Radicalisation Awareness Network
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EX POST PAPERS
RAN LOCAL and RAN H&SC – Multi-agency meeting
29 May 2019, Paris (FR)

RAN Ex Post paper Taking mental health insights into account in local P/CVE

Introduction

First-line practitioners from several different RAN Working Groups have indicated a correlation between mental health illnesses and susceptibility to radicalisation. With the assumptions that susceptibility for radicalisation and recruitment is higher for persons with a specific mental illness, the meeting addressed the role of local authorities in detecting early-stage symptoms and how to safeguard such individuals. Mental health experts shared relevant findings in regard to the nexus between specific mental health issues, triggers, disorders, and higher susceptibility to extremist thoughts and violence and how these may manifest. Participants of the meeting agreed that involving mental health specialists in preventing violent extremism (PVE) and countering violent extremism (CVE) is necessary. This is needed to make sure vulnerable individuals and radicalised individuals with traits of mental illnesses are safeguarded adequately and that public safety is being safeguarded as well. For local authorities and healthcare services, a whole range of different areas of responsibility can only be addressed through multi-agency work (MAW). One of the key challenges here is to set up clear information sharing protocols that enable different stakeholders to be able to exchange crucial information (e.g. for the reintegration of a former extremist or for the disengagement of a person). In this ex post paper the 'why' and 'how' of involving mental health specialism in the PVE/CVE multi-agency cooperation at local or regional level is explored.

Product of the RAN Centre of Excellence and the RAN LOCAL and H&SC working groups.
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Mental health in a local context

For the purpose of this paper, we will not focus on specific mental illnesses as risk factors but will more generally talk about mental health in relation to how local prevention strategies can safeguard individuals with mental illnesses in general. When discussing the link between mental health disorders and radicalisation, local authorities need to understand the different links between mental health disorders (and certain aspects of mental health disorders) and vulnerabilities to radicalisation. The link actually consists of many different links that include social, economic, cultural and psychological factors. Symptoms of mental illness can play a role in the process of radicalisation or the vulnerability to radicalise, yet more often than not involve a whole range/combination of other factors. Understanding the interplay between **mental health disorder functioning** and **push and pull factors** leading to radicalisation are important to come to a comprehensive prevention strategy. In this regard, local authorities need to understand the following.

- There is a tendency to put the blame more on the mental disorder than on any other factor when it concerns radicalisation, which in effect stigmatises people who are already in a vulnerable position. People with mental illness are not more vulnerable per se, but if the mental illness is not addressed or treated adequately, the risk of engaging in violence increases.
- People with mental health problems are significantly **more likely to experience many different problems in their lives**. Difficulties in social contact, social withdrawal, behaving unconventionally and consequently annoying others in their environment might evoke aggressive or even violent reactions or vice versa. A person with a mental health disorder might in such a situation feel despair, stress or panic. Because of their condition, they might have lost the ability to rationalise the situation, which increases their vulnerability. In most known cases, there were other bad things happening in the lives of people with mental health disorders that were expressed in radicalisation or violence.
- Someone with a mental health disorder is generally ruled out from joining terrorist organisations, being seen as a risk factor. Nonetheless, **groups have recognised they can also use people with mental illness**. For example, people with autism (ASD — autism spectrum disorder) were targeted by terrorist groups online for the specific purpose of committing lone-actor attacks. People with ASD struggle with the day-to-day physical world and often prefer to engage online. Social naivety and other specific symptoms open them up for manipulation by people with bad intent, leading to them being recruited in the online world.
- Some mental illness-related cases are already dangerous (potentially violent), but with an **ideology stamp**, perhaps even more so (due to the ideological indoctrination that gives clarity as to who is the enemy). Radicalisation in these cases may serve as a frame, or a way of expressing the mental illness, with conceivably disastrous consequences if aimed at bigger targets. Two rules to remember when working with violent mental health patients: **previous violence is the best indicator for future violence**, and **protect your back**. Obsession is a defence mechanism used to keep their life in order, so understand that you might be the target of their obsession.

