The TVT Strengths, needs, and risks: Assessment & Management Tool (T-SAM)

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Conflict of Interest: Disclosure

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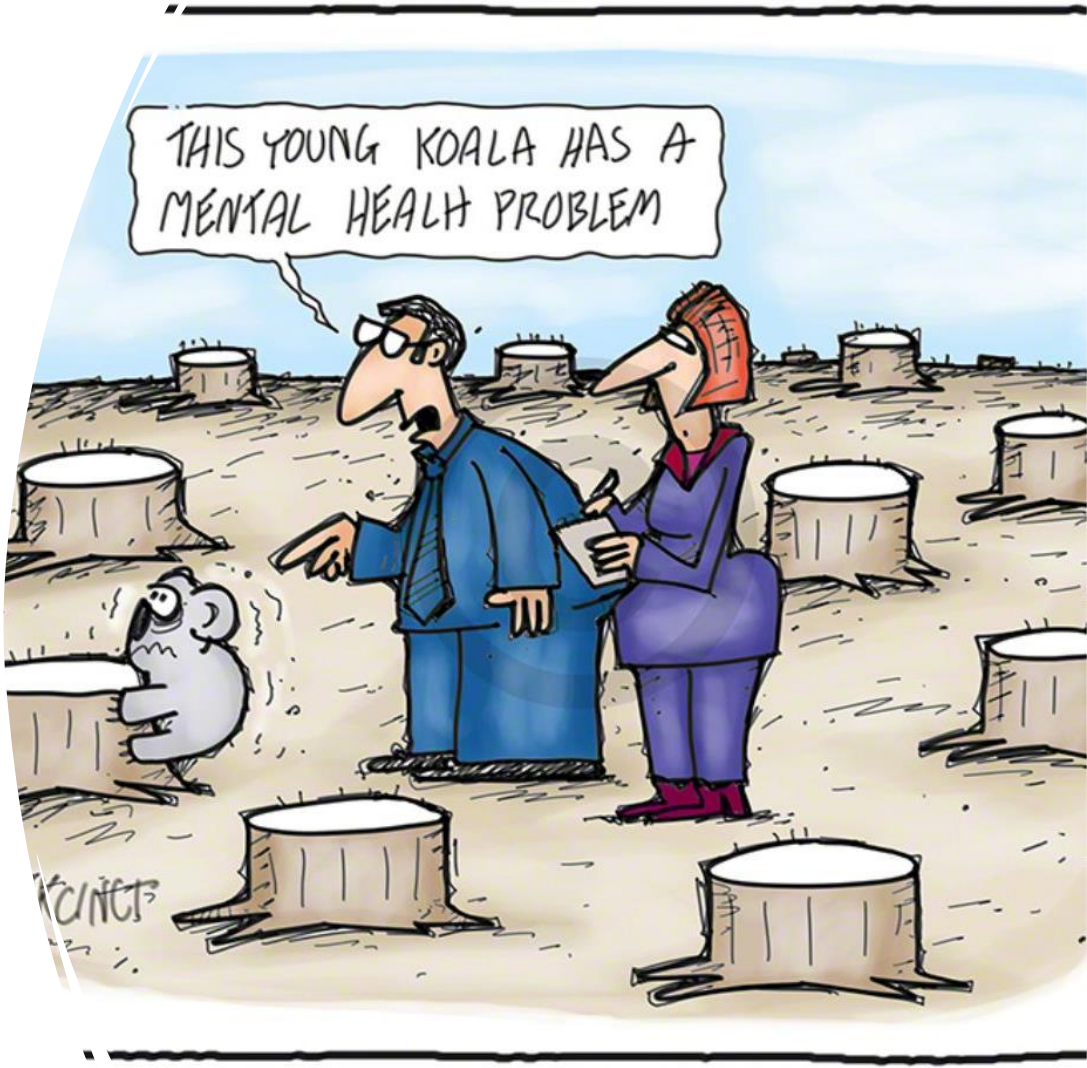
Agenda

- The relationship between mental health and violence risk
- Principles of violence risk assessment
- Introduction to the T-SAM framework
- Learn the T-SAM:
  - Practice Sections A through D of the T-SAM Initial Assessment Form
- Developing risk management plans
- Risk formulation and documentation
- Next steps!

What is the role of mental health in addressing targeted violence risk?



Key Themes from the Frontline

There is no single profile

The relationship between violence and mental health is complex

We are assessing thoughts, feelings, behaviors, and pathways, not diagnoses

Mental Health and Violence Risk

- “Diagnosis alone is never enough to tell you if someone is likely to be violent again in the future” (APA, 2021)
- FBI data (2018) suggests about ~25% of shooters diagnosed previously

People are in crisis…

…with limited options for support

- Approximately 75% of mass shooters between 1966 and 2020 were suicidal either before or at the time of the attack
- Nearly all plotters and attackers experienced ACEs/life stressors in the previous five years leading up to the plot/attack

- The majority of medical care focused on identifying and responding to violence risk is delivered in the ED
- Federal guidelines for improving mental health crisis care included almost no strategies for assessing and responding to violence risk

Leyenaar et al., 2021; NTAC, 2019; Park et al., 2009; Peterson & Densley, 2021

Feb 12, 2024

- US schools are sending more kids to psychiatrists out of fears of violence. Clinicians are concerned

- Psychiatric evaluations are meant to keep students safe, but experts say schools often misuse and misunderstand them

The Guardian

Evolution of Violence Risk Assessment

UNSTRUCTURED CLINICAL INTERVIEW

ACTUARIAL METHOD

STRUCTURED PROFESSIONAL JUDGMENT

Risk, Needs and Threat Assessment

Threat assessment:

assessment of a behavioral threat, based on empirical indicators with a risk determination typically of transient/substantiative or low, med, high

Risk and needs assessment:

assessment of an individual, using a biopsychosocial model with structured professional judgement with recommendations to mitigate risk and enhance protective factors

What violence risk assessment is NOT

It is not a guarantee

It will not predict the future

It does not treat violent risk as a fixed or static construct

It is not a blanket statement of risk

What violence risk assessment does provide

A time-limited assessment of violence risk

An assessment of risk specific to circumstances

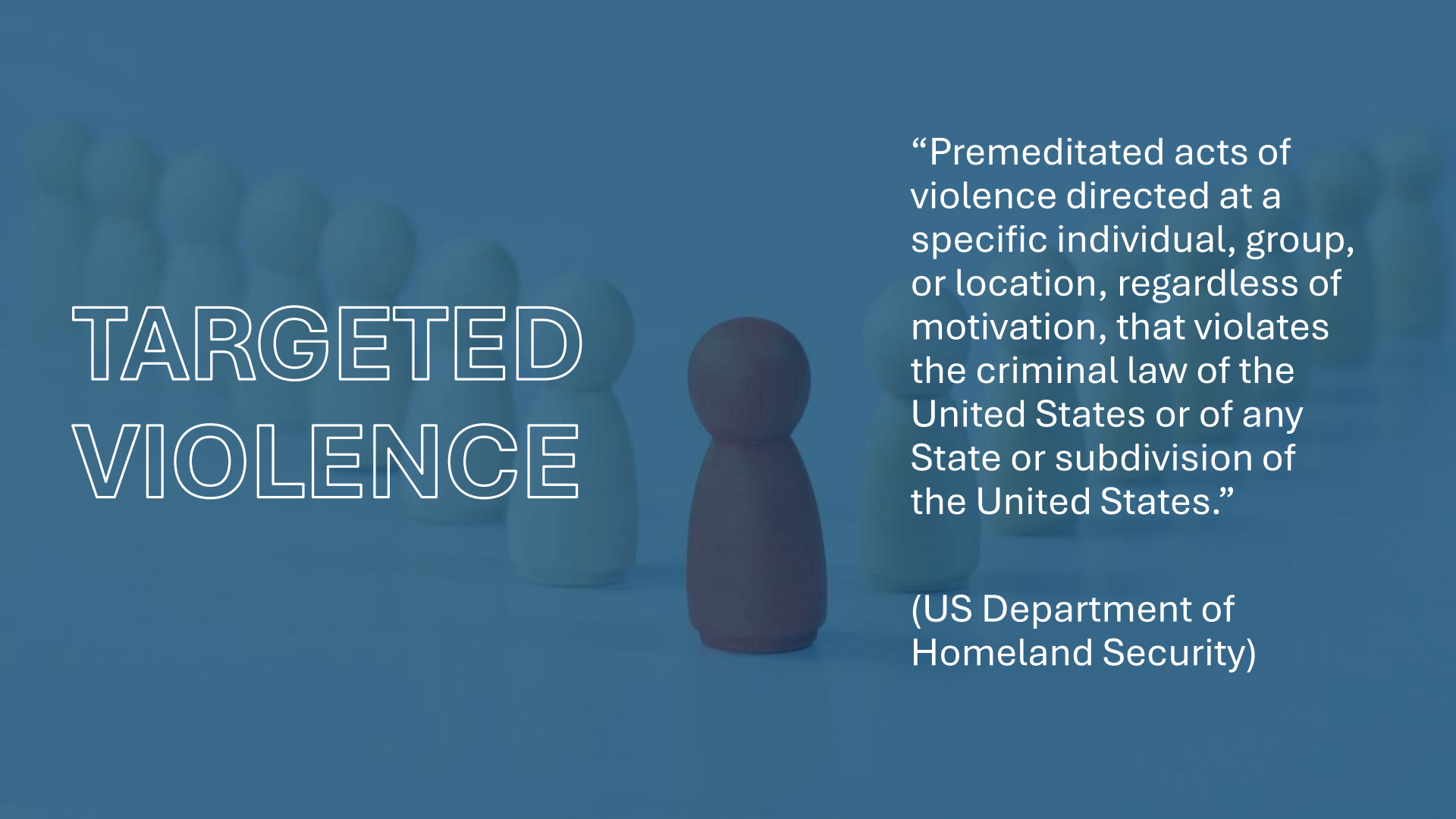
An understanding of the salient factors that contribute to risk

