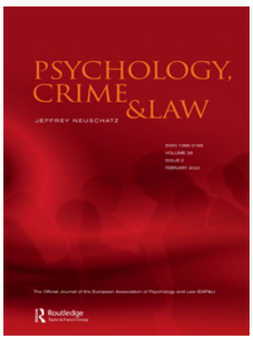

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Perceptions of radicalisation in mental health care and the security domain: roles, responsibilities, and collaboration

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ABSTRACT

This study investigates how perceptions of radicalisation and co-occurring mental health issues differ between mental health care and the security domain, and how these perceptions affect intersectoral collaboration. It is generally thought that intersectoral collaboration is a useful strategy for preventing radicalisation and terrorism, especially when it concerns radicalised persons with mental health issues. It is not clear, however, what perceptions professionals have of radicalisation and collaboration with other disciplines. Data was obtained from focus groups and individual interviews with practitioners and trainers from mental health care and the security domain in the Netherlands. The results show a lack of knowledge about radicalisation in mental health care, whereas in the security domain, there is little understanding of mental health issues. This leads to a mad-bad dichotomy which has a negative effect on collaboration and risk management. Improvement of the intersectoral collaboration by cross-domain familiarization, and strengthening of trust and mutual understanding, should begin with the basic training of professionals in both domains. The Care and Safety Houses in the Netherlands offer a sound base for intersectoral collaboration. Future professionals from different domains ought to be familiarized with each other's possibilities, limitations, tasks, and roles.

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Perceptions; radicalisation; mental health care; police; intersectoral collaboration

Introduction

In the past six decades, a great deal of terrorism research has centred on the relationship between psychological factors and terrorism in general. With the increase in terrorist attacks by individually operating perpetrators (lone actors) in Western countries, academic and professional interest has shifted from the general contribution of psychological risk factors for terrorism towards a specific interest in the mental health status of an individual attacker, and its implications for the role of mental health care in preventing attacks (Dom et al., 2018; RCPSYCH, 2016; Yakeley & Taylor, 2017). This coincides with the

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observation that the media, public, and professionals in the security domain have held mental health care (partly) accountable for attacks by lone actors because mental health problems were assumed to play a causal role (Trimbur et al., 2021; Yakeley & Taylor, 2017). Psychiatrists and psychologists have since been drawn from a position on the side-line into the arena of multidisciplinary intersectoral collaboration on radicalisation of individuals (Sestoft et al., 2017). Radicalisation is assumed to be a precursor of extremist violence (Doosje et al., 2016), and intersectoral collaboration is believed to be an effective way to curb individual pathways to violence (RAN, 2016; Weine et al., 2017). Due to the paucity of literature on the views of practice-based professionals with respect to radicalisation (Peddell et al., 2016), little is known about how radicalisation is perceived by professionals from different domains, or what their views are on responsibilities and actual contribution to the preventive collaboration. In this study, we want to explore what the perceptions of radicalisation are among professionals in the Netherlands from the security domain (police, military police, and public prosecutor's office) and from mental health care, and how views of each other's roles and responsibilities differ with respect to the management of radicalisation co-occurring with mental health problems. We also want to reflect on how differences in perceptions between both domains could impact on intersectoral collaboration.

Mental health and radicalisation

Whereas terrorism can be defined as a conscious, deliberate strategic use of violence against a specific type of target to influence the political process (Horgan, 2014), radicalisation is seen as the phase preceding terrorism (Doosje et al., 2016). Prevention of terrorism is complicated by the fact that only very few radicalised individuals become terrorists (Bhui, Silva, et al., 2016; Borum, 2011; Doosje et al., 2016; Kruglanski et al., 2014; McCauley & Moskalenko, 2008), and that mental health problems can mask, attenuate or accentuate violent intentions. The relationship between mental health and radicalisation or terrorism is controversial, and over the years views have changed considerably.

Before 1970, mental illness was assumed to be the common psychological causal factor for terrorist acts, based in the idea that killing innocent people from an ideological motive must imply a mental disorder (Pearce & Macmillan, 1977). Roughly between 1970 and 1980, the assumption was that only a limited number of mental health conditions play a role in terrorism, in particular, personality disorders (e.g. narcissism) and abusive parenting (Lash, 1979; Pearlstein, 1991). In the 1980s, a host of other psycho-biological explanations for terrorist behaviour emerged, like vitamin deficiencies, hearing impairments, and neurotransmitter or hormone imbalances. Also, the frustration-aggression hypothesis was promoted, attributing excessive (extremist) violence to an unresolved grievance, stemming from a (real or imagined) underprivileged and disadvantaged status (Tittmar, 1992). In the 1990s, the focus shifted to psycho-dynamic accounts (for a review, see Horgan, 2014, chapter 3). Silke (1998) reviewed the available literature concerning the relationship between extremist violence and mental health and concluded that in this material, there was little sound scientific evidence for the psychological abnormalities of terrorists, mainly because of the poor methodological methods used (Silke, 1998). Other studies since then show that much of the research still has empirical and methodological flaws (Horgan, 2014; Trimbur et al., 2021; Victoroff, 2005). Silke's review has

frequently been misquoted with the generalizing conclusion that terrorists are sane. In other words, the absence of proof (as demonstrated by Silke) was interpreted as a proof of absence (of a relationship between mental health problems and terrorism). In the first decade of this century, therefore, the contribution of mental health care in preventive programs on radicalisation and terrorism was limited.

