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Risk Assessment Challenges in a Specialized Clinic for Individuals Referred for Violent Extremism

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In the field of forensic psychology, assessing the risk for violence is a core component of treatment planning and intervention monitoring. However, practitioners from the violent extremism (VE) field currently lack guidance on which tools to use when addressing the risk of VE in individuals with mental disorders. This study details challenges associated with risk assessment in a specialized clinic providing services for individuals with mental disorders referred because of concerns about VE, describes an approach to risk assessment for these individuals, and examines its perceived utility for clinicians. A mixed-method concurrent triangulation design was used to combine available quantitative data on the risk assessment of individuals referred to the Montreal Polarization team, obtained through a file review (n = 53), with qualitative data collected through clinical ethnography and a focus group with practitioners who use the Short-Term Assessment of Risk and Treatability and Terrorist Radicalization Assessment Protocol–18 tools. Results suggest that risk assessment for patients attracted to VE is complex. Clinicians often combine structured instruments for persons with mental disorders with those for individuals on VE trajectories because they address different dimensions of risk. Disagreement in the level of risk seemed to reflect biases related to the therapeutic alliance and to societal prejudices, and may indicate the need for continuous monitoring. Structured clinical judgment approach tools, while perceived as useful in the VE field, may benefit from better integration with more traditional tools developed for forensic and mental health populations. The limits of cross-sectional data in risk assessment tool validation call for more prospective and longitudinal research in the field.

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Public Significance Statement
Risk assessment in individuals presenting mental health problems who are attracted by violent extremism is challenging and requires questioning the relative usefulness of risk assessment instruments in those two fields. Structured professional judgment risk assessment instruments are helpful to support clinical decisions and engage partners in intervention with this clientele. Further research should explore the potential benefits of combining mental health and violent extremism risk assessment tools.

Keywords: risk assessment, violent extremism, structured clinical judgment, Short-Term Assessment of Risk and Treatability, Terrorist Radicalization Assessment Protocol–18

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The association between mental disorders and violent extremism (VE) is complex (Gill et al., 2021). The concept of VE is used to describe the beliefs and actions of people who support or use violence to achieve extreme ideological, religious, or political goals (Public Safety Canada, 2018).

It is well established that attitudes toward VE are a global social phenomenon that may interact with individual vulnerabilities such as psychological distress, grievances, and history of adversity (Rousseau et al., 2020). Trajectory analyses reveal that many individuals attracted to VE that have acted violently had documented or probable mental health vulnerabilities, but causality has not yet been established (Gill et al., 2021; Silver et al., 2018). In essence, there is a dearth of literature on the association between mental illness and VE behaviors.

In the field of forensic mental health, assessing the risk of violence is a core component of treatment planning and intervention monitoring (Andrews & Bonta, 2010). However, in light of the slim body of literature attesting to the validation of VE-specific risk tools, practitioners from the VE field currently lack guidance as to the appropriate tools to use (Hassan et al., 2022; Scarcella et al., 2016). A question frequently brought up by practitioners is whether validated tools from other fields could be useful in the assessment of individuals on a VE trajectory and, thus, assist their decision making (Hassan et al., 2020; Madriaza, 2018). The present study explores challenges associated with risk assessment in a specialized clinic called Polarization, which provides services for individuals with mental health disorders referred for concerns about VE. It uses a mixed-method design to examine the potential usefulness of the Short-Term Assessment of Risk and Treatability (START; Weersing et al., 2006), a structured professional judgment (SPJ) instrument developed for people with mental illness. The study draws on data from the Polarization clinic assessing the START risk profiles of clients at risk of VE and details the perceived usefulness of such tools for the Polarization clinical team.

Estimating the probability of the risk for violence through unstructured methodology has generally been shown to produce low levels of interrater reliability or predictive validity (Dawes et al., 1989; Grove et al., 2000; Guy et al., 2015). Over the past 30 years, over 400 risk actuarial and structured professional judgment approaches and tools have been developed (Singh et al., 2016). Modern structured assessment protocols emphasize the importance of assessing both strengths and vulnerabilities in factors associated with violence (Andrews & Bonta, 2010; de Vogel et al., 2011). Risk assessment approaches typically take both static (unchangeable, past) and dynamic (changeable, ongoing) risk factors into account (Andrews & Bonta, 2010; Douglas & Skeem, 2005). Although much of the research in the area was developed with forensic and/or correctional populations, there remains a dearth of literature in community settings, in particular when addressing VE (Hassan et al., 2022; Scarcella et al., 2016). The prevalence of mental disorders in lone actors, with or without an adherence to an ideological VE framework (Corner & Gill, 2015), suggests that risk assessment tools for individuals with mental disorders may be useful to assess factors contributing to risk for this clientele. To our knowledge, the use of violence risk assessment tools has not yet been thoroughly studied nor validated for patient

populations considered at risk of VE, despite violence risk instruments designed for specific populations producing higher rates of predictive validity than instruments designed for more general populations (Singh et al., 2011).

