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Caroline Logan & Rachel Sellers

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Risk assessment and management in violent extremism: a primer for mental health practitioners

Caroline Logan^a and Rachel Sellers^b

^aGreater Manchester Mental Health NHS Foundation Trust, University of Manchester, Manchester, UK; ^bDepartment of Security and Crime Science, University College London, London, UK

ABSTRACT

This paper introduces a special issue of the Journal of Forensic Psychiatry and Psychology dedicated to violent extremism and mental health. We address three challenges faced by mental health practitioners who work with people whose harm potential may be ideologically motivated. First, how can practitioners engage in good practice in risk assessment and management when the evidence base for such practice in the violent extremism field is limited? Second, how can a mental health practitioner establish and understand the role of an extremist ideology in a client in their care and differentiate it from motivational drivers that may result in broadly similar kinds of actual, attempted or threatened violence? Third, how can practitioners and their services respond to the risks posed in ways that recognise and balance the needs of both the client and those multiple other agencies dedicated to public protection? Following the examination of these challenges, and a brief comment about the relevance of coronavirus to risk of violent extremism, each paper in the special issue will be introduced and their contribution to the work of practitioners who carry such responsibility summarised. The paper concludes with key points and recommendations linked to the three challenges addressed.

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Introduction

Violent extremism is a perplexing phenomenon. The evidence on its presentation in individuals is small (and growing) but fragmented by myriad different perspectives on the evolution of harmful behaviour of this particular kind (Borum, 2015). Also, an act of violent extremism is ultimately a harmful act, and there exists good guidance for understanding and managing a wide range of violence potential (e.g., Eaves et al., 2019; Meloy & Hoffmann, 2014; Otto & Douglas, 2011). However, adjustments are required in order to account for the specific characteristics of violence motivated by an extremist ideology

CONTACT Caroline Logan  caroline.logan@manchester.ac.uk

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or mindset (Hart et al., 2017). It is still to be established what those characteristics are. Additionally, there remains uncertainty about the extent to which novel guidance may apply not only to the risk of violent extremism but to acts in *support* of violent extremism, such as facilitating others to plan and carry out a terrorist attack, fundraising for violent extremist organisations, promoting extremist ideologies on- and offline, the passive consumption of proscribed violent extremist material, and so on (Monahan, 2016).

Specialist guidance on risk assessment and management in relation to violent extremism does exist (for recent overviews of the field, see Hart et al., 2017; Herzog-Evans, 2018; Logan & Lloyd, 2019; Scarcella et al., 2016). For example, in England and Wales, the *Extremism Risk Guidance-22+* (ERG-22+, Lloyd & Dean, 2015; Webster et al., 2017) supports the work of forensic psychologists in Her Majesty's Prison and Probation Service (HMPPS) to understand and manage the risk potential of already convicted terrorist offenders. However, the ERG-22+ is not available currently for use outside of HMPPS in this jurisdiction. An alternative is the *Terrorist Risk Assessment Protocol-18* (TRAP-18, Meloy, 2018; Meloy & Gill, 2016), which has been developed to assist investigators understand the nature of the terrorist threat posed by an individual. However, its utility for mental health professionals working directly with clients and who require guidance on risk management is unknown. The *Multi-Level Guidelines* (MLG, Cook et al., 2013) is a robust set of structured professional guidance for understanding violence potential within groups, such as criminal gangs, and has obvious relevance to violent extremists who operate in response to group forces. However, its application to violent extremism has yet to be substantially tested as has its application to individuals who are not part of terrorist groups. There is also the *Violent Extremism Risk Assessment-2 Revised* (VERA-2 R, Pressman, 2018; Pressman et al., 2016), which is a set of risk assessment guidance used internationally across practitioner and investigative communities. However, the VERA-2 R focuses on the extent to which risk and some protective factors are present and offers no guidance as yet on risk formulation or risk management.

Therefore, whilst there exists guidance to which mental health practitioners may refer to enhance their understanding of the harm potential of someone who threatens violence and claims adherence to an extremist ideology as a motive or justification, the support that guidance can offer is variable and potentially limited at this time. Given the implications of assessments of violence risk for an individual's liberty, it is important to know the nature of those limitations and the ways in which they may be supplemented or overcome in order to address the particular challenges faced by mental health practitioners (e.g., psychologists, psychiatrists, nurses). Thus, if a mental health service is referred an individual who is both psychotic and a fervent admirer of a violent and extreme right-wing ideology, how are its practitioners to make sense of the relationship between the disorder and the

beliefs and to manage interventions and risk accordingly? Also, how might this process of assessing and managing risk differ if the individual has a form of high functioning autism instead of a psychotic disorder? Alternatively, if a practitioner is working with a person with an antisocial personality disorder, a significant history of non-extremist criminality and violence, and a recent conversion to an extremist interpretation of a religious faith, how might *this* combination of variables impact on the practitioner's formulation of that person's risk of both extremist and non-extremist violence? It is our assertion in this paper and this special issue that these challenges may benefit from discussion in order to ensure that existing guidance on the risk assessment and management of violent extremism – and on violence potential more generally – can be applied appropriately and usefully by mental health practitioners to address the clinical situations they encounter.

