

Evaluating the Risk for Gun Violence in Patients

David Rosmarin, M.D.

Director, Forensic Psychiatry Service

rosmarin.david@gmail.com



Disclaimer



No commercial or other conflicts of interest.

Opinions expressed are my personal ones, and not those of McLean or Harvard Medical School.

Overlapping Categories of Gun Violence

- Gun violence by the seriously mentally ill (SMI)
- Gun violence by troubled, angry, aggrieved,
- Gun violence intra-family, intra-relationship
- Gun violence involving a stranger
- Gun violence in crime commission
- Gun violence in gang and criminal subcultures
- Gun violence political, racial, religious
- Gun violence terrorist
- Individuals vs. rampage or spree—no bright line
- Murder vs. murder/suicide
- **Suicide-by far most common-not today's scope**

3

SMI Gun Violence: Sensational but Rare

- SMI account for 3-5% of all US violence, and only a fraction involves guns—so laws focused on this cohort will be low yield and waste resources
- MacArthur Violence Risk Assessment Study: only 1% of stranger gun violence by mentally ill
- Appelbaum: if all violence, not just gun violence by MI eliminated, 90-97% of violence remains
- Most violence, including gun violence, involves SA as prime factor, not MI
- When SMI violent, usually involves family
- SMI more likely violence victims than aggressors

4

Rampage: Nobody Just Snaps



- Study of 100 US cases of spree murders, 1949-99
- Not: domestic, criminal or gang, serial, political
- Ignored warnings and signs along the way—by co-workers, family, schools, stretched MH system
- 34 cases families or friends desperately tried to find help for a person they feared, but rebuffed by the police, school, or mental health
- 63 cases: killers made general threats of violence to others in advance
- 54 cases: specific threats against specific people
- Precipitators: job loss 47; divorce/partner loss 22

5

Rampage Risk: Easy in Retrospect



- 55 cases: killers had regularly expressed explosive anger or frustration
- 35 killers had a history of violent behavior
- 40 killers had sudden behavioral change before assault
- 47 killers had a history of mental health problems
20 had been hospitalized for psychiatric problems
42 had been seen by mental health professionals
- 23 killers showed signs of serious depression before the killings; 49 expressed paranoid ideas
- 6 females of 102 killers

6

Rampage Risk: Easy in Retrospect



- 33 of the offenders killed themselves after their crimes
- 9 tried or wanted to commit suicide, and 4 killed themselves later
- 9 were killed by police or others, perhaps "suicide by cop"
- Many had planned and prepared over time
- Only a small fraction of rampage murders have been subject to psychological autopsy

7

Mass Killers: No One Typology



- Social alienation
- Media/cultural: copycat, paradigms, "commandos"
- Acting solo (adults)
- Advance planning
- Expect suicide or death by police
- Paranoid traits: suspiciousness, grudge-holding, resentful, blaming or anti-society, entitlement
- Rumination about humiliations/injustice
- Revenge fantasies
- Victims relate to motive and resentment focus: school, workplace, specific community, family, pseudo-community, specific group/community

8

NICS: 4M MI of 13M Records

- National Instant Criminal Background Check System, in tandem with 1968 Gun Control Act
- “Adjudicated mentally defective” (committed, can’t manage affairs), domestic violence, criminals
- Records civil commitment, NGRI/insanity, ICST
- Not voluntary inpatient, variable state reporting
- MI denials only 1.5 % of total 1998-2015
- Issue: given that gun violence by SMI rare, registries are resource intensive, low yield, registry is stigmatizing and dissuades treatment seeking, is this effective?
- Compare to third party reporting leaked intent and assessment by forensic assessment teams

9

NICS: Too Much and Little

- Criteria are **underinclusive**
Many dangerous persons are never treated for mental illness or may never have been involuntarily hospitalized, e.g., Loughner
- Criteria are **overinclusive**
Many people who have been involuntarily hospitalized have never been dangerous (despite dangerousness-based criteria) or no longer are

10

NY SAFE ACT of 2013

- MH professionals, RNs, MDs mandated to report to Division of Criminal Justice patients “likely to engage in conduct that would result in serious harm to self or other” Plus: NGI, ICST, committed
- If found to have a firearm license, police retrieve any firearms
- From 2014-2014, 34,500 patient reports yielded fewer than 300 people with gun permits
- Creates class of patients known to police as likely dangerous and violates confidential relationship
- Compare to laws with temporary gun removal for dangerousness related or unrelated to MI, e.g. CT

