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Healthcare Threat Management: *Patients & Guns*

By Sheridan Ryan

Mr. Green was angry at his physician. A few days earlier, he told his doctor he was experiencing dizziness and nausea; not surprisingly, his doctor advised him to have someone bring him to the emergency department. There, he was admitted and tests were run. Mr. Green's health had been declining in recent years and he required medical treatments every two weeks. He was frustrated, didn't know how long he had left to live and he viewed the recent hospitalization as an unnecessary expense and a waste of his time. But mostly, he was angry that he had once again wasted a weekend in the hospital and he blamed his physician. He wondered – how many more weekends did he have left?

Mr. Green knew he needed to make a follow-up outpatient appointment, but instead he just showed up to the clinic. The staff, long familiar with him, brought him back to an exam room. His doctor wasn't in, but another provider agreed to see him. Part way through the appointment, Mr. Green revealed the gun in his pocket.

A Growing Problem

Even when patients make no mention of a gun or shooting anyone, "***What if they come back with a gun?"*** is foremost among providers' concerns after an interaction with an angry, intimidating, hostile or threatening patient. And with good reason – consider the gun environment within which healthcare providers work:

Recently a Canadian trauma surgeon and founder of "Canadian Doctors for Protection from Guns" was the target of an aggressive, coordinated campaign of political intimidation by a Canadian gun lobby group.[1] Around the same time in the United States, doctors were warned by the National Rifle Association (NRA) to "stay in their lane,"[2] and for years NRA gun lobbyists have aggressively pressured American politicians who plainly fear them. At the same time, while the majority of Americans supported common sense gun control reform, it remained a low priority among voters.[3]

After a mass shooting in Port Arthur, Tasmania in 1996, Australia swiftly passed strict gun-control laws which were widely praised because of Australia's resultant low incidence of mass shootings. Until May 11, 2018, that is, when Australia's worst mass shooting in decades occurred. What changed between 1996 and 2018? Pro-gun lobby groups in Australia mounted a high-pressure campaign

against Australia's government and laws gradually eroded.[4] In the U.S., post-Sandy Hook[5] through December 14, 2019, the NRA can take credit for more than 460 pro-gun measures that have passed state legislatures.[6]

On September 13, 1994, the Public Safety and Recreational Firearms Use Protection Act ("Federal Assault Weapons Ban"), part of the Violent Crime Control and Law Enforcement Act of 1994, was signed into law. The ban was law for a decade before expiring on September 13, 2004. Although both the period of time during the weapons ban and since its expiration are small sample sizes in comparison to a look back at U.S. mass shootings all the way to 1900, the fact remains that mass shootings have grown rapidly in *frequency* and *fatalities* since the ban expired.[7]

In addition to long-standing high-pressure campaigns by pro-gun lobbyists, weak legislative response and low voting priority, recent political unrest has added to an unsafe firearm environment broadly, creating potentially hazardous workplace environments across industries. Gun sales are surging, with a 65% spike in October 2020 compared to October 2019, and the unrest has only worsened since that data report.[8] 2020 single handgun sales increased year-over-year by 81%.[9] A record 18.6 million firearms were sold by October 2020, continuing 2020's record firearms sales pace.[10] In January 2021, guns sales hit record highs as violent riots hit the U.S. Capitol.[11] Never before have so many Americans decided to arm themselves, with an estimated 6.9 million purchasing a firearm for the first time this year."[12] There are well over 300 million guns in the hands of U.S. citizens.[13] Yet when a workplace shooting occurs, questions are raised not about the gun industry, the gun lobby, or gun legislation – no, questions are raised as to whether police or security should have done more.

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Healthcare Efforts to Minimize Workplace Shootings

In response to increasing gun violence, healthcare has ramped up its workplace violence prevention efforts and "Active Shooter" training has become routine.[14] In 2018, ninety-six percent of hospital survey respondents reported having an active-shooter policy, up from one percent in 2016.[15] Healthcare accrediting and regulatory bodies and numerous professional associations provide guidance to healthcare organizations.[16] Part of that guidance focuses on workplace violence prevention policies and procedures, visitor management systems, ongoing and repeated organizational risk assessments, and root-cause analyses following significant events and risk assessment following any changes to the physical or operational environment.[17]

Isn't There a Policy for This?

