Preventing violent extremism in the UK:
Public health solutions

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FACULTY OF PUBLIC HEALTH

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Foreword

By Dr Tracey Cooper
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The continual threat of violent extremism touches the lives of everyone in the UK. Terrorist events in Manchester and London have had long lasting impacts not only on those immediately affected, but also on their families, communities and many others who feel that they or their loved ones could be the target of future attacks. Atrocities such as the recent incidents in Mosques in Christchurch, New Zealand, or the bomb attacks on churches and hotels in Sri Lanka, are a stark reminder that terrorism comes from all extremes, that the combined efforts of all communities are required to eradicate the risk of such bloodshed, and that all sectors of society will benefit from the elimination of violent extremism.

We have an effective criminal justice response for suppressing violent extremist activity in the UK. However, we have learnt from our experience of other forms of violence (such as youth and gang violence, child maltreatment and domestic abuse) that public health issues are at the root of so much violence and public health interventions must be part of the solution. With this in mind, in 2018 I contacted my counterparts in all the UK nations and agreed that Public Health Wales would take forward an examination of the role of public health in countering violent extremism to inform our respective public health approaches across the UK. We are delighted that the UK Faculty of Public Health has joined us as a partner in this important work and that so many other stakeholders have also contributed to its development.

The findings of this report demonstrate the population wide negative consequences of violent extremism to the well-being and cohesion of our communities. They identify how poverty, inequalities, isolation, abusive childhoods, difficulties with identity and mental ill-health can contribute to risks of violent extremism. Critically, the report examines how a public health approach can offer solutions that target these risk factors whilst police activities continue to tackle those who are already actively planning terrorist atrocities.

Prevention is possible. However, this requires better population intelligence informing us about not only how extremism is affecting communities but also how our interventions are interpreted by the individuals of different genders, ethnicities and religious groups. Such intelligence should underpin the concerted efforts of multiple agencies working with communities to develop trust and build upon their community-owned assets.

This report is only one first step in developing a public health approach to countering violent extremism. However, I hope it can form part of a firm foundation that recognises that the roots of violent extremism are linked with the causes of many other types of violence, and in fact with the roots of many of the other public health challenges we currently face.

Executive Summary

The UK faces a complex and evolving threat of violent extremism (VE) and terrorism (see Glossary for definition of terms). These severe and often indiscriminate acts of violence have far-reaching and devastating individual and population health effects, impacting the well-being of the public across all aspects of society and contributing to the erosion of social trust and the spread of prejudice and fear. The current criminal justice framework in the UK targets those most at risk of developing violent extremist ideologies; often within the criminal space (see section 1.3). However, drawing on learning and principles from public health offers an opportunity to extend our understanding of risk and protective factors for violent extremist ideologies. Such an approach supports prevention policies and programmes that work upstream to address the multitude of needs individuals vulnerable to VE may have, and also work on a universal footprint to promote societies and communities that are cohesive, resilient and free from the appeals of violence. To explore the opportunities and support for a UK-wide public health response to extremist violence that complements existing criminal justice strategies, this document provides a briefing on the extent, broader impacts and risk and protective factors for VE. It then suggests options for the future development of a public health approach to preventing VE.

Understanding the extent of the problem

The overall spread and impact of VE continues to grow, with almost 19,000 lives lost as a result of terrorist activity across the globe in 2017 (see section 2.1; Figure 2). The four most prominent radical Islamist terror groups accounted for over half of all deaths from terrorism in this year. Further, far-right terrorism was also a growing concern, with an unprecedented number of incidents and fatalities in Western Europe and North America. In 2017, the UK was one of only five European countries that saw an increase in levels of terrorism (section 2.2). A record high number of arrests for terrorism-related offences were associated with this peak of activity, although arrests declined by 31% the following year (2017/18; section 2.3). In 2017/18, 7,318 people in England, Wales and Scotland were referred to Prevent – part of the UK's counter-terrorism strategy that works with a range of sectors to provide practical help to safeguard those who are at risk of being drawn into terrorism (see Glossary). Just under 400 of these individuals were deemed suitable for continued support following vulnerability assessment (section 2.4). Estimates also suggest that the UK provides one of the largest sources of foreign fighters in Europe, with approximately 850 supporters of Islamic state having left the UK in 2016/17 to participate in conflict in locations such as Syria (section 2.5).

Around one in ten people in the UK are said to have been the victim of VE or know somebody that has. Data from known terrorist actions may represent only the tip of the iceberg for the extent of all VE in the UK. However, opinion polls and surveys offer some insight into levels of fear or concern, as well as sympathy and support for extremist ideals. Whilst the majority condemn the use of violence, surveys suggest that between a fifth and a quarter of the British public understand why other people may be attracted to radicalism (see section 2.6.1). Surveys also suggest that levels of fascism may be increasing in the UK. Overall high levels of concern are expressed about rising levels of extremism and the threat of future terrorist attacks in the UK (section 2.6.2; Figure 6).

The impact of terrorism

Unlike many other sources of trauma, widespread disruption and fear are actually the intent of terrorism, with these hidden, deliberate and often indiscriminate acts of violence having far-reaching and long-lasting impacts on individuals, communities or entire nations. Although fatalities are rare, terrorism continues to be a cause of premature mortality, with 42 lives lost to terrorism in the UK in 2017 (see section 3.1). Victims of terror may suffer life-threatening or life-limiting physical injuries and significant psychological harm. Over a third of direct victims of terrorist attacks experience some form of post-traumatic stress disorder (PTSD). Women, children, ethnic minorities, migrants and other groups such as emergency services personnel may experience a disproportionate burden of such harms (section 3.2 and Box 1). Further, fear and feelings of vulnerability resulting from threat of or exposure to VE can lead individuals to change their daily lives in an attempt to control and reduce risk. Evidence shows increases in health harming behaviours such as alcohol or substance use as coping mechanisms in the aftermath of terrorist attacks (section 3.3.1), along with changes in willingness to travel or political attitudes and behaviours (e.g. voting in elections; section 3.3.2 and 3.3.3).

Major terrorist attacks and subsequent responses (e.g. anti-terrorism architecture) can shape the public's wider attitudes and values (section 3.5). Increases in prejudice have been reported, not just against those perceived to be associated with responsible groups, but also against entirely unconnected minorities. Global terrorist events have contributed to interrupting positive trends in attitudes towards immigrants. Counter-terrorism strategies may contribute to hostility, divided pressures and loyalties among targeted groups and increased feelings of isolation and disconnection from the state. In 2017, direct costs of terrorism (e.g. death, injury, destruction of property and emergency responses) and indirect costs for loss of productivity amounted to an estimated US$52 billion for the world's economy (section 3.6). However, this is a conservative estimate that does not account for indirect costs to businesses and investments or the diversion of resources away from economic productivity.

Risk and protective factors for violent extremism

Individuals who possess certain traits or characteristics, or who have lived through particular experiences, may be more likely to be drawn into VE (see section 4.1). Interpersonal violence (such as youth violence, domestic violence and child maltreatment), conflict (e.g. war and state violence) and VE are linked but our exchange of evidence and expertise largely is not. Current evidence does not adequately consider risk and protective factors among the wider population. It is likely that risk factors for VE vary according to the ideology of the perpetrator and interplay with the social, political and economic climate. However, little work has been undertaken in the UK to understand life courses that ended in VE and what opportunities were missed to intervene early in perpetrators' lives. Developing an understanding of the distribution of risks for VE is crucial for developing effective public health approaches. Applying the prevention paradox – a concept that describes when the majority of the overall risk (here of VE) may be represented by individuals outside of the highest risk category – provides some useful insight for considering vulnerability to VE and highlights the need to reduce overall levels of risk across the entire population (section 4.2; Box 2).

In this report, four major groups of risk factors were identified:

- **Early vulnerability and lack of resilience** (section 4.3.1) – Early childhood trauma or chronic stress is associated with later social and emotional development problems, ill health and risks such as involvement in violence and crime. Such trauma can result in a 'cognitive

opening' as individuals try to understand the world around them. For those with high levels of resilience (Box 3), having positive skills and relationships may help them to navigate such openings without developing propensities for extremism. For those without such factors, these openings may create vulnerability to negative influences. Evidence is beginning to emerge that links childhood adversity to extremism in adolescence and adulthood; although the experiences of children affected through war or displacement needs further exploration.

– Whilst social capital (social resources in families and communities that can facilitate positive outcomes) is an established determinant of positive population health, social isolation is associated with low self-worth, intolerance, and risk of radicalisation or involvement in violence. Equally, whilst positive peer relationships offer a source of resilience, negative or exploitative relationships may direct individuals towards deviant behaviour or adverse outcomes. For some adolescents, the challenges of managing multiple identities and reconciling mainstream culture with different ethnic or religious cultures in their families and communities can contribute to an ideological vacuum in which they have to make difficult life choices with no guidance from suitable role models. Although the relationship between mental health psychopathology and VE remains poorly understood, mental ill health represents a further mechanism by which individuals may become stigmatised and isolated or excluded from mainstream society; potentially driving them to seek acceptance from other sources or making them vulnerable to ideological abuse.

- **Unsatiated desire for status, belonging or a sense of purpose** (section 4.3.2) – When individuals experience challenges in achieving a cohesive sense of identity, association with extremist groups can appeal to psychological needs, such as a desire for belonging, status, or a sense of purpose. Connectivity to an ideology provides a rhetoric to make sense of feelings of injustice, grievance or dissatisfaction. Further, association with extremist groups may offer a source of power, a greater means of exercising influence, or other direct financial rewards and incentives. Social benefits may appeal to those who do not identify with groups in mainstream society, or who are otherwise stigmatised. The presence of radicalised others in friendship or kinship networks increases the likelihood of involvement in extremist violence.

- **Reinforced prejudice** (section 4.3.3) – Intolerance to diversity can foster societal problems such as prejudice and inter-group conflict. Individuals who feel they are treated unfairly or discriminated against may experience high levels of anger and frustration, as well as negative health and well-being outcomes. When their identity is threatened, moral outrage may increase the likelihood of adopting more radical positions. Inequity experienced through socioeconomic conditions can compound these frustrations, particularly when expectations of social mobility or economic welfare are not met.

- **An aggrieved world view** (section 4.3.4) – An individual's grievances, or those of groups with which they identify, can influence their world view and understanding of how to effect change. When people feel unable to access legitimate avenues to address inequality and grievances, particularly those against the state (e.g. towards foreign policy), violence may be considered the only viable means of action. This is a world view that extremist propaganda exploits, as political dissatisfaction is used as justification for terror.

Prevention

Conventional approaches to countering violent extremism (CVE) developed within criminal justice frameworks have been met with criticisms, and emerging practice is often not evidence-based and lacks description or evaluation. Universal approaches, directed at broader populations, should be considered (see section 5.1.1). These aim to reduce the number of new individuals developing extremist views and violent tendencies; recognise underlying socioeconomic, cultural and legislative determinants of health; and work with individual, family and community assets. Whilst much developing practice focuses on adolescents, there is a growing case for earlier interventions that prevent adversity, support healthy social and emotional development and build resilience (section 5.1.2). By decreasing social inequalities (e.g. income, opportunity, gender, race), addressing basic needs and strengthening and empowering communities' voices for social and political change, people can be helped to become healthy and proactive participants in communities that promote tolerance and diversity and reject violent ideologies (section 5.2; Figure 15).

A developing evidence base for transforming and preventing VE highlights approaches which help to build individual resilience, focusing on strengthening protective factors such as problem solving or decision-making skills and exploring concepts like personal identity and belonging (section 5.3.1). Although there is evidence to suggest that resilience interventions can create positive short term benefits for mental health and well-being, more work is required to understand the impact of these interventions on different demographic groups and VE. Anecdotal evidence further supports the role of programmes that promote peace and diversity by increasing multicultural awareness, encouraging pluralist values and promoting human rights (section 5.3.2). Many such approaches include inter-group contact or cooperative learning. Other emerging approaches offer opportunities to engage in society in legitimate and meaningful ways; promoting the core values of democratic society (section 5.3.3). Whilst civic and political participation is keenly represented in youth policy frameworks across the globe, its application to VE is yet to be established. Offering alternative or counter narratives is often a core theme of CVE. These approaches provide access to knowledge and support personal thought processes that are counter to extremist ideals (section 5.3.4). Although criticised for their lack of strong theoretical foundation, they appear to have particular face validity with terrorism survivors. Important considerations in the primary prevention of VE include: the avoidance of unforeseen negative effects; identifying and engaging credible voices; ensuring that approaches are culturally appropriate and address inequalities and divergent beliefs; and ensuring that effectiveness towards clear outcomes of interest is evaluated (section 5.4).

The current early intervention and prevention landscape in the UK is represented in the CONTEST strategy by the Prevent Programme. The UK government suggest that Prevent has: made significant strides in removing illegal terrorist material online; supported far-reaching counter narrative campaigns; reduced the number of people travelling to fight in conflicts in Syria and Iraq; and provided support to vulnerable individuals through the Channel programme (see Glossary; section 5.5.2). However, there is a notable lack of information on the outcomes of Channel cases and the impacts of Prevent on community resilience and cohesion remain largely unknown (section 5.5.1). Front-line practitioners have expressed concerns about counter-terrorism measures in the UK, suggesting that discretionary thresholds for referral and a lack of agreed definitions make it difficult to deliver Prevent duties. Some professionals also fear that the Prevent duty poses a threat to their professional identity (i.e. that was previously centred on the provision of care) and may be contributing to the securitisation of institutions.

Options for future development

Public health approaches and systems can offer non–threatening solutions to what have previously been seen as criminal justice issues. To inform their design it is crucial to understand which life course experiences, behaviours or beliefs increase involvement in VE, and to develop intelligence systems to monitor changes in the number of individuals exposed to such risk factors. Although this report does not provide detailed recommendations for policy makers and practitioners, it does identify potential policy and practice options related to both: (a) broader developments that can reduce community-level risks of VE; and (b) approaches specifically designed to address individual risk and protective factors by adopting principles of early intervention and population approaches and utilising assets from health, education and other sectors.

Reducing community-level risk (see section 6.1 for full description)

i. Perceived unfairness and inequity within societies and between communities can be sources of unrest and drive individuals to pursue extreme and violent means to effect change. Gender equality, societal intolerance of domestic abuse and equity in political representation and opportunities for progression are all linked with less violent societies. **CVE should be a consideration of policy and practice measures to reduce inequalities and barriers to advancement across communities, genders and other demographics.**

ii. Intolerance and discrimination on the basis of religious, ethnic, cultural or political diversity are threats to well-being, including involvement in VE. **National and local public health professionals and systems are well placed to raise discrimination as a threat to well-being and to coordinate multi-agency activities to identify the benefits of and opportunities for more plural societies.**

iii. Adverse childhood experiences (ACEs) can impact individuals' risks of ill health and involvement in violence across the whole life course. More consideration should be given to the relationship between ACEs and VE. **CVE activities should identify where they can incorporate the three pillars of tackling ACEs (ACE prevention; building resilience in those exposed to ACEs; and developing trauma-informed services)** and existing ACE programmes should examine how they can incorporate CVE as an additional outcome. This may involve expanding current understanding of childhood adversity to ensure it is culturally, politically and socially appropriate**.**

iv. Poor mental health is one of the biggest current threats to public health. For vulnerable individuals with multiple complex needs (see Box 6), radicalisation may not be their primary need. **Actions that protect and improve community and individual mental health should consider how to contribute to preventing violent extremism as a desired outcome.**

v. Supporting the health of asylum seekers, refugees and other migrant populations, many of whom may have been exposed to high levels of child adversity and adult trauma (Box 7), is an important consideration. Actions are needed to **measure the levels and types of trauma people may experience before arriving in the UK, enabling the relationship between trauma exposure and physical and mental health to be examined.** To support this, **staff at all points of contact should be trauma-informed (Box 10) and able to help build resilience and reduce propensity for violence.**

vi. People who experience competing cultures may face challenges in establishing their own personal and social identity. There is little evidence of what interventions can work to support people navigating such identity crises. Lack of shared social spaces and exclusion from particular activities on the basis of different cultural practices or beliefs may contribute to

isolation and poor mental well-being. However, **facilitating a range of different opportunities for individuals to engage with a diverse range of others should be considered an integration enabler. For example, this may include broadening the night time economy to include non-alcohol based activities.**

vii.   Asset based community development (ABCD; Box 8) can generate sustainable approaches to difficult problems without demonising communities. **Public health learning and approaches to ABCD should be applied to CVE in order to develop community interventions that utilise assets to move norms away from extremist violence.**

viii.   Data exchange is a core element in early prevention and adequate response. **Better routine data exchange between health and criminal justice services combined with emerging advancements in data processing should be considered in CVE.** In the case of VE perpetrators and high risk individuals, intelligence exchanges should also support reviews to examine where earlier intervention on a multi-agency basis might occur.

ix.   Currently, the restricted approach to CVE has largely limited understanding and engagement to a small group of specialists. As health, education and social workers routinely contact individuals and families and provide support and community engagement to enhance well-being, the potential contribution of these wider public services to CVE should be explored. This should be supported by **multi-agency training and materials that highlight the importance of tackling early vulnerability, lack of belonging, prejudice and aggrieved societal views for reducing CVE.**

Addressing individual risk and protective factors (see section 6.2 for full description)

x.   Extremism and CVE require a combined epidemiological framework that includes examination of their relationships with each other. Data on how policies, legislation and CVE interventions impact communities' sympathy or antagonism towards VE are critical to understanding impact. **Strategic responses to VE would be improved by routine surveys and monitoring of: attitudes towards VE; community and population-level impacts of relevant policy and practice; and distribution and trends of risk factors.**

xi.   **Valuable insight into the population level impacts of existing and potential CVE initiatives could also be collected through prospective impact assessments (IAs),** which should gather information from all stakeholders and cultural and political perspectives. Evaluation and dissemination will be needed to ensure best practice is established for CVE related IA.

xii.   **Public health could use existing and developing intelligence to provide a balanced population perspective on levels of risk represented by VE.** This would include communication that: places VE in a broader risk context; provides better population information on risk factors and the protective impact of community engagement and belonging; and helps to identify the appropriate balance between vigilance and mental well-being.

xiii.   Health systems are typically trusted by the public, and both **national and local public health systems could develop a more informative dialogue with all communities on actions that have been undertaken to address VE and why.** These communications should: provide balanced messages that avoid political and cultural extremes; enhance understanding of factors that build resilience and reduce risk; engage communities on critical issues like hate crime; and ensure that VE is not seen as a single community issue.

xiv.   As the majority of the British public think the threat of terrorism is high, **efforts are needed to improve understanding of how perceived threats affect well-being, including for vulnerable groups** (e.g. those with mental health issues), and how to address the impacts of living with the perpetual threat of VE.

xv.   Whilst the number of people directly exposed to VE remains relatively low, with an estimated one in ten people being affected themselves or knowing someone who has, it is important to improve support by developing **research programmes that understand the direct or near direct (e.g. on family and friends) impacts of VE.** Other fields of trauma-informed work should be examined and staff suitably trauma-informed to allow peer support and ensure that service engagement with all communities remains supportive.

xii.   **Training on vulnerability and trauma should be considered in primary care so that services can help reduce risks of VE** and support vulnerable individuals by providing information, advice and suitable referral pathways for those in need of additional support.

xiii.   **Terrorist events should not undermine activities designed to reduce the number of individuals sympathetic to or attracted to VE**. Thus public health and wider prevention messages are critical in the aftermath of an event and should be facilitated by: a code of reporting that minimises the risk of copycat behaviour; an understanding of narratives that are most likely to be effective across all populations and cultures; including public health messages in emergency response planning activities; and giving consideration to vulnerable individuals (for example those with mental health issues or from the communities from which perpetrators may have emerged) in communications with the public and professionals**.**

Conclusion

Acts of VE are relatively rare. This presents considerable challenges for understanding the pathways that lead individuals to commit such atrocities and for generating evidence on actions that may effectively reduce risks and consequences of VE. The field of CVE currently lacks a focus on the evaluation of programmes and has largely been considered separately from the richer evidence base on public health measures for reducing other types of violence. Whilst interpersonal violence, conflict and VE are causally linked, our exchange of evidence or expertise is not. A carefully constructed and sensitively implemented public health approach could help to identify a population consensus that rejects all forms of extremist violence and terror.

1. Introduction

Countering violent extremism (CVE) is a national security priority in the UK. Over the last decade, an increase in delivered attacks has established violent extremism (VE) and terrorism (see Glossary for description of terms) as principle concerns and consequently pressures on the general well-being of the public across all aspects of society. As the reach of some organised Islamist extremist groups[1] and the prevalence of lone-actors have both risen (IEP, 2018), the threat of terrorism has become more decentralised and unpredictable, creating new and complex challenges for its prevention. Worldwide, the unprecedented development of cyberspace and the rapid flow of information facilitate extremism. In the UK, erosion of social trust and resultant fears and prejudices are also echoed in an increased threat of far-right extremism. Historically, CVE has focused on law enforcement approaches developed using criminal justice frameworks and targeted at individuals most at risk of VE or within the criminal space. However, tackling VE has many elements in common with other contemporary public health issues. It is associated with marginalised and sometimes vulnerable individuals; it impacts the health and well-being of whole communities; and successful responses are likely to require both addressing those at greatest risk and reducing the wider pool of individuals from which they are drawn. Consequently, there are increasing calls for greater public health involvement (Bhui et al., 2012) and the incorporation of family and community-based approaches that consider the risk of radicalisation to VE alongside addressing the wider health and well-being needs of affected individuals and communities (Weine et al., 2016). Interpersonal violence (such as youth violence, domestic violence and child maltreatment), conflict (e.g. war and state violence) and VE are linked but currently our exchange of evidence and expertise largely is not.

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1   Reference to Islamist terror or extremism describes support for an ideology or behaviours that are religiously motivated, but not supported by mainstream religious bodies or representative of the views of the majority.

1.1   About this document

This document provides a briefing on current evidence and offers insight from a public health perspective into possible approaches for the prevention of radicalisation and VE. By widening the prevention discussion, drawing on learning and principles from public health, and considering these alongside the current criminal justice framework, this document aims to foster interest and support for a UK-wide public health response to the growing threat of extremist violence. The document is intended primarily for public health professionals. However, as it is also intended to facilitate multi-agency responses to VE, it may be of interest to anyone in health, criminal justice, international law, education, political science, faith or other sectors with related policy making or service delivery responsibilities.

Detailed debate about whether radicalisation is a necessary and sufficient pathway for the development of VE is beyond the scope of this document but is described elsewhere (Horgan, 2003; Sageman, 2004). Instead, here radicalisation and extremism are both framed as potential precursors to violence (either collectively or independently) and are therefore presented as key opportunities for intervention and prevention. The UK has a history of terrorism that dates back beyond The Troubles in Northern Ireland (see Glossary). However, the focus here is on VE in the 21st century, reflecting how the threat of global and domestic terrorism has fundamentally changed following the events of 9/11 in the United States[2]. Since 2001, Islamist terrorism has represented the largest terror threat in the UK (IEP, 2018). Therefore, it is a focus for much of the data and evidence provided throughout this document. Recognition is also given to other forms of extremist violence addressed by UK counter-terrorism strategy (see section 1.3) and, where possible, these are compared and contrasted with understanding of Islamist extremism. However, as this reports considers VE in the UK it draws largely upon data and evidence from high income countries with similar social, economic, cultural and political environments.

The document is structured into six sections. The first section defines and frames radicalisation and VE as a public health issue and introduces the reader to the current policy context and legislative framework in the UK. Section 2 outlines the extent of terrorism and VE nationally and briefly examines historic trends since the turn of the 21st century. Section 3 describes some of the devastating health and social impacts of terrorism for individuals and communities across the UK, as well as highlighting wider impacts on businesses and the economy. In section 4, current evidence for risk and protective factors is summarised and readers are introduced to a public health model for understanding population-level risk. Available evidence for prevention is explored in section 5, which begins by introducing some key public health principles and offers examples of developing practice as well as summarising key ongoing challenges for prevention. Finally, section 6 draws on the preceding sections to outline elements of a public health response to CVE and discuss the role of public health professionals in prevention and advocacy. Key findings are summarised and opportunities for practice and research presented.

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2   See Appendix Table 1 for a list of major global terrorist attacks referenced in this document.

1.2   Violent extremism as a public health issue

Extremist violence has both individual and population-level health effects (section 3), making it a core issue for public health and identifying a need for prevention policies and programmes that operate across both of these domains. Such prevention requires understanding the risk and protective factors for violent extremist ideologies and pathways to terrorism (i.e. things that increase and decrease the likelihood of involvement) in order to promote societies free from such appeals. Further, vulnerable individuals may have multiple needs. Thus, addressing exposure to extremist narratives or groups can be only one of many factors requiring intervention in order to reduce risks of violence. Public health has much to offer in this space by helping to bring together input from diverse disciplines (including psychology; sociology; education; public policy, criminal justice and health) and drawing on established expertise in areas such as developing and implementing community-based programmes, administering services, conducting research and evaluation, and recommending policies concerned with total systems development. For example, increasingly VE appears to share common risk and protective factors with other forms of violence (Bellis et al., 2017a; Eisenman & Flavahan, 2017). The potential benefit of applying theories, best practice and evidence from public health and extending learning from approaches such as gang violence (Eisenman and Flavahan, 2017) requires urgent examination. The UK Government's Serious Violence Strategy (HM Government, 2018a) establishes a new balance between prevention and law enforcement. It aims to take a public health approach by harnessing the value of cross-sector partnerships in the reduction of homicide, knife and gun crime and the drug markets that have strong links to violence. Whilst consideration has been given to how duties that are involved in the prevention of terrorism may be applied to serious violence, conversely ways in which the CVE agenda may benefit from public health approaches used in tackling serious violence remain largely unexplored.

1.3   The UK policy context and the current criminal justice framework

Counter-terrorism (CT) legislation was introduced in the UK in 2000 and initially amended in 2001 in response to the 9/11 attack in the United States. A brief summary and history of CT legislation and strategy is provided in Figure 1. In 2003, the UK government first introduced CONTEST as a comprehensive domestic CT strategy. CONTEST aims to 'reduce the risk to the UK and its citizens and interests overseas from terrorism, so that people can go about their lives freely and with confidence' (HM Government, 2011; pg 9)[3]. Its guiding principles are outlined as proportionality, flexibility and inclusivity. Responsibility for CONTEST sits with the Home Secretary, supported by the Home Office's Office for Security and Counter-Terrorism (OSCT). The strategy comprises four core interconnected strands designed to provide an end-to-end response to threat:

- **Prevent** – reducing intent by safeguarding people from becoming terrorists or supporting terrorism;
- **Pursue** – reducing capability by stopping terrorist attacks from happening;
- **Protect** – reducing vulnerability by strengthening the UK's protection against attacks;
- **Prepare** – reducing impact by mitigating the effects if terrorist incidents do occur.

The latest reconfiguration of the CONTEST strategy, released in 2018, reportedly builds on what is referred to as this 'tried and tested' strategic framework (HM Government, 2018b; pg 13), as well as incorporating key lessons from the attacks that took place in London and Manchester in 2017 (see Appendix Table 1). Publication of the revised strategy is described as reflecting the government's commitment to greater transparency.

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3   CONTEST addresses all forms of terrorism that affect the UK and interests overseas, with the exception of Northern Ireland related terrorism in Northern Ireland, which is the responsibility of the Secretary of State for Northern Ireland.

Figure 1. Timeline of counter-terrorism (CT) legislation and strategy

Counter-Terrorism Strategy

CONTEST (see 1.3)

CONTEST (revised)

CONTEST (revised)

CONTEST (revised)

9/11

7 July London Bombings

Manchester and London Bombings

2000   2005   2010   2015   2018

Terrorism Act 2000
Provided legal basis for prosecuting terrorists and proscribing organisations.

Anti-Terrorism Crime and Security Act 2001
Contained measures rejected from previous act; allowed indefinite detainment of foreign terrorist suspects.

The Prevention of Terrorism Act 2005
Introduced "control orders" (a form of house arrest) on those suspected of terrorist involvement; subject of extended parliamentary dispute; later considered incompatible with rights to a fair trial under article 6 of the European Convention of Human Rights.

The Terrorism Act 2006
Defined the offence of "glorifying terrorism"; revised the period of detention without charge to up to 28 days.

The Counter-Terrorism Act 2008
Allowed police questioning of suspects after they have been charged; requires convicted terrorists to notify police of their whereabouts; extended jurisdiction of courts over terrorism offences abroad; attempt to extend period of detention without charge to 42 days defeated.

Counter-Terrorism and Security Act 2015
Introduced temporary exclusion orders to control the return to the UK of British citizens suspected of involvement in international terrorism (e.g. inclusion on 'no fly' lists); new statutory duty on local authorities, prisons, NHS trusts and education institutions to prevent individuals being drawn into terrorism; advanced passenger information required for air travel; requirements for internet service providers to generate records identifying users and their activities and share with police and security services.

Counter-Terrorism Legislation

1.3.1 Prevent and the Channel programme

The Prevent strand of CONTEST aims to: tackle the causes of radicalisation and respond to the ideological challenge of terrorism; safeguard people from becoming or supporting terrorists; and support the rehabilitation and disengagement of those already involved in terrorism. The Prevent delivery model is based on the premise that there is no consistent socio-demographic profile of a terrorist or no single pathway to involvement with terrorist organisations. However several factors may converge to create conditions in which radicalisation may occur.

The Prevent referral process operates by allowing a member of the public or someone working with the public to raise concerns about any person whom they feel may be radicalised. Referrals are made to the local authority or police force, who determine if there is a genuine vulnerability, and if this vulnerability relates to terrorism (in cases where it does not, onward referral can be made for other support as needed). If vulnerability to being drawn into terrorism is confirmed by the police, an individual may be referred to Channel (England and Wales) or the Prevent Professional Concerns (PPC) programme (Scotland). Here a multi-agency panel (chaired by the local authority) gathers information from partners to agree the level of vulnerability (Vulnerability Assessment Framework) and the nature of the support required. Where help is deemed appropriate, a bespoke care package can be developed based on a given individual's needs. However, participation is voluntary and individuals may withdraw from the programme at any time (see section 2.4 for data on engagement with Prevent).

For individuals that have previously been convicted of violent offences, including terrorism and domestic extremism, Multi-Agency Public Protection Arrangements (MAPPA) provide a mechanism by which police, probation and prison services can work together with other agencies to manage the risks posed by offenders living in the community. MAPPA offenders are managed at one of three levels, according to the extent of agency involvement needed from a number of different

agencies. Multi-agency meetings determine risk factors for future extremist involvement and areas for concern prior to release. This may inform the development of a risk management plan.

1.3.2 Counter extremism strategy and the Commission for Countering Extremism (CCE)

The Counter Extremism Strategy (HM Government, 2015) was introduced in England, Wales and Scotland[4] to build on the work of the CONTEST Strategy and the Prevent duty by countering the ideology of non-violent and violent extremists. The strategy intends to protect people from the harm caused by extremism and focuses on the following four areas: (1) countering extremist ideology by confronting and challenging propaganda and promoting alternative narratives; (2) building a partnership with all those opposed to extremism; (3) disrupting extremists through existing powers and the creation of new targeted powers (e.g. concerning citizenship or restricted access to premises used to support extremism); and (4) building more cohesive communities and understanding and addressing why some people do not identify with the UK and share its values (Commission for Countering Extremism, 2018). The strategy outlines a response to the challenges of isolated and segregated communities which builds on programmes such as the National Citizen Service and English language training to remove barriers between communities. Public health should be well-placed and prepared to support many of the objectives of the strategy; especially through aspects of community cohesion, countering extremist narratives and partnership building.

In 2016, the Home Office launched the Building a Stronger Britain Together (BSBT) programme (Home Office, 2016). BSBT is currently engaged with over 100 organisations or programmes across England and Wales. It offers funding and support to civil society and community organisations in delivering programmes that support the goals of the Counter Extremism Strategy in creating more resilient communities and offering vulnerable individuals a more positive alternative to VE. For example, Reset Communities and Refugees is a registered charity that aims to change the way that the UK community responds to the current refugee crisis by implementing community-led resettlement programmes. The charity supports communities in coming together to mobilise existing skills and resources to collaboratively welcome, support and help refugee families to rebuild their lives. Families' integration is supported by a resettlement plan that addresses a range of needs from accommodation and schooling through to language.

The Commision for Countering Extremism (CCE) is an independent body that was launched in England and Wales in March 2018 to support society to fight all forms of extremism. The commission is a non-statutory expert committee of the Home Office and advises the government on extremism-related policies and powers. Whilst it has no remit on CT policies (including Prevent), the CCE aims to engage with the public sector, communities, civil society, families and legal and academic experts to explore the threat of and current response to extremism. This includes the study of the following key themes through academic literature, reports, government data, and expert and public opinion: public understanding of extremism; the scale of extremism (including extremism-related criminal offending, e.g. hate crime and segregation); extremists' tactics and objectives; the harm caused by extremism; and the effectiveness of the current response (including developing an understanding of a positive, inclusive vision for England and Wales).

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4   To varying degrees, responsibility for counter-extremism is devolved in Wales, Scotland and Northern Ireland, with each devolved administration having its own approach in the areas devolved to them. Whilst the UK government have worked with devolved governments to apply the Counter Extremism Strategy in Wales and Scotland, at the time of writing, this was not the case in Northern Ireland.

