The Journal of Forensic Psychiatry & Psychology
2010, 1–16, i*First* article

Routledge
Taylor & Francis Group

RESEARCH ARTICLE

The Fixated Threat Assessment Centre: preventing harm and facilitating care

David V. James[a,b]*, Thomas R. Kerrigan[b], Robin Forfar[a,b], Frank R. Farnham[a,b] and Lulu F. Preston[a,b]

[a]*North London Forensic Service, Camlet 3, Chase Farm Campus, The Ridgeway, Enfield, EN2 8JL, UK;* [b]*Fixated Threat Assessment Centre, 4-5 Buckingham Gate, London SW1E 6JP, UK*

(*Received 21 October 2009; final version received 4 January 2010*)

The main risk of death or serious harm to public figures in western countries comes not from terrorists or criminals, but from the activities of lone individuals with intense pathological fixations, the majority of whom are mentally disordered. We report preliminary efficacy data from the Fixated Threat Assessment Centre (FTAC), the first joint police/National Health Service unit in the United Kingdom, which was set up to assess and manage such risks. One hundred consecutive cases assessed as being of moderate or high concern were examined. Eighty-six per cent suffered from psychotic illness. Following FTAC intervention, 57% were admitted to hospital by local psychiatric services, and 26% taken on by community psychiatric teams. Concern levels were reduced to low through FTAC interventions in 80% of cases. FTAC proved able to catalyse suitable health outcomes which both benefited the patients and reduced risk to public figures. The advantages of joint police-National Health Service units are discussed.

Keywords: threat assessment; stalking; public figures; diversion; risk; violence

'*A civilized society is one which tolerates eccentricity to the point of doubtful sanity*'.
Robert Frost.

Introduction

The Fixated Threat Assessment Centre (FTAC) was established in October 2006 to assess and manage threat to public figures from lone individuals with intense, pathological fixations (the 'fixated'), the majority of whom are mentally ill. Given the central importance of mental illness, it was necessary

*Corresponding author. Email: david.james5@ntlworld.com

ISSN 1478-9949 print/ISSN 1478-9957 online

DOI: 10.1080/14789941003596981
http://www.informaworld.com

that such a unit incorporate mental health personnel from the National Health Service (NHS), as well as police personnel. FTAC is the first joint police-NHS unit in the United Kingdom, a significant innovation. It has a national remit. It is commissioned by the Department of Health and the Home Office and provided jointly by the Metropolitan Police Service and the North London Forensic Service.

Its establishment followed the recognition that, whereas well-established systems were in place to assess threat from terrorists and criminals, no such mechanisms existed with regard to problems posed by disturbed members of the general public. Some such individuals exhibit a pattern of stalking-type behaviour towards public figures, with repeated attempts at communication and/or approach. These can give rise to anxiety, fear or concern, and may result in disruption, embarrassment, the dissipation of policing resources, physical risk to the individual themselves and, occasionally, violence to others. However, in contrast to other groups whose motives are usually easy to understand and whose *modi operandi* follow predictable patterns, the fixated are usually difficult to understand in terms of motivation, their actions are often unpredictable and they do not fit easily into standard policing mechanisms for assessing and managing threat (Mullen et al., 2009).

FTAC was originally financed for 18 months as a pilot unit, part of its brief being that it should audit its own activity during this period in order to demonstrate its efficacy. Accordingly, FTAC collected data on its activities. The resultant descriptive study is the subject of this paper. Its aims were to explore the practicability of the joint police-NHS working model; to examine whether it was able to bring about appropriate psychiatric interventions; and, in so doing, whether it could be successful in reducing or managing risk.

Background

Problems caused to public figures by fixated individuals are not new. The files of nineteenth century lunatic asylums contain examples of fixated behaviour towards public figures which are barely distinguishable from cases encountered today (Poole, 2000). Mentally ill individuals featured prominently in historical attacks on the Royal Family (James et al., 2008), and delusionally driven individuals were responsible for the killings of the Prime Minister Spencer Perceval in 1812 (Hanrahan, 2008; Wilson, 1812) and Edward Drummond, the private secretary to the Prime Minister, in 1843 (West & Walk, 1977). Nor are these problems confined to the United Kingdom. In a survey of members of parliament in Sweden for the years 1998–2005, 74% had been subject to harassment, threats or violence and 68% of the perpetrators were deemed by their victims to be mentally ill (SOU, 2006). A survey of Canadian politicians found that 29.9% had

suffered harassment, with 87.4% believing their harassers to be suffering from a mental disorder (Adams, Hazelwood, Pitre, Bedard, & Landry, 2009). The importance of fixation and mental illness in terms of risk to public figures is also clear from the work of those involved in threat assessment for the US Capitol Police (Scalora et al., 2002a, 2002b, 2003), the US Secret Service (Phillips, 2006, 2007, 2008; Takeuchi, Solomon, & Menninger, 1981) and the Swedish Security Police (Mullen, Pathé, & Purcell, 2009, p. 207).

