

Counter-terrorism and psychiatry



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Counter-terrorism and psychiatry

LEGAL CONTEXT

Psychiatrists place the care, treatment and safety of their patients at the centre of all they do. In doing so, they work within the General Medical Council's (GMC, 2009) and the Royal College of Psychiatrists' (2010) legal and ethical guidance, including that relating to the breaching of patient confidentiality. It is clear that there are times when it is necessary, in the public interest, to breach patient confidentiality. If required, this can be done without patient consent, for example to prevent or to prosecute serious crime and for the purposes of child safeguarding. In making these decisions, psychiatrists consult with peers and seek organisational advice and guidance on breaching confidentiality in accordance with professional and ethical principles.

Like other professionals, psychiatrists have a duty to safeguard both their patients and the public. If a psychiatrist is asked to see an individual with a serious mental health problem and assesses them as being a significant risk to themselves or to others, they will act to provide appropriate care and to minimise risk. This happens within a highly developed legal system, in all areas of the UK, on a daily basis. Psychiatrists also have considerable skills in multidisciplinary working, and are involved with panels assessing risk and safeguarding. In addition, they have a role in dealing with the aftermath of traumatic incidents (Royal College of Psychiatrists, 2016).

Terrorism causes enormous human suffering, and in itself can lead to psychiatric consequences.

The Terrorism Act 2000, amended by subsequent Acts, defines terrorism as the use or threat of action designed to influence governments or to intimidate the public to advance a political, religious, racial or ideological cause, if it involves serious violence against a person or damage to property, endangers life, risks the health or safety of the public, or disrupts an electronic system.

Section 26(1) of the Counter-Terrorism and Security Act 2015 states that specified authorities, including health bodies, 'must, in the exercise of [their] functions, have due regard to the need to prevent people from being drawn into terrorism' (this is sometimes referred to as the Prevent duty). The major elements of the UK government's efforts to prevent terrorism, known as CONTEST, are its Prevent strategy and its accompanying Prevent training, which is made available to all professionals working for specified authorities (HM Government, 2011*a,b*, 2016), but may be perceived as being legally mandated under the Prevent duty. Channel, a key element of Prevent, is a multi-agency approach to identifying and providing support to individuals at risk of being drawn into terrorism (HM Government, 2015).

The Department of Health (2011) has provided guidance on this for healthcare organisations, and the GMC set out doctors' responsibilities in relation to the Prevent duty in a letter to the Health Select Committee in August 2015 (Dickson, 2015). The letter stated the GMC's view that the new Prevent duty 'does not alter the circumstances in which doctors are obliged to report concerns about patients, and does not impose any new duties on doctors (whether in their private or personal lives)'. It also clarified that 'it is not within [the GMC's] remit to advise on how the new "Prevent duty" [...] should operate in practice, or what would constitute "a concern that someone is being drawn into terrorism"' (Dickson, 2015).

The Royal College of Psychiatrists supports and encourages psychiatrists to fulfil their safeguarding responsibilities, but has some concerns about the implementation of Prevent. These focus in particular on the variable quality of the evidence underpinning the strategy, and potential conflicts with the duties of a doctor as defined by the GMC. There is also a risk that Prevent could reduce the willingness of people to access mental health treatment.

In the process of evaluation all agencies leading on Prevent need to share data and information as standard practice unless it can be shown that there are overriding security reasons not to. Data should be shared where necessary for the purposes of clinical care, audit, research, the safety of the patient and/or others according to the existing guidance and governance systems. Clinicians will also need feedback for their individual patients to know what happens to them in the Prevent and Channel processes. Overall, it would be beneficial for the culture within the evaluation of Prevent to be one in which the sharing of information is the norm, and secrecy, including the perception of secrecy, actively avoided.

Those fleeing war-torn parts of the world have a high risk of psychological distress, and many are escaping terrorist violence in their country of origin. The College is concerned that there should not be a system that overly identifies them with the terrorism from which they have fled, as this could add to their trauma. There is no single profile of a terrorist or pathway to terrorism. A combination of factors and influences can increase vulnerability to radicalisation and carrying out terrorist acts. These factors are not exclusive to any particular cultural, ethnic or religious group.

The prevention of terrorism poses many major challenges. For the psychiatric profession, these include ethical, clinical, professional-boundary and confidentiality issues.

TERRORISM, RADICALISATION AND MENTAL ILLNESS

Terrorism is a complex phenomenon, with a broad range of perspectives and many definitions; even basic concepts are open to question. For example, any assumption that there is a generally identifiable 'path to radicalisation', to which some individuals will be psychologically vulnerable, needs to be treated with caution.

