



**PREVENTION  
PRACTITIONERS  
NETWORK<sup>SM</sup>**

# Interventions to Prevent Targeted Violence and Terrorism

A PRACTICE GUIDE FOR THE  
US PREVENTION PRACTITIONERS NETWORK



**ERADICATE  
HATE  
GLOBAL SUMMIT™**

**ISD**

Powering solutions  
to extremism, hate  
and disinformation





## About this Practice Guide

The US Prevention Practitioners Network [Eradicate Hate](#), with support from the [Institute for Strategic Dialogue](#) (ISD) and a steering committee of violence prevention and social safety experts, have been developing and engaging a [US practitioners network](#) for individuals working in **targeted violence and terrorism prevention (TVTP)**. The aim of this is not only to connect practitioners across the US with one another, but also to build their capacity and the efficacy of their programs through a series of workshops that cover both theoretical and practical elements of delivering prevention and intervention initiatives, and through providing information packs and practice guides in supplement to the workshops.

### Learn More

For more information about the Network or to access past information packs and practice guides, visit the [Prevention Practitioners Network page](#) on Eradicate Hate's website.

*For any inquiries, please contact Program Manager Neil Saul at [nsaul@eradicatehatesummit.org](mailto:nsaul@eradicatehatesummit.org)*

This project was originally funded by the U.S. Department of Homeland Security's Center for Prevention Programs and Partnerships, opportunity number EMW-2020-GR-00065.

## About this Document

This document is one in a series of practice guides that ISD and Eradicate Hate produced for the Prevention Practitioners Network. It is a resource for existing and prospective network members that deliver (or seek to deliver) TVTP interventions. This particular guide supplements the third and fourth workshops that were delivered for the emerging Network, and covers civil and criminal liabilities, as well as considerations for information sharing in TVTP. **Note that the contents of this practice guide do not constitute legal advice. This guide is for informational purposes only.**

### How does this differ from the read-ahead materials prepared in advance of the workshops?

The read-ahead materials provided to participants prior to each workshop are entry-level resources that provide context and background on a given topic, helping participants prepare for the workshop and identify potential questions for discussion. Read-ahead materials are prepared and provided for every workshop. You can access past read ahead-materials [here](#).

The practice guides, on the other hand, combine the contents of the read-ahead materials with insights from the workshops, to produce instructive and action-oriented guides that Network members can refer to in their work. Each practice guide covers several workshop topics.

Practice guides will be provided to Network members every few months. The first practice guide, on staffing interventions to prevent targeted violence and terrorism, can be found [here](#).

# Contents

<b>Chapter One - What are TVTP Interventions?</b>	<b>5</b>
Single vs. Multi-disciplinary Interventions	5
What do Interventions Involve?	6
<b>Chapter Two - Setting Up a Multi-disciplinary Team</b>	<b>7</b>
Relevant Disciplines for a TVTP Multi-disciplinary Team	7
Considerations for Setting Up a Multi-disciplinary Team	9
The Role of the MDT Chair	10
In Practice - Learning from the Strong Cities Network	11
<b>Chapter Three - Intake</b>	<b>12</b>
What is the Intake Process?	12
Setting up and Staffing the Intake Process	12
<b>Chapter Four - Risk, Needs and Threat Assessment</b>	<b>15</b>
Distinguishing between Risk, Needs and Threat Assessment	15
Who Should Lead the Assessment?	16
Assessment in Practice - the VERA-2R and the ERG 22+	17
<b>Chapter Five - Intervention Delivery</b>	<b>18</b>
What is the Intervention Process and Should Lead It?	18
Key Considerations During Intervention Delivery	19
Intervention in Practice - the UK Channel Program	21
<b>Chapter Six - Aftercare</b>	<b>22</b>
What is the Aftercare Process and Who Should Design It?	22
Aftercare in Practice - the Citizens Crime Commission	23
<b>Appendices</b>	<b>24</b>
Appendix A - Glossary of Useful Terms	24
Appendix B - Most Common Risk Assessment Tools	26
Appendix C - Visualizing the Four Stages of Intervention	28
Appendix D - Further Reading Recommendations	30
Appendix E - Key Considerations Checklists and Tools	33

## Chapter One

# What are TVTP Interventions?

This practice guide uses the following [definition of interventions](#):

*Interventions are initiatives that seek to prevent or reverse radicalization (to violence) through contact (either face to face or through a communications medium) with individuals who may have been, or are at risk of being, radicalized.*

Interventions therefore involve an intervention provider and an intervention recipient or participant, where the recipient is an individual deemed potentially at risk of radicalization, and the provider is a trained professional delivering services or support to the recipient.

---

## Single vs. Multi-Disciplinary Interventions

In TVTP and related social work and criminal justice disciplines, interventions can be single- or multi-disciplinary:

- ▶ **Single-disciplinary interventions** - approaches that focus on one domain of intervention.

Historically, these have generally focused on ideological and psychological intervention.

- **What does this look like?**

In some cases, the program may be geared entirely towards this single domain. For example, Yemen's Committee for Dialogue program paired prison detainees with religious scholars, seeking to rehabilitate and reintegrate individuals through religious "re-education". In this case, the only option for intervention was ideological.

Other programs may default with a single-disciplinary ideological or psychological intervention but have multi-disciplinary teams or referral mechanisms in place should the individual require other types of support.

- ▶ **Multi-disciplinary interventions** - approaches that leverage multiple disciplines and types of expertise to provide a more holistic wrap-around service that addresses various domains, ranging from mental and medical health to ideological convictions and employability skills.

- **What does this look like?**

Generally, a "lead" intervention provider delivers the core intervention. This individual usually comes from a social work or psychology background. Their intervention is then supplemented with support provided by practitioners from other disciplines and agencies. The [Danish Aarhus model](#), for example, uses practitioners trained in "life psychology" to deliver the core intervention and to serve as mentors throughout the life cycle of intervention. This core delivery is then augmented with other types of support, depending on the specific needs and vulnerabilities identified for the individual being engaged (e.g. education, employability, housing, religious mentorship).

## What do Interventions Involve?

The following steps were identified by the US Prevention Practitioners Network's Steering Committee as the core parts of intervention delivery.



### 1. Intake

Intake is the process of receiving referrals, determining their appropriateness for intervention and, if they are deemed eligible, preparing for case planning and management.



### 2. Risk, Needs and/or Threat Assessment

Risk assessments seek to measure and understand the extent to which an individual is susceptible to radicalization, targeted violence or terrorism. Threat assessments often form part of this larger risk assessment and are used specifically to assess the imminence of danger, for example whether an individual poses an immediate threat to themselves or others. Needs assessments, on the other hand, are used to identify treatment and services that will improve their circumstances and build their resilience against radicalization, targeted violence and terrorism.



### 3. Intervention Delivery

Intervention refers to the provision of services, which are informed by the risk, needs and/or threat assessments conducted, and are intended to mitigate or minimize risk of (further) harm to the individual concerned.



### 4. Aftercare

Aftercare is an essential part of an intervention program concerned with long-term support and care. Once it has been agreed that the intervention has met its objectives, an “exit” strategy should be designed to facilitate the individual’s long term resilience against radicalization and/or recidivism to violence.

This practice guide takes you through each step, providing key practice considerations per step, particularly as this pertains to staffing.

## Chapter Two

# Setting Up a Multi-disciplinary Team

Radicalization to violence is a complex and multi-dimensional process “[best served by multi-level and multi-disciplinary solutions](#).” Multi-disciplinary approaches to targeted violence prevention, especially in the needs assessment and intervention stages, are therefore preferred over single-disciplinary approaches, and are increasingly regarded as best practice in TVTP. This chapter outlines the disciplines that have historically been involved in TVTP interventions, how they can be leveraged, and provides guidance for setting up a **multi-disciplinary team (MDT)**.

## Relevant Disciplines for a TVTP MDT



### Mental health professionals

Mental health professionals can play an integral role in both risk and needs assessments, as well as leading interventions for individuals deemed in need of support and broader case management.

For example, depending on the setting of the intervention program, **social workers**, particularly those with a counseling background, may be well-placed to lead TVTP interventions, provided they have subject-matter expertise in targeted violence, terrorism, radicalization and other related processes. Social workers with such a background are also well-placed to support the families of referred individuals with counseling and guidance on how to facilitate the individual’s long term rehabilitation and resilience against harm. **Psychologists and psychiatrists** can also provide such support.



Equally, social workers that have experience **working with children** are essential for programs that work with minors. Where a minor is referred to a program, child protection social workers may check whether they’ve worked with that individual and their family before and in what capacity. If a child is deemed eligible for intervention, child specialists can ensure the support package created for them is age-appropriate and considerate of their specific developmental and other needs. For more on the role mental health professionals can play in TVTP, [see this factsheet](#).



### Tip for Practitioners

Representatives from these services will not necessarily join as experts in TVTP, but as experts in their respective professions, providing multi-agency input and transferable learnings into the MDT’s activities.



### **Educators**

The inclusion of educational professionals might be important for students who may need additional care and services to build their resilience against violent influences. In addition, educational pursuit and skills training may form part of the support package designed for a vulnerable individual, the development and delivery of which would benefit from educator input. [See this factsheet](#) for more on how educational professionals can support TVTP programs.



