EX POST PAPER

Multi-problem target group: the influence of mental health disorders and substance abuse on Exit work

Summary

When confronted with persons at risk or vulnerable to radicalisation or who have already been radicalised, practitioners are faced with serious challenges. Disengagement work is complex as it involves numerous spheres of personal life and requires the cooperation and coordination of practitioners from different areas. However, when alcohol, drug or medicine abuse are also at play, a person suffers from serious mental health issues or both issues are present, the work gets even more complicated. What can practitioners do?

This paper discusses approaches to deal with so-called multi-problem target groups. Where to start with and how to develop the work in these cases?

The role of mental health disorders and substance abuse during the radicalisation process

Mental health disorders and substance abuse are closely interlinked, as comorbidity of these phenomenon (i.e. the co-occurrence of both conditions) is highly prevalent.[1] The relationship between these conditions is very complex as it differs depending on the specific mental disorder, on one side, and on the substance and the way it is (ab)used, on the other side. Obviously, there is no one clear pathway applicable to all cases. Various hypotheses could explain the common comorbidity, namely:

- The existence of **common risk factors** that lead to the development of both disorders: risk factors can be genetic, environmental, or both. For instance, trauma can be passed down through generations and may contribute to the development of mental illness and substance abuse (transgenerational trauma);
- **Psychiatric disorders** are a risk factor for drug use and substance use disorders;
- **Substance abuse** could trigger the development of mental illness, either temporarily (e.g. intoxication or withdrawal) or permanently (e.g. it can change the way the teenage brain develops).

Given the high prevalence of comorbidity of substance abuse and mental health disorders, the link between them should be considered. A distinction needs to be drawn between substance use, abuse and addiction.

Substance use implies deliberate and controlled use, but when this use leads to immediate problems it is considered **abuse**. **Substance addiction** implies that the individual has built tolerance to the substance. In these cases, the use of the substance leads to specific problems, such as brain alterations, withdrawal symptoms and relapse.

Several studies assessed the **comorbidity of smoking, alcohol and drug use and psychotic illness** in the general population[2]. A study by Conway et al (2016)[3] found an association between prior lifetime mental disorders with substance abuse in adolescents. In particular, adolescents with mental disorders had high rates of alcohol (10.3%) and illicit drug abuse (14.9%). The study concluded that prior disorders increased the possibility of jumping to 'the next level' in substance use, i.e. from no-use to use or from use to problematic use. In general, alcohol and drug dependence in adults has double chances to develop in individuals with anxiety, affective disorders

[1] EMCDDA, Perspectives on drugs, Comorbidity of substance abuse and mental health disorders in Europe (2016)

[2] See
Kessler RC, Birnbaum H, Demler O, et al. The prevalence and correlates of nonaffective psychosis in the National Comorbidity Survey Replication (NCS-R).Biol Psychiatry. 2005;58(8):668-676; Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication [published correction appears in Arch Gen Psychiatry. 2005;62(7):709]. Arch Gen Psychiatry. 2005;62(6):617-627; Lasser K, Boyd JW, Woolhandler S, Himmelstein DU, McCormick D, Bor DH. Smoking and mental illness: a population-based prevalence study. JAMA. 2000;284(20):2606-2610; Regier DA, Farmer ME, Rae DS, et al. Comorbidity of mental disorders with alcohol and other drug abuse: results from the Epidemiologic Catchment Area (ECA) Study. JAMA. 1990;264(19):2511-2518.

[3] Conway, K. P., et al. (2016) Association of Lifetime Mental Disorders and Subsequent Alchol and Illicit Drug Use: Results from the National Comorbidity Survey-Adolescent Supplement, Journal of the American Academy of Child & Adolescent Psychiatry, Vol. 55, Issue 4, pg. 280-288.

and psychotic disorders[4]. Another study by Hartz et al (2014)[5] compared substance use in individuals with severe psychotic illness with substance use in the general population. It found that in individuals with severe psychotic illness, the rates of substance abuse were significantly higher than substance use in individuals with mild mental illness. Substances at stake included tobacco, alcohol, marijuana and recreational drugs.

The following sections discuss whether and how each of these disorders play a role during the radicalisation process.