Thus, this opening paper of this special issue of the *Journal of Forensic Psychiatry and Psychology* dedicated to violent extremism and mental health addresses three challenges in the field likely to be relevant to practitioners dedicated to supportive and preventative interventions with their clients. First, how might mental health practitioners engage in good practice in risk assessment and management with clients at risk of an act of violence that is motivated at least in part by an extremist ideology? Second, how can a mental health practitioner establish and understand the role of an extremist ideology in a client in their care and differentiate it from motivational drivers that may result in broadly similar kinds of actual, attempted or threatened violence? Third, how can mental health practitioners and their services respond to the risks posed in ways that recognise and balance the needs of both the client and other agencies dedicated to public protection? Following the examination of these challenges (which will be explored in much more detail in Logan, Gill & Borum, in preparation), and a brief postscript about the relevance of coronavirus to our subject, each of the papers in the special issue will be introduced in turn and their contribution to the work of practitioners who carry such immense responsibility briefly summarised. The paper will end with a summary of its main conclusions and a set of recommendations linked to the three challenges it addresses.

Three challenges in violent extremism and mental health practice

Challenge 1: good practice in risk assessment and management in violent extremism

Good practice in risk assessment and management is underpinned by several important principles (e.g., Logan, in press, 25). First, risk assessment is for the purpose of risk management; assessing risk without proposing a range of possible strategies for its mitigation is a recipe for high blood pressure only

(Farnham, 2016). Second, risk assessment and management are live and reviewable undertakings; that is, they should both anticipate and respond to changing circumstances, especially the receipt of new information or following direct interventions. Risk assessment and management should never be one-off, static and unchanging (Eaves et al., 2019). Third, the harm potential of an individual at any one time is a reflection of the interplay among a range of risk *and* protective factors that range across the individual and their context, whose influence upon one another and the context in which they operate should be considered in the round – in the aggregate – rather than separately (Douglas et al., 2013a).

Fourth, risk assessment and management guidance, such as the ERG-22 + and the VERA-2 R, may be viewed as maps that one might use to explore the terrain of a person's hitherto unknown harm potential. The landscape of violent extremism as a whole is relatively uncharted territory compared to the general violence or sexual violence fields. Therefore, at the present time, there are comparatively few maps available to support risk assessment and management activity in this field compared to others (Hart et al., 2017; Logan & Lloyd, 2019). However, what we have in the guidance available is an important start. The opportunity exists now to develop more guidance and the existing frameworks further in order that we might chart more fully the range of violent acts motivated by an extremist ideology (e.g., from acts of violence through to radicalisation of others and fundraising for extremist causes). In addition, opportunities must be taken to develop guidance to range across different degrees of granularity (e.g., from rapid and relatively superficial risk triage through to in-depth and more comprehensive risk evaluations), depending on the requirements of the undertaking.

Fifth, the structured professional judgement approach to risk assessment and management – most fully operationalised in the general violence field by the *Historical, Clinical and Risk Management-20 Violence Risk Guidance* 3rd edition (HCR-20^{V3}, Douglas et al., 2013b) – is the industry recommended approach in the field of violent extremism risk assessment and management (Borum, 2003; Monahan, 2016). Actuarial approaches, focusing on risk prediction rather than prevention, are extremely limited in their potential to assist and may be misleading (Cooke & Logan, in press, 25). Sixth, those undertaking such evaluations and making risk management recommendations that may impact significantly on the liberty of clients in their care ought to have expertise in both risk assessment and management in general *and* violent extremism specifically. The quality of the risk formulations and intervention plans produced by specialists in one area but not the other should be subject to quality assurance.

Seven, in the violent extremism field, as in all others, there is a requirement and a duty to ensure evidence-based, transparent, accountable, and

defensible practice in understanding and managing risk (Douglas et al., 2013a). Therefore, the explicit use of evidence-based guidance to inform information gathering, problem exploration and explanation, and decision-making about risk management is recommended to support that level of practice. Finally, peer support, clinical supervision, and the informal and formal evaluation of practice are strongly recommended in order to ensure and indeed demonstrate the highest level of clinical care. Given the very broad range of ideologies that can influence harmful behaviour and the many ways that those ideologies can manifest in harmful form, it is not possible for a single practitioner to have expertise in all – but teamwork can ensure a high level of overall competency.

These eight principles apply to the violent extremism field at least as much as they apply to risk assessment and management activity elsewhere. Indeed, they may be more applicable given the nascent state of research, practice, and evaluation in this field and the very particular scrutiny that such evaluations are liable to attract. This is especially so when fears about an individual's harm potential are realised (e.g., Intelligence and Security Committee of Parliament, 2018).

Concluding comments

Good practice in risk assessment and management in the field of violent extremism should reflect good practice elsewhere in respect of harm prevention. The key requirements are systematic decision-making processes, often embodied in a set of published guidance for practitioners, built on evidence about the harmful behaviour to be prevented, as well as a commitment to evaluation and continuously improved practice.

Challenge 2: establishing an extremist motive

Violence and aggression are always the consequence of a decision made by the actor – its perpetrator – to behave in such a way (Douglas et al., 2013a). That is, violence and aggression are purposeful and intentional, regardless of whether the outcome was the one planned by the actor (e.g., as when the victim died when the actor only meant to assault or threaten that person). Further, the perpetrator chooses violence and aggression from amongst all the options available to him or her because these specific behaviours are thought most likely to bring about the desired outcome and at the speed required. Violence and aggression may be selected in encounters between a perpetrator and one or more victims for a variety of reasons (e.g., Daffern & Howells, 2009; Howells, 2011; Logan, 2017). For example, one person may be harmful towards another in order to protect the perpetrator from the harm the victim intended to do to them until stopped (a *self-defence motive*). Alternatively, a perpetrator may decide to be violent towards a victim in

order to gain something from that person (e.g., their money or possessions, or sexual gratification; a *gain or profit motive*). Violence and aggression may also be chosen in order to make victims do things they do not want to do, such as to comply with orders or do something different to what they had planned (e.g., stay in a relationship the victim was otherwise intending to leave; a *control or compliance motive*). However, violence may also be chosen in order to gratify the perpetrator – such as by enhancing their sense of power or mastery, their self-esteem, or to alter their level of arousal (a *gratification motive*) – or to give cathartic expression to negative feelings such as anger or resentment or grievance (a *justice or revenge motive*). In many cases, the decision to use violence and aggression to achieve a desired outcome may be influenced by multiple motivational drivers rather than just one (Borum, 2003; 2015).