### **Prison and probationary staff**

Where intervention programs are being delivered in criminal or post-crime settings, whether for individuals convicted of targeted violence and/or terrorism-related offenses or individuals at risk of radicalizing in prisons, criminal justice staff should be trained both to monitor the progress of individuals about whom there are concerns and to respond effectively.



### **Law enforcement**

Law enforcement trained in TVTP can support with receiving referrals and safeguarding concerns from the public, and with information gathering (e.g. criminal histories) about the individuals concerned. Intervention programs should also have escalation processes in place with local law enforcement, should a referral or existing intervention case require urgent police response, for example if they pose an immediate danger to themselves or to others.



### **Community and/or religious leaders**

Community and/or religious leaders can be called upon to support the reintegration of an individual back into their local communities post-intervention. Equally, in some cases, religious mentorship or theological intervention may be identified as a need and as an essential part of the support package created for an at-risk individual.



### **Formers**

Former (violent) extremists can play an integral role in TVTP intervention programs. Not only can they leverage their understanding of extremist narratives and networks to identify individuals who may benefit from intervention, they can directly support the intervention process through mentorship, in which they use their experiences with disengagement and deradicalization to support others with this journey. See, for example, [EXIT Fryshuset](#) and [Life After Hate](#).

## Considerations for Setting Up a MDT



### Mapping local services

A mapping exercise that locates local services and identifies which can be leveraged for TVTP is an important step in establishing a well-rounded MDT with representation from diverse professional and community-based services.



### Establishing and Training the MDT

Once you've identified the services that can support TVTP, gauge their interest and ability to commit. Be transparent about the role you expect them to play - for example, will they be expected to partake in intervention delivery, or solely help guide the risk assessment process?

Information-sharing agreements and Memorandums of Understanding will then need to be developed and signed by all parties who agree to take part in the MDT and TVTP program. **These must abide by federal and state laws regarding confidentiality and data security.**

Once the MDT is set up, members of the MDT will ideally be **trained** by the lead organization or another subject-matter expert to ensure all members have the same level of awareness and understanding of targeted violence and related phenomena. This training should also form a mandatory part of the induction process for new members in the future.



### Additional considerations

It can be helpful to come up with guiding principles and codes of conduct that all members of the MDT are to abide by. This will help maintain transparency, professionalism, foster collaboration, and unite the

panel with mutual expectations of one another. It also ensures there is documentation that new members can be provided in their induction. Consider also structural and practical questions:

### Meeting frequency and quorum

- ▶ How frequently should the MDT meet to discuss existing case progress and new referrals? Schedule in a regular meeting that all members of the MDT are expected to attend.
- ▶ How should ad hoc meetings (for example, if a case needs to be discussed urgently) be arranged? Who is in charge of convening this and is there a minimum amount of MDT members that are expected to attend for it to count as a formal convening of the team?
- ▶ In what format should meetings take place?
  - If in person, choose a secure and private location.
  - If virtual, be sure to use encrypted conferencing systems to guarantee privacy.

### Data security and privacy

- ▶ How should data and meeting notes be shared? Set up encrypted messaging systems and secure servers to store data.
- ▶ How will data be shared? Consider setting up an encrypted, new email address for every MDT member, to avoid them using existing professional or personal emails in communications related to the MDT and associated TVTP program.

## The Role of the MDT Chair

For a MDT to function effectively and to coordinate representatives from the different professions appropriately, there should be a designated “chair” or “lead” responsible for overseeing activities and convening the MDT.



### Scope of Role

Some of the responsibilities of an MDT chair include:

- ▶ convening and chairing meetings of the MDT, including agenda-setting and post-meeting follow-up
- ▶ having oversight of all live MDT cases
- ▶ facilitating appropriate information exchange between MDT members and between the MDT and external services (e.g. for aftercare)
- ▶ requesting the necessary updates and reporting from MDT members
- ▶ leading strategic-thinking and sustainability of the MDT
- ▶ dispute resolution between MDT members
- ▶ external and public relationship management
- ▶ supporting member induction and exit processes
- ▶ securing information-sharing agreements between members and between the MDT and external services



### Staffing Considerations

Given this role, an MDT chair will ideally have the following qualifications:

- ▶ assertive and able to lead a large team
- ▶ thorough understanding of targeted violence and related phenomena, particularly as this pertains to the US
- ▶ up-to-date on good practice in TVTP
- ▶ experience with TVTP or a similar (caregiving) discipline
- ▶ experience with stakeholder management and liaising with individuals of diverse professional backgrounds
- ▶ have the time needed to commit to this role
- ▶ trained in recognizing and mitigating
- ▶ unconscious bias

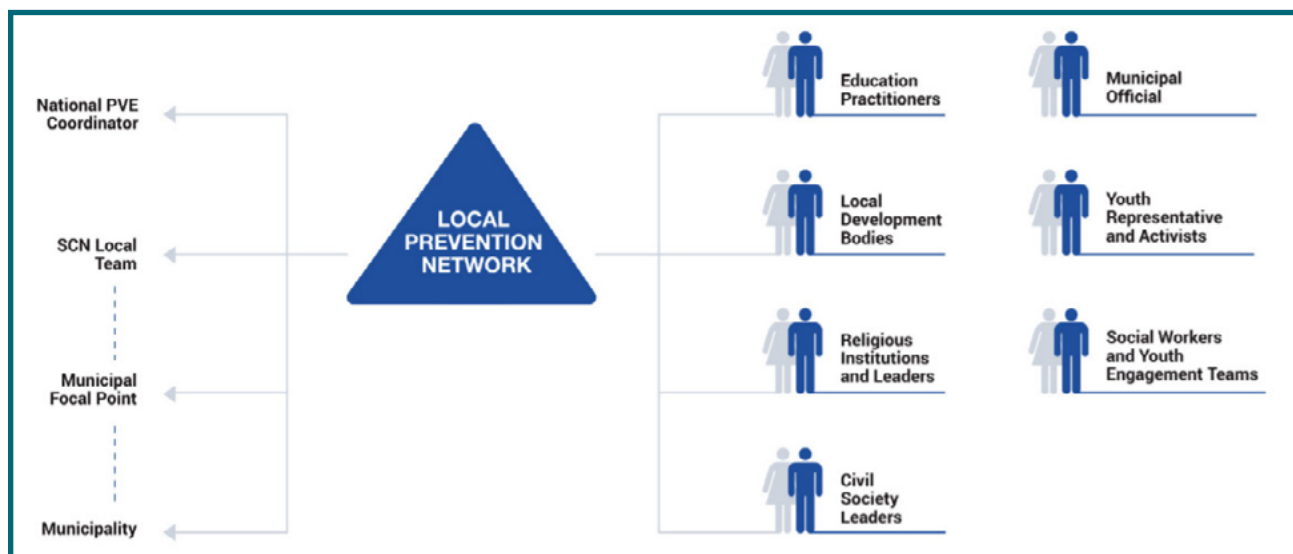
## In Practice - Learning from the Strong Cities Network

Launched at the UN General Assembly in 2015, the [Strong Cities Network](#) (SCN) is a global network of local leaders dedicated to combating hate, polarization, and extremism. The SCN is comprised of 150 member cities across the world, providing mayors and local practitioners internationally with the expertise, tools, and resources needed to drive an effective grassroots response to targeted violence.

To this end, the SCN has tested and proven a **local prevention network model that unites city leaders, local public services and grassroots communities to build a coordinated response to targeted violence**. SCN's local prevention network model comprises representatives from existing professional services that work at the community-level, trains them up on targeted violence, and gives them the practical skills to support its prevention. Also represented in the model is local government through the inclusion of designated focal points that sit within local governance structures. The model therefore really captures the "whole-of-society approach" increasingly regarded as best practice in TVTP.

Key recommendations from setting up these multi-disciplinary networks include:

- ▶ Facilitate sustainability of local prevention by providing the established MDT with thematic and practical training on targeted violence.
- ▶ Consider how best to incentivize services to participate - is coordination with other services and training enough to foster involvement?
- ▶ Always operate with and communicate the "Do No Harm" principle - all activities by the local prevention network or MDT as entities, and by individual members, must prioritize the safety of the individuals or communities the network or MDT works with.
- ▶ Be realistic in what you can apply from other contexts.
- ▶ **Develop very localized approaches that account for the specific context in which you operate.**



SCN Local Prevention Network model (based on the networks established in Lebanon and Jordan). For more information, see the [SCN's Policy and Practice Model](#) for local prevention.




## Chapter Three

# Intake

### What is the Intake Process?

Intake is **the process of receiving referrals, determining their appropriateness for intervention and, if they are deemed eligible, preparing for case management.**

Once a referral is received, an intake assessment should be conducted to determine:

-  If the individual is eligible for intervention - the individual referred is deemed vulnerable to radicalization or engaging in targeted violence and the MDT is qualified to provide the needed support.
-  If the individual should be referred elsewhere - for example, if they are not deemed vulnerable to radicalization or to committing targeted violence, but would still benefit from some form of care, or if there is an immediate threat that needs to be escalated to law enforcement;
-  If the referral is a false positive. Note that if you receive a lot of false positives, this may speak to the need for broader awareness-raising and education about targeted violence. This is important to mitigate risk of certain behaviors and personalities being stigmatized or wrongly perceived as inherently harmful.