Evidence base for the establishment of FTAC

The decision to set up FTAC was not an arbitrary one. FTAC was founded following a painstaking three-year research project, commissioned by the Home Office, which was undertaken by an international group of experts on stalking, styled the Fixated Research Group (FRG). Its remit was to evaluate the risks posed to public figures by the fixated and to devise and effect a mechanism by which such risks could be reduced. The FRG conducted a detailed review of the US literature on public figure threats and attacks (Meloy et al., 2004), and produced studies of attacks on Western European politicians from 1990 to 2004 (James et al., 2007) and attacks on the British Royal Family between 1778 and 1994 (James et al., 2008). The FRG then produced a series of studies based on the detailed exploration of 8001 files created by the Royalty Protection Division of the U.K.'s Metropolitan Police Service over a 15-year period between 1998 and 2003 on the people who engaged in inappropriate or threatening communications or approaches to members of the Royal Family.

The study of attacks on European politicians (James et al., 2007; James et al., 2008) produced two key findings. The main risk of serious harm to public figures came from lone individuals, the majority of whom were mentally ill and driven by highly personal causes or quests for 'justice'. Additionally, the importance became apparent of 'warning behaviours' in attack cases, these being activities engaged in by perpetrators, often over months or years, which gave evidence of their fixations and of the threat which they went on to constitute. Death and serious injury were significantly associated with the presence of mental disorder ($p = 0.012$, $\varphi = 0.57$) and of psychosis, ($p = 0.036$, $\varphi = 0.49$). Half of the cases in the sample had engaged in warning behaviours and these had the same associations as death and serious injury, in other words the presence of mental disorder ($p = 0.000$, $\varphi = 0.77$) and of psychosis ($p = 0.003$, $\varphi = 0.65$). The warning behaviours were not subtle. They comprised chaotic deluded letters to politicians and police, threatening letters to politicians, paranoid contacts with MPs, law suits against the government, attempted self-immolation, newspaper advertisement, posters, leafleting and telling friends. The attacks

were not predicable, but were potentially preventable, had a system been in place to assess warning behaviours.

The case file project produced an array of evidence of use in risk assessment. More than 80% of the individuals concerned were found to be suffering from serious mental illness, and different forms of behaviour were associated with different patterns of symptomatology (James et al., 2009). It proved possible to allocate the files to eight motivational types (Mullen et al., 2009), there being marked differences between groups in the intrusiveness of behaviour (James et al., 2009). Most notably, 'querulants' (Mullen & Lester, 2006) and similar cases fixated on highly personalised quests for 'justice' were significantly over-represented among those breaching security barriers, those gaining close proximity to a Royal Family member and among those carrying weapons, behaviours considered to be proxies for attack (James et al., in press a). This finding was consistent with the FRG's findings on the importance of this group in cases of completed attack (James et al., 2007).

The case file study also illustrated the association of particular symptoms and motivations with particular risks. Those who engaged in inappropriate or threatening approaches to members of the Royal Family were significantly more likely to evidence serious mental illness and grandiosity, to employ multiple means of communication and to be driven by motivations that incorporated a sense of personal entitlement to the prominent individual (James et al., in press b). Escalation from communication to approach was particularly associated with grandiosity. A painstaking dissection of three studies on US politicians and two on Hollywood celebrities found that similar associations with approach were apparent in their data (Meloy et al., in press). The likelihood of inappropriate behaviours persisting was found to be associated with the presence of psychotic illness, intimacy-seeking motivation and the use of multiple or intrusive forms of communication. The same factors were found to be associated with persistence in a general stalking sample, from which those with previous sexual relationships with their stalkers had been removed (James et al., 2009). Finally, it was concluded that risk factors identified in the study of general stalker samples, with ex-intimates removed, could be applied to public figure samples (MacKenzie et al., 2009). This meant that an extant risk literature became immediately available for use.

FTAC's operations

Information about the composition and operational functioning of FTAC is already in the public domain (*Hansard*, 2007; *Hansard*, 2009; Rose, 2007). In brief, FTAC operates on a referral basis, its initial remit being limited to those engaging in inappropriate approaches or communications to members of the Royal Family, senior politicians and so-called 'iconic sites', these

being buildings in which public figures live or work, such as Buckingham Palace, the Palace of Westminster, Downing Street and various other locations in the central London government security zone. Information is gathered by police and mental health professionals, and a risk assessment conducted. Appropriate intervention is decided upon and a management plan drawn up. In cases where mental illness is evident, this usually involves liaison with psychiatric services in the relevant parts of the UK or abroad. In this respect, FTAC's operations have some similarities with psychiatric diversion schemes at magistrates' courts and police stations (James et al., 2002), with the important difference that FTAC does not itself detain anyone. Rather, it ensures that psychiatric services learn of mentally disordered fixated people in their areas, so that they may become actively involved in their care, thereby potentially contributing both to such individuals' health and to their targets' safety (Mullen et al., 2009).

