False Positives

the Prevent counter-extremism
policy in healthcare

MEDACT

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.

About the author

This report was written by Medact Research Manager Dr Hilary Aked.

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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/

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Foreword

The research and writing of this report were conducted across 18 months, the vast majority of which preceded the outbreak of Covid-19 in the UK. For most of that time counter-terrorism sat alongside pandemic preparedness at the top of the government's risk register. The Prevent programme was, and still is, a major element of the government's approach, and has been incorporated by law into healthcare.

Intended to prevent terrorist threats before they emerge, the government has allocated millions of pounds to integrate Prevent within healthcare policy and practice. NHS trusts are mandated to train their staff to spot so-called "signs of radicalisation" and refer cases to the programme.

While the government's independent review of Prevent has yet to be finished, our report has uncovered many serious potential harms in this attempt to marry counter-terrorism with healthcare; not least of which is an erosion of trust in the NHS. This threatens to undermine the deeply felt appreciation of health workers so visibly demonstrated by the public during the pandemic.

The pandemic has also shone a spotlight on the widening health inequalities in the UK; with people in deprived areas and black and ethnic minority groups suffering disproportionately more covid-related severe illness and death. Again, our research shows that the Prevent programme threatens to stigmatise those groups and exacerbate health inequalities.

Covid-19 has, at a tragic cost, served as a reminder that we need a more holistic understanding of security than the relatively narrow approach underpinning policies like Prevent. At Medact, we believe that a healthy society must tackle the root causes of violence, rather than seek to address it with measures that encourage discrimination and risk worsening existing health inequalities.

We are living in a changed world now, but one in which these health inequalities are more sharply visible than ever. Racism is increasingly recognised as a public health issue and the impact of the Prevent duty in healthcare remains acutely relevant. Recent events have starkly highlighted the divisive and polarising effects of crude stereotyping and unconscious bias.

This report is the most comprehensive and in-depth study to date of the implementation and impacts of Prevent in the NHS. It provides much-needed scrutiny of a controversial policy at a time when structural racism has risen to the top of the public and political agenda.

Professor Alan Maryon-Davis FFPH FRCP

Chair of Medact

Executive Summary

1. Introduction & context

- Prevent was implemented in 2006 following the London 7/7 bombings.

- It costs at least £40 million a year, yet **there is no solid evidence base that it reduces terrorism risk** and it has never been independently evaluated.

- The UK is the **only country in the world** where healthcare bodies are — since 2015 — legally obliged to be vigilant for potential terrorists.

- The proportion of Prevent referrals coming from the health sector **has consistently risen since 2015**.

- **Impacts of counter-terrorism measures in the NHS are under-researched** and the views and experiences of health workers themselves have rarely been heard.

2. Methodology

- This research investigates **four areas**: the impact on specific **ethnic and religious** communities; the impact on people with **mental health** conditions; the positioning of Prevent as **safeguarding**; and how the Prevent duty interacts with the duty of **confidentiality**.

- We employ both **qualitative and quantitative** data collection and analysis techniques, including interviews, focus groups and case studies, as well as Freedom of Information requests.

- We encountered **significant obstacles and transparency failures** during this research.

3. Basic statistics: rates, regions & Channel progression

- We analysed original data gathered through **Freedom of Information requests made to a sample of 77 NHS Trusts** in Prevent priority areas.

- We found **significant variation in terms of numbers of referrals** across different NHS trusts.

- We identified six trusts with unusually high referral rates. The **top three referrers in our sample were Camden and Islington NHS Foundation Trust, Birmingham and Solihull Mental Health NHS Foundation Trust and Leicestershire Partnership NHS Trust**.

- **London and the Midlands** were the major geographical Prevent "hotspots".

- There was also **wide variation in "false positive" rates** (proportion of Prevent referrals not leading to Channel interventions) with some NHS trusts' rates as high as 98%, others as low as 58%.

- Our data suggests **rates of Channel interventions in Prevent referrals from healthcare may be higher on average** than other sectors.

4. Racial & religious impact

- We found that **Asians/British Asians were reported to Prevent four times more than non-Asians** in the NHS trusts in our sample which disclosed this data.

- We also found that **Muslims were referred to Prevent eight times more than non-Muslims**.

- Our qualitative data, including case studies, suggests that this **disproportionality is, at least in part, a result of racial and religious discrimination**.

- We found **racial bias in official Prevent training materials** used to explain to health workers the factors that may increase "radicalisation" risk.

- In the absence of reliable predictive criteria, **health workers are also told to rely on "instinct"**.

- We conclude that **the negative impacts of false positive Prevent referrals**, including on physical and mental health, confidentiality and trust, **are felt disproportionately by minority groups**, which **risks worsening existing health inequalities.**

- We also found widespread neglect of equalities monitoring around Prevent, raising **questions about compliance with public sector equality duties**.

5. Mental health impacts

- We found that the **evidence for official claims that people with mental health conditions are more likely to be drawn into terrorism is not robust** enough to base policy upon.

- We found disagreement among the health community on this point, but some **mental health specialists believe the claim risks pathologisation and exacerbating stigma.**

- Both quantitative and qualitative data from our research indicated that **people with mental health conditions are disproportionately referred to Prevent.**

- Our case studies suggest **this may be compounded when an individual is also Muslim and/or BAME.**

- We found evidence that **Prevent referrals can damage people's physical and mental health**, as well as their families, in a variety of direct and indirect ways.

- Mental health harms came about through **damage inflicted on therapeutic relationships, setting back recovery, interrupting care, causing patients to disengage**, limiting the support which health services can provide, and even apparently **triggering mental health problems in individuals with no prior psychiatric history.**

- We also found that **the secretive Vulnerability Support Hubs scheme** which embeds NHS mental health professionals into a counter-terrorism police-led project, **raises acute ethical concerns.**

6. Case studies

- **Ten case studies, illustrating numerous aspects of Prevent,** demonstrate the damage referral can do to peoples' health and the **potential trauma inflicted on "false positive" cases.**

- Many of these cases feature young BAME Muslim men, and a significant number feature mental health conditions, showing how **Prevent plays out at the intersections of race, religion, mental health and age.**

- They include the case of **a Muslim teenage boy who apparently developed OCD as a direct result of the trauma of his Prevent referral**, the case of **a severely ill young Muslim man who was unable to self-feed but was reported to Prevent** by a physiotherapist, and the case of **a Muslim man with schizophrenia experiencing paranoid delusions about police persecution** who was **questioned by police after being referred to Prevent, harming the therapeutic relationship with his psychiatry team**.

- The cases also document the **often complex situations health workers are asked to navigate and the huge pressure placed on them to comply, and to refer**, often without consent.

7. Prevent & safeguarding

- There was dissensus among health workers about the legitimacy of **Prevent's unique concept of "vulnerability"**, which we found to be broader than established safeguarding criteria.

- Despite claiming to be "a supportive practice", our analysis of Prevent materials found that **the programme ultimately views its subjects as dangerous, rather than in danger**.

- Health workers highlighted **a range of practical discrepancies between Prevent and safeguarding practices**, including subjective indicators, separate pathways and lack of transparency.

- We found that **very few health workers believe Prevent offers anything beneficial to patients**.

- Qualitative evidence raises the **disturbing possibility that it may actually harm the vulnerable, rather than safeguarding them**.

- Some health workers fear that **preoccupation with potential radicalisation may crowd out more tangible and pressing safeguarding concerns**.

8. Confidentiality, consent & trust

- We found **widespread confusion** in the health community around confidentiality and consent with regard to Prevent.

- Our analysis concluded that **non-consensual referrals can never rely on a public interest justification**, since Prevent does not deal with immediate risk.

- Yet we found that many if not most referrals do not involve informed consent, suggesting

that **Prevent has circumvented normal confidentiality expectations via the backdoor.**

- We found that **Prevent training materials strongly emphasise the importance of disclosure** while consistently providing disclaimers around, or **even discouraging, consent-seeking**.

- We found that **health workers are deeply concerned about the possibility of a broader erosion of trust** and some are concerned about criminalisation, in the context of all Prevent referral data being recorded on a police database.

- We conclude that the Prevent policy in health relies on **grey areas, lack of clarity, conflation of safeguarding with public protection and a failure to distinguish between "vulnerable" patients and patients lacking capacity.**

9. Conclusions & recommendations

- We conclude that **Prevent is harmful to physical and mental health in multiple direct and indirect ways** and that "safeguarding" is therefore a misnomer.

- The **huge variation in Prevent referral and false positive rates** across NHS trusts **suggests inadequate, racially biased assessment tools are being applied in arbitrary, uneven ways**.

- Our analysis shows clearly that **Prevent causes discrimination against Muslims and Asian communities in particular**.

- Prevent **stigmatises people with mental health conditions**, and often **damages the care they receive**.

- There is also strong evidence that **Prevent is damaging presumption of patient consent and confidential medical care**, and trust in the medical profession.

Recommendations

In light of our conclusions, our key recommendations to the government are:

1. **Repeal the Prevent policy in healthcare** in light of the lack of evidence of efficacy and documented evidence of harm.

2. **Refocus counter-terrorism efforts on combating violence** instead of arbitrary concepts like "extremism", while healthcare and safeguarding should be ring-fenced from counter-terrorism.

3. **Adopt evidence-based public health policies** based on a holistic understanding of security, which address broader, long-term determinants of violence, including policies which drastically reduce inequality and reallocate funds towards mental health services, youth services, and drug and alcohol dependency services.

4. **Take steps to address the harms caused by Prevent** and rebuild trust in confidential, non-discriminatory healthcare services including supporting NHS staff to receive equalities training.

5. **End lack of transparency and accountability** by immediately publishing historic data on the religion and ethnicity of people referred under Prevent, proportion of non-consensual Prevent referrals, evidence underpinning the ERG 22+, and evaluation of the "Vulnerability Support Hubs" project.

Introduction & context

1.1. What is Prevent?

Since its implementation in 2006 following the London 7/7 bombings, the Prevent programme has been by far the most controversial of the four strands of the UK government's counter-terrorism policy, CONTEST. Unlike the three other strands,[1] Prevent — thought to cost around £40m a year[2] — is not designed to respond to *acts*, or even threats, of political violence but to "the ideological challenge of terrorism".[3] Typifying contemporary counter-terrorism practices which increasingly emphasise "risk and threat anticipation" and pre-emptive intervention,[4] the programme's stated aim is to stop people "from becoming terrorists or supporting terrorism" *before* they commit any crime, in the so-called "pre-criminal space".[5]

A key plank of Prevent is the training of public sector workers in how to spot the "signs of radicalisation".[6] According to the Home Office, over a million frontline practitioners including teachers, university lecturers, doctors, nurses and probation officers have received such training.[7] When the Counter-Terrorism and Security Act 2015 made Prevent a statutory duty, requiring specified authorities to "have due regard to the need to prevent people from being drawn into terrorism", the prevalence of these trainings increased significantly. So, too, did the number of people being referred under the programme.[8]

The Prevent & Channel process

When a Prevent referral is made — for example because a doctor suspects a patient of showing "signs of radicalisation" — the case will be screened by the Prevent lead within the organisation, often a safeguarding professional. Police will also check the individual is not the subject of an active counter-terrorism investigation. If the referral is deemed a legitimate radicalisation concern at this stage — and not, for example, "misguided, malicious or misinformed" (the so-called "3Ms test")[9] — the case may then be considered at a "Channel Panel" meeting.[10]

Figure 1: The Prevent process (Source: Home Office)
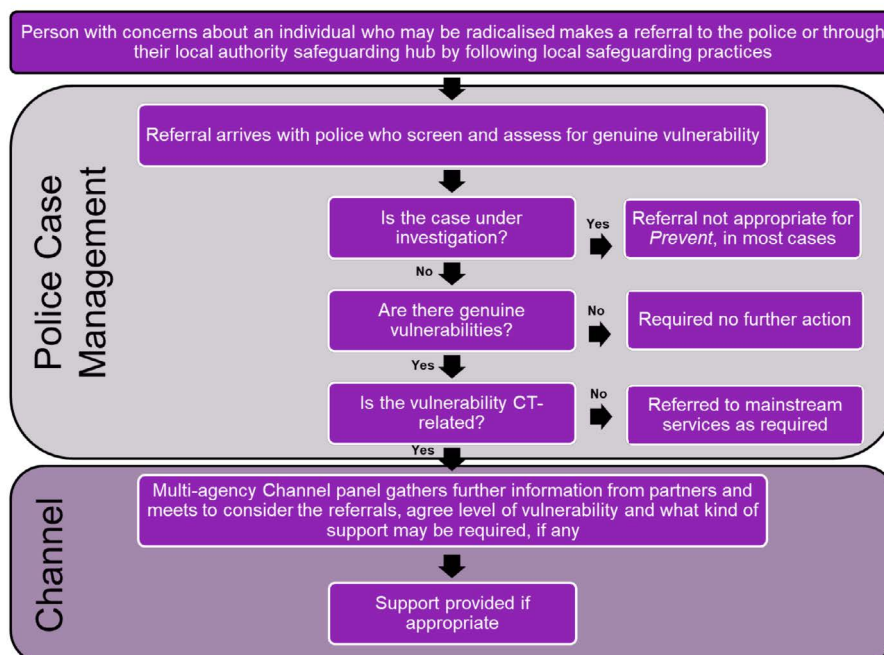
A Channel Panel is a multi-agency group, led by the police, and involving representatives from the local authority, health, education and other services. At this stage, many cases are either discarded entirely, or referred to housing, mental health support or elsewhere. **Just a small fraction — between 5-10% of all Prevent referrals — are deemed to warrant "Channel" intervention. This means that at least 90-95% of referrals were, even in the eyes of the police, "false positives". Importantly, even if a Prevent case never reaches a Channel Panel,** *all* **referrals are recorded by the police in a Prevent Case Management (PCM) database,[11] and reportedly stored for seven years.[12]** In addition, those people reported to Prevent who are not referred to other services may have their cases recorded as "no further action" but this may be something of a misnomer, since they sometimes still receive a visit from police prior to that decision (for example, see Case 7 in Chapter 6).

Since 2012, more than 1,500 people have been through the Channel programme.[13] What this highly secretive programme involves is "barely known", notes the BBC. One participant likened it to "a black box".[14] The BBC calls it "re-education",[15] but the Home Office uses a different term — "ideological mentoring" — and insists that participation is both "voluntary and confidential".[16]

Does Prevent work? Evidence, evaluation & the "signs of radicalisation"

The Prevent model, pioneered in the UK and described as "world-leading" by the Home Office,[17] has been exported around the globe.[18] **Yet, remarkably, this is being done without a solid, transparent evidence base showing that such programmes actually work.[19]**

Iceberg image from "Let's Talk About It" website (Source: www.ltai.info)

Extremely rare events such as terrorist attacks are notoriously difficult to predict. However, "radicalisation" theory argues that a process which precedes an act of terrorism provides opportunities to intervene.[20] An image of an iceberg is sometimes used to illustrate this concept, with only the peak (the attack) easily visible. **Prevent training materials therefore prime people to spot so-called "signs of radicalisation" based on criteria called the Extremism Risk Guidance 22+ (ERG22+),** also known as Channel Vulnerability Assessment Framework. These were originally based on a single psychological study which identified at least 22 factors deemed to potentially indicate radicalisation risk.[21] Figure 2 lists these signs.

The ERG22+ paper was initially classified, and was not published in a peer-reviewed journal until 2015. Despite this, the framework has been embedded in Prevent since 2011.[22] Moreover, the underlying dataset has never been published. This is a problem from a scientific perspective since "instruments need to be tested, validity and reliability cross-verified and studies need to be capable of being replicated and critiqued".[23] The Royal College of Psychiatrists has criticised this state of affairs, saying "public policy cannot be based on... lack of transparency about evidence", and calling for it to be "comprehensively published and readily accessible."[24] In February 2020, the UN's Special Rapporteur on the promotion and protection of human rights and fundamental freedoms while countering terrorism noted that **psychometric systems like the ERG22+ "mix structured forensic analysis models, traditionally focused on mental illness and deviance, with other models of intelligence analysis containing strong ideological and political connotations" and "consistently use ambiguous factors in their application".[25]** Chapter 4 discusses health workers' doubts about the predictive value of the ERG22+ and examines how engagement factors 1, 3 and 8 have been extrapolated in greater detail.

The Home Office states that 85% of Channel participants leave the programme with "no further radicalisation concerns".[26] However, "pre-crime" is a murky area. It is of course impossible to verify a counterfactual and ascertain whether Channel participants would otherwise have gone on to become terrorists, absent state intervention. **Thus claims about the efficacy or otherwise of Prevent and Channel are empirically unverifiable.** However, we do know of people — such as the Parsons Green bomber — who went on to commit attacks *despite* being flagged to Prevent.[27] Nor is there solid evidence that "deradicalisation" programmes designed for those convicted of terror-related offences are effective. Psychologist Chris Dean — who co-authored the ERG22+ paper — recently admitted as much, to the BBC,[28] which describes these programmes as "in essence experimental".[29] The perpetrator of the December 2019 London Bridge attack had reportedly completed one such programme.[30]

Figure 2: Potential signs of 'radicalisation' according to Extremism Risk Guidance (ERG22+)[31]

Engagement factors

1. Need to redress injustice/grievance
2. Need to defend against threat
3. Need for identity, meaning & belonging
4. Need for status
5. Need for excitement, comradeship or adventure
6. Need for dominance
7. Susceptibility to indoctrination
8. Political/moral motivation
9. Opportunistic involvement
10. Family or friends support extremist offending
11. Transitional periods
12. Group influence and control
13. Mental health

Intent factors

14. Over-identification with a group or cause
15. Us and Them thinking
16. Dehumanisation of the enemy
17. Attitudes that justify offending
18. Harmful means to an end
19. Harmful end objectives

Capability factors

20. Individual knowledge, skills & competencies
21. Access to networks, funding and equipment
22. Criminal history

+ Any other factor

There has never been an independent evaluation of Prevent. In 2019, the government succumbed to longstanding pressure and set up an independent review. However, it appointed Lord Carlile — a leading advocate of Prevent — to conduct it, leading to a judicial review from civil society. Rather than fight the case, the government removed Lord Carlile, the review collapsed and the appointment process was started afresh. It is likely the new reviewer will now not be required to complete their work until August 2021.[32]

Concepts & concerns: "extremism", racism & civil liberties

The government describes "radicalisation" as "the process by which a person comes to support terrorism and extremist ideologies associated with terrorist groups".[33] In turn, extremism is defined as "vocal or active opposition" to "fundamental British values", which are said to include "democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs".[34] But some academics have challenged the concept of "radicalisation" and so-called "conveyor belt" theories of terrorism, which assume that acquiring radical views is likely to be a precursor to acts of violence.[35] Similarly, **after the government last year abandoned an attempt to define "extremism" in law, the former reviewer of terrorism legislation, David Anderson QC, dubbed the term "broad and ill-defined", arguing that it risked making legitimate political and religious activity illegal.**[36] Even the government-appointed Commission for Countering Extremism has itself criticised the definition of extremism, noting that it is highly subjective and "means different things" to different people.[37]

Many of the human rights-related concerns about Prevent stem from this lack of clarity. In particular, **since the 2011 revised Prevent strategy widened its remit beyond a focus on** *violence* **to include groups and ideas which are** *non-violent* **but nonetheless deemed "extremist", civil liberties criticisms have sharpened.**[38] Driving home how malleable this definition is, Prevent has been applied at various times to a range of dissenting voices. In January 2020, it transpired that a counter-terrorism police guide sent to doctors, schools and safeguarding children boards, warned readers to be aware of people "speaking in strong or emotive terms about environmental issues like climate change".[39] It also highlighted mainstream organisations such as Greenpeace and the Campaign for Nuclear Disarmament, alongside the Extinction Rebellion movement and a host of anti-racist, anti-militarist and pro-Palestinian groups.[40] This was not the first time left-wing and environmental campaigns had been targeted by Prevent.[41]

Extracts on left wing and environmental groups from a 2019 counter-terrorism police guide (Source: Counter Terrorism Policing)

In 2018, the UN special rapporteur on contemporary forms of racism condemned the Prevent policy and called on the UK government to "suspend the Prevent duty, and implement a comprehensive audit of its impact on racial equality."[42] Criticisms related to the perceived discriminatory — particularly Islamophobic — impact of Prevent have existed since its inception. Today, the government insists that Prevent "deals with all forms of terrorism, including Islamist and extreme right-wing, and does not focus on any one community."[43] However, **when first introduced, Prevent funding was allocated to different areas according to a crude algorithm which used the size of the local Muslim population to estimate risk.**[44] While the programme has evolved and developed a great deal since then, leaks which emerged in 2019 from the Office for Security and Counter-Terrorism's communications arm (within the Home Office) demonstrated that Prevent's target demographics remain the same.[45] The documents described "Prevent audiences" as British Muslims, particularly males, aged 15-39.[46] For this reason, **Muslim community groups say that Prevent continues to treat them as a "suspect community",** a position echoed by a number of scholars.[47]

Prevent categories & statistics

Although transparency around Prevent and Channel is very limited, the Home Office has released official statistics annually since 2016. They show that after Prevent was made a statutory duty in 2015, referrals rose sharply.[48] Since then, they have fluctuated somewhat (see Table 1). Prevent officials themselves have pointed out that the occurrence of terrorist attacks in any given year can increase sensitisation and cause spikes in referral rates.[49] The most recent figures, for the year ending March 2019, showed the lowest numbers of referrals since Prevent became a statutory duty.[50] At the same time, the proportion receiving Channel interventions (approximately 10%) was the highest ever.[51]

The demographic data which the Home Office provides about people referred to Prevent includes statistics on age, gender, geographical location and type of extremism concern. Notably, **people aged 20 years or under (i.e. including children) consistently account for the majority of referrals. Information about faith and ethnicity is absent from the data the Home Office releases.** Alongside right-wing extremism and Islamist extremism, a new category called "mixed, unstable or unclear" (MUU) ideology was introduced in 2017. While right-wing referrals have risen in recent years, referrals for alleged Islamist extremism concerns have generally constituted the largest group. However, in the latest official statistics the MUU category accounted for the majority of referrals. The 2019 Home Office report also mentioned, for the first time, "left-wing radicalisation".[52]

1.2. Prevent in the NHS

The handful of cases of health workers who have committed acts of political violence — such as junior doctor Bilal Abdullah, one of two perpetrators of the 2007 Glasgow Airport attack — have been well-publicised.[53] Similarly, the multi-faceted negative health impacts on survivors of terrorist attacks are rightly well-studied. However, **the implementation and impacts of counter-terrorism measures in the NHS are markedly under-researched.** Despite over 830,000 NHS staff having received Basic Prevent Awareness training and over 470,000 having attended advanced training,[54] there are very few studies exploring Prevent's impact in healthcare. **The views and experiences of health workers themselves have rarely been heard. This report seeks to help fill that gap.**

The government has long seen the health sector as a "critical partner" for Prevent. The NHS, with its 1.3 million workforce and 315,000 daily contacts with patients in England alone, is

Image from the Let's Talk About It website (Source: www.ltai.info)

thought to be well placed "to identify individuals who may be groomed into terrorist activity".[55] Currently, **the UK is the only country in the world where healthcare bodies are legally obliged to be vigilant for potential terrorists.**[56]

Table 1: All Prevent referrals and proportion from health sector, 2015-2019 (Source: Home Office annual Prevent statistics, 2016-2019)

	2015/16	2016/17	2017/18	2018/19
All sectors	7631	6093	7318	5738
Health	6% (457)	8% (464)	9% (680)	10% (564)

Alongside their statutory duty set out in the Counter Terrorism and Security Act 2015, NHS organisations' Prevent obligations are reinforced by a clause in the NHS Standard Contract which providers sign with Clinical Commission Groups. This states that each provider must nominate a Prevent Lead, comply with Prevent strategy and guidance in all policies and procedures, and raise awareness of Prevent among staff and volunteers.[57] Elsewhere, specific targets are set with regard to the online "e-learning" Basic Prevent Awareness (BPA) training and the Workshop to Raise Awareness of Prevent (WRAP), usually delivered in-person. NHS bodies are expected to train 85% of staff in at least the fundamentals

of Prevent.[58]

In terms of data collection, NHS trusts and foundation trusts submit figures on numbers of referrals made and their Prevent training levels to NHS England (via NHS Digital) on a quarterly basis (see Appendix 1).[59] From here it is shared with the Home Office. As Table 1 shows, **the existing data indicates that the proportion of Prevent referrals originating in the health sector has steadily increased over time**. The Office for Security and Counter Terrorism, within the Home Office, funds a number of Regional Prevent Coordinators (RPCs)[60] within NHS England, who report to the Department of Health and Social Care (see Appendix 2). Paul McCann, the RPC for London and the South, told Medact that NHS England's role in Prevent is "to ensure that the Duty is fully implemented across the health economy".[61] To this end, **NHS England's "Prevent Implementation Group" began holding quarterly meetings in summer 2019 at the Department of Health and Social Care (DHSC)**.[62] Medact made a Freedom of Information request to see the minutes of these meetings, but they were deemed exempt from disclosure under section 24 of the Act, related to "safeguarding national security". **DHSC also contributes financially towards the implementation of Prevent in the health sector.**[63]

> " *The UK is the only country in the world where healthcare bodies are legally obliged to be vigilant for potential terrorists*

Rather than being framed as a security measure, **Prevent has been incorporated into the existing safeguarding duties of healthcare workers**, as Chapter 7 explains. As such, the Care Quality Commission (CQC), England's healthcare regulator, sometimes plays a role in compliance monitoring via its periodic inspections.[64] Figure 3 shows the key institutions and data sharing relationships involved in the delivery and enforcement of Prevent in the health sector.

Figure 3: Institutional enforcement of Prevent in the NHS[65]
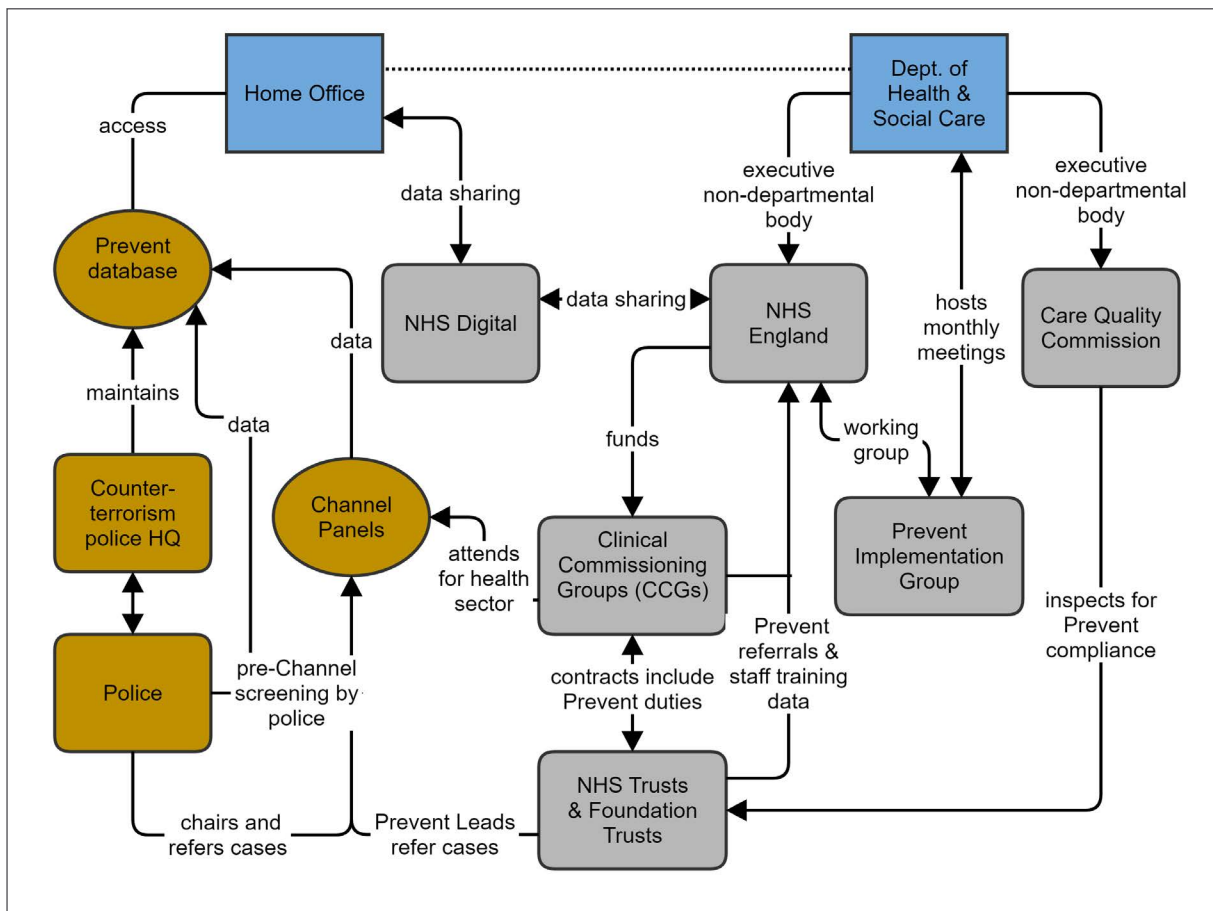
Key issues of concern

The limited literature on Prevent in the health sector suggests four key issues of concern. These are:

- **The impact on specific ethnic and religious communities:**

  - NHS staff appear to be "drawing from popular culture to understand radicalisation".[66]

  - Counter-terrorism within healthcare settings "disproportionately impacts British Muslims",[67] constituting institutional racism[68] and raising concerns about violations of the right to be free of discrimination and the right to manifest religion.[69]

  - Individuals (including children) who are erroneously referred experience this as "stigmatising and intensely intimidating".[70]

- **The impact on people with mental health conditions:**

  - University of Warwick researchers argued that "the line between mental illness and radicalisation is becoming increasingly blurred" and discovered that some mental health trusts have adopted automatic radicalisation screening practices for all service users, which risks "inappropriately stigmatising" people with mental illness.[71]

  - Instructions to mental health services to fast-track people flagged as radicalisation risks may create perverse incentives to report people, to expedite their access to care.[72]

- **The positioning of Prevent as safeguarding and the tensions created by this:**

  - The University of Warwick study concluded that "the positioning of Prevent as a safeguarding measure is ambiguous".[73]

  - It found that "significant differences exist" compared to pre-existing safeguarding procedures.

  - It identified a "legal grey area between the provisions of the Care Act and the Counter-terrorism and Security Act".[74]

- **Medical professionals' duty of confidentiality and how the Prevent duty may affect trust in the health services:**

  - A report by the Open Society Justice Initiative argued that Prevent has the potential to violate the right to privacy and concluded that the policy is "eroding trust" in both educational and healthcare settings.[75]

  - It also suggested that the lack of adverse consequences for making erroneous referrals creates incentives "to err on the side of reporting" and a "rush to refer".[76]

  - Prevent may have a chilling effect on both staff and patients, leading to self-censorship.[77]

Methodology

2.1. Objectives & scope of research

Given the dearth of literature on the impacts of the Prevent policy in healthcare, **this research sought to better understand the implementation and impacts of the Prevent counter-extremism policy within the sector.** This report documents primary research undertaken by Medact, particularly aiming to shed light on four areas:

1. Equalities issues, including the impact on specific **ethnic and religious communities**; and

2. the impact on people with **mental health conditions.**

3. The positioning of **Prevent as safeguarding** and the tensions created by it.

4. Medical professionals' **duty of confidentiality** and how the Prevent duty interacts with it.

Given the focus on these issues, it is not within the scope of this report to offer an in-depth analysis of why policies like Prevent have been adopted in the context of neoliberalism and the NHS funding crisis. Nor can we propose a fully-realised vision of an alternative public health approach to how political violence in our society might be reduced. **The report provides some valuable new evidence of the harmful impact Prevent can have on those referred, but in this respect we recognise it is far from comprehensive, focusing as it does on health workers' views and experiences, as opposed to those of patients.**

2.2. Interviews, focus groups & case studies

Qualitative data used in this report are based on content analysis of three sets of Prevent training materials from three different NHS institutions, Freedom of Information (FOI) requests, interviews and focus groups.

Twenty-one in-depth, semi-structured interviews — lasting on average approximately 45 minutes each and conducted both face-to-face and via telephone — were conducted with a range of people including GPs, public health officials, academics, safeguarding and confidentiality experts, Prevent "whistleblowers", mental health specialists working with children and adolescents and senior figures at a number of the key medical Royal Colleges. The majority of interviewees were selected via purposive sampling; meaning they were chosen specifically because of their expertise, experiences or professional role.

We made particular efforts to interview supporters of Prevent. However, this proved difficult since several either declined to be interviewed or agreed but then stopped replying to emails.[1] A number of individuals responsible for the delivery of Prevent, including in healthcare, also declined to be interviewed, with one stating that a "decision has been taken at a senior level" that "NHS England/NHS Improvement will not be participating in any independent research at this time, but will instead be supporting the forthcoming independent review" (initially led by Lord Carlile).[2] **We wrote formally to the Home Office to request an interview but received a reply saying no officials would be available for interview.[3] As we explain below, this is just one of a range of barriers imposed on research into Prevent. Nonetheless, some of our interviewees could still be characterised as sympathetic or even supportive of the Prevent policy — or aspects of it — and some previously or currently held positions within the policy apparatus.** In total, 15 people declined to be interviewed and 22 did not respond.

Five focus groups were also conducted in four UK cities. These were London, Birmingham, Manchester — England's three biggest urban areas — and Brighton, which like the other cities has witnessed significant Prevent interest after high profile

cases of radicalisation. There was also a degree of pragmatism in the selection, since in four of the initial eight cities on our list we did not get enough volunteers coming forward to participate. Each focus group had at least five participants and in total 27 people working in a range of health professions (doctors, nurses, midwives, psychiatrists, radiologists) took part in focus groups which lasted approximately an hour each. In some cases, we "piggybacked" on existing meetings of healthcare workers but in others we drew on Medact's existing networks. As well as being a small sample, we acknowledge that this may mean our sample was somewhat slanted towards socially-engaged, politically-aware health workers. Nonetheless, **our focus group participants included those who were sympathetic to Prevent, those who had made Prevent referrals, and those who knew little or nothing about it.** Participants were of varying ages, religions and ethnic backgrounds and at different stages in their careers. Following transcription, responses were systematically analysed according to theme. **In total, almost 20 hours of audio and over 500 pages of qualitative data were collected and analysed from the interviews and focus groups.**

The case studies included in Chapter 6 of this report are drawn from both interviews and focus groups. Little has been written about the effects of being reported to Prevent, including health impacts. **These case studies make visible some of the hidden harms of**

> " *Case studies make visible some of the hidden harms of Prevent in healthcare*

Prevent in healthcare, which usually remain unseen due to a combination of patient confidentiality, shame and stigma experienced by those reported and the fact that already marginalised minorities are principally affected. They provide anecdotal insights into the often traumatic experience of being reported to Prevent and constitute a key contribution of the research. Details have sometimes been changed to protect individuals' anonymity.

2.3. Freedom of Information requests

Quantitative data used in this report is predominantly drawn from FOI requests to NHS trusts, as well as a range of secondary sources.

There are over 200 NHS trusts and foundation trusts in England.[4] Of these, we compiled a sample of 77 trusts based on lists of Prevent priority areas identified in official documents.[5] Each was sent an FOI request, asking for data for 2017-18 and 2018-19 on:

1. The number of Prevent referrals made.

2. The number of referrals discussed at a Channel Panel.

3. The number of referrals subsequently entered into the Channel programme.

For each of the above, we also asked for:

4. The numbers broken down by faith of the people referred.

5. The numbers broken down by ethnicity of the people referred.

6. The numbers broken down by type of extremism concern (using the Home Office's three categories: right wing, Islamist, and "mixed, unstable or unclear").

7. The numbers broken down by whether they were referred from a mental health or non-mental health department.

Figure 4 shows NHS trusts' FOI disclosure rates. From our sample of 77 NHS trusts and foundation trusts, 28 refused to disclose any data, while 49 trusts did disclose information. Overall, 29% supplied only data about the numbers of Prevent referrals, with a further 7% also providing data on how many of these were discussed at Channel Panel and/or entered into the Channel programme. In total, 25% of trusts made what we have called "partial disclosures", which indicates that they supplied basic figures on Prevent referrals and additional data, often including Channel figures as well as some demographic data on faith and ethnicity and/or statistics about the number of referrals from mental health vis-a-vis other departments. **Only 4% of trusts in the sample made 'full disclosures' ie. provided numbers for Prevent, Channel, faith and ethnicity data and statistics on referrals from mental health.**

Analysis of this quantitative data appears in Chapters 3, 4 and 5. **In Chapter 4, we also draw on additional data requested**

via FOIs relating to the faith and ethnicity of all admissions at a smaller sample of NHS trusts, in order to calculate relative disproportionality ratios. Our method for doing so is described in Appendix 3.

These are two important limitations of our data. Firstly, we did not request statistics on the age or gender of people referred to Prevent. In addition, **we have assumed that the vast majority of referrals are of patients by staff but a minority are very likely to be staff who have been referred by colleagues. We do not know what proportion of Prevent referral data relates to health workers themselves**.

