EX POST PAPER

Methods of evidence-based approaches: assessment and CVE/PVE

Introduction

Evaluation and planning are integral to any health and social care intervention. Historically, evaluation of such practices has been considered problematic for two reasons: the reliance on professional judgement rather than measurement **tools**, and the limited concern for **justifying** intervention in view of achieving an outcome. However, recently, for financial, governance, security and professional development reasons, evaluation of health and social care interventions has become the norm and is an expected element of intervention planning. It is increasingly recognised that practice evaluation can improve existing knowledge frameworks and result in increased effectiveness and greater accountability (Shaw & Lishman, 1999). The first part of this paper explores the literature on evaluating CVE/PVE intervention, and the second presents findings from the related RAN meeting held in Amsterdam.

This paper is written by **Orla Lynch for the** RAN Centre of Excellence. The views expressed in this paper are those of the authors and do not necessarily reflect the views of the RAN Centre of Excellence, the European Commission, any other institution, or participants of the RAN working groups.

Measuring CVE/PVE impact: **literature review**

Assessment

Although intervention by social care and health professionals for the purpose of countering violent extremism (CVE) and/or preventing violent extremism (PVE) is a relatively new category of intervention, it is no different to the other types of interventions used in existing social and health care practice and is subject to the existing issues in evaluation. Although the purpose, overall aim or intended outcome of interventions for individuals may vary, they share a common goal; there are universal qualities in human behaviour regardless of the consequences of such behaviour. It is important that health and social care workers take care to avoid any form of exceptionalism in the case of potential or actual extreme behaviour linked to terrorism.

This starting point for this discussion is that all human behaviour can be understood through reference to well-established explanatory frameworks from related academic disciplines as well as lessons learned from the implementation of these frameworks in practice. This is followed by recommendations on evaluating the role of health and social care workers and their interventions for the purpose of PVE/CVE.

CVE and PVE

While CVE and PVE, as initiatives in their own right, are in their infancy, it is important to note that the **measures** used for related interventions have been tried and tested by social and health care professionals. The difference in the case of CVE and PVE is the expected outcome of the interventions, and ultimately, the overall aim of the process. CVE and PVE initiatives began appearing in the early 2000s, but similar measures were already commonplace in conflict zones in the form of post-conflict initiatives — albeit under different names (e.g. disarmament, demobilization and reintegration (DDR)). Since 2013, the issue of foreign fighters of ISIS and related groups has become a global concern, and CVE and PVE initiatives have become more visible as key processes enacted both in statutory and non-statutory forums as counterterrorism measures. It was recognised that we 'we cannot arrest our way out of this problem [i.e. the foreign fighter phenomenon]' (p. 50) (Vidino, as cited in Mastroe, 2016) and so alternatives to the criminal justice model of counterterrorism became a valued element in the fight against extremism (Schmid, 2005). With the increasing prominence of CVE and PVE as a means of non-violent terrorism prevention, the terrorism studies literature has seen a persistent call for evaluation of these interventions at both government and community level and a thorough examination of their planning, enactment and outcomes.

Evaluating PVE and CVE

While the attempt to evaluate PVE and CVE using frameworks advocated by academics and practitioners concerned solely with counterterrorism initiatives is laudable (see the work of Horgan and Braddock, 2016), health and social care workers, particularly those in the statutory services, are bound by particular occupational and professional evaluation and reporting obligations. For example, a psychologist or

psychiatrist engaged in CVE or PVE work will resort to the use of well-established psychometric tools in their evaluation of patients. These professionals will most likely evaluate their clients' progress as a function of their well-being or functioning in the workplace/school rather than use a measure of their risk of engaging in violent extremism. Likewise, social workers and youth workers have existing measurement tools for use in evaluation of their work.

Examples of tools commonly used for working with vulnerable children include the Children's Social Vulnerability Questionnaire (Seward, Bayliss and Ohan, 2018), the Strengths and Difficulties Questionnaire (SDQ) and the Child Behavior Checklist (CBCL) (Goemans et al., 2018). In the light of such tools, what is the role, if any, of bespoke CVE/PVE evaluation measures for social care and health workers? The **short** answer is that CVE and PVE are multidisciplinary efforts involving clinicians, security service staff, social services staff, civil servants and often clerics — so evaluation cannot be a process that focuses on the outcome of one **element** of the intervention alone. Evaluation must be viewed as an ongoing, dynamic process that can capture the range of interventions offered and can be targeted to achieve the outcomes set out in the planning stages. Lastly, it needs to be flexible enough to respond to changes in the process. For health and social care workers, this may mean focusing, in an isolated manner, on their own element of the intervention and feeding up results to a higher-order evaluation that has oversight of the entirety of the CVE/PVE initiative.