Mental health disorders

The issue of identifying and addressing mental health problems has been previously discussed in the context of the Radicalisation Awareness Network (RAN). The **concept of mental disorders** is very broad, as it comprises a broad range of problems that cause mild to severe disturbances in the mood, thinking and behaviour of an individual: for the purposes of this paper, we consider mental disorders as including psychiatric, behavioural and cognitive conditions. Examples of these are depression, bipolar disorder, schizophrenia post-traumatic stress disorder (PTSD) and autism spectrum disorders (ASD). It should be noted, however, that ASD is considered a neurological development disorder as its symptoms generally appear at a very early age.

In the last years, counter-radicalisation practitioners have pointed to a potential link between mental illness on one side, and radicalisation on the other side. However, academic research on the prevalence of mental illness among terrorists have failed to produce clear evidence supporting this hypothesis. In fact, studies conducted since 2012 seem to repeatedly reach the conclusion that there is no clear connection between mental illness and terrorism.[6] Similarly, although Gill et al (2012) suggested that it is possible to identify "distinguishable differences between subgroups"[7] such as the increased likelihood among single-issue offenders of having a history of mental illness, studies have failed to identify a causal link to particular pathologies. More recently, Corner et al (2016) have also referred to recent findings on the high prevalence of mental health disorders among lone-actor terrorists, arguing that "mental disorder as a variable for explaining terrorist behaviour remains dichotomous" in terrorism research.[8]

Trauma

Among the wide array of mental health disorders, **trauma deserves special attention in the area of criminal research**. A correlation between PTSD and delinquency and re-offending rates has been found, although this does not necessarily mean causality[9]. Similarly, trauma – including trauma passed down through generations – and other

[4] Merikangas KR, Akiskal HS, Angst J, et al. Lifetime and 12-month prevalence of bipolar spectrum disorder in the National Comorbidity Survey replication. Arch Gen Psychiatry. 2007;64(5):543-552.
[5] Hartz SM, Pato CN, Medeiros H, et al. Comorbidity of Severe Psychotic Disorders With Measures of Substance Use. JAMA Psychiatry. 2014;71(3):248–254. doi:10.1001/jamapsychiatry.2013.3726
[6] Heath-Kelly, C, Terrorism, Autism and Mental Illness in the UK Prevent Strategy (2018). Available at: https://discoversociety.org/2018/06/05/terrorism-autism-and-mental-illness-in-the-uk-prevent-strategy/
[7] Gill P, Horgan J., Deckert P., 2013, Bombing Alone:Tracing the Motivations and Antecedent Behaviors of Lone-Actor Terrorists, Journal of Forensic Sciences, Volume 59, Issue 2.
[8] Corner, E., Gill, P., Mason, O., 2016, Mental Health Disorders and the Terrorist: A Research Note Probing Selection Effects and Disorder Prevalence, Studies in Conflict & Terrorism, Taylor & Francis Group.
[9] RAN HSC, 2018, PTSD, trauma, stress and the risk of (re)turning to violence, Ex-post paper available at 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

complex psychological problems constitute one of many factors that, combined, can lead to violent extremism.[10]

To understand the role that trauma can play in the radicalisation process, it is important to note that trauma is not a static phenomenon. Traumas should not be understood as a happening from the past but rather as a **dynamic process whereby the response to the traumatic event is delayed or sustained in time**.[11] In fact, an individual suffering from PTSD may "re-live" and react to the traumatic experience as though it were happening repeatedly, often leading to chronic fear and helplessness.

Another aspect to consider regarding trauma is **the window of tolerance**. The exposure to trauma for long periods of time may reduce the window of tolerance, which may result in the person suffering from PTSD to adopt a risky behaviour to activate emotional triggers. This so-called "appetite aggression" is often seen in former combatants who become used to violence to a point that they start to enjoy it. Examples of this can be found in cases of foreign fighters returning from war as they are more likely than the average person to suffer from mental health problems. Similarly, evidence shows that in Northern Ireland, 14% of the adult population suffers from mental health problems as a result of the Troubles[12] and that in Croatia, the war in former Yugoslavia has led to half a million veterans (11% of the population) to suffer from PTSD. This is also reflected in the number of suicides among former combatants, as in both countries suicide rates are so high that they have surpassed the number of deaths during the conflicts.

