# Ethical Guidelines for Working on P/CVE in Mental Health Care

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This paper describes the task of mental health professionals working in the context of preventing and countering violent extremism (P/CVE) and provides guidance on how this can be undertaken to be consistent with ethical practice. In the section on **Ethical Dilemmas**, the key concerns of psychiatrists, psychologists and psychiatric nurses in relation to this work are identified and addressed. These concern their dual responsibility towards their patients and the wider public, the challenges of breaching confidentiality and sharing information, the dangers of pathologising beliefs, and the importance of ensuring that their practice is evidence-based and does not take them beyond the limits of their competence as mental health practitioners. The different contexts in which mental health professionals are called upon for professional advice and the possible links between mental health and radicalisation are described, as are the consequences for the risk of harm. The paper concludes with a section titled **Guidelines** that presents the ethical guidelines that are consistent with the professional codes of practice of mental health professionals under the four headings of Respect, Responsibility, Competence and Integrity.

# Introduction

Mental health professionals, including forensic practitioners, have become engaged in preventing and countering violent extremism (P/CVE) through their role in assessing the risk and needs of individual extremist offenders, and in identifying the role that mental health issues may have in engagement with extremist ideologies and/or extremist violence. This may be either before or after an offence is committed; before in the context of P/CVE work, and after in the context of advising the courts or assessing the risk of extremist reoffending. More recently, this role has included assessing the mental health needs of returning foreign fighters and their families, to determine how mental health issues might bear on possible future terrorist intent, and/or to identify reintegration needs that might include addressing post-traumatic stress symptoms. In all these contexts, the same broad ethical principles apply, and those developed for psychologists working in forensic contexts have informed the content of this paper. The key difference of the pre-crime context is the legal status of the patient or client, when mental health assessment cannot be compelled by law. However, good ethical practice would expect that in both contexts voluntary cooperation would be sought in a spirit of openness and transparency, to deliver the best-informed assessment for both the client and the wider public. This work, in both criminal justice and P/CVE settings, is currently being carried out by forensic and/or mental health professionals working within criminological and medical models, and therefore the term patient/client is used to describe the individual assessed throughout this paper.

The lack of clear boundaries between a diagnosable mental disorder and other psychological difficulties that may be relevant to extremist behaviour is reflected in the terminology used here. As both can constitute a vulnerability to extremism, the wider term “mental health issues” is used to encompass both, and the term “mental disorder” is confined to a diagnosable disorder that is listed within a recognised diagnostic manual.

The key task of mental health professionals is not to predict risk, an aspiration that forensic risk assessment experts have largely abandoned in favour of its prevention. Rather, it is to identify symptoms that may, either directly or indirectly, account for an interest in extremist ideology or violence, such that treating or managing these symptoms, or providing more general support, might prevent a violent outcome. An example of a direct link between mental disorder and the risk of harm is a command hallucination to attack a specific target, where treating the psychosis will directly reduce the risk of harm. An example of an indirect link is the presence of psychological distress where treatment may reduce this distress and increase resilience against radicalisation. This paper stresses the importance of establishing whether there is such a functional link between a mental health issue and engagement in extremism, in order to clarify the likely consequence of treating the mental health issue. Where there is no clear functional link, treating the issue will not in itself mitigate engagement in extremist ideology or violence.

A further consideration for mental health professionals working with radicalisation is that there is an important distinction to be made between an interest in extremist ideology and an intention to engage in extremist violence. It is self-evident that there are many more people with extremist sympathies than there are terrorists. Engagement in ideology is not therefore a sufficient indicator of risk of harm. The terms “extremist interest” and “extremist violence” are therefore used to discriminate between these different positions. The term “radicalisation” is also avoided where a clearer distinction is needed between engagement with ideology and an intent to cause harm, and the term “terrorist” is avoided as it can be alarmist and potentially stigmatising. It is advisable to avoid this term in direct conversation with patients/clients about whom there are extremist

concerns. It can undermine the perceived legitimacy of the mental health practitioner in the eyes of patient/clients who reject the designation terrorist and prefer to see themselves as warriors in a noble cause.

