Substance use and violent extremism

Authored by **Lotta Carlsson**, RAN Expert Pool Member

Radicalisation Awareness Network
RAN Practitioners

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Introduction

Alcohol and drugs have historically been linked to human violent behaviour. And despite the fact that many politically and religiously motivated extremist ideologies and groups promote purity of body and mind as an ideal, drug use and mind-altering substances have been widely reported in violent Islamist extremist (VIE) and violent right-wing extremist (VRWE) contexts. While this phenomenon has been discussed before, its implications for preventing and countering violent extremism (P/CVE) have not been assessed in depth, to date.

Although clinical research on the topic of substance use and misuse and radicalisation remains sparse, practitioners will benefit from a consolidated overview of existing research, best practice case studies and theory to inform their decision-making and programme design. According to the *RAN Extremism, Radicalisation & Mental Health: Handbook for Practitioners*, substance use and misuse may play a role in creating vulnerability and triggering pathways to extremism, it may sustain this vulnerability, and it may lower behavioural and mental thresholds for committing violent acts.

The objective of this paper is therefore to examine the ways in which drugs and alcohol form part of the wider social practices of different extremist groups and phenomena. The paper considers how drugs can be utilised for recruitment or radicalisation purposes, and specifically, how drugs are used to lower the threshold for committing extremist violence and/or terrorism.

While substance use and misuse has been a recurring theme in RAN meetings in the past years, it is typically a side issue (with the notable exception of a joint RAN Exit and Health and Social Care (HSC) meeting in 2018). This paper seeks to take a closer look at this topic and provide much needed background on the use of drugs and alcohol by extremist groups as well as the implications for P/CVE.

For the purposes of this paper, licit (e.g. alcohol) and illicit drugs are studied together, because they are typically researched together in related literature, and because in practice, they frequently interact and are inextricably linked. The paper will examine substance use and addiction [1]. Substance addiction implies that the individual has built tolerance to the substance. In these cases, use of the substance leads to specific problems such as brain alterations, withdrawal symptoms and relapse. Alcohol and substance use disorders are a type of mental health disorder and are listed in the Diagnostic and Statistical Manual of Mental Disorders.

Social drug use in extremist scenes

This section will examine the role drugs play in the social practices of VIE and VRWE groups and scenes in the European Union, as well as how these groups use licit and illicit substances to recruit and radicalise new followers and members.

Literature exploring the psychology of people committing violent extremist acts has made advances in recent years. Previously, researchers believed that people with mental illnesses or psychopathic tendencies committed extremist acts [2]. Scholars later eschewed these explanations in favour of the theory that radicalised individuals were rational actors in pursuit of specific objectives [3]. Today, the literature overwhelmingly recognises that pathways to radicalisation are complex, multifaceted and interconnected and that there is no 'single pathway' to radicalisation.

There is ample research and evidence on how violent extremist groups use the drug trade to finance their operations [4]. However, far fewer studies focus on the links between drug and alcohol use and radicalisation. Existing research suggests that drug and substance use can play a significant role in extremist social scenes

[1] The term "substance abuse" is now widely considered to be stigmatizing and has been found to have a high association with negative judgments and punishment (see Kelly & Westerhoff 2009). This paper will therefore instead use the terms "substance use", "alcohol use disorder" or "substance use disorder" to mean the recurring consumption of alcohol or illicit drugs in excessive amounts, leading to physical, emotional or social harm.
[2] Gill et al., Systematic review of mental health problems and violent extremism.
[3] Ibid.
[4] United Nations Office on Drugs and Crime. (n.d.). Countering Terrorist Financing.

(especially due to their link to violence [5]) – and as a risk factor. However, because of the multifaceted nature of the pathways to radicalisation, studies rarely investigate a single cause of radicalisation alone (e.g. only the link between substance use/misuse and radicalisation). Rather than focusing on the exclusive relationship between substance use and extremism, researchers tend to look at individual life circumstances and interrelated risk factors and vulnerabilities in this context, considering substance use as just one of several vulnerability indicators.

There are, however, three main ways that substance use plays a role in recruitment and radicalisation of individuals. First, people with a substance use disorder tend to be in a vulnerable state and are therefore potentially more susceptible to joining violent extremist groups [6]. Second, substance use and addiction may sustain that vulnerability, thereby keeping that individual within the extremist group. Third, in some cases, extremist groups proactively recruit not only among people who are addicted to substances, but also among those struggling with addiction more broadly.

Substance misuse can cause and compound distress, confusion, social isolation and anxiety, depleting people's sense of purpose and meaning in life. These conditions may generate a sense of injustice, anger, fear, threat, guilt and helplessness, which many may feel they are unable to overcome. Those feelings of distress, grievance and loss of meaning, identity, purpose and belonging, and an amplified need to escape or restore control and redeem oneself, are factors that can heighten an individual's vulnerability to extremism [7]. Substance use as a vulnerability indicator is reportedly high for both VRWE and VIE, although it is higher for VRWE [8].

It is important to note that only substances which act as 'uppers' (e.g. amphetamines, cocaine, ecstasy and caffeine) and 'downers' (e.g. opioids, cannabis and alcohol) can lead to addiction. Psychedelic substances (e.g. LSD, ketamine and peyote) are not addictive, although they can trigger violent behaviour.

Substance use and VRWE

In the case of VRWE, recruitment often takes place in spaces where alcohol is consumed (e.g. pubs) or where drugs and alcohol form an integral part of the social scene. The 'hooligan' and 'ultra' culture surrounding football clubs is a particularly fertile ground for recruitment, because of its strong association with violence and alcohol [9].