A thoughtful plan to remediate areas of risk

A plan to enhance protective factors

Metrics to assess if a management plan is working

TARGETED VIOLENCE



"Premeditated acts of violence directed at a specific individual, group, or location, regardless of motivation, that violates the criminal law of the United States or of any State or subdivision of the United States."

(US Department of Homeland Security)

Where?	Against whom?	Why?	How?
Public spaces (retail, restaurants, concerts, festivals) Semi-public spaces (workplaces, schools, houses of worship, military bases)	Specific people are targeted or randomly selected based on their perceived identity or location	Personal grievances Ideologically driven Desire to kill Desire for fame/notoriety Suicidality Can be associated with severe mental health conditions	Firearms Vehicles Sharp edged weapons Explosive, incendiary mechanisms

LOW PROBABILITY, HIGH IMPACT

RISK & PROTECTIVE FACTORS

Biopsychosocial and Ecological Risk Factors

- Mental health disorders (anxiety, depression, personality disorders, psychosis)
- Feelings of anxiety, hopelessness, humiliation, shame, or anger
- Trauma and Adverse Childhood Experiences
- Cognitive inflexibility
- Deficits in emotion regulation, empathy, and problem solving
- Difficulties with impulsivity and self control
- Thrill seeking or risk-taking behavior
- Perceptions of grievance or injustice, victim mentality
- Violence-justifying beliefs
- Social isolation, rejection, or weak interpersonal relationships
- Problematic internet use
- Antisocial peers
- Access to weapons
- Societal narratives that promote violence or harmful gender norms

Ideologies, even ideologies you might think of as extremist, are not considered a risk factor for targeted violence.

Violence-justifying ideologies are associated with some acts of targeted violence.
Violence-justifying ideologies follow a relatively consistent script:

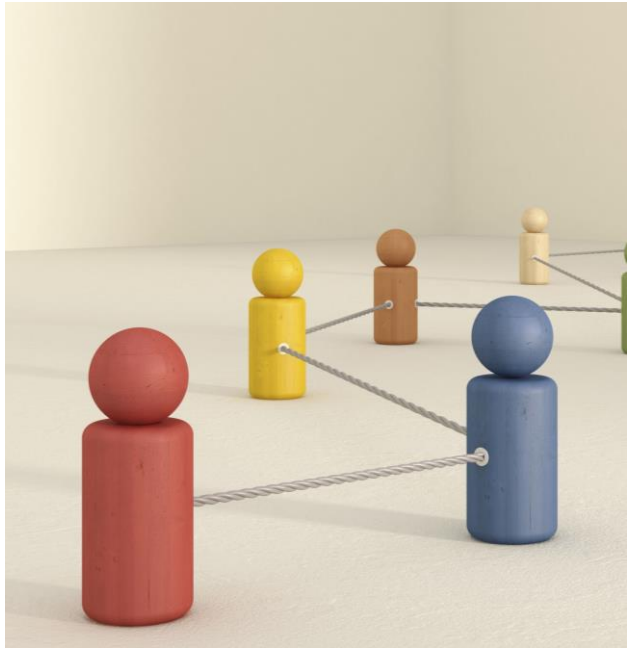
- What is wrong?
- Who is to blame?
- Why is violence justified or mandated?

Critical Factor: When the individual feels they have a personal right and obligation to use violence.

ELEPHANT IN THE ROOM: EXTREMIST IDEOLOGIES

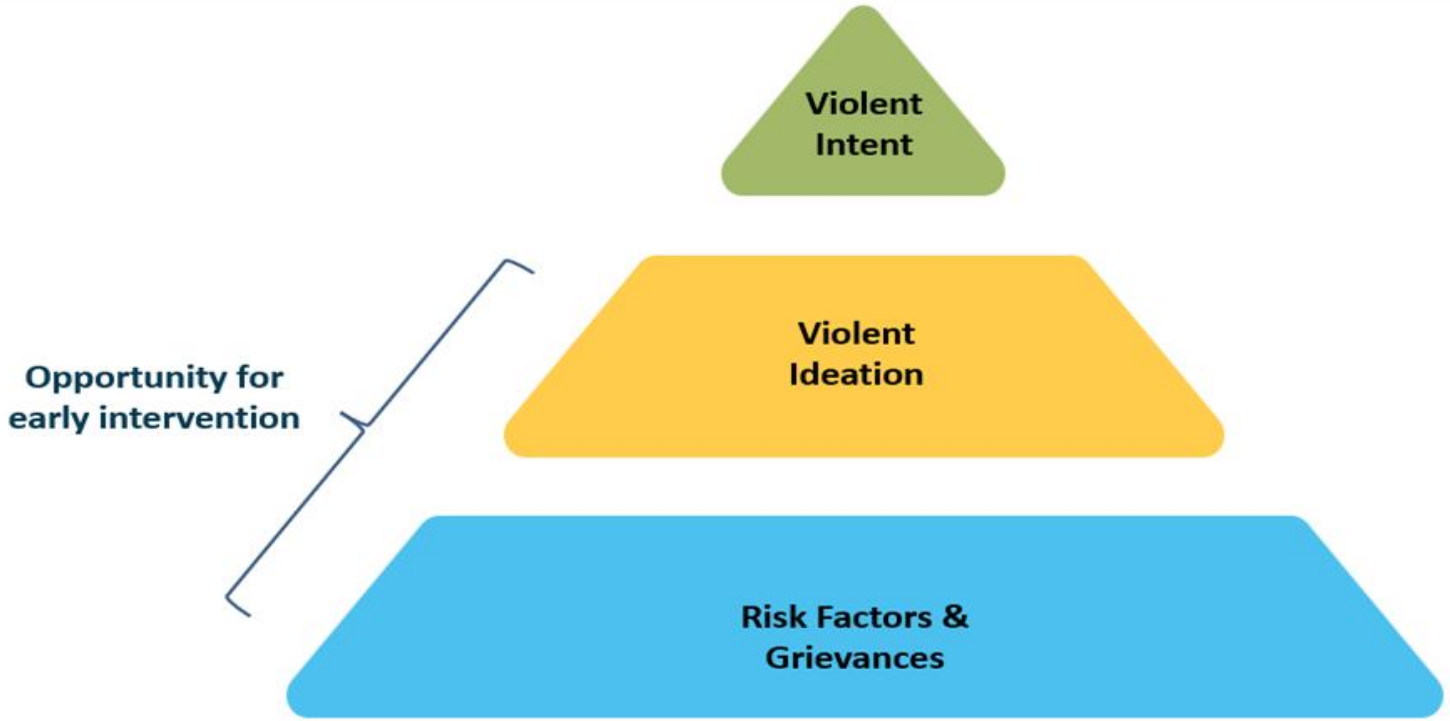
PROTECTIVE FACTORS

- Self control
- Empathy and perspective-taking
- Value and identity complexity
- Strong social network; prosocial peers
- Bonding to employment or school
- Employment or educational opportunities or achievement
- Fear of negative consequences
- Hope for future
- Commitment to nonviolence, belief in nonviolence to solve problems
- Strong problem-solving skills



