RAN H&SC

Ex post paper

27-28 January 2016, Zagreb (Croatia)

Working group meeting on identifying and treating lone actors

The first RAN H&SC working group (WG) meeting with the support of the RAN Centre of Excellence took place in Zagreb on 27 and 28 January 2016 in the form of a two-day event focusing on the topic of '**Identifying and treating lone actors'**. The meeting was chaired by the RAN H&SC working group leader Hamp Harmsen and his co-leader Sergej Erdelja. Hamp Harmsen was co-leading the previous RAN Health working group and works as a policy advisor in the Dutch Mental Health Branch organisation (GGZ Nederland) whereas Sergej is new to the RAN and adds his value through his experience as a social worker in the Department of Youth and Families at the Social Care Centre Krapina (Croatia).

The main objectives of this first H&SC working group meeting were to: introduce the general theme of RAN H&SC and its main focus, provide a comparative overview of the H&SC sectors across Europe and try to understand what their respective role is (or could be) in the prevention of radicalisation and VE; present national strategies in addressing the issue of radicalisation at the general level and the issue of identifying and treating lone actors specifically as well as present concrete regional and local multi-agency approaches to prevent radicalisation and violent extremism committed by lone actors.

Introduction of the H&SC WG theme, the RAN CoE and the H&SC European contexts

As well as the police, local authorities, schools, families, etc., the professionals working in the health and social care sectors have a crucial role to fulfil in preventing radicalisation. Key in their role is that they are part of a multi-agency approach, as many of the interesting examples presented during the two-day meeting demonstrated.

Given this was the first meeting of the H&SC WG, the RAN CoE and the RAN DNA were explained to the participants stressing the key involvement of practitioners and people working on the ground as well as the focus on prevention rather than a reactive approach.

In order to understand what the key contextual elements at play are in each country, affecting the work being undertaken by the H&SC professionals in a positive or negative way, a comparative overview was given on 12 European countries[1] based on 18 answers to a questionnaire distributed before the meeting. It was found that the national level organisation of the health and social care system differs from fully centralised (e.g. Hungary and the UK) to rather decentralised given more responsibilities to regional and local authorities to address the problems (e.g. Finland and Sweden). Whereas some countries run health and social care under the same government department (e.g. Hungary and Norway), social care may fall under a separate department in other countries impacting on the level of cooperation between these two sectors (e.g. Croatia, Slovenia and the UK). Overall however, the majority of participants agreed that

[1] The 12 countries covered were: Belgium, Bosnia and Herzegovina, Croatia, Hungary, Finland, France, the Netherlands, Norway, Slovenia, Spain, Sweden and the UK.

there is a need for closer cooperation and especially an identification of the exact role each actor has to be play in addressing prevention of radicalisation. Moreover many countries report the engagement of a multitude of other actors in the prevention approach, beyond H&SC service provision provided at national, regional and local levels, such as for example research institutes, NGOs, prison and probation services, military support agencies, specialised agencies (e.g. focusing on 'fixated' people), religious communities, informal and voluntary networks, education and training institutions and the media.

It is widely acknowledged that political support is crucial in developing effective strategies to the prevention of radicalisation and violent extremism (VE) and in this regard it has to be noted that there a varying levels across Europe (both with regard to the support offered by a general prevent strategy and the involvement of the H&SC sector in such a strategy). The levels range from a very low political interest and support (e.g. Hungary and Spain), to medium support translated into developed and currently being developed national strategies to address the issue (e.g. Finland, Slovenia and the Netherlands) to high level interest demonstrated by the H&SC sectors in some countries being fully involved in the strategies with a clear role assigned in the multi-agency approach (e.g. the UK, Norway). In some countries (e.g. Croatia), the issue of prevention of radicalisation and VE is considered to be part of the defence and security policy areas and as such the H&SC role is perceived as limited to awareness raising on violent behaviour in general. The following factors were considered to be crucial for the H&SC sector to work effectively on preventing radicalisation and VE and have currently been identified as either a strength or a weakness in some countries: awareness of the role the H&SC sector can play; research knowledge on the subject of terrorism and those involved as well as what works and does not work in terms of identifying and treating them; availability of financial and capacity resources, training of staff and risk assessment tools; cooperation between services; political support. On the other hand, the following factors are specifically perceived as challenging for all or some countries: the constantly changing face of the problem and thus developing the appropriate understanding and response; confidentiality issues and the resistance from civil liberty groups.