Whereas much effort continues to be put into looking for the psychological dispositions as 'root causes' of radicalisation and terrorism, Schmid (2013), for example, pleads 'to look for roots of radicalisation beyond this micro-level and include a focus on the meso-level – the radical milieu – and the macro-level – the radicalisation of public opinion and party politics – to gain a better understanding of the dynamic processes driving escalation' (Schmid, 2013). Similarly, Horgan (2008) warns against oversimplifying psychological correlates to answer the question 'what causes terrorism?' (Horgan, 2008). He concludes: 'It may ultimately be more useful for us to trace not roots (either in terms of personality factors or root causes) but routes'.

The debate on the relationship between mental health and radicalisation or terrorism has become more nuanced, as solid empirical research started to focus on the personal characteristics of known terrorists. Corner and colleagues, for example, showed that in a cohort of 119 lone actor terrorists and a matched sample of 119 group terrorists, the prevalence of mental health problems (from open-source data) differed between group terrorists (3.4%) and lone actors (31.9%) (Corner & Gill, 2015). The contribution of mental illness as factor in the temporal pathway to extremist violence was demonstrated to be highly variable, with ambiguous directions of causality (Corner et al., 2019). In other words, the authors found that while depression, for example, can contribute to violent intentions in one instance, it may inhibit aggressive behaviour in other circumstances. They found the same bi-directional associations for anti-depressant use. Psychiatric problems may also be the result of involvement in terrorism and radicalisation (Horgan, 2008). Therefore, the mere presence of a mental illness diagnosis is by no means the silver bullet that researchers and policymakers have been hoping for to explain radicalisation and terrorism (Horgan, 2014).

Social theories for terrorism emerged in response to the failure of psychopathology and in particular personality disorders to explain terrorism. Early group theories emphasized that group dynamics explained why a heterogeneous collection of individuals could be moulded into a close-knit group, when members align themselves with the group narrative (Turner et al., 1987). Whereas the early theories of group identification meant that the personal-self fades into the collectiveness of the group, the more recent identity-fusion approach stresses that personal agency is retained and is channelled into pro-group action (Swann et al., 2010). Identity-fusion together with sacred values characterise 'devote actors' who are likely to make extreme sacrifices for the in-group, which they regard as a family (Atran, 2021). A sacred value refers to a predilection for certain objects or beliefs that are considered invaluable and cannot be modified with economic incentives (Atran, 2016). The notion of sacred value in relation to the willingness to fight and die has been operationalised by neuro-imaging research, showing that a high willingness activates brain areas typically associated with subjective (sacred) values rather than brain areas related to integration of material (economic) costs. This supports the notion that decisions on costly personal sacrifices (such as dying in a suicide attack) may not be mediated by cost–benefit computation (Hamid et al., 2019; Pretus et al., 2018;

Pretus et al., 2019). This clearly has implications for the management of radicalising individuals in particular and for counter-terrorism strategies in general because disengagement and de-radicalisation are more likely to be reached by using deontological, as opposed to logical (economic) arguments.

In summary, the relationship between psychological correlates and radicalisation or terrorism is complex, dynamic and context-dependent. To prevent radicalised individuals from committing terrorist crimes, we will need to understand how they got there, what drove them and how they perceive the world. For this, the contribution of more than one discipline is needed (Decety et al., 2018).

Intersectoral collaboration

In prevention programs, the emphasis has been on early detection and management of emerging radicalisation, using models that describe the 'pathway to intended violence' (Doosje et al., 2016; McCauley & Moskalenko, 2008; Moghaddam, 2005). Horgan warns, however, that despite these models ' … we still do not understand the interactive processes that characterize the overarching global macro-social issues and the smaller, regional and micro-level issues that exercise influence over day-to-day commitment, involvement and engagement in terrorist operations' (Horgan, 2014, p. 156). Given the complexity of the process of radicalisation and the involvement of a broad range of scattered determinants from different domains, including mental health issues, prevention of terrorism requires intersectoral collaboration to detect and integrate relevant information in an early stage (Freilich et al., 2019; RAN, 2016).