Risk assessment for VE has traditionally been linked to national security issues, focusing on prevention, disruption, and detection rather than intervention and treatment (Gill et al., 2021). Recently, the scope of what needed to be assessed increased from risk of terrorist violence to risk of previolence factors contributing to risk of radicalization, as well as vulnerability to radicalization. As in the mental health field, this has led to the development of a number of terrorist and extremist risk assessment tools, mainly inspired by the SPJ approach (Skeem & Monahan, 2011). In fact, at present, all tools designed to assess the risk of violent radicalization that are operationally used by clinicians are SPJ tools (Hassan et al., 2022). Recently, the stock of available VE risk tools and the empirical evidence supporting their use were reviewed by Gill et al. (2021). As emphasized in their review, most VE risk instruments were designed primarily on offender populations and, thus, may not be valid for noncorrectional settings or other subpopulations (in particular females). The perceived usefulness for practitioners of VE risk assessment instruments is also an area of concern, the same being true for training and ongoing supervision as it relates to the implementation process (Corner & Pyszora, 2022). In addition, some instruments require comprehensive training that may not be readily accessible (or available) to clinicians unless they specialize in the field of forensic psychiatry.

Risk assessment for VE has traditionally focused on social grievances, past criminal/violence history, ideological commitment, and, more recently, protective factors. Such factors may be individual or collective (family, school, community). There is considerable overlap between risk and protective factors in radicalization/VE risk tools and those which are related to interpersonal violence (Gill et al., 2021)—a finding also emphasized by Wolfowicz et al. (2020) meta-analysis of risk and protective factors for VE. The main differences are that (a) VE tools specifically tap into the importance of ideology and extremist affiliations and (b) tools from the mental health and correctional field consider outcomes other than violence, namely suicide, self-mutilation, and victimization (C. Webster et al., 2009). The latter also pay attention to compliance and observance of treatment.

Setting and Risk Assessment Approach: The Montreal Polarization Team

Since 2016, a novel intervention model was developed in Québec (Canada) to address social polarization and VE. Specialized clinical teams were launched in five urban centers across the province: Montreal, Quebec City, Laval, Sherbrooke, and Gatineau. The Montreal Polarization team provides a diversity of services to individuals, professionals, and communities, including training and consultations, evaluations, and psychosocial follow-ups for individuals at risk of extremism, their significant others or relatives, and victims of hate crimes. The intervention model is flexible and based on a multiple entry point system to facilitate outreach, referrals, and access to services (Rousseau et al., 2022). The multidisciplinary team operates in tight coordination with proximity services and local partners. A mentoring program was also developed to work on social integration and life skills for some referred individuals.

To assess and monitor risk of violent acting out, the team chose the Short-Term Assessment of Risk and Treatability (START), an SPJ instrument developed for people with mental illness (C. D. Webster et al., 2006). The START was designed to guide short-term risk assessment (i.e., over weeks to months) across seven adverse outcomes, that is, violence, self-harm, suicide, self-neglect, victimization, substance abuse, and unauthorized leave. For each outcome, the START instructs raters to assign a specific risk estimate (SRE) of high, moderate, or low risk. To inform the formulation of SREs, the START considers a wide range of items (O'Shea & Dickens, 2014), of which the more frequently studied are 20 dynamic items rated both as protective factors ("strengths") and risk factors ("vulnerabilities"). The START distinguishes itself from other risk assessment instruments by its emphasis on dynamic variables, the inclusion of strengths in the assessment process, and its consideration of understudied outcomes such as substance misuse, self-neglect, unauthorized leave, and victimization (Marriott et al., 2017; Whittington et al., 2022). A youth version was

developed and validated: the START adolescent version (START-AV; J. L. Viljoen et al., 2012, 2014). Studies have provided empirical support for the clinical usefulness of the START by describing its successful implementation (Crocker et al., 2011; Kroppan et al., 2017; Singh et al., 2014). The START is included in Polarization patients' medical files.

When deemed necessary, the team's clinicians also use a VE-specific risk assessment tools, the Terrorist Radicalization Assessment Protocol–18 (TRAP-18; Meloy, 2018), to complement the START. The TRAP-18 is an instrument designed for assessing individuals who may engage in "lone-actor terrorism." Derived from a retrospective analysis of 111 lone-actor terrorists from the United States and Europe, it is designed to code for eight proximal warning behaviors (e.g., fixation, energy burst, last resort behavior) and 10 longer term distal characteristics (e.g., personal grievance, ideological framing, history of mental disorder; Meloy, 2018). Although some of the social grievance items overlap with START risk and protection items, the TRAP-18's contribution is to introduce ideological dimensions of radicalization and the possible networks, motivations, plans, and actions mobilized around a potential act of VE. The use of the TRAP-18 in conjunction with other risk assessment tools has been documented (Vargen & Challacombe, 2023).

Objectives and Research Questions

The goal of this study was twofold: (a) to describe the risk profiles of persons served by the specialized Polarization clinic, and (b) to document the clinical team's perspective on risk assessment and their perception of the usefulness and limitations of the START and TRAP-18 instruments for this group of patients.

The specific research questions were:

1. What are the risk profiles emerging from the START and START-AV in a sample of patients referred for VE in a specialized clinic?
2. What are the associations between START risk outcomes, sociodemographic factors, types of VE, mental disorder diagnoses, and social grievances?
3. What are clinicians' perceptions of risk assessment practice with clients referred for VE? More specifically:
   - Do they consider the START and the TRAP-18 to be useful individually or concurrently?
   - What are the perceived usefulness and limits of both instruments?
   - How does clinical consensus, or its absence, inform the treatment plan and risk monitoring?

