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BEHAVIORAL AND PUBLIC HEALTH PERSPECTIVES ON VIOLENCE PREVENTION: A SURVEY OF ILLINOIS PRACTITIONERS

ILLINOIS CRIMINAL JUSTICE INFORMATION AUTHORITY
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Abstract: Violence is one of the top three leading causes of death for individuals between the ages of 15 and 34 in the United States, and the American Public Health Association and Centers for Disease Control have designated violence a public health crisis. Important to combating this crisis are behavioral and public health professionals and practitioners who directly work to prevent violence. The present study sought to understand behavioral and public health providers' competencies, capacities, comfort, confidence, and preparedness in violence prevention. Results from a survey of 152 respondents indicated there are areas for improving the education and training around violence prevention, as well as legal and ethical liabilities among practitioners. Further, few practitioners reported receiving client referrals from law enforcement agencies.

Introduction

Prevention of any kind—disease, violence, crime, and other public health concerns—necessitates understanding factors that mitigate public safety concerns and community well-being, in addition to incorporating effective prevention and intervention responses. The goal of public health is to protect and improve the health and well-being of individuals and their communities through the promotion of awareness, education, research, and responses to public health concerns,[1] Important to successful prevention are the capabilities and capacities of behavioral and public health professionals who provide the direct care and services to individuals and their communities.[2]

This article focuses on behavioral health providers and public health practitioners who have a direct impact on individuals within communities and are part of a broader violence prevention and intervention framework. They play a crucial role in the lives of individuals who may be at-risk for violence, suicide, or other behavioral health concerns.[3] Behavioral health providers and public health practitioners also are on the front lines of preventing violence and enhancing community member well-being and resilience—thus, impacting overall community well-being.

The present study attempted to identify practitioner comfort and confidence working in the violence prevention space. In addition, researchers sought to gain practitioner understanding of client confidentiality, duty to warn, and legal liability surrounding violence prevention and targeted violence prevention. Researchers conducted a survey of behavioral and public health professionals to gain understanding around practitioner capacity and competency to address violence prevention in general as well as targeted violence specifically. This survey was conducted as part of a larger project to inform the Illinois Criminal Justice Information Authority's (ICJIA) Targeted Violence Prevention Program (TVPP). Information gleaned from this survey was used to help provide general insights to the to better understand what connecting an individual to a behavioral or health practitioner, who may espouse ideologies or beliefs that justify the use of violence as a means to further political, economic, or social objectives to a provider in the community, and gain insight as to what providers know, feel comfortable with, and are prepared for working with individuals who espouse beliefs or ideologies that justify the use of violence. [4] In addition, practitioners were asked questions surrounding behavioral and public health professionals' knowledge on client confidentiality and duty to warn, as well as questions regarding referrals from law enforcement and knowledge about client confidentiality and duty to warn as it relates to those referrals.

Client confidentiality refers to the privileged, legally protected communications between a provider and a client, and the very specific situations in which clinical practitioners can share client information with (or without) the client's consent.[5]

Duty to warn refers to the specific situation(s) in which a behavioral health practitioner can disclose confidential information without legal liability for breaching confidentiality.[6] Usually, behavioral health practitioners must keep practitioner-client communications

confidential; however, state and federal laws have identified exceptions that protect a potential victim from a client's threat to the individual's safety.[7] In Illinois, there are two laws regarding duty to warn:

1. 740 ILCS 110/11, which, among other provisions, allows for disclosure of confidential information, "when, and to the extent, in the therapist's sole discretion, disclosure is necessary to warn or protect a specific individual against whom a recipient has made a specific threat of violence where there exists a therapist-recipient relationship or a special recipient-individual relationship."
2. 405 ILCS 5/6-103 where there is, "no liability on the part of, and no cause of action shall arise against, any person who is a physician, clinical psychologist, or qualified examiner based upon that person's failure to warn of and protect from a recipient's threatened or actual violent behavior except where the recipient has communicated to the person a serious threat of physical violence against a reasonably identifiable victim or victims."

Present Study

ICJIA researchers surveyed behavioral and public health practitioners in Illinois about their experiences, understanding, confidence, capacities, and concern regarding violence prevention and intervention.[8]

Research questions included:

1. What are practitioners' current confidence and comfort in suicide and violence prevention?
2. What is the extent of practitioners' knowledge in working with individuals who may:
    a. Be referred to services by a law enforcement agency?
    b. Have a history of violence?
    c. Espouse beliefs that justify the use of violence?
3. What, if any, concerns do practitioners have with regard to working with individuals who may espouse beliefs that justify the use of violence (e.g. legal liability, confidentiality)?
4. What are the current practitioner capacities and competencies in violence and targeted violence prevention and intervention?

Methodology

ICJIA researchers identified relevant local, regional, and statewide associations to ask for their assistance in either emailing the survey and survey completion reminders directly to their members or providing an association list for direct emailing from ICJIA researchers. Seven entities participated as part of the survey, including four statewide associations and three county/local organizations. Survey participants were recruited through local, regional, and statewide associations serving social workers, psychologists and other behavioral health professionals, and other service providers at hospitals and public health agencies. Only direct behavioral and/or public health service providers in Illinois were asked to participate, and only

those that indicated direct service provision were included in analyses. The study was approved by ICJIA's Institutional Review Board through exempt review; data collected via surveys did not include identifying information. Demographic information on race, ethnicity, and gender was limited.

