting guidelines sometimes suggest the perpetrator not even be named, or his or her photo printed or broadcast. More important, guidelines suggest making sure that emergency contact information for an organization that can render assistance is included in any stories about the subject that might be considered triggering. Some organizations now offer “trigger warnings” at the beginning of a story or broadcast.

While recognizing the risk of contagion from stories concerning suicides or mass violence, it would be difficult to actually restrict media coverage the way some of these guidelines suggest. And, given the proliferation of information on social media — sometimes before journalists even get it — one could wonder if asking a reporter not to report something will really keep it from the public.

Implicit in any guidelines — and any teaching of journalists about covering such stories — is that the journalist does everything possible to get the mental health reporting right, which is trickier than it seems. Getting actual information about a perpetrator or victim, what treatment they may or may not have been getting, how compliant they were, whether or not they had family support for treatment, what their treating professional thinks, etc., is very difficult even when reporters have the luxury of time. Some journalists believe that if untreated or improperly treated mental illness is part of the story, it needs to be communicated to reporters and they must cover it fairly and compassionately. On the other hand, mental health professionals and advocates, and even personal acquaintances, might object to this level of detail in reporting as invasion of privacy.

While mental health professionals may debate whether or not they are able to help a journalist get detailed information (which could mean nothing more than suggesting the family request treatment records), there is no debate that more and better information is the key to accurate stories. Journalists who want to do evidence-based reporting on mental health care are encouraged to ask individuals or family members if they are willing to ask for their own or their family member’s medical records, rather

than use the memories of primary and secondary sources to detail facts about care. Sometimes it is only possible for journalists to offer true perspective once some time has passed and sources who initially would not agree to be interviewed change their minds. One of the best examples of this would be the profile of Adam Lanza's father (Solomon, 2014).

Journalists always try to do fair and balanced stories; when it comes to mass shootings, there are many definitions of fair and balanced that are based on the mental health politics of the sources (psychiatrist sources often focus on medical treatment issues and failures; psychologist and social worker sources often focus on social issues). Often these ideas are being injected into coverage — especially the instant broadcast coverage — to fill time until more facts emerge.

Finally, recognition must be paid to the fact that covering these events can be traumatizing for the journalists themselves, just as it is for the first responders and the community as a whole. Journalists, like many others in our community not directly impacted by the event, are often close to the periphery of these traumatic experiences and may be considered secondary victims.

CONCLUSIONS

The following conclusions and recommendations were derived from the members of our workgroup, relevant literature and discussions among workgroup members and editors. They should not be construed as the position of any association represented by individual experts and may not reflect the personal or professional views of all individuals in the expert panel.

1. Mass violence is not a major cause of death or injury in statistical terms, even though such incidents are increasing in number and frequency in the United States. Nevertheless, they receive extensive media attention, elicit strong emotional reactions in the population and are powerful motivators for government officials. Consequently, this disturbing phenomenon constitutes a major social and public health problem for our country.
2. Mass violence occurs in many, if not all, countries but is more common, inflicts more casualties and more often involves firearms in the United States.
3. While people with mental illness account for a small proportion of the violent crime in the United States, they perpetrate a somewhat larger portion of mass violence crimes.
4. Having a mental illness like schizophrenia, bipolar disorder or severe depression does not automatically make a person a high risk for perpetrating mass violence. At the same time, the nature of their symptoms, whether they are effectively treated, and other factors in their lives (drug use, family or workplace conflict, access to weapons) can increase their potential for such behaviors.
5. Perpetrators of mass violence may be motivated by mental distress from life events and circumstances or by the symptoms of mental illness. These are not the same and thus require different modes of detection and prevention. At present, our current health care delivery system is not designed to address the causes or detect and provide interventions for people at risk for mass violence behavior.
6. Mass violence is a societal phenomenon that is amenable to actions that could reduce its frequency; this requires cooperation among multiple national systems and institutions, including the health care, law enforcement, judicial, correctional and school systems, as well as government and community leaders and officials.
7. Legislation that restricts firearms, which has been enacted in some states (as discussed on pages 21–27), is associated with moderately reduced mass violence.
8. Profile-based screening, even when coupled with individual clinical evaluation, cannot precisely predict who and when specific people will perpetrate mass violence, but research to improve methods of prediction and intervention are ongoing and progressing.
9. Additional resources for research and interventions are needed in communities, in general, and for the educational and health care systems, in particular, to identify and provide assistance to people who are experiencing extreme emotional distress and/or experiencing symptoms of mental illness that may increase their violence risk and who have ready access to firearms.