Method

Mixed-Method Design

This article follows a mixed-method concurrent triangulation design (Creswell & Clark, 2017) to combine available quantitative data on the risk assessment of individuals referred to the Montreal Polarization team with qualitative data collected through a focus group with practitioners and clinical ethnography. Approval was obtained from the appropriate Research and Ethics Board.

Quantitative Arm

Sample

Clients of the Polarization team are individuals at risk of VE, family members of individuals at risk of VE, and victims of hate crimes. This study includes only clients who received services (at least one clinical session) between January 1, 2016 and December 31, 2021 and who were referred because they were at risk of VE ($N = 86$). Among these clients, 53 had START assessments and were included in the quantitative analyses. Because the START is an SPJ instrument, which requires in-depth knowledge of the patient and is preferably coded in teams, it is not present in the files of patients who were only assessed and referred outside the clinic, which explains the discrepancy between the 86 patients (total client population referred for VE) and the 53 patients with at a least one START in their files.

Procedure

Data from medical charts were extracted and transferred to the Research Electronic Data Capture (REDCap) software by two research assistants (RAs) trained by a member of the clinical team. The following categories of variables were extracted: sociodemographic characteristics, VE types, diagnosis, social grievances,

and START scores. To assess interrater reliability and ensure consistency for the data extraction process, two RAs independently extracted data from the first five medical charts and results were compared against the same data extracted by a research team member with experience in medical chart review. Disagreements were discussed and resolved with the experienced member of the research team, and the process was repeated until the two RAs reached an 80% agreement on the extraction process.

Measures

Sociodemographic Characteristics. The recorded sociodemographic information included age (continuous), gender identity (woman/man), marital status (single, married/has partner, or separated/widowed), current enrolment in school (yes/no), highest level of education (high school or under, college, or university), and current employment status (yes/no). Substance use or abuse in the period during which clients received services, history of engagement in mental health treatment, and history of involvement in the criminal justice system were documented as binary variables.

Violent Extremism. The types of violent extremist ideologies documented in this study included far-right, far-left, religious, gender, nationalism, and conspiratorial ideologies. Nonideological violence was also categorized separately. Categories were chosen based on existing literature of types of radical ideologies (Doosje et al., 2016) and the expertise of the clinical team. Of late, commonly understood distinctions between left and right have been reconfigured by the emergence of extremist political ideologies. Political scholars have observed the emergence of a "third position" politics, which combines left-leaning opposition to capitalism, support for environmental causes and welfare labor policies, with culturally right-wing ideas encompassing anti-immigration, antifeminist, and anti-LGBT sentiments associated with neotraditional values. Identity politics, rather than economics, has been noted as a key point of division in the political spectrum (Almond et al., 2004; Mammone, 2009).

Despite a considerable degree of ideological overlap in our clientele, we categorized clients as far-right or far-left based on their degree of investment in radically progressive (left) or radically conservative (right) identity politics. Categories were initially identified at the time of referral and revised after evaluation and follow-up, according to the prevalence of specific themes in clients' preoccupations and conflicts with others. Those with a higher prevalence of religious (e.g., Christian far-right, Islamic fundamentalism), gender-based (e.g., masculinists), or conspiratorial themes were categorized accordingly. Those who combined ideological elements to justify a dystopian worldview in the absence of adherence to a political cause were coded as nonideological (Almond et al., 2004; Mammone, 2009). Individuals could align with one or more ideologies (Doosje et al., 2016). The number of types of extremist ideas endorsed by a person was calculated as a continuous variable.

Diagnosis. Six main categories of diagnoses were computed: neurodevelopmental disorders, stress-related disorders, mood/anxiety disorders, psychotic spectrum disorders, externalizing disorders (i.e., attention-deficit/hyperactivity disorders, oppositional defiant disorders, conduct disorders, and some personality disorders), and other disorders. Diagnoses were established by the team's psychiatrists and psychologists. In cases of patients who had already received one or multiple diagnoses, those were confirmed, or in some cases, modified after evaluation. Clients may have multiple diagnoses across categories. The number of concurrent diagnoses was calculated as a continuous variable.

Social Grievances. Eight social grievances were documented: trauma, discrimination, harassment/bullying, romantic relationship breakup, social isolation, family grievances, work grievances, and school grievances.

START. Specific risk estimates from the first START rating of each patient were used for the purpose of analyses. The risk estimations provided by the START for violence toward others, self-harm, suicide, unauthorized leave, substance abuse, self-neglect, victimization, and noncriminal offense (START-AV only) were categorized as low, moderate, or high.

Data Analysis

Descriptive statistics were provided for sample characteristics and START risk estimates. Pearson's chi-square tests of independence were performed in R (R Development Core Team, 2017) to examine the association between

START violence outcome, types of extremism, social grievances, and clinical diagnoses. Cramer's *V* was used as a measure of effect size.

