Fixated Threat Assessment Centre New Zealand

Annual Report July 2019 - June 2020

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Introduction

The Fixated Threat Assessment Centre New Zealand (FTACNZ) is a prevention-focused collaboration that brings police and mental health professionals together to appropriately share information, conduct assessments, and facilitate mental health, law enforcement or other interventions to address the risks posed by fixated individuals (Fixation Definitions, appendix B).

The concept of a FTAC has its origins in research by the Fixated Research Group in the United Kingdom which identified the critical role of mental illness in those that threaten and approach royalty. This lead to the first FTAC in the United Kingdom (UKFTAC) initially as a pilot in 2006. There has been impressive growth in the research base and the development of services since that time. The second dedicated FTAC opened in Queensland in 2013, after a similar service was established in the Netherlands. Since then all states and territories in Australia have established some capacity, with well-developed services in Victoria, Queensland, New South Wales and Western Australia.

After a pilot project which ran from September 2017, FTACNZ was established on 1 July 2019. The development of the New Zealand service took several years and was the result of dedicated work and commitment to the concept by a small group of interested individuals. The demonstration of the high level of harassment experienced by New Zealand Members of Parliament in a survey in 2014, published in 2015 (appendix F) and a dramatic event at Parliament in May 2016 were important springboards to the establishment of the service.

FTACNZ operates as a joint service with police staff and senior clinicians from the forensic mental health service working together (Service Structure, appendix A). An important function of the FTAC is to identify individuals who may be fixated upon a cause or individual. As the 2014 survey demonstrated, fixated people frequently petition, approach, communicate in concerning ways or threaten Members of Parliament and their staff. Overseas research and the data from our first year of operations demonstrates that these people are commonly mentally ill. Further, the recognition of warning behaviours and impact of their communications on themselves and others provides the opportunity for intervention. From a mental health perspective this allows for a unique opportunity to intervene by facilitating treatment for a group who may have fallen out of treatment, never received treatment or are in treatment in situations where the full extent of their activities is not known.

These interventions have been proven to reduce harm to the individual themselves, those around them in the community and those that are the subject of their attentions. Thus, a key aspect of FTAC is that it provides a public health intervention and has an emphasis on prevention. In addition, other interventions occur including liaison with police in ways that reduce the burden on resources and facilitate better outcomes for those involved. The importance of Police in the service is emphasised by the high rates of Police involvement including criminal convictions in those referred.

ACKNOWLEDGEMENTS

It is timely, at the point of reviewing the first year of operations of FTAC to acknowledge the debt of gratitude owed to a number people and services. The establishment of a service that spans several discrete organisations requires a high level of cooperation, good will and intent. Thanks, are extended to all who were involved including those within Police, the Ministry of Health, Parliamentary Services, and the Forensic Mental Health services of Capital and Coast District Health Board. We offer a special acknowledgement to our colleagues within the Security Enablement Team. It is their expertise

and skill that allows FTAC to do our core work, with its emphasis on prevention and intervention to reduce harm to people in the community and public office holders.

A critical aspect of the functioning of FTAC is the sharing of information. The development of a sophisticated process for dealing with the inevitable privacy issues that arise was a key aspect of the establishment of the service. The basis for information sharing sets out the provisions under which this is made (appendix C). We are grateful for the assistance of the Ministry of Health and Police experts in this area and the advice provided by the Privacy Commission in the establishment of our privacy impact assessment. Privacy remains a salient issue that influences our practice and thinking day-to-day. It is achieving the balance between the respect for an individual's privacy and the good that comes from appropriately sharing information in a considered way between agencies that lies at the heart of how the service operates.

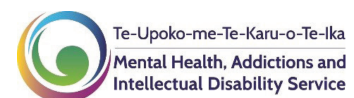
Finally, we would like to thank the police and mental health colleagues that work alongside us for their expertise, commitment and work over the last year.

Dr Justin Barry-Walsh
Consultant Forensic Psychiatrist

Aidan Neville
Detective Sergeant

CAVEAT

The Annual Report is primarily constructed on the data collected by FTACNZ (Appendix D) and is based on information recorded during FTACNZ's first operational year, 1 July 2019 to 30 June 2020. Due to the trial activity of FTACNZ between 1 August 2017 and 30 June 2019 and the improvements in reporting processes, FTAC has undergone several amendments to the data recorded. The data used for this report was that available on 1 July 2020.



OPERATIONAL REVIEW

This report has been prepared to provide an overview of FTACNZ operations and outcomes during the first year.

The value of the service is demonstrated in the pages that follow, and a deliberate effort has been made to provide both a holistic overview and a more focussed observation of particular behaviours exhibited.

New Zealand's political open-door policy and approachable image provides the perfect platform for individuals to correspond and/or approach Members of Parliament. With the general public having access to both their MP's office and the Beehive, the system inspires person-to-person interactions, with politicians trying to promote their approachability. The impression from our first year of operations is that this feature of our political landscape, valued by both politicians and the public, increases the likelihood people will communicate with and fixate upon politicians and their staff and heightens the need for an FTAC service.

One statistic that stands out is that of the 87 referrals received in the year, 44 had a serious psychotic illness of whom 14 had never previously been in treatment, 20 were not in treatment at the time of referral and the remaining 10 were in treatment. Given the research and what has been learnt from other FTACs these numbers while concerning are not surprising. The ability to share appropriate information between Police, Parliament and Mental Health Services allowed for much better treatment and outcomes for this group of people.

The value of speaking directly to these troubled people, including those where there is no clear mental illness is also highlighted. A number of cases could be resolved by listening to and understanding a person's concerns and identifying ways that they can be supported and assisted. This also allowed for tailored advice and support to be provided to those making the referrals including vulnerable electorate offices. The feedback we received both directly and via the Security Enablement Team was that this advice was highly valued.

The advent of the COVID-19 pandemic had a substantial impact on the functioning of the service and the threat environment. Changes in behaviour forced by lockdown reduced the number of direct referrals coming from Parliament. This is consistent with anecdotal reports from overseas, particularly Australia. It appears people fixated on causes and grievances moved more to online expressions of their distress. This shift emphasises the value of having the service located within the National Intelligence Centre as there has been a natural education within that environment of the functioning of the FTAC leading to appropriate referrals to the FTAC when such online activity has been identified through general reporting processes.

Future direction

It is expected that the operational demand for an FTAC service will continue and likely grow as has been seen in overseas jurisdictions. In anticipation of this FTACNZ continue to engage with partners and report to Governance Group on areas of likely future demand.

KEY ENGAGEMENT AND TRAINING

During the first year of operation, engagement has occurred with key partners and government agencies, including the Independent Police Conduct Authority, the Office of the Ombudsman and the Human Rights Commission amongst others. The purpose of this engagement has been to identify FTACNZ to those organisations and provide them with an understanding of what FTACNZ is and does. While this is useful so that these agencies are informed of the FTACNZ's existence, it has become obvious those agencies also receive attention from similar, if not in some instances the same, individuals. This poses an important question on how FTACNZ should operate and whether it should be widened to receive referrals from other agencies.

Staff within FTACNZ have attended international events. This included the Asia Pacific Association of Threat Assessment Professionals (APATAP) conference in Melbourne in February 2020. Dr Barry-Walsh in conjunction with colleagues from Western Australia and Canberra presented a forum on the FTAC model in Singapore in November 2019. This event was a joint conference between the Royal Australian and New Zealand College of Psychiatrists Faculty of Forensic Psychiatry and the Australia and New Zealand Association of Psychiatry, Psychology and the Law.

Although COVID-19 has meant international conferences are not occurring in person at the moment, staff from FTAC will also be presenting as part of a webinar series developed by APATAP.

In April a review paper on FTAC (Appendix G) co-written by Dr Barry-Walsh was published in the widely read CNS Spectrums Journal and a book chapter is also planned.

Liaison with other FTACs continues, with regular meetings taking place with the other jurisdictions facilitated both by the ANZCTC and a less formal community of practice model. In the past year FTAC staff have taken the opportunity to visit United Kingdom FTAC (Justin Barry-Walsh), Victoria FTAC (Emily Pike, Aidan Neville and Justin Barry-Walsh) and Queensland FTAC (Justin Barry-Walsh.)

Engagement with mental health services within New Zealand is ongoing. This has included presentations by senior clinicians at inpatient units within the region; a presentation to the crisis response service for the region; and a presentation at the Southern District Health Board mental health grand round (Continuing Professional Development sessions) which was widely zoomed. Referrals to mental health services provide an opportunity to explain and educate about the service. When referrals are made there is routine liaison with the Director of Area Mental Health Services (DAMHS).

GOVERNANCE

FTAC is overseen by Governance Group members from senior levels of the agencies currently involved.

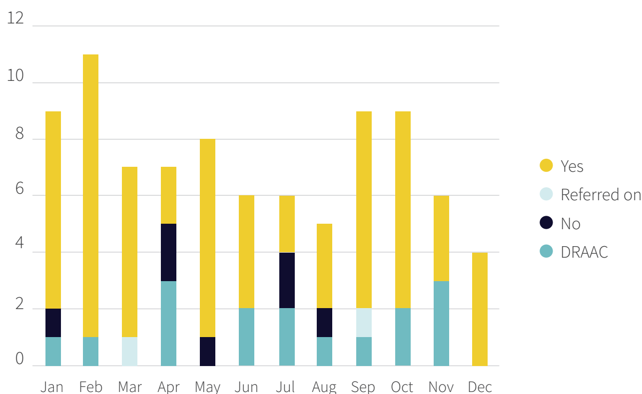
The key legislative tools under which the team operates include the Privacy Act 1993, Health Information Privacy Code 1994, and the Mental Health (Compulsory Assessment and Treatment) Act 1992.

The Year in Review

REFERRALS

For the purpose of this report, a referral means a person referred to FTAC believed to be exhibiting fixated or otherwise concerning behaviours that come under FTAC scope.

Between 1 July 2019 and 30 June 2020, FTAC received a total of 87 referrals; 62 were accepted, seven were declined with no further action and a further 16 that were declined referrals with alternative action completed (DRAAC). Two were referred on to other FTACs overseas.



Data is collected for each referral for reporting and analysis. The data reported on within this report is consistent with that collected by other FTAC services and in line with guidance provided by the Australia New Zealand Counter Terrorism Committee (ANZCTC).

FTAC received referrals from the Parliamentary Security Enablement Team (SET), New Zealand Police (NZP), District Health Boards (DHB), United Kingdom FTAC (UKFTAC) and Queensland FTAC (QFTAC).

SET provided the most referrals with 59, NZP 21, UKFTAC four, QFTAC two and DHB one.

As of 01 July 2021, 73% (n = 64) of referrals were closed, 21% (n = 18) open and 6% (n = 5) were currently being monitored.

With the exception of onward referrals to overseas jurisdictions, all referrals considered by FTAC are assessed against a tool called the Risk Aide Memoire (RAM). This tool is utilised by all FTACs to assist in determination of the concern level posed by an individual. Where possible the RAM concern level for onward referrals is obtained from that FTAC.

CONCERN LEVEL

Referrals are assessed with the assistance of the RAM. Concern levels fall into three categories unless further information is required or there is insufficient information to conduct a RAM determination. These are High, Moderate and Low (Appendix E).

