Routledge
Taylor & Francis Group

Behavioral Sciences of Terrorism and Political Aggression

ISSN: 1943-4472 (Print) 1943-4480 (Online) Journal homepage: https://www.tandfonline.com/loi/rirt20

Between vulnerability and risk? Mental health in UK counter-terrorism

Rita Augestad Knudsen

To cite this article: Rita Augestad Knudsen (2020): Between vulnerability and risk? Mental health in UK counter-terrorism, Behavioral Sciences of Terrorism and Political Aggression, DOI: 10.1080/19434472.2019.1703782

To link to this article: https://doi.org/10.1080/19434472.2019.1703782

Published online: 06 Jan 2020.

BEHAVIORAL SCIENCES OF TERRORISM AND POLITICAL AGGRESSION
https://doi.org/10.1080/19434472.2019.1703782

Routledge
Taylor & Francis Group

Between vulnerability and risk? Mental health in UK counter-terrorism

Rita Augestad Knudsen

Norwegian Institute of International Affairs, Security and Defence Group, Oslo, Norway

ABSTRACT

The relationship between terrorism and mental health has been a scholarly concern for decades. So far, the literature has concentrated on the relationship between terrorism and diagnosable disorders, and the prevalence of certain psychological traits among terrorist offenders. Meanwhile, the incorporation of perspectives regarding mental health in the operational space of counter-terrorism has been largely ignored. This article explores three current approaches to individual mental health in UK counter-terrorism: the use of 'appropriate adults' in terrorism-related cases; the 'mental health hubs' introduced in 2016; and counter-terrorism-related risk and vulnerability assessments. The article argues that in light of the UK's new counter-terrorism strategy, these practices show an increasing merger between conceptualisations of vulnerabilities and risks in how UK counter-terrorism approaches mental health.

ARTICLE HISTORY
Received 30 October 2019
Accepted 9 December 2019

KEYWORDS
Counter-terrorism; mental health; risk; vulnerability

Introduction

The relationship between mental health and engagement in terrorism has been a scholarly concern for at least several decades. The main question investigated by researchers on the topic historically and today involve the prevalence of identifiable mental disorders and personality traits among individuals involved in committing acts of terrorist violence. Whereas scholars have tacked the issue from a range of disciplines and vantage points, the possible *causal* relationship between mental health and engagement in terrorism remains unclear (e.g. Bhui & Jones, 2017; Corner & Gill, 2015; Horgan, 2008; Lankford, 2016; McGilloway, Ghosh, & Bhui, 2015; Paulussen, Nijman, & Lismont, 2017; Silke, 1998, 2003). Certainly, acts of terrorism do not on their own signify the presence of mental illness or disorder; conversely, being mentally ill obviously does not by necessity lead one to commit terrorist acts. Similarly left unanswered are questions around what role various mental health issues might play as vulnerabilities, risk factors, or as protective factors, and what the implications of this might be for counter-terrorism.

Practices of handling mental health concerns in the institutional and operational space of counter-terrorism have not been subjected to equal levels of scrutiny. Partial exceptions

CONTACT Rita Augestad Knudsen rak@nupi.no

have been provided by practitioners themselves, such as social care workers and psychiatrists who have become involved in counter-terrorism-related work: Research and writings by and on such professionals have concentrated on opportunities and challenges raised by their field's engagement with counter-terrorism, including questions around effectiveness, professional ethics, worries about securitisation and of over-extension of competences (e.g. Peddell, Eyre, McManus, & Bonworth, 2016; RCP, 2016; Sestoft, Hansen, & Christensen, 2017; Tunariu, Tribe, Frings, & Albery, 2017; Ventriglio et al., 2017; Weine et al., 2017; Wright, 2016; Yakeley & Taylor, 2017).

Meanwhile, the day-to-day practice of counter-terrorism – in the fields of law enforcement, broad-based prevention, and other domains – continues to involve an array of issues related to the mental health of individuals seen to be of concern for terrorism-, extremism- or 'radicalisation'-related reasons. These would include, but not be limited to, the identification of diagnosed mental illness among such populations and how to follow up on their treatment needs, to questions around individuals' capacity for self-representation, and implications of possible mental health issues on criminal prosecutions, including on decisions around sectioning and/or criminal accountability. This article explores how counter-terrorism incorporates conceptualisations about individual mental health operationally and in practice. It is also interested in *what conceptualisations* are operationalised; and in particular, what counter-terrorism's operationalisation of such understandings may say about the field's evolving ideas of risk and vulnerability.

To this end, the article examines three different approaches to mental health within UK counter-terrorism. The UK is often seen to set the tone for other (especially European) countries' adoption of counter-terrorism policies and practices, although uncertainties around the shape and itinerary of the Brexit process may have implications for its continued 'forerunner' status (see e.g. Omand, 2016). The UK also deserves attention at present in light of the recent update of its counter-terrorism strategy CONTEST. In its latest iteration, this strategy foregrounded 'safeguarding' as a core counter-terrorism principle, especially on the field of prevention (HM Government, 2018), with apparent implications for the role of mental health in the area of counter-terrorism.

The three practices this article examines are: (1) the use of *appropriate adults* for 'vulnerable' adults in terrorism-related cases; (2) the *mental health hubs* originally piloted in England in 2016 to liaise and improve cooperation between counter-terrorism police and national health services; and (3) individual terrorism-, extremism-, and radicalisation-related *risk and vulnerability assessments* used in the UK and the role of mental health within the most prominent of these tools. In different ways, these three practical incorporations of various mental health considerations in the field of UK counter-terrorism reveal conceptualisations about the relationship between mental health and counter-terrorism. They also show how ideas of risk and vulnerability are being framed in the space where counter-terrorism and mental health meet.

The article argues that in light of the UK's new counter-terrorism strategy, these three operational approaches to mental health show a more pronounced blurring of the lines between what is considered 'vulnerabilities' and what is understood as 'risks' in the field of UK counter-terrorism. The three cases also confirm the practical and increasingly close relationship between the 'Prevent' and 'Pursue' strands of UK counter-terrorism announced in the 2018 counter-terrorism strategy.

UK counter-terrorism, safeguarding and mental health

In June 2018, the most recent version of the UK's counter-terrorism strategy CONTEST formalised *safeguarding* as a central part of the country's counter-terrorism. In particular, the part of the four-pronged strategy that aims to prevent terrorist attacks, *Prevent*, was then articulated as having as its core purpose 'to safeguard and support vulnerable people to stop them from becoming terrorists or supporting terrorism' (HM Government, 2018, p. 31). The objectives of Prevent were formulated as to 'tackle the causes of radicalisation and respond to the ideological challenge of terrorism' (HM Government, 2018, p. 31); to identify, safeguard and support 'those most at risk of radicalisation through early intervention' (HM Government, 2018, p. 31); and enabling disengagement and rehabilitation of former terrorists (HM Government, 2018, p. 31).

The previous version of CONTEST, published in 2011, was not as unambiguous on the position of safeguarding within UK counter-terrorism. That 2011 document stated that Prevent aimed to 'prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support' (HM Government, 2011; see also Heath-Kelly, 2016; Heath-Kelly & Strausz, 2018). One key part of Prevent, *Channel*, was then described as 'working *alongside* safeguarding partnerships and crime reduction panels' – in other words, it was not presented as in itself a means of safeguarding (HM Government, 2011, p. 64, added emphasis; also HM Government, 2012b). Furthermore, the 2011 strategy also noted that it might not be appropriate to include 'Prevent indicators' into already existing safeguarding mechanisms, as these might not have sufficient 'flexibility' (HM Government, 2011, p. 65). By contrast, in the 2018 version of CONTEST, 'safeguarding' is cited 19 times, with reference to Prevent as itself being a mechanism of safeguarding (HM Government, 2018; see Dresser, 2018 for the place of 'safeguarding' in the 2015 Counter-Terrorism and Security Act).

