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Working to Prevent Violent Extremism: Readiness of Behavioral Health Professionals in New York State

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Abstract

Violent extremism has risen markedly in the United States in recent years, renewing concern about prevention but leaving behavioral health professionals (BHPs) with limited empirical guidance on their role. This study presents, to the authors' knowledge, the first quantitative analysis of U.S. BHPs' readiness to engage in preventing violent extremism (PVE) and behavioral threat assessment and management (BTAM). Guided by prior focus groups in the same region, an online survey was administered to 149 clinicians in a large, diverse New York State county recently affected by extremist violence. Measures assessed perceived threat, ethics, professional role, preparedness, and willingness to collaborate with law enforcement, alongside demographic and practice characteristics. BHPs overwhelmingly endorsed having a significant role in PVE and an ethical obligation to work both with communities and individuals exiting violent extremism, and most supported collaboration with law enforcement while simultaneously expressing concern about structural problems in policing. However, substantial gaps in perceived preparedness emerged, with social workers, rural practitioners, less-experienced clinicians, women, and White BHPs reporting lower readiness than their counterparts. These findings highlight both a strong professional mandate for BHP involvement in PVE and critical inequities in training and confidence, suggesting targeted, discipline- and context-specific capacity-building as a priority for policy and practice.

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Introduction

An analysis of violent extremism plots against government targets for partisan beliefs conducted by the Center for Strategic and International Studies (CSIS) showed that threats tripled from 2016 to 2024 compared to the previous 25 years combined. Meanwhile, hate crimes are on the rise. Federal Bureau of Investigation (FBI) tracking of hate crimes in the United States (US) showed a 16.8% increase in hate crimes and incidents reported from 10,498 in 2020 to 12,265 in 2024 (FBI, 2025). High profile assassinations and attempted

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assassinations of political figures, judges, and other public figures have resulted in renewed focus on the prevention of violent extremism. However, the Trump administration has gutted the US prevention infrastructure for targeted violence and terrorism at the federal-level through the dismantling of the Targeted Violence and Terrorism Prevention Program (TVTP) at the Center for Prevention Partnerships and Programs (commonly known as CP3) at the Department of Homeland Security (DHS) while simultaneously dissolving the Office of Countering Violent Extremism in the Bureau of Counterterrorism at the US Department of State. Given the lack of infrastructure at the federal level to support prevention, state-level agencies may need to rely more on individual professionals to detect, report, and respond to threats.

Starting in the late 2000's, public health practice models have been advocated as an effective avenue to meet preventing violent extremism objectives (Hutson, Long, & Page, 2009; Weine et al., 2009). Support for these approaches has grown, with multiple scholars and think tanks now advocating for the use of public health models for preventing violent extremism (PVE) (Bosley, 2019; Ellis & Abdi, 2017; National Academy of Sciences [NAS], 2017). Further, a diverse body of multilateral organizations has also advocated for public health approaches (Global Community Engagement and Resiliency Fund, 2025; Global Counterterrorism Forum [GCTF], 2016). A common theme among these models is the promotion of a "whole of society" approach that advocates for the incorporation of all sectors within communities: civil society, private sectors, the public, and the government to plan, address, and evaluate these prevention models. Particularly, Behavioral Threat Assessment and Management (BTAM) models have been advocated throughout the US interagency (e.g., US Secret Service, DHS, US Department of Justice) as a preferred secondary prevention strategy. Research suggests that for lone actor terrorism, mental health and trauma histories may be a significant contributing factor (Comer & Gill, 2015). Along with BTAMs, social workers, psychologists, and other behavioral health specialists have also been suggested as frontline implementers for primary, upstream PVE programming by a host of domestic and international researchers and think tanks (Berner, 2022; GCTF, 2020, Hutson, 2021). However, there have been serious critiques in the literature in the utilization of behavioral health professionals (BHPs) in countering violent extremism from European social work

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scholars (e.g., Finch et al., 2019; Haugstvedt, 2019; McKendrick & Finch, 2017), particularly the use of behavioral threat assessment. The authors have been critical of the underlying assumptions of the prevention models that target youth deemed at risk and the threat of labeling; the securitization of the profession; the lack of validated assessment, treatment models, and trainings; and the potential to lose community trust (Awan & Guru, 2017; Guru, 2010; Ponsot et al., 2018; Stanley et al., 2018; Stanley & Guru, 2015).

