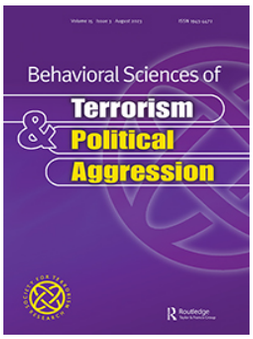

Routledge
Taylor & Francis Group

Behavioral Sciences of Terrorism and Political Aggression

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

Practitioners' perspectives on the challenges of dealing with the interaction between mental illness and violent extremism in Countering Violent Extremism (CVE)

Norah Schulten

To cite this article: Norah Schulten (2022): Practitioners' perspectives on the challenges of dealing with the interaction between mental illness and violent extremism in Countering Violent Extremism (CVE), Behavioral Sciences of Terrorism and Political Aggression, DOI: 10.1080/19434472.2022.2142268

To link to this article: https://doi.org/10.1080/19434472.2022.2142268

© 2022 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group

Published online: 01 Dec 2022.

Submit your article to this journal

Article views: 985

View related articles

View Crossmark data

Full Terms & Conditions of access and use can be found at
https://www.tandfonline.com/action/journalInformation?journalCode=rirt20

BEHAVIORAL SCIENCES OF TERRORISM AND POLITICAL AGGRESSION
https://doi.org/10.1080/19434472.2022.2142268

Routledge
Taylor & Francis Group

OPEN ACCESS Check for updates

Practitioners' perspectives on the challenges of dealing with the interaction between mental illness and violent extremism in Countering Violent Extremism (CVE)

Norah Schulten

Political Science Department, University of Amsterdam, Amsterdam, The Netherlands

ABSTRACT

While mental health frameworks are increasingly accepted in Countering Violent Extremism (CVE) policies, little is known about practitioners' experiences when individuals are mentally ill. This paper discusses how mental health clinicians review interactions between psychopathology and violent extremism, and which challenges Dutch practitioners face in decision-making processes around including severely mentally ill people in CVE individual case management approaches. Inclusion means that people are identified as (potential) violent extremists, which justifies CVE interventions on top of regular mental health care. Semi-structured interviews were conducted with 12 international mental health clinicians and 13 Dutch CVE practitioners. Data was analysed with qualitative thematic analysis. Results show that professionals usually view the risk of extremist violence, and not psychopathology, as the decisive factor for inclusion, unless (forensic) mental health clinicians advise otherwise. Nevertheless, some practitioners can experience challenges around making dichotomous choices about including mentally ill persons. Some expressed concerns about illegitimately labelling certain people as 'radicalised' when they suffer from severe mental illnesses (e.g. psychosis). CVE cases with mental illnesses are, however, characterised by heterogeneity, non-dichotomy and missing information. False negatives and false positives concerning uptake in pre-emptive CVE policies can have detrimental individual and societal effects. Future research suggestions are provided.

ARTICLE HISTORY
Received 9 March 2022
Accepted 27 October 2022

KEYWORDS
Psychopathology; violent extremism; CVE; CT; radicalisation; terrorism

Introduction

It is becoming increasingly clear that people who are vulnerable to being drawn into violent extremism can also suffer from mental health problems. In the Netherlands, a recent governmental report stated that a few hundred right-wing adolescents were entering (online) extremist networks and that they relatively often suffer from psychological problems (NCTV, 2021). The emphasis on mental health problems in extremism raises many questions for professionals who work on pre-emptive individual case management in Countering Violent Extremism (CVE) policies. These CVE case management

CONTACT Norah Schulten n.schulten@uva.nl

© 2022 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group
This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives License (http://creativecommons.org/licenses/by-nc-nd/4.0/), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited, and is not altered, transformed, or built upon in any way.

programmes aim to identify and provide support, via non-coercive (care) interventions, to individuals who are at risk of being drawn to violent extremism (Cherney & Belton, 2021; Wolfowicz et al., 2021). This paper discusses how mental health clinicians review interactions between psychopathology and violent extremism, and which challenges Dutch practitioners face in decision-making processes around including severely mentally ill people in CVE individual case management approaches.

This question is relevant for society, because extremist attacks by mentally ill people usually spark post-hoc discussions on what could have been done to prevent them. The case of Malek F. in the Netherlands in 2018 shows the complexity behind this discussion. Malek F., who attacked people on the street, was not convicted of a terrorist offence, but of attempts of manslaughter. The emphasis lied on his psychopathology, and his terrorist motives were too difficult to prove. However, there were disagreements on whether his terrorist motives also contributed to his actions (Vermeulen et al., 2022). Retrospectively, questions could be raised about whether he would also have benefitted from CVE interventions that focused on both his mental illness and his radical views, while he was still operating in a pre-criminal space. The current paper does not provide an answer for this specific case, but it discusses the complexity behind these types of questions.

CVE practitioners often have to make complex decisions on whether and how they will intervene with people who are at risk and operate in a pre-crime space (Van de Weert & Eijkman, 2019). This decision-making process is accompanied by many challenges, which is why academic researchers are also increasingly emphasising the importance of investigating how psychopathology plays a role in these (potentially biased) operational practices in CVE policies (Augestad Knudsen, 2021). Augestad Knudsen (2021), for instance, analysed how in pre-emptive CVE policies, the boundaries between psychopathology as a vulnerability and a risk factor can become blurred. How is this role of psychopathology perceived in CVE practices in the Netherlands? To the best of the author's knowledge, this is the first paper that merges the expertise of mental health clinicians with the potential challenges Dutch CVE practitioners face when deciding on whether to include a mentally ill person in a CVE individual case management approach.

Defining psychopathology and violent extremism

In the last decade, the literature has brought us nuances about the interaction between psychopathology and violent extremism (Gill et al., 2021) and the challenges CVE professionals face when psychopathology is included (Augestad Knudsen, 2021; Hellevik et al., 2022). The conceptualisations of both psychopathology and violent extremism explain some part of the complexity behind this interaction.

Psychopathology, i.e. the study of patterns of abnormal behaviour and abnormal psychological processes (Willerman & Cohen, 1990), includes a diversity of mental health disorders. The 5th edition of the Diagnostic and statistical manual of mental disorders (DSM-5; APA, 2013, p. 20) partly defines a mental disorder as 'a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning'. The DSM-5 distinguishes many mental disorders and symptoms that can largely be organised within the

internalising/emotional spectrum (e.g. anxiety and depression), the externalising spectrum (e.g. antisocial personality disorder and substance abuse), the thought disorder spectrum (e.g. psychosis and schizophrenia), the neuro-cognitive spectrum (e.g. delirium and dementia) and the neurodevelopmental disorder spectrum (e.g. autism spectrum disorder) (Eaton et al., 2012; Kotov et al., 2017; Skeem & Mulvey, 2020). Clinicians stress that, in terms of mental health problems, only focusing on official diagnoses is problematic. Subclinical symptoms and mild symptoms could potentially have detrimental effects on a person's life and thus radicalisation processes (Al-Attar, 2019; Gill et al., 2021; Schulten et al., 2019). In the field of extremism, it has been therefore advised to move beyond categorical classification of mental illnesses. The DSM-5 also increasingly aims to include dimensional perspectives (Gotzsche-Astrup & Lindekilde, 2019).

The concepts of radicalisation, (violent) extremism and terrorism are often used interchangeably in academic papers and CVE, but much has been written about the importance of not using these terms as synonyms (Van de Weert & Eijkman, 2019). Bartlett and Miller (2012, p. 1) state that 'to be radical is merely to reject the status quo, and not necessarily in a problematic or violent way'. The purpose of this paper is to better understand CVE case management that only includes those individuals with violent extremist ideologies who show 'preparedness' to break the law or who broke the law (violent extremism and terrorism) (Van de Weert & Eijkman, 2019). The Dutch government defines (violent) extremism as the phenomenon 'in which persons or groups are prepared for ideological reasons to seriously violate the law or carry out activities that undermine the democratic legal order' (NCTV, 2022). As Stephens (2021, p. 347) states, the 'concept of 'violent extremism' tends toward a more behavioural than idealistic definition, in that it places focus on violence as a means, rather than the holding of extreme views themselves' (Neumann, 2003). Nonetheless, it is not always easy to identify if someone is radicalising towards ideological-based violence or to non-violence (Kundnani, 2012; Van de Weert & Eijkman, 2019). Many 'potential' extremists are still operating in the legal, pre-criminal space and a very large proportion will never end up using violence (Augestad Knudsen, 2021; McCauley & Moskalenko, 2014).

Interaction between psychopathology and violent extremism

Research on the interaction between violent extremism and psychopathology shows that all forms of psychopathology can be present in violent extremists and terrorists. It is important to note that no strong evidence exists that psychopathology can be used as a direct causal predictor for extremism in the general population (Sarma et al., 2022); extremists are not necessarily psychologically ill, persons with severe mental illnesses can also have extremist views, and radicalisation is not a mental disorder (Al-Attar, 2019; Schulten et al., 2019). Only a few in the general population are considered to be (violent) extremists, while mental disorders are relatively common (Corner et al., 2018). In addition, people with mental disorders are often victims rather than perpetrators (Dom et al., 2018). Finally, people with mental health problems mustn't be too quickly stigmatised, for instance with a 'radicalisation label', which in the worst case threatens good ties between communities and mental health care (Augestad Knudsen, 2021; Faccini & Allely, 2017; Heath-Kelly & Strausz, 2019; Misiak et al., 2019).