Figure 4: NHS trusts' FOI disclosure rates (n = 77)
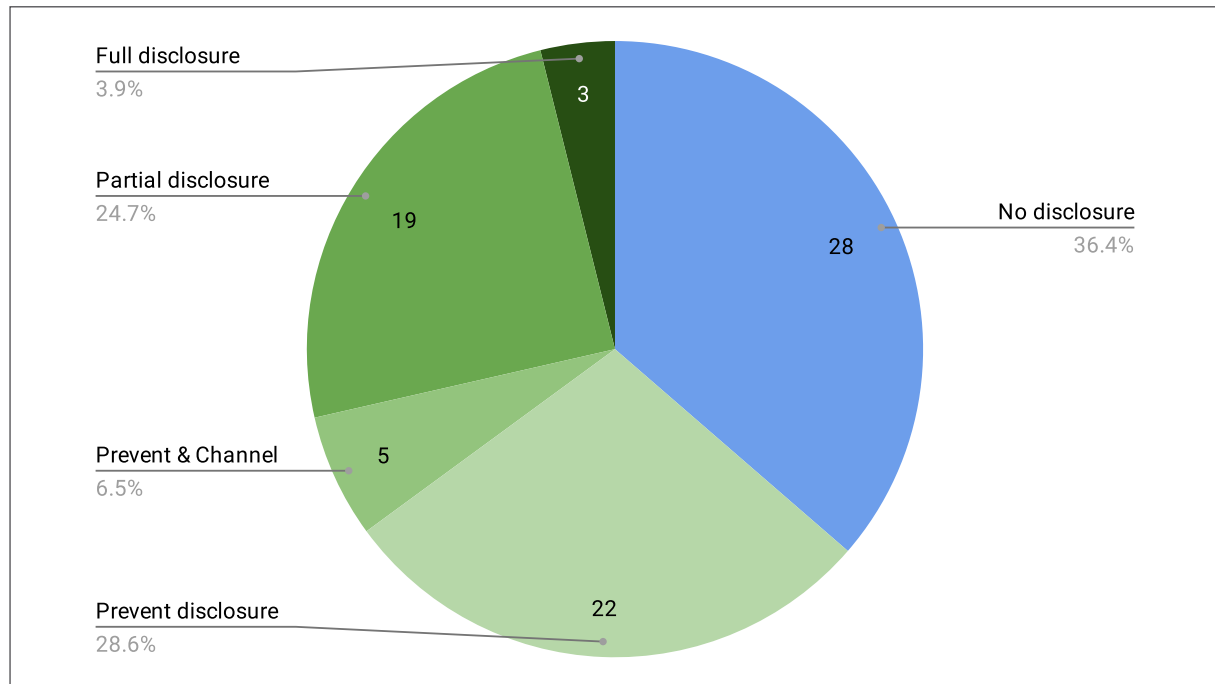
2.4. Obstacles to research & failures of transparency

The most common Freedom of Information Act exemptions cited by NHS trusts refusing to disclose data related to their Prevent referrals were "national security" (section 24), "crime prevention" (section 31), "personal information" (section 40) and "information provided in confidence" (section 41). Even after being challenged via internal review on public interest grounds, many trusts upheld their disclosure refusals. **In particular, any information perceived to be related to national security — such as Prevent — seems to engender an especially acute lack of transparency.**

It also appears that government agencies have specifically sought to encourage health bodies to maintain secrecy and undermine public access to information around Prevent and Channel. A document authored by NHS England and the Department of Health and Social Care provided to us by more than one trust contains guidance for trusts on how to argue *against* disclosure when FOIs related to Prevent are received. It includes advice from the Home Office citing the above exemptions and provides "suggested text" to use, which a number of trusts recycled — completely or mostly verbatim — in their responses to us.

The document also instructs that when an FOI request related to Prevent is received by NHS England or the Department of Health and Social Care, the Home Office should be contacted, and its FOI team will "assist as necessary by advising which further exemptions under the law may be applied".[6] A number of NHS trusts which refused to disclose data told us that they had indeed consulted with Prevent coordinators of the Home Office before responding to our requests.[7]

This appears to be an attempt to undermine Freedom of Information legislation by imposing central government control on information held by a range of public authorities in health. Together with the Home Office's refusal to be interviewed and its failure to release the results of more than one evaluation of Prevent and Channel,[8] this lack of transparency — and indeed, active attempts to evade transparency — should be regarded as a grave problem in a democratic society. Notably, before being promoted to Britain's most senior counter-terrorism police officer, even Scotland Yard's assistant commissioner Neil Basu himself acknowledged that "more transparency" around Prevent is needed.[9]

Data on faith and ethnicity of people referred via Prevent was especially difficult to gather. As Chapter 1 noted, Prevent statistics published by the Home Office omit this demographic data. **As a reason for non-disclosure, some public bodies appeared to suggest that release of this information could be reputationally damaging.** For instance, one piece of Home Office advice states that disclosure of certain data could reveal "information about communities which can be misinterpreted and this can be presented in a way which is not conducive to serving the public interest in fostering safe and cohesive communities".[10] More explicitly, one NHS trust told Medact: "Figures on the ethnicity, religion or type of concern of participants may fuel perceived grievances such as the view that young Muslims are being targeted...This would bring the process into disrepute, destroy trust and damage Prevent at a national level".[11] Similarly, another trust stated: "Allegations of 'spying in the community' and 'targeting certain groups' misrepresent and undermine the intention of the Prevent programme...Figures on ethnicity and faith may fuel perceived grievances that certain groups are being targeted".[12]

Some trusts also told us — implausibly in our view — that providing aggregate data on faith and ethnicity could lead to the identification of individuals concerned. As suggested by the justifications related to avoiding damage to Prevent's reputation, **a more plausible reason for official reluctance to release faith and ethnicity data is that public bodies are well aware that — as Chapter 4 demonstrates — racial and religious minorities are disproportionately reported to Prevent.**

Basic statistics: rates, regions & Channel progressions

3.1. Prevent referral rates

Across all NHS trusts, our data captured 195 referrals in 2017-18 and 237 in 2018-19. Since Home Office data puts total referrals from health at 680 (2017-18) and 564 (2018-19), this means that **our sample of disclosing trusts (which focused on Prevent priority areas) captured approximately 29% of all referrals from health in 2017-18 and around 42% of all referrals from health in 2018-19**. Our data shows that:

- **The majority of trusts (43, 88%) made a maximum of ten referrals in total across both years.**

- **Nineteen trusts (39%) made no more than a single referral per year.**

- **One in five trusts (10, 20%) made zero referrals across the entire two-year period.**

- **The average number of referrals across all trusts for both years was 4.4.**

The mean average rises from 4.0 (2017-18) to 4.8 (2018-19), but more longitudinal data would be needed to confidently assess change over time.[1]

Figure 5 shows the total numbers of Prevent referrals across two years (2017-19) made by the 49 NHS trusts in our sample which disclosed this data, ordered by total disclosures.[2] **It demonstrates the significant levels of variation across trusts. Six trusts, in particular the first three, stand out as having unusually high referral rates:**

- **Camden and Islington NHS Foundation Trust (98 total referrals)**

- **Birmingham and Solihull Mental Health NHS Foundation Trust (65 total referrals)**

- **Leicestershire Partnership NHS Trust (46 total referrals)**

- Leeds and York Partnership NHS Foundation Trust (29 total referrals)

- Nottinghamshire Healthcare NHS Foundation Trust (20 total referrals)

- West London NHS Trust (20 total referrals)

All but one of these six show consistently higher than average rates of Prevent referrals across both years.[3] **Importantly, this is not simply a reflection of admissions rates.** Several of the top twenty busiest trusts in the country (by admissions in 2018-19) are featured in the sample but have average or below average Prevent referral rates. (These include Nottingham University Hospitals NHS Trust, King's College Hospital NHS Foundation Trust, Oxford University Hospitals NHS Foundation Trust and University Hospitals of Derby and Burton NHS Foundation Trust.[4]) By contrast, none of the top Prevent referrers are among the busiest trusts by admissions, so relative size does not appear to be skewing our interpretation of the data. Instead, other factors — whether particularly diligent safeguarding teams or some other cause — must explain these trusts' unusually high Prevent referral rates.

In the case of the Birmingham and Solihull Mental Health NHS Foundation Trust, one possible explanation could be heightened levels of staff sensitisation to Prevent due to a longstanding partnership between the trust and West Midlands Counter Terrorism Unit. In 2013, trust staff delivered "Mental Health First Aid" training to Channel mentors and others working in Prevent.[5] In 2015, clinical staff at the trust were commissioned by the UK's Counter-Terrorism Police Headquarters to conduct a "needs assessment" examining the high prevalence of mental health conditions among people referred to Channel.[6] Subsequently, the trust became a key partner in delivering "Vulnerability Support Hubs", a joint NHS/ Police project designed to address this issue (see Box 1, Chapter 5).

Figure 5: Prevent referrals by NHS trust, 2017-19

Legend: 2017-18, 2018-19

Trusts (top to bottom):
Camden & Islington, B'ham & Solihull MH, Leicestershire Partnership, Leeds & York Partnership, Nottinghamshire Healthcare, West London NHS Trust, SW London & St Georges MH, Berkshire Healthcare, Guy's & St. Thomas', Northern Care Alliance, Dudley & Walsall MH, Black Country Partnership, Essex Partnership, Tameside & Glossop, Oxford Health, Luton & Dunstable, B'ham Comm. Healthcare, Kings College Hospital, Buck'shire Healthcare, Hillingdon Hospitals, West Herts Hospitals, Dudley Group, Oxford Uni. Hospitals, Cam'shire & P'borough MH, Sandwell & West B'ham, B'ham Women's & Children's, Bedford Hospital, Croydon Health Services, Barnet, Enfield & Haringey MH, Rotherham, London NW Uni. Healthcare, Ashford & St Peters Hosp., Wrightington, Wigan & Leigh, Great Ormond Street Hospital, Homerton Uni. Hospital, Bradford Teaching Hospitals, Uni. Hosp.of Derby & Burton, Nottingham Uni. Hospitals, Derbyshire Comm. Health, Liverpool Women's, Mid Yorkshire Hosp., North West Anglia, Uni. Hosp. Bristol, Moorfields Eye Hospital, Hounslow & Richmond, Royal Berkshire, Chelsea & Westminster, Central London Comm., Liverpool Heart & Chest

X-axis: 0, 25, 50, 75, 100

Figure 6: Prevent referrals by region, 2017-19

Y-axis: 0, 50, 100, 150, 200

X-axis: South East, East of England, London, Yorkshire & Humber, East Midlands, West Midlands, North West, North East, South West
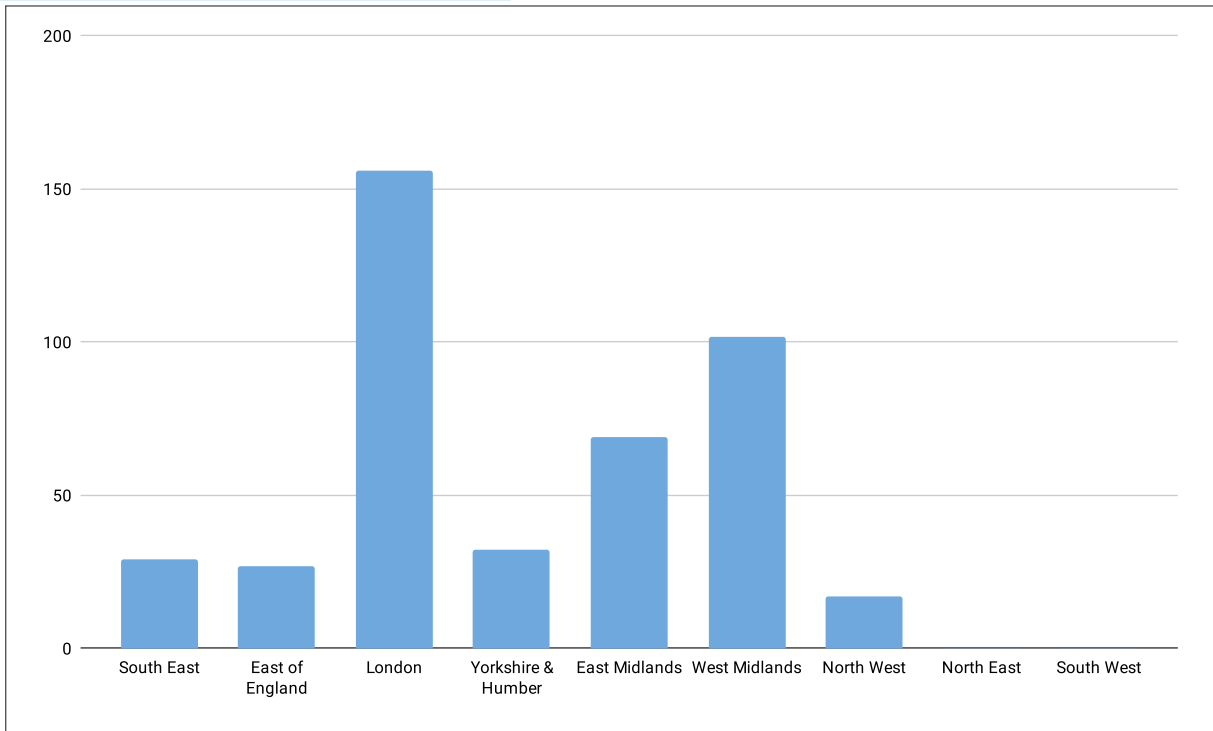
3.2. Geographical hotspots

Figure 6 aggregates data on the geographical location of Prevent referrals by NHS trusts in different regions of England.

It is clear that within our sample — which, it is important to remember, was already focused on Prevent priority areas — there are three major 'hotspots' where the majority of Prevent referrals are concentrated: London, the West Midlands and the East Midlands. Indeed, **London and the Midlands alone account for 76% (327) of all Prevent referrals in our sample**. The very high proportion of referrals from these regions may partly be explained by population levels in these areas as we have not adjusted the figures according to relative population density. However, other factors — such as levels of ethnic diversity — may also be playing a role (see Chapter 4).

## 3.3. Progression of Prevent referrals to the Channel programme

Figure 7 shows "false positive" rates across different trusts', ie. how many of their referrals Prevent did not progress through to the Channel process (explained in Chapter 1), for the 17 trusts which provided data on this. Green indicates a referral was recorded on the Prevent database only but was not deemed to warrant discussion at a Channel Panel. Orange indicates the number of cases that, after being referred under Prevent, were then *also* progressed to a Channel Panel discussion but *not* at that stage deemed to require Channel intervention. Finally, red indicates the cases that went through all these prior stages (Prevent and Channel panel discussion) and were

> **"** *Camden and Islington NHS Foundation Trust had a false positive rate of 98%*

also entered into the Channel programme at the end of the process. It should be noted that **while there is no requirement of reasonable suspicion for a health professional or other public sector worker to make a referral to Prevent, under section 36(3) of the Counter-terrorism and Security Act 2015, the police or a local authority must have "reasonable grounds" to progress an individual to the Channel programme (though, even at this stage, they are still not guilty of any crime).**

Our data suggest that rates of Channel interventions in Prevent referrals from healthcare may be higher than other sectors, which may indicate a slightly more stringent approach to referrals. Home Office data shows that, nationwide, between 5-10% of all Prevent referrals ultimately result in Channel interventions. In our sample, almost one third were entered into the Channel programme (approximately 32%, 63 of 195 Prevent referrals about which progression data was disclosed).

However, not all trusts fit this pattern. Indeed, **the data again shows huge variation across trusts in terms of their "false positive" rates. For example, just 2% of the people referred to Prevent at the trust with the most referrals, Camden and Islington NHS Foundation Trust, were deemed to warrant Channel intervention — a false positive rate of 98%. By contrast, 42% of Prevent cases at the next highest referrer, Birmingham and Solihull Mental Health NHS Foundation Trust, resulted in people entering the Channel programme — a false positive rate of 58%. These discrepancies may be indicative of a substantial degree of subjectivity in how Prevent and Channel are operationalised and applied at different institutions.** Interpreting the difference in the specific example cited is challenging without fine-grained qualitative research in these trusts, but the discrepancy may be connected to the links drawn by officials between mental health conditions and terrorism and the over-representation of people with mental health conditions in the Prevent programme (see Chapter 5).

Figure 7: Prevent referrals' progression through Channel by NHS trust, 2017-19
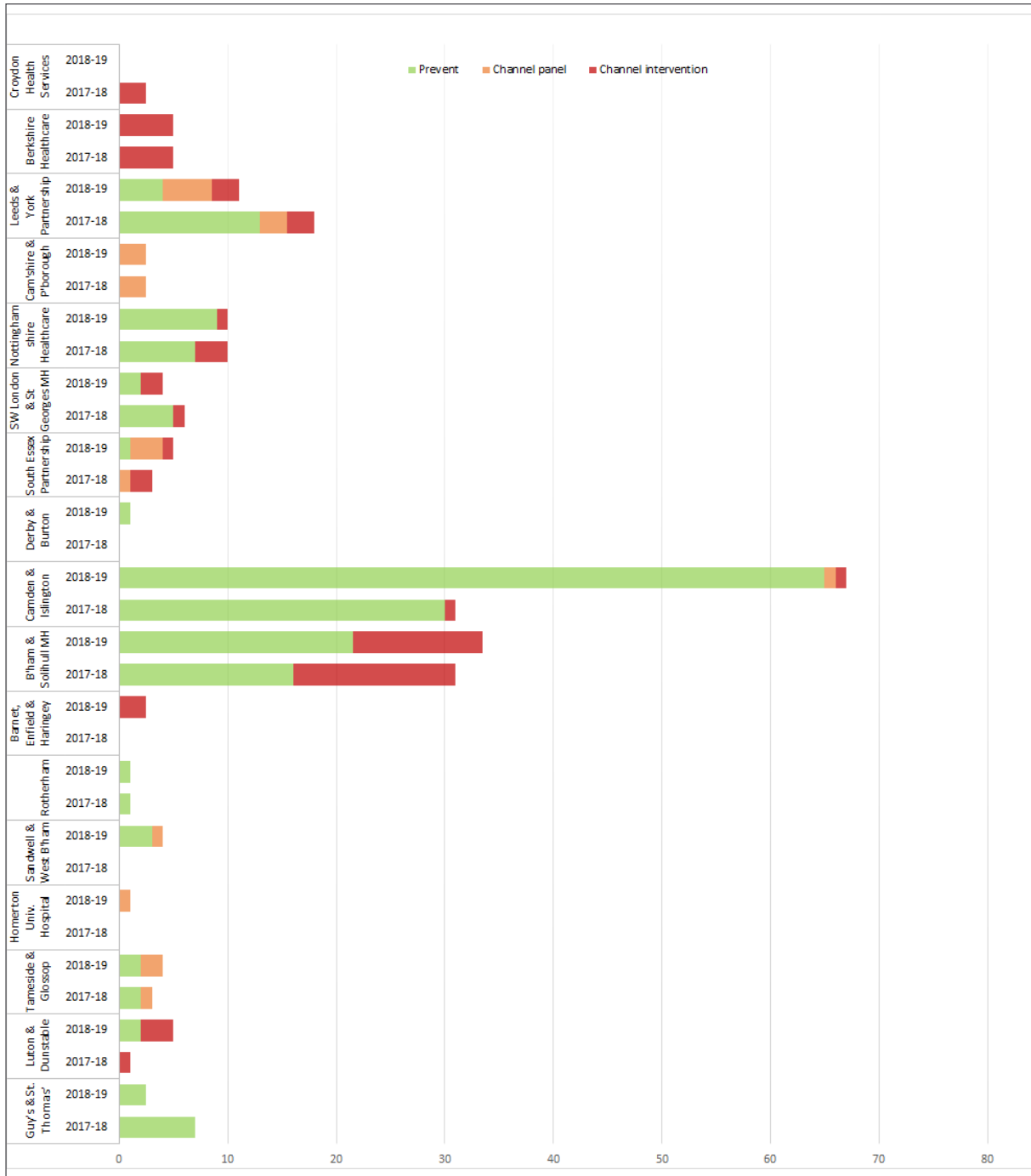
CHAPTER 4

Racial & religious impact

In March 2018, a host of experts including the United Nations Special Rapporteur on contemporary forms of racism, issued a statement warning of increasing levels of racism around the world.[1] **Britain in the Brexit era is no exception, with racial inequality entrenched in our society**[2] and racism of all kinds — ranging from anti-Semitic hate crime to racially disproportionate police use of stop and search powers — increasing in recent years.[3] Rising levels of Islamophobic hate crime and ongoing socio-economic disparities attest to the racism affecting British Muslims.[4] In common with other racialised minorities, Muslims face systematic patterns of disadvantage and exclusion, high unemployment, and poor health. Half of all Muslims in the UK live in the most deprived fifth of the country.[5]

Within the NHS, racism is recognised as a historically ingrained problem. While the workforce is relatively diverse, Black And Minority Ethnic (BAME) staff are under-represented in senior positions[6] and report some of the poorest workplace experiences.[7] The most recent Workforce Race Equality Standard report by NHS England also highlighted rising discrimination.[8] As patients, a recent *British Medical Journal* special edition on racism in medicine observed that ethnic minorities experience differential outcomes in healthcare, encompassing worse rates of diabetes, cancer survival, maternal mortality and overall life expectancy.[9] While data on religious groups is somewhat limited, in 2001 the Office for National Statistics found that Muslims reported the highest rates of ill health.[10] In addition, the poorer areas where many live are often the hardest hit by cuts to health services.[11]

Simultaneously, opponents of the government's healthcare charges for people with insecure or no immigration status — ostensibly introduced to prevent so-called "health tourism" — say the policy has embedded "racial profiling" within healthcare and fostered an environment of racialised suspicion.[12] As Chapter 1 explained, while all UK counter-terrorism measures contribute to "perceptions of racial and religious discrimination",[13] these concerns are particularly acute in the case of Prevent. **This chapter demonstrates the disproportionate impact of Prevent within healthcare on certain racial and religious groups.**[14] **It argues that this amounts to discrimination and occurs as a result of the poor predictive value and racial biases of the "radicalisation" evidence base and risk assessment tools underlying Prevent, combined with exhortations to health workers to rely on "instinct" which empower unconscious bias.**

4.1. Muslims & Asians disproportionately referred

Since its inception, despite a much-publicised recent rise in suspected sympathisers of extreme right-wing causes being referred,[15] **Prevent has disproportionately affected ethnic and religious minorities. Our research shows that this pattern is replicated within the NHS, with people of Asian ethnicity and Muslim faith disproportionately referred to Prevent.**[16]

When asked to provide data on faith and ethnicity of people referred to Prevent from the health sector, the Home Office told us it "only holds data on Channel referrals" a small subset of overall Prevent referrals, and "detailed statistics on overall Prevent referrals are held by the Police".[17] It also stated that neither ethnicity nor religion is "a mandatory field" that "the case officer" (usually police) handling a Channel referral must record.[18]

Figure 8 shows the data released by the Home Office on referrals from health at Channel Panels and in the Channel programme, for one year (2017-18). The huge amount of "not completed" data for both ethnicity and religion, particularly the latter, immediately stands out. **These monitoring failures raise serious questions about whether the Home Office is fulfilling its public sector equality duty under the Equality Act 2010, which requires public bodies to assess the impact of policies on protected groups**.[19] At both stages, the high proportion of referrals for which the "extremism concern" was "Islamist" suggests that many of the referrals for which religious affiliation information was not recorded were likely Muslims, or read as such.

Racial disproportionality

NHS Digital and more than 10 NHS trusts also told Medact that they did not collect data on the ethnicity and faith of people reported to Prevent, again raising questions about compliance with equalities legislation. As the section on obstacles to research in Chapter 2 described, other NHS trusts refused to disclose the data, some offering reasons which suggested that revealing the breakdown of the data could be reputationally damaging.

We were able to obtain demographic data on the racial identity and religious affiliation of people referred under Prevent from a smaller sample of ten NHS trusts. Figure 9 shows how Prevent referrals across two years are grouped according to ethnicity. The most common categories by far in both years are "Asian British" and "White British".[20] However, we need to take into account the proportion of the population each group makes up in order to understand the extent of the disproportionality these figures represent.

A disproportionality "risk ratio", succinctly expressing the disparities between different groups' likelihood of being targeted under Prevent, can be calculated by dividing the minority population's risk of being referred by the majority population's risk. To obtain as precise a figure as possible to use as the population base in our calculations, we also requested admissions figures broken down by race and religion from the ten NHS trusts (pertaining to the same two years for which we had data on Prevent referrals). We also excluded one trust from the calculation because all its referrals were of "unknown" ethnicity. **The disproportionality was stark. Our analysis of ethnicity data from the nine NHS trusts in question found that Asians were reported to Prevent four times more than non-Asians. Disproportionality was consistent across all trusts, with the exception of Sandwell & West Birmingham, and was especially marked at Essex Partnership University NHS Foundation Trust.** The full table of data and a more detailed explanation of our method, explaining why this is a conservative estimate, can be found in Appendix 3.

Figure 8: Ethnicity, religion and alleged extremism of Channel referrals from health, 2017-18 (Source: Home Office)

Discussed at Channel panel					
Ethnicity		**Religion**		**Concern**	
White	54	Christian	<10	Islamist	80
Black	13	Muslim	34	Extreme RW	40
Asian	26	Hindu	<10	Other	11
Mixed	<10	Jewish	0	Unspecified	13
Other	<10	Sikh	0		
Refused	0	Other religion	<10		
Not completed	45	No religion	<10		
		Prefer not to say	<10		
		Not completed	99	**TOTAL**	**144**
Channel interventions					
Ethnicity		**Religion**		**Concern**	
White	19	Christian	<10	Islamist	27
Black	0	Muslim	10	Extreme RW	17
Asian	<10	Hindu	0	Other	<10
Mixed	0	Jewish	0	Unspecified	0
Other	<10	Sikh	0		
Refused	0	Other religion	0		
Not completed	20	No religion	<10		
		Prefer not to say	0		
		Not completed	33	**TOTAL**	**46**

Figure 9: Racial identity of people referred to Prevent from 10 NHS trusts, 2017-19
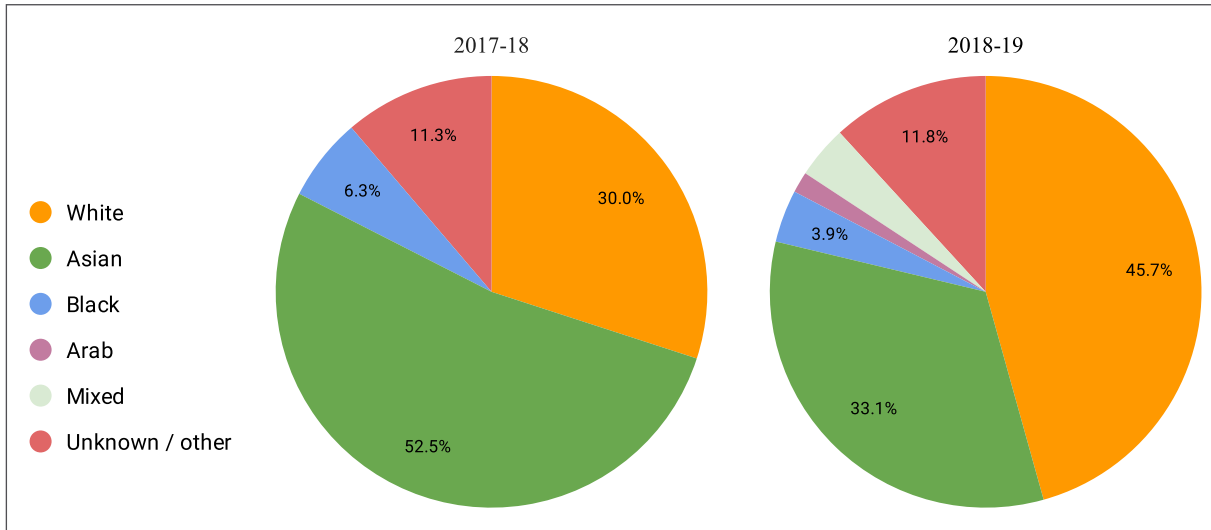
Religious disproportionality

Figure 10 shows how Prevent referrals from the ten NHS trusts break down across the two years according to religious affiliation. The most common categories by far in both years are 'Islam' and 'Unknown'. Again, we calculated disproportionality using data on patient admissions and religion. In this case, we excluded four of the ten trusts, either because all their referrals were of "unknown" faith or because they told us they do not record religious affiliation data. **Here, the disproportionality was even more marked. Our analysis of data on religion from six NHS trusts found that Muslims were referred to Prevent eight times more than non-Muslims. Disproportionality was a consistent pattern across all trusts and once again especially marked at Essex Partnership University NHS Foundation Trust.** Appendix 3 provides the full table of figures showing how disproportionality was calculated and explaining why this is a very conservative estimate.

> " *Asians were reported to Prevent four times more than non-Asians. Muslims were referred eight times more than non-Muslims*

Figure 10: Religious affiliation of people referred to Prevent from 10 NHS trusts, 2017-19
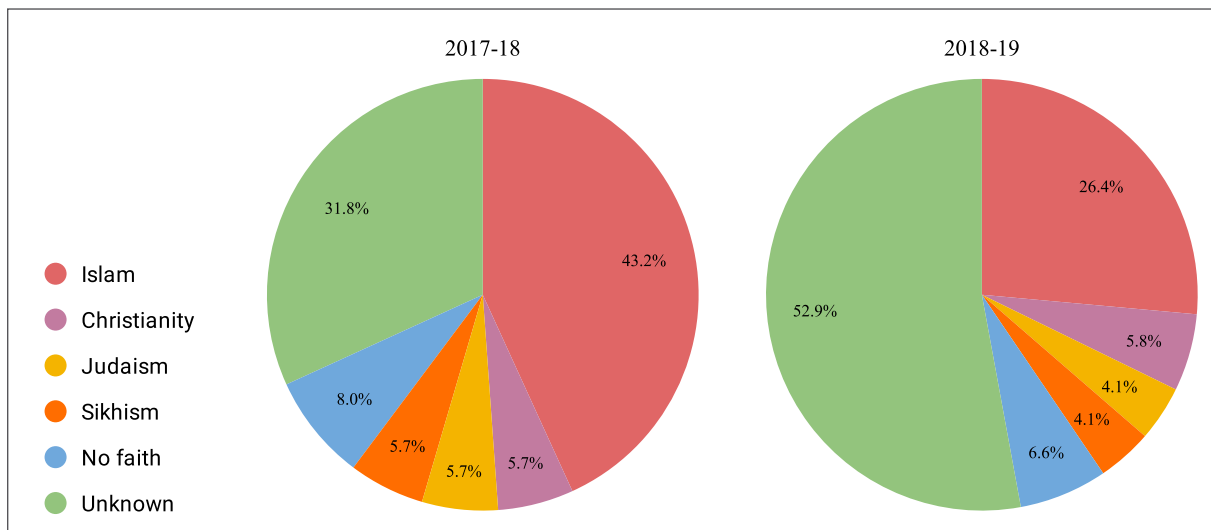
Types of alleged extremism

Figure 11 shows the types of extremism suspected of people referred to Prevent from nine NHS Trusts which provided this data. It may go some way towards compensating for the large amount of "unknown" religious affiliation data, since those suspected of "Islamist" extremism (the majority in both years) can reasonably be assumed to have been Muslims, or read as such. Note that **this suggests our disproportionality calculations above — in which we treated any "unknown" data as non-Asian or non-Muslim — very likely under-estimate true levels of disproportionality.**

Overall, these figures show that Prevent in the NHS mirrors the racial and religious disproportionality seen in other sectors.[21] This is especially concerning when we bear in mind that the vast majority (90-95%) of Prevent referrals are deemed false positives, not warranting Channel intervention even in the eyes of police.

Figure 11: Alleged extremism of people referred to Prevent from nine NHS trusts, 2017-19
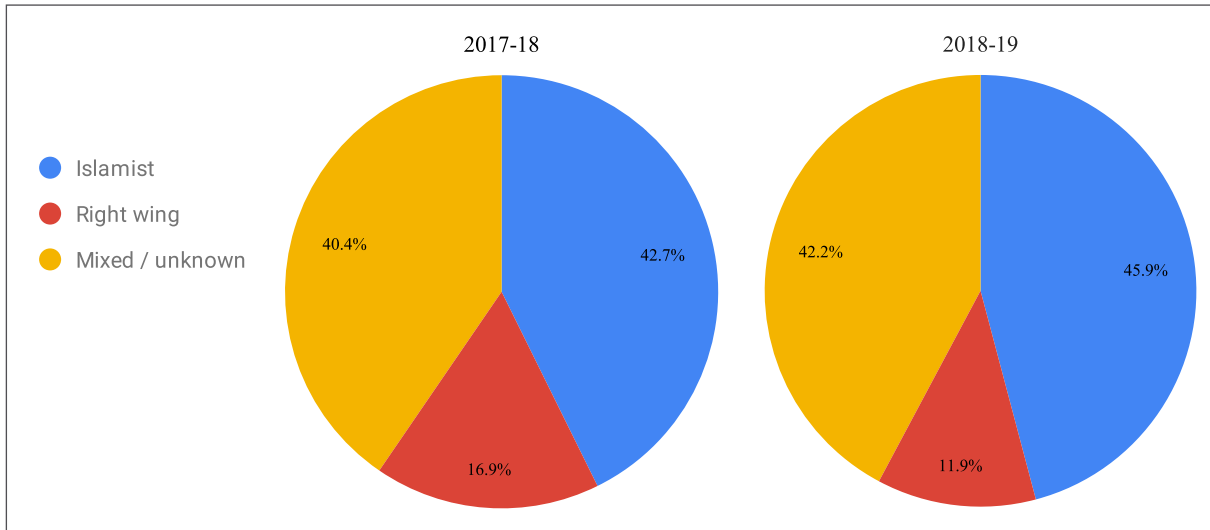
Disproportionality & discrimination

International human rights law, and domestic legislation such as the Race Relations Acts and Health and Social Care Act 2008, prohibit discrimination on the basis of race, religion and other protected characteristics.[22] Once differential treatment is demonstrated, the burden of proof to justify this treatment lies with the state.[23] However, as a legal academic explained to Medact, there is a distinction between disproportionality and discrimination and "unequal application would only be discriminatory [in law] if the unequal application cannot be justified by factual determinants."[24] This means that disproportionality does not *necessarily* equal discrimination — but it does demand explanation.

Advocates of Prevent often argue that the disproportionality which is a distinct feature of the policy merely reflects the "threat picture". The danger of this argument is its potentially tautological nature, especially in the area of pre-crime where there is no observable way to verify through tangible evidence that *any* Prevent referral is "correct" and the vast majority are indeed false positives, never progressed to Channel. In addition, numerous academic studies attest to the continued pervasiveness of "racialized notions of criminal threat".[25] Given the long history of the racialisation of crime,[26] it is especially dangerous to argue that disproportionate impact on certain racial and religious groups merely reflects the "threat picture". As the sociological study *Policing the Crisis* famously illustrated, once racialised explanations of crime infiltrate society and its criminal justice system, they can effectively become self-fulfilling prophecies.[27] The alternative explanation is that racism operating within the system could account for some, or all, of the disproportionality seen in Prevent referral statistics.

When asked to explain racial and religious disproportionality in Prevent referrals, some of our research participants made reference to contemporary political conflicts in Muslim countries. More frequently, however, they stated the belief that racism in society — especially the media — was feeding into the health system. A few named both as possible factors.[28] **To properly assess the meaning behind the numbers we need to look at qualitative data in more depth. As the next section explains, the interviews and focus groups we conducted, including evidence gathered about a number of case studies, suggest that perceived racial and religious identity are often important factors in informing health workers' judgements about what potentially constitutes "extremism" or "radicalisation" and can therefore critically influence decisions about when to make a Prevent referral.**

4.2. Prevent training: a little knowledge is a dangerous thing

Health workers 'not immune' to societal stereotypes

Perceptions that Prevent involves "racism",[29] "Islamophobia",[30] "racial profiling",[31] "pathologising difference"[32] and "intolerance to different belief systems"[33] are widespread among health workers. Most believe they themselves are "not immune"[34] to sharing "stereotypes"[35] and "prejudice"[36] circulating in society in a climate of widespread Islamophobia.[37] Just one focus group participant, in contrast, argued that healthcare professionals would have "good equality and diversity" training and would not make "assumptions".[38] Far more commonly, health workers voiced concerns that individuals may be judged on "how they look and what they wear",[39] that decisions about what constitutes extremism are "not an objective thing" and that Prevent could be "playing into people's subconscious biases".[40]

During our research, these unconscious biases — which are by no means unique to health workers[41] — occasionally became visible. Mostly prominently, "extremism" was often assumed to be an ethnic minority issue. For example, Dr Al Dowie, a Senior Lecturer in Medical Ethics and Law at the University of Glasgow, told Medact that at a 2017 training day for Scottish psychiatry registrars "the opinion in the room was that the Prevent strategy doesn't really come into play with the sorts of patients in their care...the implication was that the spectrum of ethnicities in a Scottish population...is such that the issue doesn't arise".[42] Similarly, another health care professional declined an interview request from Medact with the explanation that "I'm working in Portsmouth these days. I'm not sure if I'd be much use to you, given the local population".[43]

Finally, one focus group participant told us "even though we don't have necessarily particularly mixed ethnicity down in Brighton, [Prevent] was deemed very applicable to us".[44] In this instance, even while pointing out an *exception* to the rule, the comment implicitly acknowledges the normative logic linking extremism with ethnic minorities.

> " *Health workers voiced concerns that decisions about what constitutes extremism are "not an objective thing"*

Any training, observes the British Medical Association's Ethics and Human Rights adviser Julian Sheather, "is only as good as the person who's using it, and people will misuse it".[45] **Health workers, however, should not shoulder the blame for the disproportionality seen in Prevent referral figures. Latent biases shared by *all* appear to be elicited and empowered by official Prevent training materials and the tools provided to health workers to operationalise and assess radicalisation potential.**

Reading between the lines: a recipe for discrimination?