Assessment difficulties

The greatest challenge in the **practice** of CVE and PVE is knowing what is effective. If the ultimate aim of CVE and PVE is considered to be the reduction or prevention of violence associated with terrorism, then the measurement should be relatively simple. The most basic of assessments would determine (using arresting/prosecution data) whether an individual engaged in violence following participation in a CVE/PVE programme: a zero-sum outcome would indicate, simply, that the individual either did or didn't engage in violence. Unfortunately, the outcome is rarely so clear-cut. Arrest and prosecution data are not always comprehensive or readily available, nor can they account for individuals travelling to other jurisdictions to engage in conflict, or capture **antecedent** behaviours related to involvement in violent extremism. Therefore, when assessing the effectiveness of a **preventive** programme, such data are not always useful — not only for the reasons mentioned above, but also because the metrics would only identify examples of the programme's failure and not of its success. In the case of CVE, a progressive reduction in the support for or use of violence, or a shift in the cognitions or basic mental patterns used to process information about terrorism are similarly not accounted for in any measure of arrest and/or prosecution. Such an approach is also problematic in terms of time frames. For example, determining the optimal period after participation in a preventive programme for assessing effectiveness is not straightforward: if the individual under consideration is not arrested within 5 years, would the intervention be considered a success — or should the period be longer than 10 years, for instance? It is clear that an alternative means of evaluating CVE and PVE initiatives is required.

As mentioned earlier, one approach is to select interventions haphazardly/arbitrarily and identify elements of the CVE strategy independent of the programme as a whole. For example, if in a particular municipality or jurisdiction, radicalisation is deemed to be largely related to problematic cognitions or patterns of thought about oneself and/or a particular ideology and/or peer relationships, then success in tackling this issue would

be measured using existing standardised psychometric measures of changes in cognitive flexibility, ideological rigidity and peer group functioning, as well as perhaps the development of critical thinking skills. However, when exploring how success in this measure relates to the success of a CVE/PVE initiative, difficulties arise, derived from the issue of defining radicalisation and precursors to radicalisation.

One of the major difficulties is the definition of the problem in the first place. This determines how radicalisation should be conceptualised, what radicalisation looks like on the ground, and whether there are identifiable features of radicalisation existing uniformly across individuals or whether each case is unique. Importantly, there must be a way to **know** that an event (i.e. radicalisation) did not happen (and that it would have happened without intervention).

Ultimately, these questions, along with questions of whether the path to extremism constitutes an individual, group or community issue (or all three), are tied intimately to the underlying assumptions about extremism, terrorism and radicalisation held by the funding/governing body. For this paper, concerned with the role of health and social care workers in PVE/CVE, the focus is on the experiences of practitioners in the development of evidence-based practice relevant to CVE/PVE and the implementation of this practice, rather than the theoretical underpinnings of terrorism research. The reality here is that, despite the complexity of academic discourse, for practitioners, the definition of what constitutes radicalisation and extremism is largely dependent on the established convention in a given local context.

The case of the United Kingdom

The United Kingdom's Strategy for Countering Terrorism (CONTEST) (Home Office, 2018), and in particular its Prevent programme has been in place in one form or another since 2006. Initially, evaluation of the success of this approach was carried out at community rather than individual level, and assessment of CVE/PVE initiatives was linked to:

- community engagement
- knowledge and understanding of violent extremism (by local councils)
- development of a Prevent action plan (by local councils)
- effective oversight, implementation and evaluation of the action plan (Mastroe, 2016).

Prevent's means of evaluation has changed over time, reflecting successive revisions and variations of the programme. In the most recent version (2015), there is statutory involvement of the Behavioural Insights Team, who conduct evaluations-based findings from the academic literature (Mastroe, 2016). This is an example of the increasingly centralised evaluation of CVE/PVE seen in the UK. However, significantly, the evaluation of CONTEST has not overcome the issues mentioned above: measuring success, identifying failure, or producing an acceptable definition of radicalisation based on peer-reviewed empirically verified data (see, for example, Ross, 2016).