Lone actors and potential link to mental health issues

The main topic of the meeting was lone actors and how to identify and treat such individuals via the H&SC sectors. Several institutions and organisations across the world have undertaken extensive research in the question whether lone actors are more prone to experience mental health issues than the average general population. During the RAN H&SC WG's first meeting an insight into two such research projects was provided.

The first research project is being undertaken by the Centre for Terrorism and Counter terrorism at the Leiden University in the Netherlands (part of the Countering Lone Actor Terrorism (CLAT) consortium) focusing on the mental health aspect of lone actor terrorism. For this research, lone-actor terrorism is defined as follows: "The threat or use of violence by a single perpetrator (or small cell), not acting out of purely personal-material reasons, with the aim of influencing a wider audience, and who acts without any direct support in the planning, preparation and execution of the attack, and whose decision to act is not directed by any group or other individuals (although possibly inspired by others)".

For this research, analysis was performed on 120 cases of lone actor terrorism committed after 2000 and 70 variables were included in the analysis such as socio-economic and demographic variables as well as variables such as criminal past and mental health state of the individual. It was found that the medium age was just under 30 years old and except for a handful of cases, all cases involved men. In terms of mental health state, in 32% of cases there was some indication reported of a mental health disorder whereas this percentage decreased to 23% in terms of an actual clinical diagnosis of such a mental health disorder. However, for 62% of the cases a clinical diagnosis was unknown and only in 15% there was a clinically diagnosed absence of a mental health disorder. When controlling[2] for religious, political or single issue ideology of the lone actor terrorist cases, 70% seemed to have had an indication of a mental health disorder.

When turning to the variable of social isolation, it is clear that there is some association between lone actors of terrorism and being socially isolated as well as a mental health disorder[3]. However, it could be argued that people with a mental health disorder might be more at risk of social isolation. Interesting to note on this variable in relation to 'age' was that the research cases in the under 25 years' old age group showed the highest percentage of socially isolated individuals. The research findings gave rise to some concrete recommendations for policy makers which included the following:

- The need for benchmarking and identifying sub-groups in order to be able to identify and treating people with a mental health disorder showing signs of radicalisation and/or intention to commit an act of VE;
- The strong need for a multi-agency cooperation and establishing lines of communication to make information sharing possible;
- To take on board lessons from other delicate policy areas such as for example child abuse and domestic violence;
- To acknowledge the limitations of what is possible to prevent.

The question on the presence of a mental health disorder and which kinds of disorders occurs in lone actors is a much debated one and there was a general consensus amongst the participants that it is very difficult to identify a person at risk of radicalising or committing an act of violent terrorism on the basis of such presence alone. As a comparison with the research findings presented by the Leiden University with regard to the occurrence of mental health disorders amongst lone actor terrorists, the World Health Organisation figures show that a similar proportion, i.e. 27% of the adult population had experienced at least one of a series of mental health disorders (this included problems arising from substance abuse, psychoses, depression, anxiety, and eating disorders)[4]. The complexity and challenge of diagnosing mental health disorders in lone actor terrorists was further illustrated with the Anders Breivik case in Norway, for whom four different experts has not been able to be affirmative on a clinical diagnosis.

[2] No regression analysis was performed within this research and therefore this is not statistically confirmed for given the total number of cases and the high number of variables.
[3] No regression analysis was performed within this research and therefore this is not confirmed with a statistically significant correlation.
[4] http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/data-and-statistics.

Other research performed by the Verwey Jonker Institute focused on 167 'threateners' of public figures who together performed 351 threats between 2008 and 2010[5]. One of the main findings of this research was that the threats or attacks (in general) are done by people with mental health issues.

Some of the participants furthermore questioned the use of a categorisation of mental health disorders in prevention and whether it would be more useful and effective to work with patterns of symptoms and the causes for these in identifying potential lone actors and subsequently treating them.