### Setting up and Staffing the Intake Process

#### Who leads the intake process?

A dedicated individual or unit within the wider program team receives referrals (setting up referral mechanisms will be covered in future practice guides). Who makes up this unit depends on the setting and model of the program. The [Danish Aarhus model](#), for example, uses an “Info House” comprised of police and municipal representation to collect referrals. The [UK Channel Program](#) receives referrals through law enforcement or local Channel representatives\*. In some cases, members of the MDT raise safeguarding concerns that they have been made aware of or have identified themselves directly with the rest of the MDT. In this case, they may be asked or expected to lead the intake process. For the purpose of this practice guide, the individual(s) in charge of the intake process will be referred to as the “Intake Unit”.



#### Tip for Practitioners

\***Community liaisons** are an effective way to raise awareness of targeted violence and terrorism at the local level. They can also serve as trusted community-based focal points for the intervention program, providing the public with a channel through which to voice concerns.

## 1. The Intake Process - Receiving Referrals

Whether by the public, through a community liaison officer, member of the MDT or law enforcement, the Intake Unit is made aware of a safeguarding concern.

**Consider the baseline of information you would like for an intake.** While this baseline may not always be achievable, it is important to have a uniform way of recording referrals. Creating a **referral form** is a good way of maintaining a level of consistency in the referrals you receive, and helps facilitate record-keeping. Where possible, you should collect the following information:

- ▶ General information, like the date and location.
- ▶ Who made the referral and was this organic or on behalf of someone else?
- ▶ How did they identify the safeguarding concern?
- ▶ How did they make this referral (e.g. through a hotline or via a community liaison officer)? This can help shed light on the most popular reporting mechanisms your program operates with.
- ▶ Personal identifiable information (e.g. name, age) about the individual about which there is a safeguarding concern.
- ▶ As much information is available about the actual safeguarding concern - what are the potential vulnerabilities that prompted the referral in the first place?



## Useful Context

### Methods for Receiving Referrals



#### Helplines

[Parents For Peace](#), for example, has a helpline that individuals can call if they are worried about someone becoming involved in extremism.



#### Online Reporting Mechanisms

[The Center for the Prevention of Radicalization Leading to Violence](#) (CPRLV) offers both a helpline and a [“Support” request form](#) that users fill out and submit via their website.



#### Through a Program Point of Contact

The UK’s Channel Program has local focal points that raise communal awareness about targeted violence and serve as channels through which civilians can flag concerns.



#### Law Enforcement

Many TVTP MDTs will have representation from law enforcement. At the very least, MDTs should have an open line of communication with local law enforcement, should either party have concerns to refer to the other.

## 2. The Intake Process - Intake Assessment

Next, the Intake Unit either does a preliminary assessment to determine relevancy of the referral, or brings the referral straight to a larger assessment panel where this is decided. Regardless, the assessment must be conducted by someone with extensive knowledge about targeted violence both locally and globally.



### Please Note

The intake assessment must be conducted by individual(s) with extensive subject-matter expertise.

There are four possible outcomes of this intake assessment:

- ▶ **The referral is a false positive\***  
The referral and alleged safeguarding concerns are either misinformed, malicious or misguided.
  - **Next Step:**  
No follow-up required with the individual. However, if you receive many false referrals, it may be worth deploying awareness-raising campaigns or working with local stakeholders to increase communal understanding of targeted violence.
- ▶ **There is a concern, but not related to targeted violence**  
The individual is not deemed vulnerable to radicalization or to committing targeted violence, but would still benefit from some form of care.
  - **Next Step:**  
The individual needs to be referred externally to the appropriate services.

- ▶ **There is a concern related to targeted violence**

The individual is potentially vulnerable to radicalization or to committing targeted violence, and the MDT is able to provide support.

- **Next Step:**  
A more in-depth needs assessment needs to take place to help inform the individual's specific support package.

- ▶ **There is an immediate threat of harm**

The intake assessment reveals the potential for imminent threat of harm or violence, either to the individual themselves, to others or to property.

- **Next Step:**  
Escalate the referral to local law enforcement.



### Tip for Practitioners

#### Thorough record-keeping is so important!

Among others, it will help you identify whether you are receiving a lot of false positives and what the nature of these may be, keep a trail of decision-making, and ensures you have documentation to refer back to as you proceed with intervention delivery.

\*In some cases, a referral may become a false negative, where safeguarding concerns are not picked up on, or it is wrongfully determined to be misinformed, malicious or misguided. It is for this reason the intake assessment must be conducted by individuals trained in the subject-matter.

## Chapter Four

# Risk, Needs and/or Threat Assessment

Once an individual has been referred to a program and deemed eligible for intervention, they should undergo a thorough risk, needs and/or threat assessment to determine the types of support that would best safeguard them from (further) harm. **This stage is essential to ensure interventions cater to the specific, identified needs of the individual concerned.** The type of assessment will depend on the setting and objective of your program. For more on this, please see Appendix B and [the first read ahead materials](#) created for the US Prevention Practitioners Network.

## Distinguishing between Risk, Needs and Threat Assessment

Although often used interchangeably, risk, needs and threat assessments differ in their objectives and in the factors they look at.



**Risk or vulnerability assessments** seek to measure and understand the extent to which an individual is susceptible to radicalization, targeted violence or terrorism. Risk assessment frameworks help practitioners assess, monitor and understand factors, and vulnerabilities of an individual that may make them susceptible to extremist narratives and/or violent behavior.



**Threat assessments** often form part of this larger risk assessment and are used specifically to determine the level and scale of immediate or potential danger that an individual poses to themselves, their surroundings and the wider community. Importantly, threat does not just refer to physical danger, for example whether an individual has intent or capability to do physical harm. It can also

refer to the influence of an individual - are they able to encourage others to commit harm on their behalf?



**Needs assessments** are used to identify treatment and services that will improve their circumstances and build their resilience against radicalization, targeted violence and terrorism. Needs assessments allow for practitioners to mitigate risk by identifying appropriate services and necessary types of support provision for the individuals concerned.

Some assessment frameworks consider **protective factors**, or the individual's strengths that keep them resilient. The Research Triangle Institute's (RTI) definition is "[Protective factors counterbalance the risk factors and help us to build resilience; these factors include self-care, coping skills, a sense of belonging, etc.](#)", while risk factors increase the likelihood or make an individual more susceptible to radicalization and/or violent behavior. Examples of protective factors include stable employment, strong ties to community, and positive influence e.g. through family or other personal relations.

## Who Should Lead the Assessment?

The following staff profile can help guide your thinking about who is most appropriate to lead a risk, needs or threat assessment.



### Please Note

The role of the risk assessment lead is simply to gather as much information as is feasible to inform the assessment and appropriate next steps.

The risk assessment lead should not provide legal advice or counsel to the individual concerned or their family. Similarly, risk assessments should not be treated as prosecutorial nor as a criminal sanction.

### Ideal Staff Background

#### ▶ Subject-matter Expertise

The recommended approach for assessment is **structured professional judgement\***. Given this, the risk assessment lead should have extensive knowledge of targeted violence and/or terrorism, of radicalization and recruitment processes.

#### ▶ Training and Experience

Ideally, the assessment lead will have experience with recognizing and mitigating bias, and/or have undergone unconscious bias training.

Further, some existing assessment tools require training before use, so it is important that any member of staff expected to use such tools have completed the necessary trainings.

#### ▶ Professional Background

If your program delivers early interventions (e.g. in a pre-crime setting), it is recommended that the risk assessment lead comes from a social work or pastoral background rather than from law enforcement. This will avoid the perception of criminalizing the individual or stigmatizing them, which may negatively impact their and the wider community's engagement with and/or perception of your program.

#### ▶ Personal Skills

Most assessments require some form of face-to-face interaction, either with the individual concerned and/or their friends and family. Staff conducting the assessment should therefore have the networks and professionalism required to **engage different stakeholders** (e.g. the



### Useful Context

#### \* Structured Professional Judgement

**Structured Professional Judgement** combines the strengths of clinical and actuarial risk assessments by leveraging both relevant statistics and practitioner experience. It is considered [the preferred method for risk assessment](#) as it accounts for the individuality of extremist offenders or individuals at risk of this, the invaluable experience of practitioners, all while still providing guidelines and criteria per assessment.

## Assessment in Practice - the VERA2-R and the ERG +22

The [Violent Extremism Risk Assessment Revised](#) (VERA-2R) and the [Extremism Risk Guidelines](#) (ERG 22+) are but two examples of assessment tools designed specially for TVTP. The former is generally used across Europe, while the latter is used in the UK's Channel Program.

