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DESISTANCE AND DISENGAGEMENT PROGRAMME IN THE UK PREVENT STRATEGY

A public health analysis

Mohammed Samir Elshimi

Introduction

The purpose of this chapter is to examine the introduction of the Desistance and Disengagement Programme (DDP) in the Prevent strand of the UK’s Counter-Terrorism Strategy (CONTEST). Little is known about DDP in the public domain and no academic investigation has been conducted to understand how it works and the impact it is having. This chapter therefore attempts to answer the following questions: Why has a counter-terrorism (CT) programme such as DDP been incorporated into a preventing and countering violent extremism (P/CVE) strategy such as Prevent? What does the emergence of DDP in the Prevent strand tell us about how Prevent is evolving?

A revised version of CONTEST was released in June 2018. CONTEST has undergone three iterations (2006, 2011, 2018) and comprises four pillars: Prevent, Pursue, Protect and Prepare. Prevent aims to ‘safeguard and support vulnerable people to stop them from becoming terrorists or supporting terrorism’ (HO 2018: 31) and is now in its fourth iteration (2006, 2009, 2011, 2018). The new element to Prevent 2018 was the integration of DDP under its purview (HO 2018: 40). DDP targets individuals already engaged in terrorism, who are required to disengage from terrorism and re-integrate back into society. DDP targets a wider category of persons than those convicted of terrorism, such as individuals who have not been convicted in court due to a lack of evidence but who are subject to court-approved restrictions, such as the Terrorism Prevention and Investigation Measures (TPIMs), and those who have returned from conflict zones in Syria or Iraq and are subject to Temporary Exclusion Orders (TEOs) (HO 2018: 40).

CONTEST 2018 states that DDP work complements the Pursue strand, which aims to stop terrorist attacks happening in the UK and overseas (HO 2018: 29). This move towards working across the four ‘P’ strands is framed as both natural and necessary considering the shift in threats facing the UK. The cross-fertilisation between Prevent and Pursue is also
presented as an opportunity to make the Home Office’s capabilities and resources increasingly interconnected, especially with respect to ‘managing the risks from terrorist travellers and prisoners, and to multi-agency work’ (Ibid).

However, preventive CT and DDP have conflicting logics. Prevent seeks to work with communities and individuals in the ‘pre-criminal space’ to prevent them from crossing over to terrorism or supporting terrorism. Although the term ‘pre-criminal space’ is not recognised in criminology and social science (Goldberg, Jadhav & Younis 2017; Heath-Kelly & Strausz 2018: 10), it nevertheless aptly encapsulates the tension inherent in a strategy eager to eschew criminalising individuals and communities on the one hand, while balancing this with the perceived need to provide corrective support on the other. In contrast to Prevent’s pre-criminal work, programmes such as DDP operate in the post-criminal space and target individuals with a previous involvement in terrorism. These programmes are designed to ensure that individuals who previously contributed to terrorism do not return to such activities and are therefore reactive, not preventive. Since June 2018, then, Prevent – a pre-emptive strategy designed to reduce the risk of people turning to terrorism – is now also concerned with people already engaged with terrorism.

And yet at this point little is known about DDP and what the blurring between P/CVE (Prevent) and CT (Pursue) means in practice. No research has hitherto examined the integration of DDP into Prevent. The lack of research on DDP is significant given that keeping the public safe is a priority for policymakers, and that de-radicalising Islamic State returnees and prisoners (sentenced under the Terrorism Act 2000 and its successors, and known as TACT offenders) is a pressing political and security issue that attracts a lot of media and public attention. In addition, the programme is currently undergoing a transition between piloting phase and having to expand rapidly (HO 2018: 40); it has to deal with scores of TACT offenders who are coming to the end of their sentences and who will re-join society; it also has to contend with the presence of various offenders with different forms of licensing arrangements and the wider issue of rehabilitating fighters, women and children linked to the Islamic State. A failure, then, to understand DDP and how it fits into Prevent can potentially lead to ill-informed policy decisions.

This chapter makes three arguments. The first is that the literature has not fully explored the implications of having a post-criminal CT programme integrated into the UK Prevent strategy. The second is that it is more intelligible to understand the incorporation of DDP into Prevent through the conceptual framework of the Public Health Model (PHM). The use of the PHM has recently gained prominence in the literature on P/CVE (Aly, Balbi & Jacques 2015; Bhui & Jones 2017; Challgren et al. 2016; Sumpter 2017; Weine, Eisenman, Kinsler, Glik & Polutnik 2017) but has not yet been applied to the analysis of Prevent in the UK. Seen therefore through the PHM framework, the inclusion of interventions that evince a rehabilitative logic within Prevent 2018 must be understood as an attempt to address different levels of risk. The incorporation of DDP under Prevent also indicates that the Prevent delivery model is being restructured in the image of the PHM.