A general trend in Europe indicates that it is mostly young men with lower levels of education and a negative outlook on their economic circumstances that are attracted to VRWE. However, rather than being guided by a coherent ideology, they seem to be driven by thrill-seeking and opportunism. Often, they have a long history of alcohol and substance use as well as involvement in criminality [10]. This experience also seems to be echoed by experiences in the United States, where 72 % of 44 former members of a violent white supremacist extremist group reported having alcohol and/or illegal drug dependence prior to their radicalisation [11]. Although most studies suggest that it is predominantly young men who are the perpetrators of violent actions, it is worth noting that recent research from Norway points to older people becoming radicalised at a faster rate than younger people [12].

Substance use is strongly interconnected with mental illness for both VRWE and VIE. Ideology is often not the main or only reason that people become radicalised. Rather, for many vulnerable people, social relations within the extremist group are a key factor. As members of this 'in' group, many vulnerable people experiencing social rejection are accepted for who they are and are taken care of as part of the socialisation

[5] Radicalisation Awareness Network, *Multi-problem target group: the influence of mental health disorders and substance abuse on Exit work*.
[6] Al-Attar, Severe Mental Disorder and Terrorism: When Psychosis, PTSD and Addictions Become a Vulnerability
[7] Radicalisation Awareness Network, *Extremism, Radicalisation & Mental Health: Handbook for Practitioners*
[8] Bouhana et al., Background and preparatory behaviours of right-wing extremist lone actors: a comparative study
[9] Kagerer, P. (2020). Zoom interview by Lotta Carlsson.
[10] Briggs & Goodwin, We need a better understanding of what drives right-wing extremist violence.
[11] Simi, P., Bubolz, B., Windisch, S., McNeel, H., & Sporer, K. (2015). Trauma as a precursor to violent extremism how non-ideological factors can influence joining an extremist group.
[12] Politiets Sikkerhetstjeneste, *What Is the Background of Right-Wing Extremists in Norway?*

process. It is often at this point that they begin taking on extreme ideologies and views [13]. As the case study below shows, social relations and social acceptance can have a profound impact on the radicalisation of vulnerable people.

Interview with Peter Kagerer, Psychotherapist at the Centre against Radicalisation (Respect), Luxembourg

(The text below is a transcript of an interview with Peter Kagerer, carried out by Lotta Carlsson)

> « *We had a client who was recruited by a VRWE group in Germany. At the heart of it was a group of men who would meet regularly at bars and pubs and drink alcohol together. He told us that nobody discussed politics with him in these groups for well over a year; the purpose was merely to gradually socialise him into the group. It was only after they had gained his trust that they started formally introducing him to the ideology and to what he called the 'unofficial' political party, which consisted of people with unofficial affiliation to the party who carried out the violent actions.* »

Beyond recruitment, drugs and alcohol play a prominent role in the social practices of VRWE. According to the German domestic intelligence agency (*Bundesamt für Verfassungsschutz* – BfV), many young people who are attracted to VRWE groups may have a relatively simplistic understanding of the binding political ideology but are attracted to the so-called subculture, which features violence and significant alcohol consumption [14].

Interview with Peter Kagerer, Psychotherapist at the Centre against Radicalisation (Respect), Luxembourg

(The text below is a transcript of an interview with Peter Kagerer, carried out by Lotta Carlsson)

> « *Drinking can be a critical part of the social relations in right-wing extremist groups. As the saying goes, 'drinking together is thinking together', and this actually has some empirical truth to it. We know from research that groups of people who drink together end up subconsciously mimicking each other's actions and behaviours. And this is also a key driver in recruitment. Small rituals often develop within the groups, and these rituals serve as visual markers to indicate who is 'in' and who is not. By consuming vast quantities of alcohol, VRWE are able to create and sustain social practices such as violence as well as extremist ideas.* »

Substance use and VIE

By contrast, the relationship between substance use and VIE is more complicated because of the religious ban on consumption and the surrounding stigma. Nonetheless, there is ample evidence that substance use can play a role in recruitment and in committing violent acts. In a case study of 147 jihadists in Europe, researchers noted that there was an overlap between drugs and terrorism: two thirds of the individuals in the sample population had a history of drug consumption before their radicalisation, ranging in intensity from occasional use to addiction [15]. Lewis Herrington analysed the backgrounds of 52 men who had carried out suicide terrorist attacks between 2012 and 2017, and he observed that 75 % of them had a history of chronic substance use [16].

[13] Ibid.
[14] Bundesamt für Verfassungsschutz, *Annual Report 2006*. Bundesamt für Verfassungsschutz, as cited in Caiani et al. (2012). *The Extreme Right and Social Movement Studies: An Introduction.* Oxford: Oxford University Press.
[15] Basra, *Drugs and Terrorism: The Overlaps in Europe*.
[16] Herrington, Predicting and preventing radicalisation: an alternative approach to suicide terrorism in Europe.

A history of substance use is also a vulnerability indicator for VIE. Research on Daesh recruitment found that among local male recruits in Iraq and Syria, poverty was the predominant factor, whereas among European recruits, the main vulnerability indicator was a history of substance use [17].

In terms of recruitment, religion can be used as a way to seek forgiveness, repentance and 'purity' for those addicted to drugs or alcohol. In some cases, by offering a path to redemption and acting as a socialising agent, Islamic fundamentalism can offer Muslim men with drug and alcohol dependence recovery programmes similar to the 12-step Alcoholics Anonymous (AA) programme [18]. In this sense, engaging in religion can provide young men with a sense of structure and discipline as well as a clear system of acceptable and forbidden behaviour, which can be appealing to those seeking direction and a purpose [19].

There is also some anecdotal evidence that extremist groups use drugs deliberately as part of their recruitment and radicalisation processes. For example, a study in Bosnia showed that certain violent extremist groups used the internet to encourage the consumption of specific drugs, in order to create further vulnerabilities in target groups and facilitate recruitment [20]. However, there is sparse research to date on if and how extremist groups use drugs to radicalise potential new recruits.

Substance use and the use of violence

This section explores how extremist groups use drugs and alcohol to lower the violence threshold and discusses how substance use may be consistent with extremist ideologies.

