Adversity, Criminality, and Mental Health Problems in Jihadists from the Netherlands

Presentation

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Anton Weenink, Senior Researcher

National Police of the Netherlands / Central Unit / Intelligence / Research & Analysis & Team CTER

Me

Background: public administration / international relations / PhD post-communist reform in Russia.

Senior Researcher at the Dutch National Police.

At Central Unit / Information dept / Research & Analysis

Posted at TEAM CTER (Counter-Terrorism, Extremism and Radicalisation).

Team CTER compiles the national List of jihadist travellers.

Research on jihadists

Point of departure (2014): The consensus on terrorist social and mental 'normality':

> **"(…) terrorists in general tend not to be impoverished or mentally ill or substance abusers or psychopaths or otherwise criminal" (Monahan, 2012).**

Result:

Risk factors for ordinary criminal violence as in LCC considered not relevant in terrorists. Mental health left out of Terrorism Risk Assessment Instruments (eg VERA).

Data at CTER Team indicated several travelers did have MH issues. Initial publication (Weenink 2015); full report, 2019. New paper in PoT (October 2019).

Positioning

Central question: what is the background of Jihadi's, in terms of demographics, adversity, criminality, and mental health?

Descriptive, but inspired by Situational Action Theory (Bouhana & Wikström, 2011): Distinguishes *Vulnerability* from *Exposure* to radicalizing settings.

Exposure is related to situational factors that are exogenous to the individual. Helps to understand the local character of radicalization.

Focus here is on historical backgrounds that may have affected individual vulnerability for travelling to Syria - taken from HCR20 – common risk factors for delinquency.

Descriptive variables

Demographic: Age, gender, immigration & religious background

Forensic from HCR20-v3:

A: Life problems and trauma ('Adversity')
- **Relationships (conflicts in or difficulties with relationships)**
- **Work, income and education**
- **Trauma/victimization/problematic home situation ('ACEs')**

B: Antisocial behavior [criminality]
- **Violent behavior**
- **Other anti-social behavior**

C: Mental health problems ('Disorders')
- **Substance abuse**
- **Mental illness ('Serious disorder')**
- **Personality disorder**

Under B: no systematic data on attitudes/believes; 'taken for granted'.

The sample

- Sample = complete research population of all travelers known to police (at risk & failed travelers included).
- 1st round: List of Travelers S1, February 2014 (n=140).
- 2nd round: List of Travelers S2, March 2016 (n=319); 108 of these were also on S1.

Data

- **Crime registration data:**

  Police registration (HKS: antecedents and suspicions)

  - **Justice Department (criminal records)**

- **Community police records:**

  - **All police contacts of an individual, up to 5 years ago.**
  - **Information on contacts with youth care, family quarrels etc.**
  - **Including police interviews/interrogations, with/of jihadi's and relatives.**
  - **Citizen's registration: family breakup & residential history.**

Caveats: fragmented data & more on criminal travelers.

Results: status on list and demography

- **To war zone:** 68% (217 of 319)
- **Rad < 2012:** 10% known at Team CTER

- **Mean Age:** 24 at dep; 4% under-age
- **Gender:** 31% female (up from 16%)
- **Religion:** 15% converts; 60% female
- **Immigration:** 71% born in NL; 93% 1st & 2nd generation, no 3rd
- **Ethnicity:** Moroccan background (50+%; in population: 2%)

Results: Adversity

Single par. fam: 48% BA-Muslim; 79% Converts; base r. 20%

Homeless: 9% with some experience.

Finance*: >91% not self-supporting (Soudijn 2019, n=131).

Work*: No data. 64% unemployed (Ljujic ao 2017, n=209, <2013); nat.av. peers (2015): 18-25% (CBS). When work, low-skilled & irregular.

Education*: 9 individuals (3%) in university, 1 graduated; 62% of all terrorism suspects did not complete secondary education; 4% higher ed. (br>30%) (Thijs ao 2018, n=279).

Results: Anti-social behavior

- 64% with crime antecedents (nat average is 14%).
- Almost no difference when controlling for ethnicity.
- Female travelers 8-10 times more often antecedents (43-50%) than women on average (5%).
- 9% >10 antecedents
- Ordinary crime, no organized crime.
- 40% some violence.

- Cf. Thijs ao (2018, n=279): 62% of all terrorism suspects had crime antecedents.

