

Racism, mental health & pre-crime policing

the ethics of Vulnerability
Support Hubs



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Cover

Images from *There Is No Alternative*, an exhibition by artist Navine G. Khan-Dossos, at The Showroom, London, 5th June–27th July 2019, photographed by Dan Weill Photography.

There Is No Alternative was a performative, durational installation combining live painting, a research archive, and a series of workshops, talks, and events open to the public. The project featured her on-going research into the complex context of the UK government's development of pre-crime and surveillance policies, questioning the politics of representation and the positioning of care that the strategies around those policies generate. The work aims to both inhabit and expose the fluctuating forces at play within the Prevent strategy, which oscillate between safeguarding, protection and surveillance by focussing on the logos and emblems used by different Police and local Councils to symbolise Prevent in their locality.

For more information, see <http://www.khandossos.com> and <https://www.theshowroom.org/>

About Medact

Medact is a global health charity that uses evidence-based campaigns to support health workers to take action on structural barriers to health equity and justice, in an effort to bring about a world in which everyone can access their human right to health.



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PERSPECTIVES ON

Racism, mental health and pre-crime policing – the ethics of Vulnerability Support Hubs



Vulnerability support hubs are very worrying. This report explains how the hubs will harness the good intentions of clinicians and tie them into practices that harm patients, particularly the racialised and pathologised minorities that the state perceives as most “vulnerable” to radicalisation. The problems expounded by this report include the lack of evidence linking mental health to terrorism, the lack of transparency in the plans and practice of these hubs, and the relentless creep of securitisation into healthcare, absent ethical scrutiny from patients, professionals or the wider public.

Dr Piyush Pushkar, SAS doctor in liaison psychiatry, Royal Bolton Hospital



We do not know if or how mental health problems are related to terrorist ideologies or action: there is no evidence to use as a guide, nor adequate theories. In the absence of either theory or evidence, the Vulnerability Support Hubs, as with the Prevent programme overall, appear to act on collective beliefs among police and security services, informed by stereotypes and suspicion, all of which disregard the mental health needs of the individuals gathered up in the net. It is a travesty of health practice that NHS staff are helping in these processes, the likely result of which is harm to the individuals referred, and widespread suspicion of mental health services by targeted communities.

Dr Amanda C de C Williams, Professor of Clinical Health Psychology UCL



This report shows that within Vulnerability Support Hubs, doctors may be working beyond their competence in helping to assess patients as a terrorism risk, which conflicts with guidance in Good Medical Practice.

In addition, ‘monitoring’ of patients referred for ‘Islamic ideology’ risks pathologising normative Muslim practices. The disproportionate rates of Muslim children being referred is also concerning – we need clarity on the reasons for this to ensure that judgements based on Islamophobia are not being made.

Dr Shazad Amin, Consultant Psychiatrist & Deputy Chair, MEND



This report is deeply concerning and vitally necessary, it shows that Vulnerability Support Hubs blur the lines between the criminal justice system and healthcare and in so doing they compromise the ethical framework for mental healthcare and increase stigma against mental health conditions. These hubs, and the absence of proper scrutiny and accountability of them, represent a potential misuse of psychiatric care.

Dr Hugh Grant-Peterkin, Consultant Liaison Psychiatrist



As a philosopher focussed on medical ethics, I'm deeply concerned to see psychiatrists working beyond their professional remit and being co-opted into entrenching the problematic and contentious presumption of a correlation between mental health and terrorism, as well as being asked to investigate mental illness based on ideological beliefs. 'Vulnerability Support Hubs' are no replacement for properly funded mental health services in the UK, and my suspicion is that these hubs will further destroy the trust of certain communities (such as Muslims) in mental health services, and are liable to normalise the erosion of health professionals' autonomy, leading to moral distress and reductions in patient care.

Dr Arianne Shahvisi, Senior Lecturer in Ethics, Brighton and Sussex Medical School



Medact's report raises serious concerns that psychiatrists have been drawn into practices which are ethically highly problematic and merit attention by the General Medical Council. The lack of transparency, and indeed the active attempts to prevent any information being subject to independent scrutiny are particularly concerning given the history of psychiatry, and its potential to slide into colluding with repressive state actions. Several of the examples in the report show how easily roles can become blurred. Fundamental principles of ethical medical practice are at risk and have, it seems, already been compromised. There must be an open conversation, with all the available evidence, about this project.

Derek Summerfield, Hon Senior Lecturer, Institute of Psychiatry, Psychology & Neuroscience, King's College, Univ of London



This vital report uncovers deeply concerning practices which point to the securitisation of mental health care. Of particular concern are the high rates of children and young people referred to the Hubs, and the focus on unaccompanied minors as a 'high concern' group. I echo the report's call for Vulnerability Support Hubs to be closed with immediate effect and urge mental health professional bodies to review their support of this model in line with their professional guidelines.

Akiko Hart, CEO, National Survivor User Network

Foreword

In the wake of the Black Lives Matter protests in the summer of 2020, when thousands of people across the UK came together to take a stand against racial injustice and police violence, and in the backdrop of COVID-19, which starkly exposed pre-existing healthcare inequalities, healthcare institutions were driven to consider their own position in maintaining systemic and institutional forms of injustice.

Many responded promptly. Within mental health, for example, the Royal College of Psychiatrists created a Race Equality Taskforce to tackle systemic racism and promote racial equality,¹ and the British Psychological Society committed to promoting racial equality, diversity and inclusion within the institution.² This year, responding to the controversial Sewell Report, widely criticised for its dismissal of institutional racism within the UK, the Royal College of Psychiatrists reiterated the distinction between individual and systemic forms of racism, and how these can lead to mental health problems.³

However, the findings of this report, and of Medact's 2020 report *False Positives: the Prevent counter-extremism policy in healthcare*, reveal the extent to which mental health professionals are participating in, or supporting – whether directly or indirectly – policing and surveillance practices that disproportionately target, impact, and ultimately harm racialised communities. This report also exposes a number of other ethical issues, such as confidentiality loopholes, that give much cause for concern.

Racism, mental health and pre-crime policing: the ethics of Vulnerability Support Hubs is particularly timely in view of the controversial Policing, Crime, Sentencing and Courts Bill. The 'Serious Violence Partnerships' proposed within this Bill – which the government lauds as a 'public health approach' to serious violence – take a pre-crime approach, just as the Prevent strategy does, and seek to build partnerships "unconstrained by organisational, professional or geographical boundaries", just as the hubs scrutinised in this report blur the boundaries between security and care.

It is precisely for these reasons that Medact's Securitisation of Health Group was set up: to challenge the embedding and expansion of policies and practices that monitor, police and criminalise people, particularly those from already marginalised communities, within healthcare; and to ensure that principles of ethical medical practice are upheld. We maintain that ethical practice in difficult and contentious fields is not served by avoiding scrutiny, and note with alarm the hurdles the authors of this report have encountered in making even partial information available to the public. This report is an important contribution to the growing body of evidence shining a light on the harms of criminalising policies within healthcare, and their impacts on professional ethics.

Medact Securitisation of Healthcare Group

May 2021

Executive summary

1. Introduction

This report examines 'Vulnerability Support Hubs', also known as the Vulnerability Support Service, a secretive mental health-related project run by UK counter-terrorism police.

- **Thousands** of individuals suspected of potential 'extremism' – a vague and racialised term which the government itself has tried and failed to legally define – have been assessed through these hubs.
- Vulnerability Support Hubs blur the boundaries between security and care in ethically problematic ways and, in effect, **deploy medicine as a security device**, illuminating a disturbing trend in counter-terrorism's 'turn to mental health'.
- The three hubs – South, Central and North – are unique because they **embed NHS mental health professionals** (who must first undergo police vetting) **within counter-terrorism police operations** and are based within regional counter-terrorism police units.

The hubs were piloted by UK counter-terrorism police in 2016-2017. This report analyses the pilot programme evaluations, based on documents which counter-terrorism police strenuously resisted disclosing.

- The scheme is currently being rolled out nationwide by the police via 'Project Cicero', despite **lack of independent evaluation and public scrutiny**, making the multiple ethical concerns raised by their activities all the more pressing.
- The **main aim of the hubs during the pilot scheme was unclear**, even to practitioners. Police premised their establishment on dubious associations between mental health and terrorism and claimed they

would divert people away from the criminal justice system.

- Their real function appears to be in helping police to **mitigate perceived risk** by **facilitating police to access health information** and providing counter-terrorism officials with a channel to contact and 'advise' mainstream mental health services.

Racism is highly significant to both mental health and policing, especially 'pre-crime' areas such as Prevent, and the hubs stand at the intersection of these two fields.

- **A racialised Muslim is at least 23 times more likely to be referred** to a mental health hub for 'Islamism' than a white British individual is for 'Far Right extremism', yet they adopt a 'colourblind' approach which masks this racial disparity and serves to perpetuate racism.
- **Racism is an overarching concern in this report** – all the other issues discussed should be understood as heavily racialised phenomena.
- **Many of those referred to the hubs are children and young people.**

2. Ethical concerns

Historically, psychiatry's ethical codes were developed to guard against the abuses seen when the profession becomes complicit in state repression of dissent and perceived criminality. **Vulnerability Support Hubs come into conflict with such ethical codes in multiple ways.**

2.1. Securitisation of care

Counter-terrorism policing's often spurious

and highly racialised pre-crime security concerns are influencing medical treatment, including:

- Mental health assessments **conducted in the presence of police**, potentially causing clinicians to vary their normal medical practice.
- Intensified **monitoring of patient medication regime compliance**, partly on the basis of problematic concerns such as “acting in an odd manner” and being a “convert to Islam”.
- **Decisions to detain individuals** under the Mental Health Act and Deprivation of Liberty Safeguards, including in cases where police appear to be applying pressure on health professionals.

There is evidence of coercive practices including serious concerns about the potential use of psychiatry to facilitate cooperation with police, undermining individuals’ right to refuse ‘deradicalisation’.

Health workers appear to be acting beyond their remits, in three ways:

- **Helping to assess individuals’ future terrorism risk** by collaborating with police to decide upon a “combined” mental health and terrorism risk assessment grading, in order to prioritise cases, **collapsing the boundaries between health and counter-terrorism**.
- Health workers are being encouraged to **perform a surveillance function** to “monitor” patients behaviours and speech.
- Health workers appear to be engaging in what is effectively ‘deradicalisation’ work of dubious scientific validity.

2.2. Pathologisation

The hubs adopt a ‘no wrong patient’ model and use sub-diagnostic thresholds:

- They include broad categories

such as ‘behavioural and emotional difficulties’ within their purview, in order to reduce instances of **‘false negatives’**.

- This is the opposite of trends seen in overstretched **mainstream** mental health services, where **criteria are becoming increasingly stringent**.
- The hubs apply ‘formulation’ – a subjective technique, liable to racial bias, which was developed in forensic settings – to the **pre-criminal arena**.

The hubs risk pathologising people who have no diagnosable mental health conditions, based on:

- **Political expression** perceived to be ‘extremist rhetoric’, the ‘suspect’ behaviour for which many were originally referred to Prevent.
- **Socioeconomic vulnerability** and precarious social status (homelessness, unemployment, immigration status), based on unevidenced assumptions, **securitising unmet need** in the context of austerity and the underfunding of mainstream mental health services.

A high proportion of patients referred to each hub were already in contact with NHS mental health services and many were actually referred into Prevent from the health sector, underlining the circularity and duplication the hubs create.

2.3. Confidentiality, criminalisation, stigma, and deterrence

The hubs circumvent and erode confidentiality expectations by facilitating police access to healthcare information:

- They use a ‘consultancy’ model in which NHS staff embedded in the hubs usually operate at arms-length from patients and **primarily provide a service to police officers**, protecting

staff from breaching confidentiality expectations.

- The mainstream NHS staff from whom they request data are unlikely to be aware of just how closely **'in-house'** hub mental health professionals are working with police and how information may be passed on to police.
- **Police praise the scheme for how much easier it has made it to access health information, saving time and money.**

These practices risk making health workers complicit in criminalisation:

- Documents explicitly state that information can be used to pursue **convictions**.
- Indeed the hubs also work to support counter-terrorism **investigations**, blurring the lines between Prevent and Pursue (which address pre-crime safeguarding, and pursuit of terrorist offenders, respectively).

The existence and practices of the hubs exacerbate stigma against poor mental health – especially amongst Muslims – as a sign of potential terrorism.

They also risk worsening mistrust and further deterring racialised groups from accessing healthcare when in need.

Conclusion & Recommendations

- **Vulnerability Support Hubs are not needed, are harmful, and should be scrapped, along with the entire Prevent programme in healthcare.**
- **Mental health concerns should be dealt with by mainstream mental health service, which urgently require more funding.**
- **The Royal College of Psychiatrists and British Psychological Association should work against the disproportionate referrals of Muslims to the hubs, remind practitioners of their ethical duties and speak out against stigmatising associations between poor mental health and terrorism.**
- **The General Medical Council should look urgently at whether health professionals are working beyond their competency and possible loopholes in confidentiality.**
- **Researchers should focus less on the hypothesised influence of poor mental health on terrorism risk and more on the tangible influence of pre-crime and counter-terrorism policing on mental health and on mental health care.**

Introduction

This report examines ‘Vulnerability Support Hubs’, a mental health-related project run by UK counter-terrorism police. Thousands of individuals suspected of potential ‘extremism’ – a vague and racialised term which the government itself has tried and failed to legally define⁴ – have been assessed through these hubs. They blur the boundaries between security and care in some ethically problematic and dangerous ways and, in effect, deploy medicine as a security device – policing through mental health. In doing so, the hubs illuminate a disturbing trend in counter-terrorism’s “turn to mental health”.⁵ The rise of strategies like Prevent, which claim to adopt a ‘public health’ approach because they intervene at the ‘pre-crime’ stage, turn political issues into individualised mental health problems of particular groups deemed ‘vulnerable’ to ‘radicalisation’.⁶

Historically, psychiatry’s ethical codes were developed to guard against the abuses seen when the profession becomes complicit in state repression of dissent and perceived criminality. In 2016, the year the Vulnerability Support Hubs were launched, the Royal College of Psychiatrists alluded to the project in a position statement, noting the importance of ensuring that psychiatric practices connected to counter-terrorism are “subject to the usual ethical safeguards”.⁷ As scholar Rita Augestad Knudsen observes, the hubs pose a range of ethical challenges.⁸ These are made all the more pressing because the scheme is currently being rolled out nationwide by the police via ‘Project Cicero’.

Section 1 of this report introduces the hubs, explores what they do and explains the methods used to gather data about their opaque practices. It also outlines the fraught intersections between racism/Islamophobia, mental health and policing (especially counter-terrorism), and analyses data on the hubs’ activities showing that they disproportionately impact Muslims.

In **Section 2**, we analyse material from the hubs with regard to three areas of ethical concern:

- the **securitisation of care**, including the way pre-crime policing concerns are influencing medical treatment, evidence of coercive practices and the way health workers appear to be acting beyond their remit
- **pathologisation**, including the hub’s sub-diagnostic thresholds, and evidence that people without diagnosable mental health conditions are at risk of being pathologised on the basis of political expression or precarious social status (homelessness, unemployment, immigration status)
- how the hubs erode **confidentiality** by facilitating police access to health information – potentially implicating health workers in **criminalisation** – and deepen mental health **stigma**, as well as exacerbate racialised patterns of **deterrence** which prevent people seeking to access healthcare when in need.

In line with Medact’s previous call for the Prevent policy in healthcare to be scrapped, **Section 3** recommends that the hubs are closed down, and that all mental health care concerns are dealt with by mainstream NHS services, which urgently require more funding.

1.1. What are Vulnerability Support Hubs?

In 2015, the UK government made its Prevent counter-extremism programme a statutory duty for a range of public bodies. This meant that, amongst others, NHS trusts were legally bound to “have due regard to the need to prevent people from being drawn into terrorism”. Health workers and others are expected to report people viewed as “vulnerable to radicalisation”. It is vital to emphasise just how broad and vague the supposed “signs” of radicalisation are: they include “need for identity, meaning and belonging”, “need for status” and “need for excitement, comradeship or adventure”.⁹ From the outset, Muslims have been disproportionately referred to Prevent.

In 2016, Counter Terrorism Police Headquarters commissioned research which suggested that around half the people referred to Prevent had “vulnerabilities related to mental health.”¹⁰ This provided the justification for piloting a new project called Vulnerability Support Hubs. The 2016-17 pilot project was part-funded by the NHS and the Home Office alongside counter-terrorism police.¹¹

“ Vulnerability Support Hubs uniquely embed NHS mental health professionals within counter-terrorism police operations ”

The scheme chimed with counter-terrorism’s contemporary “turn to mental health”,¹² which in some cases has led to specialist mental health trusts automatically screening all patients for signs of radicalisation.¹³ Those behind the new project called it “groundbreaking”.¹⁴

Vulnerability Support Hubs are exceptional because they uniquely embed NHS mental health professionals within counter-terrorism police operations.¹⁵ Each hub employs several mental health professionals including consultant psychiatrists, consultant psychologists and mental health nurses.¹⁶ These health professionals must undergo police vetting to obtain security clearance and so-called ‘STRAP’ accreditation, a system used to restrict access to highly sensitive intelligence.¹⁷

Crucially, police maintain overall control.¹⁸ Indeed, the three hubs, established between February and September 2016, are “co-located” within regional counter-terrorism police units in England’s three biggest urban areas – London, Birmingham and Manchester:

- **The South Hub**, also known as Prevent Liaison and Diversion (PLAD), based within SO15, the Metropolitan Police’s specialist Counter Terrorism Command unit, with staff from Barnet, Enfield and Haringey Mental Health NHS Trust.
- **The Central Hub**, also known as Prevent-in-Place (PiP), based within Counter Terrorism Policing West Midlands, with staff from Birmingham and Solihull Mental Health NHS Foundation Trust.
- **The North Hub**, also known as the Northern Mental Health Team (NMHT), based within Counter Terrorism Policing North West, with staff from Lancashire and South Cumbria NHS Foundation Trust (and latterly Greater Manchester Mental Health NHS Foundation Trust in addition).¹⁹

Image 1: Police forces and NHS trusts involved in Vulnerability Support Hubs



Source: Interim Evaluation 2 – page 1.

