Violent Extremism, Community-Based Violence Prevention, and Mental Health Professionals

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Abstract: New community-based initiatives being developed to address violent extremism in the United States are utilizing mental health services and leadership. This article reviews current approaches to preventing violent extremism, the contribution that mental illness and psychosocial problems can make to violent extremism, and the rationale for integrating mental health strategies into preventing violent extremism. The authors describe a community-based targeted violence prevention model and the potential roles of mental health professionals. This model consists of a multidisciplinary team that assesses at-risk individuals with comprehensive threat and behavioral evaluations, arranges for ongoing support and treatment, conducts follow-up evaluations, and offers outreach, education, and resources for communities. This model would enable mental health professionals in local communities to play key roles in preventing violent extremism through their practice and leadership.

Key Words: Violence, terrorism, prevention, community

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BACKGROUND

How to best address violent extremism in the United States is a top local law enforcement and national security concern. Violent extremism refers to "advocating, engaging in, preparing, or otherwise supporting ideologically motivated or justified violence to further social, economic or political objectives" (US Agency for International Development, 2011). In the United States, violent extremist attacks have come from the far right, as well as from Islamic extremists and the far left (Chermak and Gruenewald, 2015). There is no one "typical" profile of individuals who have committed terrorism. The rise and expanding reach of the Islamic State, punctuated by recent attacks in New York, New Jersey, Minneapolis, Orlando, San Bernardino, Paris, and Brussels, have caused concerns about violent extremism to rise in many US communities.

Countering violent extremism (CVE) has emerged as a key supplement to law enforcement–driven approaches to violent extremism, which investigate, arrest, and prosecute. CVE refers to the "use of non-coercive means to dissuade individuals or groups from mobilizing towards violence and to mitigate recruitment, support, facilitation or engagement in ideologically motivated terrorism by non-state actors in furtherance of political objectives" (Kahn, 2015).

CVE in the United States is rooted in the White House Strategic Implementation Plan (SIP) of 2011 updated in 2016 (Executive Office of the President of the United States National Security Staff, 2011, 2016). It outlined the government's and law enforcement's role in empowering local stakeholders to build resilience against violent extremism through devising new violence prevention activities. The SIP underlined that partnerships with community-based organizations are necessary to respond to community concerns and to support community-based solutions. These were intended in part to increase opportunities in communities and to create hope, especially for young persons.

Controversies around such programs have arisen, however, with members of some communities for whom CVE programs have been developed raising concerns that their community has been targeted and that this amounts to profiling (Weine et al., 2015a). Some community members have also voiced concerns that CVE programming is actually geared toward gathering intelligence on community members. Efforts to develop community-based violence prevention programs, even if independent from law enforcement and government, will still encounter these concerns. Thus, it is necessary for stakeholders to proceed with great sensitivity in seeking community buy-in and collaboration and to assure that civil liberties are protected.

In the United States and other countries, there is a recent call for second-wave CVE activities to be more focused in the areas of primary and secondary prevention (Romaniuk, 2015). Primary prevention activities are directed at a community level to diminish exposure to risk factors and increase protective factors with respect to violent extremism (O'Connell et al., 2009). Secondary prevention activities are directed at individuals who have already adopted extremist ideologies that condone violence or are in contact with violent extremists but are not yet engaged in planning or carrying out acts of violence.

Both primary and secondary prevention activities require the participation of a range of community actors in addition to law enforcement. One reason for this is that law enforcement is primarily focused on stopping crimes and is constitutionally forbidden from getting involved in communities' or individuals' religious beliefs.

Research in several US communities has shown that community members seldom identify violent extremism as a primary concern (Weine, 2015). Thus, policies and programs should address not only violent extremism but also other stated priorities of communities regarding the promotion and protection of their well-being and health. This could include addressing a range of problems, for example, hate crimes, suicidality, drugs and alcohol, criminal gangs, and domestic violence, through incorporating both primary and secondary prevention strategies.