On the specific role foreseen to be played by health actors within the Prevent prong of CONTEST, however, already the 2011 version had noted that the Department of Health would 'raise awareness of the parallels between Prevent and other types of safeguarding to promote gradual mainstreaming of Prevent across the health service'. (HM Government, 2011, p. 69) That same year, a Department of Health guidance to Prevent for healthcare workers directly situated Prevent within the sphere of safeguarding: Prevent, the guidance said, would be 'most appropriately managed within existing safeguarding structures' (Department of Health [DoH], 2011, p. 4; see also National Health Service [NHS], 2017; and Heath-Kelly & Strausz, 2018 on how this has occurred in practice). With the 2018 version of CONTEST, the positioning of Prevent as a measure of safeguarding was both bolstered and moved closer to the core of what UK counter-terrorism was presented as being about.

When underlining the evolving role of Prevent as a safeguarding measure within UK counter-terrorism, the 2018 CONTEST document stated that '(h)ealth workers and social care staff are at the heart of safeguarding' (HM Government, 2018, p. 36) – hence placing health and social care at the heart of counter-terrorism too. Notably, the part of CONTEST which then addressed the role of the health care sector in delivering Prevent was primarily concerned with *mental* health. In the words of the strategy, while 'no links have been established between mental disorder and group-based terrorism, terrorists who act alone may be more likely to have a background that includes mental ill health';

it is in this context the mental health care sector should ensure that those 'at risk of radicalisation will be able to access the mental health support and treatment they need', and work with counter-terrorism police to manage those at risk of radicalisation (HM Government, 2018, p. 36). When referencing the management of terrorist offenders, the strategy also cited 'mental health issues' as a distinct terrorism-related 'vulnerability' (HM Government, 2018, p. 41).

In addition, as called for by the strategy – and like with the rest of the health, education, social care and related sectors in the UK – mental health care workers were expected to carry out their Prevent duty by referring individuals of concern. The way this duty has been operationalised within these different domains have varied greatly. Educational institutions have accounted for around one third of total referrals to Prevent, police for another third, while health authorities have been responsible for 6% of Prevent referrals (Home Office, 2017d, p. 8). Ever since it was introduced, the Prevent duty and its management by such institutions has also been subjected to intense examination by scholars, examining the many questions and possible trade-offs involved for professionals in terms of confidentiality, ethics and in weighing professional duties against security concerns (see Busher, Choudhury, & Thomas, 2019 for a recent summary regarding the field of education; Heath-Kelly & Strausz, 2019 for health).

The expressed articulation of Prevent as a safeguarding mechanism in the 2018 strategy, and the related alignment between Prevent and the health and social care sectors in the UK have happened as Prevent both remained at the core of CONTEST, and while Prevent was also being brought closer to the *Pursue* part of UK counter-terrorism (see also Elshimi, 2018). Pursue, in the words of CONTEST, had as its key purpose 'to stop terrorist attacks happening in this country and against UK interests overseas' (HM Government, 2018, p. 43), working by means of law enforcement and intelligence measures such as detection, investigation, and prosecution. The 2018 CONTEST document drew up unprecedentedly strong interconnections between Prevent and Pursue, and formulated their purpose jointly, as being 'to reduce the threats we face' (HM Government, 2018, p. 6). Presenting an argument for adjoining the two, the strategy stated that '(t)he timescale for individuals moving from radicalisation to carrying out an attack can be rapid' (HM Government, 2018, p. 13).

The conjoining of the Prevent and Pursue strands of CONTEST represented a shift away from the widely shared – while somewhat simplified, still broadly correct – perception that Prevent addresses 'prevention' meaning what occurs before and in order to prevent the enactment of a terrorist offence (terrorist violence as well as the advocating, planning, or training for an act of violence) and Pursue addresses what happens after a specific offence has been committed. Both, however, target behaviour carried out before an all-out terrorist attack has taken place, in order to stop one from occurring.

The 2018 strategy's closer alignment between Prevent and Pursue hence contributes to undermine the idea that there is a clear distinction between a 'pre'- and 'post'-criminal phase in the chronology leading towards an act of terrorist violence. In earlier counter-terrorism parlance, the UK Government sometimes referred to parts of Prevent as addressing a 'pre-criminal' space, but this phrase does not appear in the 2018 CONTEST document. That updated strategy's merger of Prevent and Pursue appears to have replaced this terminology with an outlook that does not sharply delineate the 'pre-' or 'non'-criminal space from the criminal one: the whole pre-attack or

pre-violence arena (whether involving criminal acts or not) seems to be conceptualised and addressed as one.

The dual and apparently contrasting move of Prevent within the 2018 CONTEST strategy – simultaneously towards a 'softer' emphasis on safeguarding and supporting vulnerable people *and* towards the 'harder' Pursue prong with that strand's emphasis on managing security risks through stopping, investigating and prosecuting crimes – seems to place mental health in the tension between security and care within the field of counter-terrorism. In lieu of either scholarly answers or clear policy guidance on the relationship between terrorism and mental health, or on what role perspectives on mental health should play in counter-terrorism – finding a place in this changing landscape would be expected to pose a challenge both to mental health care workers and counter-terrorism practitioners in the UK.

Preventing terrorism: risk, vulnerability and anticipatory action

The 'Prevent' element of the UK's counter-terrorism strategy is concerned with acting early to stop terrorist acts from being carried out. Clearly, prevention has a long and multifaceted history within police, social and youth work – as well as in other fields including health and natural disasters – and is, for instance, at the core of the 'Scandinavian model' of counter-terrorism and counter-'radicalisation'. Within (critical) security studies scholarship, however, some have questioned the role and nature of preventative counter-terrorism work, considering its present-day development as signifying a temporal focus shift away from primarily stopping looming acts of terrorist violence (and responding to these), towards stages further back in an assumed pre-attack chronology. Such scholarly framings seem in part inspired by strands of military doctrine, which has sometimes described preventative action as behaviourally indistinguishable from aggressive acts, in that both entail acting on perceived risks that have not (yet) matured into threats (Gray, 2007, p. 36).

Writing on counter-terrorism, Jessica Stern and Jonathan B. Wiener, for instance, have warned of undertaking counter-terrorist action against potential threats before these become imminent; such action, they argue, would likely be too expansive, possibly counter-productive – and problematically shifts the burden of proof onto those arguing for restraint (Stern & Wiener, 2008, esp. p. 131; also Brown & Cox, 2011). Louise Amoore has relatedly cautioned against limited information on potential risks becoming the grounds for wide-ranging preventive counter-terrorism measures (Amoore, 2013; also Amoore & de Goede, 2008; Bracken, Bremmer, & Gordon, 2008, esp. pp. 1–15). And including counter-terrorism in a wider discussion of temporality and risk, Ben Anderson questions how, when allowing anticipatory action to become the norm, an unknown future becomes the justification for action in the here and now (see Anderson, 2010, pp. 778–780). A resembling temporal move could be observed on the field of terrorism legislation: Broadly speaking, the tendency of terrorism legislation has been to criminalise behaviour increasingly further back in the chronology from an act of terrorist violence, capturing for instance planning, encouraging, financing, training for, and providing material support for terrorism (see e.g. United Kingdom Terrorism Act [TACT], 2006).