	The VERA-2R	The ERG 22+
Usage	<p>Restricted access, requires training.</p> <p>Designed to be informed by multiple sources of information.</p>	<p>Restricted access (not available to the public).</p> <p>Intended for use by probation officers and practitioners with the UK's National Offender Management Service (NOMS).</p>
Factor Categories	<ul style="list-style-type: none"> <li>▶ Beliefs and Attitudes (e.g. hostility to national collective identity)</li> <li>▶ Context and Intent (e.g. personal contact with violent extremists)</li> <li>▶ History and Capability (e.g. prior criminal history)</li> <li>▶ Commitment and Motivation (e.g. driven by criminal opportunism)</li> <li>▶ Protective factors (e.g. community and family dynamics)</li> </ul>	<ul style="list-style-type: none"> <li>▶ Engagement</li> <li>▶ Intent</li> <li>▶ Capability</li> <li>▶ Any other factor" (incl. protective factors)</li> </ul> <p>Less structured than other frameworks in that factors provided serve more as guidelines - they don't all need to be coded.</p>
Requires Training		
Strengths	<ul style="list-style-type: none"> <li>▶ Accounts for protective factors</li> <li>▶ The 34 factors considered in the framework have extensive descriptions and include sample questions</li> <li>▶ Framework also provides thorough criteria per risk rating</li> <li>▶ Allows for factors not listed in the framework to be considered / added to the assessment</li> <li>▶ Requires training and upon completion of training, practitioners receive a VERA-2R manual to refer to as they use the framework. This facilitates consistency in use and quality assurance</li> </ul>	<ul style="list-style-type: none"> <li>▶ Restricted access and training requirements help facilitate consistent and proper use</li> <li>▶ Development was informed by an independent evaluation of its predecessor, the Structured Risk Guidelines (SRG)</li> <li>▶ Considers protective factors and allows for inclusion of risk factors that are not specified by the framework</li> <li>▶ The assessment is delivered collaboratively (offenders are encouraged to input) and is intended to be informed by multiple sources of information</li> <li>▶ Encourages practitioners to consider external factors that may influence current or future risk level</li> </ul>
Limitations	<ul style="list-style-type: none"> <li>▶ Although this is somewhat mitigated by the capability risk domain, there is no explicit guidance on red flag factors or indicators listed. This may make thresholding or decision-making around escalation more difficult</li> <li>▶ The protective factors included are limited and do not sufficiently account for individual characteristics that facilitate resilience to extremism and extremist violence</li> </ul>	<ul style="list-style-type: none"> <li>▶ Training requirements may be a barrier for smaller organizations</li> <li>▶ No red flag indicators may make thresholding more difficult</li> <li>▶ The development of the ERG 22+ was informed partially by existing casework, but casework at the time of its development predominantly concerned Islamist extremism, potentially affecting the applicability to other forms of extremism</li> <li>▶ Equally, given it was developed in the early 2010s, it requires updating and refinement</li> </ul>

## Chapter Five

# Intervention Delivery

## What is the Intervention Process and Who Should Lead It?

Once an individual's vulnerabilities and needs have been assessed, the program team should identify the most appropriate response - interventions developed for an individual should be tailored to their specific needs, and should prioritize their safety.

### Who should lead the intervention?

Depending on the vulnerabilities identified in the risk, needs and/or threat assessments, the assessment panel or program team might decide that a single-disciplinary intervention focused on attitudinal and ideological rehabilitation is sufficient. In this case, a trauma-informed social worker, mental health professional or former extremist may prove to be the appropriate intervention provider.

*Regardless of professional background, the lead intervention provider should have an extensive understanding of targeted violence, terrorism, radicalization and recruitment, both at a local and regional/global level.*

Intervention providers should also be certified to serve as such, or have been offered and undergone the necessary trainings as part of the intervention program.

Importantly, **intervention providers should never try to provide a professional service they aren't qualified for.** Where multiple domains of need are identified, a multi-disciplinary intervention should be

adopted. The types of support a MDT can offer to supplement the lead intervention provider depends on its make-up, but may include some of the following:

- ▶ Life skills training
- ▶ Educational support
- ▶ Employability and job skills training
- ▶ Anger management and other specific behavioral issues
- ▶ Medical and mental health awareness (e.g. substance abuse rehabilitation, eating disorders, self-harm, depression, suicidal ideation)
- ▶ Housing support
- ▶ Family support
- ▶ Mentorship (general or specific e.g. to a career path, hobbies and interests, religious)



## Appointing a Case Manager

- ▶ The case manager is usually the lead intervention provider
- ▶ Even in a multi-disciplinary approach, there should be a single case manager responsible for collating information from all providers assigned to a case and for monitoring the overall progress and appropriateness of the support package being provided

## Key Considerations During Intervention Delivery



### Outreach - Initiating the Intervention

Interventions may be:

- ▶ Voluntary (e.g. for offering support when an individual's behavior is escalating towards criminality) or
- ▶ Mandatory (e.g. as part of conditions set for avoiding prosecution or upon release from prison).

Either way, outreach and engagement to introduce the intervention process needs to be thoughtful and considerate of the individual's background, and informed by the assessment(s) previously conducted.

**The MDT must determine on a case-by-case basis who is the most appropriate and effective person to make that first approach.** Consider, among others:

- ▶ Age - if the individual concerned is a minor, ensure a parent or guardian is present
- ▶ Gender
- ▶ Criminal history (if any)
- ▶ Specific interests

Be transparent when you introduce the proposed support package to the individual concerned (and their parent or guardian, if they are a minor). Make clear the expected trajectory of the intervention, including its objectives, any requirements for participation and, in the case of a multi-disciplinary intervention, which service providers will be involved and why. Where interventions are voluntary, lay out the advantages and potential risks of not participating, so that the individual can provide informed consent.



### Record-keeping and Data Protection

The entire intervention process needs to be thoroughly recorded. **All records, forms, documentation, and data related to a case need to be stored securely - digital records should be stored in an encrypted drive, while any hard copies must be locked up.** There should be clear justification for who has access to certain case files and why.

With the individual receiving the intervention, be transparent about who has access to their case files and why, and if they were to engage in criminal activity, that law enforcement may request and receive access.



### Tip for Practitioners

Encourage **active participation** by involving the individual concerned in planning their intervention, particularly if they are being offered a multi-disciplinary support package. Prompt them to feedback on the proposed pace, scope and scale of the intervention



### Format - Delivering the Intervention

Consider where you hold the interventions - interventions must be delivered in a safe space with the privacy needed to have honest and open conversations. Choose a neutral location, such as a trusted community center. To mitigate potential backlash or stigmatization, avoid holding interventions in venues affiliated with law enforcement.

**Operate with the principles of transparency, consistency and flexibility, and always prioritize the wellbeing and safety of the individual receiving the intervention.**



### Monitoring and evaluation

The intervention process needs to be monitored thoroughly with regular, clear and succinct reporting. Consider:

- ▶ **Clear objectives** - prior to starting the intervention, identify clear objectives that are informed by the various partners involved in providing support, as well as the individual themselves.
- ▶ **Reporting template** - creating a reporting template that intervention providers are expected to fill out during or post every session helps facilitate consistent record-keeping and can help practitioners monitor changes in specific domains.
- ▶ **Self-reporting vs. practitioner judgement** - given structured professional judgement is considered best practice in risk, needs, and threat assessment, seek to apply the same principles as you monitor case progress. For example, consider creating a reporting template that accounts for quantitative data recording, the provider's professional judgement based on intervention sessions, and the intervention recipient's own assessment of their progress.
- ▶ **Progress reporting** - set expectations about what each provider is expected to communicate back to the MDT. Having clear agendas that are circulated ahead of MDT meetings helps members prepare the necessary case notes appropriately.

The importance of consistent and thorough monitoring cannot be understated. Monitoring and evaluation plays an essential role not just in determining the impact of the intervention, but also in assessing **whether or not an individual is ready to transition from intervention into aftercare**. It will be easier to assess this if you have clear progress reports at hand, and objectives to refer back to.