As mentioned above, the effects of trauma are not circumscribed to the individual who directly experienced the traumatic event, as it can be transferred from parents to children (i.e. transgenerational trauma). This phenomenon has been widely researched since it was first noticed in grandchildren of Holocaust survivors. In Europe, research on children of Croatian veterans who fought in the Yugoslav wars reveals that 30% of the children of veterans with PTSD suffer from secondary trauma, 10% of those who survive a traumatic event will later develop symptoms of PTSD, and 10% develop behavioural disorders or psychological conditions that disturb their normal functioning.[13]

While a causal link between trauma and radicalisation cannot be established, anecdotal evidence from radicalised individuals suggests that **extremist groups (both religious and non-religious) tend to exploit the mental issues arising from trauma**. For instance, some cases of radicalised individuals in Bosnia point to a few common characteristics, such as broken dysfunctional families, abusive parents, traumatised individuals, frequent instances of transfer of trauma, mental health issues, etc. These issues were not adequately addressed by professionals in a timely fashion, which allowed for extremist groups to feed on the insecurities of the individuals, offering them comfort and a safe haven.

Against this background, it could be tempting to assume that the traumas experienced by migrants and refugees during a difficult journey towards Europe could become potential grievances that

[10] Ranstorp, M., 2016, The Root Causes of Violent Extremism, RAN Issue Paper.
[11] Ghaffarzadegan, N., Ebrahimvandi, A., Jalali, M. S., 2016, A Dynamic Model of Post-Traumatic Stress Disorder for Military Personnel and Veterans, PLOS ONE (Open Access journal).
[12] See: https://www.cvsni.org/media/1171/towards-a-better-future-march-2015.pdf
[13] Boričević-Maršanić at al.(2014). Sekundarna traumatizacija djece veterana oboljelih od posttraumatskog stresnog poremećaja, available at https://hrcak.srce.hr/file/198789

terrorist recruiters could exploit[14]. It is indeed vital to adequately address the consequences of the distress these experiences may trigger; on the other side, it is dangerous to automatically accept such an assumption as it could lead to the stigmatisation these groups.

Autism Spectrum Disorder (ASD)

The role of ASD (i.e. autism) as a risk factor leading to radicalisation has not been as extensively explored as other mental health disorders, and ideas about its role remain inconsistent. While recent research suggests that individuals with traits of ASD could be more at risk of being radicalised, it fails to establish a substantial link between ASD and terrorism.[15] Indeed, despite the concerns raised by authorities, **the incidence among radicalised individuals remains very low**, at approximately 1% in the UK, a figure that corresponds to that among the general population.

Autism may however act as a context for radicalisation. Where a radicalised individual has a diagnosis of autism, it is necessary to assess the extent to which the different aspects of autistic functioning determine his or her offence trajectory and modus operandi. In this context, seven facets of autism are particularly relevant:

- **Circumscribed interests**: persons with autism generally develop a high interest in specific topics (e.g. history, politics, technical interests), which they pursue tirelessly. When doing so, they may stumble upon extremist propaganda. Furthermore, a circumscribed interest in, for instance, explosives or terrorist organisations, may shape their pathway toward radicalisation.
- **Rich/vivid fantasy** in conjunction with limited social imagination: this can lead to acting out an image or a story that they have seen in a book or the internet without awareness of its consequences. Limited social imagination and awareness of consequences facilitates the process of dehumanisation of the enemy, typically used by terrorists to legitimise the use of violence against the enemy;
- Need for **order, rules, routine** and predictability: extremist explanations may provide the orderly solution to the chaos of the world as they promise absolutist solutions;
- Tendency toward **obsessional behaviour and repetition**: once the individual with autism has accepted an extremist theory of the world it can become an obsession;
- **Social and communication difficulties**: internet can act as a safe haven for autistic people for whom social interaction is difficult. In addition, they may fail to discern between extremist propaganda and facts, rendering them a good target for exploitation by radical groups;
- **Cognitive styles**: given their so-called cognitive "myopia" (i.e. they tend to focus on something and ignore the rest), extremist views may make sense to them because they provide clear and dual explanation of the world. On the other hand, the importance of visual processing may push them to write, draw or keep images relating to a group or ideology; and
- **Sensory processing**: they may seek vivid extremist images and may find weapons

[14] See Ranstorp, M., 2016, RAN Issue Paper The Root Causes of Violent Extremism, available at https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/ran-papers/docs/issue_paper_root-causes_jan2016_en.pdf

[15] Faccini L., Allely, C.S., 2017, Rare instances of individuals with autism supporting or engaging in terrorism, Journal of Intellectual Disabilities and Offending Behaviour, Vol. 8 Issue: 2, pp.70-82

to be aesthetically appealing (i.e. they produce bright lights and loud noises). Alternatively, sensory avoidance may lead to house-bound, meaning that the only means to socialise is through the virtual world, where they can stumble upon radical ideas easily.