Methods: exposing the hubs through FOI

Notwithstanding their unique role within UK counterterrorism, little was known – until now – about what Vulnerability Support Hubs actually do. Their activities have largely remained shrouded in secrecy, with very limited information publicly available. Therefore, the hubs' work has been subject to almost no scrutiny from the media, scholars or the public. This lack of transparency is itself a major ethical concern since it severely limits possibilities for proper accountability.²⁰

According to a rare news report on the hubs, psychiatrists working on the Vulnerability Support Hubs pilot scheme were told by the Office for Security and Counter-Terrorism within the Home Office “not to disclose any details of their findings ahead of a final report”, due to be released in November 2017.²¹ For unknown reasons, this report was never released. However, following a series of long-running Freedom of Information (FOI) requests, Medact obtained the original pilot project evaluations and carried out documentary analysis. Despite several references to “independent evaluation” when the pilot was set up,²² these evaluations were in fact produced internally (and with an eye on securing continued funding). Medact is publishing the documents alongside this report, which is based on the unprecedented levels of insight into the hubs' activities that they provide.

Given increasing official tendencies towards cynical disregard for FOI laws, highlighted in the recent Open Democracy report *Art of Darkness*,²³ it is important to highlight how strenuously counter-terrorism police stalled and sought to resist full disclosure. Medact first requested the evaluations in November 2019 but police initially claimed, even after an internal review, that no relevant data was held.²⁴ However, after we appealed to the Information Commissioner's Officer

“ *Public policy cannot be based on either no evidence or a lack of transparency about evidence*

– Royal College of Psychiatrists

(ICO), the police released a document entitled *Prevent mental health hubs: final evaluation report*²⁵ a whole year later, in November 2020.²⁶

But this “evaluation” chiefly consisted of a list of innocuous recommendations; the substantive data was contained within appendices, which police had omitted to disclose.²⁷ After we again appealed to the ICO, it issued a “decision notice” saying that the appendices should be released.²⁸ At this point, counter-terrorism police informed Medact that a “mistake” had been made and asked if we would accept redacted versions, stating that it would otherwise “have no alternative” but to lodge an appeal with the Information Tribunal – in other words, launch a court case to dispute the ICO’s decision.²⁹

In the event, the police did not follow through with legal action and released the appendices, almost entirely unredacted. However, two and a half weeks later, they quietly published a new document about the scheme which states that “since the inception of the [project] a number of improvements have been made”. This appears to be an attempt to preempt criticisms about the hubs following disclosure of the evaluations.³⁰

What the hubs do

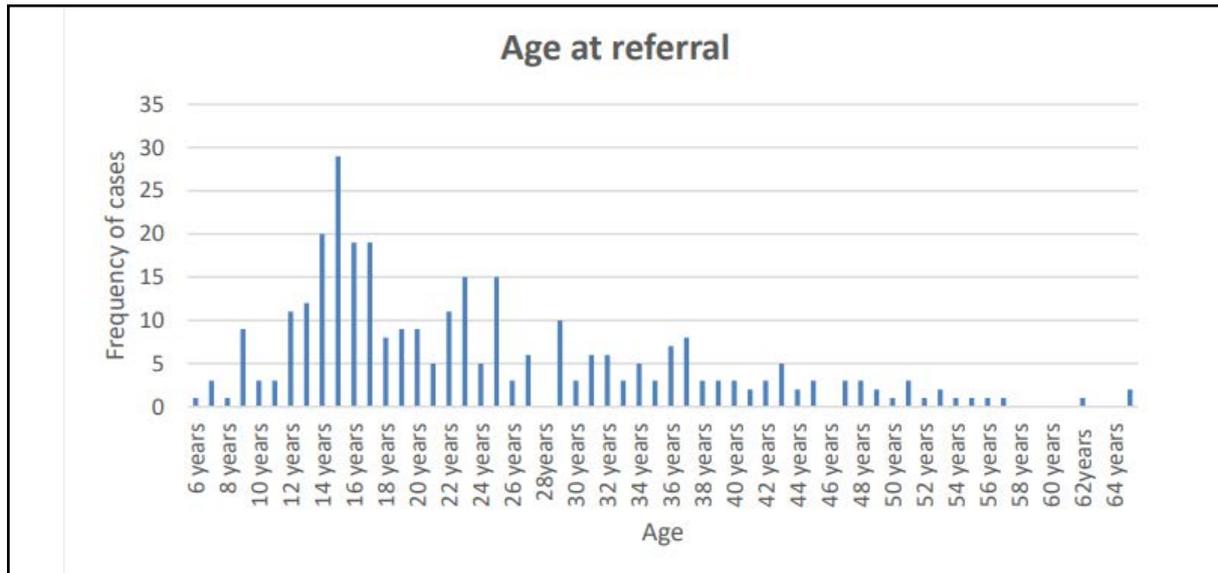
Most of the individuals assessed at the hubs are people who have been referred to Prevent whom the police suspect may have mental health conditions. It should be emphasised that Prevent operates in the ‘pre-criminal space’ and individuals are referred to the programme purely on the basis of suspicion, rather than for committing any crime. (Indeed, Muslims have been reported to Prevent for such supposedly suspicious behaviours as reading a book on terrorism in a university library and debating environmental activism in a school classroom).³¹ The hubs must therefore be distinguished from forensic settings which mostly deal with individuals convicted of criminal offences – though, as we will see, they blur the lines between pre-crime and prosecution in significant ways.

While no standardised data collection techniques were used across the three hubs during the pilot, the documents reports show that many of those referred are children. Concerningly, as Figure 1 shows, those referred to the Central Hub during the pilot were mostly teenagers. The youngest was just six years old. This is consistent with the wider Prevent programme (in which most referrals come from the education sector),³² and may indicate the degree to which the supposed ‘signs’ of ‘radicalisation’ render many normal adolescent behaviours suspect. This is particularly the case where the young person concerned is Muslim. As we will see, the data shows that Muslims are disproportionately referred to the hubs, again in line with the wider Prevent programme.

Moreover, only *some* of the people referred to the hubs actually do have mental health conditions, as Section 2.2 on pathologisation explains. However, of those who do, many (for example, 42.6% of all referrals to the North Hub and the majority of referrals to the South Hub) are *already* in contact with mental health services. Common diagnoses of people processed by the hubs include psychotic disorders such as schizophrenia, personality disorders, mood disorders and Autistic Spectrum Disorders, as well as learning difficulties.³³

“ The main aim of the hubs during the pilot scheme was unclear even to practitioners

Figure 1: Ages of individuals referred to the Central Hub, 2016-17



Source: Central Hub – page 16.

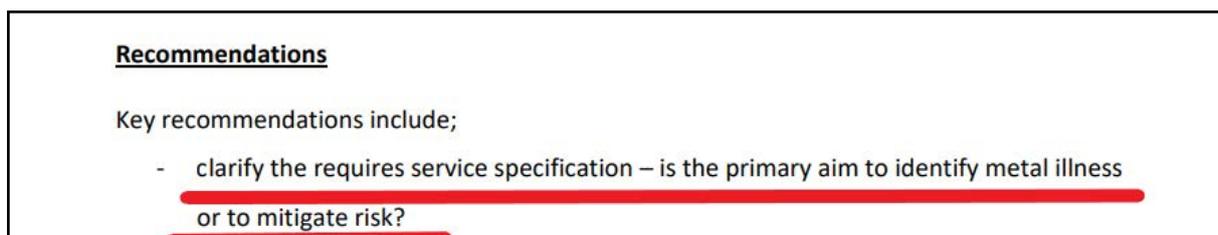
Rarely are those referred to the hubs actually assessed directly by the psychologists, psychiatrists and mental health nurses at the hubs.³⁴ Instead, the hub mental health professionals usually operate at arms-length from the Prevent referees and primarily work in a “consultancy”³⁵ capacity, providing “a service to the referring police officer”.³⁶ Indeed, such is the closeness of their relationship to the police that they are referred to in the evaluation documents as an “in-house” team.³⁷

Importantly, as the excerpt in Image 2 shows, the main aim of the hubs during the pilot scheme was unclear, even to practitioners. In public, the establishment of the hubs was substantially

“ *Most of those referred to the Central Hub during the pilot were teenagers. The youngest was just six years old.* ”

premised on the questionable idea that there is a meaningful association between mental health and terrorism. They would, according to the police, “improve the understanding of both police and health professionals of the associations between mental health conditions and vulnerability to radicalisation”.³⁸ In addition, it was claimed the hubs would “increase access to mainstream services for vulnerable individuals and – as a result of early intervention – improve health outcomes, achieve cost efficiency savings and reduce risk to the public”.³⁹

Image 2: Recommendation to clarify the main aim of the hubs

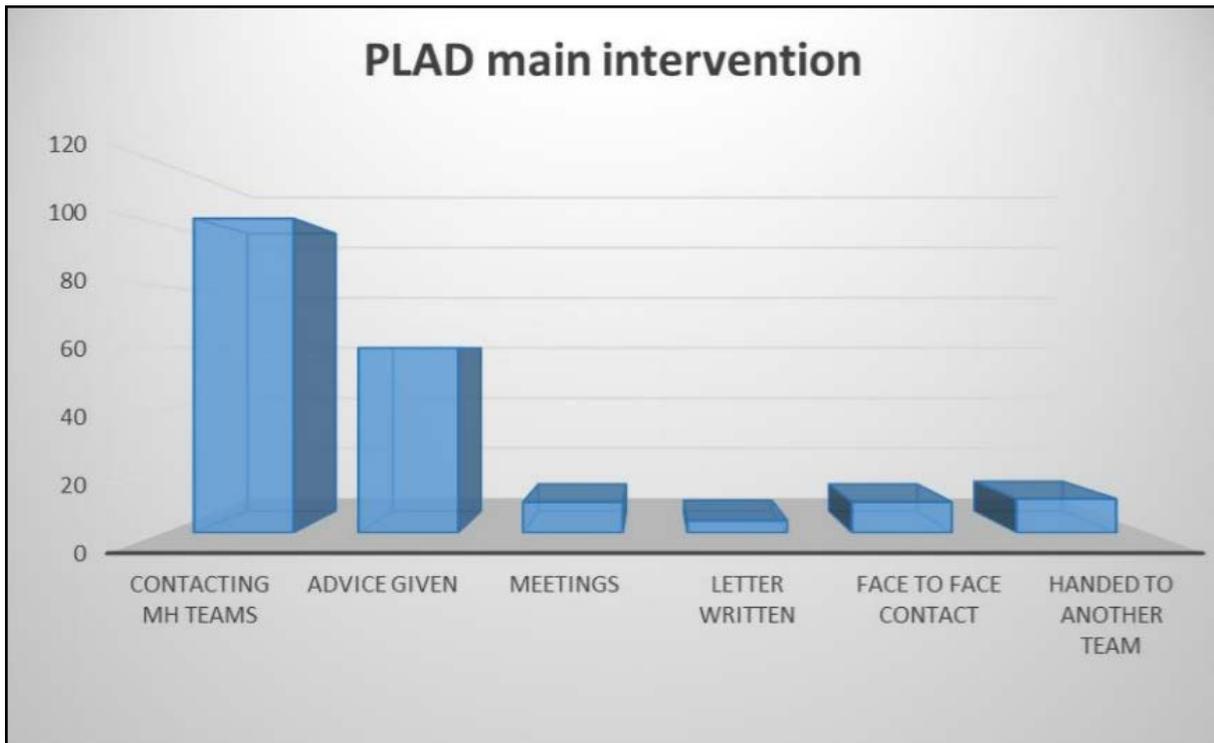


Source: Central Hub – page 27.

However, as we will see, the hubs’ implied research purpose was soon dropped. Moreover, the internal evaluation documents – which refer to the hubs as a “bespoke service model”⁴⁰ – make

plain that improving mental health outcomes for patients is not the priority. Rather, the hubs' main purpose emerges implicitly as helping police to mitigate the perceived risk posed by the individuals referred. These people, it bears repeating, often do not have mental health conditions and have not committed a crime, but have been referred on the basis of suspicion alone. The hubs' risk management function is exercised through two main activities. Firstly, the hubs help police to access health information, as Section 2.3 on confidentiality explores. This in turn, police note, saves time and therefore money. Secondly, as the graph in Figure 2 shows, the hubs' main activity is contacting and 'advising' mainstream mental health services in order to "ensure that the CT [counter-terrorism] risk is considered".⁴¹ Section 2.1 explains the consequences of this securitisation of care.

Figure 2: Main 'interventions' by the South Hub ('PLAD'): contacting and 'advising'



Source: South Hub – page 15.

Why are the hubs concerning?

The Vulnerability Support Hubs are in their fifth year of operation. During that time, according to a response to an FOI request, no specific ethical guidelines have been developed. However, another FOI request reveals that thousands of individuals have been assessed by the hubs (see Table 1).

Today, counter-terrorism police are rolling out the scheme – now being referred to as the Vulnerability Support Service (VSS) – nationwide. This is being done under the name 'Project Cicero', which is currently underway.⁴² The rollout is taking place in the absence of public scrutiny, despite the lack of an independent evaluation, and without any clear evidence of the scheme's *impact on the individuals referred*, with a particular emphasis on the potential for coercion. Nor have the ethics of pre-criminal counter-terrorism-based mental health hubs been assessed, either

Table 1: Total numbers of people assessed by each hub, 2016-2020

South Hub	Central Hub	North Hub
1,388	1,528	926

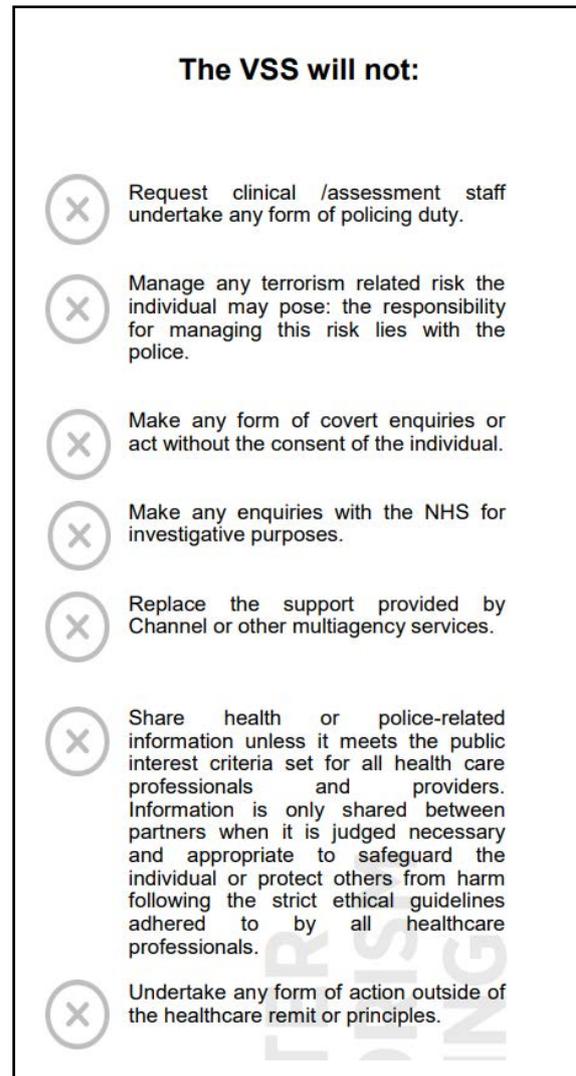
Source: FOI requests.

for the professional integrity of the psychodisciplines involved, nor the potential impact on mental health access for marginalised communities – especially Muslims. Indeed, the main substantive measure of success offered in the evaluations is the fact that “police officer feedback in all three hubs has been positive”.

The fact that the Vulnerability Support Hubs are becoming a permanent feature of the UK counter-terrorism apparatus makes the multiple ethical concerns raised by their activities all the more pressing. A document published by police in February 2021, after they were forced to disclose the hub evaluations, includes a list of unethical practices which it says the hubs “will not” do (see Image 3).⁴³ These explicit denials appear to have been issued in an attempt to preempt criticisms, because – as this report shows – *all of these practices do in fact appear to have taken place at the hubs*. Moreover, there is no evidence that such malpractice has been rectified since the scheme was piloted. Based on our analysis of the documents, we raise the following significant ethical concerns about ongoing activities at Vulnerability Support Hubs which blur the lines between security and care:

- Counter-terrorism police’s often spurious and racialised pre-crime security concerns are influencing mental health care, including:
 - decisions to detain individuals under the Mental Health Act
 - intensified monitoring of patient compliance with medication regimes
 - coercively undermining individuals’ right to refuse medical care and/or ‘deradicalisation’.
- NHS mental health professionals are being encouraged to go beyond their remit to:
 - help assess individuals’ likely future terrorism risk
 - perform a surveillance function to “monitor” patients
 - engage in ‘deradicalisation’ work of dubious scientific validity.
- The hubs use sub-diagnostic thresholds and are at risk of:
 - pathologising people with no diagnosable mental health conditions, on the basis of political expression perceived to be ‘extremist rhetoric’
 - pathologising and/or criminalising people on the basis of precarious immigration status and socioeconomic vulnerability.

Image 3: Unethical practices the hubs ‘will not’ do according to counter-terrorism police



Source: VSS doc – page 7.

- The hubs also:
 - erode confidentiality by facilitating police access to healthcare information
 - risk making health workers complicit in criminalisation
 - stigmatise poor mental health – especially amongst Muslims – as a sign of potential terrorism
 - risk further deterring racialised groups from accessing healthcare.