Qualitative Arm

A focus group was held in June 2022 with members from the Montreal Polarization team. Five clinicians participated in the discussion, more specifically, three psychologists, one social worker, and one psychiatrist (three women and two men). The group discussion lasted 47 min, was facilitated by one of the coauthors, and was conducted in French as all participants were proficient in that language. The interview guide covered questions on the clinicians' perceptions and experiences with risk assessment in their daily professional practice, including the role of team discussions, clinical consensus and disagreements, as well as the different uses, advantages, and limitations of risk assessment tools such as the START and TRAP-18. The focus group was audio-recorded and transcribed verbatim, and one coauthor conducted a thematic analysis on the collected material (Braun & Clarke, 2006) with the assistance of the NVivo software. By going back and forth between the transcript, the field notes, and a priori and emerging codes, a saturation of categories was reached. Key themes and subthemes were identified and discussed among coauthors. For publication purpose, focus group extracts were translated from French to English and research results were cautiously examined and anonymized to preserve participants' confidentiality.

Over the course of 1 year, observational and reflective notes were collected by one of the coauthors in a monthly community of practice, which brings together 30 clinicians belonging to regional teams. The Polarization community of practice meetings are structured around case discussions and always address risk assessment challenges.

Finally, to illustrate some of the predicaments, which emerged from qualitative data on the START and TRAP-18, the team's clinicians produced four prototypical vignettes, which described the differences and complementarity of the two instruments when applied to a VE clientele.

Mixed-Method Analysis

The results of the quantitative and qualitative analyses were compared in terms of convergence, complementarity, and divergence. A mixed-method matrix technique (O'Cathain et al., 2010) was used to integrate qualitative and quantitative data and to allow for a more comprehensive understanding of the study topic.

Results

Quantitative Analyses

As previously described (Rousseau et al., 2022), the Polarization team's service users were predominantly men, the majority of whom already had a history of mental health service use. Among the 53 clients for whom at least one START assessment was available, the most frequent types of endorsed VE ideologies were far-right (35.8%), gender (32.1%), religious (26.4%), and nonideological violence (20.8%). The most common diagnoses were mood/anxiety disorders (42.3%), neurodevelopmental disorders (40.4%), externalizing disorders (36.5%), and stress-related disorders (34.6%; see Table 1). The main grievances experienced by participants were related to family (75.5%), social isolation (54.7%), trauma (43.4%), harassment/bullying (41.5%), and school-related grievances (41.5%). Among START risk estimates, the risk of violence toward others was by far the most common, with 50.9% of clients at moderate or high risk, followed by the risk of victimization (43.4%) and suicide (26.4%; see Table 2).

Clients who were deemed at moderate or high risk of violence toward others were more often diagnosed with an externalizing disorder compared to those who were not, $\chi^2(df) = 4.79(1); p = .03$, *Cramer's* $V = 0.30$. No significant association was found between risk of violence and other main diagnoses, types of extremist ideologies, social grievances, or other risk outcomes.

Qualitative Analyses

Four main themes emerged from the focus group: (a) favoring an ecosystemic approach over a risk assessment instrument-focused approach, (b) combining approaches to assess risk, (c) the importance of clinician- and institution-related factors, and (d) limitations and challenges of risk assessment.

Table 1
Social Grievances and Psychiatric and Extremist Ideology Profile of Radicalized Individuals Engaged in Clinical Services From 2016 to 2021 (N = 53)

Characteristics	Total (N = 53)	
	N	%
Number of extremist ideologies		
1	37	69.8
2	9	17.0
3	7	13.2
Extremist ideologies		
Far-right	19	35.8
Far-left	2	3.8
Religious	14	26.4
Gender	17	32.1
Nationalism	4	7.5
Conspiratorial	9	17.0
Nonideological violence	11	20.8
Number of diagnoses		
0	1	1.9
1	23	43.4
2	17	32.1
3	10	18.9
4	2	3.8
Diagnoses		
Neurodevelopmental disorders	21	40.4
Stress-related disorders	18	34.6
Mood and anxiety disorders	22	42.3
Psychotic disorders	5	9.6
Externalizing disorders	19	36.5
Other	5	9.6
Not applicable	1	
Social grievances		
Trauma	23	43.4
Discrimination	13	24.5
Harassment/bullying	22	41.5
Romantic relationship breakup	13	24.5
Social isolation	29	54.7
Family	40	75.5
Work	7	13.2
School	22	41.5

An Ecosystemic Model

Risk and Protective Factors. When they were asked how they approach risk assessment in their practice, focus group participants emphasized the importance of adopting an ecosystemic approach, that is, of assessing both risk and protective factors, and both at the individual and environmental levels. As mentioned by an interviewee:

> I have a grid of risk factors and protective factors [in the back of my head] that is quite clear. … Has the person experienced a recent loss? Has there been a recent change in mental state such as a sudden lack of sleep, change in appetite, mood? Degradation in hygiene. Substance abuse. Potential trauma. Increased isolation.

Trajectories. Clinicians also mentioned the importance of paying attention to variations of risk over time, and to the idea of a "trigger" or "turning point," that is, of "something that could bring about a flip in the person." They described different trajectories, in which environmental factors almost always played a key role. A recurring situation described individuals experiencing overall high social grievances, for which the risk was waning and waxing as a function of life events. Another less common trajectory represented an acute exacerbation of risk following an adverse event experienced as catastrophic, in individuals who could go back to a relatively stable mode of functioning afterward. Finally, in a number of very socially isolated individuals, the risk remained latent for prolonged periods, with resentment sometimes slowly building up toward a planned acting out.