Moreover, radical groups may leverage the confusion that people with autism usually feel and exploit it by offering an alternative to the difficulties they experience.

Substance abuse

The link between substance abuse and radicalisation has been investigated to a limited extent compared to mental health disorders. Firstly, a correlation came to light when it emerged that more and more radicalised individuals apprehended by the police were known to them as they had previously been involved in petty crime, often related to drugs. The narrative perpetrated by terrorist recruiters refers to these addictions by promising them forgiveness for their sins, including the use of drugs and alcohol. In particular, De Poot and Sonnenschein et al (2011)[16] found that within the Dutch Jihadist networks many individuals subject to criminal investigation had been substance abusers.

While there is no established relation between the use of drugs and radicalisation, **the role of drugs and other addictive substances (e.g. alcohol) in the radicalisation process must be considered due to their link to violence**, which is multi-layered. Violence is one of the side-effects of drugs and alcohol. For instance, psychoactive substances are well known for triggering violent behaviour. For this reason, some substances are deliberately used by extremist groups during the brain-washing process or to incite violence in their members. For example, fenethylline – a cognitive enhancer that triggers violence – has been reportedly used by ISIS to scale up aggressions.

The extent to which substance use and abuse prevails among radicalised individuals go beyond their capacity to trigger violent behaviour. It has been observed that drug use (mostly cannabis) is highly prevalent among radicalised subjects, and that heavy drinking is associated with right-wing extremists. There is also **clear evidence that FTFs are also using other drugs**, such as Tramadol (a legal opioid painkiller)[17] and Captagon (the so-called "Jihadi Pill", a substance similar to amphetamine with milder effects). Anecdotal evidence from radicalised individuals in Bosnia also show that in former Yugoslavia, **substance abuse converges with trauma in some cases**. The use that radical groups make of the internet is important as they use thematic pages to incite the use of some substances, a practice that can be very effective due to the significant role of peer pressure within these groups.

Substance abuse disorder is considered a mental illness and it is also associated with other mental health issues, like lower-self-sufficiency. It also changes the way in which the brain works, especially when used during the teenage years (i.e. when the brain is still developing). It should be noted that only substances that act as uppers (e.g. amphetamines, cocaine, ecstasy, caffeine) and downers (e.g. opioids, cannabis, alcohol) may lead to addictions. Psychedelic substances (e.g. LSD, ketamine, peyote) are not addictive, although they may trigger violent behaviour.

[16] C.J. De Poot, & A. Sonnenschein et.al. (2011) Jihadi terrorism in the Netherlands. A description based on closed criminal investigations. The Hague: WODC & Meppel: Boom Juridische Uitgevers; www.wodc.nl

[17] In November 2017, Italian authorities intercepted 24 million pills of Tramadol allegedly meant to reach ISIS fighters in Syria.

Implications of mental health disorders and substance abuse on the Exit work

In most countries, substance abuse disorder is traditionally treated by mental health practitioners as it is considered a mental illness. Radicalisation, on the other hand, is usually dealt with by social workers, although in some countries (e.g. UK) mental health professionals have a duty to identify signs of radicalisation and report these cases as part of the prevention efforts.[18]

Challenges

When dealing with multi-problem individuals, **exit workers face many challenges**. From a mental health perspective, they usually lack adequate **psychiatric care** as waiting lists in some countries are long or the specialised care is very expensive and the level of cooperation between professionals and specialists is rather limited or non-existing. They may also lack training and specialist knowledge on how to address these cases. In some cases, they may not be aware of existing tools at local levels to ensure a structured approach.

Along with this, the **co-existence of substance abuse or mental health issues** may slow down or even hinder the de-radicalisation process. Experience from adjacent fields, such as cults, shows that some radical groups tend to reject traditional medication on the basis of non-scientific theories and ideas. This adds a layer of complexity to the challenge of working on exit strategies with a radicalised person that at the same time is in need of medication. Moreover, when confronted with the need to decide on what to do next, practitioners usually need to make judgement calls based on very limited information.

Finally, a challenge come also from the **specific context**: some exit workers work in prison or probation settings, or at some point along the path of the judicial process. This might influence the way clients behave, in a negative way. For example, they might be less honest or withhold information.