The third argument is that, rather than being something entirely new, the advent of DDP in Prevent 2018 represents rather a culmination of longer historical trends, in which responses to terrorism have become increasingly medicalised. The medicalisation of terrorism has expanded the medical gaze to include an ever-growing category of persons within the purview of CT, as well as individualising, pathologising and de-politicising Prevent’s responses to terrorism.
This chapter is divided into the following sections. The next section examines what is known about DDP in the literature and identifies the pre-existing limitations of trying to analyse DDP through the existing literature on Prevent. The second section introduces the PHM and how the literature has treated the role of public health approaches in relation to P/CVE. In the third section Prevent is situated in a historical context in order to highlight its evolution and how it has reconfigured its activities, over the years, in the paradigmatic image of the PHM. The section after applies the PHM framework to Prevent and attempts to demonstrate that Prevent fits well into the PHM. Lastly, the implications of viewing Prevent through the PHM is analysed through the concept of ‘medicalisation’ and explores what this means for current Prevent practices.

**DDP, de-radicalisation and Prevent**

Little is known about DDP in the public domain, except for what is conveyed in Prevent. A freedom of information request by the Guardian newspaper to the Home Office revealed that 116 people were subject to the DDP between October 2016 and September 2018 (Grierson 2019). Due to the sensitive nature of DDP work and the fact that the programme has not fully matured yet, details of individuals and organisations selected to deliver interventions are not known. In addition, data on how DDP operates in practice, how it interacts with the rest of Prevent work and an understanding of the impact it is having is not available.

Prevent 2018 does not define several key terms associated with DDP, such as ‘desistance’, ‘disengagement’, ‘re-integration’ and ‘rehabilitation’. Although these terms are often employed interchangeably, they nonetheless connote subtle conceptual and operational differences, which in practice impact the approach taken by rehabilitation programmes. Many European governments employ the terms ‘de-radicalisation’ and ‘disengagement’ to refer to the process of moving away from terrorism, whereas the terms ‘re-integration’ and ‘rehabilitation’ refer to the aims of such interventions (RAN 2017:43). In the literature, ‘re-integration’, which is often synonymous with ‘rehabilitation’, is understood as a safe transition to the community, by which individuals proceed to live a law-abiding life following their release and acquire attitudes and behaviours that generally lead to productive functioning in society (Veldhuis 2012: 2). The use of these terms to distinguish between the process and objective of programmes echoes Prevent’s use of the terms, where the objective of DDP is ‘rehabilitation’, with ‘desistance’ and ‘disengagement’ denoting the process itself (HO 2018: 40).

It is significant that Prevent frames its terrorist rehabilitation programme as ‘desistance and disengagement’ and not ‘de-radicalisation’, not least because DDP measures include mentoring, psychological support and theological and ideological advice, all of which are components of a typical de-radicalisation intervention (HO 2018: 40). Prevent, notably, alludes to ‘de-radicalisation mentors’ once, but not to de-radicalisation programmes/interventions (HO 2018: 50). De-radicalisation is commonly conceptualised as a social and psychological process that results in attitudinal change, effectively reducing an individual’s commitment to the belief that personal involvement in violence is necessary and justified (Schuurman & Bakker 2016: 3). Key to understanding the concept of de-radicalisation is the notion of a cognitive shift and the use of counter-ideology and theological deconstruction in inducing a fundamental change in behaviour.

However, Prevent’s reticence to employ the term ‘de-radicalisation’ can be attributed to the conceptual and practical challenges inherent in the concept. De-radicalisation is criticised
for its emphasis on belief change, because it represents a reductive conceptualisation of the process and posits an intervention objective that diverts resources away from more realistic policy aims. Conceptually, it also excludes the dynamic interplay between various non-ideational factors involved in the process of leaving terrorism behind (Bjorgo & Horgan 2009; Ferguson 2016; Horgan 2008). Research, for example, emphasises that ideational and ideological factors play little or no role in persuading individuals to enter or leave such groups and movements (Bjorgo 2009: 36–40).

The term de-radicalisation is also seen as problematic in liberal democratic societies because of the implicit implication that the state is interested in regulating the beliefs and views of its citizens (Elshimi 2017: 60–61). De-radicalisation, then, is not merely about reducing the risk of terrorism and ideological transformation but is also about normative change; participants’ pre-intervention worldview is not only construed as being risky, but it is also assumed to be wrong. De-radicalisation therefore suggests that intervention participants should adopt a preferred ideational worldview.

Historically, in the UK, the meaning and practice of de-radicalisation have evolved over the last 12 years. Between 2006 and 2010, de-radicalisation was used as a broad catch-all term to encompass different-but-related methods and techniques aimed at reducing society’s risk from terrorism, such as ‘countering violent extremism’ and ‘preventing violent extremism’ (Elshimi 2017). In other words, the UK Prevent strategy was synonymous with the term ‘de-radicalisation’. De-radicalisation was subsequently employed as a concept to describe the police-administered and multi-agency referral mechanism, the Channel programme, between 2011 and 2015 (Home Office 2011: 65) – an association that was only severed after the Prevent Duty became statutory law in 2015 and when Channel re-framed itself as a safeguarding programme. It is for these, and the above reasons, that policymakers prefer to brand Prevent’s post-criminal rehabilitation work as ‘desistance and disengagement programmes’ rather than ‘de-radicalisation’, even though de-radicalisation work appears to be taking place in DDP.