An online survey was created in Qualtrics and consisted of 39 questions, including some with multiple parts. The total number of questions answered may have differed based on skip patterns. The survey questions included those related to:

- Types of services, clientele, certifications, setting, and qualifications of the respondent.
- Types of referrals, insurance accepted, and attendance to any specialized training.
- Comfort and preparation in assessing, preventing, and intervening with clients who have previously committed violence, who have a history of violence, and/or working with those who espouse beliefs that justify violence as a means to further his/her end goal (e.g. social, economic, political).
- Knowledge regarding violence prevention and targeted violence, specifically.
- Types of assessments known, previously utilized, and/or currently used.
- Information on legal liability regarding confidentiality, duty to warn, and law enforcement referrals.

E-mails by ICJIA researchers to the designated association points of contact were sent on the same day and the points of contact were also asked to distribute the survey using a scripted recruitment e-mail on October 17, 2018. The same scripts were used when ICJIA researchers directly distributed the survey. Two reminders were e-mailed using the same process of scripted e-mails. The survey closed on January 9, 2019.

A total of 201 surveys were submitted, 152 of which were included in the final study sample (49 respondents excluded). Surveys with a significant number of missing responses (i.e. only the demographic information was filled out) were excluded, as were surveys from those who did not provide direct service in the capacity of behavioral or public health (e.g., dental assistants, substitute teacher, school administrators, administrative assistants, Medicaid/health insurance navigators, other administrative personnel). Researchers were unable to calculate a response rate, as there was an unknown base number for survey distribution. Minimally, 500 surveys were distributed through four of the seven associations; some individuals receiving the survey were ineligible for study inclusion.

Of the 152 respondents, 82 percent identified as White (non-Latinx) and female (87 percent). Respondents most frequently indicated serving clients in Cook County (n=59) and Champaign County (n=25). A total of 29 percent identified themselves as mental health counselors, 12 percent identified themselves as social workers, and 11 percent identified themselves case managers. In addition, 28 percent self-identified as "other," which predominately consisted of administrators and/or directors who reported some direct client contact. Further, 25 percent of the sample indicated they were licensed clinical social workers (LCSW) and 20 percent said they were licensed clinical professional counselors (LCPC). A total

of 36 percent listed an "other" degree or certification, which predominately consisted of a bachelor's degree.

Study limitations. The study used a convenience sample and the sample size was small, incorporating just seven community mental health centers/agencies of more than 160 in Illinois.[9] The largest percentage of respondents served clients in two urban cities. Because of the convenience sample and limited responses from other areas across the state, the results are not generalizable to all mental, behavioral, and public health practitioners across the state. Further, some administrators or supervisors were included in the survey as they identified working on a limited basis directly with some clients. This is a limitation as they likely see fewer clients, on average, than those who provide direct service as non-administrators. Future research could benefit from collecting information on the specificity about type of work and number direct client contact hours of providers, as well as information about the direct service setting and employment level within the organization (e.g. administration, line staff, auxiliary staff).

Study Findings

Below are the findings from the survey of 152 behavioral and public health practitioners in Illinois.

Clients, Services, and Referrals

Table 1 provides the breakdown of the respondents' identified clientele. Respondents identified serving a wide range of clients from varying socioeconomic classes, race/ethnicities, and age ranges.

Table 1

Characteristics of Clients Served by Respondents (N=152)

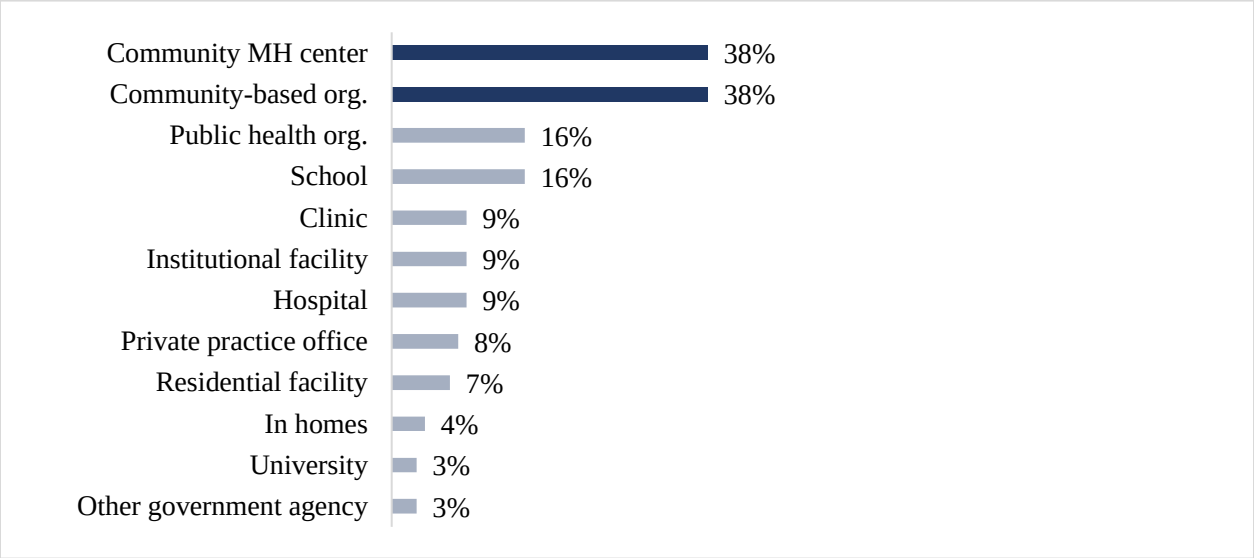
Clients	**% (n)**
People of color	86 (131)
Females	82 (124)
Adults (Ages 25+)	80 (122)
Young adults (Ages 18 – 24)	69 (105)
Co-occurring disorders	66 (100)
LGBTQI	66 (101)
Families	65 (98)
Justice-involved	61 (93)
Homeless	59 (89)
Youth (Ages 11 – 17)	56 (85)
Children (Ages 10 or younger)	51 (77)
Non-English speakers	43 (65)
Intellectually disabled	41 (62)
Undocumented immigrants	41 (62)