Although collaboration has been promoted as the ideal solution to solve complex problems, its mechanism is treated as a 'black box' (Keast, 2016). Coordination, cooperation, and collaboration differ in the degree of formal structure, strength of interpersonal connections, intentions, and organized funding (Brown & Keast, 2003). Collaboration is the most formal of these three forms and is characterized by doing something new or making a change, in which there is an interdependency between participants based on trust and a long relational timeframe (Keast, 2016; Mandell, 2001). We argue that this form is most appropriate for collecting, evaluating, and re-assembling information from different sectors into designing tailored preventive management programs for radicalised individuals who also have mental health problems. The success of collaboration according to Keast (2016) depends on key process factors, such as: 'nurturing new and building on existing relationships, establishing trusting relationships, forging agreements on what to work on together and how to work together, building new leadership capacities and managing conflicts' (Keast, 2016, p. 162).

There are several examples of initiatives where professionals from the security domain and mental health care jointly focus on radicalised individuals, of which those in the United States, the United Kingdom, Denmark and the Netherlands are highlighted below. In the United States, the community-based targeted violence prevention model consists of a multidisciplinary team that assesses individuals at-risk for violent extremism and arranges support. The model also provides outreaching training for communities (Weine et al., 2017). The authors suggest that mental health professionals are best poised to contribute towards effective primary and secondary prevention of violent extremism. In a review, Weine and colleagues (2015) promote intersectoral collaboration at

community level as the preferred strategy for preventing violent extremism by stopping the engagement with extremist affairs and offering multimodal care (Weine et al., 2015). The effectiveness of this model has, however, not yet been studied.

The United Kingdom's (UK) counterterrorism strategy (CONTEST) has four key components, one of which (Prevent) is aimed at preventing people from becoming terrorists. The Channel assessment framework is part of the Prevent strategy and is based on a multiagency effort to identify and provide care for individuals at risk for radicalisation (RCPSYCH, 2016). Peddell and colleagues (2016) mention that in the Channel framework, mental health problems are regarded as a risk factor for the engagement of an individual with an ideology, which implies a referral role for mental health care (Peddell et al., 2016). The authors refer to the scarcity of practice-based data in empirical research on counterterrorism and argue that more research needs to focus on different practitioners' perceptions of lone-actor terrorists, to improve prevention strategies. Yakeley and Taylor (2017) mention that the emphasis on compulsory reporting on, and referring of individuals at risk for radicalisation by (health care) professionals has fueled the controversy over the Prevent strategy (Yakeley & Taylor, 2017). In a recent paper on counterterrorism developments in the UK, Augestad Knudsen (2021) points to the risks of criminalizing concerning behaviour at a very early stage, where 'vulnerability' has become a security parameter instead of a health care issue. She notes that the aim of the security domain to detect 'vulnerability' in individuals is mainly to prevent terrorism and not to provide care for vulnerable people (Augestad Knudsen, 2021). The author reflects on the mental health hub as one of the projects within the CONTEST strategy. These hubs are intended to improve cooperation between counterterrorism police and national health services. In these hubs, mental health professionals are embedded within police teams to detect and assess mental health problems earlier. In addition, the hubs can promote the exchange of information between the police and mental health care. As opposed to Danish and Dutch forms of interaction between several domains (see below), the hubs consist of only two stakeholders and are therefore not broad-based. The embeddedness of the mental health professional within the police team can, according to the author, result in an unintended role shift from providing care into (medical) intelligence gathering for the benefit of the investigative sector. Although these risks and related ethical dilemmas are valid and important to consider, several studies on the effectiveness of fixated threat assessment (police) teams with embedded mental health professionals show that the mental health position of individuals with a fixated grievance posing a threat to public figures can benefit from this joint approach (James et al., 2010; James & Farnham, 2016; Pathé, Haworth, et al., 2015; Pathé, Lowry, et al., 2015; Sizoo & van Nobelen, 2021).

In Denmark, the Police, Social Services, and Psychiatry (PSP) model has been developed and is a structured form of cooperation between different local stakeholders. Initially, the aim of the PSP model was to share relevant information on citizens at risk for radicalisation and extremist violence to improve supportive measures. In 2011, the model was evaluated, showing a positive effect on mental health, domestic violence, and cooperation (Sestoft et al., 2017). The model is also considered to be appropriate for preventing radicalisation and extremist violence and for arranging supportive measures for potential perpetrators. The PSP participants have been trained from 2013 onwards to raise awareness and provide background information on radicalisation, with a special emphasis on preventing stigmatization of persons showing concerning behaviour.