2. Understanding the extent of the problem

2.1 The global context

In 2017, 18,814 lives were lost as a result of terrorist activity across the world (IEP, 2018). Whilst the total death toll and number of attacks have been declining since 2014 (National Consortium for the Study of Terrorism and Responses to Terrorism (START), 2018; Figure 2), and the percentage of unsuccessful attacks has increased over the same period, the overall spread and impact of terrorism is continuing to grow. Thus, in 2017 two thirds of all countries experienced at least one terrorist attack. Radical Islamist terror and Jihadi militants comprised the world's four deadliest terror groups in 2017, with ISIL (Islamic State of Iraq and the Levant), The Taliban, Al-Shabaab and Boko Haram (see Glossary) taking responsibility for over 56% of all deaths from terrorism. Whilst the capacity of ISIL and other jihadist groups is said to have descreased considerably with the loss of terrority in Iraq and Syria, ISIL activity alone affected 286 cities worldwide in 2017, with the organisation driving a shift in terrorist tactics towards simpler attacks against non-traditional and 'soft' civilian targets. However, far-right terrorism is also a growing concern, as the number of recorded incidents in Western Europe and North America associated with far-right groups rose from just ten in 2014, to 59 in 2017. Recorded deaths from far-right terrorism peaked at 17 in 2017 (IEP, 2018)[5]. In non-conflict countries, 57% of terrorist attacks target civilians. Whilst bombings and explosions account for over half of all terrorist attacks, attacks on infrastructure are more common in Europe (23% of all attacks) and North America (48%). In Europe, terrorist activity in 2017 was concentrated in Turkey, the UK, France and Germany (IEP, 2018).

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5   In March 2019, after the publication of the Global Terrorism Index, a right-wing terrorist attack took place in Christchurch, New Zealand, in which a single gunman targeted two mosques, killing 50 people and injuring many more.

Figure 2. Global deaths from 21ˢᵗ century terrorism, 2000-2017
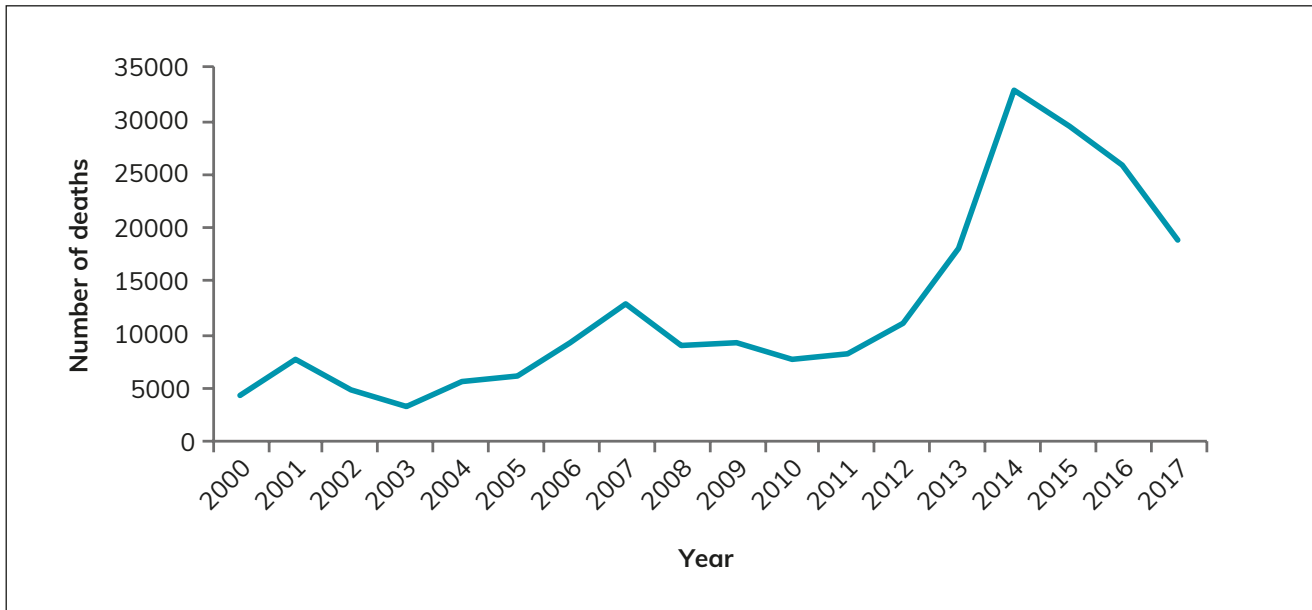
Source: Global Terrorism Database (National Consortium for the Study of Terrorism and Responses to Terrorism (START), 2018)

Research highlights the growing prevalence of lone actor terrorists (see Glossary) acting without the direct control and command of a wider network (RUSI, 2016). Among 98 planned attacks across EU Member States, Norway and Switzerland between 2000 and 2014, Great Britain provided the geographical target for the highest number of lone actor terrorism plots (38 planned attacks). Religiously inspired attacks were the most frequent of lone actor attacks (38%) but right-wing[6] attacks were identified as more lethal – accounting for 24% of attacks but nearly half of all fatalities (48%). Approximately two thirds of lone actors perpetrating acts of terror in Europe are considered to have never been active within an extremist group (RUSI, 2016).

## 2.2   Terrorist attacks in the UK

According to the 2018 Global Terrorism Index, the UK ranks 28 out of 163 indexed countries in a score that describes the measurable impact of terrorism through attacks, fatalities, injuries and property damage (IEP, 2018)[7]. In 2017, four terrorist attacks in London and Manchester (see Appendix Table 1) resulted in 36 fatalities, with many more injured. The UK was one of only five countries in Europe that saw an increase in terrorism in 2017 (IEP, 2018). However, the UK experienced its greatest loss of life from terrorism in the 1980s (National Consortium for the Study of Terrorism and Responses to Terrorism (START), 2018; Figure 3), when 270 people died when a Pan Am Passenger airline exploded over Lockerbie in Scotland (The Lockerbie Disaster; see Appendix Table 1). The highest rate of wounding occurred in 2005, when 784 people suffered non-fatal injuries in the 7/7 London transport bombings (see Appendix Table 1). Despite the current notoriety of jihadist violence in the 21st century, Northern Ireland remains the UK nation experiencing the most terrorism-related deaths, as the Northern Ireland Conflict (The Troubles) has resulted in considerable loss of life for both Northern Irish (69% of deaths in this conflict) and other British (29%) nationals since its beginning in 1970. The murder of Labour Member of Parliament Jo Cox in June 2016 and the vehicular attack on a Mosque in Finsbury Park, London in June 2017 (see Appendix Table 1) also highlight the growing threat of right-wing/white supremacist violence across the UK.

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6   Right-wing (also know as far-right) ideologies, which are based on the premise that certain 'superior' groups should have greater rights than other 'inferior' groups, include: white supremacism, authoritarianism, nativism, neo-facism, neo-Nazism (see also Glossary).

7   UK score for 2018 = 5.610 (out of 10), where 0 is least affected by terrorism and 10 is most affected.

According to Europol data, of the 205 failed, foiled or completed attacks reported in EU member states in 2017, 107 were experienced in the UK. Over 80% of these UK attacks were classified as ethno-nationalist or separatist, with 58 shooting and 30 bombing incidents in Northern Ireland. Five UK attacks in 2017 were attributed to right-wing extremists and no single-issue attacks[8] were reported (Europol, 2018). In contrast to the assassinations common to the ethno-nationalist conflict in Northern Ireland (34% of attacks), terror in the UK in the 21st century has been more frequently conducted by bombings or explosions (40% of attacks) and more focused on facilities or infrastructure (32% of attacks; National Consortium for the Study of Terrorism and Responses to Terrorism (START), 2018). A third of UK terror attacks have targeted businesses (32% of targets), as well as government (13%) and religious figures or institutions (8%; National Consortium for the Study of Terrorism and Responses to Terrorism (START), 2018). According to a 2016 survey, around one in ten UK respondents said they had been the victim of VE or knew somebody that had (CSIS, 2016).

Figure 3. Terrorism in the United Kingdom (excluding the Northern Ireland conflict)
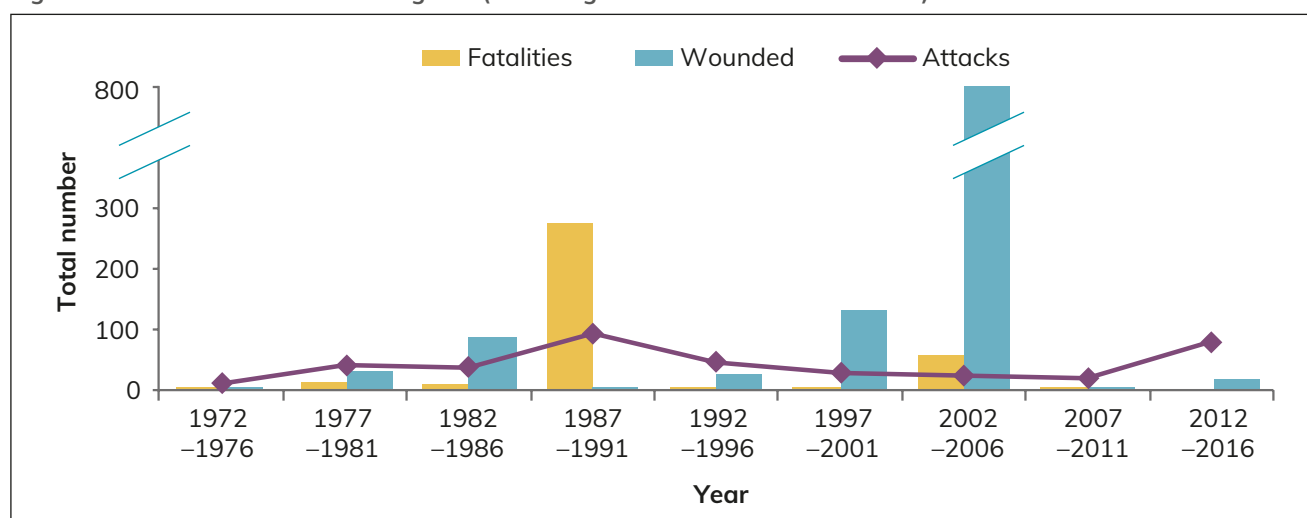
Source: Global Terrorism Database (National Consortium for the Study of Terrorism and Responses to Terrorism (START), 2018)
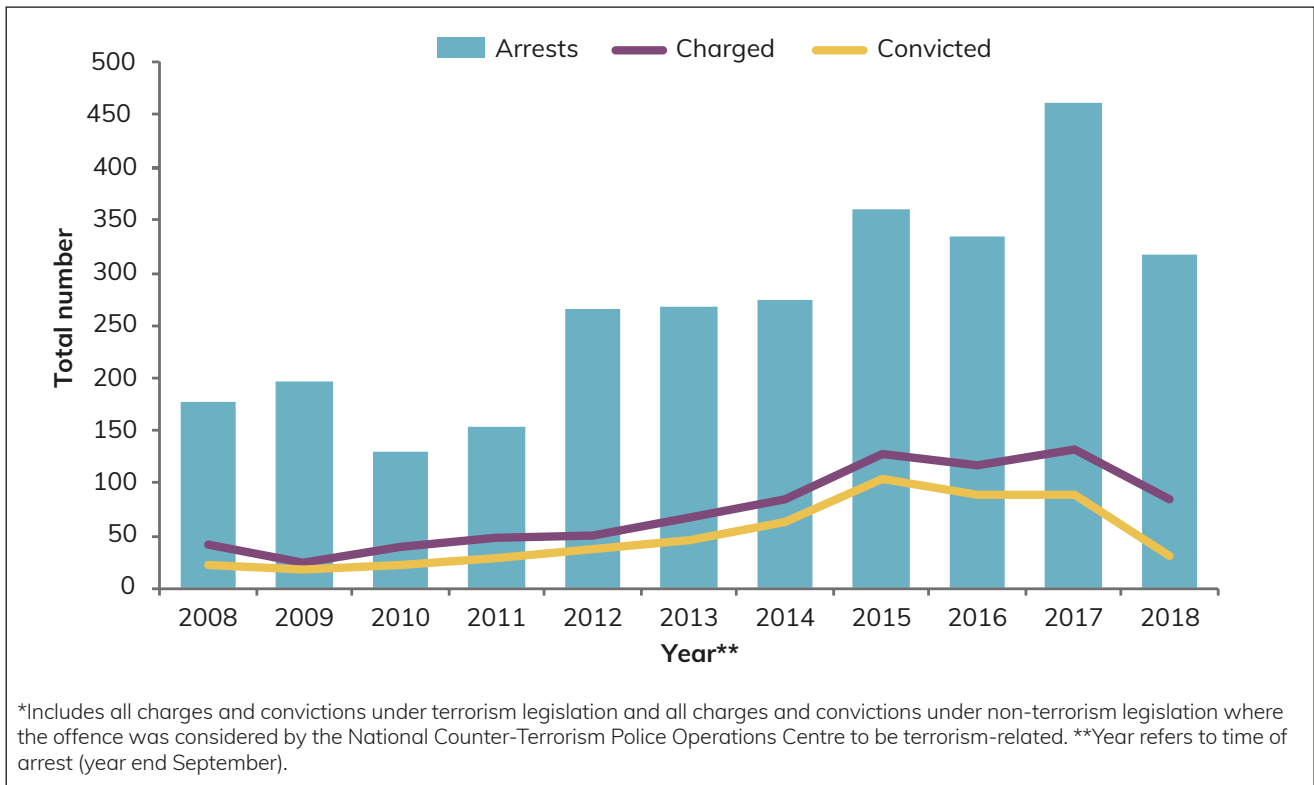
2.3 Arrests and prosecutions for terrorism-related offences

In the year ending September 2018, there were a total of 317 arrests for terrorism-related offences in England, Scotland and Wales. This was a decrease of 31% compared with the previous year (year ending September 2017), which saw a record high over the previous decade of 462 arrests, many of which were in the wake of the attacks on London and Manchester (see Appendix Table 1; Home Office, 2018a; Figure 4).

Half of those arrested in 2017/18 were released without charge, with 85 people subsequently charged with terrorism-related offences. As of December 2018, 37 of these individuals had been prosecuted and convicted (32 for terrorism-related offences; 5 for non terrorism-related offences). According to the Home Office, males represent over 90% of all those arrested for terrorism offences since 2001, with over three quarters of arrests classified as relating to international terrorism. Historic data also show increases in the number of arrests for terrorism-related offences across all ethnic groups. Just under three quarters (72%) of those arrested in 2017/18 described themselves as British or a dual British national (Home Office, 2018a). On 30th September 2018 there were 224 individuals in prison in England, Scotland and Wales classed as terrorist or extremist prisoners, continuing the upward trend of persons in custody of previous years. Eighty percent of these prisoners reported holding Islamist-extremist ideals (Home Office, 2018a).

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8   Single-issue attacks refer to extremists in protest movements related to specific social issues such as environmental and animal rights issues.

Figure 4. Arrests, charges and convictions for terrorism-related offences* in England, Scotland and Wales

*Includes all charges and convictions under terrorism legislation and all charges and convictions under non-terrorism legislation where the offence was considered by the National Counter-Terrorism Police Operations Centre to be terrorism-related. **Year refers to time of arrest (year end September).

Source: Home Office, 2018a

2.4 The Prevent strategy and referrals into Channel

Between April 2017 and March 2018, 7,318 people were referred via Prevent (see section 1.3), with a third of referrals (33%) from the education sector and a third (32%) from the police. Only 9% of referrals in 2017/18 came through health (Home Office, 2018b). One in six (18%) referrals were for concerns related to right-wing extremism, with 44% referred for concerns related to Islamist extremism. The outcomes of these referrals are shown in Figure 5. Support was given to 394 people following vulnerability assessment by a Channel panel. Over half (62%) of individuals discussed at a Channel panel were aged 20 years or younger and the majority (86%) were male. Forty five percent of those who received Channel support were referred for concerns related to Islamist extremism and 44% for concerns related to right-wing extremism. Of those subsequently referred to alternative services, 16% were referred to health services (Home Office, 2018b).

Figure 5. Outcomes of referrals to Prevent in 2017/18 (n=7,318)
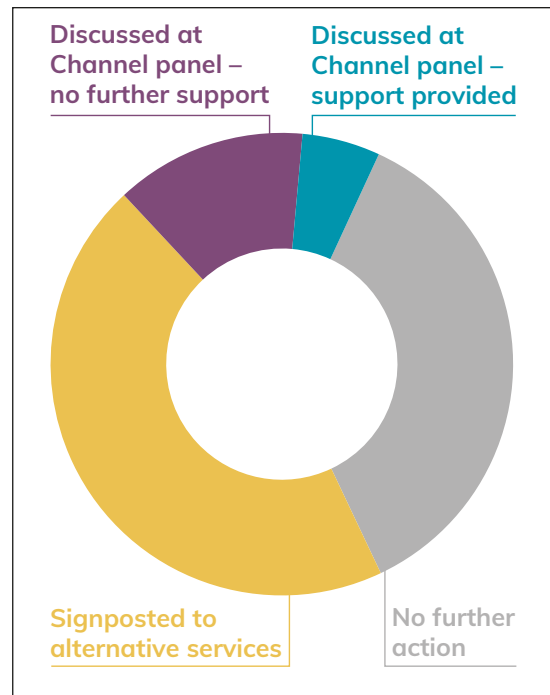
Source: Home Office, 2018b

2.5   Foreign fighters leaving the UK

Individuals from the UK may travel to locations such as Syria to participate directly in conflict, support terrorist organisations through non-violent means, or may be compelled to travel (i.e. in the case of some accompanying women and children). Used almost exclusively in reference to Islamist terror, the term 'foreign fighter' describes those who cross borders (i.e. beyond their state of residence) in order to participate in the planning, preparation or implementation of terrorist activity, including receiving training in tactics and combat. Although the exact numbers of foreign fighters are unknown, estimates suggest that around 850 supporters of Islamic state had left the UK in 2016/17, placing the UK as one of the largest European sources of foreign fighters (Barrett, 2017). Estimates suggest that around 30% of foreign fighters who have joined insurgent terrorist groups in conflict zones like Syria and Iraq since 2011 have already returned home (European Parliament, 2018). The true extent of this group ('returnees') and the level of threat they pose, both directly (i.e. by conducting an attack) and indirectly (i.e. by leveraging existing pockets of domestic support for VE) remains unclear (UN CTED, 2018). Whilst some authors argue that only one in approximately every 360 returnees become involved in active terror plots or attacks (Hegghammer and Nesser, 2015), in a dataset of 27 ISIL-linked attacks and 19 plots in Western Europe from January 2014 to July 2016, 18 attacks reportedly involved returnees providing operational or logistical support (Cragin, 2017).

2.6   Exploring public perceptions

2.6.1 Support for extremist violence

Opinion polls provide a possible means of exploring the extent of sympathy and support for violent extremist ideals and terrorist organisations and their activities. A review of opinion surveys on Islamist violence found a "sizeable undercurrent of sympathy and support" in both Muslim-majority countries and among Muslims in the west, highlighting a potential hotbed for radicalisation (Schmid, 2017). For example, a survey of 1,081 adult British Muslims conducted for a Channel 4 documentary in April-May 2015 found that 6% of those surveyed reported sympathising with people who threaten terrorist action as part of political protest, with 4% sympathising with those who actually commit such acts. However, over half of surveyed Muslims (57%) explicitly condemned violence organised by groups to protect their own religion, and an even larger majority (85%) condemned the use of suicide bombing to fight injustice (ICM, 2016). Interestingly, whilst only 13% of Muslim respondents suggested they could understand why a British Muslim would be attracted to radicalism, 27% of the non-Muslim control sample agreed. A quarter of respondents in both groups also said they understood why school girls may be attracted to becoming Jihadi brides (ICM, 2016).

A poll by BMG research in 2016 (N=1,507) found that almost half of UK adults surveyed (46%) believed that the number of people with fascist views in the UK is increasing (BMG, 2017). However, support for right-wing extremism, including white supremacism, is not well studied and there is some evidence to suggest that anxieties about diversity and integration in white majority areas of the UK have largely failed to coalesce into support for organised groups (Thomas et al., 2017). In 2012, a poll by YouGov revealed that only a third of respondents had actually heard of the English Defence League (EDL)[9]; of those that had, 11% reported that they would ever consider joining (YouGov, 2012). Although it was reported that support for the EDL grew following the murder of Lee Rigby in 2013 (Appendix Table 1), 'counter-jihadi', white supremacist and neo-nazi movements in the UK are under researched (Goodwin et al., 2016). Just under one in five London adults surveyed in October 2018 (N=1090) reported that they had witnessed views promoting, endorsing or supporting extremism in the past 12 months, with a further 7% suggesting they had directly experienced these views (YouGov, 2018a).

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9   The EDL are a far-right Islamophobic organisation in the UK that formed in London in 2009 and are known for demonstrations and marches that incite violence against Muslims.

2.6.2 Security and perceived levels of threat

Data from a YouGov survey undertaken in March 2017 show high levels of concern among the UK general public as to the likelihood of future terrorist attacks in Britain, with 90% of respondents reporting that future attacks are fairly or very likely (Figure 6; N=1690; YouGov, 2017a). A similar poll in England and Wales (N=1486) in June 2018 found that 73% of respondents were worried about rising levels of extremism in the UK (YouGov, 2018b). This is supported by findings from the Global Attitudes Survey, in which 79% of respondents considered ISIL to be a major threat to the UK (Pew Research Centre, 2017). The importance of terrorism and foreign fighters to security across Europe was also highlighted by UK respondents in a 2015 Eurobarometer poll (N=1330; European Parliament, 2016). Here, 41% felt that the threat of terrorism is most efficiently combated at the global level. Just under half of UK respondents (48%) felt that the fight against the roots of terrorism and radicalisation was the most urgent security concern. An Ipsos MORI survey in June 2017 (completed shortly after the attacks in London and Manchester; N=965) revealed defence and terrorism as the third biggest concern facing the British public, after the NHS and Brexit (Ipsos MORI, 2017). Qualitative evidence drawn from online sources suggests that around a third of people feel that foreign fighters are a serious threat in the UK and should be forbidden from returning and criminally punished (da Silva and Crilley, 2017).

Figure 6. UK public perceptions of the threat of terrorism
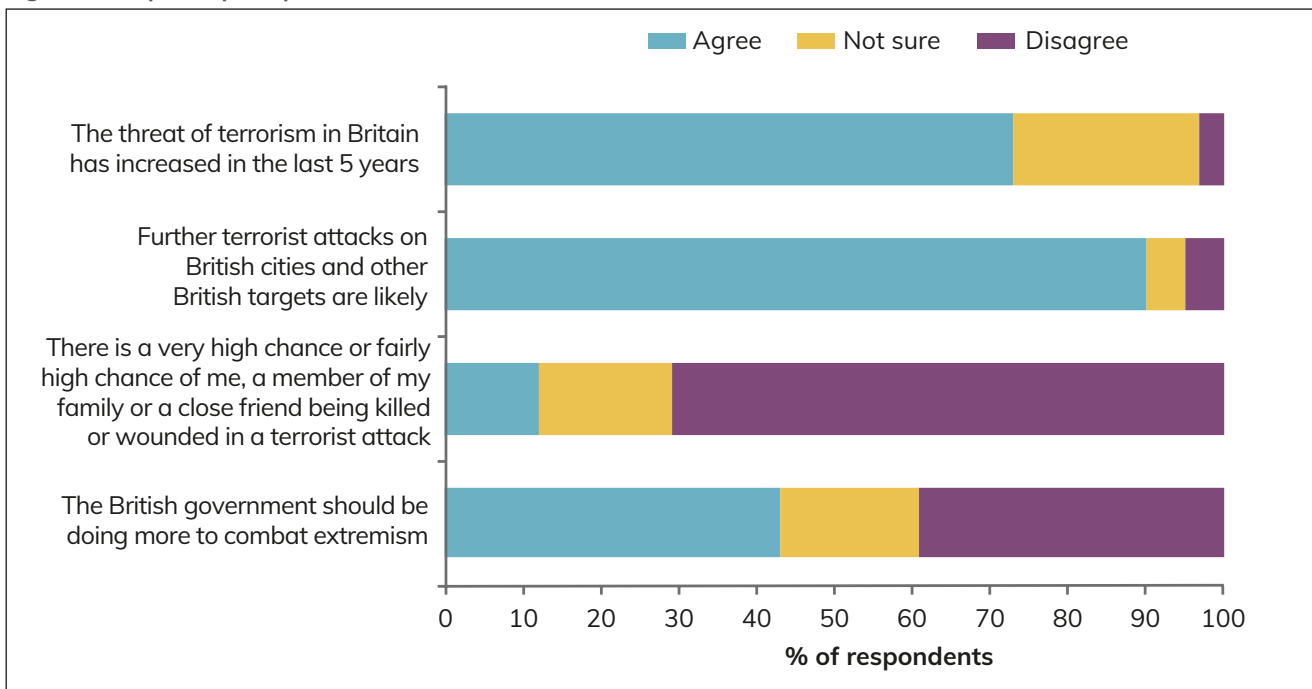
Source: YouGov, 2017a

2.7 Limitations

Resources such as the Global Terrorism Database, through analyses of credible open media sources, provide access to information on domestic and international terrorist events that have taken place all over the world in the last 45 years. Whilst offering a summary of the concentration and intensity of known terrorist actions, this data represents only the tip of the iceberg, overlooking unsuccessful, abandoned or disrupted attacks or ongoing and planned activity not described in the public domain. Further, the extent to which radicalisation to VE takes places in institutions, communities, homes and a vast array of other settings remains entirely absent from academic literature. However, for the UK, data exploring criminal justice involvement and perceptions held by the general public may offer some further insight into the current reach and appeal of extremist ideals.

3. The impact of terrorism

Like many other threats to public health (e.g. incidents relating to infectious diseases or natural hazards, such as flooding), acts of terrorism can have a devastating impact on individuals, families, and neighbourhoods, directly threatening life and risking harm to health, well-being and prosperity. Further, effective responses to these emergencies can place a huge burden on public services and have long-term economic impacts on investment and development. However, exposure to terrorism is also different from many other sources of trauma in ways that have considerable implications for resilience and recovery. Widespread disruption and fear are actually the intent of terrorism. The hidden, deliberate and often indiscriminate nature of the threat to life on a mass scale means terrorist attacks can have more widespread and long-lasting impacts on whole communities or even entire nations. With the ever-present threat of terrorism, the ongoing potential for future attacks can limit any reasonable return to previous states of stability and instead require new ways of behaving (e.g. security checks) which act as continual reminders of the threat. There is, at present, limited evidence quantifying the impacts of more recent terror attacks in the UK. However, some empirical understanding can be drawn from studies of both the immediate and longer-term impacts of 9/11 and other historic terror attacks across Western Europe (see Appendix Table 1).

3.1 Physical health and loss of life

Terrorism is a cause of premature mortality, with 42 people losing their lives in terrorist attacks in the UK in 2017 and a total of 3,452 deaths since 1970 (National Consortium for the Study of Terrorism and Responses to Terrorism (START), 2018). Although fatalities are rare, terrorist attacks can also cause significant physical injuries which, in spite of persistent threats for chemical, radiological and biological attacks, largely result from direct trauma. Bombs and explosions cause unique patterns of life-threatening and life-limiting injuries that are rarely seen outside of military combat. In large-scale attacks, many people may also suffer minor injuries. For example, 85% of the 900 patients treated by the two nearby New York hospitals in the days following 9/11 (see Appendix Table 1) were recorded as 'walking wounded', with injuries such as ocular injuries, sprains or fractures and lacerations (Cushman et al., 2003). Evidence also points to injuries and other lifestyle changes following terrorist attacks (see section 3.3) as predictors of the development of chronic disease. For example, a longitudinal cohort study of 9/11 survivors found that a quarter of those who reported an injury also reported a chronic condition such as respiratory disease at 6-year follow up, compared with only 16% of those with no injury (Brackbill et al., 2014). Injuries may also be a prominent risk factor for the later development of mental health conditions (North et al., 1999; Pfefferbaum et al., 2001; section 3.2). Further evidence is beginning to emerge of the detrimental impact of in utero exposure to terrorism during the first trimester on birth outcomes such as birth weight and foetal deaths (Quintana-Domeque, 2017).

3.2 Mental health and well-being

Exposure to traumatic life events can provoke acute (short-term) and chronic (ongoing) stress responses with profound impacts on the body and brain. Over 10% of the general population in Madrid, Spain, were reported to experience symptoms of a panic attack following the Madrid bombings in 2004 (Appendix Table 1), with the incidence of panic symptomology increasing to 16% among those in the immediate vicinity at the time of the attacks (Miguel-Tobal et al., 2005). In the two weeks following the transport attacks in London in 2005 (see Appendix Table 1), 31% of 1010 respondents in a representative telephone survey of London residents reported substantial levels of stress (Rubin, 2005). Research by Victim Support in England and Wales outlined the prevalence of severe consequences of terrorism for survivors and bereaved family members. These include: significant psychological harm (94% of respondents); difficulties falling or staying asleep (73%); outbursts of anger (55%); and experiencing flashbacks (36%). Families also reported facing financial difficulties, for example as a result of funeral expenses or through lost wages (Barker and Dinisman, 2016). Disasters caused by human intent are associated with a particularly high risk of psychopathology (DiMaggio et al., 2008), with a systematic review suggesting that over a third of direct victims of terrorist attacks worldwide develop Post Traumatic Stress Disorder (PTSD) in the following year (Paz Garcia-Vera et al., 2016). Women have been shown to experience greater levels of anxiety in response to terrorism (Birkeland et al., 2017) and increasing numbers of young children in the UK seek mental health support in the wake of attacks (The Guardian, 2017; NSPCC, 2016). Emergency services personnel may be particularly affected by the impacts of terrorism-related trauma (Box 1). A study including samples from 81 countries found that experiencing terrorism significantly reduced life satisfaction (Farzanegan et al., 2016). Novel research immediately following the Boston marathon bombing (see Appendix Table 1) equated the sharp reduction in local residents' well-being to the equivalent impact of a two point percentage rise in unemployment (Clark et al., 2017). However, these effects only persisted for one week, suggesting a high level of individual and/or community resilience. Such levels of resilience may depend, in part, on the support received from statutory and community services. A survey of UK victims of terrorism conducted in 2018 (N=271) found that as many as 17% of respondents felt that the overall level of support they

received was poor, with a further 18% describing the support as only adequate. Respondents were generally positive about both the immediate and longer term support received from the emergency services and the NHS. However, 76% highlighted mental health services as a particular area for improvement, with a notable absence of quality support for children (Survivors Against Terror, 2018).

Box 1. The impact of terrorism on the emergency services

Personnel providing immediate response to terrorist attacks can be exposed to scenes of devastation and destruction, with the potential for witnessing considerable loss of life. Emergency services may also become the targets of attacks, including the use of secondary explosive devices and delayed detonation following primary incidents. Reported prevalence of PTSD among emergency services staff following an attack varies greatly between studies (Thompson et al., 2014). A cohort study of 28,962 rescue workers who worked at the World Trade Center site (9/11 attack; Appendix Table 1) reported a 12% prevalence of trauma symptoms, with increased risk among those who: arrived earlier; were on the scene for longer; and were asked to undertake roles that were not within their usual professional remit (Perrin et al., 2007). A study investigating the impact of the London transport bombings (Appendix Table 1) on the ambulance service found that 15% of those involved in responding reported substantial stress (Misra et al., 2009). In spite of the commonality of these psychological impacts, evidence suggests that many emergency services personnel are reluctant to seek support following terrorist attacks, even when dedicated services are provided (Misra et al., 2009). As well as considerable impacts on morale and other organisational difficulties such as attendance, reports also suggest that emergency services personnel may change their lifestyles and behaviours as a result of the threat of future attacks, such as not consuming alcohol in their leisure time, motivated by the desire to be ready to respond to emergencies, even when not on call (Torjesen, 2017).

3.3   Fear and lifestyle changes

The pervasive threat of terrorism can create and spread fear and contribute to feelings of vulnerability. Research into public attitudes in both the UK and the US has found that people tend to overestimate the risk of future terrorist attacks and their personal likelihood of victimisation (Allouche and Lind, 2010). In response to these feelings of vulnerability, individuals may make changes to their daily lives in an attempt to control and reduce risk. Three quarters (77%) of respondents in a 2009 UK survey reported that the world has become a more frightening place and that people are generally more frightened and anxious than they were a decade ago (Mental Health Foundation, 2009). Many factors were suggested as contributing to overall increasing levels of fear, including information about threats, fear of terrorism, and reduced sense of solidarity and community (Figure 7). In a telephone survey conducted a year after 9/11 (see Appendix Table 1), a nationally representative sample of over 800 US adults reported a range of different behavioural changes. These included: coping mechanisms such as turning more to religion or prayer; limiting outside activities; increased caution of surroundings; changing modes of transport; and increased concerns over politics and world events (Torabi and Seo, 2004). However, not all changes were considered negative, with respondents also becoming more appreciative of life, family and friends, and feeling more patriotic. Women were more likely to report behaviour changes, whilst those aged over 64 years were less likely to describe doing anything differently in their daily lives. Vulnerable populations, such as individuals who have a mental illness or disability, those from ethnic minorities, or migrants and foreign nationals may experience a disproportionate burden of the psychological impact of terrorist threats (Eisenman et al., 2009). Evidence also highlights the importance of risk-related events, such as media coverage, in mediating the impact of terrorism on behaviour (Velias and Corr, 2017).

