Radicalisation Awareness Network
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CONCLUSION PAPER
RAN event – Ethics for mental health professionals working in P/CVE
16-17 June 2020
Digital meeting

Ethics for Mental Health Professionals Working in P/CVE

Summary

On 16 and 17 June, mental health professionals working in preventing and countering violent extremism (P/CVE) discussed the ethical challenges they are confronted with in their daily practice. They are worried about their inability to genuinely assure patients of confidentiality, their complicity in the perpetuation of stigma, and conflicts between their core ethos and their public safety duties. Each EU Member State has its specific legal and cultural contexts that shape these ethical considerations. As a result, there are many conceptual definitions of radicalisation and mental health. Practitioners from the mental health profession demonstrated through different case studies how ethical dilemmas are best dealt with.

This conclusion paper is a result of this meeting and shares practical insights on:

- conceptual issues and agreements in the field of P/CVE and mental health,
- legislation and ethics,
- key lessons and tips for first-line practitioners for ethical decision-making.

Product of the Radicalisation Awareness Network
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Introduction & Context

Mental health practitioners working in P/CVE operate in different contexts and situations. For example, when treating patients who are convicted, charged or held under suspicion of committing terrorist offences, mental health workers focus on treating mental illnesses as they would for any patient. In another setting, mental health workers are asked to assess an individual to determine their risk of engaging in terrorist acts in the future, or to treat a patient with the aim of addressing psychological characteristics associated with terrorism. Mental health workers can face this situation both when there is a doctor–patient relationship and when there is not (i.e. when a psychiatrist acts as an expert witness and provides a court report). In all circumstances, there are multiple ethical considerations. By discussing several cases presented by practitioners, the meeting participants looked for tangible ways to work on such dilemmas while staying within ethical guidelines.

- To what degree do we need a common understanding of the concept of P/CVE in mental health (e.g. how should we define (security) risk?), and in what way can we best deal with common misunderstandings concerning concepts and definitions?

- How are national and supranational legal frameworks affecting ethical considerations (in, for example, risk assessment, public prosecution cases, confidentiality) for mental health practitioners?

- What ethical guidelines should mental health practitioners follow?

The aim of this paper is to provide mental health workers with ethical guidelines for those working with people susceptible to violent extremism, convicted of violent extremism or under accusation of planning terrorist acts. The outcomes of the RAN Mental Health meeting are described in this concise overview with concrete tips and will also feed into the RAN ethical guidelines paper due to be published in 2020.

This paper consists of three sections: 1) an introduction to ethical concerns and the debate on radicalisation and mental illness and its practical implications; 2) the key outcomes of this meeting, outlining conceptual definitions in P/CVE, legislative national frameworks and ethical principles for mental health professionals; and 3) practical tips on how to work ethically and key recommendations.

Early ethical concerns: Lessons from the United Kingdom

Ethical concerns regarding P/CVE and involving mental health practitioners were addressed early in the United Kingdom (UK). Some of the early ethical dilemmas concerned the question as to whether or not we are criminalising (extreme) belief. However, most would agree that it is not the ideology in itself but the use of violence based on that belief that is being criminalised. For mental health professionals, this brought about a complex challenge. Their ethos dictates a focus on the safeguarding of vulnerable individuals and their rehabilitation. This raised the question as to whether or not they can — as mental health professionals — ethically intervene before a crime is committed. Would this result in individuals being arrested or charged for being engaged in ideology, rather than taking part in an act of violence? And what if individuals are referred because of concerns that they may be showing signs of becoming engaged? In the UK, it was decided that prevention work should be seen as a safeguarding issue. Any pre-crime intervention should be benign, discrete, protective and voluntary, increase well-being and not be coercive. However, in an evaluation done by Dr Charlotte Heath-Kelly and Dr Erzsébet Strausz, they state that: "The positioning of the Prevent Duty as a safeguarding measure is ambiguous. Safeguarding professionals alerted us that they are operating in a 'grey area' with Prevent, and that significant differences exist between Prevent Duty safeguarding and normal safeguarding" ([1]).