Combining Approaches and Perspectives

Borrowing From the VE and Mental Health Field. Participants emphasized the importance of combining tools, approaches, and perspectives. From their point of view, existing risk assessment tools reflected specific disciplines and fields, which all had specific strengths, biases, and limitations. This was deemed to warrant the combination of different tools and approaches.

> I think that the more people are close to a security approach, the more criminology tools will predominate, or national security tools, like the VERA or the TRAP-18. And then the more you're going to be in mental health, the more it's going to be other tools … like the START …, and the more it's going to be psychosocial.

The clinicians emphasized that the two instruments most used (START and TRAP-18) did not pick up the same types of risk, and that the work in disciplinary silos could lead to problematic risk assessment (as reflected in the prototype vignettes discussed below).

The Influence of Diagnosis on Risk Assessment. The interaction between diagnostic profile and risk assessment was discussed. Participants highlighted the differences in narrative strategies among patients with personality disorders, individuals with neurological differences (such as the autism spectrum), and patient having experienced trauma. Narrative strategies were differentiated by patterns of disclosure,

Table 2
START Risk Estimates of Radicalized Individuals Engaged in Clinical Services From 2016 to 2021 (N = 53)

	Adult (*N* = 35)		Pediatric (*N* = 18)		Overall (*N* = 53)	
START risk estimates	*N*	%	*N*	%	*N*	%
Risk of violence toward others						
Low	19	54.3	7	38.9	26	49.1
Moderate	12	34.3	8	44.4	20	37.7
High	4	11.4	3	16.7	7	13.2
Risk of self-harm						
Low	28	80.0	16	88.9	44	83.0
Moderate	5	14.3	2	11.1	7	13.2
High	2	5.7	0	0	2	3.8
Risk of suicide						
Low	23	65.7	16	88.9	39	73.6
Moderate	11	31.4	2	11.1	13	24.5
High	1	2.9	0	0	1	1.9
Risk of unauthorized leave						
Low	34	97.1	14	77.8	48	90.6
Moderate	1	2.9	4	22.2	5	9.4
High	0	0	0	0	0	0
Risk of substance abuse						
Low	26	74.3	16	88.9	42	79.2
Moderate	7	20.0	1	5.6	8	15.1
High	2	5.7	1	5.6	3	5.7
Risk of self-neglect						
Low	31	88.6	15	83.3	46	86.8
Moderate	3	8.6	3	16.7	6	11.3
High	1	2.9	0	0	1	1.9
Risk of victimization						
Low	21	60.0	9	50.0	30	56.6
Moderate	12	34.3	8	44.4	20	37.7
High	2	5.7	1	5.6	3	5.7
Risk of noncriminal offense						
Low	N/A	N/A	15	83.3	N/A	N/A
Moderate	N/A	N/A	3	16.7	N/A	N/A
High	N/A	N/A	0	0	N/A	N/A

Note. START = Short-Term Assessment of Risk and Treatability; N/A = not applicable. Risk of noncriminal offense is only an item in the pediatric version.

social desirability, and capacity to conform or to lie. The question of provocation and fear was also addressed:

> We have patients who scare people a lot. It's a defense mechanism and they don't seem dangerous to us. Versus people who don't scare people at all, because they're able to hide what they're thinking, and who do scare us a lot. … So there's a kind of discrepancy. It's not the people who seem the most dangerous who are necessarily the most dangerous.

Having the perspectives of multiple practitioners and repeated measures of risk were seen as possible mitigation strategies.

Structured Professional Judgment and Clinical Intuition. Among the beneficial uses of risk assessment tools, participants mentioned that they provide a mean for formalizing one's observation of variations in patient presentation over time. However, it was also noted that although tools are useful to "organize one's thinking," they must also be combined with a "clinical outlook," as one focus group participant put it. As such, the sensitivity or embodied experience of clinicians can represent an asset to complement tools. In this sense, while one participant said "I am listening with my antennas," another clinician highlighted that structured risk assessment was also "a question of feeling." All participants, however, recognized that clinical intuition had limits and were influenced by a number of unconscious biases: the clinical alliance (which usually led to the minimization of risk), emotional reaction toward the ideological frame and social positioning of the individuals, and so on. Thus, they all recognized the central role of team discussions about risk, even if these frequently led to major disagreements.

Clinicians- and Institution-Related Factors

The Importance of the Team. All focus group participants emphasized the importance of teamwork, discussion, and concertation. The value of clinical consensus as an assessment strategy consistently emerged as a key theme, both in the focus group and in the community of practice monthly discussions. Focus group participants noted the importance of weekly clinical team meetings to discuss cases with moderate and manageable levels of risk. They also identified the urge for immediate and informal consultations with colleagues as a good "intuitive" indicator of a higher level of risk in a patient.