The initial concern level of the referral determines the urgency of interventions and if the concern level is low the referral is not accepted. However, there may be an underlying duty of care or other constructive input that FTAC can provide. Thus, it is common for those not accepted to require further input hence the DRAAC category. Initial concern levels were recorded as low (n = 33), moderate (n = 30) and high (n = 24).

Of those cases where the concern level was reviewed within the time frame of the report (some were still active and subject to on-going intervention) as the table below demonstrates all but two had reduced in their level of concern including all initially rated as of high concern.

Concern Level	#
High-Low	17
High-Mod	3
Mod-Low	20
Mod-Mod	1
Low-Low	8
Low-Mod	1

Not all referrals can have their concern level reduced, nor can FTAC achieve a reduction in concerning behaviours in all instances, however wider knowledge of these behaviours allows for mitigations to be put in place. Where a low level of concern is initially determined, a review of the concern level is only conducted where deemed necessary.

DEMOGRAPHIC

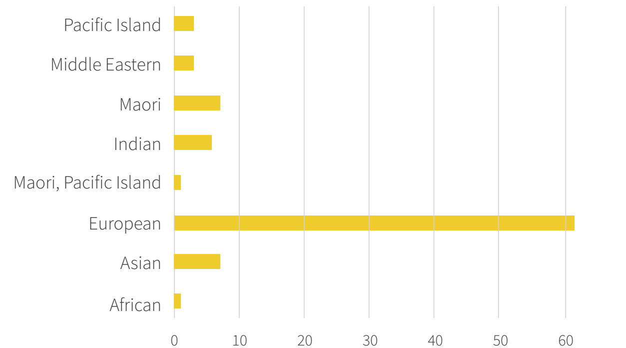
Demographic information recorded are age, gender, ethnicity and location (location recorded by town and policing district).

Sixty two of the referrals were male (71%) and 25 (29%) female.

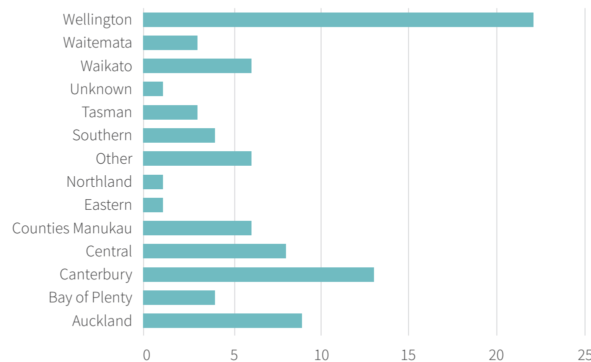
Age ranges are from 17 to 71, the most common age range of referrals were aged between 47-56 years; the median age is 47.

Age Range	#
17-26	4
27-36	14
37-46	25
47-56	27
57-66	17
67-76	2

Ethnicity of referrals include African, Asian, European, Indian, Maori, Middle Eastern and Pacific Island. Europeans are the highest represented ethnicity with 69%.



The geographical location of referrals to FTAC is categorised by the 12 police districts, with 'Other' representing referrals residing internationally. The top three where FTAC Persons of Interest (POI) reside are Wellington 25% (n = 22), Canterbury 15% (n = 13) and Auckland 10% (n = 9). (Auckland City, Counties Manakau and Waitemata combined, n = 18).



TARGET

Target refers to a specific entity an individual is directing their messages to and is detailed into nine categories; government organisation, royal, judiciary, politician, police, community, workplace, school and other.

Target	#
Politicians	65
Government Organisation	23
Police	9
Royals	6
Other	6
Judiciary	4
Community	5
Workplace	1

As expected, politicians (75%) and government organisations (26%) were the two most targeted entities. There is overlap as fixated individuals are known to target multiple entities. 29% (n = 25) of referrals sent correspondence to more than one target.

METHOD OF CONTACT

The method of contact records the form of communication (where identified), that a referral used.

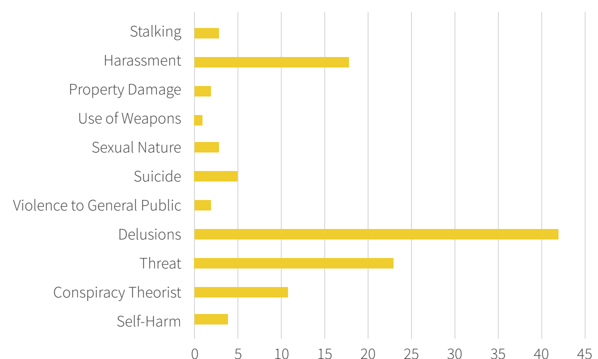
Method of Contact	#
Email	50
Approach indirectly	24
Social Media	18
Handwritten or Typed letter	14
Telephone	13
Approach directly	5

Emails (57%) are the most common method of corresponding. A concerning outcome is the number of referrals which involved indirect and direct approaches. Approach behaviours are a well-recognised warning sign in the threat assessment literature.

Indirect approach was the second most utilised method of contact with 28%, whereas approach directly is 6%. Approach indirectly refers to when a referral would visit the representative's building, e.g. parliamentary precinct, MP's electorate office, etc. in person. Approach directly refers to approaching the target (public figure) in person.

PRESENTING PROBLEMS

Presenting problems represents the concerning behaviour that is initially observable at time of referral and are recorded as self-harm, conspiracy theorist, threat, delusions, violence to family/ friends/acquaintances, violence to general public, suicide, sexual nature, drug use, use of weapons, arson, property damage, harassment and stalking. The categories are not mutually exclusive. Delusions are an ANZCTC Category and encompasses a range of behaviours driven by delusional beliefs. The most common behaviour in this group is petitioning of politicians. Often these individuals communicate a high level of distress which raises concern for their welfare and those close to them.

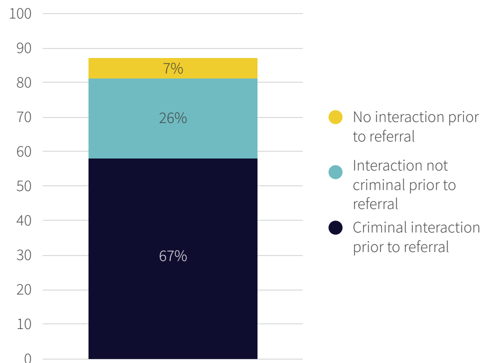


Delusion (48%, n = 42) is the most common observed concerning behaviour, followed by threat (26%, n = 23) and harassment (21%, n = 18).

POLICE HISTORY

Police history is split into two datasets and the relevant data is pulled from the Police National Intelligence Application (NIA).

The first dataset identifies whether or not police had previously interacted with a referral and is split into three categories; no interaction prior to referral (n = 6), interaction but not criminal prior to referral (n = 23) and criminal interaction prior to referral (n = 58).



The second set identifies criminal history (exclusively includes convictions) and is categorised by the following; fraud, disorder, alcohol related, car conversion, dishonesty, weapons, drugs, property damage, family violence, arson, theft/burglary, sexual, driving offences, stalking/harassment, breach of intervention, assaults and other.

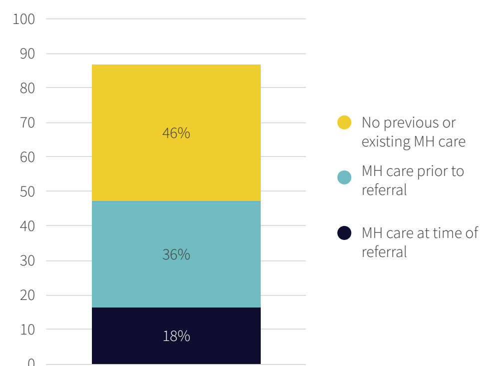
Conviction	#
Assaults	28
Driving Offences	24
Other	20
Disorder	16
Property Damage	15
Drugs	13
Theft/burglary	12
Car Conversion	9
Family Violence	7
Fraud	6
Alcohol Related	6
Breach of Intervention	5
Sexual	4
Dishonesty/Deception	3
Weapons	2
Stalking/Harassment	2
Arson	1

Assaults was the most common conviction, with 32% previously being convicted of violent offences.

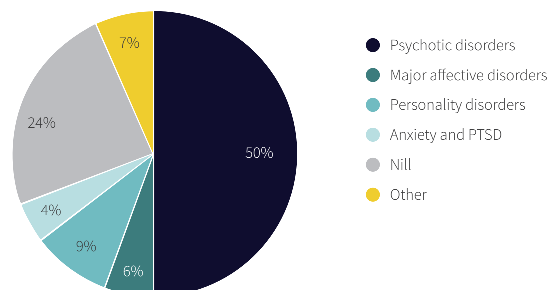
MENTAL HEALTH HISTORY

Mental health history is split into two datasets.

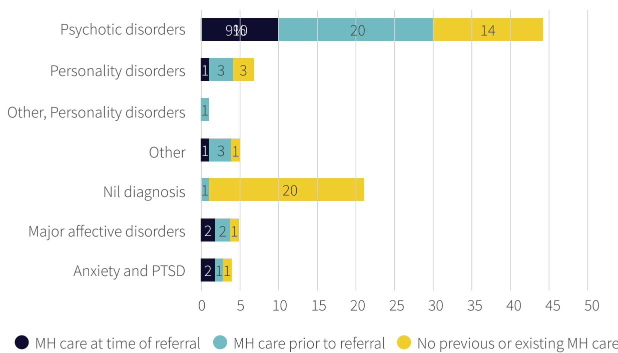
The first dataset identified whether or not a referral has interacted with mental health and is split into three categories; no previous or existing mental health care (n = 40), mental health care prior to referral (n = 31) and mental health care at time of referral (n= 16).



The second set identifies a referral's mental health diagnosis and is recorded as psychotic disorders (n = 44), major affective disorders (n = 5), personality disorders (n = 8), anxiety and PTSD (n = 4), any psychiatric diagnosis (n = 0), nil diagnosis (n = 21) and other (n = 6). All diagnoses were determined by the psychiatrist.



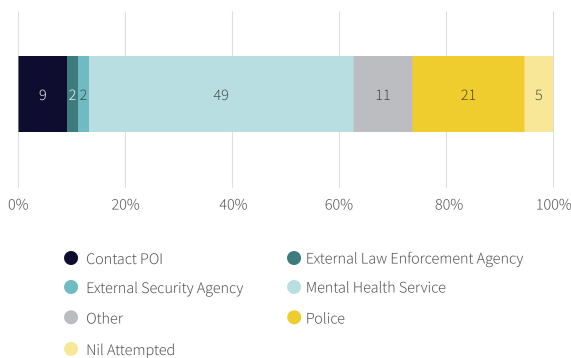
No history of mental health care and psychotic disorders are the highest represented data within their separate dataset. 16% of referrals had no prior mental health history; but were diagnosed with a psychotic disorder.



N.B. only one referral had a history of interacting with mental health but had no formal diagnosis.

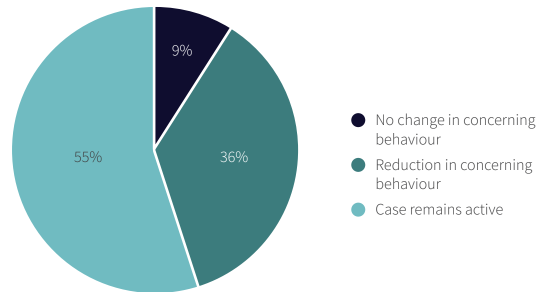
INTERVENTION AND OUTCOME

Interventions utilised are as follows; contact GP, contact POI, external law enforcement agency, external security agency, mental health service, other, police and nil attempted.