With the 2018 CONTEST document's emplacement of safeguarding at the core of UK counter-terrorism practice, the concept of vulnerability has properly entered onto the

counter-terrorism-specific (but not counter-terrorism exclusive) scene of risk and temporality. Scholars generally conceptualising vulnerability from different disciplinary angles have already argued for understanding vulnerability in terms of how it compels state responsiveness, rather than as a feature existing 'in itself' (e.g. Dehaghani & Newman, 2017): Others have provided categorisations including both inherent conditions such as e.g. age or disability, and contextual circumstances (for a more nuanced categorisation, see e.g. Brown, 2015, esp. pp. 29–48), whereas others again have posited vulnerability as a universal feature of the human condition; not so much an innate quality as a characteristic emerging from an individual's embeddedness in a social and institutional setting (Fineman, 2013).

In UK governance and legislation, 'vulnerability' has tended to be defined in terms of an individual lacking capacities and needing protection (DoH, 2000, 2014; UK Care Act, 2014; UK Safeguarding Vulnerable Groups Act [SVGA], 2006); the operational meaning of the term within the field of counter-terrorism will be returned to in the three sections below. From the discipline of political sociology, Kate Brown (e.g. 2011) has argued that the concept of 'vulnerability' functions in problematic ways, especially in interactions between individuals and the state with regard to welfare provision. In particular, she claims, the uncertainties, ambiguities and contingencies in the operational meaning of 'vulnerability', as well as the political, ethical and practical implications and baggage of this term, makes reliance upon categorisations of 'vulnerability' potentially damaging to social justice. Within this line of critical inquiry, defining someone as 'vulnerable' undermines their agency and opens up for potentially baseless and possibly damaging state interventions (see also Coppock & McGovern, 2014).

Within UK counter-terrorism, the 2018 CONTEST strategy seems to present 'vulnerability' as specifically tied to individual mental ill health, and to posit this notion as central to its reframing of counter-terrorism and especially Prevent in terms of safeguarding. This version of the strategy, it is worth recalling, was launched while scholarship has remained unsettled on the relationship between mental health and terrorism – and while numerous questions are still unresolved around how different mental health issues could be either contributing to, protecting from, or resulting from terrorist engagement.

It is worth stressing that scholars interested in vulnerability in a terrorism context have also insisted on the importance of distinguishing between vulnerabilities in the 'general' senses theorised by the literature cited above, and the specific vulnerabilities that may be of note in relation to someone's terrorist involvement (Bhui, 2016; Cole, Alison, Cole, & Alison, 2014; Corner, Bouhana, & Gill, 2018a, p. 8). Some have suggested that the 'vulnerabilities' actually relevant in a 'radicalisation' or terrorist setting might be broadly categorised in terms of being susceptible to moral change, and exposed to radicalisation settings (Bouhana & Wickström, 2011; see also Bhui, 2016; Corner et al., 2018a, p. 8). This, however, does not appear to have been taken on board by the Prevent practitioners (from a range of sectors not specified) cited in one study as summing up the vulnerabilities relevant to their field as being 'mental health problems', social isolation, and relative deprivation (Peddell et al., 2016). Also other research from the UK shows that both crime- and care-related 'vulnerabilities' tend to be understood in general ways not particularly relevant to radicalisation or terrorism – and in manners that could be contingent and arbitrary (Braye, Orr, & Preston-Shoot, 2011; Dehaghani, 2017a, 2018b).

The centrality of conceptualisations of mental health vulnerabilities and safeguarding in the 2018 CONTEST strategy makes it pertinent to explore how mental health perspectives are being incorporated in UK counter-terrorism in practice. Examining such practices will also serve to show how changing understandings are translated into concrete counter-terrorism action, and reveal the underlying assumptions of mental health, vulnerabilities, risks, and of the relationships between these concepts.

Risk assessment and mental health

One place to start such an examination would be with the main risk and vulnerability assessments directly aimed at capturing the risks and vulnerabilities relevant in a counter-terrorism context. Indeed, individual risk assessment has long been central to counter-terrorism. In the UK, such risk assessments have been important to the custodial follow-up of sentenced terrorism offenders and other prisoners since 2011, and of individuals receiving interventions through the *Channel programme* as part of the Prevent strategy since 2012 (Augestad Knudsen, 2018). The UK's recent CONTEST strategy in effect significantly increased the number of individuals of interest to authorities from a counter-terrorism perspective. Specifically, the strategy included a strengthened focus on closed and closing subjects of interest, in total more than 20,000 individuals, as well as hundreds of returning foreign fighters/travellers along with at least 700 ex-offenders (HM Government, 2018, p. 21, 26, 40–41). As authorities seek to decide on whom among these large and diverse populations to devote special attention, the importance of terrorism-related individual risk assessments would seem to grow even further.

Until 2018, the two main terrorism-related risk and vulnerability assessment tools in use in the UK were the Extremism Risk Guidance (ERG 22+) and the Vulnerability Assessment Framework (VAF) (Lloyd & Dean, 2015; HM Government, 2012a). The ERG 22+ is used on offenders in prison, while the VAF is being used as one part of the Channel process – Channel is a key part of Prevent aimed at identifying and providing support to those at risk of 'radicalisation' (HM Government, 2012a, 2012b). While applied to different parts of the UK counter-terrorism system, the two tools are closely related. The VAF was developed based on the ERG22+ with one of that tool's two main authors involved. Both tools contain the same 22 risk indicators, similarly grouped into three categories. In April 2018, a trial of two additional and linked risk assessment tools created for and by UK counter-terrorism police were rolled out in England by Counter-Terrorism Policing Headquarters Prevent. The two new tools are now in review until January 2019.

Of the 22 indicators that the ERG22+ and the VAF share, one is referred to as 'mental health'. In both the ERG22+ and the VAF, the mental health indicator belongs to the category of 'engagement' indicators. The creators of the ERG22+ – from which the VAF was later derived – have described 'engagement' as referring to 'the process by which individuals become involved with or identify with an extremist group, cause, or ideology', and as 'a term emerging in the literature that reflected a commitment to ideology, group, or cause'(Lloyd & Dean, 2015, p. 42, 45). The engagement factors are jointly described as able to capture 'relevant beliefs' (Lloyd & Dean, 2015, p. 45).

While the ERG22+ does come with guidelines that should be expected to provide some detail on how to understand and register the 'mental health' indicator, the VAF (HM Government, 2012b, p. 2) simply references '(r)elevant mental health issues' without further

elaboration. When completing a VAF, therefore, the local authority officials or police in charge of such assessments as part of the Channel process are therefore left to decide for themselves – without the relevant mental health training – if the indicator of 'relevant mental health issues' is present or not present. The research cited above on how security practitioners conceptualise mental health-related and other vulnerabilities does not seem to offer insurance that this indicator would be registered accurately (Peddell et al., 2016; see also Dehaghani, 2017b; Home Office, 2017c; Local Government Association [LGA], 2018; also Martin, 2018).

In fact, some of those completing ERG22+ assessments in a prison context might face a similar challenge, regardless of the specificity of the tool's written guidelines. Whereas forensic psychologists and psychiatrists might be well equipped to identify the relevant mental health issues when carrying out an ERG22+, probation officers – however experienced – would probably not be, even after the required two-day training in the tool. Indeed, it would seem like a daunting task for anyone without proper mental health training to spot which mental health issues should be cited as vulnerabilities in a counter-terrorism context, or why – let alone what to do with such information, were one able to acquire it. This might be difficult even for experienced psychiatrists or psychologists, should they lack specific training and experience with *terrorism*-related risk and mental health vulnerabilities. The changing profiles of those involved in terrorism in the UK and elsewhere would further complicate this picture. Research from 2016, for instance, showed that this demographic then included more people than earlier with a criminal record, as well as of lower socio-economic and educational status than before, likely reflecting changing recruiting patterns among terrorist groups (Basra & Neumann, 2016, e.g. p. 13).