# Ethical dilemmas

## What are the legal frameworks within which healthcare professionals work and how do they relate to ethics?

It is generally recognised that medical healthcare cannot be delivered effectively without a trusting relationship between doctor and patient that is supported by confidentiality. Across Europe, it is accepted that this is an important ethical and legal duty expected of all health professionals, but nowhere is it treated as absolute. Article 8 of the European Court of Human Rights (ECHR) has determined that the right of privacy can be lawfully restricted where this complies with national law and the ECHR. Across Europe the legal frameworks will differ, but the principles of ethical practice should not. So also will the detail of professional codes of practice for different mental health professionals, but all will permit disclosure where this is required by law or ordered by a judge. All accept that there is a responsibility on the part of health professionals to maintain their competence, to practise effectively and responsibly, to honour the trust that is placed in them, and to prioritise the individual patient/client. But there are also references to a dual responsibility, to both the wider public and to individual patients. This is particularly relevant to forensic practitioners, whose clients include the criminal justice system and the general public, as well as their individual patient/client. In these circumstances guidance states that only the information that is relevant to the request is disclosed, and that wherever practicable the patient is informed of this disclosure, unless this would prejudice the prevention, the detection, or the prosecution of serious crime.

**Article 8 II ECHR.**

There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of **national security, public safety** or the economic well-being of the country, for the **prevention of disorder or crime**, for the protection of health or morals, or for the protection of the rights and freedoms of others.

In the UK, a statutory 'Prevent duty' requires local authorities, health facilities, schools, institutes of education, and probation and police officers to "have due regard to the need to prevent people from being drawn into terrorism". This is controversial for pluralist societies because of the danger of pathologising beliefs where a wide spectrum of beliefs is the norm, and beliefs are not regarded per se as indicators of mental disorder. The Royal College of Psychiatrists (RCP) has expressed these concerns explicitly. They question whether there is a sufficient evidence base for a relationship between mental illness and terrorism, and whether they should report to the authorities those who show signs of engagement in extremist ideology but who do not express an intent to cause harm. However, their Code of Ethics also acknowledges that:

*Where possible, sharing confidential information should take place in a transparent way, with the patient's full informed consent, and at all times in compliance with best practice and law. There are information governance systems and leads in all health and social care organisations to enable psychiatrists to carry out this duty ([1]).*

([1]) RCP, Good Psychiatric Practice. Code of Ethics, p. 9.

## How do we understand the concepts of Respect, Competence, Responsibility and Integrity?

These four concepts underpin ethical practice for practitioner psychologists across Europe and the United States of America (USA). The European Federation of Psychologists' Associations (EFPA) has produced a Meta-Code of Ethics ([2]) that provides specific recommendations for its interpretation in forensic contexts. The three generic principles of Respect, Responsibility and Integrity overlap to a large extent and are described in generalities, such that individual practitioners are advised to consult with colleagues, and potentially lawyers, to clarify their position if faced with a particularly novel or complex challenge. The principle of Competence is more pragmatic and concerns the importance of maintaining high standards and working within the limits of one's knowledge, skills, training and experience. Competence has been a source of specific concern to many health professionals who do not feel that they are sufficiently skilled to work with extremism, or that it is appropriate for them to do so. This is addressed below in the section entitled 'What are the ethical considerations regarding risk assessment for mental health professionals?'

## How can practitioners deal with the issue of confidentiality?

In P/CVE work, the immediate priority for mental health professionals remains the well-being of the patient/client, but there is also a responsibility to members of the community who could become a target for violence. Maintaining complete confidentiality therefore may result not only in harm to the patient/client but also to the wider community. The interests of both are therefore served by a degree of information sharing with the relevant authorities, who in this scenario are likely to be P/CVE officials. It remains the case, however, that there is no mental health expertise that can predict whether an individual will commit an offence of extremist violence, especially when there is no history of previous criminal behaviour. In these circumstances, assessment should be transparent and evidenced, and any statements that bear on the risk of harm tentative and nuanced. In the P/CVE space, it is particularly important that the patient/client's legal status is acknowledged and respected, and that the individual is made aware that they are free to decline the contact with a mental health professional.

**British Psychological Society, DFP, ethical guidelines, p. 6**

Practitioner psychologists may be asked to conduct work with those who have not been arrested, convicted or sentenced for terrorism or terrorism-related offences but who are under suspicion. In these circumstances, practitioner psychologists should be sensitive to an individual's legal status and seek consent to interview them; and encourage their clients' engagement and be open about the nature of their role and the potential benefits of engagement both for the individual and for the safety of the general public. They should also acknowledge the limitations of predictions of harm based on pre-criminal behaviour.