Equally important, it is not clear how ‘desistance’ is distinguished from ‘disengagement’ in Prevent 2018. It is notable that ‘desistance’ from terrorism does not appear to be used anywhere else in the world except the UK, and actually has a longer track record in offenders’ programmes in the UK than ‘disengagement’ (Dean 2016; Marsden 2017; McNeil 2005). Christopher Dean, who designed an offender’s programme called the ‘Healthy Identity Intervention’ (HII), claims that the programme was not referred to as de-radicalisation or disengagement because of concerns surrounding the terms’ applicability to other offending behavioural programmes in prison (Dean 2016: 27, footnote 21). The primary goal of HII is to facilitate desistance, which may require changes to personal identity, thinking, behaviour and relationships (Dean 2016: 27, footnote 21). Desistance, simply, denotes the process by which individuals cease criminal activity or offending (Altier, Thoroughgood & Horgan 2014: 17).

According to Dean’s conception, then, desistance may be commensurate with the goals of de-radicalisation and disengagement but not reduced to either. Disengagement is not considered necessary for desistance to occur, especially temporary or even lifelong desistance, which may require identity change (Dean 2016: 27, footnote 21). In the literature, disengagement is the process whereby an individual undergoes a change in role or function that is usually associated with a reduction of violent participation. It may not necessarily involve leaving the movement but is most frequently associated with significant temporary or permanent role change. Additionally, while disengagement may stem from role change, that role change may be influenced by psychological factors such as disillusionment, burnout or
the failure to reach the expectations that influenced initial involvement (Horgan 2009a: 152). In relation to Prevent, ‘desistance’ seems to refer to the cessation of terrorist activity, while the ideological dimension of terrorism is confusingly subsumed by the term ‘disengagement’, and not the usual term ‘de-radicalisation’.

Significantly, research has not been conducted on DDP. Most of the scholarship treats de-radicalisation, disengagement, desistance, re-integration and rehabilitation programmes through the lens of CT and not how they operate in a preventive pre-criminal strategy like Prevent. This body of work primarily examines these programmes in prisons with the view of reducing the risk of terrorism (Silke 2013). Attention has primarily focused on descriptive case studies of programmes in different countries (Ashour 2009; Bjorgo & Horgan 2009a; El-Said 2012; Horgan 2009b; Horgan et al. 2010; Khalil et al. 2019; Sukabdi 2015); the process of leaving terrorism behind (Alonso 2011; Ashour 2009; Altier, Boyle, Shortland & Horgan 2017; Bjorgo & Horgan 2009; Clubb 2017; Ferguson 2016; Hwang 2017; Reinares 2011); the efficacy of programmes (Cherney 2018; Koehler 2017; Schuurman & Bakker 2016; Veldhuis 2016; Webber et al. 2017); the re-integration of extremist offenders back into society (Barrelle 2015; Marsden 2017; Weggemans & De Graaf 2017); the modelling of de-radicalisation pathways (Altier et al. 2014; Barrelle 2015; Harris, Gringart & Drake 2017); and conceptual and terminological issues (Horgan 2008; Schmid 2013).

Meanwhile, the literature on Prevent has addressed the development of the strategy in the pre-criminal, and not in the post-criminal space. Prevent has been critiqued for enabling the performance of state sovereignty (Heath-Kelly 2013); creating a spatial pre-criminal geography of detection (Heath-Kelly 2017b); creating suspect communities (Pantazis & Pemberton 2009); delegating the responsibility of surveillance to self-policed communities (Ragazzi 2016); securitising health (Heath-Kelly 2017a), education (Durodie 2016; McGovern 2017; O’Donnell 2015) and citizenship (Jarvis & Lister 2015); using counter-insurgency to manage British Muslim populations (Sabir 2017); undermining community cohesion policies (Thomas 2015); depoliticising and delegitimising dissent (Kundnani 2009); straining community–police relations (Innes, Roberts, Innes, Lowe & Lakhani 2011), re-configuring domestic multiculturalism (Brighton 2007); and suppressing and asserting new forms of identity (Elshimi 2017; Martin 2014).

There has been limited treatment of the concept and practice of de-radicalisation in the pre-criminal space in the wider P/CVE literature. The most relevant contributions have come from works that employ a Foucauldian analysis, in which P/CVE is viewed through the prism of governmentality. Lindekiilde (2012, 2015) and Elshimi’s works (2015, 2017), for example, argue that de-radicalisation practices in P/CVE aim at regulating the ideational boundaries of the nation-state and the conduct of citizens in European societies. While these works engage critically with the concept and practice of de-radicalisation, they do so in relation to P/CVE and not specially with respect to how de-radicalisation in the post-criminal space operates in the context of P/CVE.