There is a need to improve preventive capabilities when managing violent extremism — especially in relation to mental health issues. Responding to the threat of violent extremism once it becomes manifest is not enough; it is crucial to address the roots of violence before its emergence, or at least as early as possible in the process of violent radicalisation. This entails identifying those at future risk of violent extremism and supporting them within a needs-based model to redirect their lives towards non-violence. Local authorities have a crucial role to play in improving the mental health of everyone in their city and tackling some of the widest and most entrenched inequalities in mental health and vulnerability.

MULTI-AGENCY WORK THAT INCLUDES MENTAL HEALTH

In an ideal situation, MAW is seamless because clear systems and structures exist to facilitate information sharing: agencies no longer work in silos, and different cultures across organisations do not inhibit collaboration. Most importantly, all parties responsible for supporting clients have access to the information and expertise needed to assess and manage client needs.

However, more often than not there is a need to improve preventive action when managing violent extremism — especially if mental health problems are involved. This entails identifying those at future risk of violent extremism and supporting them within a needs-based model to (re)direct their lives towards non-violence.

In responding to violent radicalisation, some level of integration of services and agencies at national and local levels is important. At the local level, MAW can facilitate the management, coordination and delivery of services.

At national level, MAW can provide guidance on good practices and other forms of support to local actors. The configuration of MAW, and its resourcing, should be based on the risks and needs within each jurisdiction.

If you accept that the risk factors are many and vary, then you must also accept that many agencies need to work together to make it work. This includes **identifying gaps in responses and support systems** aimed at safeguarding individuals with mental illnesses. Gaps exist due to the diversity of goals, demands, needs and the **diffusion of responsibility**.

The prevention of extremism and radicalisation is based on a comprehensive and varied approach, using different types of intervention depending on the target group. This is illustrated by the prevention pyramid, which is also used for crime prevention efforts. Comprehensive public health support systems should generally attempt to implement measures at each level of intervention to maximise synergy and the likelihood of long-term success.

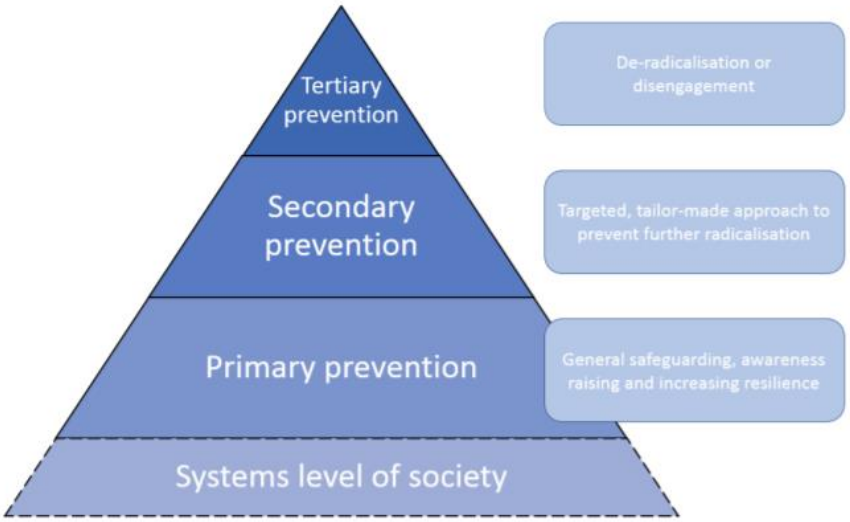

Figure 1: A simplified Prevention Pyramid. Based on: Declerck, J. Cautaert, S., Dupont, V., & Ideler, I. (2001); Gielen, A.J. (2017)

It is clear that there is a **need to strengthen the level of collaboration** with the individual municipalities and health services to support a comprehensive, integrated approach in the prevention efforts. Even so, local authorities are finding it difficult to involve health services in their prevention strategies, especially at the primary prevention level.