The two most utilised interventions are referral to mental health services (56%, n = 49) and liaison with police (24%, n = 21). Half required more than one intervention (52%, n = 45).

At the point of closure, cases were assessed on the basis of evidence of change in concerning behaviour. This was either reduction in concerning behaviour (n = 31), increase in concerning behaviour (n = 0) or no change in concerning behaviour (n = 8).



The case remains active section refers to cases where the case had not yet been closed or there was insufficient elapse of time to determine whether there had been a change in concerning behaviour.

CASES AND SUB-GROUPS

Most POIs were referred as they had established or possible grievances. This included a number of people with identifiable mental illness. However, there were several subgroups which differed. These included those fixated-on individuals, the querulous and those who may best be seen as presenting a risk of lone actor grievance-fuelled violence. Several illustrative cases and further consideration of these sub-groups are below.

GRIEVANCE

Most POIs are preoccupied with a grievance arising from a perceived injustice and have a feeling of resentment from being unjustly treated. The actions of POIs fixated in this manner are directed at Public Office Holders (POH) usually either because they believe the POH will support or assist them or because the POH has become the focus of their resentment, often because they believe the POH has ultimate responsibility in their case.

THE QUERULOUS

The querulous are people who feel like they have been wronged by a person, agency, system or government as a whole, and obsessively pursue this injustice. The main distinction between grievance and querulous is that querulous people are complainants in a relentless pursuit of justice.

Despite this distinction there is a great deal of overlap between the two groups.

Using a narrow definition there were two querulants. Both had convictions prior to referral to FTAC. One had a diagnosis of an anxiety disorder and prior contact with Mental Health, the other no diagnosis.

One case was initially assessed of low concern, but as their behaviour worsened were increased to moderate concern. With further intervention they were reduced again to low concern. The other was initially of moderate concern but later reduced to low. Both required both Police and Mental Health intervention.

INDIVIDUAL

The subcategory of individual refers to a POI fixated on an individual as opposed to fixation a grievance. This fixation type often occurs in individuals who develop delusions about a relationship with a Public Office Holder.

In total 20 POIs were fixated on an individual. The gender make-up of this referral type was divided evenly between males and females (n = 10) and 85% (n = 17) were European.

Age ranged from 17 to 66 years. 50% (n = 10) were aged 57 to 66. All but two had had contact with Police and/or Mental Health.

Of this group, 22% (n = 4) were already engaged with mental health treatment when the referral was made, and 44% (n = 8) had received mental health treatment prior to being referred.

The three most frequent diagnoses among referrals who had a history of mental health treatment were psychotic disorders (n = 10), personality disorders (n = 2) and major affective disorders (n = 2). 25% (n = 5) had no diagnosis.

All referrals in this group who were closed by 31 June 2020 had their concern level reduced; or unchanged in the case of those initially assessed as low concern. 40% (n = 8) were initially assessed as low concern, 25% (n = 5) assessed as moderate concern and 35% (n = 7) as high concern.

LONE ACTOR GRIEVANCE-FUELLED VIOLENCE

Lone actor grievance-fuelled violence (LAGFV) refers to the use of hostile acts with the aim of achieving objectives that have significance for the individual. Perpetrators of LAGFV are often motivated by a sense of victimisation, injustice, loss or injury.[1] LAGFV encompasses those that threaten or engage in lone act terrorism, mass shootings and other mass homicides. These individuals often exhibit warning behaviours.

While FTAC does not currently offer a service of dealing with the LAGFV cohort as a wraparound service, there are overlaps with FTAC scope that result in FTAC involvement with a number of individuals who fall under this group.

All seven referrals who could be regarded as LAGFV were male and five were European. They ranged in age from 17 to 56 years.

Two referrals had no prior interaction with Police or mental health services. One had mental health care previous to the time of referral (n=1, 14%); 5 had no prior contact with mental health and one was in treatment at the time of referral. Four had a diagnosis of psychosis, one of Autistic Spectrum Disorder and two no diagnosis. Five had interacted with Police for criminal matters prior to referral. One individual had perpetrated serious physical violence leading to his referral. This man and several others had exhibited a range of warning behaviours on-line. No referrals had non-criminal Police interactions prior to referral. Five were initially rated of moderate concern, one of high concern and one of low concern. Following intervention all were reduced to low concern. Four were referred to mental health services, two to Police and two to Australian FTAC counterparts.

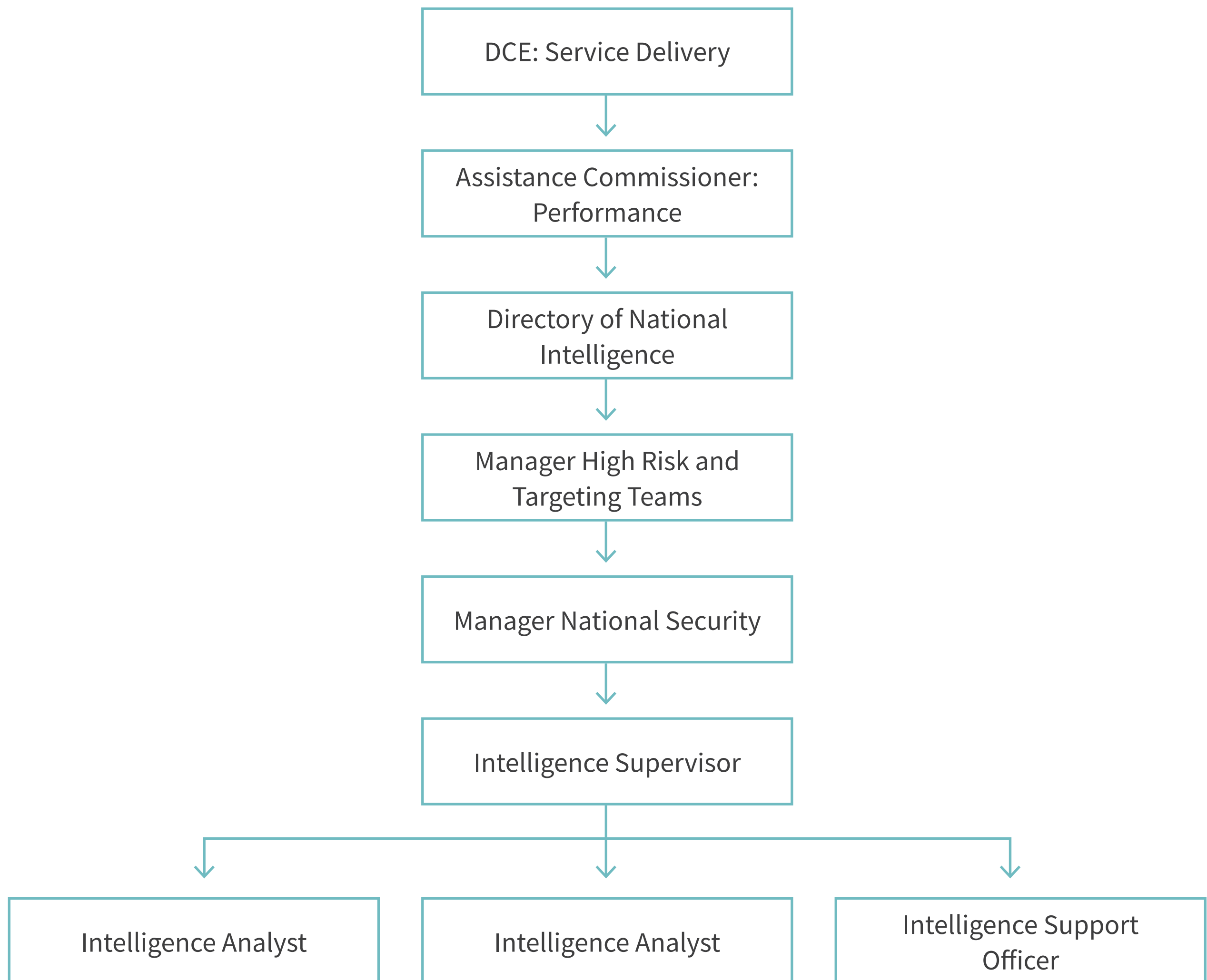
1 Michele T. Pathé, Debbie J. Haworth, Terri-Ann Goodwin, Amanda G. Holman, Stephen J. Amos, Paul Winterbourne & Leanne Day (2018) Establishing a joint agency response to the threat of lone-actor grievance-fuelled violence, The Journal of Forensic Psychiatry & Psychology, 29:1

Appendix

APPENDIX A: SERVICE STRUCTURE

FTAC is comprised of three full-time Police staff and three part-time CCDHB staff.

Each organisation has a separate reporting line (refer to Figure 1).



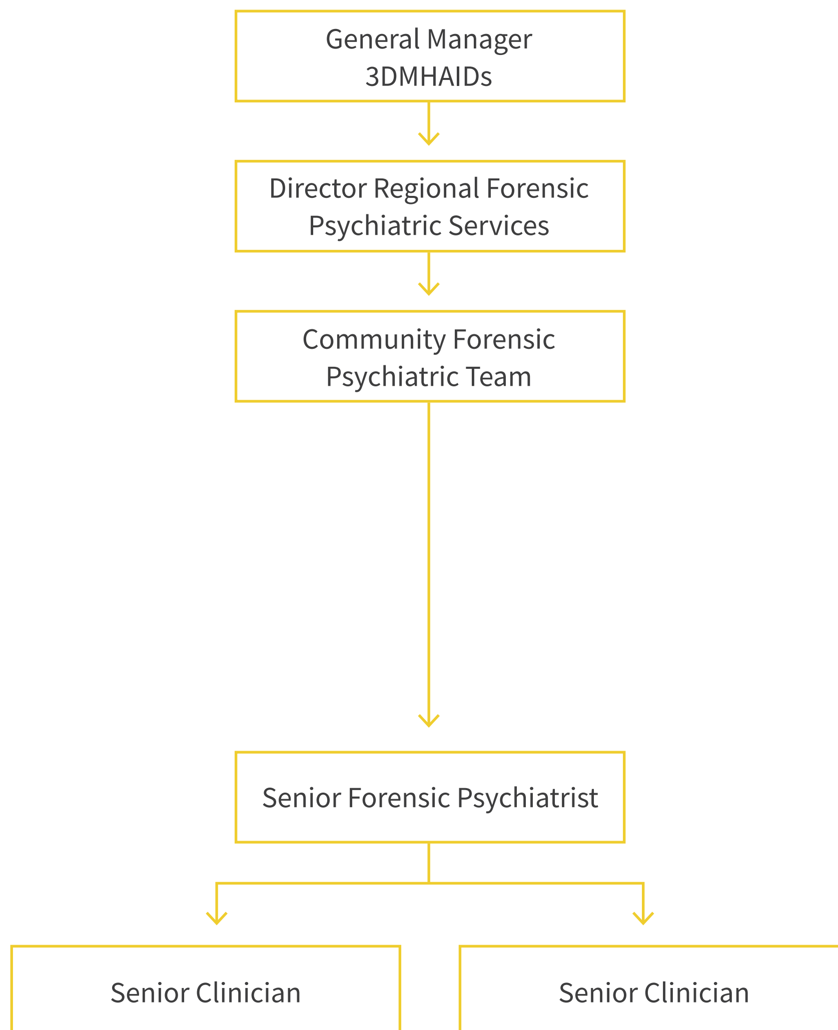


Figure 1. Service Structure

APPENDIX B: FIXATION DEFINITIONS

Fixation: 'Fixation' is defined as "intense preoccupations with an individual, place or cause that are pursued to an excessive or irrational degree",[2] where a cause' refers to "some intense, personal and occasionally bizarre grievance or quest for justice".[3] Fixation generally fall into one of two categories:

i. ***Cause:*** an individual becomes fixated with a particular issue, which they then believe a public figure has caused or has responsibility for; or

ii. ***Individual:*** an individual becomes fixated with a specific public figure (e.g. a member of the Royal Family) owing to an imagined relationship of some nature.