Figure 7. Factors contributing to increased fear in UK residents
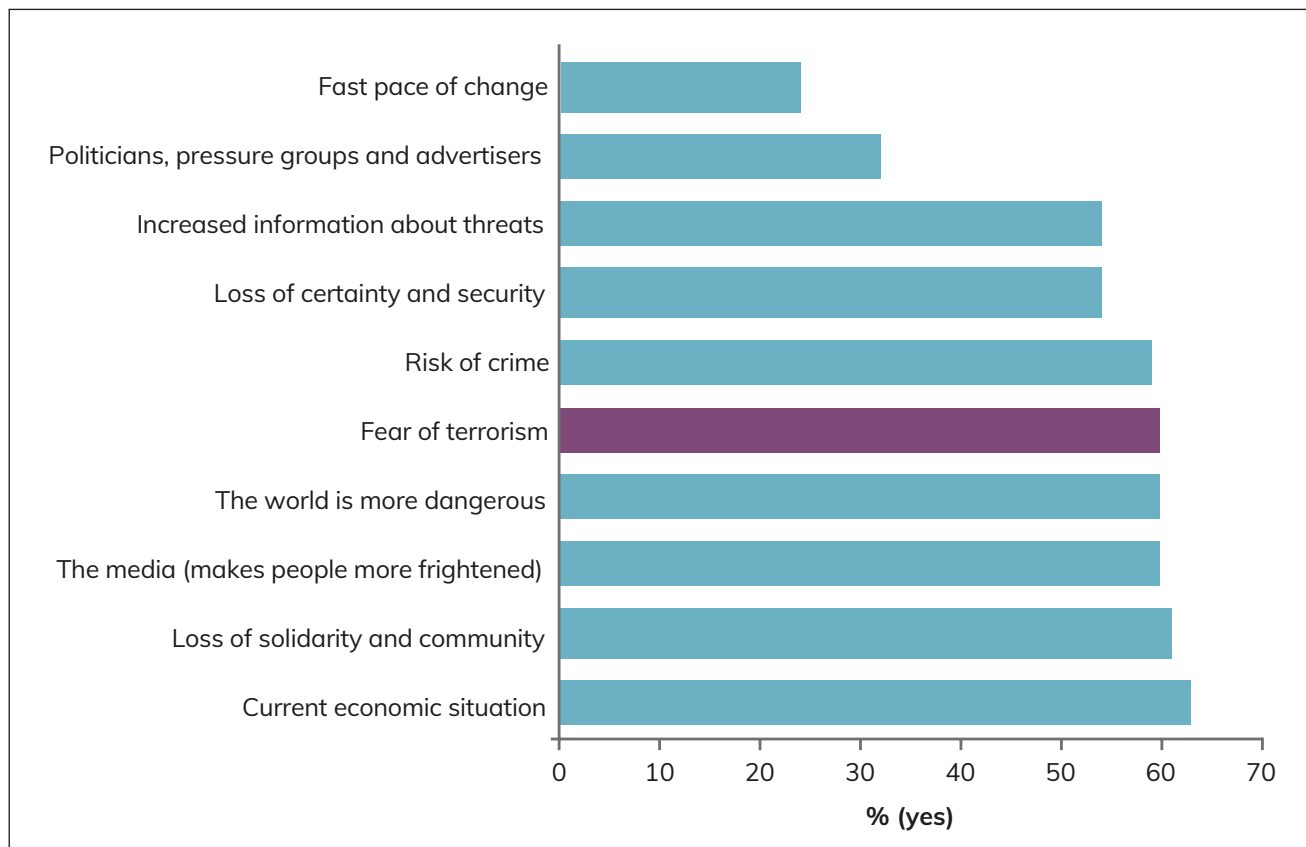
Source: Mental Health Foundation, 2009

Whilst low-probability, high-consequence events may be a cause of mortality, attempts to avoid perceived risks may also result in harms to health. For example, an increase in road travel in the US following the deaths of air passengers in 9/11 (i.e people avoiding the 'dread risk' of air travel) has been associated with a higher level of fatal road crashes (Gigerenzer, 2004). This highlights the importance of raising public awareness of possible psychological reactions to catastrophic events and the potential risks associated with behaviour changes that are intended to avoid these risks.

3.3.1 Substance use

People who experience terrorism may use substances as a means of self-medication and to assist coping with negative affect and trauma. In one US study exploring coping mechanisms in the two months immediately following 9/11, 38% of respondents reported that they had used alcohol, medications or other drugs to relax, sleep, or generally feel better because of their worries about terrorism (Stein et al., 2004). A meta-analysis of 31 population-based studies concluded that between 6 and 14% of people affected by terrorism are likely to experience increased alcohol consumption in the two years following an attack (DiMaggio et al., 2008). Underlining the role of substance use as a coping mechanism, a survey of emergency services personnel who responded to the terror attacks in Madrid in 2004 (see Appendix Table 1) found that, whilst respondents showed evidence of being able to control their emotional reactions, as many as 30% reported increased tobacco use following the events (Miguel-Tobal et al., 2005). Exposure to terrorism has also been associated with abandoning attempts to quit among smokers and re-uptake among ex-smokers (Forman-Hoffman et al., 2005; Pesko, 2013). In many cases, these negative behavioural choices, as well as other health-harming behaviours such as poor diet and lack of exercise, have been linked with having experienced terrorism-related injuries (Brackbill et al., 2014).

3.3.2 Travel and tourism

Many suggested behavioural changes following terrorist attacks relate to people's willingness to travel and their choice of both transport and destination. Travel and tourism is estimated to contribute 10.8% of GDP in the UK, generating a total revenue of over 200 billion pounds per year and directly supporting over 1.5 million jobs (figures for 2016; World Travel and Tourism Council, 2017). However, it is an industry that is particularly under threat from terrorism. Islamist terrorists are often found to target Western tourists as symbols of Western culture, especially those from countries whose governments offer military, political or economic support to governments of countries that these organisations are attempting to overthrow (Neumayer and Plumper, 2016). Targeting tourism attacks a potentially key source of revenue for that country and can result in sought after high-profile media coverage for any ideology. Busy tourist locations also offer a degree of anonymity in the planning and execution of attacks (Goeldner and Richie, 2009). As well as potential risk of future threats deterring people from travel, Foreign Office advice and changes in security measures or visa policies following an attack may also lead to a country being perceived as more restrictive. This also contributes to reductions in travel to that destination. Nevertheless, there is evidence to suggest that for previously attractive destinations, these changes in popularity are only short-lived (Coshall, 2003), particularly in high income and democratic countries (Liu and Pratt, 2017). For example, immediately following the attack on London Bridge in 2017 (Appendix Table 1), bookings on international flights to London were down 12% on the previous year. However, a return to normal levels of inbound travel was seen after just two weeks (ForwardKeys, 2017). In fact, overseas travel by UK residents in 2017 showed a 3% increase on the previous year, and the number of visitors to the UK over the same 12-month period reached a record high of 39.2 million (up 4% on the previous year; Office for National Statistics, 2017). As the threat of terrorism increases however, some traveller choices may change, with evidence of preferences for established chains rather than independent hotels, and more expensive rather than heavily discounted holiday packages (Walters et al., 2018). As many as 45% of Britons said that safety concerns such as terrorism and crime would influence when and where they would holiday abroad in 2019 (YouGov, 2019).

Unlike international tourism - an industry thought to have high levels of resilience - it is unclear whether domestic tourism in the UK has suffered as a result of terrorist attacks. Data from Visit Britain suggests that the number of people taking day trips in England declined in 2017 (Figure 8). Although 43% of these day trips represent people visiting large cities, only 9% of trips were to identified major tourist attractions (e.g. the London Eye or Madame Tussauds; Visit Britain, 2018). While this may suggest reluctance to visit potential target locations, direct links to terrorism are uncertain.

Figure 8. Domestic day trips in England; 2011-2017
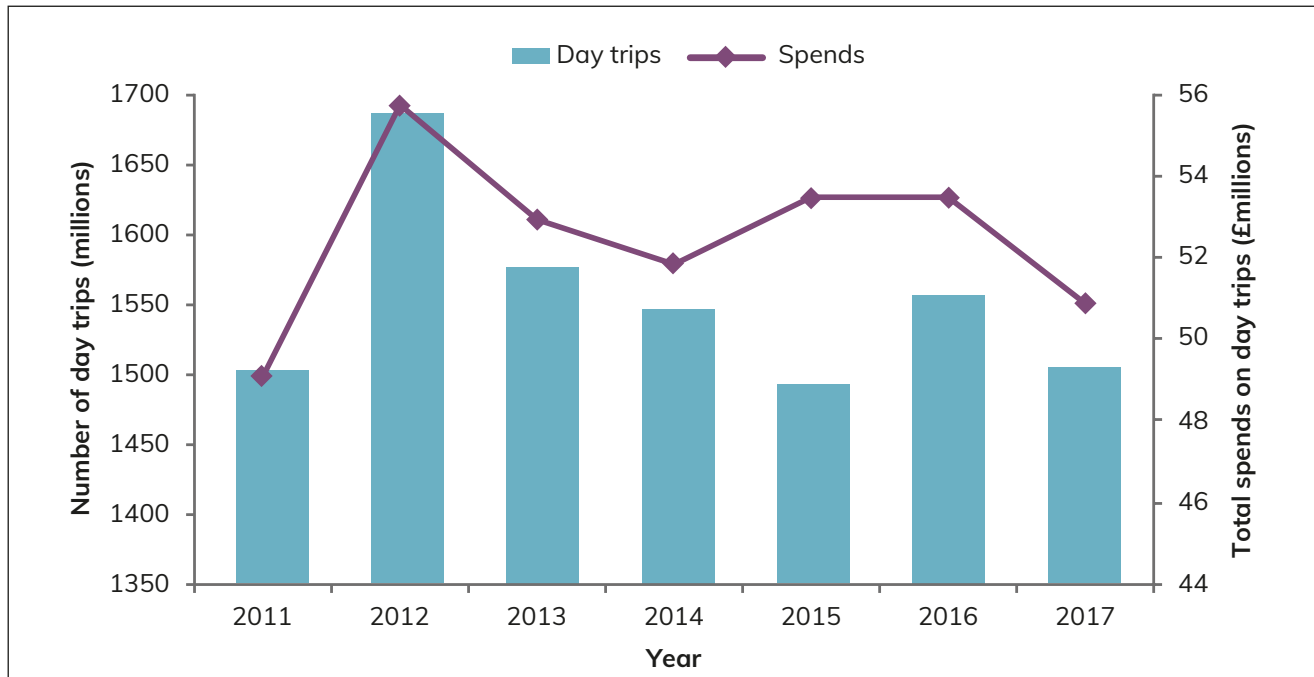
Source: Visit Britain, 2018

3.3.3 Political attitudes and participation

Terrorism can influence both political attitudes and voters' behaviour. In the US, the threat of terrorism has been linked to presidential approval (Davis and Silver, 2004), whilst greater fears of terrorism have been found to positively predict increased trust in government (Sinclair and LoCicero, 2010). Studies have also shown an increase in political activities following terror attacks. Those who experience increased fear become more motivated towards political information seeking, whilst those whose emotional reactions are characterised by anger are more likely to show increased participation in activities such as political rallies (Vasilopoulous, 2018). A cross-national analysis of 51 democracies revealed that, when controlling for economic, social and political variables, voter turnout was higher when a terrorist attack had occurred within the 365 days prior to the election (Robbins et al., 2013). Here, the occurrence of a lethal terrorist event was associated with a 2.9% increase in turnout. In June 2017, following terror attacks in Manchester and London, the UK general election saw its highest turnout in 25 years (68.7% of the electorate; The Telegraph, 2017a). Although there is no clear evidence about which factors contributed to this turnout, it is likely that the final few weeks of election campaigning were shaped by these attacks (Financial Times, 2017); shifting focuses away from other political priorities. Evidence from France following the attacks in 2015-16 (Appendix Table 1) showed a change in political attitudes among left-wing sympathisers, towards the right-wing, but only for issues directly related to security (Vasilopoulous et al., 2018).

3.4   Security and control

Changes in security and risk management strategies may often occur in the wake of a terrorist attack. Whilst many of these may be symbolic measures aimed at reassuring people, some can also have considerable impact on daily life. These include: the cancellation of certain events or festivities (e.g. outdoor Christmas markets); systematic bag searches, including in previously un-policed locations (e.g. throughout shopping centres in central Paris); stricter ID checks; and the use of additional security barriers. In the UK there have been well-publicised changes to security measures at high-profile events, such as the provision of concrete roadside barriers to Wimbledon

Tennis Tournament (BBC, 2017). Whilst these changes may incur considerable cost, and represent changes to stakeholder expectations, there is some evidence that they do not detract from patrons' enjoyment (Taylor and Toohey, 2005).

Some of the biggest security changes both in the UK and abroad since 2001 are in relation to aviation. Following 9/11, the Anti-Terrorism, Crime and Security Act (2001) increased the enforcement of aviation security requirements and granted police greater jurisdiction to act at airports and onboard aircraft. As a result of an independent report on airport security in May 2002, Multi-agency Threat and Risk Assessment (MATRA) processes were established at all UK airports, engaging all stakeholders in the risk management process for the first time. Also that year, the International Civil Aviation Organisation adopted new standards for tightening in-flight security, including the introduction of reinforced cockpit doors (Butcher, 2011). After thwarted aeroplane plots in 2006 (UK) and 2009 (US), the UK Department for Transport introduced full body scanners and automatic threat recognition software to airport security pathways. From March 2009, all passengers travelling in and out of the UK were required to provide advanced passenger information[10] prior to arrival at the airport. Research suggests that 70% of UK air travellers believe that standards are higher now than historically and 59% feel the right balance has been struck between screening and convenience to passengers. However, almost half of passengers (49%) are concerned by lack of consistency across airports or countries (Civil Aviation Authority, 2015). Qualitative findings also suggest that the presentation of additional security information may actually increase fear and anxiety among travellers (Civil Aviation Authority, 2015).

3.5   Community cohesion

Beyond the initial reactions of horror and concern for the suffering of those directly affected, major terrorist attacks and the subsequent local, national and global responses can shape the public's wider attitudes, values and prejudices. This may polarise existing ideologies (Greenberg and Jonas, 2003). Evidence finds that the continued threat of terrorism can increase public support for the restriction of civil liberties (Choma et al., 2014). Across many different contexts, increases in prejudice have also been reported. For example, a study comparing attitudes before and after the bombings in Madrid (Appendix Table 1) found that terrorist attacks provoked stronger prejudices not just against those who were perceived to be associated with the responsible group, but even against other unconnected minorities (e.g. Jewish citizens; Echebarria-Echabe and Fernández-Guede, 2006). Similarly, a study comparing attitudes of the British population before and after the attacks on the London transport system in 2005 (Appendix Table 1) found increased negative attitudes and reduced tolerance towards both Muslims and immigrants among previously more liberal participants (Van-der-Vyver et al., 2016). Even in countries that are not the target of attacks, there is evidence to suggest that major global terrorist events such as 9/11 may have contributed to breaking positive trends in attitudes towards immigrants (Sweden; Aslund and Rooth, 2005), with some minority groups subjected to increased levels of abuse following these attacks (Allen and Nielsen, 2002). Fear of terrorism was found to be associated with negative views of asylum seekers among Australian nationals (Pedersen et al., 2007). According to a YouGov poll in 2017 following the London Bridge attack (see Appendix Table 1), whilst 35% of respondents reported feelings of solidarity, 14% reported feelings of hate (YouGov, 2017b). However, in Norway, following the attack on government buildings in Oslo and the youth wing of the Labour party at summer camp in 2011 (Appendix Table 1), public attitudes became more positive towards out-groups, with people actively dissociating from the right-wing ideology (Solheim, 2018).

The majority of evidence exploring impacts on social cohesion actually focuses on the role of counter-terrorism (CT) policy or legislation in constructing 'suspect' communities and therefore the

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10   Full name; nationality; date of birth; passport number, expiry date and country of issue.

impacts on the everyday experiences and sense of belonging of members of these communities (Hickman et al., 2011). Here, it has been suggested that the anti-terrorism architecture has led to the eroding of basic rights and a 'weakening of citizenship' (Gillespie and O'Loughlin, 2009; Haque, 2002; Open Society Foundation, 2016). Further, CT strategies may contribute to hostility towards Muslims and create a climate of fear and suspicion (Choudhury et al., 2011). Insight work with Muslim communities following the terrorist attacks in London and Manchester in 2017 highlights the potential for communities such as British Muslims to feel a sense of divided pressures and loyalties. Community and religious leaders expressed feeling under considerable pressure to be seen to actively denounce every act of global terrorism, so as not to be considered complicit. They also indicated that young Muslims were becoming disengaged from local mosques through fears of being 'tainted' with certain views. Widespread concerns were held about Prevent (see sections 1.3 and 5.5.1) and the unequal treatment of certain groups by current laws. Further concerns included lack of meaningful engagement by national or local government, and lack of proportionality in the on-going actions of police and security services. Critically, respondents felt that an exclusive focus on preventing VE had resulted in the neglect of other important support needs for many communities, such as housing, health, education, employment and crime (Forward Thinking, 2017). In focus groups with diverse communities across the UK exploring public perceptions of citizenship, Black and Asian participants described how they felt that anti-terrorism measures had directly reduced their ability to participate in the public sphere, and increased feelings of isolation or disconnection from the state.

Discrimination and marginalisation on the basis of ethnicity or religion is not the only threat to community cohesion in this context. Tentative evidence suggests that reports of suspected mental illness among persons committing terrorist attacks may increase notions of the dangerousness and unpredictability of those suffering mental health problems; representing a negative attitude change and stigma regarding mental illness (Schomerus et al., 2017).

3.6   The economic impact of terrorism

According to the Global Terrorism Index, the global economic impact of terrorism in 2017 was an estimated US$52 billion (IEP, 2018). This includes direct costs such as death, injury, destruction of property, victim costs and government expenditure in the form of emergency services responses, medical care and the restoration of systems and infrastructure. Here certain indirect costs are also reflected, such as loss of productivity and earnings (Figure 9). Direct economic costs are typically short-term in nature. For example, additional airline security measures were temporarily introduced across the UK in August 2006 following a thwarted attempt to carry out a terrorist attack. British airlines incurred costs of approximately £50 million per day for the additional security measures, whilst passenger numbers fell and queuing times doubled (House of Commons Transport Committee, 2007).

Figure 9. Proportions of direct costs of terrorism to the global economy
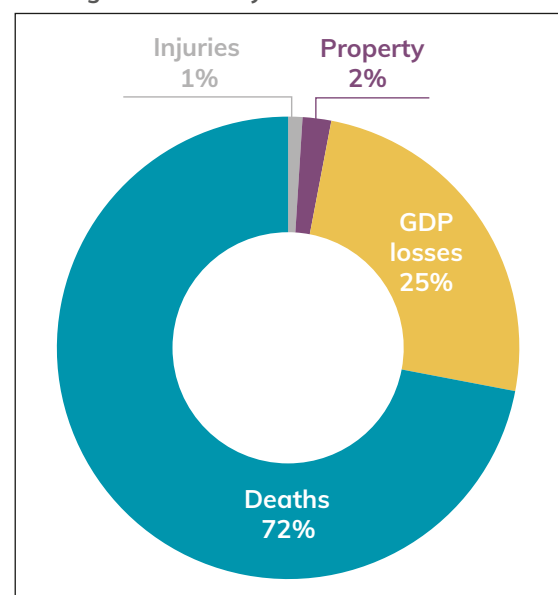
Source: IEP, 2018

However, these estimates fail to capture the true severity of the medium and longer-term economic impact; not accounting for the indirect costs to business and investments, or how terrorism

may undermine consumer and investor confidence and divert resources away from economic production to enhancing national security. Disruptions to business continuity may lead to reduced foreign investment, with knock-on effects for savings and growth. The use of increased security measures following terrorist attacks can also limit foreign trade by increasing transaction costs. Terrorism influences the stock markets in two ways: with increased costs of production or reduced demand limiting expected profits, and/or an increase in risk premiums due to more uncertain market prospects overall (Frey et al., 2004). Evidence suggests an increase in stock market volatility across Europe following incidents of domestic terror, particularly those involving bombings or explosions (Corbert et al., 2017). However, whilst financial markets may initially decline in the 'shock' response to terrorism, investors can see terrorist attacks as one-off incidents and therefore negative effects on trading patterns tend only to be temporary. For example, analyses of the effects of the London bomb attacks in 2005 (Appendix Table 1) on the London Stock Exchange suggested that the stock market can be very quick to rebound following terror and may do so within a single trading day. Nevertheless, certain markets – such as real estate and life insurance – take longer (>20 days) to return to pre-event levels (Kollias et al., 2011).

4. Risk and protective factors for violent extremism

4.1 The challenge of understanding risk

Evidence of potential risk factors for carrying out acts of terrorism and extremist violence continues to grow; based largely on case histories of known perpetrators. However, understanding of the process of radicalisation, or indeed how else individuals may develop extremist ideals, remains starkly incomplete. The breadth of different attitudinal or behavioural outcomes considered within the concept of radicalisation make it difficult to synthesise information on risk (LaFree and Ackerman, 2009). Typically therefore the focus is on the resultant act of violence, rather than the early process and thoughts before violent action or intent occurred (Scarcella et al., 2016). This state of understanding mirrors early approaches to other health challenges when the focus was the immediate condition (e.g. a heart attack) rather than the history of events and behaviours that led to that event.

For terrorism, key challenges arise in understanding very low probability events. Relatively few individuals become radicalised and the proportion of radicals who actually transition to violence is small (Brooks, 2011). It is also difficult to separate quality evidence from popular discourse, with a weighting of interest and evidence for certain ideologies or risk factors. Radicalisation to VE is a complex and often highly individualised process, involving many different interacting factors (Gill and Corner, 2017). Thus, violent extremists are a heterogeneous population who do not necessarily share a consistent demographic, social or psychological profile. However, individuals vulnerable to radicalisation or other pathways to VE may be more likely to possess certain traits or characteristics, or more likely to have lived with or be living with certain adverse experiences, when compared with the general population (Jensen et al., 2018). Current evidence focused on those already in contact with the criminal justice system does not adequately consider the risk and protective factors among the wider population which a public health approach would aim to address (see section 4.2). Thus, understanding a more objective set of factors related to vulnerability to VE and how those factors may interact, is imperative in identifying more appropriate early intervention and prevention strategies (see section 5).

4.2 Population-level risk, the prevention paradox and moving the extremism curve

Across the population, individuals' propensity for involvement in VE will vary by person and with time. Thus, some people will have a collection of experiences, views and conditions that place them at very high risk of VE. Others may have no such risk factors. Between these two extremes, typically there will be a substantial group of people with only some risk factors and/or less severe forms of these (i.e. at increasing risk). Part of developing an effective public health approach to VE requires understanding the distribution of risks for VE across the whole population.

When considering risk in a whole population, often the number of individuals at high risk is far outweighed by those at increasing risk but not necessarily reaching a high risk category. When the majority of overall risk is represented by individuals outside of the high risk category it is termed a **prevention paradox**. Thus, whilst the individual risk of a violent act is lower in those at increasing (vs. high) risk, as a group, those at increasing risk may represent a substantial or even greater overall threat than those at high risk. A hypothetical example is given in Box 2. When risk for VE is distributed across wider populations (albeit with a strong focus in a small number of individuals) this can have repercussions in developing CVE measures. These are considered below.

Addressing only individuals at highest risk may miss the majority of population risk – There have been many reports of VE where perpetrators were known to authorities but were not thought to be of high risk (The Telegraph, 2017b). With proportionally less information on how many people are in this broader risk category (Box 2; Figure 10) it may not be possible to predict whether the threat from this population is increasing or diminishing. However, it is critical to understanding the overall risk of extremist events. The emergence of lone actor terrorists may also be related more to the increasing risk group as more dispersed individuals (i.e. in a population with a lower proportion of people prepared to act violently) may be less likely to be linked to other violent extremists.

Individuals can be nudged from the increasing risk group to the high risk group – People in the increasing risk group represent a pool of individuals at increased likelihood of moving into the high risk group. State activities that target those at high risk but are not supported by those at increasing risk (e.g. restriction of liberties, perceived prejudice; see section 5.4) may create or enhance grievances and perceived injustices that move the extremism curve towards higher risk (Box 2; Figure 11b). Insight into the impact of actions to address those at high risk on those at increasing risk is poorly developed. Concerns are also expressed that returning foreign fighters (see section 2.5) may leverage support for VE from increasing risk groups. Friendships and group pressure can contribute to the re-engagement of former violent extremists currently at increasing risk status (Sim and Ismail, 2016).

Identifying most individuals at high risk may be prohibitively expensive and working on a broader footprint may be a more effective strategy – Identifying who is high risk can be resource intensive. Those at high or even increasing risk may be particularly motivated to conceal indicators of their ideology, being aware that their beliefs or motivators may be stigmatising. Therefore, interventions that address wider populations may be able to direct more resource at actual preventative intervention (i.e. rather than just at identifying participants) and potentially achieve more than targeted interventions alone. Universal population interventions (see section 5.1) aim to move the average risk (e.g. of VE) and may even move some people from high risk into increasing risk (see Figure 11a).

Individuals in high risk groups rely on those in the increasing risk group for support – Moving societal norms or population means (i.e. impacting groups other than those at highest risk; Figure 11) can reduce community support for extremists. This may reduce the community assets violent extremists can rely on to operate violently and increase the chances that those who may be aware of their activities will cooperate with the authorities.

Extremist views are often relative to societal norms and may change as the overall opinion of communities change – As 'typical' views held by the wider population become less tolerant of violence this may also reduce tolerance of violence even in the more extreme individuals as their views may otherwise appear increasingly isolated from their peers.

The pool for recruitment into high risk groups is likely to rely on those at increasing risk – Individuals in the increasing risk group (Figure 10) provide a large pool of individuals potentially at risk of radicalisation or who may already be on a journey to the high risk category. Even when interventions to address societal norms are ineffective at influencing those already at high risk they may reduce the number in the increasing risk category or the number in this category susceptible to further radicalisation. Consequently, they may reduce the flow of new individuals into the high risk group.

Population approaches do not typically provide immediate protection to the public – Mechanisms that address societal norms can result in small changes in larger numbers of individuals. This may take time, may not affect individuals with already strongly established views and so may be insufficient to move an individual who is already at high risk of committing a violent act into a less threatening category. Actions to address population norms are therefore a complementary set of activities that work alongside actions to control and dissipate immediate threats.

Individuals at the high level of risk still require additional attention – There is inevitably a need to focus considerable resource on those at high risk. The approach of maintaining a broader population approach but focusing more resource on those at higher risk is referred to as proportional universalism. In the case of preventing VE it requires having an effectiveness informed approach to how much resource is targeted at those at high risk and how quickly levels of resource reduce with reducing risk.

Interventions that move the whole population are more likely to be stable and require less future resource to maintain – Changes can be considered stable if they are supported by enough of the overall population and attract longer-term democratic support. In this case public support bolsters the intervention's long-term objectives and the need for enforcement and additional investment may decline with time. However, when interventions result in population antagonism they may be considered unstable and require persistent enforcement and resource.

The prevention paradox has typically been used to describe the prevention of health problems such as heart disease. However, it has already also been applied in interpersonal (Cerdá et al., 2014) and self-directed violence prevention (Christoffersen, 2018). In these contexts, broader population strategies have been criticised for not adequately addressing the structural, economic and political factors that lead to different distribution of risk between different social groups. Thus, in many cases populations are not a single continuum where individuals move from one level of risk to another, but can be made up of many different sub-populations that experience and respond to risk and intervention differently. The issue of how different sub-populations are affected by CVE measures is particularly relevant to societal approaches (Box 2; Figure 12). Thus, actions that might reduce overall levels of risk in one population (e.g. targeted support for immigrant populations) may increase risk in others (e.g. far right groups).

Box 2. Moving the extremism curve

Where the majority of risk is found for VE will vary depending on the form of extremism and types of risks to which populations are exposed. Currently, there are inadequate data to properly describe a population level risk model of different violent extremist risk, but a hypothetical example is given below.

Risk level	Number in group	Risk of violent event per person	Total events predicted
High risk	1,000	1 in 100	10
Increasing risk	100,000	1 in 1000	100

The distribution of risk can also be considered as one of a number of different curves (Figure 10). The shapes of any curves for extremism risk in the UK or in any sub-populations or communities within it are poorly understood. However, to demonstrate the potential impacts of moving whole populations towards lower (here away from extremism – Figure 11a) or higher risk (towards extremism– Figure 11b) a normal distribution is used for illustrative purposes.

Key (Figs. 10 - 12)

Risk of violent extremism

No to low risk

Increasing risk

High risk

Figure 10. A hypothetical curve for risk of extremism

SOCIAL NORM

INCREASING RISK
Here, individual risk is lower (than very high group) but numbers of people in category is much greater

HIGH RISK
Individual risk is high but number of people in category is relatively low

Relative numbers In population

Risk of violent extremism
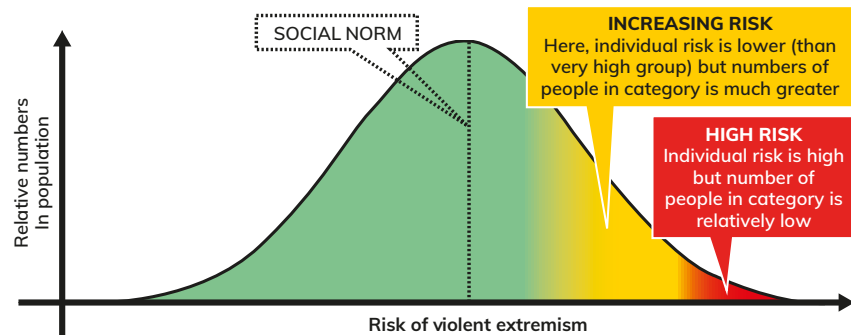
Figure 11. Moving the curve:
a) towards lower risk

NEW SOCIAL NORM

More individuals at no or low risk

Fewer individuals with increasing risk views who could be pushed into violence

Fewer individuals with the most extreme views

Less support for extremists in the wider population

Relative numbers In population

Risk of violent extremism

or b) towards higher risk

NEW SOCIAL NORM

Fewer individuals at no or low risk

More individuals with increasing risk views who could be pushed into violence

Escalating numbers with the most extreme views

Relative numbers In population

Risk of violent extremism

Figure 12. Moving the curve(s) for populations with divergent views

Activities to move individuals to the left in for instance an Islamic context (black curves) may include increased religious freedoms, tolerances and support for cultural practices and representation

If interventions are regarded as unacceptable to other larger populations (blue curves), even small movements in these (to the right) may increase numbers at risk of violent extremism and potentially increase intolerance of the smaller population

Relative numbers In population

Risk of violent extremism

33

There is currently a paucity of empirical information on population risk in the fields of VE and CT and the following need to be better understood to appropriately determine the applicability of the prevention paradox model to CVE:

- The distribution of risk in different community groups;

- The relationships between risk and violent activity;

- The impact of any activities that target high risk individuals on the views of those at lower risk;

- What interventions are effective at moving whole populations or sub-populations towards lower (Figure 11a) or higher risk (Figure 11b).

In the following sections we consider both individual risk related to VE and some of the broader aspects of risk that may impact populations at lower levels of risk but still contribute to the threat of VE.

4.3   Four key components of risk

The risk factors for VE vary depending on the ideology, but also on the context in which that ideology exists (Kis-Katos et al., 2014). A range of enabling factors within the social, political or economic landscape can increase the probability of violence and domestic or international terror by threatening stability and increasing fragility. Factors such as poverty, deprivation, inequalities and corruption or weak rule of law are all in some way associated with levels of radicalisation, extremism and terrorism worldwide. Whilst these issues have been summarised elsewhere (Bellis et al., 2017a), this report is concerned with levels of threat and the application of different approaches in the UK context. Therefore, the focus here is not on global determinants or factors such as macro-political decisions of support for armed conflict abroad, but on factors affecting the individual, or characteristics of their relationships within homes and communities in the UK which may make them more vulnerable (or resilient) to radicalisation and VE. Whilst certain demographic factors appear more common among active violent extremists, such as male gender and younger age, these factors are so broad they lack any real predictive power (Sarma, 2017). Therefore they are not discussed in any detail here. Consideration of other personal factors associated with VE is relatively scarce and such factors are sometimes explored in relation to cognitive radicalisation (i.e. the adoption and internalisation of violent and extremist beliefs) but rarely behavioural radicalisation (i.e. engagement in violent action; Vergani et al., 2018). This absence from academic literature may, in part, reflect difficulties in accessing reliable biographical data.

The following sections address the four key components of risk shown in Figure 13 that appear common across different conceptual models of drivers for/pathways to VE (including radicalisation; Campelo et al., 2018; Jensen et al., 2018; McCauley and Moskalenko, 2008; Rosseau et al., 2017; Vergani et al., 2018).

Figure 13. Risk factors for VE
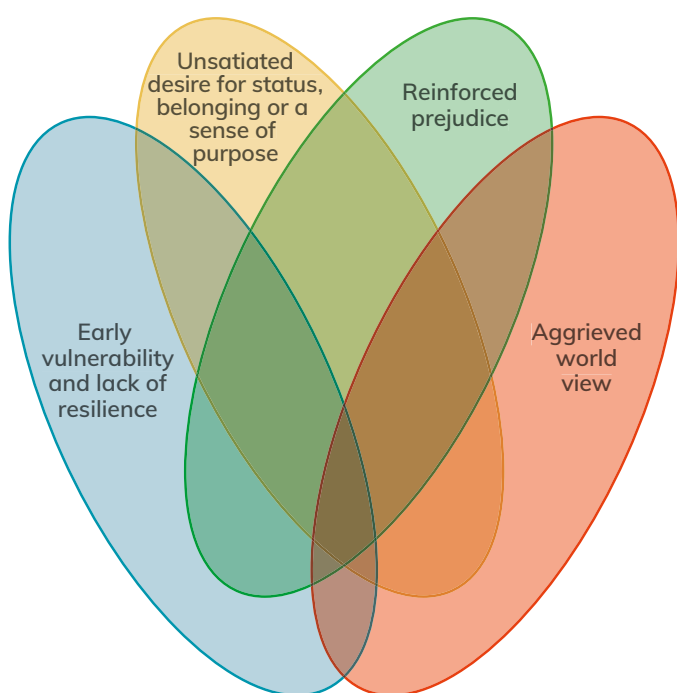
4.3.1 Early vulnerability and lack of resilience

Many studies support the relevance of adverse experiences such as abuse or social rejection as key turning points in an individual's vulnerability to radical influences (Webber et al., 2017). Psychological crises are thought to result in 'cognitive openings' that lead people to search for new ways of interpreting and interacting with the world around them (Horgan, 2005). This post-traumatic growth can result in changes in beliefs, goals, behaviours and identity in order to ascribe meaning to the trauma and reduce emotional distress. For some, resilience supporting factors such as having caring and supportive relationships, positive role models, high emotional intelligence and problem solving skills may help them to overcome adversity (Windle, 2011; Box 3). However, for those who do not possess these resilience factors, it is during these 'cognitive openings' that deviant or radical ideologies may be adopted (Wiktorowicz, 2005).