In this light it seems on point to call for more nuance in how 'mental health' is included in tools for assessing terrorism-related risk (see e.g. Corner et al., 2018a). Scholars have also questioned the absence of guidance as to the base rate prevalence of various mental health conditions, and of instructions regarding appropriate processes for information gathering (Corner, Gill, Schouten, & Farnham, 2018b, p. 8; Sarma, 2017). Whereas the first of these omissions would be relevant primarily to the *weighing* of a mental health indicator in terms of risk, it seems even more important that the tools do not explain how being generally 'vulnerable' through experiencing mental health problems would make one vulnerable specifically to *radicalisation* or *terrorism* (see also Chisholm & Coulter, 2017; Corner et al., 2018a, p. 6). As already touched upon, mental health problems could certainly be described as making people 'vulnerable' in that they could negatively impact on their day-to-day functioning and relationships. But how such a generalised vulnerability translates into a *counter-terrorism* context is much less clear (see also Rousseau, Ellis, & Lantos, 2017; Scurich, 2016, p. 5).

It is worth noting here that mental health does not appear to play the same role risk wise with regard to terrorist engagement or terrorist violence as it does in the enactment of 'generic' violence (see e.g. Monahan, 2012). When explaining why she developed one of the main (Canada-originated) specialised risk assessment tools for extremism-related violence (VERA2 – Violent Extremism Risk Assessment, Version 2), Elaine Pressman stressed that the existing, generic risk assessment models – aimed at capturing violence risk among a general population and the mentally disordered – weighed mental illness heavily (Pressman, 2009, p. 16). Noting this as an explanation for why she developed a

specialised risk assessment tool for extremism-related risk clearly implies that mental health – while possibly relevant to include – should *not* be weighted as heavily in assessments of this kind.

Regardless of practice so far, to put significant expectations and weight onto a disaggregated category of 'mental health' in any new or existing terrorism- extremism- or 'radicalisation'-related risk or vulnerability assessment tool would hence seem ill advised (see also Powis, Randhawa, & Bishopp, 2019). It would also pose the possible hazard of unnecessarily increasing the stigma already associated with mental health difficulties, and of securitising such difficulties by associating an unspecified idea of 'mental health' with terrorism-related risk (see also Bhui, James, & Wessely, 2016; also McKendrick & Finch, 2017a, 2017b; Weine et al., 2017). The continuing existence of insufficiently clear categories of 'mental health' indicators in terrorism-related risk assessment tools certainly moves mental health vulnerabilities closer to the field of terrorism-related *risk* within UK counter-terrorism.

Appropriate adults

In turning from the attempts to measure terrorism-related risk and vulnerability to ideas vulnerability in UK counter-terrorism, the appointing of 'Appropriate Adults' to individuals above the age of 18 in terrorism-related cases is a useful practice to explore. Besides helping to further unpack UK counter-terrorism's conceptualisations of 'vulnerability', the practice should serve to illuminate one of the ways in which considerations around mental health are operationalised in the counter-terrorism domain. Specifically, Appropriate Adults are appointed to any detainee below the age of 18, as well as to adult detainees deemed to be 'vulnerable', but not so vulnerable as to warrant a full mental health assessment – in terrorism-related and in other cases (National Appropriate Adult Network [NAAN], 2018a).

The Appropriate Adult function is an explicit safeguarding mechanism. Historically, the practice of appointing Appropriate Adults was introduced in the UK in 1984 explicitly to safeguard the rights, entitlements and welfare of juveniles and vulnerable persons and in order to avoid miscarriages of justice. Appropriate Adults should be present in terrorism-related and in other cases during a vulnerable individual's interactions with police, to observe whether police are acting correctly and whether the person's situation has changed. They can assist the detainee in understanding rules and procedures including for instance those regulating searches and interviews, and/or advise police in effective communication with the person. They can also intervene if the detainee is not being treated properly, or if the Appropriate Adult believes the person would benefit from having a solicitor present (Gov.UK, 2014; NAAN, 2018a).

There is no statutory requirement for the police to appoint an Appropriate Adult for detainees aged 18 or older, but they are obliged to do so for persons aged 17 or under (e.g. Dehaghani, 2017a, e.g. p. 190). However, if an Appropriate Adult is *not* appointed and it later turns out that one should have been, the evidence gathered without the Appropriate Adult present – for instance during a police interview – might not hold up in court. Nonetheless, 2014 figures showed that while at least 39% of those in contact with probation would then have met the threshold for having an Appropriate Adult present (Bath, 2014a), certain areas of the UK requested the service in only 0.016% of cases (Bath, 2014b).

According to Chris Bath, chief executive of the UK's National Appropriate Adult Network, the threshold for appointing Appropriate Adults may effectively be lower in terrorism-related cases than in other cases. From the police perspective, terrorism-related cases are both associated with more resources and a higher degree of risk, increasing incentives for implementing all safeguards that would protect the validity of evidence and avoid future challenge or the collapse of prosecutions. At the same time, some TACT custody facilities are located in areas where there are no organised Appropriate Adult services available for adults (Bath, 2018).

Since the criteria for a detained adult having an Appropriate Adult appointed – in terrorism-related as in other cases – is that the person is 'vulnerable', the concept of vulnerability is at the heart of the practice (see also Dehaghani, 2017b). Interestingly, in 2018, the same summer as the UK launched its new CONTEST strategy, the country's regulations for detention, treatment and questioning by police officers (Police and Criminal Evidence Act, PACE) specifically including its definition of 'vulnerability' was revised too. The revisions in the definition of vulnerability similarly encompassed in both the version of PACE regulating ordinary arrests – Code C – and the version regulating detention, treatment and questioning by police under the UK Terrorism ACT (TACT) – Code H (Home Office, 2018a, 2018b). Since the focus of this article is on counter-terrorism, only Code H will be discussed here.

Before the summer of 2018, PACE described 'vulnerable' adults as 'people who are mentally disordered or otherwise mentally vulnerable', and further stated:

> "(m)entally vulnerable" applies to any detainee who, because of their mental state or capacity, may not understand the significance of what is said, of questions or of their replies. "Mental disorder" is defined in the Mental Health Act 1983, section 1(2) as "any disorder or disability of mind". (Home Office, 2017a and 2017b – Codes C and H, Notes for Guidance 1D and 1G)

In other words, if a detainee had a mental disorder, that person would ipso facto be categorised as vulnerable and should have an Appropriate Adult appointed. If the detainee did not have a mental disorder, the person could still be categorised as vulnerable if they did not understand (the significance of) what was being said or what they themselves said.

In July 2018, this protocol changed with PACE's new definition of 'vulnerability'. According to the new code:

> *(d) 'vulnerable' applies to any person who, because of their mental health condition or mental disorder (…)*:
>
> *(i) may have difficulty understanding or communicating effectively about the full implications for them of any procedures and processes connected with*:
>
> • their arrest and detention at a police station or elsewhere;
>
> • the exercise of their rights and entitlements.
>
> *(ii) does not appear to understand the significance of what they are told, of questions they are asked or of their replies*.
>
> *(iii) appears to be particularly prone to*:
>
> • becoming confused and unclear about their position;
>
> • providing unreliable, misleading or incriminating information without knowing or wishing to do so;

- accepting or acting on suggestions from others without consciously knowing or wishing to do so; or

- readily agreeing to suggestions or proposals without any protest or question. (Home Office, 2018b – Code H – section 1.17. Code C, section 1.13 provides an almost identical definition, Home Office, 2018a).