FTAC is unable to take referrals of individuals simply because they show evidence of mental illness. Were it to do so, its limited resources would immediately be swamped. The FRG established that the Royal Family alone receives about 10 thousand letters a year from people who are evidently mentally ill. FTAC, rather, relies upon specific referral criteria comprising factors associated with different types of risk. These are taken from the risk assessment literature and the FRG's findings, and have similarities to screening tools already in the public domain (e.g. Calhoun & Weston, 2003, p. 68). These act as a first filter, and they are applied by the referring agencies, not FTAC. Referrals received by FTAC are then subject to initial investigation and risk assessment, at which point cases deemed to be of low concern are not taken further. The risk assessment approach adopted by FTAC is not concerned with the impossible task of attempting to forecast who will do what in the future. Rather, it aims to identify that small proportion of cases, among which are likely to be found those that may go on to constitute a risk. Intervening to manage risk factors in this sub-population reduces the likelihood of future adverse events (Mullen et al., 2009).

Method

Case selection

The study concerned the first 100 cases to be taken on by FTAC for case-working, having been judged to be of moderate or high concern at initial risk evaluation. The 'matrix' used to aid in the evaluation of risk during the pilot period was adapted from the work of Scalora and colleagues in the Capitol Police Threat Assessment section, the framework of which has since been published (Scalora, Zimmerman, & Wells, 2008). Cases concerned referrals made in the period from October 2006 to March 2007.

Data collection

A standard 120-item data proforma was completed on each case. This included socio-demographical details, criminal history, details of previous psychiatric treatment, motivation, presenting behaviours, risk evaluation and levels of concern, details of interventions and outcome of intervention, followed by post intervention level of concern. Details of case management were available for a period of one year after referral. Sources of information comprised policing, general practice and psychiatric records, supplemented by the case papers relating to FTAC intervention.

Definitions of concern level

Concern differs from risk in that it reflects current contextual factors. For instance a high-risk individual will be of low concern, if currently held in a maximum security establishment. Standardised definitions of concern levels were also taken from the work of Scalora (unpublished). Initial concern level was determined following initial investigations, multi-disciplinary case discussion and application of the standard risk matrix as a structured aid to clinical judgement. In low concern cases, few risk factors for adverse consequences (harm, embarrassment, distress, disruption) were present. There had been no inappropriate approach behaviours and no stated intention to engage in any. The subject's interest contained no form of threat or desperation, and was generally at a nuisance level. Further FTAC investigation was not currently warranted and the case was returned to the referrer and closed. In moderate concern cases, a number of risk factors were evident which indicated a potential for adverse consequences. The individual had either threatened a public figure or those close to them (directly or indirectly) or had exhibited both unusual interest and a willingness or capability to travel. Further investigation and intervention was necessary, and alert notifications may have been warranted. High concern cases revealed behaviours which indicated a likelihood of adverse consequences and a capacity and intent to cause such consequences. An urgent management plan was required and instituted with running review. The descriptions of concern levels following intervention were similar, it being specified that this was the position despite initial management.

Criminal records data

These were taken from the Police National Computer, or for cases in other countries, from data supplied by Interpol or by policing organisations in the relevant jurisdictions.

Motivation

Motivation is recorded in two ways: according to the typologies of Mullen and colleagues (2009) and that of MacKenzie et al. (2009). The first of these was based upon study of inappropriate communications and approaches to the British Royal Family and reflected the variety of underlying delusions. It separates individuals into the following groups: (1) Delusions of identity: those with delusions of being the heir to the throne, the prime minister, a member of the Royal Family, etc. (2) Pursuing an agenda: those concerned with a very personal agenda or personal identification with a wider cause, which may involve a quest for 'justice', a desire to right a perceived wrong or avenge perceived harm. This includes querulants, chronic complainants, vexatious litigants and cases with a similar flavour (Mullen & Lester, 2006), which is characterised by a stubborn belief in the righteousness of their cause. Such individuals tend to be angry and demanding. (3) Intimacy Seekers: these are subdivided into two. 'Erotic' cases comprise those seeking sex, love or marriage, and include both erotomanics and suitors with a delusional certainty that their proposals will be accepted. Amity-seeking cases desire friendship or some form of closeness, and are oblivious to the unrealistic nature of their aspirations. (4) The persecuted: those with beliefs that they are being persecuted directly by the person with whom they are engaging in inappropriate contact. (5) Requests for help: those pleading in a hopeless or hopeful way for assistance or intercession. (6) Counsellors: those offering advice, information or opinions in a manner characterised by grandiosity, self-importance and entitlement to influence. (7) Publicity Seekers: those seeking individual publicity or notoriety. (8) Chaotic: those whose motives and manner of expression are so confused by symptoms of illness that it is impossible to discern any singularity of purpose.