Finally, in the Netherlands the Care and Safety House (CSH) method (Dutch: *zorg- en veiligheidshuis*) is a collaborative approach by municipalities, care providers, and judicial agencies to address multi-problem behaviour at a local level. Cases of radicalisation are also eligible for the CSH approach. Each municipality has its own CSH, or is attached to a regional CSH. A CSH is chaired by a process manager who ensures that conditions are in place for effective collaboration. Every two weeks, a case meeting is held where complex cases are discussed, and information is exchanged to arrive at a joint plan as to how to deal with the problematic situation. Subsequently, the plan is implemented, and regular feedback is provided on progress made. Each CSH has a covenant that is signed by all participating agencies. The covenants regulate information sharing between parties but cannot exempt health workers from the strict laws on medical confidentiality. The law prohibits practitioners from sharing any personal information about patients without explicit informed consent unless there is an imminent danger which can only be averted by breaching confidentiality.

As the emphasis on preventing extremist violence grew in the Netherlands, special counter-terrorism sections within CSH were formed in urban areas, which tended to exclude mental health professionals from discussions, supposedly for security reasons. There are, however, more concerns among professionals and policy makers in the Netherlands about the quality of intersectoral collaboration on issues related to radicalisation. Paulussen and colleagues (2017), for example, organized an expert meeting to explore the relationship between mental health and the foreign fighter phenomenon in 2016. Professionals from mental health care expressed a need for more insight into the relationship between mental health and radicalisation, as well as a desire to improve cooperation and information sharing between the different stakeholders and sectors to detect development towards extremist violence as early as possible (Paulussen et al., 2017). They also noted that pressure from the police to contribute towards safety and security can conflict with the treatment interests of psychiatric patients.

Role of mental health professionals

Whereas the role of the security domain in preventing terrorism and dealing with radicalisation is undisputed, the role of mental health care in this respect is not clear, partly because of the complex relationship between mental health issues and radicalisation (Yakeley & Taylor, 2017). What then should the role of professionals in mental health care be, and what responsibilities do they have? According to the European Psychiatric Association, professionals in mental health care have four possible roles with respect to mass violence: (a) treatment of victims, (b) an advocacy role in countering stigmatization of psychiatric patients, (c) conducting scientific research into motives of mass violence, and (d) assessing signals of radicalisation in psychiatric patients in order to protect them and society (Dom et al., 2018). This last role, acknowledging that mental health professionals can contribute towards preventing terrorism, is shared by others (Peddell et al., 2016; RAN, 2016; Sestoft et al., 2017; Yakeley & Taylor, 2017) and suggests that this must be part of a multidisciplinary and interdisciplinary effort (Horgan, 2014, p. 72; Pathé, Haworth, et al., 2015; Sestoft et al., 2017). However, there are challenges for mental health professionals who participate in intersectoral collaboration. For example: being drawn into the terrorism field by media pressure (Trimbur et al., 2021; Yakeley & Taylor,

2017), shifting their attention to counterterrorism intelligence instead of psychiatric care (Augestad Knudsen, 2021), and the overall challenge to remain focused on patient needs (Weine et al., 2017). Clearly, participating in intersectoral collaboration is not as straightforward as is sometimes assumed (Keast, 2016). To understand more about the dynamics of collaboration and to make suggestions for future directions, more research is needed on how practitioners across domains perceive the problem of radicalisation when mental health problems coexist, and what their own role, and that of other participants should be.

In summary, there is an association between radicalisation, terrorism, and mental health conditions, which has drawn attention to the role of mental health care in the prevention of radicalisation and terrorism. Collaboration on this issue between professionals in the security domain and the mental health care domain is likely to be influenced by perceptions of radicalisation, including the roles and responsibilities of all involved. This study examines these perceptions in the security domain and mental health care domain and reflects on the possible implications of differences in perception for intersectoral collaboration.

Materials and methods

The study was conducted with participants from mental health care and the security domain in the Netherlands. To explore the perceptions in both domains with respect to radicalisation, data was collected through focus groups and in-depth interviews with professionals and trainers. This qualitative method of data collection is often applied to gain in-depth understanding of social issues, elicit different perspectives, and facilitate discussion on the subject (Nyumba et al., 2018).

Participants

Participants were recruited from both domains using purposive sampling. The selection was based on profession, role, and location of work in the country to allow for a variation in experiences with radicalisation (Table 1). Professionals were drawn from general police and public prosecutor's departments, not specialized in counterterrorism. For the mental

Table 1. Details of participants in focus groups and interviews with mental health (MH) and Security Domain (SD) professionals.