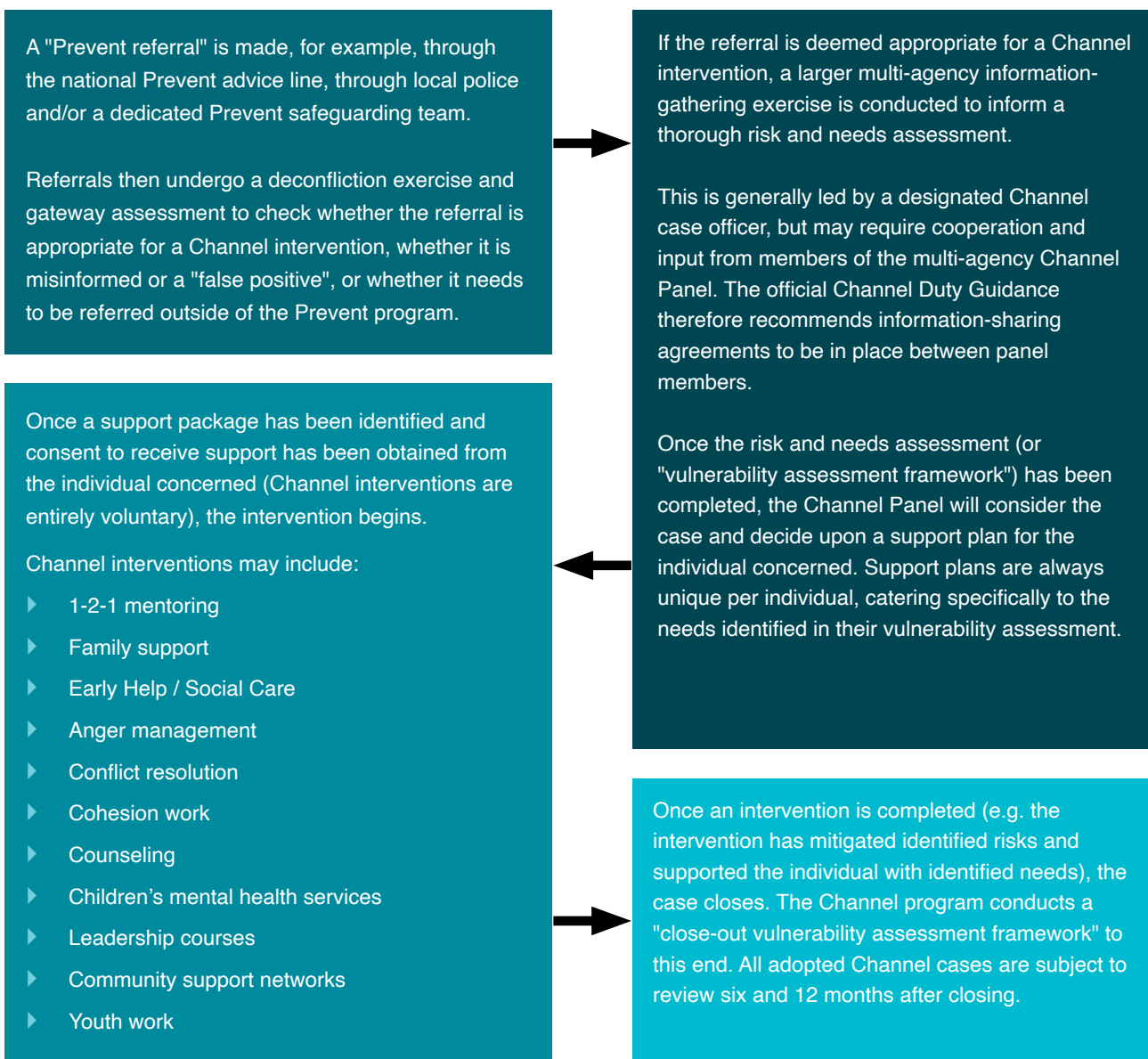


### Tip for Practitioners

In some disciplines, the assessment tool used to identify the initial "level" of risk is used throughout the intervention process to help monitor changes to this "level" of risk. This also allows service providers to make informed judgements about whether or not the intervention is having its desired impact.

## In Practice - the UK's Channel Program

The UK's [Channel Program](#) "provides a multi-agency approach to support people vulnerable to the risk of radicalization". It forms part of the country's nationwide Prevent policy, the aim of which is to stop people from becoming radicalized, joining extremist or terrorist movements, and committing extremist or terrorist violence. Channel provides early support for individuals deemed potentially vulnerable to radicalization and operates at the local level - police or local authorities coordinate a "Prevent Multi-Agency Panel" (PMAP, also referred to as the "Channel Panel"), which is a body of local service providers that are convened to assess potential cases of radicalization and provide the required support to mitigate vulnerabilities. The diagram provided summarizes the Channel process. For more information, see the official [Channel Duty Guidance](#).



## Chapter Six

# Aftercare

## What is the Aftercare Process and Who Should Design It?

Once the case manager and larger assessment panel or program team have jointly decided the support package provided to an individual has met its objectives (e.g. risks have been appropriately mitigated, needs have been adequately addressed), an exit or aftercare strategy needs to be developed and implemented. **Aftercare is the care, treatment, help or supervision given to an individual after they have completed their core treatment or support package.** Aftercare is crucial in that it helps facilitate long-term behavioral change and resilience, and it provides a transition or buffer period that ensures the individual isn't suddenly without any support after months of regular care.

Although this is an integral part of the intervention process, there is limited literature on how to structure this specifically in TVTP programs. However, a review of what this entails for other types of interventions (e.g. alcoholism, substance abuse) provides transferable insights. Aftercare strategies may include:

- ▶ **The provision of a resource pack**, including, for example, a list of local services (e.g. counseling, therapy, classes) that can support should they feel they need it, or guidance and tips for healthy coping mechanisms and maintaining a healthy routine.
- ▶ **A communications plan** - for example, if the intervention provider wants to check-in on the individual in a few months' time or if the individual wants to maintain the option to contact the intervention provider.
- ▶ **Expectations from the intervention program team** and from other agencies if the individual received a multidisciplinary support package. For example - attending x-number of Alcoholics Anonymous sessions in one year (if substance abuse was identified as an issue).
- ▶ **Counseling, mentorship and other wraparound services** by community-based organizations, but geared towards overall well-being rather than ideological rehabilitation. Identifying and training local partners and service providers in TVTP is therefore an important process to facilitate smooth transition from formal intervention to aftercare.
- ▶ **Facilitation of alternative treatments.** Aftercare strategies for individuals that have undergone alcoholism interventions often include [referral to alternative therapies](#). Examples include art therapy, music therapy, meditation, exercise programs and regimes. This should be recommended based on the interests and hobbies of the individual. A young person, for example, might benefit from a team-based exercise program to harness important life skills like leadership, teamwork, collaboration, and to build a network of peers. This may also provide important structure to their personal life.



## Tip for Practitioners

**Start the transition process during intervention** - if, for example, the MDT determines that an intervention recipient may benefit from a long-term life coach, introduce the life coach and arrange a few sessions prior to the completion of the core support package. This allows for a smoother and more stable transition from intervention to aftercare.

### Who should design this strategy?

The strategy should be designed by the lead intervention provider with input and sign-off, where possible, from the MDT. Feedback from the individual receiving the intervention is also important to manage expectations and to account for support they feel they will benefit from. Where family serves as a risk or protective factor, or if the intervention recipient is a minor, they too should be considered in the design of the aftercare strategy.

## Aftercare in Practice - the Citizens Crime Commission

The [Citizens Crime Commission](#) (CCC) is an independent, nonpartisan organization working to reduce crime and to improve the criminal justice system and safety of New York City. Among others, the CCC delivers youth gun violence prevention programming, as well as TVTP through its “Disruption and Early Engagement Project”.

Through these efforts, the CCC has significant experience delivering interventions and organizing appropriate aftercare programming. Key learnings from this experience include:

- ▶ Behavior change is complex - it is in no way linear. Intervention recipients ideally will reach their ideological and/or behavioral objectives

with you as you deliver their tailored intervention package. Interventions aren't for life, however, nor should they be intended as such. Aftercare programming is an important next step that provides lighter-touch supervision post-intervention to facilitate long-term application of the positive changes individuals made throughout the intervention process. It helps sustain the skills that were built in intervention programming, and helps ensure support is available if an individual was to “revert” or “relapse” into unhealthy behaviors.

- ▶ Aftercare should consider an individual's interests, identified vulnerabilities and protective factors, including where there is a lack of the latter.
- ▶ **Challenges and recommended mitigations based on the CCC's experience include:**
  - Program fatigue - interventions can be emotionally fatiguing. It is possible, therefore, that the individual wants support to end after intervention, rather than transitioning into an aftercare program. To mitigate this, include the individual in aftercare planning. Account for their interests and what strategies have worked during intervention. Account also for their time and personal networks - if their family serves as a protective factor, consider how they can be incorporated into aftercare (e.g. family art therapy, giving the family informed guidance and tips for confidence- and resilience-building in the home, etc.).
  - Triggering feelings of abandonment - to avoid feelings of abandonment, continue to be a source of support - ensure an open channel of communication between the individual and the lead intervention provider (or another designated member of the MDT) remains. Inform the individual of the aftercare strategy in due time so you can support them as they emotionally prepare to transition from intervention to aftercare.

## Appendix A

# Glossary of Useful Terms

### Targeted violence

In its [Strategic Framework for Countering Terrorism and Targeted Violence](#), the Department of Homeland Security defines targeted violence as “any incident of violence that implicates homeland security and/or U.S. Department of Homeland Security (DHS) activities, and in which a known or knowable attacker selects a particular target prior to the violent attack”. The definition is based on [research from the NIJ](#), wherein the term was first coined.

### Criminogenic needs

Criminogenic needs are needs which, if not filled, may lead to criminal behavior. They typically encompass four to eight needs domains. [See here](#) for more.

### Risk factors

Factors that [make an individual more susceptible to recruitment](#) by violent extremist organizations and movements. In the case of TVTP, factors that increase the likelihood of radicalization and violence.

### Protective factors

Factors that may decrease the likelihood that an individual may move toward violence. In the case of TVTP, factors that [“insulate and buffer an individual’s resilience to radicalization into violent extremist ideologies and organizations”](#).

### Factors vs. indicators

Although often used interchangeably, factors and indicators are distinct. RTI distinguishes between the two as follows: [“...factors increase the likelihood of a given outcome, while indicators help signal the presence of that outcome”](#). In practice, therefore, a risk factor could be having an extensive criminal history, while an indicator would be an individual expressing threats or violence offline or online.