Several interviewees criticised the Prevent training they had received. Dr Jonathan Leach, Joint Honorary Secretary of the Royal College of GPs, told Medact he "felt in many cases, it was pandering to stereotypes".[46] The BMA's Julian Sheather agreed, suggesting that "cliches of appearance, cliches of lifestyle" could easily become part of Prevent training.[47] Some healthcare workers said their Prevent training was overly focused on Islam, while giving only "a nod" to the far-right.[48] One Muslim GP told us that Prevent training made her feel "extremely uncomfortable", since she perceived it to be "mainly focused on people of Muslim faith" and believed it implied "that if people become more religious, they'd be more likely to become terrorists". By contrast, she said, it made "only very passing references to the far right".[49]

An NHS safeguarding professional at a Midlands hospital told Medact that Prevent officials say "all the right things" about how a terrorist can be "any gender, race, or religion". They explained, however, that **the way that terrorism is presented within Prevent training has the effect of ensuring that Islam is an ever-present fixture. Trainers approved to deliver the Workshop to Raise Awareness of Prevent are given a "script" and a "standard disc" with a series of clips and told they may choose which to show but "one of them must be a Muslim person and one must be far right".[50]**

As an interviewee noted, ultimately, "people understand what they're supposed to be looking for in a manner that is informed by the dominant narratives around risk".[51] **What one scholar has called the "racial subtext to the entire discourse of counter-terrorism",[52] shows up explicitly in some official Prevent materials, which focus attention on ethnic and religious minorities**. For example, a Channel referral form used by East and North Hertfordshire Clinical Commissioning Group (Appendix 4) is littered with references to "cultural anxiety", "travel abroad", "lack of integration" and "language

barriers" as well as mentions of religious beliefs (though Islam is never specifically named).[53] Likewise, a guide produced by National Counter-Terrorism Police warned that someone who "promotes the view that Muslims are persecuted in the UK by the government and media" or voices "concern for 'oppressed Muslims' in other countries" could be a member of the Islamist group Al Muhajiroun.[54]

"Spotting the signs": excerpts from the Let's Talk About It website based on ERG22+[55]

FEELINGS OF GRIEVANCE AND INJUSTICE

Feelings of grievance and injustice: "*often the most vulnerable [to radicalisation] are those who perceive discrimination, experience racial or religious harrassment,* or distrust government. They may have experienced poverty, disadvantage or social exclusion that has left them with a distorted opinion of the world".[56]

A DESIRE FOR POLITICAL OR MORAL CHANGE

Desire for political, social or moral change: "individuals may have been *personally affected by international events* in areas of conflict and civil unrest...watching the suffering in places of conflict and believing that they are unable to contribute can create extreme feelings of anger and alienation".

A NEED FOR IDENTITY, MEANING AND BELONGING

Need for identity, meaning and belonging: "individuals may be distanced from *their cultural/religious heritage* and feel uncomfortable with their place in the society around them".

Similarly, the Let's Talk About It website[57] — which is recommended by both National Counter-Terrorism Police[58] and the short-lived Independent Prevent Inquiry[59] — contains a "helpful guide" to "spotting the signs" of someone "who may be vulnerable to becoming involved in extremism or terrorism". At least three of the factors (listed here with our emphases), unambiguously apply to ethnic minorities, particularly recent or second-generation immigrants. Similar traits are also listed in the Prevent e-learning training slide shown. Importantly, these are all extrapolated from the Extremism Risk Guidance 22+, discussed in Chapter 1. **This means that the officially recommended Prevent training and risk assessment materials for identifying and assessing radicalisation potential contain in-built racial biases.**

Prevent e-learning image: "feeling excluded" due to "poverty or racism" and "feeling disconnected from cultural or religious heritage" listed as potential radicalisation risk factors

However, not all health workers felt Prevent training was overly focused on Islam or ethnic minorities. In fact, some were conversely acutely aware of what they perceived as an *ostentatious even-handedness*. One focus group participant commented that "you could almost smell them trying to balance it"[60], while another observed that Prevent trainers were "really hammering home the idea that they *really* wanted to focus on right wing radicalisation".[61] One interviewee suggested that a key purpose of such an approach within Prevent training might be to justify a policy whose outcomes remain disproportionate: "It's almost as if they're saying, 'Look, now it's not Islamophobic'", she argued.[62] **These participants' experiences may reflect official efforts being made to shift the perception that Prevent targets Muslims and to ensure it appears non-discriminatory. They also suggest that these efforts have failed.**

Dr Tarek Younis calls the ostentatious even-handedness of Prevent training materials "performance colour blindness", described as the "active recognition and dismissal of racial logic which associates racialised Muslims with the threat of terrorism".[63] He argues that even when Prevent training materials appear to be explicitly *combatting* and *undermining* anti-Muslim stereotypes (such as in the two e-learning images shown), they actually *reinforce* their logic. Academic studies which suggest that "myth busting" can be counterproductive and in fact merely serve to reinforce myths, provide support for Younis's argument.[64] This could explain health workers' consciousness of an elephant in the room — the spectre of Islamist extremism — even when it is apparently being downplayed and denied, and their scepticism about whether Prevent is substantively non-discriminatory. It would seem to confirm that Prevent "has never gotten away from its original articulation",[65] which as Chapter 1 explained was unambiguously focused on Muslim communities.

Prevent e-learning image: 'Studying Islam' does NOT increase susceptibility to radicalisation

Prevent e-learning image: 'Attending the local mosque' is NOT a likely means of radicalisation

Understanding risk & operationalising instinct

Department of Health and Social Care guidance notes that "the key challenge is to ensure that healthcare workers are confident and knowledgeable".[66] A few of our interviewees felt that longer or "better" training could address the disproportionality of Prevent referrals. Others felt the problem was rooted in the poor quality of underlying evidence.[67]

The "signs" of possible radicalisation discussed in Prevent materials are all based on the Extremism Risk Guidance 22+ psychometric system, concerns about the robustness of which were discussed in Chapter 1. **Some in the health community are sceptical about whether these "symptoms" listed in the ERG22+ contain real predictive value.**[68] For example, Royal College of Psychiatrists president Dr Adrian James, voicing concerns shared by a considerable proportion of health workers in our study, noted that "the trouble is many of those [ERG22+] factors are relatively common."[69] Similarly, other health workers suggest that the framing of radicalisation casts suspicion on a "huge swathe of people", resulting in a broad-brush approach like "using a sledgehammer to crack a nut".[70] Unsurprisingly, many health workers in our study felt that the expectation on them to identify individuals who may go on to commit an act of terrorism in the future was unrealistic, impractical and unfair.

> " *Some in the health community are sceptical about whether the "symptoms" listed in the ERG22+ contain real predictive value*

To fill the vacuum left by the absence of validated, usable risk criteria or reliable concrete indicators, official documents advise that health workers must exercise "judgement".[71] Additionally, Prevent training materials tell them to "trust your instincts".[72] It is here — at the point where health workers are ultimately advised to rely on gut feelings, while being asked to make extremely difficult decisions about who might be a *pre-terrorist* **— that their unconscious bias may be coming into play in the way they understand and operationalise highly subjective, and at least partially racialised, criteria.** One NHS safeguarding professional responsible for Prevent at a Midlands hospital said they believed this was happening — "because it is so broad, I think what you're trusting is your unconscious bias".[73]

Prevent e-learning image: "Trust your professional instincts and voice your concerns"

Remember

You do not have to make any decisions alone. Trust your professional instinct and voice your concerns.

In the context of police use of stop and search powers, Bill Bowling, a Professor of Criminology at King's College London has explained that "wherever officers have the broadest discretion is where you find the greatest disproportionality and discrimination," because, in the absence of a requirement to have reasonable grounds for suspicion, police end up "using their own stereotypes about who's worth stopping".[74] The same phenomenon may be playing out in healthcare with Prevent referrals. Health workers are not expected to demonstrate reasonable grounds for suspicion to report someone to Prevent.[75] On the contrary, they are given "broad discretion" and encouraged to interpret terrorist potential according to their gut feelings.[76] Moreover, as the previous section discussed, this is combined with Prevent training materials which actively point towards minorities as higher risk, and an absence of penalties for making referrals which turn out to be false positives.[77]

The case studies documented in Chapter 6 demonstrate some of the outcomes of this equation. In Case 1, a psychiatrist acknowledges that had "religious justification" not accompanied "threats to commit violence" from two schizophrenic and "floridly psychotic" patients — one a Somali Muslim, the other a British-Pakistani Muslim — he would probably not have triggered Prevent referrals in either case. He also concedes retrospectively that ethnicity, as well as religion, likely had some influence on the decision. In Case 4, a GP who referred a severely depressed British-Pakistani Muslim man to

Prevent despite *not* seeing him as a radicalisation risk, admitted to her appraiser that she would not have done so had he been white and non-religious. Case 9, again, features the same intersection of Islam and severe mental health issues, with the psychiatrist involved in the case unaware of any more tangible factors explaining the interest of Prevent police in the patient in question besides schizophrenia and religious affiliation. In Cases 2, 3, 5, 6, and 8, also involving Muslims, religious identity may also have played a part.[78]

4.3. 'Weaponising prejudice'

Quantitative evidence shows that Asians and especially Muslims are disproportionately reported to Prevent within the NHS. Qualitative evidence indicates that this disproportionality is, at least in part, a result of discrimination. A combination of factors produces these outcomes. Foremost amongst them appears to be the **training provided to health workers to spot pre-terrorists, which offers blunt and biased tools to operationalise "radicalisation" risk using vague, arbitrary, and racialised criteria**. Health workers share entrenched societal stereotypes common to all of us. We should not be surprised that when faced with the difficult and arguably impossible task of identifying future terrorists, some rely at times on cognitive shortcuts informed by a climate of anxiety about immigration and Islamophobia, acknowledged even by former police Prevent lead Simon Cole.[79] Their unconscious biases, in fact, appear to be actively elicited by exhortations in Prevent training to act on "instinct", in the absence of underlying evidence and risk assessment models with strong predictive value. **It is difficult not to conclude, therefore, that the Prevent programme is "weaponising prejudice".[80]**

UN special rapporteurs have come to some very similar conclusions. In 2018, the special rapporteur on contemporary forms of racism condemned the Prevent policy and called on the UK government to "suspend the Prevent duty, and implement a comprehensive audit of its impact on racial equality".[81] In February 2020, the special rapporteur on the promotion and protection of human rights and fundamental freedoms while countering terrorism highlighted that risk assessment models like the ERG22+ and similar tools often "function as profiling tools...tainted by prejudice, politicization or specific ignorance, particularly in multicultural contexts".[82] In many countries, she argued, counter-extremism programmes end up violating minority ethnic and religious groups' rights to freedom of expression and religion, and privacy. **A further important implication of the racial and religious disproportionality of the Prevent programme in healthcare is that its potentially harmful impacts on physical and mental health and confidentiality** — as documented in Chapter 5, the case studies in Chapter 6, and Chapter 8 — **will chiefly be affecting Asian and Muslim communities. This includes the possibility that false positive Prevent referrals disproportionately falling on minorities in a discriminatory fashion could result in a racialised deterrent effect, which would risk worsening existing health inequalities.**

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Chapter 5

Mental health impacts

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Approximately 1 in 4 people in the UK will experience some form of mental health problem each year.[1] Yet there is an ongoing crisis in mental healthcare provision, with England's healthcare regulator the Care Quality Commission warning in 2019 of a "perfect storm" for patients using mental health and learning disability services.[2] Last year suicides in the UK reached their highest level since 2002, including a 19-year high in the rate of children and young people (aged 10 to 24) taking their own lives.[3] Our research participants spoke of the "terrible access to CAMHS" (Child and Adolescent Mental Health Services),[4] due to under-funding, and highlighted the contrast with counter-extremism work: "they've cut services everywhere but still somehow seem to have millions for Prevent".[5]

As the previous chapter noted, significant health inequalities structured by race and religion are connected to economic deprivation. These are reflected in mental health care.[6] People of Asian heritage are one-third less likely to be in contact with mental health services, and the perception that these services insufficiently cater to Muslim communities, and people of colour generally, is widespread.[7] Islamophobia negatively affects British Muslims' experiences of mental health care.[8] There is also a pattern of greater coercion and violence impacting BAME people experiencing mental health problems: they are more likely than white British people to be detained compulsorily under mental health legislation and more likely to be forcibly restrained.[9] In securitised contexts, this can have fatal consequences. Notably, the proportion of BAME deaths in custody involving mental health-related issues is nearly twice the rate for others.[10]

This chapter assesses claims that people with mental health conditions are more likely to be drawn into terrorism, examines evidence indicating disproportionate referrals to Prevent and looks at some mental health harms of Prevent. It also highlights a nationwide but little-known project involving NHS mental health professionals working alongside counter-terrorism police.

5.1. A greater risk of radicalisation? Evidence and pathologisation

The officially endorsed ERG22+ tool, explained in Chapter 1, identifies "mental health" as a radicalisation risk factor. The UK government's Prevent strategy also claims that "[p]eople with mental health issues or learning disabilities...may be more easily drawn into terrorism."[11] Similarly, police website "Let's Talk About It" lists "mental health issues" on a page about "spotting the signs" of potential radicalisation. Mark Rowley — formerly Britain's most senior counter-terrorism officer — has argued that "[i]f part of the terrorist methodology is to prey on the vulnerable...then it stands to reason that there will be people with certain mental health conditions who will be...susceptible to that".[12]

Some health workers we spoke to during our research also believed that mental illness could increase the risk of being drawn into terrorism. Amongst them were senior figures such as Royal College of Physicians president Professor Andrew Goddard, who reasoned:

> *Individuals with learning disabilities and with mental health problems are vulnerable in all sorts of ways...So, given that we've already said that we think that radicalization is exploitation, it follows [that they could be more likely to be drawn into terrorism].[13]*

Another said: "I think it probably is objectively true [that people with mental health conditions are more likely to be drawn into terrorism] but you have to be really careful how you act on that, because otherwise you're pigeonholing this group of people".[14]

However, other health workers strongly disagreed. Dr Adrian James — President of the Royal College of Psychiatrists — told Medact:

> *There are a number of published studies [on mental health and terrorism]. The one that's most often quoted is a study that compares lone-actor versus group terrorist actions.[15] All it did was say that if you look at...people [with mental health conditions] who definitely have been involved in terrorism, you're more likely to find them here [in the lone-actor group] than there [in group-based terrorist networks]. It isn't a study, and never was a study that said, "you're [people with mental health issues] more likely as a group [to engage in terrorism]". And there is no study that has shown that that is the case. But I think it's always been extrapolated to say, people with mental illness are more likely to be involved in terrorist attacks, which I don't believe there is actually any evidence of.[16]*

The authors of the study described above, based at UCL's Department of Security and Crime Science, have produced a number of other studies, one of which does claim to have found an incidence of mental health conditions higher than the global average among lone actors inspired by ISIS.[17] However, despite 40 years of empirical research investigating possible links between psychopathology and terrorism, even these leading authors concede that the evidence is far from robust.[18]

More broadly, it has long been clear that "symptoms of mental illness are strongly connected with public fears about potential violence".[19] The need to manage any risk of violence (to self or others) is always taken into account by psychiatrists and the ability to detain a patient, where it is deemed necessary, is incorporated into the Mental Health Act. **The evidence, though, is in fact "not adequate to suggest that severe mental illness can independently predict violent behaviour".[20]**

Some studies do suggest a statistical relationship between violence and a small number of serious mental illnesses, such as schizophrenia.[21] However, it remains problematic to theorise a *causal* relationship given the prevalence of confounding variables such as drug and alcohol misuse,[22] as well as what Professor Peter Beresford calls the "slow violence" of inadequate public policies which exacerbate marginalisation, poverty and discrimination already suffered by people with mental health conditions.[23]

With regard to terrorism specifically, evidence suggests (as Dr Adrian James explained) that if and when people with mental illnesses do engage in terrorism they may be more likely to be lone-actors than part of a group. This would appear to contradict the notion that they are more vulnerable to recruitment by terrorist networks, as was claimed by the senior counter-terrorism police officer quoted earlier. Indeed, some evidence suggests such groups actively *avoid* recruiting people with mental health issues.[24] One focus group participant suggested that this could be because those living with serious mental illness are rarely "capable of the organized thought needed to carry out such an enterprise".[25] Moreover, **use of "mental health" as a generalised, disaggregated category by government and by the ERG22+ is "too ambiguous to be meaningful".[26]**

MENTAL HEALTH ISSUES

Common forms of mental distress or disorders such as anxiety, depression, Post-Traumatic Stress Disorder (PTSD) and relational or personality problems can leave individuals particularly susceptible to radicalisation.

Perceived 'support' from others can offer a release from inner angst and turmoil. This is why those suffering from mental health issues can be particularly at risk of becoming the victims of radicalisers or groups supporting a terrorist ideology.

Vulnerability to radicalising influences is heightened among young people in particular who may be suffering from long-term, undiagnosed mental health problems.

The Let's Talk About It website describes mental health issues as a radicalisation risk factor (Source: www.ltai.info)

Prevent e-learning training case studies featuring non-specific "mental health issues"

Gillian has mental health issues. She is a British born Muslim. Her friends at her local mosque have been concerned as she has recently been meeting with known extremists. In which of the following ways might her new friends affect her life?

Choose three options and select Submit.

☐ She may lose interest in other friends

☐ She may attempt to recruit others

☐ She may start to lose weight

☐ She may be spending more time in their company

Submit	Show feedback

Amil attends a monthly clinic because of his mental health issues. He has recently made some new friends online who are persuading him to visit a training camp abroad for people who are not happy about the way Britain treats Muslims. Would it be appropriate to raise a concern about Amil?

Choose the correct option and select Submit.

○ No because his political views are not relevant to his mental health

○ Yes because there is a possible risk that he is a person vulnerable to being radicalised

Submit	Show feedback

Sally has mental health problems and has attempted to take her own life. She is on your ward and you overhear her friends trying to persuade her of their extremist ideological views. You are concerned that she is being radicalised. Do you have any responsibilities in relation to this situation?

Choose the correct option and select Submit.

○ No because I am a healthcare professional and the conversation has nothing to do with health

○ Yes because we all have a duty to share concerns in relation to radicalisation

Submit	Show feedback

In sum, the evidence for the government's sweeping claims is weak and does not support the assertion that people with mental health conditions are more likely to be involved in terrorism. **Policy should therefore not be premised on such a claim.** People with mental health conditions are more likely to be victims of violence than perpetrators.[27]

One major risk of tenuous attempts to link mental illness and terrorism is that such efforts may lead to the pathologisation of a fundamentally political issue. Several interviewees stressed the importance of distinguishing between radicalisation and mental illness, pointing out that radicalisation "is not like a medical condition",[28] "isn't a mental illness" and that "there is no evidence that it's amenable to a program of treatment".[29] Even Christopher Dean — the psychologist who co-authored the paper on which the ERG22+ framework is based and now runs a government-approved Channel deradicalisation programme called Healthy Identity Intervention — recently conceded that there was no certainty terror offenders can be "cured".[30]

At its worst, Julian Sheather, special adviser in ethics and human rights to the British Medical Association, fears a conflation between mental health and holding radical, extreme or subversive political opinions could "start to get into the realms of Soviet psychiatry, where the state starts to monitor people's belief systems."[31] The potential for medicalised discourses of political dissidence to be used as a tool of repression is a clear lesson from history.[32] In the context of Prevent's pre-crime approach — and studies examining political opinions as opposed to criminal acts, as part of an apparent turn towards mental health to explain terrorism[33] — this issue demands attention from all those concerned with medical ethics. Another significant risk, discussed later in this chapter, is the possibility of exacerbating stigma.

5.2. People with mental health conditions disproportionately referred to Prevent

Both quantitative and qualitative data from our research point towards Prevent having a disproportionate impact on people with mental health issues.

Many trusts would or could not break their Prevent referrals down by whether or not they came from mental health departments, raising questions about whether trusts are monitoring the equalities impact of the policy on the people with mental health conditions. However, 22 NHS trusts[34] did provide data on whether Prevent referrals over two years (2017-2019) came from mental health or other departments. The number of referrals coming from mental health departments was stark, as Table 2 shows.

Table 2: Prevent referrals from 22 NHS trusts by department, 2017-19[35]

2017-18		2018-19	
Mental health department referrals	Referrals from other departments	Mental health department referrals	Referrals from other departments
50	31	52	46

It is important to exercise caution in interpreting these figures since some of the trusts in our sample were specialist mental health trusts while others may offer limited mental health services. Furthermore, within trusts which offer both, the relative size of different departments may vary. Nonetheless, **comparing Prevent referrals from the four specialist mental health trusts in our sub-sample to the 18 non-specialist trusts (Table 3) still suggests that mental health patients are disproportionately represented.**

Table 3: Prevent referrals from 4 mental health trusts and 18 non-specialist trusts, 2017-19

Referrals from 4 mental health trusts		Referrals from 18 non-specialist NHS trusts	
2017-18	2018-19	2017-18	2018-19
44	45	37	53
Overall annual average: 11.1		Overall annual average: 2.5	

Even when we exclude the four specialist mental health trusts which contributed such a large proportion of referrals, the picture looks very similar (Table 4). Moreover, given that mental health conditions often go under-reported or undiagnosed, even on hospital wards where a patient might be receiving treatment for a physical condition, **it is also worth noting that these data may underestimate the correlation between mental illness and Prevent referral.**

Table 4: Prevent referrals from 18 non-specialist NHS trusts by department, 2017-19[36]

2017-18		2018-19	
Mental health department referrals	Referrals from other departments	Mental health department referrals	Referrals from other departments
19	17	21	28

While further research is urgently needed, it appears that mental health may be a significant factor related to Prevent referral. This conclusion echoes research published in the *BMJ* in 2016 which similarly found that '[m]ental health trusts in England recorded a much higher level of referrals".[37] Likewise, British counter-terrorism police reportedly concluded in 2016 that around 50% of individuals referred to Prevent may have had some kind of mental health condition and launched a project to investigate the interaction (see Box 1). The estimated prevalence of mental health conditions among Channel cases that same year was at least 44%.[38]

This is supported by qualitative evidence from our research. A former Prevent Lead in an English primary care trust and ex-Channel Panel member told Medact that a "substantial" proportion of cases he looked at via Channel — and quite possibly "the majority" — involved "some kind of mental health issues".[39] In addition, as discussed in more detail later in this chapter, **more than half of the Prevent referrals in our case studies (provided in Chapter 6), involved pre-existing mental health conditions including schizophrenia, depression, and bipolar disorder.**

5.3. Stigma & mental health harms of Prevent

As discussed earlier, the evidence for a causal link between having a mental health condition and being drawn into terrorism is weak. Therefore, **th**e fact that people living with mental health conditions seem to be disproportionately referred to Prevent and Channel may partly be a result of stigmatising claims about a link, rather than evidence of a heightened threat.[64]

Some health workers, especially mental health specialists, voiced concerns that the claim was

> *If you unjustifiably link these sorts of things to mental illness…it's profoundly damaging*
>
> — Dr Adrian James
> President, Royal College of Psychiatrists

harmful. For example, Dr Shazad Amin, a retired consultant psychiatrist who is now CEO of Muslim community group MEND, said "in mental health…one of the most difficult areas that we have as a speciality — which other areas of medicine don't have — is stigma" and the government's claim, he argued, merely "adds an extra layer of stigma to an already difficult area."[65] Royal College of Psychiatrists president Dr Adrian James echoed this sentiment:

> *if you've got a mental illness, let's say like depression, and the papers are always reporting that people who've got a mental illness, they're off doing this [violent] stuff, again, it reflects on them. People feel bad about themselves, people around them distance themselves, they have less opportunities in life, people might be more suspicious about employing people, even having them as a child at school. So, if you unjustifiably link these sorts of things to mental illness, it puts a whole sort of cloud in perspective over everybody who experiences mental illness — and there are lots of them. So it's profoundly damaging.*[66]

Box 1: 'Vulnerability support hubs': the secretive counter-terrorism mental health project

In 2015, Counter-Terrorism Police Headquarters commissioned a mental health "needs assessment" from clinical staff at Birmingham and Solihull Mental Health NHS Foundation Trust.[40] This research found that around 50% of referrals across England and Wales had "vulnerabilities related to mental health."[41]

As a result, in April 2016 counter-terror police, reportedly with the support of NHS England,[42] launched a "groundbreaking"[43] one-year pilot programme to "embed mental health experts with counter-terrorism officers" in England's three biggest urban areas — London, Birmingham and Manchester.[44] Today, these little-known "hubs" are a permanent feature of the UK counter-terrorism apparatus.

Each of the three regional "Vulnerability Support Hubs" in the West Midlands, North West and London comprises a police sergeant, a police lead, an administrator, and several NHS professionals including a consultant psychiatrist, a consultant psychologist, and at least four mental health nurses.[45]

The scheme was originally overseen by Chief Inspector Debbie Mackenzie,[46] with responsibility passing to Chief Inspector Karl Curran in November 2019.[47] NHS England Regional Prevent Coordinator for the Midlands, Andy Smith, reportedly holds responsibility for "mental health" including the "VS Hubs".[48]

The reported aim of the original pilot was to "to improve the understanding of both police and health professionals of the associations between mental health conditions and vulnerability to radicalisation"[49] and "to assess the value of mental health professionals working alongside counter terrorism police officers... in relation to the management of individuals referred to the police with known or suspected mental disorders who may be vulnerable to radicalisation and extremism."[50]

According to *Reuters*, it was also intended "to give psychiatrists the chance to identify people referred to Britain's counter-radicalisation programme Prevent who had mental health issues, and treat them".[51] The National Police Chiefs' Council and Birmingham and Solihull Mental Health NHS Foundation Trust both stated that the pilot project would be independently evaluated.[52]

Dr Adrian James, president of the Royal College of Psychiatrists, told Medact he recalls being informed of the project about three years ago by contacts at the Home Office. "They were going to do a proper evaluation of the routes from health and the routes into health, what happens to people, who they were... diagnoses, and...what the outcomes were", he states.

"It started, we were told about this...and it was never published. And my understanding was it had been shelved."[53]

Similarly, *Reuters* reports that that the Office for Security and Counter-Terrorism had instructed psychiatrists working on the project not to pre-empt a "final report" due for release in November 2017 by disclosing its findings. But no evaluation of the project has ever been made public.

Nonetheless, the scheme was rolled out nationwide in November 2017.[54] Professor Jennifer Shaw — a forensic psychiatrist at the University of Manchester who serves as the mental health lead for Greater Manchester Police on the project — attributed this expansion to the project being considered highly successful by the government.[55]

Despite the lack of publicly available information about the project, it is reportedly set to become a centrally commissioned "single service model with national oversight" by 2021.[56]

From documents obtained through an FOI request to the National Police Chief's Council, Medact ascertained that overall control of the hubs lies with counter-terrorism units.[57] The pilot project — which cost nearly £800,000 in its first year — was jointly funded by counter-terrorism police, the NHS and the Home Office.[58]

While the initial NHS contribution of £90,000[59] was relatively small, this unique deployment of scarce NHS resources towards a police-led counter-terrorism programme signals the increasing blurring of the lines between security and care. As scholar Rita Augestad Knudsen observes, this highly unusual embedding of NHS mental health professionals within counter-terrorism police also raises important ethical issues.

She fears the hubs could become "tools of intelligence gathering" for active counter-terrorism investigations.[60] Moreover, as the programme is police-led, the mental health treatment of the individuals concerned is "located squarely within a security framework".[61] The potential impact of police contact on vulnerable individuals with mental health conditions is also a serious issue of concern, especially "the potent combination" of racism, mental health and frontlines policing.[62]

While police praise the project for saving resources by "reducing the time it takes to get health information"[63], the appropriateness of such close collaboration between the NHS and counter-terrorism police must be questioned.

As mentioned, more than half of the nine Prevent referrals involved in the 10 case studies included in this report (Chapter 6), involved a pre-existing mental health condition, including schizophrenia, depression, and bipolar disorder. **If this over-representation of people with mental health conditions in Prevent referrals may be — at least in part — a consequence of unwarranted and harmful suspicion, this stigma appears to be compounded in a number of cases in which patients are also Muslim and/or BAME.** For instance, these factors combined in Case 1, in which a psychiatrist who was not unused to patients making threats to commit violence treated two schizophrenic BAME Muslim patients whose threats had a rhetorically religious inflection as potentially more dangerous and referred them to Prevent. Similarly, in Case 4 a GP treated a severely depressed, psychotic BAME Muslim man's suicidal ideation as a Prevent issue because he expressed a wish to die "for my religion". In Case 9, a schizophrenic with "delusional ideas" became of interest to police when he converted to Islam.

Our research also found some evidence that Prevent referrals can directly and indirectly damage the physical and mental health of the individuals concerned, as well as their families. This happens in multiple ways.

Firstly, we documented several case studies in which **Prevent referrals of people already being treated for pre-existing mental health conditions damaged therapeutic relationships between health practitioners and patients.** In Case 1, according to the psychiatrist involved, a Prevent referral almost certainly set back an "extremely paranoid and unwell" schizophrenic man's recovery by impeding the development of a trusting relationship between patient and health care staff. In Case 4, even though the GP in question did not believe her "acutely depressed" and "psychotic" patient posed a real threat, she referred to Prevent before referring to mental health services, potentially delaying mental health care and causing unnecessary distress. In Case 7, Dr Lyn Jenkin describes how he discontinued his treatment as a result of a Prevent referral by a psychologist from a branch of the Oxford NHS Health Foundation, having lost trust in their services.

Secondly, we found some evidence of **Prevent referrals apparently triggering mental health problems, including in individuals with no prior reported history of mental illness.** Case 5 outlines the case of a young man who, according to his GP, developed obsessive compulsive disorder (OCD) apparently as a direct result of the trauma and anxiety caused by being referred to Prevent by his school. His GP told us the boy had no prior psychiatric history. **Prevent referral can have profoundly negative indirect impacts on the family of someone referred.** In Case 3, the parents of a boy referred under Prevent experienced health and mental health conditions including depression and a bout of angina, which they believed were brought on by stress as a result of their son being suspected of displaying terrorist potential. In this case, the boy's school eventually apologised for making the referral.

Thirdly, **lack of trust as a result of a Prevent referral can damage the care and support which health services are able to provide.** Case 8 illustrates this with the example of a young person diagnosed with a developmental disorder. In this case, the young man's school had referred him to Prevent, leading to a complete breakdown in trust between the family and public bodies in general. As a result, his parents did not give permission to CAMHS (Child and Adolescent Mental Health Services) to tell the school about the boy's diagnosis, detrimentally impacting the support he received. In Case 2, although to our knowledge no official Prevent referral was made, an NHS psychiatrist describes her experience of being disciplined for questioning Prevent training. Remarkably, she now says she would not herself use NHS mental health services if she could avoid them.

> " *Prevent's negative impacts are likely to affect children and young people, and BAME and Muslim, communities most*

Taken together, this qualitative evidence suggests that **Prevent referrals can damage people's physical and mental health in a variety of direct and indirect ways.** Given the number of cases we know are false positive referrals, it also indicates that some patients are being needlessly reported to Prevent when they are in fact in need of mental health care.

It is important to highlight that **the negative effects are likely to be impacting the health and mental health of certain groups — specifically children and young people and BAME and Muslim communities — more than others.** Children and young people are impacted more because the majority of Prevent referrals are of people aged 20 or younger, according to Home Office data[67] and, as Chapter 4 explained, Asian/British-Asian and especially Muslim communities are disproportionately referred to Prevent.

Moreover, as Chapter 8 discusses, some health workers fear that **the negative impacts may affect not only individuals and their families directly but potentially also whole communities by harming trust in the health profession.** While more

research is needed to ascertain whether a deterrent effect is actually present, **this risk is especially concerning in the context of mental health,** where patients are already more likely to be "isolated" and "paranoid", already making it "hard to gain their trust".[68] As a clinical psychologist working in CAMHS in London explained, if people are put off from seeking care:

> *That would be likely to have a knock-on impact on anything that they might need help with, mental health or physical health. People would try out the other ways of coping — drugs or whatever — or just doing nothing. They would put off seeking help and only seek help in crisis, and that would mean that their problems got worse. And they would end up having more coercive interventions in the long run, which is definitely what happens in mental health.[69]*

Given the already poor provision of mental health care, particularly to young people and BAME communities, it is extremely concerning that Prevent may be exacerbating the problem and worsening existing health inequalities.

5.4. Securitising mental illness?

The evidence for the government's assertion that people with mental health conditions or learning disabilities are more likely to be involved in terrorism is far from robust. The claim is misleading to both health professionals and the public and should not be used as a basis for policy. Our findings support the view that "the line between mental illness and radicalisation is becoming increasingly blurred"[70] and this risks pathologising a fundamentally political issue as well as potentially increasing stigma, a significant concern for mental health care professionals. **The ERG22+ system fails to disaggregate between different conditions and merely lists "mental health" as a radicalisation risk factor, which could be one factor explaining why people with mental health issues are disproportionately reported to Prevent**. The reality of this over-representation seems to be compounded when patients are also Muslim and/or BAME, and may constitute a form of double discrimination.

The secretive Vulnerability Support Hubs project which embeds NHS mental health professionals into a counter-terrorism police-led project raises acute ethical concerns about the possible impacts of securitisation on mental health care. Care should be the priority in interactions between health workers and people with mental health conditions. However, while NHS guidance does acknowledge in passing the need to weigh up the potential harms of a Prevent referral,[71] there is very little research into the impact of this often highly traumatic experience on vulnerable individuals with mental health conditions. **While both counterterrorism police and NHS England claim that a positive by-product of Prevent is that it will benefit patients with undiagnosed conditions who may not otherwise come into contact with mental health services,[72] we found considerable counter-evidence of harm. In several cases, Prevent referrals damaged therapeutic relationships between health practitioners and patients already receiving treatment for mental health conditions**. **In one or two cases, referral apparently triggered new mental health problems in individuals with no prior history of psychiatric illness** and in others Prevent negatively affected the care and support which health services were able to provide. **The direct and indirect health harms of Prevent on individuals and their families are likely to be felt mostly by children and young people, and BAME and Muslim communities**. More broadly, the potential for eroding trust and deterring health-seeking behaviour is clear, and especially concerning in the context of mental health, meaning Prevent could be exacerbating mental health inequalities.

Case studies

CASE 1. Psychiatrist's referral of 'floridly psychotic' patient 'harmed therapeutic relationship'

A psychiatrist explained to Medact that he had been involved in two Prevent referrals while working under different consultants, one in 2014 and one in 2017. Both patients were, in his words, "floridly psychotic", with diagnoses of schizophrenia, "extremely paranoid and unwell and making really quite bizarre but threatening statements". However, "with neither of them was there anything we would have thought of as an imminent or even particularly likely risk". Indeed, the psychiatrist believes that had Prevent training not been given, the cases would never have been discussed with police.

Both patients were BAME Muslim men and religious rhetoric appears to have been a critical factor. The psychiatrist explained: "In psychiatry, we're thinking about managing risk, which includes risk of harm to other people, and perhaps wouldn't see threats to commit violence with a religious justification as different from other threats to cause violence if somebody's very unwell with a psychotic illness." But, he conceded, "I suppose because they were expressing a religious justification for what they had thought of doing, then that's what triggered us to make a referral to Prevent in those cases." He later noted that ethnicity, as well as faith, likely played a role in the decision to refer, saying "I don't doubt that that would have had some influence on it."

In both cases, police came in and interviewed the patients. "They struck me as not having very much experience of serious mental illness, and they were really quite taken aback at how unwell these people were." The psychiatrist's impression was that police "felt completely out of their depth", "didn't really want anything to do with it" and were "relieved to hear" that neither patient was "going anywhere fast", i.e. likely to be discharged to live independently in the near future. However, the police did not advise the psychiatrists that they had been wrong to refer.

Prior to referring, the psychiatrist discussed the referral with the first patient, a Muslim man of Somali origin — but describes him as "so euphoric, he didn't care". He also discussed it with the second patient, a British-Pakistani Muslim man, but — again — doubts whether this constituted informed consent, since the patient's "capacity to weigh up information" was impaired. In retrospect, the psychiatrist believes this Prevent referral "probably harmed the therapeutic relationship" and set back the patient's road to recovery.

He explained that this patient, who was detained in hospital under the Mental Health Act at that time, "didn't trust anyone at all" and believed "all the staff on the ward were poisoning him, his family were poisoning him, [and] that there was some huge conspiracy to be monitoring him." The psychiatrist felt that "us getting a policeman in to speak to him would have made him even more suspicious of us" and likely "reinforced" his delusions, in part "because some of his persecutory delusions were centred on the police". The "only thing" that can heal such severe paranoia, said the psychiatrist, is antipsychotic medication combined with "having a long-term relationship where you build up trust". The psychiatrist concluded: "There's no doubt us having arranged for a policeman from the Prevent programme to speak to him will have set that back a few spaces". He added: "his suspicion of mental health services would have been compounded by our being associated with the police in this way". The Prevent referral, therefore, not only failed to add "any value to either the patient's clinical care or the management of their risk, or...any aim that the policemen would have had", it also "came with a cost".

> **There's no doubt us having arranged for a policeman from the Prevent programme to speak to him will have set back recovery a few spaces**

CASE 2.   NHS psychiatrist 'would not use NHS mental health services' after Prevent experience

A female Muslim psychiatrist recounted what happened when she had to attend a Prevent workshop while a trainee, in a group consisting mostly of junior doctors. During the session, she mentioned the Royal College of Psychiatrists' position statement on Prevent and criticised the programme as discriminatory, harmful to confidentiality and lacking in transparency. This sparked a discussion. Other doctors chipped in too. The Prevent trainer seemed uncomfortable with the debate and soon ended the discussion. A few weeks later, the trainee psychiatrist's educational supervisor informed her a concern had been raised about her comments during the session.

She recalls "I was obviously thinking 'Oh my gosh, it's something clinical, I've made a mistake whilst I was on call' but it turned out that the Prevent trainer had made a complaint about me." Although her initial reaction was to laugh as it seemed "so ridiculous", over subsequent weeks she became "embroiled in this Kafka-esque nightmare" which "took on a life of its own". The three-page complaint and subsequent emails, she states, linked her to an Islamic organization she had no links with and had not mentioned. Indeed, she had not mentioned her religion at all but is visibly Muslim due to her hijab, as well as from a BAME background. "None of the white doctors" who had been present, she later determined, had complaints filed against them.