	N	Male	Composition[a]	Age	
				Mean (SD)	Statistics[b]
Focus groups					
MH	10	9	5 PSY, 2 MHN, 2 PSC, 1 RN	56.1 (4.80)	MW-U = 19.5, $p = .175$
SD	4	3	3 POL, 1 PPO	52.0 (7.35)	
MH and SD	8	7	2 PSY, 2 MHN, 1 PSC, 1 PPO, 2 POL	54.0 (10.32)	
Interviews					
MH	10	6	2 PSY, 5 PSC, 1 RN, 2 MHN	48.8 (13.16)	MW-U = 43.5, $p = .902$
SD	9	6	7 POL, 1 PPO, 1 MP	49.1 (3.10)	
MH-trainers	5	3	1 PSY, 2 PSC, 2 RN	56.0 (8.57)	MW-U = 9.0, $p = .465$
SD-trainers	5	4	3 POL, 2 PPO	48.6 (16.41)	

[a]PSY = psychiatrist, MHN = mental health nurse, PSC = psychologist, RN = registered nurse, POL = police, MP = military police, PPO = public prosecutor's office.
[b]MW-U = Mann–Whitney *U*, Significance level $\alpha = .05$.

health sector, participants were recruited from clinical, out-patient, and out-reaching teams. Only one psychologist declined the invitation to participate because her team was afraid that her participation could compromise the relationship with some patients.

Procedures

Ethical approval was obtained from the University of Amsterdam Ethical Board (reference 2019-SP-10524). Participants were approached by the main researcher (BS) who explained the aim and procedures of the study. All gave written informed consent. The focus group discussions were video recorded and transcribed verbatim into anonymized transcripts. The individual interviews were audio-recorded. After transcription, the recordings were permanently deleted. The three focus groups were moderated by two authors (BS and BD), who have a broad experience in research on radicalisation (BD), and on management of radicalised individuals with mental health conditions (BS). The topics in the two domain-specific focus groups (security domain and mental health care separately) were: perception on (a) radicalisation, (b) views on each other's tasks and roles and (c) the collaboration between the two domains. The third, combined, focus group (consisting partly of new participants and partly of participants from the first two focus groups) was only devoted to the topic of collaboration. The themes that emerged from the focus group meetings were further explored in the subsequent individual interviews with practitioners and trainers from both domains. The focus group topics were also used for the interviews.

Analysis and evaluation

A qualitative content analysis was performed according to the principles of thematic analysis according to Braun and Clarke (Braun & Clarke, 2006). The transcripts were analyzed by stepwise inductive construction of codes and themes, using a six-step approach (Caulfield, 2019). The first step involved familiarization with the collected data. In the second step, sections of the text referring to perceptions were highlighted as codes. The codes of all the transcripts were categorized into themes in the third step. In the following step, the themes were cross-checked with the original text to ascertain that they were a proper representation of the data. In the fifth step, the themes were categorized into perceptions on radicalisation, tasks and roles, and collaboration. The final step involved writing up the text in the results section. For the analysis, the MAXQDA Analytics Pro 2018© software package was used.

Results

Table 1 shows the characteristics of the participants. Men were significantly over-represented in the focus groups and interviews.

Focus groups

First, perceptions of radicalisation, as well as the tasks and roles of professionals in the mental health care and security domain are highlighted, followed by the perceived consequences for intersectoral collaboration and ideas for improvement.

Radicalisation

In the mental health focus group, professionals believed that there was too little knowledge about radicalisation in their domain, and that in most cases, radicalisation was assumed to be associated with ideology. Some thought, however, that violence framed as a terrorist attack could better be explained as copycat behaviour without the ideological motive of radicalisation. Despite their lack of knowledge about radicalisation, professionals in the mental health focus group were quite certain that radicalisation was not causally linked to mental health problems, and that radicalised individuals should therefore not be referred to them by the security domain. The participants in the mental health focus group believed that this lack of knowledge also explained why mental health care professionals do not respond effectively when they are confronted with radicalised ideas by patients. In the combined focus group, professionals attributed this lack of knowledge and poor response to the low prevalence of radicalisation in mental health care, which, they said, also explained why mental health professionals make little use of risk assessment tools for radicalisation. In the security domain focus group, participants noted the lack of knowledge about the complex relationship between radicalisation and mental health conditions in their domain. This corresponded with the ideas in the mental health focus group that professionals in the security domain (wrongly) considered radicalised ideas to be causally related to co-occurring mental health problems. According to professionals in the mental health focus group, a mad-or-bad dichotomy is often used in the security domain to assign cases either to mental health care or to the security domain: 'bad' is for the security domain, while 'mad' as well as 'mad and bad' is considered to be for mental health care. The tendency to reduce complex cases to single-domain issues by professionals in the security domain was echoed in the combined focus group. Here, participants pointed to the danger of a tunnel vision and rigid dichotomization, when a complex case is labelled as either radicalisation related, or mental health related. Participants regretted that a combined and more holistic, flexible, and analytic approach was rare in the security domain.