BTAM is a multidisciplinary approach designed to identify, assess, and manage individuals who may be progressing toward radicalized violence before an attack occurs. Unlike traditional law enforcement models that focus primarily on criminal investigations or static risk factors, BTAM emphasizes the dynamic assessment of observable behaviors, warning signs, stressors, grievances, and protective factors that may indicate an escalating pathway to violence. BTAM teams, typically regionally- or organizationally-based (e.g., schools, hospitals, etc.) comprise of representatives from law enforcement, behavioral health, education, human resources, and other community stakeholders who collaboratively develop individualized management strategies aimed at reducing risk while connecting individuals to appropriate services and supports. The approach is grounded in the premise that targeted violence is often preceded by identifiable behaviors and opportunities for intervention, making coordinated, multidisciplinary case management a critical component of secondary prevention efforts. In a typical BTAM process, a referral is made when an individual exhibits concerning behaviors or communications that suggest escalating risk. This referral can be from any stakeholder and is not tied to specific disciplines or expertise. A multidisciplinary team then gathers and integrates information from multiple sources, including behavioral observations, collateral contacts, criminal justice records, educational or employment records, and mental health or social service providers when legally appropriate. Rather than attempting to predict violence based on demographic characteristics or ideology alone, the team assesses whether the individual is progressing along a pathway toward violence by evaluating motivations, stressors, grievances, capability, intent, and protective factors. Based on this assessment, the team develops a management plan that may include mental health treatment, social services, conflict resolution, monitoring, law enforcement intervention, or other individualized strategies designed to reduce risk while addressing underlying psychosocial

needs. Cases are reassessed over time to determine next steps and effectiveness of the process (DHS, 2024; McCain Institute, 2025; START, 2025; Strong Cities, 2025).

To date, only one peer-reviewed study has been conducted in the United States on the willingness, capabilities, and training needs of BHPs for the engagement in PVE through BTAM, and this analysis was combined with several areas around the world (Ponsot et al., 2018). While there have been trainings offered for BHPs through several institutes and other entities for US audiences (e.g., National Consortium for the Study of Terrorism and Responses to Terrorism (START), McCain Institute, DHS, Strong Cities) (DHS, 2024; McCain Institute, 2025; START, 2025; Strong Cities, 2025), empirical validation of either the effectiveness of the trainings themselves or of the interventions recommended has not been established.

Although empirical evidence supporting the effectiveness of public health approaches to preventing violent extremism remains limited, the success of these approaches depends heavily on the willingness and capacity of frontline practitioners to participate in multidisciplinary prevention systems. BHPs occupy a unique position within these systems because they routinely engage individuals experiencing psychological distress, trauma, social isolation, and other factors that are identified pathways toward violent radicalization and have the expertise and experience to identify and address those psychosocial issues. Effective BTAM models rely on close collaboration between BHPs, educators, civil society organizations, and law enforcement to identify, assess, and mitigate risk before violence occurs. Consequently, understanding behavioral health professionals' perceptions of their role, their preparedness, and their willingness to collaborate with other stakeholders is essential for strengthening multidisciplinary prevention efforts and informing training and policy development. Relatively little empirical work has examined these issues in the United States, however, research conducted in Western Europe and the United Kingdom provides important insights into practitioners' attitudes toward participation in P/CVE and the challenges they perceive in implementing these approaches.

Haugstved's (2019) qualitative study of social workers working with radicalizing(ed) individuals in Norway, and Ponsot et al.'s (2018) international study of BHPs from numerous countries, are perhaps the most insightful of studies examining attitudes and practices of any

BHPs in PVE. In both cases, their studies found the same concerns previous studies had found. BHPs felt that there was significant lack of training, validated assessment protocols, and empirically-supported interventions, and thus felt unequipped to work in PVE. In working with radicalizing individuals and their families, many BHPs in these studies relied on established methods for the reintegration of criminal justice-involved individuals. Trust building and rapport establishment, strengths-focused, and other common baseline approaches were also found to be common among BHPs in working with these cases (Haugstved, 2019).

Theoretical Framework

Protection Motivation Theory (PMT) undergirds our analysis because it provides a useful model for understanding the extent to which behavioral health professionals (BHPs) perceive violent extremism as a threat and how those perceptions influence their preparedness and willingness to engage in P/CVE. This theory has been widely applied to explain health care professionals' adoption of protective occupational behaviors, including infection prevention, workplace safety, and risk mitigation practices (Mortada et al., 2021; Nouri et al., 2024; Norman et al., 2005). The theory posits that individuals' protective actions are influenced by their appraisal of threat severity and vulnerability, as well as their perceived efficacy and ability to respond effectively (Rogers, 1983). Given that participation in BTAM requires practitioners to recognize violent extremism as a meaningful threat, and to believe they possess the knowledge and skills necessary to intervene, PMT provides a logical framework for examining practitioners' attitudes, preparedness, and motivation to engage in these prevention activities. The core components of PMT (Rogers, 1983) suggest that people adopt changes in health behaviors in response to a series of cognitive processes. In short, the perceived severity of the threat to health and the perceived vulnerability to the threat, along with one's sense of efficacy and response costs, leads to protective motivation and ultimately to changes in behavior to increase security (Norman et al., 2005).