The use of drugs and alcohol to lower the threshold for violence is well reported and has been studied across a number of different contexts. Drug and alcohol consumption has been shown to increase violent acts in situations of armed conflict [21], VRWE and VIE [22], public violence [23] and intimate partner violence [24]. Research clearly indicates that substance use does increase the prevalence of violence. It is known to make people more aggressive and violent, while at the same time eliminating social constraints against the use of violence [25]. However, because there are so many interrelated risk factors in the radicalisation process, there is no empirically established connection between the use of drugs and radicalisation. Drug and substance use more generally are markedly connected to violence. Psychoactive substances in particular are notorious for triggering violent behaviour [26].

However, it is important to stress that substance use is not exclusively responsible for such behaviour, but rather plays a role alongside several other psychosocial factors including trauma, personal history, childhood, and cultural and social circumstances [27]. It is also worth noting that under certain conditions, substance use may be a cause of radicalisation, or a consequence of it – or even both. Membership of extremist groups is highly stressful and psychologically straining, and is accompanied by toxic stress and high probability for trauma that increases the risk of substance use[28]. Practitioners should therefore treat substance use within this larger, holistic context when designing programmes for P/CVE [29].

[17] Speckhard & Ellenberg, ISIS in their own words: recruitment history, motivations for joining, travel, experiences in ISIS, and disillusionment over time – analysis of 220 in-depth interviews of ISIS returnees, defectors and prisoners.
[18] Ibid.
[19] De Poot et al., *Jihadi terrorism in the Netherlands. A description based on closed criminal investigations.*
[20] Radicalisation Awareness Network, *Multi-problem target group: the influence of mental health disorders and substance abuse on Exit work*.
[21] Hecker & Haer, Drugs boosting conflict? a micro-level test of the linkage between substance use and violence.
[22] McCleery & Edwards, A micro-sociological analysis of homegrown violent extremist attacks in the UK in 2017.
[23] van Amsterdam, J. G., Ramaekers, J. G., Verkes, R. J., Kuypers, K. P., Goudriaan, A. E., & van den Brink, W. (2020). Alcohol-and drug-related public violence in Europe. *European Journal of Criminology*, *17*(6), 806-825.
[24] Leonard, K. E., & Quigley, B. M. (2017). Thirty years of research show alcohol to be a cause of intimate partner violence: Future research needs to identify who to treat and how to treat them. *Drug and alcohol review*, *36*(1), 7-9.
[25] Hecker & Haer, Drugs boosting conflict? a micro-level test of the linkage between substance use and violence.
[26] Radicalisation Awareness Network, *Multi-problem target group: the influence of mental health disorders and substance abuse on Exit work*, p.6.
[27] Fagan, J. (1993). Set and setting revisited: influences of alcohol and illicit drugs. In S.E. Martin (Ed.), *Alcohol and interpersonal violence: fostering multidisciplinary perspectives* (pp. 161-192). US Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism, Rockville, MD.
[28] Andersen, S. L., & Teicher, M. H. (2009). Desperately driven and no brakes: developmental stress exposure and subsequent risk for substance abuse. *Neuroscience & Biobehavioral Reviews*, *33*(4), 516-524.
[29] Gill et al., Systematic review of mental health problems and violent extremism.

Intersections

In the context of violent extremism, research rarely concentrates on the relationship between substance use and violence. Rather, it is often considered as one factor among others that shape people's pathways to radicalisation. There are, however, numerous examples in recent years where substance use was reported before the violent acts were committed. A report examining where drug use and VIE terrorist attacks overlap in Europe found five instances where drugs had been consumed before the attack :

> « [Consumption prior to the attack] *was the case with the December 2016, Berlin Christmas market attack; the March 2017 Orly Airport attack; the July 2017 Hamburg supermarket attack; the October 2017 Marseille stabbing; and the March 2018 Carcassonne and Trèbes attacks. These 5 individuals represent 7 % of the total 75 perpetrators of jihadist attacks between 2012 and 2018.* » [30]

The report shows that many people who committed violent extremist acts have a history of consuming illicit drugs, sometimes even just before committing these acts. Although the author draws no formalised or structural links between the drug trade and VIE, where drug consumption has been recorded in VIE, drug consumption prior to radicalisation generally stayed the same after radicalisation [31]. It is possible that these people took drugs to calm their nerves, or that it was a daily habit.

One interesting but less studied phenomenon is the fact that attraction to a specific cause or hate group can have a similar addictive effect on some violent extremists. Even without substance use, commitment to the extremist group can result in withdrawal-like physical and psychological effects when individuals try to leave the extremist group [32].

Substance use to enhance performance

Many criminals self-report substance consumption before committing crimes that is a means to help them deal with nervousness and fear [33]. Famously, when he was arrested, Anders Breivik reported that he had taken a combination of ephedrine, caffeine and aspirin in order to enhance his performance [34]. Research also shows that certain violent extremist groups experimented with the use of Fenethylline (often known under the brand name Captagon) as a stimulant during armed conflict in the Middle East – the drug was sometimes even referred to as the 'Jihadi Pill'. It has been widely reported that Daesh fighters in Syria and Iraq used Captagon because of a belief that it would improve military performance by purportedly enhancing their bravery during combat [35]. A large shipment of 24 million pills of the legal opioid painkiller Tramadol, intended to reach Daesh fighters, was intercepted by Italian police in 2017, which suggests that this drug was used systematically by the group [36].

However, research on the extent to which extremist groups use drugs remains mixed. It is suggested that most of the evidence presented by newspapers is anecdotal, thereby making it extremely difficult to draw wider deductions about if and how drug consumption was deployed systematically as a strategy by Daesh. Captagon consumption could likely have been the result of isolated pockets of fighters who resorted to this drug, rather than a large-scale operation by Daesh to produce, distribute and provide their fighters with Captagon [37].

