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Counter Extremism Care: The Dutch Approach

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Abstract
Radicalization and violent extremism pose challenges that cut across the security, social care, and mental health domains. The evidence base on CVE has broadened, yet detailed accounts of multidisciplinary exit programs, and the characteristics of the people they support, remain scarce. Drawing on the case of the National Support Center for Extremism (NSCfE) in the Netherlands, this article asks how an integrated, multidisciplinary exit program organizes mental health, social, and spiritual care around individual cases, and who its clients are. The NSCfE brings together (forensic) mental health care, social work, and spiritual care to support desistance, disengagement, and, where possible, deradicalization among radicalized individuals and their families. Approaching extremism as a 'wicked problem' expressed across multiple life domains, the NSCfE integrates these disciplines in a strength-based model that links each domain (i.e., mental health, social functioning, and ideology) to targeted interventions and to shared goals of stabilization, resilience, and prosocial reintegration. We describe the organization's development from an ad hoc exit facility into structured, professionalized care delivered by an interdisciplinary team of case managers. The article describes its individual-counseling ("Forsa") program and characterizes the demographic, sociological, and clinical heterogeneity of its clientele by retrospectively coding the anonymized case files of 69 individuals enrolled between 2016 and 2023. We situate this account alongside two earlier commissioned independent evaluations of the program and the current literature on CVE and exit programs. It thereby contributes practice-based evidence on how integrated, care-oriented CVE is organized, and specifies the longitudinal, outcome-focused research required to establish evidence-based practice.

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Introduction

Radicalization and violent extremism present multifaceted challenges with profound societal implications. Addressing radicalization and extremism requires a nuanced understanding of the diverse factors that drive individuals toward radical ideologies, ranging from

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psychological vulnerabilities to social alienation and ideological influences (Da Silva et al., 2024). Different types of interventions have been developed over the last decades, from hard and repressive to soft and socialization approaches, which are applied differently from country to country (Weggemans & De Graaf, 2017). Prevention and intervention efforts by soft approach actors, like social care professionals, focus on lowering risk and strengthening protective factors to promote reintegration into society for those individuals who are drawn towards or are entangled in extremist lifestyles (Lewis et al., 2024; Rousseau et al., 2022).

Although structured exit work in Europe predates this period, with pioneering programs in Germany in the late 1980s and in Scandinavia in the 1990s, the post-9/11 era and especially the Syrian conflict drove a marked expansion in the number of exit programs, which provided what could be labeled as public-crisis case management to counter violent extremism (CVE) (Koehler, 2016). These exit programs had an ad-hoc character, as they used personnel with professional and non-professional backgrounds working together without using specific evidence-based or established methods. Reintegration of individuals profiled as extremist was operationalized through a mentor-mentee approach, which was characterized by a focus on ideology (Bertelsen, 2018; Lindekilde, 2014; Spalek & Davies, 2012; Weggemans & De Graaf, 2017). Due to the lack of systematic evaluation of primary data, the field remains underdeveloped with regards to evidence-based interventions (Busher et al., 2024; Hansen & Lid, 2020; Feddes et al., 2025; Schuurman, 2020a). In the meantime, practice-based evidence from both organizational and methodological development may offer valuable insight into areas that warrant more rigorous research (see Rousseau et al., 2022). This article outlines the development of the organization and integrative methodology of the National Support Center for Extremism in the Netherlands (Dutch: Landelijk Steunpunt Extremisme, referred to from here on as NSCfE). All authors are affiliated with the NSCfE and have worked within or alongside the organization for several years: two as (forensic) mental-health science-practitioners and researchers, one as a spiritual-care worker and researcher, and one as a research-consultant. This article is therefore an insider account: a practitioner-led, narrative self-evaluation rather than an independent external study. This position affords rare and detailed access to the organization's development, methodology, and case files, but it also carries a risk of favorable bias. We have sought to mitigate this in three ways: by grounding descriptive claims in retrospectively coded case data verified through a four-eyes procedure;

by drawing on two external evaluations commissioned from independent third parties; and by presenting the available outcome data as informative rather than as proof of causal effectiveness. We invite readers to weigh our account with this dual character (i.e., privileged access alongside practitioner involvement) in mind.

The article is structured as follows. First, a conceptual background about radicalization and extremism is provided. Second, the NSCfE approach incorporating mental health, social work and spiritual care interventions is explained. Third, NSCfE's clientele and the program's effectiveness are described. Finally, the Dutch approach is discussed in a broader context including practical implications, challenges, and future directions for research. This article aims to answer the following research questions: How do the mental health, social work, and spiritual care disciplines work together in a CVE program? What are the demographic, sociological, and clinical characteristics of individuals enrolled in the Dutch exit program? Answering these research questions contributes to the academic field by advancing the understanding of interdisciplinary collaboration in CVE programs. By describing the heterogeneity among radicalized individuals, the article provides unique insight into the diversity of needs in this population, informing practitioners, policy makers, and researchers.