Research Questions

This is the first quantitative study of BHPs attitudes and preferences regarding PVE participation and training in the US to the authors' knowledge. Given the trepidation in

working broadly in P/CVE and UK Prevent outlined by the scholars cited above, the core research question was conceptualized as, "To what extent will BHPs be willing to engage in the practice of P/CVE?" This is an important first-order question, as there are numerous BTAM trainings available across multiple platforms, yet engagement appears lacking. The present analysis was part of a mixed methods study designed to develop practitioner-driven training platforms to best meet the needs of BHPs in New York and to encourage BHPs to participate in local BTAMs. This goal was ultimately not achieved as a result of grant funding cuts implemented by the Trump Administration. The focus groups were utilized to inform the investigators on the subsequent quantitative survey using a standard exploratory mixed method design (Creswell & Clark, 2018). Findings of the focus groups are presented in a different paper. The survey results presented here were derived from those focus groups and were intended to address several research questions:

1) To what extent do BHPs see violent extremism as a threat?
2) To what extent do BHPs think that they have a role in PVE?
3) To what extent do BHPs feel comfortable working with law enforcement organizations in PVE?
4) To what extent do BHPs think working in PVE is ethical practice?
5) To what extent do BHPs feel prepared to work in PVE?

As the body of literature concerning BHPs and PVE is relatively small, particularly in the US context, these questions are exploratory and no hypotheses were formed a priori.

Methods

Sample and Procedure

All study procedures were approved by the University at Buffalo's Institutional Review Board. Funding from a regional governmental emergency management organization necessitated that recruitment be limited to a specific large and diverse county [Erie County, New York], which had recently been the site of a major violent extremist incident [2022 Tops

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Friendly Markets mass shooting in Buffalo, New York]. The recruitment materials invited anyone who worked in mental health, social work, counseling, or other aspects of behavioral health to share their thoughts about violent extremism in their professional practice. Any practicing psychologist, psychiatrist, social worker, or other mental health counselor who self-reported as over age 18, was proficient in English, and who lived or worked in the targeted county was eligible to participate and received a $30 Target gift card to for their time. REDCap online survey software was utilized to administer and record responses to the survey.

Initial recruitment started by advertising through listservs and professional networks in the county on August 30, 2024. Response rates were slow until the survey was posted on social media (Meta and X platforms) by university personnel on Sep 5, 2024. Within hours, the maximum cap for the survey was reached and it was evident that spam accounts and bots had responded to the survey. The survey was taken offline, and anti-bot questions were added. From the initial 172 responses recorded, ultimately 58 were deemed credible in this wave of the survey.

The revised survey was opened to respondents on December 2, 2024, but was not posted on any social media sites; recruitment occurred through professional listservs and word of mouth. The number of suspicious completions decreased dramatically, and the survey was closed on December 13, 2024.

Seventeen responses were taken out of that sample as responses appeared to be automatically generated via bot, or there were unreasonable and/or illogical entries for the demographics (e.g., 3 or more PhDs), or had suspect responses (e.g., British English spelling for qualitative responses with 2 PhDs. After all suspicious responses were removed, a total of 149 valid responses were retained for which we had full demographic information.

Measures

Demographics of gender, age, race, geography of practice (urban/rural/suburban), length of clinical practice, professional degrees were obtained. There are no currently available normalized instruments to assess readiness and experiences of working in behavioral threat assessment and management for behavioral health professionals. Given this, the

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investigators drafted a series of questions related to practitioners' attitudes about with working with law enforcement, working with individuals espousing violent extremist ideologies, how they obtained their knowledge regarding violent extremism, their perception of violent extremism threats, attitudes regarding who is responsible to address violent extremism, self-reported perceived preparedness to deal with violent extremism, resources needed, community support needed, and participants' beliefs around the ethics of working in PVE. As noted, these questions were drafted using the information collected from prior focus groups of behavioral health professionals. Details for most questions are provided below in the discussion of the results. A series of open-ended questions were also asked about their personal definitions of violent extremism and types of trainings desired (see Appendix A for questionnaire).

Results

Of the sample, 30.2% were male, 67.1% were female, and 2.7% stated they were non-binary or other (see Table 1). Whites accounted for 57.7% of the sample, followed by Black/African American at 36.2%, Native American/Native Alaskan/First Nation at 2.7%, and multi-race and Asian at 2.34% respectively. Other race/ethnicity accounted for 0.7% of the sample. The average age of the respondents was 37.3 years (SD = 7.4) with a range from 23 – 68. Given the low Ns of some of the categories, "race" was dichotomized to White and BIPOC in subsequent analyses. There were several types of professional degrees assessed in the survey (e.g., DSW, MSW, PsyD, MD, EdD, etc.). For purposes of analysis and to identify discipline, the discipline in which the person achieved their highest degree was used to categorize individuals. The three categories created were 32.2% social work, 35.6% counseling/education/education counseling, and 32.2% psychology/MD (psychiatry). Because "years of clinical practice experience" was highly positively skewed (M = 7.6, SD = 5.6), we categorized those years into three separate categories for the purposes of analysis. Those with 1-5 years of experience accounted for 37.6% of the sample, while 51.0% had 6 – 10 years, and 11.4% had 11 or more years of experience. A majority of the respondents worked in urban areas, with 67.1% stating that region was the primary area of practice, followed by

suburban at 22.2%, rural at 8.7%, and other at 2.0%.