Other research on the mental health state of lone actor terrorists was performed at the University of Sarajevo. More specifically, a number of individuals who had committed violent extremist acts were analysed in order to find out whether it was possible to identify a single profile and to filter out 'typical' personality indicators. A number of commonalities were found which related to: coming from a broken family, usually with a history of domestic violence; mental health issues (potentially as a consequence of traumatic events in younger years), substance abuse in a number of cases, as well as previous criminal records and religious radicalization. With regard to the latter, a clear pattern emerged across the cases in that a certain kind of 'alternative treatment' was followed which consisted in a sort of rite clearing out evil spirits (reminiscent of exorcism in Catholic church) performed by a figure of trust to the lone actor (usually a troubled individual). The research findings seem to suggest that it is during these rites that the lone actor, who was already vulnerable due to a traumatic event and/or mental health disorder, got radicalised and might have been incited to commit a terrorist crime. The people performing the rituals are not registered imams. Similar incidences have been noted in other European countries. For example in Sweden these kind of rituals are known to take place in so called 'basement mosques' performed by local healers on immigrants with war traumas who tend to come from countries without a mental health sector. Also in Croatia and Slovenia evidence was found of these rituals. Youngsters are sometimes radicalised through the non licenced Vehabist imams. Certain number of Croatian and Slovenian citizens went to Syria through Bosnia, where they received this "treatment."

Current national political support for the H&SC sector organisations in preventing radicalisation

The UK Prevent Strategy

As explained above in the comparative overview of the state of play with regard to national strategies on prevention of radicalisation and VE, some countries, like the UK, have set up an integrated overall approach in trying to identify and address signs of radicalisation. This strategy, called Prevent and which is one element under the overarching CONTEST strategy the UK has developed since 2011 in the area of counter terrorism, was presented with a focus on its support in building the capacity of the public H&SC sector to prevent radicalisation. Besides putting a statutory duty on health and social care authorities to prevent people from being drawn into terrorism, Prevent prescribes this same duty for police, universities, schools, prisons and probation and local authorities. The Prevent strategy and accompanying Channel programme is intended to ensure that the duty to prevent is consistently applied across local areas and institutions. In order to do so, organisations need to train their staff. In order to

[5] http://www.verwey-jonker.nl/doc/vitaliteit/rapport-individuele-bedreigers_tcm126-444088_1160.pdf (in Dutch).

build this capacity for the H&SC sector, the Workshop to Raise Awareness of Prevent (WRAP) has been developed by the Home Office including video clips, facilitator workbook and a script. WRAP delivery to social workers is catered for by normal delivery of training alongside other local authority or healthcare staff. It has to be noted that staff are being trained to detect possible signs of radicalisation both in patients as well as in colleagues.

Since 2011, over 350,000 NHS staff (of the 2 million) has been WRAP trained and a network of 10,000 Home Office accredited WRAP facilitators exists. The WRAP product consists of the following elements:

- Introduction Video –aims of Prevent.
- The Iceberg Analogy – changing perceptions of what is meant by "Terrorism" and showing where Prevent sits on the path violence.
- Vulnerabilities Exercise – getting the audience to think about the emotions and feelings that make someone vulnerable.
- Behaviours Exercise – what do these vulnerabilities (and others) actually look like?
- Radicalisation Video – how do people become radicalised.
- Notice Check Share – the procedure for sharing concerns to receive a proportionate response.

The WRAP video is intended to make the audiences pick up on vulnerabilities such as family upheaval, anger, loss, propaganda and social exclusion as well as on behaviours such as angry, withdrawn, new found arrogance, scripted speech/fixated on a subject, saying inappropriate things/ a call to violence, new circle of friends and the use of internet.

Under the Prevent Strategy, a specific procedure is to be followed if a front-line worker were to notice something related to radicalisation or violent extremism. Firstly, the person has to check with the line manager who will share the information with the safeguarding team which includes a lead for Prevent. If judged necessary, the lead will go the Safeguarding hub in the local authority or the Police Channel Coordinator. Concerns may lead to a referral to Channel – a multi-agency panel - for support which can consist of: counselling, help with education, employment etc.