While both academic communities have significantly contributed to the scholarly understanding of rehabilitation programmes in the post-criminal space on the one hand, and Prevent in the pre-criminal space on the other hand, the knowledge of behavioural change programmes, which are designed to mitigate the risk of terrorism in the P/CVE and CT fields, has nevertheless developed along mutually exclusive lines. Research has thus not yet investigated what the adoption of DDP within Prevent entails and what the implication of this move in British CT means.
The Public Health Model

One promising avenue that allows us to understand the adoption of DDP within the Prevent paradigm can be found in the burgeoning prominence of the PHM in the classification of P/CVE (Aly et al. 2015; Bhui & Jones 2017; Challgren et al. 2016; Sumpter 2017; Weine et al. 2017). Public health approaches have been applied to violence prevention in general (Mitton, 2019) and to behaviours such as suicide, drug taking, crime and now, also, to radicalisation and terrorism. According to the World Health Organization public health refers to:

all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases. Thus, public health is concerned with the total system and not only the eradication of a particular disease.

(World Health Organization 2016: 9)

The PHM refers to the study of ‘the distribution and determinants of health-related states or events and the application of this study to the control of diseases and other health problems’ (WHO). It relies on a three-pronged approach of identification, interruption and behavioural change (Riemann 2019: 147). The PHM tries to collate data on contagious areas, communities, spaces and individuals in order to map and localise populations at ‘risk’ and ‘vulnerable’ to disease. It classifies the population into three levels that correspond to varying degrees of risk: the ‘primary level’ refers to the pre-risk stage among the generation population; the ‘secondary level’ refers to individuals and communities at risk of radicalisation; and the ‘tertiary level’ comprises individuals and groups who actually have the ‘disease’.

The PHM is appealing for some academics and practitioners working in P/CVE because it offers a coherent, structured and multi-pronged approach to identifying and responding to different types of risk among populations. For Bhui and Jones (2017), public health approaches improve the understanding of radicalisation pathways because they seek to understand the social and psychological conditions and promote interest in protective factors. For Hardcastle et al. (2019), public health approaches afford other ways of addressing the problem of terrorism beyond the conventional criminal justice approach to CT. Weine et al. (2017: 210) identify a gap in social services for those at-risk for terrorism who have not yet committed a crime. The pre-criminal space of the P/CVE field becomes their public health focus. The PHM is therefore seen as a way of limiting the use of law enforcement in P/CVE and reducing the stigma associated with it. The PHM also encourages commitment to improving the monitoring and evaluation of programmes, leveraging existing public health resources, as well as promoting multi-sectorial cooperation (Mitton 2019: 136).

Other scholars have critiqued the deployment of the PHM to address terrorism and other forms of violence (Aggarwal 2018; Heath-Kelly 2017b; Riemann 2019). Neil Aggarwal (2018) argues that the American Government is using public health systems to extend the net of surveillance to a wider population (Aggarwal 2018: 4). According to Aggarwal, public health screening assumes that clinical procedures can detect risk factors for an illness whose early detection leads to effective interventions (Aggarwal 2018: 2). He also claims that there is a danger of health professionals becoming co-opted into the American Government’s security agenda and that the health system risks serving governments by sequestering populations that are deemed undesirable at the expense of promoting the health interests of
individuals. Aggarwal’s analysis does not evaluate the effectiveness of the PHM and is based on a critical analysis of a few public documents, but it does draw our attention to the challenges that arise from the deployment of the PHM in P/CVE.

Only a couple of scholars have drawn parallels between public health approaches and the delivery of UK Prevent (Goldberg et al. 2017; Heath-Kelly 2017b). Heath-Kelly (2017b) argues that Prevent under the Labour Government (2006–2010) borrowed from historical models of public health to imagine radicalisation risk as an epidemiological concern in areas showing a 2% or higher demography of Muslims (p. 298). She lays out the public health ‘geography’ characterising UK Prevent and how it was constituted around notions of proximity and contagion. According to Heath-Kelly, tertiary level interventions were considered preventive rather than punitive because the judicial response to crime aimed at the reduction of recidivism through the separation of offenders from the population (imprisonment), rehabilitation programmes and treatment programmes for addiction (p. 303).

While Heath-Kelly draws our attention to the geographical and epistemological shifts in the deployment of the UK Prevent strategy between 2007 and 2017, she nevertheless wrote her article at a time when there were no tertiary level interventions in the UK. This explains why her reference to tertiary level interventions was vague, describing it in a generic way, without pinning her analysis to a specific example (p. 306). Heath-Kelly also presents tertiary level interventions in the UK as eliding with secondary level interventions, encapsulated in Channel’s rehabilitative work (p. 304). Importantly, however, she argues that early iterations of Prevent were premised on public health approaches, as well as the pre-profiling of suspect communities. For Heath-Kelly, Prevent 2011 marked the move away from the deductive logic of public health approaches and towards the adoption of modern surveillance techniques based on inductive big data logic. While she presents a compelling case, this article argues instead that it is not until the introduction of DDP in Prevent in 2018 that Prevent can be said to have fully restructured itself in the image of the PHM. In other words, Prevent has been gradually evolving in the direction of the PHM and has not moved away from it.