Even if a healthcare organization follows all workplace violence prevention recommendations and has robust policies, procedures, and training, there is no policy that can be created that will effectively address the concern raised by a patient showing up with a gun. There is no dismissal policy, no gun policy, no aggressive patient policy, no zero-tolerance policy or any other policy that can be written in such a way as to prevent patients from returning with a gun and using it. A policy – no matter how expertly written – cannot address individual situations; it cannot take the place of the threat assessment and management process to evaluate the level of concern for targeted violence in a particular situation and implement a plan to minimize that risk.

Threat assessment and management is time-intensive and requires education and training in threat assessment core competencies.[18] Perhaps that's why common approaches to deal with threatening patients are often the quicker ones; for example, policies that call for dismissal of threatening patients from medical care and banning from the premises. The problem with those approaches is that to be effective, they require cooperation from the most uncooperative of patients. Further, those approaches can risk escalating the situation.[19] Consider: banning a patient from the premises does nothing to address the fact the patient can return anytime.[20] So if the concern is that a patient will show up and shoot someone – dismissing that patient from care does nothing to address the fact that the patient can return and do exactly that.

There can be strong resistance NOT to dismiss threatening patients from medical care. When differing opinions exist, it's not unusual for someone to suggest bringing in an outside expert to make the decision. It's a fair point, so let's consider it next.

Call in the Outside Expert! Won't That Help?

Is it a good idea to bring in an outside expert to direct next steps in an individual case? Certainly, if no one in the organization has sufficient knowledge, training and experience, but guns and patients have become too frequent of an occurrence for that approach to be practical for long. I'm reminded of the time in 2009 when four months into my new job as a risk manager for the Medical College of Wisconsin I was presented with my first death threat in the form of an anonymous note left on the windshield of an emergency room doctor's car. The doctor suspected he knew the author's identity and police had recommended he file for a restraining order against the individual, a grieving mother. Instinctively I knew the wrong move could worsen the situation, did some research,

and got in touch with Robert Martin at Gavin de Becker & Associates – world leaders in personal protection, threat assessment and management. I described the situation to Martin and inquired whether it was the type of matter on which they advise. Martin pointed out that threats are common; did I anticipate handing over every threat that came my way? His message was clear - we needed to learn how to manage non-immediate threatening situations because they happen far too often for outsourcing to be a viable option.

Eventually, and with his help and guidance from his colleague Jim "Doc" McGee,[21] our office gained competence and confidence in our threat assessment and management knowledge base. Handling non-immediate threats – those received via email, letter, phone, voicemail, text, internet post, etc. – can be safely managed. But even now, over a decade later, I recognize the importance of reaching out for help if the situation is one in which we lack familiarity or expertise. For example, in 2013 our office was handling a case involving a provider who was being inappropriately pursued by a patient. Efforts were made to transition the patient to another provider (who was fully informed of the situation) but the patient declined to make the transition and periodically continued to inappropriately contact our employee. The matter, over several years, was being managed safely when we learned new information about the pursuer. We learned she was an anti-abortionist to such an extreme that the "regular" anti-abortion protestors at various clinics kept their distance from her. Not being familiar with anti-abortion extremists, I again turned to Martin, who put me in touch with his colleague Bryan Niederhelm.[22] Those discussions were helpful as I considered the threat level of concern this inappropriate pursuer, who was both issue-driven and individual-driven (which was dominant?), posed to our employee, and what management plan to optimize safety.

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So indeed, calling in external resources can be a wise move, such as when a threatening situation is outside of one's level of expertise, or to get a fresh perspective on a particular situation or to review policies, processes, and the physical environment. However, when it comes to a patient coming onto hospital or clinic grounds with a gun – absent implementing significant physical changes to allow entry by many who are welcome yet effectively ban the few who are not – *there is no outside expert who's going to be able to prevent someone from returning with a gun and using it.*

Call the Police! Won't They Take Care of It?

We expect police to control immediately dangerous situations and in order to do so, they are trained in use of force; it should be no surprise then that police are inclined toward direct intervention.[23] When police are called upon to control the behavior of unstable or uncooperative individuals, they want to help, but their tools for doing so – the ability to arrest and prosecute for violation of restraining orders or no trespass orders – while often fine, are not in cases in which their contact exacerbates the unwanted behavior rather than deterring it.[24] *Reasonable* people comply with such orders but *unreasonable* people do not.