Source: ICJIA analysis of survey data.

Most frequently, respondents indicated providing services within community-based organizations (38 percent, n=57) and community mental health centers (38 percent, n=57). *Figure 1* lists settings in which respondents indicated they provide services to clients.

Figure 1

Settings for Service Provision (N=152)



Source: ICJIA analysis of survey data.

Table 2 gives the breakdown of respondents' provision of services. Over half of the respondents indicated they provide individual counseling, mental health assessments, and/or case management services.

Table 2

Services Provided (N=152)

Services	% (n)
Individual counseling	66 (100)
Mental health assessments	55 (84)
Case management	55 (84)
Group counseling	40 (60)
Family counseling	34 (52)
Evaluations	24 (36)
Parenting classes/counseling	22 (34)
Substance use disorder treatment/services	21 (32)
Child abuse counseling/services	13 (19)
Intimate partner violence/domestic violence services	12 (18)
Community Support Team Services (CST)	11 (17)
Violence prevention/education	9 (14)
Psychiatric care	8 (12)
Art therapy	7 (10)
Assertive Community Treatment (ACT)	3 (5)
Psychoanalysis	1 (2)
Partner Abuse Intervention Program (PAIP)	1 (2)
Other	
Crisis services	3 (5)
System navigation	3 (5)
Other relevant services	3 (5)
Peer support services	1 (3)
Other health services	1 (2)

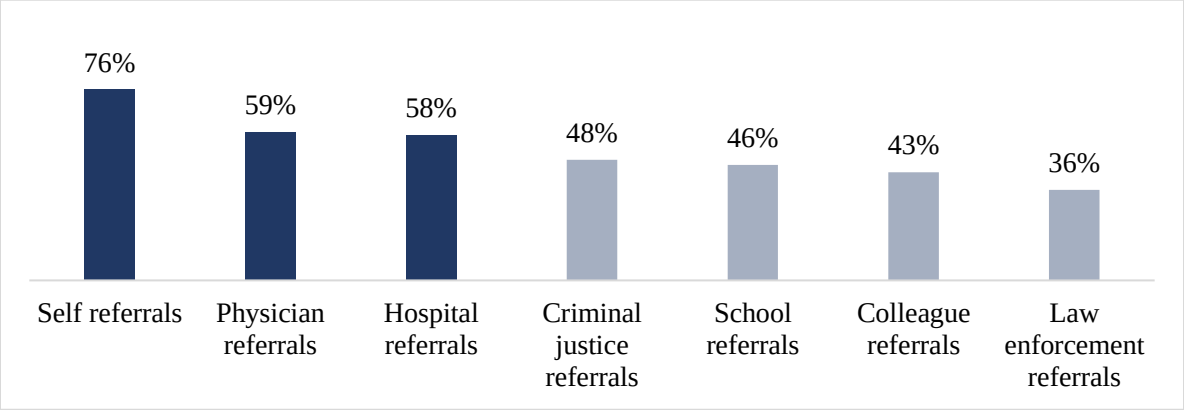
Source: ICJIA analysis of survey data.

Notes: Other relevant services include mental health consultation to teachers, career counseling, bereavement services, and anger management/trauma-informed parenting.

Survey respondents indicated that they (or their agencies) accept a range of insurance and payment options. The majority of respondents reported taking Medicaid clients (72 percent) and over half reported taking uninsured clients (55 percent). In addition, many reported taking clients who have PPOs (49 percent), HMOs (43 percent), and Medicare (40 percent). A total of 47 percent of respondents indicated they provide the option to pay for services on a sliding scale. Few respondents indicated they took out-of-network insurance for client services (9 percent). Most clients were self-referred (*Figure 2*).