Nonetheless, several prevalence studies have reported that people who have committed an extremist act may also suffer from mental health problems (Gruenewald et al., 2013 and see Gill et al., 2021; Sarma et al., 2022; and Trimbur et al., 2021 for an overview of the literature). Gill et al. (2021) reported that prevalence rates of mental health problems range from 0% to 57% (Gill et al., 2021). The reasons for the heterogeneity in these percentages are that these studies examined different subgroups in different contexts, had access to different data sources and methods, and finally interpreted psychopathology differently. These previous studies do suggest that all mental disorders can be present and range from mild complaints (e.g. mild anxiety) to severe mental illnesses, such as schizophrenia, and certain personality disorders and severe lifelong disorders (e.g. autism) (Al-Attar, 2019). In one sample of lone actors, schizophrenia, delusional disorders and autism spectrum disorders seemed relatively elevated compared to the general population base rate (Corner et al., 2016). Furthermore, researchers have found certain psychological problems in subgroups of extremists, such as jihadists (e.g. psychotic disorders and PTSD; Van Leyenhorst & Andreas, 2017; Weenink, 2019), white supremacists (e.g. substance use; Bubolz & Simi, 2019), suicide extremists (e.g. depression and suicidality; Merari et al., 2009), extremists imprisoned in Dutch jails' (e.g. psychotic disorders, autism spectrum disorders, mild intellectual disabilities and cannabis use disorder; Thijssen et al., 2021) and finally a screened group of (potential) extremists (e.g. preliminary mood and anxiety (PTSD), mild intellectual disability, substance-related disorders, personality disorders, autism spectrum disorders, and psychotic disorders; Grimbergen & Fassaert, 2022).

The roles that mental health problems play within extremism seem to vary by subgroup, context and individual. Psychological complaints, when present, can interact with a highly individualised chain of vulnerability, resilience and situational factors in a complex contextually dependent pathway towards violent extremism (Schulten et al., 2019). Complex needs that are associated with extremism can also be associated with psychopathology, such as experienced discrimination, family and relationship problems, problems in employment, sudden negative life changes, substance abuse/addiction, abuse and trauma (Gill et al., 2021; Grimbergen & Fassaert, 2022). Research into small samples and individual case histories and the clinical view of experts also provide us with first insights into how symptoms could contribute to extremist violence (see Al-Attar (2019; 2020) for a discussion). For instance, some symptoms can contribute to the development or maintenance of high-risk violent behaviours, or they can be a trigger for the decision to conduct violent behaviour (Al-Attar, 2019; Misiak et al., 2019). Faccini and Allely (2017) explain for specific and rare cases, where autism coexisted with extremism, how symptoms of this disorder, such as social naivety, obsessive interests, rigidity on rules, aggressiveness and a lack of understanding of social situations, could support their terrorist behaviours or susceptibility to recruitment. On the other hand, when present, mental health problems can also simply co-exist next to a path towards violent extremism, or function as a resilience factor. Mental health problems can even arise due to stressful events during participation in terrorist groups and integration with extremist ideologies (Al-Attar, 2019; Gill et al., 2021; Gill & Corner, 2017). Hence, individuals radicalise towards violent extremism for a wide variety of reasons and every case should be approached separately and holistically (Jacques & Taylor, 2013; Koehler, 2015; Morgades-Bamba et al., 2020; Oppetit et al., 2019; Van San, 2018).

Practitioners' challenges and implications of psychopathology in CVE

Looking at the rising number of empirical studies on the prevalence and relevance of mental illness in extremist groups, many researchers and CVE professionals agree that a mental health framework should be included in multi-agency CVE individual case management approaches (Al-Attar, 2019; Cherney & Belton, 2021; Gill et al., 2021; Schulten et al., 2019; Sestoft et al., 2017). In Norway, police officers stated that it is indeed a common part of their CVE work to assess someone's mental state and need for treatment (Hellevik et al., 2022). Mental health difficulties were also found in target groups of pre-emptive CVE policies in the United Kingdom (UK) and the Netherlands (Grimbergen & Fassaert, 2022; NPCC, 2019). In line with this, several internationally renowned extremism assessment instruments recommend that clinicians include the role of mental disorders and their possible association with other complex needs of individuals. Examples of such tools are the *Terrorist Radicalization Assessment Protocol* (TRAP-18) and *Violent Extremism Risk Assessment* (VERA revised version 2) (Goodwill & Meloy, 2019; Lloyd, 2019; Pressman, 2009). Although it is not always clear to underequipped professionals who work with these assessment tools how they can identify if and how present mental health problems are vulnerabilities, or even relevant, in someone's radicalisation process (Augestad Knudsen, 2021).

While there seems to be consensus on this inclusion of the mental health framework in CVE, researchers are calling for a stronger academic focus on how this works in the operational space. One of these questions refers to what the practitioners' experiences are with cases of mentally ill individuals at risk (Augestad Knudsen, 2021; Cherney & Belton, 2021; Sestoft et al., 2017; Van de Weert & Eijkman, 2019; 2020). Previous research already reports that the inclusion of a mental health framework in CVE practices does not come without challenges (Hellevik et al., 2022). Vermeulen et al. (2022) use the experiences of CVE professionals to explain how, in the Netherlands, a lack of clinical experience and skills of practitioners in CVE, and/or a lack of experience and skills in dealing with extremist ideologies, could potentially lead to different or one sided interpretations of the integration between psychopathology and ideology in cases of female radicalising individuals, right wing radical groups, left wing radical groups, religious radical groups, and potentially radical young people. The reasons for these challenges lie in practical issues, such as expectations, unclear responsibilities or the complexity of sharing information between disciplines. These challenges are however also due to the potential ways the role of psychopathology is interpreted by professionals from different disciplines (Hellevik et al., 2022; Sizoo & Doosje, 2020; Vermeulen et al., 2022). Assessments of radical ideologies are a complex affair, let alone when severe psychopathology plays a role. Incomplete interpretations of psychopathology, which could foster false positives or false negatives, could have detrimental consequences for individuals and society in general (Vermeulen et al., 2022).

False negatives in the pre-emptive phase can prevent individuals from receiving the necessary CVE support. However, an excess of false positives, for instance through a perception of psychopathology as a causal predictive risk factor, can be also damaging to the individual and society. Augestad Knudsen (2021) warns about this excess in her essay on the CVE Mental Health (now Vulnerability Support) Hubs in the UK. These hubs are 'a cooperation between National Counter-Terrorism Policing and the NHS (UK National

Health Service) in which counter-terrorism police officers work alongside mental health professionals with the goal of bettering their understanding of, and approach to, mental health-related issues in PVE [Preventing Violent Extremism] work' (Hellevik et al., 2022, pp. 2–3). Although the inclusion of a mental health framework is increasingly accepted in CVE (Sizoo et al., 2022), Augestad Knudsen (2021) argues that the existence and set-up of these hubs and threat assessment tools indicate that UK CVE strategies are at risk of unintendedly seeing mental health problems as a vulnerability that is associated with a pre-attack timeline that deserves crime risk management. As a result, mental health care could be potentially implemented for security measures, rather than care. The Vulnerability Support Hubs also received harsh criticism for not being perfectly able to rule out complex counter-effects of CVE, such as securitisation of care (Aked, 2022). This shows that the combination of criminal justice measures with healthcare measures is inherently difficult (Augestad Knudsen, 2021; Hellevik et al., 2022; Sizoo et al., 2022).

CVE practitioners themselves have also reported concerns that they might be susceptible to potential bias, which could lead to an imbalance between false positives and false negatives. Interviews with some CVE professionals in the Norwegian police revealed their experiences of feeling challenged about assessing whether individual cases were primarily crime-related (e.g. violent extremists) or mental health-related, while some cases could be easily compartmentalised in both (Hellevik et al., 2022). Seeing someone's attitudes and views as extreme or as simply an indication of mental health problems was viewed as a challenge (Hellevik et al., 2022). Finally, surveys among NHS staff in de UK showed that, even though there were positive views on the inclusion of the mental health paradigm and related services in CVE, there was also uncertainty about the exact role of including mental health in CVE, and fears around being part of stigmatisation and improper surveillance practices were reported (Heath-Kelly & Strausz, 2019). Interviews with 16 critical NHS professionals also confirmed the challenges these professionals face, as they reported stress, distrust and fear towards moral and political expectations they felt were being put upon them (Younis & Jadhav, 2019). While the Netherlands does not operate in the same context as other countries (e.g. there is no Prevent duty), false positives and false negatives around inclusion after someone is already referred can still have harmful impacts on the individuals who are seen as either (a potential) extremist or not (Van de Weert & Eijkman, 2019). Therefore, it is crucial to assess which challenges Dutch CVE practitioners face around inclusion when they encounter cases with mental health problems.

Dutch CVE multi-agency individual case management

In the Netherlands, local authorities (e.g. municipalities) often have a directing role in the individual CVE case management approaches. These are collaborative approaches that make use of multidisciplinary teams, consisting of care providers, security agencies and judicial agencies (Sizoo et al., 2022). While unique, to cater to the country's and local needs, the multidisciplinary case-management approaches are quite similar to CVE case approaches in other countries, such as Denmark (Sestoft et al., 2017) and Australia (Cherney, 2022). These approaches include working with individuals about whom there are reasonable concerns about being at risk of committing extremist violent behaviour (Dijkman & Gielen, 2021; Sizoo et al., 2022; VNG, 2015). Individual case management approaches can thus also intervene in a pre-criminal space. Many sources can refer

individuals who show worrisome behaviour to the CVE approach, such as professionals who work in education, security, or care institutions. Once referred, several multi-agency meetings are held and assessment tools are used to decide on whether to include someone in the CVE individual case management approach. Hence, the CVE practitioners (assessors) have to decide whether there is enough evidence of reasonable concerns that an individual is at risk of committing extremist violent behaviour. Alongside this, they also assess the complex needs of the referred individual, including mental health problems. Accordingly, a tailor-made intervention strategy is set up, for health care-based interventions often on a voluntary basis (VNG, 2015). In the latter steps, health-care workers adhere to strict medical confidentiality laws. For instance, multi-agency teams can often gather more information about cases after inclusion. This makes information-sharing more complex and difficult (see Sizoo et al. (2022) for a study on the challenges concerning medical information sharing and collaborating in a multidisciplinary team in the Netherlands).