RECOMMENDATIONS

Based on the review, discussion and analysis of published information by the National Council Expert Panel on Mass Violence, the following recommendations were made. These recommendations may not reflect and should not be construed as representing, the views of each individual on the expert panel or the organizations to which they belong. Rather, these recommendations are derived from the National Council Expert Panel on Mass Violence process for the purposes of this paper.

General Recommendations

- Identify root causes of mass violence and develop strategies to alleviate them, instead of focusing only on quick fixes downstream from the sources of the problem.
- Mental health providers and advocacy groups must acknowledge the role mental illness plays in mass violence and support efforts to prevent the portion of mass violence perpetrated by people with mental illness.
- Mass violence should be considered a public health emergency similar to an anticipated strain of influenza or a contaminated food supply. Efforts to address this should include:
 - Orient and align societal institutions and stakeholder organizations to the need to stem the frequency of, and eliminate the causes of, mass violence as perpetrated by people who are mentally ill and mentally distressed.
 - These institutions may include, but are not limited to, health care providers, law enforcement, judicial and criminal justice personnel and educators.
 - These institutions can be better served by providing information and protocols for surveillance, threat assessment, engagement and establishing means for referral to mental health care providers.
 - Ensure access to quality mental health care for all people. This includes establishing:
 - An adequate mental health workforce.
 - Geographic distribution of facilities.
 - Reduction of stigma, lack of awareness and other barriers to seeking care.
 - Ensure that mental health care benefits are included equitably in health insurance coverage (as mandated by the Mental Health Parity and Addiction Equity Act).
 - Implement proactive screening for mental illness and promote mental health.

Recommendations for Health Care Organizations

The National Council Expert Panel on Mass Violence made a number of recommendations for health care organizations, including those that provide mental health care services to people who have mental and substance use disorders and developmental disabilities. Many of these require funding that is not currently available and will not be achievable without payment methodologies such as the Certified Community Behavioral Health Clinic prospective payment system, which covers the actual costs of the interventions, without compromising funding for traditional mental health and substance use services or integrated health care models. Specific recommendations follow.

- Provide training to mental health professionals in threat assessment (including suicide) and educate them about the protocols to follow when patients exceed a threshold of risk. Help establish and participate in community threat/risk assessment and management teams. These multidisciplinary teams should include representatives from mental health, security, human resources, legal and law enforcement.
 - Implement ongoing quality improvement around the issues of violence risk assessment and threat assessment and management.
 - One-off trainings will not be successful, especially with turnover in behavioral health and health care organizations.
 - Ensure continuity of threat management across silos by promoting case conferencing and successful handoffs from one agency to another for individuals who may be at risk for violence.
- Train staff in lethal means reduction. This is a rational strategy for lethal violence reduction and very helpful in combating suicide.
- Add required professional development training as part of initial and continued professional licensure and for accreditation of programs and facilities providing behavioral health care, so that these professionals know how to talk to clients or patients and their families about firearms safety.
- Establish crisis intervention services staffed by personnel trained in threat assessment and management of distressed, symptomatic and potentially dangerous patients including:
 - Use crisis hotlines to help determine whether someone is at risk for self-violence and/or violence toward others. Train the professionals and volunteers who staff these lines in behavioral/violence risk assessment models using evidence-based research about risk factors for violence among those who are in crisis. Train them on how to activate follow-up threat assessment and preventive services.
 - Provide mobile crisis services that make home visits in the community.
 - Provide Crisis Intervention Team (CIT) training.
 - Ensure that health care provider organizations have adequate mental health staff or access to or means of referral to mental health providers. Implement the recommendations of “The Psychiatric Shortage — Causes and Solutions” (National Council Medical Director Institute, 2017).
- Train mental health personnel in the use of legal mechanisms such as assisted outpatient treatment and outpatient commitment. Train health care personnel and educate patients in the use of mental health or psychiatric advanced directives, including Ulysses contracts, to aid in treatment decisions during times of exacerbation of mental illness.
- Provide primary care support, e.g., community psychiatry access programs, such as the one in Massachusetts and similar models in other states, with urgent psychiatric consultation available for primary care clinicians on the frontlines of addressing mental health and potential risks in children and adolescents (http://web.jhu.edu/pedmentalhealth/nncpap_members.html).
- Prepare staff for vicarious trauma and compassion fatigue. Provide resources for self-care rituals and support for staff needs.