The question of disagreements among team members was also addressed, in light of the recognition that all complex cases include both reassuring and worrisome elements that have to be considered and interpreted. One participant suggested that in these cases, the place and posture of the clinician can have an impact on risk assessment, particularly in connection with proximity (e.g., strong alliance) and involvement in the clinical follow-up, once again stressing the importance of teamwork and reflexivity in this

line of work. The following excerpt illustrates this point:

> When there is consensus within the team, it has a reassuring effect [about what to do]. … When we all agree that there is a significant risk, it may not be comforting but at least we are clear about the action to take. … When some of the team members think there is a risk, but others think there is not, … that is when making a decision is the most difficult. … When there is disagreement, what we usually see is that those who are the most involved in a therapeutic alliance with clients tend to be closer to their positive sides, to have more attachment, to see their strengths, and to minimize the risk.

Major team disagreements are thus an indication for close monitoring, but also for restraining from invasive interventions until the balance tilts in a specific direction.

Clinician–Patient Relationship and Risk Assessment. The place of the patient's subjectivity was also briefly addressed, and how there are different ways to make room for it. While one participant considered that risk assessment through tools is "done as if the person is an object and not a subject," another participant pointed out that different postures can be adopted by clinicians when dealing with the patient's place in risk assessment: "It's whether you position yourself in 'I want to know if you are dangerous', which is a possible perspective, or 'I would like things to get better in your life, and I also want to prevent you from getting into trouble'." The gap between patients who adopt a position of social desirability and those who alarm clinicians was highlighted, recognizing that explicit communication about risk often did not directly relate to the actual level of risk.

Administrative and Institutional Usefulness of Risk Assessment. In addition to being used as clinical instruments within the team, it was noted by participants that risk assessment tools could, on occasion, be used to document their clinical practice for administrators. Specifically, it was used as a way of demonstrating the burdensome nature of the work and to explain or justify the results of the clinical assessment and the intervention plan. In a few cases, joint START and TRAP-18 were used to demonstrate the high level of danger when dealing with uncommitted partner institutions. The clinicians explained that, through their work with partners and administrators, had at times found a tendency for stakeholders involved in case management but without exposure to patients to minimize risk. In other cases, workers from partner institutions who had not received training on VE and were, as such, unaccustomed with ideological domains, could also overinterpret risk (e.g., when giving too much weight to radicalized statements reflecting shared beliefs rather than individual intent to act). Formal risk assessment scores were thus deemed useful to coordination in interinstitution case management.

Limitations and Challenges to Risk Assessment

Contextual Biases. Clinicians identified a few limitations of existing instruments. Participants emphasized that a systematic use of instruments in a decontextualized manner could result in possible drifts toward a logic of detection, increase the risk of profiling individuals belonging to marginalized communities, and increase the risk of "false positives" if the scoring was based on incomplete or biased information such as hearsay or speculation. Moreover, the unrealistic goal of monitoring all individuals motivated by an ideology was underlined, notably in terms of resources. Participants also mentioned the risk of pathologizing ideologies and dissent, which were seen as inherently slippery, particularly in the case of ideologies that departed from the mainstream. This was deemed to be a complicated issue in light of the largely unacknowledged (and unmonitored) ideological dimension framing some institutional discourses and practices (e.g., those that may underplay or trivialize hate toward some groups).

Finally, the arbitrariness and uncertainty that will always be present in risk assessment were also mentioned during the focus group. Participants stressed that risk assessment is never undertaken in a sociocultural and relational vacuum, and that cultural and interpersonal variables are rarely taken into account in formal assessments.

Challenges associated with limited information were also identified. Clinicians explained that completing a risk assessment at the beginning of a follow-up, when the clinician does not know much about the patient, presents distinct challenges. They mentioned other potential confounding factors, such as patients' personality traits influencing the sharing of information (e.g., disclosure with an autistic individual vs.

concealment and manipulation with an individual with psychopathic traits).

Potential Harms Associated With Risk Assessments. Participants raised the question of the "iatrogenic harm" that may unintentionally be inflicted on vulnerable individuals through unjustified labeling and related punitive interventions (e.g., school or work expulsion), thus producing additional grievances that can increase the risk of acting out. The question of the potential negative side effects of risk assessment was thus raised:

> Isn't sounding the alarm without trying to mitigate the risk with the individual's strengths or their environment more dangerous than not sounding the alarm? Identifying the risk can make the person even more socially vulnerable and thus increase the risk unintentionally, which often happens with security interventions. If you intervene in a security manner with someone who is making threats online but is extremely vulnerable, you run the risk of increasing their vulnerability. … You can do a lot of harm by doing a risk assessment.

It was also suggested that if the goal when assessing risk is to mitigate it, then the focus cannot only be on risk indicators, but also on protective factors that will be supported and reinforced by psychosocial interventions.

The Dual Use of the START and the TRAP-18

In order to illustrate the most common patterns encountered in cases of combining the START and the TRAP-18, the clinicians identified four large prototype vignettes (see Table 3). These patterns seemed to cover a majority of the cases and were associated with specific risk assessment challenges leading to exaggeration or minimization of the risk. Clinicians emphasized the fact that the dual use of the START and the TRAP-18 could be helpful to account for both the risk associated with psychiatric crisis and the risk related to online extremist engagement. However, because of the lability in trajectories, they felt that the wish to infer medium- to long-term predictions could be misleading or dangerous.