MacKenzie et al. (2009) took the motivational typology of stalking developed by Mullen and colleagues (Mullen et al., 1999; Mullen, Pathé, & Purcell, 2009) which is recognised as the international standard (Pinals, 2007) and adapted it for use with public figure cases. This was based on the realisation that stalking and harassment of the general public involves the same motivations as that of public figures, if former sexual partners are excluded. The main typological groups are broader than those in the typology of Mullen and colleagues described above, and reflect a more fundamental level of motivational drive. The categories of Rejected and Predatory were excluded. To the remaining categories of the Resentful, Intimacy Seekers and Incompetent Suitors were added three further groups: Help-seekers, Attention Seekers and the Chaotic. Cases were allocated to motivational group following multi-disciplinary discussion at case review meetings.

Organisation

The concept of 'organisation' was adopted. 'Organised' individuals are those who appear unremarkable in their general functioning and who are able to make plans and put them into effect. This includes mentally ill people with structured delusional systems which allow them to preserve a surface rationality and to function relatively normally in many aspects of day-to-day living.

Diagnosis

Diagnoses were those made by clinical teams in psychiatric services by which the individual had been treated previously or was treated subsequently to FTAC intervention. In a minority of cases, diagnoses recorded are those made by FTAC psychiatric personnel following the review of the case material and interview of the individual by FTAC case workers.

Results

What were the behaviours which precipitated referral to FTAC?

The behaviour which precipitated referral concerned approaches to iconic sites or prominent individuals in 66% of cases, inappropriate communications in 19% of cases, and both to an equal degree in 15%. The focus of interest concerned Royal Family members in 37%, specific politicians in 27%, and both a Royal Family member and a politician in 4%. In 32%, buildings themselves were the focus, these being inhabited or frequented by those perceived to wield power, either malign or beneficent. Such sites included Buckingham Palace and the Palace of Westminster, but also the Ministry of Defence, New Scotland Yard and the respective headquarters of the Security Service (MI5) and the Secret Intelligence Service (MI6).

Personal characteristics and conviction history

Seventy-six per cent of the sample was male and 24% female. Ethnic composition, using the standard police classification, was as follows: white North European 65%, white South European 4%, black 15%, Asian (Indian sub-continent)11%, Chinese/south Asian 4% and Arabic/north African 2%. Only 3% were in employment. Sixty-two per cent had a record of criminal convictions in the UK or in other countries. Thirty-three per cent of the whole sample had criminal convictions for violent offences (a category which does not include sexual offences or harassment).

Motivation

Using the categorisation of Mullen et al. (2009), 18% showed delusions of identity; 48% were pursuing an agenda; 4% were seeking forms of intimacy; the persecuted accounted for 5%, requests for help 6%, counsellors 3%, publicity seekers 2% and the chaotic 13%. Using the stalking categorisation of MacKenzie et al. (2009), 25% of the sample were Intimacy Seekers, 54% Resentful, 6% Help-Seekers, 2% Attention Seekers and 13% Chaotic.

Diagnosis

Most cases were suffering from serious mental illness. The diagnostic breakdown of the cases was as follows: schizophrenia 61%, paranoid psychosis (unspecified) 9%, delusional disorder 8%, schizo-affective disorder 3%, bipolar disorder 5%, chronic drug intoxication (with psychotic features) 2%, depression 2%, personality disorders (variously described as characterised by narcissistic and paranoid features) 10%. Forty per cent of cases were typed as 'organised'.

FTAC interventions

FTAC activities can be separated into initial investigation and case-working interventions. Initial investigation routinely involved gathering information from police and criminal records databases, as well as NHS sources, the latter being accessed by health service workers alone. FTAC interventions involved multiple and varied interactions with a range of other agencies over periods of days, weeks or months. In 70% of cases, there was direct engagement with the relevant Community Mental Health Team and in 46% direct liaison with the general practitioner. In 15% of cases, there was liaison with regional forensic psychiatry services. In 4% of cases, there was contact with psychiatric services in other countries. FTAC's initial intervention involved direct contact between FTAC personnel and the referred person in 30% of cases. The subject was interviewed in person by FTAC personnel in 26% of cases. There was telephone contact with the subject in 9% of cases. Eleven per cent of the cases were visited at their home by FTAC personnel. There was contact with the person's family in 12% of cases. The number and directness of interventions undertaken was greater in cases assessed as being of high risk.