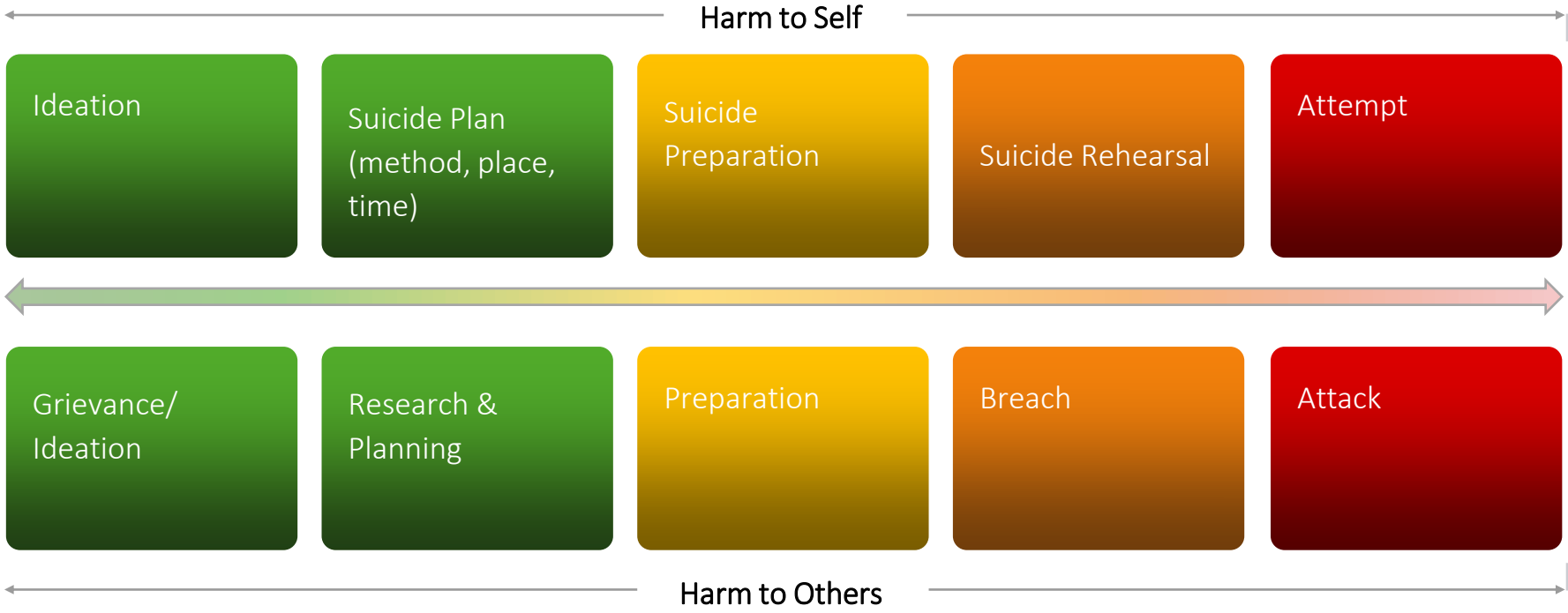
USING RISK AND PROTECTIVE FACTORS IN PRACTICE

- Provide opportunities for intervention
  - Static vs dynamic
  - Treatment or management
- Interactive, not summative
- Sensitive, not predictive



EARLY INTERVENTION: ADDRESSING RISK FACTORS

PATHWAY TO TARGETED VIOLENCE

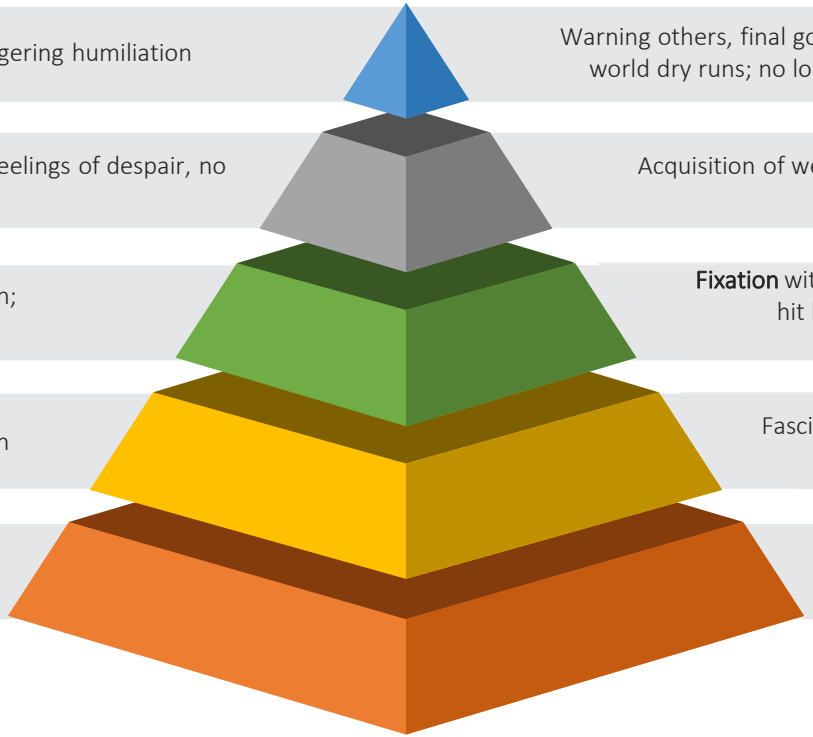


PATHWAY TO TARGETED VIOLENCE

WHAT’S MISSING?

INTERNAL STATES

OBSERVABLE BEHAVIORS



INTERNAL STATES	OBSERVABLE BEHAVIORS
Acceptance, relief, eerie calm; final, triggering humiliation	Warning others, final goodbyes, private rituals. Mental, digital, or real-world dry runs; no longer engaging in typical ADLs or other self care
Sense of urgency or increased energy; Feelings of despair, no way out, no other alternatives	Acquisition of weapons, safety gear, or clothing; practicing; **last resort/violence is imperative** statements
Preoccupation with revenge or retaliation; hopelessness or despair; paranoia	**Fixation** with revenge, persons, or a cause; talking about a hit list; researching modus operandi; deteriorating functioning
Feelings of exclusion, injustice or being victimized; violent fantasies for self worth regulation	Fascination with violent acts or offenders; excessive use of violent media; **warrior identity**
Feelings of shame, humiliation; rejection or social alienation	Engaging with content or communities that address grievances

Adapted from: Hoffmann, J., & Roshdi, K. (2012). School shootings in Germany: Research, prevention through risk assessment and threat management. In *School shootings: International research, case studies, and concepts for prevention* (pp. 363-378). New York, NY: Springer New York.

But how will I know if this person will harm someone?

Traditional VRA

Primary assessment question: Is it safe for X to be in Y setting?

Approach: collecting information from client, referral source, and collaterals to evaluate the presence/absence of risk and protective factors

Purpose: to make an informed hypothesis about the likelihood of outcomes

Outcome: risk determination using a categorical approach that guides disposition and management planning

T-SAM Approach

Primary assessment question: What's motivating X to want to commit an act of violence?