- Educate health care providers in HIPAA policy, which allows sharing information when a person presents a risk of harming others. Keep HIPAA training brief and simple.
- Train personnel and establish programs in the use of mechanisms and services to enhance treatment adherence, including:
 - Increase the number, capacity and use of Assertive Community Treatment teams
 - Train providers in medication adherence interventions as described in “Medication Matters: Causes and Solutions to Medication Non-Adherence” (National Council Medical Director Institute, 2018).

Recommendations for Schools

While mass violence has and can occur in numerous venues, the National Council Expert Panel on Mass Violence focused on the educational system and made recommendations about what schools should and shouldn't do to create an environment of safety and emphasize violence prevention. Many of these recommendations, such as the need to conduct evidence-based shooter drills, are not unique to schools but apply to other venues (e.g., workplaces), as well. Specific recommendations follow.

- Revise zero-tolerance policies to avoid suspensions and expulsions as they are ineffective and harmful practices that may increase the student's isolation, alienation, feelings of injustice and sense of hopelessness, which increases risk. Replace zero tolerance with interventions that examine the circumstances of concern and increase engagement. Teachers and students should make efforts to include students who exhibit social shyness, awkwardness, unique ideas, mannerisms or interests. All concerns should be taken seriously; this does not mean that a child should be automatically expelled for behavior that is not considered dangerous (e.g., bringing a plastic knife to school) or that an employee will be fired automatically for yelling at someone in the workplace.
- Schools should be resourced to provide in-school mental health and substance use evaluation and treatment (or means for referral) for students and to promote better school environments.
- Avoid measures that create a correctional facility-like atmosphere such as bulletproof glass, armed security guards and metal detectors. These are costly and, as physical reminders of potential danger, can create a threatening atmosphere and an environment not conducive to education. Less heavy-handed measures such as limited entry points into the school and surveillance cameras can be just as effective and less intrusive.
- Emphasize and train staff in interpersonally based and emotionally supportive prevention measures, such as Youth Mental Health First Aid, which have been shown to reduce violence and enhance positive educational school environments.
- Establish threat/risk assessment and management teams. These multidisciplinary teams should include representatives from mental health, security, human resources, legal and law enforcement.
- There is no current evidence regarding the efficacy of arming teachers as a means to reduce fatalities from mass violence and there are significant concerns about possible unintended and unfortunate psychological and physical consequences of such policies.
- Schools should not emphasize high-stress security drills. Some security drills are fine and recommended, but those in which students are not informed that they are participating in a drill, can be traumatizing. Shooter drills should be no more stressful or realistic than fire drills. Trauma-informed drill design and the availability of counselors for students and staff should be considered.

The National Association of School Psychologists (NASP) and the National Association of School Resource Officers (NASRO) have published a set of “Best Practice Considerations for Schools in Active Shooter and Other Armed Assailant Drills” (NASP & NASRO, 2017).

- Schools should endeavor to ensure an environment in which students feel comfortable coming forward to a responsible adult with information regarding a threatening situation from any source. Schools should create a positive school environment and should be required vis-à-vis a set of national standards to assess their schools for physical and emotional safety.
- Schools should endeavor to implement universal social-emotional learning and add mental health to the school health curriculum. A program such as Typical or Troubled (see the Appendices for more information) is an example of curricula that can help schools be more prepared.
- Schools should endeavor to train staff in how to properly respond to students who provide them with information about a threatening or disturbing situation and selected staff should be trained on how to deal with actual threats.
- Schools should endeavor to train staff and other school personnel in how to address the impact of trauma and bereavement on young people and their learning; likely reactions they may see; practical strategies for providing psychological first aid, bereavement support and academic accommodations; and indications for referral for mental health services.
- We recognize that many of these recommendations add additional functions to the traditional educational mandate and scope of services of schools and represent mission creep. Therefore, we endorse the following recommendation from the National Commission on Children and Disasters Teacher Training and other groups, including the Sandy Hook Advisory Commission:

Congress and the U.S. Department of Education should award funding to states to teach educators basic skills in providing support to grieving students and students in crisis and establish statewide requirements related to teacher certification and recertification.