The trainee psychiatrist continued to perform her medical duties as the case dragged on for six weeks. The complaint was reportedly "rapidly escalated" to the "most senior management of the trust". Remarkably, she was never asked for her own account of what happened and says she was "made to feel completely invisible" during the process, "as if I was guilty until proven innocent". It culminated in the trainee psychiatrist's consultant being asked to provide an "assurance that the individual is now more aligned to the Prevent strategy". In the end, the trainee psychiatrist agreed to a statement that she was clear about her responsibilities under the General Medical Council (GMC) with respect to breaching confidentiality.

The psychiatrist feels that she was targeted as a Muslim and believes the affair was an example of "stifling dissent against Prevent". But, she says, "there was no acknowledgement that I had been the victim of discrimination" and instead "everyone pretended as if nothing had happened". The episode had "profound impact" on her life, she explains, and left her trust in the NHS — despite working within it — badly damaged: "It certainly affected me as a potential patient. It's definitely massively increased the threshold of me seeking psychiatric help. And certainly, I wouldn't seek help for mental health problems under the NHS. And this is me, somebody who knows about the system, I'm an insider. So I just keep thinking, well, what about somebody on the street? What about somebody who's really unwell and doesn't know the system, and doesn't know what this means? What about them?"

CASE 3. Health impacts on parents of Muslim schoolboy referred to Prevent

A father, who previously sat on the Prevent Strategic Group of a local authority, and is now an advisor to a police Counter-Terrorism Unit, told Medact about the 2016 Prevent referral of his son and its dire health impacts on the whole family.

The boy, a nine-year-old Muslim attending a Catholic school, made a joke in a conversation with friends about how he would "blow the windows" out of a limousine going to the upcoming school dance, in order to "eat the chocolate" inside. Another child of the same age reported these remarks to a teacher. The teacher went to the headteacher, who questioned the boy and contacted the Prevent coordinator.

Besides the direct, deeply upsetting impact on the boy, his father and mother were both "very badly affected" too. The father was admitted overnight to hospital with angina after experiencing bad chest pains "brought on by the stress of the situation". The Prevent referral left his wife deeply anxious about the environment in which her son was being educated, to the extent that she was diagnosed with depression and began taking medication.

The father explains that his family "were strong enough to challenge" the referral, and eventually the school apologised. But, he asks, "how many other families can't do that, and what damage is caused to their health?" He stepped down from the Prevent Strategic Group as a result of this experience.

CASE 4. GP 'panicked' when mentally ill Muslim patient hearing voices mentioned Turkey

A GP told Medact of a 2018 Prevent referral he encountered second-hand when conducting confidential appraisals of other doctors. A doctor knew that a patient of hers — a middle-aged, British-Pakistani man — had a history of mental illness. Accompanied by his wife, this man came to see the doctor and reportedly said, amongst many other things, "I want to die fighting for my religion, I want to go to Turkey". He also said

> " *If I don't do anything, I don't want my name to be in the headlines the next day*

"my religion is what is important to me and if I'm going to die, I want to die for my religion", but was vague about specifics. At the same time, the patient presented as acutely depressed, psychotic and hearing voices.

The GP appraiser told us the doctor "did all the right things, did an assessment, referred him to mental health services and referred him to Social Services — because he admitted he'd hit his wife as well, who was with him at the time — but before she did any of that, she rang the police and she referred him to Prevent." Prevent officers arrived two hours later and interviewed the man. After about half an hour, they decided they weren't interested.

The doctor told the GP appraiser that she had asked the man's consent to refer him to Prevent and reported that he had said "fine". However, the GP appraiser felt strongly that those with serious mental illness are "vulnerable" and therefore often "compliant, because they're not well", trusting health professionals to act in their best interests. He also told Medact that he learnt the man "had gone to A&E the day before but, because they kept him waiting, he left after about four hours", suggesting that this illustrated the man "was seeking help and was clearly not someone who's planning to commit an act of violence".

After hearing about the case, the GP appraiser asked the doctor whether she had viewed the patient as a terrorist or potential terrorist and she replied "no". He asked if she thought the patient was radicalised and she replied "no". He asked why she had therefore referred to Prevent and she replied (in his words): "Look, he said the words 'I want to die', he said the words 'religion' and 'Turkey'. You know what? I just panicked. I wanted to get it off my case. I thought the best thing to do is just refer it to Prevent, right?" He asked her if the patient had been white British and non-religious whether she would still have referred to Prevent and she said "no". The doctor nonetheless felt she had done the right thing. She explained to the GP appraiser "If I don't do anything, I don't want my name to be in the headlines the next day."

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Case 5.   Muslim teenage boy 'developed OCD after Prevent referral'

A GP told us about the "tragic" case of an academically high-achieving Muslim teenage boy who developed Obsessive Compulsive Disorder (OCD) after being referred to Prevent. He had originally been praised for a history presentation at his sixth form college in which he mentioned the Ottoman Islamic Caliphate. However, the following week — Counter-terrorism Awareness Week — a teacher made a Prevent referral retrospectively.

The case "went back and forth for over a year". It was prolonged because the boy's school was in a London borough where the referral met the local criteria to be passed on to a Channel Panel, whereas — demonstrating the subjectivity of referral criteria — in the adjoining London borough where he lived, his case was dismissed.

Due to their fear of stigma following this experience, the family — although practising Muslims — wrote "none" in the religion section of the registration form when they joined the GP's surgery. In addition, while we cannot be certain of what other factors in the teenager's life might have played a role, his GP firmly believes that the boy's OCD symptoms were triggered by this traumatic experience. He explained: "I had all of his medical details, and this is not somebody who had any past history of self-harm or anxiety, no psychiatric history, but this is what happened after that."

Case 6.   Family lost trust in care team after severely ill young Muslim man, unable to self-feed, referred to Prevent by physiotherapist

A GP told us about the case of a young Muslim man in his twenties who began suffering from a severe illness rendering him "totally dependent on carers and his mother", as well as daily visits from physiotherapists. He was "quite a religious lad" and while unwell would often watch YouTube videos of Islamic scholars talking about religion.

In 2018, a physiotherapist noticed the young man watching one such video and decided to make a Prevent referral. As a result, counter-terrorism police contacted the GP to ask for their opinion on the case. The GP told the police "I can't believe that this has been referred to Prevent. The young man cannot walk or feed himself and yet you're asking me if he's a threat or risk."

> " *The young man cannot walk or feed himself and yet you're asking me if he's a threat*

The health worker did not refer "out of malice", commented the GP, but "because of the training that they've had, they think they are doing the right thing." The GP felt obliged to inform the family "because at the end of the day, they're allowing people into their home to look after their child who they're totally trusting". Since the physiotherapist who made the referral did not identify themselves to the family — let alone ask for consent — the incident led to a complete breakdown in trust between the family and the entire healthcare team, which interrupted the young man's treatment. The GP explained: "We had to get new carers, new physios in, and it affects the continuity of care because obviously they were looking after him, they knew the routine and everything."

Case 7.   Climate change activist and ex-GP seeking mental health treatment referred to Prevent

Dr Lyn Jenkins, who retired five years ago, told Medact that towards the end of his long career as a GP and primary care ophthalmologist, he recalls being given Prevent training. While he was troubled by the ambiguity of when a health professional would be justified in breaking confidentiality, in large part the training was "water off a duck's back" because, at that time, he perceived Prevent to pertain to people "on the verge of becoming terrorists" and thought himself unlikely to ever encounter such a patient.

Concerned about climate change, in 2019 Jenkins decided to join Extinction Rebellion (XR) protests and "intended to get arrested" because he "agree with that precept, that the only way to get systemic change is to be civilly disobedient". Concerned his claustrophobia would be triggered by being in a police cell, he sought medical help and was referred to Healthy Minds, a mental health branch of the Oxford Health NHS Foundation Trust, in March. He also suffered from cyclothymia, a minor form of bipolar disorder. He had four weekly sessions involving graduated exposure therapy and made some progress at being in enclosed spaces without panicking.

In April, the young student psychologist Jenkins had been seeing telephoned and informed him she had discussed his case with her supervisor and that together they had decided to refer his case to Prevent. "I objected," Jenkins says. "I said 'Why? XR is not a terrorist organisation', and I didn't think I was a vulnerable adult, who was capable of being brainwashed." When he complained to management, he was told it was "normal safeguarding procedure" and that "the remit of Prevent was wider than terrorism".

At XR's "Easter Rebellion" protest, Jenkins avoided being arrested, fearing it could "complicate things" due to the Prevent referral hanging over his head. After about a month of waiting, he chased up his own case. He was informed that police were "not going to take it further" but also that he could do nothing about the fact that a record of the Prevent referral would be kept on file. Then, "two weeks later, two police officers knocked on the door" and "said they wanted to know if I was okay". Jenkins told us: "My wife had a terrible shock, she thought somebody had died. I was amused and slightly bemused...the whole thing felt Kafka-esque."

When Jenkins' case was reported in the Guardian,[1] Thames Valley police referred to this as a "welfare check". Jenkins did not continue his treatment with Healthy Minds: "I didn't go back. I told them I was disappointed in them, and that I felt I'd been let down."

Case 8.   Communication breakdown: lack of trust following Prevent referral had detrimental impact on Muslim boy's health and education

A clinical psychologist working in Child and Adolescent Mental Health Services (CAMHS) related to Medact the case of a British-Bengali Muslim secondary school pupil whose Prevent referral by his school — apparently for watching certain videos online — shattered his family's trust in educational authorities. Although the psychologist did not believe the case progressed to Channel, it did have a "knock-on impact" on the child's health, making it difficult for him to get the help he needed when he was later diagnosed with a developmental disorder.

"It's always beneficial for CAMHS and a school to be able to work together to support a young person", explained the psychologist. But in this case, the parents "were so suspicious of the school, their trust was so low" that "CAMHS weren't given permission to tell the school anything about the child's subsequent diagnosis, or anything that the school needed to do differently". This meant "the child's school didn't get the information they needed to adapt their approach in the way that he would have needed."

CASE 9.   Schizophrenic patient who converted to Islam attracted interest of Prevent police

A psychiatrist told Medact about a patient with schizophrenia whose mental health problems included delusional ideas. During the course of his care and treatment, the patient changed his religion several times. (The psychiatrist explained: "It is difficult to say if the decisions to change their religion were capacitous decisions or not, but good practice is to respect their belief systems, so long as they are not harming or distressing themselves or others.") None of his previous religious conversions, which became known in the community, had attracted the attention of the police. However, that changed when he began practising Islam. Suddenly clinical staff received a phone call from the police "fishing for information" and wanting to arrange a meeting to discuss the patient as a potential Prevent case.

The psychiatrist explained that some frontline staff who received these police inquiries were alarmed and agreed to the meeting, observing: "When Prevent gets mentioned, people feel worried about potentially very negative consequences, partly because of the influence of the media, so there is a heightened fear. As a result, confidentiality, which is normally quite well preserved, gets a bit shakier and things start to wobble." Although in this case, as a multidisciplinary team, the clinical team did not meet with the police and were able to work within GMC guidelines on confidentiality, it left the psychiatrist deeply concerned about the "stereotyping" that they perceived to be involved in Prevent policing. "Just because someone's got a mental illness and has chosen that faith, I don't understand why the police decided to say 'we want to know more'. There was no further basis. It just struck me as totally unfair and wrong and it just speaks to the prejudice that's out there".

The psychiatrist remains unsure whether the patient ever knew that police had contacted clinical staff and attempted to gather information about him.

CASE 10.   Prevent at south London hospice 'the antithesis of care'

> " *This policy prevents you from delivering positive and holistic care*

Marcelo Camus has worked as a community artist at St Christopher's Hospice in Sydenham, south London, for six years, running projects with patients and their families. He told Medact what happened when, last summer, Prevent training was rolled out at the hospice: "I was already aware of Prevent and critical of it, so I wrote to my line manager saying I wanted to opt out for ethical reasons because I believe it is based on stereotypes and encourages racial profiling. There were other BME staff members who didn't like it either but they didn't feel they could speak out. The response from management was 'it's mandatory' and I kept getting repeated emails about it saying 'you have to do it' and asking 'when are you doing it?' HR said there would be disciplinary measures. I even spoke to a lawyer about it."

The hospice has two types of patients, in-patients and out-patients. The latter may have terminal conditions but can, for example, drive to and from the hospice themselves. Camus also works in the community, including in groups for asylum seekers and people with long-term mental health conditions, and says he got the sense that no group was free of suspicion. He explains: "I was so disturbed by what I saw. People don't think twice about its interpersonal impacts, they just do it, in a very bureaucratic way. I felt there was a contradiction in wanting to think about total care at the end of life while also thinking about reporting people. And I didn't think it was really necessary. A lot of people we work with are vulnerable. When patients come to the end of their lives, there's an incredible amount of frailty, both physical and emotional. Sitting with that patient and thinking about the signs of radicalisation? That's the complete antithesis to the notion of care at the end of life."

Camus explains that his own mental health suffered due to the workplace conflict over Prevent, which created "a huge amount of stress and anxiety". Eventually, he agreed to do the training but remains a strong critic of Prevent. He maintains: "What this policy 'prevents' is it prevents you from delivering positive and holistic care."

CHAPTER 7

Prevent & safeguarding

In early articulations of Prevent, words like "vulnerability" and "safeguarding" rarely appeared in the policy lexicon. Today, however, they are central to its vocabulary. Originally, the programme was seen as working "alongside" safeguarding — not as a form of safeguarding in itself.[1] But the 2011 Prevent strategy spoke of the need to "embed" Prevent within safeguarding, observing that since 2009, "there has been an increasing shift in the regional management of Prevent towards the safeguarding and nursing areas [which] has facilitated take up and familiarisation".[2] The strategy also argued that: "[s]ituating Prevent within safeguarding will ensure it continues regardless of future changes to NHS organisational structures" and is "in line with wider attempts to mainstream Prevent in other sectors".[3]

Image from Prevent e-learning training comparing "radicalisation" to child sexual exploitation
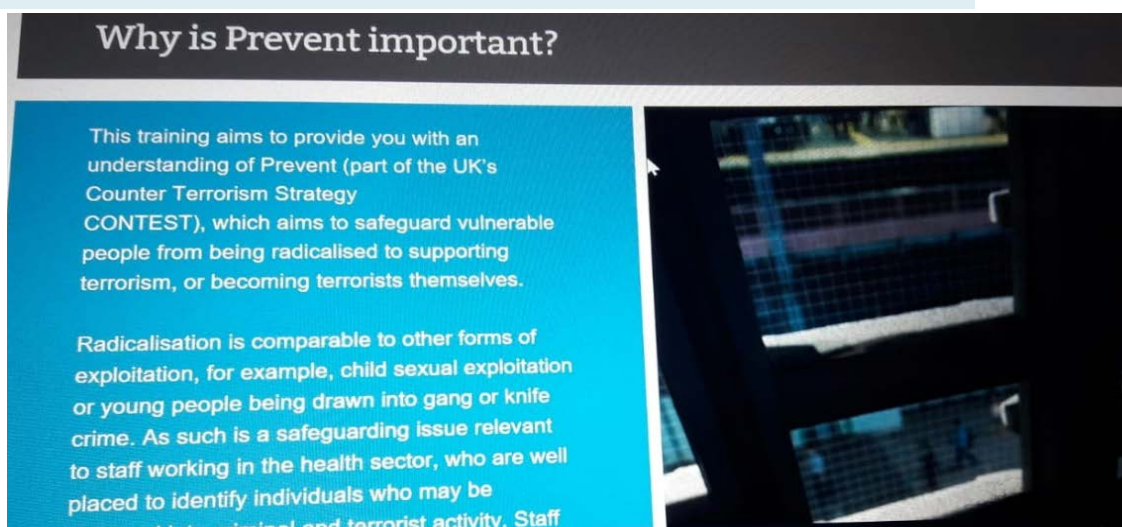
Official framings of Prevent in policy documents and training materials now present it as an ordinary safeguarding practice which "does not require [health workers] to do anything in addition to [their] normal duties".[4] Intercollegiate safeguarding documents and the NHS Safeguarding Policy list the need to prevent people being drawn into extremism or terrorism — "radicalisation" — alongside the need to prevent harm from various forms of abuse and neglect such as psychological, financial or sexual exploitation, trafficking or FGM.[5] The Care Quality Commission, England's independent health regulatory body, may inspect for compliance with Prevent training frameworks under the "safeguarding" bracket of its "Safety" key line of inquiry.[6] Yet questions have been raised about whether Prevent is a legitimate form of safeguarding.[7]

This chapter examines Prevent's unique concept of "vulnerability" and discusses a range of practical discrepancies with established safeguarding. It examines evidence raising the disturbing possibility that Prevent may actually harm, rather than safeguard, some individuals as well as crowding out more pressing safeguarding issues.

Prevent e-learning: "If you encounter anyone you suspect is being radicalised you have a duty to report your suspicions", cites the Children Acts of 1989 and 2004 and the Care Act 2014[8]
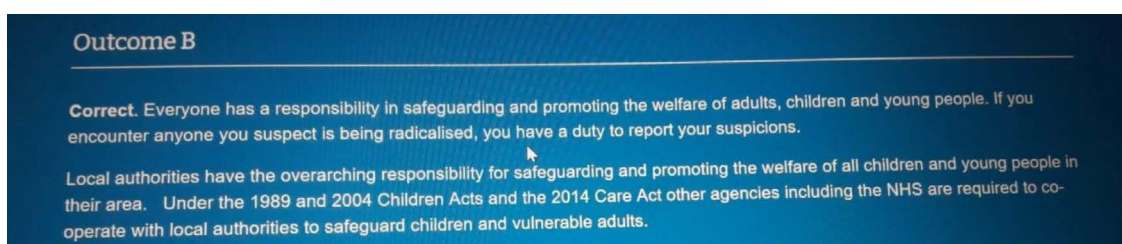
7.1. Dangerous vulnerability: how Prevent imagines terrorism risk

What is safeguarding and who is it for? The NHS Safeguarding Policy states that "safeguarding means protecting a person's right to live in safety, free from abuse and neglect".[9] The Children Acts of 1989 and 2004 specify particular legal duties with regard to safeguarding children (anyone aged under 18). **Adult safeguarding, however, applies only to certain groups deemed "vulnerable" or "at risk". Section 42 of The Care Act 2014 defines an adult to whom safeguarding duties apply as someone who meets three specific criteria:**

1.   has needs for care and support (whether or not the authority is meeting any of those needs)

2.   is experiencing, or is at risk of, abuse or neglect, and

3.   as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.[10]

This is often referred to, in shorthand, as "adults with care and support needs".[11] Care and support needs can arise from a number of factors, generally understood to include: age; illness; mental health conditions, including dementia or memory problems; dependence on alcohol or drugs; physical, sensory or learning impairments or disabilities;[12] experiences of domestic abuse; asylum seeker status.[13]

We found that many healthcare workers in our focus groups believed that preventing people being drawn into terrorism is, or at least *can be*, a form of safeguarding. We also found that many health workers, who are accustomed to using the language of "vulnerability", often accepted this terminology in relation to potential terrorism risk. For instance, when asked to describe their understanding of Prevent, one focus group participant spoke of "having a duty to report anyone that you think's vulnerable to radicalisation".[14]

However, sometimes purely technical reasons — such as the fact that Prevent training was given as part of safeguarding — were cited to justify this. Moreover, **acceptance of radicalisation as a form of "exploitation" (and thus acceptance of Prevent as a potential form of safeguarding), very often appeared contingent on the person in question meeting the aforementioned criteria to be classed as vulnerable.** For example, BMA human rights and ethics adviser Julian Sheather argued that "you could posit circumstances in which you think [safeguarding] is a legitimate response" and, as an example, referred to the plot of Joseph Conrad's *Secret Agent*, in which "a terrorist gives the bomb to the learning disabled son of his mistress".[15] Others also acknowledged the possibility that **Prevent could be construed as safeguarding, but generally only if and when it pertained to adults with care and support needs,[16] especially those lacking "capacity"[17] to make "autonomous decisions"[18] in order to protect themselves from harm.[19]** Opinion was somewhat divided over whether vulnerable people were genuinely most likely to be those drawn into terrorism, with some arguing that they were[20] and others suggesting the evidence did not support this.[21]

By contrast, central to the roll-out of Prevent in the health sector has been the promotion of an additional concept and category of vulnerability, namely "vulnerability to radicalisation".[22] Instead of arising from care and support needs linked to age, illness or disability, vulnerability to radicalisation is created — highly tautologically — by susceptibility or exposure. For example, the Great Ormond Street Hospital for Children NHS Foundation Trust defines "vulnerable person" in its Prevent policy as "someone who is susceptible to extremists' messages and is at risk of being drawn into terrorism".[23] Meanwhile, the NHS Safeguarding policy lists "those who may be exposed to violent extremism" on a list of groups of people "particularly vulnerable to harm and exploitation".[24] As Chapter 1 explained, the ERG22+ lists potential "signs of radicalisation", or vulnerability to it, unique to Prevent.

A significant minority of our research participants — including several specialist interviewees — were highly sceptical about Prevent's notion of vulnerability. An NHS safeguarding professional working in a Midlands hospital said:

> *with safeguarding adults...they have to be unable to protect themselves because of those [care and support] needs and they are the only people who come under safeguarding, unless it's Prevent. And [with] Prevent, they still say they're "vulnerable", but Prevent has completely altered the terminology for vulnerable...And my personal view is, it's bullshit.[25]*

Roy McClelland, Consultant Psychiatrist and Emeritus Professor of Mental Health at Queen's University Belfast, suggested to Medact that "there may be a play on words, stretching the concept", since "a rather different class" of vulnerability appears to be at work in Prevent.[26] In sum, it seems that although Prevent training materials (like the image shown here) make reference to key safeguarding legislation — in order to impress upon health workers their "duty to report...suspicions" — **the definition of vulnerability relied upon by Prevent in practice is broader and less tangible than that specified in the**

Care Act 2014.[27] Therefore, while the scope of traditional safeguarding is limited to those with care and support needs, it is plausible that Prevent is being applied more widely.

Compared to other forms of safeguarding, there is also a lack of clarity in Prevent about sources of risk. Dr Charlotte Heath-Kelly has noted the ambivalence at the heart of Prevent's narrative of vulnerability, which merges the notions "at risk" and "risky".[28] Some interviewees also raised this. Dr Adrian James, president of the Royal College of Psychiatrists, noted the "ambiguity" around the question "is [Prevent] about them getting help or is it about protecting society?"[29] Likewise, Dr Lyn Jenkins, an ex-GP who was himself referred to Prevent (see Case 7, Chapter 6), asked:

> *was the whole point of it really...nothing to do with safeguarding people who might be becoming terrorists, but about safeguarding people from terrorists? It was never clear which direction they were coming from. Or were they trying to do both things at the same time?[30]*

This confusion is compounded by Prevent training materials. They tell a narrative in which the patients that health workers may encounter are always "vulnerable", without agency or responsibility, and may need to be referred to Prevent for "support". Meanwhile, a third party "radicaliser" is imagined as exploiting the vulnerable patient, yet never accessing healthcare themselves. At certain points it becomes clear that these two characters are in fact the same person. In the Prevent e-learning training image shown here, for example, Mahasin is both a "vulnerable service user" "being radicalised" by external forces and in need of "support" but simultaneously someone who "could incite others to violence" and "could become a terrorist".

Prevent e-learning image: a "vulnerable service user" needs "support" but could also "become a terrorist"

It should be acknowledged that there are plausible circumstances in which a patient may potentially be both at risk themselves, and a risk to others. Nonetheless, Prevent appears to prioritise the latter while making rhetorical gestures towards the former. For instance, one NHS Foundation Trust's Prevent policy contains a flowchart (excerpted here) showing the approved referral process, which at one stage asks "Is the person *at* immediate risk?", before explaining in parentheses that what needs to be assessed at this point is "Is the person...likely *to be* an immediate risk...?" — in other words, whether the person in fact *constitutes* a risk to others.[31] **Prevent subjects are thus predominantly viewed as dangerous rather than in danger.[32]**

Those who rejected Prevent's concept of vulnerability also rejected its legitimacy as a safeguarding practice.[33] Fundamentally, this group saw Prevent as "politically driven"[34] and "national security"-oriented[35] rather than focused on individual patient welfare and thus tended to argue that Prevent inverted and "turned on its head", rather than aligned with, pre-existing safeguarding.[36] For instance, Shazad Amin, retired consultant psychiatrist and CEO of Muslim community group MEND, argued that "the general premise of safeguarding" is "protecting the person who is vulnerable... from other people" but that "safeguarding in Prevent appears to be the opposite way round, you're protecting society from the person".[37]

Indeed, some participants claimed that labelling Prevent as safeguarding was "disingenuous"[38] and amounted to little more than spin intended to market the policy to health workers.[39] Professor McClelland was particularly scathing in this regard, saying Prevent was merely "masquerading" as safeguarding but was "actually all about public protection". Although, like others, he acknowledged that public protection was legitimate and vital,[40] he concluded: "[n]ot only are patients being misled, I think the staff who are being trained are being misled, and I think that that's not correct, morally".[41]

> " *Not only are patients being misled, I think the staff who are being trained are being misled*
>
> — Prof Roy McClelland

Excerpt from Prevent Policy of Great Ormond Street Children's Hospital NHS Foundation Trust (Source: Great Ormond Street)

Is the person at immediate risk?
(Is the person indicating/showing behaviours that indicate they are likely to be an immediate risk of initiating a violent extremist attack?)

7.2. Differences between Prevent and established safeguarding practices

Health workers perceived there to be some parallels between Prevent and established safeguarding, principally negative features including the potential for both to be racist,[42] classist[43] and coercive.[44] However, they predominantly pointed to contrasts, supporting the findings of a Warwick University study which found that "significant differences exist" between Prevent and pre-existing safeguarding procedures.[45] In addition to the underlying question of whether Prevent should be understood as safeguarding or would more logically be classified as public protection, **at least seven *practical* differences between Prevent and pre-existing safeguarding procedures were raised by health workers in focus groups and interviews.**

Firstly, health workers generally found the indicators of vulnerability to radicalisation to be far more subjective than the criteria applied in other forms of safeguarding. This is certainly not to imply that safeguarding decisions are always easy or clear-cut. Identifying abuse or neglect can be very difficult, since "signs and symptoms are often ambiguous".[46] However, health workers consistently stated that they saw the signs of vulnerability to radicalisation, discussed in Chapter 1, as "vague",[47] "grey",[48] "indeterminate",[49] "nebulous"[50] and "subjective".[51] Some interviewees said Prevent's referral criteria were so loose, and the threshold so low, that they would be rejected in other areas of safeguarding.[52] For one GP, Prevent training was "very different to when you go for, say, your CSE [child sex exploitation] training...because [with the latter] there are quite specific indicators that you look for."[53] Similarly, a second GP told Medact:

> " *I worry that it's not an objective thing. Whereas it's very objective about other kinds of safeguarding....we have very clear definitions for forms of abuse. We have very clear definitions in terms of self-neglect, that kind of thing....any of these safeguarding things can be difficult in terms of when somebody meets the threshold... but I feel like...it draws less on your own life experience and your own prejudices.*

Royal College of Physicians President Professor Andrew Goddard made a similar point:

> " *when it comes to safeguarding from the aspects of vulnerable people, be it children, be it those with learning difficulties or be it the elderly, or [other] groups, then in some ways it's slightly easier to disentangle. But I think as soon as you start to try and differentiate between what is radicalisation and what is just part of an individual's culture, that's much harder.*[54]

A second point was that **the Prevent model of safeguarding is of course "pre-criminal", and concerns potential events which may happen in future**, whereas most safeguarding deals with criminal acts which either have occurred or are occurring (or are believed to be), since social workers "don't have the capacity and the ability to deal with proper prevention, because they're having to deal with actual people who are being harmed."[55]

The third issue some health workers raised was the perception that the rate of false positives in Prevent is very high compared to other forms of safeguarding.[56] As Chapter 1 explained, only around 5-10% of Prevent referrals progress to the Channel scheme (and this in itself indicates nothing more than that police deemed the initial suspicion of vulnerability to radicalisation to be legitimate). The majority of actions taken as a result of Prevent referrals involve passing people on to other services — such as housing or mental health — unrelated to the original radicalisation concern. Some healthcare professionals perceived the high false positive rate to be a product of the first two factors — the pre-criminal nature of Prevent and its broad, vague vulnerability criteria — creating a low threshold for referral, and felt the rate would be interpreted as problematic in any other area of safeguarding.[57] It may also suggest that Prevent referrals are neglecting proportionality, a key principle of safeguarding.[58]

However, **a fourth important difference to which health workers we spoke to pointed, was the fact that Prevent referrals move along separate pathways, outside of established safeguarding channels.** There is variation between trusts but the flowchart shown here, taken from Northern, Eastern and Western Devon CCG's Prevent policy provides an interesting example.[59] Note the very clear distinction made between referrals which meet safeguarding criteria related to care needs and those which do not. **Anomalously, according to the process shown, cases may still be referred to Prevent even when there are "no identified care needs" and "safeguarding adult criteria" are "not met".**

In many cases, Prevent referrals will not necessarily proceed to a Multi-Agency Safeguarding Hub (MASH). For instance, Dudley Group NHS Foundation Trust explained to Medact:

> " *If the Trust has any such [radicalisation-related] safeguarding concerns it contacts the Dudley Prevent Lead to discuss. The Dudley Prevent Lead will advise if the Trust needs to send a referral via a Prevent template to Counter Terrorism Unit or send a referral indicating multiple safeguarding concerns to the Multi Agency Safeguarding Hub (MASH), who then if concerned would refer on to the Channel Panel should there be a Prevent concern.*

One interviewee — who sits on a safeguarding board in the Midlands — said Prevent appeared to create "different tiers" of safeguarding.[60]

Importantly, **numerous participants criticised the unique multi-agency arrangements in place for Prevent. Many did not feel that the relative risk of radicalisation warranted a specific Prevent training or separate pathway**, but instead felt it ought to be embedded.[61] For example, Dr Jonathan Leach, formerly the named GP for safeguarding children in Redditch and Bromsgrove and now Joint-Honorary Secretary of the Royal College of GPs (RCGP) stressed that there should be "a single point of access" for referring all forms of safeguarding concerns.[62] **Moreover, most did not see what value Prevent added to pre-existing safeguarding procedures, which many pointed out are already supplemented by the duty to inform the police if an immediate risk is posed.[63]**

Excerpt from Northern, Eastern and Western Devon CCG's Prevent policy (Source: Northern, Eastern and Western Devon CCG)
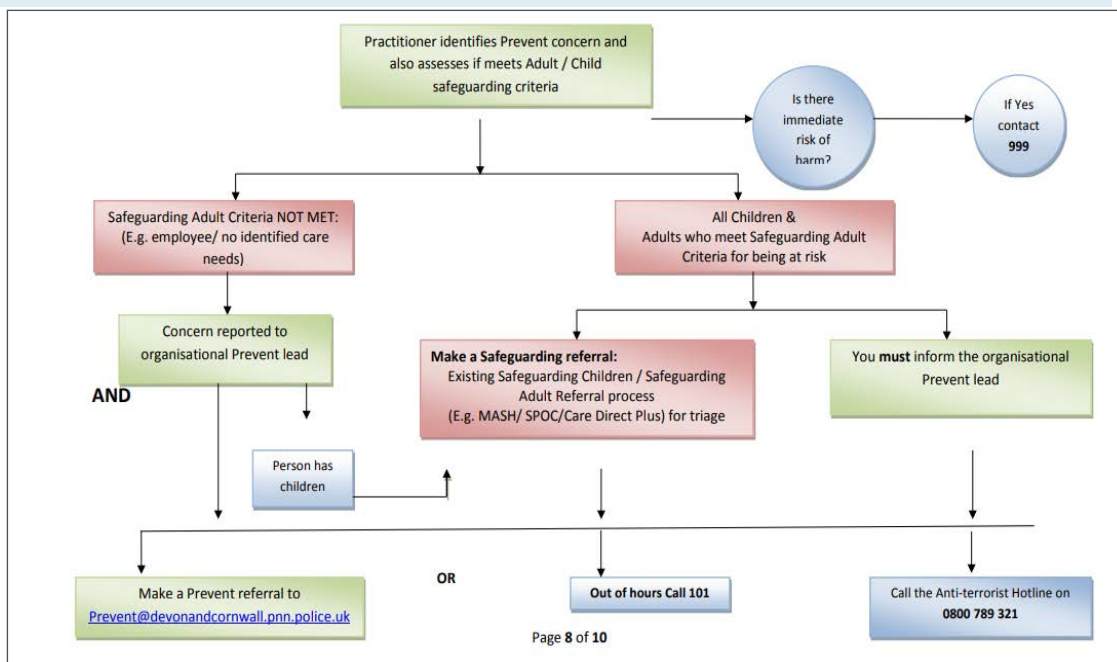
A fifth contrast between established safeguarding and Prevent was the latter's lack of transparency. None of the health workers we spoke to felt familiar with the Prevent referral pathway — which was described more than once as "mysterious"[64] — and this lack of knowledge increased their suspicion of the programme and reluctance to refer patients to it. Since accountability is a key principle of safeguarding, transparency is key.[65] A number of health workers emphasised the superior "openness" of pre-existing safeguarding practices,[66] about which local authorities "have an obligation to publish data in the public domain" within annual reports, since they are providing a public service.[67] By comparison, only national Prevent data is published, and more micro-level data is very difficult to obtain as Chapter 1 explained. Neither "significant event analyses", as used in primary care, or "serious case reviews" — conducted by local safeguarding agencies when a child or vulnerable adult dies or is seriously injured in circumstances involving abuse or neglect — are routine in Prevent.[68]

The sixth difference some research participants highlighted related to their own involvement in the Prevent process. To the extent that they understood the pathway, some were aware that the continued involvement a healthcare professional would expect to have — to at least some degree — after making a safeguarding referral, was absent in Prevent. For example, Dr Adrian James explained his perception that Prevent referrals would "disappear outside" "into an external agency", saying:

> *My understanding is [that] most people you are referring [to Prevent], you often don't then know what actually happens, whether somebody is provided with any support, no support, what the support is...and you certainly don't know what happens to in terms of any policing involvement. So, it's not bringing somebody in to, say, my multidisciplinary team... it's completely externalised. And then I have absolutely nothing whatever to do with it.[69]*

Likewise, several health workers compared Prevent unfavourably to established safeguarding in this respect. One GP said:

> *Let's say I suspect a child's being abused. I'll ring up social services...they'll see the child, they'll do their assessment, they'll call an MDT [multidisciplinary team] meeting. I'll be invited to it. I'll be asked to give a report. There'll be a case conference. There'll be an investigation. I'm kept abreast of everything all along.... with Prevent...there's no follow on from us as GPs...we have absolutely no idea what's going on, and there's nobody we can ring to say, "How is Patient X getting along....?" ...we're just left in the dark.[70]*

Another GP noted that normally she would expect to get minutes of meetings held into a child protection case she had referred, as well as input, but with Prevent, as she saw it, "that's it, you ring safeguarding, the referral's gone" and "nothing further is heard".[71] Dr Shazad Amin was also of the opinion that a health professional who refers to Prevent "won't necessarily be invited to a Channel [panel]" and therefore concluded that "there's often much closer working in [other safeguarding] scenarios than with Prevent".[72]

A few interviewees claimed that, by contrast, the police are much more heavily involved in Prevent than in other forms of safeguarding. Dr Jonathan Leach of the RCGP pointed out that "there is a police presence, helping [the] decision-making" at most safeguarding hubs and that sometimes — for instance with suspected cases of FGM — health workers are "supposed to call the police" directly.[73] However, a GP told us he felt that the police are normally "very much bit part" in safeguarding meetings, whereas with Prevent "they are front-and-center",[74] a perception shared by a handful of other participants.[75]

The seventh and final disparity health workers perceived to exist between Prevent and pre-existing safeguarding practices was the crucial issue of consent — central to the drive to respect individual autonomy and "make safeguarding personal".[76] This issue is discussed fully in Chapter 8, since it is inextricably tied to the question of when a health worker can justify disclosing confidential personal information about a patient.

7.3. First, do no harm: impacts on patients and wider safeguarding work

What are the impacts of Prevent — perceived and actual — on patients who are referred? And how does Prevent affect established safeguarding work?

One of the "key messages" on Prevent training materials is that the programme is "a supportive process" and "not a sanction".[77] This is "the line you keep hearing off people", noted one safeguarding professional. But, she asked: "What support? Nobody can tell you".[78] In addition to the Prevent referral pathway being seen as "mysterious", opacity was perceived to be even more pronounced with regard to the deradicalisation programmes which constitute a key element of the "treatment" offered to a minority of Channel referrals.[79] For example, one focus group participant asked:

> *If we're supposed to engage with this person and offer them this referral to this wonderful deradicalisation service... like...does deradicalisation work? I don't know, it sounds like something somebody made up...how... evidence-based is this strategy?[80]*

Doubts such as this were widespread and **very few health workers believed that Prevent offered anything beneficial to patients.**[81] For instance, another focus group participant conceded: "I don't have any faith in the system that exists to do anything productive and supportive with it."[82] **As Chapter 1 noted, our literature review found no evidence that deradicalisation is effective or beneficial to patients, seemingly vindicating health workers' concerns.**

As well as doubting Prevent's capacity to offer patients meaningful support, the majority of health workers were — with just one or two exceptions[83] — on the contrary, more concerned about inadvertently causing harm.[84] These **harms included generating mistrust, stigma, trauma and the perception among some health workers that Prevent**

> *Very few health workers believed that Prevent offered anything beneficial to patients*

was really a "punitive" measure potentially leading to criminalisation.[85] Several expressed the fear that a Prevent referral would "impact"[86] or even "ruin"[87] their relationship with the patient concerned. Others spoke of how a patient referred to Prevent — even if ultimately not deemed to require Channel intervention — could be negatively affected by "stigmatising" police contact that might follow,[88] which would not be in their "best interests" and could "conflict" with safeguarding.[89] BMA ethics adviser Julian Sheather pointed to the potential for direct criminalisation, noting:

> *if you make a [safeguarding] referral...the individual, the vulnerable adult, isn't the person who ends up in front of the police. It's the "abuser", if you like. And it could be the case [with Prevent] that may also happen, but I think there's a potential for confusion.*

As demonstrated earlier, training materials reveal that Prevent sometimes understands its subjects as both "vulnerable" parties and simultaneously as abusers, exploiters or radicalisers. **As the next chapter explains, all Prevent referrals are recorded on a police database. Moreover, on at least one occasion, a person referred to Prevent and then Channel was prosecuted and convicted for terrorism offences related to possession of literature, critically with his Channel "mentor" apparently helping police to bolster the case.**[90] **Fears that Prevent may lead to direct criminalisation are therefore not unfounded.**[91]

Our case study evidence suggests that, in practice, groups who might be considered vulnerable do make up a large proportion of Prevent referrals. Those affected by Prevent often seem to be children[92] (Cases 3, 5, and 8) and people with mental health conditions (Cases 1, 4, 7, 9). Other case studies involve a Prevent referral of a patient with a serious physical health condition (Case 6) and the Prevent programme being rolled out at a hospice, among staff in some cases caring for those with terminal illnesses at the end of their lives (Case 10). However, whether all of those featured as case studies in this report would meet traditional safeguarding criteria for vulnerability — in the sense of having care and support needs — is questionable. Moreover, **even patients who may be vulnerable and in need of safeguarding usually still retain capacity to make decisions[93] and should therefore have their agency respected and their consent requested — which does not appear to happen regularly**. Chapter 8 explores this further.