Querulent behaviour: This is "a pattern of behaviour involving the unusually persistent pursuit of personal grievance in a manner seriously damaging to the individual's economic, social and personal interests, and disruptive to the functioning of the courts and/or other agencies attempting to resolve the claims."[4]

Lone Actor Grievance-Fuelled Violence (LAGFV): A 'lone actor' is any individual who engages in hostile acts against others in pursuit of aims that have a particular meaning for them. Grievance-fuelled violence arises from a real or imagined grievance, injustice or loss.[5]

Suspected Mental Illness (SMI): An individual who does not necessarily meet the criteria of fixated; however, presents as someone who displays an undiagnosed mental illness.

Grievance: A grievance occurs when an individual has a strong belief that they (or others/a group with which they identity) have been the subject of a perceived injustice and this generated feelings of outrage/ desperation and a sense of victimisation. [6]

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2 (Mullen, Pathe & Purcell, 2009).
3 (Mullen, Pathe & Purcell, 2009).
4 Mullen, P. E. and Lester, G. (2006), Vexatious litigants and unusually persistent complainants and petitioners: from querulous paranoia to querulous behaviour. Behav. Sci. Law, 24: 333-349.
5 VFTAC Training Resources
6 Pathe et al. 2018

APPENDIX C: BASIS FOR INFORMATION SHARING

In most circumstances' information will be shared due to the serious threat of harm, and the FTACNZ agencies consider that information-sharing is justified to lessen the threat. Further, the sharing of information will only be to the extent to enable each party to do its job for the purposes of FTACNZ. Where circumstances enable such action, FTACNZ may interact with the fixated individual and seek authority to share information. However, it is likely that in most circumstances the basis for sharing personal information between parties is that:

- The disclosure of the personal information is one of the purposes in connection with which the personal information was obtained or is directly related to the purpose in connection with which the personal information was obtained (Principle 11 (a) Privacy Act 1993 and HIPC Rule 11 (c)). The personal information was obtained and will be shared to further the statutory roles and purposes of each of the FTACNZ Agencies; OR
- That personal information sharing is necessary to avoid prejudice to the maintenance of the law by a public sector agency in (Principle 11(e) Privacy Act 1993 and HIPC Rule 11 (2)(i)(l)) […]; OR
- That the disclosure of the personal information is necessary to reduce or lessen a serious threat to public health or public safety or the life or health of the fixated person or other individuals (Principle 11 (f) Privacy Act 1993 and HIPC Rule 11 (2)(d)).
- In addition, section 22C of the Health Act 1956 authorises disclosure of health information by health service providers to various persons including probation officers, social workers, and constables for the purpose of performing their powers, duties and functions.

APPENDIX D: FTAC DATA COLLECTION

Data has been collated and examined and stored for all cases referred to FTAC during the period 1 July 2019 to 30 June 2020. Qualitative characteristics recorded include:

- Number of referrals
  - Accepted, declined, alternative action completed (DRAAC) and referred on to another FTAC
- Personal identification variables
- Referral demographics
  - Date of birth, gender, ethnicity, location (town and police district)
- Referral agency, date of referral and closure
- Fixation type
  - Fixation, grievance, lone actor grievance fuelled violence, querulous and possible mental illness
- Fixation target
  - Government organisation, royals, judiciary, politicians, police, community, workplace, school, other
- Type of contact
  - Social media, email, handwritten or typed letter, telephone, SMS, approach, physical assault
- Presenting problems
  - Self-harm, conspiracy theorist, threat, delusions, violence to family/friends/acquaintances, violence to general public, suicide, sexual nature, drug use, use of weapons, arson, property damage and harassment/stalking
- Criminal conviction history and alerts
- Mental health history and diagnosis
- Initial levels of concern and reassessed concern level.
- Interventions taken by FTAC
- Outcome of FTAC interaction
  - Reduction in concerning behaviour
  - Increase in concerning behaviour
  - No change in concerning behaviour

APPENDIX E: CONCERN LEVEL DEFINITIONS

Low concern

No problematic approach behaviours and no stated intention to engage in any. None of checklist criteria satisfied, or initial investigation has found them to be non-significant. Subject's interest contains no form of threat or desperation, and/or is generally at a nuisance level. Initial presentation indicates a low potential for adverse consequences:

- The items listed in the RAM have not presented.
- Referred persons have not previously engaged in inappropriate approach.
- The referred person's interest contains no form of threats or desperation and is generally at a mild nuisance level.

Moderate concern

Initial presentation indicates a moderate potential for adverse consequences (disruption, distress, persistence, escalation or violence):

- One or more of the factors listed within the RAM are present.
- The referred person has exhibited an unusual interest and displayed this in a manner that suggests problematic behaviours will continue or escalate.
- The referred person has stated an intention
- The referred person has made direct or indirect threats towards the POH.

High concern

Initial information and/or investigations reveal behaviours which indicate a high likelihood of adverse consequences (disruption, distress, persistence, escalation and/or violence) which require prioritised intervention. Risk factors indicate a capacity or intent to cause such consequences. High-profile intrusions fall into this category, even in temporary custody.

- Any case where a 'red flag' indicator is clearly present,
- Cases where risk factors indicate a clear capacity and/or intent to cause adverse consequences,
- Includes cases where intrusive harassment has occurred, or is highly likely to occur,
- Cases where a clear propensity for violence is evident.

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Harassment, stalking, threats and attacks targeting New Zealand politicians: A mental health issue

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Abstract

Objective: Due to the nature of their work, politicians are at greater risk of stalking, harassment and attack than the general population. The small, but significantly elevated risk of violence to politicians is predominantly due not to organised terrorism or politically motivated extremists but to fixated individuals with untreated serious mental disorders, usually psychosis. Our objective was to ascertain the frequency, nature and effects of unwanted harassment of politicians in New Zealand and the possible role of mental illness in this harassment.

Methods: New Zealand Members of Parliament were surveyed, with an 84% response rate ($n=102$). Quantitative and qualitative data were collected on Parliamentarians' experiences of harassment and stalking.

Results: Eighty-seven percent of politicians reported unwanted harassment ranging from disturbing communications to physical violence, with most experiencing harassment in multiple modalities and on multiple occasions. Cyberstalking and other forms of online harassment were common, and politicians felt they (and their families) had become more exposed as a result of the Internet. Half of MPs had been personally approached by their harassers, 48% had been directly threatened and 15% had been attacked. Some of these incidents were serious, involving weapons such as guns, Molotov cocktails and blunt instruments. One in three politicians had been targeted at their homes. Respondents believed the majority of those responsible for the harassment exhibited signs of mental illness.

Conclusion: The harassment of politicians in New Zealand is common and concerning. Many of those responsible were thought to be mentally ill by their victims. This harassment has significant psychosocial costs for both the victim and the perpetrator and represents an opportunity for mental health intervention.

Keywords
Mental illness, fixated threat assessment, stalking, public figures, cyber harassment

Introduction

On 15 December 2014, Man Horan Monis held 18 people at gunpoint inside the Lindt café in Sydney, a siege that tragically culminated in the deaths of two captives and Monis himself. Initially thought to be part of a terrorist group, it transpired Monis was acting independently – a so-called lone wolf with '*serious mental health problems*' and a long history of harassing public figures (BBC, 2014). Although unclear whether he had attracted the attention of local mental health services, a specialist psychiatric/law enforcement collaboration in the United Kingdom had identified Monis as high risk on three occasions based on his disturbing and threatening correspondence with British public figures (Fixated Threat Assessment Centre [FTAC], 19 December 2014, personal communication). This UK service of course

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had no jurisdiction over Australian citizens and could only refer the case to the Australian Federal Police.

Earlier in 2014, Russell John Tully stormed a New Zealand Work and Income Building, shooting three employees, with only one survivor. He too had apparently signalled his growing disaffection in correspondence with politicians prior to the attack.

Politicians, or their associates, frequently become targets for fixated individuals. We recall the assassination attempt on American Democrat, Gabrielle Gifford, in 2011 by a fixated man with paranoid schizophrenia. A horrifying assault on young Norwegian Labour party supporters also occurred in 2011, resulting in 77 fatalities, mainly adolescents – the perpetrator Anders Breivik, whose psychiatric diagnosis remains controversial.

Most fixated individuals who engage in violence exhibit warning behaviour prior to the attack (James et al., 2013). As in the case of Monis and Tully, this may include disturbed communication to, or contact with, politicians or other public figures. This paper focuses on harassment of Members of Parliament (MPs) in New Zealand and the possible role of psychiatric illness.

Politicians are at greater risk of being hurt by fixated individuals than by terrorists

Due to their public profiles and the nature of their work, politicians are more vulnerable to being stalked and threatened than the general population (Dietz et al., 1991; Mohandie et al., 2006). Compared with other public figures (such as celebrities), politicians also have an elevated risk of being physically attacked by their harassers (James et al., 2013). While media coverage might suggest otherwise, the small, but significantly elevated risk of violence to politicians is predominantly due not to organised terrorism or politically or criminally motivated extremists but to fixated individuals with serious untreated mental disorders (Meloy et al., 2004; Mullen et al., 2009a; James et al., 2011; Scalora et al., 2003). Corner and Gill (2015) suggest that distinguishing between mentally ill attackers and lone-actor terrorists (such as Monis) may be '*a false dichotomy*'. Studying 119 lone wolfs, they found 32% had been diagnosed with a mental illness. Conversely, organised terrorist groups had a relatively low prevalence of mental illness, with only 3.4% of those studied having psychiatric diagnoses.

Harassers of politicians have high rates of mental illness

First, it must be recognised that the vast majority of people with mental illness do *not* harass or stalk public figures (or indeed, anyone) and, of the small fraction who do, only a minority behave violently. However, despite the small numbers, untreated mentally disordered fixated individuals can cause significant societal harm.

Research into the harassment of politicians and other public figures in Northern America and Western Europe consistently demonstrates a high incidence of severe mental illness in the perpetrators (Hoffmann et al., 2011; James et al., 2007; Meloy et al., 2004; Mullen et al., 2009a; Scalora et al., 2003; Schoeneman et al., 2011; Van der Meer et al., 2012).

Hoffmann et al. (2011) found the majority of individuals who fatally attacked German public figures were psychotic. Similarly, more than three quarters of those making inappropriate contact with the British and Dutch royal families had psychotic illnesses (James et al., 2009; Van der Meer et al., 2012).