Figure 2

Percentage of Client Referrals by Type of Referral (N=152)

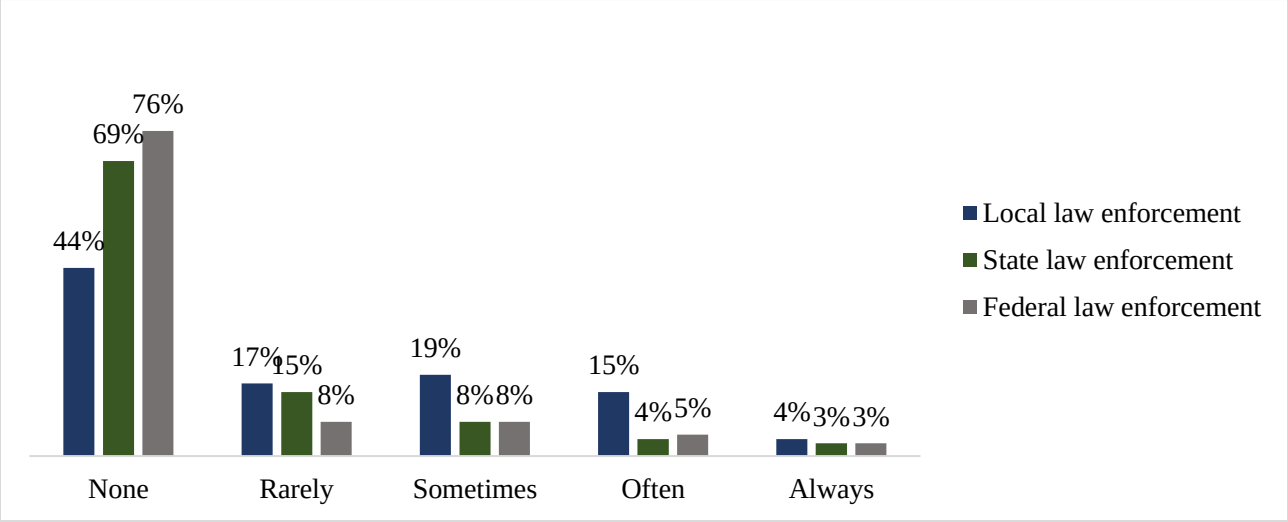


Source: ICJIA analysis of survey data.

Figure 3 depicts the frequency with which respondents received referrals from law enforcement agencies within the previous 12 months. Most often, respondents indicated never receiving referrals from local (44 percent), state (69 percent), or federal (76 percent) law enforcement. Over half of the survey respondents reported receiving self-referrals (76 percent), physician referrals (59 percent), and hospital referrals (58 percent).

Figure 3

Client Referrals from Law Enforcement within the Past 12 Months (N=152)



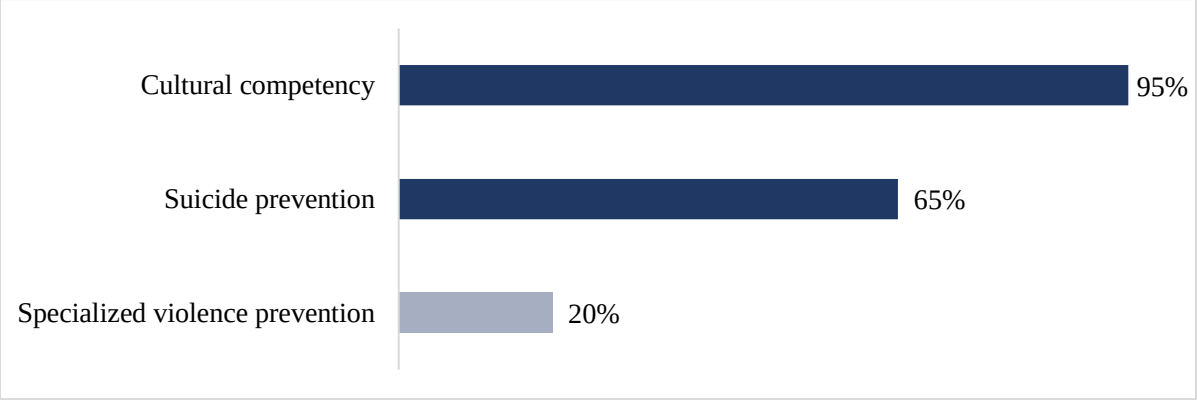
Source: ICJIA analysis of survey data.

Respondent Training

In the survey, researchers asked behavioral and public health practitioners about the types and frequency of training they receive, along with assessments used by practitioners to determine client needs. Seventy-one percent reported receiving annual continuing education. Many reported receiving training in suicide prevention, cultural competency (the ability to understand and work with diverse cultures, values, and beliefs), and specialized violence prevention (*Figure 4*). While most indicated receiving cultural competency training, less than a quarter of respondents indicated participating in specialized violence prevention training.

Figure 4

Percentage of Respondents Who Received Each Type of Training (N=152)

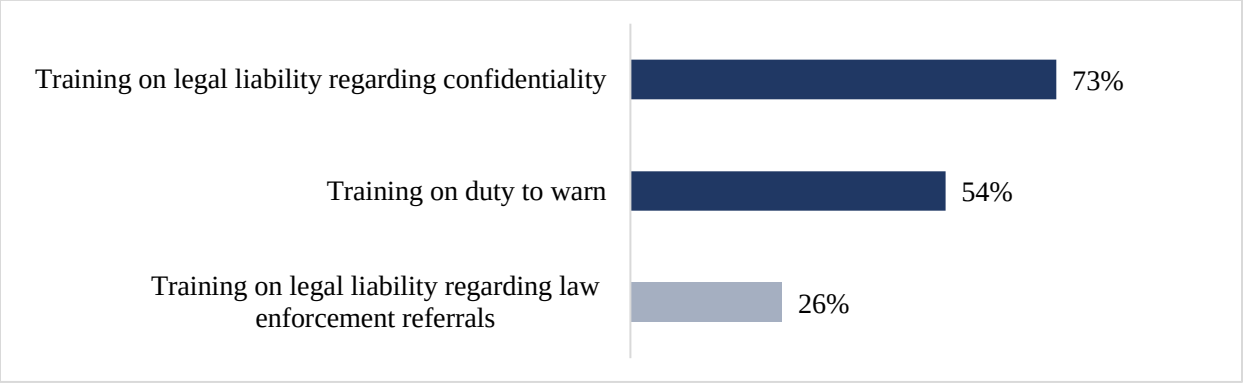


Source: ICJIA analysis of survey data.