1.2. Racism, mental health and pre-crime policing

The large body of research on ‘madness’, racialisation and crime shows us that throughout history, racialised and dispossessed groups have been pathologised and criminalised. Today, racism remains highly significant to both mental health and counter-terrorism. Standing at the intersection of these two fields, the Vulnerability Support Hubs exemplify how discrimination in each arena can be mutually compounding yet display a determined ‘colourblindness’ which serves to perpetuate racism.

Race and mental health

Racism has a long history within psychology and psychiatry.⁴⁴ Within psychiatry, the most famous examples of racialised pathologisation are three conditions ‘identified’ by Dr Samuel Cartwright in the mid-nineteenth century: ‘drapetomania’ – the ‘disease’ that caused enslaved Africans to run away; ‘rascality’ – the ‘disease’ that made enslaved Africans commit petty offenses; and ‘dysaesthesia ethiopica’ – which purportedly made enslaved Africans “insensible and indifferent to punishment”.⁴⁵ Cartwright’s racialised medicine pathologised the distress experienced by kidnapped, enslaved people – framing their pain through the discourses of eugenics common at the time, attributing it to biological defects.

“ *Racialised groups are more likely to be subjected to coercion and violence when experiencing mental distress* ”

More recently, sociologist Nikolas Rose has argued that psychological knowledge has been central in the state’s framing of ideal citizenry on the one hand, and the surveillance and capture of anti-citizens – alleged extremists – on the other.⁴⁶ For instance, Jonathan Metzl documents the fact that American psychiatrists discussed how “black men developed ‘hostile and aggressive feelings’ and ‘delusional anti-whiteness’ after listening to the words of Malcolm X, joining the Black Muslims, or aligning with groups that preached militant resistance to white society”.⁴⁷

Today, the supposedly universal scientific ‘tools’ used to assess and address ‘mental illness’ continue to be inflected by pervasive racial bias. Race is an important factor at every stage – from access to mental health care, through to diagnosis and treatment. Racialised groups are more likely to be subjected to coercion and violence when experiencing mental distress.⁴⁸ For example, Black communities are three times more likely to be diagnosed with schizophrenia than average, and are disproportionately sectioned under the Mental Health Act.⁴⁹ Given that these hubs, as we will see, mostly deal with British Muslims, it is important to note that, according to studies:

- Muslims face a range of challenges in accessing mental health services, not least Islamophobia. Muslims have recovery rates much lower than the national average for psychological therapies (3% versus 8%)⁵⁰
- mental health settings necessarily reflect normalised Islamophobic logics found in wider society, such as anxiety around women wearing the headscarf⁵¹
- mental health services are uncertain how to engage with ethnic and religious diversity.⁵²

The upshot of all this is that mental health services, as a recent report asserts, ought to recognise and be aware of the impact of racism and discrimination.⁵³ This is a fundamental first step towards seeking to address and eradicate racist practices from within such services. It is also pertinent to note that research shows that people with mental health conditions are in general perceived as potentially dangerous.⁵⁴ Since racialised groups are also pervasively associated with threat, this perception is highly likely to be compounded when racialised individuals experience mental ill-health.

Race, policing and counter-terrorism

UK police have long been accused of racism. Discrimination in policing is often most pronounced in areas of ‘pre-crime’ – from historic ‘sus’ laws to contemporary stop and search practices – due, in no small part, to racialised perceptions of threat and narratives about crime.⁵⁵

With regard to perceptions of terrorist deviancy, the figure of the Muslim is preeminent and has evolved through time to incorporate a range of ethnic groups including Arabs, South Asians and Black people.⁵⁶ As a contemporary form of racism, therefore, Islamophobia is intimately connected to the War on Terror. (But it is far from exclusive to this domain: indeed, there is evidence of widespread Islamophobia in the criminal justice system, with Muslims making up just 5% of the population but 17% of UK prisoners, only 1% of whom have been incarcerated for terrorism-related offences).⁵⁷ Preemptive counter-terrorism policing such as Schedule 7 and the Prevent programme have consistently disproportionately impacted Muslims.⁵⁸

In 2020, Medact research found that Muslims were at least eight times more likely than non-Muslims – and Asians at least four times more likely than non-Asians – to be referred to Prevent from a sample of NHS trusts.⁵⁹ This over-representation is the product of the racial bias encoded in

health sector guidance on spotting the “signs of radicalisation”, combined with official exhortations to health workers to trust “gut instinct”.⁶⁰ As a survey of 329 NHS staff found, health workers inevitably draw on representations in popular culture to understand and operationalise elusive and racialised notions of “extremism” and “radicalisation” for which they are asked to be vigilant.⁶¹

“ Overall, a racialised Muslim is at least 23 times more likely to be referred to a mental health hub for “Islamism” than a white British individual is for “Far Right extremism”

Image 4: “Mr X was referred...following concerns that he had converted to Islam”

Mr X was referred to the Prevent-in-Place Team following concerns that he had converted to Islam in prison, that he was behaving bizarrely and that he had a history of threatening behaviour **S38 Health and Safety**. This referral was presented as an urgent referral **S38 Health and Safety**

Source: Central Hub – page 42.

The hubs’ racial disproportionality and ‘colourblindness’

Vulnerability Support Hubs stand at the nexus of mental health and counter-terrorism policing. Yet despite the racism prevalent in each field independently, and the potency of combining these two arenas, the hub evaluation documents are completely silent on the issue. Such ‘colorblindness’ – the pretense that racial discrimination does not exist – serves to reproduce the egregious racism apparent in the hub statistics.

Islamophobia is a form of racism.⁶² The evaluation documents do not record religious affiliation data and so the extent of discrimination against Muslims is difficult to gauge, since individuals of any ethnicity (including white people) can be Muslims. Indeed, the hub documents contain two cases of individuals whose conversion to Islam is treated as highly suspicious, such as the one shown in Image 4.

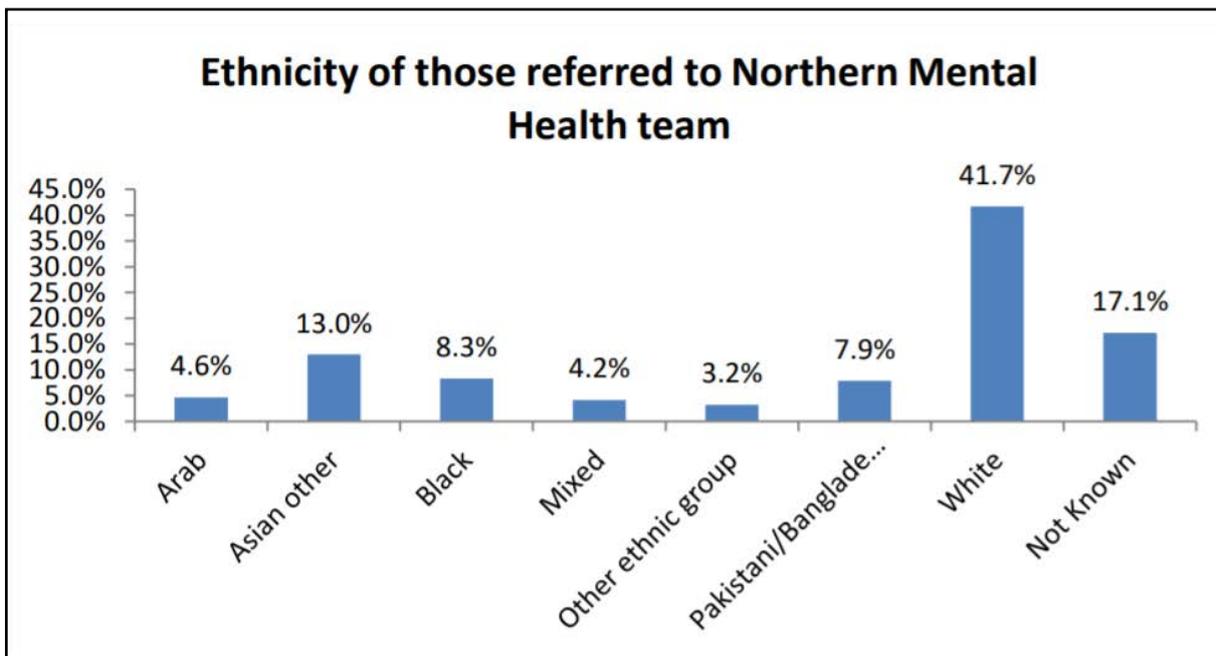
However, “Islamist” ideology can reasonably be assumed to indicate Muslim individuals and “Far-Right” can be treated as a proxy for white British individuals. Overall, the majority of those referred

across the hubs were categorised as presenting with “Islamist extremism”.⁶³ At the South Hub, the figure was 49.3% (compared to 10% “Far-Right extremism”).⁶⁴ At the North Hub, 53% of people referred were labelled “Islamist”.⁶⁵

When accounting for population demographics, the statistics reveal gross Islamophobic disproportionality.⁶⁶ Overall, a racialised Muslim is *at least* 23 times more likely to be referred to a mental health hub for “Islamism” than a white British individual is for “Far Right extremism”. Note these ratios are calculated from 2011 population demographics, and so they likely produce a conservative estimate given the growth of the British Muslim population. The full data used is shown in the Appendix.

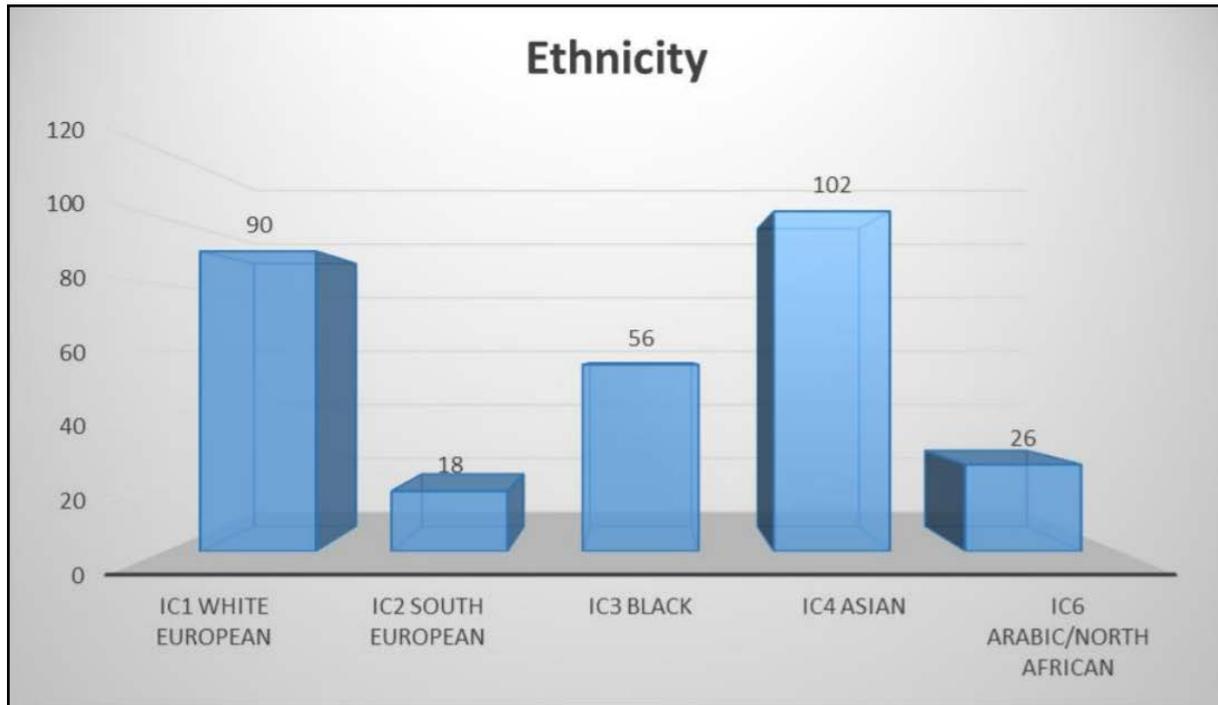
The statistics for ethnicity are similar. At the North Hub for example, as the graph in Figure 3 shows, while 41.7% of referrals were white, the combined total of referrals from different racialised groups was almost equal, at 41.2%. Bearing in mind the proportion of the population who are from racialised groups vis-a-vis white people, this equivalence also speaks to gross disproportionality. At the South Hub, as shown in Figure 4, the most referrals during the period analysed were of Asian⁶⁷ ethnicity (102), followed by white Europeans (90), Black people (56) and Arabs (26) – again, figures indicative of racialised groups’ over-representation. Unsurprisingly, migrants are also massively overrepresented: at the North Hub, an astounding 48% of those referred were not UK-born.⁶⁸

Figure 3: Racialised groups constitute 41.2% of referrals vis-a-vis 41.7% white people (North Hub)



Source: North Hub – page 5.

Figure 4: Asians, Black people and Arabs all over-represented (South Hub)



Source: South Hub – page 7.

Yet, rather than acknowledging with concern the racial disproportionality to which these numbers attest, the South Hub actually used its demographic data to *explicitly profile* a typical referral, as the excerpt in Image 5 shows.

Image 5: Explicit profiling using racial and other demographic data from (South Hub)

Following a review of the data below it would suggest that the most recurrent profile of person referred to PLAD is male, aged 25, presenting with an ideology relating to Daesh (ISIS), is of Asian ethnicity, with a diagnosis of schizophrenia, currently known to mental health services and has previous criminal convictions.

Source: South Hub – page 5.

Racism is itself a major ethical issue. While the rest of this report deals with specific ethical issues at the intersection of counter-terrorism and mental ill-health, racism is an overarching concern which runs throughout. Since racialised groups, especially Muslims, are disproportionately referred to the hubs, all the issues discussed in what follows – including securitisation, coercion, pathologisation and criminalisation – should be understood as heavily racialised phenomena.

Ethical concerns

In a democracy, safeguards exist to prevent governments from exercising excessive power over psychiatric treatment and detention. Professional codes of ethics have been established for good reason. Throughout the 1970s and 80s, the Soviet Union repressed political dissidents (democratic activists) through the psychiatric system – diagnosing many as suffering from “sluggish schizophrenia”. At the suggestion of security agents, dissidents could be assessed by psychiatrists and then detained for lengthy periods in psychiatric institutions.⁶⁹ The political repression of democracy activists outraged Western psychiatric associations, who then codified strict ethical standards which limited collaboration between psychiatrists and the security services/police to providing care for those detained and to serving the best interests of patients.

However, ethics scandals have also rocked western mental health establishments, including in recent years in relation to the War on Terror. Notably, the American Psychological Association was exposed as having secretly collaborated with the US Department of Defense and ultimately amended their code of ethics in order to permit psychologists to colluded in the torture of detainees during interrogations at Gauntanamo Bay.⁷⁰

Meanwhile, the UK’s Royal College of Psychiatrists states in its professional ethics code that psychiatrists are not permitted to diagnose a person as mentally ill on the basis of their political, religious or ideological beliefs, and, when working with the police and/or intelligence services, psychiatrists must “be aware of their dual role and allegiance, seek advice and act in the patient’s best interests”.⁷¹ The activities of Vulnerability Support Hubs frequently come into conflict with these longstanding ethical principles.

“ *The first psychiatric ethical codes were produced in response to abusive collaboration between psychiatrists and security services* ”

2.1. Securitising care

This section shows that through the Vulnerability Support Hubs project:

- counter-terrorism police's often spurious and racialised pre-crime security concerns are influencing mental health care, including:
 - mental health assessments conducted in the presence of police
 - intensified monitoring of patient medication regime compliance
 - decisions to detain individuals under the Mental Health Act
 - coercively undermining individuals' right to refuse 'deradicalisation'
- NHS mental health professionals are being encouraged to go beyond their remit to:
 - help assess individuals' likely future terrorism risk
 - perform a surveillance function to "monitor" patients behaviours and speech
 - engage in 'deradicalisation' work of dubious scientific validity.