A review of public figure stalking literature compared stalkers who physically confront their victims (approachers) with those who remain at a distance (Meloy et al., 2011). Approachers invested considerable energy into their activities, with multiple modalities of communication, multiple contacts and multiple targets being more common than for non-approachers. Approachers were also more likely to incorporate pleas for help into their communication. Mental illness, common in all the public figure stalker samples, was more prevalent among approachers than non-approachers.

FTAC in the United Kingdom is a joint police/mental health agency tasked with assessing and managing the risk to public figures from fixated individuals. A founding tenet was that psychiatry is central to this task (James et al., 2013). Indeed, 86 of the first 100 '*moderate-to-high risk*' cases referred to FTAC were suffering from psychotic illnesses. As a result of FTAC intervention, 57% of those at-risk individuals were admitted to hospital and a further 26% were accepted for treatment by community mental health teams. The concern level was reduced to low for 80% of patients as a result of FTAC management (James et al., 2010).

People who harass politicians may also pose risks to the community

Those with untreated mental illness who harass public figures may in fact pose a greater risk of violence towards community members than to the politician they are harassing (Dietz and Martell, 1989), with family, friends or even strangers becoming victims. For example, Monis' victims were unknown to him, and in the attempted assassination on Congresswoman Giffords (discussed earlier), she survived, albeit with critical injuries, but six bystanders were killed, including a 9-year-old girl.

While the risk of injury or death is the prevailing concern, the fixated also pose other risks. They are often persistent and disruptive, may cause public embarrassment for their target and consume the resources of protection services, particularly when '*copy cat*' behaviours are triggered. Their victims are often left fearful and distressed.

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The fixated themselves may experience significant disadvantage, becoming alienated and disenfranchised due to their singular focus and untreated mental health needs.

Harassment of politicians is common

New Zealand Parliamentary Services monitor an array of threatening behaviour, with approximately 600 people identified as potential security risks at any one time, of which 75% (n=450) have established or suspected mental illness (personal correspondence John Hood, Parliamentary Security Manager). During the data collection phase of this research, an agitated man equipped with a firearm arrived on the Parliamentary precinct, resulting in Parliamentary lockdown. Other recent incidents include the following: multiple '*white powder*' scares and bomb threats, a mentally ill male with a petrol canister intended as an incendiary device outside Parliament and an attempt by a disturbed 54-year-old to launch himself from a public viewing balcony onto MPs in the debating chamber below. In 1999, the secretary of a MP was held hostage at gunpoint by a disgruntled mental health patient, but escaped unharmed.

Anecdotal accounts aside, there is no published New Zealand data regarding the prevalence and gravity of threatening behaviour towards politicians and other high-profile individuals. However, research from other Western countries shows threats and harassment of public figures is common.

Surveys of MPs' experiences of threatening behaviour have been conducted in Canada, Britain, Australia, Sweden and the Netherlands (Adams et al., 2009; Hoffmann et al., 2013; James et al., 2013; Malsch et al., 2002; Pathé et al., 2014).

Harassing or stalking behaviours were experienced by 30–93% of politicians across samples. Harassment had a negative impact on almost all (94%) of the victimised politicians (Adams et al., 2009). The prevalence of mental illness in the perpetrators was high, with the lowest estimate at 40% (James et al., 2013) and the highest at 87% (Adams et al., 2009).

The objectives of this study

Given the lack of local data, the purpose of this study was to establish (1) the nature, frequency and severity of harassment of New Zealand MPs; (2) what impact this harassment had upon individual MPs; and (3) the likely contribution of mental illness.

We also wished to establish whether this area represented an opportunity for mental health intervention in New Zealand. International research has suggested this cohort of fixated individuals presents an important opportunity for cost-effective psychiatric intervention and harm reduction. Directing such individuals into treatment may improve health outcomes and social functioning alongside reducing the risk to public figures and third parties (e.g. James et al., 2010).

Method

An anonymous survey was distributed to the Wellington offices of all 121 New Zealand MPs with a covering letter inviting their participation. To preserve anonymity, we did not collect signed consent forms and no identifying information was collected. Consent was inferred by the return of the completed questionnaire.

The Parliamentary security manager distributed and answered questions about the survey. Participants were encouraged to complete the survey, regardless of whether they had experienced harassing behaviours.

The survey was intentionally similar to other surveys successfully conducted in the United Kingdom (David James, FTAC, 8 September 2013, personal communication) and in Australia (Pathé et al., 2014) to allow comparative analysis. It comprised 42 separate questions with categorical options available as answers (e.g. As an MP, has any person, male or female, ever physically attacked or tried to attack you? Options: YES or NO). If the response was affirmative, the respondent was directed to further questions to elucidate the nature, frequency, location and duration of their experience. The frequency of all types of harassment was recorded using the following four categories: 1, 2, 3–9, >10. Most sections allowed additional free text replies, so respondents could qualify their answers and provide any further information as they saw fit.

Data were collected between 28 April and 27 June 2014. Responses were assigned a random numerical code between 1 and 102. Quantitative data were entered and analysed using an SPSS statistical package. To minimise bias, missing responses were imputed as indicating the absence of the event in question. Qualitative data were extracted and analysed for recurrent themes.

The study was supported by Parliamentary Services, the New Zealand Police, the Party Whips and the Speaker of the House. Ethics approval was granted by the Otago Human Ethics Committee Research Ethics (Health).

Results

Completed questionnaires were received from 102 of 121 MPs (84%). The most common reason cited for not participating was lack of time. Qualitative data were provided by approximately half of respondents.

The frequency and nature of harassment

Harassment was reported by 87% of respondents, ranging from disturbing communication to actual physical violence. The vast majority of MPs described multiple modalities of harassment occurring on multiple occasions. Letters, faxes or emails were the most common form (68%), followed by alarming behaviour at the electorate office (62%) and inappropriate social media contact (60%). The type and frequency of the different forms of harassment are shown in Table 1.

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Table 1. The type and frequency of harassing behaviours experienced by MPs during their time in office.

	No. who answered	% Experiencing	Number of times experienced				
			0	1	2	3–9	10 or more
Inappropriate letters, faxes or emails	101	68%	32	3	8	19	34
Inappropriate social media contact	101	60%	40	5	7	15	34
Inappropriate telephone calls	101	45%	56	1	6	24	15
Alarming behaviour at electorate office	101	62%	41	9	13	32	6
Unwanted approaches	99	50%	48	9	14	16	12
Distribution of malicious material	100	48%	51	7	5	15	16
Threats to harm	102	48%	54	9	13	20	4
Loitering	102	28%	73	6	12	7	3
Following behaviour	102	22%	80	6	8	6	1
Property interference	102	31%	70	5	15	7	2
Spurious legal action	102	11%	91	1	5	4	1
Physical attack, actual or attempted	102	15%	87	6	3	6	0

MP: Member of Parliament.

The duration of harassment ranged from less than 1 hour to 16 years. Harassment commonly occurred at Parliament, the electorate office, online and at their homes, but MPs reported also being targeted at a wide variety of public places including the supermarket, street, airport, a rest home, a cattle fair and opening of a cycleway.

Almost half (48%) of all MPs had been threatened. Although we did not specifically ask about the subcategories of threats, death threats were spontaneously reported by 12% of MPs and threats of rape and other sexual violation by 4%. Examples of these threats are reported below:

Emails to kill, rape, injure. (Participant 25)

Death threats, threats of GBH, camera drone photography of house, rubbish bins rifled, verbal abuse (when with family). (Participant 45)

Sexual violation with an instrument. (Participant 80)

[I was] threatened by a constituent and pushed against the rails on a 2nd floor property … so could have been pushed over the rails. (Participant 60)

I was sent some 1080 [poison] in the mail. (Participant 40)

Some respondents, such as Participant 79, ran out of space listing the threats they had received:

Threatened to throw rock through window, threat of bomb in the office, threatened to blow up office building with a car full of petrol, threatened to blow me up, threatened to shoot everyone, threatened legal action etc etc. (Participant 79)

In all, 7% of MPs reported direct threats against their families, while at least one in six MPs reported harassment that involved their families:

Very unpleasant letters including one obscene one with photos of female genitalia. It referenced my younger daughter. (Participant 11)

Threats to kill me, threats to kill members of family. Made by text message. (Participant 51)

Smashed my back door, threw a bullet through my toilet window. Terrified my daughter and partner who were at my house when the back door glass smashed. (Participant 24)

Accusations at my wife, accusing her of being a 'gang whore' and also threats to my children and staff. (Participant 3)

Actual or attempted attacks were reported by 15% of MPs. MPs were shoved, punched, slapped and attacked with weapons. Weapons included a gun (which was not fired), Molotov cocktail, wooden sticks and placards. Injuries ranged from minor cuts and bruising to long-term musculoskeletal injuries. No injuries to MPs' staff or relatives were reported.

Property violations were relatively common, being reported by 31% of MPs. Several MPs reported attacks on their homes, with bricks being thrown through windows, a caravan being set on fire and windows being smashed.

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The role of mental illness

In all, 50% of MPs believed that those responsible for the most memorable harassment had a mental illness, 29% were unsure and 21% did not believe their harassers were mentally ill.

Some MPs were aware of their harasser's diagnoses, identifying schizophrenia or bipolar affective disorder as established conditions, whereas others described their harasser's mental state (e.g. delusional, psychotic, manic) or just noted, as below, the presence of mental illness:

> *[He had a] long term mental illness and associated behavioural issues ... a frequent flyer with Police, Council, NGOs and my office. (Participant 73)*

Several MPs emphasised that although their mentally ill harassers had challenging behaviour, in the parliamentarian's view, they did not pose a risk and had important needs. Providing recognition was sometimes helpful in moderating the behaviour:

> *[He had] serious mental health issues, fighting for justice and needing the Queen to intervene ... I was concerned to make sure he had access to me so that he was not totally excluded. He was difficult, but had a real need to be taken seriously. I think that's my job. (Participant 81)*

> *They often just want a listening ear. (Participant 76)*

> *Having mentally ill people visit my electorate office is a daily occurrence. (Participant 79)*

A recurrent theme was that supporting aggrieved mentally ill constituents was harder for front line staff:

> *... I feel confident that I can handle most difficult behaviours and those presenting with mental health issues. However staff don't necessarily have the same experience, confidence or interest in helping such people ... Managing this is tricky. (Participant 82)*

MPs were invited to speculate on the motivations of their harassers. Only 52% of them answered this question. One respondent described '*racism*' as the root cause of the harassment. Otherwise, the descriptions suggested harassers were fixated on a cause or perceived injustice for which they wanted recognition, recompense or revenge. No MPs reported the presence of romantic notions, such as erotomanic delusions, as a motivational driver.

Four parliamentarians volunteered that it was difficult to respond to constituents contacting their offices threatening suicide.

The impact of the harassment on politicians

The impact on those harassed included a degree of fearfulness (reported by 60%), a reduction in social outings (12%), concern going out in public (12%), concern being alone at home (11%), a change in routine (10%), a change in their personal relationships (9%) and lost time from work (5%).

MPs appeared resilient. No MP described mental health concerns arising from these experiences (e.g. post-traumatic stress disorder, anxiety and depression), but personal stress and discomfort were reported:

> *It has however made me more self-conscious when I am in social situations or just out and about ... I am also more protective of my daughter which interferes in her ability to be as independent as she has been used to. (Participant 9)*

> *Although most may not be of concern, when threats occur it is unsettling as we can not ignore it. Hypervigilance can also be a problem as it adds to the stress level and enjoyment of work reduces. (Participant 79)*

Half of MPs reported their families experienced some degree of fear and 80% reported fearfulness in their staff. The degree of discomfort was assessed as moderately fearful or very fearful for 20% of MPs, 15% of families and 60% of staff.