Working with Law Enforcement

As previous literature had suggested a strong reluctance of BHPs working with law enforcement and the fear of the securitization of the profession as a result of working in this area, we asked a series of questions about working with law enforcement. There were three queries about this topic, all using a 5-point agreement Likert scale: For all questions, we collapsed analysis into those who strongly agreed or agreed versus those who did not: 1) "Behavioral health professionals *should not work with law enforcement* if it can be avoided", 2) It is *important for behavioral health professionals to collaborate* with law enforcement to prevent violence, and 3) "The structural problems with law enforcement make me *hesitant to work with* them as a behavioral health professional."

The majority of BHPs queried disagreed that BHPs should not work with law enforcement (#1); only 20.13% agreed or strongly agreed with that statement (see Table 2). Years of practice (in three categories as described above) was the only characteristic found to be significantly associated with willingness to work with LEOs. Those with 1-5 years of experience were significantly less likely than those with 6-10 and 11 or more years (32.1% vs. 10.5% and 23.5%, respectively; X^2 =9.51, df = 2, p< .01). There were no significant differences on gender (Male dummy variable), race/ethnicity, professional discipline, or urban vs all other regions.

BHPs also agreed that it was important to collaborate with LEOs (#2), with 85.23% agreeing or strongly agreeing with that statement (See Table 2). In examining differences by race/ethnicity, professional discipline, gender, urban vs. rural/suburban, and length of clinical practice using chi-squared analysis, we find that BHPs that identified as White were significantly less likely to agree than their BIPOC counterparts (80.2% vs. 92.1%, respectively; X^2 = 4.04: df = 1, p < .05). There was also a significant difference in agreement between disciplines. Social workers were much less likely to agree that it was important to collaborate with LEOs relative to their counseling/education counseling and psychology/psychiatry counterparts (70.8% vs. 92.5% and 91.7%, respectively; X^2 = 11.68, df = 2, p < .01). Length of practice (categorized) was also found to be significantly associated

with willingness to collaborate with LEOs. We find that those with 1-5 years of experience we significantly less likely than 6-10 and 11 or more years (71.4%, 96.1%, and 82.4%, respectively; χ^2 = 15.67, df = 2, p< .001). There were no significant differences based on gender or urban vs all other regions. However, when presented with statement #3 regarding hesitancy to work with LEOs because of structural problems, there was significant agreement (69.80%). The only significant difference detected was in length of professional practice. Those with 6-10 years of experience were significantly more likely to agree (78.9%) vs. 1-5 years (62.5%), and 11 or more (52.9%) (χ^2 = 6.72, df = 2, p< .05). There were no significant differences on professional discipline, White vs. BIPOC BHPs, gender, urban vs. all other regions.

BHP Roles, Ethics, Threat Perception, and Perceived Preparedness

<u>BHPs' Role in PVE</u>

There was one 5-point Likert-style statement (strongly disagree to strongly agree) that addressed attitudes of BHPs on the role they could play in PVE, "Behavioral health professionals can play a significant role in preventing and addressing domestic violent extremism within their communities?" Of respondents, 89.26% agreed/strongly agreed with that statement (see Table 3). Examining the demographic and professional features of the respondents, we find years of practice and race/ethnicity are significantly associated with agreeing with this statement. Those with 1 – 5 years of experience agreed 80.4% of the time relative to 95.7% for those with 6 -10 and 94.1% with those with 11 or more years (χ^2 = 7.43; df = 2, p < .05). BIPOC BHPs were also substantially more likely to agree, with 98.4% agreeing with that statement relative to 82.6% for White BHPs (χ^2 = 9.54; df = 1; p < .01).

<u>Ethics of Working in PVE</u>

There were two questions (also answered using a Likert-style agreement structure) regarding the ethics of working in PVE; 1) "My professional code of ethics directs me, either explicitly or implicitly, to work to prevent violent extremism in my community," 2) "My professional code of ethics directs me, either explicitly or implicitly, to work with individuals

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seeking to exit violent extremism in my community." Of the respondents, 86.6% agree/highly agreed with the ethical obligation to work in PVE for the community, while a slightly lower 81.6% agreed/strongly agreed with working with individuals exiting violent extremism. Conversely, agreement with that is unethical to work with individuals exiting violent extremism was 14.1%, and for the participation in PVE only 10.1% agreed/strongly agreed (results of individual queries not shown).

Because the ethics questions were highly correlated, we summed the two ethical obligation items as the internal consistency was high ($\alpha = 0.81$); the summation was highly positively skewed ($\bar{x} = 3.27$, SD = 1.61). Consistent with other Likert scales in this study, we dichotomized this variable as those whose sum score was less than or equal to four (strong agreement that it is ethical) and those above four. Of respondents, 79.9% had summed ethical scores less than or equal to four (see Table 3). Examining demographic difference based on this summed item regarding ethics (see Table 2), we find that only years of practice categories are statistically different from one another ($\chi^2 = 8.06$, df = 2, $p < .05$). Of those with 1 – 5 years of experience, 67.9% had aggregated agreement scores of four or less (strong agreement), compared to 86.8% for those with 6 – 10 years, and 88.2% for those with 11 or more years.