This paper will look closer at the challenges Dutch CVE practitioners face when mental health issues are present and decisions have to be made about uptake in a CVE programme. Before discussing these challenges, the insights and expertise of mental health experts are necessary to place the challenges CVE practitioners face in the context of the theoretical-empirical interactions between psychopathology and extremism. Since the pool of mental health clinicians who are specialised in CVE in one country (e.g. the Netherlands) is considerably small, mental health clinicians were selected in an international setting. So there are two research questions in this paper: (1) How do international CVE mental health clinicians (e.g. psychiatrists, clinical psychologists and psychologists) understand the interaction between psychopathology and violent extremism?; and (2) Which challenges, in terms of their perceptions of interactions of psychopathology and violent extremism, do Dutch CVE practitioners encounter when deciding on whether to include severely mentally ill people in CVE individual case management approaches?

Method

Respondents

Two pools of respondents, consisting of international mental health clinicians and Dutch CVE practitioners, were approached for this study via *purposive sampling*. This means that their selection was based on their expertise, their position and the feasibility within the research period. The study on clinician expertise was approved by the Ethics Committee of UCL (University College London: Z6364106/2019/10/156) and the study on practitioners' experiences and challenges was approved by the UvA (University of Amsterdam: 2020-AISSR-12914).[1] After reading the information brochure, the professionals signed an *informed consent* form if they agreed to participate. The term 'professionals' is used here to refer to the whole sample of 25 professionals. See Appendix A for an overview of the respondents, their reference number and their expertise.

The interviews with the pool of European and American mental health clinicians (N = 12) were collected for a study on the interaction between psychopathology and mental illness. To identify respondents for this study, the author sent out an information brochure

to a large pool of CVE clinicians via the research group lead's contacts, an international network that is specialised in radicalisation and extremism, and via interviewed respondents themselves (snowball effect). If clinicians were interested in participating, they contacted the researcher directly. The author herself conducted the interviews with the CVE clinicians in 2020/2021: three psychiatrists, five (forensic) clinical psychologists, and four psychologists (e.g. psychotherapists). Their experience ranged from 2 to over 20 years, and the majority had been in direct (face-to-face) contact with radicalising individuals, extremists and/or terrorists.

The interviews with the pool of Dutch CVE practitioners ($N = 13$) were collected for a study to better understand challenges in the decision-making strategies of these practitioners in individual multi-agency case management approaches. The author contacted CVE practitioners via their management or directly. The author randomly chose one or two CVE practitioners from different institutions and disciplines to contact for an interview (e.g. security, legal and care institutions). This strategy ensured that insights from the different disciplines (and therefore different perspectives and expertise) were covered and that various interpretations of violence-legitimising ideologies, safety and mental health problems were taken into account. This Dutch sample consists of two mental health experts, five case directors and six CVE managers/policymakers from multi-agency CVE teams. These experienced practitioners work for instance for security institutions, legal departments, childcare, municipal officials and (mental) healthcare organisations. Their experience ranged from 2 to over 20 years.

To ensure the openness of respondents on this sensitive topic, the author granted anonymity to the interviewees. Therefore, the paper does not link specific disciplines, institutions, the local context and policy and names to the interviewees and their quotes. The results of this paper should also act as a way to better grasp potential dilemmas that could play a role in CVE, but they do not necessarily represent a characteristic of specific CVE policies.

Data collection: interview protocol

All professionals were interviewed by the author in 30- to 60-minute semi-structured interviews that were held in a secured online environment. The insights and expertise of the clinicians are necessary to place the challenges of the CVE practitioners in the context of theoretical–empirical interactions. Because of their different experiences and expertise, both samples had a separate interview protocol.

In the interviews with mental health clinicians, the author aimed to use their empirical knowledge to build upon literature reviews about the interaction between psychopathology and extremism. They were asked to base their claims on their practical experiences and perceptions. The clinicians were specifically asked about which type of mental health disorders and problems were present in their respective target groups, if and how mental health disorders and problems interacted in individual pathways towards radicalisation, violent extremism and terrorism, which interventions were effective, and what role mental health clinicians should play.

In the interviews with the Dutch practitioners, the author aimed to better understand how CVE practitioners reached their decisions on whether to include someone in the CVE programme, and the challenges they encountered during this

procedure. Specifically, the author asked about how the CVE practitioners perceived the interaction between psychopathology and violent extremism, if and how information was gathered about the mental health of individuals who were referred to the CVE case management approach, which institutions and actors were involved in the decision-making process, if and how the presence of psychopathology played a role in the decision-making process, which challenges they as practitioners faced during this process and finally what their experiences were with mental health interventions within the CVE framework.

Analysis procedure

All interviews were transcribed verbatim for research analysis. The same thematic analysis procedure of Braun and Clarke (2006) was used for the analysis of all 25 interviews. This focuses on the perceptions and experiences of professionals who are influenced by social processes and contextual factors. Because research on the role of psychopathology in procedural practices of CVE is relatively new but also increasing, the coding scheme was based on a combination of emerging (inductive) and *a priori* (deductive) coding (Schmidt, 2020; Stemler, 2001). For the first deductive coding scheme, codes were derived from the semi-structured interview themes, which were based on theory (Augestad Knudsen, 2021; Schulten et al., 2019). Additionally, the researcher inductively conducted two rounds of initial coding and focused coding (Saldaña, 2013). The final themes that emerged from these three rounds of coding were: the presence of mental health problems; the role of mental health problems in extremism; intervention pathways; how the perceived integration of psychopathology and extremism impacts inclusion in CVE and the framing of someone as a violent extremist (subdivided into 'Risks behind false positives and false negatives during the decision-making process on CVE individual case management approach inclusion' and 'The challenge of being better sure than sorry'); and finally the role of clinicians in multi-agency CVE teams.[2] All perceptions of professionals (i.e. mental health clinicians and CVE practitioners) were accordingly coded one final (fourth) time with these themes.

A limitation of this study is that all the coding and interpretation of data were developed by a single researcher. To ensure credibility (Guba & Lincoln, 1989), the author made sure to engage in a prolonged matter with the data by conducting the interviews herself, by discussing some of the results of the preliminary report with peers and policymakers of individual case management approaches, and by doing four rounds of coding. Because of this strategy, several perceptions are reflected in the paper. The reality of the challenges faced is difficult to quantify and the data did not seem suitable to measure the weight of diverse perceptions. The lack of quantification is however not problematic as the goal of this paper was to identify possible perceptions to create awareness and to generate hypotheses for future testing.

Results

To answer the research questions, there is first a discussion of how experiences of mental health clinicians with CVE cases who are mentally ill help us to gain insights into the interaction between psychopathology and violent extremism. The second results section

discusses how Dutch CVE practitioners take psychopathology into account in their decision-making about CVE inclusion and which challenges they encounter in their decision-making process on including mentally ill individuals in CVE case management approaches.

Clinicians' perspective: integrating mental illness in pathways towards violent extremism in a CVE context

In the interviews, clinicians mentioned that psychopathology, if present, is always part of a complex individual story with many other complex needs. Therefore, it needs to be approached holistically (Respondent 12). As a result, multi-agency teams with experts from each area, including forensic clinical experts, are crucial to analyse the enormous individual variability present in the interaction between psychopathology, extremism and other identified factors per case (Respondent 14). This holistic approach is explained in the following quotes of clinicians:

> Respondent 2: *"I don't believe that people with autism are a direct risk of being violent extremists, because there are way more people with autism who are not terrorists. So there is something in this person with autism that makes him a terrorist. You cannot be in a tunnel and only think he has autism so you treat that, and everything will be fine. Because autism is not the reason why someone is violent. And also borderline [personality disorder] is not the reason, and neither is the personality, because there are so many more people that have this and are not behaving violently, and who are not placed on a terrorist wing. So if someone is mentally ill or psychotic I ask the question: why are you in this prison? There are way more people diagnosed with schizophrenia outside, in regular healthcare, than in this chair, [talking] with me. So you need to explain that. I think there is always more. We try to see it in a broader perspective. We always try the holistic approach. So someone with a trauma gets therapy, but we also do these other interventions."*

> Respondent 1: *"For example, depression can be a protective factor but it can also be a risk factor. Medication is the same thing. So, it's much more complicated than just making a list of risk factors; you really have to reconstruct the story … Ideally you want to examine someone's first-person perspective directly. We talk too much about people, and too little with them."*

Interactions of psychopathology and violent extremism can play out in all possible ways. On an individual level, the relationship could be causal, independent, co-existing and non-relevant, interrelated, personal, inter-relational, contextual, substantial etc., as explained by a clinical psychologist:

> Respondent 11: *"People assume that mental health is a causal factor, so prevalence and relevance. Just because it is present, it does not mean that it is relevant. It could be relevant, it could be completely irrelevant, or it could be dependent on a lot of completely different factors … . Sometimes, for people diagnosed with mental illness, it is a direct factor, or a direct causal factor in their risk. Sometimes it has nothing to do with it at all, but most commonly we find lots of interrelated factors. Some of them are personal, some are inter-relational, some contextual or substantial. People exist within their context. You can't just pick out one factor and say that – [well,] sometimes you can, but in general, you really cannot."*

In one given example, the disorder did even directly explain the extremist behaviour, as illustrated in the following quote:

> Respondent 2: *"One person where I really saw a direct link between the disorder and the crime he committed was someone who had bipolar disorder … Then he was very psychotic and we gave*

him lithium, and he stabilized and thought 'Oh my gosh, what did I do?' … . So then you see a very direct link between the disorder and the behaviour. But I think in most cases it's a little more subtle."