For each country, where there are processes in place to regulate the sharing of health information, these should be complied with. Good practice suggests that the practitioner should act as an honest broker who shapes the expectations of both the patient/client and the referrer, and manages the process of assessment and information sharing transparently through to its conclusion. Psychiatric opinion is that any sharing of confidential information should take place openly with the patient's full and informed consent. Such sharing should also be limited to the minimum to safeguard the individual and protect the public, mindful of the individual's right to freedom of information and access to personal data which are endorsed by the EU, subject to the needs of national security ([3]). What is disclosed to the authorities should also therefore be shared in full with the patient/client unless this puts the mental health practitioner at risk or would reveal sensitive information that should not be disclosed. Ideally therefore, a written consent form should be signed

([2]) EFPA, The European psychologist in forensic work and as expert witness, p. 3.
([3]) Directive 95/46/EC, the Data Protection directive.

by the patient/client before the assessment detailing the possible need for information sharing and the possibility that what has been shared may not be disclosed to them.

## What are the ethical considerations regarding risk assessment for mental health professionals?

The main ethical concerns of mental health professionals are those articulated by the RCP above in 2017 ([4]), and repeated within the RAN Mental Health network of professionals meeting on ethical practice. They concern the pathologising of beliefs, especially in young people for whom embracing idealistic beliefs can be a normal part of the process of becoming an adult, and the apparent lack, at this time, of validated risk assessment protocols for assessing the risk of extremist violence.

Advances have been made since these early beginnings. It is now a key function of correctional risk assessors to discriminate between those who show only signs of engagement in extremist ideology and those who also show signs of intent to carry out a terrorist attack ([5]). Recent research on white supremacist extremists suggests that violent talk in chat rooms can act as an end in itself, by providing a "sense of doing" and an opportunity to express frustration and anger that may substitute for violence ([6]). Moreover, a recently published trend analysis of the prevalence of right-wing terrorism and violence in western Europe suggests that grooming vulnerable individuals to carry out attacks has become a "dark and morbid subcultural practice" in chat rooms for the "lulz" (amusement) of those who have no intention of carrying out attacks themselves ([7]). Despite this separation between engagement and intent, in many countries behaviours that promote extremist ideologies that sanction violence are criminalised in the same way as the direct plotting of a terrorist attack, though the risk of harm is arguably lower. This is because the ideology itself promotes or justifies violence, and in OECD countries such as in Europe, where there are legitimate means for expressing political dissent, ideologies that promote the use of violence to further a political cause are viewed as neither necessary nor acceptable. The role of radicaliser and/or recruiter to extremist causes is therefore treated as a criminal offence.

A distinction is often made, however, between those who radicalise and those who are radicalised. It is widely accepted that young people and vulnerable adults should be protected from sophisticated radicalisers who would exploit their vulnerability and potentially sacrifice them to their cause. It is important, therefore, that where young people or vulnerable adults are referred to P/CVE because of concerns about extremism, this is not treated as criminal behaviour but as a safeguarding issue. Mental health professionals can help to discriminate between those who are vulnerable by virtue of a mental health issue and those with a criminal intent. Pre-crime, the interventions offered by P/CVE projects are therefore patient/client-centred in the form of activities and mentoring that are benign, discrete, protective, voluntary, and have the goal of increasing well-being and resilience.

There has been progress, too, in establishing the validity of risk assessment frameworks. None of the frameworks in use in Europe at the present time have been validated, though this is largely due to lack of access to sensitive information. In contrast, in the USA there is an established body of threat assessment research into lone actor targeted violence that includes assassinations, mass shootings and stalking, and a long tradition of the FBI working collaboratively with academics and practitioners. This has been extended to research into lone actor terrorists and contributed to the development of the Terrorist Radicalization Assessment Protocol (TRAP-18) for the assessment of lone-actor terrorist violence and the imminence of risk, which has achieved validation. ([8]) The application of this framework has generated further learning about the role of warning behaviours and the changes in thinking and emotion that signal the shift from victim to perpetrator and constitute the mind-set of intent to harm, findings that are all consistent with the evidence base for the VERA 2R and other frameworks.