More importantly, in a number of the case studies, Prevent appears to have had various types of negative impacts. These include damaging the therapeutic relationship between patient and practitioner, possibly setting back recovery (Case 1) and damaging patient trust in health professionals in a way that interrupts care (Case 6) or causes them to disengage

entirely (Case 7). In one instance, a Prevent referral appears to have been the trigger for a young man to develop obsessive compulsive disorder (OCD) according to his GP (Case 5), and the parents of another young man reported physical and mental health impacts as a result of the trauma of their son's referral (Case 3). In Case 10, a community artist working at a south London hospice was dismayed at being pressured to take Prevent training, telling Medact he saw "a contradiction in wanting to think about total care at the end of life" while also watching for "signs of radicalisation" and "thinking about reporting people" which he characterised as "the complete antithesis" of care. **Taken together, these cases raise the disturbing possibility that Prevent may actually harm the vulnerable, or damage their care, rather than helping or safeguarding them.**

Some health workers are also concerned about the broader impact of Prevent on safeguarding. For example, one NHS safeguarding professional who also delivers WRAP (Workshop to Raise Awareness of Prevent) trainings as part of her role, told us she felt Prevent could spread confusion about the notion of vulnerability with potentially damaging implications:

> *we spend half our time when we're training [other safeguarding issues] saying, "Look, guys, your patient has to fit into this criteria else you're just wasting your time." ...and then I may well be teaching them Prevent the day after and I'm saying everything the opposite.*

Then there was the pressure of other demands on health professionals' limited time. Notably, health workers already feel "overloaded".[94] One GP told Medact:

> *One of the trends that's been happening in recent years is that things like safeguarding have been stripped out of social services which have been run on a shoestring...and the workload and the responsibility's being put onto us. General practice is breaking at the moment, and I know it's the case in hospitals as well, so you're basically pushing one more responsibility on to already overburdened professionals who are undertrained to do it.[95]*

This context seemed to underlie several **participants' concerns that Prevent could "distract" health workers from attending to much more common and pressing safeguarding issues[96],** including modern slavery.[97] When mandatory reporting for social workers in relation to child protection was proposed by government in 2016, LSE Professor of Social Policy Eileen Munro — who conducted a review of child protection in England in the wake of the "Baby P" controversy — raised a similar concern, saying the measures might actually *worsen* children's safety if professionals were taken away from other areas of work to handle the possible deluge of referrals. In the Prevent context, Dr Tarek Younis's work provides a worrying example of this happening in practice. In the case study he documents, the need to protect "Joan", a woman experiencing domestic violence, was relegated in importance compared to wholly unsubstantiated radicalisation fears.[98]

7.4. Better safe than sorry?

This chapter has explored Prevent's novel concept of dangerous vulnerability, discussed its marked divergences from established safeguarding practices and assessed actual and perceived impacts on patients and on wider safeguarding. **A majority of healthcare workers did feel Prevent *could be* a form of safeguarding, albeit on the aforementioned premise that the person in question is vulnerable in the sense of having care and support needs. In practice, this condition may not always be met. Even when it is, vulnerability does not automatically equate to lacking capacity to make decisions in one's own interests**, a crucially important distinction which the next chapter explores further. Many health workers felt Prevent indicators of vulnerability to radicalisation were more subjective than established forms of safeguarding and do not see the unique Prevent pathway as necessary. Other key concerns included Prevent's lack of transparency and health workers' lack of continued involvement in the process.

Doubts about whether Prevent benefits patients were widespread, as were concerns about harms — some of which have been evidenced in our case studies and elsewhere. As well as raising the alarming possibility that Prevent may actually harm the vulnerable, or damage their care, rather than helping or safeguarding them, a wider concern is that undue attention on Prevent may crowd out more immediate and pressing safeguarding issues. Health workers want to, and should, play a role in safeguarding the vulnerable. But Prevent appears focused on safeguarding national security over safeguarding patients who are referred. Even if deemed legitimate as a form of public protection, to present Prevent as safeguarding may be "a corruption of the word safeguarding".[99]

CHAPTER 8

Confidentiality, consent & trust

Health workers recognise that trust is "the bedrock" of their therapeutic relationship with patients.[1] **Central to this trust is the understanding that personal information which a health worker comes to know as a result of their professional relationship with a patient is subject to a common law duty of confidentiality.** This is a "huge principle"[2] in all health care professions, codified in guidance such as the NHS Code of Practice,[3] 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.[4] However, in practice **there are worrying indications that Prevent has eroded and undermined the expectation of confidentiality.** While more systematic data is needed, **this chapter examines evidence which suggests that many, if not most, Prevent referrals take place on a very low evidence threshold and *without* patient consent,** undermining the Home Office's claim that it is a "voluntary" programme.[5]

Moreover, some official Prevent training materials appear to actively *discourage* health workers from seeking informed consent from patients, as well as fudging the crucial difference between disclosures made for the purpose of safeguarding and disclosures justified in the public interest. Finally, while the Prevent duty only applies to organisations, Prevent training materials inaccurately present individual clinicians themselves as legally responsible for reporting suspicions about radicalisation. As a result, many health workers believe they may be held individually accountable for failing to refer, which creates pressure and in some circumstances leads to a "rush to refer".[6]

8.1. 'Grey areas': confusion around consent and Prevent

Our research revealed confusion and divergent views over whether health workers should seek informed consent before making a Prevent referral.[7] The crux of this disagreement hinged on whether Prevent is perceived as safeguarding or as a public protection programme. Professor Roy McClelland, a member of the GMC's Confidentiality task group which helped to revise its latest guidance, told Medact that the purpose of disclosure is "fundamental" since "you really need to be purpose-specific in order to make good decisions" when considering breaching confidentiality. He explained:

> *There are two quite different purposes for which one might disclose confidential information on...a patient... One is to protect that individual and the other is to protect the public...when we get down to justifications for disclosure, the criteria and what's at stake are different.[8] (our emphasis)*

The criteria for justifying breaching confidentiality in the public interest are narrow and specific. There needs to be a concrete "risk of death or serious harm".[9] In general, the stringency of this principle appeared to be universally accepted and understood by healthcare workers — and indeed fiercely defended.[10] For example, one health worker in Brighton asserted "I'd have to be really convinced that they're at risk of doing harm to themselves or others",[11] while a Birmingham GP declared "the GMC line for breaking confidentiality is immediate, identifiable...risk to life or limb...so those are my lines. You'll have a hard time getting me to step outside of them".[12]

Yet, in the context of Prevent, a handful of participants believed that informed consent should *not* be sought to make a referral, since they saw disclosure as a public protection issue that could meet the above criteria. For example, when asked if health professionals should generally seek informed consent before making a Prevent referral, Royal College of Physicians president Dr Andrew Goddard reasoned:

> *No, because I think if you genuinely believe that the public is at risk because of what you have witnessed by an individual or group of individuals, asking for informed consent is likely to aggravate that situation. So that is one of those things where it is inappropriate, I think, to seek informed consent.[13]*

Similarly, when asked if health workers should seek consent to make a Prevent referral, a Manchester-based GP told us "I wouldn't have thought so, because they obviously think that person is dangerous."[14] A legal academic interviewed for this study also responded negatively on the question of consent, explaining "because Prevent is a security program, in my view".[15] While the Royal College of GP's Dr Jonathan Leach felt consent *should* be sought, he held some sympathy for these public protection arguments. He suggested that while information sharing protocols are "written as black and white", Prevent is a "grey area" — a phrase which recurred in several separate interviews and focus groups[16] — arguing that it highlighted a "tension" between "confidentiality of the individual as compared to our broader societal responsibilities".[17] **Notably, guidance produced by NHS England's Prevent team also emphasises the legality of bypassing informed consent, also by alluding misleadingly to a possible public interest justification.**[18]

Prevent e-learning image emphasising its remit of intervening BEFORE terrorist involvement
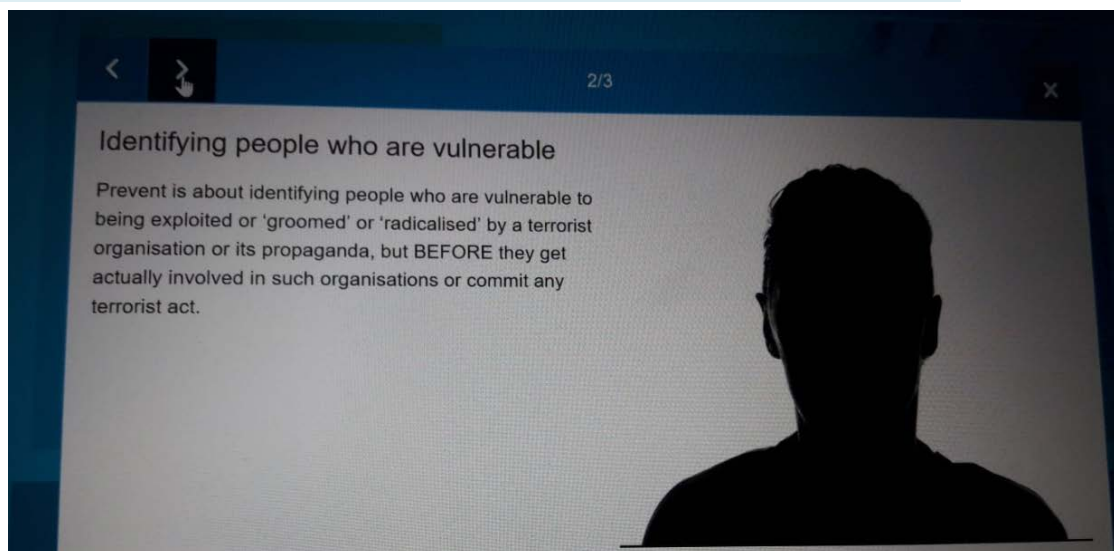
However, **other participants argued that there was a considerable gap between a Prevent subject "at risk of being radicalised" and a patient who poses an "imminent risk" justifying a public interest disclosure.**[19] Some assert that this means Prevent encourages a much lower standard for disclosure of confidential information than that warranted by the common law duty of confidentiality enshrined in the NHS confidentiality code of practice, since it is explicitly *not ab*out immediate risk.[20] (One interviewee even claimed there was, in practice, "no threshold".[21]) The British Medical Association's Julian Sheather pointed out that with Prevent "we're talking about speculative risks in the quite distant future". Similarly, Dr Lyn Jenkin — who was himself referred to Prevent — observed:

> *it's a very grey area, isn't it? You're just suspecting that somebody might one day carry out a terrorist act in the future. You're not even saying that you think they're a terrorist, you're saying you think they might become a terrorist. Well, that's very soft, isn't it, for evidence?*[22]

Dr Adrian James, president of the Royal College of Psychiatrists described health workers' lack of understanding around Prevent as "a bit of a grey area", adding that some "think that it relates to people who are at quite significant risk of carrying out an act and that isn't what it's designed for at all".[23] Our evidence underlined this confusion, with one London GP, for example, admitting: "I just don't really understand the standard for disclosure, it's just very vague".[24] **Dr Adrian James, Julian Sheather and other health workers conclude that in fact the public interest justification "should never apply to Prevent".**[25] **We think this is correct. As Chapter 1 explained, Prevent is indeed designed to identify risk, and intervene, far "upstream" of any actual, or even imminent risk of, violence.** By contrast, as many health workers pointed out, there is already a duty to inform the police if an immediate risk is ever posed.[26]

The irreconcilability of Prevent's pre-crime approach with accepted notions of justifiable public interest disclosures may help to explain why Prevent has officially been labelled a form of safeguarding. As the previous chapter explored, there are significant questions about the legitimacy of this. Critically, however, when Prevent is classified as a form of safeguarding, avenues open up for people who pose *no immediate risk* to be referred.

The first of these avenues would be through giving their informed consent, whether implied or explicit. In contrast to the small number of participants who believed that consent should not be sought because of the perceived risk posed to the public, **the majority of our participants said that informed consent** *should* **be sought before a Prevent referral is**

made.[27] Indeed many were insistent on this point. One health worker explained that "the big thing" ever since the Care Act 2014 is the concept of "making safeguarding personal".[28] This phrase sums up an approach which seeks to move away from paternalism and instead enable safeguarding "to be done with, not to, people"[29]; to safeguard individuals "in a way that supports them in making choices and having control in how they choose to live their lives".[30] Fundamental to this personalisation and empowerment agenda is the principle of respecting each individual's autonomy and therefore the presumption of person-led decisions. In short, **as many participants emphatically stated, good safeguarding should always seek to be "consensual".[31]**

Yet while most health workers agree that informed consent should *in principle* **be obtained to make a Prevent referral as a form of safeguarding, they doubt whether** *in practice* **this is realistic or even possible.** A number of health workers were incredulous that anyone would give their informed consent to be referred to Prevent.[32] One focus group participant pondered that "you're offering to deradicalise them from things that they deeply believe at the time",[33] while interviewee Dr Lyn Jenkin suggested "I think in the case of identifying people who are being radicalised for terrorism, they're almost by definition not going to agree to be referred."[34] Meanwhile, some health workers voiced concerns that knowing so little about the Prevent pathway themselves (as the previous chapter noted) would make truly *informed* consent unachievable for their patients.[35] "I don't know what's at the end of the [Prevent] referral pathway for my patient", confessed one Birmingham-based health worker.[36] **"Informed consent", a GP observed, "requires a proper conversation about the risks, benefits".[37]**

> ❝ *Adult safeguarding presents some classic challenges... But the basic assumption is where an adult has capacity, it's up to them to make a decision about disclosure*
>
> — Julian Sheather, Ethics Advisor, British Medical Association

The second possible avenue for making a safeguarding referral arises if a patient lacks the *capacity* **to consent.** In such a situation — for example with a patient who has serious learning disabilities, rendering them unable to process the information necessary to make decisions about their own safety — it would be permissible for a health worker to disclose information without the patient's consent, on the assumption that disclosure is in the patient's best interest.[38] **Importantly, the health worker should still** *inform* **the patient about how and why their personal information is being shared.[39]** The only exceptions would be if this was "not practicable" or would "undermine the purpose of the disclosure".[40]

However, the right of all adults *with* **capacity to make their own decisions is a fundamental principle.** The BMA's Julian Sheather explains:

> ❝ *Adult safeguarding presents some classic challenges. What do you do where you have an adult, who has the capacity to make a decision about the disclosure of information and says, 'I don't want this information disclosed, I don't want a referral made', and you have serious suspicions that they are being coerced by other adults, but they retain capacity? It's difficult...But the basic assumption is where an adult has capacity, it's up to them to make a decision about disclosure unless there is a clear risk of harm (our emphasis).[41]*

Professor Roy McClelland echoed this position strongly, drawing out its significance for Prevent:

> ❝ *You can't refer them for deradicalization if they don't want it. To me, that's the issue of capacitous individuals having the right to refuse even though you think they're putting themselves at risk.[42]*

Importantly, GMC guidance makes clear that health workers "must not assume a patient lacks capacity to make a decision solely because of their age, disability, appearance, behaviour, medical condition (including mental illness), beliefs, apparent inability to communicate, or because they make a decision you disagree with".[43] There is, then, a *critical* **distinction to be made between adults who remain "capacitous" despite being** *vulnerable* **(perhaps due to age or mental illness) and adults who lack capacity, as defined in the Mental Capacity Act 2005.[44] In practice, however, this distinction is not being made by some health workers,** as case studies in this report highlight. The next section discusses how and why patients clearly not lacking mental capacity may come to be referred to Prevent without even being *informed*, let alone asked to give informed consent.

8.2. Through the back door: exceptions as the rule?

"Is it possible that I could be referred to Prevent and then discussed at a Channel panel without ever knowing?", we asked an ex-Channel Panel member, also a former Prevent lead in an English primary care trust. "Yeah, I think there would be cases like that", he replied.[45] The case studies in Chapter 6 of this report suggest that this may in fact be commonplace. **If, as the Home Office insists, Prevent is a "voluntary" programme, the only route to referral should be through patient consent.[46] Yet only in a minority of cases did we find evidence that health workers had requested consent to make Prevent referrals — and, even then, whether patients gave truly informed consent may be questionable.**

In Case 1, a psychiatrist told Medact about two Prevent referrals he had been involved in, both of which concerned patients with schizophrenia. He expressed doubts about whether each patient's agreement to the Prevent referral constituted informed consent, since their "capacity to weigh up information" was impaired. As explained in the previous section, a safeguarding referral can be made without consent if a patient lacks capacity, *when it serves their best interests*. In at least one of these cases, however, the psychiatrist believes the Prevent referral ultimately "harmed the therapeutic relationship" and likely slowed down the patient's recovery. **The psychiatrist told us he and his consultant saw making a Prevent referral as "ticking the box" and "something we were obliged to do".**[47]

In Case 4, the GP concerned did ask permission to make a Prevent referral and the patient reportedly said "fine". However, the health worker who told Medact about the case argued that patients who are seriously ill are often "compliant because they're not well" and trust health professionals to act in their best interests. He suggested that the Prevent referral was not in the best interests of the patient, who was acutely depressed, psychotic, hearing voices and had visited A&E the previous day seeking help. In fact, **the GP in question did not believe the patient was a potential terrorist but explained that she "panicked" and decided to report to Prevent anyway, because "If I don't do anything, I don't want my name to be in the headlines the next day."**

In a majority of cases, no consent was sought to report a patient to Prevent. Cases 6 and 7 are perhaps most stark. In the former, a physiotherapist reported a severely ill young man who "could not walk or feed himself" to Prevent, after observing him watching YouTube videos of Islamic scholars talking about religion. The family's GP came to know about this after being contacted by police and told Medact "I informed the mum that the referral had been done, because the family had no idea". This led to a "complete breakdown in the relationship" between the physiotherapy team and the family, affecting the continuity of the young man's care. In this case, the risk of harm from not sharing confidential information seems extremely low, arguably clearly outweighed by the possibility of a non-consensual referral causing harm and distress to the patient. **Episodes like this highlight the fact that despite confidentiality guidance counselling health workers to consider whether raising concerns is "proportionate", Prevent referrals often do not abide by this principle.**[48]

In Case 7, Dr Lyn Jenkin was not asked for his consent to be referred to Prevent and was only retrospectively informed that it had been done. The former GP — who told Medact "I didn't think I was a vulnerable adult who was capable of being brainwashed" — was effectively treated as if he lacked capacity to make his own decisions. This was apparently assumed on the basis of having a mental health condition, a minor form of bipolar disorder called cyclothymia, and being involved with the environmental protest group Extinction Rebellion. When he complained, Dr Jenkin was told that this was "normal safeguarding procedure". **This suggests a distinctly non-consensual approach to safeguarding, potentially setting a precedent for ignoring the agency of very large swathes of people**.

In Cases 3, 5, 8 and 9, there was also no apparent attempt to seek the consent of those concerned to make a Prevent referral (though the first three involved children and were originally referred from the education sector, not healthcare). In Case 9, the psychiatrist remained unsure if the patient concerned was aware of becoming the interest of Prevent police. They explained their view that:

> *When Prevent gets mentioned, people feel worried about potentially very negative consequences, partly because of the influence of the media, so there is a heightened fear. As a result, confidentiality, which is normally quite well preserved, gets a bit shakier and things start to wobble.*

In the other cases, **the discovery of having been non-consensually reported to Prevent caused serious damage to trust, marked by individuals and their families adopting a position of deep suspicion towards health and educational bodies** as a consequence of their experience. Cases 2 and 10 document the experiences of staff who questioned or attempted to resist Prevent training and demonstrate the considerable pressure brought to bear on them to comply.

Why do such cases occur despite Prevent *theoretically* changing nothing about the circumstances in which it is acceptable to breach confidentiality?

Firstly, confidentiality is being put under strain via pressure from above. **While there is no evidence that Prevent referral "targets" exist, numbers of reports are used by the government as one way to judge whether public bodies are compliant with Prevent**. For example, a document released by NHS England/Digital under Freedom of Information laws states that "the level of referrals made" to Prevent is one indicator used to "demonstrate how NHS Providers are delivering the key elements of the Duty".[49] By submitting this and other data, NHS Trusts and Foundation Trusts provide "the necessary assurance that the priority area organisations are compliant with the Prevent Duty".[50]

> " *The NHS mandatory training is telling me that it is wrong to gain consent to refer to Prevent*
>
> — anonymous health worker

This pressure from the government on NHS Trusts would appear to filter down to staff through Prevent training, levels of which are another key indicator of compliance. **Scrutinising the materials used in training, one finds a plethora of statements encouraging health workers to disclose information.** For example, the following statements are a selection of the exhortations littered throughout a single Prevent e-learning training (consisting of approximately 120 screens) and appear to reach a crescendo of urgency as the training progresses:

1. "If you are concerned that a patient/colleague is being exploited/influenced by a group you are expected to raise this concern."[51]

2. "...take action where necessary for safeguarding and crime prevention purposes."[52]

3. "We don't have a surveillance role but staff in the health sector are encouraged to simply: NOTICE / CHECK / SHARE."[53]

4. "Voice your concern: trust your professional instincts and speak about them with a colleague or line manager."[54]

5. "Be aware of your professional responsibilities in relation to safeguarding and Prevent."[55]

6. "Protocols around information sharing should never be a barrier to safeguarding vulnerable individuals."[56]

7. "We need to make sure that we share information. There have been cases where not sharing information has resulted in missed opportunities."[57]

8. "Don't be the person who knew and didn't act — trust your instincts".[58]

9. "Don't rely on others to refer, you have a duty and responsibility to report any concerns."[59]

10. "Understand the importance of sharing information (including the consequences of failing to do so)."[60]

Noticeably, none of the above statements mention seeking the patient's consent to disclose. In contrast, whenever it is mentioned that that the patient should be informed (on only two occasions in the training) or that consent should be sought to make a referral (on only two occasions) — a disclaimer *always* accompanies this instruction.[61] In each example below, we have emphasised the relevant clause.

- "Sharing your concerns, where appropriate, with partner agencies, and *as far as possible being open and honest with the individual* around your duty to share concerns".[62]

- "Be open and honest with the person (and/or their family where appropriate) on what information will be shared and why, *unless it is unsafe or inappropriate to do so*".[63]

- "Share with consent where appropriate. *You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest*".[64]

Retired psychiatrist and MEND director Shazad Amin believes that, **in terms of their overall impact, such opt-out clauses communicate to health workers not to worry too much about consent when it comes to Prevent.** "People are using the exception as routine", he claims, "and for me, that is completely unacceptable, because it drives a coach and horses through a very sacred aspect of the doctor-patient relationship. Prevent....seems to, through a backdoor, have circumvented all the well-held notions of what constitutes confidentiality and when you can break confidentiality."[65]

Indeed, a different set of Prevent e-learning materials unequivocally implied that consent-seeking should be *avoided altogether*. As the image shows, in answer to the question "If you suspect that an individual is being groomed for terrorist activities, to whom would you discuss your concerns?", health workers must select three possible correct answers from five options. The correct answers are "Your line manager", "Your Trust's Prevent lead" and "Your Trust's safeguarding lead". "The vulnerable adult" is therefore an *incorrect* answer. **As the health worker who sent this image to Medact noted, "the NHS mandatory training is telling me that it is wrong to gain consent to refer to Prevent".[66]**

Separately, a different health worker told Medact she had come across a pop-up notice on an electronic patient record system at a former place of work which said, in red writing, "Referred to Channel, do not tell patient".[67] However, Medact was unable to independently verify this claim.

The widespread confusion in the health community, documented in the previous section, over whether Prevent referrals are for safeguarding or public protection, and whether or not consent should be sought, likely stems in large part from training materials like these. They appear to confirm Prof McClelland's fear that "in the training forum, public protection is conflated with the protection of the individual" (for example, in statement 2, above) and "vulnerability" is misleadingly "over-sold as a justifiable threshold" for breaching confidentiality (for example, in statement 6, above), undermining the right of adults with capacity to make their own decisions.[68]

Health workers in our study were very clear that they did not want to be "spies", a "surveillance"[69] or "monitoring system", **which many perceived Prevent to be.[70]** Yet while the Counter-terrorism and Security Act 2015 only places a legal duty on *institutions* to "have due regard" to prevent people being drawn into terrorism, **Prevent training materials inculcate the notion that health workers are personally responsible for reporting suspicions.** The belief that they are professionally obliged to report is fairly widespread,[71] creating "fear",[72] of getting into "trouble for not having made a referral",[73] being "seriously castigated for not referring",[74] or even "legal ramifications for us if we don't report somebody".[75] Even though Prevent has been classified as a form of individual safeguarding, the "ultimate risk" — the spectre of a terrorist attack — inevitably rears its head in health workers' minds.[76] Moreover, **given the absence of penalties for false positive Prevent referrals, health workers have incentives to err on the side of reporting when a difficult situation arises. This equation produces a "rush to refer",[77] in which confidentiality is overridden — even though, as several experts state unambiguously, this puts practitioners squarely in breach of their professional obligations, GMC guidance and the law.[78]** Ironically, as Professor John Middleton has pointed out, this situation could actually end up exposing health professionals to the "risk of litigation".[79]

Prevent e-learning image advising health workers NOT to speak to the patient about their concern

8.3. The data & the damage done

In October 2019, a Freedom of Information request by campaign group Liberty revealed that **all Prevent referrals are entered onto a police database called the Prevent Case Management Tracker,[80] and are reportedly held for seven years.[81]** Leaked counter-terrorism police documents also made clear that public sector workers such as doctors who contact Prevent staff for advice (as counselled to do by the mantra "NOTICE / CHECK / SHARE") could unwittingly be triggering a Prevent referral that would be entered onto this database.[82] While only a handful of research participants explicitly raised concerns about this, **the implications of Prevent data retention and sharing practices are considerable.[83]**

Firstly, it is important to emphasise that many if not most **Prevent subjects may not know their names have been added to a police database**, despite having committed no crime. This makes it impossible to challenge their inclusion on the list. Secondly, **once in the system, this data can end up in a number of places.[84]** The database reportedly "cannot be searched for DBS checks"[85] and "would not be shared with future employers".[86] However, Medact has established through a Freedom of Information request to the Home Office that a small number of Prevent referrals (less than 10 in 2017/18) are flagged to immigration enforcement agencies, potentially leading to detention and/or deportation of the individuals concerned. Through another FOI, we discovered that a number of further education and higher education establishments in Manchester and Salford had discussed and drafted a data sharing policy which would allow colleges to inform universities about any new students with a Prevent history.[87] It has also been reported by *The Times* that **Channel mentors "routinely" share information on their mentees with the police,** with one senior Home Office official telling the newspaper: "Channel is there to deradicalise and safeguard people from extremism, not serve as a tool for intelligence gathering to advance police investigations into people who we claim to be helping...These conversations are supposed to be confidential. That is not how the programme should be functioning. It's completely underhand."[88]

> **"** *The impact on trust in the medical profession is a major issue of concern for many health workers*

All this fatally undermines the claim that Prevent is "voluntary" and "supportive".[89] It would be difficult to argue that inclusion on a police database and potential detention, deportation or prosecution are forms of safeguarding in the interests of the individual in question. It is also worth noting that in order to share Prevent data, the NHS can rely upon a crime prevention exemption to the Data Protection Act (section 29), as opposed to any safeguarding justification.[90]

The impact on trust in the medical profession is a major issue of concern for many health workers. For context, a 2017 Ipsos Mori poll put nurses as the most trusted professionals in the UK with doctors a close second.[91] As one participant put it, "the health profession are the only people that can tell you to drop your trousers and you will drop your trousers...this is how much trust and faith we have".[92] Even though most of our research participants did not feel their relationship with patients had changed as a result of Prevent, **the majority feared that this trust, seen as the "bedrock of our relationship with patients",[93] could (as others have argued) be seriously eroded.[94]** The case studies discussed earlier in the chapter document individual instances of the destructive impact of Prevent on trusting therapeutic relationships. **Many health workers are also concerned about a possible broader "chilling effect" felt far beyond those actually referred to Prevent.** They expressed the concern that Prevent could affect health professionals' reputation[95] and they could "lose credibility".[96] Some asserted the belief that Prevent "has the potential to destroy" the fiduciary "nurse-patient relationship"[97] or ""doctor/patient relationship".[98] Despite formerly serving as an army doctor, RCGP's Dr Jonathan Leach stated that he did not see himself as "an arm of the government"[99], while another drew parallels with the government's "hostile environment" policy in the NHS, known to have deterred undocumented migrants from accessing healthcare.[100] A legal academic voiced the view that Prevent could engender a "corruption of the relationship between the healthcare professional and the patient and the healthcare professional and the state".[101] As the previous chapter noted, some in the health community also worry that damage inflicted on trust by Prevent could undermine safeguarding efforts.[102]

While practitioners noted the lack of research into how widespread fear of Prevent may be among patients[103], many viewed it as highly likely that at least some could be deterred from seeking healthcare. Importantly, this would not only be to the detriment of both the individual patient,[104] undermining their right to health, but also society as a whole due to the public interest in confidential medical care and the imperatives of public health.[105] Moreover, **participants in both focus groups and interviews believed that any such deterrent effect would be disproportionately affecting already marginalised groups, in particular Muslim communities.[106] As such Prevent would risk exacerbating existing health inequalities.**

Finally, some health workers highlighted the potential for mistrust to be spread amongst colleagues, arguing that Prevent training emphasises "that even doctors can become radicalised" and effectively implies that "you have to be suspicious of everyone".[107]

8.4. A policy reliant on confusion

This chapter has argued that if Prevent is a form of safeguarding, as the government says, then there are only two circumstances in which a referral would not constitute a breach of confidentiality. These are, firstly, a referral with the patient's informed consent, or secondly, a referral in the best interests of a patient who lacked capacity. Critically, even "vulnerable" patients, if they retain *capacity*, should be asked for their consent. **We have argued that a non-consensual Prevent referral can never rely on a public interest justification, that the two are incompatible.** This is because health workers already have a duty to call police in the event of an immediate risk of serious harm whereas Prevent's pre-crime approach is not designed to respond to immediate threats. However, **there appears to be widespread confusion in the health community around the complex and nuanced question of consent, with regard to Prevent.** For example, some health workers believe referrals can be made in the public interest and thus do not believe consent should be sought. Others believe it should be — but doubt that informed consent is either possible or realistic in practice. **In most case studies in this report, consent was not sought,** which supports this latter view.

Even though the Prevent duty has not technically changed the exceptional circumstances in which breaches of confidentiality are permissible, in practice it seems to have circumvented normal confidentiality expectations via the backdoor.[108] This appears to be happening in large part because of misleading **Prevent training materials which strongly emphasise the importance of disclosure while consistently offering opt-out clauses** with regard to consent, sometimes even directly implying it should not be sought. Indeed, **the Prevent policy seems to rely on perceived "grey areas" and a lack of clarity about consent, conflation of safeguarding with public protection and a critical failure to distinguish between "vulnerable" patients and patients lacking capacity.** Though health workers do not wish to be a surveillance mechanism, Prevent training helps to inculcate the fear that they could be held individually responsible for failing to refer. As a consequence, **confidentiality is sometimes overridden even when this puts health workers squarely in breach of their professional obligations, GMC guidance and the law.**

The fact that all Prevent referral data is recorded on a police database, which in some cases leads to detention, deportation or prosecution, **undermines the government's claims that it is "voluntary" and "supportive".** Moreover, as well as having a detrimental effect on fiduciary patient-health worker relationships in individual cases, **there is deep concern that a broader erosion of trust could deter some people from seeking healthcare, particularly already-marginalised groups — meaning Prevent could risk exacerbating existing health inequalities.** Finally, some health workers feel the strain put on confidentiality by Prevent could undermine safeguarding efforts and spread mistrust among staff.

Conclusions & recommendations

In theory, both medicine and counter-terrorism seek to preserve human life and keep people safe, but they do so using very different logics. The blurring of the two contrasting approaches raises serious questions, both professional and ethical.

The UK is the only country in the world where healthcare bodies are legally obliged to be vigilant for potential terrorists; yet there remains no evidence that the mandatory Prevent duty is effective in reducing terrorism. Conversely, this report adds to evidence of its detrimental impacts. It makes visible some of the hidden harms of Prevent in healthcare, which usually remain unseen. It shows that for huge numbers of the "false positive" cases referred each year, being reported to Prevent can be a significantly traumatising experience.[1]

The case studies in this report suggest multiple direct and indirect ways in which Prevent can harm the physical and mental health of individuals and their families. Damage inflicted on fiduciary and therapeutic relationships can set back recovery, interrupt care, cause patients to disengage or limit the support which health services are able to provide. **Some evidence suggests Prevent can even be a trigger for the onset of mental health problems in individuals with no prior psychiatric history.**

Prevent training materials conflate safeguarding with public protection and fail to make the critical distinction between "vulnerable" patients and patients lacking capacity. They strongly emphasise disclosure of information while apparently discouraging or disclaiming the importance of consent-seeking and imply that non-consensual Prevent referrals may be justifiable in the public interest — inaccurately so, given that Prevent does not deal with immediate risk. As a result, there is confusion among health workers about how Prevent sits within confidentiality expectations. **This leads to Prevent referrals without patient consent, even when this breaches professional obligations, medical guidance and the law.**

In the absence of reliable predictive criteria, Prevent training also encourages health workers to rely on "instinct". The huge variation in Prevent referral rates and "false positive" versus Channel intervention rates across NHS Trusts speaks to the degree of subjectivity involved in operationalising vague radicalisation risk criteria. Moreover, **training materials which explicitly and implicitly focus attention on ethnic minorities imbue racial bias into the very tools used to assess radicalisation potential, effectively weaponising unconscious bias**.

Unsurprisingly, therefore, **the negative impacts of Prevent — including health and mental health harms and breaches of confidentiality — are disproportionately felt by certain ethnic and religious groups** who are over-represented in Prevent referral statistics. Specifically, in the NHS Trusts we analysed, **Asians were referred four times more than non-Asians, and Muslims eight times more than non-Muslims.**[2] Children and young people, and people with mental health conditions, are also disproportionately referred. For individuals who exist at the intersection of these ethnic, religious, age and mental health identity markers, the discrimination that this amounts to may be compounded.

Although the government continues to premise the policy in part on the stigmatising claim that people with mental health conditions are more likely to be drawn into terrorism, this

> " *The evidence raises the disturbing possibility that Prevent may actually harm the vulnerable, rather than "safeguard" them*

assertion is not supported by robust evidence and risks pathologising a political problem. The expansion of **the secretive Vulnerability Support Hubs scheme**, embedding NHS mental health professionals into a counter-terrorism police-led project, **raises particularly acute ethical concerns** about the securitisation of healthcare.

In sum, the evidence raises the disturbing possibility that Prevent may actually harm the vulnerable, rather than "safeguard" them. We therefore conclude that "safeguarding" is a misnomer for Prevent. Despite its claims to be "a supportive practice", very few health workers believe Prevent offers anything beneficial to patients but many are concerned the policy could contribute to a broader erosion of trust. **Due to the uneven impacts of Prevent's documented harms, and the possibility of a broader deterrent effect, we conclude that the policy risks exacerbating existing health inequalities.**

The evidence underlying the Prevent policy — which some experts argue may actually be counter-productive[3] — is negligible and the policy is long overdue independent evaluation. Although police have asserted that Prevent represents a "public health approach",[4] it in fact merely outsources policing responsibilities onto health workers and others via a damaging "whole society" approach to counter-terrorism which securitises healthcare and other sectors.[5] **As the covid-19 pandemic has reminded us, at a tragic cost, we need a far more holistic understanding of "security" than the one underpinning policies like Prevent.[6] The so-called "public health turn" in "second wave" countering violent extremism literature often profoundly misunderstands the essence of public health.[7]**

Real public health initiatives adopt a preventive approach but are pre-eminently concerned with doing so by creating conditions which protect the health of whole populations, not by targeting individual patients. They address

> " *The Prevent policy risks exacerbating existing health inequalities*

root causes, not symptoms, and therefore often seek to address social and economic structures as fundamental determinants of health. Public health approaches concern themselves with inequality and exclusion, promoting equity and accessibility instead.[8] Work moving in this direction to date is welcome but remains mired in counter-terrorism orthodoxies and does not go far enough in adopting an alternative, non-discriminatory, transformative agenda.[9] More radical proposals are urgently required.[10] The long term solutions which public health can offer may have little appeal for politicians seeking quick fixes but they are, ultimately, most likely to be effective.

Recommendations

To Government and the Independent Reviewer of Prevent:

1. **Repeal the Prevent policy in healthcare.** The absence of evidence showing Prevent to be effective undermines any argument that the significant harms, documented in our research and elsewhere, may be a "price worth paying".

   - Counter-terrorism efforts should restore their focus on combating violence instead of vague concepts like "extremism", while healthcare and safeguarding should be ring-fenced from counter-terrorism.