These changes meant that after the summer of 2018, only those who met the 'functionality test' outlined above would count as being vulnerable and as meeting the threshold for having an Appropriate Adult appointed to them (NAAN, 2018b offers a thorough overview of this and the other PACE revisions). Whereas previously, a detainee with a diagnosed mental disorder would automatically be considered vulnerable and as having met the threshold for having an Appropriate Adult, such an individual would now be defined as vulnerable and get an Appropriate Adult only if that person was also seen to be *functionally* vulnerable. As per the criteria above, this would primarily entail having difficulties with understanding and communicating, in ways observable and identifiable to the police.

The latter is significant and related to another relevant change to PACE with the 2018 version, apparently further raising the threshold for appointing Appropriate Adults. The previous version of the document stated that a detainee should be treated as vulnerable – and hence prompt the appointment of an Appropriate Adult – if police '*any doubt* about the mental state or capacity of the detainee' (Home Office, 2017a, 2017b, Notes for Guidance 1G, added emphasis). In the 2018 version, this was changed to state that a person should be treated as vulnerable and have an Appropriate Adult appointed if an officer 'has any *reason* to suspect' that a person might be vulnerable (Home Office, 2018b section 1.10, added emphasis). The code did not provide any guidance of how precisely to determine whether there had been sufficient 'reason' to believe that a detainee was in fact vulnerable.

These changes to how PACE defined and approached vulnerability effectively removed mental health disorders from clear inclusion in the category of 'vulnerability' within this specific part of UK counter-terrorism and security practice. This also seemed to limit the opportunities for those with a mental health diagnosis to access the safeguard provided by having an Appropriate Adult present at important moments during their detention. Although seemingly unrelated, and occurring at a very specific location in the changing topography of UK counter-terrorism, it is striking that this happened at the same time as mental health care and mental illness were placed at the heart of CONTEST – and as mandate of the mental health hubs expanded further into the Pursue space. Taken together with the continued inclusion of a disaggregated category of 'mental health' in terrorism-related risk assessment, these practices seem to represent a repackaging of mental difficulties, mental illness and/or mental disorders from being seen as vulnerabilities to being addressed as risks within the framework of UK counter-terrorism.

Mental health hubs

The final practice to be addressed here, is the mental health 'hubs' piloted in three English cities in 2016, with a mandate extended in 2017, and now likely to be made a permanent feature of UK counter-terrorism. The hubs are perhaps the clearest example of how ideas around vulnerabilities and risks are materialised in UK counter-terrorism. Initiated as a

collaboration between National Counter-Terrorism Policing, the NHS (National Health Service) through the Department of Health, as well as the Home Office (National Police Chiefs' Council [NPCC], 2016), the hubs received joint funding from each of these bodies. The articulated aim of the hubs was to

> assess the value of mental health professionals working alongside counter terrorism police officers. This is in relation to the management of individuals referred to the police with known or suspected mental disorders who may be vulnerable to radicalisation and extremism. (Radicalization Awareness Network [RAN] / National Counter Terrorism Policing Head Quarters [NCTPHQ], Undated; see also NPCC, 2016, 2017, Undated)

The three hubs were established in London (covering London, the South East and South West), Birmingham (covering the East Midlands, the West Midlands and Wales), and Manchester (covering the North).

Initially, the hubs were meant to support counter-terrorism police involved in Prevent in liaising with health services, and to offer advice to Prevent and other counter-terrorism teams. A core objective from the start was to 'improve the understanding of both police and health professionals of the associations between mental health conditions and vulnerability to radicalisation'. This was initiated after a research programme had identified 'a broad range of mental health and psychological difficulties' in around half of 657 Prevent referrals (NPCC, Undated; see also Corner et al., 2018b).

By embedding mental health professionals within police teams, the hubs should – from their inception and as their continue their work today – enable police to detect earlier those who had or had previously had mental health difficulties, hence 'increase access to mainstream service for vulnerable individuals and – as a result of early intervention – improve health outcomes, achieve cost efficiency savings and reduce risk to the public'. (NPCC, Undated; Holden, 2017; Taylor, 2018). Another key purpose is to promote better information sharing between health services and police, since the police had experienced problems with reaching medical practitioners in the past (Holden, 2017). The hubs involved mental health nurses, as well as senior clinical psychologists and psychiatrists employed by the NHS, working on cases in close collaboration with counter-terrorism police.

To some extent, the UK hub initiative resembles multisector cooperation arrangements elsewhere, including variations on the Scandinavian SSP (School, Social and health services, and Police) model, such as the PSP (police, social services, and psychiatry) in Denmark (e.g. Sestoft et al., 2017) – or, relatedly, the formalised cooperation between prison authorities and Oslo University Hospital in Norway (OU, 2019). However, the focus of the 'Scandinavian model' is on broad-based multisector collaboration and early prevention as integrated parts of the countries' general provision of welfare (e.g. Regjeringen, 2019). And in the latter case, the focus has primarily if not only been on addressing and resolving questions around criminal accountability and the prospects of a possible 'insanity defence'. The UK hubs, however, are distinguished from these initiatives in that they are police led, could involve other counter-terrorism and security actors, and are hence squarely located within a security framework.

The development of the workload of the hubs seems to have removed them even further from models such as the Scandinavian ones. At the start, the hubs were almost exclusively working on Prevent referral cases, although from the outset primarily on police-led ones, rather than on the Prevent cases that were held by local authorities

(Holden, 2017; NPCC, 2016, Undated). Increasingly, however, the hubs have worked with referrals also from the investigation space, and handle live cases too (Taylor, 2018). This seems to represent a reorienting of the hubs' original objectives from being in the main Prevent-focused to an increasing involvement with Pursue – in line with the overall development of UK counter-terrorism and the alignment between these two CONTEST strands. From an initiative chiefly set out to liaise between health and security services in order to divert individuals onto the support they need *before* and so they should not go on and commit terrorist crimes, the hubs have become a potential measure for assisting investigations into individuals who may already have committed crimes.

Such a reorientation raises questions as to whether the hubs may risk transforming from being principally measures of health care into tools of intelligence gathering for preparing or conducting active counter-terrorism investigations. The critical security studies 'risk' literature referenced above would warn of such a development, and be especially wary of the prospect of extending the hubs' mandate even further, such as into the fields of covert operations and surveillance. In the framing of such security studies scholarship, counter-terrorism's general tendency towards over-extension would warrant alertness of the hubs being used as a risk assessment technique targeted *even further back* in the chronology from a committed offence – at capturing signs of terrorism-related risk in individual behaviour and traits.

The experienced practitioners involved with the hubs should be expected to be attentive to the range of ethical challenges involved with their work. Nonetheless, the hubs place them in a different role than their usual one as primarily being NHS health care providers: at the hubs, they provide counter-terrorism police with direct as well as 'indirect' assessments (that is, assessments not based on an in-person meeting with the patient) of individuals of concern, and are not themselves involved in individuals' treatment (Bhui, 2016; NPCC, Undated; also Stanley, 2018; Yakeley & Taylor, 2017). Moreover, while there is no reason to believe that the hubs are not adhering to information sharing and confidentiality laws and regulations, they would have made accessing individual health records, for instance, easier for security authorities – than when these would have had to approach such records from the 'outside' (see also British Medical Journal, 2017a; Wright, 2016).