On the contrary, professionals also mentioned cases in which 'empty' radical statements or behaviours may have been favoured by psychological problems (Respondent 6). Often, however, only after long-term assessments and treatment does it become clear how these radical statements/behaviours and the mental disorder relate. In some cases, like the case mentioned above, treatment for the mental health disorder through medication or therapy softened or diminished the radical ideology (Respondent 2). The reverse effect was, however, also found in other examples in which radical ideologies strengthened after effective therapy. While awareness is also necessary that treatment is not always effective, the following quotes show the diversity in possible outcomes after treatment (with medication):

Respondent 3: "*It always comes when he stops taking his medication. He sometimes stops taking the medication and then the radicalised outburst comes, sort of like getting violent … because he feels anxious, he feels scared, he has delusions."*

Respondent 2: "*We had one person who was labelled with schizophrenia, but when we treated him with anti-psychotic medication and he was not psychotic any more, he became more and more radical. What we saw was that his psychosis was covering the more radical violent ideas he also had."*

Once severe psychiatric disorders (mental illnesses, such as psychotic disorders) accompany or even reinforce radical ideologies, violent extremist behaviours or a threat of violence, several clinicians referred to the challenge of assessing the accountability of someone's radical ideology and violent extremism. One psychiatrist, for instance, claimed that you cannot label someone as a terrorist if the terrorist act is done because of a psychosis or delusional state, as is clearly stated in the following quote:

Respondent 6: *"So you cannot consider somebody who does that because of a psychotic or delusional state as a terrorist."*

Warnings for dichotomous thinking are also given, because violent extremist ideologies and mental illness do not necessarily exclude one or the other, according to Respondent 11. This is also shown by the following quote from a forensic clinical psychologist.

Respondent 2: *"But I think you can also be confused and radical together. And then you need to think about which part is confused and which part is radical. […] Especially with people with a very problematic past and a lot of psychiatric or personality disorders, I think they are very vulnerable to becoming radicalised fast. It can be if they meet the wrong people, but it could also happen when they search for it on Google."*

Dichotomous thinking refers to whether someone can be assessed as completely mentally ill or completely radicalised (e.g. mad or bad). Ideal types, in which it is completely one or the other, do not occur often in practice, according to one mental health expert:

Respondent 14: *"What you see in the media and the layman opinion is always that, if something happens, it's either a psychiatric patient or it was a radicalised criminal, so to speak. As if one must choose between those two extremes. What one actually learns in such a CVE approach*

is that a lot of different factors always play a role. And then it is often very difficult to say: well, that was the decisive one."

It is not always possible to assess whether someone is extreme, mentally ill, both, or neither. The following quote illustrates that much research is necessary per case before the role of psychopathology can become clear, while it is also perfectly possible that CVE teams will never find out how psychopathology and a violent ideology are integrated in one person:

Respondent 2: *"So I think it's always, you need to see the case and look very much into that. Why is someone doing what he is doing? Is it because of schizophrenia, and is that the direct or indirect link to the behaviour? Is someone psychotic but maybe also radicalised? How was his behaviour before he was psychotic? Because you are not psychotic your whole life. We always like to make a timeline of someone's life. So someone is born, and someone is in prison, but what happened in [between]? [This means] we can understand why they are in prison. And then you try to understand what it was, and sometimes you will never know. It can be very difficult to find out."*

On a general level, more research on the level of the risk of certain mental illnesses is necessary to better understand their interactions, as illustrated by the following quote.

Respondent 11: *"People assume that autism will definitely increase someone's vulnerability to being drawn towards terrorism, when we do not have the evidence about how autism is relevant and in what circumstances. So it concerns me. You cannot dismiss the factor, because arguably autism would make them more vulnerable, particularly online – especially in lockdown, because people are online a lot more. But at the same time, there is lots of focus on autism lately, and we don't actually know … whether or not it's actually a risk factor, or a risk factor to be identified."*

Challenges of Dutch professionals in CVE around including mentally ill individuals in CVE case management approaches

The current paper focuses on the challenges that Dutch CVE practitioners could experience when they have to decide on whether a mentally ill person is deemed suitable for a CVE individual case management approach. The majority of interviewed practitioners, including managers and policymakers, explicitly mentioned that they do not automatically perceive psychopathology as a causal predictor for violent extremism. In line with this, most CVE practitioners explained that the inclusion criteria around whether there is an identifiable risk of violent extremism, also coming from security data, determine whether someone would be suitable for an individual CVE case management approach. The majority of interviewed practitioners stated that psychopathology would not play a primary role in these criteria by default, unless (forensic) mental health clinicians of a chain-partner mental health care institution justifiably claimed that the mental illness of the individual was an inclusion indicator, or a contra-indicator for inclusion (Respondents 20 and 21). The risk of extremist behaviour, and not psychopathology, thus seems to be the decisive factor for inclusion. The following quotes of a case director and manager are representative of this procedure:

Respondent 20: *"The ideological threat of violence should be present if someone is included in a CVE approach. This threat should be the leading factor. Psychopathology can be of course something that contributes to this, but it should not be reasoned the other way around."*

> Respondent 21: *"From the moment that we see statements and behaviour from which a risk can be detected, I don't think it's that relevant to think about where this behaviour is coming from … In that first phase, I think it's just not always feasible to already take a position on mental health problems and to say something about whether or not admission is based on mental health problems."*

Nonetheless, in the Dutch operational CVE space, a few proclaimed it to be challenging if the population of individuals who are referred to CVE individual case management approaches suffer from severe mental health disorders and showcase misunderstood (possibly psychotic and delusional) behaviour, for instance. A few CVE practitioners referred to the challenging discussion on '*whether to include someone in CVE who is also a psychiatric patient*'. Professionals raised questions such as: can someone be ethically framed as radicalised and be referred to radicalisation CVE interventions if they are severely mentally ill? Should healthcare be integrated with security- and ideological-based CVE interventions? The following quote is an illustration of this dilemma for one practitioner, a CVE manager:

> Respondent 16: "*But for me it's an ethical question. If we know that someone has a certain mental disorder and makes statements based on that disorder, how legitimate is it if you then say: ok, we will include that person in this CVE approach, because then we can do something with it?"*

The risks behind the dichotomy of including versus excluding mentally ill people: false positives and false negatives

The wrong identification of a severely mentally person as a potential violent extremist can have wide-ranging harmful consequences on the individual. After all, the inclusion of individuals into pre-emptive CVE policies infringes a person's privacy, as emphasised by a case director and policymaker.

> Respondent 21: *"At all times one must be able to explain well why they are infringing someone's privacy!"*

An illegitimate uptake (false positive) could be potentially damaging, and in the worst case, increase someone's susceptibility to a pathway towards extremism. One psychiatrist mentioned that when a person still operates in a pre-criminal space, it would be a goal to strengthen that person's position in life through CVE interventions, and it must be prevented that an unjustified label of being 'potential violent extremist' negatively influences someone's position (Respondent 14). A case director of a Dutch approach mentioned that it can additionally have negative consequences for society, for instance fear, if people are identified as radicalised more often than is legitimate (Respondent 18). Another psychiatrist who works in CVE states that the lines are blurred when someone can be framed as a terrorist. But he also cautioned that we must be careful as a society not to frame acts too quickly as terrorist acts, as illustrated by the following quote of a psychiatrist:

> Respondent 6: *"This influence of the social context on the delusional thematic state is something that is difficult to understand … . We cannot label all the criminal acts that are committed by people as terrorist acts, just because they say 'Allahu Akbar'."*

On the contrary, some practitioners mentioned the importance of not concluding too quickly and illegitimately that someone is unsuitable for CVE due to the presence of

mental health disorders, as this could lead to false negatives. For mentally ill individuals with extremist tendencies, (security) CVE interventions are possibly beneficial (Respondent 14). A CVE mental health expert warned that if someone is only referred to regular mental health care (without support from other (security) agencies), this person usually only sees a clinician who is primarily responsible for the care and treatment of the mental disorder. In this context, a clinician does not necessarily have the opportunity to understand extremist ideologies and to monitor possible worrisome extremist behaviour outside of therapy contact hours. That violent extremists who are suffering from mental illness should be embedded in a CVE intervention approach, next to receiving mental health care, is expressed in the following quote:

> Respondent 14: *"If you just refer someone to psychiatry … the psychiatrist or psychologist, these clinicians really don't know what's going on all those hours of the day that the person isn't there; they don't have access to all that safety information. You don't want that. This concerns a group that can exhibit potentially dangerous behaviour. If they meet the requirements in terms of safety, they must [be] enrol[led] in the CVE programme."*

To conclude, a few CVE practitioners in the Netherlands suffer from the demand for dichotomous choices between inclusion versus exclusion in the operational spaces of the individual case management approach. Here, both false positives as well as false negatives can have major consequences. Inclusion of a mentally ill person would justify CVE interventions on top of regular mental health care, but it also means that they receive a label of being a '(potential) violent extremist'. The risk of the misidentification that they are on the way to violent extremism can have the perverse effect of potentiating extremist ideology. Additionally, there is a risk of establishing a causal predictive association between mental illness and extremism. On the other hand, misidentification towards exclusion means that mentally ill people who are on the pathway to violent extremism might not receive this label of being a '(potential) violent extremist' and thus the corresponding CVE (security) interventions of a multi-agency CVE team. Excluding someone from the CVE approach just because they have a mental illness can prevent timely work from being done to counter the development of the extremist ideology.