Outcome of intervention

Compulsory admission to hospital was the outcome in 53% of cases and voluntary admission in 4%. Twenty-six per cent of cases were taken on for

management by community mental health teams or assertive outreach services. General practitioners engaged 4%; continued FTAC management alone was the outcome in 4%. Two per cent were arrested and prosecuted, 2% disappeared and were untraceable in the UK, one was deported, and 4% underwent other outcomes. In brief, 57% were admitted to hospital as a result of FTAC intervention, with a further 26% receiving care from mental health services in the community. This amounts to 83% of cases, with a further 4% receiving care from their GP.

Of the 100 cases, 21% were classified at initial evaluation as being of high concern and 79% of medium concern. Reductions in concern level following FTAC interventions, taken at the end of year one, were as follows: high to low 11%; high to medium 10%; medium to low 69%; medium to medium 10%. In brief, 80% of cases had been managed down to a low level of concern by the end of the period considered. The cases at medium concern after initial intervention remained active FTAC cases.

Previous contact of FTAC cases with psychiatric services

Of the 100 cases, 81% had previously been treated by psychiatric services and 57% had previously undergone compulsory admission to hospital. Of all those with a history of psychiatric treatment, 60% (49) remained notionally under the care (or 'on the books') of a community mental health team (CMHT).

Of the 49 cases that remained 'on the books' of CMHTs, 61% (30) were known to have stopped taking their medication and 59% (29) had no contact with their teams and had in effect fallen out of care. In all, of the 49 cases nominally under the care of a community team, 71% (35) had either abandoned medication and/or fallen out of care completely. Of the 40% of those with previous psychiatric treatment who were *not* currently on the books of a CMHT ($n = 32$), 59% (19) were known to have been lost to care and subsequently been crossed off the books as active cases. The remainder ($n = 13$), who constituted 16% of those with previous psychiatric treatment, are presumed to have been discharged from CMHT care for reasons other than non-attendance.

In all, 54 cases were known to have defaulted from community care packages, this amounting to 67% with histories of psychiatric treatment. Forty-one per cent (22) of these cases were recorded on the Police National Computer as having convictions for violent offences. Forty-three per cent (23) of those who had fallen out of care were judged to be 'organised' in terms of the definition given above.

Of the 49 cases under the care of a mental health team, one-third (13) were in contact with their teams and still thought to be compliant with medication. Almost half (6) were admitted to hospital and the remainder given new, more intensive community care packages following FTAC

intervention. These cases were engaging in inappropriate and concerning behaviours and had prominent symptoms, of which their CMHTs had not been aware.

Those with no history of contact with psychiatric services comprised 19 of the 100 cases. Thirteen suffered from psychotic illnesses, one repeated drug intoxication and five personality disorder. Seven were compulsorily admitted, one admitted voluntarily and two given community care packages. Two disappeared, one was prosecuted.

Discussion

The principle aim of this study was to determine whether FTAC was able to effect outcomes, both in terms of reductions in level of concern and in case disposal. Cases were taken on by FTAC on the basis of a standardised examination of risk factors and a resultant determination as to level of concern. Of the 100 cases meeting criteria for high or medium concern at initial evaluation, 90 were suffering from mental illness, which in 86 cases fell into the psychotic spectrum. This is a notably high proportion. It confirms the appropriateness of the involvement of psychiatric personnel in risk assessment of inappropriate communications and approaches to prominent people and sites. In all, 83% of cases were provided with psychiatric care as a result of FTAC intervention, with a further 4% receiving care from their GP. The fact that 57 of the 100 cases were admitted to psychiatric hospitals as a result of FTAC intervention reflects both the level of morbidity in this population and the efficacy of the FTAC case workers in mobilising local psychiatric services in individual cases.

It has not been possible in this account to include case details, lest they should prove identifiable. However, levels of symptomatology and associated distress in the case series included examples of psychotic illness which were among the most severe that the authors have encountered in clinical practice. The proportion of cases admitted to hospital supports previous observations that attention to inappropriate contacts with public figures is a useful tool for identifying the severely ill who have fallen through the care net (James et al., 2009) and that participation by psychiatrists in threat assessment fulfils an important public health function (Mullen et al., 2009; Mullen, Pathé, & Purcell, 2009).

FTAC is a joint police-NHS unit, and its function is not only a public health one, but a preventative policing function in terms of protecting public figures against the intrusions of the fixated. The efficacy of the intervention needs therefore to be measured in terms of prevention of harm. The use of 'concern' levels is a method of accomplishing such measurement which has two advantages. First, it overcomes the impossibility of defining efficacy in terms of events that have not occurred. Second, it provides an index which reflects the realities of operational policing, where initial decisions have to be

made in the light of available information. Cases were not taken on by FTAC for management unless they satisfied criteria for medium or high concern. The fact that 80% of cases had been managed down to low concern through FTAC intervention indicates that the service was effective in reducing concern level. The continuing involvement in the remainder of the cases reflects the importance of FTAC's role in the management, not simply the assessment of risk.