Recommendations for Communities

The National Council Expert Panel on Mass Violence considered the special needs of those who might be at enhanced risk of perpetrating violence and made the following recommendations.

- Create and support broad community partnerships that include behavioral health, law enforcement, schools, the faith and medical communities, etc., to strengthen the connections among those systems that interact with individuals who have mental illnesses and addictions and may be at risk for committing violence.
- Do not focus solely on people with a prior diagnosis of schizophrenia, bipolar disorder or other serious mental illness. Communities should involve clinicians in prioritizing people with narcissistic and/or paranoid personality traits who are fixated on thoughts and feelings of injustice and who have few social relationships and recent stresses, as this is the higher-risk group.
- Establish a workplace culture of responsibility and safety in commercial establishments and service organizations so that employees feel comfortable reporting their concerns about a colleague. Educate employees about warning signs and risky behaviors. Ensure that they understand the response will be one of caring and not punishment, even if the individual has to be removed from the workplace temporarily, for example, to seek appropriate mental health treatment.

- Institute a mandatory employee assistance program evaluation for employees threatening others.
- Establish community threat/risk assessment and management teams. These multidisciplinary teams should include representatives from mental health, security, human resources, legal and law enforcement.
- Ensure close collaboration between domestic violence services and behavioral health providers. Prioritize people with a prior history of domestic violence for threat assessment and management.
- Encourage education on the role of substance use in violence, rather than emphasizing mental illness as the single most relevant cause of violence. Provide information about co-existing issues that can trigger violence but may not be causal, given the complexity of violence in society.
- Promote health and wellness, including social-emotional learning, resiliency and skill building in community-based settings (including schools, employment, religious, primary health care) as population-wide goals.
- Expand early childcare and home visiting programs that are known to reduce abuse and promote school readiness.
- Ensure that communities have adequate, accessible, quality, comprehensive mental health services and that people are encouraged to seek assistance when they or their family members are in need.
- Provide training in Mental Health First Aid, which teaches the skills to respond to the signs of mental and substance use disorders. This can be modeled on similar public health programs to educate the public in lifesaving and health promoting procedures, including cardiopulmonary resuscitation and the Heimlich maneuver.

Recommendations for Judicial, Correctional and Law Enforcement Institutions

The National Council Expert Panel on Mass Violence considered the special needs of judicial, correctional and law enforcement institutions and made the following recommendations.

- Help law enforcement and other first responders be better equipped to manage people who are mentally disturbed and other threatening individuals, including better training of law enforcement and more involvement of mental health professionals in threat assessments conducted by law enforcement and implementation of red flag laws.
- Help correctional system officers and employees be better equipped to manage people who are mentally disturbed and other threatening individuals, including better training in the recognition and management of mental illness and more on-site involvement of mental health professionals and referral options or access to telepsychiatry consultations.
- Develop a basic educational toolkit for judges on the nuances of risk assessment, the role of trauma and the need for additional supports for individuals who may pose risks — particularly in juvenile courts, veterans' courts, mental health and drug courts, domestic violence courts and family courts — but also for traditional (non-problem-solving) courts, such as through the Judicial Psychiatry Leadership Initiative. Help judges understand such issues as prevalence of mental illness, cautions about over-assuming risk of violence for people with mental illness and consideration of other risk factors that may be relevant and the usefulness of programs that allow for reporting their concerns

(“if you see something, say something”), as well as the importance of long-term monitoring and follow-up for people at elevated risk.

Recommendations for Legislation and Government Agencies

The National Council Expert Panel on Mass Violence made the following recommendations for legislative and government agencies.