Apart from lack of knowledge and the perceived dichotomy between radicalisation and mental health problems, there were perceptions of how privacy rules defined the context within which professionals can operate in both domains. In the combined focus group, participants agreed that collaboration between domains is negatively influenced by privacy rules on sharing personal information about (radicalised) individuals. The opinion in the security domain focus group was that medical records of suspects contain information that can be relevant for counterterrorism units in the security domain. However, medical confidentiality is, in their opinion, an obstacle for effective risk management because, according to them, regulations only allow for information to be shared (in cases where no consent has been given by the person in question) when there is an imminent danger, but not in an early preventive phase, where future danger is a possibility. Participants in the mental health focus group believed that the police officers generally interpret privacy rules too freely, given their observations that police officers often provide more details than strictly necessary about a person, especially when they want professionals in mental health care to act.

Tasks and roles

Another concern regarding the early detection of radicalisation expressed by the participants in the mental health focus group was that the police is increasingly withdrawing from care-tasks. Police policy makers argue that mental health care, and not the police, is responsible for responding to individuals with disturbing behaviour.[1] Participants in the mental health focus group strongly disagreed with this role attribution; they claimed that only in a minority of cases which present with disturbing behaviour, there are underlying treatable psychiatric conditions. It is therefore not up to mental health care to deal with all disturbing behaviour in the community, regardless of whether there is also a radicalisation component involved.

In the security domain focus group, the role of police with respect to dealing with violence associated with terrorism was undisputed, but participants believed that only a minority of police professionals were actively involved in radicalisation or terrorism cases. Some participants doubted whether prevention and management of radicalisation was a key role for the police, except for community police officers, who have a clear signalling and preventive task in this regard. They also believed that professionals in the mental health care domain have a role in contributing towards the safety in the community, but that in general mental health professionals neglect this preventive task, especially with respect to radicalisation. The security domain focus group participants believed that mental health professionals use the regulations about medical confidentiality as an excuse for not having to collaborate with the police. The security domain focus group participants suggested that professionals in mental health care should feel a similar responsibility towards dealing with radicalisation, as they already have towards reporting domestic violence.[2] According to the security domain focus group, this reluctance to involve the police in cases of (possible) radicalisation results from a too rigid role-interpretation by mental health professionals. They put (too) much emphasis on the protection of their patients. These mental health professionals believe that once they share concerns with the police, patients will be harmed by repressive measures, which will then also have a negative impact on the therapeutic alliance between het mental health care professional and the patient.

Participants in all three focus groups believed that Care and Safety Houses have a prominent role in dealing with radicalisation, since these institutions have specifically been established to ensure effective collaboration between professionals from different domains. However, participants in the combined focus group believed that despite the Care and Safety House covenants on sharing information, it still requires courage from professionals to disclose relevant information to other disciplines. According to them, role performance on dealing with radicalisation can be increased by professional training in both domains, with a particular focus on knowledge and skill development regarding mental health conditions, radicalisation, and the (possible) interaction between both.

In the mental health focus group, participants believed that management teams of mental health care institutions neglect concerns raised by practitioners about possibly radicalised patients. The participants felt that protocols on how to deal with signs of radicalisation need to be introduced in mental health care and youth institutions to assure that colleagues are encouraged and feel safe to share their concerns with knowledgeable and experienced colleagues. In addition, it was felt that in the mental health care domain,

the use of validated risk assessment tools should be promoted to verify of falsify suspicions of radicalisation as quickly as possible to prevent unethical stigmatization. To promote a common understanding with professionals from the security domain, participants advised to use a similar assessment tool in both domains.

Collaboration

The perception in the combined focus group was that collaboration can only be effective when participants understand and respect the constraints and capabilities of professionals in the other domain. According to the participants, training should be provided to students in both domains for a familiarisation with intersectoral collaboration, based on a mutual understanding and respect of competences and responsibilities. However, the participants also stressed that it was not just the responsibility of trainers, but of all professionals at different management levels in both domains to increase awareness and knowledge of mutual constraints and capabilities in the prevention and management of radicalisation. In addition, they believed that it was the responsibility of managers to encourage visits to each other's workplaces to increase the familiarity with working practices of other disciplines involved. Another perception voiced in the combined focus group was that regular cross-domain evaluations of complex cases enhance trust and mutual understanding and thus contribute to the quality of working procedures.

Individual interviews with practitioners

The purpose of these interviews was to deepen the perceptions that had emerged in the focus groups and to determine whether the individual perceptions matched those elicited from the focus groups.

Radicalisation

The mental health care participants emphasised the complexity of radicalisation in combination with cultural and psychological problems, which poses a great challenge for diagnostic assessment and treatment. They emphasized the risk of stigmatisation through unfounded suspicions of radicalisation. This stigmatisation can negatively affect treatment and, in the worst case, provoke radicalisation.

