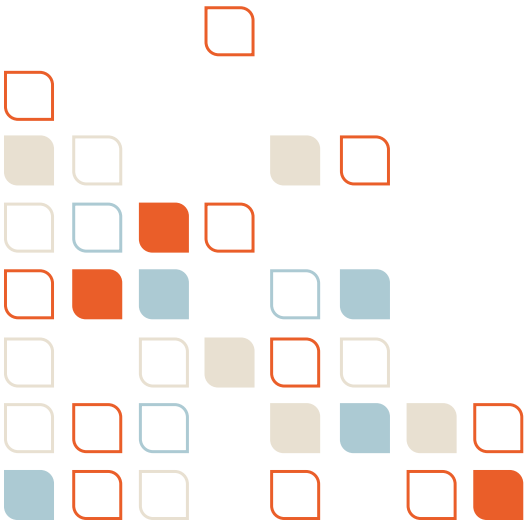
National Council for Mental Wellbeing
Medical Director Institute

Mass Violence in the United States: Definition, Prevalence, Causes, Impacts and Solutions

A CALL TO ACTION

NATIONAL COUNCIL
for Mental Wellbeing

2024



National Council Medical Director Institute

The National Council for Mental Wellbeing is a membership organization that drives policy and social change on behalf of more than 3,400 mental health and substance use treatment organizations and the more than 10 million children, adults and families they serve. It advocates for policies to ensure access to high-quality services. It builds the capacity of mental health and substance use treatment organizations. And it promotes greater understanding of mental wellbeing as a core component of comprehensive health and health care.

In 2015, the National Council's Board of Directors commissioned the Medical Director Institute (MDI) to advise National Council members on clinical best practices and address major priorities in care for mental illnesses and substance use disorders (SUDs). The MDI is composed of organizational medical directors from every region of the country who have been recognized for their outstanding leadership in shaping psychiatric and SUD service delivery.

One of the ways we fulfill our charge is by developing technical documents that highlight challenges at the forefront of mental health and substance use care, providing guidance and identifying practical solutions to overcome those challenges. Prior scholarly reports and white papers include "Advancing Measurement-informed Care in Community Behavioral Health" (2024) and "Quality Measurement in Crisis Services" (2023).

The 2019 report "Mass Violence in America: Causes, Impacts and Solutions" addressed the problem of mass violence (in which mass gun violence plays the major role) in the United States and, specifically, the extent to which mental illness does or does not contribute to this social pathology. In 2023, the MDI decided that an update on the topic had become necessary, as events of mass gun violence have become more frequent, intense and destructive. We hope that further scrutiny, research, education, training and collaboration will lead to more effective solutions.

THE MASS VIOLENCE EXPERT PANEL PROCESS

We convened a panel of individuals with varied expertise pertaining to mental health care and violence — including clinicians who treat people living with mental illnesses and SUDs, as well as administrators, policymakers, researchers, educators, policy champions, law enforcement personnel, judges, parents and payers — for a two-day meeting, during which we conducted an in-depth review and analysis of mass violence, integrating multiple perspectives. Panel members provided input from their practical experience and research, including their unique perspectives on the problem of mass violence. (See Appendix 1 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 met the test of feasibility and effectiveness based on the conclusions of the expert panel.

We engaged a technical writer and co-editors to record the proceedings, compile the panel members' literature submissions and draw on other sources for 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 most substantiated and consistent findings across the literature, while relying on the consensus of the panel members in areas with less empirical research.

The technical writer and co-editors completed a first draft that was circulated to all panel members. The members' written comments and feedback were incorporated into a second draft. This process was repeated until the document was completed, published and distributed in 2019.

The goal of this updated paper is to update the 2019 report, further examine existing data and expertise on mass violence (including mass gun violence), provide more analyses 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 policy groups; state mental health authorities; policymakers in the behavioral health arena; educators; judges; law enforcement officers; and workplace representatives.

A CALL TO ACTION

Mass gun violence is a pernicious social phenomenon that is becoming more frequent and deadly in the United States, largely because of the availability of firearms, insufficient funding for research and program development, and inconsistent use of prevention and harm mitigation programs. We possess the means to limit, if not stop, mass gun violence, but we have not taken the necessary steps to do so. We have the knowledge, capacity and means to address firearm violence and fund training, personnel and research.

While we still have much to learn about the root biological, psychological and social causes of mass violence, we can make additional progress by understanding the challenges we face. This updated report provides practical guidelines and multidisciplinary, collaborative models with which to address and alleviate this scourge on the United States.

Now is the time to mobilize, and this is the way to take action.

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Executive Summary

OVERVIEW

Among advanced countries, the U.S. experiences an astonishing rate of mass violence. Frequently, in the wake of these tragedies, policymakers and the public search for the causes of this violence, raising the specter of mental illness as a major contributing factor. In 2018, the National Council for Mental Wellbeing's Medical Director Institute (MDI) 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 range of stakeholders. A summary of their deliberations, conclusions and recommendations was published in 2019. In 2023, the MDI decided to update this paper to address the rapidly changing parameters and the lack of consistent improvement in rates of prevention, injury and death.

Given that a substantial majority of mass violence occurs via mass shootings — from 2006 to May 2024, shooting victims made up 81% of the 3,057 victims of mass killings since 2006 (Associated Press et al., n.d.) — and that the rate at which mass shootings occur and the number of people impacted are increasing dramatically, this report will focus primarily on mass shootings. As Lopez et al. (2020) note, "Preparedness for mass shootings — deeply traumatizing social phenomena as elusive as they are disruptive — will require an increasingly focused and coordinated effort by the research and practice communities as we move forward." Unified standards of defining mass shootings must be used to inform data collection and develop recommendations for effective and sustainable policies, funding and treatment.

The lack of a cohesive, consistent definition complicates data collection and interpretation, which in turn makes professional and community responses difficult to develop, sustain and measure for efficacy. There are numerous definitions of mass violence, often focused on or limited by the following parameters:

- Numbers of people killed and/or injured
- Circumstances or motivations
- Location and duration
- Number of shooters
- Sources and methods of data collection (Booty et al., 2019)

For this report, we will use the definition of a mass shooting offered by the Gun Violence Archive (GVA) (2023a): "Four or more shot and/or killed in a single event … at the same general time and location not including the shooter."

FINDINGS

Gun ownership remains high: 32% of U.S. adults say they own a gun. Further, the number of gun deaths has increased by 23% since 2019 (Gramlich, 2023). When polled in 2023, about 60% of U.S. Americans (up from 9% in 2022) placed gun violence as a major concern (Gramlich, 2023). The number of guns, however, is not the sole variable to consider when studying the increasing frequency, morbidity and mortality of mass shootings.

It is important to remember that people are more likely to die by suicide with a gun than to be killed in a mass shooting or other type of homicide. Despite the fear and public scrutiny they evoke, mass shootings are statistically rare events. They accounted for less than 0.2% of homicides in the United States between 2000 and 2016, and less than 1% by 2023 (GVA, 2023b.). Even school shootings are infrequent, though deeply tragic.

However, while mass shootings are rare events, they are also increasing in frequency, morbidity and mortality. As reported by the Gun Violence Archive, by the end of 2021, there were 645 mass shooting events, 702 mass shooting deaths and 2,844 injuries. In 2022, there were 689 mass shooting events, 675 mass shooting deaths, and 2,689 injuries. By the end of August 2023, there had been 466 mass shooting events, with 545 deaths and 1,869 injuries. The devastating economic costs and profound trauma for victims, survivors, families and communities suggest that, though these events are infrequent, it is imperative that we increase our understanding of the complex phenomena of mass shootings and diligently seek solutions (GVA, 2023a).

PERPETRATORS SHARE CERTAIN CHARACTERISTICS

While perpetrators of mass gun violence can be categorized by motivation, the characteristics of individual perpetrators cut across demographic, sociologic, cultural and occupational groups. The most frequently observed characteristics of perpetrators are male; having grievances related to work, school, finances or interpersonal relationships; feeling victimized and sympathizing with others whom they perceive to be similarly mistreated; and suicidal feelings of hopelessness and/or indifference to life. They frequently plan and prepare for their attack and share information about the attack with others, though often not with the intended victims. Nevertheless, there is no valid profile of a mass shooter. When assessing a person at potential risk, it is important to recognize that risk is driven by intent and behavior, rather than population characteristics.

MENTAL ILLNESS PLAYS A LIMITED ROLE IN MASS VIOLENCE

Events of mass violence are so terrifying and traumatic that the community responds defensively and demands an immediate explanation. After such tragedies, political leaders often invoke mental illness as the reason for mass violence, a narrative that resonates with the widespread public belief that people with mental illness, 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, Text Revision" provides a catalog of varied brain-related health conditions that impair a person's 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/or refrain from intentional self-injury. While a subset of people perpetrating mass violence have personality disorders or psychosis characterized by paranoia or command hallucinations, substantial evidence indicates that the vast majority 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 people 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. According to most studies, the majority of perpetrators do not have a major psychiatric disorder and the overwhelming majority of people with diagnosable mental illnesses are *not* violent toward others.

While there is a modest link between some forms of mental illness and violence for a few particular conditions, there is no justification for the public's generalized fear of people with mental illness. Having a psychiatric diagnosis is neither necessary nor sufficient as a causal factor for committing an act of mass violence. For that reason, this updated report includes a broader range of considerations and recommendations beyond the subset of mass violence with a link to mental illness.

There is increasing demand to identify potential perpetrators of violence and develop preventive measures. However, there has been insufficient research on the root causes of the problem and insufficient resources to address them.

Such causes include social alienation and social determinants, including deficiencies in the educational system, poverty, discrimination and lack of job opportunities. The lack of access to mental health care and the inadequate quality and comprehensiveness of mental health services also play a consequential role.

BEHAVIORAL THREAT ASSESSMENT AND MANAGEMENT MAY HELP PREVENT MASS VIOLENCE

Behavioral threat assessment and management (BTAM), often shortened to "threat assessment," is an approach that originated in law enforcement to prevent violence against public figures. Over time, threat assessment has developed as a general strategy to prevent targeted violence in many different domains, such as businesses, college and university campuses and K-12 schools. A hallmark of threat assessment is the effort to identify people who have directly or indirectly communicated intentions to harm a targeted individual or group, and to engage in preventive interventions that attempt to reduce the risk of violence through conflict resolution, mental health services, security measures, law enforcement actions and other techniques.

A BTAM team within a business or school is a multidisciplinary group that typically includes representatives from security and law enforcement, behavioral health care, human resources, legal and management, along with others who have expertise both in their primary discipline and in threat management in general. The team conducts a focused violence risk assessment and seeks ways to divert the individual before they reach the point of an attack. For example, school-based teams identify the need for student services that can be delivered at school or through community resources. Most states now require or encourage schools to use threat assessment, and more than 60% of U.S. schools report the use of threat assessment teams (National Association of State Boards of Education, n.d.; Wang et al., 2022). Multiple studies have found that threat assessment protocols can be conducted safely, resulting in reduced use of exclusionary discipline and increased mental health and counseling services for students (Cornell et al., 2012; Crepeau-Hobson & Leech, 2022; Maeng et al., 2023).

MASS VIOLENCE IN SCHOOLS MAY PROMPT ILL-CONSIDERED POLICY DECISIONS

Though schools are much safer than the public might believe, school shootings grab national headlines and can lead to ill-considered policy decisions. One example is the use of zero tolerance behavior policies in schools. There is substantial evidence that exclusionary school discipline is rarely effective in correcting student misbehavior and has unintended consequences of increasing dropout rates and juvenile court involvement (Fabelo et al., 2011; Johnson & Johnson, 2023; Morgan et al., 2014). Moreover, school removal can be counterproductive to safety if the student is left unsupervised to plan and prepare for an attack (Alathari et al., 2018a).

A second problematic reaction is that schools may divert funding into expensive security measures such as bulletproof building entrances, electronic door locks, gunshot detectors, metal detectors and panic rooms. The available research indicates that such measures are untested or ineffective and can have detrimental effects on students' feelings of safety (King & Bracy, 2019; Limber & Kowalski, 2020; Mowen & Freng, 2019). 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, which can be psychologically harmful. Some research suggests that carefully planned, low-key safety drills can prepare students and staff to respond appropriately in a crisis (Schildkraut & Nickerson, 2020).

RECOMMENDATIONS

The MDI Expert Panel on Mass Violence developed specific recommendations for key stakeholders. Highlights of these updated recommendations follow.

Community solutions should involve all stakeholders, including community members, law enforcement, behavioral health care providers, the courts and faith-based organizations. Mass violence is a communitywide problem that cannot be solved by any one organization or system alone.

Key stakeholders

- **Primary care providers** — Primary care offers an opportunity to uncover, diagnose, refer and treat underlying mental disorders (e.g., conduct disorder, depression, psychosis). In response to mass violence in schools, primary care and behavioral health teams have developed innovative ways of working together to support children and their families.
- **Behavioral health providers** — Community mental health centers and mental health treatment providers are essential components in the systems of care for people with mental health symptoms, especially those with the greatest, often unmet, needs. Additionally, these providers play a vital role in the community response to a mass violence event. Behavioral health providers offer support to victims and their families, first responders and the community at large, and they deliver a variety of evidence-informed, trauma-specific therapies. They contribute to the critical event response and command structure and leverage key relationships to support a reeling community. Sometimes they are called on to determine the role mental illness may have played in the event. Although there is a modest link between mental illness and violence, it can be difficult to access quality mental health treatment in a timely manner, especially in some areas of the country. Still, behavioral health providers can assist in identifying the best access points. Lastly, behavioral health professionals need to be involved in violence prevention, not because violence is driven by diagnoses but because it is driven by behavior, and they are very good at understanding behavior.
- **Law enforcement** — In many parts of the country, local, state and federal law enforcement officials receive crisis intervention training that teaches them how to respond to calls that involve people in crisis, including those with mental illnesses. The goal is for officers to divert these people from the legal system by defusing the situation, working collaboratively with the person's mental health providers and the person's family and friends, and linking the person to services.
- **Courts** — There are now more than 3,800 problem-solving courts across the country, including drug, mental health, veterans, domestic violence, reentry, family, adult mentoring and Tribal Healing to Wellness courts. These interdisciplinary and collaborative courts help fill gaps in psychosocial services, provide early identification of and intervention with people 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 (ERPOs) resulting in the temporary removal of firearms when there is high risk 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 danger. Courts also are heavily involved in shaping boundaries regarding firearm restrictions (RAND, 2023).
- **Legislation and government policies** — Legislative and executive actions have had an impact on gun violence. While a lack of firearm restrictions has supported the increase in numbers and types of guns available to the public, more recent considerations on limiting access to guns (by increasing and enforcing background checks, use of ERPOs/red flag laws, and enhancing safety through training, gun locks and safe storage) merit further consideration. There is some early, limited evidence that ERPO laws may help prevent mass shootings, as well as better evidence that assault weapon bans and high-capacity magazine bans can limit higher-mortality events. Additionally, the 2022 Bipartisan Safer Communities Act mandates development and funding of enhanced crisis and trauma services.
- **Media** — 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 on causation, especially on 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 and uninformed speculation about the links between violence and mental illness in general. But subject matter experts may have an opportunity to help educate the media and the public about the truth regarding mental illness: that

only a small subset of mental illnesses — psychosis with paranoia, command hallucinations to be violent and/or severe narcissistic personality disorder — have an association with increased risk of violence. The media should provide a framework for understanding these rare but disturbing events and offer general information about mental illness treatment and services and the problems caused by lack of access to them.

General recommendations

- Instead of focusing only on quick fixes downstream from the sources of the problem, we should identify root causes of mass gun violence and develop strategies to alleviate them.
- We cannot predict which people will commit a violent act, but we can prevent violence by reducing risk. This is a public health approach that should be emphasized in violence prevention. Prevention does not require prediction.
- Although most people who commit acts of mass violence do not have diagnosable mental illnesses according to conventional criteria, they may have mental health difficulties, personal crises or interpersonal conflicts that could respond to mental health services and psychosocial interventions.
- Mental health providers and policy groups should acknowledge the role mental illness can play in some cases of 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 BTAM teams that include representatives from behavioral health, security and law enforcement, human resources and legal services.
- Implement ongoing quality improvement of violence risk assessment and BTAM.
- Train staff in lethal means reduction, a rational strategy for reducing lethal violence, which is very helpful in combating suicide.
- Prepare staff for vicarious trauma and compassion fatigue. Provide resources for self-care and support for staff needs.

Recommendations for schools

- Reconsider and revise zero tolerance policies and their resultant suspensions and expulsions, as these are ineffective and harmful practices. Rely instead on more effective disciplinary measures, student support services and well-trained, multidisciplinary BTAM teams.
- Avoid measures that create a correctional facility-like atmosphere, such as bulletproof glass, armed security guards and metal detectors.
- Refrain from high-stress security drills. Realistic enactments by law enforcement should not involve students or school staff. Prohibit the use of deception in drills (i.e., where children or staff are led to believe that the drill is an actual crisis event), and avoid involving children in high-intensity active shooter drills (e.g., using real weapons, gunfire or blanks; theatrical makeup to give a realistic image of blood or gunshot wounds; predatory and aggressive acting by the person posing as the shooter) — both can be traumatizing. Use security drills that can be practiced without undue stress (e.g., lock doors, turn off lights, move out of sight, remain silent).
- Establish an emotionally connected safe-school climate where each student can feel comfortable bringing matters of concern to a responsible adult.
- 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 Youth Mental Health First Aid, bereavement support and academic accommodations.
- Implement universal emotional literacy and social skills training and anti-bullying programs and add mental health to the school health curriculum.

Recommendations for communities in identifying and intervening with higher-risk groups and individuals

- Create and support broad community partnerships that include behavioral health, law enforcement, schools, faith and medical communities, etc., to strengthen the connections among those systems that interact with people who have mental illnesses and substance use disorders and may be at risk for committing violence.
- Prioritize as high risk those people with narcissistic and/or paranoid personality traits, who are fixated on thoughts and feelings of injustice and grievance, and who have few social relationships and recent stresses, as well as those with a psychosis characterized by persecutory delusions and/or homicidal command hallucinations.
- The 988 Suicide & Crisis Lifeline and other crisis call centers should include harm to others (HTO) assessment portions in their risk assessment sections, separate from harm to self (HTS). Crisis staff should be trained in HTO assessment. The HTO has some similarities to the risk rating of HTS, using categories of desire, intent and capability to guide the risk rating, plus or minus modifying factors. There are also similarities in interventions with HTO and HTS.
- Establish BTAM teams. These multidisciplinary, collaborative teams should include representatives from mental health, law enforcement and security, human resources and legal services.
- Provide training in Mental Health First Aid (MHFA), which teaches skills to respond to the signs and symptoms of mental health and substance use challenges.

Recommendations for judicial, correctional and law enforcement institutions

- Develop a basic educational toolkit for judges, covering risk assessment, the role of trauma and the need for additional supports for people who may pose risks for violence.
- Involve mental health professionals in threat assessments conducted by law enforcement and in implementation of extreme risk protection orders (ERPOs).
- Provide training in MHFA for Corrections Professionals and MHFA for Public Safety.

Recommendations for legislators and government agencies

- Fully implement and enforce the existing federal background check requirement for firearms purchases from gun dealers. Fully enforce state laws requiring background checks, where present.
- Use the Bipartisan Safer Communities Act, which began funding programs in February 2023, to increase the availability of threat assessment training at the local, state, tribal and national levels, and to expand implementation of ERPOs.
- Establish sustainable funding streams for developing BTAM strategies and programs.
- Promote expansion of the Certified Community Behavioral Health Clinic (CCBHC) model. These clinics are required to provide extensive crisis response, and the CCBHC prospective payment system model can support the development and operation of threat assessment teams.
- Enact state ERPOs that allow the temporary removal of guns from people who are known to pose a high risk of harming others or themselves in the near future.
- Support expanding federal funding for research on gun-related deaths and injuries (which was essentially eradicated in 1996 by the Dickey Amendment but revived in 2019, though still significantly limited — e.g., $25 million in 2019).

Recommendations for research

- Support a unified standard definition of mass violence.
- Support research on the nature of and contributors to mass violence, including neurobiological, psychological and sociological factors.
- Support research on methods and instruments for identifying and intervening with people at risk of carrying out acts of mass violence.
- Create a multiagency team, including the Department of Justice and the Department of Homeland Security, to conduct a standardized, mandatory investigation/analysis of each mass violence event.
- Evaluate ERPOs 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.
- 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 crisis.
- 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 and are much more likely to be victims of violence. Speak to the impact of untreated or undertreated mental illness in combination with other risk factors.
- Work with the media to develop guidance for the public on risk factors for violence. Help the public understand the importance of "see something, say something," and encourage public training in MHFA.

Introduction

TERMINOLOGY

Mass violence

Mass violence is a term that encompasses all physical assaults with implements to cause injury (including knives, clubs, motor vehicles, guns, assault weapons and bombs). In the context of the National Council Medical Director Institute (MDI) Expert Panel on Mass Violence meeting, mass violence was 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 and discussion that follows refers specifically to mass shootings, because they constitute the majority of incidents and result in greater loss of life and emotional impact on the public.

There are numerous definitions of mass violence, often focused on or limited by:

- Numbers of people killed and/or injured (considering the trauma on families and communities from deaths and injuries).
- Circumstances or motivations (e.g., deciding whether to include terrorism, drug-related, crime-related [domestic abuse, robbery] or gang-related shootings).
- Location and duration.
- Number of shooters.
- Sources and methods of data collection (e.g., is data objective and verifiable; is it collected by researchers, open sources or practitioners; does the process consider proximal and distal causes?) (Lopez et al., 2020).

Mental illness

Frequently, once a mass shooting occurs, speculation on the perpetrator's possible diagnosis of mental illness proceeds rapidly. Unless otherwise specified, the term "mental illness" refers to the more serious disorders in the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision" (DSM-5-TR), 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 (SUDs) are also considered, when co-occurring with mental illnesses.

While the term "mental illness" broadly refers to those conditions in DSM-5-TR, only a very small portion of people diagnosed with psychosis with paranoia, command hallucinations to be violent, and/or severe narcissistic personality disorder are associated with the potential for serious violence resulting from the illness itself. Definitions vary widely across organizations and studies of mass violence, and different definitions of what constitutes a mental illness yield different conclusions about the role mental illness plays in mass violence events.

In contrast to mental illness, mental wellness or resilience reflects a pattern of adaptive thoughts, emotions and behaviors. Most people 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.

COMMENTARY ON THE CHALLENGE (WHO, WHAT, WHEN, WHERE, WHY, HOW)

Who

While perpetrators and victims of mass violence come from every race, sex, age, education, occupation and socioeconomic level, most perpetrators are white males who use guns to kill, act alone and often 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, intending to kill themselves 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 verdict. Perpetrators of hate-motivated mass shootings present with some common characteristics, and their victims are often from vulnerable populations.