The Wicked Problem of Extremism

In this article, as well as in the CVE initiative discussed below, the term radicalization refers to the broader idea of the social and psychological process of incrementally experienced commitment to extremist political or religious ideology (Horgan, 2009). Such commitment can develop along different pathways: some individuals are recruited into and socialized within an extremist group or network before internalizing its ideology, while others radicalize largely on their own, without specific targeted ideological exposure or group recruitment. Likewise, some act within an organized movement, whereas others operate as lone actors without formal group membership or direct group interaction. The NSCfE works with clients across this full spectrum (O'Connor et al., 2024; van der Heide & Kearney, 2020; see also Peels, 2025). This understanding points to the behavioral dimension of radicalization and recognizes that there are many factors that shape or characterize individual pathways towards involvement in terrorism and violent extremism. Radicalization processes are not necessarily

guided by ideological convictions but also driven by things such as quests for meaning, social ties, justice, or adventure (Schuurman, 2020b; see also Bjørgo, 2005; De Graaf, 2024; Feddes et al., 2025; Horgan, 2008; Kruglanski et al., 2014; Weggemans & De Graaf, 2017). Peels (2025) emphasizes that individuals or groups can be radicalized through either cognitive or behavioral means or both, depending on a large web of different contexts, beliefs, and needs. An explanatory split between either cognitive or behavioral radicalization would miss the larger web of factors involved (Peels, 2025).

Extremism defines itself by beliefs and behaviors which dehumanize and endorse hostility towards specific groups within society. It overlaps with violent crime and anti-social behavior but also distinguishes itself from it by its use of meta-narratives which justify and motivate hate and violence towards a specific out-group (Griffin, 2012; Schmid, 2011). Cassam (2022) explains it less as a doctrine or narrative, which does apply on a group level, than as a mindset, which fits closer to the individual level. Extremism is then more a characteristic set of preoccupations (for example with purity, victimhood, or existential threat), attitudes (such as indifference to the human cost of one's aims), and habits of thought (such as us–them thinking) that dispose a person toward extremist positions. At its core, extremism is an in-group/out-group worldview that narrows the moral circle, placing the out-group beyond ordinary moral obligation and thereby licensing hostility toward them (Berger, 2018). Extremism is a multiform phenomenon as it provides a "conflict identity" which expresses itself within the life domains of a person, such as meaning and purpose, mental health, and social relations (Van Leeuwen-den Dekker & Poll, 2016). To be profiled as an extremist implies that extremist beliefs and behavior is explicitly present within one or more of the life domains (Bloom, 2013). Taking the multiplexity of radicalization as a process and extremism as an attitudinal worldview, a single-focus approach towards CVE is problematic. We, therefore, according to Peels (2025), 'need pluriform CVE programs that *also* engage radical beliefs, ideology, and other dimensions' (11).

Dealing with extremist behavior and organized activity, which can include terrorism, is primarily a (national) security issue and the focus of organizations tasked with assessment and containment of the risks caused by extremists within a society (Schuurman & Carthy, 2023; van der Heide & Kearney, 2020). Security interventions can generate short-term effects (e.g., reduction of extremist behavior and influence) by enforced desistance and

disengagement from extremist networks. To achieve lasting deradicalization (i.e., distancing oneself from extremist ideology), initiatives require a level of participation grounded in the individual's autonomy and intrinsic motivation (Marsden, 2016). This distinction matters because the central challenge is not behavioral compliance but the persistence of radical beliefs: disengagement refers to abstaining from violence while extremist beliefs may remain intact, whereas deradicalization refers to a genuine change in those beliefs (Schmid, 2014; Williams, 2021). Combining security measures with a mental health and social care approach allows for assessment of all relevant life domains such as meaning-making, psychological needs and social relations. CVE programs, such as the NSCfE, use mental health and social care interventions in the individual's problematic life domains to help the individual transition out of an extremist lifeworld and reintegrate into a non-extremist lifeworld (Khalil et al., 2023; Koehler, 2016).

Radicalized/extremist clients present a 'wicked problem' for mental health and social care, due to the unusual political and public security aspects involved which are added to, in most cases, already troubled lives. This calls for the need to develop a 'wicked method' of counter extremism care (Dijkman, 2021; Groothuis, 2023; Tromp, 2018; Weenink, 2019). This involves working methodologically in a multidisciplinary and interdisciplinary fashion using an integral approach bringing together disciplines such as mental health, social work, spiritual care or chaplaincy, terrorism studies and combining the 'hard' and 'soft' approaches of the security and health care domains (Axelsson et al., 2023; Grimbergen & Fassaert, 2022; Williams, 2009). Intervening in extremist lifestyles both in its non-illegal phase as preventive reintegration and post-conviction as rehabilitative reintegration, require long-term interventions which aim to assist extremists in reentering society in a stable and flourishing way (Dijkman, 2021; Feddes et al., 2025; Khalil et al., 2023; Koehler, 2016).

From Exit Program to Counter Extremism Care

The following account both describes how the NSCfE developed and sets out the rationale for the choices made along the way. With the sudden rise of terrorist threat due to the Syrian civil war, the Dutch National Coordinator for Security and Counterterrorism set up a CVE program in 2015 that included an exit facility that applied family and individual social care as a

deradicalization strategy, namely the NSCfE (AEF, 2018; Feddes et al., 2025; Vermeulen & Visser, 2021). The center worked together with multiple partners which were involved with the extremist clients, such as municipalities, social work organizations, schools, mental health care services, probation service, the public prosecution service, the Child Care and Protection Board, national and regional security services, and terrorist wings of prisons (Gielen, 2018). Within this first period, the intervention program was focused on individuals and their families, who planned or travelled to conflict zones in which jihadist terror groups were active. In recent years, the focus of NSCfE has been expanded to include individuals radicalized by a wider range of extremist movements and terrorist groups such as right-wing extremism and anti-institutional extremism (AEF, 2018; Dijkman, 2021; Gielen, 2020a; RadarAdvies, 2021).