Another way in which the hubs could challenge the traditional roles of a mental health care provider, is that they open for diverting vulnerable people away from prosecution and into 'urgent care pathway' treatment (only) if they are considered at risk of radicalisation or of committing a terrorism-related offence (NPCC, Undated, p. 2018). One of the hubs' original objectives was to assist in the provision of mental health care to those who need it in order to prevent them from causing harm to themselves and others. All the same, as pointed out in a recent report, this could create 'incentives for practitioners to refer patients to Prevent', if they predicted that patients this way would get treatment faster (Heath-Kelly & Strausz, 2018, pp. 53–54). Such misrepresentations of individual diagnostic and risk profiles might unnecessarily categorise someone as a terrorism-related subject of interest, and undermine trust in both health and security authorities.

Apart from the practical and operational evolution of the hubs, authorities' descriptions of them also contribute to reframe mental health related 'vulnerabilities' for a counter-terrorism context. As summed up by the National Police Chiefs' Council,

> Not all of these cases offered support (after assessment by the hubs) will have a CT *vulnerability* but all will have unmet health needs. Clinicians are embedded within police Prevent teams and together they are reducing the *risk* to individuals and the public. (NPCC, 2017)

Similarly, in a 2017 interview, the policing lead on UK counter-terrorism explained that police and health care services needed to cooperate closely in order to stop vulnerable people (and those) with mental health issues from becoming radicalised. Because, he stated '(i)f we don't intervene soon enough, that victim becomes a very serious perpetrator' (BMJ, 2017b). These statements suggest some fluctuation in the conceptual boundaries between mental health – and/or counter-terrorism-related vulnerability, and between vulnerabilities and risks – and between the risks individuals may pose to themselves and/or to the public.

The very setting up the hubs as part of an increased counter-terrorism focus on mental health within Prevent, as well as the hubs' movement towards clearer inclusion in the more 'hard security'-oriented Pursue suggest a certain direction of travel: Towards mental health vulnerability gradually becoming part of the conceptual domain of terrorism-related *risk*, and being addressed as such within the UK counter-terrorism system (see also Holden, 2017; Stanley, 2018).

Conclusions

The 2018 UK counter-terrorism strategy implicitly proposed a partial discursive recasting of counter-terrorism: from being about protecting (the public and the state) from security risks, to providing support (to individuals) in managing and overcoming vulnerabilities – and a corresponding shift in the field's location between care and security. At the same time, the formalisation of mental health vulnerability and safeguarding in UK counter-terrorism seems not to have changed counter-terrorism's overall risk calculus, but simply incorporated vulnerability as 'early' type of (potential) risk. While 'vulnerability' from the perspective of the state has conventionally been connected with lack of capacity and with care needs (e.g. DoH, 2014; UK Care Act, 2014), UK counter-terrorism now appears to be increasingly direct in linking mental health vulnerability to a potential capacity for involvement in terrorism. From a primary conceptual location within a domain of care, 'vulnerability' now seems relatively more closely associated with an early stage of a foreseen pre-attack timeline, prompting responses emphasising crime risk management such as surveillance and investigation rather than a treatment pathway.

The practical approaches to mental health examined in this article show how central concerns around mental health have become to the domestic counter-terrorism practices of what might be Europe's leading state on the field. In different ways, they can serve as both inspiration and warning to other states in search of better counter-terrorism policies and ways in which to incorporate mental health considerations. At a basic level, the three practices reveal that UK counter-terrorism considers mental health as relevant to addressing terrorism, and regards ill mental health – from diagnosed disorders to issues that may not involve psychiatry – both as a risk and as a vulnerability, sometimes at the same time. The relatively long experience within the UK (compared to many other Western countries) with using specialised terrorism-related risk and vulnerability assessment as well as dedicated mental health hubs should provide some lessons for those countries interested in developing similar models.

Take the mental health hubs. Although no full study has been conducted of them yet, anecdotal evidence suggests that the mental health have successfully diverted individuals vulnerable for mental health reasons onto treatment instead of locking them into a criminal prosecution pathway. At the same time, the development of the hubs particularly their increasing involvement in live cases are evidence of the increasing merger between the Prevent and Pursue strands of UK counter-terrorism. This de-emphasising of the boundaries between these two strands of counter-terrorism indicates a rethinking of the presumed sequencing of a pre-attack chronology, and more fundamentally, of the causality of terrorism. This again seems to manifest change the focus of counter-terrorism action further back in a an assumed causal chain leading to criminal action – with a desire for policy action more than a sound evidence basis as the driver of this change. Before counter-terrorism in the UK or elsewhere continues in this direction, there is a clear need to take stock and establish a more solid evidentiary ground on which to proceed.

Moreover, these different counter-terrorism domains offer no additional and sorely needed guidance on how, exactly, different vulnerabilities might be relevant to prevent terrorism, or on how these might manifest or be observable in practice – or on what the precise mechanisms may be for making 'mental health' a vulnerability and/or a risk in the specific context of counter-terrorism. The absence of such guidance in all the practices examined here creates the unfortunate possibility of grouping together populations as 'vulnerable' or 'risky' who may not in fact be so and who may have little in common in terms of how they should be meaningfully approached by counter-terrorism.

Acknowledgements

The author is grateful for the support of the Norwegian Ministry of Justice and Public Safety, which provided partial funding for the research this article is based on. Thanks also to Ole Martin Stormoen for invaluable support and copy editing.

Disclosure statement

No potential conflict of interest was reported by the author.

Funding

The author is grateful for the support of the Norwegian Ministry of Justice and Public Security, which provided partial funding for the research this article is based on.

Notes on contributor

Rita Augestad Knudsen is the Senior Researcher on counter-terrorism at the Norwegian Institute of International Affairs (NUPI), Security and Defence Group and the Managing Director of the Consortium for Research and Terrorism and International Crime.

References

Amoore, L. (2013). *The politics of possibility: Security and risk beyond probability*. Durham, NC: Duke University Press.

Amoore, L., & de Goede, M. (Eds.). (2008). *Risk and the war on terror*. New York: Routledge.