Overall, the important message underlying the Prevent Strategy is that the front-line workers are not supposed to become experts on radicalisation but that they are aware of possible signs of radicalisation and check with the right people whether further steps should be taken. Currently, out of all the referrals made to Channel, 10% comes from the H&SC sector.

Other existing national strategies and current challenges in their design and implementation

Other existing national strategies to address the prevention of radicalisation have been developed or are being developed and implemented in a few European countries such as for example in Sweden, Bosnia and Herzegovina. However, these strategies generally, except for the one in Bosnia and Herzegovina and the UK, tend to not be one national strategies involving all the necessary actors at that level but are rather being developed at regional or even local levels and do not necessarily follow a uniform approach across sectors (such as if for example the case for Belgium). The main messages stemming from

discussions during the two-day event on existing strategies, involving the H&SC sector, to prevent radicalisation and VE, include the following:

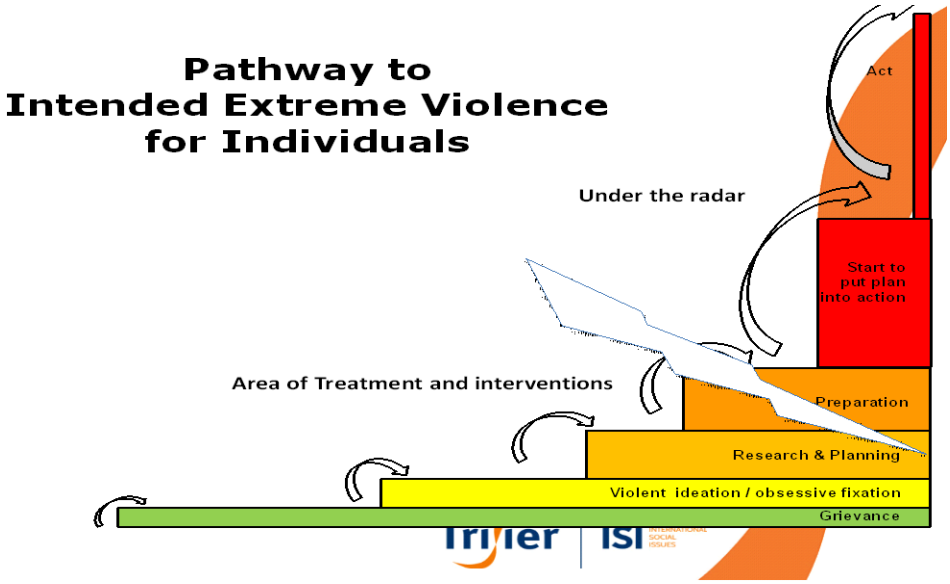
- At various levels and degrees, each country has to deal with complex organisational structures and adapt strategies to this context;
- All the participants are in favour of a joint public health and social care approach in terms of prevention and harm reduction, but it needs to be a structured approach with clear role allocation, acknowledging cooperation tensions and addressing funding inequalities;
- Both top down leadership as well bottom-up, innovative and sound evaluated initiatives are needed;
- Often relevant national strategies start in an isolated way in some sectors, like prison services only after that multi-agency work starts its journey. Some countries have built up a successful experience so far;
- The regions across Europe have some very different characteristics, needs and risk levels. There is evidence of trying to manage current emergencies in response to for example the refugee crisis/returnees rather than building up a longer-term comprehensive prevention strategy. It was made clear that the very nature of the problem necessitates often quick and immediate policy response compared to other policy areas where there is an opportunity to take more time for preparation and long-term strategy.
- All participants agreed that a national strategy with the aim of preventing radicalisation and violent extremism is needed, including a crucial role for the H&SC sector actors but that the concrete implementation of such a strategy takes place at regional and local levels in a multi-agency approach allowing for good practices to develop at these levels.