The NSCfE set up two client-focused programs: individual counseling (titled 'Forsa') which combines a life-course analysis (see Carlsson et al., 2020) and risk- and life-domain assessment to design an individualized intervention program promoting desistance, disengagement, and/or deradicalization and thereby facilitate a certain level of prosocial reintegration. The second program involves supporting families dealing with the life domain-disrupting effects of extremist family members.

In the pioneering phase of the organization (2015-2019), all clients were involved with religion-inspired extremism. Case managers were recruited from diverse backgrounds in social work, counseling, chaplaincy, teaching, language interpreters, anthropology, and community engagement. The mentorship approach focused on the ability to connect with clients rather than methodological and professional health care requirements. This diversity of backgrounds and ad-hoc character of engaging with clients problematized structured recording of interventions and client progression which hampered systematic evaluation. Early exit work methodology included a high focus on ideology and presented radicalization as a special type of belief and identity which differentiated it from established forms of health and social care.

Since 2019, the distance between established health and social care has lessened as by now the team almost exclusively consisted of health and social care professionals. All case managers complete a structured training and supervision program, addressing a gap the field has flagged, where counselor competencies are too often assumed rather than deliberately

trained (Koehler & Fiebig, 2019). New case managers in the first year follow an internal training program covering (a) the conceptual understanding of radicalization, extremism, and deradicalization; (b) extremist profiling and structured risk assessment (e.g., VERA-2R; Pressman et al., 2018); (c) the disciplinary methods of (forensic) mental-health, social, and spiritual care and how these are combined within a single case; and (d) inter-agency collaboration with the diverse security and care partners involved in a case. Training is delivered by NSCfE researchers and professionals, supplemented by courses from local and international exit and counter-extremism organizations, and is reinforced by ongoing case supervision and structured peer consultation (intervision), so that competencies are maintained and calibrated across the team.

While the program's multidisciplinary collaboration with municipalities, social services, and security agencies remained consistent, its methodological focus evolved from an ad-hoc, ideology-centric approach to a comprehensive healthcare perspective. Combining professional working methods of (forensic) mental health, social and spiritual care, the organization's extensive client experience, and research on evidence- and practice-based insights on reintegration, extremist clientele started to be approached from a specialized but also holistic health care perspective using structured case management in reporting, intervention, and methodology. This shift fits well with the diversification among clients' ideologies and needs. Throughout the changes, the NSCfE has maintained its flexibility to adapt to new phenomena while sustaining its ability to provide tailored intervention programs. The current reintegration approach towards clients can be displayed as such:

Table 1. Integral Counter Extremism Care.

Life domain	**Disciplines**	**Scientific background**	**Interventions**	**Goal**
Mental health	Psychiatrist, psychologists	(Forensic) psychology, psychiatry, psychotherapy	Psychodiagnostics, psychoeducation, psychotherapy, family therapy, medication, risk assessment	Symptom reduction, psychoeducation, increasing protective factors and channeling psychopathological needs in a more adaptive way
Social functioning	Social care workers	Social work, pedagogy, counseling, coaching	Social relations, physical health, work and activity, finances, housing, assistance with dealing with government agencies, risk assessment	Installing protective factors, improving connections with society and connectedness with prosocial networks
Ideology	Spiritual care workers, chaplains, philosophical counselors	Humanities, theology, religious studies, philosophy	Providing counter- and alternative narratives, introduction to prosocial religious or ideological networks, adopting healthy religiosity	Critical reflective skills on ideology and conflict, healthy religiosity and community engagement, resilience against extremist recruitment and narratives, prosocial understanding of religious and secular ideas, broader tolerance for diversity and pluralism, and spiritual well-being

As shown in Table 1, interventions from the three life domains involved in NSCfE's programs, as a strength-based model, work towards different goals enhancing stabilization, resilience, and pro-socialization (Axelsson et al., 2023). Regarding mental health, various

kinds of interventions are applied to reduce the burden of psychopathology, improve quality of life, and decrease vulnerability for attraction to extremist groups or ideologies. They can be categorized in a number of overarching themes like symptom reduction, psychoeducation, increasing protective factors, and channeling psychopathological needs in a more adaptive way. These interventions can be conducted simultaneously, partly overlap and reinforce each other.

Symptoms of mental health disorders such as depression, psychosis, ADHD, and PTSD can increase vulnerability to extremist groups and ideologies (Al-Attar, 2019; Feddes et al., 2025; Van Dam et al., 2024). This may occur through transdiagnostic psychological mechanisms such as influenceability, dichotomous thinking, poor impulse control, or guilt. Targeted treatments aimed at reducing these symptoms, including pharmacological interventions to manage psychosis, impulsivity, or mood disturbances, and psychological therapies such as Cognitive Behavioral Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR), can help mitigate risk. Interventions derived from Dialectical Behavioral Therapy (DBT), Mentalization-Based Treatment (MBT), and Schema-Focused Therapy (SFT) may also address traits like impulsivity, dependency, and rigid thinking that contribute to susceptibility (Al-Attar, 2019; Krueger & Eaton, 2015; Van Dam et al., 2024). Psychoeducation for individuals and their social environments further aids in recognizing vulnerabilities, particularly in chronic conditions such as schizophrenia, intellectual disability, and autism spectrum disorder, promoting adaptive coping strategies and social support. The mental health professionals also focus on understanding and redirecting the psychological needs that extremist ideologies fulfill. For example, providing alternative ways to satisfy a narcissistic individual's need for superiority or a person with borderline personality disorder's need for belonging can reduce reliance on extremist groups (Kruglanski et al., 2019; Van Dam et al., 2024).