The mental health care participants mainly reflected on the complex intertwining of radicalisation and mental health problems, while participants from the security domain saw these as two separate aspects that should be dealt with either by the security domain or mental health care. One participant put it this way: 'The police think in binary terms and are far too reactive'.

Tasks and roles

Participants from the security domain turned out to have high expectations of the mental health care to identify 'the mental health component' and then to treat it, while the mental health participants stressed how complicated it is to understand the relationship between the radical convictions and a mental health condition, assuming that there is one. Participants from both domains suggested that it should be possible to call on external (mobile) expert teams with a great deal of knowledge about radicalisation in combination with mental health problems.

Collaboration

The theme of information sharing was frequently mentioned in both domains. While mental health care participants discussed under what conditions information *could* be shared, participants from the security domain believed that mental health information *should* be shared in the interests of safety in the community. Participants in the mental health care sector believed that the internal procedures must be improved in order to identify and, if needed, intensify action following alleged radical behaviour by patients. It was also felt that regulations on information sharing should be adapted by law in such a way that it would become possible to breach confidentiality under strict conditions, even when there is no acute danger. In both domains, the Care and Safety House method was seen as a logical place to share information and secure collaboration.

Individual interviews with trainers

The goal of the interviews with trainers from both sectors was to examine how the issue radicalization in combination with mental health issues was addressed in the curriculum of the education. Trainers recognised that the theme of radicalisation in combination with mental health problems was a complex social issue for which their students were insufficiently prepared. They believed interprofessional cooperation and coordination to be important because the various areas of expertise in both domains can then complement each other. Almost all trainers said that students need to learn about the possibilities and impossibilities of partners in adjacent social domains, because collaboration with other sectors has become inevitable.

Both sectors made similar suggestions to pool knowledge and experience from the different domains regarding case management. Professionals need to know what to expect of each other, and they must inform each other in a timely and careful manner to facilitate a coordinated plan of action. The trainers also called for further professionalisation of Care and Safety House method in the training courses with practice-based lessons for a combined group of students and trainers from various sectors.

Trainers acknowledged that the time restriction in curricula can mean that students will come across situations later in their careers where they lack essential knowledge about the social problems, or even do not know that they lack knowledge. A mental health care trainer said: 'The focus [in the training] is mainly on person-centred mental health and not so much on what is happening around this person'. Several trainers stressed that for this reason it is important that students start thinking in terms of networks and learn to consult another discipline if they notice that they are running up against the limits of their knowledge and experience.

Discussion

Collaboration on issues concerning radicalisation appears to occur within the context of available knowledge of stakeholders, the legal framework, and the conceptualization of radicalisation co-occurring with mental health conditions. In addition, the initiation and quality of intersectoral collaboration depend on whether in mental health care signs of radicalisation are identified in patients, or conversely, on whether mental health problems among suspects of radicalisation are identified by the police. The third possibility is when

an individual is both under investigation and in treatment, but police and mental health professionals are unaware of each other's involvement, and signs of radicalisation or mental health problems are neither identified nor shared. In each of these contexts, perceptions of roles and responsibilities can have a positive or negative effect on collaboration. For example, the perceived lack of knowledge of the subject of radicalisation in mental health care has a negative impact on collaboration. It makes mental health professionals uncertain of what to do when confronted with radicalised patients and may result in denying or underestimating the risks involved, for example, by attributing radical statements to the underlying psychiatric condition. Knowledge can be enhanced by training but is difficult to sustain because of the low prevalence of radicalisation in mental health care. A possible solution is to secure a basic awareness among mental health professionals of the different forms of radicalisation and to make it possible to consult mobile teams with expert knowledge on radicalisation and mental health conditions. That calls for establishing internal protocols which make it easier to share concerns regarding possible radicalisation with knowledgeable mental health staff members or other experts. These experts can apply validated risk assessment tools in use by both domains and plan further action when necessary.

Whereas professionals in the mental health care domain may be inclined to avoid signs of radicalisation in patients or consider radical beliefs to be part of the psychiatric symptoms, professionals in the security domain appear to believe that presence of a mental health component implies that the mental health care domain is responsible for further management. This conclusion is partly due to a lack of knowledge in the security domain about mental health conditions. For example, the assumption that once a mental health condition is diagnosed, it permanently and completely determines someone's behaviour. This obstacle calls for additional mental health training for security domain professionals. Conversely, if professionals in the security domain decide that a case is their responsibility due to the radicalisation component, co-occurring mental health problems are either neglected or not shared with mental health care for presumed security reasons. We believe that this dichotomy of radicalisation and mental health should be avoided by encouraging intersectoral collaboration right from the start of a case where mental health issues and radicalisation co-occur.