Local multi-agency approaches in the H&SC sector to address the issue of lone actors

In contrast to the first day of the meeting, where the focus lay very much on current national strategies being developed and implemented to prevent radicalisation of individuals at risk, the second day took a more regional and local angle into the topic area and centred around current local practices and approaches involving actors from the H&SC sector as well as from other sectors to form multi-agency and multi-disciplinary teams and which are designed to prevent and address radicalisation of people who might get or are involved in radicalisation and VE ideologies.

In a first presentation, radicalisation was explained as being the result of both sociological and psychological processes. Also, individuals with mental health issues might be more vulnerable towards lifestyle risks such as binge drinking and drug abuse. When an individual has to deal with an all-determining difficult event and has vulnerability issues, the person can suffer from what is called by Professor Michael Linden 'Posttraumatic Embitterment Disorder' (PTED)[6]. In this kind of state, the individual can develop a monomaniac worldview (or fixation) in which extreme political-social visions can lead to feelings of or intending to revenge. A model to help multi-disciplinary teams to address radicalisation and discuss signs present in an individual at risk a model called Pathway to Intended Extreme Violence for Individuals (P-IEVI) has been developed by Trifier/ISI and is presented below.

[6] Linden, M. (2003). The Posttraumatic Embitterment Disorder. Psychotherapy and Psychosomatics, 72, 195–202.



The above presented model raises the question on the issue of potentially lone actors of terrorism remaining under the radar, 'undetectable' to the different actors involved and thus difficult to stop from committing a violent act.

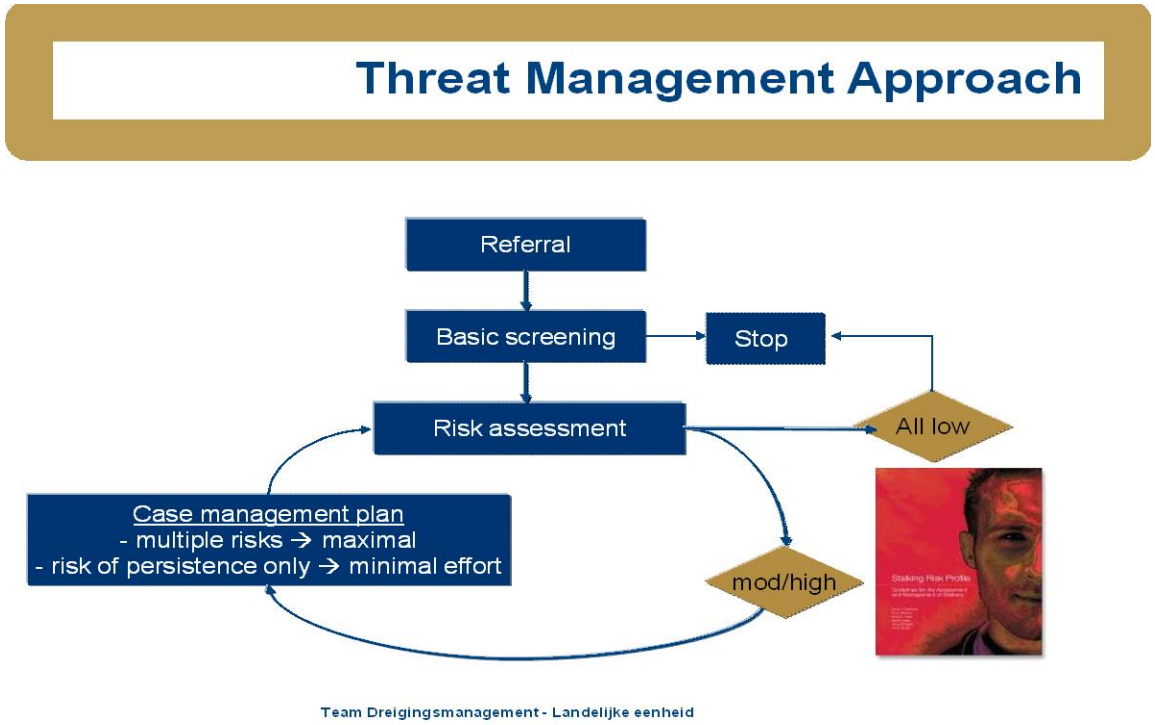
A group of three presentations followed, all illustrative of the multi-agency approach in preventing radicalisation and committing VE acts. The main findings for each of these examples is summarise below.