### Disengagement vs. deradicalization

Disengagement in TVTP refers to [“the abandonment of extremist activity, \[while\] deradicalization is viewed as involving the abandonment or rejection of extremist beliefs and ideology”](#). [“Deradicalization,” meanwhile, refers to the process of divorcing a person, voluntarily or otherwise, from their extreme views, while “disengagement” refers to the process of moving a person away from their extreme group’s activities, without necessarily deradicalizing that person or changing their views.](#)

### Radicalization vs. mobilization

In TVTP, radicalization is the complex process by which an individual adopts extremist beliefs and ideology. Mobilization refers to when an individual [prepares to engage in violent extremist or terrorist activity](#), for example facilitating or committing an attack, or traveling for violent extremist or terrorist purposes.

## Types of Assessment

**Clinical risk assessments** are based on interviews and qualitative data collection between a clinician or practitioner and the individual concerned. Clinical risk assessments are often criticized as too subjective, as the assessment relies predominantly on the practitioner’s judgement or “weighting” of identified risk factors and is therefore subject to significant personal bias.

In the criminal justice space, **actuarial risk assessments** [“use measurable and statistically significant predictors or risk factors”](#) to provide a quantitative assessment of risk informed by databases of offenders with similar criminal and/or personal histories. Actuarial assessments are typically disregarded in TVTP as too inflexible as they are based on static factors that the individual has or doesn’t have in common with other offenders.

**Structured Professional Judgement** combines the strengths of clinical and actuarial risk assessments by leveraging both relevant statistics and practitioner experience. They are presently considered [the preferred method for risk assessment](#) as they account for the individuality of extremist offenders or individuals at risk of this, the invaluable experience of practitioners, all while still providing guidelines and criteria per assessment.

## Appendix B

# Common TVTP Risk Assessment Tools\*

*\*The list provided is not exhaustive.*

### **Extremism Risk Guidelines (ERG 22+)**

Structured Professional Judgement, post-crime, all ideologies

*Useful sources:*

- ▶ [Inter-rater reliability of the ERG 22+](#)
- ▶ [The Structural Properties of the ERG 22+](#)

### **Identifying Vulnerable People (IVP)\***

Structured Professional Judgement, pre-crime, any individual in a community setting about which there is concern, all ideologies but domains assessed steer heavily towards Islamist.

*Useful source:*

- ▶ [Guidance for IVP to Recruitment into Violent Extremism](#)

### **Islamic Radicalization (IR 46)**

Structured Professional Judgement, pre-crime, for individuals who may be susceptible to Islamist extremist ideology, for Islamist extremism only.

*Useful source:*

- ▶ [CREST Extremism Risk Assessment directory](#), pp. 19-23.

### **Multi-Level Guidelines (MLG)**

Structured Professional Judgement, pre and post-crime, for any individual affiliated with or formally a member of an extremist group.

*Useful sources:*

- ▶ [MLG](#)
- ▶ [Risk Assessment and Management of Group-Based Violence](#)

### **RADAR**

Structured Professional Judgement, pre-crime, for individuals identified as (potentially) at risk by counter-terrorism officials.

*Useful source:*

- ▶ [Evaluating Case-Managed Approaches](#), see “Data Sources”

### **Radicalization Prevention in Prisons (R2PRIS) / Radicalization Risk Assessment in Prison (RRAP)**

R2PRIS provides two frameworks - the Frontline Behavioral Observational Guidelines and the Individual Radicalization Screening (IRS). Both are Structured Professional Judgement, both are intended for use in prisons.

*Useful source:*

- ▶ [www.r2pris.org](http://www.r2pris.org)

### Returnee 45

Structured Professional Judgement, designed specifically to assess the commitment, motivations and risk of returning foreign fighters and family members thereof from Syria and Iraq.

*Useful source:*

- ▶ [RAN Manual Responses to Returnees](#), p. 30

### Significance Quest Assessment Test (SQAT)

Uses a self-questionnaire, for individuals in or after detention. It uses the **3N radicalization model of “needs, narrative and network”** and Likert scales to assess risk or degree of radicalization.

*Useful source:*

- ▶ [The Practitioner’s Guide to the Galaxy](#), pp. 15-16

### Terrorist Radicalization Assessment Protocol (TRAP-18)\*

Structured Professional Judgement, pre-crime, for individuals identified as (potentially) at risk by counter-terrorism officials and law enforcement.

*Useful sources:*

- ▶ [Manual](#)
- ▶ [Risk Management Authority](#)

### Violent Extremism Risk Assessment Revised (VERA-2R)

Structured Professional Judgement, pre and post-crime, all ideologies

*Useful sources:*

- ▶ [European Commission](#)
- ▶ [Risk Management Authority](#)

### Vulnerability Assessment Framework (VAF)

Structured Professional Judgement, any individual deemed at risk of radicalization, all ideologies. Has since been replaced by the ERG 22+.

*Useful source:*

- ▶ [Channel Vulnerability Assessment](#)

## Considerations as you learn about assessment

### Method

Structured professional judgement has become the go-to method for risk and needs assessment. This is generally lauded by professionals and academics, and is considered the leading existing practice.

### Factors

Literature about existing frameworks for TVTP risk assessments demonstrate there is notable overlap in the risk factors they consider. Generally, they consider ideological / attitudinal factors, as well as capability considerations.

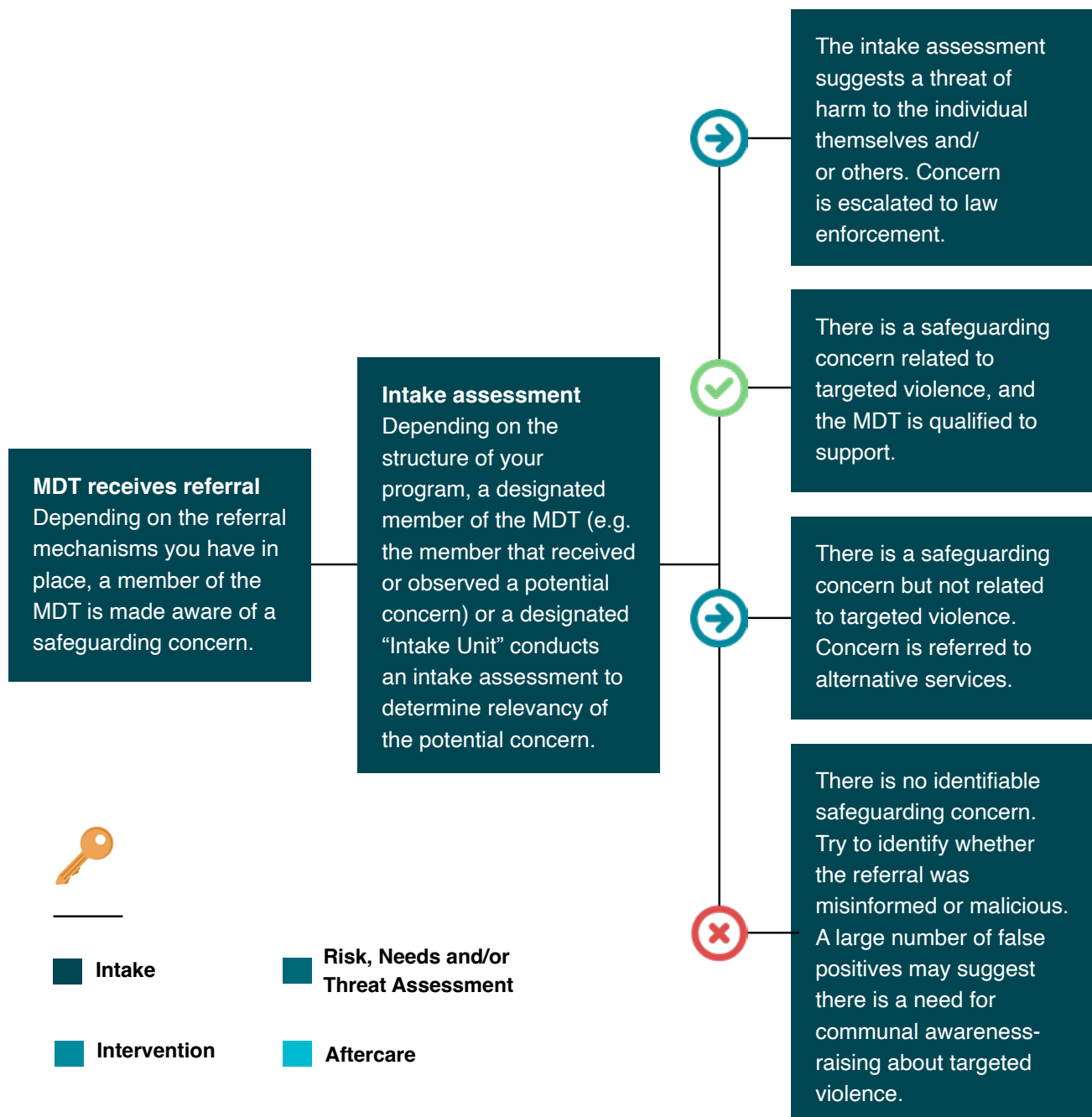
While some don’t include explicit red flag indicators to determine threat and imminence thereof, the “capability” domain they include helps mitigate this by still accounting for ability to commit violence.