Consistency

Whether substance use is consistent with the core ideologies of violent extremist groups is a complicated question to address. The ban on alcohol consumption in Islam is well established; however, consumption of

[30] Basra, *Drugs and Terrorism: The Overlaps in Europe.*
[31] Ibid.
[32] Simi et al., Addicted to hate: Identity residual among former white supremacists.
[33] Gill et al., Terrorist decision making in the context of risk, attack planning, and attack commission.
[34] McCleery & Edwards, A micro-sociological analysis of homegrown violent extremist attacks in the UK in 2017.
[35] El Khoury, The use of stimulants in the ranks of Islamic State: Myth or reality of the Syrian conflict.
[36] Giuffrida, A., Italian police intercept €50M Tramadol haul potentially bound for Isis.
[37] El Khoury, The use of stimulants in the ranks of Islamic State: Myth or reality of the Syrian conflict.

narcotics seems to be less clear-cut. This is especially the case for narcotics that were available at the time of the prophet Muhammad, which can explain in part the contradiction between religious adherence and use of narcotic substances [38]. Nevertheless, drug use remains heavily stigmatised in most Muslim communities; statistics and figures on the consumption of drugs and alcohol therefore likely remain underreported.

Case study based on an interview with Peter Kagerer, Psychotherapist at the Centre against Radicalisation (Respect), Luxembourg

(The text below is a transcript of an interview with Peter Kagerer, carried out by Lotta Carlsson)

> « *A young man entered my clinic at the age of 27 or 28. He came from a broken home. His mother had four children by four partners, and she had a fractured relationship with all of them. By the time he was 13, he was effectively homeless. It was at this time that he began to use drugs and alcohol. Later on, he was in a very serious accident in the underground railway in Germany, resulting in his lower leg being amputated (he now has a prosthetic leg). This was massively traumatic for him, and he felt a deep sense of shame because he had always been a very physically active person. One night, he was assaulted by a group of teenagers and was badly beaten. A young woman saw him in this condition and decided to help him. She cleaned him up and brought him to a bar where she was having some drinks with a group of friends. This group of friends happened to be members of a VRWE group. Inside this social circle, he found acceptance. He had not been political at any point in his life. The political ideology of the group did not matter – what mattered was that he was accepted. The recruitment did not happen overnight, of course. Rather, over a period of weeks and months they kept inviting and integrating him into the group through social gatherings. Alcohol consumption, often in very large quantities, was integral to this. He later explained this to me. He recognised that the group used alcohol consumption very proactively in their recruitment and in committing violence. This is an interesting case study because it demonstrates all of the intersecting themes in radicalisation: family history, violence, and alcohol and substance use. It took years of concerted effort of individual and group therapy from many different agencies, but the young man now has a job and has been deradicalised for almost 10 years.* »

Extremist substance use and challenges for P/CVE

This section discusses the challenges posed by substance use for P/CVE for different practitioners in Europe and explores how they can overcome these challenges, and carry out sustainable and effective work.

One of the key challenges for practitioners is that the connection between substance use and violent extremism cannot be isolated – substance use is one of many factors that create vulnerabilities for radicalisation and promote violent attitudes and acts. Drug use may be a coping strategy to help individuals deal with earlier trauma or it may be a prevalent part of the criminal subcultures from which many violent extremists are recruited [39]. Ensuring that individuals receive specialised support while undergoing deradicalisation programmes poses a number of key challenges for practitioners in the field of P/CVE in Europe. Generally speaking, more research is needed on the role of mental health and how it is linked to radicalisation [40]. In the past, it was assumed that mental health illness or disorders were no more prevalent in those who committed violent extremist acts than in the general population; however, the proliferation of studies on this topic in recent years indicates that the situation may be more complicated [41]. Mental health

[38] Ibid.
[39] Baron, Canadian male street skinheads: street gang or street terrorists?
[40] Knight & Keatley, What do we know about radicalization? A commentary on key issues, findings and a framework for future research for the scientific and applied community.
[41] Gill & Corner, There and back again: The study of mental disorder and terrorist involvement.

can be a risk factor for radicalisation and acts of violent extremism; being a member of a violent extremist group might cause trauma and result in mental illness. All of this has an impact on the practice of P/CVE.

Dealing with substance use, mental illness and radicalisation requires specialised expertise, and a single practitioner is rarely able to deliver this multifaceted expert advice alone. This is complicated by the fact that exit work calls for effective multi-agency cooperation between several practitioners, and in cases of substance use, this cooperation must be highly efficient. However, a key challenge for many practitioners is that it is often challenging to find specialised care for their clients that can run parallel with their exit work. This can potentially present a serious dilemma: carrying out exit work without addressing other key vulnerabilities (such as substance use) can end up being ineffective and possibly counterproductive. P/CVE practitioners therefore find themselves in a difficult situation when trying to continue rehabilitation work with an individual who should also be receiving care from mental health specialists on substance use. This puts practitioners in a predicament where they are constantly trying to determine the best approach and working in fields in which they are untrained [42].

Disengagement from a violent group is often the first step, but understood more broadly, deradicalisation means a wholesale cognitive shift away from extremist beliefs and the adoption of new values and belief systems. The turn to extremist ideology can stem from a response to trauma experienced earlier in life. Many people are drawn to the stability and simplicity inherent in a structured lifestyle and coherent belief system of extremist ideologies. If the underlying trauma is not addressed, there is a risk that, even if the person has been deradicalised or disengaged from violent extremist groups, they may turn back to previous coping mechanisms (addiction), and this may present a risk factor for becoming radicalised again.