Fixated Threat Assessment Centre (FTAC)

In the United Kingdom, the Fixated Threat Assessment Centre (FTAC) is a joint police/mental health unit set up in October 2006 by the Home Office, the Department of Health and Metropolitan Police Service to assess and manage the risk to politicians, members of the British Royal Family, and other public figures from obsessive individuals. FTAC started in London and centred around stalkers and harassers of public figures. They deal with around 1,400 referrals a year of people who have engaged in threatening or harassing communications towards politicians or the Royal Family. Around half are assessed as being of low risk after initial enquiries. The remainder are investigated by FTAC staff. They among other use the letters written by the stalkers to look for indicators of mental health issues. The FTAC team consist of ten police officers from the Metropolitan Police Service, three full-time senior forensic nurses, a full-time senior social worker and a number of senior forensic psychiatrists and psychologists.

Threat Management – A Person Centred approach

As a consequence of a series of events in the Netherlands involving the following similarities, i.e. lone actors, psychiatric problems, targeting royals or officials and leaving a great impact, a pilot project was started based on the FTAC model (explained above) involving the police and mental heath care practitioners resulting later on in the Threat Management approach (TM) which also involves knowledge provided by an expertise centre. The figure below presents the approach taken by the TM in addressing potential lone actor terrorists.



Important elements underpinning this approach are the focus on prevention rather than prosecution, sharing information and focusing on the family surrounding the person and trying to involve them in the process.

With regard to information sharing and the related confidentiality issues, some of the participants remarked that this should not always be perceived as a hurdle in multi-agency work if looked at from the right angle. More specifically, the main aim of information sharing can be limited to just flag up whether a person shows signs of radicalisation or might be included to commit an act of terrorism rather than for example the need to share a detailed medical or psychiatric history record.

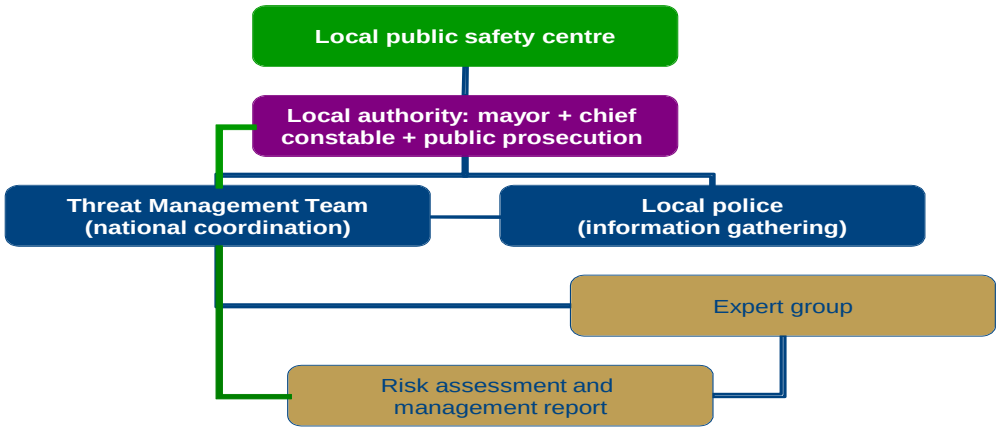
Threat Management Team (TDT) – Multi-agency approach dealing with violent extremist cases

A particular recent focus within the Dutch police is the returned foreign fighter. Between 2013-2014 there were 160 foreign fighters in the Netherlands of which 30 have returned and 18 known to be killed. Research was done on 140 cases of people travelling to Syria or preparing to do so. The average age was 24 and the overall majority were men. In terms of criminal history, 53% had a criminal record of which 22% had committed more than 10 crimes or a serious crime. In terms of mental health state, 20% had a psychiatric disorder/symptoms and 60% had some kind of problem behaviour. Only 8% had a problematic social setting.