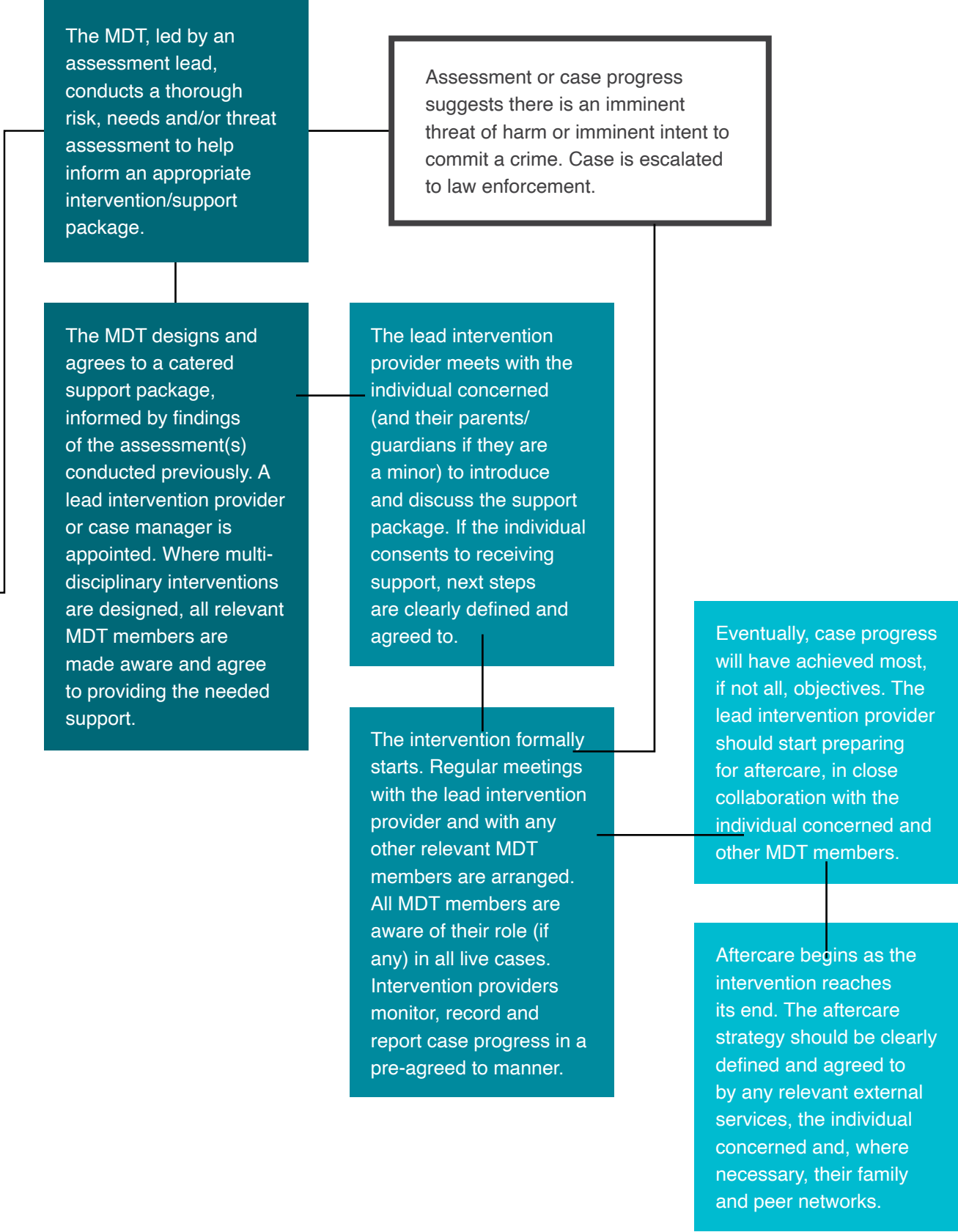
In summary and conclusion, the inclusion of protective factors in assessment, although improving and [recommended as good practice](#), is still limited.

Where possible, choose a tool that accounts for protective factors.

## Appendix C

# Visualizing the Four Stages of Intervention





The MDT, led by an assessment lead, conducts a thorough risk, needs and/or threat assessment to help inform an appropriate intervention/support package.

Assessment or case progress suggests there is an imminent threat of harm or imminent intent to commit a crime. Case is escalated to law enforcement.

The MDT designs and agrees to a catered support package, informed by findings of the assessment(s) conducted previously. A lead intervention provider or case manager is appointed. Where multi-disciplinary interventions are designed, all relevant MDT members are made aware and agree to providing the needed support.

The lead intervention provider meets with the individual concerned (and their parents/guardians if they are a minor) to introduce and discuss the support package. If the individual consents to receiving support, next steps are clearly defined and agreed to.

The intervention formally starts. Regular meetings with the lead intervention provider and with any other relevant MDT members are arranged. All MDT members are aware of their role (if any) in all live cases. Intervention providers monitor, record and report case progress in a pre-agreed to manner.

Eventually, case progress will have achieved most, if not all, objectives. The lead intervention provider should start preparing for aftercare, in close collaboration with the individual concerned and other MDT members.

Aftercare begins as the intervention reaches its end. The aftercare strategy should be clearly defined and agreed to by any relevant external services, the individual concerned and, where necessary, their family and peer networks.

## Appendix D

# Further Reading Recommendations

## General

- ▶ [Introductory Guide: Countering Violent Extremism; Countering Violent Extremism: A Guide to Good Practice; De-radicalization Programs: Introductory Guide](#)  
A series of guides by the Centre for Research and Evidence on Security Threats (CREST) for designing counter-extremism intervention programs. This touches on primary to tertiary interventions.
- ▶ [Understanding Referral Mechanisms in Preventing and Countering Violent Extremism and Radicalization That Lead to Terrorism](#)  
By the Organization for Security and Co-operation in Europe - *an overview of key concepts, challenges and considerations for TVTP referral mechanisms.*
- ▶ [Lessons Learnt from Mental Health and Education: Identifying Best Practices for Addressing Violent Extremism](#)  
By the National Consortium for the Study of Terrorism and Responses to Terrorism at the University of Maryland - *a very useful resource that looks at the integration of mental health and educational professionals with TVTP.*
- ▶ [De-radicalization of Terrorists: Theoretical Analysis and Case Studies](#)  
By the International Centre for Political Violence and Terrorism Research - *a thematic overview of interventions in counter-terrorism. Also provides short summaries of different approaches.*
- ▶ [Knowing What to Do: Academic and Practitioner Understanding How to Counter Violent Radicalization](#)  
By the Terrorism Research Initiative - *an overview of learnings from TVTP academia and practice.*
- ▶ [Enhancing Civil Society Engagement](#)  
By the Global Center on Cooperative Security - *a useful resource for learning more about how civil society can support TVTP programs.*
- ▶ [The Role of Formers in Countering Violent Extremism](#)  
By the International Centre for Counter-terrorism - *a run through of the support former extremists can provide for TVTP initiatives.*
- ▶ [Planning for Prevention: A Framework to Develop and Evaluate National Action Plans to Prevent and Counter Violent Extremism](#)  
By the Global Center on Cooperative Security - *guidance for national authorities on implementing TVTP programs. Has useful transferable learnings.*
- ▶ [Understanding the needs of children returning from formerly ISIS-controlled territories through an emotional security lens: Implications for practice](#)  
By Heidi Ellis, Emma Cardeli, Mia Bloom, Zachary Brahmbatt and Stevan Weine - *a useful and important look at support for children in rehabilitation and reintegration.*

- ▶ [The Challenge and Promise of a Multidisciplinary Team Response to the Problem of Violent Radicalization](#)  
By Heidi Ellis, Alisa B. Miller, Ronald Schouten, Naima Y. Agalab and Saida M. Abdi - *a helpful resource about the potential of multidisciplinary responses to violent radicalization.*
- ▶ [An Imprecise Science: assessing interventions for the prevention, disengagement, and deradicalization of left and right-wing extremists](#)  
By the Institute for Strategic Dialogue (ISD) - *research based on interviews with online and offline intervention providers.*
- ▶ [Women, Girls and Islamism - A Toolkit for Intervention Providers](#)  
By ISD - *highlights effective practices and processes for intervention provision, based on insights from intervention providers in the UK and the Netherlands.*

## Risk, Needs and Threat Assessment:

- ▶ [Extremism Risk Assessment: a directory](#)  
By the Centre for Research and Evidence on Security Threats (CREST) - *provides a useful overview of six TVTP risk assessment frameworks (ERG 22+, IR 46, IVP, MLG, TRAP-18, VERA-2R)*
- ▶ [The Practitioner's Guide to the Galaxy - A Comparison of Risk Assessment Tools for Violent Extremism](#)  
By the International Centre for Counter-Terrorism (ICCT) - *compares the VERA-2R, ERG 22+, SQAT, IR 46, RRAP, Radar and VAF*
- ▶ [Risk Factors and Indicators Associated With Radicalization to Terrorism in the United States: What Research Sponsored by the National Institute of Justice Tells Us](#)  
By Allison G. Smith Ph. D. - *this is a very useful source, which compares two TVTP risk assessments with one for generic violence*
- ▶ [Countering Violent Extremism: The Application of Risk Assessment Tools in the Criminal Justice and Rehabilitation Process](#)  
By the Research Triangle Institute (RTI) - *a useful overview of the history of risk assessment and challenges this in TVTP*
- ▶ [Countering Violent Extremism: The Use of Assessment Tools for Measuring Violence Risk](#)  
By RTI - *runs through existing frameworks for risk assessment and associated challenges*
- ▶ [Developing, implementing and using risk assessment for violent extremist and terrorist offenders](#)  
By the Radicalization Awareness Network (RAN) - *provides guidance for risk assessment in TVTP*
- ▶ [Violent Extremism: a comparison of approaches to assessing and managing risk](#)  
By Caroline Logan and Monica Lloyd - *maps the landscape of risk assessment, with a close look at a selection of existing frameworks. Also includes guidance for making risk assessments.*