Discussion

Risk Assessment Tools and VE Clientele Profiles

The quantitative results showed that according to the START (adult and adolescent versions), only 50% of the patients referred for possible VE to the Montreal Polarization clinical team were thought to have a moderate to high risk of violence toward others. This could be due to numerous factors.

First, as reported by the clinicians, the START seems to have some limitations to pick up the risk of VE in a selected group of patients, which have well-integrated social desirability predicaments. Second, the strong affects elicited by the public discourse concerning VE may exacerbate the perception of risk in clients and lead to profiling or to exaggerated worries about radical discourses. Third, there could be a bias from the team's clinicians to minimize the risk of their patients because of high exposure to the VE clientele, which may lead to a relative normalization of extremist discourses and related online groups. All of these hypotheses may be partially contributing to the observed START profiles.

The quantitative results also show that 48.4% of clients are rated as having significant levels of victimization risk, as measured by the corresponding START outcome. This finding is partially corroborated by the high level of multiple past adverse events (trauma, bullying, discrimination) documented in the files, which suggest that traumatic reenactment processes may lead the patients to poorly protect themselves or to unconsciously take risks. The high exposure to social and relational adversity is consistent with the interpersonal violence literature repeatedly underlying the frequent coexistence of victimization and aggression (Siller et al., 2022), as well as the VE literature emphasizing the high prevalence of previous experiences of bullying and violence in youth displaying sympathy for VE and in lone-actor life histories (Ellis et al., 2021; Gill et al., 2017; Miconi et al., 2021; Rousseau et al., 2019; Schröder et al., 2022). The absence of significant associations between the START violence outcome assessment and the type of VE converges with the literature on the similarities of pathways among different forms of extremism (Schmid, 2013). This suggests that although the most common types of VE and the means of violence may change with the social context and the historical period, this does not necessarily imply that the underlying psychological processes are different (Rousseau et al., 2021). The increased risk of violence toward others in individuals with an

Table 3
Dual Utilization of Risk Instruments: Prototype Vignettes

Prototype	START: Violence toward others	TRAP-18: Proximal behaviors	Clinical presentation	Risk assessment challenges
1. Narcissistic/"dark triad"	Low	High	Patients with narcissistic/"dark triad" profiles with or without substance abuse. Very high levels of resentment and bitterness. Capacity to avoid saying things, which would put them in legal problems or justify involuntary interventions. They may disclose worrisome elements (e.g., plan, manifestos) only when a person has gained their trust and when they expect approbation, narcissistic validation, or support.	These patients navigate very well the psychiatric and legal systems. Initial assessments are usually inconclusive. The risk assessment requires a robust alliance established over time. Careful exploration of ideology and virtual relations is key.
2. Mental health issues and social grievances	High	Low	Patients with mental health issues and social grievances. Typically not considered as extremists by their mainstream treating teams. Not displaying adhesion to an ideology when they are not decompensated. Their shift toward an extremist project and violent action can be very rapid when decompensated (usually after stopping their medication or experiencing an adverse life event).	The risk in these patients is often missed because psychiatric teams do not usually investigate ideology in crisis periods, or tend to consider it as an innocuous delirious content without verifying if there are influences, which may push toward action.
3. Chronic risk with event-related exacerbations	Moderate	Moderate	Patients presenting worrisome elements (presence of an ideology with hateful speech, legitimation of violence) but no plan for action or warning behaviors. These are the majority of the team's cases. They represent a chronic risk with exacerbations associated with adverse life events.	The monitoring is here the main challenge. Intervention is usually associated with a decrease in risk, which can be misleading if interpreted as a stable state.
4. Potential cultural or social profiling	Low	Low	Patients with low risk according to both the START and TRAP-18. Cultural or social profiling may be at stake, or the referral was prompted by a momentary state of distress with emotional dysregulation and angry behavior. These patients are referred for support, to address social grievances, and foster social integration as needed.	These are the majority of false positives referred from mainstream services. They reflect social polarization, and their identification as risky often aggravate social grievances.

Note. START = Short-Term Assessment of Risk and Treatability; TRAP-18 = Terrorist Radicalization Assessment Protocol–18.

externalizing disorder is not surprising. Impulsivity and a past history of acting out are classically associated with the risk of violence in the forensic psychiatry literature (Douglas et al., 2013).

Risk Assessment Tools' Perceived Utility to Support Clinical Decision Making

In line with the literature in both mental health (Singh et al., 2011) and VE fields (Gill et al., 2021), structured clinical judgment instruments such as the START and the TRAP-18 were perceived by clinicians from the team and the community of practice as a useful mean to obtain clinical consensus around risk for a patient that has mental disorders and adheres to violent extremist ideas (Allely & Wicks, 2022).

The clinicians' impressions that their ratings of tools were influenced in complex ways by the strength of the therapeutic alliance and other clinician unconscious biases are rarely mentioned in the literature, which instead tends to emphasize the time burden that these instruments may represent and the disciplinary differences in their use (Hurducas et al., 2014). According to clinicians from the Montreal Polarization team, triangulation of risk perceptions through team discussion was key to guide treatment formulation. In case of disagreements, clinicians considered that close monitoring was warranted.