In situations that do not involve imminent danger, what can be done instead of calling police? One option to consider is calling the patient's emergency contact. For example, if a patient is showing up at a clinic without appointments, bothering staff, and not listening to instructions to leave, rather than call police to intervene, the patient's emergency contact could be informed of the situation, and asked to take the patient home. The emergency contact has the benefit of knowing the patient, whereas police do not. To the police, the patient is likely a stranger,[25] and someone whose conduct they've been called upon to control. We can help our law enforcement partners by managing non-violent patient situations whenever possible rather than calling upon police to do so.

The question of whether or not to call police in situations that are not imminently dangerous is one appropriately considered by the healthcare threat assessment team, whose members can help clarify what the healthcare organization's expectations would be of the police in a particular situation, keeping in mind that police have constitutional limitations to heed.[26]

The Immediate Threat is Over. Now what?

Mr. Green revealing a firearm during his appointment was an ***immediate safety concern*** and one that was appropriately responded to by healthcare security personnel and law enforcement. No shots were fired. After several hours at the police station and citations for disorderly conduct and weapons offenses, Mr. Green went home. Once an immediate safety concern is addressed, the situation moves into one of a ***non-immediate safety concern*** – the territory of threat assessment and management. The next day, Mr. Green called to schedule his next treatment, which was already overdue.

Should the appointment be scheduled? Should Mr. Green be dismissed from medical care?

The Case for and Against Dismissal

Dismissing a patient from medical care is considerably less work than implementing a management plan for continued medical care. However, there is safety risk in terminating a patient's medical care because there is no way to ensure the patient - now angrier - does not return with a gun (and use it). While *most* aggrieved persons do not return and fire a weapon, some do. Banning patients and hoping for the best is *not* threat management; it's playing the odds, and it could lead to a false sense of security.

Most healthcare facilities are designed for people to come onto the premises rather than keep them out, which means there is likely no effective means to prevent a banned person from returning if they choose to. Dismissing a patient does not mean they cannot come back with a gun – something that could occur in the short-term, or many years later. In Houston, the son of a patient harbored a grudge for more than 20 years before he returned with a gun and shot his mother's cardiologist.[27] Termination by the healthcare organization does not necessarily mean the end of the story for the person terminated.

Moreover, if everyone in healthcare took the position of routinely dismissing patients who brought in weapons, healthcare facilities would be trading these patients among themselves, but without the knowledge of what occurred.

By continuing medical care, communication is continued which may provide insight into the patient's thinking so that grievances can be addressed and the situation improved. Additional information can be gathered to aid the threat assessment. Continuing care avoids introducing the rejection of termination from care; rejection being a common trigger to violence. "It is contrary to the practice of threat assessment to actually be responsible for further escalating a situation."[28] Unless a facility has effective physical barriers to prevent unwelcome armed persons from entering, there really is no choice to make; the safer plan likely is to continue medical care, but within a broader threat management safety plan.

Safety Planning

Mr. Green had contemplated suicide several years earlier, going so far as to put a loaded gun in his mouth. He battled depression over the years but refused mental health treatment.

By bringing a loaded firearm to his clinic appointment, Mr. Green introduced a major obstacle to the delivery of healthcare services. His mindset was not ideal for firearm possession. He was dying, depressed, had a history of suicidal ideation, and was angry. While he had recently been cancelling appointments, after bringing the gun to clinic he decided he wanted to continue with medical treatment after all.

Rather than try to figure out how to ensure Mr. Green doesn't bring a gun into the clinic, a good place to start may be a conversation with Mr. Green about the pros and cons of firearm possession at this particular time in his life.

Here are some facts:

- 94% of gun-related suicides WOULD NOT occur under the same circumstances had no gun been present[29]
- 41% of gun-related homicides WOULD NOT occur under the same circumstances had no gun been present[30]
- 1000% is the increase in risk of intimate partner homicide if a gun is present[31]

The benefit to Mr. Green of getting rid of his gun(s) is immediate and significant: it would show a good faith effort toward re-establishing a trusting relationship with his healthcare team, it would probably allow his care to continue earlier than if he retains his guns, and it would greatly reduce the risk of gun violence, whether suicide, homicide, or mass-murder suicide. Perhaps most importantly, asking Mr. Green if he would consider giving up his guns shows him that he retains some control over the situation, which in itself can promote safety.[32] So even if we don't expect anyone to give up their guns – and we won't know until we ask – there is value in asking the question.

In Mr. Green's case, as far as we could determine, there were no conversations about the risks involved in having a loaded firearm readily accessible, and nothing changed in that regard – he still had at least one firearm, and then he asked to schedule his next medical treatment as soon as possible.