Therefore, if violence is a conscious choice and enacted in situations in which its perpetrator is likely to feel that a less forceful act will be ineffective given the nature of the outcome sought, what drives violent extremism? Further, how might the motivational drivers for terrorist acts be differentiated from those that may lead to more common forms of violence – can they even be differentiated at all?

Violent extremism may be defined as actual, attempted or threatened acts intended to cause physical harm to others and/or the fear of harm, which are justified by an ideology supported by only a minority of people, opposed to and intolerant of the values and beliefs of the majority, and dedicated to diminishing social cohesion and influencing if not bringing about fundamental political, religious, social or other change (from Hart, 2019). Therefore, for an act of violence or aggression to be identified as an act of terrorism or violent extremism, it must be underpinned by an ideology that promotes such intolerance and aspirations, and in which the use of force is accepted if not actively encouraged in order to bring about the desired changes. Extremist ideologies may be broadly differentiated in terms of those that focus on how the community, society or nation ought to be run (e.g., extreme left and right wing and nationalist ideologies, including sovereign citizen movements) and those that concentrate on how people ought to live their lives (e.g., extreme religious ideologies, pro-life and animal rights movements). Such ideologies rely on propaganda to perpetuate their messages and to undermine the prevailing views. Such propaganda nurtures intolerance and grievances as well as widespread distrust, especially with central institutions like law and order, government and the press. As a result, more inclusive values like tolerance, trust and cooperation are challenged and communities are divided. The proponents of extremist ideologies may be identified by their willingness to perpetuate such propaganda, to add to it, and urge the taking of personal responsibility for the changes required, encouraging if not using violence as deemed necessary (Borum, 2003).

The contexts in which extremist ideologies flourish is critical. The growth in their support is invariably nurtured in settings in which there are widely held and at least to some extent valid feelings of injustice, inequality, marginalisation, and powerlessness. Objective realities are perceived as unfair, threatening and victimising, and protest and active insurgency may come to be seen in some as potentially more effective than interminable discussion and painfully negotiated change. At an individual level, the strength of such perceptions is influenced by the personal and social resources the person can bring to bear on their experience. Thus, an individual's perception of reality as unfair or unjust may be influenced by his or her belief that they lack the resources to change that reality – or indeed, that they are denied the resources they need and the opportunity to apply them.

Mental health problems, which can severely limit the personal and social resources available to individuals, have the potential to significantly influence how a person perceives the world and how they confront the challenges they experience within it. Consequently, the potential for individuals with mental health problems – with a compromised set of personal and social resources – to find common cause with extremist ideologies that give voice and explanation to the shortfalls in their capacity to influence and control their circumstances and direct responsibility elsewhere cannot be overlooked. [Figure 1](#) illustrates a model of the suggested interactions between individual and environment and the influence of personal and social resources on outcomes in the short and long-term. This illustration is based on the Michigan model of stress and coping (Israel et al., 1992). Mental health problems have the

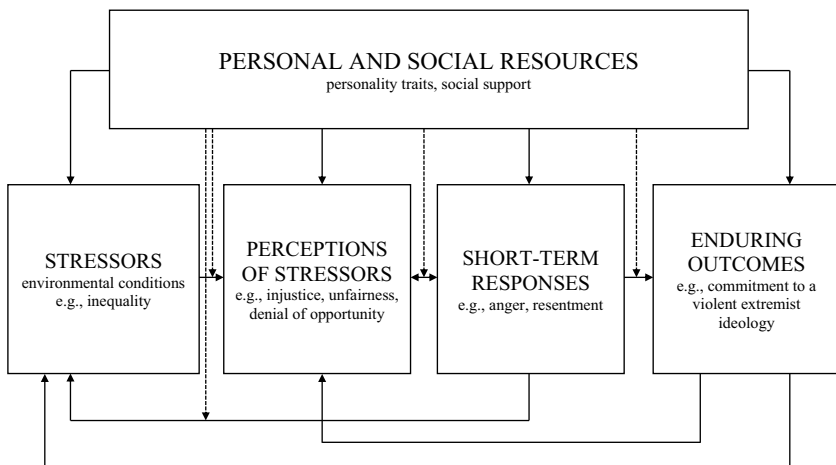


Figure 1. A model of the interaction between individual and environment and the influence of personal and social resources on outcomes in the short and long-term, based on the Michigan model of stress and coping.

potential to influence the availability and application of personal and social resources to each part of the response process and to result in a cumulatively negative outcome. It is this coming together of context and individual that has the potential to bring terrorism directly into the remit of the mental health practitioner.