It is worth investing in a **structural relationship** with health services, as the benefit of a trustworthy relationship across different stakeholders will open up opportunities for creating a comprehensive approach. It is crucial to do so, as the health sector might well be best positioned to build the support and develop the partnerships required for positive change.

The bottom level: Early prevention

Socioeconomic status is a strong determinant of health, both within and across countries. The bottom level of the pyramid basically comprises all citizens, but for this paper we will focus specifically on people with mental health disorders. Initiatives at this level are intended to further the welfare, development and active citizenship of children and young people, as well as prevent the development of risk behaviour.

In regard to mental health, acting early is of great importance. People with mental health issues need to be supported in their life, for example by **solving attachment difficulties** and **normalising** their position in their environment. Most effective interventions happen at the earliest phases of integration in society and communities. We move from mental health into public health that way. At this level, local authorities have the potential to play a shaping role.

The challenges local authorities could address mostly involve access to (mental) health services. By not having access to mental health institutions in some areas (For example, due to social inequalities or cultural taboos), individuals in need of support are left unattended. Local authorities could play a role in coordinating this through the following actions.

- Setting up **local detection systems** and providing screening indicators for people with a mental health problem at higher risk. **Referral systems** should be in place and clear.
- **Provide information** on health access and treatment. This is also aimed at **breaking cultural taboos or misinformation** that perseveres in some communities and keeps them away from seeking help from mental health care professionals. In some known cases, this has led people right into the arms of groomers and recruiters.
- Help is not always accessible. **Access to mental health services is already a protective factor**, and hence health services should together with local authorities and other stakeholders look at how to improve access and to avoid waiting lists, especially for individuals in need of immediate care.

The second level: Risk behaviour

This level addresses acute distress where a few risk factors/behaviours are present or signs of radicalisation are there. Efforts at this level are designed to stem risk behaviour before it escalates into something more serious. Anticipatory interventions that specifically address challenges of extremism and radicalisation must be seen in conjunction with other, more general social and crime-preventive efforts — such as social housing initiatives in vulnerable areas — which address risk behaviour more indirectly. **Anticipatory interventions** are, for example, carried out through the municipalities' social efforts and mentoring schemes and within the framework of the relational work that is carried out by professionals in institutions, schools and street-based initiatives in vulnerable residential areas. Additionally, **effective mental health and psychosocial support require intersectoral coordination that includes health services**, as all stakeholders have responsibilities to promote mental health and psychosocial well-being.

Thus, coordination must include health, education, protection and social services, and, depending on the case, representatives of local communities. Coordination helps to ensure that:

(a) **all aspects of the response are implemented** in a way that promotes the mental health and psychosocial well-being of the individual and the community;

(b) **specific mental health and psychosocial support activities are included**. In order to do this, stakeholders must agree on an overall strategy and division of work that support the individual and the communities.

Poor coordination can lead to ineffective, inefficient, unsuitable outcomes or even harm. A number of key difficulties exist in ensuring appropriate coordination. **Bridging the gap** between "mental health" and "psychosocial" support is a key challenge. For example, for people in psychiatric institutions, facilitate community-based care and appropriate alternative living arrangements.

The top level: Treatment and disengagement

This part comprises individuals who have committed or are deemed likely to commit criminal acts, are possibly radicalised and have been diagnosed with a mental health illness. They are possibly, although not likely, part of an extremist group. Coordination has been especially challenging in high-profile cases involving large numbers of actors.

Interventions for this target group are intended to prevent (further) extremist criminal acts and to support such individuals in breaking out of an extremist environment. Direct interventions aimed at individuals in extremist groups must be considered in conjunction with the relevant criminal procedures, where criminal acts are assessed by the courts of law.

Direct interventions are mainly carried out by the police, the prison and probation services, and via the municipalities' social measures and mentoring schemes. Treatment is needed from health services or health professionals to deal with the mental illness. Furthermore, the symptoms and traits of the mental illness in question need to be assessed and understood by all relevant professionals. Without taking into account these symptoms and traits, disengagement work is doomed to fail. Hence, health professionals should always be included in such assessments.