   - Police should delete all data derived from healthcare stored on the national Prevent Case Management Tracker database.

2. **Adopt a spectrum of evidence-based public health policies based on a holistic understanding of security, which address broader, long-term, interconnected determinants of violence.**

   - Drastically reducing inequality through employment, welfare, housing, education and health policies — services to which many Prevent cases end up being referred — would begin to address key underlying causes of violence in society.

   - Providing urgently needed funding for mental health services, youth services, and drug and alcohol dependency services are examples of more ethical, proportionate and effective allocations of funding.

3. **Take steps to address the harms caused by Prevent.** Measures to rebuild trust in confidential, non-discriminatory healthcare services, especially among the most impacted groups, should include:

   - Withdrawing stigmatising claims about a link between mental health conditions and terrorism.

   - Supporting NHS staff to receive equalities training.

4. **End lack of transparency and accountability,** including by immediately publishing:

   - Historic data on the religion and ethnicity of people referred under Prevent (which should be assessed in light of public sector equality duties under the Equality Act 2010).

   - Historic data on the proportion of non-consensual Prevent referrals.

   - Evidence on the efficacy or otherwise of Prevent, including the unpublished Behavioural Insights Team study of 33 deradicalisation programmes.

   - The evidence underpinning the Extremism Risk Guidance 22+ factors used as potential indicators of radicalisation and other data relating to these criteria.

   - The evaluation of the "Vulnerability Support Hubs" project into counter-terrorism and mental health.

To health bodies including Royal Colleges:

1. **All health bodies should call on Government to repeal the Prevent policy in healthcare** and ringfence the health sector from involvement in counter-terrorism.

   - Royal Colleges and the BMA should consider submitting evidence to the Independent Review of Prevent to this end.

2. **Until Prevent in healthcare is repealed, the GMC and other health bodies should strengthen their guidance around confidentiality and consent, clarifying that Prevent is incompatible with public interest disclosure**.

   - Healthcare bodies should urgently request that government and NHS Prevent teams publish data on the proportion of historic Prevent referrals which were non-consensual.

3. **NHS Trusts should conduct their own equality impact assessments.**

   - Particular attention should be paid to the disproportionate impact of Prevent referrals on Muslims, BAME groups, people with mental health conditions, and children and young people.

4. **Mental health specialists should continue to challenge the government's claims and policies.**

   - The evidence that people with mental health conditions are more likely to be involved in terrorism is very weak and risks exacerbating stigma and causing people to be disproportionately referred.

   - The "Vulnerability Support Hubs" project risks bringing vulnerable people experiencing mental health crises into potentially harmful contact with police.

To researchers and funding bodies:

1. **Conduct research into the physical and mental health impacts of Prevent referral.**

   - This is a chronically under-studied area in which further evidence is urgently needed.

   - Particular attention should be paid to people with mental health conditions, Muslims, BAME groups, and children and young people.

   - Research, especially among these communities most impacted, should also seek to ascertain the extent of any deterrent effect exerted by Prevent, and any knock-on impact on access to healthcare and health inequalities.

2. **Conduct research into real public health alternatives to Prevent.**

   - These alternatives should adopt "proportionate universalism" as an approach, rather than focusing on individuals, avoid pathologisation and discrimination, and draw on existing work on effective public health violence-reduction strategies.

   - Make the case for approaches which understand security holistically and reduce extremism as a by-product of a more wholesale, systemic transformation of society based on equity and justice.

3. **Make funding available for more research on Prevent and similar issues.**

   - Funders including the National Institute for Health Research, the Medical Research Council, Public Health England — as part of its health justice and inequalities work — and academic institutions should prioritise provision of funding for research on Prevent and other areas related to racialised health inequalities.

Appendix 1. Prevent data collection form, NHS Strategic Data Collection Service (Source: NHS Digital)

NATIONAL PREVENT DUTY DATA SET

Please ensure all yellow fields are completed

#			Input data:
	Organisational Information		
1	Organisation	0	
2	Organisational Lead		
3	Prevent Lead		
4	Total number of current employees and volunteers		
	Workshop to Raise Awareness of Prevent (WRAP)		
5	Total number of staff and volunteers that your organisation has assessed as requiring to be in date with Prevent Training for Staff at Level 3 or above (to comply with the Prevent Duty)		
6	Total number of staff and volunteers in the organisation who have attended **WRAP or an approved eLearning Package for Prevent Training for Staff at Level 3 or above** this quarter		
	Of these, please indicate the number of staff and volunteers receiving WRAP training **this quarter** by:		
6a		a. MH E-learning	
6b		b. Generic Health E-Learning	
7	Total number of staff and volunteers in your organisation that are **currently** in date with **Prevent Training for Staff at Level 3 or above** (of those who require Prevent Training for Staff at Level 3 or above to comply with the Prevent Duty).		
7b	Percentage of staff and volunteers **currently** in your organisation that are currently in date with **Prevent Training for Staff at Level 3 or above** (of those who require WRAP)	#DIV/0!	
8	Number of **WRAP** sessions provided this quarter		
9	How does your organisation deliver **Prevent Training for Staff at Level 3 or above refresher inputs** for all relevant staff and volunteers?		
	Basic Prevent Awareness Training (BPAT)		
10	Total number of staff and volunteers that your organisation has assessed as requiring to be in date with BPAT (to comply with the Prevent Duty)		
11	Total number of staff and volunteers in your organisation that have received **BPAT** this quarter		
12	Total number of staff and volunteers in your organisation that are **currently** in date with BPAT (of those who require BPAT to comply with the Prevent Duty)		
12b	Percentage of staff and volunteers **currently** in your organisation that are currently in date with **BPAT** (of those who require BPAT)	#DIV/0!	
13	How does your organisation deliver **BPAT** to staff and volunteers who require it?		
14	How is refresher training delivered for **BPAT**		
	Prevent Policy and Referrals Information		
15	Do your organisational systems allow staff to record data relating to referrals appropriately and in line with organisational policy?		
16	Total number of Prevent related **general enquiries** received by your Prevent Lead this quarter		
17	Number of referrals made to your Prevent Lead for assessment and consideration this quarter		
18	Number of referrals made from your Prevent Lead to the Channel Coordinator this quarter		
19	Number of individual referral cases for which your organisation has been requested to provide information either during their assessment for Channel during their management by the Channel Panel during this quarter		
20	Please indicate the number of information sharing requests that have not been fulfilled this quarter (by the reason the information was withheld) **(Fill in zeros for each reason if no cases)**:		*Number of information sharing requests not fulfilled:*
		a. The request was made too close to the required deadline date for us to reasonably be able to respond	
		b. Did not have the capacity to support the request in the time period	
		c. Not sent due to information sharing concerns	
		d. Other	
21	Does your organisation have links to the Channel panel?		
22	Does your organisation send a representative to the Channel Panel?		
23	Do representatives from your organisation attend any of the following Prevent Related meetings:		*Select Yes or No for each meeting:*
		a. Channel Panel	
		b. Regional Prevent Forum	
		c. Local Prevent meetings	
		d. Community safety partnerships	
		e. Contest Board	
		f. EPRR	
		g. Other	
24	Is your Prevent policy a stand-alone or is it integrated into your Safeguarding policies?		
25	When was the Prevent Policy last reviewed?		
26	Does your organisation have a Prevent Delivery Plan?		
27	Is your Prevent Plan compliant with the Self-Assessment Tool provided by the Building Partnership Staying Safe Guidance?		
	This sections needs to be completed by Mental Health Trusts ONLY		
28	(MH Trusts only) Number of referrals received by the Prevent Lead from the Channel Panel/police, citing a potential MH need that could be relevant to their vulnerability and therefore need an assessment		
29	(MH Trusts only) Of the number of referrals that were received, what number were offered an assessment within 1 week?		
30	(MH Trusts only) Of the number of referrals that were received, what number resulted in a diagnosis/confirmation that there is a relevant MH issue prevalent?		

APPENDIX 2. EXCERPT FROM HEALTH REGIONAL PREVENT COORDINATOR REPORTING FORM TO DHSC (SOURCE: NHS ENGLAND)

Reporting period	
Name(s)	
Region	

Number of organisations in the region		Total number	# Priority areas	# Non priority areas	Comments/Examples
	Acute				
	Community Provider				
	Mental Health				
	Ambulance				

The following should be completed each month/ quarter and should not represent the sum of all work

				Total number	# Priority areas	# Non priority areas	Comments/Examples
1	Coordination of local delivery	1.1	Number of trusts/organisations in region engaged with in capacity **beyond** training e.g events/presentations				
		1.2	Number of engagements/inputs with Counter Terrorism Local Profiles				
		1.3	Number of trusts/organisations directly supported with WRAP (or equivalent level) training				
2	Partnership working	2.1	Number of engagements/cross-sector Prevent meetings attended with other Prevent Leads or RPCs				
3	Monitoring and escalation	3.1	Number of organisations requiring enhanced support with implementation of Prevent duty requirements. Please outline what support has been given (e.g. use of Prevent toolkit)				
4	Implementation of national workplan (also noted in the Quarterly Progress column in the Helath workplan document)	4.1	Strategic area of responsibility				
		4.2	Primary objective in this area of the quarter				
		4.3	Achievements in this area				
		4.4	Issues related to this which require escalation (please note the provider and give rationale for escalation)				
5	Reporting	5.1	Number of Forums hosted in this quarter				
		5.2	Number of Safeguarding conferences				
		5.3	Number of times asked to provide information for DHSC/HO (to be copied to Kenny Gibson - 5 day response)				

				Comment			
6	Reflective Practise	6.1	Instances where RPC's interaction with a local service/ provider has positively impacted the perception of Prevent				
		6.2	Instances where Prevent myths have been rebutted (e.g. those referred are put onto a watch list/ Prevent is about spying on patients). Please give details of the myth/ issue and your response				
		6.3	Other issues which require flagging				
		6.4	How do Prevent referrals data compare to Domestic Violence/ Modern Slavery referrals?				

Strategic Area	Lead RPC
Assurance and information sharing	xxxxx
Channel	xxxxx
Communications	
Mental health + VS Hubs	xxxxx
Primary care	xxxxx
Training	xxxxx

Region
London
North
South
Mids and East

Appendix 3. Calculating disproportionality ratios for race and religion

Data from Freedom of Information requests was analysed to calculate Disproportionality Ratios for Prevent referrals of Asians vs Non-Asians and Muslims vs Non-Muslims across a number of NHS trusts.

Of 77 trusts to which we submitted FOI requests, 10 trusts returned data with respect to ethnicity and religion. Our analysis of ethnicity is limited to 9 of these trusts (since we excluded one because all its referrals were of "unknown" ethnicity). Our analysis of religion is limited to 6 of these trusts since we excluded four either because either because all their referrals were of "unknown" faith or because they told us they do not record religious affiliation data of total admissions to use as our population base rate.

The disproportionality ratio is in effect a risk ratio, indicating the number of times more likely someone of Asian ethnicity or Muslim faith was to be referred compared to the rest of the population.

This is calculated as follows:

Disproportionality Ratio for Asian Referrals = (# of referrals of Asians / # of Asians in the overall population) / (# referrals of non-Asians / # of non-Asians in the overall population) = (# Asian referrals / # non-Asian referrals) / (# of Asians in the overall population / # non-Asians in the overall population)

and equivalently for Muslims

We used patient admissions data for the trusts in question for the corresponding period to provide figures for the "population" at risk of being referred.

The overall Disproportionality Ratio for Asian:non-Asian referrals across 9 trusts observed in the data was 4.

The overall Disproportionality Ratio for Muslims:non-Muslims referrals across 6 trusts observed in the data was 8.

Disproportionality Ratio calculations for race

Trust	ADMISSIONS 2017-19				REFERRALS 2017-19				ASSUME UNKN. NON-ASIAN		EXCLUDING UNKNOWNS	
	TOTAL	ASIAN	NON-ASIAN	RATIO	TOTAL	ASIAN	NON-ASIAN	ETHN. UNKN.	REFERRAL RATIO	D.R.	REFERRAL RATIO	D.R.
Bradford Teaching Hosp	271144	79215	191929	0.41	1	1	0	0	∞	∞	∞	∞
Brum & Solihull MH	4472	739	3733	0.20	66	29	30	7	0.78	**3.96**	0.97	4.88
Brum Wo. & Childrens	89304	27030	62274	0.43	4	3	0	1	3.00	**6.91**	∞	∞
Luton & Dunstable	230596	36313	194283	0.19	6	2	2	2	0.50	**2.68**	1.00	5.35
Notts Uni Hosp	441146	19469	421677	0.05	1	1	0	0	∞	∞	∞	∞
Rotherham	144858	3407	141451	0.02	2	2	0	0	∞	∞	∞	∞
Sandwell & West Brum	222771	55496	167275	0.33	4	1	3	0	0.33	**1.00**	0.33	1.00
Essex Partnership	12772	226	12546	0.02	8	2	5	1	0.33	**18.50**	0.40	22.21
Tameside & Glossop	107171	5933	101238	0.06	7	1	4	2	0.17	**2.84**	0.25	4.27
TOTAL	**1524234**	**227828**	**1296406**	**0.18**	**99**	**42**	**44**	**13**	**0.74**	**4.19**	**0.95**	**5.43**
									SE(logRR)	0.2157		0.2157
									lower bound (95% confidence)	2.9		3.8

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Disproportionality Ratio calculations for religion

Trust	ADMISSIONS 2017-19				REFERRALS 2017-19				ASSUMING ALL UNKNOWNS NON-MUSLIM		EXCLUDING UNKNOWNS	
	TOTAL	MUSLIM	NON-MUSLIM	RATIO	TOTAL	MUSLIM	NON-MUSLIM	RELIG. UNKN.	REFERRAL RATIO	D.R.	REFERRAL RATIO	D.R.
Brum & Solihull MH	4472	407	4065	0.10	66	25	13	28	0.61	**6.09**	1.92	19.21
Luton & Dunstable	230596	28363	202233	0.14	6	3	1	2	1.00	**7.13**	3.00	21.39
Notts Uni Hosp	441146	7247	433899	0.02	1	1	0	0	∞	**∞**	∞	∞
Sandwell & West Brum	222771	28691	194080	0.15	4	1	0	3	0.33	**2.25**	∞	∞
Essex Partnership	12772	86	12686	0.01	8	3	5	0	0.60	**88.51**	0.60	88.51
Tameside & Glossop	107171	2477	104694	0.02	7	1	0	6	0.17	**7.04**	∞	∞
TOTAL	**1018928**	**67271**	**951657**	**0.07**	**92**	**34**	**19**	**39**	**0.59**	**8.29**	**1.79**	**25.31**
								SE(logRR)		0.286		0.286
								lower bound (95% confidence)		5.2		15.8

Notes

Referral data breakdowns for some trusts contained not-insignificant numbers marked "unknown". Where this is the case, we have made the very conservative assumption that all unknowns were non-Asian or non-Muslim. Excluding unknowns from the analysis yielded higher Disproportionality Ratio figures of 5 for Asian:non-Asian referrals and 25 for Muslim:non-Muslim referrals (as the final two pale grey columns show).

Assuming log(DR) is normally distributed with Standard Error sqrt(1 / # target group referrals + 1 / # non-target group referrals – 1 / # group admission – 1 / # non-target group admission) yields a 95% confidence interval on these RDRs of at least 2.9 and 5.2 respectively, indicating a statistically significant result.[1]

The trend of disproportionality is consistent across all trusts, with the exception of Sandwell & West Birmingham's figures for Asian:non-Asian referrals.

A Cochran–Mantel–Haenszel test for risk ratios stratified by trust returned comparable overall risk ratio, ruling out trust as a possible confounder. We were not however able to gauge the effect of any other potential confounding variables — such as age — using the data available to us.

While the referral numbers in these calculations are small, and a larger study would be preferable, these figures are consistent with qualitative evidence suggesting disproportionate targeting of these groups in the referral process.

APPENDIX 4. EAST AND NORTH HERTFORDSHIRE CLINICAL COMMISSION GROUP CHANNEL REFERRAL FORM[2] (OUR HIGHLIGHTS)

CONFIDENTIAL (When Completed)
NOT PROTECTIVELY MARKED

CHANNEL REFERRAL FORM

Name of Subject:		DOB:
Guardian:		Relationship:
Ethnicity:	Place of Birth:	Religion:
Address		Referral Date
Telephone number		
Author	Organisation	
Contact Details		

This form is to help you refer concerns to CHANNEL, regarding an individual who may be vulnerable to being drawn into terrorism. On the reverse are questions which may assist in helping you quantify and structure your concerns in order to better record them below. They are intended as a guide to help communicate your professional judgement about what has led you to make this referral. Completed forms should be sent to the Channel team.

What is the behaviour / occurrence that has led you to make this referral

Assessment	Comment / Evidence
Faith / Ideology	
Personal / emotional & Social	
Risk / Protective factors	

Please forward completed forms to the PREVENT team at prevent@herts.pnn.police.uk
Please substitute @herts with @bedfordshire @cambs @essex @suffolk or @norfolk as required.
NOT PROTECTIVELY MARKED when incomplete

Desire for change	

From what you know of the referral:

Faith / ideology

Are they new to a particular faith / faith strand? What was the context of their conversion?

Do they seem to have naïve, narrow or limited religious / political knowledge?

Are there concerns about a highly inconsistent vocalisation / practicing of their faith?

Have there been sudden changes in their observance, behaviour, interaction or attendance at their place of worship / organised meeting?

Have there been specific examples or is there an undertone of " Them and Us " language or violent rhetoric being used or behaviour occurring?

Is there evidence of increasing association with a closed tight knit group of individuals / known recruiters / extremists / restricted events?

Are there particular grievances either personal or global that appear to be unresolved / festering?

Has there been an increase in unusual or sudden travel abroad without satisfactory explanation?

Personal / emotional / social issues

Are there concerns over conflict with their families regarding religious beliefs / lifestyle choices?

Is there evidence of cultural anxiety and / or isolation linked to insularity / lack of integration?

Is there evidence of increasing isolation from family, friends or groups towards a smaller group of individuals or a known location?

Is there history in petty criminality and / or unusual hedonistic behaviour (alcohol/drug use, casual sexual relationships, and addictive behaviours)?

Have they got / had extremist propaganda materials (DVD's, CD's, leaflets etc.) in their possession?

Do they associate with negative / criminal peers or known groups of concern?

Are there concerns regarding their emotional stability and or mental health?

Is there evidence of participation in survivalist / combat simulation activities, e.g. paint balling?

Risk / Protective Factors

What are the specific factors which are contributing towards making the referral more vulnerable to radicalisation by others or moving towards violent extremism? E.g; mental health, language barriers, cultural anxiety, impressionability, criminality, specific grievance etc.

Is there any evidence of others targeting or exploiting these vulnerabilities or risks?

What factors are there already in place or could be developed to firm up support for the referral or help them increase their resilience to negative influences? E.g. positive family ties, employment, mentor / agency input etc.

Desire for change

Do they have the ability to change with / without support? Why / Why not?

How motivated are they to make steps towards changing their attitudes and behaviour?

How sustainable do you think their motivation / desire is?

Please forward completed forms to the PREVENT team at prevent@herts.pnn.police.uk
Please substitute @herts with @bedfordshire @cambs @essex @suffolk or @norfolk as required.
NOT PROTECTIVELY MARKED when incomplete

Notes & references

Chapter 1. Introduction & context

1   The other three strands of CONTEST are Pursue (stopping terrorist attacks happening in the UK and overseas), Protect (strengthen protection against a terrorist attack in the UK or overseas) and Prepare (mitigate the impact of a terrorist incident if it occurs).

2   "Reality Check: What is the Prevent strategy?", BBC News, 4 June 2017, https://www.bbc.co.uk/news/election-2017-40151991.

3   HM Government, "Prevent Strategy", June 2011, 7, https://assets.publishing. service.gov.uk/government/uploads/system/uploads/attachment_data/ file/97976/prevent-strategy-review.pdf.

4   McCulloch, Jude and Sharon Pickering (2014) "Pre-crime and counter-terrorism: imagining future crime in the 'war on terror'", British Journal of Criminology, 49(5): 628–645.

5   Goldberg, David, Sushrut Jadhav and Tarek Younis (2017) "Prevent: what is pre-criminal space?", BJPsych bulletin, 41(4): 208-211.

6   Home Office, "Factsheet: Prevent and Channel", 5 November 2019, https://homeofficemedia.blog.gov.uk/2019/11/05/factsheet-prevent-and-channel.

7   Ibid.

8   More recently, the government has begun rolling out Prevent training in the private sector, with corporations like Tesco and McDonald's taking part (Helen Warrell, "Police enlist companies to spot extremism in workers", Financial Times, 20 March 2019, https://www.ft.com/content/45db1d3c-4a64-11e9-bbc9-6917dce3dc62). Complementing this expansion into unchartered sectors of society, all UK citizens have been encouraged to take a counter-terrorism training modeule which has been made available for free online (Charles Hymas, "Free counter-terrorism training offered online by police to all Britons in run-up to Christmas", The Telegraph, 8 December 2019, https://www.telegraph.co.uk/news/2019/12/08/free-counter-terrorism-training-offered-online-police-britons.)

9   The existence of the "3Ms" test serves as an implicit procedural acknowledgement of the likelihood of false positive referrals. For more on the 3Ms test, see: https://www.elearning.prevent.homeoffice.gov.uk/prevent_referrals/04-the-3ms.html#.

10   In Scotland, the equivalent to the Channel programme implemented in England and Wales is called the Prevent Professional Concerns programme .

11   Jamie Grierson, "Counter-terror police running secret Prevent database", Guardian, 6 October 2019, https://www.theguardian.com/uk-news/2019/ oct/06/counter-terror-police-are-running-secret-prevent-database.

12   NHS England, "Guidance for mental health services in exercising duties to safeguard people from the risk of radicalisation", November 2017, 17, https:// www.england.nhs.uk/wp-content/uploads/2017/11/prevent-mental-health-guidance.pdf.

13   Home Office, "Factsheet: Prevent and Channel".

14   Interview with retired consultant psychiatrist and MEND CEO Dr Shazad Amin, 29 August 2019.

15   Catrin Nye, "The man who is being deradicalised", BBC News, 1 September 2015, https://www.bbc.co.uk/news/uk-34073367.

16   Home Office, "Factsheet: Prevent and Channel".

17   Ibid.

18   Kundnani, Arun, and Ben Hayes (2018) The Globalisation of Countering Violent Extremism policies, Amsterdam: Transnational Institute.

19   Ex-Security Minister Ben Wallace, asked in 2019 about the evidence base for Prevent, said "I think my evidence base is that I do believe it is working". (Helen Warrell, "Inside Prevent, the UK's controversial anti-terrorism programme", Financial Times, 24 January 2019, https://www.ft.com/content/a82e18b4-1ea3-11e9-b126-46fc3ad87c65).

20   Sedgwick, Mark (2010) "The Concept of Radicalization as a Source of Confusion", Terrorism and Political Violence, 4(22): 479-494.

21   Lloyd, Monica, and Christopher Dean (2015), "The Development of Structured Guidelines for Assessing Risk in Extremist Offenders", Journal of Threat Assessment and Management, 2(1): 40–52; Scarcella, Akimi, Ruairi Page and Vivek Furtado (2016), "Terrorism, radicalisation, extremism, authoritarianism and fundamentalism: a systematic review of the quality and psychometric properties of assessments," PloS One 11(12); Qureshi, Asim, (2016) The 'Science of Pre-Crime': The Secret 'Radicalisation' Study Underpinning Prevent, London: CAGE.

22   Lloyd, and Dean, "The Development of Structured Guidelines".

23   Scarcella et al., "Terrorism, radicalisation, extremism".

24   Royal College of Psychiatrists, "Counter-terrorism and Psychiatry: Position statement PS04/16", September 2016, 7, https://www.rcpsych.ac.uk/pdf/ PS04_16.pdf.

25   Special rapporteur on the promotion and protection of human rights and fundamental freedoms while countering terrorism (2020) Human rights impact of policies and practices aimed at preventing and countering violent extremism, United Nations Human Rights Council, A/HRC/43/46, 8, https:// documents-dds-ny.un.org/doc/UNDOC/GEN/G20/045/67/PDF/G2004567. pdf?OpenElement.

26   Home Office, "Individuals referred to and supported through the Prevent programme, England and Wales, April 2018 to March 2019", 19 December 2019, 7, https://assets.publishing.service.gov.uk/government/uploads/system/ uploads/attachment_data/file/853646/individuals-referred-supported-prevent-programme-apr2018-mar2019-hosb3219.pdf.

27   Ian Acheson, "Prevent let the Parsons Green bomber through the net. That can't happen again", Guardian, 28 March 2018, https://www.theguardian. com/commentisfree/2018/mar/28/prevent-parsons-green-bomber-counter-terrorism.

28   Dean said: "I think we have to be very careful about ever saying that somebody no longer presents a risk of committing an offence. I don't think you can ever be sure. We have to be very careful about saying someone has totally changed or has been cured." (Dominic Casciani, "Top psychologist: No certainty terror offenders can be 'cured'", BBC News, 2 January 2020, https://www.bbc.co.uk/ news/uk-50967100.)

29   Danny Shaw, "London Bridge: Usman Khan completed untested rehabilitation scheme — Analysis", BBC News, 4 December 2019, https://www.bbc.co.uk/ news/uk-50653191.

30   Usman Khan, who killed two people in the London Bridge attack, had completed the "Healthy Identity Intervention Programme" in prison and following his release, participated in the Desistance and Disengagement Programme ("London Bridge: Usman Khan completed untested rehabilitation scheme", BBC News, 4 December 2019, https://www.bbc.co.uk/news/uk-50653191).

31   Lloyd, and Dean, "The Development of Structured Guidelines"; Qureshi, The 'Science of Pre-Crime'.

32   Ian Cobain, "UK government to extend legally binding deadline on Prevent review to August 2021", Middle East Eye, 20 May 2020, https://www. middleeasteye.net/news/uk-government-extend-legally-binding-deadline-prevent-review-august-2021.

33   Home Office, "Revised Prevent duty guidance: for England and Wales", 10 April 2019, https://www.gov.uk/government/publications/prevent-duty-guidance/ revised-prevent-duty-guidance-for-england-and-wales.

34   HM Government, "Prevent Strategy".

35   Kundnani, Arun (2012) "Radicalisation: The journey of a concept", Race & Class, 54(2): 3-25; Kundani, Arun (2015) The Muslims are coming: Islamophobia, extremism and the domestic war on terror, New York: Verso.

36   Hayley Dixon, "Extremism definition fails Clarkson test: Government gave up on laws to fight ideology because it's 'too difficult'", The Telegraph, 6 April 2019, https://www.telegraph.co.uk/news/2019/04/06/government-abandoned-creating-extremism-laws-difficult-former.

37   Commission for Countering Extremism, Challenging Hateful Extremism, October 2019, 26, https://assets.publishing.service.gov.uk/government/ uploads/system/uploads/attachment_data/file/874101/200320_Challenging_ Hateful_Extremism.pdf.

38   HM Government, "Prevent Strategy".

39   Medical staff in the NHS in Scotland were sent this guide as recently as January 2020, by a detective inspector in Police Scotland's counter-terrorism unit (Severin Carrell and Alasdair Clark, "Police Scotland sent out guide listing Extinction Rebellion with neo-Nazis", Guardian, 7 February 2020, https://www. theguardian.com/uk-news/2020/feb/07/police-scotland-sent-out-guide-listing-extinction-rebellion-with-neo-nazis.

40   Vikram Dodd and Jamie Grierson, "Terrorism police list Extinction Rebellion as extremist ideology", Guardian, 10 January 2020, https://www.theguardian. com/uk-news/2020/jan/10/xr-extinction-rebellion-listed-extremist-ideology-police-prevent-scheme-guidance; Basit Mahmood, "Terror police recall guidance listing 'standard Muslim beliefs' as signs of extremism", Metro, 15 January 2020, https://metro.co.uk/2020/01/15/terror-police-recall-guidance-listing-standard-muslim-beliefs-signs-extremism-12062622/?ito=cb; Vikram Dodd and Jamie Grierson, "Greenpeace included with neo-Nazis on UK counter-terror list", Guardian, 17 January 2020, https://www.theguardian.com/ uk-news/2020/jan/17/greenpeace-included-with-neo-nazis-on-uk-counter-terror-list.

41   For example, anti-fracking activists have repeatedly been referred to Prevent. See Mark Townsend and Ian Cobain, "Home Office forced to defend anti-fracking groups from extremism claims", Guardian, 10 December 2016, https:// www.theguardian.com/uk-news/2016/dec/10/home-office-defends-anti-fracking-groups-extremism-claims-prevent and Helen Pidd, "Boy, 14, referred to anti-extremism scheme over fracking activism", Guardian, 30 July 2018, https://www.theguardian.com/world/2018/jul/30/boy-14-referred-to-anti-extremism-scheme-over-fracking-activism.

42   Diane Taylor, "Hospice staff 'trained to report dying patients as part of terror strategy'", Guardian, 22 June 2018, https://www.theguardian.com/uk-news/2018/jun/11/nhs-staff-trained-to-signs-of-radicalisation-in-terminally-ill-says-whistleblower

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46   Ian Cobain, "'This Is Woke': The media outfit that's actually a UK counter-terror programme", Middle East Eye, 15 August 2019, "https://www.middleeasteye.net/news/revealed-woke-media-outfit-thats-actually-uk-counterterror-programme.

47   Kundani, Spooked!; Awan, Imran (2012). "I am a Muslim not an extremist": How the Prevent Strategy has constructed a "suspect" community, Politics & Policy, 40(6): 1158-1185; Breen-Smyth, Marie (2014), "Theorising the 'suspect community': counter-terrorism, security practices and the public imagination", Critical Studies on Terrorism, 7(2): 223-240; Tufyal Choudhury and Helen Fenwick (2011) The impact of counter-terrorism measures on Muslim communities, Manchester: Equality and Human Rights Commission, https://www.equalityhumanrights.com/sites/default/files/research-report-72-the-impact-of-counter-terrorism-measures-on-muslim-communities.pdf; Qurashi, Fahad (2018), "The Prevent strategy and the UK 'war on terror': embedding infrastructures of surveillance in Muslim communities", Palgrave Communications, 4(1), 1-13.

48   Massoumi, Narzanin, Tom Mills and David Miller (Eds.) (2017), What is Islamophobia? Racism, social movements and the state, London: Pluto Press, 11.

49   It was noted in a 2017 report, for example, that the terrorist attack in Paris on 13th November 2015 was "likely to have contributed to" an increase in referrals in the second half of 2015/16 (Home Office, "Individuals referred to and supported through the Prevent programme, England and Wales, April 2015 to March 2016", 9 November 2017, 9, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/853646/individuals-referred-supported-prevent-programme-apr2018-mar2019-hosb3219.pdf.

50   Home Office, "Individuals referred to and supported through the Prevent programme, England and Wales, April 2018 to March 2019", 19 December 2017, 1.

51   Ibid.

52   Ibid, 11. See also: Ben Quinn, "Home Office urged to release leftwing extremism report", Guardian, 10 February 2019, https://www.theguardian.com/world/2019/feb/10/home-office-urged-to-release-leftwing-extremist-report.

53   Wessely, Simon (2007) "When doctors become terrorists", New England Journal of Medicine 357(7); Andrew Alderson, Ben Leach and Duncan Gardham, "Bilal Abdulla: Doctor by day, terrorist by night — the secret life of a new breed of terrorist", The Telegraph, 20 December 2008, https://www.telegraph.co.uk/news/uknews/law-and-order/3867334/Bilal-Abdulla-Doctor-by-day-terrorist-by-night-the-secret-life-of-a-new-breed-of-terrorist.html.

54   UK Parliament (14 November 2018). NHS: Counter-terrorism: Written question — HL11484 https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Lords/2018-11-14/HL11484. We are grateful to Dr Tarek Younis for pointing us to these figures.

55   Paul Wright, "Prevent Strategy: Senior doctor calls for boycott of

government's"'unethical' counter-terrorism programme", International Business Times, 22 February 2016, https://www.ibtimes.co.uk/prevent-strategy-senior-doctor-calls-boycott-governments-unethical-counter-terrorism-1544722.

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57   Service Condition 32, NHS Standard Contract 2017/19 and 2018/19 Service Conditions (Full Length), May 2018 edition.

58   NHS England, "Prevent Training and Competencies Framework", October 2017, 11, https://www.england.nhs.uk/wp-content/uploads/2017/10/prevent-training-competencies-framework-v3.pdf.

59   "Prevent", NHS Digital, 17 February 2020, https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/prevent.

60   "SDCS Prevent Data Set & Explanations 2019", NHS Digital, 21 March 2019, released under Freedom of Information Act; Home Office, "Impact Assessment: Counter-Terrorism and Security Bill — Prevent", 25 November 2014.

61   Email from Paul McCann, 9 August 2019.

62   "Terms of Reference: Prevent Task and FInish Group", NHS England, 27 October 2017, released under Freedom of Information Act. Senior figures from Public Health England, NHS Improvement and the Care Quality Commission are listed as members of the group. See also: "Prevent", NHS England, https://www.england.nhs.uk/safeguarding/workstreams/prevent.

63   HM Government, "Prevent Strategy", 34.

64   The organisation's key lines of inquiry during inspections include "Safety" and Prevent sits under "Safeguarding" within this bracket. Therefore sometimes (though not always) CQC may look at the "effectiveness" with which Prevent is being delivered (Email response to Freedom of Information request from CQC, 11 December 2019).

65   The diagram shows government bodies (blue), health bodies (grey) and police/police-led bodies (brown).

66   Heath-Kelly and Strausz, Counter-terrorism in the NHS, 3.

67   Younis, Tarek and Sushrut Jadhav (2019), "Keeping our mouths shut: the fear and racialized self-censorship of British healthcare professionals in PREVENT training", Culture, Medicine and Psychiatry, 43(3), 404.

68   Younis, Tarek and Sushrut Jadhav (2020), "Islamophobia in the National Health Service: an ethnography of institutional racism in PREVENT's counter-radicalisation policy", Sociology of Health & Illness, 42(3), 610-626.

69   Amrit Singh (2016) Eroding Trust: The UK's Prevent Counter-Extremism Strategy in Health and Education, Open Society Justice Initiative, https://www.justiceinitiative.org/uploads/f87bd3ad-50fb-42d0-95a8-54ba85dce818/eroding-trust-20161017_0.pdf.

70   Ibid, 16.

71   Heath-Kelly and Strausz, Counter-terrorism in the NHS, 3.

72   Ibid.

73   Ibid.

74   Ibid.

75   Singh, Eroding Trust.

76   Singh (2016) Eroding Trust, 72 and 43.

77   Younis and Jadhav, "Keeping our mouths shut", 404-424.

Chapter 2. Methodology

1   These included, for example, Dr Col Glyn Evans — who spoke against a motion criticising Prevent at the British Medical Association 2018 annual conference — and Dr Jonathan Hurlow, a consultant forensic psychiatrist who defended Prevent in the British Medical Journal.

2   These included Leicestershire Prevent Coordinator Sean Arbuthnot, NHS England Prevent Regional Coordinator (London and South) Paul McCann. The latter's colleague, NHS England Prevent Regional Coordinator (North) Chris Stoddart, told Medact: "As stated by my colleague the NHS England/Improvement position is that because NHSE is not accountable for the Prevent policy and given there is currently a national Prevent review, we will not be commenting or being interviewed. We would advise that you engage with the Home Office or DHSC for any further comment."

3   Letter from J. Fanshawe, Home Office, to Dr Hilary Aked, 2 October 2019.

4   Trusts are frequently merging, making it hard to find precise up-to-date figures. One recent source puts the number at 226 acute, mental health, specialist, and community NHS trusts, excluding ambulance trusts (Williams, Matt, Abbie Jordan, Jenny Scott & Mattew Jones (2018) "Operating a patient medicines helpline: A survey study exploring current practice in England using the RE-AIM evaluation framework', BMC Health Services Research, 18(1), 2), while another gives a figure of 239 trusts (Castelli, Adriana, Martin Chalkley, James Gaughan, Maria Lucia Pace, Idaira Rodriguez Santana, "Productivity of the English National Health Service: 2016/17 Update", CHE Research Paper 163, April 2019, 43).

5   Department for Communities and Local Government (2007) Preventing

violent extremism: pathfinder fund 2007/08 Case Studies, Department for Communities and Local Government, 14, http://www.tedcantle.co.uk/publications/022%20Preventing%20violent%20extremism%20pathfinder%20fund%20case%20studie.pdf; Local Government Association (2008) Strategic issues — Preventing Violent Extremism, Local Government Association, 4, https://lga.moderngov.co.uk/Data/LGA%20Leadership%20Board/20080416/Agenda/$Item%202a%20-%20Violent%20(REV).doc.pdf; Home Office (2015) Local Delivery Best Practice Catalogue: Prevent Strategy, Home Office, passim, https://powerbase.info/images/6/61/OSCT-Prevent_catalogue-March_2015.pdf.

6   Department of Health and NHS England, "Process for Responding to Prevent / Extremism Freedom of Information Act Requests", September 2016, https://www.england.nhs.uk/wp-content/uploads/2016/09/prevent-foi-guidance.pdf.

7   For example, Central and North West London NHS Foundation Trust said its response was "based off [sic] advice from the Regional Head of Prevent", Lewisham and Greenwich NHS Trust said it had "advised" by "our Regional Head of Prevent", Southern Health NHS Foundation Trust told us "a view on disclosure has been sought from the NHS Improvement/NHS England Prevent Lead for our region" and South Tees Hospitals NHS Foundation Trust said it had "sought clarification from Home Office". The Whittington Hospital NHS Trust, Stockport NHS Foundation Trust and Pennine Acute Hospitals NHS Trust all stated that "It is Home Office policy and NHS Agreement that any Freedom of Information (FOI) Requests relating to referrals on Prevent and Channel should go to the Central Home Office Unit" and tried to redirect the

request to the Home Office.