In most if not all jurisdictions, criminal justice and mental health services have reason to work together closely in their response to offending behaviour and its mitigation (e.g., Knauer, Walker & Roberts, 2017; Puntis et al., 2018). Increasingly, mental health practitioners work in partnership with law enforcement professionals in the management of threat (e.g., James & Farnham, 2016; Meloy & Hoffmann, 2014), including in the prevention of violent extremism (Augestad Knudsen, 2020). However, the alignment of mental health problems with extremist ideologies can mean that practitioners face the challenge of determining whether an extremist ideology is a primary motivational driver for actual, attempted or threatened violence, or whether and the extent to which more personal drivers are responsible. This determination is relevant to their understanding and management of the individual and to the recommendations they make to other bodies, including the Courts. The following case study illustrates this point.

John: an illustrative case study

John is a middle-aged single male, with a long history of alcohol dependence. He is strongly of the view that he is uneducated, unemployed, living with chronic health conditions and in poor quality social housing because families who have recently arrived into his country as a result of forced migration have snapped up the best school places, jobs, and homes. Further, they have jumped ahead of him and his ailing mother in the queue for limited local health and mental health care services. John feels inclined to blame these incomers, who are distinct because of the way they dress and because of the colour of their skin, for his unfortunate living conditions; it is easier to blame them than to try to improve his own difficult circumstances, which feel insurmountable to him. He gets very angry about his life, not having what he thinks he deserves, and he watches hateful and violent recordings online made by like-minded people in the UK and especially the US as a way of releasing his anger and making him feel justified and more in control.

John actively seeks out other people who feel just like him and favours an online group that pillories successful people, especially migrant workers, people of colour or whose faith is non-Christian, women, and those from the LGBTQ+ community, as well as the politicians and journalists who advocate for them. The members of this soon to be proscribed group are very positive to John – they make him feel welcome and as if he belongs with them, that they care about what he thinks and are concerned for his wellbeing, and for the wellbeing of all their followers battling against what they

see as injustice and discrimination. The group introduces him to more arguments in favour of the beliefs they share, in addition to misleading and false information about the impact of immigration, the changing roles of women, and the increasing recognition of the range of non-binary expressions of gender and sexuality. They guide John to more extreme materials to view and in things to say and do to let his feelings more effectively be known and understood by others. They nurture his belief that he is being discriminated against as a white British man and justify his feelings of victimisation and marginalisation. Further, they encourage John to feel that he is at risk of attack from people unlike him, that such people are dangerous and not to be trusted, and that he must be on his guard at all times. They advocate the use of violence against such members of his community, justifying it in terms of his self-defence.

John starts to carry a kitchen knife when he leaves the house in order to feel safe. He eschews the company of the few members of his family and network of friends he still has who might challenge what he now thinks and does. Also, his loyalty to his new friends encourages him to feel even more accepted, at home among them, and grateful. Such gratitude makes it more likely John will say yes when it is suggested to him that he engage in acts of public disorder or violence in order to protect himself and marginalised people like him.

With their encouragement, John starts going out on 'patrol' in the evenings. His motive is to protect innocent people – like him – from attack. One evening, he spots a group of young men chatting animatedly outside a Middle Eastern fast food shop. John perceives their behaviour as threatening to the other people who happen to be on the street at the time. He starts shouting abuse at the group of young men. One of them challenges John about what he is saying – he retaliates by repeatedly making fascist salute signs and shouting associated and extremely racist slogans and statements at the top of his voice. Then John takes out his knife, runs across the street, and stabs in the neck the young man who challenged him as well as stabbing two other men who came quickly to the first victim's aid.

John is wrestled to the ground by the other men of that group and quickly overwhelmed. He is arrested shortly afterwards by the police on suspicion of attempted murder, an arrest that he challenges at the time on the grounds that he acted in self-defence. When the police search John's home in the early hours of the following morning, they find a stockpile of extreme right wing memorabilia, as well as a range of weapons (e.g., machetes, samurai swords, zombie knives, knuckle dusters, CS gas, bomb-making equipment and 14 viable pipe-bombs and component parts). They also find evidence of his engagement with the extremist group. The police observe daubed on the walls of his badly maintained flat many intolerant and obscene slogans and symbols, as well as a list of the names and local home addresses of politicians, journalists, as well as community leaders under the heading 'Race Traitors Hit

List'. Consequently, he is considered for an additional prosecution under national terrorism legislation.

This (fictional) case raises three points of interest to the mental health practitioner – such as the psychiatrist consulted by the senior investigating police officer seeking guidance on interviewing his suspect, or the forensic psychologist approached by the prison healthcare wishing support to help manage John whilst he is detained on remand, or the expert witness asked by the prosecution to opine on the motive for John's offending behaviour in order to assist the judge in his trial in relation to sentencing. First, does John support a violent extremist ideology? Second, to what extent has his adherence to such an ideology driven his assault on the three young men? Finally, why do the answers to these questions matter?

The answer to the first question is yes; John clearly agrees with and promotes a worldview disseminated by a soon to be proscribed group recognised for its highly pejorative attitudes towards certain groups in society, its willingness to encourage others to share such views and indeed to act upon them to the detriment of those who are its target, and whose aspiration is radical social unrest and change. However, is John a violent extremist – a terrorist – or a person with a variety of difficulties of which his extremist interests and affiliation is only one?