What

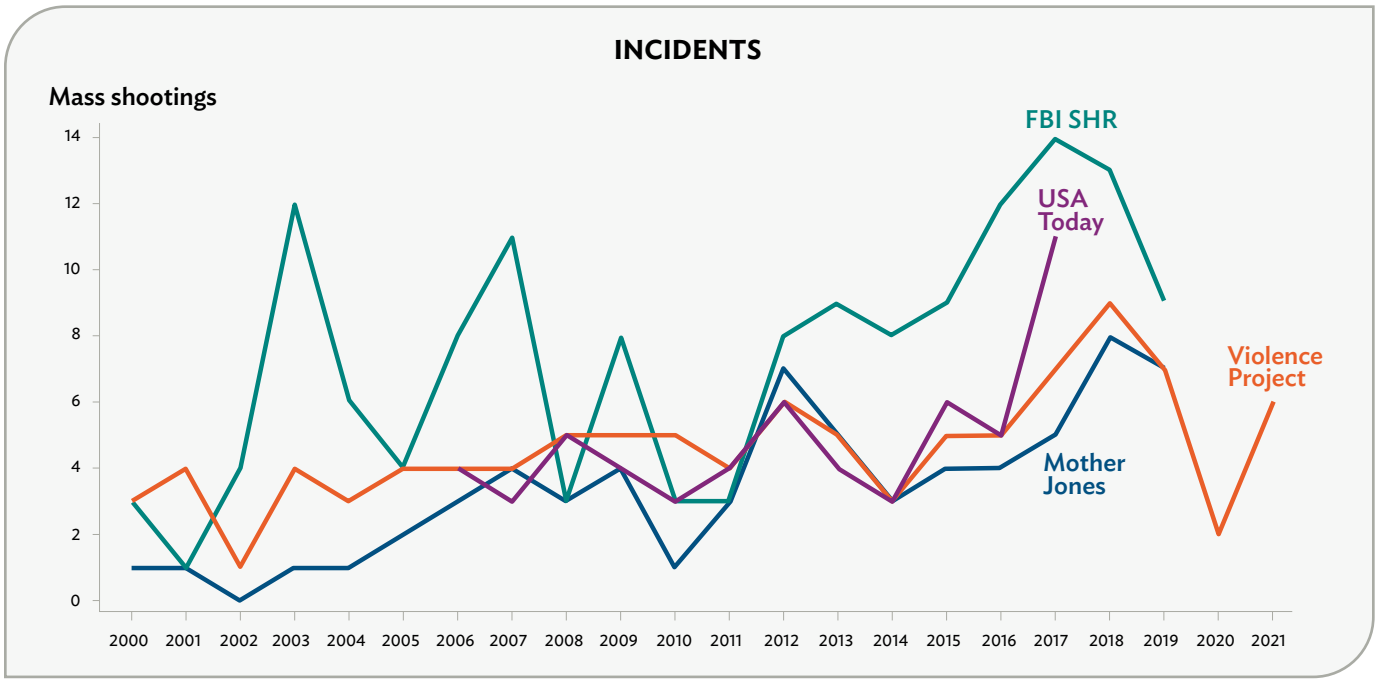
In the United States, the National Violent Death Reporting System tracks homicides by mechanism, stratified by a single victim or two or more victims. The United States has more mass violence (when defined as crimes in which four or more people are injured in an event or related series of events) than any other high-income or developed country in the world (Wintemute, 2015; Associated Press [AP] et al., n.d.). From 2006 to May 2024, guns were used in 74% of the instances where four or more people were killed (AP et al., n.d.). *Thus, in the United States, mass violence is usually a type of gun violence.*

When

Studies indicate that the rate at which mass shootings occur has progressively increased since 2011. Between 1982 and 2011, a mass shooting occurred roughly once every 200 days. Between 2011 and 2014, there was at least one mass shooting every 64 days (Cohen et al., 2014; Lemieux, 2014; Blair & Schweit, 2014). By September 2023, the U.S. was averaging *almost two mass shootings per day* (Gun Violence Archive [GVA], 2023b), and there had been 54 school shootings (leaving 29 dead and more than 58 injured), 17 on college campuses and 37 on K-12 campuses (Matthews, 2023).

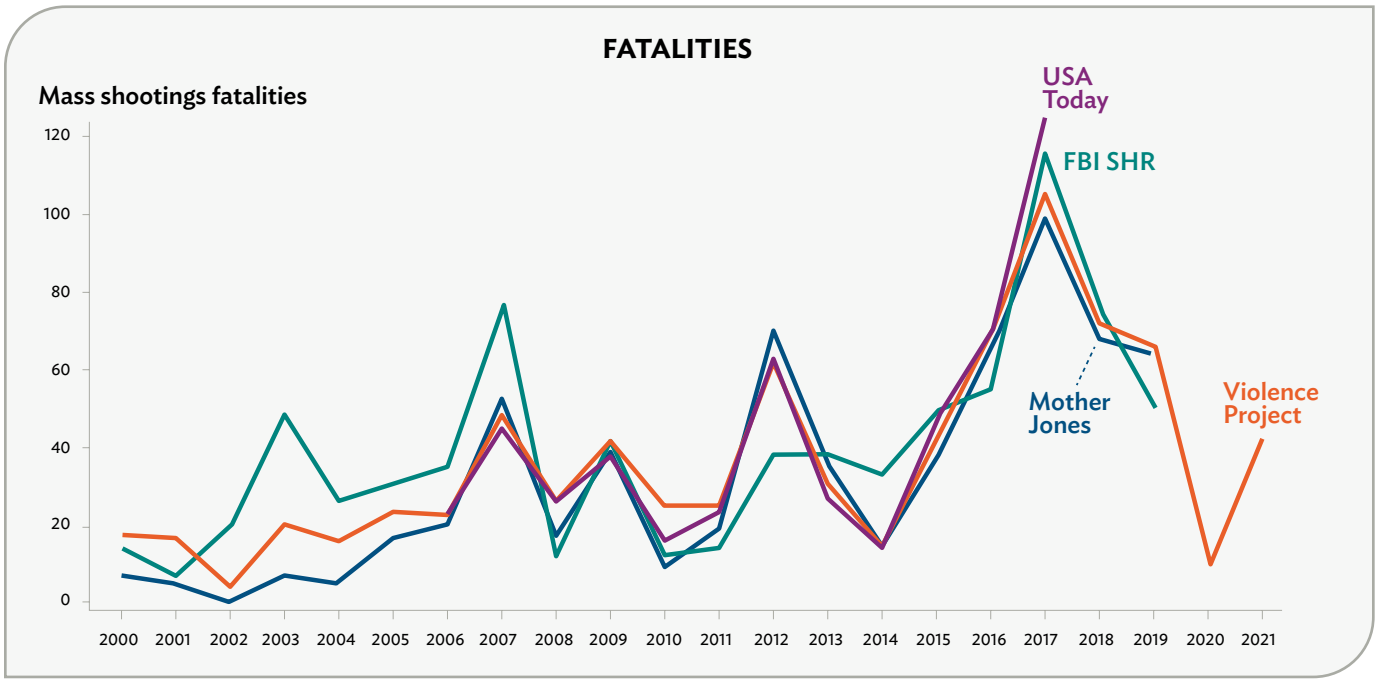
Most data sets show an increase in the number and lethality of mass shootings between 2000 and 2019 (see Exhibits 1 and 2) (Soni & Tekin, 2022).

Exhibit 1. U.S. mass shooting events by year and data source



Source: Authors' analysis of mass shootings databases compiled by Mother Jones, the Federal Bureau of Investigation's Supplementary Homicide Reports (FBI SHR), The Violence Project and USA Today.

Exhibit 2. U.S. mass shooting fatalities by year and data source



Source: Authors' analysis of mass shootings databases compiled by Mother Jones, FBI SHR, The Violence Project and USA Today.

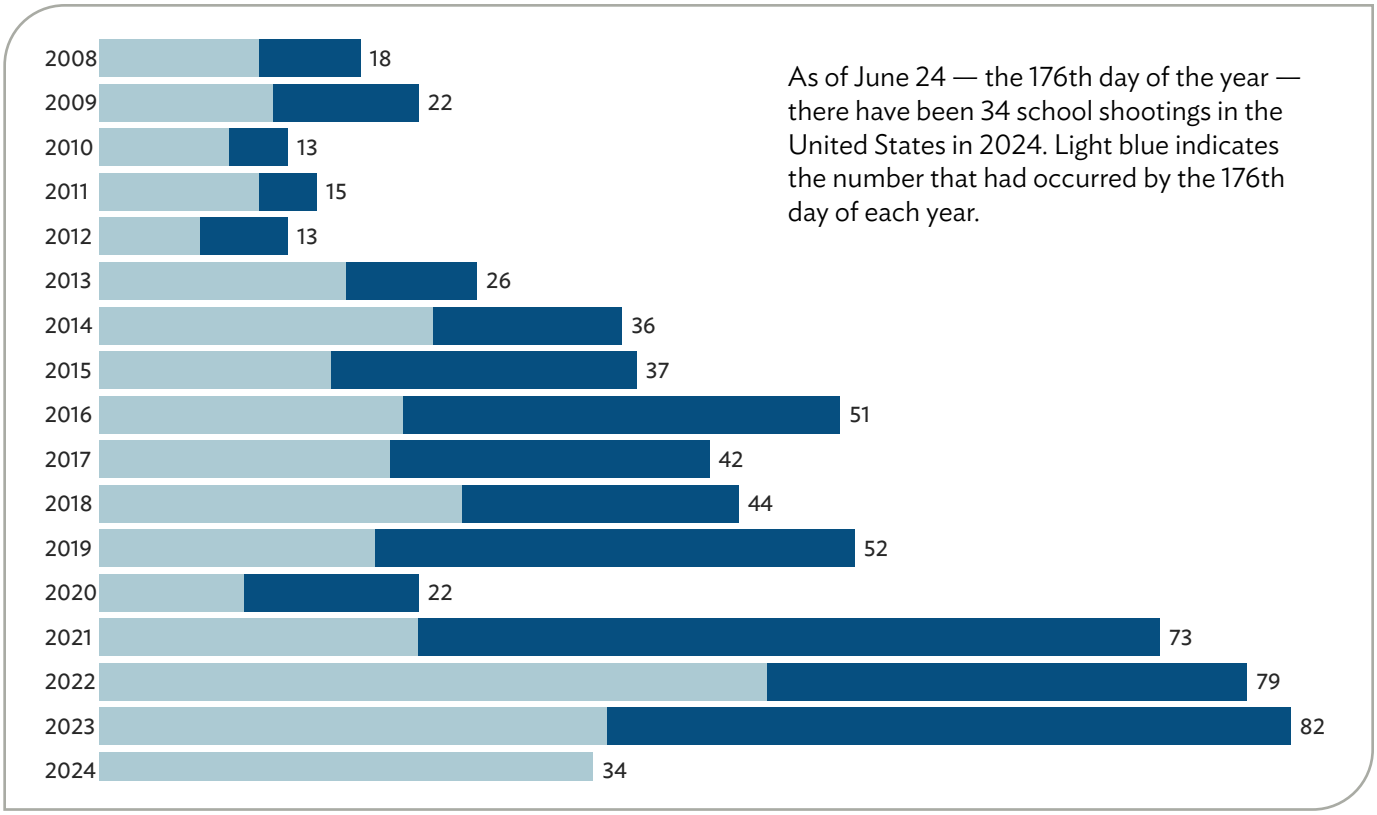
The Gun Violence Archive (GVA) (n.d.) notes the rising trajectory of mass shootings since 2014:

2014: 272	**2019: 414**
2015: 333	**2020: 610**
2016: 383	**2021: 689**
2017: 347	**2022: 645**
2018: 335	**2023: 655**

Per the GVA, deaths and injuries from mass shootings were as follows:

2021: 668 deaths and **2,758** injuries
2022: 642 deaths and **684** injuries
2023: 715 deaths and **2,684** injuries

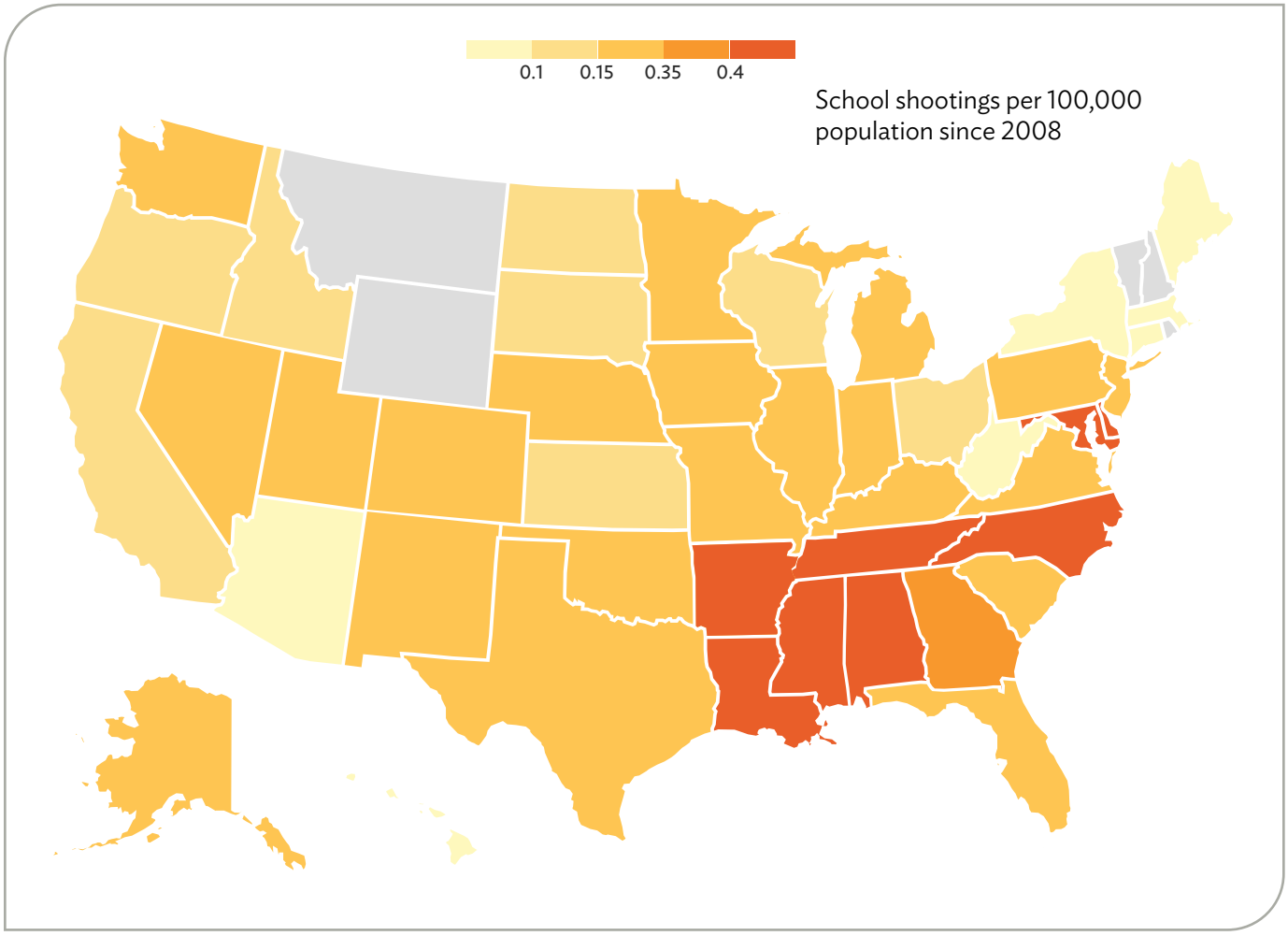
Exhibit 3. How school shootings so far this year compare to the same point in past years



Note: CNN reviewed incidents reported by the Gun Violence Archive, Everytown and Education Week.
Source: CNN school shootings database
Graphic: Alex Leeds Matthews, CNN

Exhibit 4. School shootings per 100,000 population since 2008

The gray indicates the five states that have not had any school shootings since 2008, according to CNN's analysis.

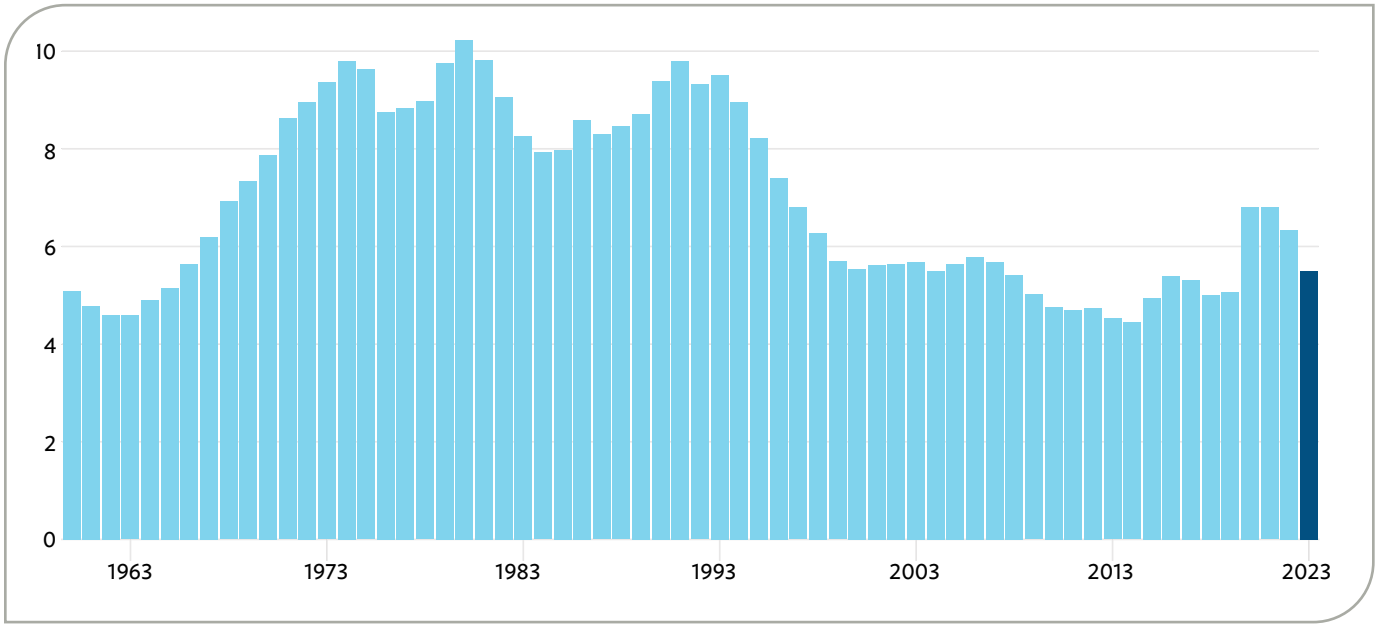


Note: Data reflects school shootings since 2008 through June 24, 2024. CNN reviewed incidents reported by the Gun Violence Archive, Everytown for Gun Safety and Education Week. Population estimates from the 2020 U.S. Census.
Sources: CNN school shootings database; U.S. Census Bureau
Graphic: Alex Leeds Matthews, CNN

It should be noted that these increases are happening against the backdrop of an overall decline in violent crime in the United States (Datalytics, n.d.), as shown in Exhibits 5

Exhibit 5. Annual rate of homicides in the U.S.

Homicide rate per 100k, 1960-2023; 2023 data is estimated



(Knutson, 2023)

Mass shootings accounted for only 0.2% of homicides in the United States between 2000 and 2016 (Follman et al., 2023b; National Center for Injury Prevention and Control [NCIPC], n.d.). In the last few years, they have increased to slightly less than 1%.

Where

Mass violence occurs in various settings, including schools, universities, churches, workplace and domestic settings, and public buildings (e.g., movie theaters, shopping malls, retail stores). In one data set collected by The Violence Project (Peterson & Densley, 2022), mass shootings in the U.S. from 1966-2021 occurred as follows: 31% in workplaces (typically by insiders of that organization), 16.7% at retail sites, 13.7% in restaurants and 11.9% in K-12 or university settings. 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 than in a mass shooting event. According to a data set collected by the National Institute of Justice (2022), restaurants are twice as dangerous as schools. Since 2014, 13% of U.S. Americans (close to 42 million) have lived within one mile of a mass shooting event (GVA, 2020).

Why

While each mass violence event has its own unique motivations and circumstances, the perpetrators predominantly fall into these 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 SUD) 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 people with mental illnesses may be more susceptible to solicitation by extremist groups and ideologies or to becoming marginalized by society and thus disaffected, lonely and alienated. Motivations of

mass shooters are complex, and individual mass shooters may have multiple motivations present. Several studies show that many perpetrators, ranging from 51% to 100%, were experiencing a personal crisis (Alathari et al., 2018b; Peterson & Densley, 2019; Silver et al., 2018). A database analysis of 177 events identified two specific groupings of crises: distressed isolation and disturbed affect, with isolation being the greatest common factor (West & Thomson, 2023). Depression and mood instability were the strongest correlates of shooting severity. The authors of the analysis concluded that social isolation is an ideal target for intervention.

Following mass shootings, public reaction in the United States predictably breaks along two lines: (1) gun-centric — those who call for either broader use of guns, believing widespread gun ownerships would decrease crime (Stroebe et al., 2022), or greater restrictions on *specific* firearms, the most common means of mass violence — or (2) 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 ignore available data on mass violence in the United States.

Rozel (2018) noted that "studies of homicide defendants and school shooters identified only about 15%-20% of offenders with identifiable psychiatric illness. In recent studies on mass shooters, only 25% had prior psychiatric diagnoses and only a minority of those had psychotic illness. Even in people with schizophrenia ... the strongest risk factors are often prior violence, nonadherence to treatment, substance use [and] victimization."

Mental illness is not the main driver of mass violence, and there are many misunderstandings and much speculation about the role of mental illness, in part because mass violence evokes disproportionately greater public, media and government reaction than other forms of violence (gang, organized crime, robbery, etc.).

In 2021, the National Institutes of Health found that 22.8% all U.S. adults had a mental illness, nearly the same as the incidence of mental illness found in perpetrators of mass violence (Merikangas et al., 2010; Substance Abuse and Mental Health Services Administration [SAMHSA], 2023).

People with mental illness account for a very small proportion of all violent crime in the United States. (According to some studies, people with a diagnosis of mental illness, especially serious mental illness previously diagnosed by a mental health provider, do appear to be overrepresented in the category of *mass* violence crimes.) Nevertheless, policies have been proposed that would restrict their access to firearms, or that would require the National Instant Criminal Background Check System (NICS) to include data on people receiving Social Security Disability Insurance for reasons of mental illness. These discussions and policies 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, unstable homes and limited supports.

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 associated factors involve antisocial personality traits, criminal behavior, substance use and negative influence of peers, as well as family discord and limited structured activity through school, work and leisure (Bonta & Andrews, 1994).

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 at least three 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 to evaluate violence potential, their ability to determine exactly who will be violent and when 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. These identified risk factors are

sensitive but not specific and, because of the low incidence, false positives are a problem. Second, risk assessments can identify the people at greatest risk but not *when* their violent actions may occur. Moreover, of those people identified as having increased risk, only a small portion ever perpetrate mass violence. Finally, since routine psychiatric evaluation in emergency or inpatient settings is now encouraged as a standard practice with people who have made serious threats of violence, more people will be evaluated because of making threats and not because of a specific concern of mental illness (Barnhorst & Rozel, 2021; BulletPoints Project, n.d.).

Another problem, perhaps even more important, is the limited availability of quality treatment for people in need. Thus, those who could be treated, thereby potentially preventing an act of violence, remain untreated. So, while there is increasing demand to identify potential perpetrators of violence and develop preventive measures, efforts to identify the root causes of the problem and resources to address them have been insufficient. Causes include social determinants (e.g., deficiencies in the educational system, poverty, discrimination and lack of job opportunities) and lack of access to quality, comprehensive mental health care. In this context, mass violence is the tip of an iceberg of more fundamental social problems in our country.

How

In 2022, 93% of the murders in the U.S. were gun related. In 74% of events where four or more people died, guns were used (AP et al., n.d.). In 78% of mass shootings from 1982-2023, handguns (pistols, revolvers, derringers, and other unspecified semiautomatic handguns) were the most common weapon used (Statista Research Department, 2023a). Semiautomatic rifles were used in 4 of the 5 deadliest shootings: Club Q in Colorado Springs (2022), Sandy Hook Elementary School in Newtown, Connecticut (2012), the First Baptist Church in Sutherland Springs, Texas (2017), and the shooting from a hotel on the Las Vegas Strip (2017) (Klarevas et al., 2019; Statista Research Department, 2023a).

Scope of the Problem

DEFINITIONS

Given the lack of one commonly accepted definitions of either mass violence overall or a mass shooting, the number of mass shootings recorded depends on the definition used. Without a universal definition of a mass shooting, and without accurate data, we will not know the true extent of mass shootings (Booty et al., 2019). Most definitions consider a mass shooting event to be one in which more than three or four people are killed by shooting in a single event by an perpetrator (or perpetrators) who is not engaging in the act as part of an organized political group. In addition, these definitions typically do not include mass violence linked to drugs, crimes like robbery, or family violence, either in the form of domestic abuse or violence with intent to kill family members (Zeoli, 2018).