Questions on **public safety versus safeguarding the individual** were difficult to answer and case-dependent, stressing the need for multi-agency cooperation. Especially in such **high-risk cases**, close cooperation with the judicial system is needed. In some serious cases — either radicalised or violent — **forced admission** is the only way of protecting the individual and the community. There is some difficulty in getting someone admitted, depending on the national legislation. National authorities and lawmakers need to address such existing difficulties by altering national legislation that prevents professionals from safeguarding the community and the individual.

Lastly, **systems of information sharing** across relevant stakeholders should be in place. In some cases, preventing violence might **outweigh patient confidentiality** and such indicators should be clear to all stakeholders (including local municipalities).

BUILDING A COMPREHENSIVE APPROACH

Building **common understandings** among stakeholders with diverse views on MAW and ensuring timely resolution of shared problems are key to effective coordination. In building a comprehensive approach, consider the following.

1) Agree upon key support issues by determining which factors or symptoms have the greatest impact on the well-being of the individual and which are most likely to be changed through support measures.
    a. Develop multi-agency strategic plans and promote joint mental health and psychosocial support systems.
    b. Integrate **specific mental health and psychosocial support** activities into national policies, plans and programmes, and ensure that programmes utilise existing policies, plans and capacities.

2) Identify key stakeholders such as health institutions, media, NGOs, policymakers and other coordinating bodies, and develop targeted key messages for each.
    a. Form a group to coordinate mental health and psychosocial support actions and jointly develop a plan stating what will be done and by whom. Form a single intersectoral coordination group, including actors traditionally associated with both the health and security services.
    b. Initiate updating of mental health policy and legislation.

3) Determine clear roles and responsibilities.
    a. Develop inter-agency indicators for work in the transition phase.
    b. Strengthen accountability: who owns which element of the risk?
    c. Create transparency on the conflicting aims.
    d. Facilitate inter-agency cooperation on joint actions (such as referral mechanisms or joint trainings).
    e. Create a single point of contact (because there are many interests among the multi-agency workers).

4) Continuity and commitment are needed from all relevant stakeholders. Lack of trust and not sharing information across the different stakeholders could have disastrous results.
    a. Conduct regular assessments and implement further in-depth situation analyses. This includes assessing the accessibility and quality of mental health care.
    b. Continue to foster collaborative relationships with local health systems.
    c. Monitor and evaluate support programmes in relation to planned activities with predefined indicators. Review data and address gaps in services for people with specific needs (at-risk groups like people with mental illness).
    d. Disseminate results and lessons from assessment, monitoring and evaluation activities.

KEY LESSONS

1. Develop the availability of mental health care professionals in PVE and CVE multi-agency structures. *Think of addressing a broad range of emergency-related situations, to more general prevention by providing people with pre-existing mental disorders with the right care through general healthcare and community-based mental health services.*

2. Provide access to care for people with severe mental disorders. *Access to mental health services is a protective factor!*

3. Seek promise of risk if possible. *Normalisation is important for disengagement and treatment. Protect and care for people with severe mental health disorders and other mental disabilities living in institutions.* In some serious cases — either radicalised or violent — **forced admission** is the only way of protecting the individual and the community.

4. Learn about and, if possible, collaborate with local communities for the sake of intercultural working and bridging cultural taboos. *Local authorities need to target communities to increase awareness and challenge stigmas that would help to reduce the barriers in seeking help.*

5. There is no one-size-fits-all model, transferability or best option. *Every case is different and includes many different factors that could have contributed to the process of radicalisation.*

6. Integrated approaches and information sharing systems are key factors in successful prevention strategies. *If you don't address the mental health disorder in your prevention strategy, you might miss something important for the whole case.* **Systems of information sharing** across relevant stakeholders should be in place. In some cases, preventing violence might **outweigh patient confidentiality** and such indicators should be clear to all stakeholders (including local municipalities).