([1]) Learn more here: Heath-Kelly, C., & Strausz, E. (n.d.). *Counter-terrorism in the NHS – Evaluating Prevent Duty safeguarding in the NHS*.
https://warwick.ac.uk/fac/soc/pais/research/researchcentres/irs/counterterrorisminthenhs/project_report_60pp.pdf

The debate on radicalisation and mental illness

There is still much debate on the role of mental health professionals in P/CVE. Much of this relates to whether or not mental ill-health could make people more vulnerable to radicalisation. Due to the lack of evidence, the line between mental illness and radicalisation is becoming increasingly blurred, with a risk of inappropriately stigmatising the mentally ill. Increasingly, however, practitioners are witnessing issues relating to mental health and violent extremism ([2]). This was also mentioned in the latest Europol report ([3]). Whenever a practitioner encounters a patient with extremist thoughts in his or her daily practice, it was advised by experienced practitioners to take as a starting point that extremist ideology is not the driver but justifies it. The drivers are personal and varied, and mental disorders can create a vulnerability, as can certain personality features and criminality, in the presence of grievance and in the absence of protective factors. The mental health professionals' job is identifying a mental health issue and advising where and how this is functionally related to radicalisation.

Possible personal drivers

- **Grievance and a desire for revenge**
- **Thwarted ambitions**
- **Cultural dissonance**
- **Relationship, family breakdown**
- **Need to find your place, seeking identity, seeking significance, attraction to authoritarian ideology**
- **Sensation seeking**
- **Desire to prove oneself, "walk the talk", be a hero**

Ethical dilemmas in practice

Particular ethical challenges arise from the need for mental health professionals to protect the interest of their patients versus the need for security services and/or governmental institutions to estimate a potential security risk that patients might pose to the greater public. Due to the differences in ethos (belief in change vs belief in justice), authorities and mental health professionals experience tension, in particular on matters like confidentiality which concerns the therapeutic relationship and the duty/need to disclose information relating to public safety and punishment of those suspected in the involvement of terrorism. Professionals have indicated that they feel particularly challenged when it comes to risk assessments and/or predictions of harm and consequently confidentiality and information sharing. This is especially complex when dealing with minors, people with mental disorders and pregnant women. There is considerable fear amongst practitioners of stigmatising vulnerable individuals and damaging the patient–doctor relationship, which ideally is built on trust.

It was considered good practice to keep in mind that more people have radical beliefs than are prepared to commit an act of violence. However, no matter how low the probability is, the potential impact is high. As mentioned by one practitioner, you are "damned if you do and damned if you don't" ([4]). Another practitioner described it as "the art of probability and the science of uncertainty" ([5]). Mental health professionals need to keep a balance between their core ethos and security issues that protect the public. They must weigh up the rights and interests of a patient on the one hand and general public protection on the other. This problem

([2]) In the trial of the individual who stabbed several people in The Hague (the Netherlands) on 5 May 2018, for example, the court held that there was no terrorist motive and that the perpetrator's actions were the result of a psychotic disorder. According to the judgment, his radical and extremist thoughts "were prompted" by his paranoid psychosis. The case had previously been treated as a terrorist incident. The perpetrator of the attack in Utrecht on 18 March 2019 was convicted for terrorism, but his personality disorder played an important part in motivating him to carry out the attack. Mental disorders were also suspected to have played a role in several right-wing extremist attacks in 2019.
([3]) Learn more here: Europol. (2020). European Union terrorism situation and trend report (TE-SAT) 2020
([4]) Statement of a first-line practitioner during the RAN Mental Health meeting "Ethics for mental health professionals working on P/CVE" on 16 and 17 June 2020.
([5]) Statement of a first-line practitioner during the RAN Mental Health meeting "Ethics for mental health professionals working on P/CVE" on 16 and 17 June 2020.

is also called the "dual relationship problem" ([6]). This means that practitioners need to recognise and respect those rights while simultaneously acknowledging the need to infringe on them at times. This is especially true about "danger thresholds" and estimating when they are crossed.