- Pass legislation to increase the availability of threat assessment training at the local, state, tribal and national levels. Many, but not all, panel members endorsed passing and funding H.R. 838/S. 265, the Threat Assessment, Prevention, and Safety Act, introduced in the 116th Congress.
- Where threat assessment is established, a payment methodology or direct funding for threat assessment and management should be provided. Such payment methodology should not compromise funding that exists for other critical ventures and should not be construed as solely related to mental health and taken out of mental health budgets. Consider raising this issue to the Interdepartmental Serious Mental Illness Coordinating Committee for funding by the U.S. Department of Justice, extension of the Joint Terrorism Task Forces and fusion centers, Centers for Medicare and Medicaid Services and the Substance Abuse and Mental Health Services Administration.
- Promote expansion of the Certified Community Behavioral Health Clinic (CCBHC) model because these clinics are required to provide extensive crisis response capability and the CCBHC prospective payment model can support the development and operation of a multidisciplinary threat assessment team. Amend CCBHC to allow for developing and participating on local community threat assessment and management teams, where appropriate.
- Award funding to states to teach educators basic skills in providing support to grieving students and students in crisis and establish statewide requirements related to teacher certification and recertification.
- Require training in the evidence-based assessment of potentially lethal violence toward self and/or others and credentialing in relevant behavioral health disciplines.
- Enact state red flag or gun violence prevention laws that will permit police, family or anyone with a relationship to a person (e.g., clergy, educator, employer, coach, colleague, neighbor or other person in a position to be aware of the gun owner’s statements and actions) to petition a state court, judge or magistrate to order the temporary removal of firearms from an individual for whom there is sufficient evidence that he or she poses a danger to themselves or others.
 - The determination to issue the order should be based on statements and actions of the firearms owner, rather than labels or classes of individuals.
 - The removal should be time-limited, subject to renewal after rehearing and with a clear process and criteria for restoration. This process should be independent from any other civil actions that may or may not be temporally related. It should not be discriminatory in its application or processes and not dependent on an individual’s health status.
 - Recommend that all officers executing these extreme-risk protection orders receive CIT or other de-escalation skills training, with knowledge of resources available for the individual.

- Fully implement the existing federal background check requirement. Expand and create more rigorous background checks for firearms purchases, including closing loopholes where background checks are not required, such as private sales or inheritance of firearms, while protecting emergency transfers from people at imminent risk of suicide or violence to trusted friends or family members.
- Remove statutory complexities and budget restrictions that restrict firearms violence research and the extension of its funding through public agencies.
 - Publicly and widely clarify that federal funding is permitted to research firearms injury and prevention, especially as it relates to mass violence.
 - Provide adequate funding for research and best practices on firearms safety, access and prevention for such agencies as the National Institutes of Health and the CDC.
 - Remove the Dickey Amendment limits on firearms injuries research and earmarking federal funds specifically for this purpose.
- Enact and enforce criminal and/or civil sanctions for people who knowingly provide firearms to people already lawfully barred from possession of a firearm.
- Enact mental health Good Samaritan laws to protect from civil or criminal liability individuals making good-faith reports to law enforcement or others about people whose conduct and/or statements raise concerns about risk to self and/or others.
- Require federal, military and state and local agencies to report circumstances that disqualify an individual from legal gun ownership to state and national (NICS) databases and clarify and broadly disseminate these disqualifying circumstances.
- Evaluate the effectiveness of state statutes that prevent those who have misdemeanor violent crime convictions from owning firearms.
- Consider adding a question about homicidal ideation, as well as related questions about the comfort of telling an adult in the school about concerns of homicidal ideation in a peer, to the Youth Risk Behavior Surveillance System (YRBSS). YRBSS is an annual survey conducted by the CDC that monitors six categories of health-related behaviors that contribute to the leading causes of death and disability among youth and adults, including behaviors that contribute to unintentional injuries and violence. The survey currently asks about suicidal ideation.
- Amend 42 CFR Part 2 and FERPA to explicitly allow sharing information when a person presents a risk of harming others and implement national training.
- Amend HIPAA and 42 CFR Part 2 to supersede state laws for the purpose of sharing information when a person presents a risk of harming others. Currently, some states have stricter laws that may prevent sharing information when a person presents a risk of harming others and create confusion regarding what is permissible sharing.

Recommendations for Research

The National Council Expert Panel on Mass Violence made a number of recommendations about the need for additional research on such topics as firearms-related violence and risk. In many cases, the goal is to use policy development as a laboratory for research. While there is a need for evidence-based policy, there is also a need for policy-informed research. Specific recommendations follow.