'Radicalisation' is not a mental illness. It is, rather, understood as a dynamic process of change in the mindset and behaviour of an individual that leads to an alteration in worldview, perception of external events and his or her understanding of them. 'De-radicalisation' implies a reverse process of altering an individual's thinking and beliefs to make him or her less likely to commit acts of terror. These constructs can lead to an erroneous inference that psychiatrists who have special expertise in treating

conditions characterised by abnormal beliefs may also have a role, as well as the technical tools, to participate in de-radicalisation programmes.

However, mental illness may in itself sometimes make individuals susceptible to adverse influences, and in this way to become victims of violence and exploitation, which is something that psychiatrists will address in their practice. When mental illness is a relevant factor, treatment of the illness might reduce the risk of violence, and this should be encouraged as part of usual psychiatric practice. However, the work of psychiatrists with patients where violence is a possibility should not be framed as de-radicalisation.

It is therefore important to distinguish the role and expertise of psychiatrists in treating psychiatric disorders from the task of altering 'extremist' views. There is a wide spectrum of beliefs held by individuals; the extreme nature of some of these does not necessarily mean that the people holding them have a mental disorder.

In this context, approaches to safeguarding people from harm should be explicit that doctors are not acting in a surveillance capacity, but rather focus on doctors working in partnership with patients, discouraging stigma and assisting individuals to access the care they need.

'Terrorism' refers to a broad and very heterogeneous group of offending behaviours. It is difficult, therefore, to make valid and empirically supported generalisations. However, to date, the evidence suggests that mental illness is probably not a useful explanatory factor in group-based political violence (Lyons & Harbinson, 1986). Indeed, there is evidence to suggest that many terrorist groups, for their own perceived security and operational reasons, screen potential recruits and may actively exclude individuals with significant mental health problems (Taylor & Quayle, 1994; De Mesquita, 2005; Merari, 2010).

The perpetrator's history of mental illness has been highlighted in coverage of some high-profile terrorist incidents, such as the Bastille Day attack in Nice in 2016, although it is uncertain whether the perpetrator's reported mental illness was relevant (BBC News, 2016), nor whether treatment would have made any difference. Particular attention should be paid to undertaking more research in this area, and to ensuring it is subject to the usual ethical safeguards.

The Royal College of Psychiatrists acknowledges that, although the weight of evidence and expert opinion suggests there is no link between mental disorder and group-based terrorism, terrorists who act alone (perpetrating what are often known as 'lone-actor' events) are statistically more likely to have a background that includes mental illness, in particular psychosis and autism spectrum disorders (Gill *et al*, 2014; Corner & Gill, 2015; Gill, 2015; Pantucci, 2015).

However, this is by no means generally the case, and there is no single pattern or diagnosis. There should therefore be no assumption that an individual who carries out an act of terror is suffering mental ill health, nor that someone with poor mental health is likely to carry out a terrorist act.

While we recognise that some individuals with mental illness might be vulnerable to being engaged, exploited and/or recruited into terrorism, there are no reliable adult or child and adolescent evidence-based tools that can predict involvement by individuals in terrorism – with or without mental health difficulties (Youth Justice Board, 2012). In essence, the epidemiological database needed to construct a valid risk-assessment instrument does not exist (Monahan, 2012). Such tools require further investigation and development. Neither are there any known, specific mental health indicators as to who will commit an act of terror, although some of

those found to carry out such acts may have experienced physical and mental health problems.

Current tools and methodologies should be viewed with considerable caution. There is a temptation to misuse them, and they should be used primarily to structure assessments in the context of the Vulnerability Assessment Framework (HM Government, 2012). Methodologies that aim to forecast rare events, such as acts of terror, yield consistently poor results. We do not know what the base-rates for radicalisation or the preparation of terrorist acts are. We have very little data on how terrorists and those who are radicalised differ from the populations they are drawn from. The lack of clear 'stand-out' factors that distinguish terrorists from other people is a common subject of comment (Pantucci, 2015).

The poor performance of both adult and child and adolescent tools designed to detect a propensity for terrorism may mean that individuals are unjustifiably referred to the Channel Panel (HM Government, 2016) and associated programmes designed to dissuade them from being drawn in to terrorism. Indeed, between April 2007 and March 2014, 80% of those referred to Channel 'will have exited the process and [been] signposted to services more appropriate to their needs' (National Police Chiefs' Council, 2014). While Channel support programmes are voluntary, simply being referred to these can be problematic for people, and refusal to accept support can lead to further assessments, if deemed necessary.

There is a risk of family members coming to the attention of public agencies during investigations and being inappropriately drawn into these programmes. If it is found that they have mental health problems, they should be signposted to appropriate services.