Approach to multi-problem radicalised subjects

Any approach to working with multi-problem radicalised individuals should be **comprehensive**. Some practitioners believe that exit work needs to cover all relevant domains (e.g. medical, social, legal, etc.) in parallel to be successful. Addressing only one issue may prove counterproductive as these issues may reinforce each other. For instance, when a person attempts to exit a radicalised environment they may experiment fear and hopelessness and this may push them to use drugs. Therefore, when dealing with multi-problem individuals, it is not sufficient to know how to address one problem or disorder. However, practitioners disagree on this point: some prefer to address one issue at time, while not loosing sight on the 'non-priority' issues.

A comprehensive approach requires **a multi-agency approach** and regular communication between the different professionals involved. Having a clear definition of the roles and of the communication channels help overcome a number of obstacles. An issue experienced by all practitioners in prevention of radicalisation is the sharing of data and information about clients with other practitioners with whom they work in a multi-agency approach. Similar issues need to be clarified at the start of working relationship

[18] To this end, the UK Government has developed guidelines to help them comply with this obligation. See: https://www.england.nhs.uk/wp-content/uploads/2017/11/prevent-mental-health-guidance.pdf

between practitioners to avoid future misunderstandings.

From an exit point of view, **regular communication** between practitioners would allow both social workers and mental health professionals also to acquire a broader vision and be able to identify the root causes of the problem(s). The inability to identify the root causes has traditionally hampered the efforts of social workers to achieve positive results with people who have experienced trauma as they fail to see the broader picture and tend to focus on the bad behaviour.

This should go hand in hand with **awareness raising and training** among all actors involved in the process, including mental health professionals, social workers, law enforcement and even the environment. For instance, there is a need for trauma-informed care policy. Therefore, trauma awareness should be a key skill imparted to all individuals working with returnee children, but also for those dealing with refugees, veterans, FTFs, etc.

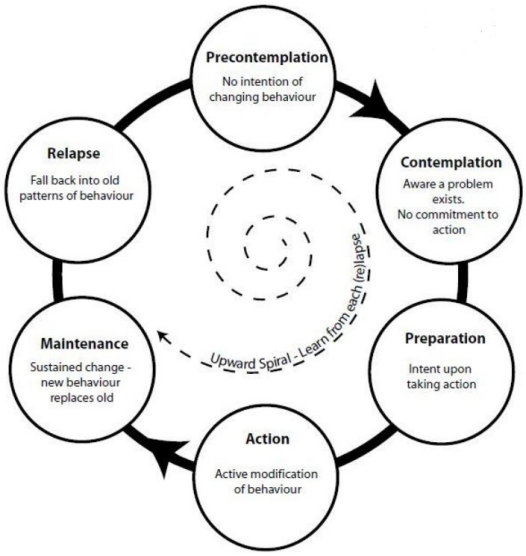
The specific treatment to follow will depend on the specific circumstances of each case and must thus be assessed on a case-by-case basis. For example, although the appropriateness of Cognitive Behaviour Therapy (CBT) to counter radicalisation has been contested by some,[19] it has been found to be effective for both children and their families in overcoming trauma-related difficulties.[20] In the field of addictions, different treatment options can be used to ensure the best possible treatment adapted to the specific circumstances (i.e. setting, psychiatric or somatic condition, type of addiction, motivation or lack thereof, and other problems that the patient may be facing). Adopting some of the elements present in addiction therapy have proved useful in the prevention of radicalisation and exit work, such as:

- **Motivational interviewing**: a key cornerstone of addiction treatments, this technique focuses on establishing a relationship of trust with the patient and activating his/her capability to change. Motivational interviewing requires empathic attitude, open-ended questioning, reflective listening, acceptance of ambivalence, change talk and guiding the patient to find solutions, which facilitates ownership of the treatment (See Figure 1)
- **Community reinforcement approach** (CRA), which has been found to be effective in the treatment of alcoholism and other addictions. This approach requires the involvement of the patient's environment, such as family. The involvement of families and social environment of the patient is a method used in exit work in a number of cases, indeed – not only in relation to substance abuse and addiction.

[19] Weilnböck, H., 2016, Confronting the counter-narrative ideology. Embedded face-to-face prevention – and youth (media) work.

[20] Steel, M., Malchiodi, C.A., 2010, Trauma Informed Practice with Children and Adolescence, Routledge, New York.