Approach: collaborate with the client to: (1) understand the problem(s) they're looking to solve through violence: and (2) to reduce uncertainty about the who, what, when, why, and how of violence

Purpose: to learn who X is and their source of pain in order to inform intervention; to reach a shared understanding of circumstances that would appreciably increase/decrease the likelihood of harm

Outcome: a co-created and agreed upon violence-focused treatment plan that includes an immediate risk management component

T-SAM Principles

Anyone is capable of violence; with the right supports, most are capable of leaving violence behind

Hate can be an indicator of emotional suffering

Everyone deserves an empathic ear

For most, violence is circumstantial, NOT pathological

People are willing to talk about their violent thoughts, and will do so honestly (even those who lie)

Behavioral health services can change lives, even for those without a psychiatric illness

Collaborative, person-centered approaches are essential to behavior change

Findings: Pilot T-SAM Training Program

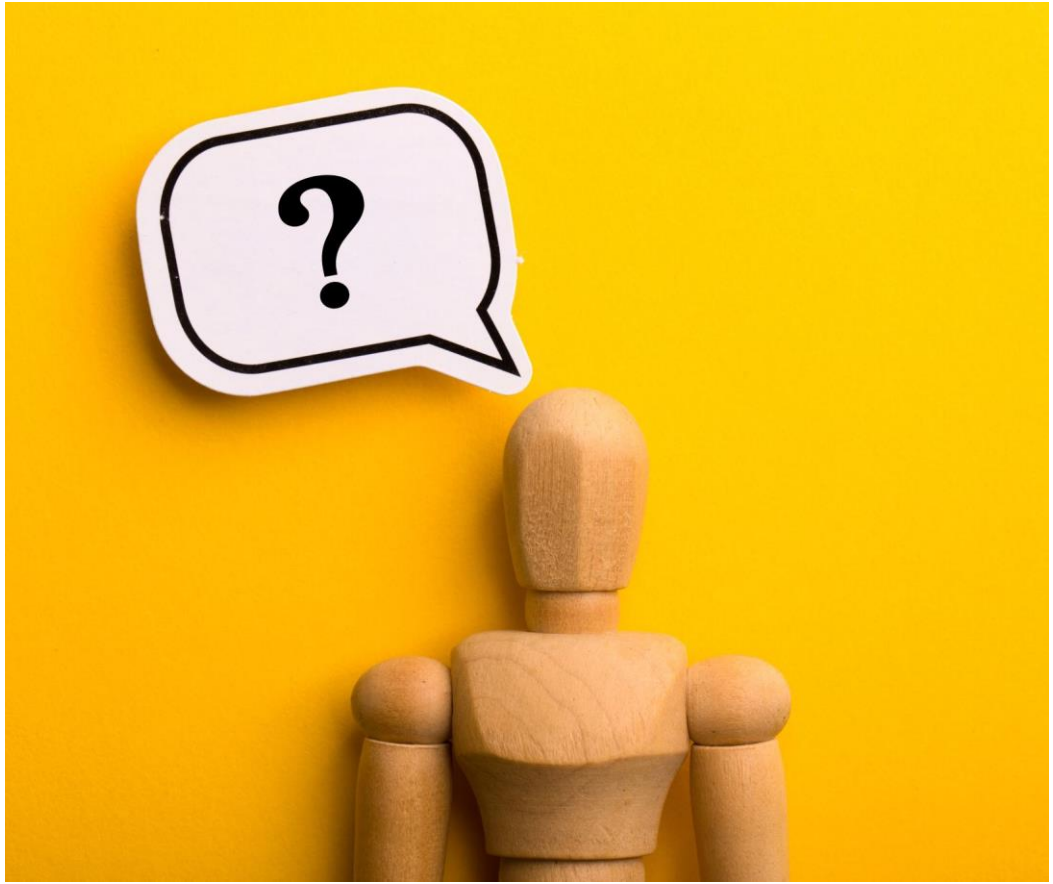
- Clinicians' confidence identifying, assessing, and treating targeted violence risk significantly increased
- Seen as a valuable tool for TVT risk assessment/management by both the clinician and client
  - Helped answer the question of "what now?"
  - Helped to build a therapeutic alliance
  - Clients felt seen, heard, and respected as a result of administration

Uses of the T-SAM

Usability
Outpatient treatment
Snapshot of acute distress to guide safety planning and disposition
One element of a larger violence risk protocol
Service planning tool for case managers
Multidisciplinary team formulation
Mitigation evaluations

MORNING BREAK

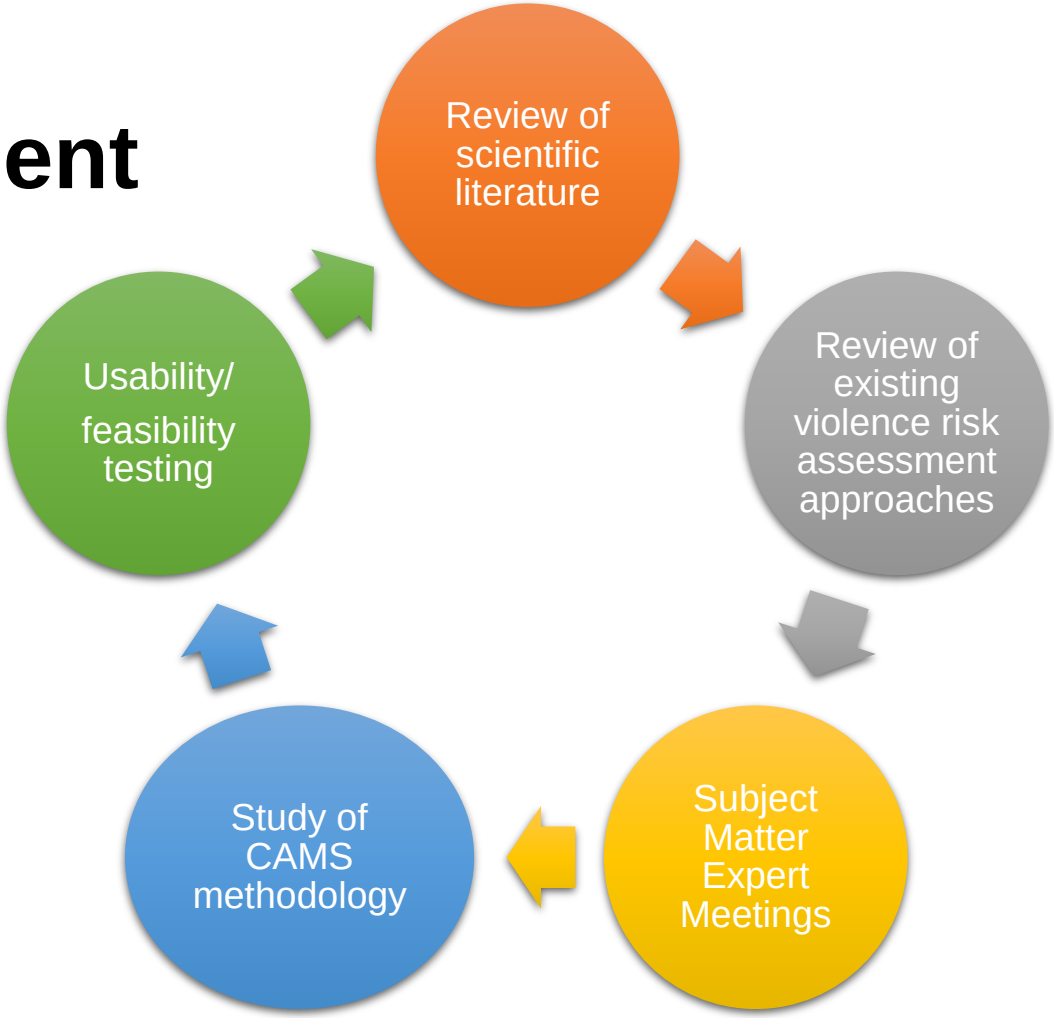
So, what is the T-SAM?