Hardcastle et al.’s study (2019) examines the challenges facing Prevent and highlights the criticism it has received, the lack of an evidence-base underpinning its interventions and the lack of rigorous evaluations (p. 58). For these authors, the real strength of the public health approach is its ability to address individual and community level risk and protective factors by adopting early interventions and utilising multi-disciplinary and multi-agency approaches (p. 62). They argue that public health approaches could address the multiple risk factors that contribute to terrorism – poverty, inequality, isolation, abusive childhoods, difficulties with identity and mental ill health. They also claim that Prevent has failed to adopt a personal life course history approach, which would enable Prevent practitioners to identify when and how an individual becomes vulnerable to terrorism (p. 61).

Hardcastle et al.’s analysis exaggerates the extent to which Prevent specifically, and P/CVE more generally, has developed according to a criminal justice framework, while understating the increasing prominence of public health approaches in Prevent. Prevent, for example, already uses the language of vulnerability and risk; targets community resilience; acknowledges the multiple factors of radicalisation; has due regard for mental health issues; targets different forms of terrorism; and uses multi-agency approaches to identify individuals in need of support. This article does not advocate that Prevent adopts public health approaches, but argues, instead, that the PHM represents a useful conceptual framework for understanding the emergence of DDP in Prevent, while also underscoring the shift of the Prevent delivery model towards the PHM.
Prevent: a strategy in evolution

To appreciate the subtle conceptual, spatial and operation shifts taking place in the delivery of Prevent, it is useful to situate Prevent in a historical context. CONTEST was developed according to principles found in risk management frameworks (Omand 2010). The architect of CONTEST, Sir David Omand, highlighted the importance of using risk management principles to reduce the security threat:

the aim has to be to take sensible steps to reduce the risk to the public at home and to our interests overseas, on the principle known in risk management as ALARP, to a level as low as is reasonably practicable.

(Omand 2010: 93)

The influence of risk management on the Prevent strategy is reflected in its aim, which does not seek to eliminate terrorism or bring it to an end, but to ‘reduce the risk’ of terrorism (HO 2018: 8). The term ‘prevent’, which describes preventive counter-terrorism, is a misnomer, given that UK Prevent has been driven by a pre-emptive logic. Pre-emption is different from prevention. Pre-emption can be understood as a forceful intervention aiming to neutralise an imminent threat from materialising (Massumi 2007). The notion is encapsulated in military doctrines that propose that threats should be neutralised as soon as possible by seeking to strike first so that the enemy cannot attack. Crucially, pre-emptive logic in the sphere of politics is shaped more by the realm of imagination and the imperative of averting the worst-case scenario from happening (Massumi 2005). While pre-emption is less concerned with facts and empirical data, preventive logic is rooted in the principle that policy objectives are based on data and facts (Massumi 2007).

In the political sphere governed by a pre-emptive logic, risk becomes based on the social construction of what the culture determines to be a threat (Githens-Mazer 2012). In 2006, the imperative for Prevent arose in response to blowback from the Iraq War and the threat of terrorism emanating from second- and third-generation British Muslims. This threat became articulated in the concept of ‘radicalisation’, which consequently justified mass-scale interventions in segments of the population through Prevent (Elshimi 2017). Prevent was thus concerned with re-engineering Muslim communities in order to govern ungoverned spaces in the country (Martin 2014), colonise an unknown future and, as a result, bring a new future into existence (Massumi 2005: 6), one in which radicalisation is drastically reduced to an acceptable level. It is in this sense that Prevent could be said to be governed more by a pre-emptive logic than a preventive one.

Prevent also exhibits a pre-emptive logic due to the challenges of identifying positive cases of terrorist profiles. The absence of a terrorist profile makes it difficult to predict which high-risk individuals will turn to terrorism in the pre-criminal space. As a result, the first two iterations of Prevent (2006–2010) attempted to map the spatial configuration of British Muslim communities in order to locate the perceived threat of radicalisation (Heath-Kelly 2017b). Funding was distributed according to the population size of Muslim communities in a locality (HO 2006, 2009; HC 2010: 50): areas with populations over 5% Muslims in the first iteration (2006) and over 2% in the second (2009). At the time, the Department for Communities and Local Government (DCLG) was responsible for delivering Prevent through the distribution of funds to local organisations and charities across the country.
During these years, Prevent was comprised almost entirely of primary level interventions. Channel, a secondary level intervention, was still a pilot project and had not been rolled out nationally yet. Tertiary level intervention was not a feature of the strategic vision of Prevent. Based on fragmented literature, we know that as early as 2007 the National Offender Management Service (NOMS) endeavoured to develop interventions targeting the drivers of radicalisation in prisons (HO 2011: 88; Spalek, Lambert & El-Awa 2008: 45–46). In 2011, under the Coalition Government, Prevent officially rolled out the Channel programme, marking the emergence of secondary level interventions (HO 2011: 65). Channel, which is a platform in which information is shared among experts from different disciplines, embodies the multi-agency approaches promoted by public health approaches. Multi-agency approaches involve representatives from a plurality of municipal agencies and local organisations – education, health, social welfare, youth, police and corrections – meeting on a regular basis for the identification, development and delivery of interventions to benefit individuals referred to the unit. Rather than focusing on the stigmatising issue of violent extremism, Channel in 2011 was framed as a programme designed to provide ‘support to vulnerable people’ (HO 2011: 65).