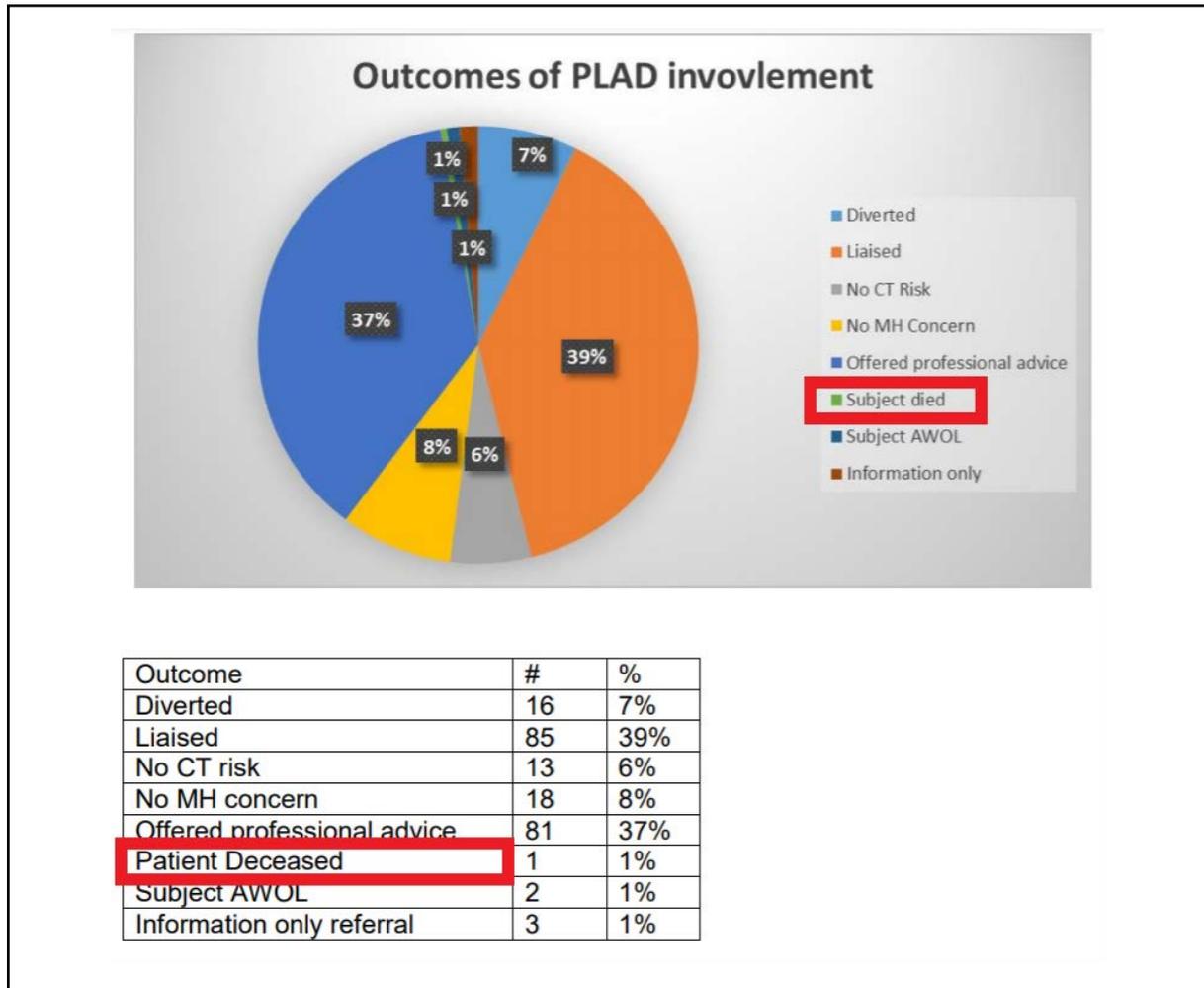
Policing concerns influencing medical treatment

Working in highly securitised contexts can pose an issue of 'dual loyalty', in which a health worker's primary duty to act in the patient's best interests can be in tension with the aims of a third party, such as their employer.⁷² The hubs are one such instance, 'co-located' within police counter-terrorism units and conducting stringent security vetting of health professionals prior to employment. In such spaces, the lines between security and care can become blurred. This is reflected, at times, in the very language used by the hubs. In one example, the same person – an individual who died while in contact with the South Hub – is referred to using police terminology as a "subject" at one point, and in health terminology as a "patient" the next (Figure 5).

In many of the case studies contained in the hub evaluation documents, it is clear that counter-terrorism policing's often spurious and racialised *pre-crime* concerns have influenced mental health care.

“ *Psychiatric examination in the presence of...security staff...[can lead health workers to] vary their normal medical practice to fit in with security concerns* ”

Figure 5: Same individual's descriptor shifts between "subject" and "patient"



Source: South Hub - page 16.

Mental health assessments conducted in the presence of police

Firstly, mental health assessments carried out by hub staff, especially those from the Central Hub, are often performed in the presence of Prevent officers and other police personnel. The excerpts in Images 6-9 show this. The deployment of police officers alongside a mental health team conducting a psychological assessment in an individual's home is praised as a "good example of collaborative working". However, this is potentially highly problematic.

Whilst it is not clear from these cases at whose behest security officials attended, nor why, their presence will undoubtedly have affected clinical assessments. As the Royal College of Psychiatrists warns, "subtle pressures" such as "psychiatric examination in the presence of...security staff" may lead health professionals to "vary their normal medical practice to fit in with security considerations".⁷³ In contexts like this, clinicians are likely to give additional weight to the issue of risk. There are also implications related to coercion, dealt with in the following section.

Finally, the police presence is concerning because Prevent questioning and intelligence gathering can itself cause significant psychological stress and be experienced as stigmatising and traumatic. Therefore, as case studies from Medact's *False Positives* report attest, the presence of police during mental health interactions can seriously damage therapeutic relationships, worsen an individual's condition or delay their recovery.⁷⁴ Yet the clear evidence that individuals' mental health care can be harmed as a consequence of such securitised interactions does not appear to be a concern for the hubs.

Image 6: Mental health assessment conducted alongside Prevent Officer⁷⁵**Rapid Identification of Unmet Need, Liaison and Diversion to MH services**

Case 3

Mr X was referred to the Prevent-in-Place Team following concerns that he was **S38 Health and Safety**, and making inflammatory and threatening statements. There were concerns regarding his behaviour, and general presentation.

A PiP clinician attended a joint visit with the Prevent Officer to complete an assessment of Mr X's mental health needs. **S38 Health and Safety** the PiP clinician was able to gather information and facilitate the arrangement of a new GP. Via liaison with the GP, a referral to secondary mental health services was made and a diagnosis of First Episode Psychosis was made. Mr X is now engaging with mental health services, and receiving treatment for psychosis.

Source: Central Hub - page 41.

Image 7: Joint visit from mental health professional and Prevent Officer

Case 4

Mr X was referred to the Prevent-in-Place team following concerns about his mental state, behavioural difficulties and accessing extremist images **S38 Health and Safety**. On reviewing his case further, he had been previously been assessed by **S38 Health and Safety** mental health services but had not met the criteria for any of them or signposted further.

A PiP clinician reviewed his case file, offered consultation to Prevent Officers and conducted a joint visit to Mr X. Over the course of **S38 Health and Safety** assessment visits, during which the PiP clinician interviewed **S38 Health and Safety**, a comprehensive psychological assessment was completed. The clinician liaised with previous services, **S38 Health and Safety** and the PiP clinician has made a referral to **S38 Health and Safety** service to offer Mr X and his family appropriate support.

Source: Central Hub - page 41.

Image 8: Mental health assessment conducted during joint visit with Prevent Officer and local police

Case 5

Mr X was referred to the Prevent-in-Place Team following concerns that he had converted to Islam in prison, that he was behaving bizarrely and that he had a history of threatening behaviour **S38 Health and Safety**. This referral was presented as an urgent referral **S38 Health and Safety**

A PiP clinician reviewed his case file, and arranged to visit jointly with the Prevent Officer and Local Policing, the following day. The PiP clinician was able to complete the assessment with **S38 Health and Safety** Mr X **S38 Health and Safety**.

Source: Central Hub - page 42.

Image 9: Mental health assessment accompanied by Prevent Officers

Case Study 1

One example was an **urgent** case which came through on Friday afternoon. A Prevent action was raised and a GMP Prevent officer was tasked with work around the subject. The subject had made comments which suggested he posed a risk to members of the Muslim community. His mental health was considered a key and primary component of this risk. Our embedded practitioner requested the emergency duty team to complete a full mental health assessment accompanied by two Prevent officers. This was to not only support the duty worker, but also to explore the ideology around the comments if appropriate in an attempt to try and mitigate the CT risk or disrupt/escalate the case if the risk remained or increased. The duty worker concluded that the individual did not require admission under the Mental Health Act and that the most likely diagnosis was antisocial personality disorder. The urgency of response was deemed necessary due to a planned extreme right wing protest scheduled to take place at the weekend. The individual was later assessed by the access and crisis team and the embedded mental health practitioner liaised with the community mental health team closely to pass on the CT concerns to enable mitigation of the CT risk. This is a good example of collaborative working not only between embedded practitioners and Police officers, but also liaison with mental health teams in the community in order to safeguard both the public and the individual.

Source: North Hub – page 13.

Intensified monitoring of patient medication regime compliance

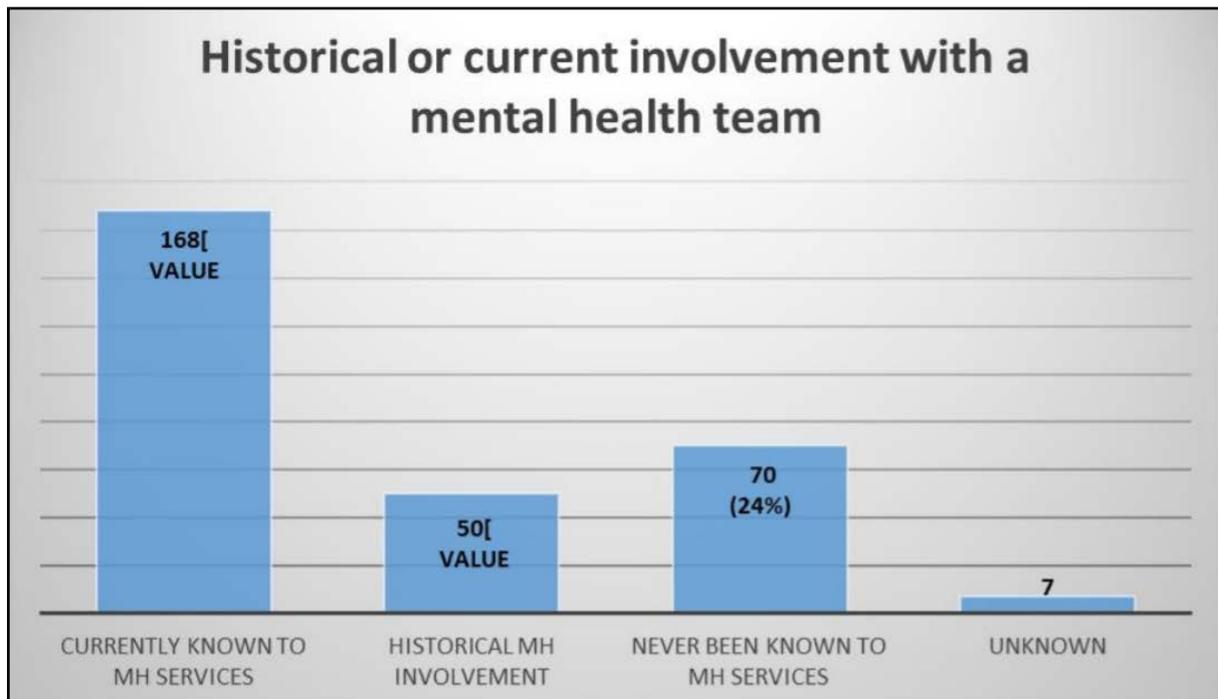
A second way in which counter-terrorism policing's security concerns impacted individuals' mental health treatment was by affecting the medication regimes of existing patients. It should be emphasised – and is discussed further in Section 2.2 on pathologisation – that not all of those referred to the hubs have diagnosable mental health conditions. However, as the graph in Figure 6 shows, the vast majority of patients referred to the South Hub were *already* in contact with NHS mental health services, or had previously been. Of referrals to the North and Central Hub, figures for those historically or currently known to mental health services were 47% and 43% respectively.⁷⁶ Section 2.2 also discusses this apparent service duplication.

Our present purpose is to note the significant medical consequences that being referred to a hub could bring about. As the three case study excerpts in Images 10-12 illustrate, interventions by the hubs to “ensure that the CT [counter-terrorism] risk is considered” led to changes in medication routines in several instances. While acting on police information is not necessarily a departure from normal psychiatric practice, the kinds of behaviours which prompted the police-led hubs to contact mental health services, resulting in escalations of treatment plans, are concerning. One case arose because a “convert to Islam” was “acting bizarrely” and making extreme right wing “comments”. Another features a schizophrenic man – whose race and religion are not mentioned but, given the statistic is highly likely to be from a racialised minority – who was perceived to be “acting in an odd manner” near London landmarks.

Even the most generous interpretation of these cases would observe that these patients being flagged as high-risk altered their healthcare, resulting in a more assertive approach. Yet, absent further details, questions about the potential influence of racist stereotyping in provoking counter-terrorism police's vague and highly speculative pre-crime fears would remain. A more critical interpretation might also be possible: that healthcare is being unjustifiably and improperly distorted in ways that do not serve the best interests of the patients concerned.

“ The hubs' reports show that police concerns may be influencing psychiatric assessment, treatment intensification and even detention ”

Figure 6: Majority of individuals referred to South Hub already in contact with mental health services



Source: South Hub – page 11.

Image 10: “Intensive support” and “increased monitoring” of Muslim convert’s medication compliance

4.2 Case Study 2

Police and ambulance services had received a call regarding a 58 year old man who was acting bizarrely. During this contact he made some comments which were of an extreme right wing nature.

There was a concern about the man’s presentation and consequently PLAD made contact with the local mental health team who knew this man. The team reported that the extreme right wing statements were out of character because the subject was a convert to Islam. Following PLAD involvement he was reviewed by the local team and offered more intensive support and increased monitoring of compliance with medication.

Source: South Hub – page 19.

Image 11: Individual with schizophrenia “became more stable on his medication” after intervention prompted by vague security concerns

4.1 Case Study 1

A 38 year old man who attended prominent London sites was seen to be acting in an odd manner which was potentially suggestive of hostile reconnaissance. During questions by police on these occasions he spoke about previous contact with mental health services and the officers were concerned about his presentation. Historic police checks note that two years ago the subject had been turned away on a number of occasions from Heathrow Airport attempting to travel without documents and stating that he had worked for secret services.

Given this background and the current vulnerability concerns PLAD made contact with the local mental health Trust and discovered that he was being managed under the primary care team from the GP surgery with a diagnosis of paranoid schizophrenia.

When PLAD discussed the above concerns with the allocated nurse the decision was taken to review his mental state with the psychiatrist. There was a consideration taken whether he met the criteria for detention under the Mental Health Act but the outcome was for him to be offered support with a home treatment team. This meant that he became more stable on his medication and he appeared to respond well to the engagement. The local clinical team addressed his understanding of vulnerability in the context of attending tourist sites.

Source: South Hub – page 19.

Decisions to detain individuals under the Mental Health Act / DoLS

Thirdly and most worryingly, the hub evaluation documents include three case studies in which individuals were deprived of their liberty under legal provisions *intended for the treatment of medical disorders and provision of care*, at least to some extent on the basis of counter-terrorism policing’s pre-crime security concerns.

While detaining individuals on the basis of risk informed by police information is a longstanding practice, the limited details provided in the case studies here, and some of the wording used, prompt concerns. In one case (Image 12), the so-called ‘disruptive safeguarding’ activities of the Northern Hub resulted in the detention (‘sectioning’) of a man with schizophrenia who had previously refused to comply with treatment or to participate in Channel – the ‘deradicalisation’ scheme within Prevent. In a striking example of the securitisation of care, after his mental health deteriorated and he engaged in racial verbal abuse, the North Hub “escalate[d] concerns” which led to him being detained under the Mental Health Act. Highly dubiously, the implication is that his ‘failure to engage’ in Channel was considered a relevant factor contributing to mental health requirements.

Image 12: Man with schizophrenia detained under the Mental Health ActCase Study 1

The first example of disruptive work occurred after one individual with extreme right wing views suffered deterioration in his mental health **Section 38 Health and Safety**. This individual had a diagnosis of schizophrenia and had a history of noncompliance with treatment and non-engagement with community mental health teams. He also had a history of violence and had demonstrated a recent escalation in his behaviour (verbally abusing people from ethnic minorities). He had also failed to engage with the Channel

process on numerous occasions. Our team was able to escalate concerns with the relevant community services which prompted a Section 135 warrant being obtained and led to the individual being detained under the Mental Health Act. This individual has since been discharged from hospital back into the community and following treatment is now willing to engage with the Channel Process to work on his right wing views. The embedded practitioner was also able to work with the Prevent officer and provide advice on a suitable intervention provider as well as upskill the allocated community mental health practitioner on managing the CT risk.

Source: North Hub – pages 14-15.

Image 13: “Escalation to secure admission” of individual receiving home treatment

WESTMINSTER COPY CAT				
High Risk, Mental Health				
TRIAGE				
Primary (CT)	Secondary (MH)	Triggers, Escalation	Unknowns	Allocation
Behaviour on bridge / M5 Car Hx criminality	Psychosis Home treatment 130 Bank holiday Friday	Recent attack Travel New 'interests' Increased risk behaviours	Intent Motivation Influences Effectiveness of MH input	RED
PCR				
Liaison with team	New behaviours but 'we know him well'. Plan - Continue Home Treatment			
Formulation	Trigger for escalation and motivation unclear – unacceptable unknown Not possible to adequately formulate (understand) risk Requires secure hospital setting.			
Action	Referral / escalation to secure admission and prevent discharge Advice and consultancy - effective risk assessment and management			
Outcome	Admission within an hour Prompt information sharing and effective multiagency working, risk assessment and risk management			

Source: Central Hub – page 37.

In another case (Image 13), an individual who had been receiving home treatment for psychosis displayed “new ‘interests’” and “increased risk behaviours”, the trigger for which was unclear. This was deemed an “unacceptable unknown” by the Central Hub, which led to “escalation to secure admission and prevent discharge” within a secure hospital setting. This phrasing sounds very much like the strong-arming of health professionals by counter-terrorism police and gives rise to questions about whether a psychiatrist would have judged the individual to meet the threshold for

admission to a secure hospital absent pressure from counter-terrorism police, via the hubs.

Moreover, the fact that this was partly based on missing information deemed “unacceptable unknowns” – rather than, say, a history of violent behaviour – suggests that highly racialised and risk-averse, pre-crime policing fears, rather than substantive issues, influenced his admission. Notably, the man has been dubbed “Westminster Copycat” despite the lack of clear indication that he had been planning to emulate the March 2017 terrorist attack (which was “recent” at the time). This emphasises both the counter-terrorism focus of assessments carried out at the hubs and the way heightened sensitivity in the wake of terrorist attacks increases the urgency with which police wield their power.

Image 14: Young man with learning disabilities detained under DoLS

RISK ASSESSMENT COMPLICATED BY MENTAL HEALTH	
Initial Referral	
Assessment	Young man with LD. Making explosions. Fake bombs. Threats to travel. AMBER
Formulation	Risk behaviours to manage distress plus secondary gains (attention) Rapid escalation due function, suggestibility and <u>lack of understanding / regard for consequences</u>
Action	Hub oversight of referrals (adult, child, inpatient, LD, forensic LD) Consultancy to Channel (SS, education, fire, police)
Outcome	Behaviours abated. Discharged
Re-referral	
Assessment	Interest in terrorism. Attempting to buy bomb making materials. Two referrals – (mental health team, public). RED
Formulation	Previous assessment - Rapid escalation in risk is highly likely <u>Risk limited by IQ but presence of radicalising influences unclear.</u> <u>Current support / monitoring not sufficient to manage risk.</u>
Action	<u>Emergency detention under DOLS</u> [Deprivation of Liberty Safeguards]
Outcome	Multiagency risk management plan with clear trip wires.