Box 3. Defining and understanding resilience

Resilience has been described as the ability to overcome serious hardship and harness resources to sustain well-being (National Scientific Council on the Developing Child, 2015; Panter-Brick and Leckman, 2013). Whilst stressors are an inevitable part of daily life, with resilience comes the ability to convert toxic stress into tolerable stress, avoiding the negative physical and psychological sequelae of trauma and adversity. Resilience is likely to be on a continuum and may be present to differing degrees at different stages of the life course, across different domains of life (e.g. work, school, home) or in response to different types of adversities (Pietrzak and Southwick, 2011). Determinants of resilience include a host of biological, psychological, social and cultural factors. However, research has identified factors that help children to achieve positive outcomes in the face of adversity. These include: having supportive adult-child relationships; building a sense of self-efficacy and perceived control; having developed self-regulatory capacities; and being able to mobilise sources of faith, hope and cultural traditions (National Scientific Council on the Developing Child, 2015). Critical periods of development during early childhood when the brain and other biological systems are most adaptable presents an ideal opportunity to lay foundations for a range of resilient behaviours. However, the development of resilience can be supported at any age (Korotana et al., 2016). How resilience is understood across different cultures is key in constructing culturally relevant approaches to building resilience and the importance of context cannot be overlooked (Bellis et al., 2017a). For example, whilst agency and perceived mastery are supported as resilience building factors in research with children in the US (Masten, 2014), research on youth involved in political violence in Middle Eastern conflict-prone areas indicates they became involved in such violence, at least in part, because their involvement gave them a sense of mastery and connection (Barber, 2009).

Childhood trauma

Experiences during childhood impact the structure of the developing brain and are a major influence for psychological and social processes and the balance of control between rational and emotional behaviour (Teicher et al., 2016). Children who are exposed to violence, abuse and other forms of chronic stress and trauma experience problems regulating emotions and managing social interactions, as well as adverse impacts on cognition, memory and learning (Pechtel and Pizzagalli, 2011). Adverse childhood

44% of adults in England and Wales were exposed to at least one ACE as children. 10% experienced ≥4 ACEs.

(Bellis et al., 2017b)

experiences (ACEs) are associated with a range of risk and health harming behaviours (Hughes et al., 2017) and evidence shows that individuals exposed to a high number of ACEs are significantly more likely to be involved in violence and/or crime as an adolescent (Duke et al., 2010) or adult (Bellis et al., 2015; Reavis et al., 2013) as well as suffer from poor physical and mental health (Hughes et al., 2017; Hughes et al., 2016). In data from 1,500 Profiles of Individual Radicalization in the United States (PIRUS), over a third of extremists (35%) were abused as children, with almost half (48%) experiencing some other form of early life trauma (Jasko et al., 2017). In a series of life history interviews with US white supremacist (far-right) violent extremists (N=44), prevalence of childhood adversity far exceeded rates found in the general population. For example, over 80% of the 44 extremists interviewed reported experiencing one or more forms of child abuse and neglect, being abandoned by parents or parental incarceration, or witnessing serious violence in their home or neighbourhood (Simi et al., 2016). Over half (59%) of interviewees reported being raised in a household in which there was substance abuse, and three quarters (73%) described family disruption such as divorce or parental death (Simi et al., 2016). Further, large cohorts of children from many parts of the world have grown up never knowing peace and stability. There remains very little empirical evidence of the impact of armed conflict on child development, but war-affected children may experience trauma and distress not only as a result of exposure to serious attacks, but also subsequent challenges that arise in their social environments (Wessells, 2016). This may be especially true for families who are displaced by conflict and experience threats to their basic needs, as well as social upheaval and reduced cultural connections. Evidence also highlights the potential for the transmission of parental trauma – for example the presence of anxiety or fear derived from experiences recalled and stories told by parents and associated imagery and empathy - among refugee children who do not have their own lived traumatic experiences (Dalgaard et al., 2016). In Northern Ireland, empirical work is underway to explore the potential inclusion of exposure to The Troubles (see Glossary) as an additional ACE (Devaney and McConville, 2016). This may provide a valuable opportunity to explore the impact of early experiences of terrorism on later health and well-being outcomes, including the adoption of non-violent or violent extremist ideals.

> **1 in 2 adults in England and Wales reported that they did not have the support of an always available trusted adult when growing up.**
> (Bellis et al., 2017b)

Social isolation

In early development, the quality and stability of the child's relationships with caregivers influences intellectual, social, emotional, physical, behavioural and moral development (National Scientific Council on the Developing Child, 2004). How children learn to form and maintain relationships can have far reaching consequences across the life course, reflected through adolescence and into adulthood as individuals strive to understand their place in the wider social world. Close relationships with non-deviant peers can help young people to develop conflict resolution skills (Rageliene, 2016) and strong social networks provide a source of practical and emotional support to navigate the challenges of daily life. Thus, social capital is an established determinant of positive population health (Alcalá et al., 2017). Conversely, social exclusion or isolation has been shown to have an adverse impact on the neurological development of individuals, especially in the brain centres that regulate emotion and self-control (Hayes, 2017). These are established risk factors for many forms of interpersonal violence and are commonly linked to intolerance (Bellis et al., 2017a). Feelings of marginalisation

> **1 in 5 children aged 7-12 years say they are lonely sometimes or often. 4 out of 5 adolescents report loneliness and a third describe these feelings as persistent and painful.**
> (Action for Children, 2017)

are associated with a decrease in sense of self worth and an increased risk of radicalisation (Lyons-Padilla et al., 2015). Equally, a study in the UK found that a greater number of social contacts was predictive of greater condemnation for acts of terrorism (Bhui et al., 2014a).

Adolescence is considered a crucial time for personal and social identity development. As well as experiencing considerable physical and emotional change, adolescents must negotiate social changes as they commonly move away from parental and familial influences, towards a greater involvement with peers (Steinberg, 2005). During this time, positive relationships offer a source of resilience, whilst negative or even exploitative relationships (especially in the absence of positive ones) may direct vulnerable individuals towards deviant behaviour or adverse outcomes. Much of popular adolescent culture in the UK includes a focus on alcohol and sexualised interactions (Sudhinaraset et al., 2016). As young people in some cultures are required to avoid these behaviours, some groups are inherently more isolated during adolescence. Weak family bonds and social exclusion also contribute to unaccountable time periods and unobserved spaces for young people (i.e. when caregivers cannot supervise or monitor offline or online activity and relationships). In a population sample of Norwegian adolescents, support for politically motivated violence was associated with low school achievement, conduct problems and increased exposure to violence in youth (Pedersen et al., 2018). This study highlighted the importance of the 'outsider position' (i.e. not identifying with any prevailing social group) in the deviant behaviour and political attitudes of vulnerable young people. Shared experiences of social isolation can foster strong alliances among minority or marginalised groups (also known as 'out-groups'; Densley, 2013; see section 4.3.2).

> **Nearly half of 11-16 year olds find it easier to be themselves online** and 3 in 5 said they would be lonely if they couldn't talk via technology.
> (Action for Children, 2017)

Identity crises and acculturative stress

> **Over a third of ethnic minorities identify more with a religion than with Britain.**
> (Integration Hub, 2018a)

For some young people there is the added challenge of managing complex multiple identities, if they identify with more than one different cultural, racial or religious group. For example, in the UK, some second and third generation Muslims have to manage a Western identity while simultaneously inheriting an ethnic and/or religious identity from their family; with a high reported prevalence of lack of self-certainty among such youth (Meeus, 2015). Different identities may require or encourage norms, values or rules for behaviour that are in direct conflict with one another (Robinson et al., 2017). This can leave youth at risk of occupying an 'ideological vacuum' in which they have to make life choices with little or no guidance from adult role models. Religious leaders, parents, teachers or other adults may not be attuned to the difficulties that adolescents can experience in reconciling mainstream culture (host-culture) and the ethnic or religious culture of their families and communities (non-host culture) – known as the process of acculturation. Establishing a balance between two cultures is continuously challenged by social and political factors. The attitudes of the host society towards the acceptance of different groups can play an important role in how acculturation takes place (Miwa,2009; see also section 4.3.3); for example, whether the host country has an open and inclusive approach to diversity, or the dominant group looks to change the views of other groups (Robinson et al., 2017). In a review of the biographical details of British Jihadists, the overwhelming majority had at least one parent with non-British ancestry (Lyall, 2017).

> **Younger cohorts of immigrants report feeling less strongly part of British society. For example, 21% of Indian immigrants aged 16-24 felt they strongly belonged, compared with 37% of those aged 25-34 and 56% of those aged 35-49.**
> (Integration Hub, 2018a)

Mental health

Mental ill health may also represent a further mechanism by which individuals become stigmatised and isolated or excluded from conventional society; driving them to seek acceptance and inclusion from other sources or leaving them vulnerable to negative influences (Wang et al., 2017). Problems developing and maintaining identity, low self-esteem, discrimination, social isolation and an unmet need for connection are all relevant factors in determining risk for a wide range of different physical and mental health problems and implicated as risks for violent behaviour (including gang involvement; see Box 5) and radicalisation (Bhui et al., 2014a; Coid et al., 2016). However, the actual relationships between mental health, psychopathology, radicalisation and terrorism remain poorly understood (Dom et al., 2018). Even the presence of mental health issues among perpetrators does not demonstrate causality (engaging in violent and/or extremist activity may lead to psychological harm) or negate individual responsibility. Therefore mental health is unlikely to be the sole causal factor in such cases (Dom et al., 2018). Whilst involvement with organised terrorist groups does not show any consistent relationship with mental health (and these groups may actively avoid those considered volatile and unable to carry out assigned tasks [Bhui et al., 2016]), lone actor mass violence may be more strongly associated with psychopathology (Corner and Gill, 2015). A study comparing homicides committed by far-right extremists in the US found that 40% of loner extremists had a known history of mental illness, compared with only 8% of other (non-violent) far-rightists (Gruenewald et al., 2013). In a sample of 153 lone actor terrorists inspired by Islamic State, the prevalence of schizophrenia, delusional disorder and autism spectrum disorder was greater than among the general population (Corner et al., 2016). Evidence from the UK suggests an association between depression and increased terrorist sympathising (Bhui et al., 2014b). Thus, those with mental health issues may represent a group particularly vulnerable to ideological abuse. Whilst some consideration has been given to these issues (see Box 4), there is a need to explore these relationships further across the wide range of mental health issues, including understanding the role of factors that compound mental ill health, such as substance abuse (LaFree et al., 2018).

> It is estimated that around two thirds of people in the UK with common **mental health problems** do not receive treatment. 16-34 year olds and those from lower income households are more likely not to receive treatment, even if they ask for it.
>
> (Mental Health Foundation, 2016)

> **Asylum seekers** are up to 5 times more likely to have **mental health needs** than the general population; 61% will experience some form of mental distress.
>
> (Eaton et al., 2011)

Box 4. Supporting mental health in individuals referred to Prevent

In 2016, a pilot was established in England to embed mental health practitioners within CT policing. Mental health hubs were established to support early identification of referrals to Prevent that have mental health difficulties and provide assistance in accessing help via mainstream services. The pilot also sought to improve understanding amongst police and health professionals of the associations between mental health conditions and vulnerability to radicalisation.

4.3.2 Unsatiated desire for status, belonging or a sense of purpose

When individuals experience challenges achieving a cohesive personal and social identity they may experience greater motivation to identify with social groups that have clear and fixed ideals and behaviours. These groups can reduce unsettling personal uncertainty (Hogg, 2014). Without positive role models, individuals may become vulnerable to those who look to exploit this form of identity crisis, by offering a clear and consistent alternative. Evidence suggests that in cases of more extreme personal uncertainty, people identify with more extreme others or groups (Hogg et al., 2007). In fact, such processes are thought to contribute to a crime-terrorism nexus, in which terrorist organisations and other organised criminal groups may recruit from or appeal to the same pool of individuals (Basra et al., 2016; see Box 5).

A third of 25 year olds reported feeling like they do not have control over their future.
(Centre for Longitudinal Studies, 2017)

Association with an extremist group (either real or perceived), as with a violent gang, can appeal to certain psychological needs and vulnerabilities, such as a desire for status (Silke, 2008), purpose or excitement (Bhui et al., 2012; McCauley and Moskalenko, 2008). For example, propaganda from Jihadists is often aimed at youth and portrays a glamorous and thrilling lifestyle in which symbols of deviance are embraced (Picart, 2015). Connectivity with an ideology can fulfil a need for identity or provide a rhetoric to make sense of feelings of dissatisfaction, grievance or injustice (Webber and Kruglanski, 2018; see section 4.3.3). Potential rewards can also be social; providing a sense of belonging and group identification that may not be found in mainstream society, particularly for vulnerable or stigmatised individuals (Sageman, 2007). In some cases ideological commitment may support group affiliation (e.g. with deliberate outreach aiming to spread the message of a certain ideology and create opportunities for interaction with potential recruits; Wiktorowicz, 2005). For others, social or group affiliations may lead to exploration of and commitment to different ideologies. Established relationships can provide mutual validation for thought and action (Malthaner and Lindekilde, 2017). Collective ritual behaviours may be particularly important for enhancing group commitment and support of the in-group in social conflicts (Watson-Jones and Legare, 2016). Whilst evidence for the relationship between VE and religion is mixed (Beller and Kröger, 2018), one study found that it was not individual religiosity (e.g. prayer; study of religious texts) but the social aspects of religion (e.g. attending mosques) that was associated with support for suicide attackers (Ginges et al., 2009). The presence of radicalised others in friendship networks increases the likelihood of involvement in violence (Jasko et al., 2017) and pre-existing friendship or kinship ties are found in the majority of cases of Jihadist radicalisation (Sageman, 2004). The search for identity and belonging is also suggested as a key driver for foreign fighters, many of whom may leave and travel in groups (Frenett and Silverman, 2016). Groups can provide a source of power and protection, with greater means of exercising influence and the offer of direct financial rewards or incentives.

The notion that extremist activities offer an outlet for the expression of certain individual personality traits remains largely unexplored empirically. However, the contributing role of thrill- or sensation-seeking may help to explain why only a small proportion of people engage in extremist action. Sensation seeking is robustly correlated with delinquency in adolescence (Mann et al., 2015) and support for its role in radicalisation comes from the association between extremism and previous criminal involvement (Bakker, 2006). Emerging evidence also highlights the possible contributing role of narcissistic personality traits (Yusoufzai and Emmerling, 2017). In a study of Dutch Muslim youth, individuals from radical groups were more inclined to use violence when their ego was threatened (Doosje et al., 2013). Perceived in-group superiority was the best predictor of attitudes towards violence and was significantly related to violent intentions. Further research is needed to explore the role of personality in vulnerability to radicalisation.

Box 5. Exploring the relationship between crime, gangs and terrorism

Whilst there is no clear indication that terrorists and organised criminal groups have merged, or that terrorists organisations are actively recruiting from criminal gangs, the two may be connected by common risk factors and shared social networks (i.e. being born from the same pool of vulnerable individuals). People involved in gangs experience a high burden of mental illness, social exclusion, inequality and disadvantage (Hughes et al., 2015). Such factors push individuals out of mainstream society and towards oppositional groups, which offer a sense of identity from alternative sub-cultures (Ilan and Sandberg, 2019). Jihadist's narratives may be well aligned to the personal needs and desires of criminals, with those that have previously been involved in crime offering a skills transfer, including: access to or use of weapons; an understanding of policing activity; the ability to act covertly and operate or live 'under the radar'; and lower thresholds for or familiarity with violence (Basra et al., 2016). Alternatively, propaganda suggests that Jihadism may offer a 'redemption narrative' for those who have been engaged in anti-social or criminal activity (Ilan and Sandberg, 2019). A European study using open source data found that 68% of Islamist violent extremists were previously involved in petty crime, with 65% having histories of perpetrating violent crime (Basra et al., 2016). Whilst there is a relative dearth of research considering right-wing extremist violence, there is some evidence to suggest that these individuals may be particularly driven by thrill seeking and engage in extremist violence following a history of criminality and alcohol and/or drug abuse (Briggs and Goodwin, 2012), some of which may be the result of gang involvement. Further research is needed to consider how experiences, norms and networks derived from involvement in crime or gangs may contribute to mobilisation to VE. However, CVE may benefit from existing learning on collective behavior, marginalisation, trauma, recruitment to and disengagement from gang violence and approaches to effective prevention (O'Connor and Waddell, 2015).

4.3.3 Reinforced prejudice

With globalisation, urbanisation and the increased movement of people, societies have become more culturally, ethnically and religiously diverse. Intolerance to diversity can foster societal problems such as prejudice and intergroup conflict where those in the majority groups may abuse their power over minorities. Misrepresentation of different minority or marginalised groups in an increasingly global media (Goli and Rezaei, 2010) may contribute to individuals' feelings of inequality, discrimination or injustice. When deemed to be treated unfairly by others, humiliation and stigmatisation can result in a high level of anger and frustration (Pressman 2009; Schmid 2013). Experiences of prejudice and discrimination are therefore associated with a range of negative health and well-being outcomes (Sageman, 2008). Among them are: increased identification with those aspects of identity that are threatened (Maalouf, 2011); emotional vulnerability and moral outrage (Sageman, 2008); and increased likelihood of adopting more radical political positions (McCauley and Moskalenko, 2008; Rygdren and Ruth, 2013). Perceived threat to a group is identified as a push factor for radicalisation in the context of both right-wing extremism (where it is primarily in racial terms; i.e. white supremacism) and jihadist radicalisation (Vergani et al., 2018).

> In a 2017 national survey, 26% of Britons described themselves as either **a little or very racially prejudiced.**
> (Kelley et al., 2017)

Socioeconomic conditions do not present a direct pathway to extremism, but the sense of inequity that stems from them may contribute to powerful and defining feelings of alienation and increasing frustration (Depuyt, 2017). Individuals whose expectations for social mobility and economic welfare have been frustrated are at a greater risk of radicalisation (Bhatia and Ghanem, 2017) and countries where a highly educated population remains largely unemployed or underemployed can act as breeding grounds for extremist ideology. Across Europe there remain differences in unemployment levels when comparing native and foreign born citizens. In 2017, the unemployment rate for migrants born outside the European Union was 6.4 percentage points higher than the rate for the native-born population (Eurostat, 2018). Such differences may contribute to feelings of unfairness and are positively associated with the number of foreign fighters (Verwimp, 2016). There is evidence that this effect also persists if inequalities were experienced by previous generations. A study of adolescents in Zurich, which measured support for VE aged 17 years, found that in general perceiving the suffering of a group they related to did not have an overall effect on an individual's support for VE. However, among youth who already justified deviant beliefs and behaviours (i.e. moral neutralisation) or believed it is sometimes necessary to ignore rules and laws (i.e. legal cynicism), perceiving the suffering of others increased susceptibility to violent extremist attitudes (Nivette et al., 2017).

> **Reported respect for people of different ethnic minorities in a local area decreases as the level of deprivation increases.**
> (Integration Hub, 2018a)

> **Black Afro-Caribbean men are 50% less likely to be employed in managerial jobs in the UK when compared with the overall rate for men.**
> (Integration Hub, 2018b)

Gender inequalities continue to be relevant to the wider VE discussion. Globally, links have been made between national security/levels of VE and the prevalence of gender-based violence (Futures Without Violence, 2017). For example, figures from the US suggest that at least 12% of individuals committing or contributing to acts of extremist violence had a record of domestic abuse, sexual violence or harassment against women, with true levels likely much higher (due to domestic violence being recorded only as assault in sentencing records; START, 2018). Inequality of any kind is socially divisive and societies that are unequal suffer a range of poorer outcomes. Fear of 'the other' that may be applied on the basis of ethnicity or religion, for example, may also apply to gender. Although the relationship between gender inequality and VE has not been suitably explored in the UK context, terrorist and VE groups may manipulate the gender stereotypes that exist in society today (e.g. promoting violent notions of masculinity; male dominance and sexual access; or even claiming to empower women) to recruit both men and women into their networks.

> **In a 2015 poll, 36% of people felt that people from other countries who come to live in Britain should leave behind their own cultural traditions and try to live like British people.**
> (YouGov, 2015)

> **37% of UK respondents felt that the way that inequalities and poverty are addressed in the UK is "rather bad".**
> (European Commission, 2008)

4.3.4 An aggrieved world view

Theories of radicalisation describe how personal grievances in an individual's own life history, or empathetic responses to the perceived persecution of groups with which they identify, can fundamentally influence how they view the world and their beliefs about their need for and ability to drive change. Perceiving relative deprivation (i.e. being worse off than others) and denied access to economic, political and other opportunities can leave people feeling unable to explore legitimate avenues to address inequality (Nasir et al., 2011). Therefore they may see violence as the only viable means of action to improve their own or their group's status (Moghaddam, 2005). Extremist propaganda exploits these views and is commonly identified as a pull factor for radicalisation (Vergani et al., 2018). Propaganda typically aims to provide justification for violence by dehumanising potential victims and moral disengagement (i.e. suggesting that usual morals do not apply in this context). Thus, with a network of people who all subscribe to that narrative, violence becomes something that is morally acceptable (Kruglanski et al., 2018). Extreme beliefs, shared by a group, promote an intense emotional commitment that grows stronger over time (Rahman, 2018). In a series of interviews with left-wing, right-wing and religious extremist Belgian youth, general feelings of dissatisfaction were reported by all respondents; with growing perceptions of injustice and inequality in society and a view to want to change these prevailing societal norms (Schils and Verhage, 2017). Interestingly, among this sample, most respondents did not start their search for positive identity and feelings of belonging from a specific ideology. Instead the ideology was actually adopted during the search, with many individuals reportedly gathering information from many different diverging viewpoints in this initial 'exploratory' stage. Similar experiences of injustice were described across different ideologies.

In 2016, 48% of British voters held authoritarian populism views (i.e. cynicism over human rights, anti-immigration and favouring a stronger emphasis on defence as part of wider foreign policy).
(YouGov, 2016)

Studies have linked radical ideals to distrust of government, animosity towards the police and the military, and a hatred for foreign policy (Bartlett et al., 2010; UNDP, 2017); all of which may reinforce feelings of disconnection from local communities and threaten the identity of minority groups. Political dissatisfaction can be used as a justification for violence, with individuals and groups fulfilling a desire to find a tangible source to blame for perceived misfortune or suffering (Schmid, 2013). Some evidence suggests individuals follow a process of injustice collecting; actively seeking out information that supports a certain unfavourable world view (Van Brunt et al., 2017). In a poll of 430 Ottawa Muslims, political grievance (disapproval of Canadian foreign policy) was identified as a better predictor of attitudes toward Western powers than any personal experiences of discrimination (McCauley and Moskalenko, 2011). Evidence gathered by the United Nations in Africa suggests that some form of 'government action' was the tipping point for 71% of respondents that joined an extremist organisation (UNDP, 2017). The role of government and other statutory and public service agencies in the UK in fostering or exacerbating dissatisfaction highlights the risk of state actors or counter-terrorism approaches paradoxically becoming radicalisation accelerators (see section 4.2). Complementary to this, grievances towards UK foreign policy are

According to a Eurobarometer poll in 2018, 38% of UK respondents said they were not very or not at all satisfied with how democracy works in their country.
(European Commission, 2018a)

42% of UK Eurobarometer respondents in 2018 felt that that their voice doesn't count in the UK and 60% said they tend not to trust government.
(European Commission, 2018b and 2018c)

exploited and manipulated by recruiting extremists. Considering how individuals see themselves, their relationships or the broader societal or global context rather than how a practitioner might label them by the observed composition of the communities in which they live may account for some of the contradictions in risk factors evidence (Littler, 2017).

Whilst four components of risk are described above, in reality these may be closely interrelated. For example, poor attachment resulting from abuse in childhood may be a causal risk factor for personal conditions such as social isolation in later life, which in turn may boost the need for group belonging and appeal of certain radical groups. Box 6 provides an example of a case description provided by Prevent which highlights the role of personal trauma and mental health needs for one indivdual's vulnerability to radical influences. Having a greater number of risk factors (across all risk components) may increase overall risk of VE, although such ordinal relationships are largely untested. Although there is little academic evidence to explore the relationship between migration and VE, this may be a key area in which the above risk factors converge and is briefly examined in Box 7.

Box 6. Identifying complex needs in a Prevent Case Study

Jane travelled to south London from another city after her marriage broke down, and had a history of being emotionally and physically abused by her previous husbands. Following her move to London, Jane faced a period of homelessness and had become very lonely. After a while she got involved with an online network who discussed travelling to Syria. After expressing interest in marrying a "soldier" in Syria, Jane enjoyed the increased attention and made plans to meet the group in Turkey. However she failed to raise the necessary funds and eventually lost contact with the group. Jane was arrested, and extremist material was found on her computer such as "How to make jihad in the West". She stated that, as a convert, she knew very little about Islam and had downloaded extremist material by accident.

Jane was offered Prevent support through the Channel intervention programme and met a specialist mentor on a regular basis to discuss how to gain a better understanding of her religion and access a safer religious environment. The mentor also worked with Jane to help her access a religious divorce from her abusive husband, and became someone that Jane was able to discuss her troubled past with. The Channel programme facilitated a referral for Jane to a domestic violence support service which assessed her situation and provided advice on how to deal with her partner, while local police investigated enforcement options against him. Support from her mentor helped her rebuild her relationship with a past partner and child, and gave her the confidence to access training and get back into part-time work, giving her a more stable life than before. Upon exit from Channel, Jane's vulnerability had dropped substantially, she had re-engaged with support networks she had abandoned in the past, and was planning on returning to her previous home.

Source: Home Office

Box 7. Migration and terrorism

Migration and terrorism are both sensitive issues that generate significant public and media attention and remain at the forefront of UK government policy. Recently there have been unprecedented levels of mixed migration flows into Europe from Africa, the Middle East and Asia. Whilst there have been isolated incidents of VE in which migrants were involved in the planning or delivery, migrants, asylum seekers and refugees are much more likely to be the victims of terrorism, rather than perpetrators (Koser and Cunningham, 2017). Despite popular interest, there remain large research and data gaps, with existing debate often failing to distinguish between these three very different groups, as well as citizens and settled ethnic minorities (i.e. the descendants of migrants). The prior political organisation, flight experiences, degree of detachment from previous self and identity, and current challenges for integration are just some of the many ways in which the experiences of migrants, asylum seekers and refugees may differ; suggesting that they may be exposed to varying numbers of risk factors for VE (Eleftheriadou, 2018). Key differences in risk of VE may also exist for those who are newly arrived, versus those who may be experiencing longer-term failures of integration and social exclusion. Figure 14 outlines some of the ways in which VE and migration may be conceptualised as interconnected phenomena. The personal histories of those arriving in the UK, their lived experiences of conflict and deprivation and exposure to chronic stress prior to departure as well as their experiences during movement (e.g. including treatment by agencies and government bodies) will all shape the challenges they face in mental health, acculturation and belonging and integration (see section 4.3.2).

Figure 14. The possible relationships between migration and violent extremism
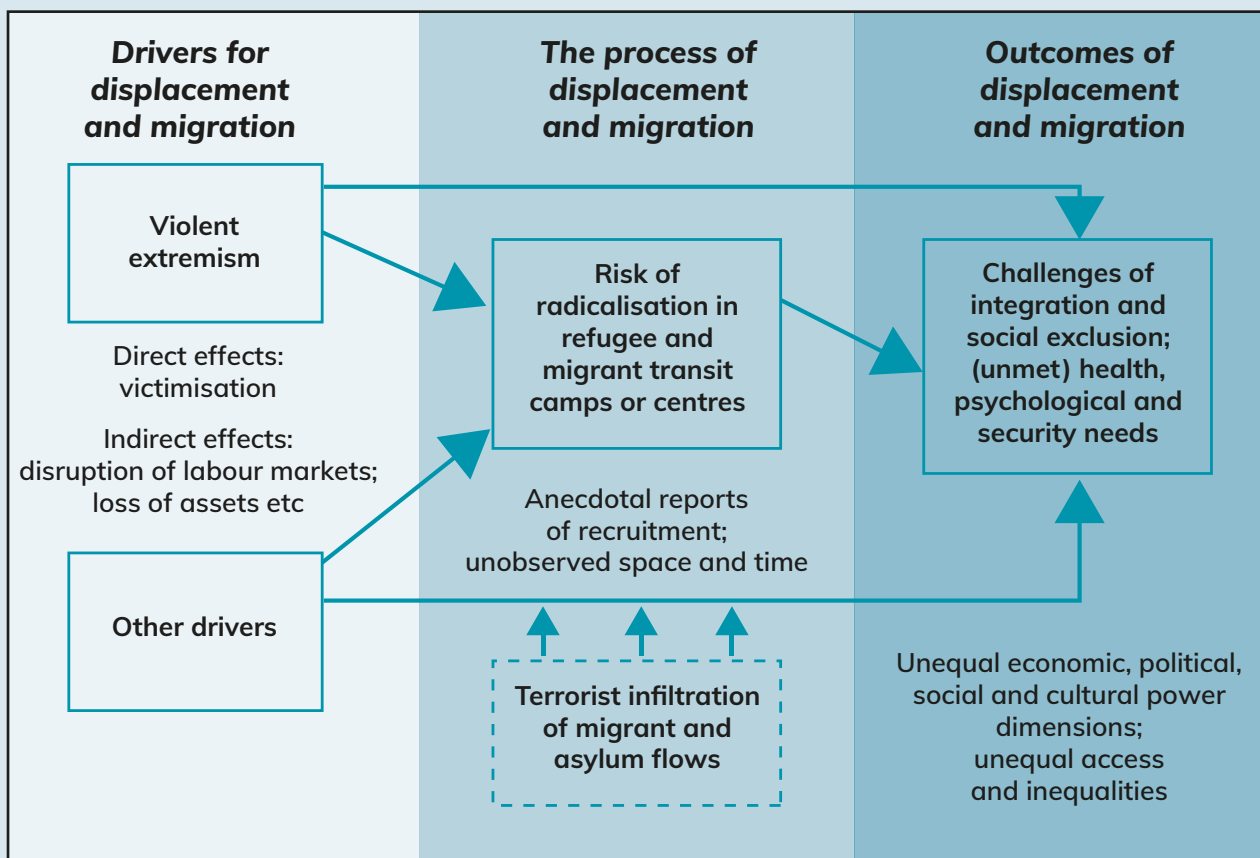
Source: Adapted from Koser and Cunningham, 2017.

5. Prevention

The previous sections have highlighted what is presently understood about both the current threat of extremist violence and terrorism in the UK (section 2), and the widespread and devastating impacts that this form of violence can have on individuals, communities and the core fabric of our society (section 3). The case for further enhancing our ability to prevent terrorist attacks from taking place in the UK could not be more persuasive. However, while our understanding of what drives a very small minority of individuals to carry out such attacks is developing (section 4), addressing the multi-faceted nature of radicalisation and subsequent relationships with VE presents huge challenges. When should we act and with whom? What are we trying to prevent: the development of ideas, or the threat or actualisation of violence? These questions arise within an emerging field of implementation which to date has been overwhelmingly rooted in a response to Islamist extremism (Wynia et al., 2017). Conventional CVE approaches are often criticised for being overly reactive and externally imposed, infringing civil liberties and targeting specific communities (Vermeulen, 2014). Concerns have also been expressed that initiatives work with supposed vulnerable individuals, yet commonly ignore the deep-rooted infrastructural factors that may drive or permit VE (Ernstofer, 2018). Further, much developing practice has not emerged from evidence-based disciplines and has not been evaluated. Implementation is rarely well described and therefore the effectiveness of different approaches or programmes remains undetermined.

Many of these criticisms stem from the prevention of VE to date having been considered largely a criminal justice issue; executed through legislation and surveillance by law enforcement agents. Although existing UK government strategy may be considered successful in preventing incidents by high-risk individuals linked to specific groups, it has been criticised for not adequately considering prevention at the earliest phases (Bhui et al., 2017). In this section, fields as diverse as social psychology and peace building[11] are considered within a public health framework in order to identity opportunities to broaden the reach of UK responses.

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11   Peace-building approaches have emerged over the last two decades in response to conflicts and focus on: (a) the reformation of structural sources of conflict (e.g. government institutions) and (b) community-based actions to improve relations between groups. These approaches are often complemented by development practices that satisfy basic survival and well-being needs. See Holmer, 2013 for more details on countering VE from this perspective.

5.1   A focus on public health principles

5.1.1 Universal primary prevention

In many instances, prevention begins with considering those who have characteristics that identify them as at risk of engaging in a particular behaviour (indicative prevention) or may already be showing signs of such behaviours (targeted prevention). To a large extent such approaches are the mainstay of much CVE and CT work. However, when the objective is to reduce the number of new individuals beginning to develop extremist views and related violent tendencies (i.e. primary prevention), more universal approaches should be considered (see Box 2). These are typically directed at broader populations and recognise underlying socioeconomic, cultural and legislative determinants of health and well-being (Faculty of Public Health, 2016). Within public health, this approach relies on a model of identifying risk and protective factors and acting early or 'upstream' to reduce risk and enhance protective factors in a population. This approach has been applied to interpersonal and self-directed violence prevention (Bellis et al., 2017a, Mikton et al., 2017) as well as to anti-social deviant behaviours including drug taking and crime (Bhui et al., 2012). For VE, this early action is often considered synonymous with preventing the process of radicalisation from occurring in the first place. However, it can be difficult to engage CT systems in primary prevention when dealing with imminent threats is considered the priority (Bhui et al., 2017). Nevertheless, a strong case can be made for driving universal approaches to preventing VE as:

It is difficult to identify those most at risk - Acts of VE occur at very low rates. Therefore even the most sensitive and specific tests available can generate high, potentially unmanageable numbers of false positive results with often prohibitive costs associated with the identification and intervention processes (Wynia et al., 2017). That is, it is difficult to target preventive interventions because violent extremists are not particularly identifiable by demographic or personal characteristics and are likely to conceal indicators of their ideology or networks (see section 4).