Case study: Jesse Morton

The case of former jihadist Jesse Morton is an instructive one. Jesse Morton grew up in a disenfranchised and abusive family; his mother physically abused him and his siblings regularly by beating them. At the age of 16, he ran away from home and became reliant on selling drugs. He was eventually incarcerated for selling narcotics and later became radicalised while in prison. Once released from prison, he became a prolific recruiter for Al Qaeda and other affiliated VIE groups for over 4 years [43]. Jesse Morton describes his deradicalisation process as beginning with disengagement from the extremist milieus:

> « *I thought I had left the ideology, and that was sufficient. In fact, what would come to haunt me was not recognising the underlying traumas: the child abuse, running away from home, living on the streets. I gravitated toward Islam for stability and community, but I gravitated toward extremist Islam because of the underlying issues that I had never had an opportunity to rectify under conditions of safety and security. But, ultimately what became of my adverse experiences in life and my trauma was addiction. The extremism fulfilled that addiction. And the problem is that, when I removed the ideological affinity and affiliation, it tapped into a lot of those root traumas…and within a very short period of time, I relapsed on drugs and alcohol for the first time in 14 years.* » [44]

Jesse Morton, now a senior researcher and practitioner at the International Center for the Study of Violent Extremism (ICSVE), promotes a form of deradicalisation practice that aims to turn post-traumatic stress away from further stressors and social problems and difficulties into personal growth. The emphasis is on offering people the camaraderie, social bonds, community, group feeling and sense of belonging that extremist groups offer recruits. Jesse Morton uses his background as a substance use counsellor to address the underlying traumas which can lead to violent behaviour, criminal lifestyles – and eventually – violent extremism, and transform them into social engagement and social interaction [45].

[42] Radicalisation Awareness Network, *Multi-problem target group: the influence of mental health disorders and substance abuse on Exit work*, p.6.
[43] Callimachi, Once a Qaeda Recruiter, Now a Voice Against Jihad.
[44] Morton et al., The Journey Back – Turning Away from Extremism and the Road to Hope and Healing.
[45] Ibid.

Case study based on an interview with Antti Hyyryläinen, Detective Chief Inspector, National Bureau of Investigation of Finland

(The text below is a transcript of an interview carried out by Lotta Carlsson with Antti Hyyryläinen)

> « *In Finland, drugs and alcohol are very prominent within the VRWE milieu, which is quite similar to the organised crime world – biker gangs, for example. They have their own clubhouses, which function as social spaces where group members gather mostly to throw parties and socialise but also to cast votes on issues concerning the group. Within these clubhouses, drugs and alcohol play a large part in the partying scene. Steroids, alcohol, cocaine and amphetamines are the chief substances consumed at the clubhouses. The groups also organise concerts at the clubhouses. Young adults can be especially susceptible to joining VRWE groups, because they are attracted to the partying, the substances and the violence. They usually know absolutely nothing about the ideology of the groups. In our experience, what we see is that groups start partying and consuming substances on Thursday or Friday, but only end up committing violence 2 or 3 days later. Consistently consuming substances over a period of days increases the likelihood of violence being perpetrated. Unfortunately, what we also see is that the influence of drugs and alcohol substantially increases the likelihood of collateral damage, which is a serious challenge for the police.*
>
> *In terms of exit work, substance abuse, and especially addiction, can be a serious challenge to the success of the individual exiting the extremist environment. In fact, in our experience, where addiction is present, it is the single biggest obstacle in ensuring that the person successfully exits. The person must realise that the substances are an integral part of that lifestyle, and unless they are able to get rid of the addiction, the exit work has almost no chance of being successful, because it will continue to create cycles of dependency, debt, criminality and other risk factors.* »

Challenges for health workers

Substance use significantly hinders the ability of health workers to successfully carry out their work. The 'dual diagnosis' of substance use and psychological or psychiatric disorders can contribute to treatment resistance and poor outcomes, making this a particularly challenging client group for practitioners [46]. Substance use is also associated with poor medication compliance, thereby increasing the likelihood of relapse, as well as increased risky behaviour, aggression and risk of suicide. Overall, substance use can exacerbate existing mental illness, thereby posing acute challenges for practitioners

The key challenge for health workers is to address the physical and mental health illness and disorders rooted in substance use and addiction. This may be particularly difficult in the context of exit work, as it calls for a mental health professional with adequate experience in both substance use and radicalisation. In many countries, these services may be limited or non-existent. Where mental health workers work with patients at risk of radicalisation, there remain challenges around how to carry out effective risk assessments while the evidence base for this is limited compared to other fields related to violence [47].

The purpose of treatment for those who suffer from trauma and have committed violent extremist acts is to ensure that they recognise the psychological triggers of their trauma, which may manifest as violence. Practically, this means that the task is to help the person recognise that their feelings of anger, frustration, anxiety and fear stem from a specific trauma or violent experience in their past. In other words, the person is asked to anchor these feelings autobiographically and offer an explanation for these feelings. Addiction and substance use can complicate this process, because it obscures and confuses memories and ongoing cognitive work [48].

[46] Davidson et al., Counselling in Substance Misuse: a review of the literature.
[47] Logan & Lloyd, Violent extremism: A comparison of approaches to assessing and managing risk.
[48] Peltonen, K. (2020). Microsoft Teams interview by Lotta Carlsson.

Mental health workers also face another unique challenge: their work with the individual must be underpinned by a humane, non-judgmental approach, which seeks to build empathy and trust between practitioner and client, and takes into consideration personal history and vulnerabilities. A comprehensive consideration of the person's history will help guide and direct the treatment options and interventions. However, it can be a challenge to convey this holistic understanding to multi-agency partners without being perceived as justifying or excusing the individual's violent acts [49].

Challenges for prison staff

There are significant challenges for prisons dealing with the issue of mental health. People with a substance use disorder have pre-existing mental health illness or disorders, and being in a prison environment is usually detrimental to these conditions [50]. This presents significant difficulties for P/CVE work: prison staff will need to determine the extent to which the substance use may or may not be relevant to radicalisation in prison. This, of course, also prompts the question of how prison staff can address the substance use in prison. Other challenges include training and capacity-building of prison staff, so as to create an environment in which inmates feel they can open up and seek support for their mental health illness or disorders. Treating inmates humanely whilst building trust and empathy is clearly conducive to this, but in many contexts, this type of training is not provided [51].