- Support research on the nature and factors that contribute to mass violence, including neurobiological, psychological and sociological factors.
- Support research on methods and instruments for identifying and predicting perpetrators of mass violence.
- Support research on methods of intervention and prevention of mass violence.
- Support the development and dissemination of standardized assessment tools for violence risk.
- Support research into copycat and contagion phenomena.
- Create a standardized, mandatory investigation/analysis of each mass violence incident, conducted by a multiagency team led by the Department of Justice. Individual case results should be aggregated in a database that allows capturing and differential coding of inchoate and complete attacks, high lethality and low lethality/high morbidity in a way that allows different hypotheses to be tested against different data mining and definitional strategies. Provide funding for rigorous academic studies with the data created by these primary studies.
- Evaluate extreme-risk protection orders in states that have enacted them to assess both the process of implementation and their effectiveness.
- Track and research individuals that have incomplete attacks or plans thereof and their motivations. Obtain data on events averted and those individuals who are high risk but don't act.

Recommendations for Working with the Media

The National Council Expert Panel on Mass Violence considered the role and the impact of media in its coverage of mass violence events and offered recommendations for mental health professionals working with reporters. Specific recommendations follow.

- Build close working relationships with media representatives ahead of any crisis situation.
- Train behavioral health staff who will be responsible for responding to the media. Develop a toolkit and protocols about who should respond to what type of request and what they should say about such topics as the role of mental illness, gun rights, involuntary outpatient commitment, etc. Develop these messages well in advance of a tragic event. A resource such as “Responding to a High-Profile Tragic Incident Involving a Person with a Serious Mental Illness” (NASMHPD and CSG Justice Center, 2010) can help. Also, many guilds, such as the American Psychiatric Association, offer media training. In many organizations, a crisis communications team will handle media requests during a mass violence incident.
- Mental health professionals should use media opportunities even when provided by tragic events to advocate for better mental health care services; greater access; and elimination of barriers, disparities and stigma.
- Choose and disseminate existing guidance, such as that offered at <https://www.reportingonmassshootings.org/>, and encourage reporters to follow these guidelines.
- In addition to media guidelines, develop or use existing guidance for messaging through the media to victims, family members and the broader community about coping with traumatic incidents and mental health in general. Use materials such as those in Appendix II to help families understand how to talk to their children about violence.
- Do not try to answer questions about why a mass shooting happened. Talk about the role of treatment in helping people at risk of violence. Highlight the fact that most people with mental illnesses will never become violent. Speak to untreated or undertreated mental illness, in combination with other risk factors.
- Share information with law enforcement partners in real time so they can respond accurately and in a timely manner to reporters’ inquiries.
- Work with the media to develop guidance for the general public on risk factors for violence. Help the public understand the importance of “see something, say something.”

SUMMATION

Mass violence is a pernicious social pathology that is increasing in the United States and becoming more deadly largely because of the availability of firearms. The good news is that we have the means to limit if not stop it. The bad news is that we have not taken the necessary steps to do so. We lack the social and political will, not the knowledge, capacity or means.

While much remains to be learned about the root causes of mass violence biologically, psychologically and socially, additional progress can be made through research. This report, composed by representatives of key stakeholder organizations that directly interface with mass violence, provides a template with which to address and alleviate this scourge on American society.

Now is the time to mobilize and this is the way to act.

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ONLINE RESOURCES

Documents

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National Center for School Crisis and Bereavement

<https://www.schoolcrisiscenter.org/>

National Child Traumatic Stress Network

<https://www.nctsn.org/>

National Mass Violence and Victimization Resource Center

<http://www.nmvvrc.org/>

Substance Abuse and Mental Health Administration, Disaster Technical Assistance Center

<https://www.samhsa.gov/dtac>

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RESOURCES

Offering Support Following Community Violence: How Health Plans Can Help

Kimberly Purinton, LCSW, Clinical Training Manager, Centene Corporation

The Stoneman Douglas High School tragedy quickly inspired a spirit of helping and service toward survivors in the community. As many do in the aftermath of senseless trauma and loss, Sunshine Health, a subsidiary of Centene Corporation, considered various ways it could best offer support while not intruding upon the sanctity of the grieving process for so many. Leadership immediately came together to assess staff needs and to organize thoughtful implementation of select larger scale assistive measures prudent for a health plan to offer. The Substance Abuse and Mental Health Services Administration (SAMSHA) principles offered guidance in decision-making, detailing how survivors or witnesses of mass violence may go through multiple phases, (acute, intermediate and long term), in which particular emotions, behaviors, and other reactions are fairly typical (Alexander & Klein, 2005; Freedy & Simpson, 2007; Goldmann & Galea, 2014; U.S. Department of Health and Human Services [HHS], SAMHSA, Center for Mental Health Services [CMHS], 2004; Yehuda & Hyman, 2005).