Targeted approaches may cause harm - Some potential risk factors for VE found in empirical literature (e.g. country of origin; religion) are so general that making them the focus of prevention programmes risks population-level harm. Thus, the process of considering a diverse group as all at risk can stigmatise and isolate individuals from wider society, growing a sense of grievance or injustice and potentially driving their involvement in extremism (Open Society Foundation, 2016; Box 2). The act of targeting a population group (e.g. a specific religion) with varied views must ensure that it does not generate extremists potentially at a faster rate than it detects them (see section 4.2; Figure 12).

Universal approaches can avoid a deficit-based approach to engagement - Approaches that focus on individual risk as something to be located and managed (i.e. a deficit approach) tend to focus on problems in communities and cultures rather than acknowledging or working with the strengths within individuals, families, and social groups. Increasingly, attention is devoted to asset-based rather than deficit-based approaches in public health and other disciplines (see Box 8). By recognising assets, communities may be empowered to safeguard and provide early support to individuals who may be vulnerable to VE as an alternative to existing pathways (e.g. Prevent referrals), which may otherwise encourage a negative view of civil society.

Universal and asset-focused approaches to prevention can be effective tools to support the long term eradication of VE and terrorism. However, such approaches can require earlier access to individuals in order to establish protective assets before risk related beliefs are engrained. Further, without international cooperation, they may also be limited by lack of access to wider populations not based in the UK (e.g. migrant and asylum seeking populations; Box 7). Equally, such approaches will typically be complemented by targeted intervention for those known to be at very high risk or already active where support and response is required.

> **Box 8. Asset based community development (ABCD)**
>
> Assets are collective resources that individuals or communities have at their disposal. Asset-based approaches recognise and build on human, social and physical capital that exists within local communities to protect people from harm and promote health (Glasgow Centre for Population Health [GCPH], 2012). Whilst often complemented by traditional models of care and methods of service improvement, ABCD is seen as a way of bringing people together to share their skills and lived experiences to achieve positive change by enhancing protective factors, tackling the social determinants of health and reducing health inequalities (Morgan et al., 2010). Individual (a.k.a. internal or developmental) assets include self-esteem, social competence, confidence and skills (Blickhem et al., 2018). However, ABCD also stresses the importance of collective, community, or social assets such as connectedness, social networks, and reciprocity (Blickhem et al., 2018). ABCD is a participatory approach and builds on the premise that positive health and social outcomes are dependent on communities having the opportunity and will to control their own futures. As approaches develop, it is important to achieve systematic ways of identifying and measuring assets. Possible methods of identification include asset mapping (akin to an inventory and highlighting the connectedness between community assets) and appreciative enquiry, which focuses on past successes (GCPH, 2012).

5.1.2 Intervention across the life course

Young people can be particularly vulnerable to radicalising influences because of greater risk of social isolation or marginalisation (see section 4). Therefore, much of the developing practice for preventing radicalisation to VE focuses on adolescents, delivered in the education or community setting. However, formative stages in children's development of empathy and trust rather than violent tendencies often precede adolescence. Here, earlier intervention is required, to prevent adversity and support those who may be exposed to it within the home (e.g. physical abuse) or the wider community (e.g. exposure to war or displacement; Bellis et al., 2017a; Drury and Williams, 2012; Yule, 2002). While there are a number of early evidence-based life interventions to prevent childhood adversity (Box 9), few have been applied to radicalisation.

Some support can be found for evidence-based approaches to building protective factors against violence through increasing resilience (Brownlee et al., 2013; Zimmerman et al., 2013) and emotional and social competence (Hahn et al., 2007). Such evidence has been predominantly conceived in high income countries and does not address issues facing children who grew up in low-resource, conflict, post-conflict and refugee settings before moving to the UK (Jordans et al., 2009; Kieling et al., 2011). However, children may experience enormous harm from conflict but may also have a potential role in peace building. Early child development programmes could help to create a shared vision for the future that focuses on children, as well as laying the foundation for positive behavioural traits such as learning to appreciate diversity and inclusivity (see section 5.3.2). Health systems in the UK are especially well placed to deliver support in early life stages and often have both the access and trust necessary to work with young children and families. However, while some health visitors and other family support services have been adopted as early violence prevention measures, their potential role in reducing VE and terrorism remains unexplored. The concept of trauma-informed care (TIC) builds on findings from ACEs and other childhood traumatisation research (see section 4.3.1). Whilst evidence in support of approaches to TIC continues to emerge (Bailey et al., 2018; Bryson et al., 2017; Purtle, 2018), generally health and other services are poorly prepared to deal with the effects of trauma (Szilagyi, 2016). Box 10 outlines the basic premise and principles of TIC.

Box 9. INSPIRE: Strategies for ending violence against children (World Health Organization, 2016)

INSPIRE is an evidence-based resource to prevent and respond to violence against children and adolescents. There are clear overlaps between the objectives of INSPIRE and early life factors related to VE (see section 4.3.1). However, little consideration has been given to the application of packages like INSPIRE in the CVE field. Principles of INSPIRE are:

- Create **safe, sustainable and nurturing family environments**, and provide specialised help and support for families at risk of violence
- Modify unsafe environments through **physical changes**
- Reduce risk factors in **public spaces** (e.g. schools, places where young people gather) to reduce the threat of violence
- Address **gender inequities** in relationships, the home, school, the workplace etc
- Change the **cultural attitudes and practices** that support the use of violence
- Ensure **legal frameworks** prohibit all forms of violence against children and limit youth access to harmful products, such as alcohol and firearms
- Provide access to **quality response services** for children affected by violence
- Eliminate the **cultural, social and economic inequalities** that contribute to violence, close the wealth gap and ensure equitable access to goods, services and opportunities
- Coordinate the actions of the **multiple sectors** that have roles to play in preventing and responding to violence against children.

Box 10. Introducing trauma-informed care (TIC)

Services and support that are trauma-informed aim to reduce the negative consequences of trauma by integrating values that promote safety and avoid re-traumatisation into policies, procedures and practices (SAMSHA, 2015; Woll, 2013). Central to providing TIC is ensuring that clinicians understand the relationship between an individual's trauma and their current symptoms and behaviours. Thus, independent of specific treatments for trauma, TIC views symptoms as normal reactions to abnormal experiences, therefore avoiding negative processes such as pathologising behaviour or labelling individuals who have suffered trauma (Evans and Coccoma, 2014). Alongside trauma awareness and acknowledgement, other core principles of TIC include: safety and trustworthiness; choice, control and collaboration; strengths-based and skills building care; and consideration of cultural, historic and gender issues. TIC should strengthen the relationship between the provider and the client and create a sense of welcome and respect (Elliott et al., 2005; Harris and Fallot, 2001).

5.2   An inclusive model for prevention

Increasingly there are calls for a focus in research, policy and practice to be given not to violent extremists, but to strengthening and empowering the communities from which they emerge (Schmid, 2013); and addressing fundamental issues such as the social fabric and values of society (Ernstofer, 2018). This has been described as an approach to 'transforming VE' (Austin and Giessman, 2018). Figure 15 summarises one proposed delineation of prevention approaches, ranging from CT measures as a tertiary and selective strategy, to community-wide peace building efforts that are primary and universal.

Figure 15. Defining different prevention approaches

| Transforming violent extremism | Preventing violent extremism | Countering violent extremism | Counter-terrorism Intelligence; surveillance; military operations; legislation |

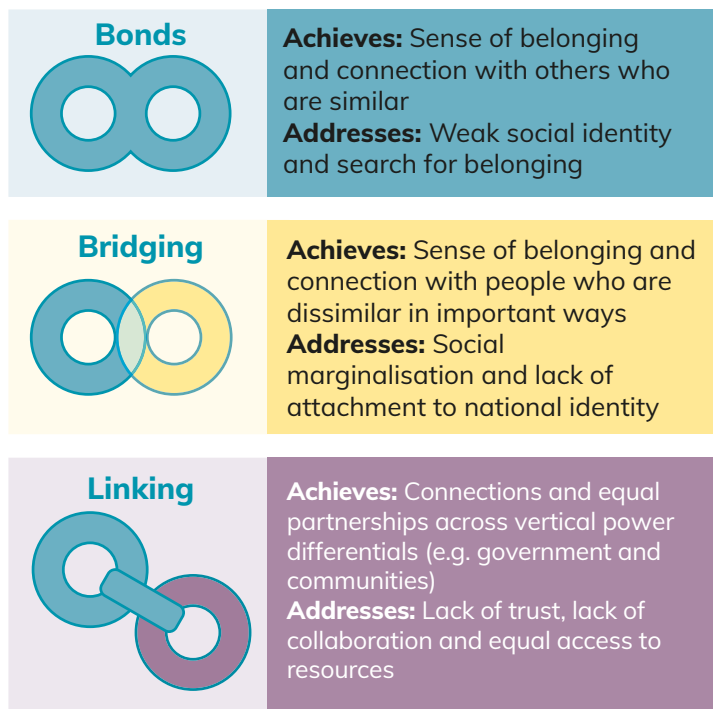| Promoting resilience (5.3.1), peace and pluralism (5.3.2) | Local communities; alternative narratives (5.3.4); mentorship | Responding to recruitment strategies; policing strategies; border security (see 5.4) |

Source: Adapted from Austin and Geissman (2018)

Such public health approaches to transforming VE aim to help people become (and remain) healthy and productive members of their communities, addressing underlying physical and psychological health, economic well-being and social connectedness. Asset-based approaches allow communities to recognise all the strengths and resources they have to improve security and health (Faculty of Public Health, 2016; see Box 8). In order to 'move the curve towards lower risk' (Figure 10) approaches must address the basic needs of a community including increasing equality, reducing the likelihood of grievances with the state and minimising the numbers of community members who are either vulnerable to extremist doctrines or prepared to support those attempting to follow them. Resilient communities collectively promote tolerance and diversity to withstand violent ideologies by providing a source of peaceful social norms and motivating community members to abide by these norms. The benefits of individuals who experience themselves as integral members of such communities not only apply to extremism but also to the development of better health, education and economic outcomes (Bellis et al., 2018; Ellis and Abdi, 2017; National Scientific Council on the Developing Child, 2015). Figure 16 summarises proposed different forms of social connection within resilient communities, and how these may mitigate the risk of VE.

Resilient communities require a level of community competence to collaborate effectively in achieving collective goals (Norris et al., 2008). Individuals within those communities must feel empowered to engage across different political and other hierarchical structures to allow those with less power to have a clear voice within the community (see section 5.3.3). Resilience requires a balance between a sense of connection to a wider national or international community and structures, along with strengthening personal and social identity (e.g. within an individual's ethnic or religious group; see section 5.3.1). Such a balance is only possible through the promotion of tolerance and acceptance of diversity (Ellis and Abdie, 2017; see section 5.3.2).

Despite efforts to improve population projections, there remains considerable uncertainty surrounding future population diversity (i.e. 'the global majority minority society'; Alba, 2018; US Census Bureau, 2017). Nevertheless, the direction of travel in the UK continues towards a more diverse future, with a greater mix of ethnic and cultural backgrounds (Rees et al., 2016). As neighbourhood residential integration is increasing in England and Wales, segregation has decreased within the majority of local authority districts for all ethnic minority groups. Dispersal from major cities to suburban and rural areas, particularly by families, is thought to be an important mechanism for this change (Catney 2013). Such demographic shifts may have profound implications for acculturation with ensuring equity of socioeconomic opportunity playing

Figure 16. The role of social connection in preventing VE

Bonds	**Achieves:** Sense of belonging and connection with others who are similar **Addresses:** Weak social identity and search for belonging
Bridging	**Achieves:** Sense of belonging and connection with people who are dissimilar in important ways **Addresses:** Social marginalisation and lack of attachment to national identity
Linking	**Achieves:** Connections and equal partnerships across vertical power differentials (e.g. government and communities) **Addresses:** Lack of trust, lack of collaboration and equal access to resources

Adapted from: Ellis and Abdi (2017)

an important part in developing community cohesion. Critically communities may not be defined by geography or physical proximity but instead represent the shared characteristics, attitudes or interests of individuals physically remote from one another. The growth of technology has fundamentally changed the concept of community, such that individuals are able to connect with people and ideas from anywhere in the world with relative ease. Whilst some communities may choose transparency, others may become increasingly unidentifiable. With technology and social media, the bounds of communities have also become much more transient, allowing engagement and disengagement, or involvement with multiple different communities with relative ease. With influences from modern phenomena of both social media and global migration, understanding of the rapid evolution in community membership is poor but essential to the development of effective interventions.

5.3 Reviewing the evidence for emerging approaches

The following sub-sections are intended to offer preliminary insight into a developing evidence base for transforming and preventing VE. They draw on process evaluations, feasibility studies and some initial empirical measurements of effectiveness. In many cases the different approaches are framed as resilience-based approaches. Here, interventions have been arranged according to key themes using differences in core objectives or intended outcomes (e.g. for improving knowledge or increasing social participation). However, there is cross-over between these themes, and some effective prevention programmes combine multiple elements. Where possible, the nature and possible content of each approach is described and example(s) of implementation are provided. While some programmes may be directly applicable to the UK, policymakers and practitioners should also consider whether the general approaches and lessons learned from more effective programmes can be applied through the large health, educational and other public services already established in the UK.

5.3.1 Building individual resilience

Resilience is described as a positive response to adversity that allows individuals to thrive, cope with stressors and overcome disadvantage (Masten, 2007; Box 3). It is generally considered a dynamic concept (i.e. altering with circumstances across the life course; Khanlou and Wray, 2014). Critically, therefore, it is amenable to targeted change and intervention (Fritz et al., 2018) when individual and social factors are addressed. Thus, resilience-building approaches focus on the strengthening of protective factors such as problem solving or decision-making skills, social and emotional learning (e.g. empathy), or mindfulness[12] (Joyce et al., 2018). Resilience programmes may explore the concepts of personal identity and belonging. There is tentative evidence that approaches that encourage individuals to maintain awareness of their personal identity (including beliefs and values) as well as express this identity in meaningful ways, are valid and acceptable for preventing VE (Ali et al., 2017).

Diamant (The Netherlands; Feddes et al., 2015)

Aim: Resilience training for adolescents with dual identity; focused on increasing self-esteem and empathy as mechanisms to preventing radicalisation.

Design and delivery: Three modules conducted over three months, delivered in groups of 15-16. The first module was designed to develop social and professional competences and support individuals in strengthening their identity through an exploration of family history and how they experience their dual identity. Additional modules covered intercultural moral judgement and conflict management. They allowed young people to reflect on their own opinion of "'good' and 'bad' behaviour and explore what is acceptable to society, including how religious standards may conflict with other societal views and practices. The programme taught participants how to think critically about their own and others' behaviour and develop skills for empathy and perspective taking to manage potential conflicts.

Outcomes: A study including 46 participants aged 14-23 years with a migrant background showed marginal increases in self-esteem, empathy and perspective taking immediately following the programme. There were also reported decreases in positive attitudes towards ideology-based violence. However, no change was reported in measures of social disconnectedness/isolation.

More than a game (Australia; Johns et al., 2014)

Aim: To develop resilience to VE by supporting a sense of belonging and encouraging pro-social behaviours among youth of different cultural backgrounds on the neutral territory of the playing field.

Design and delivery: Year-long sport-based mentoring scheme for young men developed by the Australian Rules Football League Western Bulldogs Football Club in association with the Australian Federal Police, community policing and the local authority.

Outcomes: In qualitative feedback, programme participants reported: improved attitudes towards different cultural groups; improvements in confidence and self-esteem, teamwork, leadership skills, intercultural communication skills and negotiating cultural stereotypes; and greater self-control in conflict situations as a result of the discipline taught through sports practice. Participants also highlighted the value/importance of the relationship of trust that was developed with the football coach.

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12 Mindfulness is an integrative mind-body approach that is designed to help people to pay attention to the present moment and uses techniques such as meditation and yoga to help in the management of thoughts and feelings.

Extensive evidence supports the effectiveness of universal resilience-based interventions for short-term positive outcomes for child and adolescent mental health (Dray et al., 2017). In particular, approaches that include cognitive behavioural therapy (CBT) or mindfulness activities have been associated with increased resilience and positive well-being outcomes in adulthood (Joyce et al., 2018). Factors that have been shown to improve resilience to psychopathology in young people who have experienced childhood adversity include: cognitive factors such as mental flexibility; emotion regulation; secure attachments and positive social interactions; self-esteem and a strong self-concept; family and parental support; and wider social support within the community (Fritz et al., 2018). There is strong evidence that resilience initiatives and interventions can help to improve mental and physical health, foster social well-being, and reduce inequitable health status for those traditionally excluded for economic reasons. However, how the effect of resilience interventions might differ in impact by race, ethnicity and culture (Adi et al., 2007) or gender (Khanlou and Wray, 2014) remains largely unexplored.

5.3.2 Promoting peace and diversity

The concepts of peace and diversity are used to support the development of strategies for accepting and embracing difference and providing alternatives to violence in difficult situations (Harris and Morrison, 2003). Approaches may aim to: increase multicultural awareness; encourage values of openness and pluralism; increase interaction to promote tolerance; or promote human rights. Knowledge-based approaches often focus on a broader and more inclusive understanding of the past (including histories of migration, colonialism, slavery, and shared histories and cooperation between nations and communities). However, other approaches include promoting inter-group contact, pro-social behaviours and cooperative learning (Aronson and Patnoe, 2011). Intergroup contact has been found to reduce prejudices by increasing empathy and knowledge about 'other' groups, thus reducing anxiety about meeting and interacting with such groups (Pettigrew and Tropp, 2011). Human rights education typically focuses on human rights law and mechanisms of protection but it can be applied in ways relevant to daily life to set expectations for social change (Tibbitts, 2002). This may involve encouraging self-reflection and positioning those with personal experiences of human rights violations to be advocates or promoters for human rights (for example within refugee camps or with victims of abuse; Tibbitts 2002). More positive outcomes may occur when human rights education is combined with opportunities to take action for positive change within the community (Monaghan and Spreen, 2016). Although the potential role of former violent extremists in peace education has been suggested (Clubb, 2016), analyses suggest that very few former terrorists are considered to have completely disengaged from terrorist organisations. This may limit the potential effectiveness and suitability of their engagement (Alonso and Diaz Bada, 2016).

Whilst there appears to be peace and diversity approaches developed across Europe much of the evidence of their effectiveness is anecdotal with systematic assessment of their impacts largely absent (van Driel et al., 2016). Nevertheless, in qualitative feedback from young people engaged in multicultural awareness approaches within the youth justice system in the UK, positive experiences of meeting new people were reported. However, respondents identified a need for more diverse groups to give them greater opportunity to hear about the views and experiences of young people from different backgrounds (Hirschfield et al., 2012). In a survey of UK terrorism survivors, just over a third (35%) of respondents felt that better integration and community cohesion was the most important action to tackle terrorism (Survivors Against Terror, 2018).

Taking Steps Towards Peace (The Basque Country; Garaigordobil, 2012)

Aim: To educate young people about peace and promote respect for human rights.

Design and delivery: School-based programme delivered by classroom teachers over 10 weekly 90 minute sessions with adolescents aged 15-17 years. The programme used techniques such as debates, role-play, and brain-storming to explore the consequences of violent and non-violent strategies to solve human conflict. Students reflect on the Basque conflict and the consequences of hatred and violence, the importance of dialogue, forgiveness, regret, empathy, etc., in solving the conflict.

Outcomes: Among 276 students, the programme evaluation showed significant increases in empathy and both internal and external control of anger, as well as demonstrating increased capacity (knowledge) to define concepts such as peace and violence immediately following the programme. However, gender differences were found in the effectiveness of the programme for changing opinions on violence, with higher rejection of violence among female participants.

Anne Frank Trust – Schools programme (Global; The Anne Frank Trust, 2016)

Aim: To educate youth about human rights and to empower and train youth from diverse backgrounds to become peer educators for issues such as tolerance and intolerance.

Design and delivery: Programmes include an exhibition of Anne Frank's life and diary, combined with workshops and peer education. Through workshops, youth are introduced to human rights, their history, contemporary importance and their relevance to the lives of young people today. Youth are encouraged to critically reflect on these issues, relate them to both local and global contexts, and to identify human rights violations in their own communities. In 2016, The Anne Frank Trust in the UK worked with over 36,000 children and trained over 1,390 peer guides. Programmes are also run all over the world including in Austria, Germany, France, Italy, Canada, the United States and Australia (https://www.annefrank.org/en/about-us/what-we-do/worldwide-activities/).

Outcomes: Young people involved in the programme in the UK reported increases in confidence, greater empathy and respect for others and reduced negativity towards different groups.

Much focus is on the formal education sector (including extra-curricular activities) for providing a safe space for discussing controversial issues and education supporting ethnic, religious, cultural and sexual diversity. However, whole school approaches and schools with stronger ties to local communities are likely to have greater potential for developing intercultural competence and promoting cohesion, with the importance of partnering with parents also highlighted (van Driel et al., 2016). Critically, where stronger local ties may occur at the expense of continued links with broader society, this could contribute to the propagation of potentially isolating doctrines. Some evidence suggests that initiatives such as mother tongue education may support self-worth and positive identity (Cummins, 2015) and reduce academic achievement gaps between language minority and native students (Stanat and Christensen, 2006). Thus, from a CVE perspective both positive or negative effects should be carefully considered (see section 5.4). Cautions remain as to the long-term effects of peace and diversity building approaches, with suggestion that only programmes that aim to increase both awareness and skills/behaviour may support more sustained outcomes over time (Bezrukova et al., 2016).

5.3.3 Increasing citizenship and civic participation

Approaches that foster citizenship aim to offer opportunities to engage in society in meaningful and legitimate ways in order to create a stronger sense of belonging to the wider community. Individuals and communities most affected by inequality, disadvantage, and discrimination are less likely to engage in community action or participate in political and democratic processes (Lancee and Van de Werfhorst, 2012). Therefore, civic education or participation models promote the core values of democratic society, increase understanding of democratic processes and how to participate in them, and offer positive problem-solving approaches. Interventions that encourage wider participation in the political arena and support meaningful (non-violent) political and social activism as a means of preventing VE were viewed positively by target communities (Ali et al., 2017).

> ## Live Democracy! Active against Right-wing Extremism, Violence and Hate
> (Germany; Federal Government, 2016)
>
> **Aim:** To promote democracy and prevent right-wing extremism, racism, antisemitism, Islamic extremism and other forms of hostility including violence, hatred and radicalisation.
>
> **Design and delivery:** The German government is working with over 700 civil society organisations to deliver programmes targeting those as young as pre-school and including all children and young people, their parents and families. Events and training activities support democratic awareness and encourage the acceptance of social diversity. Networks and peer-education projects are developed for young people to awaken their political interest. Particular focus is given to historic political education to allow critical analysis of the time of National Socialism and dictatorship to ensure this is not glorified or trivialised and to underline the dangers of anti-democratic ideologies.
>
> **Outcomes:** Not reported.

Emphasis on both civic and political participation is represented in youth policy frameworks from both the United Nations (e.g. UNDP Youth Strategy)[13] and the European Union (e.g. EU Strategy for Youth: Investing and Empowering[14]; Chaskin et al., 2018). In the UK, active citizenship for young people is promoted through the National Citizen Service (NCS)[15] which engages those from diverse backgrounds in social action projects. An independent evaluation of the programme in 2016 found positive impacts on social cohesion (e.g. positive views on integration with people from different backgrounds), social mobility (e.g. confidence being a leader and meeting new people) and social and political engagement (e.g. perceived ability to influence local area or intentions to vote; Panayiotou et al., 2017). However, VE outcomes were not an objective of the programme and were therefore not considered. Overall, empirical evidence for a positive effect of civic education on normative political participation (i.e. engagement though the state's established democratic processes) among young people is limited (Manning and Edwards, 2013), and its application in preventing radicalisation to VE is yet to be established.

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13 http://www.undp.org/content/dam/undp/library/Democratic%20Governance/Youth/UNDP_Youth-Strategy-2014-17_Web.pdf

14 https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2009:0200:FIN:EN:PDF

15 NCS is a 2-4 week programme delivered by charities, colleges, voluntary and community enterprises and private sector partners and takes place in community settings outside of the school term. It provides young people aged 15-17 years with the opportunity to experience independent living and undertake new activities during a residential phase, followed by completing a social action project to give back to their local community. For more information see www.ncsyes.co.uk.

5.3.4 Offering alternative or counter narratives

Moderating the content of social media platforms to limit hate speech should be complemented by approaches that provide alternative or counter narratives. Such narratives aim to build personal thought processes resilient to extremist ideologies and facilitate access to knowledge and understanding of non-violent messages. These offer a different set of principles that are rooted in dignity, equality and pluralism (Ernstofer, 2018). Narratives may be delivered via many media, including face-to-face debate, online or radio programming.

Voices Against Extremism (Canada; Macnair and Frank, 2017)

Aim: To promote awareness and education in the community and empower its members to become actively involved in confronting extremism by 'humanising' people who are given different 'labels' (e.g. refugees; immigrants).

Design and delivery: Stories of resilience were provided by an online social media campaign which described how individuals of various social and professional backgrounds had been personally affected by extremism and their thoughts and opinions on community and Canadian identity.

Outcomes: No measures of effectiveness reported. Process measures indicated that messages of respect and acceptance had reached over 160,000 online users.

Beyond Bali (Australia; Aly et al. 2014)

Aim: To increase individual resilience to psychologically resist the moral disengagement mechanisms embedded in violent extremist narratives.

Design and delivery: A five-module programme based around knowledge and reflection on the Bali bombing and integrated into the Australian school curriculum. Young people are supported in constructing VE as morally unjust and inhumane, empathising with victims of VE and understanding the harmful effects of VE for individuals and communities. Concrete examples are provided of how societies can respond to VE in positive and productive ways (e.g. the development of a peace park at the site of a bombing).

Outcomes: Success of the programme was not measured in quantitative terms, but students expressed that using the story of a Bali Bombing survivor in the programme content was very powerful and allowed them to put a personal, more human face to the tragedy of terrorism.

At present there is limited evidence in support of the effectiveness of alternative or counter narratives (Beutel et al., 2016; Ferguson, 2016), with criticism that interventions often lack strong theoretical foundations and do not address the mechanisms that underlie the radicalisation process, such as contextual factors or identity issues (Davies et al., 2016). Former extremists have cited exposure to alternative narratives as reasons for their disengagement (Barrelle, 2015). However, their utility in primary prevention remains unknown due to relatively poor research and evaluation frameworks leaving a lack of information on impact. Although it is not always clear whether interventions focus on messages or messengers, proponents highlight the importance of: including less moderate voices/participants (so not just 'preaching to the converted'), including those from groups that actively oppose dialogue with outsiders; recognising (rather than denying) perceived grievances; and not simply avoiding the most controversial issues. As some people are living with these issues on a daily basis, counter narratives will not be considered authentic or relevant if they do not adequately consider these concerns (Ernstofer, 2018). In spite of the lack of empirical support, half (51%) of UK terrorism survivors responding to a survey in 2018 felt that combating hate speech online and offline was the most important action needed to tackle terrorism (Survivors Against Terror, 2018), and counter narratives provide one of the focuses of the work of the CCE (see section 1.3.2).

5.4   Challenges for primary prevention

Considering the current empirical literature and the academic, practice-based and public discourse, the following key challenges are identified for the design and delivery of the above types of interventions or programmes for VE primary prevention. These may also be important considerations when incorporating CVE in broader public health approaches:

- **Avoiding moving opinion in the wrong direction - Iatrogenic effects of interventions**

Iatrogenic effects are unintended harms or the opposite outcomes from those proposed that can be causally related to an intervention. For example, negative behavioural outcomes of group-based interventions for delinquent youth which actually provide opportunity for participants to reinforce each other's anti-social actions (peer contagion; e.g. Cecile and Born, 2009; Petrosino et al., 2003). Such effects are a particular risk with interventions with young people (Gottfredson, 2010) – identified in this document as a key target for primary CVE approaches (see section 4.3.2). The following are two examples of iatrogenic effects:

a)   The process of being identified as 'at risk' (either through individual factors or by way of membership to a certain group) can label and stigmatise a person as a potential extremist, leading to a sense of defiance that becomes a self-fulfilling prophecy (Cherney, 2017; section 4.2). For example, analysis of Muslims' perceptions of the Danish government's action plan for radicalisation prevention based on shaping liberal-democratic citizens revealed a variety of potential unintended consequences. These included: young Muslim men feeling degraded by generalisations and isolating themselves in order to avoid suspicion of association with extremists; reluctance to engage in activities promoting civic engagement; and degraded trust in authorities (Lindeklide, 2012).

b)   The process of raising awareness of terrorism and VE in the broader population (see section 5.3.2) can create, in the population, an unfounded extrapolation of risk from a small number of radicalised individuals to a much broader sub-population (e.g. Muslims in general; Doosje et al., 2009). This risks isolating such sub-populations through an 'us and them' mentality, reducing shared understanding and integration (sections 3.5 and 4.3.3). It also risks acts of violence being undertaken against members of the sub-population through a misguided idea of revenge.

- **Avoiding inappropriate net widening**

Net widening occurs when the bounds of a process are changed (increased) to widen social control and more people are referred into an official (i.e. criminal justice) response. There is a strong argument for working with broader populations than just those at high risk (see section 4.2). However, this does not suggest that approaches designed for those at high risk are suitable for those at lower levels of risk. Net widening potentially diverts resources into areas with low effectiveness including through increased risk of 'false positives'; for example with youth rebellion or frustration misinterpreted as a risk factor for radicalisation (Cherney, 2017). This can cause concerns and frustrations among frontline practitioners, who may experience difficulties identifying those in need of intervention. Appropriately tiered responses supported by a reliable system of referral may help to prevent net widening. For example, it is suggested that programmes for youth in general may benefit from being voluntary and remaining unaffiliated with the criminal justice system (Macallair and Roche, 2001).

- **Finding and using credible voices**

Influencing the attitudes and behaviours of certain audiences requires careful consideration of both the message and the messenger (see section 5.3.4). Evidence from practice suggests that audiences are more receptive to CVE messages that are delivered by peers and individuals that have a particular story to tell (Cherney, 2017). Messengers that appeal to an audience's sense of identity or experiences may be perceived to have greater legitimacy, rather than (or along with) 'experts' from beyond the communities of interest. Thus, there are continued calls for clearer lines of responsibility between government, civil society and private sector actors, so that law enforcement and related intelligence agencies are not involved in the preventative space (Barzegar et al., 2016; see section 5.5). Such conflicts have also arisen with other illegal activities (e.g. drug use), where coordinated public health programmes have effectively deployed support and diversion from harmful behaviours and networks (e.g. Ashton and Seymour, 2010; Skogan, 2008). Whilst the role of public health and healthcare for CVE has not been as widely considered (Weine et al., 2016), health professionals are routinely immersed in communities and offer a non-stigmatising avenue for engagement (see section 5.1). However, harnessing credible voices may require looking beyond traditional facilitators to consider novel figures that may be more relevant to the target audience, such as YouTube stars or viral personalities (Barzegar et al., 2016).

- **Creating cultural competence**

Cultural competence describes the ability to interact effectively with people of different cultures, ensuring that the needs of all community members are addressed. This includes being respectful and responsive to beliefs and practices and recognising cultural and linguistic needs (National Center for Cultural Competence, 2018). Elements of cultural competence form a key part of many strategic prevention frameworks and are important to their design and delivery. However, this is often limited to awareness of existing cultural dynamics and processes, rather than practical skills in delivering programmes to address religious or ethnic inequalities and divergent beliefs (see section 5.3.2). To date, even fundamental issues remain unaddressed such as whether approaches should be impartial (e.g. 'active listening' approaches) or judgement-based, such as promoting British values (see section 5.5.1).

- **Decisions on ownership and engagement**

Challenges may arise when national and local government, civic society and community members have different perspectives on priorities for supporting individuals and building resilient communities. Evidence from Europe suggests that tensions between central and local priorities can be a considerable barrier to the planning and implementation of effective local CVE responses (Mastroe, 2016; Schuurman and Bakker, 2016). Agendas that are entirely driven by government (i.e. top down) can meet resistance particularly if they engage only the 'usual suspects' but exclude those considered too radical in their political, social or religious outlook for government engagement to formally legitimise.

- **Evaluating success**

There are many challenges to evaluating VE prevention programmes, not least the lack of accepted definitions for key concepts such as radicalisation or resilience (Box 3). Evaluating effectiveness when the 'gold standard' randomised case control trials are not possible requires alternative methods. Equally, it is also difficult to identify success when the ultimate desired outcome is the absence of a relatively rare event (i.e. no terrorist attacks) and when proxy outcomes (e.g. population views on terrorism as a legitimate act or stated violent intentions; Gielen, 2017) have poorly understood relationships with subsequent acts of terror and are themselves difficult to measure. Although

attitudinal change may be the most viable outcome, the present evidence base is heavily focused on short-term outcomes and there is a pressing need for longer-term evaluations to consider the sustainability of effects over time. Without greater insight into the views and experiences of all members of society, the actual benefits and harms of interventions cannot be established.