Key Features of the TVT Strengths, needs, and risks: Assessment & Management Tool (T-SAM)

- Clarifies the role of the MHP in TVT risk assessment/management
- Offers a client-centered, highly collaborative approach
- Requires that multiple perspectives be considered in order to fully understand strengths and needs
- Links assessment results directly to treatment planning
- Provides a structured process for re-evaluating risk at every client contact
- Encourages consultation with other providers from similar and different disciplines

T-SAM Development



T-SAM Initial Assessment Form

A

- Client-centered and collaborative
- Begin to build an understanding of “drivers”

B

- Enhanced clinical interview, including assessment of the pathway to violence
- Encourages collection of data from multiple sources

C

- Collaborative treatment plan
- Stabilization plan

D

- Post-session MSE, diagnostic impressions, scenario planning, and stages of change
- Risk formulation and “stability rating”

Section A: Patient-Centered Assessment

Includes both quantitative ratings and qualitative items to understand a client's experience of:

Feeling understood

Disconnected

Anger

Disgust

Thrill-seeking

Apathy

Sense of importance

Urgency

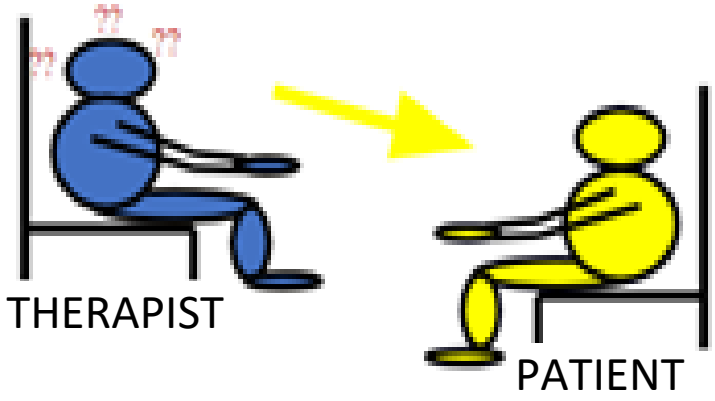
Agitation

Psychological pain

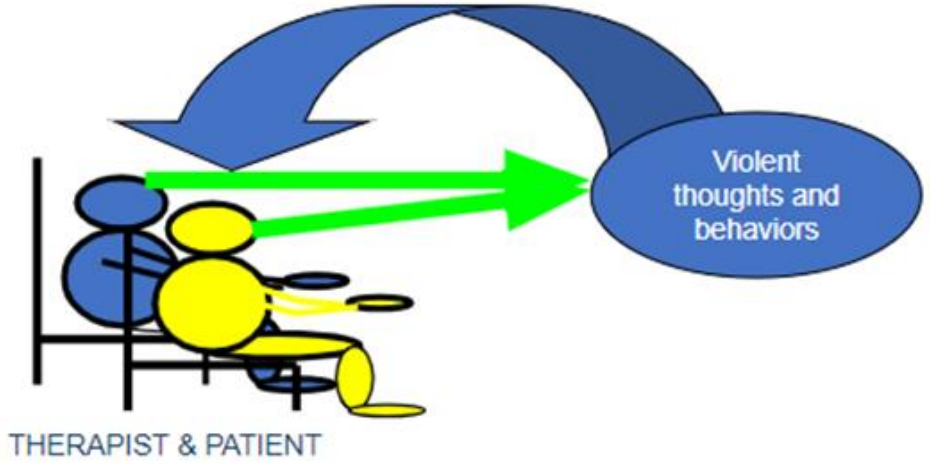
Hopelessness

Self-hate

Traditional Assessment Model



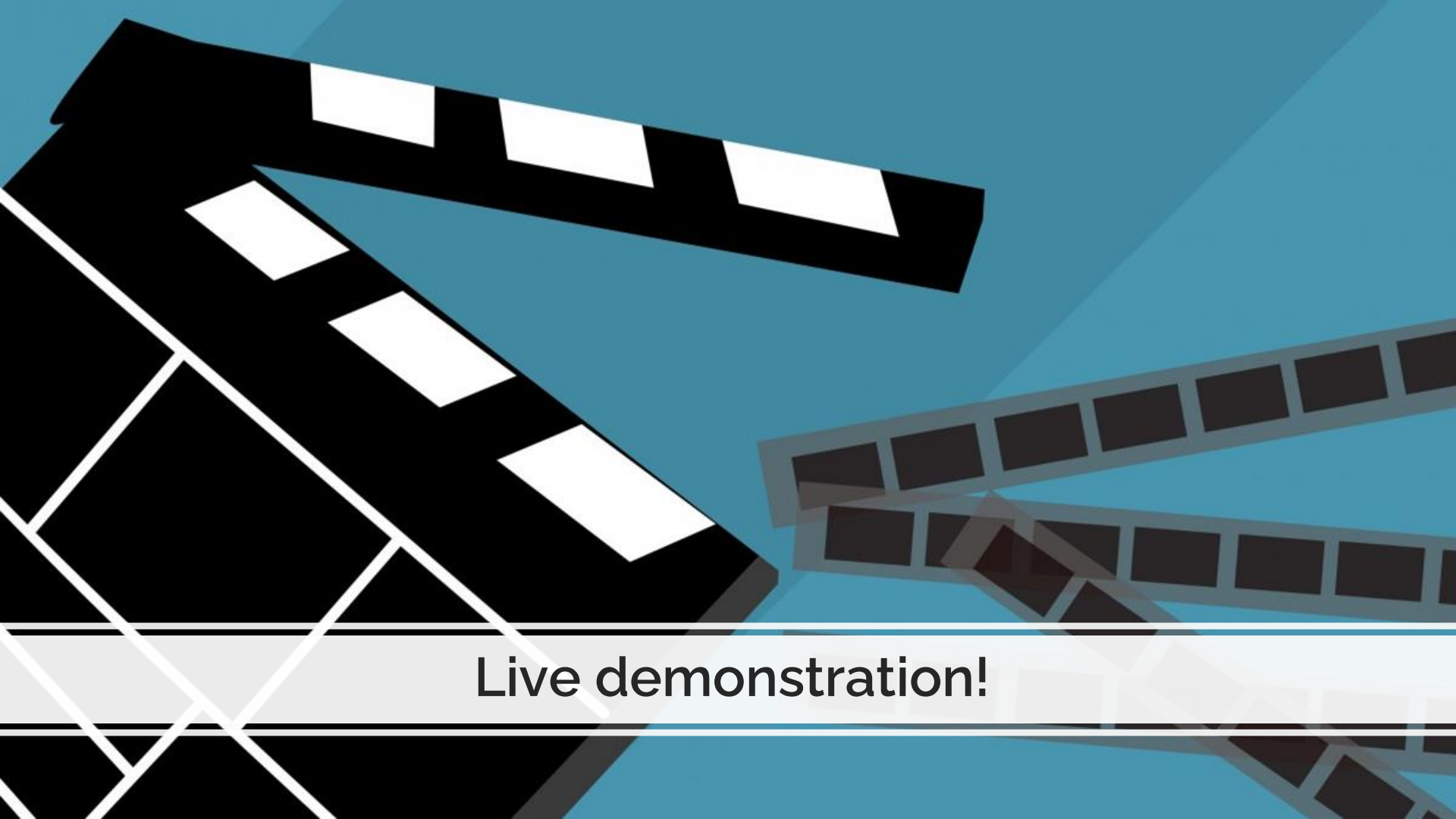
T-SAM Collaborative Approach



Considerations for Section A

- Transparency and empathic curiosity is key
- Keep it conversational
- Record the client's experience in their own words
  - "I don't know" can suffice as an answer
- Prepare to explain core items
  - Opportunity to increase emotional literacy
- Only ask follow-up questions when essential

T-SAM Items	Alternative Definitions
Understood	“Like people get you without you having to explain yourself”
Disconnected	“Like you’re different from the people around you, even people you see regularly or have relationships with, like family or friends.” “…feeling like you’re not part of any group.”
Disgust	“Strongly dislike someone…like you don’t want to be around them; maybe being around them even makes you feel sick to your stomach”
Thrill-seeking	“Not afraid to do anything, even in situations where you think you or others might get hurt” “...you like to do things that make you feel excited no matter what the consequences are”
Important	“Like you matter…like other people look up to you”
Urgency	“That feeling you get when you know you need to do something right away…when you feel like you have no other choice but to act now”
Agitation	“Feeling tense or uneasy in your body…restless…like your body can’t hold your energy and you need to move”
Psychological Pain	“Feeling extremely hurt, sad or upset about something”


Live demonstration!

Brendon

Brendon is a 14-year-old white male who was referred by the FBI to a violence prevention clinic for mental health services. Brendon was referred due to his online activity, which included engagement with ISIS, acquiring materials, and information to construct a bomb. Brendon has shared anti-America ideology; however, he has not identified a specific target or articulated a focused grievance.


Questions?

Time to Practice!

How Did it Go?