The social care interventions by the case managers are also targeted at installing protective factors, like boosting a client's healthy autonomy in life domains such as work, activity, healthy lifestyle, housing, financial security, and connection to prosocial networks. The help offered by case managers is adjusted to specific clients' needs and may be practical in nature by providing assistance with dealing with government agencies regarding procedures and difficulties with language. It may also encompass encouragement of critical

reflection and empowerment in relation to a client's network or ex-network. Special attention is paid to reinforcing prosocial networks, which may be related to work, hobbies, peers, and family. Additional focus lies on family support. To deal with the radicalized individual and to prevent other family members from radicalizing, family members are provided with psychoeducation and practical and emotional support to deal with the situation. Specifically, this may involve support with and repair of family relationships, boosting resilience in periods of uncertainty, and providing information and knowledge about processes of radicalization (AEF, 2018; Feddes et al., 2025; Lewis et al., 2024).

Spiritual care combines pastoral, theological and philosophical methodologies which focus on the client's general worldview, the possible presence of major life events, meaning-making needs, spiritual well-being, religiosity, the type of religious and/or secular ideologies present, the level of moral (dis)engagement, and to what degree these may affect lifeview narratives (Mensch, 2016; Smit, 2015). A worldview, in this context, denotes the more or less coherent framework of beliefs, values, and commitments through which a person interprets reality and orients their life (Valk, 2021; Van der Kooij et al., 2013). Spiritual care differs from general chaplaincy or pastoral work due to its ability to collaborate with clients from diverse religious and secular backgrounds, its capability to work within security and healthcare settings e.g., prison or hospital chaplaincy, and to work with goal-oriented interventions instead of open-ended counseling interactions characteristic of pastoral care (Heard et al., 2022; Flierman, 2012; Tretera & Horák, 2019; Grung, 2023; Liefbroer et al., 2024; Nieuwsma et al., 2016; Van Nieuw Amerongen-Meeuse et al., 2021). Spiritual care workers integrate their interventions with social and mental health care interventions, for example when a client is reluctant or in denial of the possible presence of mental health problems, spiritual care workers can help them accept psychological assessments and possible treatment (Malviya & Greenham, 2025; Leget & Boelsbjerg, 2023; Nissen et al., 2021). Spiritual care workers can also assess what can be deemed as normative religiosity and if and to what degree extremist orientations affect the client's worldview and behavior (Malviya & Greenham, 2025). Spiritual care interventions include providing counter theology or counter ideology narratives, understanding religious, and ideological sources and history, education in critical reflection skills, enhancing moral circles, engaging healthy religiosity and prosocial community engagement, learning to differentiate between normative and extremist ideas, and

how to deal with societal diversity and pluralism which can be confusing and/or negatively triggering the client's spiritual well-being (Abbas, 2021; Vellenga & de Groot, 2019). Religious and/or secular extremism are tied into the personal worldview of the client whereby beliefs and social environment are experienced as conflicting or even at war with each other (Wilkinson, 2019). As beliefs are grounded in the autonomy and experience of the client, and as these are protected by human rights, intervening in the worldview of clients requires voluntary and long-term interactions between case manager and client (Parker, 2019).

The NSCfE thus provides tailored intervention programs to accommodate the needs and characteristics of each client. To give insight into the diversity of NSCfE's clients, demographic, sociological and clinical characteristics are reported below.

Methods

Study design

This practice-based case study of the NSCfE's Forsa program employed a retrospective design using secondary data, as the data were not collected primarily for scientific purposes. Data are included to show the heterogeneity of characteristics among clients who received the Forsa program.

Participants

In total, 69 individuals were included who received the Forsa program offered by the NSCfE at any point between 1 January 2016 to 31 December 2023. Clients enrolled in the Forsa program through referral by a professional organization such as municipalities, social work organizations, schools, mental health care services, judicial or probation services, the childcare and protection board or national and regional security services. Individuals were eligible for the Forsa program if they a) are in a radicalization process, b) are/were active in a (violent) extremist network, c) hold, endorse or propagate (violent) extremist beliefs, or d) are suspected or convicted of terroristic crimes and when they were open to receive support. Participation in the Forsa program was either voluntary or court mandated. The intake procedure began after clients signed the informed consent form. This form included general information about Forsa, information about Dutch privacy laws and how to file complaints.

Signing the informed consent form meant that clients agreed to the use of their anonymized data for scientific purposes. Clients could opt out of the use of their data without consequences for receiving support.