11

Loci of Violence Assessment

- Workplace, fitness for duty
- Emergency room
- Inpatient med/surg or psychiatry
- Consultation by outpatient treater
- School, university
- Stalking assessments
- Law enforcement consultation
- Court settings

12

Safety Considerations First



- If psychotic/manic/agitated: ER, not workplace
- Consider on-site security/police
- Low bar for requiring frisk/car inspection
- Evaluatee may be irate, offended
- Potential anger, substance use, paranoia
- Consider safety plans
- Always ask about gun access, try to confirm
- Always ask about thoughts of harm to self/others
- Do not rely on words only: **total clinical picture**
- Never ignore “hairs on back of neck”
- Fine to ask if patient verging on violence to you

13

High Stakes for Doctor and Patient



- Loss of job, student status, relationships
- Loss of privacy, confidential psychiatric information
- Assessment inherently stigmatizing, humiliating
- Potential for litigation
- Risk to the general public with certain professions (physicians, airline pilots, police)
- Need to triangulate and balance:
 1. Anxiety/ambiguity/uncertainty
 2. Duty to mitigate violence risk
 3. Tendency to over-assess risk

14

Usual Evaluation Procedures

- Discuss and review presenting problem
- Broad record review when feasible
- Employee cannot be required to provide personal medical/psychiatric records
- Social media!!
- On-site school records available if violence risk
- Interview collaterals in advance when feasible
- Informed consent verbal and written (“Lamb”)
- No gratuitous info in report
- Mass law requires report release to patient if requested
- Duty to protect may trump confidentiality

15

Risk Assessment, not Prediction

- **Magnitude:** verbal, shove, strike, shoot
- **Likelihood:** low, medium, high
- **Imminence:** immediate, short-term, chronic
- **Frequency:** one-time, repeated
- For each and overall: low, medium or high
- Be humble, tolerate uncertainty, and try to articulate the valence given each factor.
- Someone may be low imminence, moderate likelihood, chronic risk, and high potential magnitude—high magnitude always the case with guns.

16

Structured Professional Judgment



- What are **dynamic** factors?
- Stressors, family/school/work conflicts, active symptoms, medication refusal/adherence, treatment availability, SA, living arrangements, limited choices, humiliation, entitlement, grudge, fatalism, grandiose fantasies, concurrent suicidality, **gun access**
- What are **static** factors?
- History of violence, mental illness, antisocial/narcissistic/paranoid/obsessive traits, violent subculture, brain insults, past injustices
- What valence is accorded each factor—a matter of judgment
- Is physician risk aversion static or dynamic?