Reporting and interpretation of data varies depending on different definitions for mass violence, considering:

- The motivation of the perpetrator: terrorism, retribution, drug-related, domestic violence, "routine" crimes like robbery.
- The number of victims who die, with and without inclusion of those injured (RAND Corporation, 2018).
- The setting for the crime (Smart & Schell, 2021).

Most definitions are limited to mass shootings where at least three victims are killed in one event (so events with "only" two deaths or victims wouldn't be considered at all), often killed indiscriminately in a public place such as a school, concert or movie theater. Examples include the following:

- **2008 FBI report cited by Mother Jones:** "A mass murderer — versus a spree killer or a serial killer — [is one who] kills four or more people in a single event (not including himself), typically in a single location" (Follman et al., 2023a).
  - Shifting fatality criterion: In 2013, criterion was revised down to three or more deaths.
- **The Gun Violence Archive (2023a)**, an online database for gun violence events in the United States, defines a mass shooting as "four or more shot and/or killed in a single event … at the same general time and location not including the shooter."
- **Congressional Research Service report (2013):** Public mass shootings "are events occurring in relatively public places, involving four or more deaths — not including the shooter(s) — and gunmen 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 (Stanford University Libraries, 2016):** Mass shootings are events with "three or more shooting victims (not necessarily fatalities), not including the shooter."
  - No fatality threshold — i.e., 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 (Follman et al., 2023a):** "The perpetrator took the lives of at least four people. … The killings were carried out by a lone shooter [with a few exceptions]."
  - Excludes most family/domestic homicides: "The shootings occurred in a public place."

A 2019 study noted that using a broader definition of a mass shooting (i.e., four or more people killed or injured, including perpetrators) captures more shootings of young Black men. Specifically, the study notes that "mass shootings largely affect the population at highest risk for firearm violence in cities: young Black men living in poor, under-resourced neighborhoods" (Beard et al., 2019).

Clearly defining numerous variables and establishing a standard definition of a mass shooting would be helpful in accurately noting the number of victims, and it would support consistent research and policy/program development and assessment.

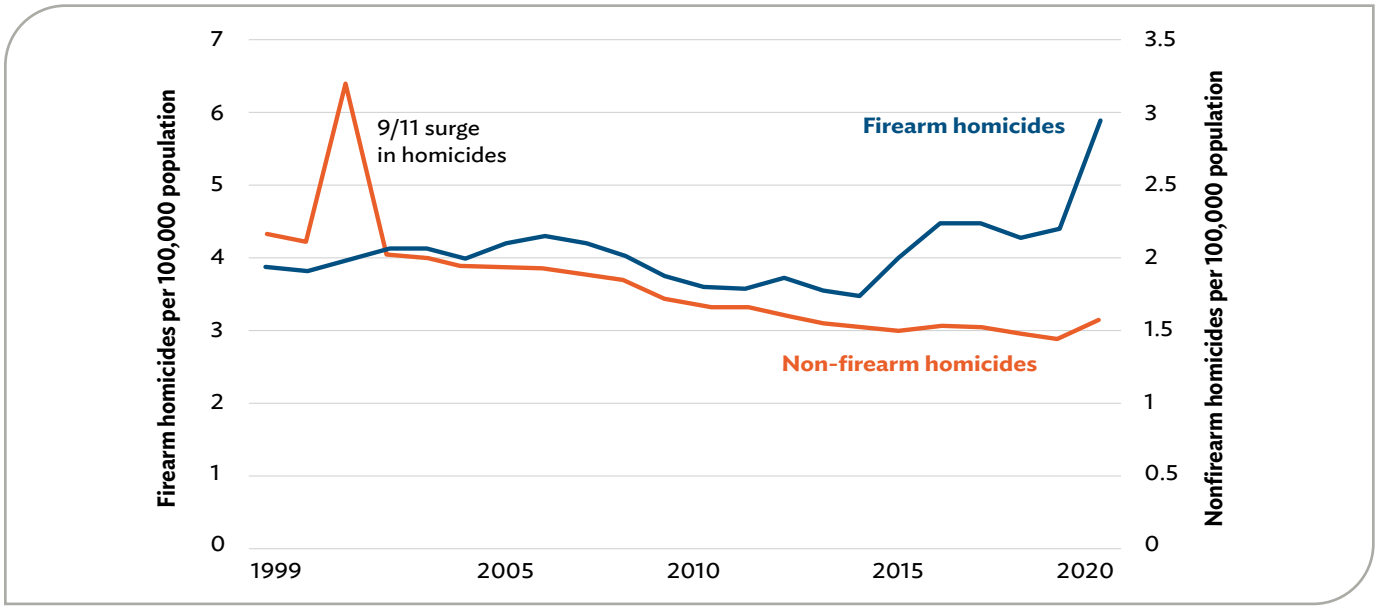
The challenges of defining a completed mass shooting are substantial; the challenges of defining an inchoate attack, even more so. It may be useful to understand the difference between people who carry out attacks and people whose efforts are successfully thwarted, to better understand how successful interventions may be replicated to stop other attacks. However, it is hard to discern the difference between a bona fide threat and ideations or fantasies of carrying out an attack without the intent or capacity to carry through (Gibson et al., 2020; Rocque et al., 2022; Schopp, 1996).

METHODS OF MASS VIOLENCE

People committing mass violence, regardless of their motivation, can employ a variety of means: knives, hammers, motor vehicles, poisons, arson, bombs and firearms. As we have noted, the vast majority of deaths and injuries involve guns, so this section will focus predominantly on firearms.

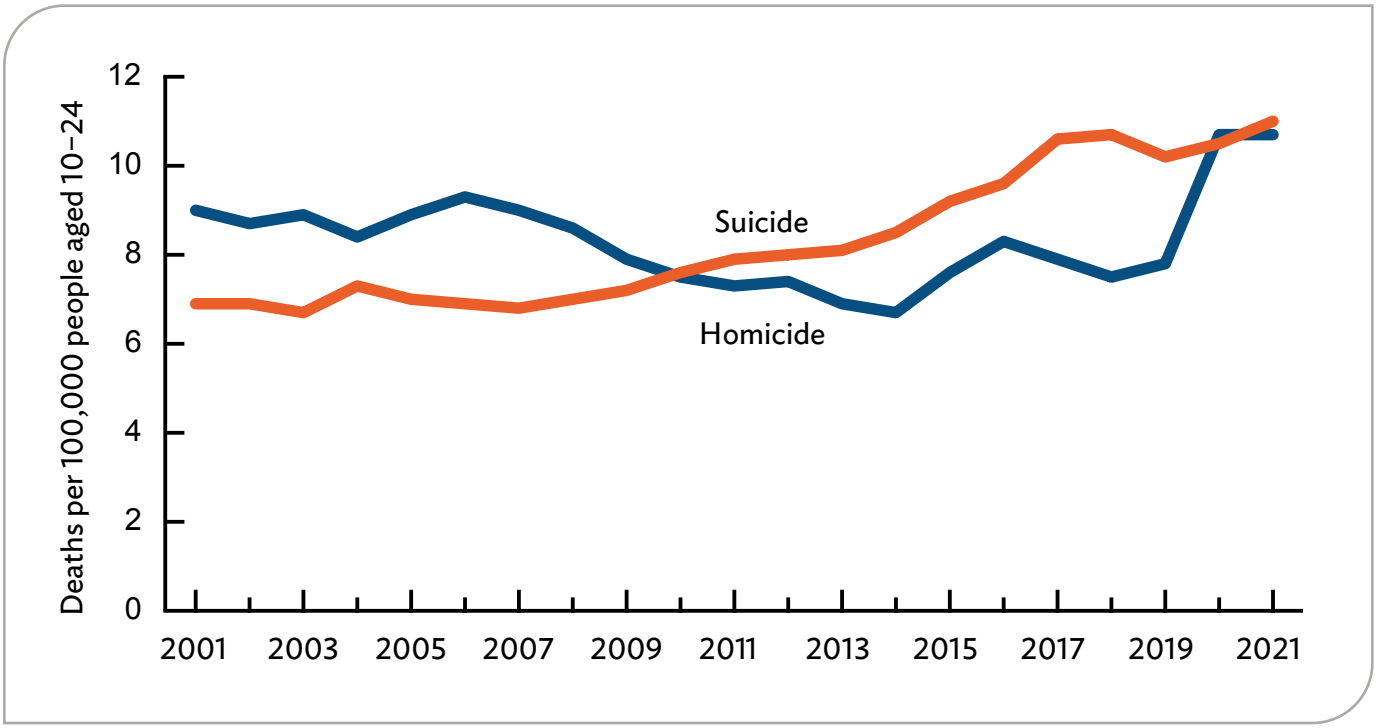
Statistics clearly show that people in the United States have greater access to firearms: U.S. homicide rates are seven times higher than in other high-income countries, driven by a gun homicide rate that is 25 times higher (Grinshteyn & Hemenway, 2016). An adult in the United States is seven times more likely to die by suicide with a firearm than an adult in another country. The U.S. rate of homicide by firearm is greater than the rate in the next seven countries combined. Estimates of the number of guns in the United States vary from slightly more than 300 million (Azrael et al., 2017) to more than 600 million (Owens, 2016), but even using a moderate estimate of just fewer than 400 million, the United States has more total guns than the next 24 countries combined (Karp, 2018). Gun sales hit a record high in 2020, and 20%-30% of those went to first-time gun owners (Stone et al., 2022).

Exhibit 6. Rates of homicide by method



"The surge in firearms homicides that began in 2015 has an important feature not highlighted in the recent CDC [Centers for Disease Control and Prevention] report. Prior to 2015, nonfirearm homicides and firearm homicides tracked each other well (figure shows raw CDC data). In 2015, these trends diverged" (Morral, 2022).

Exhibit 7. Death rates from suicide and homicide among people aged 10-24



"The suicide rate for persons aged 10-14 declined from 2000 (1.5) to 2007 (0.9), and then nearly tripled from 2007 to 2017 (2.5)" (Curtin & Heron, 2019).

Exhibit 8. Civilian-owned firearms in U.S.

393,000,000 civilian-owned firearms in U.S.

(Karp 2018)

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

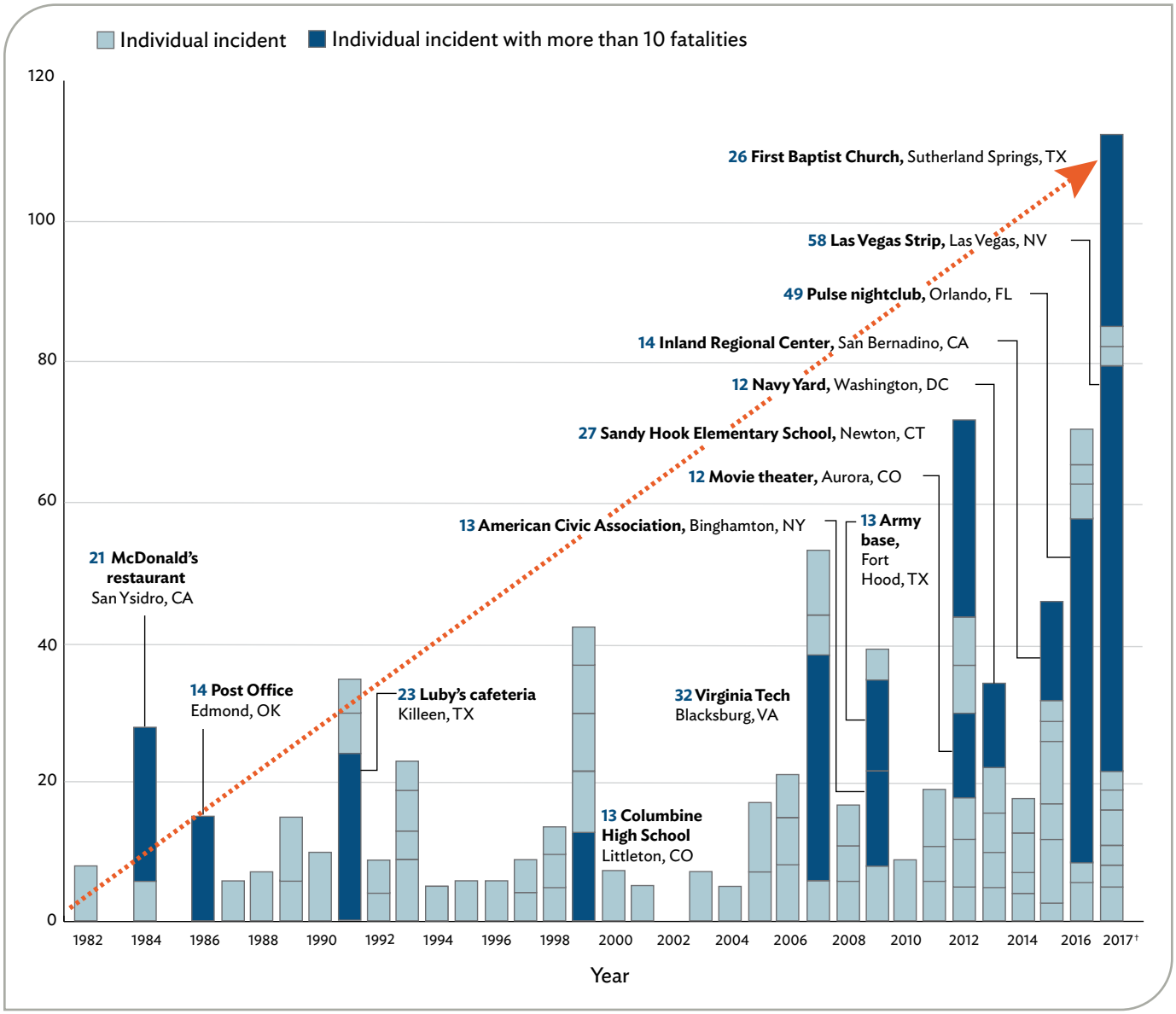
PREVALENCE OF VIOLENCE AND MASS VIOLENCE

Overall violence in the United States is declining. Data over the past 50 years shows a downward trend in the homicide rate, with a slight uptick in 2020 (Asher, 2022). Much of the upward trend in 2020 was due to heightened pandemic-induced stress, higher rates of domestic violence and increased distrust of law enforcement (Saric, 2021). The two most frequent methods of homicide (cutting/piercing and suffocation) have remained stable over time (Pifer & Minino, 2018; Statista Research Department, 2023b; NCIPC, 2018). Although people in the United States are less likely to be assaulted than those in other countries, when people in the United States become violent, the violence is often more lethal than in other countries because it more often involves firearms (Wintemute, 2015).

Despite the numerous (and therefore confusing) definitions of mass violence, there is evidence that the frequency of mass shootings is increasing, as are the numbers of deaths and injuries resulting from these events. Studies indicate that the rate at which mass shootings occur has increased progressively since 2004 (Statista, 2023a). Comparing rates from two studies using different data sets with different sources and definitions, it appears that the intervals between mass shootings are getting shorter and the toll of injuries and deaths is becoming greater. 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 et al., 2014; Lemieux, 2014; Blair & Schweit, 2014). *By September 2023, the U.S. was averaging almost two mass shootings per day* (GVA, 2023b).

The data from multiple studies suggests a slight increase in the incidence of mass public shootings over the past four decades (Cohen et al., 2014; Krouse & Richardson, 2015; Duwe, 2020). From 2016 to 2018, the annual rate of mass public shootings was about one event per 50 million people in the United States (Duwe, 2020). Considering the number of fatalities in these shootings, this corresponds to approximately 0.4% of all homicides, or approximately 0.2% of all firearm deaths, over that period. However, using an expanded definition of mass shootings that includes domestic- or felony-related killings, there is little evidence to suggest that mass shooting events or fatalities have increased (Cohen et al., 2014; Krouse & Richardson, 2015; Fox & Fridel, 2016). By that measure (adjusted for changes in the size of the U.S. population), the incidence of all mass shootings (four or more fatally injured victims, excluding the offender, regardless of shooter motivation or circumstances) was highest in the late 1980s and early 1990s, averaging one event per 10 million people from 1989 to 1993 (Duwe, 2020). More recently, between 2016 and 2018, the annual rate of all mass shooting events was about one event per 14 million people (Duwe, 2020). Considering the number of fatalities in these mass shootings, this corresponds to approximately 0.8% of all homicides, or approximately 0.4% of all firearm deaths, over that period.

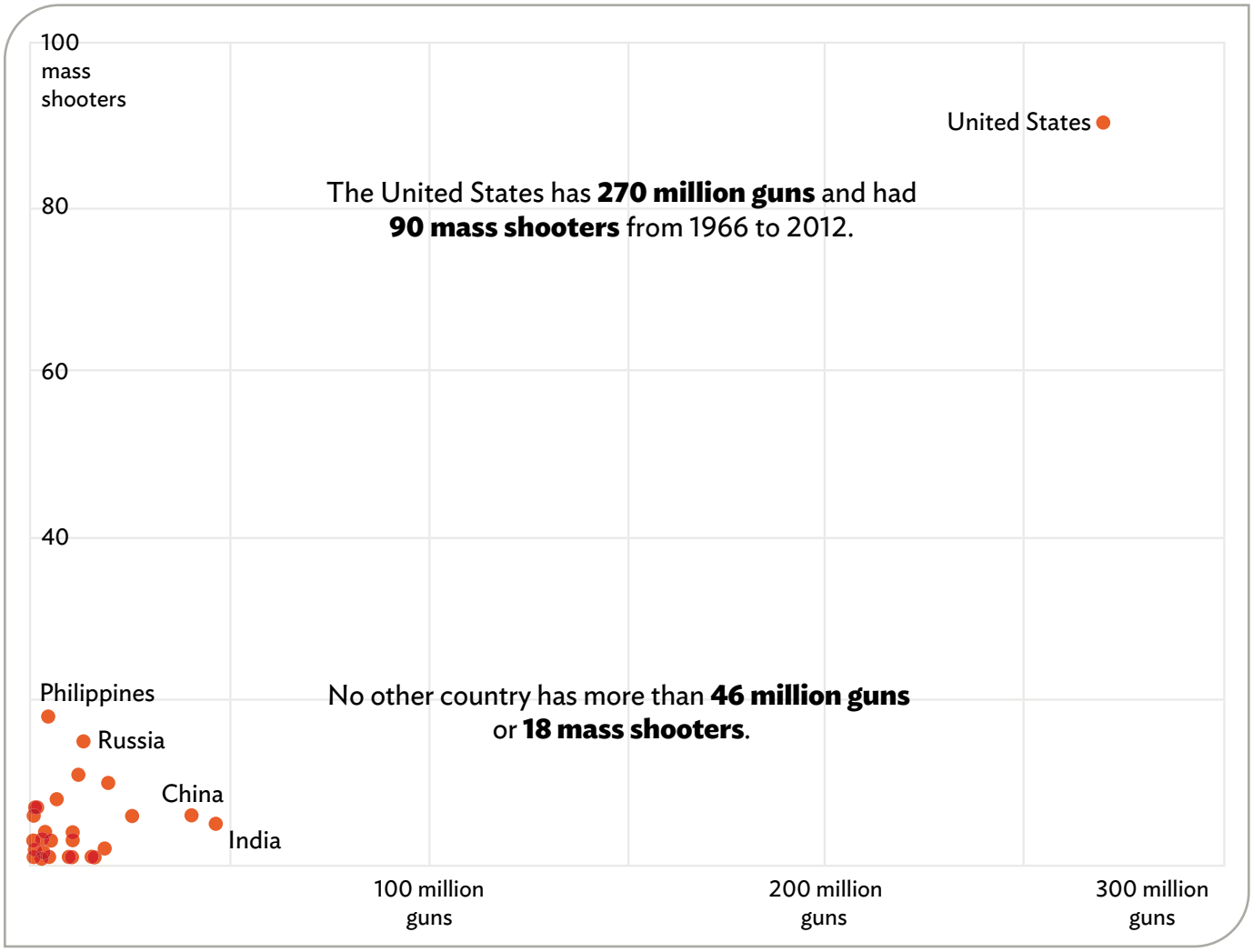
Exhibit 9. Mass shootings: United States, 1982-2017



** Shootings with three or more fatalities excluding perpetrator(s). Before January 2013, with four or more fatalities. Not comprehensive.*
† As of 6 a.m. CST, November 6, 2017
Sources: Mother Jones (Follman et al., 2023b); press reports

As Booty et al. (2019) note, because of the various data sources used in definitions of what a mass shooting involves, data sets "never overlap completely and at times can verge on being mutually exclusive." Thus, different choices about how to define a mass shooting result in different findings for both the prevalence of these events at a given time and whether their frequency or severity has changed over time. Ultimately, though, data indicates the United States has more mass shooters and more guns per capita than other economically developed countries (Wintemute, 2015; Fisher & Keller, 2017).

Exhibit 10. Number of guns vs. number of mass shooters across countries



The New York Times | Source: Adam Lankford, The University of Alabama (shooters); Aaron Karp, Small Arms Survey (guns). Note: Includes countries with more than 10 million people and at least one mass public shooting with four or more victims.

Despite enormous media attention focused on public mass shootings, these are rare events. Using the definition of a mass shooting event from the Gun Violence Archive, in 2017 there were 417 deaths and 1,788 injuries in 347 events in 2017. This compares to the following causes of death:

Firearm homicides, 2016 *(NCIPC, n.d.)*	**14,415**	**Drug overdoses, 2017** *(NCIPC, n.d.)*	**72,287**
All homicides, 2017 *(FBI, n.d.-a)*	**16,617**	**Medical errors, 2016** *(Anderson & Abrahamson, 2017)*	**~250,000**
Firearm suicides, 2016 *(NCIPC, n.d.)*	**21,808**		

There are myriad challenges to addressing mass violence: Gun ownership has risen; gun deaths have been increasing, including gun-related suicides; there are more mass shooting events, deaths and injuries. To move forward and develop evidence-based policies and solutions, discrete variables must be codified and accepted by all stakeholders.

FIREARM POLICIES (LEGAL RULINGS AND LEGISLATION, EXTANT RESEARCH)

Judiciary

The rights of people in the United States to own guns, protected by the Second Amendment to the Constitution, has been upheld in two recent U.S. Supreme Court decisions. District of Columbia et al. v. Heller (2008) held that the Second Amendment guarantees a person's right to possess a firearm unconnected with service in a militia and to use that weapon for traditionally lawful purposes, such as self-defense within the home. McDonald v. Chicago (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. (The common use test was discussed in District of Columbia et al. v. Heller at 128 S. Ct. 2815.) 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 both legally and illegally, suggesting that no single restriction will prevent all forms of gun violence.