John's intolerance and prejudices significantly pre-date his enthusiastic endorsement of the group that he supports. His long-standing problems with alcohol dependence, his physical ill health, and his limited opportunities in education and employment have made a significant contribution to the conditions that led to his resentment of others who appear to him to have more prospects than he does. With regards to [Figure 1](#), the personal and social resources available to John to assist in the generation of helpful and positive responses to his circumstances are limited, and so his responses are more problematic and influenced negatively by others, and increasingly so as his problems worsen. Therefore, an extremist ideology is unlikely to be the only motivational driver for his violent offending. Indeed, what would appear to be some of the core motivational drivers of his behaviour – frustration, a desire for change, revenge, perhaps a (very) misguided sense of justice, as a means of improving his self-esteem and sense of mastery (Douglas et al., 2013a; Howells, 2011) – may suggest that an extremist motive is in fact secondary to those more dominant and long-standing drivers.

This line of thought – how mental health needs interact with other risk and protective factors and with the context in which they have developed and play out, and the expectation that violence will be driven by more than one if not multiple motives – is essential in every case. Violence is rarely driven by a single risk factor in isolation, such as mental ill health. Therefore, the management of that risk factor alone – such as the treatment of substance misuse problems, or other kinds of problems like depression or

psychosis – will not be sufficient to manage risk overall. A more holistic understanding and approach to risk management is required, necessitating the careful collection of historical information about the person and the rational sequencing of causes and effects, in order to discern the various influences on past and potential future behaviour. Thus, the answer to the second question posed above – to what extent has John's adherence to an extremist ideology driven his assault on the three young men? – is that his extremist views are one of several motivational drivers in this case, which will mean that risk management must be about more than challenging his beliefs about others.

Acknowledging this opinion is unlikely to make a difference to how John is charged and prosecuted in law. However, it *should* make a difference to how his behaviour is assessed and understood (formulated), how he is managed on a day-to-day basis, and the interventions suggested for him in prison following sentencing and in the community when he is released on licence (Logan, 2020). It is the duty and the responsibility of mental health professionals to go beyond behaviour towards an understanding of its function – its purpose for the individual (or individuals) who enact it (Johnstone & Boyle, 2018). That is, what was this act of violence, at this time and in this place against those victims, intended to achieve? Mental health professionals are trained and well placed to undertake such a task.

Why do the answers to the first two questions matter? The answers matter because violent extremism is a high-profile risk and a complicated behaviour evoking very strong feelings amongst members of the public, the emergency services, politicians, and journalists. However, mental health professionals may lack a good understanding of extremism to inform their risk assessments and risk management recommendations. Fundamentally, violent extremism is a form of violence and the usual rules apply to its considered evaluation and response (Hart, 2019). The use of guidance in risk assessment and management, and guidance that operationalises the structured professional judgement approach, ideally optimised to the behaviour of people for whom a violent extremist ideology is prominent, offers a protection against the kinds of failures of insight that can be encouraged in such high-pressure situations. Therefore, mental health professionals have the potential to play a unique role in understanding and managing the risk of an act of violent extremism. A key task, however, is understanding the motivational drivers of the behaviours of past concern in order to inform understanding of future potential.

Concluding comments

The task of establishing a violent extremist motive is nuanced and ultimately challenging. However, mental health professionals, with their experience of complex human behaviour as well as the practice of risk assessment and

management, are well placed to try to understand the nature of risk in the individual case and the requirements of risk management planning.

Challenge 3: the responsibilities of mental health practitioners

Mental health practitioners working in services with individuals who are at risk of an act of violent extremism have at least three important responsibilities. First, the risk management of any violent offender should be underpinned by an understanding of the nature of the harmful behaviour in which they engage (HMPPS/DH, 2020) – the risk of violent extremism is no exception. This understanding will be developed from a comprehensive history of the person and incorporated into a formulation – a statement explaining what the person is at risk of and why – which should in turn guide risk management planning, including direct therapeutic interventions with the individual (Livesley et al., 2016; Sturme & McMurran, 2011). However, it can be a challenge to generate an understanding without that effort being seen by multiagency partners as something akin to excusing the individual for their behaviour or explaining their risks away – and this point is as applicable in the violent extremism field as it is elsewhere (HMPPS/DH, 2020). Further, because violent extremism is as yet a poorly understood area of risk, the temptation may be to be overly restrictive rather than too lax; we do not risk manage with confidence what we do not understand. Therefore, time and effort are required to encourage more understanding of violent extremism in order to support more unified working practices and cohesive risk management. The practice of risk formulation is essential to this end and mental health practitioners have particular skills in this area (Logan, 2017).

Second, the management of violence risk requires multiagency cooperation to varying degrees depending on the nature of the risk presented in the individual case (Keyser & McSherry, 2011). Multiagency cooperation is essential in the violent extremism field. However, multiagency cooperation is not guaranteed to be successful despite the common aims of the services in partnership – it requires hard work in order to happen. The achievement and maintenance of multiagency cooperation in respect of the risk assessment and management of potentially violent extremists will be dependent on several factors: the existence and availability of good and up-to-date policies addressing standard operating procedures and information sharing; clarity of purpose and role delineation; and the protection of goodwill and trust between the agencies involved and their major stakeholders. It is all too easy for the distrust and frustration experienced by many of those at risk of violence to be experienced in turn by the practitioners working with them and played out among the professionals without awareness of their origins (HMPPS/DH, 2020).