However, the specific role of mental health professionals is not to carry out a full forensic assessment or to challenge religious beliefs, both of which are beyond their competence unless they are specifically trained to

([4]) RCP, Position Statement PS04/16S.
([5]) Lloyd & Dean, 'The development of structured guidelines for assessing risk in extremist offenders', p. 41.
([6]) Simi & Windisch, 'The Culture of Violent Talk: An Interpretive Approach'.
([7]) Ravndal et al., *RTV Trend Report*, p. 21.
([8]) Risk Management Authority, *TRAP-18*™, online.

do so. Their task is confined to identifying the presence of any mental health issue and its relationship to any apparent extremist interest or violent intention. In the absence of any direct or indirect functional link, the mental health problem remains a private matter with no direct consequences for public safety. In these circumstances, communicating this to the P/CVE authorities leaves the matter of risk management to the authorities, and the mental health issue with themselves to be addressed separately. However, consistent with a holistic patient-centred approach, it may also be helpful for the mental health practitioner to identify any protective factors in the patient/client's life that may have emerged from the assessment, or to suggest who or what may provide protection going forward. If a functional link is present, the mental health professional may advise on the treatability of the mental health issue, and the likely consequence of its successful treatment or management for the extremist interest to which it is linked. If treatment for a mental health issue with a functional link to the extremist interest is not available, or if the patient/client is not willing to cooperate with this, the consequences could well be an ongoing or potentially increasing risk of harm. Any such conclusions should be clearly evidenced and phrased tentatively to reflect the limitations of such predictions.

## How can the boundaries between mental disorder and psychological difficulties be distinguished and maintained?

This is complex, as mental disorders that may be relevant to extremist behaviour include a wide spread of mental health problems. These range from severe and enduring mental illness and affective disorders to developmental disorders such as autism spectrum disorder (ASD), post-traumatic stress disorder, personality disorders and substance misuse. In addition, there is the possibility of co-morbidity and the features of criminality that are common in the backgrounds of many terrorists, which include sensation seeking, impulsivity, lack of critical reasoning, addiction and violence ([9]). The RAN (2019) Handbook for Practitioners provides specific guidance on which aspects of mental illness across the main diagnostic categories may be relevant to risk and in what way. All of these can be accompanied by a sense of psychological distress as they affect the individual's quality of life, and can thereby reduce resilience and constitute an indirect vulnerability to extremism. The reality, therefore, is that there is no clear delineation between mental disorders and psychological difficulties as vulnerabilities to extremism. A recent study of the autobiographies of 91 group-actor terrorists revealed that only 12 % disclosed any mental disorder over the course of their lifetime, but 23 % claimed they were suffering psychological distress at the point at which they became engaged with a terrorist group ([10]).

These distinctions are nuanced and central to the skills of mental health professionals, who are ideally placed to help operational staff make sense of the real-life complexities of mental health presentations that might not reach a threshold for diagnosis, but may still constitute a vulnerability to extremism.

## How to deal with the false assumption that mental disorders are a precondition of terrorism

It will be evident by now that mental disorders are not a precondition of terrorism, but one of an array of factors that contribute to an individual's vulnerability and risk. Research indicates that there is an elevated level of diagnosed mental disorders among lone-actor terrorists, above that of the general population in the areas of ASD, schizophrenia and personality disorder ([11]), but this accounts for between only a third and a half of lone actors ([12]). Other than in these three areas, the prevalence of mental disorder in lone actors does not exceed that of the general population. Moreover, in group actors the level of mental disorders appears to be considerably lower than that of the general population, though this undoubtedly reflects a lack of assessment rather than superior mental health. Group actors are rarely assessed for mental disorders as they present as largely cognitively and emotionally intact. In terms of pathways, most are characterised by a criminal history, failed employment, failed relationships, domestic abuse and street violence. A smaller proportion without a criminal past are conditioned to overcome their inhibitions about committing a terrorist

([9]) Raine, *The Anatomy of Violence: The Biological Roots of Crime*.
([10]) Corner & Gill, 'Psychological Distress, Terrorist Involvement and Disengagement from Terrorism: A Sequence Analysis Approach'.
([11]) Corner et al., 'Mental Health Disorders and the Terrorist: A Research Note Probing Selection Effects and Disorder Prevalence'.
([12]) Gill, '*Lone-actor terrorists. A behavioural analysis'.*

offence by skilled radicalisers who exploit their idealism and allow them to believe they are contributing to a noble cause. Group actors with a diagnosable mental disorder are empirically very small in number ([13]).