Eighty-one per cent of the cases had previously received psychiatric care, and 57% of the whole sample had previously been admitted to psychiatric hospital on a compulsory basis under mental health legislation. Fifty-four cases were known to have defaulted from community care packages, this amounting to 67% of those with histories of psychiatric treatment. The question arises as to why there should have been such a high fall-out rate. The characteristics of the fixated are often such as to make them unwelcome as patients. They are by definition without insight, frequently paranoid and nearly always resistant to psychiatric intervention and follow-up; and querulant cases are in addition markedly litigious. A proportion of cases were suffering from delusional disorders or schizophrenic illnesses which were sufficiently encapsulated to allow individuals to function effectively in many aspects of day-to-day living. In other words, they did not exhibit the gross behavioural disturbances that oblige mental health services to provide care. It may also be the case that the significance of inappropriate communications and approaches to the prominent is insufficiently appreciated by treating teams, who may erroneously regard such behaviours as innocuous or quaint. The problem in some cases may simply be that those in charge of a patient's care are not aware of the specific verbal or behavioural threats that an individual makes, and therefore they cannot evaluate the case accurately.

It proved practicable to allocate cases into the motivational typology developed by the study of Royalty Protection police files (Mullen et al., 2009). This is important in that it indicates the appropriateness of applying to FTAC cases the findings of the FRG's studies concerning motivation and risk. The fact that cases could also be allocated to the amended public figure version of Mullen and colleagues' standard stalking classification is useful, as it enables the adoption of the Stalking Risk Profile (MacKenzie et al., 2009) as an aid to risk assessment at FTAC. The Stalking Risk Profile is a manualised assessment of different domains of risk, following a structured professional judgement model, which points to treatment options in individual cases. This approach separates risk into different domains, for which risk factors differ (persistence, escalation, recurrence, psycho-social damage to stalker, disruption and violence), and recognises that risks in each domain vary according to motivational group. Given the underdeveloped nature of public figure threat assessment, it is important that FTAC's procedures remain under review and incorporate new research and practice developments and findings from audit of its own activities.

There are a number of limitations to this study. First, it examines the impact of a new service on an extant problem. There may, therefore, have been a pool of cases waiting to be tapped when the service began. This may have resulted in a higher proportion of cases with serious mental illness suitable for compulsory admission. It is likely that, as the service matures, more cases will comprise querulants and those with delusional disorders or paranoid personalities, for whom more complicated forms of management will be required. Second, although this preliminary study has demonstrated that FTAC is able to accomplish interventions and thereby reduce level of concern, it has not examined the issues of whether its interventions achieve longer term health benefit or prevent cases engaging in further inappropriate behaviours subsequently. The evidence from court diversion admissions is that health gain in diversion admissions is similar to that in community admissions and that diversion produces a reduction in offending (James et al., 2002). Follow-up study of FTAC cases will be necessary in order to establish whether FTAC intervention produces similar and lasting health and protection benefits.

The strengths of the FTAC system have, however, been illustrated by this examination of its performance. The power of FTAC's intervention lies in producing detailed packages of information about each individual, which provide evidence of the underlying problems and/or pathology, and also point to possible management and treatment options. The combination of information from policing sources with information available to local psychiatric services is illuminating and amounts to more than the sum of its individual parts. Police databases contain information about behaviour and past encounters with police which is often completely unknown to supervising psychiatrists and can prove invaluable in decision-making as regards severity of illness and need for treatment. FTAC's interventions, unlike those of diversion schemes, include a role in follow-through and aiding case management in an area unfamiliar to many general psychiatry teams. However, the role remains primarily one of catalysing a response by local services, and decisions about admission and treatment are made independently by local psychiatric services in the area in which the individual lives. This both ensures the independence of FTAC and avoids duplication of resources.