Perceptions of Threat

Protection Motivation Theory suggests that perceptions of threat and the belief that a threat can affect their safety or the safety of those they care about can influence their behavior to mitigate that threat (Norman, et al., 2005). To examine BHP perception of threat, we queried respondents using a 5-point Likert agreement scale (1 = Strongly Agree) using the following three statements: 1) "Violent extremism is an imminent threat to my community," 2) "Violent extremism is an imminent threat to New York State," and 3) "Violent extremism is an imminent threat to the country." The three were highly correlated with each other and demonstrated high internal consistency ($\alpha = 0.89$). As a result, the three scores were added together for a summative score. The distribution of the sum of these queries was highly positively skewed ($\bar{x} = 5.12$, SD = 2.67). To address this, we dichotomized threat perception as "high threat perception" as a score of 4 or below (53.7%) and the other category as 5 and above (46.3%) before examining differences across demographic characteristics (see Table 3).

There were significant differences by gender (χ^2 = 7.89; df = 1; p< .01). Males perceived higher threats 71.1% of the time, relative to 46.2% of the other genders. Those with 6-10 years of clinical experience we substantially more likely to perceive high threats (71.1%) than 1-5 years (32.1%) and 11 or more years (47.1%) (χ^2 = 19.97; df = 2; p< .001). No significant associations between urban vs. rural/suburban or discipline were found. Race/ethnicity was approaching significance (p = .09), with 61.9% of BIPOC BHPs perceiving a high threat relative to 47.7% of White BHPs.

Behavioral Health Professional Preparedness

There were two direct queries regarding perceptions of preparedness for addressing violent extremism, all using agreement statements on a 5-point Likert Scale (1 = Strongly Agree): 1) "How well-prepared do you feel professionally to address violent extremism within your community?" and 2) "How well-prepared do you feel professionally to engage individual clients who express violent extremist ideologies?" The queries were highly correlated with each other (r = .84, p< .01). Given the high internal consistency (α = .91), the scores were combined for a composite score between 2 and 10. The distribution of this scale was highly positively skewed, so a dichotomous variable of a score of 4 or below (highly prepared) and 5 and above on this scale was created. Of the total sample, 65.1% of the sample fit the definition of "highly prepared."

There was a significant difference in perception of preparedness (χ^2 = 40.58; df = 2; p< .001) based on years of experience (see Table 3). Only 39.3% of those with 1 -5 years of experience and 41.2% of those with 11 or more years felt highly prepared relative to 89.5% of 6 – 10 years. Gender was also significantly associated, with perceptions of preparedness (χ^2 = 10.62; df = 1; p< .001). The percentage of males that felt they were highly prepared was substantially higher than BHPs of other genders (84.4% vs. 56.7%). Race/ethnicity was also highly associated with feeling highly prepared (χ^2 = 23.68; df = 1, p< .001). BIPOC BHPs felt much higher prepared (87.3%) relative to White individuals (48.8%). There were also significant differences in practice discipline (χ^2 = 46.70; df = 2; p< .001). Social workers were less likely to feel highly prepared relative to their other BHP colleagues, with only 27.1% of social workers scoring in that range relative to 77.4% of counseling/education and 89.6% of

psychology/psychiatry (χ^2 = 46.70; df = 2; p< .001). Lastly, urban BHPs scored in the highly prepared range more often (72.0%) relative to rural/suburban BHPs (51.0%; χ^2 = 6.37; df = 1; p= .012).

Multivariate Analyses

Working with Law Enforcement Officers

We then ran a series of logistic regressions on the various agreement statements to examine characteristics simultaneously. On law enforcement engagement, for the agreement statement regarding NOT working with LEO (see Table 4), the only statistically significant association was gender; after controlling for other variables, men were 2.87 times more likely (OR 2.87; 95% CI 1.12 – 7.35) to agree with that statement relative to all other genders. For the logistic regression for statement #2 (BHPs should work with LEO), we found only two variables approaching significance (p < .10): those that identify as social workers (OR 0.30; 95% CI 0.08 – 1.11) were 70% less likely to agree than their psychology/psychiatry counterparts and working in urban areas relative to their suburban/rural colleagues showed 69% less likelihood of agreeing with this statement (OR 0.31; 95% CI 0.09 – 1.02). With regards to hesitancy to work with LEOs because of structural problems (Statement #3), none of the characteristics were significantly associated with agreement with that statement. Only being male relative to all other genders was approaching significance, with males being over two times more likely to agree with that statement than their counterparts (OR 2.13; 95% CI 0.89 – 5.10).