Prevent 2011 was organised around three ‘Is’: ideas, individuals and institutions (HO 2011). ‘Ideas’ referred to the objective of countering Islamist ideology; ‘individuals’ denoted that the strategy focused on supporting vulnerable individuals ‘at risk’ of radicalisation, while ‘institutions’ referred to the way that state institutions were tasked with the responsibility of identifying individuals at risk of radicalisation. The responsibility for delivering was also taken away from DCLG and given to the Office for Security and Counter-Terrorism (OSCT) at the Home Office, indicating the growing centralisation of Prevent operations and the relegation of local approaches and the disentanglement of community cohesion policy from Prevent (Elshimi 2017: 146). With the development of secondary level interventions and the centralisation of Prevent there was thus an evolution in its scope, language and delivery mechanism.

With Prevent 2011, however, we see the first indications that tertiary level prison interventions were being developed. Prevent 2011 stated that ‘progress has been slower’ due to the lack of ‘proven methodology’ and the lack of templates to develop interventions from (HO 2011: 89), although national implementation was planned for 2012. One of the goals of Prevent 2011 was ‘significantly scaling up’ de-radicalisation interventions in prisons. By 2012, there were two intervention programmes in prisons for extremist offenders – the Healthy Identity Intervention and Al Furqan (Dean 2016; PSJ 2012: 31). But beyond descriptive and fragmented references to prison de-radicalisation, Prevent did not officially have a prison de-radicalisation programme. It was not until 2018, then, that we see the advent of tertiary level interventions in the form of DDP.

The passing of the Counter-Terrorism and Security Bill of February 2015 that enshrined the Prevent Duty in statutory law was a critical watershed moment in the development of Prevent. The Act made it a legal requirement for specified authorities to have due regard to the need to prevent people from being drawn into terrorism. Firstly, it led to a huge spike of referrals to Channel after 2015. In the year 2017/18, for example, a total of 7,318 individuals were subject to a referral (HO 2018b), whereas between 2007 and 2010 only 1,120 individuals were referred to Channel (HO 2011: 59). Secondly, it led to Prevent being reframed as a ‘safeguarding’ strategy in Prevent 2018 (HO 2018: 31). Safeguarding is a measure used by local authorities to intervene in vulnerable people’s lives (children, young people and vulnerable adults) to protect them from physical, sexual or criminal abuse (DHSC 2018). In Prevent, safeguarding is framed as a form of protection against terrorism, in which radicalisation is compared to a form of...
grooming, whereby an abuser exerts control over a victim. Potential terrorists are now seen as individuals who are vulnerable to ideological indoctrination on the one hand and a potential danger to the public on the other hand.

While the adoption of DDP in 2018 indicated the turning point in which Prevent reconfigures itself in the paradigmatic image of the PHM, there have been several other developments historically with the delivery of Prevent that underscore the adoption of public health approaches. Although the PHM is often invoked to promote more universal and upstream approaches in policy, many of its other core aspects, such as multi-disciplinary and multi-agency work, identifying the multifaceted nature involved in behaviour change, improving the protective factors and reducing the risk factors at the individual level, now characterise the work taking place in Prevent.

Classifying Prevent through the Public Health Model

Prevent 2018 has three objectives, illustrated in the following model:

1. Tackle the causes of radicalisation and respond to the ideological challenge of terrorism.
2. Safeguard and support those most at risk of radicalisation through early intervention, identifying them and offering support.
3. Enable those who have already engaged in terrorism to disengage and rehabilitate.

Instead of the Prevent delivery model depicted in Figure 17.1, it is more fruitful to situate the inherent paradox of having DDP localised in a Prevent strategy through the lens of a PHM framework. Figure 17.2 is an adapted version of the PHM and reveals in more detail how the PHM frames the P/CVE field.

![Figure 17.1 Prevent Delivery Model. DDP, Desistance and Disengagement Programme. Source: Adapted from CONTEST 2018, p. 32.](image-url)
The PHM not only represents the Prevent delivery model more accurately but also reflects the evolution of the Prevent strategy. The difference is that, while the Prevent strategy does not see itself in the PHM mould – there are no references, for example, to it in CONTEST – it has nonetheless inadvertently reconfigured its delivery model in the paradigmatic image of the PHM.

Following the emergence of DDP in 2018, Prevent is now organised according to three levels. The primary level describes broad-based, mass prevention programmes that target the general population. Interventions at this level aim to address the causes of radicalisation. Activities at this level focus on awareness raising, delegitimising terrorism and equipping individuals and communities with the skills to mitigate the threat of radicalisation. These include strategic communication and counter-narratives, community-based interventions, educational initiatives, social activities, skills development and capacity building. The communication aspect of primary interventions includes removing extremist content online by the Internet Referral Unit (HO 2018: 35), as well as various types of products produced by the Research, Information and Communications Unit (RICU) at the Home Office. The goal at the primary level is articulated in terms of building individual and communal ‘resilience’ against radicalisation (Edwards 2016; HO 2018: 33).