The Clinical Interview: Section B

Section B: The Clinical Interview

- Psychosocial interview that includes questions about:
  - Violent ideation and behaviors (pathway behaviors)
  - Affiliation with a group, movement, or cause
  - Online use
  - Identity and values
  - Past (PA) and Present (PR) stressors

- Response options:
  - Yes/No/Unknown at this time
  - Interview/Collateral/Record Review
  - Descriptive responses

POSSIBLE MOTIVATIONS FOR TARGETED VIOLENCE

Revenge/retaliation

Desire for notoriety, fame, or recognition

Perceived responsibility on behalf of a group or cause

Restore honor

Establish or strengthen bonds to like minded others

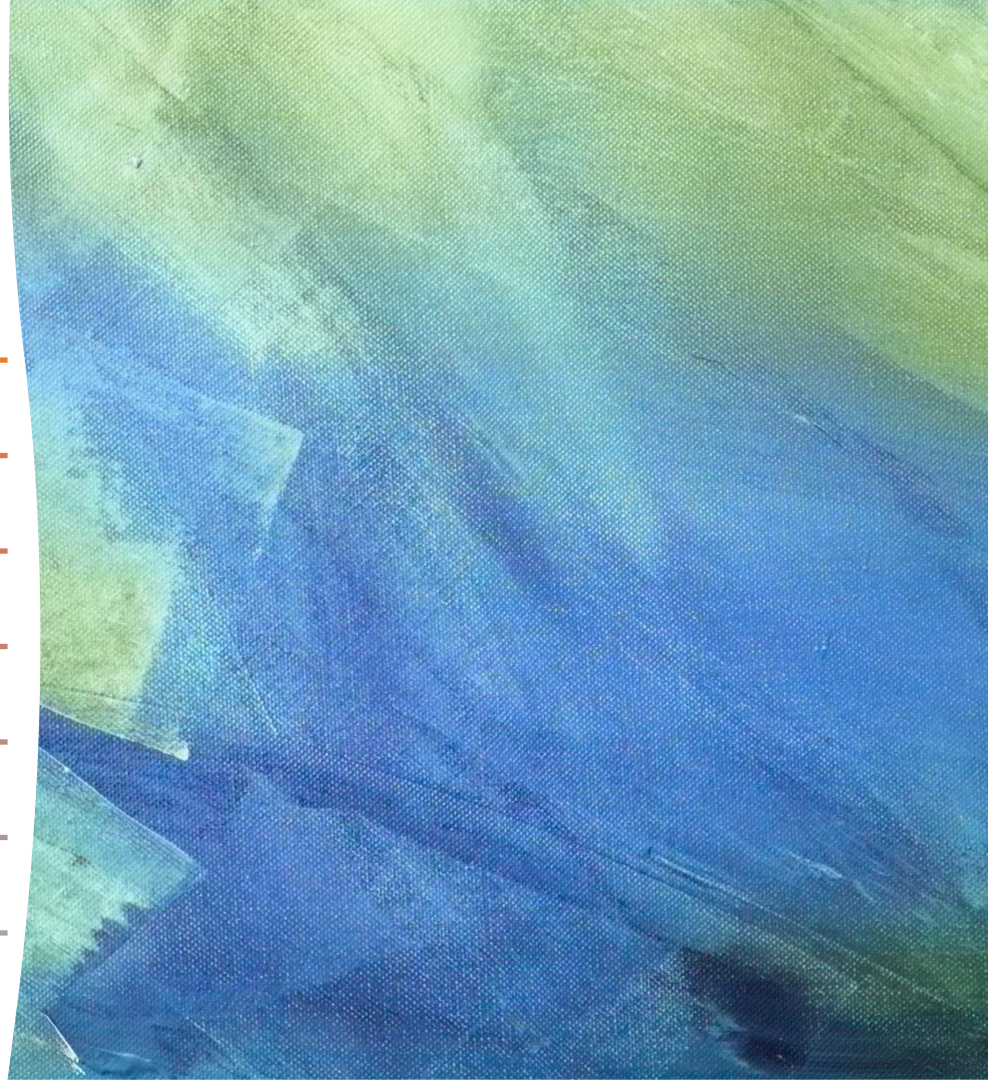
Despair

Reduce boredom

Thrill-seeking

Possible Precipitants: Stressful Events

- Recent Personal Losses
- Relationship Conflict
- Occupational or Educational Losses
- Financial Difficulties
- Health Challenges
- Failure to Achieve an Important Goal or Aspiration
- External Direction



PATHWAY TO TARGETED VIOLENCE

T-SAM: Pathway Assessment

Motivation

- **Section A** (internal states, intent, justification)
- **Section B**
  - Ideation
  - Alternatives/inhibitors
  - Interest in/exposure to violent content online
  - Motivators

Capability

- **Section B**
  - Novel and repeated aggression
  - Suicidal thinking and behaviors
  - Desensitization to violence
  - Research and planning
  - Preparation

Opportunity

- **Section B**
  - Access to means
  - Attack plan

Considerations for the Clinical Interview

Prioritize safety; otherwise, order is not important

Can include information collected from other sources

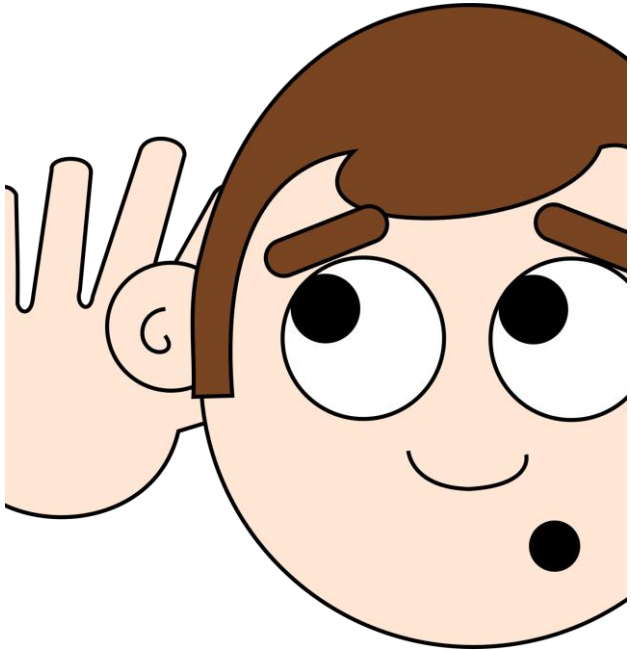
Assess for the presence of both positive and negative social relationships

Leave time for treatment planning, including completion of the stabilization plan

Complete based on what you can gather from the initial assessment; you can always come back

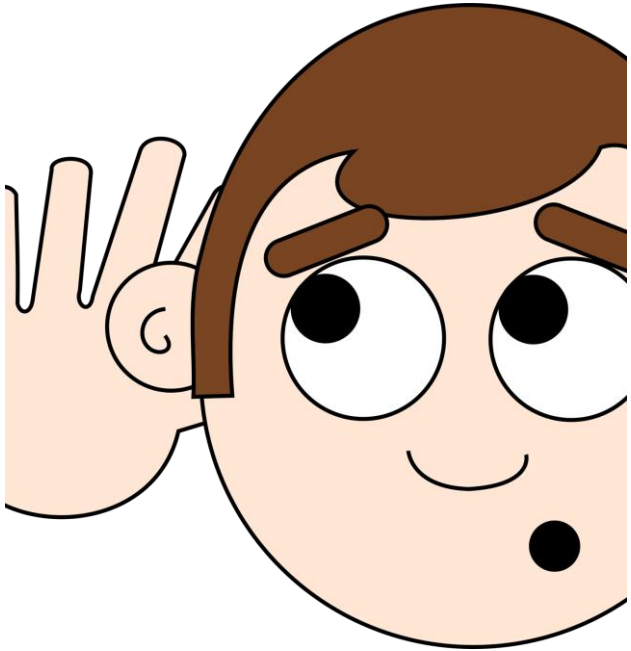
Things to Listen For

- Personal grievance (+ ideological framing?)
- Trauma and loss
- Function of violence/aggression
- Coping capacities
- Thinking style: e.g., fusion, rigidity, inflexibility, and fixations
- Relational style



Things to Listen For (Cont'd)