The purpose of this article is to help mental health professionals understand and be equipped to consider participating in these emerging community-based violence prevention programs as practitioners, leaders, or evaluators. This article addresses a) the contributions that mental health and psychosocial problems make to the risk for some persons becoming involved in violent extremism, b) the rationale for integrating mental health strategies in dealing with the issue of violent extremism at a community level, c) a services model for community-based violence prevention, and d) ethical and legal considerations.

THE CONTRIBUTION OF MENTAL HEALTH AND PSYCHOSOCIAL FACTORS

Previous research on the relationship between mental illness and violent extremism has not demonstrated any clear relationship

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(McCauley et al., 2013). Terrorism studies have long taught that terrorists were rational actors not driven by mental illness; however, important new research has been finding evidence that suggests associations, more so with lone than group actors. Up to 40% of lone wolf terrorists had identifiable mental health problems (Corner and Gill, 2015). Violent white supremacist groups were found to have elevated rates of childhood physical abuse (45%), family substance abuse (49%), and mental illness (57%) (Simi, 2015). Among persons who travelled from the Netherlands to Syria, 60% had psychosocial problems and 46% displayed problem behavior; just 6% had a diagnosed mental health problem (Weenick, 2015).

There are many paths into violent extremism. Mental illness or psychosocial problems cannot explain all cases of terrorism and other mass casualty attacks. Given the low base rate of violent extremism, these studies should not be taken to mean that mental illness or psychosocial problems alone are causally associated with violent extremism. However, they may be able to explain enough for a subset of persons to create new opportunities for community-based secondary prevention. Studies of school shooters have shown that most attacks were preceded by a pattern of detectable maladjustment with communication and behaviors of concern (USSS Safe School Initiative, 2000). Mental health professional trained in threat assessment have expertise in determining the level of risk of persons and whether treatment could be offered to help reduce their level of risk. Presently in most U.S. communities, most of those persons of concern are not being linked to mental health professionals trained in threat assessment, either by law enforcement or by community members.

INTEGRATING MENTAL HEALTH AND CVE

Although violent extremism cannot be reduced to a mental health issue, best practices drawn from both community-based practitioners and empirical research indicate that those with mental health expertise are uniquely poised to contribute to effective primary and secondary prevention activities concerning violent extremism. However, new strategies are needed to organize their involvement because most individuals getting involved with violent extremism will not present independently requesting mental health services. A 2015 review on integrating mental health and preventing violent extremism (Weine et al., 2015b) identified three overall key strategies: a) communities need to have a say in how to prioritize and organize actions intended to build their resilience to violent extremism; b) strategies for preventing violent extremism need to be organized and led by community-based multidisciplinary teams who draw upon mental health, public health, religious, educational, and law enforcement frameworks and remedies; and c) efforts to address violent extremism should adopt comprehensive approaches to promoting community safety that includes ideologically inspired violent extremism as one of many forms of violence that afflict communities.

Operationalizing these strategies entails significant rethinking of the overall criminal justice driven CVE framework under which activities to reduce violent extremism have largely been developed and/or delivered thus far. The law enforcement emphasis of earlier CVE efforts has been an area of contention from both community advocates and academic critics, as noted earlier (Weine, 2015). An alternative to a primarily law enforcement–driven approach to CVE is to locate new violence prevention activities within human services disciplines, especially public health, which also includes mental health. Multilevel cooperation with law enforcement would be of vital importance, but the work should be rooted in theories, evidence, practices, workers, and systems that come from outside of criminal justice.

Preventing violent extremism could also be placed in the context of preventing other forms of violence and other public safety concerns. Different forms of violence—child abuse and neglect, youth violence, intimate partner violence, sexual violence, elder abuse, and suicidal behavior—are strongly connected in many ways (Centers for Disease Control, 2016). Understanding and addressing possible areas of convergence between violent extremism and other crime types, such as criminal gangs and human trafficking, are also needed. Mental health professionals may be able to play important roles in collaborative primary and secondary prevention to steer people away from these other types of crime.