Results: Mental health

- 89 subjects (28%) some indication. In 41 cases (13%) clearly present, in 48 cases some indication (15%).
- Converts higher prevalence: 53% against 24% for 'born-agains'
- WHO: base rate of 27% (in NL 22%, RIVM 2017). This includes afflictions of the brain that are not relevant here (e.g. dementia).
- For psychiatric disorders (serious disorders, personality disorders, and substance abuse), prevalence in the Netherlands is around 11%, and for the age group 20-39, it is around 8% (RIVM 2017).
- Other practitioners: MH service (n=300): psychosocial problems in 60% of cases of 'at risk radicals'; in women it was 80%; 25% (esp men) had serious disorders (Paulussen a.o., 2017).

Overall conclusion

Jihadists from the Netherlands, on average, experienced more adversity, were more criminal, and had more MH problems than their peers. Backgrounds resemble those of ordinary criminals, but jihadists do score slightly 'less worse' than criminals (Thijs ao 2018).

Caveat: travelers different from radicals or attackers?

Similar – not identical - patterns in right wing extremists, lone actors and foreign fighters in the YPG.

'Minor issues', not disorders or full syndromes per se (cf Corrado et al). Disordered yet able to plan. Personality traits & states-of-mind, eg due to temporary stress.

Discussion

No solution to the problem of specifity, but distinction vulnerability-exposure helps: Context matters.

Over-generalization (9/11) led to undervaluation of mental health issues (cf. Simi 2019), e.g. in Terrorism Risk Assessment Instruments (VERA, IVP).

Radicalization and emotion: not just what they say, but how they speak.

Findings support a public health approach to deradicalization and disengegament.

Discussion

- Terrorism Riska Assessment: 'in-house'/clinical RA vs ways of identifying at-risk individuals in the community.

- Frontliners tend not to fill in lengthy diagnostic questionnaires. An appeal to simplicity: Rule-of-thumb approach in non-clinical TRA of at-risk lone actors, e.g.:

"Start looking for warning behaviors (cf Meloy) when

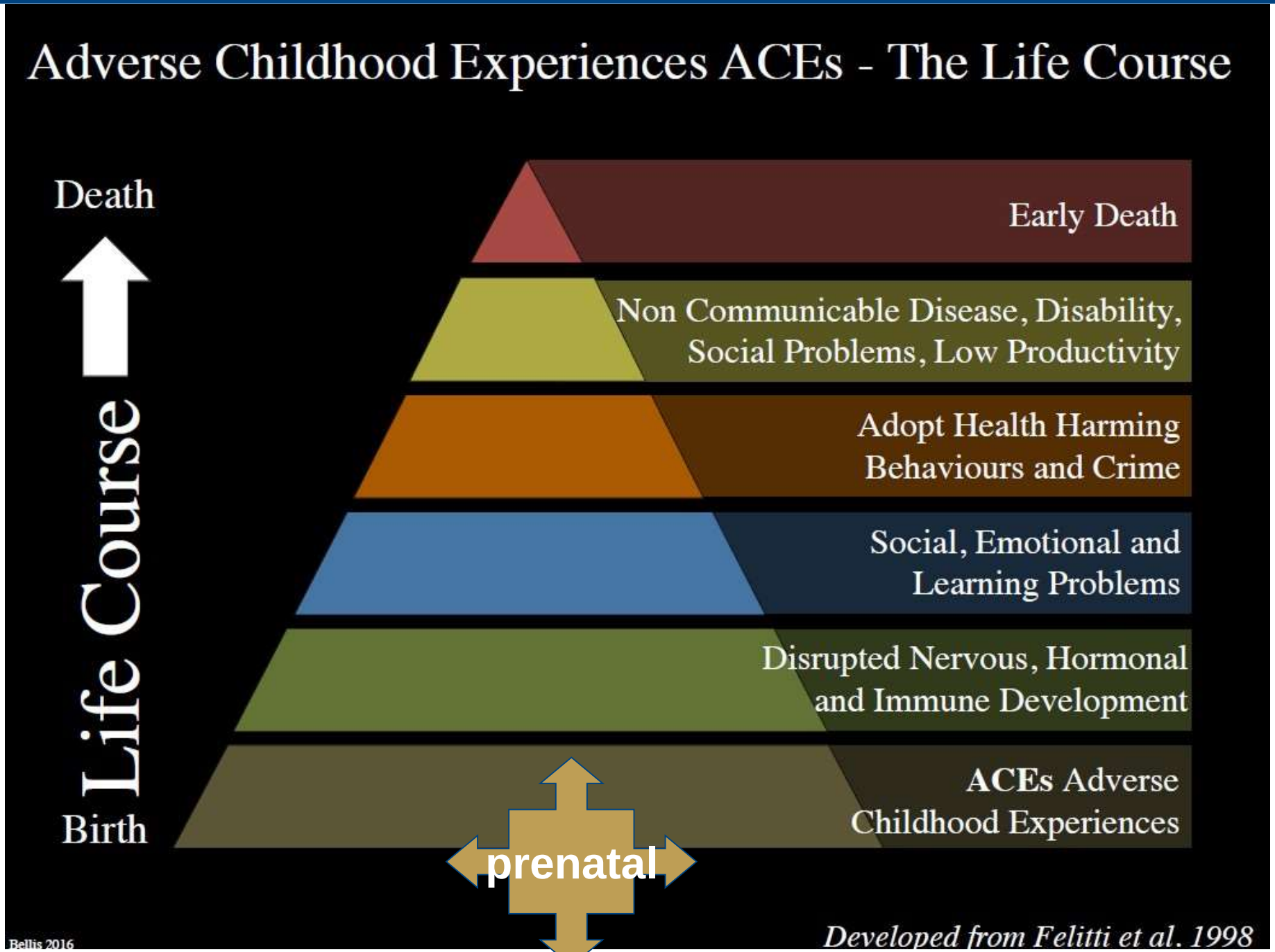
- a known 'vulnerable' individual, with
- a history of violence
- is confronted with a serious stressor."