Procedure

Client files were retrospectively coded to obtain the data presented in this article. A case manager maintained the client's file for the duration of the program, including treatment plans, support goals, frequent evaluation reports, meeting notes, and correspondence. Retrospective coding was performed by a single researcher associated with the NSCfE using a codebook. The coding was deductive: the codebook, based on the methodology used in the program's earlier external evaluations and on the variables routinely recorded in client files, defined a fixed set of categories in advance, which the researcher applied to each dossier rather than deriving new categories inductively from the data.

To safeguard coding accuracy, an additional check was performed by the researcher and the case manager in accordance with the four eyes principle (i.e., a two-person verification procedure to improve validity).

Measures

The recorded data were organized in three domains: demographic, sociological and clinical variables. These domains were selected based on the available data that were recorded in client files and reflect relevant variables for case management rather than variables specified by theoretical models of radicalization. Demographic variables, which were recorded at the starting point of the Forsa program, included age, gender (male, female), marital status (single, married/partnered, divorced/widowed), level of education (high school or under, vocational college, college), employment status (unemployed, student, employed), housing situation (independent, with family, homeless, in detention/institution), financial situation (sufficient, limited, problematic), whether the individual was a (re)convert (yes, no) and judicial convictions (terrorism related, non-terrorism related, absence of criminal convictions). Three sociological factors were recorded: family's religious context (Islamic, Christian, or non-religious), whether any family member was also radicalized (one, more than one, none) and the extremist manifestation of the client (religion-inspired, right-wing

extremism). This typology is based on the phenomenon analysis by Nanninga and colleagues (2022). The category 'religion-inspired extremism' refers predominantly to jihadist and Salafi-jihadist orientations, reflecting the program's origins in the 2013–2017 outflow to Syria and Iraq, while 'right-wing extremism' covers ethno-nationalist, white-nationalist, and neo-Nazi orientations, including more recent accelerationist strands; a small but growing group presents anti-institutional or conspiracy-driven extremism (Nanninga et al., 2022). Because coding drew on case-management files rather than a dedicated ideological assessment, we recorded the broad manifestation type rather than fine-grained belief content. The specific doctrinal beliefs of individual clients were documented narratively in the dossier but were not systematically coded, a limitation we return to below. Furthermore, it was recorded whether a client had a psychiatric diagnosis (yes or no) and, if so, which DSM diagnosis they had (ASD, AD(H)D, PTSD/trauma-related, personality disorder, intellectual disability, depression/fear-related, psychotic related, no diagnosis). Client's substance abuse was measured and, if applicable, the severity was recorded (unproblematic, problematic). Lastly, clients were asked whether they suffered physical and/or emotional abuse or whether this is not applicable.

Results

Client characteristics

As shown in Table 2, clients vary in a number of different variables. As the aim of this article is descriptive rather than inferential, no hypothesis tests, effect sizes, or multivariable models were included. For 63 out of the 69 clients, the birth date and date of registration was known, the mean age was 24.2 (standard deviation = 9.0) years at the start of the program. For all other variables, the number presented is based on the total sample of 69 clients. More than three quarters was male (78.3%), only 21.7% was female. Most of the clients were single at the time, about 24.6% were married or had a partner. None of the clients had a university degree and 15.9% completed only high school or only primary education. Of the clients with available data, about 21.9% were unemployed, 13.7% was a student and 15.1% had an occupation. For a large number of clients data regarding education and employment were unknown as this was not recorded in the first couple of years. A large group still lived with their family (38.0%), probably because clients were quite young and often single. Many

clients also lived in an institution, for example where they received mental health treatment, or in detention (25.4%). Just under one third of clients (re)converted to a religion (29%). Most clients had no convictions, and the clients with a conviction were about equally divided between terrorism (e.g., joining a terrorist organization or preparing a terrorist attack) (20.3%) and non-terrorism related (e.g., robbery or aggravated assault) crimes (18.8%).

Table 2. Demographic, sociological, and clinical characteristics of NSCfE clients ($N = 69$).

Demographic characteristic	*n*	%
Gender		
Male	54	78.3
Female	15	21.7
Marital status		
Single	37	53.6
Married/partnered*	17	24.6
Divorced/widowed	9	13.0
Unknown	6	8.7
Highest educational level		
High school or under	11	15.9
Vocational college	15	21.7
College	5	7.2
Unknown	38	55.1
Employment**		
Unemployed	16	21.9
Student	10	13.7
Employed	11	15.1
Unknown	36	49.3
Housing situation**		
Independent	13	18.3
With family	27	38.0
Homeless/Unstable	3	4.2
In detention/institution	18	25.4
Unknown	10	14.1
Financial situation		
Sufficient	17	24.6
Limited	21	30.4
Problematic	12	17.4
Unknown	19	27.5
(re)Convert		
Yes	20	29.0
No	43	62.3
Unknown	6	8.7
Judicial history		

Terrorism-related conviction	14	20.3
Non-terrorism-related conviction	13	18.8
No conviction	32	46.4
Unknown	10	14.5
Sociological characteristic		
Religious family context**		
Islamic	46	65.7
Christian	5	7.1
Non-religious	11	15.7
Unknown	8	11.4
Radicalization family member		
One family member	7	10.1
Two or more	4	5.8
None	48	69.6
Unknown	10	14.5
Extremist manifestation		
Religion-inspired extremism	55	79.7
Right-wing extremism	7	10.1
Unknown	7	10.1
Clinical characteristic		
DSM diagnosis**		
ASD	5	5.8
AD(H)D	5	5.8
PTSD/Trauma-related	9	10.5
Personality disorder	10	11.6
Intellectual disability	9	10.5
Depression/fear-related	3	3.5
Psychotic-related	6	7.0
No diagnosis	7	8.1
Unknown	32	37.2
Substance abuse		
No	39	56.5
Yes, unproblematic	11	15.9
Yes, problematic	3	4.3
Unknown	16	23.2
Suffered abuse/neglect		
Physical	5	7.2
Emotional	10	14.5
Physical & Emotional	17	24.6
No abuse	25	36.2
Unknown	12	17.4

Note. *Includes Islamic marriage. **Clients may be categorized multiple times.