Practitioners' perspective on including severely mentally ill people: a challenge of being 'better safe than sorry'

The demand for dichotomous choices between inclusion versus exclusion, and the attendant risks of false negatives or false positives, can enhance the challenge for CVE practitioners even more in cases in which the perceived integration of psychopathology and violent extremism is not clear-cut. The inclusion of a severely mentally ill person in an individual case management approach would frame this person as a '(potential) violent extremist'. But is this frame legitimate when it is not obvious what causes the extremist expressions? At least four interviewed CVE practitioners mentioned the difficulty they experienced in finding a balance between '*being safe rather than sorry*' or *'being sure rather than sorry'* when they have to make this decision. These practitioners also explicitly acknowledged their lack of knowledge on psychopathology, that information is often missing, and the need for information from mental health clinicians with knowledge on extremism to make this decision, as stated in the following quote:

Respondent 22: "*I actually do not think I am capable of judging whether someone has a disorder for which other care is more relevant than the CVE individual case management approach*."

For some cases with severe mental illness, such as a psychotic disorder, a non-clinician professional raised concerns on whether the mental illness in these cases would be the primary cause for the behaviour, and thus potentially delegitimise the ideological component behind extremist expressions. In other words, they expressed doubt about the accountability of and/or risk of the radical ideological behaviour. Is someone radicalised if the radical statements are made because of the disorder? The following quote is an illustration of this CVE practitioner, who explained that it is difficult to decide whether to include someone in a CVE programme if they show confused behaviour and express violent extremist-like threats. It is an example of a referral case that illustrates the complexity behind the integration of mental illness and radicalisation:

Respondent 16: *The moment someone is in the picture, that weighing up will take place. [Let's say] the report shows that someone has a history of therapy. But that report shows that someone actually screams out everything that is possible in fifteen minutes. So that person does not say anything that, for example, can be read in a manifesto about what they are planning. And you also do not see the preparation actions, no. Someone is calling out the whole gamut: I'm going to blow myself up, I'm going to plant a bomb – everything will pass. To what extent can you, and I say this as a layman, say that it's strange that someone actually shouts out everything that's possible? You know that that person is confused. How seriously am I supposed to take this? How big is the risk if someone actually throws everything out [in the open]?*

A few professionals indicated that some people who show confused behaviour because of their mental health disorder possibly benefit more from regular mental health care or other case management approaches for potentially violent psychiatric patients, as they perhaps do not benefit from CVE interventions. The following quote from a case director shows such a case, but then in relation to exclusion from a programme rather than inclusion in it:

Respondent 17: *"He makes his statements purely to shock. And also from his mental state he does that and then I think: yes, you know, is it right that someone with such a syndrome is involved in an approach for radicalisation or should something else be done?"*

Should someone with a similar profile be included in CVE individual case management approaches? Sometimes professionals do not know whether these statements are made purely to shock, for instance. To be '*better sure than sorry*' can thus refer to the notion that individuals who are eligible for inclusion in CVE policies primarily adhere to the radical ideological behaviour that they express, also in states of confusion (due to mental illness). Possibly even more relevant, it can also refer to the 'being sure' of the risk that someone indeed acts upon their radical violent statements. Some practitioners stated they preferred to be able to conduct more assessments before inclusion so that they can be '*better sure than sorry*'. Often though, not enough information is present to be '*better sure than sorry*' before inclusion decisions have to be made, which can create dilemmas:

Respondent 16: *"We just struggle with that: if there is a question of psychopathology, and then the manifestations of radicalisation, or what arises from it. Someone makes certain statements out of confusion that gets them labelled as radical. Is it because of the fact that someone is confused? Or can it also be the other way around? Someone might call out certain things, and it has*

nothing to do with the confusion at all, because that person is just radical. That's something we, in any case I, struggle a lot with in our decision-making process."

One forensic clinical psychologist, however, described the complexity of disentangling what part is from the disorder (e.g. the delusion) and what part is the radical ideology. This can even be a difficult assessment, even for clinical experts:

Respondent 9: *"So, it's really interesting to look at that nexus between severe psychopathology and extremism, and it is typically the personal experience … It is the personalisation of the extremist belief that often separates the mentally ill terrorists from others and that will then motivate them to engage in violent behaviour … . it's not necessarily a delusion, and may be an extreme overvalued belief … that is where you have to distinguish between the delusion and the beliefs held by other members of the extremist group. Usually the delusion is quite personal and often bizarre, but closely related to the ideology. That is critical, but it is really hard for clinicians to do, to understand that … you have to understand the ideology of the person and how they came to identify with that belief system. Often the ideology, if different from the clinician's beliefs, may seem quite bizarre, but unless it is personalised – often in an unusual and idiosyncratic way – it may not be a delusion."*

The majority of CVE practitioners and managers, as stated above, do indicate that psychopathology does not play a primary role in the criterion of violent extremism by default, unless (forensic) clinicians advise otherwise (Respondents 21 and 23). The risk of violent extremist behaviour, and not psychopathology, thus seems to be the decisive factor for inclusion. They state that when an individual does fall within the criteria of being at risk of committing violent extremist behaviour, even if they are also severely mentally ill, they should be included and receive a two-track intervention strategy of both CVE and mental health care interventions. The quotes below nuance this finding:

Respondent 13: *"As long as someone is psychotic, it is difficult to know if they are indeed radicalised. If someone falls within the criteria of radicalisation, this person should be included [in CVE]. You can decide to exclude this person again from a CVE programme. If you reason the other way around, and we don't include someone because this person is confused, then it would be risky."*

Respondent 23: *"If you talk about inclusion, and of cases for which it is known that there is clearly confused behaviour, and it is still unclear what exactly the problem is … . and you then ask, should that person be treated in the mental health care system, because they are not suitable for the approach? If that's the question, then I would say no, because I see them as separate things. There is an extremist ideology, meaning violence based on an ideology. So I think we should have a two-track policy in that case, absolutely provided that mental health care is in the lead because they have the knowledge and skills in house. So we try to get someone there, but the fact that they do have those expressions of extremist violence – we can't close our eyes to that and we also have to do something with mental health care. Because it hasn't been proven yet whether it's the chicken or the egg, what it is, how that works. Is someone an extremist just because he happened to become an extremist, or if he were mentally okay, would he have been an extremist too? If no one has an answer to that, and as long as we don't know, I say that we should use a two-track policy."*

Discussion

This paper has discussed how mental health clinicians review interactions between psychopathology and violent extremism, and which challenges Dutch practitioners face in

decision-making processes around including severely mentally ill people in CVE individual case management approaches. Findings show that CVE cases with mental health problems are complex. The majority of the interviewed Dutch CVE professionals view the risk of extremist violent behaviour as the decisive factor for inclusion in a pre-emptive CVE individual case management approach. Psychopathology does not primarily play a role in this decision-making process, unless forensic mental health clinicians advise otherwise. This seems reasonable, as interviews with mental health clinicians show that it is not always possible to investigate how psychopathology and extremism are integrated within a case before decisions have to be made on inclusion in a CVE individual case management approach. The integration often becomes clearer after long-term monitoring and treatment, and still then it is not always possible to gain clarity. Making decisions in a pre-emptive pre-criminal space for severely mentally ill individuals (e.g. people diagnosed with psychotic disorders) is therefore not always simple. Some CVE professionals referred to cases in which extremist attitudes and behaviour ceased to exist after effective clinical treatment. Additionally, society cannot frame everyone who uses terms framed in the media as extremist terms – such as '*Allahu Akbar*' – in a cry for help as a potential violent extremist. On the other hand, there are cases in which the disorder (including severe mental illnesses) plays a role in the pathway towards extremism. Concluding, many cases are characterised by heterogeneity, non-dichotomy (i.e. neither completely mentally ill nor completely radicalised), and missing information.

In line with the heterogeneity and complexity of cases, interviews with 13 Dutch practitioners show that a few of these practitioners experienced a challenge in making a dichotomous choice about including a severely mentally ill person in, or excluding them from, a CVE individual case management approach. Inclusion means that they are identified as a potential violent extremist, which would justify CVE interventions on top of regular mental health care. If someone is excluded, on the other hand, CVE interventions are not necessarily implemented. One reason for this challenge is that some practitioners can become concerned about illegitimately labelling people as 'radicalised' or a '(potential) violent extremist'. Extremist behaviour can then be dismissed as psychopathological, rather than ideological. For these few cases, some practitioners might perceive the severe psychopathology (e.g. psychosis) as an exclusion criterion. They, however, simply do not always feel as if they can make that call. Because false negatives and false positives can have detrimental effects for the individual and society, practitioners can thus experience challenges about whether to '*be safe rather than sorry*' or '*be sure rather than sorry*' when it comes to including some severely mentally ill people in a CVE programme.

This paper did not merge the findings of CVE mental health clinicians and practitioners to provide an answer as to the best choice for inclusion versus exclusion for these types of cases in pre-emptive CVE practices. The paper did aim to show the heterogeneity of possible relationships between violent extremism and psychopathology. Partly because of this heterogeneity, CVE professionals could face challenges when having to choose inclusion versus exclusion when someone is severely mentally ill. While CVE programmes often demand dichotomous choices, also for mentally ill people, the reality of the interaction between psychopathology and violent extremism is often not so clear-cut, non-dichotomous and extremely complex. Therefore, this paper concludes that (forensic) mental

health clinicians who understand radicalisation processes should be involved in the management of these complex cases.