Should that appointment be scheduled? Certainly banning him and terminating his care carried risk, but how could we continue to see a patient who already showed his willingness to disregard our "no guns" policy and remains angry at his doctor?

What Do 1970s Hijackers Have to Do with Guns in Healthcare Today?

Between 1968 and 1972, more than 130 American airplanes were hijacked, sometimes more than one on the same day.[33] At that time, there were no metal detectors in airports. To deal with the threat of being held hostage at gunpoint 10,000 feet in the air, airlines, the U.S. government and the Federal Aviation Administration made various recommendations to passengers, including the idea that all passengers wear boxing gloves so no one would be able to hold a gun.[34] Of course, "the obvious solution was to just screen passengers with a metal detector."[35] Recently interviewed, Martin McNally, who hijacked a plane in 1972, said "if there had been metal detectors, I wouldn't have been on that plane. Period."[36] Instead, he was able to board with a sawed-off rifle, a pistol, and a smoke grenade.

At the time, arguments against the feasibility of metal detectors at airports were plentiful and included inconvenience, a negative effect on business, and the fear it would make customers feel like criminals.[37] Of course, today, it's doubtful anyone would feel comfortable *NOT* having all passengers screened for weapons. In that sense, healthcare facilities today are similar to airports in the 1970's: weak arguments against the feasibility of metal detectors abound (expense, inability to prevent 100%, making patients feel like criminals, need for more staff), yet in today's environment of uncontrolled gun access the obvious solution, as with airport security, is to screen patients for weapons.

While healthcare may be a ways away from airport-style weapons screening, some ability to screen for firearms can be an important threat management tool that may

allow for safely continuing medical care, continuing communication, reducing anger, and moving away from – rather than toward – a violent outcome. Even without the ability to screen every patient at every entrance, weapons screening can play an important role. "The ability to screen specific individuals under unique circumstances allows us to assess patients who have raised safety concerns, but for whom simply distancing isn't a reasonable, reliable option."[38]

What Can the C-suite Do to Help?[39]

There are several ways executive leadership can help workplace violence prevention efforts. First, because violence affects everyone whether at home, work, or anywhere else, gaining a fundamental understanding of violence and clearing up myths can help defeat violence in the workplace and beyond through informed decision-making. People do not just "snap,"[40] and gun violence is not inevitable; through a comprehensive public health approach, it can be prevented and our workplaces and communities made safer.[41]

Second, leadership can support the formation of healthcare threat assessment teams and prioritize ensuring team members are able to obtain proper training in the handling of non-immediate threatening situations (i.e., threat assessment and management). Resisting long-standing practices of dismissing or seeking restraining orders against threatening patients takes significant education to overcome; sending one person for threat assessment training and expecting that person to effectively convey the rationale for changing long-standing practices is not likely to succeed. Healthcare organizations at the forefront of threat assessment and management invest in education and training.

For example, Mayo Clinic is known for its team approach to healthcare and uses that same lens with their Global Security Threat Assessment Team. "At Mayo Clinic, we invest in training, because we have world class healthcare providers and staff who can't provide world class healthcare if they don't feel safe," says Matt Horace, Mayo Clinic Chief Security Officer.

Recently, that investment at Mayo Clinic included partnering with the Rochester Police Department and adding Hospital Resource Officers (HROs) modeled after School Resource Officers (SROs) who are staffed on site in the hospital. According to Melissa Zwiefelhofer, Senior Security Specialist at Mayo Clinic, "We asked their leaders to invest in their training relating to threat assessment, recognizing that this will be different than the traditional law enforcement role. We have already begun to stress the importance of avoiding short-term solutions (e.g., restraining orders), that risk escalating the situation long-term. As a team we can engage the HROs in our specialized approach to manage the situation. This includes using a fact-based method of assessing behavior as a team and a unified team approach to mitigation strategies and recommendations. We are working toward an environment of safety, free of silos, where safety and security is everyone's responsibility."

Third, leadership can assure those managing violently-inclined situations they won't be second-guessed for decisions made based on solid threat assessment and management principles. Because security is often the first to be blamed if violence occurs, it's no wonder that security may be hesitant to advise *against* such things as filing for a restraining order or dismissing a patient – no doubt they foresee criticism for not taking what may seem like basic safety measures, but which too often actually risk worsening the situation.