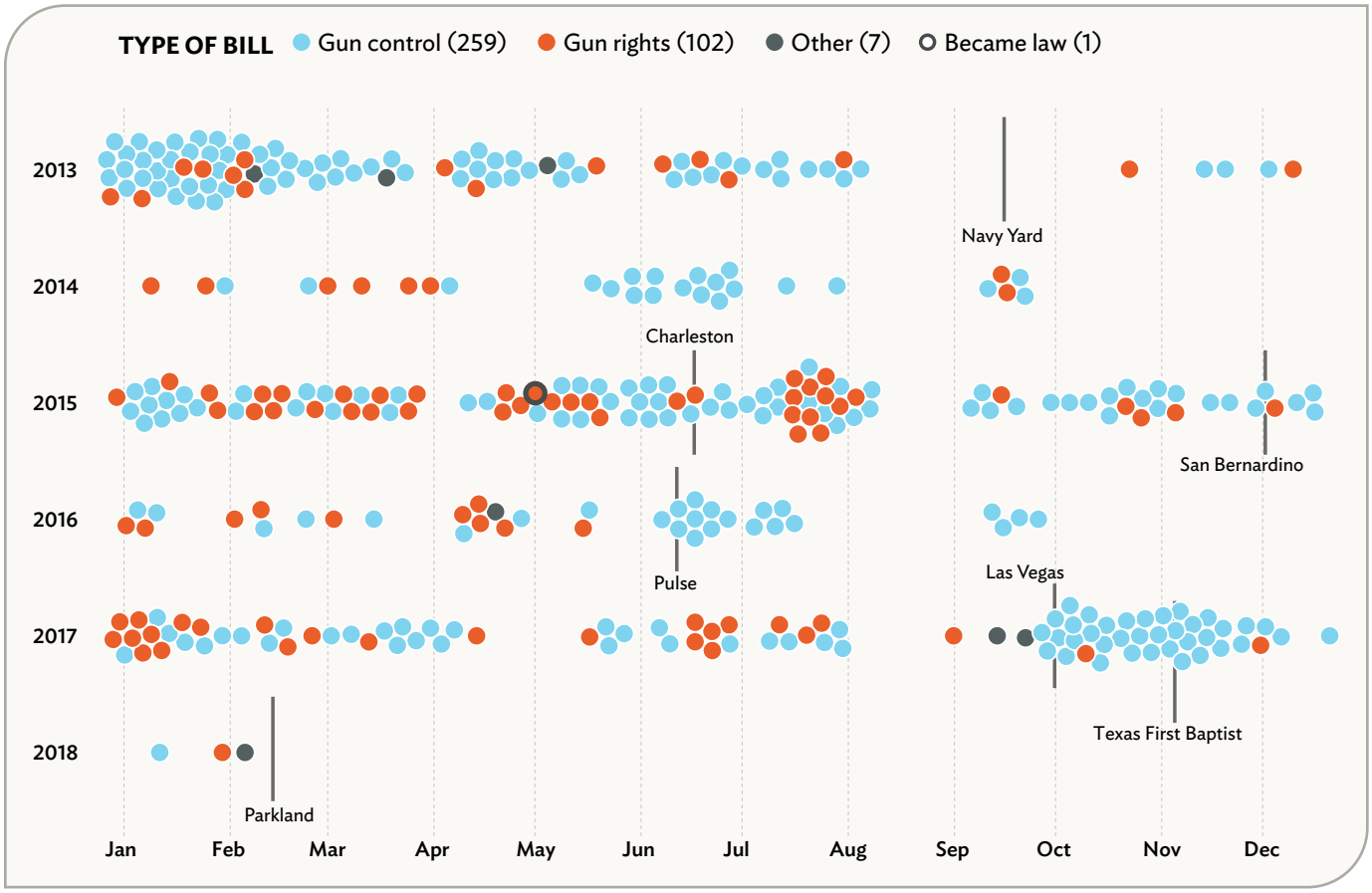
In 2022, the U.S. Supreme Court made a substantial change in the jurisprudence of Second Amendment interpretation in New York State Rifle & Pistol Association v. Bruen. Nominally, this was a case about processes and standards for issuing concealed carry permits in New York state. The majority opinion, however, identified a new standard for review of future Second Amendment cases which had not previously come before the court: Specifically, laws restricting access to firearms must be consistent with some similar historical provision present at the time of the enactment of the Second Amendment. This is a departure from prior review, which allowed balancing of interests and placed judicial decision-making at the feet of historical analysis rather than public health and policy considerations. Several previously accepted prohibitions — including access to firearms by violent felons, domestic abusers and those in active substance use — have been called into question. It remains to be seen how this new legal standard will be applied going forward, as many of these cases have continued in the appellate system (Charles, 2023).

Legislation

Currently, the Brady Handgun Violence Prevention Act of 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 policy 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. Of all the gun control and guns rights legislation introduced in Congress since the Sandy Hook Elementary School shootings of 20 children and six staff in Newtown, Connecticut, 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 et al., 2018).

Exhibit 11. Gun access bills introduced in Congress since 2013



(Fleegler et al., 2013)

After a mass shooting, there often are calls to reinstate the federal assault weapons ban. Fox and DeLateur (2014) studied the impact of the ban, which was in effect from 1994 to 2004, and found that assault rifles were used in fewer than 25% of shootings and that 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 change the rate of mass shooting events significantly, reducing the number of fatalities from mass shootings may be a more actionable goal.

Exhibit 12. Mass shootings and the federal assault weapon ban (1994-2004)

	INCIDENTS		VICTIMS	
Time period	**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

(Fox & DeLateur, 2014)

Exhibit 13. Weapons used in public 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**

(Follman et al., 2023b)

Furthermore, although the use of assault weapons in mass shootings was less frequent 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., 2019).

Federal research/policies

As noted, presenting consistent gun violence findings is challenging. 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 Uniform Crime Reporting (UCR) Program lack a highly reliable, standardized, centralized data set for tracking firearms crime, shootings, injuries and deaths. The National Institutes of Health (NIH) awarded only three major grants to study gun violence between 1973 and 2012 (Masters, 2016). Federal support for gun research was significantly limited by the 1976 Dickey Amendment, which prohibited the use of federal funds to support issues of gun control. The small amount of funding due to bureaucratic impediments and political factors significantly reduced research on gun violence issues. The Dickey Amendment was reversed in 2019, now allowing federal support for gun violence research (including mass gun violence), as long as it doesn't promote gun control. Stark and Shah (2017) found that firearms injuries research received only 1.6% of the expected funding between 2004 and 2015. Since 2019, research monies have begun to flow (split 50/50 between CDC and NIH), though most still consider funding to be significantly insufficient.

In 2022, the federal Bipartisan Safer Communities Act was passed and signed into law to combat gun violence, increase access to mental health care, support schools in developing safety policies and procedures, increase services for children with grief and trauma from gun violence, support the 988 Suicide & Crisis Lifeline, expand background checks on those under 21 years of age, and increase the scope of existing firearm restrictions and extreme risk protection orders (ERPOs) (Executive Office of the President of the United States, 2022).

Summary

The boundary conditions the Supreme Court has set on the Second Amendment have encouraged state legislatures to approach firearm restrictions in different ways: limiting high-capacity magazines and mandating locked guns, safe storage, background checks and training before guns are sold. The 2022 Bipartisan Safer Communities Act enables better research on firearms regulation and supports funding and mandates to expand programs.

CHARACTERISTICS OF MASS VIOLENCE PERPETRATORS

The perpetrators of mass public shootings (neither drug nor domestic violence associated) in the United States have been overwhelmingly male (98%). They are most commonly younger than age 45 (82%); more specifically, 26% of mass public shooters from 1976 to 2018 were younger than age 25, 27% were aged 25 to 34, and 29% were aged 35 to 44. Relative to the overall U.S. population, mass public shooting offenders are much more likely to be male and are somewhat younger; relative to other homicide offenders, they are more likely to be older, non-Hispanic white males (Smart & Schell, 2021).

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; and who plan and prepare for their attack. Silver et al. (2018) reported that planning duration varied widely in the 34 cases where the time spent planning could be determined, with the majority taking up to two months. It took much less time to procure the means for the attack, with 53% acquiring the firearm(s) within seven days prior to the event. The majority shared information about the attack with others, though often not with the intended victims. Among such people are those who exaggerate and personalize slights and misfortunes, and others whose anger and fear stem from symptoms of psychosis. Still others act out of a misguided desire to end the financial, physical and/or mental suffering of loved ones, as well as themselves.

The Violence Project (Petersen & Densley, 2022) examined 168 mass shootings from 1966-2020 and interviewed five living (in prison) mass shooting murderers. The study collected 100 life history variables, and considerable similarities were reported:

- Many felt hopeless and helpless.
- 42% had experienced early childhood trauma (physical/sexual abuse, parental suicide, bullying, domestic violence).
- 80% reached a crisis point relatively (days to months) close to the day of the shooting.
- 50% had been reprimanded, suspended or fired recently.
- 25% had lost a romantic relationship.
- 72% were suicidal before or at the time of the shooting.

The literature is replete with observational studies of mass shooting perpetrators. Numerous studies and databases provide common demographics associated with people who commit mass violence. The FBI (Blair & Schweit, 2014) identified 160 active shooter events in the United States between 2003 and 2013 and found that:

- All but two involved single shooters.
- 70% of events involved either a commercial or educational location.
- In at least 5%-6% of events, the shooter killed one or more family members before moving to a public location.
- The shooter was female in only 3.75% of events.
- More than 50% of public mass murderers leak information about their intentions to family members, friends or coworkers, on social media or in other ways. While family members are the most likely to be aware of possible events, they are least likely to report them.
- In 56% of the events, the shooter ended the event (e.g., died by suicide, stopped shooting, fled).
- In 40% of the events, the shooter died by suicide — 84% of them at the site of the shootings.

FBI (2022) findings for the 61 mass shootings perpetrated by 61 shooters in 2021 were similar:

> "Sixty shooters were male, and one was female. Sixty shooters acted alone. The youngest shooter was 12 years old; the oldest was 67 years old. Other details about the shooters are as follows:
>
> - Two shooters wore body armor.
> - One shooter had four IEDs [improvised explosive devices].
> - Thirty of the shooters were apprehended by law enforcement (13 at the scene and 17 at another location).
> - Fourteen shooters were killed by law enforcement (13 at the scene and one at another location).
> - Four shooters were killed by armed citizens.
> - One shooter was killed at another location in a vehicle crash.
> - Eleven shooters committed suicide (four at the scene before law enforcement arrived, four at the scene after law enforcement arrived, and three at another location before law enforcement arrived).
> - One shooter remains at large.
> - Six shooters were employees, four shooters were former employees, two shooters were current students, two shooters had past personal or professional relationships, and one shooter was a business owner."

Lankford (2018) found characteristics that mass shooters share:

- They are nearly always 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 and familiarity with the weapon.
- Many are suicidal or indifferent to life.
- Many perceive victimization of themselves and/or a group with which they identify.
- Many seek personal notoriety and/or attention for a group or a cause.
- Many perceive acute social and/or situational factors that contribute to the drive to attack.
- Many leak to others their intent to attack.
- Some have narcissistic personality features (e.g., attention seeking, feeling unvalued).
- Many have paranoid traits (e.g., deep sense of disgruntlement, injustice) or symptoms.
- Some have deep empathy for or identify with people perceived as similarly victimized and/or who responded to their victimization with violence.
- Many have a psychological fixation (e.g., rumination on victimization, hopelessness, meaningless).
- There is a 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 represents 22.8% of the adult general population — or 57.8 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 (Merikangas et al., 2010; SAMHSA, 2023).

In addition, Lankford notes that previous distinctions made between mass shooting attackers and suicide terrorists are becoming less clear as more mass shooters are motivated by ideological, religious and other discriminatory

considerations, and as suicide terrorists rely less on bombings and specific organizational support and more on firearms to inflict mass casualties. The attributes of an event and the characteristics of the perpetrator interact in myriad ways to create idiosyncratic situations that are difficult to predict.

The U.S. Secret Service compiled information on 28 mass attacks in public spaces during 2017 (Alathari et al., 2018b). The events 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 semipublic 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 and 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 and two with knives.
- Fifteen attackers (54%) had histories of SUD.
- Twenty attackers (71%) had prior criminal histories, nine with domestic charges or police responses.
- Eighteen (64%) had prior histories of violence.
- Eighteen (64%) had mental health symptoms prior to attack (50% of those with psychosis, 33% with suicidal ideation and 20% with depression), with seven having received prior known mental health treatment.
- Motives included personal grievances (13, with five of them domestic), ideology (one), beliefs based on skin color (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 and other events of mass violence.
- Sixteen harmed only random people, four harmed people that they had preselected, and 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 beliefs based on skin color in seven cases.
- Evidence of fixation in 11 cases.
- Aggressive narcissism traits in 23 cases.
- Threats or concerning communication in 22 cases.
- Had elicited others' concern in 22 cases, 13 specifically about safety.

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

- Prior to the events, other people knew about the attacker's idea and/or plan to attack. In over three-quarters of the events, at least one person had information that the attacker was thinking about or planning the school attack. In nearly two-thirds of the events, more than one person had information about the attack before it occurred.

- Events of targeted violence at schools rarely were sudden, impulsive acts.
- Most attackers did not threaten their targets directly prior to 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 prior to the attack.
- Most attackers had access to and had used weapons prior to the attack.
- Despite prompt law enforcement responses, most shooting events 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 event that caused others concern or indicated a need for help.
- Few of the attackers had prior psychiatric care or formal diagnoses.

Two studies also noted several behavioral patterns of mass murderers termed "proximal warning behaviors suggesting that one was on their way to violence" (Meloy et al., 2012; Meloy & Hoffman, 2021):

1. Pathway
2. Fixation/preoccupation with person or cause
3. Novel aggression
4. Energy burst
5. Leakage
6. Last resort
7. Directly communicated threat
8. Deterioration in social/occupational functioning
9. Researching and planning the attack
10. Identification with previous mass shooters

Hate-motivated mass shootings

The FBI defines a hate crime as "a criminal offense against a person or property motivated in whole or in part by an offender's bias against race, religion, disability, sexual orientation, ethnicity, gender, or gender identity." (FBI, n.d.-b) Law enforcement reports that, from 2020 to 2022, hate crimes went up 11.6%. The Anti-Defamation League (ADL) Center on Extremism (2023) noted, "From the 1970s through the 2000s, domestic extremist-related mass killings were relatively uncommon. However, 2010-2022, their number has greatly increased. Most of these mass killings were committed by right-wing extremists, but left-wing and domestic Islamist extremists were also responsible for events." The center identified "62 extremist-connected mass killing events since 1970, with 46 of them being ideologically motivated. Disturbingly, more than half (26, or 57%) of the ideological mass killings have occurred 2010-2022." Of particular concern in recent years are shootings inspired by white supremacist "accelerationist" propaganda urging such attacks. However, while some who commit or are charged with hate crimes are fully engaged with the worlds of bigotry and hate, others act upon common themes of prejudice in U.S. communities. Many of these offenders had mixed motives, including financial and other material goals (National Institute of Justice, 2021).

Summary

Across multiple venues and reports of mass shootings (not related to drugs, retribution, domestic violence or "routine crime"), patterns of common perpetrator characteristics have emerged:

- Male (rarely female).
- Planned/prepared in advance.
- Occasionally wore body armor.
- Acted alone.
- Occasionally shared information prior to event, but did not always communicate threats.
- Indifferent to life or suicidal.
- Harbored grievance and felt victimized, bullied, persecuted, slighted or undervalued.
- Exaggerated slights or was angry/fearful from psychosis.
- Had difficulty coping with recent stressors.
- Perhaps seeking notoriety or attention.
- Occasional prior criminal history.
- History of access/exposure to guns.
- Spectrum of history of mental illness and variable history of SUDs.

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 et al., 2015). Swanson (1994) analyzed community-representative data from the National Institute of Mental Health's Epidemiologic Catchment Area surveys and found that the population's attributable risk of any violent behavior associated with serious mental illness alone (e.g., a DSM diagnosis of schizophrenia spectrum disorder, bipolar disorder or major depression) is about 4%.

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%; 96% 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, having a history of antisocial behavior beginning in childhood or adolescence, and social determinants like living in poverty, having a history of childhood abuse, being exposed to abuse and violence in the social environment, and becoming involved with the criminal justice system (Swanson et al., 2015).

Substance use disorders (SUDs) account for 34% of the risk of committing violence toward others. These disorders can exacerbate the effects of certain kinds of psychiatric symptoms, like excessive threat perception, and can expose people to toxic social factors. Overall, the best predictor of future violence is past violence (Elbogen & Johnson, 2009; Rozel et al., 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 in the community over one year and examined the occurrence of violent behavior in relation to numerous predictors. The MVRAS found that SUD 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 SUD — 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 or the National Epidemiologic Survey of Alcohol and Related Conditions (Van Dorn et al., 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 et al., 2015).

The risk of violent behavior tends to fluctuate over time and recedes with age, in people with or without mental illness. 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 people are seen during a mental health crisis. In particular, patients seen in psychiatric emergency departments or those who have been involuntarily hospitalized, as well as those experiencing their first episode of psychosis, are at higher risk of violent behavior (Choe et al., 2008; Large & Nielssen, 2011; Brucato et al., 2018). Those with co-occurring SUDs, untreated psychosis, a history of oppositional defiant disorder as children, or a history of antisocial personality disorder[1] as adults are also at increased risk (Witt et al., 2013). But risk declines substantially over time, for example in a person with a single involuntary hospitalization occurring in young adulthood (Felthous & Swanson, 2017).

Certain psychotic symptoms increase the risk of violence, including paranoid delusions or hallucinations of threat from others, command hallucinations and impulsive anger. 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 perpetrators are both 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 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 events and environmental exposures over the lifespan.

In summary, there is a modest link between mental illness and violence. Those at higher risk include those with comorbid SUDs, those who are not in treatment (either because of limited supports and/or access, anosognosia [no insight into their illness], or medication non-adherence) or those with paranoid psychosis. There is no basis for the public's generalized fear of people with mental illness.

THE ROLE OF MENTAL ILLNESS IN MASS VIOLENCE

Events 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. The events often provoke a defensive response from mental health supporters. After such events, political leaders invariably invoke mental illness as the reason for mass violence, a narrative that resonates with the widespread public belief that mentally ill people 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 the solutions involve restricting the liberty of people with mental illnesses — even removing them from the community — or preventing them from owning guns. This simplistic conclusion ignores multiple 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.

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1 It is important to note that the U.S. Supreme Court held in Foucha v. Louisiana (1992) that antisocial personality disorder alone does not meet the legal definition of a mental illness.

However, rather than being sympathetic to the plight of people with mental illness, 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 it is often used without definition in the mass violence narrative. It is important to have a clear definition of mental illness when considering its role in mass shootings.

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

Exhibit 14. Violence and mass shootings: Likelihood of "mental illness"

4%	Violence attributable to mental illness (Swanson, 1994)
17%	Any non-SUD Axis I in murder defendants (Martone, 2013)
4.7%	NICS-disqualifying mental illness (Silver et al., 2018)
11%	Evidence of prior mental health "concerns" (Everytown for Gun Safety, 2015)
17%	Pre-incident diagnosis, school shooters (Vossekuil/SSI, 2002)
25%	Evidence of serious mental illness (Stone, 2015)
25%	Pre-incident diagnosis of any kind (Silver et al., 2018)
28%	Evidence of mental illness, ISIS-influenced (Gill et al., 2017)
40%	Prior diagnosis in targeted school attacks (Alathari et al., 2019)
59%	"Signs of serious mental illness" (Duwe, 2007)
62%	Mental health "stressor" (Silver et al., 2018)

Alathari, L., Drysdale, D., Driscoll, S., Blair, A., Carlock, A., Cotkin, A., Johnston, B., Foley, C., Mauldin, D., McGarry, J., Nemet, J., Vineyard, N., & Bullwinkel, J. (2019). Protecting America's schools: A U.S. Secret Service analysis of targeted school violence. U.S. Department of Homeland Security, United States Secret Service National Threat Assessment Center. https://www.secretservice.gov/sites/default/files/2020-04/Protecting_Americas_Schools.pdf

Duwe, G. (2007). Mass murder in the United States: A history. McFarland & Company. https://archive.org/details/massmurderinunit0000duwe/mode/2up

Everytown for Gun Safety (2015, August). Analysis of recent mass shootings. https://www.issuelab.org/resources/22702/22702.pdf

Gill, P., Silver, J., Horgan, J., & Corner, E. (2017, May). Shooting alone: The pre-attack experiences and behaviors of U.S. solo mass murderers. Journal of Forensic Sciences, 62(3), 710-714. https://doi.org/10.1111/1556-4029.13330

Martone, C. A., Mulvey, E. P., Yang, S., Nemoianu, A., Shugarman, R., & Soliman, L. (2013, September). Psychiatric characteristics of homicide defendants. The American Journal of Psychiatry, 170(9), 994-1002. https://doi.org/10.1176/appi.ajp.2013.12060858

Stone, M. H. (2015, March). Mass murder, mental illness, and men. Violence and Gender, 2(1), 51-86. https://doi.org/10.1089/vio.2015.0006

In a study of the pre-attack behaviors of 63 active shooters (Silver et al., 2018), the FBI found that 16 (25%) 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% of their sample but concluded that "declarations that all active shooters must simply be mentally ill are misleading and unhelpful." This is partly 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 offenders who kill three or more people, it appears that about 60% have evidence of some sort of unspecified psychological distress, even if they do not meet formal diagnostic criteria (Follman, 2012). Corner and Gill (2015) and

Gruenewald et al. (2013) found that mass casualty offenders/lone actor terrorists are significantly more likely to have a mental disorder than group actors: 32% of lone actors have evidence of mental illness, compared to 3% 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 people diagnosed with mental illness only account for 5% of all violent crime in the United States, a higher proportion of perpetrators of mass homicides have mental illness in comparison to perpetrators of other types of violence (Fazel & Grann, 2006). However, having a diagnosis of any kind is not the same as having a diagnosis that is associated with a greater likelihood of mass violence. The DSM-5-TR provides a broad catalog of varied brain-related health conditions that impair a person's 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 none of these mental illnesses are associated with an increased risk of violence, as opposed to a diagnosis of severe personality disorder, which is applied to a remorseless killer whose compulsive, aberrant behavior manifests in willfully destroying others.

In addition, there is a difference between someone with mental illness (e.g., a person with schizophrenia, bipolar disorder or psychotic depression whose delusional thoughts impel them to violence) and someone in urgent emotional distress (e.g., 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 based on their fears — the result is that millions of harmless people 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 or may not have played in their crime. In addition to the lack of research into whether perpetrators have histories of mental illness, the fact that these illnesses often go unrecognized and untreated adds to further underestimation, especially when considering young people who may not have been diagnosed yet.

Apart from establishing a diagnosis, there is the issue of whether the symptoms of the person's illness *caused* the violent behavior in question. It is important to remember that 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 a sufficient risk factor for committing an act of mass violence.

In the same way that law enforcement must establish the motivation for a crime, the ways 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 could motivate violent behavior, it is difficult to meaningfully characterize the role various kinds of psychopathology might play in acts of mass violence. *Merely to assert that "all mass violence perpetrators are mentally ill" is to make an empty and misleading statement*.

Some violent acts have 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 preexisting "intermittent explosive disorder" and been thus predisposed to violence, while another may have been especially affected by their termination.

The stereotype of a person 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 (diagnosed or not) or distress, or to be in crisis, and they usually are receiving no or inadequate treatment (Rozel, 2018).

VENUES OF MASS VIOLENCE

Mass violence is perpetrated in numerous venues, including 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 (i.e., further protected) at the risk of potentially restricting personal freedoms, installing security systems (e.g., metal detectors, surveillance cameras, barricades, locks) or eliminating specific high-risk groups' access to weapons.

Beyond identifying and alleviating root causes of violence, venue security has been identified as a key component of mitigation of the risks of mass shootings. A comprehensive report on these security issues is beyond the scope of this paper, although research on effective practices in schools is summarized later in this report, in a section titled "Mass Gun Violence in Schools" on page 47. These are particularly vulnerable and painful venues for violence because of their defenselessness, the youth of the potential victims and the large numbers that gather in educational settings.