(where vulnerability may be related to radicalization, or not)

Thank you

Extra’s

Adverse Childhood Experiences ACEs - The Life Course



Limitations and strengths

- **Limitations**:
  - No discussion of individual cases (anonimity)
  - Travel and radicalization, not terrorism per se
  - No access to medical files (I do not diagnose)
  - Police data bases incomplete
  - Statistical analysis forthcoming (S.J. Cohen)

- **Strengths**:
  - Sources that are normally not open
  - Complete research population of travelers: not a sample.

The research population S2 (March 2016), status as of March 2017

1.	In conflict zone	120	
2.	Returned	40	
3.	Presumed dead	57	
	Total Successful:	*217*	*(68%)*
1.	Failed/attempt	41	
2.	Expressed intent	59	
3.	Facilitator	2	
	Total At Risk	*102*	*(32%)*
Total		319	221 M (69%), 98 F (31%)

Adversity (Life problems and trauma)

H.8 Adverse or traumatic experiences (cf. ACE's)

1. Broken family
2. Death of sibling, child or partner
3. Chronic physical health problems in the family
4. Mental health problems in the family
5. Financial problems of the parents
6. Crime in the family
7. Sexual abuse
8. Domestic violence (victim, witness, unknown role)
9. Refugee background
10. Homelessness
11. Chronic physical health problems of the subject
12. Financial problems of the subject

H.3 Problematic social relations

1. Loner / impressionable
2. Problems with non-intimate relationships
3. Problems with intimate relationships (domestic violence excluded)