At the other end of the evaluation spectrum in the UK are the tools used to assess **individual** risk. Risk assessment tools in the UK have two purposes:

1. to evaluate individuals who have been convicted and are in prison (Extremism Risk Guidance (ERG22+));
2. to assess individuals considered vulnerable to becoming radicalised at some future point (Vulnerability Assessment Framework (VAF) (Knudsen, 2018)).

It is vital to note that the evidence base underpinning these tools (rather than the tools themselves) is widely regarded as weak (Knudsen, 2018). See, for example, an open letter to a newspaper online regarding the lack of evidence for radicalisation assessment (Armstrong, 2016) as well as the work of Scarcella, Page and Furtado (2016). The notion of radicalisation as included in such tools (some tools use the notion of extremism rather than radicalisation) is ultimately based on the existence of a link between an individual holding radical ideas and this individual exhibiting radical behaviour (i.e. terrorism). The majority of terrorism studies scholars would reject this position outright and point to the need to differentiate between cognitive and behavioural radicalisation (Knudsen, 2018).

CVE/PVE and health, social and care workers

It is vital that social, health and care workers engaging with individuals considered to be at risk of or involved in radicalisation/extremism have clearly and unambiguously defined professional roles, responsibilities and positions on any ethical issues that might arise. Politically and ideologically motivated offenders are a unique group of individuals and are predominantly **not** suffering with clinical psychological disorders (Misiak, Samochowiec et al., 2018). Health, social and care workers are very likely to lack experience in this area in either assessment or treatment. However, existing expertise gained by working with other population groups can prove useful (e.g. cultural awareness training). It is also important to consider the ethical dilemmas faced by social/health/care workers expected to carry out risk assessment activities and interventions where the outcomes have implications for the client. Although professionals do provide feedback to police, security and probation services when appropriate, this must be made clear at the outset and it forms an important part of informed consent for the client.

Importantly, and according to Dernevik, Beck, Grann, Hogue and McGuire (2009), it is unsafe to presume that mental health professionals are able to assess the risk of terrorist violence recidivism. Given their experience with other populations, these professionals may be capable of carrying out assessments of narrowly defined populations (e.g. mental health patients), but in the case of radicalisation and extremism, other frameworks are essential in order to ensure understanding (e.g. the role of conflict, culture or religion).

Measuring CVE/PVE: recommendations for health and social care practitioners

Recommendations

In a meeting held by the Radicalisation Awareness Network Health and Social Care (RAN H&SC) work group, 25 practitioners and academics from 15 European countries met to discuss evidence-based approaches to the evaluation of CVE and PVE. Participants considered how practitioner issues intersect with academic proposals on the evaluation of and planning for CVE and PVE. Participants were surveyed on their views and experiences of CVE and PVE in their home countries and they attended workshops on key issues for practitioners in monitoring and evaluating individuals associated with radicalisation and extremism. Findings from both the survey and the workshops have informed the recommendations in this paper.

The aim of the meeting was to engage with practitioners on the issue of measurement and to examine how the evaluation of CVE and PVE in the academic literature corresponds to the needs and expectations of practitioners in the field.

While the meeting was focused on evidence-based approaches to the delivery and evaluation of CVE and PVE, it was stressed that certain significant issues needed to be dealt with in **preparation**, to ensure that evidence-based planning and evaluation could form an integral part of CVE and PVE initiatives. One issue is recognising the needs of practitioners engaged with individuals involved in radicalisation and/or extremism. It was widely felt that evaluation was secondary to appropriately preparing and training front-line staff. In addition, participants had difficulty situating their work within a radicalisation and extremism framework — some expressed the belief that this work is exceptional and should be treated as such, while others adopted a 'business as usual' approach, viewing the definitions of radicalisation and extremism as **almost** irrelevant to the intervention and aiming to focus on needs and resiliency, just as they would with any other client. In addition, there was concern about the client-therapist relationship, which is key to the success of any intervention — although this criterion might not be quantifiable in any usable way, there was a call for it be recognised nevertheless. This discussion was prefaced by reference to the **political context** that is inherently part of any intervention targeting radicalisation and extremism. There was also a call to acknowledge the impact on individuals of the stigma associated with terrorism and the impact that involvement of the security services may have on ethical practice and the day-to-day reality of health and social care service delivery.