The finding in the interviews, that many CVE cases seem to be characterised by multi-dimensional heterogeneity, non-dichotomy and missing information, is in line with previous research on the interaction between psychopathology and violent extremism (Al-Attar, 2019; Corner & Gill, 2015; Gotzsche-Astrup & Lindekilde, 2019). Dichotomous thinking (someone is either completely mentally ill or completely radicalised, e.g. mad or bad) could foster perceptions in which mental disorders are seen as automatic risk factors or as exclusion factors. This could foster a potential incorrect perception that either mental health care alone will be enough or that no mental health care is necessary at all. Seeing psychopathology as either a risk or as an exclusion criterion could lead to true positives and true negatives for individual cases. Nonetheless, automatic lines of reasoning in how mental illness is being considered in pre-emptive CVE practices could also lead to an excessive number of both false positives and false negatives (Augestad Knudsen, 2021; Sizoo et al., 2022; Vermeulen et al., 2022). This finding is in line with the conclusion of Vermeulen et al. (2022) that practitioners have to be careful with the automatic, and hence excessive dismissal of extremist statements as signs of psychopathology rather than an extremist ideology.

The challenges and worries that CVE practitioners can face when they have to make dichotomous choices in the CVE individual case management approach are logical when looking at the previous literature. After all, the harmful consequences of wrong decision-making become increasingly clear in these previous studies (e.g. Aked, 2022; Van de Weert & Eijkman, 2019). Nevertheless, the finding of this paper that a few Dutch practitioners experience concerns that, in some cases, severe mental illness potentially acts as a contra-indication for CVE inclusion shows a different picture than the findings of Augestad Knudsen (2021). This study did not find that Dutch CVE practitioners risk unjustifiably treating mental health problems as a vulnerability that is associated with a pre-attack timeline that deserves crime risk management over a treatment pathway. The findings do confirm the results of Hellevik et al. (2022) on the difficulty that Norwegian police officers had in deciding whether extreme attitudes were just extreme or also indications of mental health issues. This study, however, goes one step further, by elaborating how this doubt can lead to the challenge for non-clinician practitioners of being '*better safe than sorry*' or '*better sure than sorry*' when including some mentally ill people in CVE case management approaches.

Previous literature also emphasised the importance of obtaining similar CVE uptake procedures for subgroups, such as women, right-wing groups, religious groups, and adolescents (Vermeulen et al., 2022). While the current study did not find that there were differences in perceptions on '*being better safe than sorry*' versus *'better sure than sorry'* for these subgroups, it did find that the integration of psychopathology and radical ideologies can be complex for professionals. Vermeulen et al. (2022) emphasised that the lack of clarity about this integration can foster potential bias that ideology can be wrongly dismissed differently per subgroup. For instance, when psychopathology is present, CVE practitioners should be careful to still give proper attention to the ideological legitimation of violence. Future studies and pre-emptive CVE policy programmes are therefore encouraged to assess whether uncertainties about the interaction between psychopathology and violent extremism can be interpreted differently per subgroup. Note that the

awareness of this potential bias is not only relevant for trained CVE practitioners, but also for partners in society who refer the cases to municipalities.

Challenges concerning mental health for non-clinician CVE practitioners can be furthermore softened if forensic mental health clinicians (e.g. psychiatrists) always play a role in the decision-making process when a mentally ill person is referred to a CVE programme because of their extremist behaviour. This is in line with previous studies on the integration of psychopathology and violent extremism in theory and in CVE operational spaces (Grimbergen & Fassaert, 2022; Hellevik et al., 2022; Sizoo et al., 2022; Vermeulen et al., 2022). Whereas mental illness might not be a primary factor in the decision-making process of whether someone is more or less suitable for a CVE individual case management approach, exceptions can be made if a (forensic) mental health clinician assesses the case and decides differently. They can, for instance, conclude that the presence of the mental disorder makes someone more vulnerable to radical ideologies and/or extremist violence, or that someone is indeed not radical and/or that there is no worrisome risk of (extremist) violence. Forensic mental health clinicians should therefore not only assess if mental disorders play a role, but more importantly how they play a role – as stated by Al-Attar (2019).

The inclusion of forensic mental health clinicians is nonetheless accompanied by multiple dilemmas concerning their required expertise and capabilities. For example, mental health clinicians are trained in and responsible for recognising, diagnosing and (psychotherapeutic/medication) treatment of mental disorders. However, radicalisation is not a mental disorder (RCPSYCH, 2016; 2017). Treatment is also not always necessarily effective. In case studies where psychopathology coincides with a radical ideology and a willingness to use violence, knowledge about radical ideologies or cooperation with radicalisation (ideology) experts, security authorities and a multi-agency team are also desirable (Hellevik et al., 2022; RCPSYCH, 2016; 2017; Vermeulen et al., 2022). Although working in the multi-agency teams does not come without ethical challenges, revolving around the expertise and responsibilities (e.g. Augestad Knudsen, 2021). Additionally, clinicians do not always have enough knowledge about radical ideologies, and cooperation with radicalisation experts is – logically – hampered by medical privacy laws (Sizoo et al., 2022). One solution would be for more forensic mental health clinicians to be trained in the topic of extremism, and meanwhile have more security-related agencies receive more training on mental health disorders (Augestad Knudsen, 2021; Hellevik et al., 2022; Vermeulen et al., 2022).

Limitations

This study has generated preliminary results that give insights into the complex decision-making process that CVE professionals can face for cases with severe mental health problems in pre-emptive CVE policies. A few limitations of this study need to be considered. First, the insights are based on interviews with only a small selection of practitioners who operate in the Dutch context, while the perceptions of CVE mental health clinicians are based on an international sample. While the insights on this interaction at the international level do also apply to the Dutch context, the results of the Dutch CVE practitioners cannot be generalised to all local CVE policies. Nonetheless, the CVE professionals' suggestion that professionals

possibly need assistance in dealing with dichotomous choices in CVE for non-dichotomous case realities is something that could be further assessed by individual CVE policies themselves.

A second limitation is that the sample consists of experts with many different professions, who work with different disciplinary perspectives and in different local contexts. Having said that, while this prevents a better understanding of the challenges one discipline faces concerning mental health, diversity in the sample creates the opportunity to synthesise the challenges on this theme for those who work in a multi-agency team – which better reflects the reality of multidisciplinary teams in which CVE professionals often work.

Third, it is relevant to mention that the practices of local CVE individual case management approaches differ and have their specific decision-making strategies and tools. We thus have to note that the findings are also not necessarily representative of one specific CVE policy. Possibly, some CVE policies demand fewer dichotomous options. The findings should be nevertheless considered as an option that can be addressed in all separate CVE policies.

Finally, it is important to note that this paper does not discuss CVE practices in which clinicians play a role in actively recognising potential radicalisation in a regular (non-CVE) mental health care setting for referral to a CVE programme. These settings are for instance regular psychiatry and clinical psychologist institutions that provide mental health therapy for the general population, and importantly not in a CVE setting. There is a complex balance between necessary referral from the general population to the actual case-managed CVE programme itself (that will make the final call about inclusion) and the risks that free speech and trust in therapy are compromised when referrals potentially have to be made by mental health clinicians (e.g. because of medical patient confidentiality and the ethics of doctor-patient relations) (Corner et al., 2018; Heath-Kelly & Strausz, 2019). Thresholds for referral and referral processes are very important to prevent inappropriate inclusion (Cherney, 2022). In the current paper, I considered the possible challenge for those cases who have already been referred to the CVE programme. The theme of referring individuals from regular mental health institutions to CVE is therefore beyond the scope of the current paper, although I do acknowledge the importance of academic research on this theme (Heath-Kelly & Strausz, 2019; Sizoo et al., 2022).

Conclusion

This paper sheds light on the possible challenges practitioners face in pre-emptive CVE programmes. Even though research on the interaction between mental health problems and individual processes towards violent extremism has made much progress over the years (e.g. Al-Attar, 2019; Faccini & Allely, 2017; Meloy, 2018; Meloy & Rahman, 2020), one clinical psychologist's statement hits the nail on the head: '*we still need to know more about the links between mental health problems and violent extremism, and it seems likely that there are different pathways and different links for people*' (Respondent 11). The findings of this paper indicate that, partly as a result of a lack of knowledge on the interactions and operational complexities, psychopathology can take on a different and complex character in pre-emptive CVE practices. This is possibly more complicated than other vulnerability factors, such as experienced grievances, a radical network or

experience of a lack of significance (Gill et al., 2021; Kruglanski et al., 2018). This paper, therefore, supports the increasing amount of papers that advocate for multi-agency teams with experts from each area, including forensic clinical mental health clinicians, to holistically analyse the enormous individual variability present in the interaction between psychopathology, extremism and many other relevant factors. It is important that these multidisciplinary teams always implement checks and balances, and protect – and even improve where possible – the ethical boundaries of their profession and field (Augestad Knudsen, 2021). This will allow the CVE teams to make more effective, tailor-made decisions for individual cases. It additionally compliments the increasing amount of research that shows the importance of investigating challenges of CVE practitioners who encounter cases with mental health problems in the operational spaces of CVE programmes.

Notes

1. The reason that two different institutions provided ethical approval for two different elements of the study is because these elements were part of separate studies. Ethical approval was thus requested in different time periods at different universities.
2. All non-English quotes were translated into English for the purpose of this article.

Acknowledgements

I would like to thank Koen Visser for his internship assistance in terms of content and help with the development of the first coding scheme and transcription of the interviews with the clinicians. The author coded all the interviews herself.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work was funded by the University of Amsterdam.