Voted by first-line practitioners: The most difficult ethical challenges

Those attending the meeting considered the following four challenges as the most pressing:

1) confidentiality and information sharing;

2) risk assessment and/or predictions of harm;

3) preventing stigma (specifically with minors);

4) challenging religious beliefs.

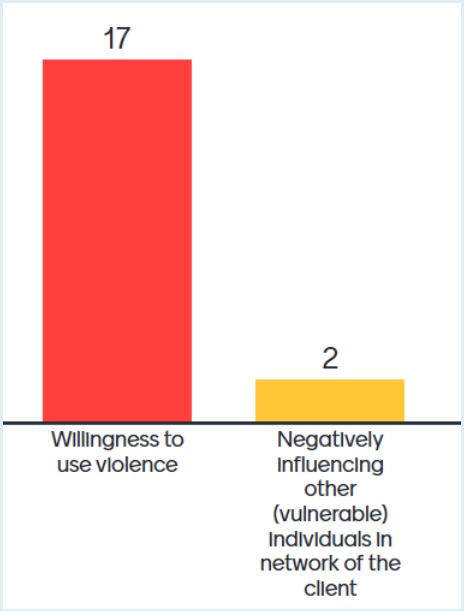
([6]) Learn more here: Ward, T. (2013). Addressing the dual relationship problem in forensic and correctional practice. Aggression and Violent Behavior, 18(1), 92-100. https://doi.org/10.1016/j.avb.2012.10.006

Key Outcomes

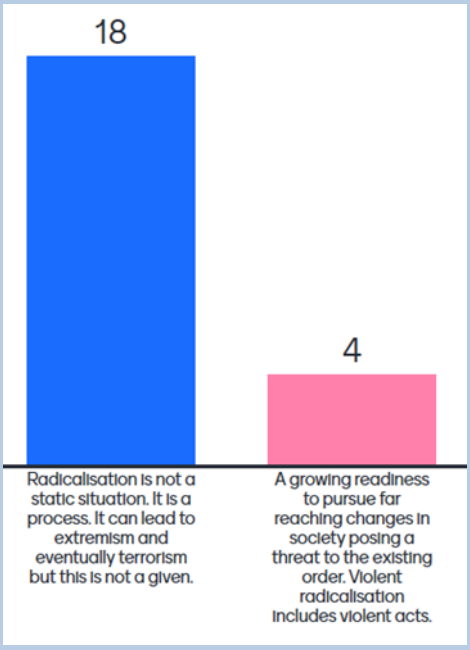
Conceptual issues and agreements

Discussions surrounding conceptual understandings are not new to mental health professionals. Already, numerous ideas and/or interpretations exist surrounding mental illness and rarely do we find a common definition shared across professions. The same could be said for the world of P/CVE. Practitioners have mentioned various ways to interpret terms such as radicalisation (in relation to mental illness in particular), security risk, treatment (therapeutic or ideology-based interventions?), and violent extremism. Different conceptual understandings can be a reason for misunderstandings between care and security professionals. By not taking into account the pivotal patient–client relationship, which is based on trust, there is a considerable risk of alienating the person in need of treatment and safeguarding. Consequently, this might lead to an increased susceptibility of patients/individuals to acts of violence or joining violent extremist groups. At the same time, there is also a need to protect the public from potentially dangerous individuals who might have become radicalised and can even be considered violent extremists. However, we tested the described assumptions on conceptual differences with a poll and this revealed that there are very similar understandings of "radicalisation" or "risk" across Europe. It was mentioned that most differences come forth from a lack of cooperation between different professionals dealing with a P/CVE case. This is not so much found in the terms themselves, but more so in a lack of multi-agency cooperation between relevant stakeholders and the difficulty of sharing information. Practitioners agreed that forming a good working relationship between mental health professionals and security professionals is key to solving such issues. However, developing a working multi-agency approach is quite difficult. Experienced practitioners shared the following tips:

Key lessons 01 – What is "risk"?