Finally, FTAC has illustrated the practicability of a joint police-NHS unit. Inter-agency co-operation and diversion programmes in the criminal justice system have been advocated by the two major government-sponsored reports of the last 20 years (Bradley, 2009; Reed, 1992). The promotion of inter-agency working and information-sharing in the interests of preventing offending has been reflected in the establishment of Multi-Agency Public Protection Arrangements and Multi-Agency Risk Assessment Conferences, these being multi-agency initiatives involving police, probation, social services, housing and psychiatric services. In effect, these initiatives shift the

diversion concept one step back, in order to initiate risk assessment and management plans before offending occurs. FTAC takes this process one stage further. Rather than involving co-operation between very different agencies on different sites, each with its own ethos, FTAC comprises a single joint agency, which has adopted a common goal. Problems of confidentiality which bedevil inter-agency working have been largely overcome. The FTAC psychiatric team, being financed by the Department of Health to provide a service to a particular group, has a legitimate role in their patients' cases which makes the sharing of relevant medical information with local NHS services appropriate. Well versed in the intricacies of public interest disclosure, the psychiatric team is then in a position to judge which information it is permissible (or, indeed, relevant) to share with police colleagues. Careful adherence to NHS clinical governance and information governance policies, together with continuing professional development and NHS clinical and line-management procedures prevent staff 'going native'. Co-operation and benchmarking exercises with agencies engaged in similar work in other countries ensure adherence to best practice.

FTAC won an Association of Chief Police Officers' Excellence Award in 2009. It is our view that the joint police-NHS model has other possible applications, such as in police responses to stalking and in homicide prevention. The joint-working approach also plays a wider role in educating police officers about mental health issues. It enables the police to gain further understanding of the psychological issues involved in their cases. It enables more efficient and effective risk assessment and management between agencies. It helps the police to understand where psychiatric intervention is indicated and aids them to navigate the complex system for obtaining psychiatric care in people with whom they deal. In our view, a logical further development would be the modification of the role of NHS-police-liaison psychiatric nurses, so that they become embedded in police responses at borough or county level in order to perform an enabling role, to the benefit of individual patients and of public protection.

Acknowledgements

We owe particular thanks to S.W., *obstitrix altrixque operis*. We are grateful to everyone at FTAC and to those in psychiatric services in the United Kingdom and further afield, with whom we have worked in partnership. The opinions expressed in this paper are those of the authors and do not necessarily represent the views of any commissioning or provider agency.

References

Adams, S.J., Hazelwood, T.E., Pitre, N.L., Bedard, T.E., & Landry, S.D. (2009). Harassment of members of parliament and the legislative assemblies in Canada by individuals believed to be mentally disordered. *Journal of Forensic Psychiatry & Psychology*, *20*(6), 801–814.

Bradley, K. (2009). *Review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health.

Calhoun, F.S., & Weston, S.W. (2003). *Contemporary threat management*. San Diego: STS.

Hanrahan, D.C. (2008). *The assassination of the Prime Minister: John Bellingham and the murder of Spencer Percival*. Stroud, UK: Stratton.

Hansard (2007). 25 Jun 2007: Column 303-4W. Retrieved October 20, 2009, from http://www.publications.parliament.uk/pa/cm200607/cmhansrd/cm070625/text/70625w0068.htm

Hansard (2009). 10 Jun 2009: Column 878-9W. Retrieved October 20, 2009, from http://www.parliament.the-stationery-office.co.uk/pa/cm200809/cmhansrd/cm090610/text/90610w0004.htm

James, D., Farnham, F., Moorey, H., Lloyd, H., Hill, K., Blizard, R., et al. (2002). *Outcome of psychiatric admission through the courts* (RDS Occasional Paper No. 79). London: Home Office.

James, D.V., Meloy, J.R., Mullen, P.E., Pathé, M.T., Preston, L.F., Darnley, B., et al. (in press b). Abnormal attentions towards the British Royal Family: Factors associated with approach and escalation. *Journal of the American Academy of Psychiatry and the Law*.

James, D.V., Mullen, P.E., Meloy, J.R., Pathé, M.T., Farnham, F.R., Preston, L., et al. (2007). The role of mental disorder in attacks on European politicians 1990–2004. *Acta Psychiatrica Scandinavica*, *116*, 334–344.

James, D.V., Mullen, P.E., Pathé, M.T., Meloy, J.R., Farnham, F.R., Preston, L., et al. (2008). Attacks on the British Royal Family: The role of psychotic illness. *Journal of the American Academy of Psychiatry and the Law*, *36*, 59–67.

James, D.V., Mullen, P.E., Pathé, M.T., Meloy, J.R., Farnham, F.R., Preston, L., et al. (in press a). Stalkers and harassers of royalty: An exploration of proxy behaviours for violence. *Behavioral Sciences and the Law*.

James, D.V., Mullen, P.E., Pathé, M.T., Meloy, J.R., Preston, L.F., Darnley, B., et al. (2009). Stalkers and harassers of royalty: The role of mental illness and motivation. *Psychological Medicine*, *39*(9), 1479–1490.

James, D.V., McEwan, T.E., MacKenzie, R.D., Meloy, J.R., Mullen, P.E., Pathé, M.T., et al. (2009). Persistence in stalking: Acomparison of associations in general forensic and public figure samples. *Journal of Forensic Psychiatry & Psychology*, DOI: 10.1080/14789940903388994.