Figure 17.2 Public Health Model (PHM).
Source: Adapted from Challgren et al. 2016, p. 17.
Secondary level interventions refer to tailor-made activities that target ‘at-risk’ populations/individuals. The aim is to prevent the progression of radicalisation and reduce the potential for future radicalisation. At this level, activities include mentoring, psycho-social support and counter-messaging (both offline and online). In the UK, secondary level interventions refer to the Channel programme, a voluntary initiative delivered through a multi-agency approach. Channel has Prevent coordinators working across local authorities and some of the police forces. Channel performs the role of a referral mechanism and ‘conduit’ between local authorities, various sectors of the state and intervention providers. A multi-agency panel meets regularly to review referrals, conduct a risk assessment and make decisions about each case, including whether to assign the individual to an intervention provider. Often, ‘support’ here means that the individual is assigned a mentor (Elshimi 2017; Thornton & Bouhana 2017).

The tertiary level describes tailor-made activities targeting radicalised individuals, those engaging with terrorism who have not been convicted, as well as those convicted of a terrorism offence. The aim is to stop and prevent various type of offenders from supporting and re-engaging with terrorism, as well as supporting their re-integration back to normal life. DDP has been running in pilot through 2017 and 2018 and plans to expand in 2019. In contrast to Prevent’s Channel programme, participation in DDP is mandatory. Interventions include counter-theology/counter-ideology which involves theological refutation of ideas, undertaken either by a mentor or an imam; mentoring, which involves providing pastoral support and guidance to participants, as well as counter-ideology; psychological support through assessment, counselling and therapy; and, where possible, supporting their ‘universal needs for identity, self-esteem, meaning and purpose’ (HO 2018: 40).

**Prevent: medicalising counter-terrorism**

Medicalisation refers to ‘a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders’ (Conrad 2007: 4). Medicalisation compares terrorism to a disease. With the inclusion of DDP at the tertiary level, the medical gaze has extended not only to those who have the disease of violent extremism to various degrees, and hence must be cured, but also to a new category of unknown threat embodied by men, women and children linked to the Islamic State, as well as those who have not been convicted in court, but who are subject to licensing conditions. This extension of the medical gaze is also evidenced by the growing preoccupation at the tertiary level with the re-integration of ex-offenders into society, and concerns about potential recidivism in the future. Combining the target populations of primary, secondary and tertiary level interventions reveals the vast scope of surveillance of human life that is subjected to the medical gaze, regulation and behavioural correction under the Prevent infrastructure. This is represented in the adaptation of the ‘career terrorist’ model set out by Horgan and Taylor (2015: 179), shown below.

I. ‘pre-radicalised’ individuals

II. vulnerable individuals

III. extremism (non-violent advocates of extreme change)

IV. radicalisation (involvement with terrorism)

V. violent radicalisation (engagement with terrorism)

VI. desistance and disengagement

VII. de-radicalisation

VIII. reintegration and rehabilitation

IX. recidivism (?)
Another example of the medicalisation of Prevent is seen in the way it now defines itself as a ‘safeguarding and support’ strategy. Although the Prevent Duty of 2015 introduced the notion of safeguarding, it was not until 2018 that Prevent defined its remit in terms of protection against terrorism, as well as support for terrorism. This conception of Prevent as a strategy that provides protection to vulnerable people is new and softens the implication of this subtle change. By transforming itself into a safeguarding strategy, Prevent has legitimised the power to monitor and regulate the various spaces and institutions of the state, as well as intervene against signs of potential radicalisation at a population scale level. The UK remains the only nation in the world to deliver CT within its education and healthcare and social care sectors as safeguarding (Heath-Kelly & Strausz 2018: 10).

With this re-framing of Prevent into a safeguarding strategy, the spatial differentiation between the outside–inside dichotomy required for paradigmatic systems of classification in the biopolitical management of human life was reconfigured (Heath-Kelly 2017a). This is exemplified by the fact that the threat is no longer external (international terrorism) or internal (home-grown terrorism) but ubiquitous – everyone in the ‘pre-radicalised’ phase (Silber & Bhatt 2007: 22) is vulnerable to catching the disease. It is no longer just Muslims, therefore, who are under scrutiny for signs of radicalisation but it is also now the general population that is being observed and examined for latent radical tendencies. Given that the safeguarding threshold is ambiguous and appears to be low in the pre-criminal space, every member of society is a potential subject of safeguarding intervention.