Third, mental health practitioners working with men, women and young people at risk of violent extremism have a wealth of skills and competencies in more common forms of harm prevention (e.g., violence, suicide). While violent extremism is not identical to these other forms of violence in terms of the range and prominence of motives and methods, the process and discipline of carefully appraising, formulating, and managing risk is ubiquitous; risk assessment and management in violent extremism must stand on the shoulders of the giants of the general field of violence risk (Logan & Lloyd, 2018). In addition, mental health practitioners are unlikely to over-simplify risk and its assessment, which can be a challenge in other agencies for whom such activity is less familiar or where evidence-based practice is less of a priority or expectation. As a consequence, the inclusion of mental health practitioners as partners in multiagency risk management with individuals at risk of violent extremism maximises the potential for best practice. Their role in such a purpose must be supported and respected.

Concluding comments

Mental health practitioners are well placed to contribute valuable information relevant to the risk management of individuals thought to be at risk of an act of violence extremism, but also to inform and support multiagency working towards managed risk.

The challenge of our time: the relevance of coronavirus to risk of violent extremism

The essential breeding ground for violent extremism is a context in which perceptions of inequality, unfairness, injustice and social division are easily made and fall along clear racial, religious or socio-economic lines. Coronavirus has been with us for only a short time but already it is obvious that it is not experienced equally across society. People who are poor and have limited access to health care as well as greater health care needs are faring less well compared to those who are more economically advantaged. Those who live in cramped or insecure housing for whom social distancing is a fantasy are more at risk of infection and complications compared to those with more space and freedom to choose where they live and with whom. Those who may be marginalised because of skin colour, language, culture, or faith and victimised as carriers of the disease whether by design or neglect are at a disadvantage compared to those who comprise the majority in our communities. Coronavirus is set to exacerbate perceptions of inequality and unfairness and to magnify existing social divisions and collective anger towards the state – for not fixing it or for being its cause. Further, coronavirus is impacting significantly on everyone's opportunities, personal resources and resilience, and it is severely affecting the hopes and aspirations of many. Public services – like health, social care, criminal

justice, and law and order – already underfunded, will be further undermined because of the need to make major cuts to pay for exceptional levels of national debt, and just at a time when demand on those services is likely to soar. The vulnerability of people with mental health problems is increasing, and so is the allure of extremist ideologies (e.g., Zuckerman, 2019). Therefore, as a direct result of coronavirus, our collective capacity to address the long-term problems it has given rise to may be diminished because we may not have adequate means to respond. The divisions in our society may widen, and social unrest is likely (Avis, 2020) – and all of this is set to last for as long as the economic fallout of the near global lockdown remains with us. The active involvement of mental health professionals in working with people at risk of violent extremism may be a challenge to fund but has never been required more.

This special issue of JFPP

Following this overarching paper, this special issue of the *Journal of Forensic Psychiatry and Psychology* comprises seven articles on the theme of violent extremism and mental health. Each paper addresses a specific range of issues relevant to this theme. Each paper will now be introduced and its links to this theme flagged.

The first paper describes a high-level and high-quality systematic review of the evidence for a link between mental health problems and violent extremism. In their comprehensive synthesis, entitled *Systematic review of mental health problems and violent extremism*, Gill, Clemmow, Hertzell and colleagues bring to the forefront the limitations of a sole focus on the presence or absence of specific disorders and the need for a more focused exploration of the possible mechanisms through which mental disorders might impact upon an individual's interest and involvement in terrorism. The authors highlight the difficulty of identifying and assessing mental health problems in terrorist samples, an issue that predominates in the extant literature. This difficulty is compounded by the heterogeneous nature of violent extremist activity, the roles a person may undertake, and their modus operandi (e.g., a lone actor versus a cell-based or network actor). On the basis of the findings they report, the authors build a compelling case for research to turn its attention to understanding more about the *relevance* of mental health and complex needs in the terrorist pathway. By understanding how and why mental health problems have influenced an individual's journey towards violent extremism, practitioners can better understand and more effectively manage the risks posed by those with mental disorder and terrorist intentions – in particular through the interventions intended to enhance the range of personal and social resources that have the potential to moderate the impact of stressors and their perception on individual wellbeing and behaviour.

In a departure from a predominantly nomothetic literature and delivering on the recommendations of Gill and colleagues, Al-Attar – in a paper entitled *Severe mental disorder and terrorism: When psychosis, post-traumatic stress disorder and addictions become a vulnerability* – explores the mechanisms through which severe mental health problems may impact on individual vulnerability and susceptibility to radicalisation and violent extremist action. Through the framework of push and pull factors to terrorism, the author considers possible interactions between an individual's context, their symptoms and psychosocial functioning and resources, and their extremist ideology, identity or group affiliation. This convergence of the terrorism literature, forensic practice and the formulation-based approach takes the first steps towards providing practitioners with theoretically derived and clinically informed risk assessment and management guidance. The focus of this paper is not on prescriptive rules or assumed causal links but on hypothesis-generation to support the kind of nuanced formulation that is required to understand, treat and manage individuals where mental disorder may be a driver of terrorism risk. It is widely acknowledged in the violence literature that symptoms of serious mental illness typically interact with other factors to cumulatively increase the likelihood of harmful outcomes for the individual (e.g., Douglas et al., 2013b). Therefore, this paper sets a precedent for discussing the formulation and exploring the myriad possible interactions among symptoms of serious mental disorder (focusing on psychosis, post-traumatic stress disorder and substance use disorder) and the risk of violent extremism.