Key lessons 02 – What is "radicalisation"?



- Often, successful collaborations are based on the good relations between individuals, but not as a group of stakeholders. This is based on the different ethical and cultural approaches. Practitioners advised to **start from a position of trust and commonality**. Often, common goals can be achieved that are beneficial to all.
- **Avoid introducing a methodology without considering its sustainability and autonomy**. There is a need to find a mechanism to negotiate between the two. Therefore, it is useful to communicate with lots of agencies and to be aware of different languages within and between agencies.
- **We need to differentiate in the language that is used and build a common language**. For example, mental health professionals find it important not to use the word "risk" with those not having done something, but instead use the term vulnerabilities.
- More tips on multi-agency working can be found in the **Further Reading** section below, or you can find **10 RAN key lessons** about multi-agency approaches via this link.

What do you need to know about legislation?

The discussion on what is ethical can also be found in the legislative frameworks in Europe surrounding P/CVE. As a first-line practitioner, it is vital to be aware of varied legal contexts, as the national and European legal order determines the paths on which the reconciliation of interests takes place. In individual cases, however, it is difficult to determine where the obligation to maintain confidentiality ends and the obligation to warn society begins. This section briefly outlines a number of examples to show different starting points in the national legal frameworks and the way these affect decision-making for mental health professionals across the world.

The common European standard on information sharing focuses on the general trust in the confidentiality of the members of certain professions as a starting point:

> *It is crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general. Without such protection, those in need of medical assistance may be deterred from revealing such information of a personal and intimate nature as may be necessary in order to receive appropriate treatment and, even, from seeking such assistance, thereby endangering their own health and, in the case of transmissible diseases, that of the community* ([7]).

Particularly in the field of P/CVE, the right of privacy can however be lawfully restricted as long as this complies with requirements under national law and the European Court of Human Rights ([8]) (i.e. for most countries, this is only the case when there is a *vital interest* for another legal person to know and thus a high probability of danger). However, unique cultural and historical developments have shaped the legal and ethical context for each EU Member State. As a result, there is a difference in focus: whereas some have a leniency to override individual rights for security reasons, others might emphasise individuals' rights through stricter data protection ([9]) and/or a focus on safeguarding. As outlined in the introductory section, the UK's Prevent Duty ([10]) is one example in which public professionals have a duty to report people with radicalised behaviour (which according to some criminalises forms of non-violent extremism). According to the case law of the German Federal Constitutional Court, there is a constitutionally guaranteed right to decide for yourself when and within what limits personal circumstances can be disclosed by a third party ('Right to informational self-determination' as part of general personality rights, Art. 2 I in conjunction with Art. 1 GG). These different stances on, for example, safeguarding, privacy, danger and self-determination, affect the ethical considerations of mental health professionals. First-line practitioners have offered a set of tips to take into account for mental health professionals and policymakers in this field.

- EU Member States face similar challenges in defining the line between violent behaviour and terrorism with regard to, for example, the role of mental conditions or the role of incitement of lone-actor terrorism. **Increased law enforcement cooperation and harmonisation of terrorism legislation and jurisprudence amongst EU Member States** will contribute to consolidating the EU's area of freedom, security and justice.

- **To balance between a patient's individual rights and the protection of society, look into the legal framework of your country in order to understand how and when to share information as a first-line practitioner**. This can provide valuable clarity on ethical questions regarding information sharing: What if you