The literature on the development and evaluation of CVE/PVE programmes refers to analytical challenges (linking cause and effect) as well as practical challenges (data collection issues). It also highlights the difficulty of measuring the impact of CVE/PVE, of knowing whether an intervention has had the desired effect. If, for instance, the measure of success is a reduction in terrorist events, the question remains of how this can be linked to the intervention itself. PVE/CVE interventions are more commonly evaluated through individual-level assessments of attitudes, behaviour **change** and social networks (Holmer, Bauman and Aryaeinejad, 2018). By examining changes over time in these criteria, it becomes evident how a given intervention may be influencing the individual in question. In order to evaluate this change, practitioners seek **tools** to assist them

in their assessment; both bespoke tools (e.g. ERG22+, Violent Extremism Risk Assessment (VERA) and VERA-2R (1)) and existing generic behavioural/attitudinal tools may be used.

This subject was disputed at the meeting, with two clear **camps** emerging around the key issue of tools. One group supported the use of existing psychological, psychiatric and social care tools in the assessment of CVE/PVE. The argument was that application of the radicalisation framework complicated health and social care intervention, because in essence intervention is based on certain needs (cognitive, spiritual, interpersonal, etc.) which are universal, not specific to individuals engaged in extremism. This group therefore advocated employing regular psychological processes to understand extremist behaviour. The opposing group was happy to use bespoke tools for radicalisation, despite inherent concerns over their validity.

The issue of tools is linked to the issue of training in the use of such tools, and this was a concern for many practitioners, given that they may have limited experience in dealing with extremism, but also may only encounter such cases very rarely. In addition, it was clear that from a policy perspective, there was significant interest in the development of tools taking into account regional diversity, and a number of tools developed particularly for specific countries were discussed.

The issue of tools and training in the use of tools was also linked with the issue of mental health and how this plays a role in evaluating individuals linked to extremism and radicalisation. It was recognised that the mental health evaluation of such individuals should not be based on '**a gut feeling**', nor simply left to the professional judgement of individual therapists and interventionists, but rather, should form part of the structure of bespoke radicalisation/extremism assessment tools. The literature on mental health and terrorism/radicalisation is highly contested. The most recent comprehensive study, published in 2018 in *European Psychiatry*, advocates exercising caution when including mental health criteria in the evaluation of radicalisation and extremism, because there is limited evidence of any relationship linking them, there are methodological problems with the existing evidence on the topic, and the validity of bespoke tests has not been established (Misiak, Samochowiec et al., 2018).

This study's findings notwithstanding, the issue of mental health and its relationship to radicalisation/extremism remains complex. While psychologists and psychiatrists may well be required to engage with these individuals around their needs (interpersonal, cognitive and emotive), they do not necessarily represent mental health concerns. For example, a young woman leaving home to travel to Syria to avoid a controlling family may need help from a therapist to deal with the family dynamics, or may need professional advice to manage family relationships in the aftermath of an arrest, but these are not mental health issues.

It is vital that the need for therapeutic intervention is not connected with mental illness, as this will only serve to misdirect efforts in the field and further confuse the relationship between extremism and mental health. There seemed to be agreement that interventions should be referred to as psychosocial or psycho-educational rather than mental health-related, and this should be stressed in any discussion on mental health

(1) More information on the the Violent Extremism Risk Assessment (version 2 revised) is available online (https://ec.europa.eu/home-affairs/node/11702_en).

and terrorism. Of course, this is not to say that mental health should not be a focus of CVE and PVE, but profiling and diagnoses and the related terms must be applied with diligence and consideration for conditions that do warrant a mental health label. In addition, professional standards for psychologists and psychiatrists to not permit diagnoses to made from a distance, and this should be upheld in the case of CVE and PVE.