Within a multi-disciplinary team, the Dutch police have so far screened more than 300 cases for potential risk based on the Threat Management Team (TMT) model. The team combines following expertise: psychology, psychiatry, religion, risk assessment, culture, extremism, terrorism, intelligence and police. In terms of the TMT model, two main questions are raised when screening a case: which cases do you give priority to and do you intervene and if so, at what level. The approach

is evidence based and explores the following SPJ (Structured Professional Judgment) tools: HCR-20 V3, VERA-2, MLG.

The figure below provides an overview of the TMT model:



Netherlands National Police - Threat Management Team

Local structure in Finland and role of H&SC sectors

Due to a changing landscape (international developments, multiculturalism, new technology) in Finland there has been much more focus on preventing radicalisation and all forms of VE (with violent jihadism constituting the main threat) since 2005 resulting in a first Action Plan in 2012. A new Action Plan is to be adopted in March 2016 and consists of the following elements: national coordination, exchange of good practices, the Finnish Exit- programme – Radinet, Helpline-service, Hate crime, virtual community policing and an electronic toolbox (good practices and other material supporting practical work). More specifically in terms of capacity building the new Action Plan aims to develop capability to prevent violent extremism in all parts of the country by:

- Anchor teams in all Police Districts, cooperation network, officials specialised in preventing violent extremism (police, mental health, social work, youth work);
- Interventions targeted to individuals, prevention targeted to groups, communities and areas;
- Developing skills in education sector, health and social sector and in the Police.

Within this approach an important role is given to the media as well as young people themselves.

Due to several school shootings in Finland in recent years, the government has also taken special precautions to stop these from happening and has addressed: safety of school buildings, teacher training, a change in legislation, curriculum changes and introduction of anti-bullying programmes.

Other local practices and more specifically, perceived challenges and key conditions deemed to be necessary were discussed by the participants resulting in the following main conclusions:

- A multidisciplinary approach for assessment and de-escalation in the pre-criminal case is important to reduce harm by providing adequate and tailor made care;
- The media can play a positive role by not giving a lone actor more 'sensation' and attention than needed;
- The importance of the education sector in teaching young people democratic values;
- Obstacles/needs identified for health care professionals and social workers include: more training in radicalisation and VE in general, fear of the word 'terrorism' and lack of understanding what their role could consist of, fear of being accused of discriminatory behaviour, information sharing and confidentiality issues, lack of resources, patients having to deal with the stigma and embarrassment of suffering from a mental health problem and thus avoiding help;
- Lack of evaluation of local practices and thus lack of lessons learned, i.e. it is difficult to establish 'what would have happened' in case no intervention was done;
- Again, the differences in regional and local contexts is very important, f.e. in post-war regions many people are in the possession of guns and at the same time potentially a high proportion of these people might suffer of PTSD;
- It is challenging to point out which actor should have the overall responsibility of the multi-agency approach.

Annexes

This report is based on the following presentations given during the working group meeting and are attached to this paper:

- Floor Kroft and Eliza Kritikos - presentation on 'The RAN CoE and RAN DNA' and on 'Comparative overview of H&SC sectors across the EU and current developments on preventing radicalisation
- Jeanine de Roy van Zuijdewijn - presentation on 'Are lone actor terrorists more prone to experience mental health issues than others'
- Vlado Azinovic - presentation on ' In the pursuit of an elusive profile: personality indicators and radicalisation into violent extremism in Bosnia and Herzegovina'
- Peter Walmsley and Hilary Garratt (in absence of Abu Ahmed) - presentation on 'Building capacity of the public Health and Social Care sector to prevent radicalisation
- Mark van Peufflik - presentation on 'Recognising early signs of radicalisation of lone actor terrorism in Health and Social Care'
- Bianca Voerman - presentation on 'Risk assessment and management; a multi-agency approach on dealing with violent extremist cases'
- Frank Farnham - presentation on 'UK response to lone actor with mental health issues: terrorism in the health service through Fixated Threat Assessment Centre (FTAC)
- Didier Rammers - presentation on 'Dutch response: Threat Management (TDM): a person centred approach – process, partnership, development
- Hannele Häkkinen - presentation on 'Local structures in Finland to prevent lone actors/violent extremism and the role of H7SC with school shootings