**The 2019 RAN Handbook for Practitioners, p. 38:**
**EXTREMISM, RADICALISATION & MENTAL HEALTH**

When extremist behaviours and mental illness are both present in an individual, practitioners would benefit from using individualised case formulations that are evidence-informed to identify any specific aspects of mental illness that contribute to extremism vulnerability or risk. Mental illness may be present but not relevant to shaping vulnerability to extremism and may in some instances be protective against it or a secondary effect of extremist engagement. Wherever mental illness is present and relevant, it may play a direct or indirect role in shaping vulnerability, often by interacting with social, environmental, and biological factors that impact the individual.

**Zainab Al-Attar, 2019**

Among lone actors are many who develop a fixated and "over-valued" belief system that allows them to project blame for their failure to thrive onto a group of persecutors who are judged to have robbed them of their birth right to a good life. Psychiatric assessment for the courts can misinterpret an over-valued belief system as a delusional disorder, though it does not fully conform with the symptomatology of schizophrenia ([14]). A useful tool is now available to discriminate between these two presentations in the context of lone-actor terrorism ([15]).

*A useful psychometric discriminates between delusional disorder and extreme over-valued beliefs in lone actors: MADDD-or-RAD-17 ([16]).*

It is with lone actors, therefore, that the need for input from mental health professionals is most critical. The RAN Ex Post Paper 'Understanding the mental health disorders pathway leading to violent extremism' (2019) addresses this directly and stresses the importance of mental health professionals being available to offer triage and in-depth assessment specifically in the area of ASD. This paper also stresses the importance of being careful not to stigmatise people with mental health disorders. A patient/client-centred approach avoids the implication that certain categories of people are more at risk of extremist violence than others.

## Guidelines

These are derived from guidelines drafted by the DFP within the British Psychological Society (BPS) in the UK, specifically to support ethical practice with extremist offenders. As such, they are focused on psychological practice that extends beyond the P/CVE space to include those convicted of terrorist offences, though they have been edited to conform more to the concerns of those working in P/CVE and to provide more direction. They are grouped under the four main principles of ethical practice that structure the codes of conduct that underpin the practice of psychology in Europe and the USA.

([13]) Lloyd & Kleinot, *Pathways into Terrorism: the Good the Bad and the Ugly.*
([14]) Rahman et al., 'Extreme Overvalued Belief and the Legacy of Carl Wernicke'.
([15]) Cunningham, 'Differentiating delusional disorder from the radicalization of extreme beliefs: A 17-factor model'.
([16]) Cunningham, 'Differentiating delusional disorder from the radicalization of extreme beliefs: A 17-factor model'.

## Respect

- Understand what the terms extremism, violent extremism and terrorism mean in your country, as defined by policy and legislation, and use these terms carefully.
  - Ensure that you do not assume that engagement in ideology is equivalent to an intent to cause harm.
  - Retain a professional focus on the illegal and/or harmful behaviour associated with extremism, and its assessment and management, and avoid labels that may be experienced as stigmatising and alarmist.
- Be clear about the limits of privacy and confidentiality you can extend and make these clear to stakeholders and to clients before face-to-face work begins.
  - Complete a clear and unambiguous written and dated consent form that takes into account the patient/client's understanding of consent and the need for an interpreter if required. (This is not necessary if you are asked for an opinion that does not involve direct contact with the client.)
  - Work within the safeguarding, disclosure and information sharing procedures required by law in your country, or by virtue of your employment.
- Remain sensitive to the legal status of your patient/client. For P/CVE patients/clients:
  - acknowledge their right to refuse to cooperate with the assessment but explain that this may have the effect of raising concerns rather than affording them protection;
  - encourage their cooperation, and be open about the nature of your role and the potential benefits of engagement, both for them and for the safety of the public;
  - acknowledge the limitations of predictions of harm based on pre-criminal behaviour and explain how you will approach your task and what the basis of your recommendations will be;
  - explain what will happen to your report, what can be shared with the patient/client, and what the likely consequences will be.
- If working in a forensic capacity that includes intervention, acknowledge that every individual has a right to hold and express their own beliefs within the limits of the law, but remain willing to challenge beliefs and attitudes where these drive or justify their offending.
  - Where beliefs are challenged, have a very clear rationale for doing so, and do it in a sensitive and respectful way that invites them to consider, address or modify their thinking, rather than demanding change.
  - Remain mindful about how your practice may be viewed by the communities from which your patient/clients are drawn, and avoid stigmatising them or their communities.
  - Seek instead to build understanding and encourage inclusion.
- Given the societal pressures and fears surrounding a terrorist threat, monitor yourself for unconscious bias, prejudice or fear that may influence your professional practice.
  - Remain mindful of how such processes may affect the objectivity of your practice.
  - Ensure regular supervision to reflect on how events may be affecting your thoughts, feelings and behaviour.