The workshop discussion and the survey results brought to the fore a significant tension for practitioners dealing with radicalisation and extremism: this relates to therapists' obligations to their client in terms of confidentiality and reporting, as well as the ethical issues inherent in engaging in such work. One of the concerns for practitioners was when to **report** an individual under their care. They felt that they would be quicker to report a terrorism-related issue (than a domestic violence-related issue, for example) due to the perception that the consequences of **not reporting** could be severe. It was agreed that guidance on this issue would be keenly welcomed, and once again, a clear division in opinion was apparent. On the one hand, there was support for applying lessons learned in the past (from probation, prison and police) to terrorism, while on the other, it was felt that **new** guidelines and recommendations were needed to deal with terrorism-related issues.

Similarly, when the subject of a code of ethics was broached, the case of the American psychologists involved in the development of **enhanced interrogation** techniques for the US military was referenced, and it was highlighted that accountability and adherence to standards are essential for practitioners dealing with terrorism, radicalisation and extremism. It was, however, quite widely accepted that the ethical standards of each practitioner's professional body (association of psychologists/psychiatrists/social workers, etc.) should provide the main guiding practice principles.

Analysis of the workshop reports and survey results point to a number of key themes. The results are presented below under five thematic headings. The subsequent recommendations are likewise based on data from the workshops and the survey.

Recommendations for evidence-based approaches to implementation and evaluation of CVE and PVE

1. Clarify the expectations of health and social care workers

- Practitioners fear their professional integrity will be compromised due to the political nature of radicalisation and extremism, and this acts as a barrier for professionals engaging in such work. In order to overcome this concern, it is recommended that managers and leaders ensure in-house peer-to-peer supervision is set up and that individuals fully understand how their own professional code of ethics applies to the work with radicalisation and extremism.
- In addition, specialist professional bodies such as the British Psychological Society have developed ethical guidelines for applied psychological practice in the field of extremism, violent extremism and terrorism. These guidelines could inform in-house recommendations for professionals dealing with issues related to political violence.
- Professional boundaries must be well-defined (e.g. between therapists and security services or police).

2. *Reassure health and social care workers of their skills and competence to deal with cases of radicalisation and extremism*

- Individuals must be supported and reassured concerning the applicability of their skills and experience to cases of radicalisation and extremism.
- Human behavioural traits should be viewed as universal, and despite the extreme nature of the actions connected with radicalisation and extremism, health and social care workers are equipped to deal with a range of behaviours across all spectrums. It should be 'business as usual' for practitioners dealing with radicalisation and extremism.
- Practitioners must feel able to reclaim their practice and have confidence in the contribution they can make to this field.

3. *Meet the needs of practitioners carrying out interventions/evaluations of radicalisation and extremism*

- In order to ensure a professional CVE/PVE intervention/evaluation, the needs of practitioners must be considered and met prior to the commencement of any intervention/evaluation process.
- Lack of appropriate training is a key concern for practitioners.
- Lack of awareness of existing resources is another worrying issue. It is recommended that accessing the RAN collection on training (2) will serve as a starting point.
- Training must be current, up to date and ongoing.
- Training and planning should be conducted in a multidisciplinary/multiteam setting, so that both policymakers and practitioners understand and share expectations of what is achievable.
- Training must have a cultural awareness component.
- Training must be relevant across the ideological spectrum (e.g. covering jihadist/far-right extremist aspects).
- Supervision (similar to clinical supervision) is an unmet need for practitioners. This should be delivered in-house.
- Training needs to be tailored to each discipline (social work, psychology, psychiatry, etc.).
- Differentiate between the different levels of training needed for a range of roles (supervisory, coordinating, support, etc.).
- Trauma training should be a key component for interventionists/practitioners. This should involve a self-care component as well as awareness of trauma in clients (3).
- Practitioners need to be able to identify radicalisation/extremism signs and elements. For practitioners, knowing 'what radicalisation/extremism looks like' depends on the relevant professional role. The radicalisation framework **complicates** analysis and intervention, so instead, a

(2) See *Preventing Radicalisation to Terrorism and Violent Extremism: Training for first-line practitioners* from RAN's Collection of Approaches and Practices (https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/ran-best-practices/docs/training_for_first_line_practitioners_en.pdf).
(3) See the RAN H&SC ex post paper *PTSD, trauma, stress and the risk of (re)turning to violence* (https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/ran-papers/docs/ran_h-sc_ptsd_trauma_stress_risk_re-turning_violence_lisbon_10-11_04_2018_en.pdf).

needs-based developmental approach should be adopted, where practitioners initially seek to understand behaviours and attitudes irrespective of other explanatory frameworks.