Another challenge specific to prisons is that some inmates may have an interest in the material benefits associated with exit programmes so as to secure better conditions in prison (more visit hours, a lower security ward, etc.). In an interview, an exit worker in Finland dealing with organised crime noted that inmates were joining exit programmes just for these benefits – upon release, they re-joined their former gangs [52]. It is not clear whether this is an experience shared in the context of radicalisation. However, it is a possibility that has also been raised in previous RAN papers [53]

Challenges

1) **Pathways to radicalisation are multifaceted and interconnected**. Multiple factors contribute to a single individual's pathway. These factors differ and their relative causal weight varies across individuals who become violent extremists. A comprehensive approach therefore requires a multi-agency approach and regular communication between the different professionals involved. Addressing only one issue may prove counterproductive, as these issues may well exacerbate one another. Many studies highlight the range and volume of co-occurring life stressors and complex needs. Concentrating solely on one risk factor is insufficient – the focus must be on the totality of an individual's circumstances. In many countries, psychologists are often not part of the decision-making process early on, but rather become involved at a later stage.

2) **There may be limited or no availability of appropriate care** for those who have substance use disorders. In some countries, inadequate resources resulting in a lack of availability of appropriate psychiatric care as well as long waiting lists can further complicate the need to take a holistic approach to deradicalisation. Moreover, this approach entails a high level of cooperation among professionals, which necessitates training, capacity-building and awareness-raising, so that appropriate referrals can be made between institutions. An in-depth understanding of the connection between substance use, mental health and radicalisation requires training and expertise which may not be readily available in some countries. Furthermore, it is important to concentrate on groups which may not have access to treatment.

3) **Substance use and mental health illness and disorders may slow down the deradicalisation process**. Because of the presence of multiple stressors, individuals belonging to violent extremist

[49] Logan & Sellers, Risk assessment and management in violent extremism: a primer for mental health practitioners.
[50] González, Mental Health in Prison.
[51] Ibid.
[52] Hyyryläinen, A. (2020). Microsoft Teams interview by Lotta Carlsson.
[53] Radicalisation Awareness Network, *Multi-problem target group: the influence of mental health disorders and substance abuse on Exit work*.

groups and having mental health illness or disorders, or substance use disorders, may require a longer time in deradicalisation programmes.

4) **Trauma might present another challenge for practitioners carrying out exit work**. People suffering from post-traumatic stress disorder (PTSD) may experience flashbacks, resulting in intense feelings of 're-living' traumatic experiences and often leading to chronic fear and feelings of helplessness. Exposure to trauma over extended periods can result in the adoption of risky behaviour to activate emotional triggers. This has often been reported in former combatants, for instance, who have experienced so much violence that they become desensitized to it. This condition poses significant challenges when combined with substance use, as drugs and alcohol have the potential to lower that threshold further. Furthermore, substance misuse can also be a coping mechanism to alleviate distress and trauma.

Key outcomes

Practitioners should consider substance use in a holistic context alongside other pathways and existing vulnerabilities. Substance use can cause and sustain other vulnerabilities; it can be used as a way to manage stress and trauma as well as lower the threshold for committing violent acts.

It is therefore vital that practitioners adopt a holistic perspective and take into account all the different risk factors when considering their interventions. Practitioners should reflect on the individual person's life history and consider how all the different vulnerabilities and risk factors interact, and then create a tailored plan based on this analysis. Deradicalisation is a psychological process that seeks to prevent further radicalisation, decrease commitment to the extremist ideology and environment, prevent a return to extremism, and finally, build a new and sustainable life and identity. The early involvement of psychologists and mental health workers is therefore critical, precisely because deradicalisation is a psychological process.

The role of mental health professionals

Mental health disorders such as substance use disorders can be a risk factor for violent extremism: symptoms may include a tendency to violence or social structures that could lead to a violent expression of symptoms [54]. Radicalised individuals who suffer from substance use may have severe experiences of stress, depression, anxiety, insomnia, lack of empathy, lack of social skills and low impulse control, which may make them prone to violent behaviour and vulnerable to extremist milieus [55].

The contribution of mental health professionals is vital: it can take the form of essential psychological support, risk assessments, and detection of early warning signals in the prevention process. It is critical that psychologists and other mental health professionals be involved early on in the deradicalisation process. As well as treating at-risk persons or persons currently undergoing deradicalisation programmes, mental health professionals can also play a critical role in implementing and/or evaluating prevention, intervention, rehabilitation and reintegration programmes [56].

Treatment models

The specific interventions that practitioners should follow will therefore depend largely on individual circumstances and will be assessed on a case-by-case basis. For example, psychologists are aware that although cognitive behaviour therapy (CBT) to counter radicalisation has been disputed by some scholars [57], it has nevertheless been found to be effective in overcoming trauma-related challenges for children and their

[54] Radicalisation Awareness Network, *Understanding the mental health disorders pathway leading to violent extremism*.
[55] Radicalisation Awareness Network, *Developing A Local Prevent Framework and Guiding Principles*.
[56] Weine et al., Utilizing mental health professionals to help prevent the next attacks.
[57] Weilnböck, *Confronting the counter-narrative ideology. Embedded face-to-face prevention – and youth (media) work*.

families [58]. Regarding substance addiction, psychologists can consider different treatment options adapted to the individual circumstances of the client. For example, motivational interviewing has proven to be a highly successful model in dealing with addiction. The interview technique aims to establish a relationship of trust with the patient and attempts to activate their capability to change. Importantly, this requires an empathetic attitude and entails open-ended questions, reflective listening, and giving the patient ownership of the treatment [59] [60]. The community reinforcement approach (CRA) has also been found to be effective in treating substance addictions. This approach involves the patient's social environment, and has also been used in radicalisation-related exit work [61]. Beyond this, family support and intervention models have also shown some success for early prevention work. Family members can provide support and positively influence at-risk persons, and in many cases can help with prevention, rehabilitation, reintegration and even deradicalisation. Families can act as a protective factor and support at-risk individuals to build resilience. It is therefore important to view families as potential partners in detecting signs of changes in behaviour, and in preventing and protecting individuals from radicalisation.