Figure 1: The Stages of Change model adapted to motivational interviewing



Source: Elaborated by Jellinek Amsterdam from Prochaska and Di Clemente (2002)

The question of what needs to be addressed first must be assessed on a **case-by-case basis**. For example, it has been observed that FTFs coming back to Europe may feel ashamed of having used amphetamines or other recreational drugs. In these cases – where their brains may be disrupted after having abused of drugs – it may be preferable to have a psychiatrist analyse the risk of psychosis and then address any other issues. The prioritisation of needs is however contested by some practitioners who consider that trying to identify the most urgent issue may be counterproductive and that they should all be addressed in parallel.

Source case study: shared by a participant to the meeting.

Case study: a multi- problem patient

Based on experience of practitioners from both exit and health care sectors, an example of multi- problem patient is given by the anonymised case below.

A 25-year old young man is about to be diagnosed with schizophrenia, when the father mentions to the psychiatrist his concerns about his son being vulnerable to extreme Islamic environments. The 25-year-old indeed shows some signs that could potentially make him vulnerable to radicalisation: while converting to Islam, he cut ties with his previous friends and stopped all the leisure activities he used to do. He also dropped school.

The approach adopted with this client takes stock of both motivational interviewing techniques and CRA (see above). Firstly, the psychiatric who diagnosed him schizophrenia contacted the local municipality due to the concerns expressed by the father. The local municipality assigns to the 25-year-old man a mentor, as well as counselling sessions with a psychologist with knowledge of schizophrenia.

The role of the mentor is to help the client to organise his daily life around a job and other purposeful activities. In addition, the mentor is also helping the client to discuss concerns, difficulties and beliefs, including religious one, he might want to discuss.

Mentors in a similar situation face a number of challenges. The mentor will have to decide how to approach the client, in view of his mental illness diagnosis, and create rapport, on one side, and how to prepare in view of the impact of the challenges of the situation on the work, on the other side. In addition, the mentor needs to identify who and what can support his/her work with the client, as a similar task can be psychologically burdensome for practitioners. Challenges include: the limited information available on the client and his past; the impact that schizophrenia might have on the building of a trust-based relationship; dealing with privacy vis-a-vis the client; the impact that the diagnosis, as well as medication, have on the client and the relationship with his mentor; the work with the family, given that there were in the past some tensions between the father and the son.

Finally, exit work with subjects in the autistic spectrum imposes an additional challenge, as the seven facets referred to above have implications for the approach to follow:

- Circumscribed interest: practitioners need to manage these interests and must allow the individual to think or talk about them while helping him or her distinguish between the safe and unsafe variants. They may also be used as incentives and rewards.
- Rich and vivid fantasy together with limited social imagination: the internal world can be a coping mechanism and thus, it should be used as aid by, for instance, using books and fantasy in rehabilitation.
- Need for order, rules, routine and predictability: practitioners should incorporate this in their treatment (i.e. predictable schedules, explanation of rules, etc.).
- Tendency toward obsessive behaviour and repetition: healthy obsessions should be allowed while fixations should be managed by finding healthy outlets or develop strategies to prevent harm.
- Social and communication difficulties: practitioners must raise awareness of other people and find opportunities to develop social links within the individual's comfort zone.
- Cognitive styles: interventions need to be adapted to the cognitive difficulties and strengths to help the subject acquire a broader vision.
- Sensory processing: use sensory rewards to develop new interests. Moreover, if extremist images have sensory value it is important to assess whether there is a safe way to enjoy them. If this is not possible, one must look for equally rewarding replacements.

Conclusions

Comorbidity of substance abuse and mental illness is a challenge for health practitioners and national health systems. Specialised expertise is required to deal with both issues and these rarely can be found in one single practitioner. To support patients with mental illness and substance addictions procedures and processes for effective cooperation among relevant professionals is required.

This is further complicated when the patient is also **radicalised and is on a disengagement programme**, as well. Exit work requires multi-agency cooperation between several practitioners by its nature. When substance abuse and mental illness, especially if severe psychotic disorders, are present, multi-agency work must be highly functional to be successful. One of the main challenges experienced by exit practitioners is the difficulty to find specialised care for their patients that can proceed in parallel with the exit work. On the other side, proceeding with exit work without a specialised care in parallel, can be useless, if not counter-productive. However, at the same time, the patient cannot be left to fend on its own and bereft of appropriate care. Exit practitioners therefore find themselves in this difficult situation of trying to do their best and beyond, covering areas for which they not necessarily have been trained.

While practitioners do not seem to agree on how similar situations can be addressed, there generally is agreement that irrespective of the specific treatment provided for each individual, **all patients (mentally ill, addictive to substances and/or radicalised) require patience and a humanistic approach**.