- **Addressing effectiveness, transferability and fidelity**

Programmes that show the most promise should be identified and adopted. However, to meet the needs of a community, these interventions should be adapted to fit the local context (e.g. cultural awareness) and ensure use of local assets and services (see Box 8). This may improve the fit of an intervention to local needs but also move it away from a design proven to be effective elsewhere or risk mission creep. Practitioners need to be adept and fully trained to implement effectively and evaluation should be embedded into local programmes to ensure that the impact of adapting them to local needs is measured. At present, lack of recognition for such issues limits the applicability and transferability of strategies across nations and between different social, economic, political and historical contexts.

5.5   The current prevention landscape in the UK

Early intervention and prevention for radicalisation in the UK is represented in the CONTEST strategy by the Prevent Programme (see also section 1.3). Whilst Prevent is cited as a strategy for CVE and has been emulated in other European countries, it has also been subject to widespread criticism (Open Society Foundation, 2016). The strategy has been through multiple reformulations since its conception. Despite practitioner experiences (beyond the education setting) often being overlooked in empirical research (e.g. social workers, GPs), some of the key challenges practitioners suggest Prevent represents are summarised below. These include that Prevent reframes radicalisation to VE as a safeguarding issue by refiguring the potential terrorist as a victim who has suffered ideological abuse (Heath-Kelly, 2017). Nevertheless, there is a lack of evidence to evaluate how Prevent is actually viewed (Dresser, 2018) and information about the outcomes of cases is not shared, even with Prevent partners (Stanley et al., 2018). Whilst some evidence describes the experiences of British Muslims, wider public perceptions and the impacts of Prevent on community resilience and cohesion remain largely unknown. Although this document also introduces the work of the CCE and the Counter Extremism Strategy (see section 1.3.2), its current role and impacts are not covered in great detail here, in large part because there has been no structured evaluation of the overall strategy or individual funded programmes. Born out of the strategy, a study of community cohesion and social integration in Britain was commissioned by the government in 2015. The Casey Review (Casey, 2016) found that integration was neither a local nor national priority and work that had been done lacked a clear evidence base or programme of evaluation. The review also suggested that key issues of diversity in society were not being discussed and sexist, patriarchal and misogynistic behaviours remain unchallenged as people feared being labelled as racist. Whilst the government has been condemned for failing to act on the conclusions and recommendations of the review, the review itself has also been criticised for its overemphasis on the integration of Muslims and disregard of other considerable minority populations, for example those from Eastern Europe (The Guardian, 2017b).

5.5.1 The Prevent strategy – The experiences and reflections of its critics

Many of the concerns that front-line practitioners hold about CT measures in the UK relate to the process of referring individuals via Prevent, with reports that thresholds for referral are discretionary and vary considerably by local authority (Thornton and Bouhana, 2017). Whilst the

strategy references the 'pre-criminal space' as the intended Prevent arena, practitioners suggest there is a lack of agreed effective definition of such a space (Goldberg et al., 2017), with the risk that certain individuals may be challenged for what is actually lawful behaviour or discourse (Open Society Foundation, 2016). With a lack of clarity around the notion of (practitioners acting with) 'due regard' (Dudenhoefer, 2018), in many cases practitioners reported feeling that the implementation of Prevent was left to their own discretion, with pressure to make referrals and considerable anxieties as to how they should assess risk (Stanley et al., 2018). Particular concerns have been raised about the suitability and clarity of Prevent training (Open Society Foundation, 2016) as well as the design, validation and transparency of the vulnerability assessment framework (see section 1.3; Royal College of Psychiatrists, 2016; Thornton and Bouhana, 2017). Reports suggest that many practitioners feel they have to wait for people to openly declare their commitment to radical views to meet the threshold, at which point the opportunity for successful intervention is potentially lost (Thornton and Bouhana, 2017).

Practitioners also describe ways in which the Prevent duty has re-imagined their roles. They suggest it requires those whose professional identities were previously centred on the provision of care to identify and manage risk and be proactive in offsetting possible radicalisation trajectories or terrorist activity (Stanley et al., 2018). Concerns have been raised about confidentiality breaches, erosion of client trust (Middleton, 2016) and suspicion and fear acting as a barrier to a positive therapeutic relationship (e.g. in psychology services; Open Society Foundation, 2016). Further, identifying and managing risk at work has also been associated with negative personal (e.g. well-being) and professional (e.g. job satisfaction) outcomes in health and social care professionals (Hunter and Segrott, 2008). However, such concerns are not universal. Some practitioners view CT policy more favourably within the wider context of continual development in their field(s) and being required to identify and respond to emerging social risks (e.g. female genital mutilation; modern slavery; Chivers et al., 2017). In the education setting, Prevent is described as contributing to the securitisation of institutions (Sieckelinck et al., 2015), with teachers concerned that a culture of fear and suspicion limits important discussion about challenging issues (e.g. religious practices; Taylor and Sono, 2017). Some evidence suggests that teachers fear undermining 'fundamental British values' although what these actually are is also unclear (Taylor and Soni, 2017) and practitioners across sectors are keen to avoid such a term that is thought to only enhance an 'us and them' mentality (Open Society Foundation, 2016).

The delivery of Prevent requires trust between institutional partners and expects organisations to work to the same goals. However, critics suggest this fails to appreciate definitional inconsistencies employed in different areas and fundamentally different work practices (Dresser, 2018). Lack of effective multiagency working models and practical tools, as well as poor information sharing between partners and lack of information about the functions of central government agencies are described as key barriers (Stanley et al., 2018). Social work practitioners also describe their concerns over the competency of accredited providers and their over-reliance on mentor-based interventions[16] within Channel (see section 1.3; Stanley et al., 2018).

A report analysing the human rights impact of Prevent in the education and health sectors argued that the strategy suffers from fundamental structural flaws (e.g. overly broad and vague definitions; lack of scientific basis; absence of adverse consequences for erroneous referrals) that risk violations of the right against discrimination and the right to freedom of expression (Open Society Foundation, 2016). Further, authors suggest that the strategy does not give adequate consideration to safeguarding obligations, with case studies demonstrating instances in which the best interests of the child were not a primary consideration.

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16   Approaches that provide older peers or adults to act as role models and provide (typically) one-to-one emotional, social and academic/employment/economic support.

Perhaps the most common criticism of Prevent is that it has a disproportionate impact on Muslim communities and so could be considered Islamophobic (Qurashi, 2017). Proponents of this view suggest it may be counter-productive in inhibiting safe spaces for expression and reflection and alienating (and therefore potentially radicalising) opponents of Prevent (Dudenhoefer, 2018). Importantly, Prevent has not been tested to see how it impacts the extremism curve (Box 2; Figure 10) and whether it reduces overall risk or moves the curve towards increasing risk - potentially creating more people with sympathy for enacting VE. Data suggest that the Prevent programme receives a disproportionate number of Muslim referrals, even though among those who are subsequently considered suitable for further support, right-wing ideologies are almost as common as Islamist ideologies (see section 2.4).

Some qualitative research describes the experiences of British Muslims who suggest that everybody knows somebody who has been adversely affected by CT policies (Abbas, 2018). Individuals describe how they live in fear of actual or imagined consequences of membership to suspect communities or guilt by association, not knowing what to do or say and adversely experiencing internal controls within their own communities (e.g. family members encouraging people to display a more moderate Muslim identity; Abbas, 2018). British Muslims in higher education describe particular concerns that their behaviour is being monitored by Prevent; constraining academic enquiry, impacting their university experience and making them feel isolated or even discouraged from attending at all (Kyriacou et al., 2017). In general, the extent to which these are minority individual perspectives or population views is poorly measured.

5.5.2. The Prevent Strategy – What has it achieved?

Evaluation of CT strategy is difficult, not least because of the 'national security' issues surrounding the data. It is not clear if and how it is determined whether, for individuals referred to Channel, the Prevent Strategy can be considered a mechanism that inhibits individuals being drawn into terrorism. Although it has not been considered through rigorous academic analysis, some evidence of the impact of Prevent can be found in annual government reports (however, it remains absent from key independent reviews[17]). The 2015 Annual Report for CONTEST (HM Government, 2016) describes how the PREVENT programme has:

- Collaborated with industry to make 'significant strides' in removing illegal terrorist material (55,000 pieces of material removed in 2015; compared with 46,000 in 2014) and suspend the accounts of those propagating this material;

- Worked with civil society groups to deliver social media training and counter narrative campaigns achieving over 15 million online views;

- Reduced the number of people travelling from the UK to the conflicts in Syria and Iraq from the previous year (2014), disrupting over 150 attempted journeys through action with police and other partners;

- Provided support to 'several hundred' people through Channel, with the 'vast majority' of cases achieving a 'successful outcome' (see Box 11 for an example);

- Worked with the National Offender Management Service (NOMS) to provide 143 specialist interventions to prisoners identified as extremists or vulnerable to extremism;

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17 A report by the Independent Reviewer of Terrorism Legislation published in January 2018 (reporting on 2016 legislation) did not consider the CONTEST strategy. Whilst CONTEST was previously covered as a subject of a 2013 report (Anderson, 2014), Prevent was considered outside of the scope of that report also.

- Significantly increased Prevent training for frontline practitioners, with over 400,000 staff trained (more than double the previous year);

- Increased the scope and scale of work with different institutions (e.g. schools, faith institutions) and community-based projects aimed at reducing vulnerabilities.


Box 11. Channel Case Study

Liam was referred by teachers to Prevent at the age of 15, after searching for extreme right-wing material on the school internet. He had also been disclosing to staff that he felt angry and intimidated because he is a minority in his classes, which included many South Asian students.

Liam disclosed that he hates all Muslims because 'they are all ISIS', and that he was part of an extreme right-wing group on Facebook. He also expressed his interest in football violence and gang culture, and that he felt picked on by teachers.

A range of actions were undertaken as part of Liam's referral, including providing mental health services to treat his anxiety and insomnia, support from a specialist Channel mentor who was able to discuss the origin of his views, and advice on internet safety was given to his parents. The local Prevent team also helped Liam enrol on the work placement scheme of a national construction company, which included support from a careers mentor, and onto the Premier League Kicks programme with his local football team.

Liam's case was successfully concluded and his behaviour in school noticeably improved, with no further issues noted of him being involved in anti-social behaviour. His mother expressed her gratitude for the intervention, saying "without the intervention from the Prevent Team my son wouldn't be on the path he is now on".

Source: Home Office

At the indidivual level, Prevent reviews appear to be missing a personal life course history which identifies when and how the individual became vulnerable to VE. At the population level there appears little consideration of how the interventions affect communities. However, as a prevention initiative these are critical aspects that require empirical and on-going examination. Moreover, such examinations should not be limited to any particular religious or ethnic group but should incorporate all aspects of society in order to understand its impact on multiple types of extremism (Box 2; Figure 12).
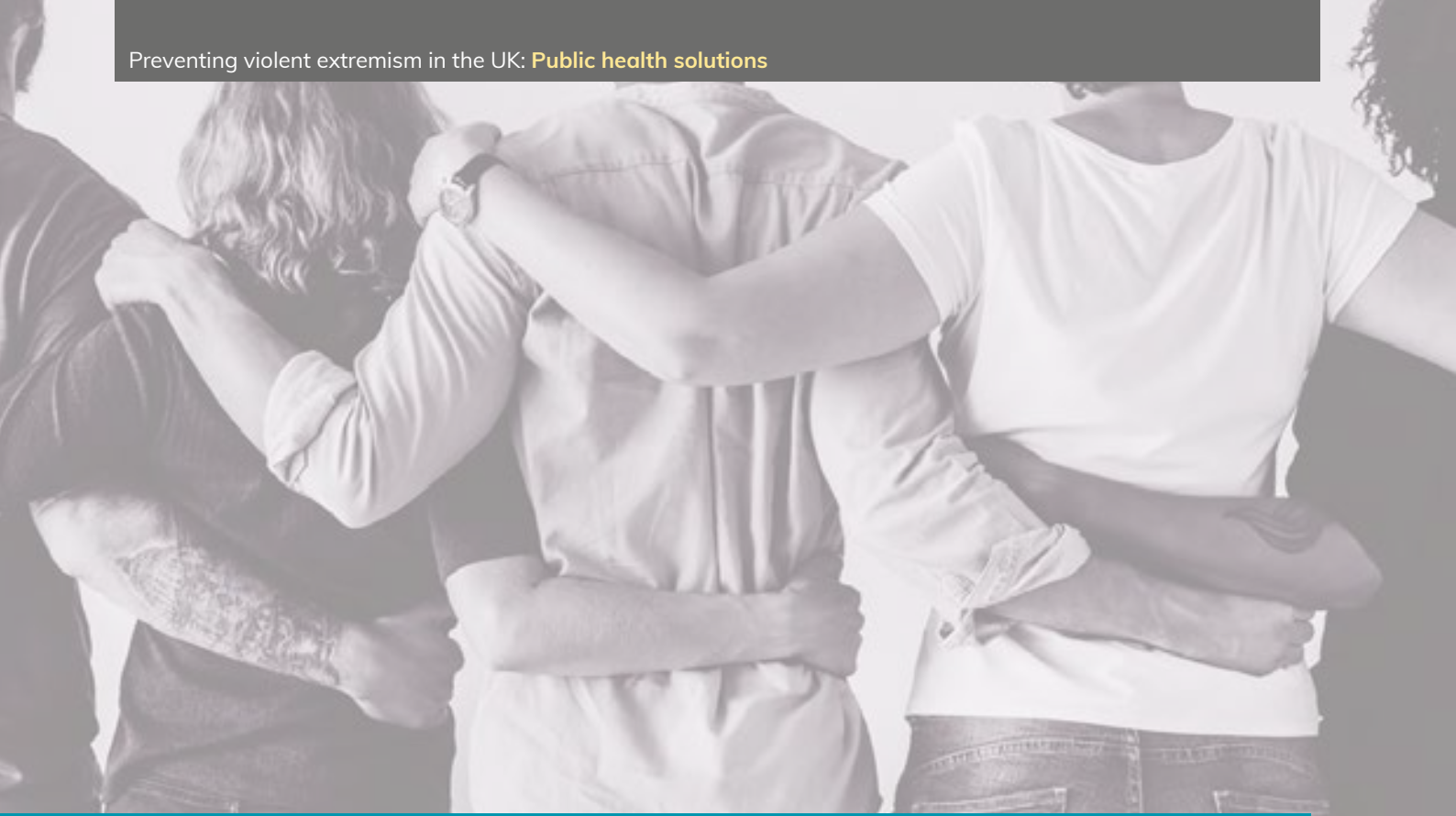
6. Options for future development and conclusions

Public health approaches and systems can offer non-threatening solutions to what have previously been seen as criminal justice issues. Thus, a combination of trust in health systems and public health approaches have resulted in successful responses to issues including substance misuse and domestic violence. Such approaches recognise the need to tackle the immediate requirements of those suffering from a life-threatening event (e.g. overdose). However, they also include broader elements (e.g. life skills training) to stop further individuals adopting behaviours that otherwise would increase numbers at risk of developing such life-threatening conditions. Public health interventions require an understanding of which life course experiences, behaviours or beliefs increase risks of life-threatening outcomes and a range of evidence-informed interventions to reduce such risk factors. They also require intelligence systems to monitor changes in the numbers of individuals exposed to risk factors and how many progress to life-threatening outcomes. These elements could inform a broader population-based approach to CVE. However, this report identified relatively little information addressing specific evidence-based interventions for CVE that are commensurate with public health approaches. Equally, to date little empirical work describes how CVE has been adopted in broader public health interventions, how this could be accomplished or when evaluations have examined success.

6.1   Including CVE in broader population health approaches

This report is intended to introduce a public health perspective to preventing VE. Whilst developing detailed recommendations for policy makers and practitioners is not within its remit, there are a range of potential policy and practice options that emerge from this briefing document. Some specifically address individual risk and protective factors for VE (see section 6.2). Others, listed below, relate to broader population health developments which could contribute to 'moving the curve' (see section 4.2; Box 2) and reducing community-level risks of VE.

i. Perceived unfairness and inequity within societies and between communities can be sources of unrest. These can drive individuals to pursue extreme and violent means to effect change, enhance group feelings between those who perceive they are suffering and may be exploited by those seeking to radicalise others (section 4.3.3). Mechanisms for tackling inequalities have been widely reviewed elsewhere (Marmot and Bell, 2016) but generally they do not consider their role in reducing risks of VE. Further, gender inequity is a recognised risk factor for violence more broadly. Gender equality, societal intolerance of domestic abuse (including physical, mental and financial abuse) and equity in political representation and opportunities for progression are linked with less violent societies (section 4.3.3). **CVE should be a consideration of policy and practice measures to reduce inequalities and barriers to advancement across communities, genders and other demographics.**

ii. Intolerance and discrimination on the basis of religious, ethnic, cultural or political diversity are related to harms to both mental and physical health and may contribute to group processes (e.g. accentuation of beliefs), anti-social behaviour and other repercussions across all communities and not just those discriminated against (section 4.3.3). In support of the proposed elements of the Counter Extremism Strategy (section 1.3.2), **national and local public health professionals and systems are well placed to raise discrimination as a threat to well-being that includes violent extremism and to coordinate multi-agency activities to identify the benefits of and opportunities for more plural societies.**

iii. Recent decades have identified how adverse childhood experiences (ACEs - e.g. sexual, physical and verbal child abuse, childhood exposure to adult domestic violence; section 4.3.1) can impact individuals' risks of ill health and involvement in violence across the whole life course. Such links are likely to extend to involvement in some forms of VE.

- **Existing ACE programmes should examine how they can incorporate CVE as an additional outcome. This may include understanding and addressing ACEs and their impacts with communities often less well represented.**

- **More consideration should be given to how ACEs contribute to involvement in violent extremism. This may involve expanding current understanding of childhood adversity to ensure it is culturally appropriate and considers ACEs specific to the political and social context of the intended cohort (e.g. ACE surveys in Northern Ireland that consider the impacts of living through The Troubles as a child; Devaney and McConville, 2016)**

- **A review of life course adversity of those who have been involved in or otherwise associated with extreme ideologies may increase the accuracy of predicting violent extremism - Channel and other programmes may be suited to gathering data for these purposes (see also bullet x; page 65).**

- **CVE activities should identify where they can incorporate the three pillars of tackling ACEs (ACE prevention, building resilience in those exposed to ACEs and developing trauma-informed services; section 5.1; Box 10).**

iv. Poor mental health is one of the biggest current threats to public health. It is associated with more deprived communities and has been associated with vulnerability to undertaking violent extremist acts; in particular for supposed lone actors (section 4.3.1). For those with multiple complex needs, radicalisation may not be their primary need (e.g. Box 6). However, extremist ideals or involvement with violent groups may provide an additional barrier to engaging with mental health and other supportive services. Protecting mental health and providing adequate and timely support for those with mental health problems are already health priorities but their contribution to CVE is often not considered. **Actions that protect and improve community and individual mental health should consider how to contribute to preventing violent extremism as a desired outcome with professional training facilitating such developments.**

v. Supporting the health of asylum seekers, refugees and other migrant populations is an important consideration for their health and for the health and well-being of the general population (e.g. communicable disease control). Many individuals in migrant populations may have experienced high levels of child (ACEs) and adult trauma which can affect mental health and even propensity for violence (section 4.3.1; Box 7). Relatively little information is systematically collected on the trauma such populations have suffered and services in areas receiving migrant populations are often not trauma-informed (Box 10) with little understanding about the long-term impacts of trauma exposure and the options for mitigating its impacts. Developments should:

- **Measure the levels and types of trauma that have been experienced by asylum seekers and refugees arriving in the UK;**

- **Examine relationships between trauma experienced in asylum seeker and refugee populations and their physical and mental health;**

- **Ensure staff at all points of contact (including intelligence services) are trauma informed (Box 10) and can address health issues arising from trauma, build resilience and reduce any propensity for violence;**

- **Ensure that systems recognise that trauma experienced by parents can be transmitted to children.**

vi. People who experience competing cultures (e.g. their culture of origin or their parents' culture is different to their current host culture) can face challenges in establishing their individual identity (known as acculturative stress; see section 4.3.1). Lack of shared social spaces and exclusion from particular activities on the basis of different cultural practices or beliefs may make these challenges worse and contribute to isolation and poor mental well-being (section 4.3.2). Efforts exist to support young people in particular in managing certain prescribed identities (e.g. as a member of their school community through education-based approaches to British values) and approaches are described that intend to increase integration (section 5.3.2 and 5.3.3). However, there is little evidence of what interventions can work to support individuals navigating their own personal and social identity, taking account of individual and family history and experiences. For example, with the exception of some public spaces (e.g. parks), use of many social settings outside of work and study times (especially for young people) is predicated on the consumption of alcohol. There are signs in the UK that a mono-culture of alcohol-based socialising is starting to recede (Office for National Statistics, 2018). However, more could be done to create spaces for multi-cultural social activities which allow mixing between wet and dry cultures; potentially helping to address issues of integration and acculturation – both vulnerabilities linked with extremism. **Facilitating a range of different opportunities for individuals to engage with a diverse range of other individuals should be considered as an integration enabler. For example, work with local**

authorities could broaden the nightlife and other social time offers to include non-alcohol-based opportunities (e.g. open cinemas, use of public buildings for non-alcohol related socialising).

vii. Asset based community development (ABCD) is a public health approach that identifies and helps build on community assets that can contribute to better health, well-being and less anti-social activity (Box 8). This positive approach can generate sustainable approaches to difficult problems without demonising affected communities. Empowering communities to identify local opportunities and tools within that community which allow earlier intervention with those vulnerable to VE may provide alternatives to pushing individuals through a criminal justice route, such as Prevent, at a later time. **Public health learning and approaches to ABCD should be applied to CVE in order to develop community interventions that utilise communities' own assets, avoid demonising populations and move norms away from violent extremism.**

viii. Individuals' problems with health, criminal justice and economic stability are frequently interlinked and often share the same root causes (section 4.3). Evidence presented here suggests the same multi-disciplinary factors may underpin elements of CVE. Data exchange between health and criminal justice is a core element in early prevention and adequate response to issues including violence, mental health, drug and alcohol problems and other risks to population health. **Better routine data exchange between health and criminal justice services combined with emerging advancements in data processing should be considered in CVE.**

ix. A restricted approach to CVE has largely limited understanding and engagement to a small group of specialists. Health, education and social workers routinely contact individuals and families in affected populations and already provide support, role models and community engagement for other well-being purposes. A broader understanding of CVE (focusing on prevention rather than surveillance) among both frontline professionals and those managing and commissioning services could better facilitate services' contributions to CVE, aligning with the objectives of the Counter Extremism Strategy (2015) and opening additional options to reduce risk and enhance resilience. **The potential contribution of the wider public service should be explored and training materials provided that explain the importance of tackling early vulnerability, lack of belonging, prejudice and aggrieved societal views for reducing CVE.**

6.2   Options aimed directly at CVE

Effective prevention of VE is likely to occur when acute responses, actions that may impact civil liberties, or those that target specific communities, also take into account impacts of population norms (in targeted and other communities; section 4.2; Box 2). Despite professional and public focus on protection and response, an integrated strategy which also includes the prevention of VE from a multi-disciplinary perspective appears absent. Thus, consideration should be given to **developing a prevention programme for violent extremism that utilises assets from health, education and other sectors, as well as criminal justice, and adopts principles of early intervention and population approaches alongside protection and response**. Such a programme might consider the following developmental elements:

x. **Extremism and countering violent extremism require a combined epidemiological framework including examination of their relationships with each other.** There appears to be little empirical data on how policies, legislation and CVE interventions impact communities' sympathy or antagonism towards VE (see sections 4.2 and 5.5.1). Such data is critical to

understanding the overall impact of activities designed to reduce risks of VE and should take account of how actions that ameliorate risk in one community may affect others. Strategic responses to VE could be improved by:

- **Better routine surveys and monitoring of sympathy and antagonism to extremism and related violent activities;**

- **Routine collection and use of data on community and population level impacts of relevant policy and practice;**

- **Measurement of the distribution and trends in those risk factors summarised in this report[18];**

- **Enhanced collection and use of data on the life course of those who have attempted acts of violent extremism or who are considered at risk of such activity in order to refine risk factors and better define what constitutes a violent extremist;**

- **Multi-agency case reviews of people who are identified through Prevent and supported through the Channel programme to consider the life course data as above and provide understanding of early unidentified needs, prior service contacts and upstream opportunities for prevention.**

xi. **Valuable insight into the population level impacts of CVE initiatives could be collected through prospective impact assessments (IAs).** To achieve the best insight on the potential impacts of CVE and extremism related measures, IAs should gather information from all stakeholders, cultural and political perspectives in order to develop options that maximise benefits and minimise unfavourable outcomes. CVE should also be a consideration of impact assessments for broader policies and developments where they have a potential to influence risk and protective factors for VE.

- **Health and other impact assessment tools should inform the development of CVE IA processes and in some circumstances should include CVE elements.**

- **Establishing best practice for CVE related IA requires on-going evaluation and dissemination.**

xii. **Public health could use existing and developing intelligence to provide a balanced population perspective on levels of risk represented by violent extremism.** There are already measurable impacts of fear of VE on mental health, recreational behaviour, increased use of alcohol as a coping mechanism and other behaviours capable of damaging broader public health (section 3). In some communities a focus on preventing VE was felt to have detracted from other community needs (e.g. housing, health, education, employment and crime). Further, perception of VE can focus on specific communities (e.g. Muslim) adding to intolerance (section 4.3.3). Public health professionals are in a strong position to provide perspective on the actual risk through:

- **Developing reports and other communication mechanisms that place violent extremism in a risk context and address its multi-cultural nature;**

- **Providing better communications of risk factors and the protective impact of community engagement and belonging;**

- **Helping to identify an appropriate balance between reasonable vigilance and mental well-being.**

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18   Early vulnerability and lack of resilience; unsatiated desire for status, belonging and purpose; reinforced prejudice; and aggrieved world view.

xiii. **Work should be undertaken to develop a more informative dialogue with all communities on what actions have been undertaken to address violent extremism and why.** Poor quality public information on CVE activity risks some populations, communities and individuals feeling unfairly targeted (due to the actions of others). Equally other communities may feel aggrieved or disempowered when they believe insufficient controls have been adopted or other communities appear to be preferentially treated (section 4.3.3). Typically, health systems are trusted by the public and both national and local public health systems could help communicate balanced messages about what actions are taken and why. Communications may:

- **Include balanced messages that avoid arguments represented only at political and cultural extremes;**

- **Aim to enhance understanding of factors that build resilience and reduce risk;**

- **Engage communities on critical issues including integration, hate crime and other issues often only considered from a law enforcement perspective;**

- **Ensure violent extremism is not seen as a single community issue and discussion includes risks from and impacts on different communities.**

xiv. **Efforts are needed to improve understanding and address the impacts of living with perpetual threat of extremist violence.** Ninety per cent of people in Britain think the threat of a terrorist attack is high (section 2.6.2). Whilst many individuals may suffer only mild concern and inconvenience from such perpetual threat levels, vulnerable individuals may be at increased risk of poor well-being or even anti-social responses such as hate crime and the adoption of extremist ideals or behaviour (section 4.3.3). There is currently a lack of empirical approaches to balancing the impacts of fear and benefits of vigilance and security.

- **Develop a better understanding of how perceived threat affects individuals' well-being and perceptions of different communities;**

- **Gather more detailed intelligence on how perpetual exposure to risk and responses to violent extremism affects vulnerable individuals – in particular those with mental health issues;**

- **Ensure population and community well-being and coherence are considered as key factors in the implementation of vigilance and security.**

xv. **Efforts are needed to improve understanding and support to those who have been or had a close relative, friend or work colleague directly impacted by extremist violence.** The number of people directly exposed to VE acts in the UK remains relatively low. However, an estimated 1 in 10 individuals have been directly affected themselves or have a friend, relative or colleague who has been exposed to a terrorist event (section 2.2). In some public services, levels may be considerably higher and include people with continued professional contact with affected or even implicated populations. Monitoring and addressing immediate and long-term impacts on the physical and mental health of all directly and indirectly affected individuals, as well as on their views of appropriate responses and retribution ideation represent important areas for development.

- **Develop research programmes to identify the impacts of direct or near direct (family, friends) exposure to extremist violence;**

- **Examine learning in other fields of trauma work to develop support for such individuals;**

- **Proactively offer support to service personnel where some groups are typically reluctant to seek support (section 3.2);**

- **Ensure all staff in health, police and other directly affected services are trauma-informed (Box 10) to allow peer support and ensure that service engagement with all communities remains supportive under conditions that include terror threats.**

xvi. **Work should develop the skills and knowledge required in primary care services to ensure they can help reduce risks of violent extremism and support those who are vulnerable at the earliest possible opportunity.** The psychological impact of VE threats and actions (section 3.2) can especially impact on individuals who have a mental illness or disability, those from ethnic minorities, or migrants and foreign nationals. Appropriate support for such individuals is important for health and may affect risks of retaliatory or other terror 'inspired' violence.

- **Incorporate training on vulnerability and trauma in primary care and, as well as their relationships with well-being in general, include information and advice on violent extremism;**

- **Identify and disseminate referral pathways from primary care for those who may require additional support. This support should be suited to addressing a multitude of needs and should be accessible and non-stigmatised.**

xvii. **Efforts are needed to ensure that population and evidence-informed responses are maintained even in the aftermath of a terrorist event.** In an environment where there are hundreds of on-going threats currently the target of operations that one tragically succeeds remains a strong likelihood. Whilst this may mark a vulnerability in intelligence it should not undermine activities designed to reduce the number of individuals sympathetic to or attracted into VE. Public health and wider prevention messages are critical in the aftermath of VE events and may be facilitated by:

- **Developing a code of reporting that ensures risk of copycat or retaliatory actions are minimised (e.g. as with suicide);**

- **Preparatory work on what narratives are likely to be most effective across all populations and cultures, both at times of more and less severe threat;**

- **Including public health messages in table top and other planning exercises that typically deal with emergency responses to violent extremism;**

- **Considering mental health and vulnerable individuals in communications with the public and professionals after incidents occur;**

- **Examining population access to online messaging and the content of such messages, including having public health narratives ready to message at these times.**

6.3 Conclusions

Acts of violent extremism are relatively rare events. This presents some challenges for understanding the pathways that lead individuals to commit such atrocities and for generating an evidence base on what actions best reduce the risks and consequences of violent events. The field of CVE currently lacks a focus on the evaluation of programmes and has largely been considered separately from a richer evidence base on public health measures aimed at reducing other types of violence. A restricted approach to data and intelligence represents another barrier to the engagement of many researchers in the analysis and understanding of CVE risk and risk reduction. However, at practice and critically policy levels, increasing such understanding is essential. Our understanding of and responses to VE have to be domestic and international. Whilst this report has been concerned largely with individuals resident in the UK, our experience of VE is intimately linked to our actions and those of other nations. The principles outlined in this report, which recognise the need for acute responses but also identify the fundamental need to understand and manage impacts on wider communities and populations, are pertinent to peace-keeping, international aid and other relationships the UK and its citizens have with an increasingly interconnected international community. Interpersonal violence (such as youth violence, domestic violence and child maltreatment), conflict (e.g. war and state violence) and VE are linked but currently our exchange of evidence and expertise largely is not. This report has also not examined thorny issues such as what are the British values, if any, to which we expect all citizens to conform or the challenges represented in areas where a mosaic of very different communities, rather than a finer multi-cultural blend, is the norm. Such problems, like the ones we have examined here, are often included in the 'too difficult to discuss' pile. However, it is in the absence of discussion with communities and individuals that these issues are most likely to manifest as violence. A carefully constructed and sensitively implemented public health approach could help develop an informed dialogue and identify a population consensus that rejects VE.

References

Abbas MS. Producing 'internal suspect bodies': divisive effects of UK counter-terrorism measures on Muslim communities in Leeds and Bradford. *British Journal of Sociology* 2018; 70(1): 261-282.

Action for Children. *Its starts with hello: a report looking into the impact of loneliness in children, young people and families.* Watford: Action for Children; 2017.

Adi Y, Kiloran A, Janmohamed K, Stewart Brown S. *Systematic review of the effectiveness of interventions to promote mental wellbeing in primary schools–universal approaches which do not focus on violence and bullying.* Warwick: University of Warwick; 2007.

Alba R. What majority-minority society? A critical analysis of the Census Bureau's Projections of America's demographic future. *Socius* 2018; 4:1-10.

Alcalá HE, Zulfacar Sharif M, Samari G. Social determinants of health, violent radicalization and terrorism: a public health perspective. *Health Equity* 2017; 1(1): 87-95.

Ali RB, Moss SA, Barelle K, Lentini P. Initiatives that counter violent radicalization but are perceived as suitable by targeted communities. *Journal of Police and Criminal Psychology* 2017; 32(1): 43-55.

Allen C, Nielsen JS. *Summary report on Islamophobia in the EU after 11 September 2001.* Vienna: University of Birmingham; 2002.

Allouche J, Lind J. *Public attitudes to global uncertainties: a research synthesis exploring the trends and gaps in knowledge.* Sussex: Institute of Development Studies; 2010.

Alonso R, Diaz Bada J. What role have former ETA terrorist played in counterterrorism and counter radicalisation initiatives in Spain? *Studies in Conflict and Terrorism* 2016; 39(11): 982-1006.

Aly A, Taylor E, Karnovsky S. Moral disengagement and building resilience to violent extremism: an education intervention. *Studies in Conflict and Terrorism* 2014; 37(4): 369-385.

Anderson D. *The terrorism acts in 2013: Report of the independent reviewer on the operation of The Terrorism Act 2000 and Part 1 of The Terrorism Act 2006.* London: David Anderson; 2014.

Anti-terrrorism, Crime and Security Act 2001. Available at https://www.legislation.gov.uk/ukpga/2001/24/contents. [accessed 14/02/2019].

Aronson E, Patnoe S. *Cooperation in the classroom: The jigsaw method* (3rd ed.). London: Pinter & Martin; 2011.