H.4 Problematic educational or professional achievement

1. Problematic academic achievement
2. Unstable work relationship

Crime-terror nexus, ethnic/religious background, and gender

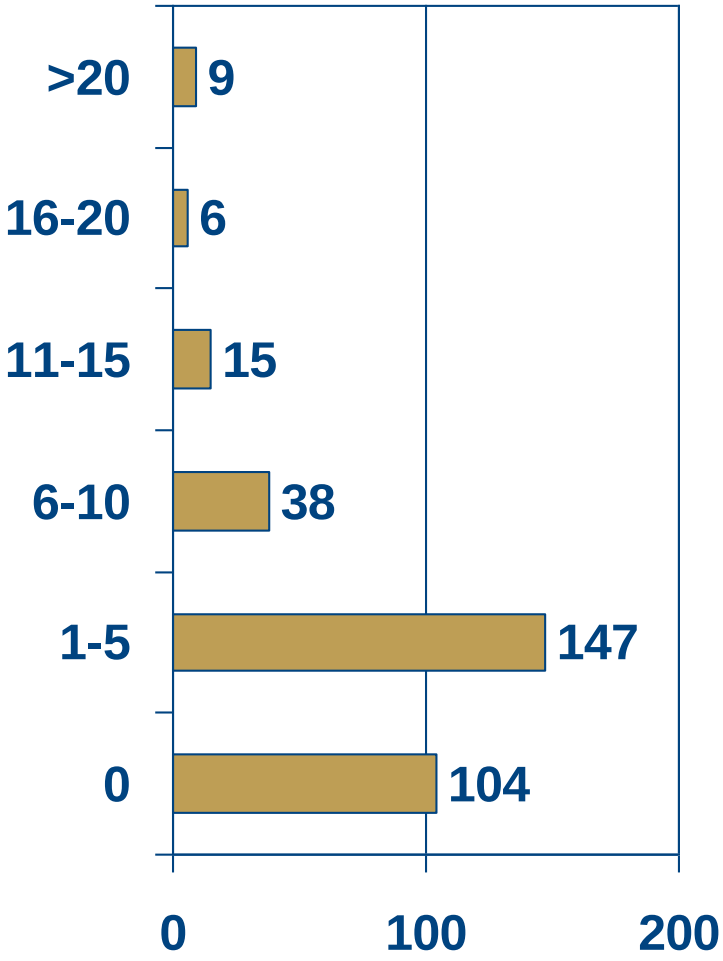
Blokland 2010; CBS 2012: People with ≥1 antecedent at age 22:		
National average	14%	M 23% F 5%
Moroccan background		M 54% F 17%
NL background		M 20% F 4%
S2 (n=319)	64%	M 72% F 45%
Mor. background (n=177)	64%	M 73% F 43%
Other background (n=142)	63%	M 72% F 47%
NL background (n=21)	52%	M 63% F 46%
Born-again Muslims (n=272)	64%	M 72% F 43%
Converts (n=47)	62%	M 79% F 50%

There are caveats here, but overrepresentation of Moroccans, appears not to be a spoiler per se for the CTN-thesis in travelers.

Note: Female travelers strongly overrepresented in crime.

Suspicions

- 68% fall in the lowest range of 1-5 suspicions.
- 68 subjects (21% of the sample) were suspected of more than 5 crimes; 30 (9%) > 10 crimes.
- 25 subjects police labeled either as ‘persistent offender’ or ‘member of a problematic youth group’



Mental health: afflictions of the brain

RIVM number includes five clusters of afflictions:

1. Disorders (1.9 mln)
2. Chronic brain afflictions: dementia, Parkinson's (1.3 mln)
3. Brain trauma: stroke, injury (0.65 mln)
4. Sleeping disorders (0.5 mln)
5. Brain afflictions that appear in the 1st year: mental impairment, afflictions of the central nervous system (0.1 mln)

Disorders in RIVM data

Cluster 1 'Disorders':

- **Neurobiolocal development disorders**
- **Psychotic disorders**
- **Mood disorders**
- **Anxiety disorders**
- **Substance abuse and addiction related disorders**
- **Personality disorders**
- **Other mental disorders**

In the age group 20-39, cluster 1 is 8%.

Disorders by type in the sample (C1 + C2)

Psychosis:	1 + 10 = 11	(3.4%)
Schizophrenia:	3 + 3 = 6	(1.8%)
ADHD/ADD:	3 + 5 = 8	(2.5%)
ASD:	2 + 3 = 5	(1.5%)
CD/ODD:	6 + 9 = 15	(4.7%)
PTSS:	6 + 5 = 11	(3.4%)
Cognition:	6 + 7 = 13	(4.1%)
Borderline:	2 + 2 = 4	(1.3%)
Mood disorders:	2 + 7 = 9	(2.8%)
Substance abuse:	6 + 6 = 12	(3.8%)
Unspecified:	16 + 0 = 16	(5.0%)

Caveats:

- Incidence / prevalence
- Low numbers
- Ethnicity

Findings from practitioners

- MH service (n=300): psychosocial problems in 60% of radicals; for females it was 80%. 25% have serious disorders, in particular the more active men (Paulussen a.o. 2017).

- Evaluation report, (Ministry of Justice, 2017): "many subjects discussed in safety houses have MH issues". Arnhem: 52% of radicals (n=42) known to MH Service (Beke, 2016).

- Probation Service & National Institute for Forensic Psychiatry (Van Leyenhorst & Andreas 2017) forensic psychiatric diagnoses of detained terrorism suspects (n=26); so far: 27% disorders.