Most MPs who were harassed informed the Police (60%) and Parliamentary Security (60%), as well as colleagues, family or friends.

MPs often reported a lower degree of distress than might be expected, with some discordance between the severity of the harassing behaviour and the MP's emotional response. For example, Participant 59 listed, '*Caravan blown up with Molotov cocktail, assaulted in trying to get into car ... once had a gun pointed at me*', all objectively fairly alarming events, but the MP described having been '*only a little or somewhat fearful*'.

Others described the following reactions: '*I laughed*' (Participant 86); '*I was always larger than them*' (Participant 10); '*I have been threatened a few times, but believe this is mostly bluff*' (Participant 48); '*I don't find it too threatening*' (Participant 87).

Of MPs who had experienced harassment, 62% said they would welcome a source of specialist advice, were they to experience such behaviour again. Many emphasised that electorate office staff should have access to greater support:

> *I've always been more concerned for my staff who are often threatened. (Participant 10)*

> *Staff definitely need the specialised help as they cop the abuse. (Participant 32)*

The Internet

The pervasive effect of the Internet was a key theme, with social networking sites, blogs, twitter and emails being commonly used modalities for harassment. This included

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direct communication with the MP and the use of the Internet to inflict psychological or reputational damage by impersonating the MP, or posting offensive material relating to them. Online death and rape threats were reported, and online harassment often extended into the MPs' private lives, with family members becoming targets:

Threats [were] made via a website, telling people to visit my home and tell my children they should be hit. (Participant 34)

MPs felt that they and their family had become more exposed due to the Internet. Some described frustration that online anonymity and the current legislatory framework meant Internet stalking was hard to combat, opining that the law in New Zealand had not kept pace with evolving technology:

Harassment through social media pages is not illegal even when it is sexual comment about my 15-year-old daughter and photos of her or my partner taken without consent. (Participant 9)

Ongoing harassment via social media which is unable to be controlled due to anonymity ... The fact there is no comeback on them is extremely frustrating. (Participant 41)

Compared with face-to-face encounters, it was harder for politicians to identify their online harassers or determine whether mental illness was a factor. Overall, politicians seemed to view online harassment as more likely due to political disenchantment than mental illness, and less likely to culminate in violence:

There is a great deal of hostility directed at us online and I recognise this as different from a real threat, although it could escalate. (Participant 35)

Discussion

Limitations and strengths of the study

This study has obvious limitations. The methodology used was an anonymous survey, and we could not identify the victims or those causing the harassment. Actual communications were not analysed. In absence of specific clinical details, our estimation of a prevalence of mental disorder relied on MPs' assessments. Some had knowledge of perpetrators' psychiatric diagnoses, while others based their assessment on their observations and general knowledge of mental illness. This methodology is unlikely to have a high degree of sensitivity, and is hypothesis generating.

To preserve confidentiality, we did not collect demographic data from the participants and hence gathered no information on gender, ethnicity, political affiliation, seniority or length of time as an MP. We cannot identify whether there are any demographic factors that make some MPs more vulnerable to harassment. Three MPs spontaneously hypothesised that female MPs were more at risk; however, we cannot answer this interesting question.

The strengths of the study include the high response rate, with 102 from 121 parliamentarians (84%) providing detailed responses. This might reflect the support we had from Parliamentary Services and the politicians' interest in the subject. A parliamentary lockdown following the arrival of an armed man on Parliamentary grounds during the data collection phase may have raised awareness of personal risk among politicians. Nonetheless, in other similar studies, response rates have been below 50% (e.g. 48% (Pathé et al., 2014), 41% (Adams et al., 2009), 37% (James et al., 2013)), and as this study took place shortly before a general election, the degree of participation was remarkable. This means the findings are likely to be representative and results can be extrapolated.

There was also a wealth of qualitative data, which provided context and highlighted emerging themes, which may serve as targets for further research.

Themes

The qualitative data emphasised the disturbing nature of some of the harassment, including implicit and explicit threats to MPs and their families. Threatened sexual violence emerged as a theme. Previous surveys have reported a low rate of actual or attempted physical assault (Adams et al., 2009; Pathé et al., 2014), but the 15% rate in our survey is surprisingly high and is concerning. The social disruption and psychological harm caused by stalking behaviour such as that captured in this study, irrespective of a violent outcome, is now well recognised (Mullen et al., 2009b). Although MPs often appeared phlegmatic about the personal impact of the harassment, they did describe elevated rates of fearfulness, with higher rates reported in their staff. This, coupled with the reported 60% of electorate offices being subject to harassment, the effects on family and nearly one-third of MPs experiencing intrusions at home, emphasises the direct harm caused by this harassment.

Previous research (e.g. Adams et al., 2009; Dietz and Martell, 1989; Hoffmann et al., 2011; Pathé et al., 2014) and the experience of the British FTAC (James et al., 2013) accentuate the high prevalence of mental illness in those who harass or communicate inappropriately with MPs. In our survey, half of MPs identified their harasser as mentally ill based on the nature of the contact, while a further 26% thought mental illness was a possibility. Of interest, the qualitative data suggest a number of MPs saw it as their role to listen and to support these mentally disturbed constituents, even if they were not referred for treatment.

The limited information gathered about the harassers' apparent motivations suggested they were fixated on a cause or grievance. Persecutory ideation or delusions

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seemed prominent, but erotomanic beliefs, common in celebrity stalker samples (Meloy et al., 2008), were not reported. This is consistent with previous findings (Adams et al., 2009; James et al., 2007; Pathé et al., 2014) and conforms with the typology of the fixated individual described by Mullen et al. (2009a).

The use of the Internet as a platform for harassment was reported more frequently than in other comparative studies and was a major concern for MPs. Inappropriate social media contact had a prevalence of 60% in this study compared with 9% in the UK study (David James, personal communication) and 17% in the Queensland study (Pathé et al., 2014). As these other studies collected data several years ago, this probably reflects increased uptake of social media over the intervening time, rather than any fundamental difference between New Zealand, Australia and the United Kingdom.

There is scant literature on cyber harassment of public figures, with technology evolving faster than the research base. It is not clear whether online harassers differ from offline harassers, particularly with respect to the prevalence of mental illness.

The online environment with its apparent anonymity, instant and effortless access and perceived lack of consequences may result in a phenomenon called the '*online disinhibition effect*' (Suler, 2004). It has been hypothesised that this effect may encourage some individuals to engage in online harassment, who would not do so otherwise (Ménard and Pincus, 2012).

There is some evidence that harassers communicating electronically are less likely to approach their victims unless electronic communication co-occurs with other forms of communication (Schoeneman et al., 2011; Schoeneman-Morris et al., 2007). However, Cavezza and McEwan (2014) found relatively few differences in the behaviours of online and offline stalkers. The majority of cyberstalkers also engaged in offline stalking behaviours, including other communication methods (e.g. telephone calls, letters) and approach behaviours (e.g. confronting, following). Overall, cyberstalkers employed a wider range of different communication and approach methods than offline stalkers. This suggests that the Internet may simply be an additional platform for the aggrieved, disgruntled and fixated.

While MPs seemed less concerned by cyber harassment, approach behaviours generated more distress. Previous research has shown that public figure harassers who approach their victims are more likely to be mentally ill than harassers who remain at a distance (Meloy et al., 2011), and as these individuals are usually identifiable, they represent an opportunity for intervention. There is currently no service in New Zealand tasked with identifying the warning signs of fixated individuals and, where indicated, facilitating interventions by mental health agencies and/or the police.

We consider there is a place for such an initiative in New Zealand. This is supported by the findings of this study, alongside information from Parliamentary Services that, of those identified as '*people of concern*', 75% have established or suspected mental illness. Evidence from the United Kingdom and Queensland, Australia has shown dual Police/Mental Health threat assessment services successfully identify high-risk people with serious mental illness who have either fallen out of, or never received treatment. Diverting this group into treatment performs an important public health function, simultaneously improving their health outcomes and reducing the risk to MPs, their families, staff and the general public. It also reduces unnecessary allocation of resources to poorly understood threats.

Conclusion

This survey of New Zealand MPs, with a response rate of 84%, found a high level of harassment, similar to previous surveys. The harassment usually occurred in multiple modalities, and impacted not only on the MPs but also their families and staff. Key themes were that harassment was frequent, multi-modal and often highly intrusive and disturbing in nature. Half of MPs had been threatened and about one-third had experienced harassing behaviour at their private residence, with similar numbers reporting property violations. One in seven had been attacked. Similar to other studies, the victims considered the majority of those responsible for the harassment exhibited signs of mental illness and were in need of psychiatric assessment.

The results provide support for the creation of a specialised threat assessment service. This would hopefully benefit Parliamentarians, their families, staff and the public, and facilitate access to psychiatric treatment for the mentally disordered fixated individual.

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REVIEW ARTICLE

Fixated Threat Assessment Centers: preventing harm and facilitating care in public figure threat cases and those thought to be at risk of lone-actor grievance-fueled violence

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The rediscovery of the importance of mental illness in the risk assessment and management of those who threaten, approach, and harm public figures has led to a new way of dealing with those that threaten public figures. This approach emphasises the role of "fixation" which may be defined as an intense preoccupation pursued to an abnormally intense degree. It integrates a threat assessment paradigm with the literature on stalking. The need for such an approach was highlighted in research on the prevalence of harassment of public figures. Psychiatry has a key role in this approach which sees mental health clinicians and Police work together in Fixated Threat Assessment Centres (FTACs). An FTAC functions by assessing the level of concern and sharing information to facilitate interventions that are often mental health based. The purpose is not the hopeless task of identifying those who will go on to perpetrate serious violence, rather to intervene in the group they emerge from, to prevent harm. As well as decreasing risk to the persons fixated upon, this approach improves care to the mentally disordered people who harass and threaten them and, in doing so, decreases the likelihood of their criminalization while enhancing their quality of life. As expertise in the area has grown, policing and security agencies in several countries have expanded the FTAC model to cover individuals thought at risk of lone-actor grievance-fueled violence, a term that captures both different forms of mass killing and lone actor terrorism.

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Introduction

Developments in threat assessment, particularly in the area of concerning communications and approaches to public figures, have led to the setting-up in a number of countries of a new style of service for assessing and managing risk to the prominent from the actions of lone individuals. Known as Fixated Threat Assessment Centers (FTACs), their central characteristic is that they are jointly staffed by police officers and by psychiatric staff from health services. They are based on the realization that the interests of the prominent in terms of protection overlap with those of the people harassing them in terms of medical care. Research over the last decade has re-established that the majority of those threatening, harassing or attacking public figures have unmet mental health needs, and that attention to these is often the most effective way of reducing risk, while at the same time improving their lot and focusing on treatment, rather than criminalization. The approach has recently been expanded to encompass assessment and intervention in individuals suspected of being radicalized into extreme ideologies and at risk of proceeding to commit terrorist acts.