Furthermore, most clients were brought up in an Islamic family context (65.7%). In 15.9% of cases, one or more family members were also radicalized. The extremist manifestation was mostly religion-inspired (79.7%), specifically Islam-inspired, 10.1% was right-wing extremism and in the rest of the cases this was unknown (10.1%). In the early days of the NSCfE, the CVE programs were geared towards individuals who travelled to Syria to join Islamic State and their family members. Over the years, as other types of extremism became more prominent, the NSCfE started to receive more requests for support for individuals who hold right-wing extremist ideals, for example.

In addition to sociodemographic characteristics, mental health aspects were also recorded of all clients. The data again show a fragmented picture: a small majority had a diagnosis (54.7%). The type of diagnosis also varied quite a lot, most clients either suffered from a personality disorder (11.6%) or PTSD or a trauma-related disorder (10.5%). Developmental disorders like ASD and AD(H)D were less frequent, both 5.8%. Some clients were diagnosed with an intellectual disability (10.5%), a psychotic-related disorder (7.0%) and a small minority had depression or a fear-related disorder (3.5%). In about 8% of cases, clients had no diagnosis and for more than 1/3 of the clients this was unknown (37.2%) In addition to having a diagnosis, clients were also asked whether they used substances and if so, whether their use was problematic. In the large majority of clients, substance (ab)use was either not present (56.5%) or the use did not lead to problems (15.9%). Among a few clients, problematic substance abuse was recorded (4.3%) and in many cases, it was unknown what a client's status was (23.2%). Lastly, data about physical/emotional abuse (including neglect) were collected. Strikingly, the groups at either end of the extreme (no abuse vs. both physical and emotional abuse) were largest, 36.2% and 24.6%, respectively. Clients who were solely emotionally abused made up 14.5% and a small group received solely physical abuse (7.2%).

External evaluation support programs

The NSCfE commissioned two independent organizations to perform evaluations of the Forsa and family support program (AEF, 2018; RadarAdvies, 2021). External evaluators assessed the programs methodologies, interviewed former clients, and analyzed anonymized data from client files.

Programs methodology

Both evaluations identified principles such as flexibility, rapid coordination, independence, and confidentiality as key factors included in Forsa program (AEF, 2018; RadarAdvies, 2021). These factors overlap with previous studies emphasizing the need for tailored interventions based on individual risk factors and needs, integrated and multidisciplinary approaches and efforts to enhance clients' self-esteem and autonomy (Gielen, 2020b; Van der Heide & Schuurman, 2019; Webber et al., 2018). More specifically, targeting cognitive, psychosocial, behavioral, and societal factors and social and educational development were found to be effective (Feddes et al., 2025). By improving critical thinking skills, learning to deal with ambiguity, improving emotion regulation and resilience, individuals can become less vulnerable to extremist influences. Work or educational involvement, skill building and increased self-worth and empathy also aid deradicalization (Feddes et al., 2025). Short duration, resistance to ideological change, stigmatization, and distrust, on the other hand, can hinder deradicalization efforts (Feddes et al., 2025). Other research looking into the role of professionals concludes that trust-building, cultural competence (e.g., understanding religious contexts), and a respectful, client-centered approach are paramount in interventions efforts (Christensen, 2015; Neumann, 2010).

Regarding the family support program created by the NSCfE, the external evaluations conclude that key principles such as tailoring support to individual family needs and emphasizing protective factors are foundational to its design. Additionally, respondents frequently highlight the professionalism, open-mindedness, and empathy of the case managers, which enhance family engagement and trust (AEF, 2018; RadarAdvies, 2021). Several success factors have been identified in research on family support programs, such as a centralized point of contact for families, effective collaboration between organizations, strengthening of protective factors to mitigate risk, using peer support as an intervention, and the expertise and cultural sensitivity of professionals within multidisciplinary teams (Cherney, 2019; Gielen, 2015; Koehler, 2013; Weggemans et al., 2018). While comparative evaluations are scarce, the programs align with emerging best practices and include effective elements suggesting its potential to contribute to radicalization prevention.

Former client interviews

Former Forsa clients expressed satisfaction with the support they received, emphasizing the trusting relationship with their case manager, case manager's in-depth knowledge of Islam, the high levels of involvement and professionalism, the focus on building resilience, and creating a positive self-image. Family members who received family support reported reduced feelings of shame and isolation, that case managers' input increased their knowledge of radicalization warning signs, and that referral to local specialist care (e.g., psychologists, relationship therapists) was often successful (AEF, 2018; RadarAdvies, 2021).