During the *acute phase*, information gathering and stabilization efforts for health plan staff was initiated, as many employees were closely impacted by the event. This included establishing clear, open and frequent communication across all organization levels within the company and offering flexibility and coverage assistance as staff attended to personal needs. Additionally, employees were reminded of various programs and services, including the Employee Assistance Program, which offered enhanced support during this time. Other staff care measures included ongoing psycho-educational webinars and in-person supportive training groups on secondary traumatic stress in anticipation of increased volume of member assistance needs related to the tragedy.

Research emphasizes the critical nature of monitoring the well-being of the impacted community during the acute phase, as well as the best practice of infusing behavioral health interventions into existing community services, as it increases the likelihood of acceptability of an intervention into that population (Goldmann & Galea, 2014; Grills-Taquechel, Littleton, & Axsom, 2011; Hobfoll et al., 2011; Sherrieb & Norris, 2013). Sunshine Health's community outreach response during this phase included instituting a 24-hour crisis hotline and partnering with local behavioral health provider to financially support the stationing of a licensed clinician at the community's Family Resource Center. The clinician provided linkages to vital community resources and crisis support.

During the *intermediate and long term phases*, services that address basic needs were provided by serving lunch for staff upon their first return to campus, as well as refreshments for 3,000 parents, children and school personnel at the parent meeting prior to classes resuming. Research indicated activities, including mental health screenings, behavioral health support, and offering psycho-educational information to affected survivor and responder groups and health care and social service providers in the community (Alexander & Klein, 2005; HHS, SAMHSA, CMHS, 2004; DOJ, OJP, OVC & American Red Cross, 2005), were provided either via the health plan or through existing community resources during all phases. Sunshine Health continues to underwrite the cost of the licensed therapist at the Family Resource Center to this day. Finally, in conjunction with its parent company, Sunshine Health continues to sponsor and facilitate trauma informed evidenced based treatment trainings to support the needs of its provider community as they continue to work with survivors and responders.

As a health plan, Sunshine Health's response has been based in research and guided by and disseminated in large part by existing community services.

PHASE	SUPPORT ACTIVITIES
Acute	<ul style="list-style-type: none"> • provided support by offering enhanced Employee Assistance Program services and work coverage options to affected health plan staff • established 24 hour state-wide crisis hotline available to our members, staff and community • disseminated psycho-educational information and tip sheets to staff, providers and community partners, on responding to community violence and trauma (NCTSN) • utilized social media to maintain communication, offer community support and promote available resources
Intermediate & Long Term	<ul style="list-style-type: none"> • served lunch for school staff upon their first return to campus • provided refreshments for 3,000 parents, children and school personnel at the parent meeting prior to classes resuming • financially support the cost of a licensed clinician at the Family Resource Center, providing linkages to community resources and crisis support • offer psycho-educational webinars and in-person supportive training groups • sponsor and facilitate trauma informed evidenced based treatment trainings to support the needs of our provider community as they continue to work with survivors and responders

Acronyms

CMHS= Center for Mental Health Services

DOJ= Department of Justice

HHS= Department of Health and Human Services

OJP= Office of Justice Programs

OVC= Office for Victims of Crime

SAMSHA= Substance Abuse and Mental Health Services Administration

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RECOMMENDATIONS

For Reporting on Mass Shootings



ABOUT THE RECOMMENDATIONS

The recommendations address how media covers an incident where a person (or a small group) shoots multiple others in a public setting. The tragedies at Columbine, Virginia Tech, Aurora and Orlando are examples of mass shootings. These recommendations are not intended to address gang violence or murder-suicide (i.e. intimate partner violence).

This consensus project was led by SAVE and included national and international experts from AFSP, the CDC, Columbia University, IASP Media Task Force, JED, NAMI-NH, SPRC, and multiple media industry experts.