Anderson, B. (2010). Pre-emption, precaution, preparedness: Anticipatory action and future geographies. *Progress in Human Geography*, *34*(6), 777–798.
Augestad Knudsen, R. (2018). Measuring radicalisation: Risk assessment conceptualisations and practice in England and Wales. *Behavioural Sciences of Terrorism and Political Aggression*, 1–18.
Basra, R., & Neumann, P. R. (2016). *Criminal pasts, terrorist futures: European Jihadists and the new crime-terror nexus*. London: International Centre for the Study of Radicalisation.
Bath, C. (2014a, April). *Who's looking out for the adults?* London: National Appropriate Adult Network.
Bath, C. (2014b, April). *Liaison & diversion and the provision of appropriate adults for mentally vulnerable adults*. London: National Appropriate Adult Network.
Bath, C. (2016). Interviewed by author through Skype and by email, October 2018.
Bhui, K. (2016). Flash, the emperor and policies without evidence: Counter-terrorism measures destined for failure and societally divisive. *British Journal of Psychiatry Bulletin*, *40*(2), 82–92.
Bhui, K., James, A., & Wessely, S. (2016, September 13). Mental illness and terrorism. *British Medical Journal*, editorial.
Bhui, K., & Jones, E. (2017). The challenge of radicalisation: A public health approach to understanding and intervention. *Psychoanalytic Psychotherapy*, *31*(4), 401–410.
Bouhana, N., & Wickström, P. H. (2011). *Al Qa'ida-influenced radicalisation: A rapid evidence assessment guided by situational action theory*. London: UK Home Office.
Bracken, P., Bremmer, I., & Gordon, D. (Eds.). (2008). *Managing strategic surprise: Lessons from risk management and risk assessment*. Cambridge: Cambridge University Press.
Braye, S., Orr, S., & Preston-Shoot, M. (2011). *The governance of adult safeguarding: Findings from research into safeguarding adults boards*. London: Social Care Institute for Excellence.
British Medical Journal (BMJ). (2017a). *Government's counterterrorism strategy is having little impact in the NHS*. London: Author. Retrieved from BMJ website: www.bmj.com/company/newsroom/governments-counterterrorism-strategy-is-having-little-impact-in-the-nhs/
British Medical Journal (BMJ). (2017b, April 27). *This is new and dynamic, and we are going to have to learn together*. Retrieved from BMJ website: www.bmj.com/content/357/bmj.j1970
Brown, G. D., & CoxJrL. A. (2011). How probabilistic risk assessment can mislead terrorism risk analysts. *Risk Analysis*, *31*(2), 196–204.
Brown, K. (2011). "Vulnerability": Handle with care. *Ethics and Social Welfare*, *5*(3), 313–321.
Brown, K. (2015). *Vulnerability and young people: Care and social control in policy and practice*. Bristol: Policy Press.
Busher, J., Choudhury, T., & Thomas, P. (2019). The enactment of the counter-terrorism "prevent duty" in British schools and colleges: Beyond reluctant accommodation or straightforward policy acceptance. *Critical Studies on Terrorism*, *12*(3), 440–462.
Chisholm, T., & Coulter, A. (2017). *Safeguarding and radicalisation*. London: Department for Education.
Cole, J., Alison, E., Cole, B., & Alison, L. (2014). *Guidance for identifying people vulnerable to recruitment into violent extremism*. Liverpool: University of Liverpool. Retrieved from https://preventforfeandtraining.org.uk/wp-content/uploads/2017/09/IVP_Guidance_Draft_v0.3_web_version.pdf
Coppock, V., & McGovern, M. (2014). 'Dangerous minds'? Deconstructing counter-terrorism discourse, radicalisation and the 'psychological vulnerability' of Muslim children and young people in Britain. *Children & Society*, *28*(3), 242–256.
Corner, E., Bouhana, N., & Gill, P. (2018a). The multifinality of vulnerability indicators in lone-actor terrorism. *Psychology, Crime & Law*, *25*(2), 111–132.
Corner, E., & Gill, P. (2015). A false dichotomy? Mental illness and lone-actor terrorism. *Law and Human Behavior*, *39*(1), 23–34.
Corner, E., Gill, P., Schouten, R., & Farnham, F. (2018b). Mental disorders, personality traits, and grievance-fueled targeted violence: The evidence base and implications for research and practice. *Journal of Personality Assessment*, *100*(5), 459–470.
Dehaghani, R. (2017a). Identifying vulnerability. *Criminal Law and Justice Weekly*, *181*(4).
Dehaghani, R. (2017b). *Vulnerability in police custody: Definition, identification and implementation in the context of the appropriate adult safeguard*. (Doctoral dissertation). Leicester Law School, University of Leicester.

Dehaghani, R., & Newman, D. (2017). 'We're vulnerable too': An (alternative) analysis of vulnerability without English criminal legal aid and police custody. *Onati Socio-Legal Series*, *7*(6), 1199–1228.

Department of Health. (2000). No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse. Retrieved from UK government website: www.gov.uk/government/publications/no-secrets-guidance-on-protecting-vulnerable-adults-in-care

Department of Health. (2011). *Building partnerships, staying safe: The health sector contribution to HM Government prevent strategy: Guidance for healthcare workers*. London: Department of Health.

Department of Health. (2014). *Care and support statutory guidance*. London: Department of Health.

Dresser, P. (2018). Counter-radicalisation through safeguarding: A political analysis of the counter-terrorism and security Act (2015). *Journal for Deradicalization* (16), 125–164.

Elshimi, M. (2018). *The new UK counterterrorism strategy: Critical questions for the "prevent" strand*. London: RUSI. Retrieved from RUSI website: rusi.org/commentary/The_New_UK_Countert errorism_Strategy.

Fineman, M. A. (2013). Equality, autonomy, and the vulnerable subject in law and politics. In M. A. Fineman, & A. Grear (Eds.), *Gender in law, culture, and society: Vulnerability: Reflections on a new ethical foundation for law and politics* (pp. 25–40). Surrey: Ashgate.

Gov.UK. (2014). *Appropriate adults: Guide for youth justice professionals*. Retrieved from UK Government website: www.gov.uk/guidance/appropriate-adults-guide-for-youth-justice-professionals

Gray, C. S. (2007). *The implications of pre-emptive and preventive war doctrines: A reconsideration*. Carlisle, PA: Strategic Studies Institute.

Heath-Kelly, C. (2016). Algorithmic autoimmunity in the NHS: Radicalisation and the clinic. *Security Dialogue*, *48*(1), 1–17.

Heath-Kelly, C., & Strausz, E. (2018). *Counter-terrorism in the NHS: Evaluating prevent duty safeguarding in the NHS*. Coventry: University of Warwick.

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.

HM Government. (2011). *CONTEST: The United Kingdom's strategy for countering terrorism*. London: UK Government.

HM Government. (2012a). *Channel: Vulnerability assessment framework*. London: UK Government.

HM Government. (2012b). *Channel duty guidance: Protecting vulnerable people from being drawn into terrorism*. London: UK Government.

HM Government. (2018). *CONTEST: The United Kingdom's strategy for countering terrorism*. London: UK Government.

Holden, M. (2017, November 7). The battle for minds – Britain expands project on mental health in terrorism. *Reuters*. Retrieved from uk.reuters.com/article/uk-britain-security-mentalhealth/the-battle-for-minds-britain-expands-project-on-mental-health-in-terrorism-idUKKBN1D718N

Home Office. (2017a). *Police and criminal evidence Act 1984 (PACE): Code C revised, code of practice for the detention, treatment and questioning of persons by police officers*. London: Home Office.

Home Office. (2017b). *Police and criminal evidence Act 1984 (PACE): Code H revised, code of practice in connection with: The detention, treatment and questioning by police officers of persons in police detention under the (TACT)*. London: Home Office.

Home Office. (2017c). *Channel: Dovetail pilot evaluation findings. OSCT Prevent*. London: Home Office.

Home Office. (2017d). *Connection: CONTEST*. London: Author. Retrieved from www.gov.uk/government/collections/con test

Home Office. (2018a). *Police and criminal evidence Act 1984 (PACE): Code C revised, code of practice for the detention, treatment and questioning of persons by police officers*. London: Home Office.

Home Office. (2018b). *Police and criminal evidence Act 1984 (PACE): Code H revised, code of practice in connection with: The detention, treatment and questioning by police officers of persons in police detention under the (TACT)*. London: Author.

Horgan, J. H. (2008). From profiles to pathways and roots to routes: Perspectives from psychology on radicalization into terrorism. *Annals of the American Academy of Political and Social Science*, *618*, 80–94.