Medicalisation is further illustrated with the de-politicisation of CONTEST’s conception of the radicalisation process. Treating terrorism as the symptom of a psychiatric disorder de-politicises it. The political dimension of terrorism is one of the very components that defines it. This de-politicisation can be seen in the mainstreaming of Channel referrals, the rendering of political violence into a problem of ‘safeguarding’ and with the diminishing prominence of ‘ideology’ from the grammar of Prevent, e.g. ‘ideology’ is mentioned 13 times in CONTEST 2018, which pales in comparison to 2011, where ideology is mentioned 103 times (HO 2011). By de-emphasising the ideological and political motivations of terrorism, Prevent is moving away from the very boundaries that distinguish terrorism from other forms of violence, such as pathological and criminal violence.

Through medicalisation, terrorism also becomes reduced to individual pathology, divorced from the social ecological factors that allow radicalised settings to emerge in the first place. While Prevent acknowledges the diverse factors involved in radicalisation to violent extremism, it nevertheless has a static view of ‘vulnerability’. This is evident with how Prevent conceptualises the ‘pre-radicalised’ person as a ‘vulnerable’ person (HO 2018: 37). According to this framing, the general and personal vulnerabilities that a person has become conflated with vulnerability to radicalisation. Here, a distinction must be made: individuals vulnerable to ‘radicalisation’ may include ‘vulnerable individuals’, but it remains to be demonstrated that ‘vulnerable individuals’ are necessarily ‘vulnerable to radicalisation’ (Corner, Bouhana & Gill 2018: 3). The profile of the violent radical is left vague so that anyone can potentially pick up the disease of radicalisation.

Research suggests that vulnerability to terrorism is situational and not innate within individuals (Corner et al. 2018: 4). Some individuals have a greater propensity to recruitment to terrorism due to personal temperaments, biographies, lesser moral control and other idiosyncratic factors. However, vulnerability to recruitment is more dependent on exposure to radicalised settings and social processes (Bouhana & Wikstrom 2011). Viewed in this way, vulnerability to recruitment is something that becomes expressed in response to a specific situation. It matters substantially whether an individual becomes exposed to a radicalised
setting, interacts with recruiters and socialises in places of recruitment. In other words, the
turn to political violence cannot be explained by reference to individual vulnerability alone.
Consequently, 95% of Channel referrals do not receive safeguarding support (HO 2018b). In
2017/18, for example, a total of 7,318 individuals were subject to a referral but only 394 indi-
viduals received Channel support following a Channel panel (HO 2018b: 4). There is
a substantial discrepancy between the numbers being referred and actual participation in inter-
ventions. Equally significant is the fact that 40% of referrals are being re-directed to other ser-
vices prior to Channel discussion taking place (HO 2018b: 4). This suggests that during a period
in which public services in the UK were slashed by central government due to austerity for the
best part of a decade, people with actual personal and social issues in need of support were being
channelled into the British CT infrastructure (Heath-Kelly & Strausz 2018: 54). The deploy-
ment of care structures in the service of CT has diverted attention and resources away from
addressing the social structures that can produce real vulnerabilities and alienation in the first
place. It underscores the way that the medicalisation of CT has eviscerated the boundaries
between public health and CT issues.

Conclusion
This chapter has made three arguments. Firstly, research has not yet examined the signi-
ficance of incorporating a tertiary level programme such as DDP in a Prevent strategy that
operates in the pre-criminal space. Specifically, this chapter has tried to understand what the
introduction of DDP tells us about how UK Prevent is evolving. Secondly, as the existing
research on tertiary level programmes is written primarily from a CT perspective, and the
literature on Prevent from a P/CVE perspective, the chapter has attempted to bridge this
aporia by utilising the PHM. The PHM allows us to conceptualise Prevent in terms of
a three-level intervention system, structured around different risk levels. Seen therefore
through the lens of the PHM, post-criminal tertiary level intervention such as DDP comple-
ments primary and secondary interventions in the pre-criminal space. Viewing DDP through
the PHM re-frames our conceptual understanding of the boundaries between CT and P/
CVE, between Pursue and Prevent, and renders the cross-fertilisation between both domains
more intelligible.

Lastly, this chapter has also explored the implication of viewing Prevent through a PHM.
A major consequence of adopting a public health approach is the medicalisation of terror-
ism: the PHM treats terrorism as a disease and takes the population into view, rather than
confining the problem to specific domains or groups, and fails to treat terrorism as a social,
cultural and political phenomenon. While this approach has advantages for the government
in terms of organising a structured response to the threat of terrorism, it nevertheless has the
effect of depoliticising terrorism and, in the process, removes the agency and culpability of
individuals, not to mention pathologising pathways to terrorism; it also divorces such pro-
cesses from the social ecological conditions that generate recruitment to terrorism. The med-
icalisation of the Prevent paradigm has hauled more activities and people under the purview
of CT.

This chapter has therefore argued that the emergence of DDP in Prevent 2018 signi-
fied the advent of tertiary level interventions and represented the culmination of
a historical process in which Prevent has increasingly, over the years, appropriated the
language and practice of public health solutions. Given the protean and rapidly shifting
security threats facing the UK, academic, political and media scrutiny of DDP will only
continue to grow.
References


The UK Prevent strategy


The UK Prevent strategy