Preparedness, Perception of Threat, Ethics, and Role Agreement

When examining the high perception of preparedness, we find that years of practice, race/ethnicity, and discipline are significantly associated with feeling highly prepared. Of particular note, BIPOC BHPs were 5.17 times more likely (OR 5.17; 95% CI 1.89 – 14.17; p< .01) to fit into the highly prepared category. Further, social workers were 91% less likely to fit into this category relative to psychology/psychiatry (OR 0.09; 95% CI 0.03 – 0.29; p< .01). Those with more experience (natural log of years in practice) also demonstrated an increased

likelihood of feeling prepared (OR 2.06; 95% CI 1.12 – 3.77; $p < .05$). As years of clinical experience was highly positively skewed, we used a natural log transform to best approximate a normal distribution.

Binary logistic regression with the high threat perception variable on the demographic characteristics simultaneously shows that being male and years of practice are significantly associated with threat perception. Males were 2.34 times more likely to fit this category (OR 2.34; 95% CI 1.06 – 5.21; $p < .05$) than other genders, net of other factors. Years of practice (natural log) was also significantly associated when controlling for other variables, with the likelihood of high threat perception increasing with practice experience (OR 1.78; 95% CI 1.07 – 2.96; $p < .05$).

When analyzing ethical agreement for working in PVE, only years of clinical practice experience (natural log) was significantly associated with agreement with ethical obligation to work in this area (Table 5). Those with more experience we more likely to agree with having a role (OR 2.05; 95% CI 1.13 – 3.71; p. < .05).

Examining the perceptions of the role that BHPs can play in PVE with characteristics simultaneously using binary logistic regression (Table 5), only race/ethnicity was significantly associated with this statement. BIPOC BHPs were 12.57 times for likely (OR 12.57; 95% CI 1.55 – 101.69) to agree with this statement relative to their White counterparts.

Limitations

The survey was conducted prior to the inauguration of Donald Trump to the presidency in 2025. The subsequent utilization of the Department of Homeland Security (DHS) for extensive and intrusive immigration enforcement may substantially alter BHPs willingness to work with law enforcement at all levels, but especially federal law enforcement agencies such as the DHS.

As this was a non-probability sample, the problem of selection bias is of concern as certain groups may be overrepresented or underrepresented depending on accessibility or willingness to participate. As a result, the findings may not accurately reflect the characteristics or opinions of the broader BHP population. Additionally, it is unknown how many individuals saw recruitment materials, so non-response metrics could not be calculated.

External validity and the ability to generalize results beyond this sample are challenged as a result.

As this is a cross-sectional design, we are unable to establish causality. Because data are collected at a single point in time, it is impossible to determine whether one variable causes change in another or whether both are influenced by an unobserved third factor. Furthermore, respondents may be vulnerable to recall bias, social desirability bias, and situational effects. Participants' responses may reflect temporary attitudes, moods, or circumstances that do not represent long-term patterns. Similarly, perceptions of preparedness may not be reflected in actuality if participants are unaware of the true risk factors and interventions needed for violent extremist radicalization.

As noted in the methods section, the investigators had to remove a substantial number of responses because of evidence of bots or other bad-faith actors responding to the survey, possibly to receive the incentive payment. Some of the responses may not have been from behavioral health professionals in spite of the investigators' best attempts at delineating fraudulent respondents. Future research should attempt to verify licensure in ways that this study could not.

Discussion

This study represents, to our knowledge, the first quantitative examination of BHPs attitudes, perceived preparedness, and willingness to engage in preventing/countering violent extremism (P/CVE) and/or BTAM within the United States. Although the findings are largely descriptive, they provide important baseline evidence regarding the readiness of a critical professional workforce that has been repeatedly identified as an essential partner in multidisciplinary prevention systems despite a lack of documented readiness. Understanding which segments of the BHP workforce perceive themselves as prepared, ethically obligated, and willing to collaborate with law enforcement and other community stakeholders is fundamental to the implementation of public health approaches to P/CVE broadly. The substantial differences observed across professional disciplines, race/ethnicity, gender, and years of clinical experience suggest that BHPs should not be viewed as a homogeneous

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workforce, and that training, workforce development, and multidisciplinary partnership strategies may need to be tailored to address these differences. In particular, given that social workers comprise the largest behavioral health profession in the United States yet reported the lowest levels of perceived preparedness, these findings have direct implications for the design of future BTAM and PVE educational initiatives and for strengthening the behavioral health component of multidisciplinary prevention efforts. Given the relatively small sample and geographic limitations of this study, recommendations for those changes are not given.

Overall, BHPs across the disciplines seem to believe they have a role in PVE (89.3%) and are willing to work with law enforcement (85.2%). With that, there was also hesitancy in working with law enforcement (69.8%). Not shown in results, we did posit the following agreement statements, “Law enforcement treat all people fairly” where only 32.9% of BHPs agreed/strongly agreed, and “Law enforcement agencies provide safety to all members of the community” to which only 43.6% agreed/strongly agreed. Though there seems to be some trepidation by BHPs, the findings suggest that recruiting and training BHPs in this area may not be as fraught as studies in Europe/UK might suggest (see above for a summary of that research).