Fourth, leadership can prioritize funding for physical environment changes such as controlled access entryways and weapons screening. Metal detectors not only aid detection of weapons, they serve as a deterrent to those seeking to bring in firearms. Guns are so prevalent today that we need both threat assessment and management knowledge AND weapons screening. Without any ability to screen for weapons, threat management options are limited. Even inexpensive handheld screening wands can be helpful. For example, with a patient like Mr. Green who still had his gun, needed medical care, but was willing to comply with restrictions for his future medical appointments, if no metal detector entrance was available for him to walk through, he instead could have been screened with a handheld wand, which would allow for continuation of his care as well as staff's safety and peace of mind.

Finally, leadership can support doing away with so-called "zero tolerance" violence policies. While OSHA has called for such policies for years, violence prevention experts have not, and the 2020 revisions to the ANSI standards specifically call for avoiding the use of the term "Zero Tolerance" because the term diminishes reporting and decreases safety.[42] Such policies, like other policies that aim for a "one size fits all" approach, result in skipping the threat assessment altogether – by contrast, a properly conducted threat assessment may reveal management opportunities that could avoid escalation to violence.

Mr. Green Today

Today, Mr. Green continues to receive medical treatment with a different provider within our

system, which allowed him a fresh start. The new provider and his colleagues were made fully aware of Mr. Green having brought a gun into the clinic. Mr. Green must travel to a further location equipped with a metal detector in order to receive medical care. To date, he has been compliant. The alternative – dismissing him from care and banning him from our premises – may have worked out fine. But then again, maybe not.

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[1] Matthew B. Stanbrook MD, PhD, "Gun Control: A Health Issue for Which Physicians Rightfully Advocate" *Canadian Medical Association Journal*, 191(16): E434-E435 (April 23 2019).

[2] Tweet by NRA November 8, 2018. For further discussion, see D Taichman, SS Bornstein, C Laine, "Firearm Injury Prevention: AFFIRMing that Doctors Are in Our Lane" *Annals of Internal Medicine* (2018).

[3] Jennifer de Pinto, Election 2018: "Voters Supported Stricter Gun Policy, but it wasn't Priority for Most," CBS News, November 9, 2018 (Election 2018 exit polling showing 6 in 10 favored stricter gun control, but only 1 in 10 voters said it was a voting priority).

[4] Sam Lee, chairman of Gun Control Australia, quoted in *The New York Times*, "Mass Shooting in Australia Leaves a Tiny Community in Shock and Grief," May 12, 2018.

[5] The December 14, 2012 mass shooting at Sandy Hook Elementary School in Newtown, CT left 20 children and 6 teachers and staff dead.

[6] Reid Wilson, "Seven Years After Sandy Hook, the Politics of Guns has Changed," *The Hill*, December 14, 2019.

[7] Therese Postel, former policy associate at The Century Foundation, "The Assault Weapons Ban: Did it Curtail Mass Shootings?" CRIMINAL JUSTICE COMMENTARY, The Century Foundation, January 11, 2013.

[8] Jurgen Brauer, Chief Economist at Small Arms Analytics & Forecasting (SAAF), a politically unaffiliated research consultancy focusing on the global small arms and ammunition markets, "U.S. Firearms Sales: 2020 Sales Continue at Record Pace" November 2, 2020.

[9] Brauer, "U.S. Firearms Sales: 2020 Sales Continue at Record Pace" November 2, 2020.

[10] Brauer, as quoted by Fox News, "Gun Sales Year-to-Date Surpass Previous Annual Record High by Nearly 2 Million, Statistics Show," November 2, 2020.

[11] Associated Press, "Gun sales hit high in January, continuing 2020 surge," February 4, 2021. https://abcnews.go.com/Politics/wireStory/gun-sales-hit-high-january-continuing-2020-surge-75693468

[12] Mark Oliva is a spokesperson for The National Shooting Sports Foundation (NSSF), a gun industry trade group. Oliva made the comment in an email to reporter Stephanie Pagones at Fox News.

[13] John Donohue is C Wendell and Edith M Carlsmith Professor of Law at Stanford University, "Ban Guns, End Shootings? How Evidence Stacks Up Around the World," *CNN and The Conversation*, August 27, 2015.

[14] For a discussion of healthcare-unique challenges when responding to active shooter incidents, see Daniel L. Schwerin, Jeff Thurman, Scott Goldstein, "Active Shooter Response," StatPearls Publishing LLC, September 23, 2020.