Another important obstacle for efficient collaboration in general is the lack of knowledge and agreement on what professionals in the other domain can and cannot do in their respective sectors. This raises false expectations of each other's possibilities, tasks and responsibilities and leads to disappointment, frustration, and false assumptions. Sharing (unfounded) adverse experiences with colleagues may set a negative tone in teams and discourage other professionals from participating in intersectoral collaboration. Knowledge of each other's roles, and familiarity with the other domain must begin (but not end) with the basic training programs of professionals, but it is the responsibility of professionals at all management levels to maintain a cross-domain awareness and familiarity. Training was also mentioned as beneficial for collaboration in the literature (Augestad Knudsen, 2021; Sestoft et al., 2017; Weine et al., 2017).

Privacy regulations are perceived to have a major negative effect on intersectoral collaboration in several ways. The legislation on medical confidentiality has a negative impact on collaboration in a preventive stage because, in the Netherlands, sharing information without a patient's consent is not allowed unless there is an imminent danger that

can only be averted by disclosing (a minimum of) personal information. In the early stage of radicalisation, however, there will not yet be an imminent danger, meaning that mental health professionals are restricted by law to share concerns about the radicalisation of patients. The disciplinary measures that have been taken in the past in response to cases where privacy rules were broken have increased the reluctance of mental health staff to disclose information. Without proper training and guidance of mental health professionals in privacy issues, the fear for repercussions will not change avoidant behaviour. There is little understanding in the security domain for this hesitancy to share information, however. We believe that a review of the privacy regulations in case of radicalisation is necessary to enhance intersectoral collaboration, as well as a further investment in the procedures of the Care and Safety Houses.

Interestingly, none of the participants in the focus groups or interviews mentioned any adverse effects of collaboration for mental health professionals, such as an inappropriate identification with the safety issue, neglecting the need for providing support to radicalised subjects with mental health problems, and sharing medical information too freely (Augestad Knudsen, 2021; Bhui, James, et al., 2016; Weine et al., 2017; Yakeley & Taylor, 2017). The results do, however, clearly support collaboration above cooperation or coordination to address the complex problem of radicalisation with mental health concerns, as the joint effort is focused on making a novel plan of action, in which there is an interdependency between participants based on trust, and a long relational timeframe (Keast, 2016). According to the participants, the success of collaboration in the Care and Safety Houses in the Netherlands depends on mutual understanding and trust, which can be improved as the results indicate.

The strength of this study is that it focuses on the dominant perceptions among professionals from different domains to promote the understanding of obstacles and from there improve efficiency of intersectoral collaboration. There are also several weaknesses. One may argue that it is a weakness that radicalisation was not defined a priori for the participants of the focus groups which may have induced a degree of ambiguity in the interpretation of the subject by the participants. However, we chose to explore the perceptions of radicalisation as participants understood it, to stay as close as possible to the personal experiences and definitions. Another drawback was the limited number of participants in the safety domain focus group (four) in comparison to the mental health focus group (ten). This was due to unforeseen late cancellations by those invited to the safety domain focus group. Despite this restriction, fortunately, the perceptions expressed during the focus groups were almost all replicated in the subsequent 29 individual interviews with professionals and trainers, enhancing the generalizability of the results (Peddell et al., 2016). Lastly, a possible limitation is that participants were, despite their enthusiasm, inclined to wander off from the subject of radicalisation and discuss general obstacles in collaboration with the other domain. However, we evaluated these general perceptions as useful for the current study, because they also accounted for collaboration problems where radicalisation is involved.

In summary, intersectoral collaboration in cases where radicalisation and mental health issues co-occur is hampered by the limited knowledge that professionals in the mental health and security domain have of each other's roles, constraints, and capabilities. In addition, the lack of knowledge in mental health care of radicalisation prevents early detection and promotes avoidance. Likewise, does too little understanding of mental

health issues among security domain professionals contribute to a mad-bad dichotomy, which can have a negative effect on collaboration, and effective risk management in counterterrorism. Improvement of the intersectoral collaboration by a cross-domain familiarisation strengthening trust and mutual understanding, begins with the basic training programs of professionals but must become common practice at all management levels of the mental health care and security domains.

Notes

1. Disturbing behaviour (Dutch: *verward gedrag*) refers to any behaviour in the public domain for which the police is called out, regardless of whether it originates from a mental health condition, intoxication, anger, or other non-psychiatric cause.
2. In the Netherlands, signs of domestic violence legally warrant disclosure of concerns by a health professional to a third trusted party or the police, at the discretion of the professional involved, despite regulations on medical confidentiality.

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Data availability statement

Due to the nature of this research, participants of this study did not agree for their data to be shared publicly, so supporting data is not available.

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