The findings on the difference in threat perception and working with law enforcement between men, women, and other genders is not consistent with prior literature on threat perception and support for aggressive responses and policies to address terrorism. Women in multiple studies have been shown to perceive terrorist and/or security threats more intensely than male counterparts, whileon the otherhand, research has also shown that men on average support more robust military/law enforcement responses (e.g., Huddy et al., 2005; Nellis, 2009; Stevens et al., 2020). Further, it is not consistent with findings on BHPs and gender with respect to perception of domestic violence, with women BHPs being more aware than men (Campbell, 2024). We did not find that here. Male BHPs were found to be less likely to support working with law enforcement and viewed the threat more intensely than females/other genders.

There are some possible reasons for this, and there are policy implications if these findings continue to hold in other regions and contexts. Male BHPs may differ in appreciable ways than their female and other gender counterparts based on awareness of and prioritization

of violent extremism compared to other social issues. First, men may work in disproportionately different fields within behavioral health care than others (Secker & Williams, 2024) that may influence their perceptions and attitudes to working in violent extremism. Other demographic features of male BHPs may also play a role in these differences as well.

The vast majority of the perpetrators of extremist violence are men and boys (Möller-Leimkühler, 2018). The lack of willingness of male BHPs to work in this field found in other studies may be problematic. First, men accounted for only 18% of the social work workforce and 20% of psychologists in 2022, with men only making up 17% of the workforce in forensic psychology (Secker & Williams, 2024). Research suggests that, for subsets of men, having a male therapist may improve satisfaction with therapy (Seidler et al., 2024) and mental health care seeking behavior (Black & Gringart, 2018). With that, we did find that men disproportionately stated they were highly prepared to work in PVE relative to the other genders (84.4% vs. 56.73%), a promising finding for future work.

Over a third of BHPs did not feel highly prepared to work in PVE. Social workers feel that they are the least prepared (27.1%) relative to their much more confident counterparts in behavioral health. These findings are consistent with studies from Europe on perceptions of preparedness (Haugstvedt, 2019). This is especially problematic in that clinical social workers by far provide the most behavioral care in the US relative to their BHP counterparts (HRSA, 2023) and are placed throughout the health care, criminal justice, and education systems.

Urban BHPs reported being more prepared (72%) than rural BHPs (51.0% rural). This is also problematic for two main reasons. First, as Medina et al. (2018) found in their geographic analysis of hate groups in the US, rural areas have the risk factors they name: “Less diversity, more poverty, less population change, and less education correlate with more hate groups” (pg. 1015). Rural associations with far-right violent extremism have also held in studies in Europe (Valldor, 2025). Secondly, rural areas in the US have fewer behavioral health resources per capita compared to urban/suburban areas. Having even fewer well-prepared BHPs in resource-deprived areas exacerbates the problems.

Lastly, we found that White BHPs felt they were less prepared than BIPOC BHPs (OR 5.17) by a wide margin. Further, BIPOC BHPs were substantially more likely to agree that

BHPs have a role in PVE (OR 12.57). The extent to which far-right, White supremacist, and anti-authority violent extremist are overwhelmingly White this could be a substantial problem. It is beyond this study to unpack why this difference exists, but it is likely that this type of client would prefer someone of their own race/ethnicity. However, a sizable proportion of White BHPs in this study thought there was role for BHPs in PVE (82.5%) and about half (48.8%) thought they were highly prepared. Helping to close this preparedness gap for White BHPs may be important for future prevention.

Future Directions

This study was exploratory in nature and designed to assess a foundational question of whether, given the uneasy historic relationship between many BHP disciplines and law enforcement, whether BHPs will engage in this area of work under a BTAM framework. The investigation was not designed to provide guidance or direction on next steps in training BHPs in BTAM, fostering collaboration, improving efficiency/effectiveness, or other important aspects of BTAM and/or P/CVE. A further investigation of improving those areas of BTAM is warranted given the findings from this study that BHPs and generally willing to work with law enforcement in this area, albeit with apparent trepidation.

This study was a non-probability sample of BHPs in one county in Western New York State. A much larger geographic region, probability sample, with larger Ns of BHPs, is warranted given these findings.

Understanding motivations for working in PVE should also be examined. We recommend the use of Protection Motivation Theory as a theoretical framework for understanding underlying motivation processes. If this theory holds, then it may be that educating BHPs on the threat landscape in violent extremism will provide sufficient motivation in working in PVE.

While BHPs may feel well-prepared in general, it is not well understood to what extent they have knowledge of violent extremism, emerging interventions for radicalizing(ed) individuals, assessment tools for violent extremism, and the overall BTAM and primary prevention frameworks. Mixed methods studies examining overall awareness and knowledge

would be helpful for future planning of trainings and awareness raising. As the first study of BHPs in the US context, this analysis provides some promising results for future prevention.