Lankford, A. (2016). Detecting mental health problems and suicidal motives among terrorists and mass shooters. *Criminal Behaviour and Mental Health*, *26*, 315–321.
Lloyd, M., & Dean, C. (2015). The development of structured guidelines for assessing risk in extremist offenders. *Journal of Threat Assessment and Management*, *2*(1), 40–52.
Local Government Association (LGA). (2018). *Operation Dovetail update*. London: Author. Retrieved from Local Government Association website http://lga.moderngov.co.uk/documents/s16757/Operation20Dovetail20update.pdf
Martin, T. (2018). Identifying potential terrorists: Visuality, security and the Channel project. *Security Dialogue*, *49*(4), 254–271.
McGilloway, A., Ghosh, P., & Bhui, K. (2015). A systematic review of pathways to and processes associated with radicalization and extremism amongst Muslims in Western societies. *International Review of Psychiatry*, *27*(1), 39–50.
McKendrick, D., & Finch, J. (2017a). 'Downpressor man': Securitisation, safeguarding and social work. *Critical and Radical Social Work*, *5*(3), 287–300.
McKendrick, D., & Finch, J. (2017b). 'Under heavy manners?': Social work, radicalisation, troubled families and non-linear war. *The British Journal of Social Work*, *47*(2), 308–324.
Monahan, J. (2012). The individual risk assessment of terrorism. *Psychology, Public Policy, and Law*, *18*(2), 167–205.
National Appropriate Adult Network UK (NAAN). (2018a). *What is an Appropriate Adult*. London: National Appropriate Adult Network. Retrieved from Appropriate Adult website: http://www.appropriateadult.org.uk/index.php/information/what-is-an-appropriate-adult
National Appropriate Adult Network UK (NAAN). (2018b). *PACE update July 2018: Changes to Codes C, E, F and H*. London: National Appropriate Adult Network. Retrieved from Appropriate Adult website: https://www.appropriateadult.org.uk/index.php/downloads/pace-updates?download=9:code-c-2018
National Police Chiefs' Council (NPCC). (2016). *Counter Terrorism Police and NHS initiative reducing risk by improving mental health provision*. Retrieved from NPCC website news.npcc.police.uk/releases/counter-terrorism-police-and-nhs-initiative-reducing-risk-by-improving-mental-health-provision.
National Police Chiefs' Council (NPCC). (2017). *Delivering prevent*. Retrieved from NPCC website: www.npcc.police.uk/CounterTerrorism/Prevent.aspx
National Police Chiefs' Council (NPCC). (Undated). *Mental health pilot hubs*. Retrieved from NPCC website: www.npcc.police.uk/NPCCBusinessAreas/TAM/MentalHealthPilotHubs.aspx
NHS England. (2017). *Guidance for mental health services in exercising duties to safeguard people from the risk of radicalisation*. London: NHS.
Omand, D. (2016). Keeping europe safe. *Foreign Affairs*. Retrieved from www.foreignaffairs.com/articles/europe/keeping-europe-safe
Oslo Universitetssykehus. (2019). Fengselspsykiatrisk poliklinikk. Retreived from oslo-universitetssykehus.no/avdelinger/klinikk-psykisk-helse-og-avhengighet/psykisk-helse-nasjonale-og-regionale-funksjoner/regional-sikkerhetsseksjon-rsa/fengselspsykiatrisk-poliklinikk#les-mer-om-fengselspsykiatrisk-poliklinikk.
Paulussen, C., Nijman, J. E., & Lismont, K. (2017). *Mental health and the foreign fighter phenomenon: A case study from the Netherlands*. The Hague: ICCT.
Peddell, D., Eyre, M., McManus, M., & Bonworth, J. (2016). Influences and vulnerabilities in radicalised lone-actor terrorists: UK practitioner perspectives. *International Journal of Police Science & Management*, *18*(2), 63–76.
Powis, B., Randhawa, K., & Bishopp, D. (2019). *The structural properties of the extremism risk guidelines (ERG22+): a structured formulation tool for extremist offenders*. London: Ministry of Justice.
Pressman, E. (2009). *Risk assessment decisions for violent political extremism 2009-02*. Ottawa: Her Majesty the Queen in Right of Canada.
Radicalisation Awareness Network (RAN), EU/ NCTPHQ, UK. (Undated). *Prevent Mental Health/Police Team*. Retrieved from European Commission website: ec.europa.eu/home-affairs/node/11454_en.
Regjeringen. (2019). Forebyggingsstrategier. Retrieved from www.regjeringen.no/no/sub/radikalisering/om-forebyggende-arbeid/Forebyggingsstrategier/id762532/

Rousseau, C., Ellis, B. H., & Lantos, J. D. (2017). The dilemma of predicting violent radicalization. *Pediatrics*, *140*(4), e20170685.

Royal College of Psychiatrists (RCP). (2016). *Counter-terrorism and psychiatry*. Position Statement PS04/16. London: Royal College of Psychiatrists.

Sarma, K. M. (2017). Risk assessment and the prevention of radicalization from nonviolence into terrorism. *American Psychologist*, *72*(3), 278–288.

Scurich, N. (2016). An introduction to the assessment of violence risk. In J. P. Singh, S. Bjørkly, & S. Fazel (Eds.), *International perspectives on violence risk assessment* (pp. 3–15). New York: Oxford University Press.

Sestoft, D., Hansen, S. M., & Christensen, A. B. (2017). The police, social services, and psychiatry (PSP) cooperation as a platform for dealing with concerns of radicalization. *International Review of Psychiatry*, *29*(4), 350–354.

Silke, A. (1998). Cheshire-cat logic: The recurring theme of terrorist abnormality in psychological research. *Psychology, Crime and Law*, *4*(1), 51–69.

Silke, A. (2003). Becoming a terrorist. In A. Silke (Ed.), *Terrorists, victims and society: Psychological perspectives on terrorism and its consequences* (pp. 29–53). Chichester: Wiley.

Stanley, T. (2018). The relevance of risk work theory to practice: The case of statutory social work and the risk of radicalisation in the UK. *Health, Risk & Society*, *20*(1-2), 104–112.

Stern, J., & Wiener, J. B. (2008). Precaution against terrorism. In P. Bracken, I. Bremmer, & D. Gordon (Eds.), *Managing Strategic Surprise* (pp. 110–183). Cambridge: Cambridge University Press.

Taylor, R. (2018, April 20). *Violent extremism and the role of mental disorder*. Oslo: Lecture at Norwegian Institute of International Affairs (NUPI).

Tunariu, A. D., Tribe, R., Frings, D., & Albery, I. P. (2017). The iNEAR programme: An existential positive psychology intervention for resilience and emotional wellbeing. *International Review of Psychiatry*, *29*(4), 362–372.

UK Care Act. (2014). Retrieved from www.legislation.gov.uk/ukpga/2014/23/contents/enacted

UK Safeguarding Vulnerable Groups Act (SVGA). (2006). Chapter 47. Retrieved from www.legislation.gov.uk/ukpga/2006/47/pdfs/ukpga_20060047_en.pdf

UK Terrorism Act (TACT). (2006). Retrieved from www.legislation.gov.uk/ukpga/2006/11/contents

Ventriglio, A., Bellomo, A., Vitrani, G., Stella, E., Gentile, A., & Bhugra, D. (2017). Migration, violence, and the role of psychiatry in Italy. *International Review of Psychiatry*, *29*(4), 327–333.

Weine, S. M., Stone, A., Saeed, A., Shanfield, S., Beahrs, J., Gutman, A., & Mihajlovic, A. (2017). Violent extremism, community-based violence prevention, and mental health professionals. *The Journal of Nervous and Mental Disease*, *205*(1), 54–57.

Wright, N. (2016, June). Preventing radicalisation and terrorism: Is there a GP response? *British Journal of General Practice*, *66*(647), 288–289. Editorial.

Yakeley, J., & Taylor, R. (2017). Terrorism and mental disorder, and the role of psychiatrists in counter-terrorism in the UK. *Psychoanalytic Psychotherapy*, *31*(4), 378–392.