8   For example, the Financial Times reports that the Behavioural Insights Team, a company part-owned by the government, studied 33 deradicalisation programmes and found only two to be effective, but the results were never published. As Box 1 in Chapter 5 discusses, nor has any evidence been published in relation to the joint project between counter-terrorism police and the NHS "to assess the value of mental health professionals working alongside counter terrorism police officers" ("Prevent Mental Health / Police Team", European Commission, n.d., https://ec.europa.eu/home-affairs/node/11454_en.)

9   Richard Kerbaj, "Anti-extremism mentors inform on clients to police", Sunday Times, 11 August 2019.

10 Department of Health and NHS England, "Process for Responding to Prevent / Extremism Freedom of Information Act Requests".

11 Email from Jeanette Randall, FOI Officer, Surrey and Sussex Healthcare NHS Trust, 28 June 2019.

12 Email from the FOI Team, Greater Manchester Mental Health NHS Foundation Trust, 18 June 2019.

Chapter 3. Basic statistics: rates, regions & Channel progressions

1   We made the choice to request only two years worth of data in order to avoid time/cost limitations on FOI requests in the Freedom of Information Act (FOIA) 2000.

2   A number of trusts claimed that providing precise referral figures, where these were low, could lead to identification of the individuals concerned and so would only give a range. Where the range cited was "0-5", between 1-5" or "less than 5", these have been counted as 2.5. Where the range cited was <10 these have been counted as 4.5. Numbers cited throughout this report have been rounded to the nearest one.

3   The only exception is West London NHS Trust which had a far higher than average number of referrals (17) in 2017-18 but a lower than average number (3) in 2018-19.

4   "Leading 20 busiest hospitals in England in the period 2018/19, ranked by the number of admissions", Statista, September 2019, https://www.statista.com/statistics/504252/leading-busy-hospitals-ranked-by-number-of-admissions-england-uk.

5   "The use of Mental Health First Aid in supporting people working in the Prevent agenda", Birmingham and Solihull Mental Health NHS Foundation Trust, n.d., https://mhfaengland.org/mhfa-centre/research-and-evaluation/bsmhft-and-counter-terrorism-unit-mhfa-course-feedback/BSMHFT_and_Counter_Terrorism_Unit.pdf.

6   "Groundbreaking pilot project helping vulnerable people to access support", Birmingham and Solihull Mental Health NHS Foundation Trust, 14 October 2016, https://www.bsmhft.nhs.uk/about-us/news/news-archives-2016/ground-breaking-pilot-project-helping-vulnerable-people-to-access-support.

Chapter 4. Racial & religious impact

1   United Nations Office of the High Commissioner for Human Rights, "Confronting the Two Faces of Racism: Resurgent Hate and Structural Discrimination", 21 March 2018, https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=22856&LangID=E.

2   Byrne, Bridget, Claire Alexander, Omar Khan, James Nazroo, and William Shankley (2020) Ethnicity, Race and Inequality in the UK, Bristol: Policy Press.

3   "Auschwitz 75 years on: Are anti-Semitic attacks rising?", BBC News, 27 January 2020, https://www.bbc.co.uk/news/51266129; "Widening racial disparity in stop and searches", StopWatch, 25 October 2019, http://www.stop-watch.org/news-comment/story/widening-racial-disparity-in-stop-and-searches.

4   Farah Elahi and Omar Khan, Islamophobia: still a challenge for us all, Runnymede Trust, March 2018: https://www.runnymedetrust.org/uploads/Islamophobia%20Report%202018%20FINAL.pdf. This report explains why Islamophobia should be considered a form of racism directed at Muslims, since Muslims have undergone similar "racialisation" processes to those which "raced" Jewish people through reification, prejudice and discrimination..

5   Tahir Abbas, "Radicalisation and Islamophobia: Poverty is the hidden cause", Middle East Eye, 28 October 2019, https://www.middleeasteye.net/opinion/islamophobia-and-radicalisation-vicious-cycle.

6   Shilpa Ross, "Life in the shadow of the snowy white peaks: race inequalities in the NHS workforce", The King's Fund, 13 June 2019, https://www.kingsfund.org.uk/blog/2019/06/race-inequalities-NHS-workforce.

7   2018 National NHS Staff Survey, cited in Interim NHS People Plan, June 2019: 4, https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf.

8   Nick Kituno, "Exclusive: Discrimination against BME staff getting worse, finds NHSE report", Health Service Journal, 13 February 2020, https://www.hsj.co.uk/workforce/exclusive-discrimination-against-bme-staff-getting-worse-finds-nhse-report/7026916.article.

9   Zosia Kmietowicz, "The Racism in Medicine issue: how we did it", British Medical Journal, 11 February 2020, https://blogs.bmj.com/bmj/2020/02/11/the-racism-in-medicine-issue-how-we-did-it.

10 "Health & Disability", Office for National Statistics, April 2001, accessed via the Internet Archive, https://web.archive.org/web/20110506145155/http://www.statistics.gov.uk/cci/nugget.asp?id=959. See also: Laird, Lance, et al. (2007) "Muslim patients and health disparities in the UK and the US." Archives of Disease in Childhood 92(10): 922-926.

11 Chris Thomas, "Hitting the poorest worst? How public health cuts have been experienced in England's most deprived communities", Institute of Public Policy Research, 5 November 2019, https://www.ippr.org/blog/public-health-cuts, cited in Natasha Dhumma, "Islamophobia and Health Inequalities", National AIDS Trust, 9 December 2019, https://www.nat.org.uk/blog/islamophobia-and-health-inequalities.

12 "Act now for #PatientsNotPassports", Medact, Docs Not Cops and Migrants Organise, https://act.patientsnotpassports.co.uk. The policy has been linked to a number of deaths, including those of at least three pregnant women, who are already more likely to die if BAME (See: Shaun Lintern, "Pregnant women died after fears Tory crackdown on 'health tourism' would bankrupt them, report delayed until after election reveals", The Independent, 13 December 2019, https://www.independent.co.uk/news/health/nhs-report-delayed-until-after-election-reveals-pregnant-women-died-because-of-mistaken-fears-they-a9245966.html and Marian Knight et. al., (2018) Saving Lives, Improving Mothers' Care, MBRRACE: iv, https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202018%20-%20Web%20Version.pdf) and undocumented migrants afraid to seek treatment during the coronavirus pandemic (See: May Bulman, "Undocumented migrants dying of coronavirus because they're too afraid to seek help, MPs and charities warn", The Independent, 17 April 2020 https://www.independent.co.uk/news/uk/home-news/coronavirus-undocumented-migrants-deaths-cases-nhs-matt-hancock-a9470581.html).

13 Tufyal Choudhury and Helen Fenwick (2011) The impact of counter-terrorism measures on Muslim communities, Equality and Human Rights Commission: vii, https://www.equalityhumanrights.com/sites/default/files/research-report-72-the-impact-of-counter-terrorism-measures-on-muslim-communities.pdf.

14 The Equality and Human Rights Commission notes that "in the Equality Act, race can mean your colour, or your nationality (including your citizenship). It can also mean your ethnic or national origins, which may not be the same as your current nationality." At times some public authorities use the term ethnicity so in this chapter, both terms are used but indicate the same concept.

15 "Right Wing-related Prevent referrals increase to record levels", Counter Terrorism Policing, 19 December 2019, https://www.counter-terrorism.police.uk/right-wing-related-prevent-referrals-increase-to-record-levels.

16 As Human Rights Watch notes, "Asian" in the UK context is a term used to describe people of South Asian origin or descent (Without Suspicion: Stop and Search under the Terrorism Act 2000, 4 July 2010, https://www.hrw.org/report/2010/07/04/without-suspicion/stop-and-search-under-terrorism-act-2000).

17 Email from J Conquest, Home Office Information Rights Team, 6 November 2019.

18 Email from Home Office Information Rights Team, 21 November 2019.

19 The public sector equality duty requires public bodies to assess the impact of policies on protected groups to identify whether they are promoting equality of opportunity and good community relations, and eliminating unlawful discrimination. The NHS Constitution also underlines patients' right not to be discriminated against. See NHS Constitution (2015), https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf and NHS England (2015) Monitoring Equalities and Health Inequalities: A Position Paper, https://www.england.nhs.uk/wp-content/uploads/2015/03/monitrg-ehi-pos-paper.pdf.

20 Since Asians were by far the most referred ethnic minority group, we focused on calculating the disproportionality rate experienced by Asians, and judged that we had insufficient data to calculate disproportionality for other minorities.

21 That said, these figures from healthcare are actually considerably less disproportionate than those generated by other similar studies looking at counter-terrorism practices, ethnicity and faith across all sectors. For instance, one study found that Pakistanis were 154 times more likely than white people to be detained under Schedule 7 of the Terrorism Act 2000 (Hurrell, Karen (2013) An experimental analysis of examinations and detentions under schedule 7 of the Terrorism Act 2000: Briefing Paper 8, Equality and Human Rights Commission: 28, https://www.equalityhumanrights.com/sites/default/files/briefing-paper-8-an-experimental-analysis-of-examinations-and-detentions-under-s7-of-the-terrorism-act-2000.pdf. Another calculated that Muslims are over 70 times more likely to be referred to the Channel programme than non-Muslims (Massoumi, Narzanin, et. al. (2017) What is Islamophobia? Racism, social movements and the state, London: Pluto Press: 11.

22 Human Rights Watch notes that the UK's Race Relations Act 1976, as amended, contains a national security exception making discrimination by public authorities, including the police, lawful for the purpose of safeguarding national security where it is shown to be justified, while international human rights law does not permit such blanket exemptions (See: Without Suspicion: Stop and Search under the Terrorism Act 2000, 4 July 2010, https://www.hrw.org/report/2010/07/04/without-suspicion/stop-and-search-under-terrorism-act-2000). Under Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities), "service users must be protected from abuse and improper treatment. Improper treatment includes discrimination and degrading treatment". See: https://www.cqc.org.uk/guidance-providers/regulations-

enforcement/regulation-13-safeguarding-service-users-abuse-improper#full-regulation.

23   Ibid.

24   Interview with a legal academic, 29 August 2019.

25   Lowe, Maria, et. al. (2017) "Who looks suspicious? Racialized surveillance in a predominantly white neighborhood", Social Currents 4(1): 34-50. In another notable example, former Prime Minister Tony Blair appeared to blame a spate of 2007 murders on black culture (Patrick Wintour and Vikram Dodd, "Blair blames spate of murders on black culture", Guardian, 12 April 2007, https://www.theguardian.com/politics/2007/apr/12/ukcrime.race.

26   Cockbain, Ella and Waqas Tufail (2020) "Failing victims, fuelling hate: challenging the harms of the 'Muslim grooming gangs' narrative", Race & Class, 61(3): 3-32.

27   Stuart Hall et. al., (1979) Policing the Crisis: Mugging, the State, and Law and Order, London: Macmillan.

28   A fairly typical response was to point out that people "connect Muslims with terrorism" because "they've had long periods being told this within the media" (Interview with a CAMHS clinical psychologist, 1 October 2019).

29   Focus group participant S (Birmingham); Focus group participants A and D (London); Interview with London GP, 26 July 2019; Interview with London GP, 27 August 2019; Interview with NHS Safeguarding professional, 17 July 2019; Interview with Derek Summerfield, former South London and Maudsley NHS Foundation Trust psychiatrist and honorary senior lecturer at King's College London Institute of Psychiatry, 17 July 2019.

30   Focus group participant S (Birmingham); Interview with Derek Summerfield; Interview with retired consultant psychiatrist and Mend CEO Dr Shazad Amin, 29 August 2019; Interview with GP in the North West, 26 July 2019; Interview with CAMHS clinical psychologist, 1 October 2019.

31   Focus group participant Z (Manchester); Interview with Dr Jackie Applebee, 24 September 2019.

32   Focus group participant A (London).

33   Focus group participant I (Brighton).

34   Interview with Dr Shazad Amin, 29 August 2019.

35   Interview with a former Prevent lead in an English primary care trust and ex-Channel Panel member, 30 August 2019; Interview with Dr Jonathan Leach, Joint Honorary Secretary of the Royal College of GPs, 19 September 2019; Interview with a legal academic, 29 August 2019; Interview with a Manchester GP, 20 August 2019.

36   Interview with CAMHS clinical psychologist, 1 October 2019; Interview with a former Prevent lead in an English primary care trust and ex-Channel Panel member, 30 August 2019; Interview with London GP, 27 August 2019; Interview with London GP, 26 July 2019; Focus group participant Z (Manchester); Focus group participant S (Birmingham).

37   Farah Elahi and Omar Khan, Islamophobia: still a challenge for us all, Runnymede Trust, March 2018: https://www.runnymedetrust.org/uploads/Islamophobia%20Report%202018%20FINAL.pdf.

38   Focus group participant J (Brighton).

39   Interview with a former Prevent lead in an English primary care trust and ex-Channel Panel member, 30 August 2019.

40   Interview with London GP, 27 August 2019.

41   Robert Booth and Aamna Mohdin, "Revealed: the stark evidence of everyday racial bias in Britain", Guardian, 2 December 2018, https://www.theguardian.com/uk-news/2018/dec/02/revealed-the-stark-evidence-of-everyday-racial-bias-in-britain.

42   Email from Dr Al Dowie, Senior Lecturer in Medical Ethics and Law at the University of Glasgow, 31 August 2019.

43   Email from anonymous health professional, 31 August 2019.

44   Focus group participant I (Brighton).

45   Interview with Julian Sheather, British Medical Association adviser on ethics and human rights, 25 September 2019.

46   At the same time, asked what factors they believed might make someone vulnerable to radicalisation, one senior health worker said: "I'm just trying to think of the evidence. So, you know, if you've got a, a cross-cultural sort of clash, that sort of thing". The RCGP has since collaborated with NHS England to produce an e-learning training module on Prevent, released in November 2019 (Email from Royal College of GPs, 23 December 2019).

47   Interview with Julian Sheather, British Medical Association adviser on ethics and human rights, 25 September 2019.

48   Focus group participant R (Birmingham); Focus group participant Z (Manchester); Interview with Dr Jackie Applebee, GP and chair of the Tower Hamlets Local Medical Committee, 24 September 2019.

49   Interview with locum GP in Manchester, 3 September 2019.

50   Interview with an NHS Safeguarding professional in a Midlands hospital, 17 July 2019.

51   Interview with a legal academic, 29 August 2019.

52   Kundnani, Arun (2014), The Muslims are coming!: Islamophobia, extremism, and the domestic war on terror, London: Verso, 23.

53   East and North Hertfordshire Clinical Commission Group Channel Referral Form, June 2018, available at: https://www.enhertsccg.nhs.uk/pathways/paediatrics-children%E2%80%99s-services/channel-referral-form.

54   Basit Mahmood, "Terror police recall guidance listing 'standard Muslim beliefs' as signs of extremism ", Metro, 15 January 2020, https://metro.co.uk/2020/01/15/terror-police-recall-guidance-listing-standard-muslim-beliefs-signs-extremism-12062622.

55   All three text excerpts come from "Spotting the Signs", Let's Talk About It, n.d., https://www.ltai.info/spotting-the-signs.

56   Here, class bias is also notable in the suggestion that someone who may have "experienced poverty, disadvantage or social exclusion" could be more likely to become involved in terrorism.

57   The site (https://www.ltai.info) was originally created by Luton Council and Bedfordshire Police (see https://www.luton.gov.uk/Community_and_living/crime-and-community-safety/letstalkaboutit/Pages/default.aspx).

58   See: https://www.counter-terrorism.police.uk/what-we-do/prevent.

59   See: https://www.gov.uk/government/collections/independent-review-of-prevent.

60   Focus Group participant Q (Birmingham).

61   Interview with CAMHS clinical psychologist, 1 October 2019.

62   Interview with a Manchester GP, 20 August 2019.

63   Dr Tarek Younis presentation at Victoria Climbié Foundation event "The impact of anti-radicalisation policies on safeguarding practices", University of East London, 28 January 2020. See also: Younis, Tarek, and Sushrut Jadhav (2019), "Islamophobia in the National Health Service: an ethnography of institutional racism in PREVENT's counter-radicalisation policy," Sociology of Health & Illness, 10(10): 1-17.

64   Skurnik, Ian et al. (2005), "How Warnings about False Claims Become Recommendations", Journal of Consumer Research, 31(4): 713-724; Loftus, Elizabeth (1992), "When a Lie Becomes Memory's Truth: Memory Distortion After Exposure to Misinformation", Current DIrections in Psychological Science, 1(4): 121-123; Nyhan Brendan and Reifler J, (2010) "When Corrections Fail: The Persistence of Political Misperceptions", Political Behavior, 32(2): 303-330; Lewandowsky, Stephan et al., (2012) "Misinformation and Its Correction: Continued Influence and Successful Debiasing", Psychological Science in the Public Interest, 13(3): 106-131.

65   Interview with a legal academic, 29 August 2019.

66   Building Partnerships, Staying Safe: The Health Sector Contribution to HM Government's Prevent Strategy: Guidance for Healthcare Organisations, Department of Health, December 2011, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215251/dh_131934.pdf.

67   One commented, for instance, that simply making training longer than the 1-2 hour WRAP workshop would not help because "you could do a whole day's training, but...what exactly am I looking for and why? No-one can answer that question" (Interview with a Manchester GP, 20 August 2019).

68   Interview with Dr Adrian James, 2 October 2019; Focus group participant Q (Birmingham); Focus group participant A (London). In February 2020, a UN rapporteur report concluded that "accurate identification" of future terrorists using tools like the ERG22+ "is largely unattainable".

69   Email from Dr Adrian James, 17 December 2019. Male gender and young age have similarly been dismissed as useful criteria, since "these factors are so broad they lack any real predictive power" (Sarma Kiran (2017) "Risk assessment and the prevention of radicalisation from nonviolence into terrorism", American Psychologist 72(3): 278-288 cited in Hardcastle, Katie, Mark Bellis, John Middleton, Dominc Harrison, Daniel Flecknoe, and Joanne Hopkins (2019) Preventing violent extremism in the UK: Public health solutions. Public Health Wales, Faculty of Public Health, 34, https://www.fph.org.uk/media/2475/preventing-violent-extremism-in-the-uk_public-health-solutions-web.pdf. It is interesting to compare the fact that many common symptoms are listed in the ERG22+ despite their poor predictive value with the debate over whether to include "loss of taste and smell" as an officially recognised symptom of covid-19. While ear, nose and throat specialists said that the symptom was a 95% accurate predictor of coronavirus infection, members of Nervtag (the government's advisory group on new and emerging respiratory virus threats) commented that the key question was "whether the positive predictive value of the symptom is high enough to warrant its inclusion in a case definition" and the aim was to "avoid large numbers of false-positive cases". (Kirstie Brewer, "Coronavirus: Why hasn't the UK listed loss of smell as a symptom of Covid-19?", BBC News, 14 May 2020, https://www.bbc.co.uk/news/stories-52638382).

70   Focus group participant H (Brighton).

71   Building Partnerships, Staying Safe: The Health Sector Contribution to HM Government's Prevent Strategy: Guidance for Healthcare Organisations, Department of Health, December 2011: 19.

72   For example, one healthcare professional shared with us the images from their short Prevent e-learning training, which stated no less than three times that healthcare workers should trust their instincts. Their training was by no means unique. For further discussion, see: Dresser, Paul (2019) "'Trust your instincts–act!' PREVENT police officers' perspectives of counter-radicalisation reporting thresholds", Critical Studies on Terrorism, 12(4): 605-628 and Van de Weert, Annemarie and Quirine AM Eijkman (2019) "Early detection of extremism? The local security professional on assessment of potential threats posed by youth", Crime, Law and Social Change, 1-17.

73   Interview with an NHS Safeguarding professional, 17 July 2019.

74   Vikram Dodd, "Black people 27 times more likely to be stopped", Guardian, 21 April 2003, https://www.theguardian.com/society/2003/apr/21/equality. politics. For example, stop and search under Section 60 of the Criminal Justice and Public Order Act, which does not require reasonable suspicion, has a greater rate of disproportionality than other forms of stop and search. Similarly, Schedule 7 of the Terrorism Act 2000 allows "suspicionless stops" for up to six hours at ports and airports. In 2014, Cambridge University researchers found 88% of people stopped using this power were Muslim. (Dan Sabbagh, "Detention of Muslims at UK ports and airports 'structural Islamophobia'", Guardian, 20 August 2019, https://www.theguardian.com/news/2019/aug/20/detention-of-muslims-at-uk-ports-and-airports-structural-islamophobia).

75   Note, however, that to be progressed to Channel, the police or a local authority must have reasonable grounds according to section 36(3) of the Counter Terrorism and Security Act 2015 (See: http://www.legislation.gov.uk/ukpga/2015/6/section/36).

76   Amrit Singh (2016) Eroding Trust: The UK's Prevent Counter-Extremism Strategy in Health and Education, Open Society Justice Initiative: 17.

77   Ibid.

78   Another interesting, though less detailed example, in which ethnicity may

Chapter 5. Mental health impacts

1   McManus, Sally, Howard Meltzer, Traolach Brugha, Paul Bebbington and Rachel Jenkins (2009), "Adult psychiatric morbidity in England, 2007: results of a household survey", The NHS Information Centre for Health and Social Care, https://files.digital.nhs.uk/publicationimport/pub02xxx/pub02931/adul-psyc-morb-res-hou-sur-eng-2007-apx.pdf.

2   Gareth Iacobucci, "Mental health services: CQC warns of 'perfect storm'", British Medical Journal, 14 October 2019, https://www.bmj.com/content/367/bmj.l6032.

3   Damien Gayle, "Suicides rates in UK increase to highest level since 2002", Guardian, 3 September 2019, https://www.theguardian.com/society/2019/sep/03/suicides-rates-in-uk-increase-to-highest-level-since-2002.

4   Focus group participant E (London). This perception was supported by some of the conclusions of a recent report: Children's Commissioner, The state of children's mental health services, January 2020, https://www.childrenscommissioner.gov.uk/wp-content/uploads/2020/01/cco-the-state-of-childrens-mental-health-services.pdf.

5   Interview with Manchester-based GP, 20 August 2019. Another interviewee observed ""the money's in Prevent" (Interview with NHS Safeguarding professional, 17 July 2019).

6   Fitzpatrick, Rob, Sarabajaya Kumar, Ohemaa Nkansa-Dwamena and Laura Thorne (2014) Ethnic Inequalities in Mental Health: Promoting Lasting Positive Change, Confluence Partnerships; Bignall, Tracey, Samir Jeraj, Emily Helsby and Jabeer Butt (2019) Racial disparities in mental health: Literature and evidence review, Race Equality Foundation.

7   "Black, Asian and Minority Ethnic (BAME) communities", Mental Health Foundation, n.d. https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities; Coco Khan, "'I thought I was a lost cause': how therapy is failing people of colour", Guardian, 10 February 2020, https://www.theguardian.com/lifeandstyle/2020/feb/10/therapy-failing-bme-patients-mental-health-counselling.

8   Hussain, Feryad (2009) "The mental health of Muslims in Britain: Relevant therapeutic concepts", International Journal of Mental Health, 38(2), 21-36, https://www.jstor.org/stable/41345282?seq=1.

9   "Health and mental health statistics", Institute of Race Relations, n.d. http://www.irr.org.uk/research/statistics/health.

10   "BAME deaths in police custody", Inquest, 2 January 2020, https://www.inquest.org.uk/bame-deaths-in-police-custody.

11   HM Government, "Prevent Strategy", June 2011, 7, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/97976/prevent-strategy-review.pdf. The case of Nicky Reilly is cited as an example: Reilly, who had Asperger's syndrome and a personality disorder, was convicted of terror offences in 2009 after trying to blow up a cafe in Exeter, and later died in prison.

12   Michael Holden, "The battle for minds — Britain expands project on mental health in terrorism", Reuters, 7 November 2017: https://uk.reuters.com/article/uk-britain-security-mentalhealth/the-battle-for-minds-britain-expands-project-on-mental-health-in-terrorism-idUKKBN1D718N.

13   Interview with Professor Andrew Goddard, 22 October 2019.

14   Interview with London GP, 27 August 2019.

15   Corner, Emily and Paul Gill (2015), "A false dichotomy? Mental illness and lone-actor terrorism", Law and Human Behavior, 39(1), 23. The study's main finding is that "[t]he odds of a lone-actor terrorist having a mental illness is 13.49 times higher than the odds of a group actor having a mental illness."

16   Interview with Dr Adrian James, 2 October 2019.

17   Corner, Emily and Paul Gill ((2017), "Is there a nexus between terrorist involvement and mental health in the age of the Islamic State?" CTC Sentinel, 10(1), 1-10. This study looked at 55 attacks between May 2014 and September 2016 where reports indicated the 76 perpetrators involved may have been influenced by IS. It found that 34% had mental health issues.

18   Ibid.

19   Link, Bruce, Jo Phelan, Michaeline Bresnahan, Ann Stueve & Bernice Pescosolido (1999) "Public conceptions of mental illness: labels, causes, dangerousness, and social distance", American Journal of Public Health, 89(9), 1328-1333.

20   Varshney, M., Mahapatra, A., Krishnan, V., Gupta, R., & Deb, K. S. (2016) "Violence and mental illness: what is the true story?" Journal of Epidemiological Community Health, 70(3), 223-225.

21   Thornicroft, Graham (2020) "People with severe mental illness as the perpetrators and victims of violence: time for a new public health approach", Lancet 5(2), February, https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(20)30002-5/fulltext?dgcid=raven_jbs_etoc_email.

22   Ibid.

23   Peter Beresford, "Violence in mental health can't be ignored, but nor can the pain of punitive policies", Guardian, 3 September 2019, https://www.theguardian.com/society/2019/sep/03/violence-mental-health-punitive-policies.

24   Sageman Marc (2005) Understanding terror networks, University of Pennsylvania Press, cited in Bhui, Kamaldeep, Adrian James and Simon Wessely (2016) "Mental illness and terrorism", British Medical Journal, 354 (September), 1-2.

25   Focus group participant Q (Birmingham).

26   Powis, Beverly, Kiran Randhawa, and Darren Bishopp (2019) "An Examination of the Structural Properties of the Extremism Risk Guidelines (ERG22+): A Structured Formulation Tool for Extremist Offenders", Terrorism and Political Violence, 13.

27   Thornicroft, "People with severe mental illness as the perpetrators and victims of violence".

28   Interview with Manchester-based GP, 20 August 2019. Note that far right figures such as Brexit Party leader Nigel Farage have used such language, calling "jihadism" a "virus". ("Nigel Farage compares Jihadism to deadly coronavirus following Streatham terror attack", LBC, 4 February 2020, https://www.lbc.co.uk/radio/presenters/nigel-farage/nigel-farage-jihadism-coronavirus/).

29   Interview with Adrian James, 2 October 2019.

30   Dominic Casciani, "Top psychologist: No certainty terror offenders can be 'cured'", BBC News, https://www.bbc.co.uk/news/uk-50967100.

31   Interview with Julian Sheather, 25 September 2019.

32   Van Voren, Robert (2010) "Political abuse of psychiatry—an historical overview," Schizophrenia Bulletin 36(1): 33-35.

33   Two examples — both studies focused exclusively on Muslims — are from Prof Kam Bhui et al, who concluded that "extremist sympathies" correlated with depressive tendencies and a separate research project, partly funded by the US Department of Defence, which used neuroimaging techniques to "map the brains of radicalised individuals": Bhui, Kamaldeep, Nasir Warfa, and Edgar Jones (2014) "Is violent radicalisation associated with poverty, migration, poor self-reported health and common mental disorders?" PloS One 9(3); Mark Townsend, "Brain scans show social exclusion creates jihadists, say researchers", Guardian, 6 January 2019 https://www.theguardian.com/uk-news/2019/jan/06/social-exclusion-radicalisation-brain-scans. Prof Bhui declined to be interviewed for this research.

34   The 22 trusts included 4 mental health trusts (Birmingham and Solihull Mental Health NHS Foundation Trust, Dudley and Walsall Mental Health Partnership NHS Trust, South West London and St George's Mental Health NHS Trust and Cambridgeshire and Peterborough Mental Health Partnership) and 18 non-specialist trusts (Bedford Hospital NHS Trust, Northern Care Alliance NHS Group, Wrightington, Wigan and Leigh NHS Foundation Trust, Great Ormond Street Hospital for Children NHS Foundation Trust, Luton and Dunstable Hospital NHS Trust, Tameside and Glossop Integrated Care NHS Foundation Trust, Homerton University Hospital NHS Foundation Trust, Sandwell and West Birmingham Hospitals NHS Trust, The Rotherham NHS Foundation Trust, Birmingham Womens and Childrens NHS Foundation Trust, Bradford Teaching Hospitals NHS Foundation Trust, University Hospitals of Derby and Burton

have played a part came from Sandwell and Birmingham NHS Trust, which provided a description of each Prevent referral it made in response to our FOI request. One read as follows: "a child referral — made by a non-mental health department — mother had attended an appointment and the child was seen to be writing letters/drawing which staff perceived to be early radicalization — Asian nationality — unknown religion (please note this was forwarded to the children's safeguarding team)".

79   Amrit Singh (2016) Eroding Trust: The UK's Prevent Counter-Extremism Strategy in Health and Education, Open Society Justice Initiative: 35.

80   Interview with London GP, 26 July 2019.

81   Diane Taylor, "Hospice staff 'trained to report dying patients as part of terror strategy'", Guardian, 22 June 2018, https://www.theguardian.com/uk-news/2018/jun/11/nhs-staff-trained-to-signs-of-radicalisation-in-terminally-ill-says-whistleblower

82   Special Rapporteur on the promotion and protection of human rights and fundamental freedoms while countering Terrorism (2020) Human rights impact of policies and practices aimed at preventing and countering violent extremism, United Nations Human Rights Council, A/HRC/43/46, 7, https://documents-dds-ny.un.org/doc/UNDOC/GEN/G20/045/67/PDF/G2004567.pdf?OpenElement.

NHS Foundation Trust, London North West University Healthcare NHS Trust, Essex Partnership University NHS Foundation Trust, Nottingham University Hospitals NHS Trust, Nottinghamshire Healthcare NHS Foundation Trust, Black Country Partnership NHS Foundation Trust, Berkshire Healthcare NHS Foundation Trust).

35   Note that in all three tables in this chapter, where figures provided by trusts were treated as 2.5 or 4.5 (see footnote 2, Chapter 3), numbers have been rounded to the nearest 1.

36   Referrals for Table 4 total 85, while referrals for Table 3 total 90 because 5 referrals were assigned "unknown" rather than to either mental health or non-mental health departments by the disclosing non-specialists trusts.

37   "Government's counter-terrorism strategy is having little impact in the NHS", BMJ, n.d. https://www.bmj.com/company/newsroom/governments-counter-terrorism-strategy-is-having-little-impact-in-the-nhs.

38   Vikram Dodd, "Police study links radicalisation to mental health problems", Guardian, 20 May 2016, https://www.theguardian.com/uk-news/2016/may/20/police-study-radicalisation-mental-health-problems. Psychologist Dr Tarek Younis has hypothesised that the category "mixed, unstable or unclear ideology" (MUU) — recently introduced by the Home Office for recording suspicions of extremism, alongside 'Islamist' and 'right wing' — is the repository being used to capture many people with mental health conditions. (https://twitter.com/Tarek_Younis_/status/1207690894922702848.) The MUU category has grown every year since it was introduced and 2019 Prevent figures released by the Home Office showed it account for 38% of referrals, more than either right wing or Islamist referrals. However, only 3% of Channel discussions and Channel cases were classified as MUU. It is unclear whether this may be indicative of people in need of mental health care having their cases discarded by Prevent as they move through the system or if these cases might be getting re-categorised as fitting specific ideologies (Home Office, "Individuals referred to and supported through the Prevent Programme, April 2018 to March 2019", 19 December 2019, 11, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/853646/individuals-referred-supported-prevent-programme-apr2018-mar2019-hosb3219.pdf.

39   Interview with former Channel Panel member and ex-Prevent lead in an English PCT, 30 August 2019.

40   The trust was paid "in the region of £12k" (Freedom of Information disclosure by Birmingham and Solihull Mental Health NHS Foundation Trust, n.d.).

41   (2017) "Complex Mental Health, Psychological and Behavioural Difficulties and Problematic Social Backgrounds in Channel Referrals in England and Wales – Summary of Methodology", Freedom of Information disclosure by Birmingham and Solihull Mental Health NHS Foundation Trust.

42   "Counter Terrorism Police and NHS initiative reducing risk by improving mental health provision", Rochdale Online, 14 October 2016, http://rochdaleonline.co.uk/news-features/2/news-headlines/105620/counter-terrorism-police-and-nhs-initiative-reducing-risk-by-improving-mental-health-provision.

43   "Ground breaking pilot project helping vulnerable people to access support", Birmingham and Solihull Mental Health NHS Foundation Trust, 14 October 2016, https://www.bsmhft.nhs.uk/about-us/news/news-archives-2016/ground-breaking-pilot-project-helping-vulnerable-people-to-access-support.

44   Michael Holden, "The battle for minds".

45   Bev Hughes – Deputy Mayor for Police, Crime, Criminal Justice services and Fire, Greater Manchester Police and Crime Panel, "GREATER MANCHESTER POLICE AND CRIME PANEL", 14 November 2019, 21, https://democracy.greatermanchester-ca.gov.uk/documents/s3545/7.%20Priority%20Two%20Standing%20Togetherfinal.pdf.

46   "Terrorism and Allied Matters", n.d, Freedom of Information disclosure by National Police Chiefs Council.

47   "Karl Curran", LinkedIn, accessed 19 May 2020, https://uk.linkedin.com/in/karl-curran-4a1341a0.

48   Regional Prevent Coordinator (RCP) Health Monitoring and Assurance reporting form to Department of Health and Social Care, Freedom of Information disclosure by NHS England.

49   "Mental Health Pilot Hubs", National Police Chiefs Council, n.d., https://www.npcc.police.uk/NPCCBusinessAreas/TAM/MentalHealthPilotHubs.aspx.

50   "Prevent Mental Health / Police Team", European Commission, 2016, https://ec.europa.eu/home-affairs/node/11454_en.

51   Michael Holden, "The battle for minds".

52   "Mental Health Pilot Hubs", National Police Chiefs Council; "Ground breaking pilot project helping vulnerable people to access support", Birmingham and Solihull Mental Health NHS Foundation Trust.

53   Interview with Adrian James, 2 October 2019.

54   In the same month, NHS England published guidance and an e-learning training package for mental health services on "exercising duties to safeguard people from the risk of radicalisation", 2 November 2017, https://www.england.nhs.uk/2017/11/nhs-england-prevent-mental-health-guidance-and-new-e-learning-package-now-available.

55   Michael Holden, "The battle for minds".

56   Bev Hughes "GREATER MANCHESTER POLICE AND CRIME PANEL".

57   "Terrorism and Allied Matters", n.d, Freedom of Information disclosure by National Police Chiefs Council.

58   "Mental Health Pilot Hubs", National Police Chiefs Council.

59   "Terrorism and Allied Matters", n.d, Freedom of Information disclosure by National Police Chiefs Council, date.

60   Augestad Knudsen, Rita (2020) "Between vulnerability and risk? Mental health in UK counter-terrorism", Behavioral Sciences of Terrorism and Political Aggression, 13.

61   Ibid, 12.

62   Nelson, Camille (2016) "Frontlines: Policing at the Nexus of Race and Mental Health", Fordham Urb. L.J, 43: 615.

63   Bev Hughes "GREATER MANCHESTER POLICE AND CRIME PANEL".

64   Previous research found that some mental health trusts have adopted automatic radicalisation screening practices for all service users, noting that this risks "inappropriately stigmatising" people with mental illness. The same study suggested that mental health services may flag people as radicalisation risks in order to expedite their access to care, but our research found no evidence of this phenomenon. See: Heath-Kelly, Charlotte and Erzsébet Strausz (2018), Counter-terrorism in the NHS: Evaluating prevent duty safeguarding in the NHS, University of Warwick: Department of Politics and International Studies, 3, https://warwick.ac.uk/fac/soc/pais/research/researchcentres/irs/counter-terrorisminthenhs/project_report_60pp.pdf.

65   Interview with Dr Shazad Amin, 29 August 2019.

66   Interview with Dr Adrian James, 2 October 2019. Some research supports the theory that perceptions of danger and other negative attitudes towards people with mental health conditions may be increased by news reports asserting suspicions of mental illness among people committing terrorist attacks. See: Schomerus, Georg, Susanne Stolzenburg, Alexandra Bauch, Sven Speerforck, Deborah Janowitz, and Matthias Angermeyer (2017), "Shifting blame? Impact of reports of violence and mental illness in the context of terrorism on population attitudes towards persons with mental illness in Germany", Psychiatry Research 252, 164-168.

67   Home Office, "Individuals referred to and supported through the Prevent Programme, April 2017 to March 2018", 13 December 2018, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/763254/individuals-referred-supported-prevent-programme-apr2017-mar2018-hosb3118.pdf.

68   Focus group participant T (Birmingham).

69   Interview with CAMHS clinical psychologist, 1 October 2019.

70   Heath-Kelly and Strausz, Counter-terrorism in the NHS, 3

71   "As with all safeguarding decisions, mental health professionals will need to consider whether a referral could escalate an individual's condition or risk disengagement from mental health services altogether." See: NHS England (2017) Guidance for mental health services in exercising duties to safeguard people from the risk of radicalisation, 14, https://www.england.nhs.uk/wp-content/uploads/2017/11/prevent-mental-health-guidance.pdf.

72   Ibid, 8.

Chapter 6. Case studies

1   Rob Evans, "NHS reports protester to Prevent for joining Extinction Rebellion", Guardian, 1 September 2019, https://www.theguardian.com/uk-news/2019/sep/01/nhs-reports-protester-to-prevent-extinction-rebellion.

Chapter 7. Prevent & safeguarding

1   Augestad Knudsen, Rita (2020), "Between vulnerability and risk? Mental health in UK counter-terrorism", Behavioral Sciences of Terrorism and Political Aggression, January: 3.