Program effect evaluation

RadarAdvies (2021) examined to what extent the support provided within Forsa had contributed to strengthening protective factors that help individuals renounce extremist violence and/or distance themselves from an extremist network. They analyzed client changes in five life domains over the duration of the Forsa program: social relations, coping, identity, ideology, and action orientation. These domains are based on the pro-integration model (Barrelle, 2015). The domains were measured using the Dutch version of the self-sufficiency matrix (SSM-D; Fassaert et al., 2014), ranging from 1 (i.e., fully self-sufficient) to 5 (i.e., urgent problems). Clients showed a 0.9 improvement in social network and 0.4 improvement in family relations. Though, it is important to note that social network started and ended at a lower baseline (i.e., start 3.7, end 2.8) than family relations (3.0 to 2.4). This means that clients still had limited self-sufficiency on social network at the end of the Forsa program despite some improvement. Within the coping domain, clients had an average improvement of 0.6 on mental health, reporting greater emotion regulation and having more (digital) resilience. The identity domain received least attention in the client files and only qualitative results from client interviews were reported. Clients reported positive changes such as being more friendly and patient but did not attribute this change to NSCfE's involvement per se. The domain involving ideology showed the largest effects, clients moved almost 1.0 average point on all aspects towards self-sufficiency. Furthermore, in 32% of clients the attitude towards the government improved, for 12% it stayed the same, 6% of clients showed a worsening attitude and it was unknown for 50% of clients. Results about action orientation reported that 64% of clients did not commit a terrorism-related offense during or after

receiving Forsa, 2% did and for 34% this is unknown. Similarly, 64% of clients did not travel to a conflict zone, 4% did and in 32% this is unknown (RadarAdvies, 2021).

Regarding family support, 23% of clients reported decreased worries about their radicalized family member, in 20% of clients, no change in worries was observed, for 4% of family members the worries worsened and for 53% this information was unknown. Additionally, 30% of clients reported having decreased worries about other family members at risk of radicalization at the end of the family support program. In 12% of clients the worries remained the same or worsened, for 32% this issue did not apply and for 26% this information is unknown.

Discussion

This article provided a unique insight into the multidisciplinary and dynamic approach to counter extremism developed by the NSCfE in the Netherlands. The organization employs (forensic) mental health, social and spiritual care professionals who work together closely to provide tailored disengagement programs for radicalized individuals and their family members. Looking at the phenomena of radicalization and extremism through a health and social care lens is pivotal as the phenomenon is often reduced to a security concern warranting repressive action (Rousseau et al., 2021; Schulten, 2022; Sizoo et al., 2022a; Sizoo et al., 2022b). An exclusive focus on repressive interventions may be counterproductive and only accelerate radicalization processes. Such measures must always be accompanied by broader, often long-term, interventions from other domains that ultimately assist extremists' sustainable reintegration in society. It is already widely acknowledged that desistance, deradicalization and the substantive changes in a person's attitudes and behaviors associated with it, are unlikely to be achieved through repression alone (Koehler, 2016). Instead, pulling an individual away from extremist narratives and lifestyles requires a holistic approach that incorporates all relevant life-aspects: from housing to finances and from social network to beliefs and mental well-being. This also highlights the importance of close collaboration between professionals and organizations with diverse roles and backgrounds.

Several features distinguish the NSCfE from many other exit and CVE initiatives, and most are tied to the Dutch context. First, rather than an ideology-first mentoring model staffed

by former extremists or volunteers, the work is delivered by an interdisciplinary team of licensed (forensic) mental-health, social-care, and spiritual-care professionals, embedding disengagement and deradicalization work within regular health and social care. Second, it treats spiritual and worldview care as a distinct professional discipline alongside mental health and social work, rather than delegating it to community religious figures, building on the well-established Dutch tradition of professional, publicly funded 'geestelijke verzorging' (spiritual and humanist care) in prisons, hospitals, and the armed forces. Third, it is a single, nationally commissioned facility serving the whole country, which allows a consistent methodology across cases and structured cooperation with the full range of Dutch security and care partners. These features presuppose a well-developed, publicly funded mental-health and social-care infrastructure and a specific national history, the post-2013 Syrian outflow that shaped the initial caseload, and would therefore need to be adapted, rather than adopted wholesale, in countries with a different security and care landscape.

A broader approach to radicalization and extremism is also more flexible and suitable to deal with the dynamics of contemporary security. Extremist narratives and movements are highly volatile and local, national, or global events are increasingly intertwined. For example, the outbreak of the civil war in Syria and the establishment of the so-called Islamic State have incentivized individuals from across the globe to become jihadist foreign fighters (Weggemans et al., 2014). The constant evolution of extremist manifestations requires professionals to keep up with current affairs and maintain a certain level of flexibility to adapt interventions to new situations. At the same time, there are many forms of extremism, and not all may end up as cases in CVE programs like the NSCfE. This is also reflected in the data presented above. For example, while there have been some cases of left-wing extremism and anti-institutional extremism, these individuals never entered the Forsa program. This could reflect a difference in the size of the phenomenon, a bias or lack of knowledge among those who refer (family, peers, or professionals), or the fact that referral and, for court-mandated cases, enforcement decisions rest with practitioners and partner agencies, whose priorities shape which ideologies reach the program. The question of what makes individuals reach out to CVE initiatives like the NSCfE, and how case managers respond to and prioritize incoming requests, is a topic worth further investigation.