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([7]) In Z v Finland (1998), the European Court of Human Rights (ECHR) stated that "respecting the confidentiality of health data is a vital principle in the legal systems of all the Contracting Parties to the Convention." The right of privacy can of course be lawfully restricted as long as this complies with requirements under national law and the ECHR.
([8]) Article 8 II ECHR: "There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others." See: European Court of Human Rights. (2019). *Guide on Article 8 of the European Convention on Human Rights*. https://www.echr.coe.int/Documents/Guide_Art_8_ENG.pdf
([9]) Regulation (EU) 2016/679 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation).
([10]) "The Counter-Terrorism and Security Act of 2015 placed a statutory duty on specified authorities within the UK's public sector to have 'due regard to the need to prevent people from being drawn into terrorism'". Learn more here: Heath-Kelly, C., & Strausz, E. (2019). The banality of counterterrorism "after, after 9/11"? Perspectives on the Prevent duty from the UK health care sector. *Critical Studies on Terrorism, 12*(1), 89-109. https://doi.org/10.1080/17539153.2018.1494123

feel like you should share information? At what point does the legal framework demand you to share information? When can you legally share information and justify it?

- Different conceptual understandings (e.g. the word "risk") can be the reason for misunderstandings between care and security professionals. Speaking the same language is best achieved through collaborative structures that provide room for clarification and feedback. **Only through understanding between different stakeholders can individual rights be respected (and thereby prevent stigmatisation and provide treatment) and at the same time public safety be guaranteed**.

- **Be aware of developments in the field**. New legal challenges keep arising. Particularly difficult challenges in this regard relate to (returning) foreign terrorist fighters, specifically in cases that relate to minors, (pregnant) women who joined Daesh and mentally ill terrorists.

- **Communicate clearly and openly** to your patient how this legal framework affects your work as a first-line practitioner to maintain your trust-built relationship.

- **Good training is considered necessary** to balance the legal and professional judgement, to estimate, that is, of when there is a present danger and when to "remain silent". This is not only the case for mental health professionals but also other actors/partners in the P/CVE network, such as probation officers and exit workers.

Codes of conduct and ethics

Most would agree that the codes of conduct and the ethical framework are compatible amongst mental health professionals across Europe. As mentioned before, mental health practitioners need to pay attention to the shared ethical principles that shape the profession. This only leaves the question what these shared ethical principles are. Based on the four principles described in the European Federation of Psychologists' Associations' paper on the 'Meta-Code of Ethics' ([11]), The British Psychological Society wrote 'Ethical guidelines for applied psychological practice in the field of extremism, violent extremism and terrorism' ([12]). In both papers, there is a distinction between four broad principles:

1. Respect for the dignity of persons and peoples

Mental health practitioners accord appropriate respect to and promote the development of the fundamental rights, dignity and worth of all people. They respect the rights of individuals to privacy and confidentiality, self-determination and autonomy, consistent with the mental health practitioners' other professional obligations and with the law. Mental health practitioners should furthermore consider communities and shared values within them, the impacts on the broader environment — living or otherwise, issues of power, consent and self-determination. And, lastly, they should consider the importance of compassionate care, including empathy, sympathy, generosity, openness, distress tolerance, commitment and courage.

2. Competence

Mental health practitioners strive to ensure and maintain high standards of competence in their work. They recognise the boundaries of their particular competencies and the limitations of their expertise. They provide only those services and use only those techniques for which they are qualified by education, training or experience. This includes understanding the limits of their competence and the potential need to refer on to another professional. Furthermore, it requires keeping track of advances in the evidence base and the need to maintain technical and practical skills. In matters of professional ethics and decision-making, any limitations to their competence to practice requires taking mitigating actions.

([11]) Read more: European Federation of Psychologists' Associations. (2005): Meta-Code of Ethics
([12]) Read more: The British Psychological Society. (2018): Ethical guidelines for applied psychological practice in the field of extremism, violent extremism and terrorism

3. Responsibility

Mental health practitioners are aware of the professional and scientific responsibilities to their patients, to the community, and to the society in which they work and live. They should avoid doing harm and are responsible for their own actions, and should ensure, as far as possible, that their services are not misused while balancing this with their duty to protect the public. Understand, in this regard, that there are potentially competing duties.