## Competence

- Become familiar with key literature on the psychology of terrorism and/or violent extremism and from the publications of non-governmental organisations and from empirical first-person accounts.
  - Be aware of your own cultural perspective and the unconscious biases embedded in the science and language of Western psychology.

  - Keep updated about government policy in the field of counterterrorism and extremism, and your legal and professional duties in relation to this.
  - Keep abreast of national and international resources and the legislative context of your work. Published policies, strategies and guidance are being regularly updated to reflect new learning.
- Be cautious about claiming expertise in this area.
  - When acting as an expert witness, clearly stipulate the limits of your expertise, and where your access to potentially important information has been restricted, state this clearly.
  - Carry out all your work in this area mindful that it could become the subject of significant public interest.
  - Before agreeing to any media engagements, weigh the intended benefits of your contribution — such as informing the wider debate — against any potential damage to your work with individuals or trusted bodies or to the reputation of your profession.

## Responsibility

- Do no harm.
  - Do not comply if an employer or referrer requires you to behave in ways that are not consistent with your code of conduct or ethics.
  - Consult with your professional peers if you are in any doubt about what constitutes appropriate professional practice.
  - Avoid working with those whose causes you are strongly opposed to and where you cannot ensure that you will be objective and dispassionate.
- Remain circumspect.
  - Given the incomplete evidence base for this work, avoid making dogmatic, definitive and unsubstantiated statements of “truth”.
  - Remain mindful of how you communicate your knowledge, acknowledging its limitations and welcoming debate and peer review.
- Maintain vigilance.
  - Have regard for your own safety (and those of family members). This patient/client group may seek to disrupt your work through intimidation or threatened or actual acts of violence.
  - Ensure there are clear procedures in place to manage such incidents.
  - Remain alert to patient/clients seeking personal details.
  - Be cautious about sharing personal details on social media.
  - Be sensitive and vigilant about the safety and welfare of patient/clients, especially those seeking to disengage from a violent extremist group. This may put them at risk from those wishing to prevent this.
  - Monitor these risks or other consequences such as social exclusion or emotional distress.

## Integrity

- This field poses complex challenges between responsibility (e.g. to reduce harm) and integrity (e.g. openness). You may be subject to heightened security vetting and be holding sensitive information that you cannot disclose to your clients. You must balance a complex set of responsibilities that has the potential to impact the security of your country, the safety of your patient/clients and the public, and the legitimate expectations of your employer.

  - Reflect on these challenges and identify an ethical balance that supports your practice and aligns with your personal values and professional code of conduct.
  - Show courage in embracing a new area of practice that can be the subject of intense or hostile scrutiny, but which has the capacity to make a vital contribution to national and global security.
- Be clear about where you stand in relation to extremist violence and be prepared to articulate this to both patient/clients and colleagues as necessary.
  - Be clear how you will respond to challenges before embarking on face-to-face work with those who may challenge your role.
  - Where you are paid by public money and can be seen as working on behalf of the state, do not deny this, but bring the conversation back to their safety and well-being as your patient/client and what you perceive to be in the best interests of all.
  - If you are part of a community that has been the direct target of a terrorist attack, consider asking to be excused from direct work with the perpetrators responsible.
  - Do not be afraid to express your values of ethical practice, and be willing to challenge other stakeholders whose actions may be undermining of their colleagues or equate to unethical practice.

## Further reading

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Information about the European Union in all the official languages of the EU is available on the Europa website at: https://europa.eu/european-union/index_en

**EU publications**

You can download or order free and priced EU publications from: https://op.europa.eu/en/publications. Multiple copies of free publications may be obtained by contacting Europe Direct or your local information centre (see https://europa.eu/european-union/contact_en).

**EU law and related documents**

For access to legal information from the EU, including all EU law since 1952 in all the official language versions, go to EUR-Lex at: http://eur-lex.europa.eu

**Open data from the EU**

The EU Open Data Portal (http://data.europa.eu/euodp/en) provides access to datasets from the EU. Data can be downloaded and reused for free, for both commercial and non-commercial purposes.

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