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

Solutions

INTRODUCTION

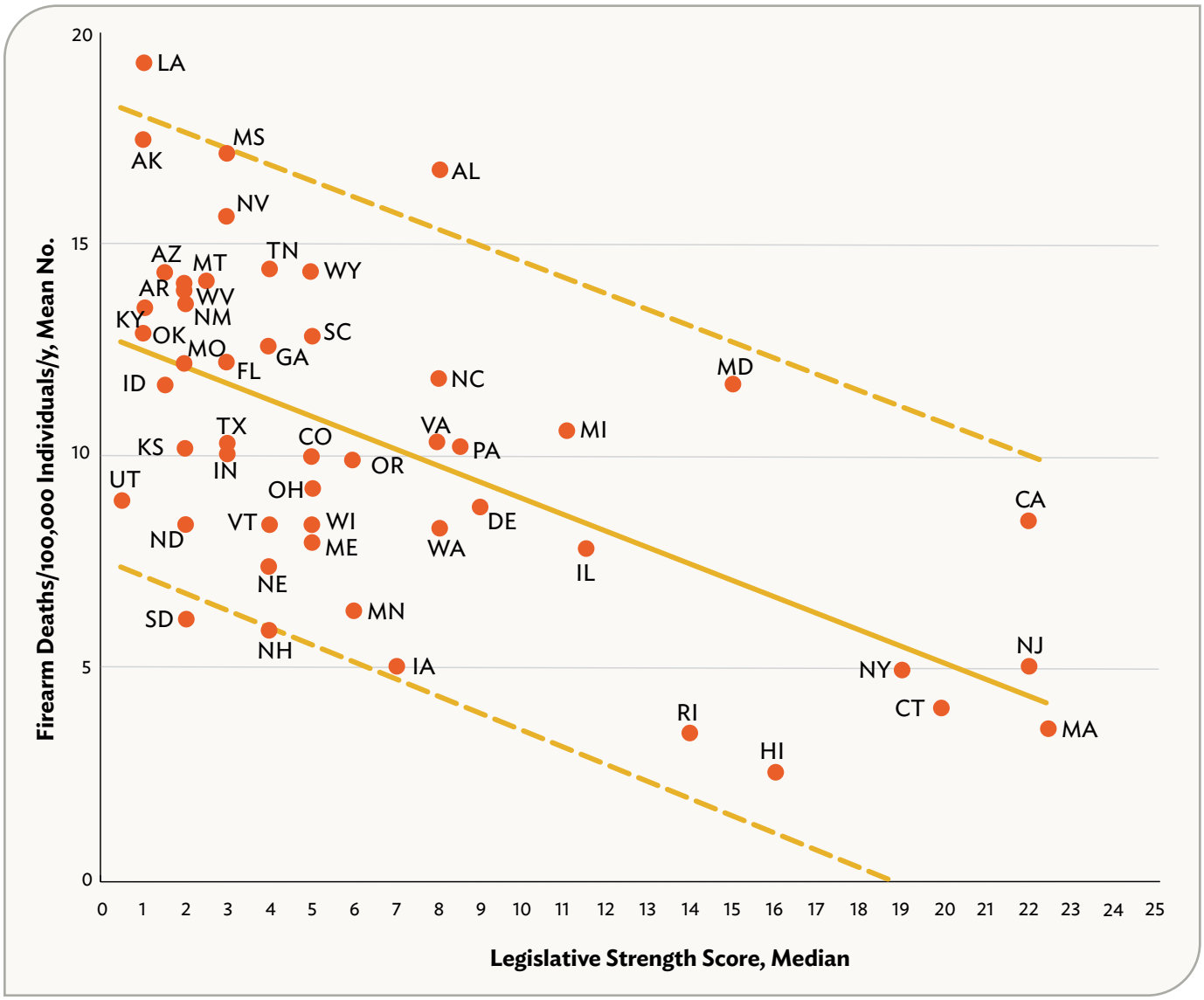
There are an extraordinary number of challenges to address when we consider "the scope of the problem" in mass shootings. While this paper is not able to delineate steps to resolving all issues, we offer many practical solutions and recommendations, suggest references and consider funding sources and human resources.

FIREARM RESTRICTIONS

Because there is no single solution to mass violence, studies of the impact of putative solutions can be misleading. RAND's (n.d.) systematic review and meta-analysis of gun policy in the United States, first released in 2018 and updated as recently as 2023, found little persuasive evidence for the effects of most policies on most outcomes. Researchers reviewed 2,975 studies, 152 of which addressed mass shootings. There were inconclusive findings on background checks, assault-style weapon 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 interventions in combination that show the impact on mass violence involving guns. Fleegler et al. (2013) used a summary score for the strength of gun control laws in each of the 50 states that, when compared to each state's homicide rate overall, showed that lower homicide rates are associated with a higher score on the strength of gun control legislation.

Exhibit 15. Rates of firearm deaths compared to firearm restrictions by state

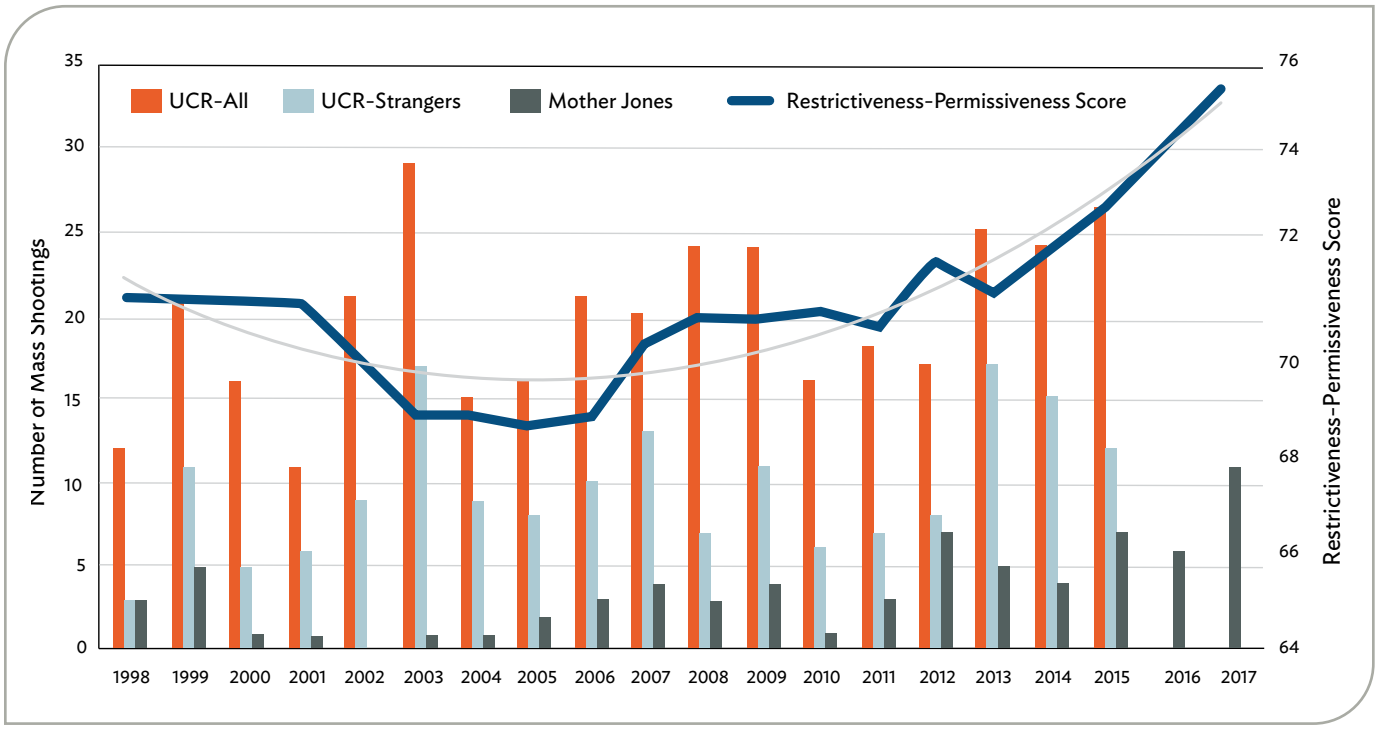


(Fleegler et al., 2013)

In a similar vein, Reeping et al. (2019) 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 limiting open carry in government buildings and banning loaded-gun permits in schools, while permissiveness includes recognizing out-of-state permits, the use of lifetime permits and allowing permitless carry. The restrictiveness score was created using ratings based on the 1998 to 2007 editions of the annual Traveler's Guide to the Firearm Laws of the Fifty States (Kappas).

Ultimately, researchers used data from 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).

Exhibit 16. Number of shootings in FBI UCR (1998-2015) and Mother Jones (1998-2017) data and state restrictiveness-permissiveness score



(Branas & Rozel, 2018)

On average, for every 10-unit increase in firearms permissiveness, there was an 11% to 13% increase in the rate of mass shootings, though the researchers cautioned 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 those are and what their specific impact might be. Comparing this score to the rate of mass shootings for each state showed that stricter state firearms laws are associated with fewer mass shootings, after adjusting for multiple population factors.

In Duchesne et al. (2022), findings supported that the strength of the state gun law *did not affect the incidence* of mass shooting events. However, when mass shooting events occurred in states with higher (more restrictive) gun-law grades, there were lower mortality rates, suggesting that additional firearm legislation could reduce deaths.

There is some agreement on certain measures aimed at addressing gun injuries and deaths in the U.S. Barry et al. (2018) found a series of evidence-based measures that have wide support, including among 75% of gun owners:

- Conducting universal background checks before sale of a firearm.
- 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.
- Implementing permitting and competence testing for concealed carry.
- Requiring states to report people to the NICS when they are involuntarily committed to a mental health facility.
- Removing firearms from a person subject to a domestic violence temporary restraining order.
- Allowing families to petition for the temporary removal of firearms.

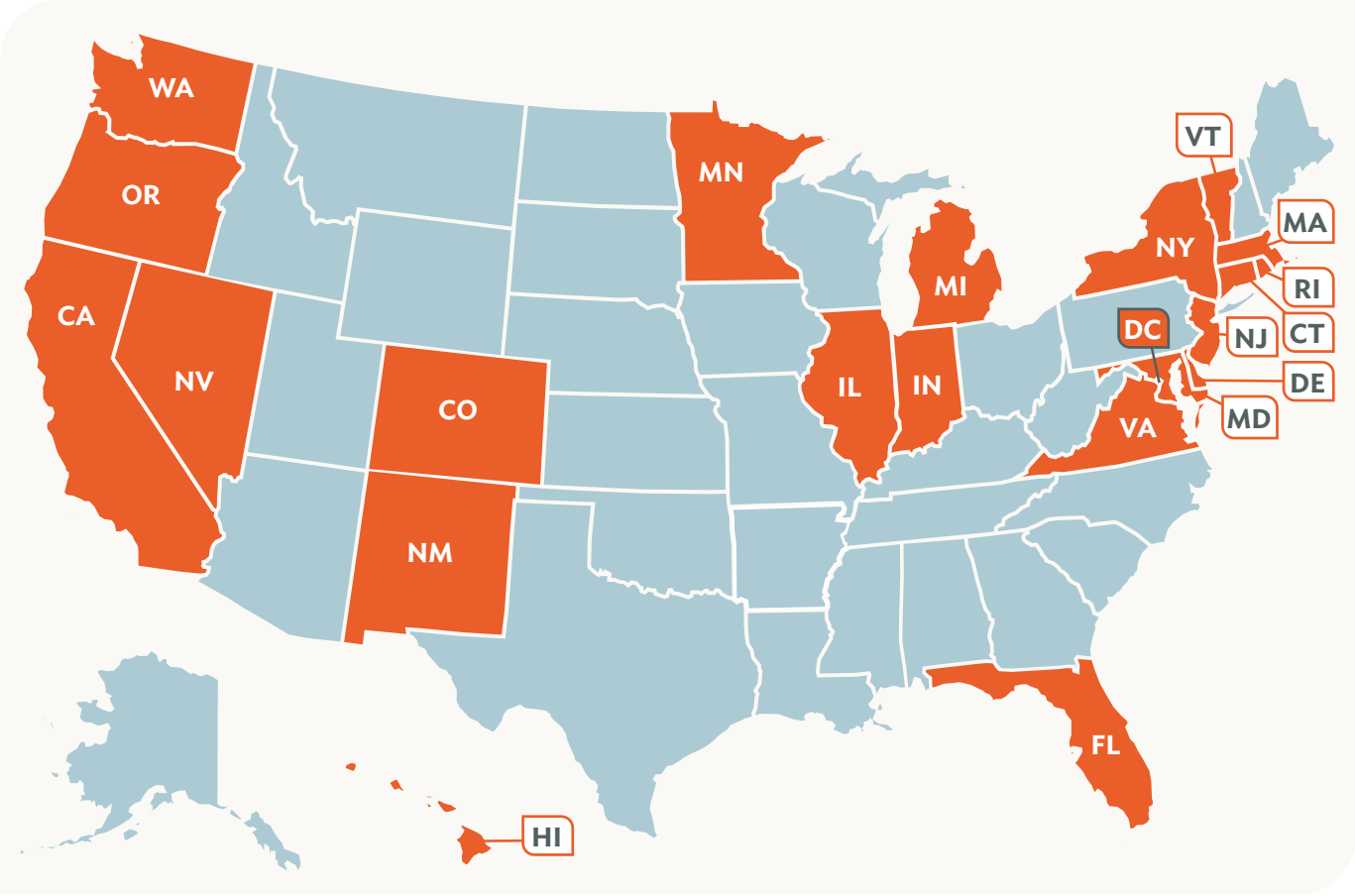
In cases involving K-12 school shootings, over 80% of the perpetrators stole guns from family members. It is obvious that safe, consistently locked storage for firearms is essential. Federal standards for firearm locks, along with public relations campaigns to encourage safe gun storage, would prevent misguided use of guns.

For any gun measures to succeed, they must have broad popular support. They should be supported by empirical evidence and 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.

Extreme Risk Protection Orders

Most mass shooters did not have a diagnosed mental disorder, but many exhibited signs of severe psychological distress, uncontrolled anger or threatening behaviors that worried people close to them. In a growing number of states, when law enforcement authorities become aware of such concerns from citizens, they can petition a court for an ERPO — a civil restraining order that authorizes police to search for and temporarily take custody of a person's firearms if they are behaving dangerously. The ERPO also prohibits purchase or possession of firearms for the duration of the order.

As of January 2024, 21 states and the District of Columbia have enacted ERPO laws.



These laws vary slightly from state to state, but they share key features. Typically, ERPO laws provide legal due process for firearm removal and time-limited prohibition, in two steps. The first step is an initial ex parte (parties not present) order designed to limit a person's access to firearms on an urgent or emergency basis. The judge must find that there

is probable cause to believe the respondent poses an imminent risk of bodily harm to others or self by possessing or acquiring a firearm. The second step provides an opportunity for a court hearing, usually held within 14 days, at which the ERPO respondent may have a lawyer present and the state must prove that the person continues to pose an imminent risk of harm to self or others. If the state meets its burden of proof — typically by the standard of clear and convincing evidence — the state retains the respondent's firearms for no longer than one year, unless renewed, in most states with ERPO laws.

In 15 of the 21 ERPO states, the relevant statute authorizes family members of a person behaving dangerously to petition the court directly for an ERPO; five states authorize clinicians as direct ERPO petitioners; four states authorize people in other categories, such as educators. ERPOs neither require, nor produce, a criminal record. They do not authorize removal of securely stored firearms belonging to other people in the same home, as long as the person of concern — the ERPO respondent — does not have access to the firearms. The orders also do not require that the subject of an order have a mental illness. Instead, they require evidence of specific recent actions and/or threats of violence, and they allow consideration of other factors (e.g., a history of using physical force against others, illegal substance use, hospitalization for mental illness) that establish a substantial risk of harm to self or others.

An emerging body of research has described the implementation of ERPO laws in a handful of states and local jurisdictions, as well as their legal status in the aftermath of the Supreme Court's Bruen decision.

Bruen decision

In 2008, the U.S. Supreme Court issued its opinion in District of Columbia et al. v. Heller, in which it articulated for the first time that the Second Amendment protected an individual's right to possess a handgun in the home for the purpose of self-defense. It failed, however, to provide lower courts with clear guidance on how to evaluate future Second Amendment cases. In the decade following Heller, federal circuit courts coalesced uniformly around a two-part test, known as tiers of scrutiny, for adjudicating Second Amendment challenges. First, relying on history, courts asked if the regulated activity implicated the Second Amendment at all; then, if it did, the court applied some form of means-end scrutiny (*District of Columbia et al. v. Heller*, 2008).

In June 2022, the Supreme Court dramatically altered Second Amendment jurisprudence in New York State Rifle & Pistol Association v. Bruen, repudiating the use of the tiers of scrutiny and articulating its own two-part test. For part one, the court must determine whether the plain text of the Second Amendment covers the conduct regulated. If so, at part two, the government bears the burden of proving that the modern law is consistent with the nation's historical tradition of firearm regulation. The court explained that, at the second part, courts may analogize modern laws to historical laws and assured that "the new analytical framework did not require 'dead ringer[s]' or 'historical twin[s]' and would not turn the Second Amendment into a 'regulatory straightjacket'" (*New York State Rifle & Pistol Association v. Bruen*, 2022).

Despite assertions that this new test would be "more legitimate, and more administrable" than the tiers of scrutiny, lower courts have grappled significantly in their attempts to apply this new standard, evaluating the same laws and historical evidence and coming to opposite conclusions regarding their constitutionality. This has created a climate of uncertainty in the current state of gun rights litigation and jurisprudence (*New York State Rifle & Pistol Association v. Bruen*, 2022).

In June 2024, the Supreme Court upheld the federal law banning gun possession by people under domestic violence retraining orders in United States v. Rahimi. This decision confirmed that under the criteria set forth in the Bruen decision, the government retains the authority to disarm individuals who pose a credible threat to others, stating, "When an individual has been found by a court to pose a credible threat to the physical safety of another, that individual may be temporarily disarmed consistent with the Second Amendment" (*United States v. Rahimi*, 2024).

Early studies examined suicide outcomes in small samples of people exposed to risk-based firearm-removal laws in Connecticut (n = 762) and Indiana (n = 395) (Kivisto & Phalen, 2018). These studies linked ERPO respondent databases to state death records and identified people who had later died by suicide, whether by firearm injury or another method. Using a counterfactual analysis based on case fatality rates, researchers estimated that for every 10-20 firearm removal actions, one life was saved by averting a suicide. A case-control study also found that ERPOs had reduced suicides in Connecticut and Indiana (Kivisto & Phalen, 2018). A new study from six states found that 1 in 10 ERPOs involved a person who threatened a multiple-victim shooting, most frequently a K-12 school (Zeoli et al., 2022).

More recently, a synthetic control study in San Diego County, California, did not find that ERPOs had a significant effect in reducing population rates of violent crime and suicide (Pear et al., 2021). However, given that only a small number of ERPOs had been issued — 355 orders over a period of four years in a population of 2.6 million — it is hardly surprising that statistically significant population-level effects could not be detected.

For ERPO laws to achieve their lifesaving potential, the challenge now lies in broader implementation. So far, the use of ERPOs has been limited. Relevant parties — including law enforcement, judges and potential petitioners — need to be aware of ERPOs and the process for obtaining one. ERPO protocols, training programs for police and judges, and information systems should be developed or disseminated more broadly. Experts and practitioners have already developed some ERPO resource guides that pool information and emerging best practices from jurisdictions where ERPO champions are using these legal tools successfully. The Bipartisan Safer Communities Act of 2022 appropriated significant grant funding for states' ERPO implementation. An ERPO training and technical assistance center has been established at the Johns Hopkins Center for Gun Violence Solutions (Blocher & Charles, 2020; Conrick et al., 2023; Frattaroli et al., 2020; Pear et al., 2023, Rowhani-Rahbar et al., 2020; Swanson et al., 2022; Willinger & Frattaroli, 2023; Wintemute et al., 2019).

Clinicians working in primary care or specialty behavioral health settings have an important opportunity to identify patients with access to firearms at a time when those patients may pose a risk of harm to self or others. If clinicians are working in a state with an ERPO law that authorizes clinicians as petitioners, they may consider filing an ERPO petition directly with the local court of jurisdiction when they encounter someone who they think meets the risk criteria specified in their state's ERPO law. In ERPO states that do not authorize clinician petitioners, clinicians can reach out to law enforcement when they have a concern about a patient who they know is behaving dangerously and has access to firearms.

Several identified concerns may pose barriers to clinicians' wider use of ERPOs: compromising patient privacy, undermining working alliances and patients' trust, potential legal jeopardy and time constraints. Each of these barriers can be overcome with training and certain implementation features or potential reforms to ERPO statutes. For example, limited immunity from liability for clinicians who use (or do not use) ERPOs has been written into some statutes. (See "Clarifications on federal regulations related to confidentiality" on page 58 for more information on allowable exceptions to nondisclosure privacy rules for patients who pose an imminent risk of harm.)

BEHAVIORAL THREAT ASSESSMENT AND MANAGEMENT: IDENTIFYING HIGH-RISK PEOPLE

It is virtually impossible to predict when and where mass shootings will happen, since it is difficult to characterize perpetrators (Swanson, 2011). Considerable research has gone into identifying risk factors for violence and assessing threat, leading to the development and application of research protocols and instruments for assessing risk of violence. While these instruments are valid at the group or population level, they are limited in their ability to identify risk at an individual level and determine with sufficient precision when a person might act. Studies reveal that there are many relevant characteristics of mass violence perpetrators and that those are shared by large numbers of people who will not commit acts of mass violence (see "Characteristics of mass violence perpetrators" on page 29). While we cannot predict which people will commit a violent act, we can still prevent violence by reducing risk. This is a public health approach that should be emphasized in violence prevention efforts — prevention does not require prediction.

Perpetrators of mass violence may share some characteristics, but they are a sufficiently heterogeneous group that models relying on profiles will almost certainly yield unacceptably high rates of both false negative and false positive identifications. Profiling is about identifying a population of possible offenders based on known elements of a crime or potential crime. Behavioral threat assessment and management (BTAM) is not profiling. BTAM is about investigating a person who has been recognized as being at potential risk for violence based upon their statements of intent, threats, or behaviors indicating acts of preparation to attack, to identify specific risk and protective factors. The focus of BTAM is to identify what interventions are most likely to reduce the risk of violence in the person of interest, as well as to look at environmental and victimological factors.

In addition, many of the risk factors for violence apply to people 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 risk factors for violence shared by people without mental illness, such as poverty, SUDs, prior violent criminal conduct, recent stressors and nondelusional belief systems that may trigger violence.

An especially problematic instance of profiling is the proposal to screen all people with mental health challenges, in an effort to prevent rare acts of serious violence. The danger is that those who are identified as being at risk of violence — far from being given priority access to treatment and becoming eligible for intensive services — will be discriminated against, deprived of their liberty and subjected 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, given that research suggests most perpetrators of violence and mass violence do not have active mental illness. Nonetheless, educating providers on threat assessment, improving behavioral health treatment access and quality, and strengthening patient engagement likely will prevent some violent episodes, making these strategies important public health interventions.

Put simply, profiling based on the presence of mental illness is unethical and ineffective, but identifying and treating mental illness in people otherwise believed to be at risk for violence is an ethical and effective strategy to reduce violence.

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

How behavioral threat assessment and management works

The concept of BTAM (often shortened to "threat assessment") originated in law enforcement as a strategy to prevent violence targeting public figures and others who have been threatened, though the meaning of the term has evolved over time. BTAM is being used more frequently, reflecting both the emphasis on the role of behaviors in understanding risk and the renewed emphasis on management of potential risk, and not merely assessment of risk at a single point in time.

A threat assessment team within a business or school is a multidisciplinary group that often includes representatives from security and law enforcement, behavioral health care, human resources, legal and management. (See more about threat assessment teams in the section "Mass gun violence in schools" on page 47.) The threat assessment model recognizes that violence is a multidetermined 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 et al., 1995; Rozel, 2018).