In further keeping with this theme, the next paper by Corner, Taylor, van der Vegt and colleagues – entitled *Reviewing the links between personality, personality disorders, and psychopathy and violent extremism* – maps the terrain of the terrorist personality, a theme that dominated the early terrorism literature. The view of the terrorist as a psychopath or as a narcissist masquerading beneath a political rhetoric is briefly contrasted against that of a selfless and noble martyr who is engaged in a shared moral struggle – and then the more recent evidence base is systematically and expertly explored. This work provides the foundations for a more sophisticated approach to research on this topic, which has clear implications for professionals working in the fields of personality disorder and violent extremism. Notwithstanding the difficulties of empirical measurement that were also identified by Gill et al., Corner and colleagues find there is no single causal factor in personality that acts as a driver for involvement in terrorism but that different personality traits can each play a role. The authors call for a contextually rich understanding that considers particular traits (such as the dark tetrad or the big five) as well as clinical disorders (such as psychopathy, antisocial personality disorder or narcissistic personality disorder) alongside other individual experiences and behaviours that could contribute to susceptibility to terrorism and an accumulation of violence risk. Very much in keeping with the approach advocated

by Al-Attar, the practitioner reader is encouraged by Corner et al. to focus in the assessment process and in subsequent intervention planning on the relevance of personality traits in relation to the particular ideology an individual subscribes to, the type of role they have within the terrorist milieu, and their specific motivations to cause harm.

Focusing specifically on addiction and substance abuse, the next paper in the special issue, by Daniel Koehler and entitled *Violent extremism, mental health and substance abuse among adolescents: Towards a trauma psychological perspective on violent radicalisation and deradicalisation*, turns our attention towards the particular vulnerability of young people to radicalisation and trauma and to the role of harmful substances in the radicalisation and terrorist engagement process. The author challenges the typically assumed unidirectional relationship between mental health and terrorism and suggests that exposure to extremist rhetoric and involvement with terrorist groups in itself can produce toxic stress that ultimately has damaging effects on mental wellbeing and future risk. Further, Koehler argues that terrorist groups and their propaganda are both stress inducing *and* therapeutic and draws attention to the impact of this on the developing teenage brain; that is, developing a sense of outrage and increasing negative emotions whilst in parallel offering affiliation, identity and social support is a toxic mix for young people especially. This paper is an especially valuable contribution to the growing field of study on interventions for young people and families who have been through a violent radicalisation process. It sends a strong message about the importance of the involvement of mental health practitioners in therapeutic work with traumatised young people but acknowledges the limitations in ability to do so as when they are in custody or in a refugee camp or separated from their families and other important personal resources. It challenges the demands of providing therapy to individuals who may, in the eyes of some, be seen as undeserving because of their history of terrorist involvement – and makes the cogent point that doing nothing about the psychological needs of this group of young people is likely to prove more costly in the long term in almost every conceivable way.

After exploring the correlates and interactions between a range of mental health problems and terrorism, the special issue then examines over two papers the putative relationship between violent extremism and autism spectrum disorder (ASD) specifically. Al-Attar's second paper in the special issue, *Autism spectrum disorders and terrorism: How different features of autism can contextualise vulnerability and resilience*, builds on a small but influential body of research that suggests that the prevalence of ASD may be higher in some sub-populations of terrorist offenders (i.e. lone actors) by exploring how different aspects of ASD may shape an individual's vulnerability to or interest in extremist pursuits. Seven facets of autism are explored in the context of push and pull factors to terrorism. For instance, the paper explores how and importantly why a person who has

social and communication difficulties plus a penchant for historical or ideological detail can thrive in an online environment and find themselves part of an extremist movement but without having associated this growing affiliation with its broader and more malign intentions. This paper provides a strong foundation for practitioners working across forensic and clinical settings with people on the autism spectrum to understand behaviours that may seem – or are indeed – extremist in nature and in the context of their functioning in general. The focus here as elsewhere in the special issue is on encouraging nuanced formulation to contextualise how the individual's experiences of ASD might influence their perceptions of the stressors they encounter and thus exacerbate their vulnerability, as well as on developing effective diversion strategies to manage the risk of harmful outcomes.

Al-Attar's paper on ASD is thoroughly complemented by the contextually rich qualitative study conducted reported by Walter, Leonard, Miha and Shaw entitled *Characteristics of autism spectrum disorder and susceptibility to radicalisation: A qualitative study*. A key theme from their interviews with professionals who work with young people with ASD is that assumptions related to causality based on the presence of a diagnosis alone should be avoided, and instead, practitioners should be supported to understand the range of ASD presentations and how vulnerability to terrorism may emerge. The authors also argue for an individualised approach that is ethical and avoids stigmatising an already marginalised group – an argument that lends itself to the formulation-based approaches strongly advocated by other contributors. The preliminary steps they propose towards improving guidance and training for professionals, supporting individualised formulations for their at risk clients, and exploring effective diversion will undoubtedly strengthen the work conducted by agencies – such as PREVENT in the UK – as well as the clinical and forensic services who may find themselves supporting individuals with ASD and extremist interests.

The final paper in this special issue stays on the themes of young people, psychopathology and terrorism. In their paper, entitled *Psychopathology of young terrorist offenders*, Duits, Alberds and Kempes comment on the breadth of evidence suggesting that particular childhood risk factors can lead to later criminality, that there is a tendency for people to become involved in terrorism at a young age, and that many later mental health problems have roots in early experiences and develop during late adolescence and early adulthood. They examine the European Terrorist Database for evidence of psychopathology in terrorist offenders under the age of 25 years, using a developmentally informed approach to consider experiences across childhood and adolescence, both in terms of neurodevelopment and the early stages of an individual's journey towards terrorism, thus setting the scene for forensic case formulation and intervention. The authors argue that similarities in the psychopathology of younger and older terrorists suggests that psychopathology

may not be relevant to radicalisation alone but may be related to continued engagement and later violent action.