Source: Central Hub – page 39.

In a third case (Image 14), a young man with learning disabilities (“LD”) was deemed to have “current support / monitoring not sufficient to manage risk”, leading to “emergency detention under DoLS [Deprivation of Liberty Safeguards]”. In this case, the individual had reportedly been attempting to buy bomb-making materials, which is clearly concerning. Nonetheless, given that deprivations of liberty are only authorised when various conditions are met, including that someone *lacks capacity* to consent, it is somewhat hard to square this with the police’s apparent belief that he nonetheless retained the ability to make a bomb, given his “lack of understanding” and low IQ. Furthermore, unlike the Mental Health Act, DoLS does not provide a framework for the “detention” of individuals – the fact that Vulnerability Support Hub staff have recorded this implies a worrying misunderstanding of the Mental Capacity Act on their part. Finally, questions remain about the extent to which counter-terrorism policing influenced the decision as to what course of action would serve this young man’s “best interests”, which British Medical Association guidelines on DoLS make clear must remain “the focus of decision-making”.⁷⁷

Coercion

Consent is an essential component in mental health services. Conversely, coercion is a major issue. In 2018, an independent review of the Mental Health Act asserted the importance of individual autonomy and the “need to support the person to express their will and preferences” in order to reduce compulsion.⁷⁸ Yet in the case of Vulnerability Support Hubs, there is an overarching question about whether medical treatment brought about, or influenced, by preemptive counter-terrorism policing can ever be truly consensual. More specifically, descriptions of practices strongly suggestive of an implicit form of coercion – one in which individuals may feel they have no choice but to consent – litter the hub evaluation documents.

The Home Office claims that Prevent is a supportive safeguarding practice.⁷⁹ However, in good safeguarding, the individual’s consent is central. Moreover, General Medical Council guidance makes clear that a patient should not be assumed to lack the capacity to consent based solely on a mental health condition. But, as the previous section noted, mental health assessments were sometimes conducted by the hubs in the presence of police. This modus operandi jars with an approach centring patient agency. It is clear that the individuals in question did not seek out these mental health assessments – but it is not clear from the documents whether or not their consent was sought. Regardless, the explicit role of policing imbues the therapeutic encounter with a distinct element of coercion, rendering the veracity of consent deeply questionable. In addition, those being assessed might feel coerced to ‘game’ their proposed mental health intervention in order to avoid unwanted accusations of extremism from police, opening up additional questions about the accuracy of diagnoses and the efficacy of treatments.

The intensified monitoring of patients’ compliance with medication regimes as a result of interventions by the hubs, and the way counter-terrorism fears influenced decisions to detain people under the Mental Health Act or Deprivation of Liberty Safeguards are even more obviously coercive. The case study in Image 12 is particularly revealing in this regard. It describes an individual who had “failed to engage...on numerous occasions” with the Channel deradicalisation programme – which the Home Office insists is “voluntary”.⁸⁰ Yet after being sectioned under the Mental Health Act, being treated and discharged, the man was suddenly “willing to engage with the Channel Process”. This raises serious concerns about possible coercion and the potential use of psychiatry to facilitate cooperation with police.

Image 15: Prevent officers “maximise likelihood of engagement” with Channel by “altering the individuals’ capacity to engage”

Working with an informed understanding of the factors that may be influencing an individuals’ behaviour and presentation from a Police / CT perspective enables Prevent Officers to approach cases more appropriately and maximise likelihood of engagement with clinical, social and Channel interventions. This improves the potential for positive outcomes from a police and social care perspective, either directly or through altering the individuals’ capacity to engage and relate to those offering help.

Source: First interim evaluation – page 6.

Images 15 and 16 similarly suggest that the hubs are substantially concerned with coercing people to engage in Channel, rather than caring for their mental health. Respectively, the excerpts speak of “altering” people’s “capacity to engage and relate to those offering help” and the hubs providing support for the “ongoing management” of individuals who refuse to engage “by linking in with their relevant NHS Mental Health provider where necessary”. Such practices may constitute the coercive deployment of medicine as a security device – in effect, policing through mental health.

Image 16: The hubs support “ongoing management of subjects who refuse to engage with Prevent” or Channel

The Hub also provides some additional support to other areas of Prevent as required. Examples include:-

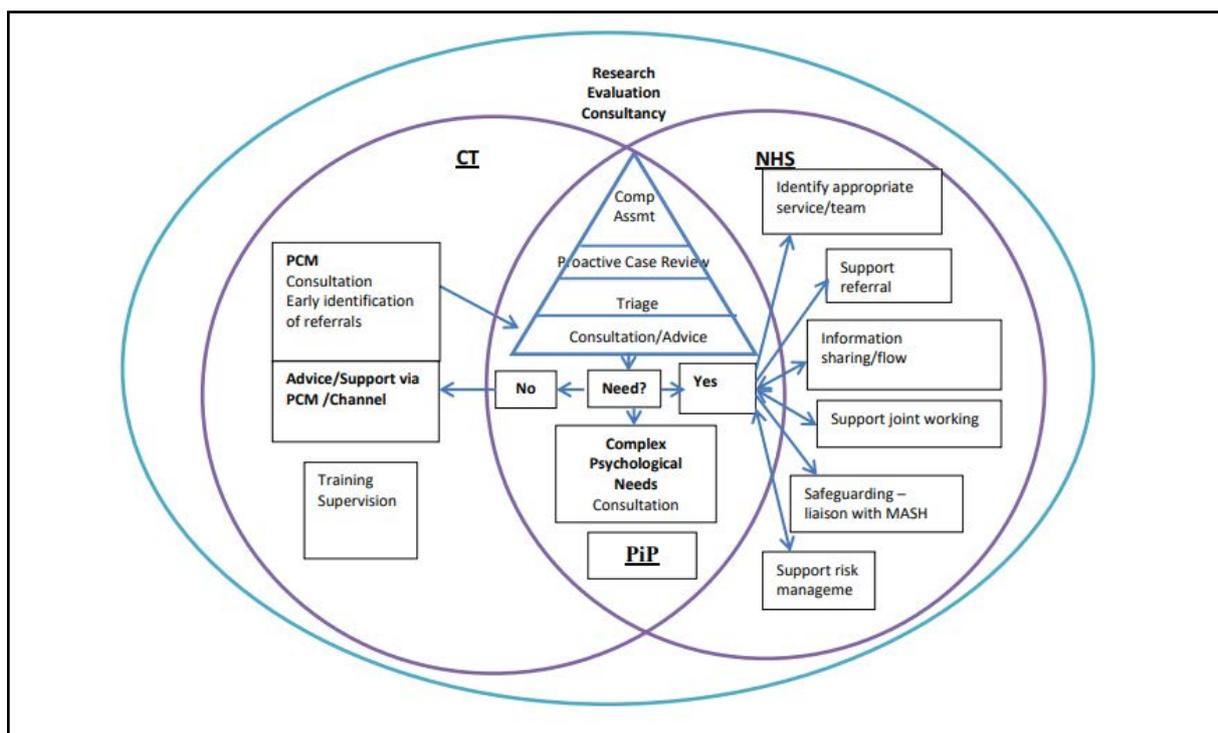
- Providing case specific support to Channel panels for complex cases or linking with provider organisations where appropriate
- Supporting the ongoing management of subjects who refuse to engage with Prevent or the Channel process by linking in with their relevant NHS Mental Health provider where necessary
- Ensuring that those cases which move out of Prevent or CT police involvement are linked to local NHS services where appropriate.

Source: Counter Terrorism Liaison and Diversion (London/Southern Hub).

Activities beyond the health remit

Working in “pressured, hermetic law-enforcement environments”, the Royal College of Psychiatrists warns, mental health specialists could be urged to work “beyond the profession’s remit”.⁸¹ The hubs’ model of multi-agency cooperation emphasises police and mental health professionals working ‘collaboratively’ on triage and other processes (though these partnerships are not equal, since the hubs are counter-terrorism-police-run projects). As the venn diagram in Figure 7 shows, the NHS mental health professionals working at hubs like ‘PiP’ (Prevent-in-Place – the Central Hub) have one foot squarely in the counter-terrorism (‘CT’) arena. As a result, despite explicitly denying that the hubs will “undertake any form of action outside of the healthcare remit”,⁸² they do in fact appear to encourage health professionals to do so. This happens in three ways: health professionals are helping to assess individuals’ future terrorism risk; they are being encouraged to perform a surveillance function to “monitor” patients behaviours and speech; and they appear to be engaging in what is effectively ‘deradicalisation’ work of dubious scientific validity.⁸³

Figure 7: NHS mental health professionals working at hubs like PiP (Prevent-in-Place – the Central Hub) have one foot in the counter-terrorism (CT) arena



Source: Central Hub – page 5.

Risk assessment

The Royal College of Psychiatrists notes that “[t]here have been unspoken expectations that risk assessments used by psychiatrists will predict a patient’s risk of committing a terrorist offence” and asserts the need “to guard against any expectation from non-psychiatric agencies that this will be possible”.⁸⁴ Yet at the Vulnerability Support Hubs, health workers are apparently helping to assess individuals’ likely future terrorism risk. While this may largely happen *through* understanding and assessing an individual’s mental health condition – assumed, arguably erroneously, to bear on their terrorist potential – the system used to collectively grade and prioritise cases *completely collapses the boundaries between health and counter-terrorism*.

Referrals to the hubs are assigned a concern level rating based on a ‘RAG’ (red/amber/green) traffic light system, as the excerpt in Images 17-19 explain. Critically, this is not only produced through a *collaborative* process but represents a “*combined* MH [mental health] concern and potential CT [counter-terrorism] risk” assessment (our emphasis). Thus, just as counter-terrorism police are influencing mental health care, health workers would seem, in turn, to be contributing to counter-terrorism risk assessment. This contradicts explicit denials by police that the hubs ever “[r]equest clinical/assessment staff undertake any form of policing duty” or “[m]anage any terrorism related risk the individual may pose”.⁸⁵ It also calls into question whether psychiatrists working at the hubs risk being referred to their regulator for breaching the General Medical Council’s definitive *Good Medical Practice* guide which states that all doctors must “recognise and work within the limits of their competence”.⁸⁶

Image 17: The hubs’ multi-agency model emphasises “collaborative” working

<p>Triage Process;</p> <ol style="list-style-type: none"> i. PiP clinicians to review available information ii. Determine current or historical involvement with MH services iii. <u>Collaborative case discussion (police / health)</u> and Level 1 formulation using the ‘Triage Decision Tool’ (see below) iv. <u>RAG rating</u> (see Operational Guidelines for details) v. Allocate (Exit, no PiP action, Level 2 Intervention)

Source: Central Hub – page 10.

Image 18: Ratings are based on ‘combined’ mental health and counter-terrorism (‘CT’) risk

<p><u>When the referrals to PLAD are screened by the team they are initially given a level of priority concern assessment grading (based on combined MH concern and potential CT risk) to decide how quickly the team needs to act upon the information it has received. At present this is based on clinical and professional judgement jointly between police and mental health professionals, informed by the best evidence available to the PLAD in the area of threat and risk assessment. The three different grades are:</u></p> <ul style="list-style-type: none"> • High Concern (Red) – Immediate risk to self/others – evidence of potential risk to self or others is clear, or significant risk factors are present such as clear homicidal or suicidal ideation, high risk psychotic symptoms, or there is indication that the level of threat to others is imminent. • Moderate Concern (Amber) – Intermediate risk to self/others – there is concern that the individual may pose a risk to self or others but there is no evidence

Source: South Hub – page 3.

Image 19: Triage decision support tool used to collaboratively produce a “RAG” rating

INITIAL REVIEW	DECISION SUPPORT TOOL									
Primary : CT/DE	Secondary: Mental Health	Escalation/ Change in Behaviours	Unknowns	RAG Rating						
	Concerns: Protective Factors:	Yes/No/ Unknown:		<p>RED</p> <input type="checkbox"/> <p>AMBER</p> <table border="1"> <tr><td>Further Info required from Prevent</td></tr> <tr><td>Further Actions</td></tr> <tr><td>No PIP Actions</td></tr> <tr><td>Other</td></tr> </table> <p>GREEN</p> <table border="1"> <tr><td>No Concerns</td></tr> <tr><td>Concerns Reduced</td></tr> </table>	Further Info required from Prevent	Further Actions	No PIP Actions	Other	No Concerns	Concerns Reduced
Further Info required from Prevent										
Further Actions										
No PIP Actions										
Other										
No Concerns										
Concerns Reduced										
Actions/ Discussion										

Source: Central Hub - page 11.

Surveillance

Critics of Prevent have long accused it of primarily being a surveillance programme, used to monitor Muslims in particular. Though its advocates dispute this, documents from the hubs only sharpen these concerns. They talk explicitly about the need for health and police “eyes” (Image 20) and about keeping Prevent files open even on those individuals unwell enough to be detained under the Mental Health Act.⁸⁷ The Central Hub’s operational guidelines reveal that mental health clinicians can be leant on by counter-terrorism police to “monitor and re-refer to Prevent, given advice about specific behaviours [believed to signal radicalisation] to monitor” (Image 21). Elsewhere, this is referred to as “establishing ‘tripwires’” (Image 22). Practices like this show that counter-terrorism police are seeking to co-opt health workers into a surveillance role and are clearly problematic.

Image 20: “New types of attackers” create a need for “health and police ‘eyes’”

- Changing landscapes – new types of attackers with a broader range of RISK AND VULNERABILITY factors – requires sophisticated health and police ‘eyes’

Source: Central Hub - page 32.

Image 21: Mental health professionals can be asked to “monitor” patients’ behaviours and speech

Any or all of these could be considered depending on the circumstances. In general it is recommended that if the risk is low, the mental health team could be asked to monitor and re-refer to Prevent, given advice about specific behaviours to monitor (e.g. saying....., doing..... going.....associating.....)and asked to formally put it on their care plans to review at Care Plan Approach Reviews (CPA meetings).

Source: Central Hub Operational Guidelines - page 18.

Image 22: “Support” for mainstream mental health to establish ‘tripwires’ which trigger re-referral to Prevent

- 3) Specialist consultancy for mainstream mental health services to support them in considering the impact of mental health on vulnerability and in developing appropriate care plans and establishing ‘tripwires’ to ensure an escalation in concern is noticed and triggers re-referral / re-engagement with Prevent.

Source: Central Hub – page 30.

The establishment of ‘tripwires’ also raises the question of the (im)possibility of mental health recovery, creating a racist two-tier system of rehabilitation. It is common for individuals with mental health conditions, such as anxiety, to cycle through various episodes of intensity during processes of recovery. If an individual’s mental health is deemed to be associated with their ‘extremism’ risk, they may be surveilled and securitised in perpetuity. Every lapse in wellbeing in which the support of mental health services is sought could provoke a ‘tripwire’ response, forcing re-engagement with Prevent.

‘Deradicalisation’ work

Finally, the Royal College of Psychiatrists notes that mental health professionals “may find themselves being asked to provide specific psychological interventions designed to treat the patient’s propensity to commit terrorist acts” and are “ethically obliged to ensure that any treatments they offer are evidence-based and suitably validated”.⁸⁸ Elsewhere, the college warns of the “erroneous inference” that psychiatrists may have “special expertise...to participate in de-radicalisation programmes”.⁸⁹

Yet NHS mental health professionals at the hubs appear to be engaging in what is effectively ‘deradicalisation’ work to meet so-called “intervention needs” of some of the referred individuals. These activities are described as “ameliorat[ing] risk by providing specific interventions unavailable/inaccessible via mainstream services” such as “Life Mentoring” to address “personal grievance”. This is concerning because of the dubious scientific validity of “deradicalisation” theory and evidence.⁹⁰

Image 23: Hubs can provide “interventions” to address “grievances” in ways “unavailable via mainstream services”

- Ameliorate risk by providing specific interventions unavailable/ inaccessible via mainstream services.
- Specific interventions will be evidence based and bespoke to the individual requirements of the case. Based on previous work scoping the intervention needs of complex cases (see appendix 4), these are likely to include;
- Comprehensive forensic mental health risk assessments conducted by a highly specialist multidisciplinary forensic mental health team
 - Diagnostic assessments; e.g. mental illness, autism, trauma.
 - Stabilisation and engagement
 - Time limited therapeutic interventions, e.g. psychoeducation/ formulation, emotional regulation and crisis planning,
 - Structured, bespoke ‘Life Mentoring’ for individuals for whom life stressors, poor coping and limited social support is associated with greater vulnerability / increased risk e.g. in maintaining a personal grievance.
- (see <https://kar.kent.ac.uk/62657/1/Executive%20Summary%20RA%20Final.pdf>)

Source: Central Hub – page 47.

2.2. Pathologisation

This section shows that the Vulnerability Support Hubs:

- adopt a ‘no wrong patient’ model which includes broad categories such as ‘behavioural and emotional difficulties’ that do not meet psychiatric diagnosis thresholds, in order to reduce instances of ‘false negatives’
- apply ‘formulation’ – a subjective technique, liable to racial bias, which was developed in forensic settings – to the pre-criminal arena
- risk pathologising people who have no diagnosable mental health conditions based on political expression perceived to be “extremist rhetoric”
- risk pathologising and criminalising precarious immigration status and socioeconomic vulnerability, securitising unmet need in the context of austerity.