While over half of survey respondents received training on legal liability regarding confidentiality and duty to warn through their agency, only one quarter of respondents reported receiving training on legal liability regarding law enforcement referrals (*Figure 5*).

Figure 5

Percentage of Respondents Whose Agencies Provide Legal Liability Training, by Type (n=136)

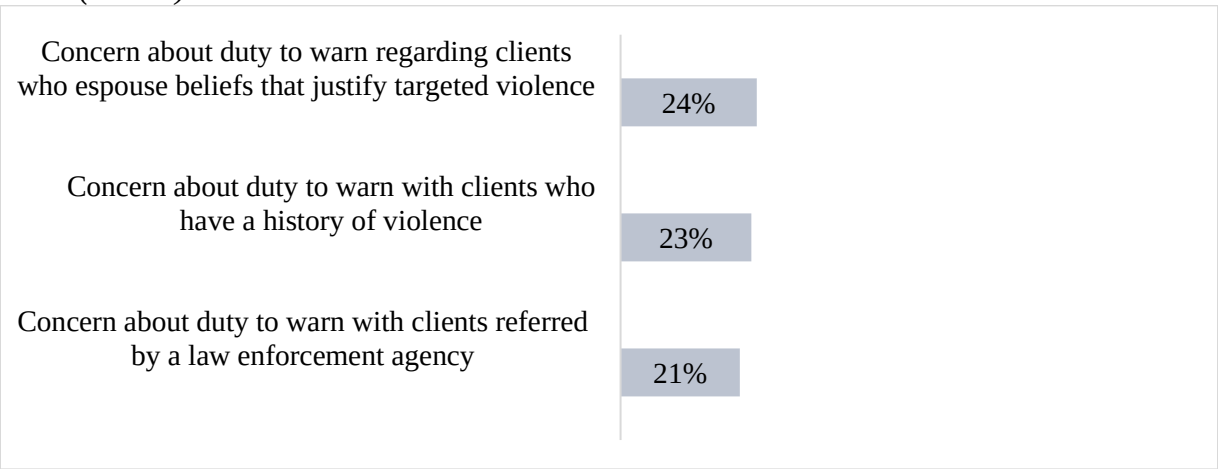


Source: ICJIA analysis of survey data.

Approximately one-fourth of respondents indicated *moderate* or *extreme* concern about their duty to warn as it relates to individuals referred by a law enforcement agency, those who have a history of violence, and those who espouse beliefs that justify targeted violence (*Figure 6*).

Figure 6

Percentage of Respondents Who Were "Moderately" or "Extremely" Concerned About Duty to Warn (n=133)

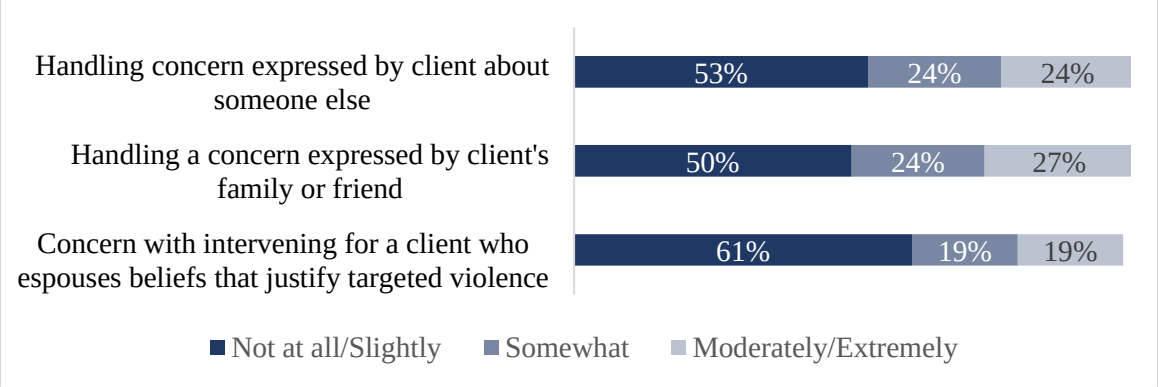


Source: ICJIA analysis of survey data.

Similarly, between one-fifth and one-fourth of respondents indicated *moderate* or *extreme* concern about legal liability regarding confidentiality as it relates to individuals referred by a law enforcement agency, those who have a history of violence, and those who espouse beliefs that justify targeted violence (*Figure 7*).