Conclusions and recommendations

This opening paper of this special issue of the *Journal of Forensic Psychiatry and Psychology* has attempted to address three challenges in the field of violent extremism and mental health: (i) how mental health practitioners can engage in good practice in risk assessment and management with clients at risk of an act of violence that is motivated at least in part by an extremist ideology, (ii) how mental health practitioners can establish and understand the role of an extremist ideology in a client in their care and differentiate it from motivational drivers that may result in broadly similar kinds of actual, attempted or threatened violence, and (iii) how mental health practitioners and their services can respond to the risks posed in ways that recognise and balance the needs of both the client and those other agencies dedicated to public protection? Each challenge has been considered in turn, and a case study used to illustrate the kinds of demands faced by practitioners. In addition, each of the papers in the special issue has been summarised and their relevance to the overarching themes highlighted. We wish to conclude this paper with three recommendations linked to the challenges addressed.

First, good practice in violent extremism risk assessment and management may be an effort to achieve when the research and guidance available to practitioners is as yet somewhat limited. Therefore, practitioners wishing to understand the risks posed by their clients will have to be pragmatic, combining good practice in violence risk assessment and management in general with a comprehensive and up-to-date understanding of the links between mental disorder and violent extremism. The contents of this special issue are a significant contribution to the latter requirement. As regards the former, we would like to suggest that practitioners who are required to undertake detailed assessments of the risks presented by their clients, such as for criminal justice proceedings, consider *combining* the application of a credible set of guidance on violence risk assessment in general with guidance on violent extremism specifically. For example, they may use guidance such as the HCR-20^{V3}, which will ensure that the relevance of a range of generic risk factors for violence is examined and that there is significant support available for subsequent risk formulation and risk management planning, *in tandem with* guidance on violent extremism specifically. The addition of guidance on assessing violent extremism risk and protective factors to a generic assessment of violence risk will ensure the broadest coverage of potentially relevant factors as well as a solid foundation in risk assessment, formulation and management. The VERA-2 R is a candidate for that supplementary role. The ERG-22+ is an excellent candidate – and could

be used as a stand-alone set of guidance – but as indicated above, at the time of writing, its use is reserved for practitioners in HMPPS in England and Wales only. The TRAP-18 and the MLG are additional supplementary options. Factors thought to be relevant to the risks presented by the individual and that are in addition to those already covered by the HCR-20^{V3} would be added to the HCR-20^{V3} assessment as *Other Historic*, *Other Clinical* or *Other Risk Management Factors*. Then all of the most relevant factors would be drawn into the risk formulation and the subsequent risk management plan for the individual, allowing consideration to varying motives and scenarios, not all of which may be linked to violent extremism. Such an approach will ensure that best practice in violence risk assessment and management is the core of the work undertaken with the individual and the addition of factors relevant to violent extremism will encourage specificity but not at the cost of sensitivity to the range of harmful outcomes possible. Thus, in respect of John, whom we considered in the case study earlier, this recommendation would ensure that risk factors for general violence were examined in addition to those relevant to his extremist mindset, and that a range of scenarios are considered with respect to his future harm potential and not just ones linked to violent extremism (e.g., those more closely linked to hate crime).

Second, as suggested above, motivational drivers for violence in general – and violent extremism in particular – can be problematic to discern, however knowledgeable the practitioner. The client may have only limited awareness of what has motivated their actual, attempted or threatened harmful behaviour in the past – or they may be reluctant to discuss their current preoccupations and intentions. Therefore, it is necessary to ensure that an assessment leads to a formulation and scenario-planning and eventually to risk management planning covering the range of options, from direct intervention and supervision, to monitoring and victim safety planning, and for a range of violent outcomes. In other words, assessment alone – the characterisation of risk and protective factors in an individual – is not recommended (re. Farnham, 2016). Thus, in respect of John, the formulation of his actions in the context of the life he has had and the circumstances of his actions, and the translation of that explanation into a range of scenarios to be prevented – apart from the best case scenario, that is – offers an opportunity to identify the emotions that fueled his behaviour and to explore a range of risk management opportunities over time linked directly to that understanding.

Finally, more so than in any other area of concern, the management of risk of violent extremism in individuals with mental health problems is a multiagency affair. Mental health services are likely to have to liaise with other agencies such as the police and criminal justice services, and in the context of a high level of scrutiny and poor understanding about violent extremism and its relationship with mental health problems. Practitioners working in this field must be knowledgeable in order to

support their colleagues, and the challenges of multiagency working must be recognised in order to ensure the safe navigation of the difficulties that will inevitably arise (e.g., in relation to information sharing, or in relation to the impact on mental health of overly restrictive risk management). Care coordination for such individuals will be essential in order to ensure comprehensive oversight and managed responses and expectations in the long-term – the alternative being that such persons are treated as individuals with mental health problems and a history of violence, or as a violent extremist, and the *combination* of those concerns may be lost. Therefore, with regards to John in the case study, his future management and care – first in the criminal justice system and then into the community and over a number of years – will inevitably require the involvement of multiple agencies. For there to be oversight on the range of concerns raised by this gentleman, the coordination of those services and the maintenance of a balanced consideration about risk and its management will be required. Mental health practitioners are ideally placed to do this and to maintain such a function over time.

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