Ashton JR, Seymour H. Public health and the origins of the Mersey Model of Harm Reduction. *International Journal of Drug Policy* 2010; 21(2): 94-96.

Aslund O, Rooth DO. Shifts in attitudes and labor market discrimination: Swedish experiences after 9-11. *Journal of Population Economics* 2005; 18 (4): 603–629.

Austin B, Giessman HJ. *Transformative approaches to violent extremism.* Berghof Handbook Dialogue Series No. 13. Berlin: Berghof Foundation; 2018.

Bailey C, Klas A, Cox R, Bergmeier H, Avery J, Skouteris H. Systematic review of organisation-wide, trauma-informed care models in out of home care settings. Health and Social Care in the Community 2018; 27(3): e10-e22.

Bakker E. *Jihadi Terrorists in Europe: Their Characteristics and the Circumstances in Which They Joined the Jihad. An Exploratory Study.* Clingendael Security and Conflict Programme, The Hague; 2006.

Barber BK(Ed.). *Adolescents and war: How youth deal with political violence.* New York; Oxford University Press: 2009.

Barker A, Dinisman T. *Meeting the needs of survivors and families bereaved through terrorism.* London: Victim Support; 2016.

Barrelle K. Pro-integration: disengagement from and life after extremism. *Behavioral Sciences of Terrorism and Political Aggression* 2015; 7(2): 129-142.

Barrett R. *Beyond the caliphate: foreign fighters and the threat of returnees.* New York: The Soufan Center; 2017.

Bartlett J, Birdwell J, King M. *The edge of violence: a radical approach to extremism.* London: Demos; 2010.

Barzegar A, Powers S, Karhili NE. *Civic approaches to confronting violent extremism: sector recommendations and best practices.* London: Institute for Strategic Dialogue; 2016.

Basra R, Neumann PR, Brunner C. *Criminal Pasts, Terrorist Futures: European Jihadists and the New Crime-Terror Nexus.* London: The International Centre for the Study of Radicalisation and Political Violence; 2016.

BBC News. Wimbledon 2017: security stepped up after terror attacks; ;2017. Available at: https://www.bbc.co.uk/news/uk-40478775 [accessed 14/12/2018].

Beller J, Kröger C. Religiosity, religious fundamentalism, and perceived threat as predictors of Muslim support for extremist violence. *Psychology of Religion and Spirituality* 2018; 10(4): 345-355.

Bellis MA et al. *Adverse childhood experiences and their impact on health harming behaviours in the Welsh adult population.* Cardiff: Public Health Wales; 2015.

Bellis MA, Hardcastle K, Hughes K, Wood S, Nurse J. *Preventing violence, promoting peace.* London: Commonwealth Secretariat; 2017a.

Bellis MA et al. Does continuous trusted adult support in childhood impart life-course resilience against adverse childhood experiences – a retrospective study on adult health-harming behaviours and mental well-being. *BMC Psychiatry* 2017b; 17: 140.

Bellis MA et al. Adverse childhood experiences and sources of childhood resilience: a retrospective study of their combined relationships with child health and educational attendance. *BMC Public Health* 2018; 18(1): 792.

Beutel A et al. Guiding principles for countering and displacing extremist narratives. *Contemporary Voices* 2016; 7(3): 35-49.

Bezrukova K, Spell CS, Perry JL, Jehn KA. A meta-analytical integration of over 40 years of research on diversity training evaluation. *Psychological Bulletin* 2016; 142(11): 1227-1274.

Bhatia K, Ghanem H. *How do Education and Unemployment Affect Support for Violent Extremism? Evidence from Eight Arab Countries. Global Economy and Development;* 2017. Retrieved from https://www.brookings.edu/research/how-do-education-and-unemployment-affect-support-for-violent-extremism/ [accessed 20/12/2018].

Bhui KS, Hicks MH, Lashley M, Jones E. A public health approach to understanding and preventing violent radicalization. *BMC Medicine* 2012; 10: 16-23.

Bhui K, Everitt B, Jones E. Might depression, psychosocial adversity and limited social assets explain vulnerability to and resistance against violent radicalisation? *PLoS One* 2014a; 9(9): e105918

Bhui K, Warfa N, Jones E. Is violent radicalisation associated with poverty, migration, poor self-reported health and common mental disorders? *PLoS One* 2014b; 9(3): e90718.

Bhui KS, James A, Wesseley S. Mental illness and terrorism. *BMJ* 2016; 354: i4869.

Bhui K, Jones E. The challenge of radicalisation: a public health approach to understanding and intervention. *Psychoanalytic Psychotherapy* 2017; 321(4): 401-410.

Birkeland MS, Blix I, Solberg O, Heir T. Gender differences in posttraumatic stress symptoms after a terrorist attack: a network approach. *Frontiers in Psychology* 2017; 8: 2091.

Blickhem C et al. What is Asset-Based Community Development and how might it improve the health of people with long term conditions? A realist synthesis. *SAGE Open* 2018; 8(3): 1-13.

BMG Research. BMG Poll; 2017. Retrieved from http://www.bmgresearch.co.uk/fascism-spreading-across-world/ [accessed 14/12/2018].

Brackbill RM, Cone JE, Farfel MR, Stellman SD. Chronic physical health consequences of being injured during the terrorist attacks on the World Trade Center on September 11, 2001. *American Journal of Epidemiology* 2014; 179(9): 1076-1085.

Briggs R, Goodwin M. *We need a better understanding of what drives right-wing extremist violence.* LSE Blog; 2012. Available at http:// from https://blogs.lse.ac.uk/politicsandpolicy/right-wing-extremist-violence-briggs-goodwin/ [accessed 14/03/2019].

Brooks RA. Muslim "homegrown" terrorism in the United States: How serious is the threat? *International Security* 2011; 36: 7-47.

Brownlee K et al. A systematic review of strengths and resilience outcome literature relevant to children and adolescents. *Child and Adolescent Social Work Journal* 2013; 30(5): 435-459.

Bryson S et al. What are effective strategies for implementing trauma-informed care in youth inpatient psychiatric and residential treatment settings? A realist systematic review. *International Journal of Mental Health Systems* 2017; 11: 36.

Butcher L. *Aviation: security*. London: House of Commons Library; 2011.

Campelo N, Oppetit A, Neau F, Cohen D, Bronsard G. Who are the European youth willing to engage in radicalisation? A multidisciplinary review of their psychological and social profiles. *European Psychiatry* 2018; 52: 1-14.

Casey L. *The Casey Review: a review into opportunity and integration*. London: Ministry of Housing, Communities and Local Government; 2016.

Catney G. *Has neighbourhood ethnic segregation decreased? Dynamics of diversity: Evidence from the 2011 Census*. Manchester: University of Manchester; February 2013.

Cecile M, Born M. Intervention in juvenile delinquency: danger of iatrogenic effects? *Children and Youth Services Review* 2009; 31(12): 1217-1221.

Centre for Longitudinal Studies. *Politics, perceptions and identity: initial findings from the Next Steps age 25 sweep*. London: UCL; 2017. https://cls.ucl.ac.uk/cls_research/initial-findings-from-the-next-steps-age-25-survey/ [accessed 03/04/2019].

Cerdá M, Tracy M, Ahern J, Galea S. Addressing population health and health inequalities: the role of fundamental cause. *American Journal of Public Health* 2014; 104(4): S609-S619.

Chaskin RJ, McGregor C, Brady B. *Supporting youth civic and political engagement: supranational and national policy frameworks in comparative perspective*. Galway: UNESCO Child and Family Research Centre, National University of Ireland Galway; 2018.

Cherney A. Designing and implementing programmes to tackle radicalisation and violent extremism: lessons from criminology. *Dynamics of Asymmetric Conflict* 2017; 9(1-3): 82-94.

Chivers C. 'What is the headspace they are in when they are making those referrals?' Exploring the life worlds and experiences of health and social care practitioners undertaking risk work within the Prevent Strategy. *Health, Risk and Society* 2017; 20(1-2): 81-103.

Christoffersen M. Is the prevention paradox useful in suicide prevention theory and strategies? *International Journal of Population Data Science* 2018; 3(2): 077.

Choma B, Charlesford JJ, Dalling L, Smith K. Effects of viewing 9/11 footage on distress and Islamophobia: a temporally expanded approach. *Journal of Applied Social Psychology* 2014; 45(6): 345-354.

Choudhury T, Fenwick H. *The impact of counter-terrorism measures on Muslim communities*. Manchester: Equality and Human Rights Commission; 2011.

Civil Aviation Authority. *Consumer research for the UK aviation sector- final report*. London: Civil Aviation Authority; 2015.

Clark AE, Doyle O, Stancanelli. *The impact of terrorism on well-being: evidence from the Boston Marathon Bombing: Working papers 201708*. Dublin: Geary Institute, University College Dublin; 2017.

Clubb G. The role of former combatants in preventing youth involvement in terrorism in Northern Ireland: a framework for assessing former Islamic State combatants. *Studies in Conflict and Terrorism* 2016; 39(9): 842-861.

Coid JW, Bhui K, MacManus D, Kallis C, Bebbington P, Ullrich S. Extremism, religion and psychiatric morbidity in a population-based sample of young men. *British Journal of Psychiatry* 2016; 209(6): 491-497.

Commission for Countering Extremism (2018). https://www.gov.uk/government/organisations/commission-for-countering-extremism [accessed 14/12/2018].

Corbert S, Gurdgiev C, Meegan A. Long-term stock market volatility and the influence of terrorist attacks in Europe. *The Quarterly Review of Economics and Finance* 2017; 68: 118-131.

Corner E, Gill P. A false dichotomy? Mental illness and lone-actor terrorism. *Law and Human Behaviour* 2015; 39: 23–34.

Corner E, Gill P, Mason OJ. Mental health disorders and the terrorist: A research note probing selection effects and disorder prevalence. *Studies in Conflict & Terrorism* 2016; 39: 560 –568.

Coshall JT. The threat of terrorism as an intervention on international travel flows. *Journal of Travel Research* 2003; 42(1): 4-12.

Cragin K. The challenge of foreign fighter returnees. *Journal of Contemporary Criminal Justice* 2017; 33(3): 292-312.

CSIS (Centre for Strategic and International Studies). *Findings from the global perceptions of violent extremism survey*; 2016. https://www.csis.org/analysis/survey-findings-global-perceptions-violent-extremism [accessed 11/05/2017].

Cummins J. Intercultural education and academic achievement: a framework for school-based policies in multi-lingual schools. *Intercultural Education* 2015; 26(6): 455-468.

Cushman JG, Leon Pachter H, Beaton HL. Two New York city hospitals' surgical response to September 11, 2001, terrorist attack in New York City. *The Journal of Trauma: Injury, Infection and Critical Care* 2003; 54(1): 147-155.

Dalgaard NT, Todd B, Daniel SIF, Montgomery E. The transmission of trauma in refugee families: associations between intra-family trauma communication style, children's attachment security and psychosocial adjustment. *Attachment and Human Development* 2016; 18(1): 69-89.

da Silva R, Crilley R. "Talk about terror in our back gardens": an analysis of online comments about British foreign fighters in Syria. *Critical Studies on Terrorism* 2017; 10(1): 162-186.

Davies G, Neudecker C, Ouellet M, Bouchard M, Ducol B. Toward a framework understanding online programs for countering violent extremism. *Journal for Deradicalization* 2016; 6: 51-86.

Davis DW, Silver BD. *The threat of terrorism, presidential approval, and the 2004 election*. Paper presented at the Annual Meeting of the American Political Science Association (APSA), Chicago, August 2004.

Densley JA. *How Gangs Work: An Ethnography of Youth Violence*. Basingstoke: Palgrave Macmillan; 2013.

Depuyt M. What makes a foreign fighter? Radicalisation and extremism in Belgium. *Corvinus Journal of International Affairs* 2017; 2(1): 31-42.

Devaney J, McConville P. Childhood neglect – the Northern Ireland experience. *Research Policy and Planning* 2016; 32(1): 53-63.

DiMaggio C, Galea S, Li G. Substance use and misuse in the aftermath of terrorism. A Bayesian meta-analysis. *Addiction* 2008; 104: 894-904.

Dom G et al. Mass violence, radicalization and terrorism: A role for psychiatric profession? *European Psychiatry* 2018; 49: 78-80.

Doosje B, Loseman A, van den Bosn K. Determinants of radicalization of Islamic youth in the Netherlands: personal uncertainty, perceived injustice, and perceived group threat. *Journal of Social Issues* 2013; 69: 586-604.

Doosje B, Zimmerman A, Beate K, Andreas Z, Roel M. Terrorist threat and perceived Islamic support for terrorist attacks as predictors of personal and institutional out-group discrimination and support for anti-immigration policies—Evidence from 9 European countries. *Revue Internationale de Psychologie Sociale* 2009; 22(3-4): 203-233.

Dray J et al. Systematic review of universal resilience-focused interventions targeting child and adolescent mental health in the school setting. *Journal of the American Academy of Child and Adolescent Psychiatry* 2017; 56(10): 813-824.

Dresser P. *PREVENT policing in practice: the need for evidence-based research*. Sunderland: Centre for Applied Social Sciences; 2018.

Drury J, Williams R. Children and young people who are refugees, internally displaced persons or survivors or perpetrators of war, mass violence and terrorism. *Current Opinion in Psychiatry* 2012; 25(4): 277-284.

Dudenhoefer L. Resisting radicalisation: a critical analysis of the UK Prevent duty. *Journal of Deradicalization* 2018; 14: 153-191.

Duke NN, Pettingell SL, McMorris BJ, Borowsky. Adolescent violence perpetration: associations with multiple types of adverse childhood experiences. *Pediatrics*. 2010;125:e778-786.

Eaton V, Ward C, Womack J, Taylor A. *Mental health and wellbeing in Leeds: an assessment of need in the adult population*. Leeds: NHS Leeds; 2011.

Echebarria-Echabe A, Fernández-Guede E. Effects of terrorism on attitudes and ideological orientation. *European Journal of Social Psychology* 2006; 36(2): 259-265.

Eisenman DP et al. Terrorism-related fear and avoidance behavior in a multi ethnic urban population. *American Journal of Public Health* 2009; 99(1): 168-174.

Eisenman DP, Flavahan L. Canaries in the coal mine: interpersonal violence, gang violence, and violent extremism through a public health prevention lens. *International Review of Psychiatry* 2017; 29(4): 341-349.

Eleftheriadou M. Refugee radicalization/militarization in the age of the European refugee crisis: a composite model. *Terrorism and Political Violence* 2018; Online first DOI: 10.1080/09546553.2018.1516643.

Elliott DE, Bjelajac P, Fallor RD, Markoff LS, Reed BG. Trauma-informed or trauma-denied: principles and implementation of trauma-informed services for women. *Journal of Community Psychology* 2005; 33(4): 461-477.

Ellis BH, Abdi S. Building community resilience to violent extremism through genuine partnerships. *American Psychologist* 2017; 72(3): 289-300.

Ernstofer A. Effective approaches to preventing violent extremism: a peacebuilding systems perspective. In: Beatrix Austin and Hans J. Giessmann (eds). *Transformative Approaches to Violent Extremism.* Berghof Handbook Dialogue Series No. 13. Berlin: Berghof Foundation; 2018.

European Commission. Public opinion (interactive data); 2008. Retrieved from http://ec.europa.eu/commfrontoffice/publicopinion/index.cfm/Chart/getChart/themeKy/27/groupKy/166 [accessed 20/12/2018].

European Commission. Public opinion (interactive data); 2018a. Retrieved from http://ec.europa.eu/commfrontoffice/publicopinion/index.cfm/Chart/getChart/themeKy/45/groupKy/226 [accessed 03/04/2019].

European Commission. Public opinion (interactive data); 2018b. Retrieved from http://ec.europa.eu/commfrontoffice/publicopinion/index.cfm/Chart/getChart/themeKy/25/groupKy/292 [accessed 03/04/2019].

European Commission. Public opinion (interactive data); 2018bc. Retrieved from http://ec.europa.eu/commfrontoffice/publicopinion/index.cfm/Chart/getChart/themeKy/18/groupKy/98 [accessed 03/04/2019].

European Parliament. *European Parliament Special Eurobarometer (EB 85.1): Europeans in 2016: Perceptions and expectations, fight against terrorism and radicalisation*; 2016. Retrieved from http://www.europarl.europa.eu/pdf/eurobarometre/2016/attentes/eb85_1_synthesis_perceptions_wishes_terrorism_en.pdf [accessed 14/12/2018].

European Parliament. *The return of foreign fighters to EU soil.* Brussels: European Union, 2018.

Europol. *European Union terrorism situation and trend report.* The Netherlands: Europol; 2018.

Eurostat. Migrant integration statistics. Luxembourg: European Commission; 2018. Retrieved from https://ec.europa.eu/eurostat/statistics-explained/index.php/Migrant_integration_statistics_-_labour_market_indicators [accessed 03/04/2019].

Evans A, Coccoma P. *Trauma-informed care: how neuroscience influences practice.* New York: Routledge; 2014.

Faculty of Public Health. *The role of public health in the prevention of violence.* London: Faculty of Public Health; 2016.

Farzanegan MR, Krieger T, Meierrieks D. Does terrorism reduce life satisfaction? *Applied Economics Letters* 2016; 24(13): 893-896.

Feddes AR, Mann L, Doosje B. Increasing self-esteem and empathy to prevent violent radicalization: a longitudinal quantitative evaluation of a resilience training focused on adolescents with a dual identity. *Journal of Applied Social Psychology* 2015; 45: 400-411.

Federal Government. *Federal government strategy to prevent extremism and promote democracy.* Berlin: Bundesministerium für Familie, Senioren, Frauen und Jugend; 2016.

Ferguson K. *Countering violent extremism through media and communication strategies: a review of the evidence.* London: Partnership for Conflict, Crime and Security Research; 2016.

Financial Times. Terror attacks shaped UK election but failed to lift May. 2017. Available at https://www.ft.com/content/204f8124-4c33-11e7-919a-1e14ce4af89b [accessed 14/12/2018].

Forman-Hoffman V, William R, Pici M. Acute impact of the September 11 tragedy on smoking and early relapse rates among smokers attempting to quit. *Psychology of Addictive Behaviours* 2005; 19(3): 277-283.

Forward Keys. *London bridge attack: impact on travel demand*; 2017. Retrieved from https://forwardkeys.com/publication-single/UK-tourism-holds-up-in-face-of-terror-attacks.html [accessed 03/04/2019].

Forward Thinking. UK *'Building Bridges' Programme. Community roundtables: a report on the aftermath of the terrorist attacks in London and Manchester.* London: Forward Thinking; 2017.

Frenett R, Silverman T. Foreign fighters: motivations for travel to foreign conflicts. In Gutty, Capone and Paulussen (Eds). *Foreign Fighters under International Law and beyond.* Netherlands: Springer; 2016.

Frey BS, Luechinger S, Stutzer A. *Calculating tragedy: assessing the costs of terrorism.* CESifo Working Paper No. 1341. Munich: Center for Economic Studies and Ifo Institute (CESifo); 2004.

Fritz J, de Graaff AM, Caisley H, van Harmelen AL, Wilkinson PO. A systematic review of amenable resilience factors that moderate and/or mediate the relationship between childhood adversity and mental health in young people. *Frontiers in Psychology* 2018; 9: 230.

Futures Without Violence. *Linking security of women & security of states.* Washington: Futures Without Violence; 2017.

Garaigordobil M. Evaluation of a program to prevent political violence in the Basque conflict: effects on the capacity of empathy, anger management and the definition of peace. *Gaceta Sanitaria* 2012; 26(3): 211-216.

Gielen AJ. Countering violent extremism: a realist review for assessing what works, for whom, in what circumstances and how? *Terrorism and Political Violence* 2017; Online first: DOI: 10.1080/09546553.2017.1313736.

Gigerenzer G. Dread risk, September 11, and fatal traffic collisions. *Psychological Science* 2004; 15(4): 286-287.

Gill P, Corner E. There and back again: the study of mental disorder and terrorist involvement. *American Psychologist* 2017; 72(3): 231-241.

Gillespie M, O'Loughlin B. News media, threats and insecurities: an ethnographic approach. *Cambridge Review of International Affairs* 2009; 22: 667–686.

Ginges J, Hansen I, Norenzayan A. Religion and support for suicide attacks. *Psychological Science* 2009; 20: 224-230.

Glasgow Centre for Population Health. *Assets in action: illustrating asset based approaches for health improvement.* Glasgow: Glasgow Centre for Population Health; 2012.

Goeldner OS, Richie B. *Tourism: principles, practices, philosophies.* New Jersey: John Wiley & Sons; 2009.

Goldberg D, Jadhav S, Younis T. Prevent: what is pre-criminal space? *BJ Psych Bulletin* 2017; 41(4): 208-211.

Goli M, Rezaei S. *House of War: Islamic Radicalisation in Denmark.* Aarhus: Centre for Studies in Islamism and Radicalisation; 2010.

Goodwin MJ, Cutts D, Janta-Lipinski L. Economic losers, protestors, islamophobes and xenophobes? Predicting public support for a counter-Jihadi movement. *Political Studies* 2016; 64(1): 4-26.

Gottfredson DC. Deviancy training: understanding how preventive interventions harm: The Academy of Experimental Criminology 2009 Joan McCord Award Lecture. *Journal of Experimental Criminology* 2010; 6(3): 229-243.

Greenberg J, Jonas E. Psychological motives and political orientation--The left, the right, and the rigid: Comment on Jost et al. (2003). *Psychological Bulletin* 2003; 129(3): 376-382.

Gruenewald J, Chermak S, Frellich JD. Distinguishing "loner" attacks from other domestic extremist violence. *Criminology* 2013; 12: 65–91.

Hahn R et al. Effectiveness of universal school-based programs to prevent violent and aggressive behaviour: a systematic review. *American Journal of Preventive Medicine* 2007; 33(2): S114-S129.

Haque MS. Government responses to terrorism: critical views of their impacts on people and public administration. *Public Administration Review* 2002; 62(2): 170-180.

Harris ME, Fallot RD. *Using trauma theory to design service systems.* San Fransisco: Jossey-Bass; 2001.

Harris I, Morrison ML. *Peace education*, 2nd edition, London: McFarland; 2003.

Hayes SW. Changing radicalization to resilience by understanding marginalization. *Peace Review* 2017; 29(2): 153-159.

Heath-Kelly C. Algorithmic autoimmunity in the NHS: Radicalisation and the clinic. *Security Dialogue* 2017; 48(1): 29-45.

Hegghammer T, Nesser P. Assessing Islamic State's commitment to attacking the west. *Perspectives on Terrorism* 2015; 9(4): 14-30.

Hickman MJ, Thomas L, Silvestri S, Nickels H. 'Suspect Communities'? *Counter-terrorism policy, the press, and the impact on Irish and Muslim communities in Britain.* London: London Metropolitan University; 2011.

Hirschfield A, Christmann K, Wilcox A, Rogerson M, Sharatt K. *Process evaluation of preventing violent extremism: programmes for young people.* London: Youth Justice Board for England and Wales; 2012.

HM Government. Counter-Terrorism Strategy (CONTEST; 2011). Available at https://www.gov.uk/government/publications/counter-terrorism-strategy-contest [accessed 14/12/2018]

HM Government, Counter-Extremism Strategy; 2015. Available at https://www.gov.uk/government/publications/counter-extremism-strategy [accessed 14/12/2018].

HM Government. CONTEST The United Kingdom's strategy for counter terrorism: Annual report for 2015. London: HM Government; 2016.

HM Government. Serious Violence Strategy; 2018a. Available at https://www.gov.uk/government/publications/serious-violence-strategy [accessed 15/02/2019].

HM Government. Counter-Terrorism Strategy (CONTEST); 2018b. Available at https://www.gov.uk/government/publications/counter-terrorism-strategy-contest-2018 [accessed 15/02/2019].

Hogg MA. From uncertainty to extremism: social categorisation and identity processes. Current Directions in Psychological Science 2014; 5: 436–54.

Hogg MA, et al. Uncertainty, entitativity, and group identification. Journal of Experimental Social Psychology 2007; 43: 135–42.

Holmer G. Countering violent extremism: a peacebuilding perspective: special report. Washington: United States Institute of Peace; 2013.

Home Office. Building a Stronger Britain Together; 2016. Available at https://www.gov.uk/guidance/building-a-stronger-britain-together [accessed 14/12/2018].

Home Office. Operation of police powers under the Terrorism Act 2000 and subsequent legislation: Arrests, outcome and stop and search, Great Britain. Quarterly update to September 2018. London: Home Office; 2018a. Retrieved from https://www.gov.uk/government/statistics/operation-of-police-powers-under-the-terrorism-act-2000-quarterly-update-to-september-2018 [accessed 14/02/2019]

Home Office. Individuals referred to and supported by the Prevent Programme, April 2017 to March 2018: statistical bulletin. London: Home Office; 2018b.

Horgan J. The search for the terrorist. In Silke A (Ed). Terrorists, victims and society: psychological perspectives on terrorism and its consequences (pp3-27). Chichester: Wiley; 2003.

Horgan J. The psychology of terrorism. London, United Kingdom: Routledge; 2005.

House of Commons Transport Committee. Passengers' experiences of air travel. London: The Stationery Office Limited; 2007.

Hughes K, Hardcastle KA, Perkins C. The mental health needs of gang affiliated young people. London: Public Health England; 2015.

Hughes K et al. The impact of multiple adverse childhood experiences on health: a systematic review and meta-analysis. Lancet Public Health. 2017;2: e356-66.

Hughes KE, Lowey H, Quigg Z, Bellis MA. Relationship between adverse childhood experiences and adult mental wellbeing: results from an English national household survey. BMC Public Health 2016; 16(1): 222-233.

Hunter B, Segrott J. Re-mapping client journeys and professional identities: A review of the literature on clinical pathways. International Journal of Nursing Studies 2008; 45(4), 608–625.

ICM Unlimited. ICM Muslims survey for Channel 4. 2016. Retrieved from https://www.icmunlimited.com/polls/icm-muslims-survey-for-channel-4/ [accessed 14/12/2018].

IEP (Institute of Economics and Peace). Global Terrorism Index 2018: Measuring the impact of terrorism. Sydney: IEP; 2018.

Ilan J, Sandberg S. How 'gangsters' become jihadists: Bourdieu, criminology and the crime–terrorism nexus. European Journal of Criminology 2019; Online first: DOI 10.1177/2F1477370819828936.

Integration Hub. Attitudes and identity; 2018a. Retrieved from http://www.integrationhub.net/module/attitudes-and-identity/ [accessed 20/12/2018].

Integration Hub. Work and welfare; 2018b. Retrieved from http://www.integrationhub.net/module/work-and-welfare/ [accessed 20/12/2018].

Ipsos Mori . Ipsos Mori/Economist Issues Index: June; 2017. Retrieved from https://www.ipsos.com/ipsos-mori/en-uk/concern-over-defenceterrorism-rises-highest-level-2015 [accessed 14/12/2018].

Jasko K, LaFree G, Kruglanski A. Quest for significance and violent extremism: the case of domestic radicalization. Political Psychology 2017; 38(5): 815-831.

Jensen MA, Atwell Seate A, James PA. Radicalisation to violence: a pathway approach to studying extremism. Terrorism and Political Violence 2018; Online first; DOI: 10.1080/09546553.2018.1442330.

Johns A, Grossman M, McDonald K. More than a game: the impact of sport-based youth mentoring schemes on developing resilience toward violent extremism. Social Inclusion 2014; 2(2): 57-70.

Jordans MJD, Toi WA, Komproe IH, De Jong J. Systematic review of evidence and treatment approaches: psychosocial and mental health care for children in war. Child and Adolescent Mental Health 2009; 14(1): 2-14.

Joyce S et al. Road to resilience: a systematic review and meta-analysis of resilience training programmes and interventions. BMJ Open 2018; 8: e017858.

Kelley N, Khan O, Sharrock S. Racial prejudice in Britain today. London: NatCen Social Research; 2017.

Khanlou N, Wray R. A whole community approach toward child and youth resilience promotion: a review of resilience literature. International Journal of Mental Health and Addiction 2014; 12(1): 64-79.

Kieling C et al. Child and adolescent mental health worldwide: evidence for action. The Lancet 2011; 378(9801): 1515-1525.

Kis-Katos K, Liebert H and Schulze GG. On the heterogeneity of terror. European Economic Review 2014; 68: 116–36.

Kollias C, Papadamou S, Stagiannis. Terrorism and capital markets: the effects of the Madrid and London bomb attacks. International Review of Economics and Finance 2011; 20: 532-541.

Korotana LM, Dobson KS, Pusch D, Josephson T. A review of primary care interventions to improve health outcomes in adult survivors of adverse childhood experiences. Clinical Psychology Review 2016; 46: 59-90.

Koser K, Cunningham A. Migration, Violent Extremism and Social Exclusion. In International Organization for Migration. World Migration Report 2018. Geneva: International Organization for Migration; 2017.

Kruglanski A, Jasko K, Webber D, Chernikova M, Molinario E. The making of violent extremists. Review of General Psychology 2018; 22(1): 107-120.

Kyriacou C, Reed BS, Davies I. British Muslim university students' perceptions of Prevent and its impact on their sense of identity. Education, Citizenship and Social Justice 2017; 12(2): 91-110.

LaFree G, Ackerman G. The empirical study of terrorism: social and legal research. Annual Review of Law and Social Science 2009; 5: 347-374.

LaFree G, Gruenewald JF. The intersection of homicide, terrorism and violent extremism. Homicide Studies 2018; 22(1): 3-7.

Lancee B, Van de Werfhorst HG. Income inequality and participation: a comparison of 24 European countries. Social Science Research 2012; 41: 1166-1178.

Lindeklide L. Neo-liberal governing of "radicals": Danish radicalization prevention policies and potential iatrogenic effects. International Journal of Conflict and Violence 2012; 6(1): 109-125.

Littler M. Rethinking democracy and terrorism: A quantitative analysis of attitudes to democratic politics and support for terrorism in the UK. Behavioural Sciences of Terrorism and Political Aggression 2017; 9(1): 52-61.

Liu A, Pratt S. Tourism's vulnerability and resilience to terrorism. Tourism Management 2017; 60: 404-417.

Lyall G. Who are the British Jihadists? Identifying salient biographical factors in the radicalisation process. Perspectives on Terrorism 2017; 11(3): 62-70.

Lyons-Padilla S, Gelfand MJ, Mirahmadi H, Farooq M, van Egmond M. Belonging nowhere: marginalization & radicalization risk among Muslim immigrants. Behaviour Science and Policy 2015; 29(2), 153-159.

Maalouf A. On identity. Random House Books; 2011.

Macallair D, Roche T. Widening the net in juvenile justice and dangers of prevention and early intervention. San Francisco: Justice Policy Institute; 2001.

Macnair , Frank R. Voices against extremism: A case study of a community-based CVE counter-narrative campaign. Journal of Deradicalisation 2017; 10: 147-174.

Malthaner S, Lindekilde L. Analyzing pathways of lone actor radicalization: a relational approach. In Constructions of Terrorism: An Interdisciplinary Approach to Research and Policy (pp. 163-180). California: University of California Press; 2017.

Mann FD, Kretsch N, Tackett JL, Harden KP, Tucker-Drob EM. Person x environment interactions on adolescent delinquency: sensation seeking, peer deviance and parental monitoring. Personal and Individual Differences 2015; 76: 129-134.

Manning N, Edwards K. Does civic education for young people increase political participation? A systematic review. Educational Review 2013; 66(1): 22-45.

Marmot M, Bell R. Social inequalities in health: a proper concern of epidemiology. *Annals of Epidemiology* 2016; 26(4): 283-240.

Masten AS. Resilience in developing systems: progress and promise as the fourth wave rises. *Developmental Psychopathology* 2007; 19(3): 921-930.

Masten AS. Global perspectives on resilience in children and youth. *Child Development* 2014; 85(1): 6-20.

Mastroe C. Evaluating CVE: Understanding the recent changes to the United Kingdom's implementation of Prevent. *Perspectives on Terrorism* 2016; 10(2): 50-60.

McCauley C, Moskalenko S. Mechanisms of political radicalisation: pathways towards terrorism. *Terrorism and Political Violence* 2008; 20: 415–33.

McCauley C, Moskalenko S. *Friction: How radicalization happens to them and us.* New York, NY: Oxford University Press; 2011.

Meeus W. Why do young people become Jihadists? A theoretical account of radical identity development. *European Journal of Developmental Psychology* 2015; 12(3): 275-281.

Mental Health Foundation. *In the face of fear: how fear and anxiety affect our health and society, and what we can do about it.* London: Mental Health Foundation; 2009.

Mental Health Foundation. *Fundamental facts about mental health.* London: Mental Health Foundation; 2016.

Middleton J. Preventing violent extremism: the role of doctors. *The Lancet* 2016; 388(10057): 2219-2221.

Miguel-Tobal JJ, Vindel AC, Iruarriazaga I, González Ordi H, Galea S. Psychopathological repercussions of the March 11 terrorist attacks in Madrid. *Psychology in Spain* 2005; 9(1): 75-80.

Mikton CR et al. Global research priorities for interpersonal violence prevention: a modified Delphi study. *Bulletin of the World Health Organization* 2017; 95(1): 36-48.

Misra M, Greenberg N, Hutchinson C, Brain A, Glozier N. Psychological impact upon London Ambulance Service of the 2005 bombings. *Occupational Medicine* 2009; 59: 428-433.

Miwa K. Host majority group members' acculturation attitudes towards immigrant groups. 2009. Master's Thesis. 4011. 1. Retrieved from http://scholarworks.sjsu.edu/etd_theses/4011 [accessed 21/12/2018].

Moghaddam FM. The staircase to terrorism: a psychological exploration. *American Psychologist* 2005; 60: 161–69.

Monaghan C, Spreen CA. From human rights to global citizenship education: peace, conflict and the post-cold war era. *International Journal of Education Science* 2016; 13(1): 42-55.