A MODEL FOR SECONDARY PREVENTION WITH VIOLENT EXTREMISM

Currently, several US localities are attempting to develop community-based violence prevention addressing violent extremism that involves mental health professionals and other community-based service providers, such as teachers and clergy. The overall purpose of these efforts is to establish a sustainable multidisciplinary program to bolster community-based services for steering at-risk individuals away from violence and toward positive alternatives. In many communities, including those with large populations of immigrants and ethnic and religious minorities, mental health and psychosocial services are not adequately available, culturally competent, or accessed. Some of these initiatives have been organized primarily by nongovernmental organizations (*e.g.*, the Muslim Public Affairs Council's Safe Spaces; MPAC, 2016), others by law enforcement (*e.g.*, The Federal Bureau of Investigation's Shared Responsibility Committees; Hussain and McLaughlin, 2016), and others by public-private partnerships (*e.g.*, the Montgomery County Model; World Organization for Resource Development and Education [WORDE], 2015).

One well-established and well-accepted program of interest is the School Threat Assessment and Response Team (START) in Los Angeles. A nationally awarded program, it has already demonstrated proof-of-concept of the potential benefits of mental health involvement in targeted violence prevention (Brown, 2014). START was established in 2009 to provide specialized mental health interventions that address the needs of individuals engaged in, or at risk for, acts of targeted violence in school settings countywide. START provides 5 key services: a) educate the public about issues related to bullying, targeted school violence and the program's capacity to intervene; b) receive referrals from educational institutions, parents and community members about persons of concern; c) provide comprehensive threat and behavioral assessments to determine an individual's risk for engaging in targeted violence; d) connect the person to necessary services and supports which address their mental health and social support needs and reduce risk factors; and e) conduct regular monitoring to prevent relapse. All these efforts are applied to prevent acts of violence and ensure that the person is receiving appropriate interventions before a person has engaged in, or has been charged with, a criminal act. Participation is voluntary, supported by the concerns and engagement of families, schools, clergy, and other community-based organizations. In a typical year, START responds to more than 3000 calls and manages approximately 80 high-risk cases.

Although definitive evidence of START's effectiveness is still needed, its model of targeted violence prevention can serve as a model for secondary prevention for violent extremism. Other US communities have similar, although in most cases less well-developed, capacities, which can be expanded and modified to include addressing ideologically inspired violence and the communities impacted by it. In the following paragraphs, we describe the basic characteristics of the community-based targeted violence prevention model based on the aforementioned START program.

Community-based violence prevention should address all forms of violent extremism in all communities no matter what the underlying ideology. Community-based violence prevention is not concerned with or focused on changing a person or community's ideology or political or religious beliefs, given that these are constitutionally protected. Rather they are concerned with stopping an individual's engagement in violent

behavior. They should also address other forms of targeted violence, such as school violence, workplace violence, and bias-motivated hate crimes.

Community-based violence preventions can accept referrals from community members or law enforcement that identify persons they believe are at risk for violent behaviors. To facilitate referrals, these programs should educate the key community advocates and providers about characteristics that may be early indicators of potential threats based upon solid evidence (not upon theory alone, such as radicalization theory). One important example could be involvement in networks of recruiters or their associates. These programs utilize a threat and behavioral assessment approach, which helps community-based professionals and advocates know who could potentially benefit from a secondary prevention and who needs an immediate referral to law enforcement (Borum, 2015). Based on a matrix of observed actions and expression, gathered from multiple sources, this approach to assessment affords a more objective indication of risk than a global clinical impression can achieve. This approach focuses on how the person is "behaving" and "communicating" based on the presumption that incidents of violent extremism are usually the end-result of an understandable and often discernable process.

These community-based violence prevention programs each establish a multidisciplinary team that is able to offer multimodal care for persons. These teams can offer activities such as individual and family therapy, medication management, mentoring, religious education, school consultation and placement, and job consultation and placement. The teams can also draw upon religious clerics, peers, and former violent extremists as interveners, given that these persons offer other strengths, complementing those of mental health professionals.