Notes on contributor

Norah Schulten, PhD Candidate, Political Science Department, Amsterdam Institute for Social Science Research (AISSR), University of Amsterdam, Amsterdam, Netherlands.

References

Aked, H. (2022). 'Mad', bad or Muslim? The UK's vulnerability support hubs and the nexus of mental health, counterterrorism and racism. *Bioethics*, *36*(3), 290–297. https://doi.org/10.1111/bioe.12983

Al-Attar, Z. (2019). *Extremism, radicalisation & mental health: Handbook for practitioners.* Radicalisation Awareness Network (RAN). Consulted on https://ec.europa.eu/home-affairs/sites/default/files/what-we-do/networks/radicalisation_awareness_network/about-ran/ran-h-and-sc/docs/ran_h-sc_handbook-for-practitioners_extremism-radicalisation-mental-health_112019_en.pdf

Al-Attar, Z. (2020). Severe mental disorder and terrorism: When psychosis, PTSD and addictions become a vulnerability. *The Journal of Forensic Psychiatry & Psychology*, *31*(6), 950–970. https://doi.org/10.1080/14789949.2020.1812696

American Psychiatric Association (APA). (2013). *Diagnostic and statistical manual of mental disorders* (5th ed).

Augestad Knudsen, R. (2021). Between vulnerability and risk? Mental health in UK counter- terrorism. *Behavioral Sciences of Terrorism and Political Aggression*, *13*(1), 43–61. https://doi.org/10.1080/19434472.2019.1703782

Bartlett, J., & Miller, C. (2012). The edge of violence: Towards telling the difference between violent and non-violent radicalization. *Terrorism and Political Violence*, *24*(1), 1–21. https://doi.org/10.1080/09546553.2011.594923

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Bubolz, B. F., & Simi, P. (2019). The problem of overgeneralization: The case of mental health problems and US violent white supremacists. *American Behavioral Scientist*, *0*(0), 0002764219831746. https://doi.org/10.1177/0002764219831746.

Cherney, A. (2022). Working with radicalised individuals: Insights from a secondary and tertiary prevention program. *Behavioral Sciences of Terrorism and Political Aggression*, 1–21. https://doi.org/10.1080/19434472.2021.2013291

Cherney, A., & Belton, E. (2021). The evaluation of case-managed programs targeting individuals at risk of radicalisation. *Terrorism and Political Violence*, 1–20. https://doi.org/10.1080/09546553.2021.1984236

Corner, E., & Gill, P. (2015). A false dichotomy? Mental illness and lone-actor terrorism. *Law and Human Behavior*, *39*(1), 23. https://doi.org/10.1037/lhb0000102

Corner, E., Gill, P., & Mason, O. (2016). Mental health disorders and the terrorist: A research note probing selection effects and disorder prevalence. *Studies in Conflict & Terrorism*, *39*(6), 560–568. https://doi.org/10.1080/1057610X.2015.1120099

Corner, E., Gill, P., Schouten, R., & Farnham, F. (2018). 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. https://doi.org/10.1080/00223891.2018.1475392

Dijkman, A., & Gielen, A. J. (2021). Pionieren in veranderende complexiteit: Evaluatie van de persoonsgerichte aanpak contraterrorisme, extremisme en radicalisering (PGA-CTER) gemeente Den Haag. Gemeente Den Haag.

Dom, G., Schouler-Ocak, M., Bhui, K., Demunter, H., Kuey, L., Raballo, A., … Samochowiec, J. (2018). Mass violence, radicalization and terrorism: A role for psychiatric profession? *European Psychiatry*, *49*, 78–80. https://doi.org/10.1016/j.eurpsy.2018.01.001

Eaton, N. R., Keyes, K. M., Krueger, R. F., Balsis, S., Skodol, A. E., Markon, K. E., … Hasin, D. S. (2012). An invariant dimensional liability model of gender differences in mental disorder prevalence: Evidence from a national sample. *Journal of Abnormal Psychology*, *121*(1), 282. https://doi.org/10.1037/a0024780

Faccini, L., & Allely, C. S. (2017). Rare instances of individuals with autism supporting or engaging in terrorism. *Journal of Intellectual Disabilities and Offending Behaviour*, *8*(2), 70–82. https://doi.org/10.1108/JIDOB-11-2016-0022

Gill, P., Clemmow, C., Hetzel, F., Rottweiler, B., Salman, N., Van Der Vegt, I., … Corner, E. (2021). Systematic review of mental health problems and violent extremism. *The Journal of Forensic Psychiatry & Psychology*, *32*(1), 51–78. https://doi.org/10.1080/14789949.2020.1820067

Gill, P., & Corner, E. (2017). There and back again: The study of mental disorder and terrorist involvement. *American Psychologist*, *72*(3), 231. https://doi.org/10.1037/amp0000090

Goodwill, A., & Meloy, J. R. (2019). Visualizing the relationship among indicators for lone actor terrorist attacks: Multidimensional scaling and the TRAP-18. *Behavioral Sciences & the Law*, *37*(5), 522–539. https://doi.org/10.1002/bsl.2434

Gotzsche-Astrup, O., & Lindekilde, L. (2019). Either or? Reconciling findings on mental health and extremism using a dimensional rather than a categorical paradigm. *Journal of Forensic Science*, *64*(4), 982–988. https://doi.org/10.1111/1556-4029.14014

Grimbergen, C., & Fassaert, T. (2022). Occurrence of psychiatric disorders, self-sufficiency problems and adverse childhood experiences in a population suspected of violent extremism. *Frontiers in Psychiatry*, *13*, 1–11. https://doi.org/10.3389/2Ffpsyt.2022.779714

Gruenewald, J., Chermak, S., & Freilich, J. D. (2013). Distinguishing "loner" attacks from other domestic extremist violence: A comparison of far-right homicide incident and offender characteristics. *Criminology & Public Policy*, *12*(1), 65–91. https://doi.org/10.1111/1745-9133.12008

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Sage.

Heath-Kelly, C., & Strausz, E. (2019). The banality of counterterrorism "after, after 9/11"? Perspectives on the prevent duty from the UK health care sector. *Critical Studies on Terrorism*, *12*(1), 89–109. https://doi.org/10.1080/17539153.2018.1494123

Hellevik, P. M., Andersen, A. J., & Engh Førde, K. (2022). Policing mental health? Norwegian police's work with preventing radicalization into violent extremism. *Behavioral Sciences of Terrorism and Political Aggression*, 1–15. https://doi.org/10.1080/19434472.2022.2067211

Jacques, K., & Taylor, P. J. (2013). Myths and realities of female-perpetrated terrorism. *Law and Human Behavior*, *37*(1), 35. https://doi.org/10.1037/h0093992

Koehler, D. (2015). Family counselling, de-radicalization and counter-terrorism: The Danish and German programs in context. In *Countering violent extremism: Developing an evidence-base for policy and practice* (pp. 129–138).

Kotov, R., Krueger, R. F., Watson, D., Achenbach, T. M., Althoff, R. R., Bagby, R. M., … Zimmerman, M. (2017). The Hierarchical Taxonomy of Psychopathology (HiTOP): A dimensional alternative to traditional nosologies. *Journal of Abnormal Psychology*, *126*(4), 454. https://doi.org/10.1037/abn0000258

Kruglanski, A., Jasko, K., Webber, D., Chernikova, M., & Molinario, E. (2018). The making of violent extremists. *Review of General Psychology*, *22*(1), 107–120. https://doi.org/10.1037/gpr0000144

Kundnani, A. (2012). Radicalisation: The journey of a concept. *Race & Class*, *54*(2), 3–25. https://doi.org/10.1177/0306396812454984

Lloyd, M. (2019). Extremism risk assessment: A directory. Full report. *Centre for Research and Evidence on Security Threats (CREST)*. Consulted on https://crestresearch.ac.uk/resources/extremism-risk-assessment-directory/

McCauley, C., & Moskalenko, S. (2014). Toward a profile of lone wolf terrorists: What moves an individual from radical opinion to radical action. *Terrorism and Political Violence*, *26*(1), 69–85. https://doi.org/10.1080/09546553.2014.849916

Meloy, J. R. (2018). The operational development and empirical testing of the Terrorist Radicalization Assessment Protocol (TRAP–18). *Journal of Personality Assessment*, *100*(5), 483–492. https://doi.org/10.1080/00223891.2018.1481077

Meloy, J. R., & Rahman, T. (2020). Cognitive-affective drivers of fixation in threat assessment. *Behavioral Sciences & the Law*, *39*(2), 170–183. https://doi.org/10.1002/bsl.2486

Merari, A., Diamant, I., Bibi, A., Broshi, Y., & Zakin, G. (2009). Personality characteristics of "self martyrs"/"suicide bombers" and organizers of suicide attacks. *Terrorism and Political Violence*, *22*(1), 87–101. https://doi.org/10.1080/09546550903409312

Misiak, B., Samochowiec, J., Bhui, K., Schouler-Ocak, M., Demunter, H., Kuey, L., Raballo, A., Gorwood, P., Frydecka, D., & Dom, G. (2019). A systematic review on the relationship between mental health, radicalization and mass violence. *European Psychiatry*, *56*(1), 51–59. https://doi.org/10.1016/j.eurpsy.2018.11.005

Morgades-Bamba, C. I., Raynal, P., & Chabrol, H. (2020). Exploring the radicalization process in young women. *Terrorism and Political Violence*, *32*(7), 1439–1457. https://doi.org/10.1080/09546553.2018.1481051

NCTV. (2021). Dreigingsbeeld Terrorisme Nederland. Consulted on https://www.nctv.nl/documenten/publicaties/2021/10/26/dreigingsbeeld-terrorisme-nederland-55

NCTV. (2022). Definities gebruikt in het Dreigingsbeeld Terrorisme Nederland. Consulted on 31-05-2022, https://www.nctv.nl/onderwerpen/dtn/definities-gebruikt-in-het-dtn

Neumann, P. R. (2003). The trouble with radicalization. *International Affairs*, *89*(4), 873–893. https://doi.org/10.1111/1468-2346.12049

NPCC (National Police Chiefs' Council). (2019). *Mental Health Pilot Hubs*. Consulted on https://www.npcc.police.uk/NPCCBusinessAreas/TAM/MentalHealthPilotHubs.aspx

Oppetit, A., Campelo, N., Bouzar, L., Pellerin, H., Hefez, S., Bronsard, G., … Cohen, D. (2019). Do radicalized minors have different social and psychological profiles from radicalized adults? *Frontiers in Psychiatry*, *10*, 644. https://doi.org/10.3389/fpsyt.2019.00644

Pressman, E. (2009). *Risk assessment decisions for violent political extremism 2009–02*. Her Majesty the Queen in Right of Canada.