Morgan A, Davies M, Ziglio E. (eds) *Health assets in a global context: theory, methods and action.* New York: Springer; 2010.

Nasir M, Ali A, Rehman FU. Determinants of terrorism: a panel data analysis of selected South Asian countries. *The Singapore Economic Review* 2011; 56(2): 175-187.

National Center for Cultural Competence. Conceptual frameworks, models, guiding values and principles; 2018. Retrieved from https://nccc.georgetown.edu/foundations/framework.php [accessed 21/12/2018].

National Consortium for the Study of Terrorism and Responses to Terrorism (START). 2018. Global Terrorism Database [Data file]. Retrieved from https://www.start.umd.edu/gtd. [accessed 01/03/2018].

National Scientific Council on the Developing Child. *Children's emotional development is built into the architecture of their brains: working paper 2.* Massachusetts: Harvard University; 2004.

National Scientific Council on the Developing Child. *Supportive relationships and active skill-building strengthen the foundations of resilience: working paper 13.* Massachusetts: Harvard University; 2015.

Neumayer E, Plumper T. Spatial spill-overs from terrorism on tourism: Western victims in Islamic destination countries. *Public Choice* 2016; 169(3): 195-206.

Nivette A, Eisner M, Ribeaud D. Developmental predictors of violent extremist attitudes: A test of general strain theory. *Journal of Research in Crime and Delinquency* 2017; 54(6): 755-790.

Norris FH, Stevens SP, Pfefferbaum B, Wyche KF, Pfefferbaum RL. Community resilience as a metaphor, theory, set of capacities, and strategy for disaster readiness. *American Journal of Community Psychology* 2008; 41(2): 127-150.

North CS et al. Psychiatric disorders among survivors of the Oklahoma City bombing. *Journal of the American Medical Association* 1999; 282: 755–762.

NSPCC. *Childline annual review 2015/2016.* London: NSPCC; 2016.

O'Connor RM, Waddell S. *What works to prevent gang involvement, youth violence and crime.* London: Early Intervention Foundation; 2015.

Office of National Statistics. *Travel trends: 2017.* Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/leisureandtourism/articles/traveltrends/2017 [accessed 14/12/2018].

Office for National Statistics. *Adult drinking habits in Great Britain: 2017;* 2018. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/drugusealcoholandsmoking/bulletins/opinionsandlifestylesurveyadultdrinkinghabitsingreatbritain/2017 [accessed 21/12/2018].

Open Society Foundation. *Eroding Trust: The UK's Prevent counter-extremism strategy in health and education.* London: Open Society Foundation; 2016.

Panayiotou S et al. *National Citizenship Service 2016 evaluation: main report.* London: Kantar Public; 2017.

Panter-Brick C , Leckman JF. Editorial commentary: resilience in child development – interconnected pathways for wellbeing. *The Journal of Child Psychology and Psychiatry* 2013; 54(4): 333-336.

Paz Garcia-Vera M, Sanz J, Gutiérrez S. A systematic review of the literature on post-traumatic stress disorder in victims of terrorist attacks. *Psychological Reports* 2016; 119(1): 328-359.

Pechtel P, Pizzagalli DA. Effects of early life stress on cognitive and affective function: an integrated review of human literature. *Psychopharmacology* 2011; 214(1): 55-70.

Pedersen A, Watt SE, Griffin B. *Prejudice against asylum seekers and the gear of terrorism: the importance of context.* Perth: Murdoch University; 2007.

Pedersen W, Vestle V, Bakken A. At risk for radicalization and Jihadism? A population-based study of Norwegian adolescents. *Cooperation and Conflict* 2018; 53(1): 61-83.

Perrin MA, DiGrande L, Wheeler K, Thorpe L, Farfel M, Brackbill R. Differences in PTSD prevalence and associated risk factors among World Trade Center disaster rescue and recovery workers. *American Journal of Psychiatry* 2007; 164(9): 1385-1349.

Pesko MF. Stress and smoking: associations with terrorism and causal impact. *Contemporary Economic Policy* 2013; 32(2): 351-371.

Petrosino A, Turpin-Petrosino C, Buehler J. ''Scared Straight'' and other juvenile awareness programs for preventing juvenile delinquency. *Annals of the American Academy of Political and Social Science* 2003; 589: 41–62.

Pettigrew TF, Tropp LR. *Essays in social psychology. When groups meet: The dynamics of intergroup contact.* New York: Psychology Press; 2011.

Pew Research Centre. *Spring 2017 Global attitudes survey;* 2017. Retrieved from http://www.pewresearch.org/fact-tank/2017/05/24/majorities-in-europe-north-america-worried-about-islamic-extremism/ [accessed 14/12/2018].

Pfefferbaum B, North CS, Flynn BW. The emotional impact of injury following an international terrorist incident. *Public Health Review* 2001; 29(2-4):271–280.

Picart CJS. "Jihad cool/Jihad chic": The roles of the internet and imagined relations in the self-radicalization of Colleen LaRose (Jihad Jane). *Societies* 2015, 5, 354–383.

Pietrzak RH, Southwick SM. Psychological resilience in OEF-OIF veterans: application of a novel classification approach and examination of demographic and psychological correlates. *Journal of Affective Disorders* 2011; 133: 560-568.

Pressman E. *Risk assessment decisions for violent political extremism. User Report 2009–02.* Ottawa, Canada: Public Safety Canada; 2009. Retrieved from http://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/2009-02-rdv/2009-02-rdv-eng.pdf [accessed 20/12/2018].

Purtle J. Systematic review of evaluations of trauma-informed organizational interventions that include staff training. *Trauma, Violence and Abuse* 2018; Online first; DOI: 10.1177/1524838018791304.

Quinatana-Domeque C, Ródenas-Serrano. The hidden costs of terrorism: the effects on health at birth. *Journal of Health Economics* 2017; 56: 47-60.

Qurashi F. Just get on with it: Implementing the Prevent duty in higher education and the role of academic expertise. *Education, Citizenship and Social Justice* 2017; 12(3): 197-212.

Rageliene T. Links of adolescents' identity development and relationship with peers: a systematic literature review. *Journal of the Canadian Academy of Child and Adolescent Psychiatry* 2016; 25(2): 97-105.

Rahman T. Extreme overvalued beliefs: how violent extremist beliefs become "normalized". *Behavioral Sciences* 2018; 8(1): 10.

Reavis JA, Looman J, Franco KA, Rojas B. Adverse childhood experiences and adult criminality: how long must we live before we possess our own lives? *Permanente Journal* 2013; 17(2): 44-48.

Rees P, Wohland P, Clark S, Lomax N, Norman P. *The future is diversity: New forecasts for the UK's ethnic groups.* Paper for the European Population Conference, 31 August to 3 September, 2016, Mainz, Germany.

Robbins JW, Hunter LY, Murray GR. Voters versus terrorists: analyzing the effect of terrorist events on voter turnout. *Journal of Peace Research* 2013; 50(4): 495-508.

Robinson L, Gardee R, Chaudhry F. Muslim youth in Britain: Acculturation, radicalization, and implications for social work practice/training. *Journal of Religion and Spirituality in Social Work* 2017; 26(1-2): 266-289.

Rosseau C, Ellis H, Lantos JD. The dilemma of predicting violent radicalization. *Pediatrics* 2017; 140(4): e20170685.

Royal College of Psychiatrists. *Counter-terrorism and psychiatry: Position statement PS04/16.* London: Royal College of Psychiatrists; 2016.

Rubin GJ, Brewin CR. Psychological and behavioural reactions to the bombings in London on 7 July 2005: cross sectional survey of a representative sample of Londoners. *BMJ* 2005; 331: 606.

RUSI (Royal United Services Institute). *Countering Lone-Actor Terrorism Series No. 4: Lone actor terrorism analysis paper.* London: RUSI; 2016.

Rydgren J, Ruth P. Contextual explanations of radical right-wing support in Sweden: socioeconomic marginalisation, group threat, and the halo effect. *Ethnic and Radical Studies* 2013; 36: 711–28

Sageman M. *Understanding terrorist networks.* Philadelphia PA: University of Pennsylvania Press; 2004.

Sageman M. *Radicalization of global Islamist terrorists.* Washington DC: United States Senate Committee on Homeland Security and Governmental Affairs; 2007.

Sageman M. *Leaderless Jihad: Terror Networks in the Twenty-First Century.* Philadelphia, PA: University of Pennsylvania Press; 2008

Sarma KM. Risk assessment and the prevention of radicalisation form nonviolence into terrorism. *American Psychologist* 2017; 72(3): 278-288.

Scarcella A, Page R, Furtado V. Terrorism, radicalisation, extremism, authoritarianism and fundamentalism: a systematic review of the quality and psychometric properties of assessments. *PLoS One* 2016; 11(12): e0166947.

Schils N, Verhage A. Understanding how and why young people enter radical or violent extremist groups. *International Journal of Conflict and Violence* 2017; 11(2): 1-17.

Schmid AP. *Radicalisation, de-radicalisation, counter-radicalisation: a conceptual discussion and literature review.* ICCT Research Paper; The Hague; 2013

Schmid AP. *Data to measure sympathy and support for Islamist terrorism: a look at Muslim opinions on Al Qaeda and IS.* Netherlands: The International Centre for Counter Terrorism; 2017.

Schomerus G et al. Shifting blame? Impacts of reports of violence and mental illness in the context of terrorism on population attitudes towards persons with mental illness in Germany. *Psychiatry Review* 2017; 252: 164-168.

Schuurman B, Bakker E. Reintegrating jihadist extremists: Evaluating a Dutch initiative, 2013–2014. *Behavioral Sciences of Terrorism and Political Aggression* 2016; 8(1): 66–85.

Sieckelinck S, Kaulingfreks F, de Winter M. Neither villains nor victims: towards an educational perspective on radicalisation. *British Journal of Educational Studies* 2015; 63(3): 329-343.

Silke A. Holy warriors: exploring the psychological processes of Jihadi Radicalisation. *European Journal of Criminology* 2008; 5: 99–123.

Sim S, Ismail NH. *Why terrorists go back to their old ways.* The Straits Times; 2016, https://www.straitstimes.com/opinion/why-terrorists-go-back-to-their-old-ways [accessed 19/12/2018].

Simi P, Sporer K, Bubolz BF. Narratives of childhood adversity and adolescent misconduct as precursors to violent extremism: a life course criminological approach. *Journal of Research in Crime and Delinquency* 2016; 53: 536–63.

Sinclair S, LoCicero A. Do fears of terrorism predict trust in government? *Journal of Aggression, Conflict and Peace Research* 2010; 2(1): 57-68.

Skogan WG et al. *Evaluation of CeaseFire - Chicago.* Chicago IL, Northwestern University, 2008.

Solheim ØB. Right-wing terrorism and out-group trust: the anatomy of a terrorist backlash. *Terrorism and Political Violence* 2018; DOI: 10.1080/09546553.2018.1457526.

Stanat P, Christensen G. *Where immigrant students succeed: a comparative review of performance and engagement in PISA 2003.* Paris: Organisation for Economic Co-operation and Development; 2006.

Stanley T, Guru S, Gupta A. Working with PREVENT: social work options for cases of 'radicalisation risk'. *Practice: Social Work in Action* 2018; 30(2): 131-146.

START. *Pre-radicalization criminal activity of United States extremists: research brief.* Maryland: University of Maryland; 2018.

Stein B et al. A national longitudinal study of the psychological consequences of the September 11 2001 terrorist attacks: reactions, impairment, and help-seeking. *Psychiatry* 2004; 67(2): 105-117.

Steinberg L. Cognitive and affective development in adolescence. *Trends in Cognitive Science* 2005; 9: 69–74.

Substance Abuse and Mental Health Services Administration (SAMHSA). *Trauma-informed approach and trauma-specific interventions;* 2015. Retrieved from http://www.samhsa.gov/nctic/trauma-interventions [accessed 20/12/2018].

Sudhinaraset M, Wigglesworth C, Takeuchi DT. Social and cultural contexts of alcohol use: influences in a social-ecological framework. *Alcohol Research Current Reviews* 2016; 38(1): 35-45.

Survivors Against Terror. *Giving voice to survivors: a survey of the views of survivors of terrorist attacks.* London: Survivors against terror; 2018.

Szilagyi M et al. Factors associated with whether pediatricians inquire about parents' adverse childhood experiences. *Academic Pediatrics* 2016; 16: 668-675.

Taylor L, Soni A. Preventing radicalisation: a systematic review of literature considering the lived experiences of the UK's Prevent strategy in educational settings. *Pastoral Care in Education* 2017; 35(4): 241-252.

Taylor T, Toohey K. Impacts of terrorism-related safety and security measures at a major sport event. *Event Management* 2005; 9(4): 199-209.

Teicher MH, Samson JA, Anderson CM, Ohashi K. The effects of childhood maltreatment on brain structure, function and connectivity. *Nature Reviews Neuroscience* 2016;17: 652-66.

The Anne Frank Trust. *The Anne Frank Trust UK: 2016 annual review and impact report.* London: The Anne Frank Trust; 2016.

The Guardian. Rise in children seeking mental health support after terror attacks; 2017. Available at https://www.theguardian.com/society/2017/jul/18/terrorism-blamed-rise-children-seeking-mental-health-support [accessed 14/12/2018].

The Guardian. Louise Casey: ministers have done absolutely nothing about cohesion. 2017b. Available at https://www.theguardian.com/society/2017/dec/05/louise-casey-ministers-have-done-absolutely-nothing-about-cohesion [accessed 21/12/2018].

The Telegraph. General election sees highest turnout in 25 years, as nearly 70% of Britons vote; 2017a. Available at https://www.telegraph.co.uk/politics/2017/06/09/general-election-sees-highest-turnout-25-years-nearly-70-britons/ [accessed 19/12/2018].

The Telegraph. The opportunities MI5 and police missed to prevent the five terror attacks of 2017; 2017b. Available at https://www.telegraph.co.uk/news/2018/11/22/missed-opportunities-prevent-2017-terror-attacks/ [accessed 19/12/2018].

Thomas P, Busher J, Macklin G, Rogerson M, Christmann K. Hope and fears: community cohesion and the white working class in one of the 'failed spaces' of multiculturalism. *Sociology* 2017; 52(2): 262-281.

Thompson J, Rehn M, Lossius HM, Lockey D. Risks to emergency medical responders at terrorist incidents: a narrative review of the medical literature. *Critical Care* 2014; 18: 521.

Thornton A, Bouhana N. Preventing radicalization in the UK: expanding the knowledge-base on the Channel programme. *Policing* 2017; Online first DOI:10.1093/police/pax036.

Tibbitts F. Understanding what we do: emerging models for human rights education. *International Review of Education* 2002; 48(3-4): 159-171.

Torabi M, Seo DC. National study of behavioural life changes since September 11. *Health Education and Behavior* 2004; 31(2): 179-192.

Torjesen I. Trauma staff change routines in wake of terrorist attack. *BMJ* 2017; 357: j1515.

UN CTED (United Nations Security Council Counter Terrorism Committee Executive Directorate). *The challenge of returning and relocating foreign terrorist fighters: research perspectives.* New York: United Nations; 2018.

UNDP. *Journey to extremism in Africa: drivers, incentives and the tipping point for recruitment.* New York: United Nations Development Programme Regional Bureau for Africa; 2017.

US Census Bureau. 2017 National Population Projections Tables. Retrieved from https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html [accessed 11/02/2019]

Van Brunt B, Murphy A, Zedguinidze A. An exploration of the risk, protective, and mobilization factors related to violent extremism in college populations. *Violence and Gender* 2017; 4(3): 81-101.

Van-der-Vyver J, Houston DM, Abrams D, Vasilijevic M. Boosting belligerence: how the July 7, 2005, London bombings affected liberals' moral foundations and prejudice. *Psychological Science* 2016; 27(2): 169-177.

van Driel B, Darmody M, Kerzil J. *Education policies and practices to foster tolerance, respect for diversity and civic responsibility in children and young people in the EU: NESET II report.* Luxembourg: Publications Office of the European Union; 2016.

Vasilopoulous P, Brouard S, Foucault M. How terrorism affects political attitudes: France in the aftermath of the 2015-2016 attacks. *West European Politics* 2018; 41(5): 1073-1099.

Velias A, Corr PJ. Effects of terrorism threat on economic preferences: the role of personality. *Journal of Terrorism Research* 2017; 8(2): 62-71.

Vergani M, Iqbal M, Ibahar I, Barton G. The three Ps of radicalisation: push, pull, and personal. A systematic scoping review of the scientific evidence about radicalisation into violent extremism. *Studies in Conflict and Terrorism* 2018; DOI: 10.1080/1057610X.2018.1505686.

Vermeulen F. Suspect communities – targeting violent extremism at the local level: policies of engagement in Amsterdam, Berlin and London. *Terrorism and Political Violence* 2014; 26(2): 286-306.

Verwimp P. Foreign fighters in Syria and Iraq and the socio-economic environment they faced at home: a comparison of European countries. *Perspectives on Terrorism* 2016; 10(6): 68-81.

Visit Britain. *The Great Britain day visitor 2017 annual report.* London: Visit England; 2018. Retrieved from https://www.visitbritain.org/sites/default/files/vb-corporate/Documents-Library/documents/England-documents/260139488_-_kantar_tns_-_gbdvs_2017_annual_report_v5r.pdf [accessed 03/04/2019].

Walters G, Wallin A, Hartley N. The threat of terrorism and tourist choice behaviour. *Journal of Travel Research* 2018; 58(3): 370-382.

Wang J et al. Social isolation in mental health: a conceptual and methodological review. *Social Psychiatry and Psychiatric Epidemiology* 2017; 52(12): 1451-1461.

Watson-Jones RE, Legare CH. The social functions of group rituals. *Current Directions in Psychological Science* 2016; 25(1): 42-46.

Webber D et al. The road to extremism: Field and experimental evidence that significance loss-induced need for closure fosters radicalization. *Journal of Personality and Social Psychology* 2017; 114(2): 270-285.

Webber D, Kruglanski AW. The social psychological markings of a terrorist. *Current Opinion in Psychology* 2018; 19: 131-134.

Weine S, Eisenman DP, Kinsler J, Glik DC, Polutnki C. Addressing violent extremism as public health policy and practice. *Behavioral Sciences of Terrorism and Political Aggression* 2016; 9(3): 208-221.

Wessells MG. Children and armed conflict: introduction and overview. *Peace and Conflict: Journal of Peace Psychology* 2016; 22(3): 198-207.

Wiktorowicz Q. *Radical Islam Rising: Muslim Extremism in the West.* Rowman & Littlefield: Oxford; 2005.

Windle G. What is resilience? A review and concept analysis. *Reviews in Clinical Gerontology* 2011; 21(2): 152-169.

Woll P. *Safety, strength, resilience, and recovery: Trauma-informed systems and communities.* Philadelphia, PA: Department of Behavioral Health and Intellectual disAbility Services; 2013.

World Health Organization. *INSPIRE: seven strategies for ending violence against children.* Geneva: World Health Organization; 2016.

Wynia MK, Eisenman D, Hanfling D. Ideologically motivated violence: a public health approach to prevention. *American Journal of Public Health* 2017; 107(8): 1244-1246.

World Travel and Tourism Council. *Travel and Tourism: Economic impact 2017 United Kingdom.* London: World Travel and Tourism Council; 2017. Retrieved from https://www.wttc.org/economic-impact/benchmark-reports/country-results/ [accessed 03/04/2019].

You Gov. Views on the English Defence League; 2012. Retrieved from https://yougov.co.uk/topics/politics/articles-reports/2012/10/08/views-english-defence-league [accessed 14/12/2018].

YouGov. Sun on Sunday survey results. 2015. Retrieved from https://d25d2506sfb94s.cloudfront.net/cumulus_uploads/document/2rm33oydgm/SOS_Results_150115_Website.pdf [accessed 20/12/2018].

YouGov. Authoritarian populism across Europe; 2016. Retrieved from https://yougov.co.uk/topics/politics/articles-reports/2016/11/16/trump-brexit-front-national-afd-branches-same-tree [accessed 20/12/2018].

YouGov. Politics and current affairs; 2017a. Retrieved from https://yougov.co.uk/topics/politics/articles-reports/2017/03/24/nine-ten-brits-think-further-terror-attacks-are-li [accessed 14/12/2018].

YouGov. Terrorism and the general election. Politics and current affairs; 2017b. Retrieved from https://yougov.co.uk/topics/politics/articles-reports/2017/06/06/terrorism-and-general-election [accessed 14/02/2019].

YouGov. MOPAC Survey results; 2018a. Retrieved from https://d25d2506sfb94s.cloudfront.net/cumulus_uploads/document/65vxz5ovsa/MOPACResults_181005_Extremism_London_W.pdf [accessed 01/02/2019].

YouGov. YouGov/Crest Advisory Service Results; 2018b. Retrieved from https://d25d2506sfb94s.cloudfront.net/cumulus_uploads/document/aewps46u9q/CrestAdvisory_Results_180906_Extremism_England_Wales_W.pdf [accessed 01/02/2019]

YouGov. YouGov Qualitative research: Travel and Countries; 2019. Retrieved from https://yougov.co.uk/topics/travel/articles-reports/2019/01/29/brexit-just-behind-terrorism-biggest-influences-br [accessed 01/02/2019].

Yule W. Alleviating the effects of war and displacement on children. *Traumatology* 2002; 8(3): 160-180.

Yusoufzai K, Emmerling F. How identity crisis, relative deprivation, personal characteristics, and empathy contribute to the engagement of Western individuals in Islamist terrorist behavior. *Contemporary Voices: St Andrews Journal of International Relations* 2017; 8(1):68–80.

Zimmerman MA et al. Adolescent resilience: promotive factors that inform prevention. *Child Development Perspectives* 2013; 7(4): 215-220.

Glossary

Adverse childhood experiences (ACEs)	Negative or traumatic experiences that occur in childhood that directly impact the child (e.g. physical abuse or neglect) or affect the household environment in which they grow up (e.g. parental separation or living with a household member who abuses alcohol or drugs).
Al-Shabaab	A Salafist militant group active in East Africa, which first emerged in a battle over Somalia's capital in the summer of 2006. As an Al-Qa'ida affiliate terrorist group based in Somalia and Kenya, Al-Shabaab pursues Islamist statehood aspirations in Somalia. African Union peacekeeping forces have been fighting Al-Shabaab since 2007 with the help of US and UN support. US troops and air support were deployed in Somalia to fight Al-Shabaab in 2017 (IEP, 2018).
Boko Haram	Originally formed in Northeast Nigeria bordering the Lake Chad region, the terror group has spread into Chad, Cameroon and Niger. Recently, internal tensions have led to multiple Boko Haram splinter groups forming. Both Boko Haram and these groups have sworn allegiance to the Islamic State. Boko Haram was the world's deadliest terror group until its decline in 2014 (IEP, 2018).
Channel	Part of the UK Government's Prevent strategy. The process is a multi-agency approach to identify and provide support to individuals who are at risk of being drawn into terrorism.
CONTEST	The UK Government's counter-terrorism strategy which aims to reduce the risk to the UK and its interests overseas from terrorism. Focuses on four key elements: stopping terrorist attacks (Pursue); stopping people from becoming terrorists or support terrorism (Prevent); strengthening protection against attacks (Protect); and mitigating the impact of terrorist attacks (Prepare).
Counter-terrorism (CT)	An overarching term for the practice, military tactics, techniques, and strategy that government, military, law enforcement, business, and intelligence agencies use to combat or prevent terrorism.
Countering violent extremism (CVE)	Describes a range of proactive actions to counter efforts by extremists to recruit, radicalise, and mobilise followers to violence. Generally CVE actions or approaches try to address the conditions and reduce the factors that are most likely to result in people being drawn into or adopting extreme violent ideologies and behaviours.
Europol	The European Union Agency for Law Enforcement Cooperation. Supports EU Member States in their fight against terrorism, cybercrime and other serious and organised forms of crime.
Foreign fighter	An individual who crosses borders (i.e. beyond their state of residence) in order to participate in the planning, preparation or implementation of terrorist activity, including receiving training in tactics and combat.
Global Terrorism Database (GTD)	An open-source database including information on over 180,000 terrorist events around the world from 1970 through 2017. Provides information on the date and location of the incident, the weapons used and nature of the target, the number of casualties, and - when identifiable - the group or individual responsible. The database is compiled and managed by The National Consortium for the Study of Terrorism and Responses to Terrorism (START) at the University of Maryland, United States.
Global Terrorism Index (GTI)	An annual report produced by the Institute for Economics and Peace (IEP) based on data from the GTD. The report provides a comprehensive summary of key global trends and patterns in terrorism.
Islamist/Islamic extremism	Defined by the British government as any form of Islam that opposes "democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs."
Islamic State of Iraq and the Levant (ISIL)	The most active terrorist organisation from 2015 to present. Often referred to as ISIL, ISIS or Daesh, the group is primarily active in Iraq and Syria but have committed attacks all over the world. ISIL is a Salafi jihadist (religious-political ideology) group that follows a fundamentalist, Salafi doctrine of Sunni Islam (the largest denomination of Islam).

Jihadi(st)	An Islamic term that is translated varyingly as "struggle," "striving," or "holy war." Violent Islamic extremist groups typically translate the term as "holy war," brandishing the word as a justification—and rallying cry—for engaging in violent conflict with non-Islamists.
Lone actor (terrorism)	The threat or use of violence by a single perpetrator (or small cell), not acting out of purely personal material reasons, with the aim of influencing a wider audience, and who acts without any direct support in the planning, preparation and execution of the attack, and whose decision to act is not directed by any group or other individuals (although possibly inspired by others).
Prevention paradox	First formally described in 1981 by the epidemiologist Geoffrey Rose. Describes the seemingly contradictory situation where the majority of cases of a disease come from a population at low or moderate risk of that disease, and only a minority of cases come from the high risk population (of the same disease).
Prevent (strategy)	One part of CONTEST. Aims to tackle the causes of radicalisation by: challenging the ideology that supports terrorism and those who promote it; protecting vulnerable people; and supporting sector and institutions where there are particular risks of radicalisation. The Prevent referral process allows a member of the public or someone working with the public to raise concerns about someone who may be at risk of radicalisation.
Radicalisation	A process by which an individual becomes increasingly extremist in their political, religious, or social ideologies.
Right-wing extremism/ terrorism	A form of extremism associated with fascism, racialism/racism, supremacism (an ideology which holds that a particular class of people is superior to others, and that it should dominate, control, and subjugate others, or is entitled to do so) and ultra-nationalism (promoting the interest of one state over all others). Characterised by the violent defence of a racial, ethnic or pseudo-national identity, and associated with radical hostility towards state authorities, minorities, immigrants and/or left-wing political groups.
The Taliban	The Taliban emerged in Afghanistan in 1994 as a reactionary group that combined groups of fighters that had previously fought against the 1979 Soviet invasion, and groups of Pashtun tribesmen (an Iranian ethnic group). The Taliban took control of Afghanistan in 1996. The group declared the country an Islamic emirate and promoted its leader to the role of head of state. Following the 2001 NATO invasion of Afghanistan, the Taliban was ousted, but it has since been steadily regaining control of its lost territory (IEP, 2018).
Terrorism	Politically motivated violence or threat with intent to instil fear.
The Troubles	An ethno-nationalist conflict in Northern Ireland that began in the late 1960s and continued until 1998, in which Unionists/loyalists (mostly Protestants) who wanted Northern Ireland to remain with the United Kingdom fought against nationalists/republicans (mostly Catholics) who wanted a united Ireland. As well as a bombing campaign against infrastructure, commercial and political targets, the Troubles were characterised by riots, mass protests and acts of civil disobedience. Over 1,800 civilians were killed throughout the Troubles, along with 1,695 combatants. An estimated 50,000 people were injured by the conflict.
Violent extremism (VE)	The beliefs and actions of people who support or use ideologically motivated violence to achieve radical ideological, religious or political views.
YouGov	A global public opinion and data company that continually collects information from over 6 million members around the world who engage in surveys via the web and mobile apps. YouGov has 1.2 million members in the UK and its surveys cover a range of topics from consumer brand preferences to political attitudes.

Appendix Table 1. Summary information for referenced terrorist attacks

Attack	Location	Date	Type of attack	Target	Scale	Perpetrator(s)(confirmed or suspected) and motivation
The Lockerbie Disaster (Pan AM Flight 103)	Lockerbie, Scotland; United Kingdom	21/12/1988	Explosion/ bombing	Pan AM transatlantic flight from Frankfurt to Detroit via London and New York; exploded over Lockerbie	259 aircraft fatalities; 11 ground fatalities	Libyan leader Muammar Gaddafi (claimed but later denied); Thought to relate to historic confrontations between Libya and the US military, although no clear motive has been confirmed.
9/11	New York & Washington DC; United States	11/09/2001	Explosion/ bombing (hi-jacked aeroplanes)	Four co-ordinated attacks on The World Trade Centre (twin towers) and The Pentagon	2,996 fatalities; approx 6,000 injured; estimated $10 billion in infrastructure and property damage	Al-Qaeda (confirmed); US support of Israel, the presence of US troops in Saudi Arabia, and sanctions against Iraq cited as motives.
Madrid bombings (11-M)	Madrid; Spain	11/03/2004	Explosion/ bombing	Coordinated bombings against the Cercanías commuter train system	193 fatalities; approx 2,000 injured	Al-Qaeda (suspected); Opposition to Spanish participation in the Iraq war.
London Transport Attacks (7/7)	London; United Kingdom	07/07/2005	Explosion/ bombing	Series of coordinated terrorist suicide attacks targeting commuters travelling on the city's public transport system (underground trains and buses) during the morning rush hour	52 fatalities; approx 700 injured	Al-Qaeda (claimed); In retaliation to atrocities against Muslims across the world (determined from a videotaped statement of one of the bombers).
22 Juli (Norweigan)	Oslo and Utøya; Norway	22/07/2011	Explosion/ bombing; mass shooting	Two sequential attacks against the government, the civilian population, and a Workers' Youth League (AUF) summer camp (the youth division of the ruling Norwegian Labour Party)	77 fatalities; 319 injured	Anders Behring Brevik (confirmed); Linked to militant far-right ideology and xenophobic world view, including support for varying degrees of cultural conservatism, right-wing populism, ultranationalism, Islamophobia.
Boston Marathon bombing	Boston; United States	15/04/2013	Explosion/ bombing	Two homemade pressure cooker bombs detonated near the finish line of the annual marathon race	3 fatalities; 264 injured (including 16 who lost limbs)	Dzhokhar Tsarnaev and Tamerlan Tsarnaev (confirmed); Both men admitted being motivated by extremist Islamist beliefs and acting in retribution for US military action in Afghanistan and Iraq.
The murder of Lee Rigby	Woolwich; United Kingdom	22/05/2013	Knife attack; assault	Off duty British Army Soldier, Fusilier Lee Rigby of the Royal Regiment of Fusiliers; attacked near the Royal Artillery Barracks	1 fatality	Michael Adebolajo and Michael Adebowale (confirmed); Claimed to have acted to avenge the killing of Muslims by British forces.
Charlie Hebdo attack	Paris; France	07/01/2015	Mass shooting	Headquarters of the satirical newspaper Charlie Hebdo	12 fatalities; 12 injured	Al-Qaeda (claimed); Retaliation against the Charlie Hebdo cartoons of numerous Islamic leaders

Appendix Table 1. continued

Attack	Location	Date	Type of attack	Target	Scale	Perpetrator(s)(confirmed or suspected) and motivation
November 2015 Paris attacks	Paris; France	13/11/2015	Explosion/bombing; mass shooting	Three suicide bombers struck outside the Stade de France in Saint-Denis during a football match. This was followed by several mass shootings and a suicide bombing, at cafés and restaurants. Gunmen carried out another mass shooting and took hostages at an Eagles of Death Metal concert in the Bataclan theatre.	137 fatalities; 413 injured	ISIL (claimed); Retaliation against French air strikes on ISIL.
The murder of Jo Cox	Birstall; United Kingdom	16/06/2016	Shooting/Knife attack	Labour Member of Parliament Jo Cox; killed outside a library whilst meeting with constituents in West Yorkshire.	1 fatality; 1 injured	Thomas Mair (confirmed); Claimed to have targeted Cox as a 'traitor to white people'; Mair expressed white supremacist and neo-Nazi ideologies and had links to far-right political groups such as National Action and the English Defence League.
Bastille Day Nice attack	Nice; France	14/07/2016	Vehicle assault	A 19-tonne cargo truck was deliberately driven into crowds of people celebrating Bastille Day on the Promenade des Anglais in Nice.	86 fatalities; 458 injured	ISIL (claimed); ISIL claimed the perpetrator was acting on their calls to target citizens of coalition nations that fight the Islamic state.
2017 Westminster attack	London; United Kingdom	22/03/2017	Vehicle assault	Targeting pedestrians and police officers outside the Palace of Westminster (seat of the British Parliament)	5 fatalities; 52 injured	Khalid Masood (confirmed; no evidence of links to terrorist organisation); Acted as revenge for Western military action in the Middle East.
Manchester Arena bombing	Manchester; United Kingdom	22/05/2017	Explosion/bombing	Patrons at the Arianne Grande concert at the arena, many of whom were children.	23 fatalities; 139 injured	Salman Ramadan Abedi (confirmed; considered to have acted alone but held strong links to other Islamist extremists); Motive not known.
2017 London Bridge attack	London; United Kingdom	03/06/2017	Vehicle assault; knife attack	Pedestrians on London Bridge and customers in restaurants and pubs.	8 fatalities; 48 injured	ISIL (claimed); Motive not known.
Finsbury Park	London; United Kingdom	19/06/2017	Vehicle assault	Pedestrians outside Finsbury Park Mosque.	1 fatality; 10 injured	Darren Osborne (confirmed); Declared the night before the attack and later in court intentions to kill senior politicians and resentment towards Muslims.