MacKenzie, R.D., McEwan, T.E., Pathé, M.T., James, D.V., Ogloff, J.R.P., & Mullen, P.E. (2009). *The stalking risk profile: Guidelines for the assessment and management of stalkers*. Melbourne: StalkInc. & Centre for Forensic Behavioural Science, Monash University.

Meloy, J.R., James, D.V., Farnham, F.R., Mullen, P.E., Pathé, M., Darnley, B., et al. (2004). A research review of public figure threats, approaches, attacks, and assassinations in the United States. *Journal of Forensic Sciences*, *49*(5), 1086–1093.

Meloy, J.R., James, D.V., Mullen, P.E., Pathé, M.T., Farnham, F.R., Darnley, B., et al. (in press). Factors associated with escalation and problematic approaches toward public figures. *Journal of Forensic Sciences*.

Mullen, P.E., James, D.V., Meloy, J.R., Pathé, M.T., Farnham, F.R., Preston, L., et al. (2009). The fixated and the pursuit of public figures. *Journal of Forensic Psychiatry & Psychology*, *20*, 33–47.

Mullen, P.E., & Lester, G. (2006). Vexatious litigants and unusually persistent complainants and petitioners: From querulous paranoia to querulous behaviour. *Behavioural Sciences and the Law*, *24*, 333–349.

Mullen, P.E., Pathé, M., & Purcell, R. (2009). *Stalkers and their victims* (2nd ed). New York: Cambridge University Press.

Mullen, P.E., Pathé, M., Purcell, R., & Stuart, G.W. (1999). Study of stalkers. *American Journal of Psychiatry*, *156*(8), 1244–1249.

Phillips, R.T.M. (2006). Assessing presidential stalkers and assassins. *Journal of the American Academy of Psychiatry and the Law*, *34*, 154–164.

Phillips, R.T.M. (2007). Celebrity and presidential targets. In D.A. Pinals (Ed.), *Stalking: psychiatric perspectives and practical approaches* (pp. 227–250). New York: Oxford University Press.

Phillips, R.T.M. (2008). Preventing assassination: Psychiatric consultation to the United States Secret Service. In J.R. Meloy, L. Sheridan, & J. Hoffman (Eds.), *Stalking, threatening and attacking public figures: A psychological and behavioural analysis* (pp. 363–386). New York: Oxford University Press.

Pinals, D.A., (Ed.). (2007). *Stalking. Psychiatric perspectives and practical approaches*. New York: Oxford University Press.

Poole, S. (2000). *The politics of regicide in England, 1760–1850: Troublesome subjects*. Manchester: Manchester University Press.

Reed, J. (1992). *Review of mental health and social services for mentally disordered offenders and others requiring similar services: Vol. 1: Final summary report. (Cm. 2088)*. London: HMSO.

Rose, D. (2007). 'I've given you the chance to help, but you haven't. Now someone is going to have to die'. *Observer*, 26.08.2007. Retrievable from: http://www.guardian.co.uk/theobserver/2007/aug/26/features.magazine67.

Scalora, M.J., Baumgartner, J.V., Callaway, D., Zimmerman, W., Hatch-Maillette, M.A., Covell, C.N., et al. (2002a). An epidemiological assessment of problematic contacts to members of Congress. *Journal of Forensic Sciences*, *47*, 1360–1364.

Scalora, M.J., Baumgartner, J.V., Zimmerman, W., Callaway, D., Hatch-Maillette, M.A., Covell, C.N., et al. (2002b). Risk factors for approach behavior toward the U.S. Congress. *Journal of Threat Assessment*, *2*, 35–55.

Scalora, M., Baumgartner, J., & Plank, G. (2003). The relationship of mental illness to targeted contact behavior toward state government agencies and officials. *Behavioral Sciences and the Law*, *21*, 239–249.

Scalora, M.J., Zimmerman, W.J., & Wells, D.G. (2008). Use of threat assessment for the protection of the United States Congress. In J.R. Meloy, L. Sheridan, & J. Hoffman (Eds.), *Stalking, threatening and attacking public figures*. Oxford: Oxford University Press.

SOU (2006). *Jakten på makten*. Stockholm: Staatens Offentliga Utredningar.

Takeuchi, J., Solomon, F., & Menninger, W.W. (Eds.). (1981). *Behavioral science and the secret service: Towards the prevention of assassination*. Washington, DC: National Academy Press.

West, D.J., & Walk, A. (1977). *Daniel McNaughton: His trial and the aftermath*. London: Gaskell.

Wilson, D. (1812). *The substance of a conversation with John Bellingham, the assassin of the late Right Hon. Spencer Percival, on Sunday May 17, 1812, the day previous to his execution, together with some general remarks*. London: Hatchard.