Evidence also shows that narrative exposure therapy for forensic offender rehabilitation (FORNET) has had positive outcomes in recovering mental health, with fewer offences committed, less drug intake and improved integration into society. Research has been carried out mostly in conflict settings, but the positive results could make this therapy interesting for mental health practitioners carrying out exit work. FORNET aims to reduce symptoms of traumatic stress and control readiness for aggressive behaviour by using exposure to guide the client through their traumatic experiences in chronological order, linking negative emotions such as fear, shame and disgust to the past context, and integrating the traumatic experiences into the autobiographical memory [62].

Families can also be a major protective factor as they are first to detect changes in behaviour. Families can also be partners in signalling, preventing and protecting individuals at risk of radicalisation and they are the foundation of building resilience in young people at risk. Developing trust and solid relationships with families is crucial, and practitioners should avoid approaching them from a security perspective, as this can result in a negative spiral of distrust developing between families and authorities. A major goal of family intervention is to assess family structures and dynamics as a basis for further support and intervention. This entails focusing on the entire family rather than just individuals at risk. However, practitioners should be aware that in some cases, families can also be a risk factor. For example, siblings of those in violent extremist groups have an increased vulnerability for joining extremist groups themselves [63] [64].

Key Lessons

1) Develop and adopt a comprehensive, multi-agency strategy for P/CVE

A comprehensive strategy requires a multi-agency approach and regular communication between the different professionals involved. Having a clear definition of the roles and communication channels can help practitioners overcome several obstacles. A notable issue for all practitioners in radicalisation prevention is the sharing of data and information about clients with other practitioners who are part of the multi-agency collaboration. These issues need to be clarified at the start of working relationships 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 to acquire a broader vision and identify the root causes of the problem(s) for a given client. The inability to identify the underlying drivers, needs and grievances has traditionally hampered the efforts of social

[58] Steele & Malchiodi, Trauma-informed practices with children and adolescents.
[59] Rollnick & Allison, Motivational Interviewing.
[60] Clark, Motivational interviewing for deradicalization: increasing the readiness to change.
[61] Meyers et al., The community reinforcement approach. Alcohol research & health.
[62] Hecker et al., Treating traumatized offenders and veterans by means of narrative exposure therapy.
[63] Radicalisation Awareness Network, *Developing A Local Prevent Framework and Guiding Principles*.
[64] Radicalisation Awareness Network, Family support: What works? Meeting on the role of family support in preventing and dealing with radicalisation in a family context.

workers working 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'.

2) Involve mental health professionals in your networks and interventions

Early input of psychologist and vulnerability assessments is critical. Involve psychologists early on in a multi-agency setting to benefit from multiple perspectives on cases from other agencies. A mental health questionnaire/vulnerability assessment should be used to effectively screen out false signals and determine how a case should be handled and by whom. Greater involvement of psychologists is needed at all levels – not only in treatment, but also in policymaking, setting up and programming interventions, training, quality assurance and research. It is vital to have a range of psychologists available: for mentoring parents, for assessing traumas, and for managing acute crises. For example, certain skills are needed when notifying parents of their child's death, others for supervision of staff/mentors/parental coaches, and still others for assessing the broader psychological health of a family (parents, siblings of the radicalised youth), etc. Together, these all facilitate a holistic approach to be adopted towards the whole family.

3) Carry out awareness-raising and training among P/CVE workers

The previous measures should go hand in hand with awareness-raising and training among all actors involved in the process, including mental health professionals, social workers and law enforcement 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 with refugees, veterans, foreign terrorist fighters, etc.

4) Ensure that interventions are trauma informed

Trauma-informed interventions are necessary as a matter of good practice for very different populations likely to have PTSD or other traumas, such as returnees, war veterans and refugees. When trauma exists in the background (personal, familial and/or communal) of an individual turning towards radicalisation, it is easy to focus on the trauma rather than the structural issues associated with the trauma.

5) Continuously monitor and evaluate the efficacy of P/CVE programmes

Responsible authorities should ensure the continuous monitoring and evaluation of P/CVE programmes, including by ensuring that there is adequate funding for substance use and addiction programmes. Effective communication channels and referrals between services are critical to the success of the multi-agency approach to exit work. Both the specific services and mechanisms of overarching programmes as well as the programmes as a whole have to be monitored and evaluated.

6) Involve CSOs with specialist knowledge in addiction

Work with and enable civil society organisations (CSOs) as independent actors to provide specialised expertise (e.g. P/CVE specialists) and carry out deradicalisation programmes and family or community empowerment and cohesion measures. Radicalised or terrorist offenders often hold a deep-rooted mistrust of state and governmental actors; because CSOs are viewed as distinct from state actors, they may be in a unique position to build trust with such offenders. CSOs may have specialised knowledge and expertise in working with substance use and addiction, and their inclusion in the

rehabilitation process can increase the efficacy of exit programmes. In countries where specialist CSOs in this field are uncommon, state organisations (e.g. public health institutions) may step in here as well.

7) Carry out further research on substance use, addiction and radicalisation

The P/CVE would benefit from further research into this field, particularly on best practices and experiences across a range of countries in Europe.

Warning signs and case studies

How to recognise signs of addiction

From a practical perspective, some general signs of addiction include:

- lack of control, or inability to stay away from a substance or behaviour;
- decreased socialisation, like abandoning commitments or ignoring relationships;
- ignoring risk factors, like sharing needles despite potential consequences;
- physical effects, like withdrawal symptoms or needing higher dosages to have an effect.

These signs are commonly interconnected, and the degree of intensity may depend on different factors. A healthy person can usually identify a negative behaviour and avoid it. This is not the case with someone with an addiction. Rather than admit the problem exists, they will find ways to justify and continue the behaviour [65].