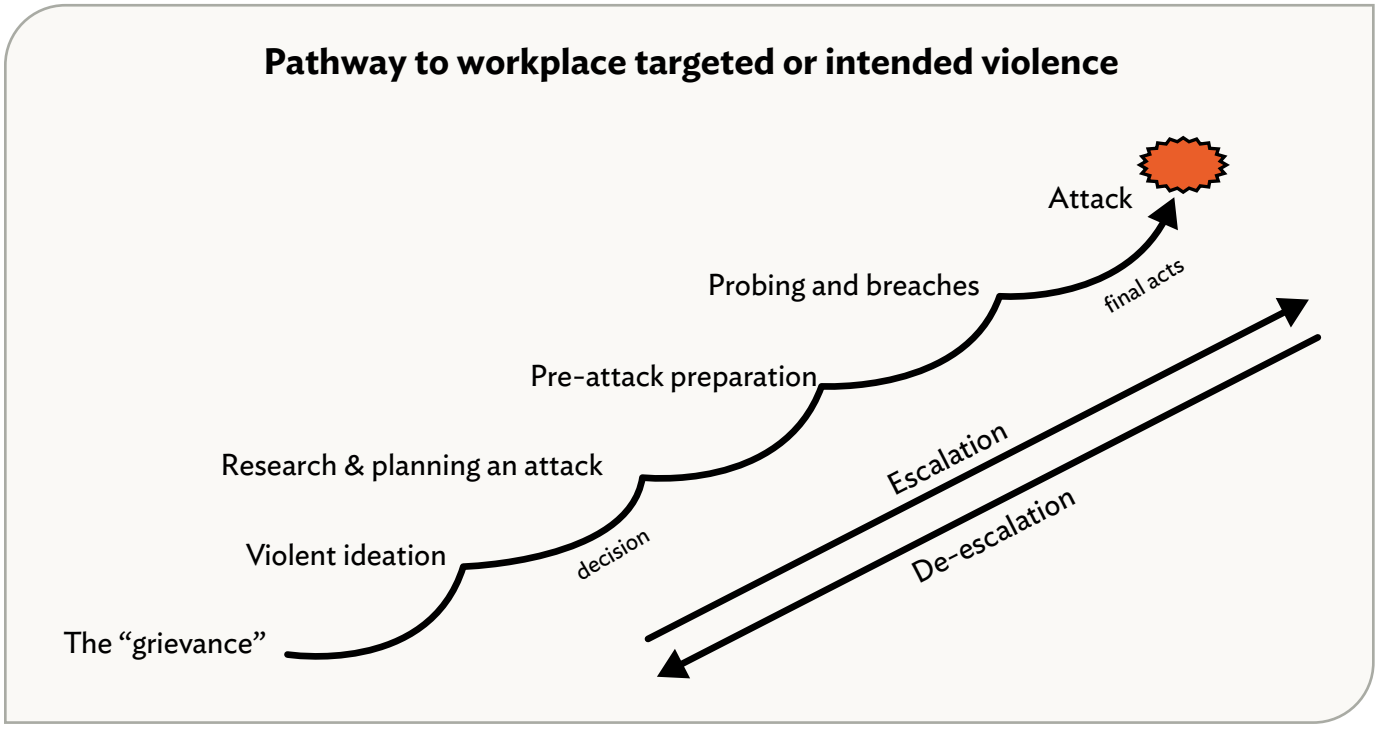
In some threat assessment situations, those assessing risk do not meet the subject or conduct a face-to-face clinical evaluation. Instead, they look at social media, written documents, oral communications, direct reports/observations from people other than the assumed person of interest, clinical records and other documentation of behavior. Then they must determine what to do with that information. BTAM is often effective in preventing violence; however, it requires more time and resources than the ineffective single-point-in-time clinical risk assessment.

Instead of focusing on people's static traits and features, threat assessment teams focus on trajectories or pathways 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 events that prompt assessment and/or interventions). Approaches that use operational threat assessment methods to assess the trajectory of a potential attacker toward or away from executing an attack also can be part of evidence-based (or potentially evidence-based) prevention and interdiction strategies within a public health model (Meloy et al., 2012). In BTAM, much like in clinical mental health care, static and historical risk factors are noted, but the focus is on recognizing and modifying dynamic risk factors and reinforcing or adding protective factors.

Calhoun and Weston (2003) conceptualized one pathway related to workplace violence that can be applied in other settings, including two key takeaways. First, targeted or intended violence usually begins with a grievance and escalates over time. Second, there are many points at which the situation can be defused. That is part of what a threat assessment team does.

Exhibit 17. The pathway to violence



Adapted with permission from Calhoun & Weston, 2003.

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 and suicide attempts. It also includes dynamic individual factors that change over time and are amenable to intervention or interdiction, including current drug use, weapons possession, untreated psychotic symptoms and personal capacity for resilience.

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, an adverse response to authority, and identification with violent perpetrators. Unemployment, lack of social support, emotional disconnection, suicidal and homicidal ideation and mental illness, and especially SUD, all can 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 et al. (2018) found that, in the year preceding the attack, active shooters typically experienced an average of 3.6 stressors; the primary stressors for 62% of those studied were related to mental health. Other studies have shown higher rates of crises. This indicates that the active shooter appeared to be struggling with, most commonly, depression, anxiety and/or paranoia in daily life during the year before the attack. Although these stressors were present, it was unclear if these symptoms were sufficient to warrant a formal diagnosis of mental illness. Other stressors were related to finances, jobs and interpersonal relationships, use of drugs and alcohol, caregiving responsibilities, conflicts at school and with family members, and sexual stress or frustration.

Exhibit 18. Stressors

STRESSORS	*n*	%
Mental health	39	62
Financial strain	31	49
Job related	22	35
Conflicts with friends/peers	18	29
Marital problems	17	27
Use 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

A critical takeaway for clinicians and health care leaders is that, while mental illness is an infrequent risk factor for serious violence, acute crises may be a useful indicator, especially at a time when there is a broad national effort to expand recognition of crises and access to crisis services through programs like Certified Community Behavioral Health Clinics (CCBHCs) and the 988 Suicide & Crisis Lifeline.

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 might mitigate the risk for violence include the availability of mental health treatment and receptivity to its use, family and other social supports, and spiritual beliefs.

While being in a high-risk group increases the probability of mass violence, the positive predictive value is still limited to "if" rather than "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 people
- Diminishing inhibitions
- Inability to pursue other options
- Obsession
- Sense of inevitability (apocalyptic vision)
- Pre-attack or ritual preparation (e.g., suicide note)
- Recent acquisition of or preparation with firearms
- Subject's response to assessment and inquiries

Critical resources for leaders interested in developing threat management programs in their community or organization include:

- Follman, M. (2022). *Trigger points: Inside the mission to stop mass shootings in America.* Dey Street Books.
  - An excellent high-level overview of the history and potential of BTAM; a good read for C-suite leaders and executive champions.
- Amman, M., Bowlin, M., Buckles, L., Burton, K. C., Brunell, K. F., Gibson, K. A., Griffin, S. H., Kennedy, K., & Robins, C. J. (2015). *Making prevention a reality: Identifying, assessing, and managing the threat of targeted attacks.* National Center for the Analysis of Violent Crime, Behavioral Analysis Unit, Federal Bureau of Investigation. https://www.fbi.gov/file-repository/making-prevention-a-reality.pdf
  - The definitive operational guidance for BTAM process and team development.
- Association of Threat Assessment Professionals. (n.d.). *Home.* https://www.atapworldwide.org/
  - The primary organization supporting education, research and professional development and networking.

BTAM concepts provide extremely useful tools for clinicians, both those doing general assessment of violence risk and those faced with caring for a high-risk individual. Two quick-reference, open-access, evidence-based resources intended for rapid initial evaluation and management are:

- Barnhorst, A., & Rozel, J. S. (2021). Evaluating threats of mass shootings in the psychiatric setting. *International Review of Psychiatry 33*(7), 607-616. https://doi.org/10.1080/09540261.2021.1947784
  - Brief article summarizing clinical evaluation and decision making in acute-care settings.
- BulletPoints Project. (n.d.). *Threat AID: Clinic tool for clinicians who encounter a patient at risk of targeted or mass violence*. https://www.bulletpointsproject.org/threat-aid-protocol/
  - A tool that provides essential evaluative steps for emergency settings.

MASS GUN 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 et al. (2015) using FBI homicide data examined the locations of homicides in 37 states over six years and found that schools, including colleges, are some of the safest places in the United States. More recent FBI homicide data using the newer National Incident-based Reporting System confirms that study's findings (FBI, n.d.-a). A person is twice as likely to be murdered in a restaurant than in a school. This applies to shootings and mass shootings, as well as homicides in general.

Firearms are the leading cause of death for children and adolescents in the U.S., with substantial disparities across groups (Roberts et al., 2023), but understanding how those shootings occur is critical. Another study looking at deaths of school-aged children and adolescents during a 25-year period revealed several important findings that may be inconsistent with beliefs held by the general population and policymakers. First, more than 98% of the firearm homicides occurred outside of school settings. Second, more than 90% of school shootings are single-target/victim events, not mass casualty events. Third, interpersonal grievances and gang activity were the most common causes of violent events (Holland et al., 2019). Finally, data from the K-12 School Shooting Database consistently indicates that in-class shootings are substantially less common than shootings in hallways and outside of the school building (Riedman, n.d.). It is critical that these data points inform any evidence-based policies or strategies to mitigate risk of violence in schools.

However, despite their statistical rarity, school shootings shock the nation. The general population is now aware that shootings are the number one cause of death in children from 1 to 18 years of age. The last few years have seemed replete with egregious mass shootings in school settings. These events caused widespread trauma for victims and their families, perpetrators' families, first responders and whole communities. The fear of school shootings has led to an emphasis 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 challenges

One example of a potentially detrimental strategy that has created harmful 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 prohibiting such things as nail clippers and plastic utensils, finger-pointing, jokes, drawings or rubber band shooting. The result of these rules is that students are suspended for a wide variety of minor misbehaviors. Often, these youth must have a doctor's note or some type of safety medical clearance to return to school. This can result in youth being sent to an emergency room, where providers need to sort out a complex situation and are unreasonably expected to attest that the youth is safe to return to school.

Many studies have found negative outcomes associated with suspension (Fabelo et al., 2011; Morgan et al., 2014; Noltemeyer et al., 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, become 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.

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 can impact student support services, causing preventive interventions to 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 in makeup to look like they have been shot. Students are taught to attack shooters with anything they have at hand. In some cases, drills are not announced in advance, and there are situations where deception is used, leading students — and sometimes staff — to believe that an active shooting is occurring, rather than a drill. Though some safety drills are warranted, those that evoke fear and might create trauma do more harm than good (Rich & Cox, 2018; Schonfeld et al., 2020). A more recent study (Schildkraut et al., 2023) notes that 95% of K-12 public schools now have some form of safety drills. Their research reflects that training and drills (lock classroom door, turn off lights, get out of the view of the assailant, be silent) build and sustain mastery, and they found that locking down the room was the most consistent and significant factor in reducing casualties and mortality. Of note, if first-responder error (e.g., delayed arrival or entry) occurred, lockdowns no longer significantly decreased casualties or deaths. 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 BTAM teams. Both are essential in violence prevention initiatives.

Establish 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.
- Positive adult role models (e.g., teachers, advisors).
- 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, and schools must have procedures in place to handle these concerns. (See discussion of threat assessment in "Behavioral threat assessment and management in schools" on page 49.) They must be willing to seek help for themselves or others. Every student must feel that they have 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 et al., 2016; Federal Commission on School Safety, 2018; Pollack et al., 2008.)

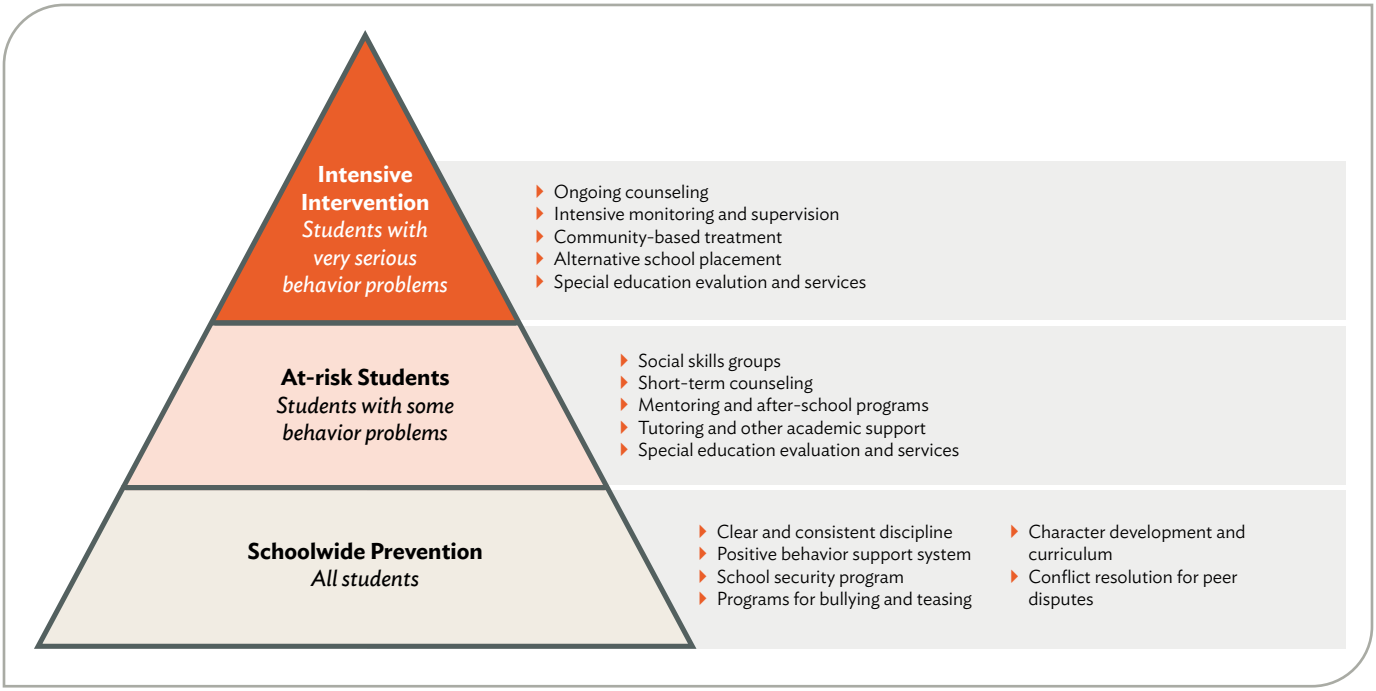
Students who feel that they are in a safe school and have an adult they can go to are more likely to report a potentially threatening situation (Pollack et al., 2008). This requires that staff are trained to respond properly to students who provide them with information about a threatening or disturbing situation, as well as to deal with actual threats. Research in Virginia schools found that students are the most frequent reporters of another student's threat to harm someone (Cornell et al., 2015). Stohlman and Cornell (2019) developed an online educational program to enhance student willingness to report threat concerns.

Behavioral threat assessment and management in schools

The FBI, Secret Service and Department of Education recommended a threat assessment approach more than 20 years ago (O'Toole, 2000; Vossekuil et al., 2004), and more recent iterations are available (Amman et al., 2015). 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 pose a threat of violence in some way. There are three components of school threat assessment, involving threat identification, evaluation and intervention: 1) The school has a reporting system that allows anyone in the school community to report a statement or behavior that raised concern about potential violence; 2) the school-based multidisciplinary team evaluates the seriousness of the threat and the danger it poses to others, recognizing that all threats are not the same; 3) the team manages the threats by recommending interventions to reduce the risk of violence and follows up to assess the intervention's results. In the most serious cases, the team may take protective action, such as warning potential victims and notifying law enforcement.

Exhibit 19. Threat assessment is part of a comprehensive approach



(D. Cornell, presentation to MDI Expert Panel on Mass Violence)

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

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 (e.g., principal or assistant principal), mental health (e.g., school counselor, psychologist, social worker) and law enforcement or security (Cornell, 2018a). 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, can respond quickly and can carry out preventive actions and monitor their effectiveness. Collaboration with law enforcement is critical: 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 they can react appropriately to more serious cases that merit law enforcement intervention.

Based on work done by the Secret Service and the Department of Education on enhancing school safety, threat assessment is predicated on a set of key principles:

- "Targeted violence is the result of an understandable, and oftentimes discernible, process of thinking and behavior.
- Targeted violence stems from an interaction among the individual, the situation, the setting and the target.
- An investigative, skeptical, inquisitive mindset is critical to successful threat assessment.
- Effective threat assessment is based upon facts rather than on characteristics or 'traits.'
- An 'integrated systems approach' should guide threat assessment inquiries and investigations.
- The central question in a threat assessment inquiry or investigation is whether a student poses a threat, not whether the student has made a threat" (Fein et al., 2004).

In 2001, a team at the University of Virginia developed the Comprehensive School Threat Assessment Guidelines, a threat assessment model specifically designed for schools (Cornell, 2018a). This model uses a decision tree to guide school-based teams in an assessment of student threats that emphasizes the distinction between the two types: 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 et al., 2018). Five controlled studies (involving over 1,000 schools) 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 Comprehensive School Threat Assessment Guidelines had 49% lower rates of school suspension and 80% fewer school transfers; students were more likely to receive counseling; and there was less bullying and student aggression and more positive perceptions of school environment and safety, as reported by teachers and students (Cornell, 2018a). From 2013-2018, all threats were successfully resolved. More recent research in a statewide sample of Florida schools involving 23,000 threat assessments found that approximately 94% were resolved without an attempted act of violence, and approximately 6% involved an assault such as a fight without serious injury. A serious injury (defined as requiring hospital care) was reported in only 0.25% of cases (Maeng et al., 2023).

Following the Sandy Hook shooting in Connecticut, 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% of threats were not attempted and less than 1% were carried out, with no serious injuries. Also, 84% of the students who made the threats continued in their original school.

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 criticized 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 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 for 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 "Clarification on federal regulations related to confidentiality" on page 58). 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 respond to known or foreseeable harm and adhere to legal requirements. This can include:

- Developing policies and procedures that address the risks of potential harm and how to manage them.
- Training employees on these policies and procedures, including periodic retraining.
- Applying the policies and procedures and following up.
- Establishing multidisciplinary BTAM teams.
- Practicing the application of these policies and procedures.
- Educating team members and others in the organization as to the actual requirements of statutes such as HIPAA and FERPA.
- Documenting cases in high-quality records and reviewing how they were handled for quality-improvement purposes.

It is important to note that merely having policies and procedures in place is not sufficient to protect against liability. Indeed, unless staff and students are trained on the policies and procedures, and they actually are applied, their existence may be used to show that the defendant knew of the risks but was negligent in failing to follow their 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. By the time they complete high school, 1 out of 20 young people experience the death of a parent, and 9 out of 10 experience the death of a close relative. However, fewer than 1 in 10 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 et al., 2024).

In a study on the effects of the September 11, 2001, terrorist attacks on New York City schoolchildren (Hoven et al., 2005), 28.6% of students surveyed six months later met the criteria for one or more probable psychiatric disorders, including post-traumatic stress disorder, major depressive disorder, separation anxiety and general anxiety disorders, panic attacks and agoraphobia. Based on the survey of 8,000 students, 87% still had at least one trauma symptom. More importantly, 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 often 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 providing individual services outside 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 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 also will be deeply impacted personally by these events and therefore often overwhelmed and less able to focus on learning new skills (Sandy Hook Advisory Commission, 2015). Prior to any major event, staff 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 (Shultz & Forbes, 2013). Given that these skills can be used to support young people who are struggling with personal and family crises, 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 (often years) needed to recover, and the time frame 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 the universal emotional literacy and social skills training may be one way to support prosocial behavior and emotional wellbeing (Jones & Doolittle, 2017). However, this investment can be challenging in schools without adequate staff-to-student ratios and with an emphasis on high academic standards and behavioral expectations in lieu of emotional literacy and social skills training.

HEALING FROM TRAUMA: INDIVIDUALS, FAMILIES, STAFF, FIRST RESPONDERS, SURVIVORS, WITNESSES, COMMUNITIES

Individuals, families and communities are horribly impacted by the trauma of mass shootings. In studies of mass shootings from 2008-2017, Soni and Tekin (2020) reported decreased community wellbeing and negative emotional health outcomes, along with decreased community satisfaction, decreased sense of safety and increased levels of stress and worry. Of the respondents, 27% reported a likelihood of moving, and 13% reported a drop in "excellent" emotional health. Abrams (2022) noted that individuals and community members reported ongoing fears of further mass shootings, with one-third avoiding places/events near the attack site. Greater exposure (being closer to the site, having a family member injured or killed) was associated with more severe symptoms (Lowe & Galea, 2017). Riehm et al. (2021) studied 2,000 youths traumatized by mass shootings and found that those with greater concerns about school shootings reported significantly more anxiety and panic six months after the event.

Everytown Research & Policy (2022) surveyed 150 survivors of mass shootings (witnessed, were wounded, knew a casualty or were providing care for someone injured) from October-November 2012. They reported that:

- 90% experienced trauma.
- 50% with prior gun violence history rated the impact of the trauma at 5/5.
- 50% said they needed legal assistance.
- 50% reported that the trauma affected their sense of wellbeing or functioning.
- 66% of those shot/wounded said they needed mental health services.
- 40% said they needed financial assistance with medication, 7% with funeral costs, 25% with home health care.
- They reported the belief that the violence broke down community bonds of cooperation and exposed children and teens to trauma, which made them more vulnerable to substance use, depression, anxiety, PTSD, failure or difficulty in school, and increased risk for engagement in criminal activities.

Family members of those who are victims of mass violence experience a wide range of effects that run the gamut of feelings of loss and grief to trauma disorders. They are grieving the loss of someone to whom they didn't say goodbye, and they are traumatized by the way their loved one died. They are likely stunned and confused and initially may want to withdraw rather than talk to providers. They may have little recall of what is discussed in bereavement counseling, so they may benefit from written materials.

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 difficulty 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. Their trauma may be retriggered as future tragedies strike, even years after an event. It is also important to attend to the recovery needs and long-term physical and mental health consequences for those who are first responders (teachers, school staff, law enforcement, medical providers) (O'Neill et al., 2020). Communities will need comfort and support. In a 2019 National Public Radio segment, Allison Aubrey offered ways to cope in the face of trauma and "make meaning out of misery":

1. "Give yourself time to build resiliency" and shift "from pain to purpose."
2. "Find your circle of support" in family and community.
3. "Make time for positive feelings" through self-care, exercise or creative outlets.
4. "Find daily moments for reflection."
5. "Become a change-maker" by taking positive action "to reclaim a sense of agency."

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 4 and was a loving brother. Three days before the April 20, 1999, shooting that left 12 students and one teacher dead and another 24 people 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 their deaths, Dylan and Eric got in trouble for stealing something from a parked van, but they were released early from a diversion program. At 17, Dylan 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 supporter who believes that every citizen should have some type of suicide prevention training and that everyone should be trained in Mental Health First Aid (MHFA). 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 challenges.

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 young people'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" (S.Klebold, presentation to the MDI Expert Panel on Mass Violence).

A Public Health Model of Gun Violence Prevention

According to the Johns Hopkins Center for Gun Violence Solutions (n.d.), "Public health is the science of reducing and preventing injury, disease and death and promoting the health and well-being of populations through the use of data, research and effective policies and practices." It incorporates education and social marketing to promote protective factors such as life skills, emotional wellness, social connectedness and a willingness to seek help when needed. It offers strategies for early intervention and a range of multidisciplinary treatment options to decrease risk and enhance mental health.

"A public health approach to prevent gun violence is a population level approach that addresses both firearm access and the factors that contribute to and protect from gun violence. This approach brings together institutions and experts across disciplines," along with policy champions, legislators, impacted communities and community-based organizations, "in a common effort to: 1) define and monitor the problem, 2) identify risk and protective factors, 3) develop and test prevention strategies, and 4) ensure widespread adoption of effective strategies. By using a public health approach we can prevent gun violence in all its forms" (Johns Hopkins Center for Gun Violence Solutions, n.d.).

Mass violence, to the limited extent that it is due to mental illness, may be best prevented by providing competent and comprehensive mental health care to the U.S. population (a situation that doesn't currently exist) and, in this context, adopting a public health model of prevention. This should include the following three components, moving from more global "screening," to individual identification, to focused action:

- **Universal:** A public education campaign to help community members identify people of concern (e.g., "see something, say something").
- **Selective:** Measures to assess and intervene with people showing specific identified warning signs — but with no history of past significant violence, communication of threat or evidence of planning — and with access to weapons capable of inflicting mass casualties (e.g., threat assessment teams, MHFA).
- **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.