‘No wrong patient’: sub-diagnostic thresholds

As the Central Hub observes, mainstream mental health services “are commissioned to treat ‘mental illness’ rather than poor mental health”.⁹¹ Yet a significant proportion of people seen by the hubs do *not* have a ‘mental illness’. As a result, many individuals seen by the hubs are deemed to be “unsuitable for mainstream services”.⁹²

It is not clear, however, that they are therefore discharged immediately from the hub’s caseload. Rather, the hubs adopt a so-called ‘no wrong patient’ approach, which expands their remit into sub-diagnostic terrain. In other words, it seems that even individuals without diagnosable mental health conditions may still potentially remain of interest to the hubs. This is ironic, given trends seen in mainstream mental health where, due to overstretched services, only patients with adequately severe symptoms are able to access treatment.⁹³

“ The hubs risk pathologising ‘radicalisation’ as an illness – suppressing the political content of dissenting views

Image 24: The hubs are not only interested in mental health disorders but also “mental health and psychological difficulties as part of Multiple and Complex Needs and Risks”

11.5 *Mental Illness versus Multiple and Complex Needs*

In line with the research outcomes detailed above a review of cases referred to Prevent In-Place revealed two main groups.

- 1) 26% (80/302) of cases presented with a diagnosable mental illness where formulation indicated that mental health was likely to be directly or indirect linked to risk and vulnerability.
- 3) 41% (125/302) of cases presented with mental health or psychological difficulties as part of Multiple and Complex Needs and Risks

Source: Central Hub – page 20.

It is highly irregular for psychiatric liaison services to be dealing with large numbers of people where no diagnosable illness is present. Yet this is what Vulnerability Support Hubs appear to do. For example, the Central Hub expands beyond mental health conditions to 'vulnerabilities', said to include 'behavioural and emotional difficulties' that do not meet the threshold for psychiatric diagnosis. Therefore, while only 26% (80 cases) of its referrals presented with a diagnosable mental illness, a further 41% (125 cases) are classified as having "mental health or psychological difficulties as part of multiple or complex needs and risks", as Image 24 shows. The extremely broad category of "multiple and complex needs" is defined as including "mental health*, substance misuse, homelessness, offending", and the category of "mental health" is itself said to include "autism, complex trauma, personality disorder, poor impulse control (risk to self and others)", as Image 25 shows.

Image 25: Broad definition of "mental health" includes "poor impulse control"

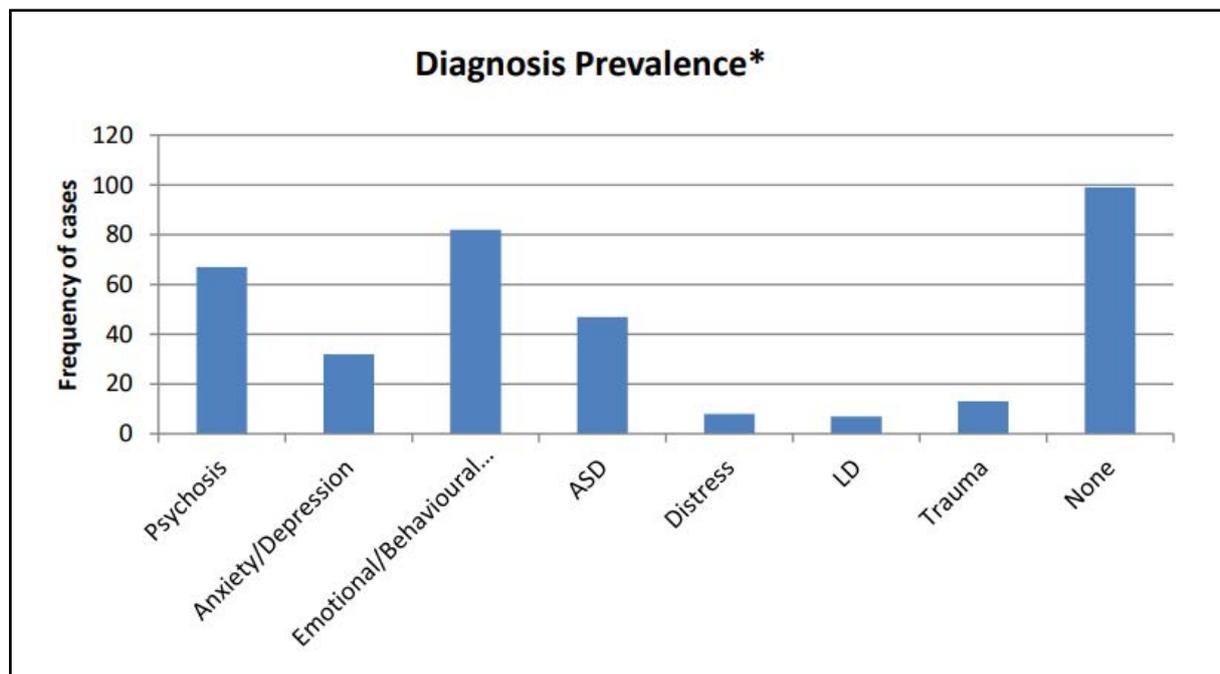
3) 41% (125 cases) have **multiple and complex needs** (mental health*, substance misuse, homelessness, offending).

*Mental health' also includes; autism, complex trauma, personality disorder, poor impulse control (risk to self and others). Mental health services are commissioned to treat 'mental illness' rather than poor mental health.

Source: Central Hub - page 44.

Despite these expansive, amorphous categories, as Figure 8 shows, the most prevalent diagnosis (approximately 33%) was "none". Similarly, the Northern Hub evaluation notes that "54% of referrals currently have no confirmed primary mental health diagnosis due to either ongoing work on the case or the individual not actually being mentally ill".⁹⁴

Figure 8: Prevalence of mental health diagnoses at the Central Hub



Source: Central Hub - page 18.

The Central Hub report explains that it adopts a "Formulation-based approach; recognising the evidence base that vulnerability to extremism is associated with a broad range of individual, social and contextual factors".⁹⁵ This formulation approach, also advocated in the overall final evaluation,

is a technique in which a clinician writes a short narrative interpretation of the way social factors combine with mental health problems or emotional difficulties in the form of a short case story. It therefore necessarily expands beyond 'mental illness' to include "behavioural and emotional difficulties" as well as "complex" social needs in the determination of – in this context – their terrorism risk.

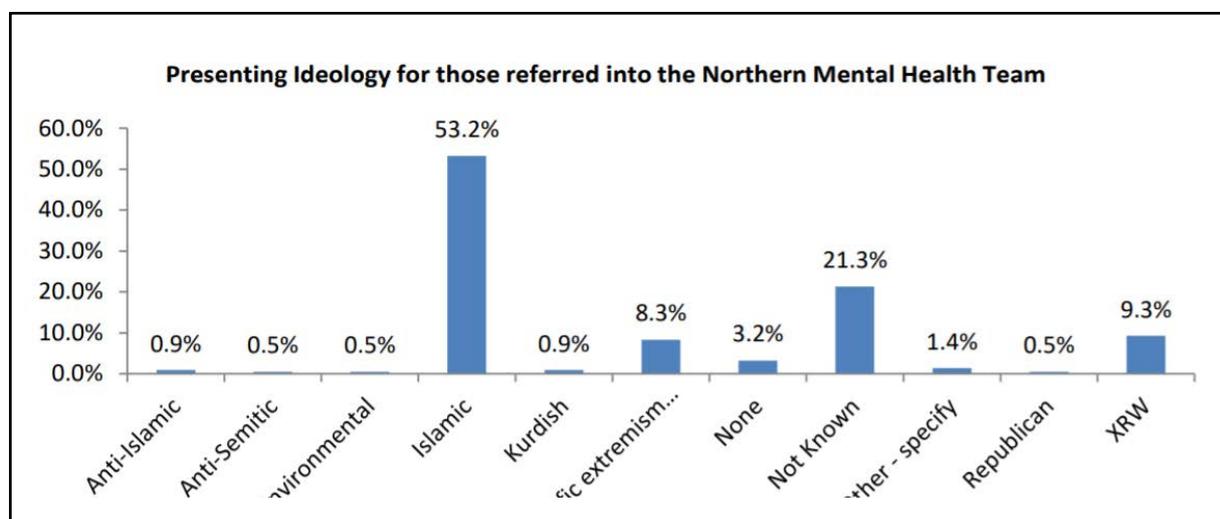
According to the British Psychological Society, there is no universally accepted definition of a formulation-based approach and the topic has been intensely debated in psychological circles.⁹⁶ The hubs rely on the work of psychologist Caroline Logan, whose forensic case formulation approach was developed for risk assessments of individuals with a history of violence. Yet the hubs are *pre-criminal*, not forensic settings and the individuals referred are not involved in terrorism but have merely been deemed 'vulnerable to radicalisation'. Moreover, use of subjective techniques such as formulation carries notable ethical risks, particularly here, since the highly securitised setting in which individuals are being assessed may be a significant factor in the perception and assessment of future risk, especially given racialised perceptions of threat which Section 1.2 discussed.

Pathologising 'extremism'

Psychiatry develops through the social mores of its time – responding to marginalised and problematised ways of being. Homosexuality, for example, was treated as a mental illness for many years. The field of Disability Studies explores the social and political construction of people's lived realities as disorders and is especially critical of the implied notion that these lives necessarily require correction.⁹⁷ Judgements about what constitutes 'mental illness' are, in this sense, to a considerable extent contingent on socio-political context and hold enormous potency. Here, the potential for medicine to be misused as a tool for social control arises. Several historical examples, including so-called 'drapetomania' and 'sluggish schizophrenia', have already been noted in this report.

As has been mentioned, abusive practices led to the codification of the first ethical standards within the profession, such as the Royal College of Psychiatrists', which makes clear that psychiatrists are not permitted to diagnose a person as mentally ill on the basis of their political, religious or ideological beliefs. On counter-terrorism specifically, the college has also stated that "'radicalisation' is not a mental illness"⁹⁸ and expressed concerns that, if treated as such, this might eventually lead to "dissent against authority in general" becoming stigmatised and the definition of 'extremism' potentially "extended to encompass those who object to certain aspects of UK foreign policy".⁹⁹

Figure 9: Ideology categorisations of individuals referred to the North Hub



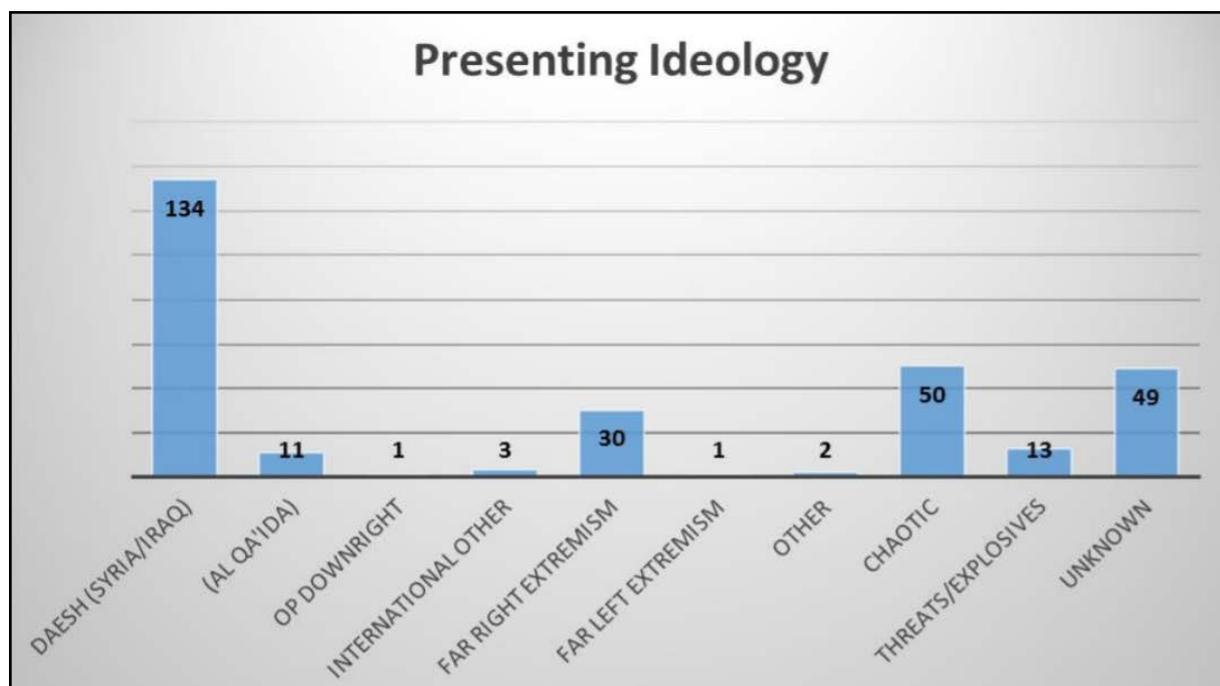
Source: North Hub – page 7. Labels are cut off in the original source.

According to statistics from the North Hub, the majority (58%) of the individuals seen were referred to Prevent for “extremist rhetoric” – in other words, comments considered to reflect a political position deemed extreme by the police. (In this context, it is worth noting that police have flagged a range of environmental, anti-militarist, animal rights, and pro-Palestinian groups, as potential counter-terrorism concerns).¹⁰⁰ As the graph in Figure 9 shows, the “presenting ideology” for more than half its cases was categorised as “Islamic”, with no explanation provided as to how this form of ‘extremism’ differs from mainstream Muslim thinking. As Figures 10 and 11 show, the other two hubs referred to “Islamist” extremism or specific Islamist groups such as Daesh.

In Figure 11, the huge, elusive category “vulnerable to radicalisation” warrants further comment. Presumably, none of these individuals have made any clear ideological statements but, based on demographic data, we can assume that a large portion of these referrals are Muslims. To be subjected to both pre-crime policing and potentially mental health assessment on the basis of political expression is problematic in itself. It is possible that behind this catch-all category lie individuals deemed “extreme” and pathologised through referral to the hubs simply on the basis of Islam.

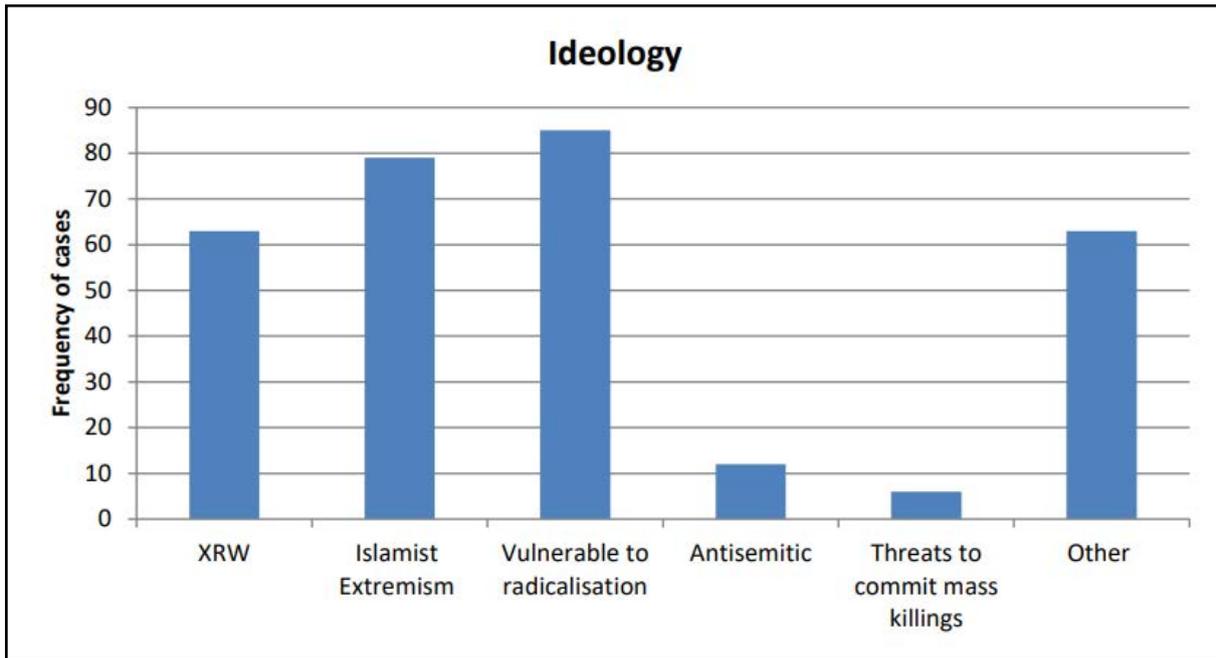
It is also important to note the number of newly diagnosed conditions that were identified following contact with a hub – contact that was often triggered by political expression. As the graph in Figure 12 shows, contact with the South Hub dramatically reduced the number of people said to have “unknown” diagnoses. In addition, the graph shows that significant numbers of mental health diagnoses changed from one condition to another. The same happened at the North Hub, where 38% of people (82 from a total caseload of 216) had their diagnosis altered while referred to the hubs, with schizophrenia the most commonly assigned misdiagnosis and 6% of the misclassified cases actually having “no mental disorder” at all.