- Identity
  - The "in between"
  - Identification with an aggressor
  - Dependence on a virtual community
  - Affiliation with a violent movement or cause
    - Level of commitment
    - Capacity for violence (violent norms or goals)
    - Social cohesion vs isolative tendencies
    - Nature and function of online/offline interactions



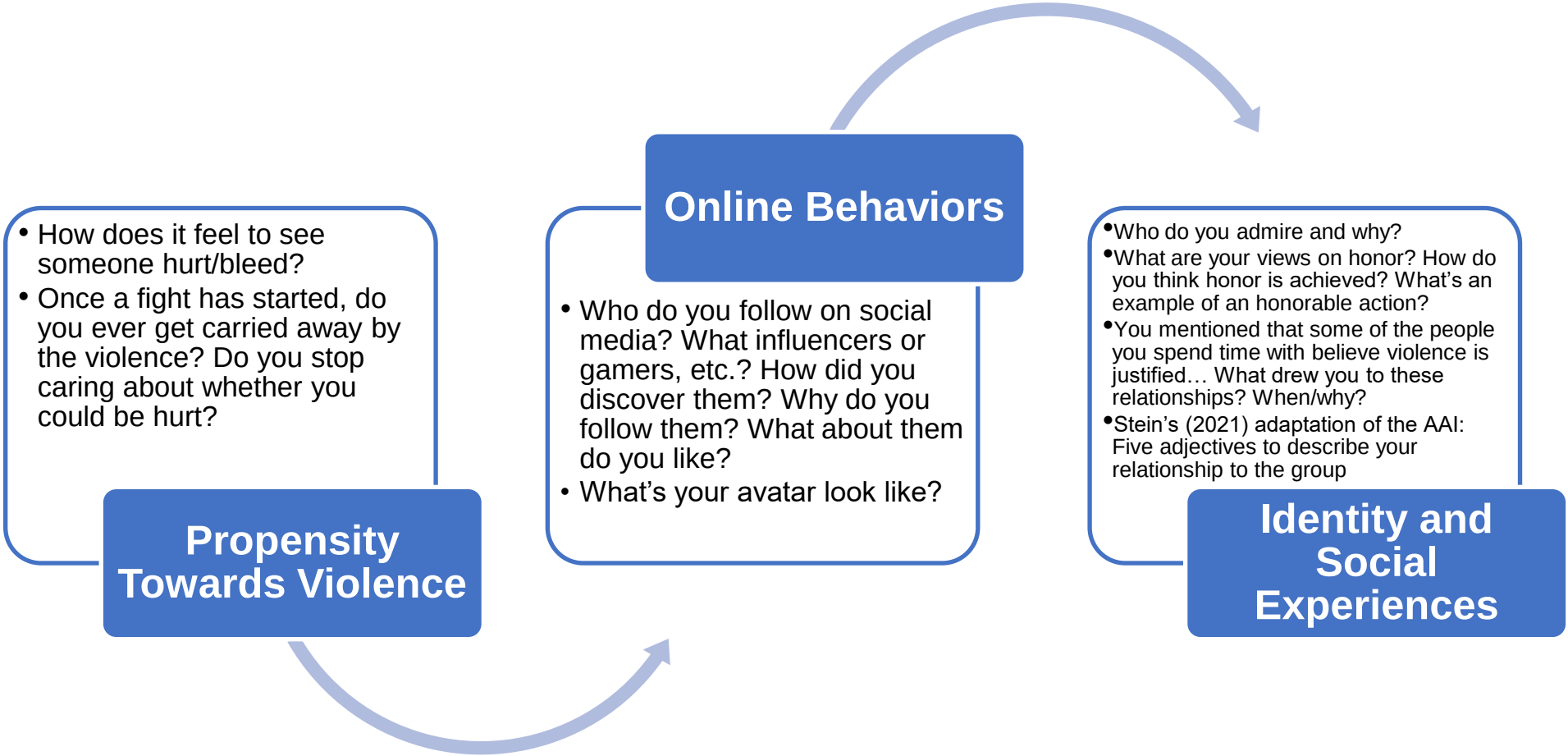
Lunch!

Breakout

- What questions would you ask Brendon to assess:
  - Identity and Social Experiences?
  - Motivation?
  - Capability and Opportunity?

- How might assessment approach change to account for developmental, cultural, or gender differences?

T-SAM Manual: Sample Questions




Section C: Collaborative Treatment Planning & Risk Management

Section C: Collaborative Treatment Planning

- Immediate Action:
  - Is there a duty to warn/report based on information collected so far?
  - Is higher level of care indicated in order to ensure the safety of your client or others?
- If community-based services are deemed clinically appropriate:
  - Develop a shared understanding of violent “drivers” (*to be revised/revisited over time)*
  - Come up with a preliminary treatment plan to address those “drivers”, with potential to harm others as the primary problem
  - Complete an initial stabilization plan

Section C: T-SAM Stabilization Plan

- Ways to make my environment safe
- Things I can do to take my mind off my problems without contacting another person
- People and social settings that provide a helpful distraction and can keep me out of trouble
- Warning signs that I need to use my safety plan
- People with whom I can ask for help when I am in crisis
    - Of these people, who am I OK with my provider calling to help me, if needed?
- Potential barriers to session attendance and solutions

Section C (*Clinician*):

T-SAM TREATMENT PLAN

Problem #	Problem Description	Goals and Objectives	Interventions	Other Supports	Duration
1	Potential to harm others	Safety and stability	Stabilization plan completed ☐		
2					
3					

YES____NO____Patient understands and concurs with treatment plan?
YES____NO____Emergency psychiatric evaluation/hospitalization indicated?