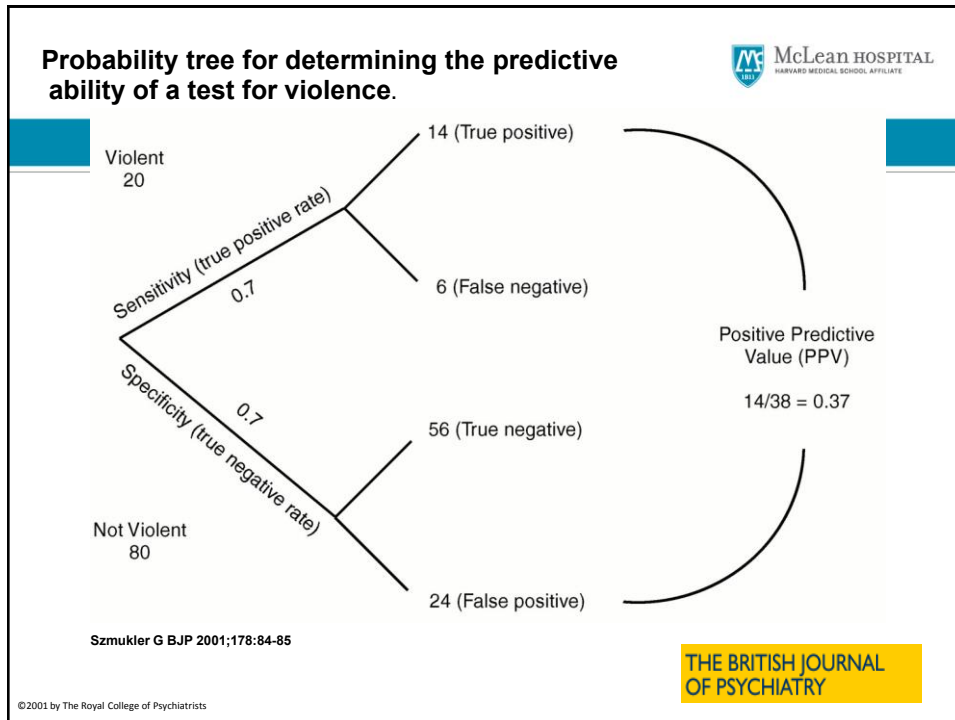
17

Violence Risk Instruments



- **HCR 20**: historical, clinical, risk management: based on research lit., widely used, incorporates judgment, adults only
- **COVR**: Classification of Violence Risk: MacArthur derived, strong empirical basis, 1000 patients post-DC, uses software, initial and contingent questions
- **VRAG**: Violence Risk Appraisal Guide: 12 item actuarial, rejects clinical judgment, developed using forensic patient discharge
- **WAVR-21**: Workplace Assessment of Violence Risk- 21-item, also applicable to students > 18

18



Low Base Rates and False Positives

- While the base rate for violence may be 20% for forensic populations, the 6-month incidence of violence in even urban populations is closer to 6%.
- This yields a positive predictive value of .14, which results in a false positive rate of nearly 90%.
- Even a test with an impossible 0.9 accuracy for both true positives and true negatives will be wrong more than nine times out of ten at a base rate of 1% for severe violence.

Receiver Operating Characteristics

- Problem: Even with a 5-10% (hypothetically high) base rate of violence, the clinician who always predicts “no violence” will be more accurate than the clinician who identifies 20% as “violent.”
- ROC statistical method quantifies trade-off between **sensitivity** (true positives rate) and **specificity** (true negative rate)
- Recognizing that a fraction will be wrong, allows for decisions about which error is preferable.
- Controls for different base rates Mossman, D, Baranoski, M, Norko, M.

21

Rosmarin Ocean’s Anxiety Twelve

- Anti-social attitudes
- SA
- Past history violence
- Active major mental illness
- Psychosis crescendo, especially first event
- Anger
- Desperation/narrow thinking/status loss
- Grievance/revenge justification/entitlement
- Specific > implied threat
- Steps taken/planning
- Fatalism/suicidality
- Gun access

22

Range of Outcomes

- Low risk, return to duty, home, school
- Return under certain conditions
- Agree for other to take control of guns **or get patient to agree (in writing) to allow local issuing police to be informed of wish to revoke permit**
- Return when outside treater says ok (with or without forensic return exam)
- Outside treatment serves as warning “radar”
- Significant risk: no return to duty, home, school
- Access/cost may argue for employer/school payment for appointments or medications
- Emergency: police, commitment, duty to protect

23

Mental Illness Defined by Statute

- Mental illness defined for commitment under Chapter 123:
- **“A substantial disorder of thought, mood, perception, orientation or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, but shall not include alcohol or substance abuse...”**
- What to do when person plainly dangerous but not from mental illness?????
- If committed, and not mentally ill, what are target symptoms for treatment and, if none, when to release?

24

Commitment Timeline



- 12 a— order to transport for screening eval. “pink paper”
- 12b screening and holding up to 3 business days
- Hospital decides whether to file commitment under Chapter 123 sections 7 and 8 with those 3 days under 12b. Patient gets counsel if indigent.
- Patient entitled to hearing within 5 business days.
- Judge may take under advisement for up to 10 calendar days before issuing decision
- Total 18 days

25

Legal Commitment Standard



- Burden on petitioner “beyond a reasonable doubt”—most other states “clear and convincing”
- Failure to hospitalize would cause a “**likelihood of serious harm.**”
- Danger to self, others or gravely disabled. (Some states and federal government allow serious property damage.)

26

Likelihood of Serious Harm Defined



- **(1) a substantial risk of physical harm to the person himself as manifested by evidence of, threats of, or attempts at, suicide or serious bodily harm;**
- **(2) a substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them; or**
- **(3) a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community.**

27

Duty to Protect Mass Ch.123 s.36B



- Tarasoff progeny, similar in many states
- Licensed MH professionals must take reasonable precautions to protect potential victims and are not tort liable if they do—no mandate
- Requires either “explicit threat” and capacity **OR** “clear and present danger” combined with known history of violence to “reasonably identified” victims
- No tort liability if: (1) communicates threat to the reasonably identified victims;(2) notifies law enforcement where patient or victim resides; (3) voluntary hospitalization;(4) involuntary hospitalization; (5) no obligation to take steps that increase danger to professional or victims

28

Mass Ch.123 ss 35, 36C, 209A



- Patients committed for MH or SA automatically have firearms permit revoked.
- After 5 years may apply to court that revocation be vacated
- With abuse prevention orders, permit and guns revoked and NICS alerted

29