2   HM Government, "Prevent Strategy", 84

3   Ibid.

4   Heath-Kelly, Charlotte. and Erzsébet Strausz (2019), "The banality of counter-terrorism 'after, after 9/11'? Perspectives on the Prevent duty from the UK health care sector", Critical Studies on Terrorism, 12(1), 89-109.

5   See for example, NHS England (2019) Safeguarding Policy, https://www.england.nhs.uk/wp-content/uploads/2019/09/safeguarding-policy.pdf.

6   Email from CQC in response to FOI request, 11 December 2019. For example, a recent CQC report on Birmingham and Solihull Mental Health NHS Foundation Trust — one of the trusts with unusually high referral rates — notes that staff highlighted their Prevent training during the inspection (https://www.cqc.org.uk/sites/default/files/rxt_coreservice_long_stay_forensic_secure_services_birmingham_and_solihull_mental_health_nhs_trust_scheduled_20140703.pdf). Prevent is also something clinical commissioning groups are "very hot on", according to one NHS safeguarding professional, who told us "they will come down on you if your Prevent training isn't high enough" (Interview with NHS Safeguarding professional, 17 July 2019).

7   Amrit Singh (2016) Eroding Trust; Mckendrick, David and Jo Finch (2017) "'Downpressor man': securitisation, safeguarding and social work", Critical and Radical Social Work, 5(3), 287–300; Heath-Kelly and Strausz (2019), "The banality of counter-terrorism"; Heath-Kelly and Strausz, Counter-terrorism in the NHS.

8   It seems reasonable to assume counter-terrorism was not what law-makers had in mind when they passed this safgeuarding legislation. It is also notable that the text omits mention of the Counter-Terrorism and Security Act 2015 which created the Prevent "duty".

9   NHS England (2019) Safeguarding Policy, https://www.england.nhs.uk/wp-content/uploads/2019/09/safeguarding-policy.pdf.

10   Care Act 2014, Section 42. Accordingly, intercollegiate adult safeguarding guidance defines "an adult at risk" as "any person who is aged 18 years or over and at risk of abuse, harm or neglect because of their needs for care and/or support and are unable to safeguard themselves" (Intercollegiate document (2018) Adult Safeguarding: Roles and Competencies for Health Care Staff, https://www.rcn.org.uk/professional-development/publications/pub-007069).

11   NHS England, Safeguarding Adults, n.d., https://www.england.nhs.uk/wp-content/uploads/2017/02/adult-pocket-guide.pdf

12   Safeguarding patients, King's College Hospital, n.d., https://www.kch.nhs.uk/about/corporate/care-standards/safeguarding-patients.

13   NHS England (2019) Safeguarding Policy. This document also lists "those who may be singled out due to their religion or ethnicity" as a group who man be "particularly vulnerable to harm and exploitation".

14   Focus group participant T (Birmingham).

15   Interview with Julian Sheather, Human Rights and Ethics Adviser to the British Medical Association, 25 September 2019.

16   Interview with retired consultant psychiatrist and MEND CEO Dr Shazad Amin, 29 August 2019.

17   Interview with Dr Jackie Applebee, 24 September 2019.

18   Focus group participant G (Brighton).

19   Focus group participant Q (Birmingham); Interview with Roy McClelland, Consultant Psychiatrist and Emeritus Professor of Mental Health at Queen's University Belfast, 19 September 2019; Interview with CAMHS clinical psychologist, 1 October 2019; Interview with legal academic, 29 August 2019.

20   Focus group participant Q (Birmingham).

21   Interview with Prof Roy McClelland, 19 September 2019.

22   For example, an online training produced by the Royal College of GPs in November 2019 uses this phrase: https://elearning.rcgp.org.uk/course/info.php?id=358.

23   Great Ormond Street Hospital Prevent Policy, April 2018. Notably, the institution's Prevent policy sits alongside its Safeguarding Vulnerable Adults at Risk Policy and its Safeguarding Children and Young People Policy. It is far from unique in this respect.

24   NHS England (2019) Safeguarding Policy.

25   Interview with NHS Safeguarding professional, 17 July 2019. Focus group participant A (London) rejected the term "vulnerable" explicitly, calling it "Prevent language".

26   Interview with Prof Roy McClelland, 19 September 2019.

27   This supports what has been identified as a "legal grey area between the provisions of the Care Act and the Counter-terrorism and Security Act" (Heath-Kelly and Strausz, Counter-terrorism in the NHS, 3).

28   Heath-Kelly Charlotte (2013), "Counter-Terrorism and the Counterfactual: Producing the 'Radicalisation' Discourse and the UK Prevent Strategy," British Journal of Politics and International Relations 15 (3): 394–415. This unusual concept of dangerous vulnerability is not unique to Prevent, however. The Metropolitan Police recently defended its gangs matrix database on the ground that it "has assisted in preventing many gang members from committing, or being the victims of, serious violent crimes" (Vikram Dodd, "Met removes hundreds from gangs matrix after breaking data laws", Guardian, 15 February, https://amp.theguardian.com/uk-news/2020/feb/15/met-removes-hundreds-from-gangs-matrix-after-breaking-data-laws).

29   Interview with Dr Adrian James, 2 October 2019.

30   Interview with Dr Lyn Jenkins, 26 September 2019.

31   Great Ormond Street Hospital Prevent Policy, April 2018. Likewise, if a referral is deemed to warrant escalation, the next step according to the procedure is to hold a "Person Who Poses a Risk (PWPR) meeting" or an "Allegations against staff" (AAS) meeting in the case of a staff member. The flow chart also appears to indicate that immediate risk is a matter for the police but not for Prevent.

32   See Coppock, Vicki, and Mark McGovern (2014) "'Dangerous minds'? Deconstructing counter-terrorism discourse, radicalisation and the 'psychological vulnerability'of Muslim children and young people in Britain," Children & Society 28(3): 242-256.

33   Focus group participant AA (Manchester).

34   Focus group participant G (Brighton).

35   Focus group participants Z (Manchester); Interview with Prof Roy McClelland, 19 September 2019; Interview with Prof Derek Summerfield, former South London and Maudsley NHS Foundation Trust consultant psychiatrist and King's College London Institute of Psychiatry honorary senior lecturer, 17

36   Focus group participant AA (Manchester); Interview with NHS Safeguarding professional, 17 July 2019.

37   Interview with Dr Shazad Amin, 29 August 2019; Interview with Manchester-based GP, 20 August 2019.

38   Interview with Prof Roy McClelland, 19 September 2019; Interview with Dr Shazad Amin, 29 August 2019.

39   Interview with NHS Safeguarding professional, 17 July 2019; Interview with Dr Shazad Amin, 29 August 2019; Interview with Manchester-based GP, 20 August 2019; Interview with Prof Roy McClelland, 19 September 2019; Interview with Manchester-based GP, 26 July 2019; Focus group participants W and Z (Manchester).

40   Focus group participant Z (Manchester); Interview with Prof Roy McClelland, 19 September 2019.

41   Interview with Prof Roy McClelland, 19 September 2019.

42   Focus group participants A (London) and G (Brighton).

43   Focus group participant G (Brighton).

44   Interview with CAMHS clinical psychologist, 1 October 2019.

45   Heath-Kelly and Strausz, Counter-terrorism in the NHS, 3.

46   Eileen Munro (2011) The Munro Review of Child Protection: Final Report, 7, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf.

47   Interview with Manchester-based GP, 26 July 2019; Interview with London-based GP, 27 August 2019.

48   Interview with London-based GP, 27 August 2019.

49   Interview with Julian Sheather, ibid.

50   Interview with NHS Safeguarding professional, 17 July 2019; Focus group participant H (Brighton).

51   Focus group participants K (London).

52   Interview with Manchester-based GP, 26 July 2019; Interview with NHS Safeguarding professional, 17 July 2019.

53   Interview with Manchester-based GP, 20 August 2019.

54   Interview with RCP President Professor Andrew Goddard, 22 October 2019.

55   Interview with London-based GP, 26 July 2019.

56   Prevent practitioners like Will Baldet (https://twitter.com/WillBaldet/status/928683089508913152) and others, such as former reviewer of terrorism legislation David Anderson, have claimed that the Prevent programme is commensurate with pre-existing safeguarding practices, on the basis of the assertion that the overall proportions of referrals with whom no further action is taken is approximately one third for both. However, this claim is misleading given that the majority of actions taken as a result of Prevent referrals involve passing people on to other services — such as housing or mental health — unrelated to the original radicalisation concern. In addition, in Baldet's case these figures appear to have been incorrectly calculated, since he gives a figure of 35.3% of cases leading to no further action ("NFA") across adult and child safeguarding, the actual figure being 33.9%. See: NHS Digital, "Safeguarding Adults: Annual Report, England 2015-16 Experimental Statistics", 5 October 2016, https://files.digital.nhs.uk/publicationimport/pub21xxx/pub21917/sac_%201516_report.pdf (in which 25% of 102,970 cases are NFA) and Department of Education, "Characteristics of children in need: 2015 to 2016", 3 November 2016, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/564620/SFR52-2016_Main_Text.pdf (in which a total of 35.3% of 621,470 cases, pre- and post-assessment are NFA).

57   Interview with Manchester-based GP, 26 July 2019; Interview with NHS Safeguarding professional, 17 July 2019.

58   Intercollegiate document (2018) Adult Safeguarding: Roles and Competencies for Health Care Staff, https://www.rcn.org.uk/professional-development/publications/pub-007069.

59   Northern, Eastern and Western Devon Clinical Commissioning Group (2016), Prevent Policy, https://www.newdevonccg.nhs.uk/file/?download=true&rid=113034.

60   Interview with member of a safeguarding children board in the Midlands, 29 August 2019.

61   Focus group participants G and J (Brighton) and S (Birmingham); Interview with former Prevent lead in an English primary care trust and ex-Channel Panel member, 30 August 2019; Interview with Derek Summerfield, 17 September 2019.

62   Interview with Dr Jonathan Leach, Joint Honorary Secretary of the Royal College of GPs, 19 September 2019. Dr Jackie Applebee agreed, arguing that "people's behavior can be weird for all sorts of reasons" and advocating that "they should be referred to safeguarding much more generally...to try and get underneath what's going on" (Interview, 24 September 2019.)

63   Interview with Manchester-based GP, 26 July 2019; Interview with Jackie Applebee, 24 September 2019; Interview with London-based GP, 27 August 2019; Interview with Manchester-based GP, 20 August 2019; Interview with Dr Shazad Amin, 29 August 2019; Focus group participants G (Brighton).

64   Interview with Dr Adrian James, 2 October 2019; Interview with NHS

65 Intercollegiate document (2018) Adult Safeguarding: Roles and Competencies for Health Care Staff, https://www.rcn.org.uk/professional-development/publications/pub-007069.

66 Interview with Manchester-based GP, 20 August 2019; Interview with NHS safeguarding professional, 17 July 2019; Interview with London-based GP, 26 July 2019.

67 Interview with London-based GP, 26 July 2019.

68 However, at least one serious case review involving apparent radicalisation — thought to be the first of its kind in England — does exist. Published in July 2017, it concerns the case of the two brothers, "W" and "X", from Brighton. The pair were previously in a child protection plan after reporting physical abuse by their father, and experiencing racist abuse in the community. Later, both travelled to Syria and died fighting for the Al Qaeda-affiliated Al Nusra Front group against the government of Bashar al Assad. See: Edi Carmi and Anna Gianfrancesco (2017) Serious Case Review: Siblings W and X, Brighton and Hove Local Safeguarding Children Board, http://www.brightonandhovelscb.org.uk/wp-content/uploads/Siblings-W-and-X-SCR-July-2017.pdf.

69 Interview with Dr Adrian James, 2 October 2019.

70 Interview with Manchester-based GP, 26 July 2019.

71 Interview with Manchester-based GP, 20 August 2019.

72 Interview with Dr Shazad Amin, 29 August 2019.

73 Interview with Dr Jonathan Leach; 19 September 2019.

74 Interview with London-based GP, 26 July 2019.

75 Interview with CAMHS clinical psychologist, 1 October 2019; Interview with Dr Jackie Applebee, 24 September 2019.

76 Interview with NHS Safeguarding professional, 17 July 2019; Intercollegiate document (2018) Adult Safeguarding: Roles and Competencies for Health Care Staff, https://www.rcn.org.uk/professional-development/publications/pub-007069.

77 Preventing Radicalisation Level 3 e-learning training, c. September 2019, screen 47.

78 Interview with NHS Safeguarding professional, 17 July 2019.

79 For example, Dr Lyn Jenkins observed: "We were never told when we had our teaching about Prevent what actually went on and what they did with the people...there's been nothing in the media to tell us what is actually going on. It's completely obscure to me what the program actually does in practice" (Interview 26 September 2019).

80 Focus group participant G (Brighton).

81 Typical comments included the following: "That's [safeguarding is] not how it seems to me, and it's not how it feels to me" (Interview with Dr Adrian James, 2 October 2019); "I wouldn't make a referral with the expectation that it would help the person who I was referring" (Interview with CAMHS clinical psychologist, 1 October 2019.)

82 Focus group participant P (London).

83 Focus group participant J (Brighton)..

84 Like health workers, social work practitioners have raised this concern. Characterising Prevent as an "ideologically driven moral panic", Stanley and Guru argue that "social work can find itself unwittingly posing a risk to the very families we set out to help". See: Stanley, Tony and Surinder Guru (2015), "Childhood Radicalisation Risk: An Emerging Practice Issue", Practice, 27(5): 353.

85 Focus group participant F (Brighton).

86 Interview with Manchester-based GP, 20 August 2019.

87 Interview with CAMHS clinical psychologist, 1 October 2019.

88 Interview with London-based GP, 26 July 2019; Focus group participant W (Manchester).

89 Focus group participants W and AA (Manchester) and R (Birmingham).

90 The person in this case was a Muslim man with schizophrenia (Richard Kerbaj, "Anti-extremism mentors inform on clients to police", The Times, 11 August 2019).

91 One research participant pointed out that safeguarding was not always the approach used in cases of apparent radicalisation: "I think it's a question of perception. Just taking the example of the Shamima [Begum] case, if she wasn't racialized the way she was, we'd probably be speaking about grooming [and] going down the paedophilia route with random men speaking to, what, a 15-year-old and then raping her at least twice. But obviously the way this is framed...in that case we definitely did not safeguard, we criminalized. So I think...that's the main conflict...one [safeguarding] appears to come from a place of altruism, the other [criminalization] appears to come from policing." (Focus group participant S, Birmingham).

92 Concerns have been raised that in Prevent the best interests of children are not always prioritised, as safeguarding requires, and that Channel duty guidance does not make this priority clear (Amrit Singh, Eroding Trust, 18).

93 About a quarter of Section 42 Safeguarding Enquiries made between 2013-16 were assessed as lacking capacity (NHS Digital, "Safeguarding Adults: Annual Report, England 2015-16 Experimental Statistics", 5 October 2016, 27, https://files.digital.nhs.uk/publicationimport/pub21xxx/pub21917/sac_%201516_report.pdf).

94 Focus group participant Q (Birmingham).

95 Ibid.

96 Interview with Dr Shazad Amin, 29 August 2019; Interview with Dr Jackie Applebee, 24 September 2019. A 2017 NHS England survey which asked of safeguarding professionals in London which issues they felt should be prioritised revealed that self-neglect, domestic violence, modern slavery, mental health and "alcohol and other drugs" accounted for the vast majority of concerns, whereas radicalisation was hardly, if ever, mentioned.

97 Interview with NHS Safeguarding professional, 17 July 2019.

98 Younis, Tarek and Sushrut Jadhav (2019), "Islamophobia in the National Health Service: an ethnography of institutional racism in PREVENT's counter-radicalisation policy", Sociology of Health & Illness, 42(3), 618-19.

99 Interview with Derek Summerfield; ibid.

Chapter 8. Confidentiality, consent & trust

1 Interview with Dr Jackie Applebee, 24 September 2019.

2 Interview with Dr Jonathan Leach, Joint Honorary Secretary of the Royal College of GPs, 19 September 2019.

3 Department of Health, "Confidentiality: NHS Code of Practice", November 2003, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/200146/Confidentiality_-_NHS_Code_of_Practice.pdf.

4 Interview with Julian Sheather, 25 September 2019.

5 Home Office, "Factsheet: Prevent and Channel".

6 Singh, Eroding Trust, 43.

7 Unexpectedly, we also uncovered some disagreement over the nature of consent itself. For Dr Jonathan Leach of the Royal College of GPs, obtaining consent could involve efforts "to persuade people" and, he maintained, "it doesn't matter that you're going to refer the patient to safeguarding anyway" (Interview with Dr Jonathan Leach, Joint Honorary Secretary of the Royal College of GPs, 19 September 2019.) In contrast, others saw a willingness to accept no for an answer as an essential ingredient of consent-seeking (Focus group participant AA (Manchester); Interview with Roy McClelland, Consultant Psychiatrist and Emeritus Professor of Mental Health at Queen's University Belfast, 19 September 2019; Interview with Julian Sheather, Human Rights and Ethics Adviser to the British Medical Association, 25 September 2019.)

8 Interview with Prof Roy McClelland, 19 September 2019.

9 General Medical Council, "Confidentiality: good practice in handling patient information", 33, https://www.gmc-uk.org/-/media/documents/gmc-guidance-for-doctors---confidentiality-good-practice-in-handling-patient-information----70080105.pdf?la=en&hash=08E96AC70CEE25912CE2EA98E5AA3303EADB5D88.

10 Interview with retired consultant psychiatrist and Mend CEO Dr Shazad Amin, 29 August 2019; Interview with Julian Sheather, Human Rights and Ethics Adviser to the British Medical Association, 25 September 2019; Focus group participant AA (Manchester); Focus group participant L (London).

11 Focus group participant I (Brighton).

12 Focus group participant Q (Birmingham).

13 Interview with Dr Andrew Goddard, 22 October 2019.

14 Interview with Manchester-based GP, 3 September 2019.

15 Interview with a legal academic based in the Midlands, 29 August 2019.

16 Focus group participants G and H (Brighton). Interview with Dr Lyn Jenkin, 26 September 2019; Interview with Dr Jonathan Leach, 19 September 2019; Interview with London GP, 27 August 2019.

17 Interview with Dr Jonathan Leach, 19 September 2019.

18 NHS England, "Practical Guidance on the sharing of information and information governance for all NHS organisations specifically for Prevent and the Channel process", July 2017, https://www.england.nhs.uk/wp-content/uploads/2017/09/information-sharing-information-governance-prevent.pdf.

19 Focus group participant AA (Manchester); Interview with Julian Sheather, 25 September 2019; Interview with Dr Adrian James, 2 October 2019; Interview with Dr Lyn Jenkin, 26 September 2019.

20 Singh, Eroding Trust, 18; Interview with a Manchester GP, 20 August 2019; Interview with an NHS Safeguarding professional in a Midlands hospital, 17 July 2019; Interview with Dr Shazad Amin, 29 August 2019.

21 Interview with GP in the North West, 26 July 2019. This is not necessarily correct. The Great Ormond Street Hospital Trust's revent policy, for example states that while a staff member does not require "proof" they should be able to "point to objective evidence" when making a Prevent referral (Great Ormond Street Hospital Prevent Policy, April 2018, 5). However, policies vary by Trust and the fact remains that there are no penalties for false positive referrals.

22   Interview with Dr Lyn Jenkin, 26 September 2019.

23   Interview with Dr Adrian James, 2 October 2019.

24   Interview with London GP, 27 August 2019.

25   Interview with Dr Adrian James, 2 October 2019; Interview with Julian Sheather, 25 September 2019.

26   Interview with Manchester-based GP, 26 July 2019; Interview with Jackie Applebee, 24 September 2019; Interview with London-based GP, 27 August 2019; Interview with Manchester-based GP, 20 August 2019; Interview with Dr Shazad Amin, 29 August 2019; Focus group participants G (Brighton). This includes laws specific to terrorist threats: under the Terrorism Act 2000, it is a criminal offence not to tell the police "as soon as is reasonably practicable" if you become aware of information which you know or believe "might be of material assistance" in preventing an act of terrorism, or securing the arrest, prosecution or conviction of someone involved in "the commission, preparation or instigation of an act of terrorism" ("Counter-terrorism and confidentiality", MDU, 30 March 2018, https://www.themdu.com/guidance-and-advice/guides/counter-terrorism-and-confidentiality.)

27   Amongst them were: Focus group participant P (London); Focus group participant Z (Manchester); Interview with Julian Sheather, 25 September 2019; Interview with Jackie Applebee, 24 September 2019; Interview with Prof Roy McClelland, 19 September 2019; Interview with Dr Jonathan Leach, 19 September 2019; Interview with a Manchester GP, 20 August 2019.

28   Interview with an NHS Safeguarding professional in a Midlands hospital, 17 July 2019.

29   Intercollegiate Document, "Adult Safeguarding: Roles and Competencies for Health Care Staff", August 2018, 9, https://www.rcn.org.uk/professional-development/publications/pub-007069.

30   NHS England "Safeguarding Adults", n.d., https://www.england.nhs.uk/wp-content/uploads/2017/02/adult-pocket-guide.pdf.

31   Interview with Julian Sheather, 25 September 2019

32   Interview with Dr Shazad Amin, 29 August 2019; Interview with an NHS Safeguarding professional in a Midlands hospital, 17 July 2019; Interview with Dr Adrian James, 2 October 2019; Interview with London GP, 26 July 2019; Focus group participants G and I (Brighton).

33   Focus group participant H (Brighton).

34   Interview with Dr Lyn Jenkin, 26 September 2019.

35   Focus group participant I (Brighton).

36   Focus group participant U (Birmingham).

37   Focus group participant Q (Birmingham).

38   Interview with Julian Sheather, 25 September 2019.

39   Interview with Prof Roy McClelland, 19 September 2019.

40   General Medical Council, "Confidentiality: good practice in handling patient information", 12, https://www.gmc-uk.org/-/media/documents/gmc-guidance-for-doctors---confidentiality-good-practice-in-handling-patient-information----70080105.pdf?la=en&hash=08E96AC70CEE25912CE2EA98E5AA3303EADB5D88.

41   Interview with Julian Sheather, 25 September 2019.

42   He added: "If you're in the business of preventing damage to vulnerable adults, it's around their decision-making capacity. If they have decision-making capacity and you don't like what they're doing then the GMC's guidance is quite clear on this, you really cannot override a person's decision to harm themselves. It's their decision." Interview with Prof Roy McClelland, 19 September 2019.

43   General Medical Council, "Confidentiality: good practice in handling patient information", 26, https://www.gmc-uk.org/-/media/documents/gmc-guidance-for-doctors---confidentiality-good-practice-in-handling-patient-information----70080105.pdf?la=en&hash=08E96AC70CEE25912CE2EA98E5AA3303EADB5D88.

44   Interview with Prof Roy McClelland, 19 September 2019.

45   Only at the stage at which "you are adopted by your local authority Channel Panel to receive support" do they "have a responsibility to inform you that your data is being processed", and seek your informed consent to "access Channel support." (Home Office, "Channel Data Privacy Information Notice", 13 March 2020, https://www.gov.uk/government/publications/channel-data-privacy-notice/channel-data-privacy-information-notice.)

46   Home Office, "Factsheet: Prevent and Channel".

47   While not included in the case study, the psychiatrist explained this in a follow-up phone call, saying: "You assess for all sorts of risks with someone who's got a severe mental illness and identify different possible ones. And there's an onus to show that if you've identified a risk, then you've explored that and taken some measures to mitigate against that. And those might be things that don't go anywhere. But sort of identifying a potential risk and not doing anything at all about it would be seen as bad practice. So in that sense, it would have been ticking a box to discuss with the police through Prevent."

48   More broadly, one interviewee highlighted a lack of proportionality suggested by the high rate of false positive referrals, saying: "if no cause was found in 90 plus percent, you have to question the sensitivity of the model…and the alienation that that causes is a real issue. I think that information [about false positive rates] is extremely important in looking at the best balance of proportionality and protecting the public" (Interview with Professor Roy McClelland, 19 September 2019).

49   "SDCS Prevent Data Set & Explanations 2019", NHS Digital, 21 March 2019, released under Freedom of Information Act.

50   Ibid.

51   Preventing Radicalisation Level 3 e-learning training, c. September 2019, screen 12.

52   Ibid, screen 13.

53   Ibid, screen 21.

54   Ibid, screen 22.

55   Ibid, screen 70.

56   Ibid, screen 73.

57   Ibid, screen 95.

58   Ibid, screen 106.

59   Ibid, screen 111.

60   Ibid, screen 150.

61   The suggestion of consulting a Caldicott Guardian, who holds expertise on confidentiality is made only once (screen 151).

62   Ibid, screen 89.

63   Ibid, screen 97.

64   Ibid, screen 99. As argued earlier, since Prevent does not deal with imminent risk, it is incommensurate with public interest justifications for breaching confidentiality so inclusion of "public interest" here is arguably irrelevant and misleading.

65   Interview with Dr Shazad Amin, 29 August 2019.

66   Anonymous via email, 21 August 2019.

67   Focus group participant Z (Manchester).

68   Interview with Prof Roy McClelland, 19 September 2019.

69   Interview with clinical psychologist working in CAMHS in London, 1 October 2019.

70   Focus group participant X (Manchester); Focus group participant AA (Manchester); Interview with CAMHS clinical psychologist, 1 October 2019; Focus group participant M (London).

71   Focus group participant G (Brighton); Interview with CAMHS clinical psychologist in London, 1 October 2019; Case study 4 (Chapter 6).

72   Interview with a Manchester GP, 20 August 2019.

73   Interview with CAMHS clinical psychologist in London, 1 October 2019.

74   Interview with Dr Jonathan Leach, 19 September 2019.

75   Focus group participant J (Brighton).

76   Focus group participant W (Manchester); Interview with Julian Sheather, 25 September 2019.

77   Singh, Eroding Trust, 43.

78   Interview with Julian Sheather, 25 September 2019; Interview with Prof Roy McClelland, 19 September 2019; Interview with Dr Adrian James, 2 October 2019.

79   John Middleston, "Preventing violent extremism: the role of doctors", Lancet, 19 October 2016, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)31902-X/fulltext.

80   Jamie Grierson, "Counter-terror police running secret Prevent database", Guardian, 6 October 2019, https://www.theguardian.com/uk-news/2019/oct/06/counter-terror-police-are-running-secret-prevent-database.

81   NHS England, "Guidance for mental health services in exercising duties to safeguard people from the risk of radicalisation", November 2017, 17, https://www.england.nhs.uk/wp-content/uploads/2017/11/prevent-mental-health-guidance.pdf.

82   Jamie Grierson, "Revealed: how teachers could unwittingly trigger counter-terror inquiries", Guardian, 21 February 2020, https://www.theguardian.com/uk-news/2020/feb/21/public-sector-teachers-doctors-prevent-inquiries-trigger-referrals.

83   Focus group participant W (Manchester); Interview with Dr Shazad Amin, 29 August 2019.

84   Similar fears have recently been raised by privacy groups about whether the Home Office will be able to access personally identifiable data retained as part of the NHS test-and-trace coronavirus programme. (Dan Sabbagh and Alex Hern, "Privacy group prepares legal challenge to NHS test-and-trace scheme", Guardian, 31 May 2020, https://www.theguardian.com/world/2020/may/31/privacy-campaigners-prepare-legal-challenge-to-uks-test-and-trace-scheme)

85   Department for Education, "Advice note: Safeguarding vulnerable individuals in Higher Education from terrorist groups", n.d., 2, https://www.safecampuscommunities.ac.uk/uploads/files/2017/05/advice_note_safeguarding_in_he_050517.pdf.

86   Grace, Jamie (2018) "Countering extremism and recording dissent: intelligence analysis and the Prevent agenda in UK Higher Education", Journal of Information Rights, Policy and Practice, 8,   http://shura.shu.ac.uk/17478/3/

Grace%20Countering%20extremism%20and%20recording%20dissent.pdf.

87   Documents released by Information Commissioner's Office under FOI. It is not clear if this policy was ever implemented.

88   Richard Kerbaj, "Anti-extremism mentors inform on clients to police", The Times, 11 August 2019. Separately, in Germany, a small far right organisation with at least one member working within state criminal investigation authorities were able to access police records to compile a "death list" of leftwing and pro-refugee targets, whom they stockpiled weapons to kill (Philip Alterman, "German far-right group 'used police data to compile death list'", Guardian, 28 June 2019, https://www.theguardian.com/world/2019/jun/28/german-far-right-group-used-police-data-to-compile-death-list). While clearly an extreme case, given that UK police arrested one serving officer in 2020 for being a member of a far right terrorist organisation, it is not impossible that data retention here could lead to a similar worst case scenario (Lizzie Dearden, "'Neo-Nazi' Metropolitan Police officer arrested on suspicion of terror offences", Independent, 5 March 2020, https://www.independent.co.uk/news/uk/crime/police-officer-terror-arrest-met-london-right-wing-group-a9379641.html.)

89   Home Office, "Factsheet: Prevent and Channel".

90   NHS England, "Practical Guidance on the sharing of information and information governance for all NHS organisations specifically for Prevent and the Channel Process", July 2017, 7, https://www.england.nhs.uk/wp-content/uploads/2017/09/information-sharing-information-governance-prevent.pdf.

91   Ipsos MORI, " Veracity Index 2017", November 2017, Social Research Institute, https://www.ipsos.com/sites/default/files/ct/news/documents/2017-11/trust-in-professions-veracity-index-2017-slides.pdf.

92   Interview with former member of a local authority Prevent Strategic Group in the Midlands in the Midlands, 29 August 2019.

93   Interview with Dr Jackie Applebee, 24 September 2019.

94   Singh (2016) Eroding Trust; Focus group participant M (London); Interview with London GP, 27 August 2019; Interview with Dr Jackie Applebee, 24 September 2019; Interview with Julian Sheather, 25 September 2019; Interview with GP in the North West, 26 July 2019; Interview with a Manchester GP, 20 August 2019; Interview with a legal academic based in the Midlands, 29 August 2019; Interview with CAMHS clinical psychologist in London, 1 October 2019; Interview with former member of a local authority Prevent Strategic Group in the Midlands in the Midlands, 29 August 2019.

95   Focus group participant Q (Birmingham).

96   Interview with former member of local authority Prevent Strategic Group, 29 August 2019.

97   Interview with an NHS Safeguarding professional, 17 July 2019.

98   Interview with Dr Jonathan Leach, 19 September 2019.

99   He explained "If I don't have trust, I don't have a therapeutic relationship.

And that's key. And I don't think that many people outside healthcare really appreciate that." (Interview with Dr Jonathan Leach, 19 September 2019).

100   Focus group participant O (London).

101   Interview with a legal academic, 29 August 2019.

102   Interview with Julian Sheather, 25 September 2019; Interview with an NHS Safeguarding professional, 17 July 2019; Focus group participant A (London) argued: "There is a therapeutic relationship that clinicians have, but one of the things that's really important in those relations is confidentiality and knowing that you have a safe relationship. For example, I've looked at loads of people that have survived domestic violence and I've always been really clear about not involving security services or police or whatever."

103   Focus group participant W (Manchester); Focus group participant O (London); Focus group participant Z (Manchester); Focus group participant R (Birmingham).

104   Interview with Dr Jonathan Leach, 19 September 2019; Interview with Dr Adrian James, 2 October 2019, Interview with CAMHS clinical psychologist, 1 October 2019; Focus group participant G (Brighton)

105   Interview with Dr Adrian James, 2 October 2019.

106   Interview with Julian Sheather, 25 September 2019; Interview with a former Prevent lead in an English primary care trust and ex-Channel Panel member, 30 August 2019; Focus group participant L (London); Focus group participant G (Brighton).

107   Interview with Manchester GP, 3 September 2019; Interview with Dr Jackie Applebee, 24 September 2019; Focus group participant AA (Manchester).

108   Prevent may be just one example of a broader erosion of confidentiality and consent in healthcare. As part of the hostile environment, data has been shared with the Home Office about patients' migration status; in hospital A&E wards, gunshot wounds and knife wounds are now reportable (Interview with Dr Jonathan Leach, 19 September 2019); the author of a study claiming a rise in false positive child protection referrals were damaging families argued that the "clear separation" made in the Children Act 1989 had been eroded in the last two decades (Louise Tickle, "Rise in referrals to social services causing trauma to families, expert says", Guardian, 15 April 2016, https://www.theguardian.com/society/2016/apr/15/rise-in-referrals-social-services-trauma-families-child-protection) there is a duty to refer in relation to homelessness and a statutory duty to share information with police if someone is at risk of child sexual exploitation (Interview with CAMHS clinical psychologist in London, 1 October 2019). During the covid-19 pandemic, care providers reported receiving significant numbers of "unlawful" DNR ("do not resuscitate") orders from medical professionals in relation to people with learning disabilities without consultation with patients or their families. (Rebecca Thomas, "Unprecedented' number of DNR orders for learning disabilities patients", Health Service Journal, 24 April 2020, https://www.hsj.co.uk/coronavirus/unprecedented-number-of-dnr-orders-for-learning-disabilities-patients/7027480.article?fbclid=IwAR0bGsIKmBO85_z1_0Wsz0mwVdju_riuFf_CZnduM3ZTGcSny0xNYlXVGOw).

Chapter 9. Conclusions & recommendations

1   The situation bears comparison to the findings of a 2016 report which concluded that a huge increase in the number of children being referred to social services was causing "catastrophic" trauma to tens of thousands of families without any corresponding increase in the number of child abuse cases detected. The Guardian concluded that "many families who have done nothing wrong are being traumatised by intrusive investigations". However, the analogy is limited because even the minority whose Prevent cases do lead to Channel intervention, are innocent of any crime. (Louise Tickle, "Rise in referrals to social services causing trauma to families, expert says", Guardian, 15 April 2016, https://www.theguardian.com/society/2016/apr/15/rise-in-referrals-social-services-trauma-families-child-protection).

2   Moreover, the Home Office does not publish statistics on faith and ethnicity of Prevent referrals and many NHS Trusts say they do not record this data, or refuse to do disclose it on the explicit grounds that to do so could damage the reputation of Prevent. Thus beneath this apparent neglect of equalities monitoring around Prevent — raising questions about compliance with public sector equality duties — there seems to be a deliberate effort to obfuscate the reality of this disproportionality.

3   See for example UN Special Rapporteur on the Right to Freedom of Assembly Maina Kiai, (Damien Gayle, "Prevent strategy 'could end up promoting extremism", Guardian, 21 April 2016, https://www.theguardian.com/politics/2016/apr/21/government-prevent-strategy-promoting-extremism-maina-kiai) and Professor Theo Gavrielides (Mark Townsend, "Priti Patel's plan to tackle radicalised youth is so flawed it's mad, says study", Guardian, 26 January 2020, https://www.theguardian.com/politics/2020/jan/26/priti-patel-radicalised-youth-plan-so-flawed-its-mad.

4   For instance, the UK's most senior counter-terrorism officer Neil Basu made this claim in September 2019. (Jamie Grierson, "Foiled terrorist attacks on UK soil have risen to 22, says top officer", Guardian, 9 September 2019, https://www.theguardian.com/uk-news/2019/sep/09/foiled-terrorist-attacks-on-uk-soil-have-risen-to-22-says-top-officer.

5   For more on "Operation Dovetail", the programme pioneered the transferring of 'Prevent' responsibilities outlined in the counter-terrorism strategy from the police to local authorities and others, see: https://www.policeprofessional.

com/news/anti-terror-commission-recommends-giving-prevent-responsibilities-to-local-authorities.

6   See: The Ammerdown Group (2016) Rethinking security: A discussion paper; Sam Perlo-Freeman (2020) Fighting the Wrong Battles: How Obsession with Military Power Diverts Resources from the Climate Crisis, Campaign Against Arms Trade.

7   Overland, Gwynyth, Arnfinn Andersen, Kristin Engh Førde (2018) Violent Extremism in the 21st Century: International Perspectives, Newcastle: Cambridge Scholars Publishing: 276-279; Lucini, Barbara (2017) The Other Side of Resilience to Terrorism: A Portrait of a Resilient-Healthy City, Cham: Springer: 26-27.

8   For instance, important public health work has connected income inequality and violence in low and middle-income countries, and advocated for "global action to moderate income inequality", in part "to reduce the global health burden of violence": Wolf, Achim, Ron Gray, and Seena Fazel, "Violence as a public health problem: An ecological study of 169 countries", Social Science & Medicine 104 (2014): 220-227.

9   Bhui, Kamaldeep, and Edgar Jones (2017) "The challenge of radicalisation: a public health approach to understanding and intervention," Psychoanalytic Psychotherapy 31(4): 401-410; Hardcastle, Katie, Mark Bellis, John Middleton, Dominc Harrison, Daniel Flecknoe, and Joanne Hopkins (2019) Preventing violent extremism in the UK: Public health solutions, Public Health Wales and Faculty of Public Health; Greater Manchester Preventing Hateful Extremism and Promoting Social Cohesion Commission (2018) A Shared Future: A Report of the Greater Manchester Preventing Hateful Extremism and Promoting Social Cohesion Commission.

10   See for example: Blakeley, Ruth, Ben Hayes, Nisha Kapoor, Arun Kundnani, Narzanin Massoumi, David Miller, Tom Mills, Rizwaan Sabir, Katy Slan, Waqas Tufail (2019). Leaving the War on Terror: A Progressive Alternative to Counter-Terrorism Policy, Amsterdam: Transnational Institute; Qureshi, Asim (2010) Beyond Prevent: A Real Alternative To Securitised Policies, Cage; Skoczylis, Joshua, and Sam Andrews (2019) "A conceptual critique of Prevent" Critical Social Policy 1-20.

Appendices

1   https://handbook-5-1.cochrane.org/chapter_7/7_7_7_3_obtaining_standard_errors_from_confidence_intervals_and.htm

2   Downloaded on 14 May 2020 from https://clinical-pathways.org.uk/clinical-pathways/radicalisation-and-extremism.

List of figures and tables