- Practitioners seek training and information on the types of interventions that have proved successful in CVE and PVE but also in other domains. If this information could be used to form the basis for a framework for intervention, it would have significant value for practitioners. It is recommended that successful interventions with gangs and cults be consulted for relevance.
- Regional multidisciplinary teams should cooperate to produce a mutually acceptable terminology for operational purposes.

4. Evaluate the CVE and PVE intervention and process

- The goal of evaluation should be stated at the outset of any intervention.
- Use the SMART framework for all interventions (i.e. Specific, Measurable, Achievable, Realistic, Timely).
- The evaluation of training (as opposed to the evaluation of intervention) is a key element in the competence of staff to engage in radicalisation and extremism work. Training should meet the needs of staff, it should evolve over time, it should be based on case studies, it should draw on the experiences of other disciplines and it should be delivered in multiple modes.
- Evaluation is complicated by the differing standards for intervention. In many municipalities, there are different thresholds for intervention with individuals involved in (or suspected of) radicalisation and extremism: this means evaluation of success cannot be compared across cases. The starting point of an individual on their **journey** is relevant for the evaluation of change/success.
- The aim of evaluation of CVE/PVE interventions should be clear. The following issues should be addressed and resolved: who determines the aim of the evaluation, whether practitioners will have access to the results, whether the evaluation will be used to improve future interventions, and whether the data can be shared across teams.
- Actuarial risk assessment is not likely to capture the complexity of the process of intervention and the impact of the intervention on the individual and on the individual's close circle. Evaluation should capture the lived experience of the individual and should consider how change is viewed and experienced by those within the family system.
- Evaluation of evidence of success versus evaluation of signs of change are often unrelated processes. Success should be defined locally.
- Evaluation should incorporate multiple sources of information including case audits, appreciative enquiry, practitioner feedback, serious case review, self-evaluation, practice groups and peer review.
- Evaluation in the case of CVE and PVE should consider staff performance, allow for a complaints process against staff, and address the issue of **forced engagement** in intervention (e.g. court-mandated mentoring).
- While remaining focused on the individual, evaluation should also recognise the individual's role in a family and/or community, and account for these systems in any measure of change.
- The evaluation and implementation of CVE/PVE interventions is complicated by the perception of risk, particularly the concern that failure of an intervention may lead to a catastrophic terrorist attack. Actuarial risk must be distinguished from the fear of risk by practitioners delivering interventions.
- Evaluation should involve pre- and post-measures to account for changes occurring during the intervention. Multiple tools can be used for this purpose (psychometric tests, interviewing, etc.). In this way, evaluation can serve a number of purposes.

- Evaluation is complicated by the hierarchical nature of many health and social care agencies, and concerns regarding negative feedback must be overcome.
- Honesty in evaluation can be encouraged by retaining anonymity in reporting.
- A clear and concise complaints process for clients involved in CVE/PVE initiatives should be in place.

5. Address ethical issues in the intervention and evaluation of PVE and CVE

- A significant concern for practitioners is the coercive nature of some of the interventions carried out in the CVE/PVE space. In many cases, individuals are mandated to attend therapy, mentoring, etc. and this has serious implications for the ethical practice of practitioners as well as the likely **success** of any intervention. This issue can be addressed by ensuring openness and honest communication with all clients, managing the expectations of clients, adhering to professional ethics and standards, and negotiating a working relationship built on interpersonal trust between clients and practitioners.
- The tension resulting from working for the security services (e.g. psychologists working for the government) while fulfilling their obligation to clients is an ongoing concern for practitioners. This can be relieved by ensuring adherence to a code of ethics and providing appropriate in-house professional supervision to support staff.
- The ethical issues arising for individuals working with CVE and PVE clients are common in certain other professions too (e.g. those in prison, probation and legal capacities) albeit on unrelated topics. However, lessons from these fields should inform the practice of interventionists in the CVE/PVE space.
- Minority groups should not be the sole focus of interventions, and cultural sensitivity should be a central tenet of any engagement with the public.
- Practitioners must balance existing obligations (e.g. child protection, human rights and other safeguarding requirements) with any reporting requirements relating to CVE and PVE. This should be managed via peer review and in-house peer support structures.

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