Those who are above a critical threshold of risk for violent behaviors are assigned to care by the multidisciplinary team. This team also conducts follow-up assessments to determine the person's' level of risk and their readiness to exit the program. Many persons referred to the programs will likely be determined to be not at risk of violence. Some of those persons will be referred for mental health care or social services. Given the potential for stigmatization not just regarding mental health but also regarding violent extremism, protecting the privacy of individuals and ensuring the trust of the community are critical to the success of any such program.

A major component of community-based violence prevention activities is outreach, education, and building relationships with community advocates and leaders, community-based professionals, and ordinary community members. One task is to offer services to community-based providers or advocates who might be concerned about a person in the community who could benefit from the services of the community-based violence prevention. Another task is to educate community members about the criteria for bringing a concern about the risk of violence to the attention of the team and the protocols defining exactly how to handle this potentially urgent and sensitive information in an effective and responsible manner.

WHAT CAN MENTAL HEALTH PROFESSIONALS DO?

In multiple localities in the United States, government, law enforcement, and community advocates are seeking the involvement of mental health professionals in both primary and secondary prevention activities of community-based violence prevention programs. The experiences of other violence prevention programs indicate that there are multiple ways for mental health professionals to be involved (Weine et al., 2015a; WORDE, 2015). A large number of mental health professionals in the community being served need to be aware of the risks of violent extremism and what steps they might take to address these risks within the context of their existing work. A smaller number of mental health professionals can become actively involved in providing secondary prevention services for those referred. An even smaller number of persons can be involved in leading, providing training for, or evaluating secondary prevention programming. Below, we identify some of the many practical ways for mental health professionals to become involved:

Attend: Provide a safe space for a client to express their views on identity, grievances, discrimination, profiling, politics, foreign policy, or violence.
Ask: Consult with religious leaders or cultural experts to better understand the context of their client's experience.
Build trust: Help community members to understand how community-based violence prevention works and why they are needed.
Mobilize: Enlist a professional peer group, including other disciplines/cultures, to discuss violent extremism.
Partner: Get to know your local law enforcement agencies and give them a directory of local providers.
Remember: Consider ideologically inspired violence when assessing for violence.
Self-educate: Get trained in threat assessment.
Educate: Teach students and trainees about the causes and responses to violent extremism.

ETHICAL AND LEGAL CONSIDERATIONS

Serving in a community-based violence prevention program raises important ethical and legal questions for participating mental health professionals. The overall challenge is to appropriately serve both individual clients' needs and public safety needs. Three key considerations include privacy, information sharing, and legal risk.

The privacy of health and mental health information for all persons involved in violence prevention is protected by the Health Insurance Portability and Accountability Act of 1996. However, mental health professionals also have a duty to share information if there is an imminent threat to individual or public safety. Those mental health professionals conducting secondary preventions should have an established relationship with law enforcement, with clear mutual expectations regarding how to communicate, especially about imminent threats.

A second area of concern is information sharing, which requires navigating federal and state mandates about confidentiality. However, this can be facilitated by predetermined agreements and informed consent, such as the START program. Mental health professionals need to work together to devise information sharing documents to maximally protect a person's information while also assuring public safety.

A third area of concern is that mental health professionals may be concerned that they could put themselves at legal risk, including especially prosecution for material support. The material support statute (Federal statute 18 U.S.C. 2339B) makes it a crime to attempt or conspire or provide material support or resources to a foreign terrorist organization. However, the Justice Department has communicated by word of mouth that there is little chance of prosecution because a) there is no precedent for these prosecutions, b) they run counter to the US government's policy for developing secondary preventions, and c) prosecutions have occurred only when it was the intent of the person to support terrorist activity. On the other hand, there is no precedent for the US Attorneys giving blanket immunity to criminal prosecution including for mental health professionals. Some community members have expressed concern that there is still not adequate clarity regarding the legal framework that would protect mental health professionals conducting violence prevention.

CONCLUSION

In conclusion, community-based violence prevention could contribute to addressing the threat of violent extremism, and mental health professionals have significant contributions to make. With suitable training and preparation, such programs could assist communities in promoting a humane, informed, and comprehensive approach

to promoting public safety. Further work is needed to implement violent prevention programs and to build an evidence base that examines their possible effectiveness.

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