Figure 7

Confidence Levels in Handling Other Concerns (N=152)



Source: ICJIA analysis of survey data

Behavioral and public health practitioners also were asked about their use of client assessments. Responses indicated little consistency in use of assessment tools across providers;

however, assessment needs may vary depending on clientele and services provided. The most commonly reported assessment tools in use by respondents and respondent agencies included:

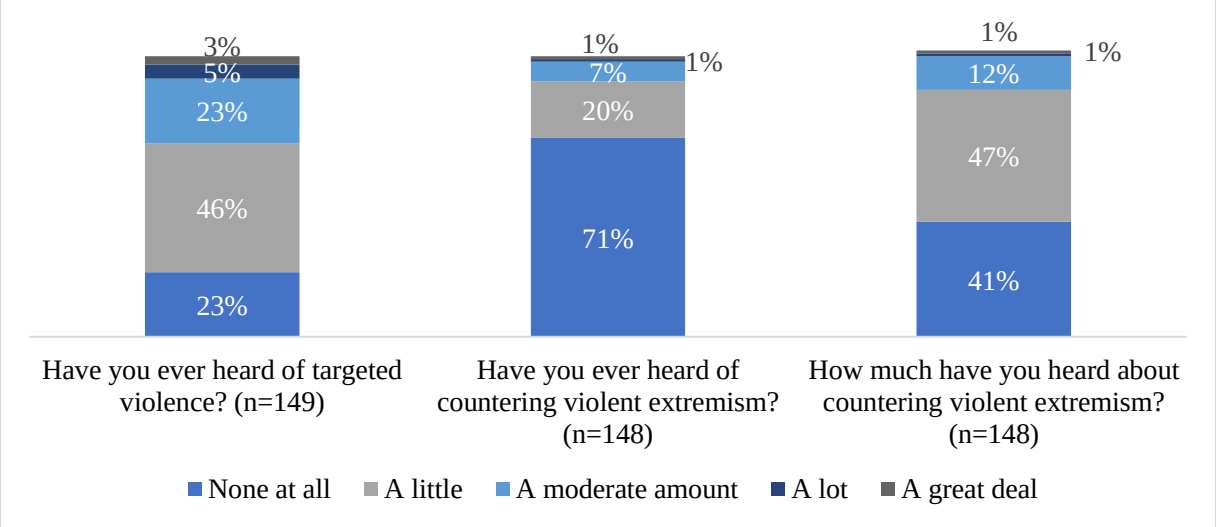
- Level of Care Utilization System (LOCUS).
- Patient Health Questionnaire 9 (PHQ-9) and PHQ-2.
- Illinois Medicaid Comprehensive Assessment of Needs (IM + CANS).
- Beck Depression Inventory.
- Trauma History Questionnaire.
- Global Assessment of Functioning (GAF) Scale.
- Daily Living Activities (DLA) Functional Assessment.
- Ohio Scales.
- Columbia Scales.

Practitioner Knowledge on Targeted Violence

Respondents were asked questions to gauge knowledge of and familiarity with targeted violence and countering violent extremism (avenues of targeted violence prevention). Targeted violence features individuals who espouse ideologies or beliefs that support the use of violence as a justified means to further political, economic, or social objectives (*Figure 8).*

Figure 8

Familiarity with Targeted Violence Prevention and Countering Violent Extremism



Source: ICJIA analysis of survey data.

Most respondents reported they had heard *nothing* or *a little* about targeted violence and countering violent extremism. Further, almost 90 percent had heard *nothing* or *a little* about countering violent extremism programs. After providing survey respondents with the definition for targeted violence, 19 percent of respondents reported currently working with clients who

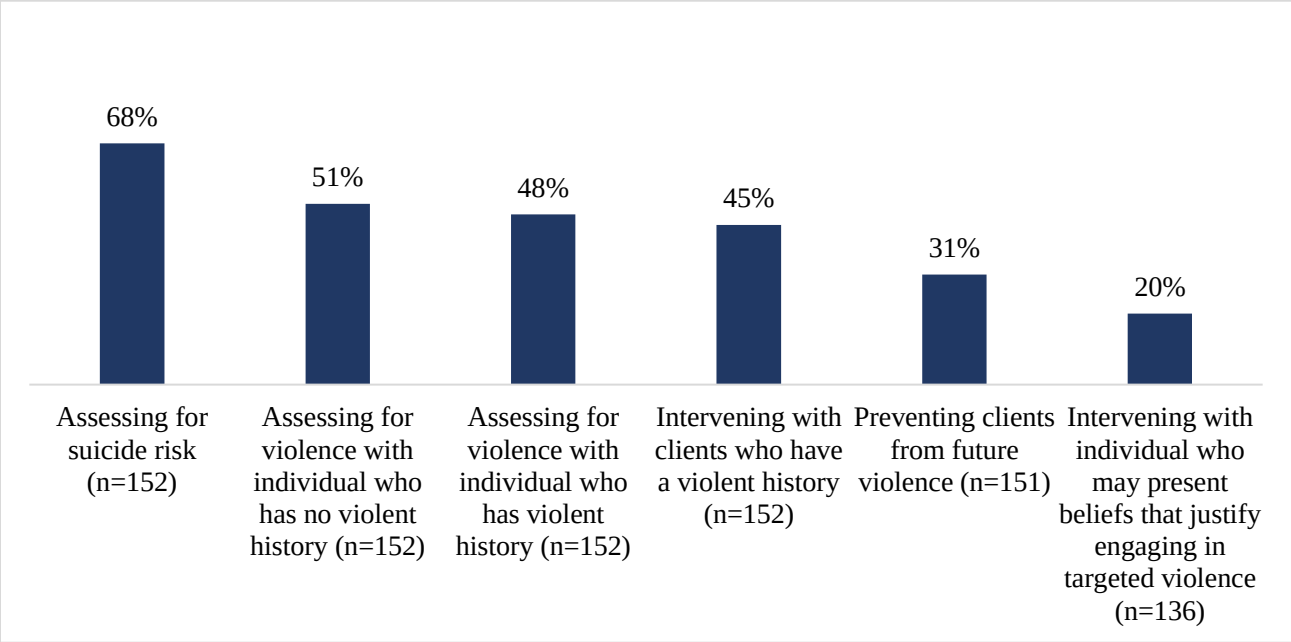
engage(d) in or talk(ed) about engaging in targeted violence and 36 percent of respondents indicated they had previously worked with a client who talked about or engaged in targeted violence. Sixty-one percent of those who reported having experience working with clients who engaged in or talked about engaging in targeted violence had never heard of targeted violence and 89 percent of them had never heard of countering violent extremism.[10]