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 violence events, but more so the result of limitations in research funding. The increased public demand to address this growing and disturbing problem should move government to action but has yet to do so significantly (though the 2022 Bipartisan Safer Communities Act should move efforts forward). 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 community prevention efforts are in "Behavioral threat assessment and management in schools" on page 49, and others follow below.

"See something, say something"

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 in what they say, what they 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. 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 violent behavior might emerge, creating a place within an organization 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 gathering information about who might cause harm.

The concept of "see something, say something" is predicated on the belief that people often demonstrate red flags in their behavior, and that the people most trained to recognize and address those flags are not the people most likely to witness them. The so-called "bystander problem" was discussed by Williams et al. (2016), who examined a program in Bethesda, Maryland, 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 the school environment is associated with student willingness to seek help for threats of violence (Millspaugh et al., 2015; Eliot et al., 2010).

Silver et al. (2018) found similar results as Williams et al. Even though the active shooters they studied displayed four to five concerning behaviors that bystanders observed, only 41% of those bystanders reported their concerns to law enforcement; 83% of bystanders communicated their concerns directly to the shooter, who would try to allay the bystander's concerns. "Multiple chances at intervention had been missed, as bystanders were reluctant to involve an authority figure." The researchers concluded that more needs to be done to help bystanders understand that their concerns will elicit a caretaking rather than a punitive response (Pollack et al., 2008; Federal Commission on School Safety, 2018). This can serve as a diversion method to avert future school shootings, because bystanders feel safe reporting the potential threat. 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, 2018).

Most recently, research from the FBI's Behavioral Analysis Unit found that, when bystanders heard threats and did not share what they knew with appropriate parties or act to intervene, the likelihood of an attack increased more than 15-fold (Silver et al., 2018). Other studies have shown that as many as 1 in 5 adults have someone in their social circle whom they have reason to believe may be at risk for committing violence (Aubel et al., 2023).

Community intervention programs

Communities should be educated that resistance (considered to be "bad" behavior) might instead be seen as a reaction to bad treatment; youth should be offered resources and support for the development of coping skills, agency, identity and ownership of their own lives (Sims-Schouten & Gilbert, 2022). Investments in home visiting programs, parental supports, maternal leave policies and access to high-quality preschools is imperative. Investment means creating healthy communities in places that too often are affected by poverty, violence and substance use.

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 communities — 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, to mental health providers and make an effort 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, the president convened a Countering Violent Extremism Summit. This led to the development of an organized approach led by the Department of Homeland Security. In addition, many communities came to understand that open dialogue and conversation, as well as the building of safety networks, would help family and friends know where to turn if concerns about behavior arise (The White House, 2015).

Early identification and treatment of mental illness reduces the risk for violence. MHFA, a community-based education and engagement program, is an 8-hour training that prepares the average person to identify someone in distress from mental health or substance use challenges, provide them with reassurance and help them get assistance.

Another option is the medical home, "an approach to providing comprehensive primary care that facilitates partnerships between patients, clinicians, medical staff and families. A medical home extends beyond the four walls of a clinical practice. It includes specialty care, educational services, family support and more" (American Academy of Pediatrics, n.d.). The pediatric medical home can serve as a hub for so-called "medical neighborhoods," which "refers to the many services and professionals that can contribute to the health and well-being of the patients and families [being] serve[d]. It includes more than just the principal focus of care and the care team that takes responsibility for each patient; the concept of a medical neighborhood acknowledges that at times the medical home cannot serve all patient needs and desires. A broader support system is sometimes necessary" (Transforming Clinical Practice Initiative, 2019). The pediatric medical home and medical neighborhood can address social determinants of health and promote positive childhood, family and community experiences over adverse ones. Several evidence-based emotional literacy and social skills training curricula exist that can aid schools and ultimately communities in this vital endeavor (Macklem, 2014).

A gun violence prevention model must also minimize exposure to traumatic events and maximize protective factors. This involves supporting growth and development in children and maximizing "resiliencing": "a focus that involves anticipating problems, improvising quickly to cope with adverse events and learning from them over time, every time" (Roeschlein, 2021).

A ROLE FOR TREATMENT PROVIDERS

Behavioral health treatment providers can play key roles in preventing and responding to events of mass violence. Engaging clinicians in these activities requires sensitivity to their concerns in several important areas.

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

Clinicians also may wrongly believe they cannot act on their concerns because of HIPAA, which protects patient privacy. In fact, providers can pass along information to law enforcement, the patient's family members or others when they feel such action is warranted to protect personal safety. (See the text box "Clarifications on federal regulations related to confidentiality" on page 58.) FERPA protects students' educational records, HIPAA covers health records, and federal restrictions on disclosure of information related to alcohol and drug use 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

When a provider believes in good faith that a warning to law enforcement, the patient's family members or others is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others, the HIPAA privacy rule allows the provider to alert those people whom the provider believes are reasonably able to prevent or lessen the threat, consistent with applicable law and standards of ethical conduct (45 CFR § 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 court order under the regulations in this part [which] 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 … 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."

FERPA (20 USC § 1232g; 34 CFR Part 99) is a federal law that protects the privacy of student educational 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 educational 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, explicitly recognizing that school authorities can disclose names and other identifying information to protect the health or safety of others. 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 contradicts the 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" (Tarasoff v. Regents of the University of California, 1976).

This rule, which originated in the California Supreme Court's decision in Tarasoff v. Regents of the University of California, has spread to many states and has been modified or rejected in others. 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 had notified the police, who contacted the patient and notified the therapist's 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, people 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 identifiable 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 to warn of threats toward groups of people. Duties to third parties vary widely 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 specified how it can be met, the reader is advised to discuss the legal duty in their state with their legal advisor.

Ideological and philosophical beliefs about an individual's rights and personal autonomy versus the safety and best interests of society may also influence providers' actions regarding violence surveillance and prevention.

Mental health advance directives, including Ulysses contracts (voluntarily made contracts about future events), 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 those guns to harm themself or others has become significant. Research shows that 46% of psychiatric patients would willingly agree to a seven-day delay or judicial review limit on firearms access (Vars et al., 2017). The psychiatric advance directive, which offers instruction for mental 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.

MASS VIOLENCE RESPONSE BY TREATMENT PROVIDERS: PLANNING FOR BEFORE AND AFTER

Before

Community mental health providers have a role both in violence risk assessments of individual clients and as part of multidisciplinary threat assessment teams. Violence risk assessment differs from BTAM. The most fundamental difference is that the latter focuses on whether a given person 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, 2021):

BTAM	VIOLENCE RISK ASSESSMENT
Investigative approach	Clinical assessment approach
Ongoing process	Single-point-in-time assessment
Includes nonclinicians (police, lawyers, etc.)	Clinicians only
More resource intensive	Less resource intensive
Includes interventions	Does not include interventions

Unfortunately, many clinicians are not adequately trained in violence risk assessment, and very few are trained in BTAM. Clinicians must have access to responsive BTAM for people 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 people at elevated risk for committing a violent act (Rozel et al., 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 challenges. However, access to care and treatment can be challenging. Although 76% of U.S. Americans think mental health is just as important as physical health, we are experiencing a crisis in access to care: 1 in 4 people in the U.S. 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 (National Council, 2018).

But we've made inroads to increasing access, such as providing consultation services to primary care providers around behavioral health issues. The 2022 Bipartisan Safer Communities Act provides funding for communities to develop programs that will provide safer, inclusive, positive school cultures, as well as develop community crisis services. Private practitioners who are not part of a mental health system may need further training and outreach to address these complex areas of concern. There are a range of specialized behavioral health services that are unfamiliar to primary care providers, including programs designed to work with youth who are experiencing a first episode of psychosis, as well as their families.

Modern crisis centers need to be prepared for mass shootings, active assailant events and related forms of targeted violence. While crisis engagement has traditionally been seen as a post-event response, crisis leaders need to educate their teams to identify people at risk for violence in advance, use tools like BTAM to reduce risk in those persons, and prepare for potential events in their community. Evidence suggests that acute stressors are a common proximal risk factor for severe violence, implying that crisis services can be an effective tool for prevention of violence (Rozel & Soliman, 2024).

The federal Interdepartmental Serious Mental Illness Coordinating Committee recognized the need to increase access to care when it released its initial report in 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 SMI [serious mental illness] and SED [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 SMI and SED."

After

Community mental health treatment providers play a vital role in the wake of a mass violence event. They provide support to victims and their families, first responders and the community at large. Sometimes they are called on to define the role that mental illness may have played in the event. Those seeking to provide this type of leadership or consulting to schools and school systems should have training and experience in systems-level consultation in the aftermath of such events, as well as experience 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 that can be beneficial in the aftermath of a tragic event. Attempting to establish those relationships during the aftermath itself can be challenging.
- Be responsive, but not intrusive. It is easy to get overinvolved and to want to be everything to everyone. Solicit an invitation from the institution that where the event occurred. Support, but don't take over.
- Identify sources of funding in advance 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 additional 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 event 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 you anticipate about the community response, it will undoubtedly change. For example, in the early days of the Sandy Hook tragedy, psychiatrists offered "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 event. 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 involved. Include business leaders, the faith community, youth, mental health consumers and law enforcement. Collaborate with local crisis providers.
- To respond after an event, consider psychological first aid (Shultz & Forbes, 2013). This is considered best practice in the aftermath of a crisis event and should be provided to all people impacted by the crisis. It involves offering psychoeducation to help people understand the impact of crisis and what to do to cope, and supportive services to promote effective and healthy coping strategies and adjustment and to accelerate the natural healing process.
- To reduce future risks, consider providing MHFA 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, be prepared with talking points about mental illness and violence, your state's commitment laws and your state's gun laws. A resource such as "Responding to a High-profile Tragic Event Involving a Person with a Serious Mental Illness" (National Association of State Mental Health Program Directors [NASMHPD] & The Council of State Governments [CSG] Justice Center, 2010) can help. See more in "Recommendations for working with the media" on page 81.

When anticipating and preparing to respond to mass gun violence, first responders, law enforcement, school staff, systems of care staff and health care providers must be educated in trauma-informed care.

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 with 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% of the problems they encounter in their practice are behavioral and psychiatric in nature (Wittchen et al., 2003). 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 8 to 10 years (National Alliance on Mental Illness, n.d.), and yet there is a nationwide shortage of child and adolescent psychiatrists and other mental health professionals. Primary care providers often are the first to detect mental illness, which offers an opportunity to diagnose, refer and treat underlying mental disorders (e.g., conduct disorder, depression, psychosis). However, 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 among primary care clinicians and a resulting ambivalence and discomfort in dealing with mental disorders. In addition, time constraints and poor payment models discourage treatment of mental health challenges 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 MDI, 2018b). 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 constrain primary care providers' ability to serve young people with behavioral health needs.

In response, some primary care and behavioral health teams have developed innovative ways of working together to support young people and their families (Coffey et al., 2017). These range from developing formal consultation and collaboration protocols to locating staff in the same facility, giving them access to the same health records. One example is Project ECHO (Extension for Community Healthcare Outcomes), a collaborative model of telehealth education and consultation that supports primary care physicians serving patients with mental illnesses, bridging the gap in health care for rural and underserved communities. 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., MCPAP in Massachusetts and MC3 in Michigan). These innovative ways of delivering care can meet the mental health needs of children and adolescents; however, alternative funding mechanisms — rather than fee-for-service — are needed to sustain this level of support.

To facilitate the integration of behavioral and mental health care into primary care, Katon et al. (2010) developed the model of "collaborative care," in which mental health providers are embedded in primary care settings. The medical community has strongly supported these important approaches. Health care organizations and individual clinicians are encouraged to champion on both state and national levels policies that promote emotional literacy and social skills training and increased access to mental health care.

The American Academy of Family Physicians offered a position paper on Prevention of Gun Violence in 2018. The recommendations address risk factors related to mass violence: "Family physicians can further address gun violence in their practices and communities by following these office- and community-based steps.

Office-based:

- Know the rates of gun violence in your area to help understand the impact on your patient population (www.gunviolencearchive.org/charts-and-maps).
- Ask patients and their families if there are guns in the home. If 'yes,' discuss safe storage of firearms and ammunition. Encourage participation in gun safety classes.
- The AAFP recommends screening for depression in the general adult population, including pregnant and postpartum women (www.aafp.org/patient-care/clinical-recommendations/all/depression.html).
  - Patients who screen positive should undergo additional assessment that considers severity of depression and comorbid psychological problems, alternate diagnoses and medical conditions. Patients with depression should be treated with antidepressant medication and/or psychotherapy.
- The AAFP recommends that clinicians screen women of childbearing age for intimate partner violence (IPV), such as domestic violence, and provide or refer women who screen positive to intervention services (www.aafp.org/patient-care/clinical-recommendations/all/domestic-violence.html).
  - The presence of guns in the home increases the risk that a woman will die due to an IPV-related homicide eightfold.

Community-based:

- Know the rates of gun violence in your area to better understand the impact on your community (www.gunviolencearchive.org/charts-and-maps).
- Participate in programs that address violence in your community.
- Communicate with your local, state and federal officials about gun violence as a public health concern. These conversations should specifically address:
  - Funding research to identify effective measures to increase the safety of firearms.
  - Gun safety legislation.
  - Strict enforcement of current gun laws.
  - Constitutionally appropriate restrictions on the manufacture and sale, for civilian use, of large-capacity magazines and firearms. ...
  - Appropriate funding for mental health services."

COURTS AND LAW ENFORCEMENT WORKING WITH AT-RISK 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 providers are an avenue for therapeutic intervention with at-risk youth and possible prevention of mass violence. Some programs work directly with children and adolescents to help prevent violence and keep 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 wellbeing 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, Massachusetts, the Safety Net collaborative works 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" (City of Cambridge, 2023). 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 each child. Plans may 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 (Barret & Janopaul-Naylor, 2016).

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 to address student misconduct within the school system and community through a memorandum of understanding, 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 lead youth into the school-to-prison pipeline. As noted in the SJP fact sheet (2022), "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."

SJP programs use evidence-based discipline strategies to address minor, nonviolent offenses, keeping kids in school and improving academic achievement. In North Carolina, Texas and Connecticut, SJP programs have resulted in 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 (SJP North Carolina, 2022). However, there is no evidence that these programs reduce mass violence.

Engaging 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. They can be powerful tools to identify potential threats and engage people in systems of care that provide the guidance and resources that might prevent further tragedies.

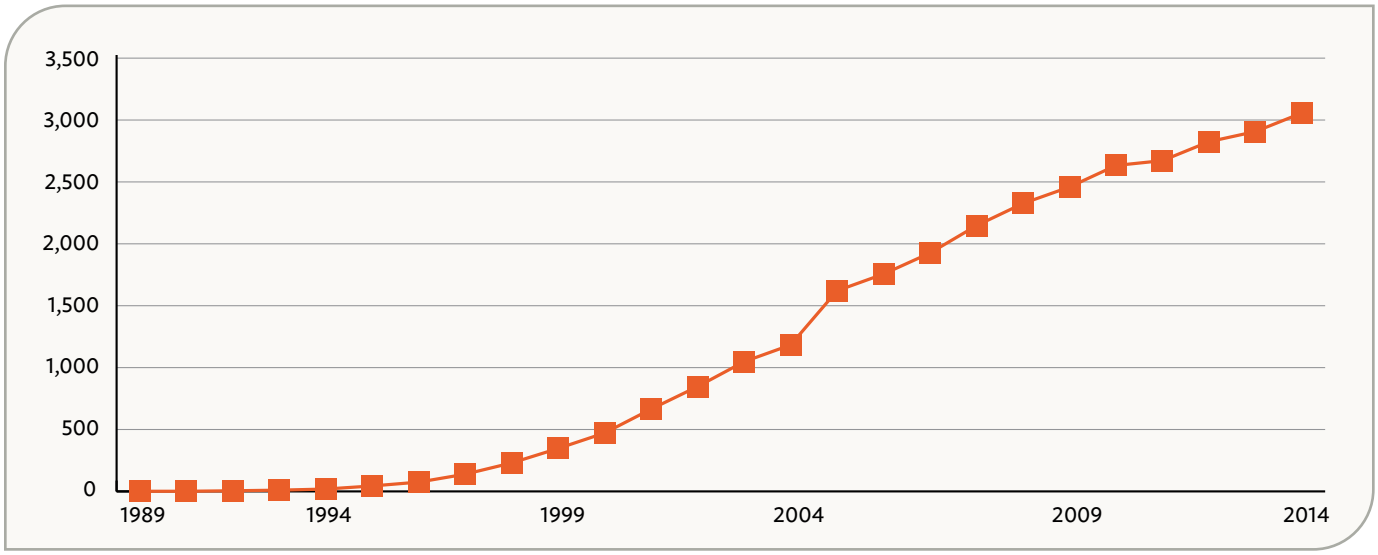
THERAPEUTIC JURISPRUDENCE IN PROBLEM-SOLVING COURTS

According to the Bureau of Justice Statistics, "Problem-solving courts were created to address underlying problems that result in criminal behavior" (Strong et al., 2016). These interdisciplinary, collaborative courts help fill gaps in psychosocial services, provide early identification and intervention with people 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" (Wexler, 1992). 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 decrease the risk of recidivism. The concept was developed in the 1980s by professors Bruce Winick and David Wexler as an academic approach to mental health law (Winick & Wexler, 2003).

Today, the range of problem-solving courts includes not only adult and juvenile drug and mental health courts, but also domestic violence courts (misdemeanor and felony), veterans courts, DWI courts, homeless courts, girls courts, community reentry courts, family courts, Tribal Healing to Wellness courts and truancy courts. 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 3,800 problem-solving courts around the country. For example, Michigan currently has 207 problem-solving courts (Michigan Supreme Court Office of Public Information, 2022), and legislation in 2018 passed to fund juvenile mental health courts statewide (Senate Fiscal Agency, 2018). In addition, courts of general jurisdiction have become more interested in using alternative sentencing models and diversion.

Exhibit 20. Number of drug courts by year in the United States, 1989-2014



(Marlowe et al., 2016)

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

Exhibit 21. 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	35.50%	65.10%	35.70%	8.50%	2.40%
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	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
Veterans	46.3	81	27.3	2.5	3.3
Tribal wellness	29.2	83.3	54.2	16.7	0
Other[d]	49.2	45.8	36.7	7.5	4.2

Note: Detail may sum to more than 100% because multiple responses were allowed. Percentages are based on 96.6% item response rate.

[a] *Includes entry after violation or revocation of parole.*
[b] *Includes acceptance on a case-by-case basis, post-referral from outside agency, entry after child adjudicated dependent, and entry after admitting to impaired ability to care for child.*
[c] *Handles alcohol- or drug-dependent offenders also charged with a driving offense.*
[d] *Includes other courts not shown.*

(Strong et al., 2016)

Problem-solving courts share common goals and objectives, and should be 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 features include individual clinical assessments, treatment planning and court oversight, typically with a diversionary approach.

Using the best evidence-based practices, problem-solving courts are trauma-informed and culturally appropriate. Judges convene a broad group of community stakeholders, including those from the behavioral health care system, who come together to develop person-centered, trauma-informed, strengths-based treatment plans. Most courts use an incentive/sanction approach — in which people are offered shortened periods of probation, suspended sentences or other reductions in legal impact in return for engaging in treatment, or they receive legal sanctions such as revocation of parole for not engaging — with the goals of improving public safety, increasing positive health outcomes and reducing recidivism.

Through a collaboration of trained interested parties and court staff, problem-solving courts typically review the impact of childhood trauma, adverse childhood experiences and identification of emotional disorders for youth and/or adults, to evaluate treatment needs and 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 (Holland, 2010).

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 to identify mental health challenges, respond appropriately and de-escalate a situation that may lead to violence. Training programs include MHFA, Crisis Intervention Team (CIT) training and motivational interviewing. There are currently more than 15,000 MHFA Instructors with the public safety designation. They have trained more than 3 million people, including officers (patrol, intake, corrections, warrant, court staff, etc.) in departments nationwide (National Council, n.d.).

The goal is for officers to work collaboratively with their partners in mental health care 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 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, a co-responder model in which every law enforcement officer in the state has access to master's-level clinicians at community mental health centers, who can help an officer assess a person and refer them to appropriate treatment. This moves the intervention upstream and helps the person avoid contact with the criminal justice system.

Mobile crisis teams in many communities and states assign a mobile crisis staff member to be 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 someone experiencing a mental health crisis.

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

COURT-MANDATED INTERVENTIONS AND CARE

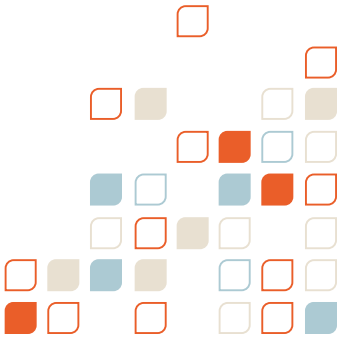
Civil commitment is a legal mechanism to treat people regarded as mentally ill and potentially dangerous, even over their objection. This is most commonly done by admitting them to mental hospitals or the psychiatric units of general hospitals. In addition, many states have statutes providing for involuntary 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) studied New York's Kendra's Law and 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 people 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 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). If the person cannot be held beyond the initial several days that a court order allows, involuntary inpatient commitment may not be the panacea some would hope. Civil commitment, whether inpatient or outpatient, is a complicated intervention. It is not clear that it could be a useful approach with a mass shooter, or even to address 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).

Extreme risk protection orders

As noted previously, ERPOs are court orders generated in response to concerns for the mental health of an individual who is also threatening self- or other-directed harm, who may also be refusing care or relinquishment of their firearms. Typically, these orders are for a limited time frame (e.g., seven days). In their study, Zeoli et al. (2021) noted that judges in Oregon granted 83% of ex parte ERPOs between January 2018 and March 2019. Rowhani-Rahbar et al. (2020) found that, between December 2016 and May 2019, judges in Washington granted 81% of ERPOs. Wintemute et al. (2019) commented that these orders typically are used to prevent suicide, noting only two reported cases of ERPOs applied to prevent mass shootings.



Media and Mass Violence: Working With the Press

Since the first highly publicized mass violence event in the U.S. in the 1960s — the University of 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 MDI Expert Panel on Mass Violence by Stephen Fried, author, investigative journalist and adjunct faculty at Columbia University.

Media coverage may be problematic for several reasons:

- Media portrayals of the role of mental illness as a cause of violence are exaggerated (McGinty et al., 2014).
- Media portrayals of the intersection of violence and mental illness drive stigma.
- Overstating the role that mental illnesses play in mass shootings further increases harmful stigma (Clement et al., 2015; Silton et al., 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 et al., 2015).
- Certain demographics are over- or underreported — reporting on rare mass shootings while underreporting of much more frequent single shootings, or reporting on deaths but ignoring long-term impact on many more who are injured (Kaufman et al., 2020).
- Ads by firearm companies target at-risk (e.g., young, male) perpetrators.

As soon as expanded live coverage was added to traditionally reported and edited stories in print, radio and television, there was concern about how mental illness was portrayed and discussed by reporters and pundits, as well as the experts who were consulted to comment on the shootings and their causes (for which there is substantial debate in the unfolding mental health literature), and how media coverage could lead to a contagion by acting as a prompt to others to commit copycat acts violence. These dynamics have become increasingly challenging with the proliferation of 24-hour cable news and the internet — much of which goes out in real time — and the reduction of traditional reporting staff at many news outlets. 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 on 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.

In critiquing the media, however, it is important to differentiate between live television interviews 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 immediately after mass violence events (and suicides of celebrities), there is a paucity of coverage the rest of the time. The scant coverage sometimes is 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 wellbeing, these biased views support a dichotomous, "us vs. them" 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 is the preferred initial and ongoing response. Typically, after any event involving mass casualty, the initial response is one of sympathy and shared solidarity.

But subject matter experts also 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 event.