GENERAL INFORMATION FOR REPORTING

- How you report on violence (mass violence, domestic violence, suicide) may influence and impact others.
- Minimize reporting on the perpetrators as others might identify with or be inspired by them.
- Avoid putting photos of the perpetrator side by side with a victim.
- Use the perpetrator's photo sparingly, especially in follow-up stories, except if police are still looking for the perpetrator or for other victims.
- Avoid reporting that increases misunderstanding and prejudice of mental illness and include information about treatment and prevention. A mental health diagnosis is not necessarily or causally related to violence.
- Do not oversimplify or sensationalize the incident because it may encourage people who may seek notoriety. (e.g. do not say, "The deadliest incident since Columbine.")
- Report on victims and how communities and the nation can mobilize to support victims and prevent future shootings.
- Avoid stigmatizing the community where the incident occurred or the people targeted by the perpetrator.
- Remember that families, including those of the perpetrator, are deeply affected and traumatized by the incident. Be sensitive when conducting interviews.

TOP 3 THINGS WE WANT YOU TO KNOW

1. Research shows that the manner in which media reports on mass shootings can contribute to contagion (copycat behavior). Responsible reporting can reduce risk.
2. The majority of people who live with a mental health condition are non-violent. Also, those who carry out mass shootings oftentimes have not been formally diagnosed with a mental health condition.
3. Responsible reporting on mass shootings can educate the public and reduce the risk of future violence.

HARMFUL MEDIA COVERAGE CAN:

- Provoke copycat incidents by people who may see the perpetrators as models or heroes.
- Further traumatize survivors, families and communities.
- Increase prejudice and stigmatization against people living with a mental illness.
- Deter people who have a mental illness from seeking or accepting help.

HELPFUL MEDIA COVERAGE CAN:

- Educate the public, helping them recognize and respond to individuals who may be considering a violent act.
- Comfort survivors, families and communities – including families of the perpetrators.
- Inform the public about warning signs of distress or potentially violent behaviors.
- Encourage people to seek help for themselves or others who might be at increased risk of harmful acts.

INSTEAD OF THIS

- Reporting that a mental illness caused the shooting.
- Reporting that one problem led to the incident.
- Stating the perpetrator's name frequently.
- Portraying the shooter as heroic, romanticized, a victim, or a tortured soul.
- Including witness statements that the shooter acted "crazy" or "insane".
- Speculating or allowing sources to speculate on the mental health condition of the perpetrator.
- Showing graphic images of the crime scene.
- Speculating on a motive with law enforcement, family, co-workers, etc.
- Showing images of the shooter with weapons or dressed in military-style clothing.

DO THIS

- Report that most who live with a mental health condition are non-violent.
- Explain that many factors contribute to a mass shooting.
- Present facts about the shooter and describe their behavior as illegal and harmful.
- Include witness statements describing what the shooter did in an objective manner.
- Consult experts to comment on mental illnesses.
- Explain that violence is complex and typically involves more than one motive.
- Be sensitive and cautious using visual images.
- Talk about the victims and their stories.
- If using photos of the perpetrator, show only the face and crop out weapons, uniforms and other visual elements that might inspire copycats.

WARNING SIGNS OF MASS SHOOTINGS

- Surveillance behaviors (casing a scene).
- Explicit verbal or written threats about plans to harm or kill others.
- Expressing admiration or identification with another perpetrator of violence.
- Online searches for weapons and obsessions with acquiring large quantities of guns and/or weapons.
- Expressed fantasies or thoughts of engaging in shootings and other violent behaviors.

REPORTING ON A MANIFESTO

- Does using it add to the story?
- Only quote a manifesto, social media or other writings when it adds important information to the story.
- Use drawings and graphic material sparingly. Avoid images that glorify violence.

A NOTE ON SUICIDE BOMBERS AND MASS SHOOTINGS

- There is no such thing as a "suicide bomber" or "suicide attack."
- Suicide is defined as **self-directed** violence (CDC).
- So called suicide bombers are intent on murdering others; consider instead saying "terrorist," "homicide bomber" or "mass killer."

PUBLIC SERVICE

- Include a tagline in your story: "For help with emotional distress and/or suicidal thoughts, call the Disaster Distress Helpline at 1-800-985-5990 or text TalkWithUs to 66746."
- Crisis Text Line: "Text HELLO to 741741."



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