The presence of psychiatry in FTACs allows the understanding of motive and mental state which is essential to accurate risk assessment. It also allows health-based interventions to lower or manage risk. The psychiatric involvement here has little to do with the application in courts of the Victorian psychiatric defense of insanity, a legal rather than a medical concept. Nor is it to do with issues of responsibility for an individual's actions which are prominent in some jurisdictions and completely absent in others. Rather, it deals with the reality that mental illness affects people's judgment and behavior, not simply through prominent symptomatology, but through the disinhibition associated with illness, the loss of judgment which comes with social isolation and the absence of a restraining peer group, and the disconnection with social

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values that often accompanies social decline. Effective interventions will involve compulsory psychiatric treatment in some cases, but in others, simple interventions such as connecting the individual with treating services. Networking with statutory agencies such as social work or housing may be highly effective, as may family contact. It is important to note at the outset that the focus of these interventions is prevention of harm. The exercise is not solely concerned with violence, but also with other forms of risk. Concerning communications and approaches may give rise to psychological distress, to fear as to what might happen next, to public embarrassment, to disruption of the ability to perform a public role, and to the use of expensive police resources, some of which prove unnecessary when comprehensive risk assessment is applied.

A key concept in this field is that of fixation. Fixation has been described by Mullen et al as "an intense preoccupation with an individual, activity, or idea," "an obsessive preoccupation ... pursued to an abnormally intense degree."[1] In the public figure context, fixation may be the result of grievances, real or otherwise, of idiosyncratic quests for "justice," of perceived rejection, bizarre amorous attachments or misguided quests for help. Fixation may arise out of mental illness, although this is not always the case. People who engage in stalking behavior and those who become vexatious litigants or querulants commonly are fixated. A striking feature of pathological fixation is the level of psychosocial harm done to the fixated individual as well as the potential for harm both to those closest to the individual and to those who are the object of their fixation. The work of FTACs and similar units in consequence limits harm, not only to prominent people, but to the families and communities from which the fixated individuals come.

The development of FTACs

In 2003, the British government funded a research project designed to increase the efficiency and effectiveness of the royal and parliamentary protection services.[2] The aim was to improve their ability to evaluate and manage the threat presented by stalkers, threateners, and those who attempted to force their way into the presence of royalty or members of parliament, whether it be with ill or benign intent. For efficiency, read decrease the escalating costs, both of monitoring increasing numbers of potentially problematic people and of providing close protection to an ever-wider circle of royalty and parliamentarians. For effectiveness, read improve methods of recognizing and managing those at high risk of acting to disrupt, or even endanger, the lives of protectees. To give some idea of the magnitude of the problem, the Queen alone, at that time, was the target of the activities of over 2000 active, problematic individuals.

The commissioning of the research reflected the realization that, in terms of threat toward public figures, although the motivation and modus operandi of terrorist and criminal groups were understood and well-established systems were in place to assess and manage them, there was little understanding of risks posed by disturbed members of the general public who exhibited a pattern of harassment and stalking towards public figures and made repeated attempts to communicate with them or enter their presence. Such individuals did not fit into standard policing methods for assessing and managing threat. While it was recognized that terrorist organizations tended to engage in random attacks on mass population targets rather than prominent individuals, isolated loners remained an unknown quantity.

At the outset of the research phase, those of us involved in what was termed the Fixated Research Group believed we would face the classic problem of identifying and prioritizing multiple factors correlated with moving from stalking and threatening to acting in a manner which placed the principals at risk. In the end, we hoped to generate some kind of predictive algorithm. The researchers were given extraordinary access to the records of the police, protection services, and mental health services. In addition, vast quantities of material generated by the stalkers and threateners were made available. Our initial assumptions about multiple factors and the need for complex algorithms proved mistaken.

As the data accumulated, it became increasingly clear that one factor above all determined both the continuing persistence and intensity of the problem behaviors themselves and the probability of progression to actions which were even more disruptive and on occasion violent. That factor was the presence of untreated mental illness. Most of the persistent stalkers and threateners had serious mental disorders, and virtually all of those attempting to break through the barriers protecting the principals, or making attempted or actual attacks, were psychotic at the time.[3] Severe mental illness was the key both to understanding an individual's motivation and to assessing different forms of risk—the probability of persistence, intensity, and progression to violence. Of course, this is not the same as saying that one has to be mad to target a public figure or that psychotic illness, which is relatively common, could be used as a marker for potential attack. Rather, it affords an avenue for better understanding and assessment of public figure threat cases, as well as opening possibilities for prevention. The treatment of mental illness was revealed as the management method most likely to reduce risk. A predominately criminal justice and security problem became a predominately mental health problem.

The findings of the Fixated Research Group, published in a series of thirteen papers in peer-reviewed journals, led to the establishment of the FTAC in the United Kingdom in 2006—a model subsequently adopted elsewhere. The unit located within the Specialist Operations section of the Metropolitan Police, based in London but

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with a national remit. Its key feature is that it is staffed both by medical personnel from the National Health Service and by police officers, being jointly funded by the Office of Security and Counter-terrorism at the Home Office and by the Department of Health.

The aims of the approach are two-fold: to improve the outcomes for the individuals referred and at the same time to reduce the risk they may pose to the individual they are focused on, or indeed others close to them. The service does not attempt the futile task of attempting to predict who might go on to act in dangerous ways. Rather, it has adopted a population model. It is possible, through looking at the associations of progressing to commit destructive behaviors, to tell which individuals lie in the minority of cases from which problems are likely to come. By intervening in all such cases, it is possible to prevent individuals going on to engage in dangerous actions without knowing which particular individuals would, without intervention, have gone on to do so. An analogy is attention to risk factors in cardiac disease: by identifying those with high cholesterol, obesity, smoking, and so on, it is possible to intervene in a population to reduce the risk of adverse outcomes without knowing exactly which cases, without intervention, would have gone on to suffer them.

A pilot scheme established for 18 months demonstrated the effectiveness of the approach,[4] and led to the unit becoming permanent. The presence of psychiatrists allowed the diagnosis of mental illness and an analysis of its influence on motivation, risk, and potential management options. U.K. FTAC considered referrals of those who made inappropriate approaches or communications to the royal family, senior politicians, and "iconic sites." These referrals led to a process of information gathering by police and mental health professionals and an assessment of the problems each individual might produce. A level of concern was used in describing these,[5] not a level of risk, given that concern levels involve decisions made on limited information in real-time operational situations, as opposed to risk assessment which involves considering large amounts of information at relative leisure. Ways of mitigating or removing concerns were then considered, and a management plan established.[6] This generally involved catalyzing action from statutory services around the country, including police, health services, social services, and even housing. Where mental illness was evident, there was usually liaison with the psychiatric services responsible for the individual's domicile. The role of FTAC was not direct involvement in treatment: rather the emphasis was on the appropriate sharing of information and the communication of this information in a targeted way to relevant agencies in the part of the country in which the individual lived, with the aim of initiating interventions from other services locally, sometimes on a multi-agency basis. In many cases, FTAC arranges a networked community response, which will involve both the monitoring of cases and practical interventions, with the provision of a support worker. Such practical interventions can be remarkably effective. This reflects the fact that the importance of mental illness to assessing and managing risk concerns not only psychotic symptomatology, but also difficulties in the correct interpretation of events, poor judgment, disinhibition, and social isolation which removes the moderating influence of personal relationships and peer groups.

The range of possible interventions also means that the model can be used in jurisdictions with very different health care arrangements and mental health laws. The United Kingdom has advantages in terms of ease of compulsory hospitalization, given the low legal threshold and the existence of the National Health Service. The United Kingdom also differs in that responsibility in the mentally ill is only relevant in homicide cases, and hospitalization is routinely used as a final disposal in sentencing at court, with the criteria being the person's health, rather than meeting any insanity criteria. Yet, the model has proved equally useful in countries with quite different systems and in jurisdictions such as Australian states which have a system not dissimilar to the competency/insanity limitations in the United States.

The efficacy of U.K. FTAC's operations was demonstrated in part by the proportion of referrals in which mental illness was identified. In a study of 100 individuals assessed as being of high or moderate concern by FTAC, 86% were found to be suffering from psychotic illness. Compulsory admission was the outcome in 53% of cases and voluntary admission in 4%, while 26.5% were taken on for management by community mental health teams or assertive outreach services.[4] With intervention, 80% of cases had been managed down to a low level of concern by the end of the study period. A more sophisticated assessment of FTAC outcomes used a mirrored design in which individuals were in effect their own controls.[7] The study looked at 1- and 2-year periods before and after FTAC intervention. It identified highly significant reductions both in the number of individuals engaging in communications and problematic approaches and also in the total numbers of incidents of concern.[7] It also saw a reduction in police call-outs, raising the possibility that the exercise might prove cost-neutral.

Re-inventing the wheel

The establishment of the U.K. FTAC, and the research upon which it was based, can be considered something of a watershed moment in that it brought a focus on mental illness back into threat assessment practice, and it illustrated the overlap between public figure threat assessment and the field of stalking, so enabling insights in terms of motivation, classification and formalized

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means of assessing threat to be brought across from stalking research.[8] Threat assessment and management as a construct and a paradigm had seen a resurgence in interest from the 1980s onwards after a century of neglect.[9] This included the development of a threat assessment service in 1986 for Congress in the United States[10] (which over time increasingly came to resemble the approach taken in the U.K. FTAC) and the establishment of the Los Angeles Police Department (LAPD) threat management unit in 1990 following the killing of Rebecca Schaeffer by an obsessive fan Robert Bardo in 1990[11,12] and the subsequent introduction of anti-stalking legislation in California. However, research in the United States into harassment, threats, and violence toward public figures had either failed to report findings about mental illness or had failed to interpret them. Dietz and Martell considered threatening and otherwise inappropriate communications to Congress in a lengthy report to the Department of Justice in 1989,[13,14] but did not include their mental illness findings in their subsequent published account.[11] The Exceptional Case Study Project in 1997 conducted for the United States Secret Service further expanded the knowledge base in the United States in this area,[15] but there was a delay in recognizing the significance of mental illness in this population.[16] Its authors looked at 83 cases, of which 45% were assassinations and 54% "near lethal approaches." They found that 61% of the individuals concerned had a history of psychiatric problems, 43% of delusional ideas and 10% of violent command hallucinations. Nevertheless, the conclusion of the authors was that mental illness was not of particular importance. This is despite the fact that, if one takes the figure for delusional ideas as representing the prevalence of psychosis in the sample and compares it with the point prevalence of psychosis in the general population of around 0.4%,[17] the study cases were 110 times more likely to have a psychotic disorder. Suggestions as to why the mental illness factor was played down are various[18]: It may be that mental illness was thought to be a politically unacceptable form of exculpation, that there was confusion between the (medically meaningless) concept of legal insanity and the presence of psychotic illness, or simply that the constellation of psychiatric services in the United States was not such that psychiatric care seemed a relevant management option. As regards the legal test of insanity in many Anglo-Saxon jurisdictions, it is relevant to note that its roots lie in criteria set out by the United Kingdom's Law Lords in 1843, in the wake of the case of Daniel McNaughton, their specific aim being to de-medicalize and recriminalize attacks on public figures by psychotic individuals.[4,18]

Dietz and Martell,[19] in reconsidering their 1989 findings 21 years later, contended that their omission of their mental illness findings in their published paper was for national security reasons. They then put forward the contention that: "Every instance of an attack on a public figure in the United States for which adequate information has been made publicly available has been the work of a mentally disorder person who issued one or more preattack signals in the form of inappropriate letters, visits or statements." (p. 344). This is along the lines of the conclusions of the Fixated Research Group's study of attacks on European politicians,[20] which found that death and serious injury were significantly associated with psychosis, the presence of delusions, loner status, and the absence of a political motive. Similar results were obtained in a subsequent and partially-overlapping study of violence toward German politicians[21] and also in the Fixated Research Group's study of historical attacks upon the British royal family.[22] However, such conclusions are not new, and it appears characteristic of research in this field that insufficient attention is paid to publications from previous centuries or to those not in the English language. None of the recent U.S. researchers had gone back to the groundbreaking work of Laschi[23]or the 1890 "exceptional case series" by Régis,[24] which had described and classified public figure attacks and identified the central role of mental illness.[18] The problem of fixated individuals, it is evident, is common across recent centuries and across different countries within the western world.