From a clinical perspective, the two main tools for diagnosing substance use disorders are the International Classification of Disease (ICD-11) or the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). The DSM-V allows clinicians to specify how severe or how much of a problem the substance use disorder is, depending on how many symptoms are identified. Two or three symptoms indicate a mild substance use disorder, four or five symptoms indicate a moderate substance use disorder, and six or more symptoms indicate a severe substance use disorder. The ICD-11 distinguishes between harmful substance use (a pattern of substance use that causes damage to physical or mental health, including that of family members) and dependence, which comprises four main criteria (craving and difficulties in controlling use; persistent use despite adverse consequences; tolerance; and withdrawal). Individuals must meet at least two criteria for a classification of dependence. To meet the criteria for harmful use, at least one item of harm must be endorsed and the criteria for dependence should not have been met.

Criterion	ICD-11	DSM-V
Substance used in larger amounts or for longer than intended	X	X
Persistent desire or unsuccessful efforts to reduce substance use		X
Craving or strong desire to use substance		X
Great deal of time spent using substance and recovering from substance use	X	X
Tolerance to substance effects	X	X
Withdrawal symptoms		X
Social, occupational and other activities affected by substance use		X
Continued use, despite recurrent social problems caused by substance use		X
Continued use, despite physical or psychological problems related to substance		X

[65] Tyler, Recognizing an Addiction Problem.

Continued use of substance, leading to failure to fulfil major role obligations	X	X
Recurrent substance use, despite legal problems	X	
Recurrent substance use in hazardous situations	X	X
Family hurt by person's use of substance	X	

Source: The European Monitoring Centre for Drugs and Drug Addiction

Case study: Police, Social Service and Psychiatry (PSP), Denmark [66]

The PSP is a structured cooperation between the police, social services and the psychiatric system in Denmark. The aim of the PSP is to ensure that relevant information is shared, and supportive measures enhanced for citizens at risk, and it involves PSP representatives from each sector meeting frequently. PSP is implemented nationwide, by law. PSP cooperation facilitates the identification of citizens at many kinds of risk (e.g. suicide, substance use, social decline, mental illness), and coordinates relevant intervention and treatment.

Since 2009, so-called Info-Houses have been established in all 12 Danish police districts. They encompass a formal structure or network of local professionals from different sectors working in the field of CVE. All stakeholders have a formal forum where local challenges and concrete concerns related to radicalisation can be discussed. It also enables a clear distribution of duties and responsibilities that can be put in place from the outset, preventing cases from being lost or neglected in referrals from one authority to the other. When the Prevention Centre under the Danish Security and Intelligence Agency (PET) receives a report of possible radicalisation, they conduct an intelligence-led assessment. If this assessment concludes that there is no threat to national security, but there is still one of radicalisation risk, the case is referred back to the Info-House for rehabilitation measures. PET offers advice on which rehabilitation measures should be used by the local authorities through the Info-House.

There have been cases where mental illness was considered a major contributing cause of the threat that falls under PET's field of operation, whether this be radicalisation or threats to public figures. With the PSP collaboration, it is possible to refer suitable cases of this type to mental health services. Here, the local PSP network can reduce the potential threat that the individual poses by focusing on the well-being of the individual through mental health treatment and support in their everyday life. Because a potential threat can be reduced by focusing on the well-being of the person at community level, where preventive measures can be initiated, one of the results of using the PSP is that PET can potentially avoid implementing traditional security and intelligence measures, which are costly and more invasive.

Case study: Luton Family Safeguarding

Luton Family Safeguarding comprises five multi-agency units, each with a mix of mental health, addiction and violence-prevention practitioners drawn from different services (e.g. violence-prevention practitioners are seconded from HM Prison and Probation Service). In addition, these units have the support of an assessment team, senior social worker and clinical psychologist. Staff from the police, health, education and social care are also co-located on the Multi-Agency Safeguarding Hub (MASH) site, as is the local Channel coordinator. The key remit of Luton Family Safeguarding is child protection. This is achieved by supporting children and families where possible, and by intervening to protect children where necessary. It is important to stress that Luton Family Safeguarding was not set up to prevent violent radicalisation leading to terrorism.

It is a statutory service responsible for protecting children and young people from birth to the age of 25. As such, it supports children and families across a range of concerns, including children who are not

[66] Sestoft et al., The Police, Social Services, and Psychiatry (PSP) cooperation as a platform for dealing with concerns of radicalization.

attending school, are at risk of child sexual exploitation or female genital mutilation, have disabilities, commit offences or return from care. Some of these concerns pertain to the protection of children within the family system, including aspects like neglect and emotional, physical or sexual abuse of children in the home. Another set of concerns, however, relates to the life trajectory of children, including the risk of becoming involved in criminality, alcohol and drug misuse, or other behaviours that are to their long-term detriment. Risk of becoming involved in terrorism is just one of many such concerns.

Further reading

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2) RAN Position Paper: Multi-Agency Working and preventing violent extremism: Paper 2. https://ec.europa.eu/home-affairs/pages/page/multi-agency-working-and-preventing-violent-extremism-paper-ii-april-2019_en

3) Basra, R. (2019). Drugs and Terrorism: The Overlaps in Europe. https://icsr.info/wp-content/uploads/2019/11/ICSR-Report-Drugs-and-Terrorism-The-Overlaps-in-Europe.pdf

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5) RAN (2021). Ethical Guidelines for Working on P/CVE in Mental Health Care. https://ec.europa.eu/home-affairs/what-we-do/networks/radicalisation_awareness_network/ran-papers/ethical-guidelines-working-pcve-mental-health-care-2021_en

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About the author:

Lotta Carlsson is a psychotherapist and exit worker at the Deaconess Foundation in Helsinki. She is a RAN Expert Pool Member and has a background in mental health and counselling work.

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