T-SAM Treatment Planning

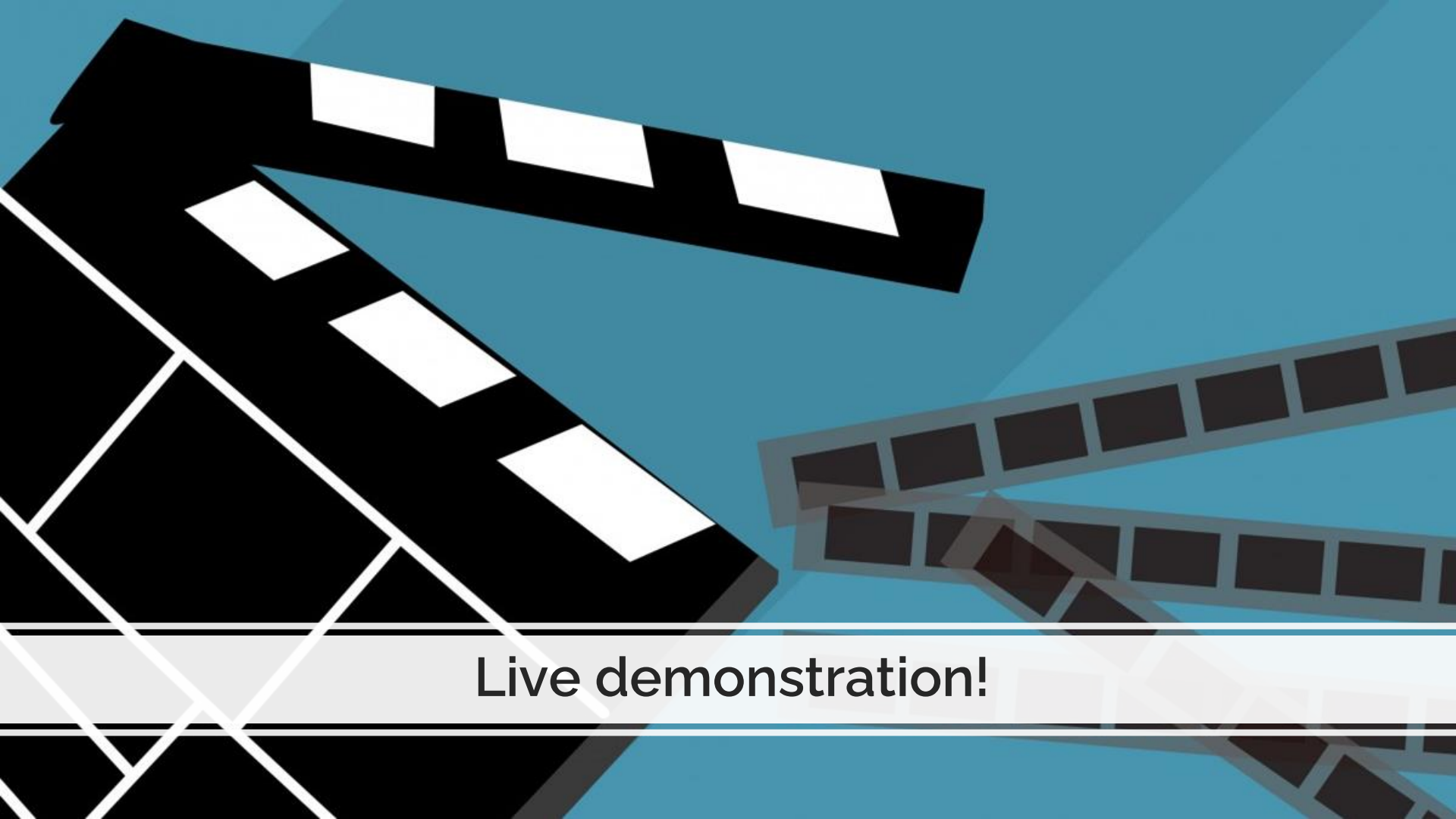
KNOW THE LAWS: TAKING STEPS TO PROTECT OTHERS FROM HARM

- **APA Code of Ethics: Do no harm**
- **Duty or permission to protect**
  - Sets expectations and limits to civil or criminal liability if you make a report or warning based on your professional opinion
  - Informed by federal law (e.g. HIPAA), state law, and case law that applies to your license and practice
  - "Health care providers may disclose the necessary protected health information to anyone who is in a position to prevent or lessen the threatened harm, including family, friends, caregivers, and law enforcement without a patient's permission" HIPPA *45 CFR 164.512(j)*

ACT BASED ON RISK

Adapted from BulletPointsProject.org

SAFE STORAGE (LOW)	Firearms are stored with a locking device, unloaded, and separate from ammunition. Keys and combinations are inaccessible to children or adults at risk.
TEMPORARY TRANSFER (MEDIUM)	Family, friends, or gun shop, or gun ranges temporarily hold on to firearms to reduce access until the crisis passes.
MENTAL HEALTH HOLD (MEDIUM/HIGH)	Reduced access by temporarily removing the individual from the environment, psychiatric treatment may address drivers or violence risk or otherwise reduce harm.
CIVIL PROTECTION ORDERS (HIGH)	Court order that temporarily removes guns and may prohibit buying new guns when there is a serious risk to the safety of self or others (may be necessary when the patient is unwilling or unable to collaborate).


Live demonstration!

Group Discussion

- What are appropriate goals for violence-focused treatment for Brendon based on assessment results?
- What therapeutic interventions might help us achieve those goals?
- What additional, non-clinical supports might be useful to stabilize risk?

Best Practice in Risk Mitigation

- Risk-Responsivity: link intervention to area of risk
- Specific and measurable plan
- Focus on enhancing protective factors as well as mitigating risk
- Plans need to have measurable outcomes and to be assessed for effectiveness

Firearm Counseling

- Open and frank discussion of relative risks and benefits can be useful in clinical settings
  - 67% of individuals and 54% of gun owners say it's appropriate
  - When the patient or someone at the home is at risk, conversations are generally well received (84%-91%, depending on the specific risk)
- Need to shift from the idea of "safe storage and removal" to that of "safer storage"
- Absence of a firearm SHOULD NOT equate with absence of concern

Image taken from: https://www.bulletpointsproject.org/how-to-counsel/

Bullet Point Project: 3 As Framework

AFTERNOON BREAK

Section D: Risk Formulation & Documentation

Section D: Clinician Post-Session Evaluation

- Mental status exam
- Diagnostic impressions
- Consider client's relational style, both with you and others
- Evaluate Stage of Change
  - Precontemplation, contemplation, preparation, action, and maintenance

Section D: Clinician Post-Session Evaluation

- Scenario planning: *What would it take for this person not to commit violence? What would it take for this person to escalate to the worst type of violence imaginable? How quickly do you think the situation could escalate if that worst case scenario occurred?*

- Rate “Concern about client’s relative stability”
  - None, moderate, extreme
  - Include rationale

- Encouraged to review formulation with another licensed clinician
  - Document either way

General Guidelines for Risk Formulation

Likelihood person will commit a violent act **if no efforts** made to manage risk, reflecting on capability and openness to change

Considers the dynamic, interplay between multiple, biopsychosocial and ecological factors

Emphasizes prevention, NOT prediction

Questions to Consider

What exactly am I worried will happen? What might they do? What might happen to this person?

Nature, frequency, and severity of potential violence

What steps should be taken to reduce a person's risk for violence?

What are the situations or contexts that may increase the risk for escalation to violence?

What am I trying to prevent? How would it happen? Who is at risk? And when?

Documentation: Adapted from FBI Guidelines

1

What you know:

- Sources of information reviewed
- Limitations of the assessment
- Summary of the issues highlighting important indicators
- Level of concern for violence and justification for that conclusion
- Potential for imminence

2

Actions taken:

- Lethal means counseling
- Safety plans developed
- Increase in session frequency
- Reports made
- Attempts to make appropriate referrals

3

Recommendations for additional actions:

- Plans to collect information from additional sources
- Additional referrals
- Reporting, mental health holds, civil protection orders

Breakout Groups for Risk Formulation

Group Discussion

- What types of violence are we most worried about and why? And in what contexts?
- How would we rate Brendon’s readiness for change?
- How would we rate Brendon’s relative stability?

Brendon's SAVRY Results

Historical Risk Factors	Social/Contextual Risk Factors	Individual/Clinical Risk Factors	Protective Factors
• Hx of violence: **Mod** • Hx of non-violent offending: **Mod** • Early initiation of violence: **Low** • Supervision/Intervention failures**: Low** • Self-harm/suicide attempts: **Mod** • Exposure to violence in home: **High** • Childhood hx of maltreatment **Low** • Parental/Caregiver Criminality: **High** • Early Caregiver Disruption: **Mod** • Poor School Achievement: **Mod**	• Peer delinquency: **High** • Peer rejection: **Mod** • Stress and poor coping skills: **High** • Lack of support: **Low** • Poor parental management: **Low** • Community disorganization: **Low**	• Negative attitudes: **Mod** • Anger management problems: **High** • Low empathy/remorse: **High** • Risk taking/impulsivity: **High*** • Poor compliance: **Low** • Substance use difficulties: **Mod** • Low Interest/ commitment to school**: High**	• Strong social support: **Absent** • Prosocial Involvement: **Absent** • Resilient personality traits: **Absent** • Attachment and bonds: **Present** • Strong commitment to School: **Absent** • Positive attitudes towards intervention and authority: **Present (intervention) & Absent (authority)** • Other Protective Factors: **Present (desire to understand self)**

The T-SAM Approach to TVT
Risk Assessment & Management

T-SAM Philosophy

- Lead with empathy —no shame, no blame
- Collaboration in all aspects of the intervention
- Assessment in and of itself is an opportunity for intervention
- Honesty and transparency throughout clinical care
- Documentation is helpful and protective

T-SAM as Framework for Therapeutic Intervention

- Focus on Violence—from beginning to middle to end
- Flexible and “Non-denominational”—across theories and techniques
- Community-focused: whenever possible, goal is to keep a client safely in the community

What's Next?

Next Steps!

PUBLISHING

T-SAM RESEARCH & DEVELOPMENT

T-SAM LEARNING COMMUNITY

T-SAM Learning Community

- **Access to the Administration Manual, T-SAM Initial Assessment Form (fillable PDF), and Readings**

- **Monthly T-SAM Case Conference:** Email Neil Saul at Eradicate Hate Global Summit! (nsaul@eradicatehatesummit.org)

- **Becoming "T-SAM Trained"**
  - Participation in a minimum of 5 consultation calls:
    - Discuss questions from the training
    - Apply T-SAM framework to real cases
    - Learn how to monitor risk using the T-SAM Re-Evaluation Form
    - Fidelity monitoring

Thank you!

T-SAM questions:
Emma.Cardeli@childrens.harvard.edu