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Table 1

Sample Demographics

	N	Frequency	Mean	SD	Range	
					Low	High
Gender						
Male	45	30.20%				
Female	100	67.11				
Non-Binary/Other	4	2.68				
Race/Ethnicity						
Black/African American	54	36.24				
Asian	2	1.34				
Non-Hispanic White	86	57.72				
Native American/Alaska Native/First Nations	4	2.68				
Multi-Race	2	1.34				
Other	1	0.67				
Region of Practice						
Urban	100	67.11				
Suburban	333	22.15				
Rural	13	8.72				
Other	3	2.01				
Discipline of Practice						
Social Work	48	32.21				
Counseling / Ed	53	35.57				
Psych / MD	48	32.21				
Years of Practice			7.57	5.61	1	40
1-5 Years	56	37.58				
6 - 10 Years	76	51.01				
11 or more Years	17	11.41				
Age	149		37.28	7.39	23	68

Table 2

Willingness to Work with Law Enforcement – Endorsement and Demographic Differences

	Should Not Work with LEOs		Important to Collaborate with LEOs		Hesitant to Work with LEOs	
	Percent	χ^2	Percent	χ^2	Percent	χ^2
Sample total	20.13		85.23		69.80	
Gender		*3.07*		1.77		*3.18*
Male	*28.89*		91.11		*80.00*	
Female/Other	*16.35*		82.69		*65.38*	
Years of Practice		***9.51***		***15.66***		6.72
1 - 5 Years	***32.14***		***71.43***		62.50	
6 - 10 Years	***10.53***		***96.05***		78.95	
11 or more Years	***23.53***		***82.35***		52.94	
Race/Ethnicity		0.30		**4.04**		<0.01
White	18.60		**80.23**		69.77	
BIPOC	22.22		**92.06**		69.84	
Professional Discipline		2.52		***11.68***		0.34
Social Work	22.92		***70.83***		68.75	
Counseling	13.21		***92.45***		67.92	
Psychology/Psychiatry	12.00		***91.67***		72.92	
Area of Practice		*2.83*		1.21		0.01
Urban	*24.00*		83.00		70.00	
Suburban/Rural	*12.24*		89.80		60.39	

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Table 3

Preparedness, Perception of Threat, Ethics, and Role– Endorsement and Demographic Differences

	BHPs Play a Role in PVE		Ethical to Work in PVE		High Threat Perception		Highly Prepared	
	Percent	χ^2	Percent	χ^2	Percent	χ^2	Percent	χ^2
Sample Total	89.26		79.87		53.69		65.10	
Gender		1.12		0.22		***7.87***		***10.62***
Male	93.33		82.22		***71.11***		***84.44***	
Female/Other	87.50		78.85		***46.15***		***56.73***	
Years of Practice		**7.43**		**8.06**		***19.97***		***40.58***
1 - 5 Years	**80.36**		**67.86**		***32.14***		***39.29***	
6 - 10 Years	**95.74**		**86.84**		***71.05***		***89.47***	
11 or more Years	**94.12**		**88.24**		***36.24***		***41.18***	
Race/Ethnicity		***9.54***		0.02		*2.96*		***23.68***
White	***82.56***		80.23		*47.67*		***48.84***	
BIPOC	***98.41***		79.37		*61.90*		***87.30***	
Professional Discipline		1.77		0.58		4.47		***46.70***
Social Work	85.42		79.17		41.67		***27.08***	
Counseling	88.68		77.36		56.60		***77.36***	
Psychology/Psychiatry	93.75		83.33		62.50		***89.58***	
Area of Practice		0.96		<.01		2.27		**6.37**
Urban	91.00		80.00		58.00		**72.00**	
Suburban/Rural	85.71		79.59		44.90		**51.02**	

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Table 4

Logistic Regressions for Willingness to Work with Law Enforcement Agreement

	BHPs should not work with LEOs			Should collaborate with LEOs to decrease violence			Hesitant to work with LEOs because of structural concerns		
	B	Standard Error	Odds Ratio Exp(B)	B	Standard Error	Odds Ratio Exp(B)	B	Standard Error	Odds Ratio Exp(B)
Constant	-1.31			1.92			0.33		
Male = 1	**1.05**	**0.48**	**2.87**	0.23	0.65	1.26	*0.75*	*0.45*	*2.13*
Ln Years Practice	-0.52	0.32	0.59	0.47	0.30	1.61	0.21	0.25	1.23
BIPOC = 1	0.20	0.46	1.22	0.90	0.59	2.45	-0.03	0.39	0.97
Social Work = 1	0.13	0.57	1.14	*-1.22*	*0.67*	*0.29*	0.08	0.51	1.08
Counseling = 1	-0.94	0.55	0.39	0.29	0.76	1.34	-0.19	0.45	0.83
Urban = 1	0.86	0.52	2.37	*-1.19*	*0.61*	*0.31*	-0.01	0.39	0.99
*- 2 loglikelihood	136.68			105.75			178.04		
Cox & Snell R^2	0.08			0.12			0.03		

Note: BIPOC = Black, Indigenous, and People of Color. $p \leq .01$ bolded italics, $p \leq .05$ in bold, $p \leq .10$ in italics. Psychology/Psychiatry is the discipline reference category. Agreement = 1 if responses are "agree" or "strongly agree."

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