Regarding the evidence for the effectiveness of the Dutch approach, two independent external evaluations have been conducted to date. Although the evaluations reported positive outcomes, there are some important limitations that warrant discussion. First, there was no control group so any changes cannot be confidently attributed to the program as these changes may also have occurred due to the passage of time. Although no causal claims can be made, the direction of the reported changes is corroborated across independent sources, dossier-based coding, clients' own accounts in interviews, and reports from external stakeholders, and the changes follow rather than precede program involvement. We therefore read this convergence as suggestive of the program's relevance, not as proof of effect. The results should therefore be regarded as exploratory and indicative for further academic exploration. Second, the data were scored by case managers and not by independent researchers, introducing the risk of biased results. To mitigate this risk, the NSCfE applied a four-eyes principle in which another NSCfE colleague reviewed the data. However, this internal check is not equivalent to rigorous scientific standards for blinded assessment and does not fully mitigate the risk of biased scoring. Third, data were gathered retrospectively based on client files compiled for tracking progress rather than research purposes, meaning that not all data were available. Given these limitations, we should consider the evaluation outcomes as informative rather than evidence for causal treatment effectiveness. Therefore, we agree with evaluators and previous researchers who stress the need for more standardized registration, longitudinal tracking of clients' progress and refinement of definitions used to formulate client goals. As the results are heavily context-dependent, it is difficult to pinpoint effective mechanisms and what works, for whom, in which context and how, for example, by investigating intervention methods and instruments to promote evidence-based practice (Gielen, 2015; 2020a). Specifically, interventions designed for patients to reduce impulsiveness or influenceability, for example, may also be suitable for clients who, in addition to their mental health problems, hold extremist beliefs. As CBT is a widely used and proven effective type of therapy for a wide range of problems, it is feasible that certain techniques may be beneficial in the context of extremism. This hypothesis has yet to be investigated, and we encourage researchers to delve into this topic. Another recommendation is to continue the work to disentangle the web of factors that play a role in radicalization processes. A couple of meta-analyses have been published on this topic, however the interplay

between factors within and between macro-, meso-, and micro-level factors is still largely unclear (Clemmow et al., 2023; Feddes et al., 2023; Wolfowicz et al., 2021).

Conclusion

What does this account add to what is already known? The P/CVE literature has established that integrated, care-based responses are preferable to purely repressive ones and has catalogued many factors associated with (de)radicalization; it has offered far less on how such an integrated program is actually run and whom it serves. This article contributes on three points. First, it documents, transparently and from the inside, how a national program organizes mental-health, social, and spiritual care around individual cases, the operational 'how' that reviews of the field identify as missing. Second, it provides a systematically coded profile of an unusually broad exit-program clientele (N = 69), showing a high load of co-occurring psychiatric, trauma, and abuse-related problems that any comparable program must be resourced to handle. Third, it models a limitations-forward way of reporting practice-based evidence, specifying the data infrastructure a field short on evidence would need to build before effectiveness can be tested. The contribution is therefore less a claim about whether care-based CVE 'works' than a transferable account of how it is done, for whom, and what it would take to evaluate it properly.

In this article we described the development of an initiative in counter extremism care involving forensic mental health, social care, and spiritual care domains. Because this approach is grounded in shared general scientific notions and ideas about radicalization process and violent extremism, it may be valuable for international audiences. On the other hand, countries differ in their experiences with violent extremism and governance landscape. As such, the Dutch approach may not offer a universal approach for radicalization and violent extremism. Over the decade, several organizations working on the nexus of mental health care and security have emerged to work with violent extremists (Koehler, 2016; Rousseau et al., 2022; Weggemans & De Graaf, 2017). Sharing organizational knowledge and ideas between academics and practitioners working in this field as well as experiences from initiatives tailored to other groups (e.g., cults, gangs, juvenile offenders, etc.) could yield relevant insights into best and worst practices that could improve existing and future approaches.

The program's own development offers several lessons, which we frame cautiously given this study's limitations (no control group, a single national setting, and retrospective dossier coding). One lesson concerns what did not work well. In the pioneering phase (2015–2019), an ideology-first model staffed for charisma and rapport rather than for clinical method built trust quickly but recorded interventions and progress inconsistently, which later made systematic evaluation difficult and left early outcomes largely undocumented. The move to a professionalized, interdisciplinary team with structured case management corrected this, but at the cost of several years of data that cannot be recovered in a critical fashion. A second, ongoing limit is that worldview- and ideology-focused work reaches its ceiling with clients whose severe psychiatric conditions or intellectual disabilities restrict reflective engagement; here the team learned to prioritize stabilization and mental-health care before, or instead of, ideological engagement.

From these experiences we offer three recommendations for comparable exit and disengagement programs elsewhere, subject to local adaptation. First, build structured data registration and a small set of validated outcome measures into the program from the outset; the capacity to evaluate later depends on how and why decisions were made and by whom. Cataloguing the client experience built-up by an organization provides the pathway out of ad hoc application and the foundation for assessing best practice. Second, staff the program with licensed, interdisciplinary professionals and invest in their systematic training and supervision rather than relying on charisma or lived experience alone (Koehler & Fiebig, 2019). Third, sequence interventions to the client's condition, stabilizing mental health and social circumstances before pursuing ideological or worldview change, and design referral pathways deliberately, since who reaches the program at all is shaped by the partners and communities that refer them.

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