## Program-specific:

- ▶ [Channel Duty Guidance](#)  
By the UK Government - *statutory guidance for Channel Panel members and partners of local panel.*
- ▶ [Countering Violent Extremism: Lessons on Early Intervention from the UK's Channel Program](#)  
By Talene Bilazarian of George Washington University's Program on Extremism - *a useful run through of the Channel Program.*
- ▶ [A list of disengagement practices](#) compiled by the Radicalization Awareness Network. See also [this document](#) for more practices.
- ▶ [The Danish Aarhus Model](#)  
By Aarhus Universitet - *an overview of the highly regarded Aarhus multi-disciplinary intervention model.*

## From other disciplines:

- ▶ [Behavioral Intervention Teams \(BTI\)](#)  
By the State Board for Community and Technical Colleges - *a compilation of resources for BTIs. See also NABITA.*
- ▶ [Evaluating Alternative Aftercare Models for Ex-Offenders](#)  
By Jason Leonard, Bradley Olson and Ron Harvey - *a study examining different types of aftercare for ex-offenders.*
- ▶ Gang Prevention Resources: [Los Angeles Gang Reduction & Youth Development \(GRYD\) Research and Evaluations](#), [Overview of GRYD Services](#)
- ▶ [Multi-disciplinary gang intervention teams](#)  
By the National Gang Center - *a useful run-through of how multi-disciplinary teams for gang intervention can operate.*
- ▶ [Programs for Recovering Alcoholics in Aftercare](#)  
By American Addiction Centers - *a useful example of how aftercare is approached in other fields.*
- ▶ [Response to Intervention \(RTI\)](#)  
By RTI Action Network - *early identification and support for students with learning and behavioral needs.*
- ▶ Risk Assessments from Other Disciplines: [Suicidality](#), [Child Sexual Exploitation Risk and Vulnerability](#), [Gender-Based Violence](#) (this has a set of questions specifically for children and adolescents), [Generic Violence Threat Assessment](#)

## Appendix E

# Key Considerations Checklists and Tools

Provided is a checklist of key considerations per each of the core stages of intervention, as well as other useful tools for documenting your thoughts and decisions. This is not an exhaustive list but serves, instead, as guidance to refer to as you design your TVTP intervention program.

## Setting up a MDT - Development Checklist

- Local services mapped
- Relevant services identified (consider the list of disciplines in Chapter One of this practice guide)
- Relevant services engaged to gauge interest and feasibility
- Appropriate documentation prepared. Consider:
  - ▶ **MDT charter** clearly stating, among others:
    - the role of the MDT, including the setting in which the MDT will operate and the types of individuals they will work with (pre-crime vs. post-crime, youth, etc)
    - membership criteria, including term of service, the induction and exit process
  - ▶ **MDT code of conduct and ethics** making clear the behavioral conduct expectations of MDT members, regarding how they engage with each other, with intervention recipients and how to serve as ambassadors for TVTP.
  - ▶ **Non-disclosure agreements (NDAs) and memorandums of understanding (MOUs).**
- Necessary documentation completed by each MDT member
- Roles and responsibilities per MDT member defined (including meeting minute-taking, meeting convenor)
- All MDT members trained on targeted violence (thematic and practical)
- Specific training needs identified per member (e.g. training requirements for any assessment tools used)
- First meeting arranged

## Intervention Program Design - Intake, Referral and Escalation

- Referral mechanisms established\*
- Intake process confirmed with MDT, including:
  - ▶ How and to who safeguarding concerns need to be communicated
  - ▶ Decision-making about the intake assessment - will this be led by the member of the MDT who received or identified the potential concern, or is there a designated "Intake Unit"?
  - ▶ How to action the results of the intake assessment - for example, if the intake assessment suggests there is an imminent threat of harm, what is the process for escalation to law enforcement? Do you have a point of contact there, if not a representative in the MDT?
- Intake tools created and rolled-out. Consider creating templates for both a referral form and an intake assessment form to add consistency to the intake process. Provide clear thresholding criteria to help inform decisions about escalation or referral.
- Process for recording referrals and results of the intake assessment established and communicated to the MDT. Consider, for example:
  - ▶ Where documents are stored - wherever you decide, ensure it is encrypted and that all members of the MDT abide by strict data security practices.
  - ▶ Who can view referrals and findings from intake assessments, and how the findings are communicated to the wider MDT.

## Intervention Program Design - Risk, Needs and Threat Assessment

- Assessment tool identified. If you choose an existing tool, make sure relevant staff are trained on how to use it, and that they have read any literature available about its use and impact. Make sure there are clear thresholding criteria for referral and escalation.

**See Appendix B for a sample list of assessment frameworks. See also the [recording of the risk, needs and threat assessment workshop](#) delivered for the Prevention Practitioners Network.**

## Intervention Program Design - Interventions and Aftercare

Role of the case manager / lead intervention provider defined

Monitoring and decision-recording tools created and rolled out. Consider creating:

- ▶ **Progress reporting templates** - one for the lead intervention provider to monitor the ideological/behavioral intervention, another that other professionals can use to record progress in cases of multi-disciplinary intervention. Decide how frequently these should be filled out (e.g. after every session, after every two sessions, once a month, etc.). Using the same form each time helps monitor case progress.
- ▶ **Escalation and referral forms** - for instances in which a case is assessed as requiring support from law enforcement or services the MDT is not qualified to provide. The availability of such forms ensures consistent record-keeping.

▶ **Aftercare forms** - a form that lays out the aftercare strategy (agreed to by all relevant parties), specific expectations and requirements for the individual (e.g. attending a certain amount of life coach sessions in the next year), and that provides the necessary information to maintain an open line of communication between the MDT and the individual.

▶ **Exit forms** - for when an individual either decides they no longer want support (in cases of voluntary interventions), or they have completed the program entirely. Again, the availability of such forms helps embed a practice of keeping record of the intervention process and key decision-making. These forms do not need to be long - an Exit form can simply be a one-pager that records the date, terms of exit and confirms the individual has chosen to leave or is ready to leave the program.

Information-sharing protocols (e.g. how to communicate sensitive information digitally, when a break of data privacy is permitted or legally required) identified and communicated to the entire MDT. This should at least account for information-sharing between members of the MDT, between the MDT or lead intervention provider and the individual receiving intervention, and between the MDT and law enforcement.



# For Notes:

# For Notes:



# PREVENTION PRACTITIONERS NETWORK<sup>SM</sup>

The Prevention Practitioners Network (PPN) is a national network of interdisciplinary professionals dedicated to preventing targeted violence, terrorism, and their impacts within the United States. PPN brings together the leading experts in psychology, psychiatry, social work, community and public safety, justice, education, trauma, criminology, sociology, and law enforcement to develop a community of practice. The focus of PPN is to convene practitioners across disciplines who are at the front lines of violence prevention, including first responders, clinicians taking referrals, judges, and law enforcement.

As a network, we conduct workshops and facilitate symposia that bridge the gap among these practitioners. Together, we discuss interdisciplinary approaches to common challenges experienced in the field. The network serves as a guiding body for organizations and institutions across the United States who are not only looking for partners and collaborative support but also best practices in a field that previously lacked resources for practitioners.

The network has expanded to include over 1,200 members participating in online workshops, attending symposia, and leveraging network resources.

At the 2023 International Counterterrorism Conference, U.S. Department of Homeland Security Secretary Alejandro Mayorkas praised PPN, describing it as a network “comprised of hundreds of interdisciplinary professionals who have created evidence-based trainings and resources for prevention program design, and a registry of mental and behavioral health clinicians who can receive and process targeted violence and terrorism prevention referrals.

## National Directory

PPN is building an inclusive index of multi-stage violence prevention resources and clinically licensed mental and behavioral health providers. Scan the QR code or you can download the app on your smartphone.



[eradicatehatesummit.org/prevention-practitioners-network/](https://eradicatehatesummit.org/prevention-practitioners-network/)

## Previous Work & Publications

PPN conducts workshops and facilitates symposia and trainings, addressing the gaps, challenges, and best practices in the interdisciplinary field of violence prevention. Recordings can be found on our website.

Some of the resources PPN publishes in partnership with the Institute for Strategic Dialogue are these practice guides for practitioners. For a full updated list of resources, please see the [PPN webpage](#).



**PREVENTION  
PRACTITIONERS  
NETWORK<sup>SM</sup>**

v1b.121624



**ERADICATE  
HATE**  
GLOBAL SUMMIT™

**Eradicate Hate Global Summit**  
500 Grant Street, Suite 4500  
Pittsburgh, PA 15219-2514

[www.EradicateHateSummit.org](http://www.EradicateHateSummit.org)