Correspondence

Identifying terror suspects: the role of psychiatrists

On 22 July 2011, Anders Behring Breivik carried out the worst attacks in Norwegian history since the Second World War, killing 77 men, women and children and injuring another 151 people. In November 2011 he was declared to have paranoid schizophrenia by a court-appointed panel of forensic psychiatrists.[1] Breivik's diagnosis evokes memories of Nicky Reilly, who has Asperger syndrome and was convicted of trying to blow up a shopping centre in Exeter in May 2008, and Andrew Ibrahim, a former drug addict who was jailed for making a bomb at his flat in Bristol in April 2008.[2]

The notion that most forms of terrorism are an understandable (if not condonable) reaction to limitations on freedom and equality has lost ground in many countries. As psychiatrist Gerrold Post pointed out, 'there is a broad spectrum of terrorist groups and organizations, each of which has a different psychology, motivation and decision making structure. Indeed, one should not speak of terrorist psychology in the singular, but rather of terrorist psychologies'.[3] Terrorist violence most often is deliberate (not impulsive), strategic and instrumental; it is linked to and justified by ideological, for example political or religious, objectives. In Breivik's case, his stated objective was to 'defend Europe against a Muslim invasion',[1] which is now being considered as part of a well-formed delusional belief system. These issues all add complexity to the construction of terrorism as a form of violence and stretch the limits of present-day clinical risk assessment.

In recent guidance, the UK Home Office requested an increased role from the UK medical professionals in identifying people at risk of committing future terrorist acts.[4] This raises a number of ethical and professional considerations which are particularly relevant to psychiatrists, given an almost certain role which might be expected from the profession in not only identifying, but treating and risk-managing terror suspects. The following four questions are pertinent in this regard.

1. Would an enhanced role in identifying and referring terror suspects as suggested by the Home Office leave the profession losing patients' trust in psychiatrists' professionalism and patients' confidentiality, as suggested by some?[5]
2. How would the public protection be balanced with the individual patient freedom in an environment of ever-increasing public protection and aversion to risk?
3. Even if psychiatrists agree to move to the forefront in the war against terror, how would our currently relatively unsophisticated arsenal of risk assessment tools detect and quantify such a complex, low-frequency and constantly changing threat?
4. The elusive question, 'Is terrorism a mental disorder?' remains unanswered and many would continue to challenge the psychiatrists' role in identifying, and potentially managing, terrorist suspects.

In our view, with the terrorist threat remaining as one of the major public protection issues for the foreseeable future, these questions will become more pertinent. The profession should without delay embark on an open and honest discussion on its role in this crucial public protection issue, and develop a clear view.

1 BBC News. Who, What, Why: How do you assess a killer's mental health? 29 November 2011 (http//www.BBC.co.uk/news/magazine-15928316).

2 Dyer C. Doctors will be asked to help identify people becoming terrorists. *BMJ* 2011; **342**: d3627.

3 Post J. *The Mind of the Terrorist: Individual and Group Psychology of Terrorist Behavior.* Testimony prepared for the Subcommittee on Emerging Threats and Capabilities, Senate Armed Services Committee, USA, 15 November 2011.

4 Home Office. Counter-Terrorism Strategy (CONTEST). Home Office, 2011 (http//www.home office.gov.UK/publications/counter-terrorism-strategy/).

5 English P. Doctors should not agree to identify potential terrorists. *BMJ* 2011; **343**: d4211.

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Time to reform fitness to plead?

The Law Commission published their comprehensive review of current fitness to plead provisions in 2011 and recommendations on the issue are expected later this year.[1] Notwithstanding the regularity with which reports addressing the issue of fitness to plead are requested of psychiatrists, there remains a lack of clarity on the subject. The legal test still derives from a case in 1836 (*R v Prichard*)[2] and there is general agreement among psychiatrists and legal professionals that the presently accepted requirements are far from adequate. Whereas these 'Prichard criteria' broadly set out the requirement for the accused to be able to enter a plea, understand the evidence against them, instruct their solicitor, follow court proceedings, and challenge a juror, in many cases it is far from clear what threshold these requirements are measured against.

To what extent does a mild intellectual disability or autism-spectrum disorder render someone unfit to plead or stand trial? We know that rates of intellectual disability are relatively high in convicted offenders; does that mean most of them are to be considered legally unfit? Is that actually in the interests of justice or the individual? Although arguably it is for the court to decide, a great deal of weight is often placed on the expert witness report and it falls to the psychiatrist to consider these questions. Efforts have been made to introduce a standardised test for fitness to plead,[3] yet none has been universally accepted. It is incumbent on courts to adopt special measures to assist vulnerable defendants to participate in proceedings; if such measures can be considered sufficient for children, does this extend to adults?

The rationale for the provisions under Prichard is to protect the vulnerable and avoid subjecting those with mental