4. Integrity

Mental health practitioners seek to promote integrity in the science, teaching and practice of psychology/psychiatry. In these activities, mental health practitioners are honest, transparent, fair and respectful of others. They attempt to clarify for relevant parties the roles they are performing and to function appropriately in accordance with those roles. In this regard, they should demonstrate accurate unbiased representation, avoid the exploitation and conflicts of interest (including self-interest), maintain personal and professional boundaries, and address misconduct.

Practical Implications

Practical tips to work ethically

This part describes practical tips coming forth from the above-described four broad principles, the overall recommendations deduced from the paper 'Ethical guidelines for applied psychological practice in the field of extremism, violent extremism and terrorism', and practical tips from practitioners.

Respect	Competence
Be clear about the limits of confidentiality before engaging • Explain your safeguarding role and the possible need for disclosure to the authorities. • Explain their choices and the consequences of continuing down a dangerous pathway that would harm them as well as others. **Obtain informed and explicit consent** • Encourage cooperation. • Do not claim you are carrying out a risk assessment unless you are trained to do so. • Stress that your job is only to comment on the possible contribution of mental health problems to concerns about radicalisation and to identify sources of support. **Separate the person from their problematic behaviour** • Show compassion and respect for the person.	**Evidence-based practice** • Complete relevant training and do not claim expertise beyond your competencies. • Make hypotheses and come to tentative conclusions consistent with an underdeveloped evidence base. **Challenging religious beliefs** • Some say belief is not your job and recommend passing this on to a religious mentor, while others recommend discussing it. More on this can be found below. • Ideology does not drive behaviour but justifies it. The drivers are personal. • Ask yourself: What function is ideology serving for this person? **Assessment** • Risk factors do not necessarily include mental health, though those at risk of radicalisation are often troubled, dissatisfied and frustrated with their lives.

- Show awareness of the political context and cultural sensitivities.
- Avoid stigmatising.

- Autism spectrum disorder and psychosis can create specific vulnerabilities to engagement in ideology, though not necessarily to terrorism. Your job is to identify a mental health issue and advise where and how it is functionally connected to the radicalisation concerns and where it is not relevant to risk of harm.

Responsibility

Contribute your knowledge, skills and values

- They can safeguard both the person of concern and the public.
- Be transparent about the nature of your role.
- Build a trusting relationship that can promote and encourage change.
- Understand that modelling respectful behaviour can challenge a person who may not expect you to respect them.

Remain ethically aware

- If you are required to work for purposes that are not consistent with your code of conduct, it is your responsibility to identify this and adhere to your code of conduct.
- Ensure regular supervision to maintain perspective and manage your own feelings about this work.
- Use reflective practice to manage the influence and implications of your own political, moral and religious views and attitudes.

Be mindful

- Carry out your role mindfully. It could become the subject of significant public interest, but do not allow this to make you risk-averse. Tell it how it is.

Integrity

- Do not deny that your work may be undertaken on behalf of the state, but do strive to create a safe and respectful space in which an honest and constructive relationship can develop.
- Ensure that you are aware of any attitudinal biases you may have towards and about the person and address these in supervision.
- Avoid working with those whose causes you may be particularly sympathetic or unsympathetic towards. If you feel unable to do so, ask to be relieved of an assessment task or intervention before meeting the individual concerned.
- Demonstrate humanity and respect for people, regardless of their religion, nationality or beliefs; this can challenge their dehumanisation of you.

Different views: Challenging religious beliefs

Challenging religious beliefs is difficult, because there is a lot of stigma on discussing religious issues with a patient. Some professionals argued that this is not their line of expertise and they consider it best to get a religious figure involved who could challenge the possible extremities in their religious interpretation. However, many others did not find this a helpful separation. The religious leader might just pass on his/her own version, instead of helping the patient discover theirs. They advised not to be afraid to ask questions. You are, as a mental health professional, already asking very intimate questions. For example, the question "What is god to you?" might help them discover

their own interpretation instead of one decided for them by their families, communities or groups. Lastly, it was questioned whether we could consider it ethical to challenge someone's religious beliefs. Most considered it ethical. Mental health professionals challenge a multitude of ideas and beliefs that potentially harm the patient or others. The aim is not to harm the patient but to engage with them and understand how they came to have these views.