Comfort, Preparedness, and Confidence in Assessing, Preventing, and Intervening

Behavioral and public health practitioners were asked about their comfort and confidence regarding assessment, prevention, and intervention regarding suicide, violence, and targeted violence. While most respondents indicated being *moderately* and *very* comfortable assessing individuals for suicide risk and assessing individuals for violence with individuals who had no history of violence, fewer respondents felt *moderately* and *very* comfortable preventing clients from future violence or intervening with individuals who may espouse beliefs that justify targeted violence (*Figures 9* and *10*).

Figure 9

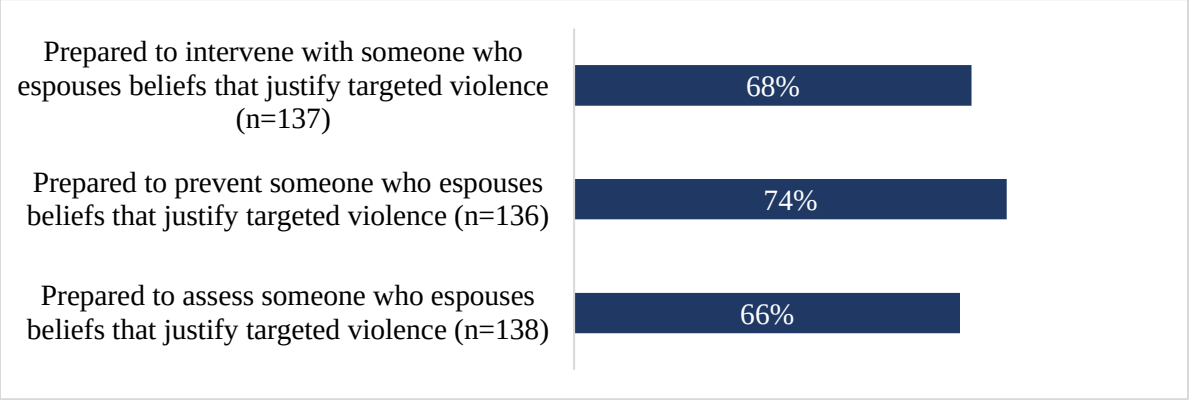
Percentage of Respondents Who Reported Being "Moderately Comfortable" or "Very Comfortable" Assessing, Preventing, and Intervening with Specific Clients



Source: ICJIA analysis of survey data.

Figure 10

Percentage of Respondents Who Reported Feeling "Not at All" or "Slightly" Prepared to Assess, Prevent, and Intervene with Individuals Who Espouse Beliefs That Justify Targeted Violence



Source: ICJIA analysis of survey data.

Most respondents indicated feeling *not at all* or *slightly* prepared to assess, prevent, or intervene with individuals who may ascribe to certain beliefs that justify or promote violence toward specific groups of people or entities (i.e. targeted violence) (*Figure 10*).

There were statistically significant differences in respondents' reported preparation for assessment, prevention, and intervention with clients who talk(ed) about or who have engaged in targeted violence based on the varying levels of experience working with those individuals (*Table 3*). Those who reported experience working with clients who espouse beliefs or ideologies that justify violence reported feeling more prepared to work with them.

Table 3

Test for Differences in Preparedness for Assessment, Prevention, and Intervention for Respondents Based on Targeted Violence Experience (N=152)

	t-test	**Sig.**	**CI Lower**	**CI Upper**
Preparedness for assessment of someone who may ascribe to beliefs or ideologies that justify violence.	-3.74	.000	-1.12	-.35
Preparedness for prevention of someone who may ascribe to beliefs or ideologies that justify violence.	-3.10	.003	-1.07	-.23
Preparedness for intervention of someone who may ascribe to beliefs or ideologies that justify violence.	-3.58	.001	-1.13	-.32

Source: ICJIA analysis of survey data.

Conclusion and Implications for Practice

While targeted violence likely falls into the same area as violence prevention, surveyed practitioners reported feeling less prepared to deal with individuals who may ascribe to beliefs or ideologies that justify violence towards specific people(s) or location(s)...