To our knowledge, the impact of risk assessment team disagreements on management plans has not yet been an object of research. Laboratory studies (on closed cases) have yielded information about interrater reliability, but the issue of managing disagreements in real-life ongoing situations remains to be explored (Corner & Pyszora, 2022; Gill et al., 2021). Because they are largely based on disclosure of violent fantasies, intents, and plans, clinicians mentioned that risk assessments could be influenced by the patient's diagnosis, which may influence their narrative strategies. More specifically, clients with an autism spectrum disorder diagnosis were seen as more likely to reveal socially undesirable thoughts, both because they would have a different appraisal of the possible reactions that this may elicit, but also because they often would not envision to lie (Rousseau et al., 2023). Interpreting this pattern of disclosure as a sign that the patients were actually more dangerous could lead to erroneous conclusions.

Finally, clinicians perceived that formal structured assessments could sometimes be helpful to establish an effective partnership around cases. They were seen as particularly useful to engage other care providers and institutions when they minimized the risk of the patient to justify their unwillingness to get involved in service provision. Because multiactor intervention is often considered a cornerstone to counter VE, establishing common standards to assess risk could be a useful avenue to support field collaborations, in the respect of the actors' specific mandate (Strandh & Eklund, 2015). Risk assessment tools were also perceived as an asset to provide "objective" support for reassurance to educators, health professionals, or security agencies when profiling was at stake (Reddy et al., 2001).

Mental Health or VE Risk Assessment Tools?

The qualitative results raised some relevant questions about the optimal choice of risk assessment instruments in situations where a mental disorder and an attraction for VE coexist. Clinicians highlighted the partial overlap between the START and the TRAP-18 in terms of documenting social grievances, while emphasizing that the TRAP-18 was clearly more specific to circumscribe the ideological content and related plans of actions, which are missed by the START. On the other hand, the mental disorder variable of the TRAP-18 was seen as underdeveloped and at risk to entail stigmatization because for nonclinical practitioners, that item could be understood as implying an association between mental disorders and potential violence. In addition, this historical (distal) variable does not capture the risk associated with the acute phases of mental disorders, where the ideological components (symptoms) are most exacerbated.

Overall, the clinicians suggested that, for a clientele of patients with mental disorders attracted to violent extremism, VE or mental disorder risk assessment tools taken individually may in some ways under- or overestimate risk. Implementing complementary instruments (e.g., START and TRAP-18) appeared to be a solution for particularly worrisome cases. However, if applied to all cases, this lengthy evaluation procedure could constitute a burden for clinical teams that would interfere with time devoted to actual intervention. Studies of practitioners'

perceptions have shown that the balance between the perceived utility and the burden of risk tools is a key determinant of their implementation (Singh et al., 2014).

Is there a need for the development of a new tool, better adapted to persons with mental illness displaying VE characteristics? The present results do not provide an answer to this question. Further, field research on samples of at-risk individuals, rather than after-the-fact analysis (Gill et al., 2021; Schuurman, 2020), is needed. In the meantime, clinicians may complement VE-specific risk tools with instruments that better document the ideological dimensions, or vice versa. They may also, as the Polarization clinicians do, combine instruments with clinical discussions to reach consensus in more sensitive cases.

Limitations

This article has a number of limitations. First, the small sample size and the associated limited statistical power considerably restrict the generalizations that can be inferred from the quantitative analyses. Second, the qualitative findings were collected in a very specific clinical setting and, thus, cannot be generalized to other services addressing VE. Third, the perspectives of risk assessment were collected with clinicians only, suggesting that the addition of nonclinical risk assessors to the focus group would have been an asset to triangulate the clinicians' perspective. Fourth, because the TRAP-18 is not systematically included in the files, it was not possible to study the joint utilization of these tools from a quantitative perspective. Finally, using longitudinal data could have provided, beyond clinicians' perceptions, some information between risk assessment and actual VE-related outcomes. The use of intermediate rather than final outcomes has often been criticized in the field of preventing violent extremism (Brouillette-Alarie et al., 2022).

In spite of these limitations, this article is the first one (to our knowledge) to address the challenges of risk assessment in patients with mental disorders referred because of VE. Therefore, it constitutes a first step that opens the way for more extensive research in a still poorly understood field.

Conclusion

This clinical study confirms that risk assessment in individuals with mental disorders and attracted by VE is a complex exercise. Results have implications for clinical practice and research. In terms of practice, they suggest that, albeit with some challenges, structured instruments are useful to assess the risk of individuals with a mental health diagnosis attracted by VE. Clinicians also reported that they found usefulness in combining tools from the mental health and VE fields. This indicates that it may be important to go beyond silos in VE risk assessment training, given the high prevalence of mental disorders in individuals with a lone-actor profile. As for research, qualitative results circumscribe the urgent need for prospective research and confirm the limits of cross-sectional risk assessment in individuals with VE and mental disorders. Future research should incorporate multiple types of professionals that assess risk and collect longitudinal data in order to document the relation between risk assessments and medium- and long-term outcomes. Comparative studies could address the potential impact of culture, social, and institutional contexts on risk assessment. Finally, to contextualize the implementation of structured risk assessment tools, studies should also document the burdens and potential harms that risk assessment procedures can represent—both for clinicians and clients assessed by these tools.

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