RCPSYCH. (2016). Counter-terrorism and psychiatry. Position Statement PS04/16 In R. C. o. Psychiatrists (Ed.). London.

RCPSYCH. (2017). Ethical considerations arising from the government's counterterrorism strategy. In R. C. o. Psychiatrists (Ed.).

Saldaña, J. (2013). *The coding manual for qualitative researchers*. International Journal. Sage.

Sarma, K. M., Carthy, S. L., & Cox, K. M. (2022). Mental disorder, psychological problems and terrorist behaviour: A systematic review and meta-analysis. *Campbell Systematic Reviews*, *18*(3), e1268. https://doi.org/10.1002/cl2.1268

Schmidt, R. (2020). Duped: Examining gender stereotypes in disengagement and deradicalization practices. *Studies in Conflict & Terrorism*, *45*(11), 953–976. https://doi.org/10.1080/1057610X.2020.1711586

Schulten, N., Doosje, B. J., Spaaij, R., & Kamphuis, J. H. (2019). Psychopathologie en Terrorisme. *Ministerie van Justitie en Veiligheid, Nederland*. Consulted on https://repository.wodc.nl/handle/20.500.12832/2397

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. https://doi.org/10.1080/09540261.2017.1343526

Sizoo, B., & Doosje, B. (2020). Percepties over radicalisering en psychische problematiek binnen de Geestelijke Gezondheidszorg (GGZ) en het Veiligheidsdomein: (Valse) verwachtingen van elkaars rol, kennis en mogelijkheden. *NCTV en Ministerie van Justitie en Veiligheid*. Consulted on http://orcat.nl/wp-content/uploads/2020/11/Rapport-PERCEPT-study-Dutch.pdf

Sizoo, B., Doosje, B., & van Meijel, B. (2022). Perceptions of radicalisation in mental health care and the security domain: Roles, responsibilities, and collaboration. *Psychology, Crime & Law*, 1–18. https://doi.org/10.1080/1068316X.2022.2030333

Skeem, J., & Mulvey, E. (2020). What role does serious mental illness play in mass shootings, and how should we address it? *Criminology & Public Policy*, *19*(1), 85–108. https://doi.org/10.1111/1745-9133.12473

Stemler, S. (2001). An overview of content analysis," practical assessment. *Research & Evaluation*, *7*(17), 1–6.

Stephens, W., Sieckelinck, S., & Boutellier, H. (2021). Preventing violent extremism: A review of the literature. *Studies in Conflict & Terrorism*, *44*(4), 346–361. https://doi.org/10.1080/1057610X.2018.1543144

Thijssen, G., Masthoff, E., Sijtsema, J., & Bogaerts, S. (2021). Understanding violent extremism: Sociodemographic, criminal and psychopathological background characteristics of detainees residing in Dutch terrorism wings. *Criminology & Criminal Justice*, *0*(0), 1–19. https://doi.org/10.1177/17488958211049019

Trimbur, M., Amad, A., Horn, M., Thomas, P., & Fovet, T. (2021). Are radicalization and terrorism associated with psychiatric disorders? A systematic review. *Journal of Psychiatric Research*, *141*, 214–222. https://doi.org/10.1016/j.jpsychires.2021.07.002

Van de Weert, A., & Eijkman, Q. A. (2019). Subjectivity in detection of radicalisation and violent extremism: A youth worker's perspective. *Behavioral Sciences of Terrorism and Political Aggression*, *11*(3), 191–214. https://doi.org/10.1080/19434472.2018.1457069

Van de Weert, A., & Eijkman, Q. A. (2020). Early detection of extremism? The local security professional on assessment of potential threats posed by youth. *Crime, Law and Social Change*, *73*(5), 491–507. https://doi.org/10.1080/19434472.2018.1457069

Van Leyenhorst, M., & Andreas, A. (2017). Dutch suspects of terrorist activity: A study of their biographical backgrounds based on primary sources. *Journal for Deradicalization*(12), 309–344. http://journals.sfu.ca/jd/index.php/jd/article/view/119

Van San, M. (2018). Dochters van de jihad. *Tijdschrift Voor Criminologie*, *60*(1), 59–75. https://doi.org/10.5553/TvC/0165182X2018060001003

Vereniging Nederlandse Gemeenten (VNG). (2015). *Rol gemeenten in integrale aanpak radicalisering*. VNG. 2 juni 2015.

Vermeulen, F., van Leyenhorst, M., Roex, I., Schulten, N., & Tuzani, N. (2022). Between psychopathology and ideology: Challenges and practices in interpreting young extremists experiencing mental illness in The Netherlands. *Frontiers in Psychiatry*, 2584. https://doi.org/10.3389/fpsyt.2021.790161

Weenink, A. W. (2019). Adversity, criminality, and mental health problems in jihadis in Dutch police files. *Perspectives on Terrorism*, *13*(5), 130–142. https://www.jstor.org/stable/26798583

Willerman, L., & Cohen, D. B. (1990). *Psychopathology*. McGraw-Hill Publishing Company.

Wolfowicz, M., Weisburd, D., & Hasisi, B. (2021). Does context matter? European-specific risk factors for radicalization. *Monatsschrift für Kriminologie und Strafrechtsreform*, *104*(3), 217–230. https://doi.org/10.1515/mks-2021-0132

Younis, T., & Jadhav, S. (2019). Keeping our mouths shut: The fear and racialized self-censorship of British healthcare professionals in PREVENT training. *Culture, Medicine, and Psychiatry*, *43*(3), 404–424. https://link.springer.com/article/10.1007s11013-019-09629-6 https://doi.org/10.1007/s11013-019-09629-6

Appendix A. Overview of interviewees and their experience in CVE

Table A1. Overview of interviewees and their experience in CVE.

Reference number of respondent	Profession	Years of experience working in CVE	CVE caseload (general and not specifically mental health-related)	Form of experience with CVE cases
Mental health clinicians who work in CVE				
1	Psychiatrist	5–10 years	5–20 cases	Indirect via case description and collaboration
2	(Forensic) clinical psychologist	5–10 years	50 + cases	Most direct experience, but also indirect experience
3	Psychologist / Psychotherapist	5–10 years	20–50 cases	Direct experience via face-to-face case management and indirect experience via case descriptions
4	Clinical psychologist	10 + years	20–50 cases	Direct experience via face-to-face case management and indirect experience via case descriptions
5	Psychologist (therapist)	2–5 years	*	*
6	Professor of Child and Adolescent Psychiatry	2–5 years	20–50 cases	Direct experience via face-to-face case management
7	(Forensic) clinical psychologist	10 + years	50 + cases	Direct experience via face-to-face case management
8	Psychologist	10 + years	1–5 cases	Direct experience via face-to-face case management
9	(Forensic) clinical psychologist	10 + years	50 + cases	Direct experience via face-to-face case management and indirect experience via case descriptions
10	Psychiatrist	10 + years	No caseload (only research)	Indirect via case description and collaboration
11	(Forensic) clinical psychologist	10 + years	50 + cases	Direct (face-to-face) assessment and indirect support of case management.
12	Psychotherapist	10 + years	50 + cases (direct experience 10 +)	Direct experience via face-to-face case management and indirect experience via case descriptions

(*Continued*)

Table A1. Continued.

Reference number of respondent	Profession	Years of experience working in CVE	CVE caseload (general and not specifically mental health-related)	Form of experience with CVE cases
Dutch practitioners who are involved in CVE individual case management approaches				
13	Mental health care expert	5–10 years	*	*
14	Mental health care expert	5–10 years	50 + cases	Direct experience via face-to-face case management and indirect experience via case descriptions
15	Case director	2–5 years	20–50 cases	Direct experience via face-to-face case management and indirect experience via case descriptions
16	Manager	2–5 years	1–5 cases	Indirect experience via case descriptions
17	Case director	0–2 years	5–20 cases	Direct experience via face-to-face case management
18	Case director	*	*	Direct experience via face-to-face case management
19	Case director	5–10 years	5–20 cases	Direct experience via face-to-face case management
20	Case director	10 + years	5–20 cases	Direct experience via face-to-face case management
21	Manager	2–5 years	20–50 cases	Direct experience via face-to-face case management and indirect experience via case descriptions
22	Manager	2–5 years	50 + cases	Indirect experience via case descriptions
23	Manager and policymaker	2–5 years	*	Indirect experience via case descriptions
24	Manager and policymaker	*	*	*
25	Manager	5–10 years	50 + cases	Direct experience via face-to-face case management and indirect experience via case descriptions

Note: * Non-disclosed information.