Psychiatrists should be cautious when working in pressured, hermetic law-enforcement environments (such as police cells, high-secure prisons, courts, tribunals and hearings), where they might find themselves urged to go beyond the profession's remit (e.g. advising on 'profiling'), and also when working in other environments where they may not have the benefit of peer support.

CONCLUSIONS

- 1 This is a complex and contested area, encompassing a broad range of issues, including the management of risk, boundaries between mental ill health and mental health, confidentiality and the need to disclose, and these are not always clear.
- 2 Predicting very rare events is extremely difficult. No tools have been developed that can reliably identify people who have been radicalised, who are at risk of radicalisation or who are likely to carry out a terrorist act. Assessment of risk is therefore best done on a case-by-case basis, as part of professional safeguarding practices.
- 3 We do not know how many people at risk of committing terrorist acts are currently being treated within secure mental health services. The College therefore recommends that mechanisms for undertaking research in this area are considered, to help inform prevention strategies.
- 4 All agencies responsible for leading on Prevent should share data and information where necessary for clinical care, audit, research, the safety of the patient and/or others according to the existing guidance and governance systems except in exceptional circumstances where there is an overriding security reason not to.

- 5 Data on evaluations of Prevent, as with any initiative requiring public services to alter their practice, must be in the public domain and subjected to peer review and scientific scrutiny. Public policy cannot be based on either no evidence or a lack of transparency about evidence. The evidence underpinning the UK's Extremism Risk Guidance 22+ (ERG22+; HM Government 2011c), and other data relating to this guidance, should be comprehensively published and readily accessible.
- 6 More public mental health research is needed, including the exploration of possible effects of mental ill health on individuals involved in terrorism, understanding what is happening at the level of the group, and risk assessment and management. The Royal College of Psychiatrists supports national pilots on assessing, advising on, and assisting in appropriate multi-agency management in these areas, including public mental health approaches to violence prevention.
- 7 Particular attention should be paid to undertaking more research in this area, and to ensuring it is subject to the usual ethical safeguards. In the meantime, caution should be exercised in forming a view on the quality of the emergent evidence, and in managing the tensions and misapprehensions that people have about what is and is not a mental illness. Everyone working in this area should promote reflection on the complexity of the issues. As stated in point 4 above, research, once completed, should always be published and open to public scrutiny, whether its findings are considered positive or negative, unless there are compelling security reasons that prevent this.
- 8 When psychiatrists attend training in this area, they may find it helpful to refer to the College's paper on the ethical considerations arising from these issues that will be published later in 2016.
- 9 When they are practising in this area, psychiatrists' primary duty is to their patient, and their clinical judgement and expertise should be valued and respected. As always, they should work within the GMC's and Royal College of Psychiatrists' legal and ethical frameworks that put patients at the centre of their work, appropriately recognising when patient confidentiality needs to be breached for the purposes of crime prevention or to safeguard patients and/or others. There should be no compulsion for psychiatrists to act in ways that go against their evidenced best judgement.
- 10 It is accepted there are mental health risk factors in the background of some 'lone actors'. Although these factors are not uncommon, terrorist acts are fortunately very rare. This means that false positives will be very common, and the positive predictive value of any of these risk factors will be correspondingly low.
- 11 Some lone actors, though not all, are adolescents and young adults, who will either have or be at risk of mental health disorders, such as early-onset psychosis, depression or autism spectrum disorders. Others may be loosely described as 'alienated' or 'troubled'. All these young people might benefit from access to existing services, in particular child and adolescent mental health services (CAMHS). It is already Department of Health and NHS England policy to increase investment in these services, echoed by the recommendations of the *Five Year Forward View for Mental Health* (Mental Health Taskforce, 2016), in which the Royal College of Psychiatrists played a prominent role. This is carried through in NHS England's plan for implementing the recommendations (NHS England, 2016), and there are similar initiatives in other UK jurisdictions.

For the most alienated young people, creative, sensitive outreach work is vital to develop trust in and engagement with mental health services, which should ideally be provided alongside better-funded youth services and community-development programmes.

- 12 There is very probably an overlap between those who are, or ought to be, seen in CAMHS or young-adult services, and those seen by the Channel programme. It is therefore important that the commitments made to improve mental health services for troubled adolescents and young people are honoured. This will have tangible benefits for mental health, might contribute to reducing the risk of lone-actor violence, and might also help to reduce some of the suspicions that exist about the Prevent agenda. It might also reduce the possibility of unintended consequences of inappropriately labelling already troubled young people, and adding to their sense of alienation and victimisation.

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