Figure 10: Ideology categorisations of individuals referred to the South Hub



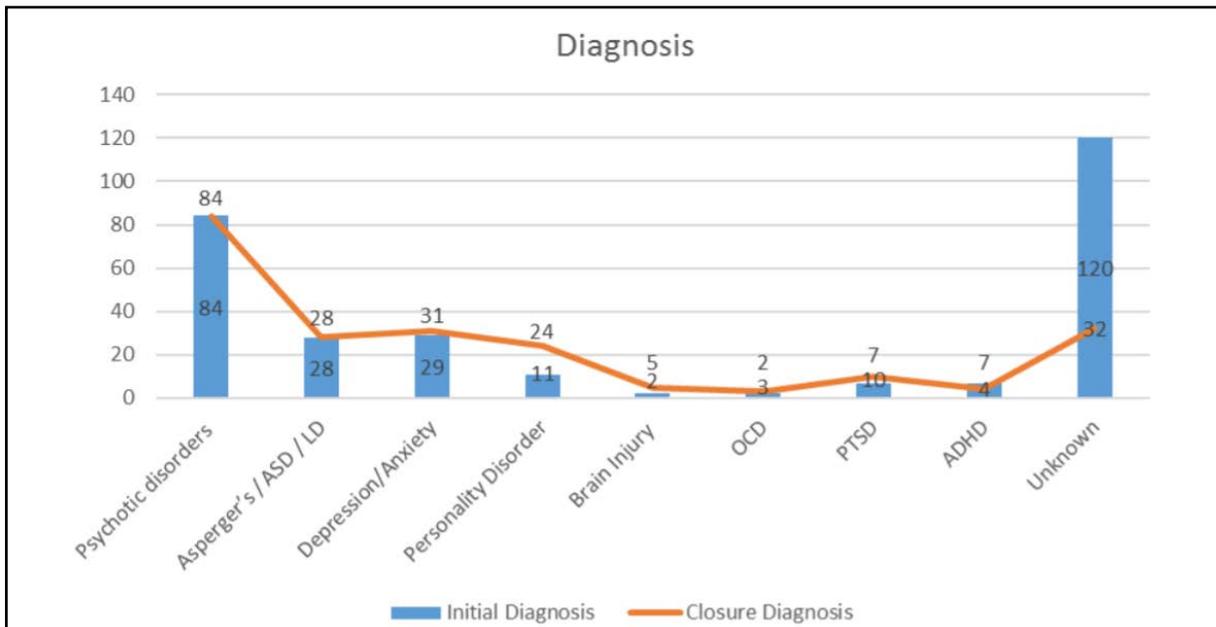
Source: South Hub – page 8.

Figure 11: Ideology categorisations of individuals referred to the Central Hub



Source: Central Hub - page 17.

Figure 12: Changes between initial diagnoses and closing diagnoses at the South Hub

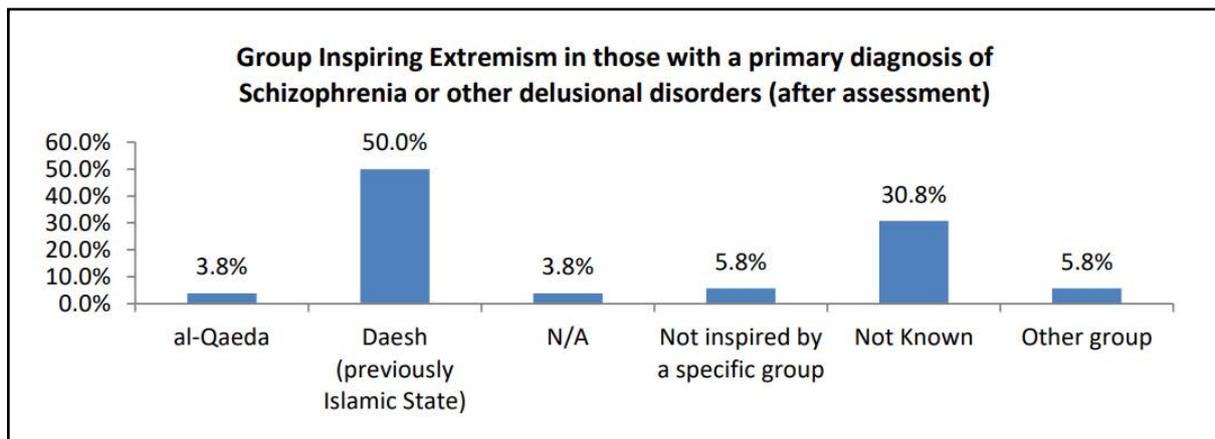


Source: South Hub - page 9.

It is, of course, possible that the reduction in “unknown” diagnoses demonstrates the provision of a social good that the hubs claim to offer – namely, early identification and treatment of mental ill-health in previously undiagnosed individuals. Furthermore – although it is not clear from the documents whether hub staff *themselves* diagnose patients – psychiatric diagnosis is an uncertain practice, with slippage between the science of mental disorder in theory, and its performance in clinical settings.¹⁰¹ In this diagnostically insecure situation, however, it is important to ask whether the securitised context of the hubs may have influenced new, or altered, diagnoses. This question is especially pertinent given the role racialisation can play in both perceptions of terrorist threat and mental health diagnoses, as Section 1.2 discussed, and given the disproportionate numbers of racialised Muslims referred to the hubs.

A final point worth noting is that the hubs were partly premised on the idea that they would “improve the understanding of both police and health professionals of the associations between mental health conditions and vulnerability to radicalisation”.¹⁰² Yet the sole attempt made to analyse the hypothesised “[i]nfluence of mental illness on vulnerability to radicalisation” in the evaluation documents comes from the North Hub, which produced the graph shown in Figure 13, ‘demonstrating’ that half of those with a primary diagnosis of schizophrenia or other delusional disorders were allegedly inspired by Daesh. This ‘finding’ may well be entirely meaningless. Moreover, the hubs’ ostensible research-related *raison d’être* was swiftly abandoned during the pilot, with the second interim overall evaluation in July 2017 stating that the hubs “will not directly provide evidence of mental health as a predictor of future behaviour and CT risk”.¹⁰³

Figure 13: North Hub’s attempt to analyse the “influence of mental illness on vulnerability to radicalisation”



Source: North Hub – page 10.

Pathologising precarity in the context of austerity

An interim evaluation report claims that the Vulnerability Support Hubs – as their name implies – assist vulnerable people, and have been “especially beneficial...for those who may have struggled to access mainstream health services due to homelessness or immigration status”.¹⁰⁴ In fact, the hubs appear to move in the direction of pathologising – and potentially criminalising – people with precarious socio-economic and immigration status.

As Section 1.2 noted, an incredible 48% of those referred to North Hub were not born in the UK. The hub reports contain frequent references to asylum seekers and migrants, including unaccompanied asylum seeking children (‘UASC’), and even people undergoing deportation proceedings, some of whom appear to have fled war and conflict, raising significant concerns of cultural competence. The distress of such people, as Image 26 shows, prompted the hubs to recommend classing them as “unmitigated risks” where services could not respond to their need. As well as revealing the stigma inherent in associating migrant communities with terrorism risk, the context of the hostile environment belies claims that the hubs are beneficial to migrants: Medact’s previous research has confirmed that referral to Prevent can lead to onward referral to immigration enforcement, potentially leading to detention or deportation for those with insecure immigration status.¹⁰⁵

Additionally, the hubs’ reports strongly suggest the pathologisation of socio-economic vulnerability – stigmatising the homeless and the unemployed as particular groups associated with terrorism risk.

The Northern Mental Health hub collected data on the living conditions of its referrals, finding a high association between Prevent referral and unemployment (as well as homelessness) in its sample. Approximately 17% were classified as living in ‘other’ conditions, a category which

encompasses people who were “homeless, AWOL or in hospital” at the time of the referral. Meanwhile, where employment status was recorded, it was found that approximately 57% of individuals were unemployed.¹⁰⁶

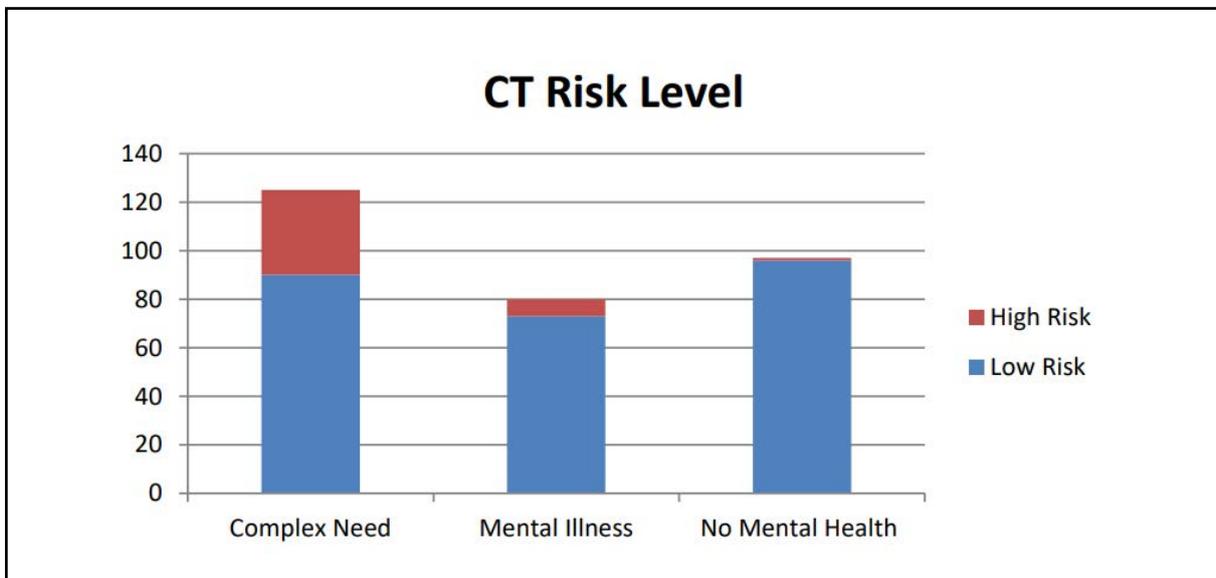
Image 26: The hubs make frequent references to asylum seekers and migrants as people with potential “unmitigated” terrorism risks¹⁰⁷

- Targeted psychological interventions for individuals with a) autism and b) multiple and complex needs and c) high concern groups (e.g. military, siblings, UASC, high risk offenders) to understand and ameliorate risk
- Psychological and practical support for asylum seekers/ migrants and unaccompanied minors and their carers, e.g. in understanding and managing adjustment and trauma
- Support / interventions for individuals with CT vulnerabilities facing deportation
- Specialist trauma / bereavement therapies e.g. for UASC, migrants, siblings of individuals that have travelled to a conflict zone

It is asserted that in the absence of a service model that is able to provide interventions to address them, these complex needs represent an unmitigated risk.

Source: Central Hub – page 24.

Figure 14: Those with complex needs more often deemed high counter-terrorism (‘CT’) risks



Source: Central Hub – page 21.

The pathologisation of precarious living conditions as a factor in terrorism risk is not supported by evidence in academic scholarship. Despite this, Prevent materials used to train NHS staff to spot the supposed ‘signs of radicalisation’ flag both poverty and unemployment as factors which could make someone more likely to be drawn into terrorism.¹⁰⁸ Additionally, some evidence suggests that unemployed or homeless people may indeed be more likely to have mental health conditions,¹⁰⁹ so this cloud of suspicion may, in part, merely reflect an underlying assumption that poor mental health increases terrorism risk. At the hubs, people described as having “complex

needs”, are often – as Figure 14 shows – deemed the most high risk with regard to terrorism. Consequently, they are also believed most likely to warrant “more intense levels of intervention”.

As Section 1.1 noted, large numbers of referrals, especially to the Central Hub, were children and young people, and the hubs may, to a degree, also be pathologising or criminalising youth. Notably, 45% of Central Hub referrals aged 17 or younger were actually found to have no mental health condition, prompting questions about whether it was proportionate to subject these children to mental health assessment in the first place, under its model of screening *all* Prevent referrals in the West Midlands area.¹¹⁰

This pathologisation of precarity occurs in the context of austerity policies and the underfunding of mainstream mental health care and social services, which could otherwise assist people in distress. The hubs are, in a sense, handmaidens to this defunding of mainstream services and were designed to make efficiency savings within the Prevent system – as the excerpt in Image 27 makes clear. The hubs become ‘necessary’ structures because of failures of social provision and laws restricting access to healthcare for certain groups of homeless people and migrants.

Image 27: The cost-saving mission of Vulnerability Support Hubs

(iv) Cost

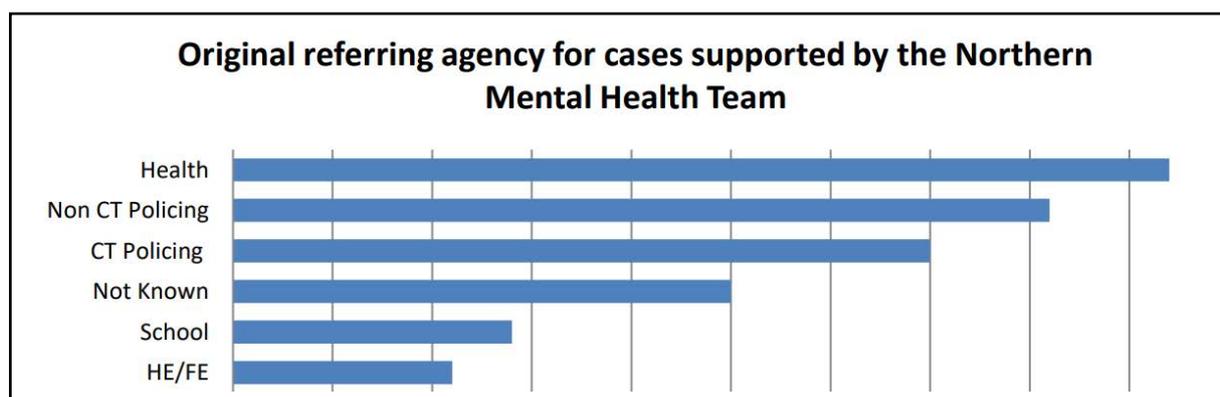
Quantifiable economic benefits of all three mental health hub pilots are undergoing evaluation and will be reported on more substantially in the final report. Initial consideration suggests that the following may all contribute to financial efficiency:-

- Reduced police time spent in trying to source information
- Fewer but more productive and informed contacts with cases
- Reduced wastage in utilising ineffective channel and social care interventions
- moving referrals through the prevent pathway more rapidly,
- reducing the likelihood of re-referrals to Prevent

Source: First Interim Evaluation – page 6.

Yet the hubs’ securitising tendencies generate duplication and circularity with healthcare services. Recalling the data set out in Section 2.1, showing that a high proportion of patients referred to each hub were *already* in contact with NHS mental health services, underlines this point. Furthermore, most people seen by the North Hub were actually referred into Prevent *from the health sector*, as the graph in Figure 15 shows. Thus, for these patients the hubs cannot be said to help them access healthcare. Instead, the hubs are clearly about managing terrorism risk – particularly that perceived to stem from marginalised groups. As Section 1 noted, they are being part-funded to do this with NHS money. This is ‘neoliberal counter-terrorism’: the securitisation of unmet needs in the context of austerity.

Figure 15: Most people seen by the North Hub originally referred from health sector



Source: North Hub – page 6.

2.3. Confidentiality, criminalisation and stigma

This section describes how Vulnerability Support Hubs:

- circumvent and erode confidentiality expectations by facilitating police access to healthcare information using an ‘in-house’ or ‘consultancy’ model in which NHS staff usually operate at arms-length from patients and primarily provide a service to police officers
- risk making health workers complicit in criminalisation when this information is used to pursue prosecutions
- stigmatise mental ill-health – especially amongst Muslims – as a sign of potential terrorism
- risk further deterring racialised groups from accessing healthcare.

Compromising confidentiality

Confidentiality is a central principle within healthcare. It is vital to patient trust and is codified in guidance such as the NHS Code of Practice, the Nursing and Midwifery Council's Code and the General Medical Council (GMC) confidentiality handbook. The circumstances in which confidentiality can be breached – i.e. information shared without the patient's explicit or implied consent – are few and exceptional. When Prevent was placed on a statutory footing in 2015, the British Medical Association declared in guidance to members that the policy did not alter these circumstances. However, in practice there are worrying indications that Prevent has eroded and undermined the expectation of confidentiality.

The police have explicitly denied that Vulnerability Support Hubs involve “any form of covert enquiries” or the sharing of “health or police-related information unless...it is judged necessary and appropriate to safeguard the individual or protect others from harm”.¹¹¹ Yet evaluation documents make clear that a key purpose of the hubs – in fact their *primary objective* according to the final overall pilot evaluation – is to “support CT [counter-terrorism] Police in liaising effectively with health services to seek and share information”, as Image 28 shows. For example, the North Hub contacted individuals' GPs for information in 74% of cases.¹¹²

Image 28: First two objectives in initial overall evaluation concern information sharing

The objectives identified for the pilot services will also be reviewed through the evaluation. These are:-

- To support CT Police in liaising effectively with health services to seek and share information.
- To develop and refine effective procedures for managing liaison and information sharing within current legislation.
- To provide advice to referrers within Prevent and other regional CT teams, and other relevant stakeholders, regarding individual cases and mental health services
- To support the early detection and engagement of individuals with mental health difficulties.
- To provide a specialist, multidisciplinary clinical team able to undertake a range of activities and interventions

Source: First interim evaluation – page 4.

Notably, consideration was given as to whether legislation change might be required – presumably in order to ensure the desired information-sharing practices were legal (Image 29). However, confidentiality expectations appear to have been circumvented instead using a workaround in the form of a ‘consultancy’ model. In this model, NHS staff at the hubs – whose role in part is to “seek information from NHS colleagues”, some of which can then be “shared with Prevent”¹¹³ – are said to be providing “expert consultancy / supervision to the professional (Police Officer) rather than assess[ing] the individual”, from whom they work at arms-length (Image 30). Tellingly, the document adds that this “protects police and health professionals from breaching information governance legislation”.

Image 29: Legislative change was considered in order to facilitate information sharing and keep files open even on individuals detained under the Mental Health Act

Information Governance Protocols

Cases where the information sharing procedures were not clear have been reviewed as agreed in the WMCTU – BSMHFT contract. It has been concluded that PIP is able to work within current legislation and no legislative changes are required. Procedures have been developed to support the legal sharing of information between Police Counter Terrorism Units and NHS for Prevent referrals, wider CTU and individuals detained under the Mental Health Act.

Source: Central Hub – page 24.

Image 30: “Consultancy” model “protects police and health professionals from breaching information governance legislation”

The aim is to provide expert consultancy / supervision to the professional (Police Officer) rather than assess the individual in line with the Offender Personality Disorder Pathway Strategy’s model to support for Probation officers understand and manage high risk PD offenders. This model is believed to improve the skills, confidence and understanding of staff and improves decision making e.g. discharge or onward referral. This model also maintains confidentiality of both the Police and health service and protects Police and health professionals from breaching information governance legislation.