Key recommendations

1) **In confidentiality and information sharing**, in some cases, **Integrity** may clash with **Responsibility**. If you are obliged to break confidentiality to disclose a concern about risk, or to withhold some information that you have been asked not to share, then **share the minimum** that you are required to share to meet your professional responsibility to protect the public, and keep irrelevant personal details confidential (e.g. it might not be necessary to share the diagnosis and treatment. Stakeholders might benefit from a list that tells them how to manage the contacts and develop a relationship. This is the same for dangerous psychiatric patients). All the above should be viewed through national legal frameworks that (in many EU Member States) define what can/has to be shared or not.

2) Mental problems can be dealt with, though it is key that a subject **participates in treatment voluntarily** and is not forced (most ideally) in order to get the best outcome for successful rehabilitation. A second question arises: Should we focus on radicalisation of the mental problems first? We concluded there should be an emphasis on the main diagnosis first.

3) We need to understand **risk assessment** more as risk management, which is a continuous process. It is only the present that can give insights into the risk, because the risk can change. Keep in mind that it is not a one-off and fixed quality assessment that predicts the future. Identify present risks and review/adjust depending on more information. The changes of a **positive outcome increase** if we feel with the patient (compassion).

4) It was recommended to focus more on **needs assessments** and include a **life course analysis**. Pay attention to identifying possible mental disorders. If possible, include the (family) system in the guidance/treatment plan. Don't get seduced into a **patient's narrative**; reflect on this regularly and check their readiness to pursue changes and positive behavioural responses.

5) Previous violence is the best **predictor of future violence**. A violent offender with criminal attitudes does not worry about overcoming inhibitions about using violence, as they do not have any. Treat this person as a violent offender with a presence of ideology. Remember that presence of that ideology is a seductive justification for them to commit violent acts against the "enemies" (e.g. *kuffar* (non-believers)). Key here is the violent offender status that can be framed within an ideology.

6) Consider carefully that **branding someone** with a mental illness as a terrorist would mean the individual would be detained amongst non-mentally ill offenders. "Regular" sentencing would not solve the radicalisation process. Also, the deterrent effect of being detained in a common penitentiary raises more questions and dilemmas as such detainee programmes would not address mental health state and/or radicalisation (though this may vary in different countries).

7) **More knowledge on the association between mental disorders and radicalisation** should be spread amongst agencies such as law enforcement or frontline workers such as social workers who deal with radicalisation cases (to help differentiate between patient and terrorist).

8) It is recommended to use a **multidisciplinary approach** that includes a (psycho) social work team to help support the person towards resocialisation and help set up realistic plans to prevent recidivism. Good collaborations start from a position of trust and commonality. Then, find a base or a common

goal that is beneficial to both service users and professionals. Avoid introducing methodology without consideration of sustainability and autonomy.

9) The **gap between the purely academic research on mental health and radicalisation and practitioners' experiences** is problematic. Researchers need to question how to separate between what they know and when to rely on reviewing academic papers and diagnoses made from an office. There is a serious risk if the latter is ill-informed. Therefore, we need to find a way to traverse this challenge.

10) There is a natural tension between low probability and highly feared impact. It was considered good practice to manage such fears by being self-aware about the tensions they raise for us. This means practitioners have to **communicate honestly and openly**. Also communicate this to the patient, talk about the consequences, choices, etc. Or, as one practitioner put it: "The more transparent we are, the safer it is, and the more information we can share if needed."

11) Self-awareness has to go in all directions. Currently, there is a risk that popular culture stereotypes will influence staff perception of radicalisation. We see left-wing overcompensation, especially in times of right-wing anger. So, **don't overcompensate and remember that terrorist groups change**. Be aware of how the terrorist world is changing (including online) and keep on developing professionally.

Further Reading

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