[15] The American Society for Health Care Engineering and the International Association for Security & Safety (IAHSS) 2018 Hospital Security Survey https://www.hfmmagazine.com/articles/3519-hospital-security-survey

[16] For a comprehensive discussion of threat assessment in healthcare, see e.g., Sarah J. Henkel, "Threat Assessment Strategies to Mitigate Violence in Healthcare" IAHSS-F RS-19-02 November 11, 2019.

[17] IAHSS as cited in 2018 Hospital Security Survey (*supra* xi).

[18] "Risk Assessment Guideline Elements for Violence: Considerations for Assessing the Risk of Future Violent Behavior," *Association of Threat Assessment Professionals* (2006).

[19] Sheridan Ryan and Robert Martin, Ed., "Restraining Orders in Healthcare: Effective, Ineffective or Dangerous?" *Appendix A: Restraining Order Worksheet* (available at https://www.mcw.edu/departments/risk-management/threat-seminar (Articles & Resources).

[20] While writing this article, the shooting at a clinic in Buffalo MN took place, resulting in the death of a medical assistant and injuries to several others. Early reports are that the shooter had been banned from the clinic due to harassing behavior and at some point in his past had been the subject of a restraining order.

[21] James McGee, PhD directs forensic psychological services for Gavin de Becker & Associates and is a frequent speaker at the *Threat Assessment & Management with a Healthcare Focus*™ seminar: Threat Seminar The author also extends appreciation to Dr. James Cawood, William Zimmerman, Michele Stuart, and Dr. Matt Logan, all of whom have made valuable contributions of their time and expertise as TA&M Seminar faculty.

[22] The author thanks Bryan Niederhelm at Gavin de Becker & Associates, whose generosity of time and expertise is greatly appreciated.

[23] *The Gift of Fear* at 131.

[24] *The Gift of Fear* at 131.

[25] Malcolm Gladwell, *Talking to Strangers*, (Penguin Random House UK, 2019), p. 342 (the author discussing problems that arise in conversations between strangers, and specifically between police and strangers).

[26] The Constitution of the United States (see e.g., Amendment IV and Amendment XIV).

[27] July 20, 2018 shooting death of Houston cardiologist Mark Hausknecht, MD.

[28] Bram B. Van der Meer and Margaret L. Kiekhuis, Chapter 4, p. 58, *International Handbook of Threat Assessment*, Meloy & Hoffmann, Editors (2014).

[29] Douglas J. Wiebe, "Homicide and Suicide Risks Associated with Firearms in the Home: A National Case-Control Study." 41 *Annals of Emergency Medicine* 771-82 (Jun 2003). For a GUNS EDUCATION FLYER FOR ADULTS, go to: https://www.mcw.edu/departments/risk-management/threat-seminar (Articles & Resources)

[30] Wiebe, "Homicide and Suicide Risks Associated with Firearms in the Home."

[31] Chelsea M. Spencer and Sandra M. Stith, "Risk factors for male perpetration and female victimization of intimate partner homicide: A meta-analysis." *Trauma, Violence & Abuse*, 21(3) (2020) pp. 527-40.

[32] James Cawood and Michael Corcoran, *Violence Assessment and Intervention: The Practitioner's Handbook (CRC Press*: FL, 2009), p. 143.

[33] CRIMINAL podcast episode 100: *Ten Thousand Feet in the Air* (October 5, 2018).

[34] CRIMINAL podcast episode 100.

[35] CRIMINAL podcast episode 100.

[36] CRIMINAL podcast episode 100 (interviewed by Phoebe Judge).

[37] CRIMINAL podcase episode 100.

[38] Jonathan Wertz, JD, Director of Clinical Risk Management at Medical College of Wisconsin.

[39] The author's risk management department has been fortunate to have the support of executive leadership in its threat assessment & management endeavors including the formation of a healthcare threat assessment team, education and CTM-certification, TA&M processes, and an annual seminar, "Threat Assessment & Management with a Healthcare Focus" devoted to continued learning and education that is open to others facing the same unique challenges to violence prevention found in healthcare. Threat Seminar

[40] *The Gift of Fear* at 150.

[41] "Gun Violence is a Public Health Crisis," American Public Health Association, *Gun Violence Prevention Fact Sheet* (2021).

[42] ANSI/ASIS WVPI AA-2020 (revision and redesignation of 2011) section 6.2.1 p. 13 An ASIS International Standard (approved May 7, 2020 ASIS International).6.2.1 i) Avoid the use of the term "Zero Tolerance" because the term diminishes reporting and decreases safety.

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