Some organizations have prepared position statements on such hot-button topics as firearms and mental illness that allow them to speak with a clear and consistent message. (See Appendix 2 for examples.)

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 a caregiver should have broken confidentiality in a case where a patient made violent threats is a fair subject for coverage (see "Tarasoff duty to protect" on page 58).

Clinicians also are bound by the ethics of their profession, which stipulate that they should maintain patient confidentiality unless they receive 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 relationship or examination [Kroll & Pouncey, 2016]). Even with these ethical standards, some mental health professionals will speak to the media. Although these individuals might not be speaking on behalf of their profession, they are credentialed and have expertise, so journalists and the public likely will 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 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 over time, the response from the mental health community will change. 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 SAMHSA'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 Appendix 2 for additional information.)

WORKING WITH REPORTERS

Studies of reporting on mass violence show that the biggest differences in how stories are covered relate to whether the perpetrator survived the event, the ethnicity of the perpetrator and the age and ethnicity of the victims. In a recent study, Silva and Capellan (2019) found the following:

"The most common mass public shooting characteristics include perpetrators that are middle-aged, white and nonideological, as well as events 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 events 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 are largely based on recommendations for reporting on suicide (a more common event than mass shootings), and they are voluntary and subject to wide interpretation. These guidelines emphasize making sure perpetrators are not glamorized and that the victims, police and other first responders get the media's attention. They also may be useful guidance for influencers and other people posting on social media. Unfortunately, following these guidelines is easier said than done, especially given the biggest open questions: Who did the killing, how and why?

The reporting guidelines for mass shootings emphasize the need to avoid sensationalizing the acts or perpetrators. Suicide reporting guidelines sometimes insist the means of suicide not be reported at all for fear of inspiring contagion; mass shooting guidelines sometimes suggest the perpetrator not even be named, nor their photo printed or broadcast. More importantly, guidelines suggest making sure any stories about the subject that might be considered triggering include emergency contact information for an organization that can render assistance. Some organizations now offer trigger warnings at the beginning of a story or broadcast. (See Appendix 2 for further suggestions of support.)

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

Implicit in any guidelines — and any journalist education about covering such stories — is that the journalist does everything possible to get the mental health reporting right, which is trickier than it seems. It is very difficult to get actual information about a perpetrator or victim, what treatment the perpetrator may or may not have been receiving, how compliant they were, whether they had family support for treatment, and what their treating professional thinks, 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 champions — and even personal acquaintances — might object to this level of detail in reporting as invasion of privacy.

While mental health professionals may debate whether they can help a journalist get detailed information (which could mean nothing more than suggesting that 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 perpetrators or family members if they are willing to request 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 is profile of Sandy Hook shooter Adam Lanza's father (Solomon, 2014).

Most journalists try hard to tell stories fairly; when it comes to mass shootings, there are many definitions of fairness and balance that are based on the mental health politics of the sources. For example, psychiatrists often focus on medical treatment issues and failures, while psychologists and social workers 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, we must recognize the fact that covering these events can be traumatizing for the journalists themselves, just as it is for the first responders and the whole community. Journalists, like many others in our community not directly impacted by the event, are often on the periphery of these traumatic experiences and may be considered secondary victims.

Conclusions

The following conclusions and recommendations were derived from 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 members of the expert panel.

1. Mass violence is not a major cause of death or injury in statistical terms, even though such events 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 communities and 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 slightly larger proportion of mass violence crimes. The majority of perpetrators do not have a major psychiatric disorder and the overwhelming majority of people with diagnosable mental illnesses are not violent toward others.
4. Mental illness in general does not automatically put a person at high risk of 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. A small portion of people with persecutory paranoid delusions, homicidal command hallucinations or severe paranoid or narcissistic personality disorder have some increased risk for mass violence.
5. Perpetrators of mass violence may be motivated by mental distress from life events (e.g., domestic violence) 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 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. There are actions that could reduce the frequency of mass violence. 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 has been enacted in some states to restricts firearms sales and possession is associated with moderately reduced levels of mass violence.
8. Profile-based screening, even when coupled with individual clinical evaluation, cannot precisely predict who will perpetrate mass violence and when, but research to improve methods of prediction and intervention are ongoing.
9. Communities generally, and the educational and health care systems in particular, need additional resources for research and interventions to identify and assist people who are experiencing extreme emotional distress and/or symptoms of mental illness that may increase their violence risk and who have ready access to firearms.

Recommendations

Based on its review, discussion and analysis of published information, the MDI Expert Panel on Mass Violence made the following recommendations. These recommendations may not reflect and should not be construed as representing the views of specific members of the expert panel or the organizations to which they belong. Rather, these recommendations are based on the substantial consensus of the MDI Expert Panel on Mass Violence as a whole.

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.
- Establish a consistent definition of a mass shooting.
- Mental health providers and supporter groups should support efforts to prevent mass violence, including efforts to reduce risk in the small portion of persons whose particular symptoms are more strongly associated with mass violence.
- 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:
  - Orienting and aligning societal institutions and stakeholder organizations to the need to stem the frequency and eliminate the causes of mass violence perpetrated by people who are mentally ill and mentally distressed.
    - These institutions may include health care providers, law enforcement, judicial and criminal justice personnel, educators, legislators and faith-based leaders.
    - These institutions should provide information and protocols for surveillance, threat assessment and engagement, and establishing means for referral to mental health care providers.
  - Ensuring access to quality mental health care for all people. This includes establishing:
    - An adequate mental health workforce.
    - Geographic distribution of facilities and access.
    - Reduction of stigma, lack of awareness and other barriers to seeking care.
  - Ensuring that mental health care benefits are included fairly in health insurance coverage, as mandated by the Mental Health Parity and Addiction Equity Act.
  - Implementing proactive screening for mental illness and promoting mental health.

RECOMMENDATIONS FOR HEALTH CARE ORGANIZATIONS

The MDI Expert Panel on Mass Violence made several recommendations for health care organizations, including those that provide mental health care services to people who have mental disorders, SUDs and developmental disabilities. Many of these require funding that is not currently available and will not be achievable without payment methodologies such as the CCBHC 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. Funding by the Bipartisan Safer Communities Act of 2022 will continue, providing impetus for evolution of systems of care.

Specific recommendations include the following:

- 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 BTAM.
  - One-off trainings will not be successful, especially with turnover in behavioral health and health care organizations, so ongoing training is essential.
  - Ensure continuity of threat management across silos by promoting case conferencing and successful handoffs from one agency to another for people who may be at risk for violence.
- Train staff in lethal means reduction, an appropriate strategy for lethal violence reduction that is 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/patients and their families about firearms safety.
- Establish and fund crisis intervention services staffed by personnel trained in BTAM for distressed, symptomatic and potentially dangerous patients. (The Bipartisan Safer Communities Act provides funds for all these services; funding has already been sent to multiple states.) Specific recommendations include:
  - Use crisis hotlines like the 988 Lifeline 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 CIT training.
  - Ensure that health care provider organizations have adequate mental health staff or that they have access to or means of referral to mental health providers. Implement the recommendations of "The Psychiatric Shortage: Causes and Solutions" (National Council MDI, 2018b).
- 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 advance directives, including Ulysses contracts, to aid in treatment decisions during times of exacerbation of mental illness.
- Prepare crisis center teams to identify people at risk for violence, use tools like BTAM to reduce risk in those people, and prepare their teams for potential events in their community. Acute stressors are a common proximal risk factor for severe violence, implying that crisis services can be a tool for prevention of violence.
- Provide primary care support (e.g., community psychiatry access programs), with urgent psychiatric consultation available for primary care clinicians on the frontlines of addressing mental health and potential risks in children and adolescents (National Network of Child Psychiatry Access Programs, n.d.; Dvir et al., 2023).
- Prepare staff for vicarious trauma and compassion fatigue. Provide resources for self-care rituals and support for staff needs.
- Educate health care providers in the HIPAA policy that allows sharing information when a person presents a risk of harming others. Keep HIPAA training brief and simple.
- Train personnel in the use of mechanisms and services to enhance treatment adherence and establish programs to do so.
  - 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 MDI, 2018a).

RECOMMENDATIONS FOR SCHOOLS

While mass violence can and does occur in numerous venues, the MDI 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 also apply to other venues (e.g., workplaces).

Specific recommendations include the following:

- 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, thereby increasing risk. Replace zero tolerance with interventions that examine the circumstances of concern and increase engagement (Klein et al., 2024). Teachers and students should make efforts to include students who exhibit social shyness, awkwardness and unique ideas, mannerisms or interests. All concerns should be taken seriously, though 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.
- Ensure that schools have the resources to provide in-school mental health and substance use evaluation and treatment for students (or means for referral) 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.
- Train staff in interpersonally based and emotionally supportive prevention measures, such as Youth MHFA, which have been shown to reduce violence and enhance positive school environments.
- Establish BTAM teams. These multidisciplinary teams should include representatives from mental health, security, human resources, legal and law enforcement.
- Schools should avoid arming teachers, as there is no current evidence regarding its efficacy in reducing 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 recommended (e.g., lock door, turn off lights, move out of sight, be silent), but those in which students do not know they are participating in a drill can be traumatizing. Shooter drills should be practiced, but they should be no more stressful or realistic than fire drills. Consider trauma-informed drill design and the availability of counselors for students and staff. The National Association of School Psychologists and the National Association of School Resource Officers (2021) have published a set of "Best Practice Considerations for Schools in Active Shooter and Other Armed Assailant Drills."
- Schools should ensure an environment in which students feel comfortable coming forward to a responsible adult with information regarding threats from any source. Schools should create a supportive environment and should be required — vis-à-vis a set of national standards — to assess their schools for physical and emotional safety.
- Schools should implement the ability to be aware of one's own and other's feelings in the present moment, interact effectively with others, control impulses, and add mental health to the school health curriculum. An American Psychiatric Association Foundation program called Notice. Talk. Act.® at School (see Appendix 2 for more information) is an example of curricula that can help schools be more prepared.
- Schools should train staff in how to respond properly when students 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 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.

- Recognizing that many of these recommendations would apply additional functions to the traditional educational mandate and scope of services of schools, we endorse the following recommendation from the National Commission on Children and Disasters 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" (Bullock et al., 2010).

The Bipartisan Safer Communities Act of 2022 should help facilitate this.

RECOMMENDATIONS FOR COMMUNITIES

The MDI Expert Panel on Mass Violence considered how various communities can address the special needs of those who might be at risk and made the following recommendations:

- Create and support broad community partnerships that include behavioral health, law enforcement, schools and the faith and medical communities to strengthen the connections among those systems that interact with people who have mental illnesses and SUDs and may be at risk for committing violence.
- Do not focus solely on people with a prior diagnosis of schizophrenia/psychosis, bipolar disorder or other serious mental illness. Communities should involve clinicians in prioritizing people in the higher-risk group: those with narcissistic and/or paranoid personality traits who are fixated on thoughts and feelings of injustice (i.e., "grievance collectors"), have few social relationships and have experienced recent stresses.
- 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. Explain that the response will be one of caring and not punishment, even if the person must be removed from the workplace temporarily to seek appropriate mental health treatment, for example.
- Through the employee assistance program, institute a mandatory evaluation for employees threatening others.
- Establish community threat/risk assessment and management teams. These multidisciplinary teams should include business representatives from mental health, security, human resources, legal and law enforcement.
- Ensure close collaboration between domestic violence services and behavioral health providers. Prioritize threat assessment and management for people with a history of domestic violence.
- 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 coexisting issues (e.g., poverty, unemployment, recent romantic breakup, social isolation) that can trigger violence but may not be causal, given the complexity of violence in society.
- Promote health and wellness, including universal emotional literacy and social skills training, resiliency and skill building in community-based settings (including schools, workplaces, religious settings and primary health care offices) 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 accessible, quality, comprehensive mental health services and that people are encouraged to seek assistance when they or their family members are in need (Minkoff et al., 2021).
- Provide training in MHFA, which teaches the skills to respond to the signs of mental health and substance use challenges.
- Use currently available federal funding to enhance protection against mass violence:
  - U.S. Department of Homeland Security's Center for Prevention Programs and Partnerships (www.dhs.gov/CP3)

- U.S. Department of Justice (DOJ) (www.justice.gov/grants)
- Federal Emergency Management Agency (fema.gov/grants/preparedness/nonprofit-security)

RECOMMENDATIONS FOR JUDICIAL, CORRECTIONAL AND LAW ENFORCEMENT INSTITUTIONS

The MDI 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 experiencing a mental health crisis and other people who may present a threat, through better training of law enforcement, more involvement of mental health professionals in threat assessments conducted by law enforcement, and implementation of ERPOs.
- Help corrections officers and employees be better equipped to manage people who are experiencing a mental health crisis and others who may present a threat, through better training in the recognition and management of mental illness, 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 people 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 courts, such as through the Judges and Psychiatrists Leadership Initiative (American Psychiatric Association Foundation, n.d.). Help judges understand issues such as the prevalence of mental illness, the danger of assuming that people with mental illness are at a high risk of violence, consideration of other risk factors that may be relevant, and the usefulness of programs that allow for reporting their concerns ("see something, say something"), as well as the importance of long-term monitoring and follow-up for people at elevated risk.

RECOMMENDATIONS FOR LEGISLATIVE AND GOVERNMENT AGENCIES

The MDI Expert Panel on Mass Violence made the following recommendations for legislative and government agencies:

- Pass legislation and provide funding to increase the availability of threat assessment training at the local, state, tribal and national levels.
- Pass the legislation to direct the CDC to fund and provide technical assistance to community-based "resilience coordinating networks" that use a public health approach to strengthen the capacity of all adults, adolescents and young children for mental wellness and resilience in the face of persistent overwhelming stresses, disasters and emergencies.
- Where threat assessment is established, ensure that a payment methodology or direct funding for BTAM is provided. Such payment methodology should not compromise funding that exists for other critical ventures, and it 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 DOJ, extension of the Joint Terrorism Task Forces and fusion centers, Centers for Medicare and Medicaid Services and SAMHSA.
- Promote expansion of the CCBHC model, since these clinics are required to provide extensive crisis response capability, and since the CCBHC prospective payment model can support the development and operation of a multidisciplinary threat assessment team. Amend CCBHC certification rules to encourage developing and participating on local community BTAM teams, where appropriate.

- Continue to award funding to states (via the Bipartisan Safer Communities Act) 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.
- In all states, enact — and ensure that communities actively use — ERPO or gun violence prevention laws that will permit police, family, clergy, educators, employers, coaches, colleagues, neighbors or any 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 when there is sufficient evidence that they pose a danger to themself 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 people.
  - The removal should be temporary, 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 should not be dependent on a person's health status.
  - Recommend that all officers executing these ERPOs receive CIT or other de-escalation skills training and are aware of resources available for the person.
- Fully implement the existing federal background check requirement — at present, the Bipartisan Safer Communities Act mandates background checks for those under 21. Expand and create more rigorous background checks for firearms purchases, including closing loopholes where background checks are not required (e.g., private sales or inheritance), while protecting emergency transfers to trusted friends or family members from people at imminent risk of suicide or violence.
- Remove statutory complexities and budget restrictions that limit 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 agencies like the National Institutes of Health and the CDC with adequate funding for research and best practices on firearms safety, access and prevention.
- Enact and enforce criminal and/or civil sanctions for people who knowingly provide firearms to people already lawfully barred from possessing a firearm.
- Enact mental health Good Samaritan laws to protect from civil or criminal liability those people who make 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, state and local agencies to report circumstances that disqualify a person from legal gun ownership to state databases and the NICS, and clarify and broadly disseminate these disqualifying circumstances.
- Evaluate the effectiveness of state statutes that prevent those with misdemeanor violent crime convictions from owning firearms.
- Consider adding a question about homicidal ideation to the Youth Risk Behavior Surveillance System (YRBSS), as well as related questions about comfort with telling an adult in the school about concerns of homicidal ideation in a peer. 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 of information when a person presents a risk of harming others, and implement national training in this policy.

- 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 may create confusion regarding what is permissible sharing.

RECOMMENDATIONS FOR RESEARCH

The MDI Expert Panel on Mass Violence made several recommendations about the need for additional research on such topics as gun 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.

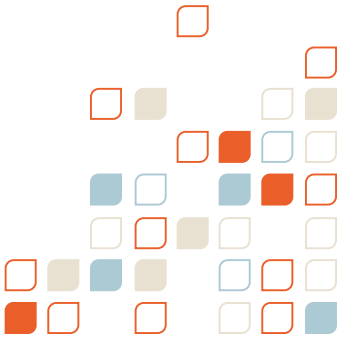
Specific recommendations include the following:

- Support research on the nature of mass violence, including neurobiological, psychological and sociological contributing factors.
- Support research on methods and instruments for identifying and predicting perpetrators of mass violence.
- Support research on methods of intervention in and prevention of mass violence.
- Support the development and dissemination of standardized tools for assessing violence risk.
- Support research into copycat and contagion phenomena.
- Create a standardized, mandatory investigation/analysis of each mass violence event, conducted by a multiagency team led by the DOJ. Individual case results should be aggregated in a database that allows capturing and differential coding of inchoate and completed attacks, high lethality and low lethality/high morbidity to allow hypotheses to be tested against different data mining and definitional strategies. Provide funding for rigorous academic studies using the data collected through these primary studies.
- Partner with local and federal law enforcement agencies and associations to better access official data on mass shootings through sources that include inmate interviews, police investigations and mining of information on multiple-victim shooting events that were not covered in any depth by the media. Create models for information exchange among local and federal stakeholders.
  - Examine data on averted attacks.
  - Compare mass shootings with other forms of mass violence.
  - Use scientific evidence to help identify and debunk misconceptions (e.g., regarding weapon choice, mental health, motivation, planning and preparation).
- Estimate costs of mass shootings and victim impacts over time.
- Develop guidelines and resources for identifying and managing people of concern.
- Create an analytical model to enable practitioners to predict mass shootings, based on the time (including date), place and modus operandi of studied mass shooting events.
- Evaluate ERPOs in states that have enacted them, to assess both the process of implementation and their effectiveness.
- Track and research people who have incomplete attacks or have made plans thereof and their motivations when identified by BTAM teams. Obtain data on averted events and those people who are high risk but don't act.

RECOMMENDATIONS FOR WORKING WITH THE MEDIA

The MDI 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:

- 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 for who should respond to what type of request and what they should say about such topics as the role of mental illness, gun rights and involuntary outpatient commitment. Develop these messages well in advance of a tragedy. A resource such as "Responding to a High-profile Tragic Event Involving a Person With a Serious Mental Illness" (NASMHPD & CSG Justice Center, 2010) can help. Also, many guilds offer media training, including the American Psychiatric Association. In many organizations, a crisis communications team will handle media requests during a mass violence event.
- Mental health professionals should use media opportunities to champion better mental health care services, greater access, and elimination of barriers, disparities and stigma, even when those opportunities are provided by tragic events.
- Choose and disseminate existing guidance, such as that offered at nbcuacademy.com/mass-shootings-media and encourage reporters to follow these guidelines.
- In addition to media guidelines, develop or employ existing guidance for using the media to communicate with victims, family members and the broader community about coping with traumatic events and mental health in general. 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 to reporters' inquiries accurately and in a timely manner.
- Work with the media to develop guidance for the public on risk factors for violence. Help the public understand the importance of "see something, say something."
- Support research into the impact weapons advertisements have on viewers and the potential influence of lawsuits against firearm companies.



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Appendix 1: Expert Panel

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Appendix 2: Online Resources

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Appendix 3: How Health Plans Can Offer Support Following Community Violence

A case example provided by Kimberly Purinton, LCSW, Clinical Training Manager, Centene Corporation

The Marjory 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. Leadership immediately came together to assess staff needs and organize thoughtful implementation of select larger-scale assistance a health plan could 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), exhibiting typical emotions, behaviors and other reactions (Alexander & Klein, 2005; Freedy & Simpson, 2007; Goldmann & Galea, 2014; U.S. Department of Health and Human Services [HHS], 2004; Yehuda & Hyman, 2005).

During the *acute phase*, Sunshine Health initiated information-gathering and stabilization efforts for health plan staff, as many employees were deeply impacted by the event. This included establishing clear, open and frequent communication across all 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 psychoeducational webinars and in-person supportive group trainings on secondary traumatic stress, in anticipation of increased volume of member assistance needs related to the tragedy.

Research emphasizes that it is critical to monitor the wellbeing of the impacted community during the acute phase, as well as to infuse behavioral health interventions into existing community services, as it increases the likelihood that the population will accept an intervention (Goldmann & Galea, 2014; Grills-Taquechel et al., 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 providers 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*, Sunshine Health provided services that address basic needs, 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. Additional research-informed activities included offering mental health screenings, behavioral health support and psychoeducational information to affected survivors and to responder groups and health care and social service providers in the community (Alexander & Klein, 2005; HHS, 2004; U.S. Department of Justice et al., 2005), which were provided either via the health plan or through existing community resources during all phases. Finally, in conjunction with its parent company, Sunshine Health continues to sponsor and facilitate trauma-informed, evidence-based treatment trainings to support the needs of its provider community as they work with survivors and responders.

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

PHASE	SUPPORT ACTIVITIES
Acute	■ Provided support by offering enhanced Employee Assistance Program services and work coverage options to affected health plan staff. ■ Established 24-hour statewide crisis hotline available to our members, staff and community. ■ Disseminated psychoeducational information and tip sheets to staff, providers and community partners on responding to community violence and trauma. ■ Used social media to maintain communication, offer community support and promote available resources.
Intermediate and long-term	■ 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 supported the cost of a licensed clinician at the Family Resource Center, providing linkages to community resources and crisis support. ■ Offered psychoeducational webinars and in-person supportive training groups. ■ Sponsored and facilitated trauma-informed, evidence-based treatment trainings to support the needs of our provider community as they continue to work with survivors and responders.

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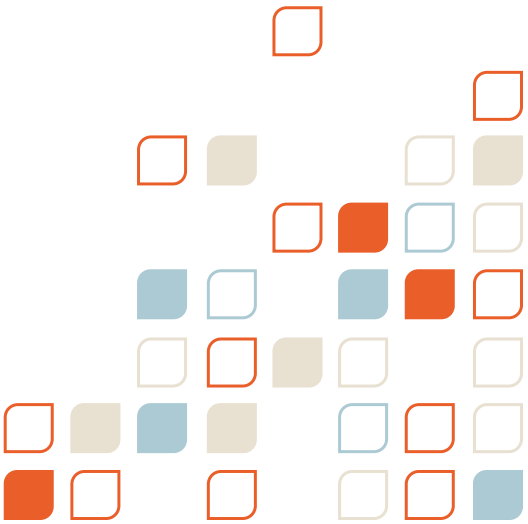
Appendix 4: Glossary of Abbreviations

AAFP	American Academy of Family Physicians
ADL	Anti-Defamation League
AP	Associated Press
BTAM	behavioral threat assessment and monitoring
CCBHC	Certified Community Behavioral Health Clinic
CD-CP	Child Development-Community Policing
CFR	Code of Federal Regulations
CIT	crisis intervention team
CSG	The Council of State Governments
DOJ	U.S. Department of Justice
DSM-5-TR	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (American Psychiatric Association, 2022)
ERPO	extreme risk protection order
FBI	Federal Bureau of Investigation
FERPA	Family Educational Rights and Privacy Act
GVA	Gun Violence Archive
HIPAA	Health Insurance Portability and Accountability Act
IED	improvised explosive device
IPV	intimate partner violence
MDI	National Council Medical Director Institute
MHFA	Mental Health First Aid
MVRAS	MacArthur Violence Risk Assessment Study
NASMHPD	National Association of State Mental Health Program Directors
NCIPC	National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
NICS	National Instant Criminal Background Check System
NIH	National Institutes of Health

SAMHSA	Substance Abuse and Mental Health Services Administration
SED	serious emotional disturbance
SJP	School Justice Partnership
SMI	serious mental illness
SUD	substance use disorder
UCR	Uniform Crime Reporting
YMHFA	Youth Mental Health First Aid



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