Source: Central Hub – page 12.

The significance of this should be elaborated. Information sharing *between NHS staff* to ensure continuity of health care is much less likely to require additional patient consent than information sharing from within the NHS to an external body, such as the police. The latter can be done, but subject to careful consideration of the specific case and with a high threshold, such as a robust public interest justification. This is where the presence of embedded NHS mental health staff at the hubs – referred to as an “in-house” team – appears to play a crucial intermediary role in facilitating police access to health information.

The Central Hub notes that in cases where face-to-face assessments are carried out, “written consent is obtained before information is shared with police”. But when embedded hub mental health staff request NHS information, it merely mentions in passing that “an information leaflet is sent to [mainstream NHS] teams on request”.¹¹⁴ Given the secrecy surrounding Vulnerability Support Hubs and their innocuous name, mainstream NHS staff are unlikely to fully appreciate how closely hub staff work with counter-terrorism police.

Image 31: Existence of the hubs (an ‘in-house’ mental health team) “greatly assisted” in convincing “somewhat hesitant” health professionals to share information

- In all of these cases the feedback received was positive with statements about how useful officers found having an ‘in-house’ mental health team.
- Responses referred to greater confidence in decision making and risk assessment by having access to mental health professionals within counter terrorism.
- Officers reported that prior to the team existing they had experienced health professionals as somewhat hesitant in sharing potentially important information about their service users with police officers. The presence of PLAD greatly assisted in this communication.

Source: South Hub – page 18.

The result is that police have easier access to information, as the South Hub comments explicitly, saying “officers reported that prior to the team existing they had experienced health professionals as somewhat hesitant in sharing potentially important information about their service users with police officers”, but the existence of the hub “greatly assisted in this communication” (Image 31). In this way, the hubs “reduce the police burden of chasing information from agencies that are often reluctant to provide it”¹¹⁵ and are therefore praised by police for “reducing the time it takes to get health information”, thus “markedly saving police time and resources” (Image 32).

Image 32: The hubs reduce “the time it takes to get health information” and are thus “markedly saving police time and resources”

Preliminary analysis of the quantitative and qualitative data presented in this interim report is suggestive of a positive impact within all three mental health hubs in relation to the following outcomes:-

- ✓ Improved detection of mental health vulnerabilities
- ✓ Significantly reducing the time it takes to get health information and has thus markedly saving police time and resources.
- ✓ Increased confidence in Police assessment of risk / vulnerability, and facilitated access to appropriate services
- ✓ Enabling more efficient use of interventions, including use of mentors and disruptions, which are now more targeted to assessed need with improved outcomes and reduced costs.

Source: First interim evaluation – page 5.

Criminalisation

Simon Cole, the chief constable of Leicestershire Police and national police lead for Prevent, has admitted that while Prevent is allegedly “entirely voluntary”, refusal to participate in Channel might “cause us to question why and you may head into the Pursuit space”.¹¹⁶ This move towards criminalisation is evident at the Vulnerability Support Hubs.

Just as the government claims that Prevent is a “safeguarding” scheme,¹¹⁷ the police assert that the hubs prevent people “ending up in the criminal justice system”.¹¹⁸ They have also denied that the hubs will “make any enquiries with the NHS for investigative purposes”.¹¹⁹ Contradicting this, Rita Augestad Knudsen – one of very few academics to have written about the hubs – warns of significant mission creep in their role “from an initiative chiefly set out to...divert individuals... before [a crime]”, into “a potential measure for assisting investigations”.¹²⁰

The documents analysed confirm this view, explaining that referrals are also received from “intelligence”, “investigations”, and other counter-terrorism police units besides Prevent. It is stated that mental health professionals are expected to “support” counter-terrorism officials “in requesting information from health” which may then be used to “pursue a conviction” (Image 33). Another source says explicitly that “[t]he principle aim of the service is to support decision making for police officers regarding referrals into Prevent or investigating cases in the CT criminal space”.¹²¹

It is evident, therefore, that the hubs’ professed remit of acting in the pre-criminal Prevent space expanded, almost as soon as the project was founded, to providing assistance to support live counter-terrorism investigations and prosecutions. As Knudsen observes, the lines between Prevent and Pursue – the investigative arm of the government’s CONTEST counter-terrorism strategy – are considerably blurred in the Vulnerability Support Hubs.

“ Providing support to counter-terrorism prosecutions conflicts with the Royal College of Psychiatrists’ ethical code on working in a patient’s best interests

Image 33: Health professionals “support” counter-terrorism police requests for health information which can be used to “pursue a conviction”

8.2.5 Wider CTU (e.g. FIMU / Investigations)

Information from Health can be sought by the Police including wider CTU departments under the Crime and Disorders Act for the purposes of supporting Police in their statutory duties, to prevent crime and pursue a conviction.

The mental health team cannot directly share information but can support CTU in requesting information from health by advising them about the use of current processes (WA170 form with s29 exemption).

Source: Central Hub’s Operational Guidelines – page 5.

A case study from the North Hub illustrates Knudsen's concern that the hubs are effectively "tools of intelligence gathering" for active police investigations.¹²² The case (Image 34) also illuminates how health professionals at the hubs become directly complicit in information sharing practices which facilitate prosecutions. This is healthcare aiding prosecution, not meeting mental health needs, and brings the hubs into direct conflict with professional codes of conduct which emphasise the importance of acting in a patient's best interests, and obtaining informed consent, even when cooperating with police and security services.

Image 34: NHS practitioner embedded at the North Hub facilitates information sharing which leads to a prosecution

Case Study 2

Another disruption occurred after an individual with possible mental health problems, who had previously been referred into Prevent, was arrested **Section 38 Health and Safety**. He was remanded in custody. **Section 38 Health and Safety**. The Mental Health DS was able to provide the embedded NHS practitioner with information from Police Intelligence systems **Section 38 Health and Safety**. The practitioner was able to contact the Responsible Clinicians on this panel and obtain a report which indicated that the consultant felt the **Section 38 Health and Safety** offence was not linked to the individual's mental illness. This report was sent to the Officer in the Case (OIC) and the individual was charged with both offences. Information was provided to support a remand application and the individual was consequently remanded in custody until his trial date (5/10/17). Information regarding CT risk and the individuals past involvement with Prevent was passed onto colleagues in the NWCTU Prison Intelligence Unit (PIU) and disseminated to the Prison. Our team also made contact with mental health services in the prison to ensure they were aware of this individual.

Source: North Hub – page 15.

Stigma and deterrence

Counter-terrorism's "turn towards mental health" rests on the highly contentious assumption of a link between mental health and terrorism. There is a large body of research into 'mental illness' and violence, and several decades of work exploring potential links to counter-terrorism, yet the existing evidence is not robust enough to support the conclusion that mental health can independently predict violent behaviour. Despite this, it is a link which the UK government persists in making, stating that people with mental health conditions – a disaggregated category – "may be more easily drawn into terrorism".¹²³ Moreover, the notional link between mental health and terrorism was one of the major premises upon which the Vulnerability Support Hubs were established and their existence reifies the hypothesised connection.

The risk of exacerbating pre-existing stigma around mental health by making these claims, on the back of flimsy evidence, is profound and has been noted by the Royal College of Psychiatrists and the *British Medical Journal*.¹²⁴ However, as the disproportionality statistics for the hubs outlined in Section 1.2 show, *mental health stigma combines with Islamophobia in the realm of counter-terrorism*. It is Muslim mental health, in particular, which has been rendered suspect. Thus Muslims who are processed by the hubs experience several intersecting layers of stigma.

More broadly, the Vulnerability Support Hubs' operations very likely increase the chances that Muslims will be deterred from accessing mental health services, for fear of being stigmatised as "extremists".

“ Despite the lack of robust evidence linking poor mental health with terrorism, the hubs have formalised these stigmatising associations

It is already known that mental health services are uncertain on how to engage with ethnic and religious diversity,¹²⁵ and the levels of trust in these services among racialised groups are low.¹²⁶ Specifically, it is known that young Muslim adults admit to withholding seeking mental health care in the NHS out of fear of a Prevent referral.¹²⁷ The extent to which counter-terrorism police are, through the hubs, leaning on mental health services and seeking confidential information, suggests that these fears may be warranted. But staying away due to fear of discrimination and securitisation may cause mental health conditions to worsen, consequently harming people in need of care.

Racialised groups' lack of trust of healthcare services has been vividly illustrated by levels of COVID-19 vaccine hesitancy in recent months.¹²⁸ Alongside policies like the hostile environment in healthcare, Prevent and Vulnerability Support Hubs specifically can only be increasing racialised minorities' distrust. In the long term, this is in turn likely to exacerbate racialised health inequalities.

Conclusion

Vulnerability Support Hubs stand at the nexus of counter-terrorism, mental health and racism. They demonstrate why conversations around racism, securitisation and coercion in mental health care are so vital. Simultaneously, they highlight problems at the heart of Prevent and pre-crime policing more generally, especially counter-terrorism's 'turn to mental health' and the disingenuous language of 'vulnerability'. Since the UK is a leading exporter of innovations in this field, the hubs may well augur a troubling direction of travel for counter-terrorism policing in general.

Multi-agency working is not necessarily a bad thing and people with lived experience of mental health problems often call for services to be better joined up. However, health and policing have very different institutional missions and the hubs blur the boundaries between them in ethically problematic ways.

Moreover, their focus does not appear to be on healthcare and, rather than tangibly benefiting patients, they create circularity within existing NHS services. Their benefits to counter-terrorism policing are much clearer: they appear to facilitate surveillance, information-sharing and risk management while coercing people deemed 'extreme' according to broad, vague criteria, to engage in dubious 'deradicalisation' schemes.

Racialised groups, especially Muslims, are grossly disproportionately referred to the hubs. Given that people with mental health conditions are often stigmatised as dangerous and that perceptions of threat are also highly racialised, the hubs appear to combine this mental health stigma with Islamophobia. They risk, on the one hand, pathologising Muslim political agency and dissent and, on the other, criminalising, or rendering suspect, poor mental health among Muslims.

The practices of Vulnerability Support Hubs pose critical questions for mental health professionals. It is important to ask whether those working closely with police at the hubs, within counter-terrorism units, are being unduly influenced to work beyond their remit. Moreover, there are fundamental questions about the scientific validity of concepts like 'extremism' and 'radicalisation', which underlie the risk assessment frameworks within which they are working.

While counter-terrorism police have claimed that "improvements have been made" since the inception of the project, the culture of secrecy around the hubs, and the lack of accountability this engenders, make it impossible to verify whether or not this is true. That the scheme is currently being rolled out nationwide without ever having apparently been independently evaluated should also raise alarm bells in the health community, which should be making very clear that psychiatric care is not a preemptive policing tool and ought to be pushing back against the police's growing appetite to co-opt mental health professionals.

Recommendations

To government

Vulnerability Support Hubs and Prevent

- Vulnerability Support Hubs / the Vulnerability Support Service is not needed, is harmful, and should be closed down.
- We also reiterate our previous call for the entire Prevent policy in healthcare to be scrapped.

Mental health care, risk management and funding

- All mental health care concerns should be dealt with by mainstream NHS services so that mental health conditions can be treated in an environment of care rather than being securitised.
- Mental health professionals already regularly carry out risk assessments and their judgement should be trusted.
- Mental health services urgently require proper funding in order to deliver good quality care that is free and accessible to all.

health stigma, they should follow the example of mental health charity Mind and speak out more against associating poor mental health with terrorism risk.

- In line with longstanding ethical codes, they should also emphasise that psychiatric care is not a preemptive policing tool, challenge the police's growing appetite to co-opt mental health professionals, and remind practitioners of their ethical duties relating to patient confidentiality and consent.

Other health bodies

- The General Medical Council should look urgently at the question of whether health professionals working at the hubs are working beyond their competency by going beyond the health remit.
- It should also revisit confidentiality concerns about Prevent in light of the Vulnerability Support Hubs' practices to determine whether loopholes have been created to allow the non-consensual sharing of sensitive health information with police.

To health bodies

Mental health bodies

- In line with recent commitments to do more to tackle racism, the Royal College of Psychiatrists and British Psychological Association, must condemn and work to end the clearly disproportionate targeting of Muslims by the hubs.
- In the interests of tackling mental

To researchers

- Researchers should focus less on the over-researched and unproven influence of poor mental health on terrorism.
- More public mental health research and critical scrutiny of pre-crime policing and counter-terrorism's influence on mental health, and on mental health care is, by contrast, urgently needed.

APPENDIX

Disproportionality calculations

Region	POPULATION			REFERRALS					RDR
	MUSLIM	WHITE BRITISH	RATIO	TOTAL	ISLAMISM	XRW	RATIO		
Northern MHH	403,222	8,572,492	0.05	216	115	20	5.75	122	
PIP	376,152	4,434,333	0.08	336	79	63	1.25	15	
PLAD	1,012,823	3,669,284	0.28	295	146	30	4.87	18	
TOTAL	1,792,197	16,676,109	0.11	847	340	113	3.01	28	
							SE(logRR)	0.1085851463	
							lower bound (95% confidence)	23.4	

Data from the Vulnerability Support Hub evaluation documents was analysed to calculate Disproportionality Ratios for referrals of Muslims ("Islamist") vs White British ("Far Right") individuals.

The disproportionality ratio is in effect a risk ratio, indicating the number of times more likely someone of or Muslim faith was to be assessed by a hub following a referral for "Islamism" compared to the risk a White British individual had of being assessed following a Prevent referral for "Far Right" extremism.

This is calculated as follows:

Disproportionality Ratio for Muslims Referrals = (# of referrals for "Islamism" / # of Muslims in the overall population) / (# referrals for "Far Right" extremism / # of White British individuals in the overall population) = (# "Islamist" referrals / # "Far Right" referrals) / (# of Muslims in the overall population / # White British in the overall population.)

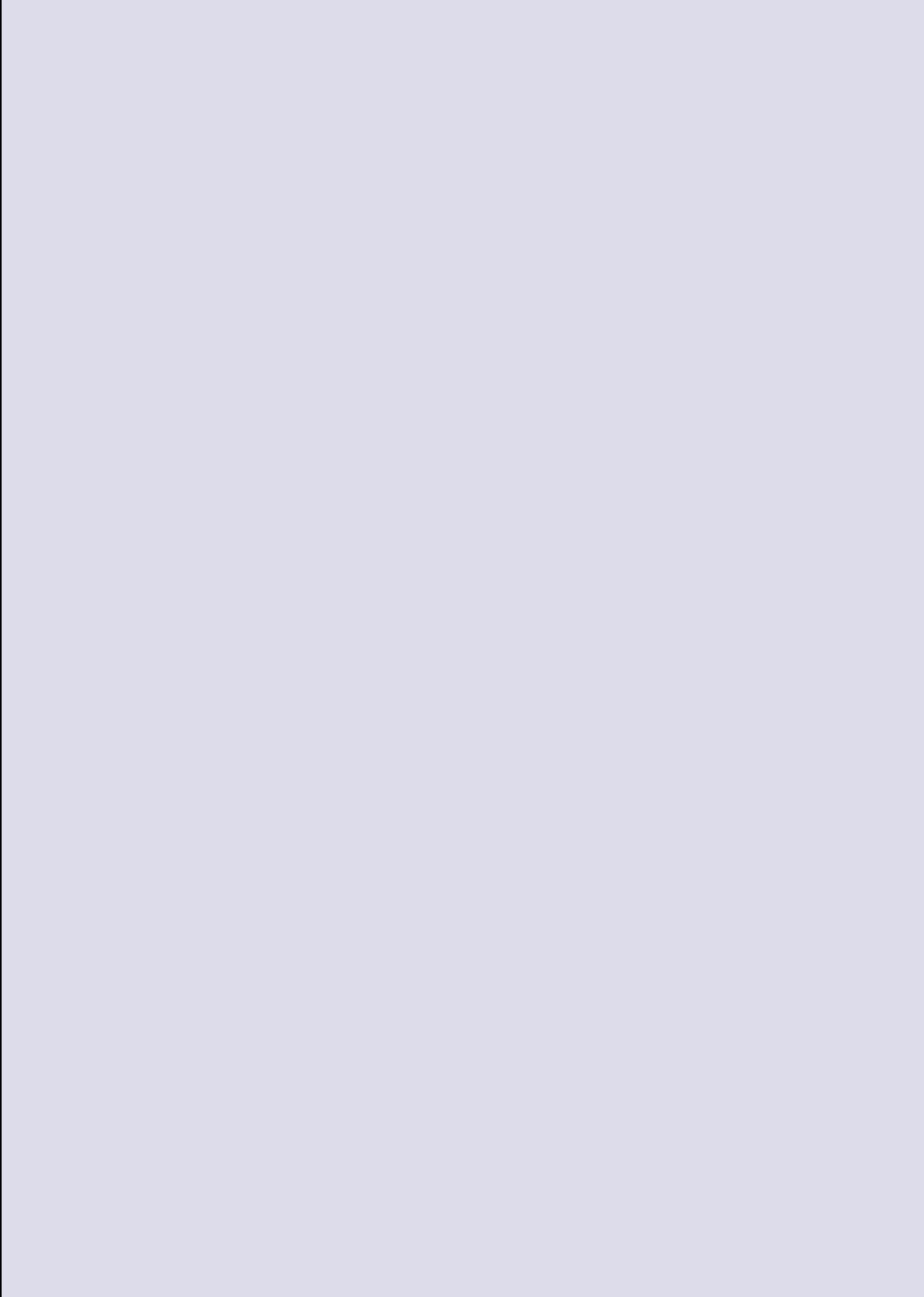
The overall Disproportionality Ratio for Muslim:White British referrals observed in the data was 23.4.

For the population base rate, we used 2011 census population demographics for the regions in which each hub is based. Given the growth of the British Muslim population in the last decade, this risk ratio is likely a conservative estimate of disproportionality.

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