Researchers also found the following:

1. Few practitioners reported receiving referrals from local, state, or federal law enforcement agencies, nor did they report receiving training on legal liability related to law enforcement referrals. Most respondents received referrals from physicians, hospitals, or self-referrals. The vast majority received cultural competency training and many reported serving individuals from varying backgrounds.
2. Most frequently, participants reported feeling comfortable assessing clients for suicide risk. They were less comfortable intervening or preventing individuals from committing future violence. Twenty percent of respondents reported receiving specialized training in violence prevention and participants infrequently identified violence risk assessments as part of regular practice.
3. About two-thirds of respondents reported they had no experience working with an individual who discussed or engaged in targeted violence, with the majority feeling unprepared to assess, prevent, or intervene with someone who may ascribe to beliefs or ideologies that justify violence.
4. Approximately half of the respondents were *somewhat* to *extremely* concerned about their legal liability regarding their duty to warn and confidentiality. This suggests that while respondents may feel they generally have a grasp on duty to warn, training and education in this area may be needed to address more specifically, how this applies to individuals who are referred from a law enforcement agency, those who have a history of violence, and/or those who may ascribe to beliefs or ideologies that justify violence.

Survey findings indicated behavioral and public health professionals may need more education and training on how to work with populations at risk for violence against themselves or others, targeted or otherwise. Practitioners may benefit from support and updates—through continuing education credits and/or from within their own organizations—about legal liability related to duty to warn, confidentiality, and managing law enforcement referrals. Continuous refreshers on these topics can maintain practitioner preparation and may create more confidence in working with individuals at risk for violence, specifically regarding the applicability of the legal and ethical requirements, especially when situations may pose ethical issues.[11]

Incorporating additional education and training around these topics may also This assist practitioners in informing their clients of their own rights to confidentiality, duty to warn, and what information practitioners can and cannot share with law enforcement. In one study, 43 percent of social workers reported they had informed clients with written descriptions about the limits of confidentiality.[12] This may be one way to maintain consistency across organizations/providers and set up-front boundaries and expectations with clients.

It may also be beneficial to provide more specialized training in violence prevention and intervention incorporating assessment, evaluation, and clinical or practical "tools" that behavioral and public health practitioners are already using in other situations (e.g. de-escalation, service linkage, cognitive-behavioral therapy, etc.). This could include training on different types of violence, such as targeted violence, interpersonal violence, hate crimes/hate-inspired violence, and gang violence. Specialized training on effective violence prevention strategies would provide clinicians with the capacity to more broadly impact violence at multiple levels, with the inclusion of effective violence prevention strategies for their workplace as well as their clients. This increased capacity, in turn, could help create more healthy and resilient communities.

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https://doi.org/10.13140/RG.2.2.21462.40007/1

[1] Centers for Disease Control Foundation. (2019). *What is public health?*. Atlanta, GA: Author. Retrieved from https://www.cdcfoundation.org/what-public-health; Weine, S., Eisenman, D. P., Kinsler, J., Glik, D. C., & Polutnik, C. (2017). Addressing violent extremism as public health policy and practice. *Behavioral Sciences of Terrorism and Political Aggression*, 9(3), 208–221. https://doi.org/10.1080/19434472.2016.1198413

[2] Centers for Disease Control Foundation. (2019). *What is public health?*. Atlanta, GA: Author. Retrieved from https://www.cdcfoundation.org/what-public-health; Weine, S., Eisenman, D. P., Kinsler, J., Glik, D. C., & Polutnik, C. (2017). Addressing violent extremism as public health policy and practice. *Behavioral Sciences of Terrorism and Political Aggression*, 9(3), 208–221. https://doi.org/10.1080/19434472.2016.1198413

[3] National Academies of Sciences, Engineering, and Medicine. (2018). *Violence and mental health: Opportunities for prevention and early detection: Proceedings of a workshop*. Washington, DC: The National Academies Press. https://doi.org/10.17226/24916

[4] U.S. Agency for International Development. (2011). *The development response to targeted violence.* Retrieved April 12, 2018, from https://www.usaid.gov/news-information/fact-sheets/development-response-violent-extremism

[5] American Psychological Association. (2019). *Protecting your privacy: Understanding confidentiality.* Washington, DC: Author. Retrieved from https://www.apa.org/helpcenter/confidentiality

[6] National Council of State Legislatures. (2018). *Mental health professionals' duty to warn.* Washington, DC: Author. Retrieved by http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx

[7] National Council of State Legislatures. (2018). *Mental health professionals' duty to warn.* Washington, DC: Author. Retrieved by http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx

[8] Aggregate information gleaned from this survey was used to help provide general insights for ICJIA's Targeted Violence Prevention Program

[9] Division on Mental Health. (n.d.). *Mental health.* Chicago, IL: Illinois Department of Human Services, Division Mental Health. Retrieved from http://www.dhs.state.il.us/page.aspx?item=29735

[10] Survey respondents were provided with the definition of targeted violence after they were asked about what they knew about targeted violence and countering violent extremism; therefore, respondents could make a more informed determination of whether they currently or had ever worked with individuals who have talked about or engaged in targeted violence.

[11] Millstein, K. (2000). Confidentiality in direct social-work practice: Inevitable challenges and ethical dilemmas. *Families in Society, 81*(3), 270-282.

[12] Millstein, K. (2000). Confidentiality in direct social-work practice: Inevitable challenges and ethical dilemmas. *Families in Society, 81*(3), 270-282.