Establishment of FTACs in other countries

Interest in the FTAC model led to the formation of the European Network of Public Figure Threat Assessment Agencies, which brought together police and security services from countries within the European Union, as well as further afield, and which functioned as a forum for discussing new developments. An FTAC was then set up in the Netherlands where a study of inappropriate communications and approaches to the Dutch royal family found that 75% were psychotic and a further 11% suffering from mood disorders.[25] Surveys were also conducted of the extent of the problem of harassment and stalking for politicians. In Sweden, a study of members of parliament from the years 1998 to 2005 found that 74% had been subject to harassment, threats, or violence and 68% of perpetrators were thought probably to be mentally ill.[26] A survey of regional politicians in Canada found that 30% had suffered harassment with 87% believing their harassers to be mentally ill.[27]

Next, a survey in the United Kingdom of members the Westminster Parliament found that 81% of respondents were subject to at least one of the intrusive/aggressive behaviors studied.[28] This survey was repeated for the Queensland (Australia) state Parliament in 2011.[29] A similarly high rate (93%) of harassment was identified. The survey was also conducted in Norway[30,31] and New Zealand.[32] The New Zealand survey benefited from

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an unusually high response rate (84%) and consistent with the other surveys found that one form of harassment or another was the norm (87% of respondents reporting such behavior) with a distinct increase in the contribution from electronic media compared with the United Kingdom (60% reported inappropriate social media contact), likely due to the later date at which the survey was conducted. The effects of such behavior are not trivial, as have been illustrated by James et al[33] with significant proportions of Members of Parliament (MPs) suffering psychological ill effects.

These surveys and the experience of established FTACs also highlighted that it is not the MPs alone who bear the brunt of this behavior, but also their staff, including those in often isolated and vulnerable constituency-based offices.

The Queensland survey led to the establishment of an FTAC in Queensland in 2013 operating under a similar model to the United Kingdom—one with an emphasis on joint work between police and mental health, and a high rate of mental health interventions in those referred.[34] Similarly, in New Zealand, a small pilot service was established in September 2017 with a permanent service following in July 2019. In both these services, referrals are drawn from those who communicate to or intrude upon members of parliament, with a finding of high rate of mental illness among the communicators and threateners, again providing an opportunity for intervention and treatment in these individuals.

Within Australia, interest in this approach was accelerated by several high-profile incidents. The inquest into the Lindt café siege in New South Wales recommended the establishment of a fixated threat service in that state.[35] The individual at the center of this siege had made abnormal communications to the Queen on several occasions, and the U.K. FTAC had notified Australian Federal Police of their concerns. In Victoria, the tragic events of January 2017 on Bourke street in Melbourne where a car was used to attack pedestrians, resulting in the death of 6 and over 30 wounded, provided further impetus for the establishment of a service in that state. In Australia, FTACs have now been established in New South Wales (2017), Victoria (2018), and Western Australia (2018). In 2016, the Australian Federal Police (AFP) established an FTAC in the Australian capital, Canberra.[36] FTAC capabilities are also evolving in smaller jurisdictions (South Australia, the Australian Capital Territory, Tasmania, and the Northern Territory).

An important finding from the new FTACs is that the cases that they deal with are virtually indistinguishable, regardless of country. This is presumably a reflection of the fact that mental disorders occur with similar frequency across different populations. A consistent finding has been the significant proportion of cases with delusional disorder, a form of psychosis which rarely presents to general mental health services, given that the personality is preserved and it does not lead to disturbance of day-to-day functions in the manner typical of the schizophrenias. Given the association of delusional disorder with querulousness and persistent litigation as well as paranoid and grandiose presentations, this finding is perhaps not surprising. The other group which appears to be consistently over-represented in FTAC samples is autistic spectrum disorder.

Lone actors and grievance-fuelled violence

The FTAC approach has obvious parallels with psychiatric diversion schemes at courts and police stations and, like those services, the aim is the prevention of further problem behavior, rather than its criminalization. Court diversion schemes are not new, with services having been set up in Chicago in 1914[37] and Baltimore in 1917,[38] the workings of which are remarkably similar to more recent initiatives developed in the United Kindom in the 1980s and 1990s.[39] Whereas this is a further lesson on the folly of failing to research the lessons of the past, it emphasizes the enduring power of the model adopted by FTAC, which has recently been expanded from the field of public figures threat to that of lone-actor and grievance-fueled violence, to which this chapter will now turn.

Régis, in his 1890 monograph, divided attackers of the prominent into three types which, restated in the modern idiom, are as follows: first, psychotic cases where the involvement of a prominent person is almost incidental: second, querulants, often suffering from a delusional disorder, pursuing a highly personal and idiosyncratic quest for justice; and a third group which shared a variety of characteristics—underlying mental disorder, a burning grievance fired by perceived maltreatment by society, a world-weariness leading to a suicidal trajectory, a seeking of notoriety in death, sometimes wrapped in religious or political flags. Recent research has found that many of the characteristics of this third group overlap with those of lone actors who engage in acts of violence toward other targets: school/university shooters, workplace killings, rampage killers, and lone-actor terrorism.[40-46] Indeed, the overlap between these various groups is such that they can be considered to form a constellation of behaviors which can be grouped together under the category of "grievance-fuelled violence."[18] Lone terrorists have more in common with fixated individuals and other forms of lone killers than they do with group terrorists. Corner and Gill[47] found that lone actor terrorists are nearly fourteen times more likely to have mental health problems than those in terrorist groups, with 40% having a history of diagnosed mental health problems. There is increasing evidence that a proportion of those that engage in this kind of violence may be mentally ill[48,49] and therefore there is a role for mental health

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professionals.[50] The possible mechanisms through which mental illness may be linked to lone actor terrorism are various.[51] Some mentally disordered people may be susceptible to ideological influences as a result of chronic stress, disenfranchisement, and social isolation.[52] Radical political or religious ideologies may resonate with this group, or tap into their delusional beliefs, so rendering them at risk of indoctrination or radicalization, and more sensitive to the contagion effects of well-publicized lone-actor violence. There may also be fixated persons pursuing some idiosyncratic quest whose wrap their cases in the flag of a wider cause in the search for greater legitimacy. Mental illness may be just one element in the mix that leads to extremist thinking or terrorist activity, rather than the driving force. However, addressing it may be a way of avoiding harmful outcomes in those at risk of progressing to various forms of grievance-fueled violence. Intervention through the fixated threat model is also supported by research from the threat assessment area that highlights that a number of people that go on to commit these kind of offences are in retrospect found to have engaged in behaviors that flagged their potential (so-called leakage[53,54]).

In the circumstances, it is unsurprising that the FTAC model should expand into these areas in which threat assessment programs incorporating information sharing and multidisciplinary working had become more common.[55-58] The violence represents the end product of a process involving social and psychological forces and effects, with a potentially identifiable and recognizable pathway. In the Netherlands, the National Police Threat Management Team created a multi-agency unit for assessing those in danger of radicalization, building on their FTAC model.[59] In London, collaboration between psychiatric staff from FTAC and anti-terrorism police was set up in 2017 to evaluate cases of potential terrorist radicalization. This was under the umbrella of the prevent program,[60] part of the contest counter-terrorism strategy. Prevent requires statutory agencies to refer to a central point all cases where the radicalization of individuals is suspected. The new development enabled the referral of cases for consideration in terms of mental ill-health and risk as part of the overall response. In Australia, the Queensland FTAC expanded its role to incorporate the assessment of cases potentially mentally ill and thought to be at risk of lone actor violence or grievance-fueled violence and the Victorian service from inception has incorporated this group.[51] All the Australian FTACs except the Canberra unit have now extended their scope beyond fixation to grievance-fueled violence in general. With FTAC involvement, counter-terrorism investigations are generally not suspended. But given that mentally ill individuals who have adopted extremist beliefs have fewer inhibitions to violent action, the detailed analysis of their networks and background should not delay critical, risk-mitigating psychiatric intervention. Referral to FTAC may change priorities in the counter-terrorism input. And where mental illness is the predominant factor, there may be no further need for involvement of counter-terrorist measures, with the FTAC services becoming the lead agency in the case. As to research findings from FTACs involved in wider lone-actor cases, only one small series is available in the public domain.[51] Security concerns take time to overcome in the publishing of results in this area.

Further activities

The U.K. FTAC has now been running for 13 years. Over time its role has expanded. With the development of expertise, it has become involved in forward security planning for major events, education, training and research.[6] It co-ordinated the fixated strand in the security arrangements for the 2012 London Olympics, both in terms of forward-planning and operations on the ground. It fulfilled similar functions for royal weddings and for other major events. Similarly, the Queensland FTAC was involved in security planning and operations for the G20 summit in Brisbane[61] and for the 2018 Commonwealth Games.

A further benefit of research in this area has been the refinement of risk assessment instruments. Such tools involve the use of risk factors, in other words characteristics or behaviors which are significantly associated statistically with the undesired outcome. It proved possible at U.K. FTAC to combine findings from the literatures on violence, stalking, harassment, and the making of threats with clinical insights and best practice from security agencies and threat assessment centers in the United States and Europe. The work at FTAC over 10 years resulted in the publication of the Communications Threat Assessment Protocol-25 (CTAP).[62] This includes a simple one-sided screen for referrers to decide which cases of concerning correspondence should be sent to threat assessment agencies for further action: if any of the list of items on the sheet is scored positive, the case must be referred. Such a screen is of practical importance for, without it, large numbers of inappropriate cases would be referred, so impairing the function of the threat assessment unit, and some cases which should be referred won't have been. A second structured tool within the CTAP allows an initial assessment of concerning communications by a threat assessment unit, allowing triage into different levels of urgency and action. For more detailed threat assessment with more information available, many of the FTACs use an adapted version of the Stalking Risk Profile, which incorporates a section on public figure harassment cases.[63]

Appendix G

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Conclusion

The FTAC model emerged as a logical response to rigorous research which demonstrated the importance of mental illness in those who approach and threaten public figures. It involves an innovative approach with police and mental health professionals working together. The primary benefit of the model is the improvement in outcomes for often unrecognized mental illness in individuals whose lives have been blighted and whose condition imperils those around them as well as public figures. It is this that brings such work within the ethical remit of medicine. By focusing on threat assessment and management rather than attempts at prediction, FTACs reduce the potential for further adverse consequences. Since the establishment of the first unit in the United Kingdom, the model has been adopted in a number of jurisdictions and countries, sometimes in modified form. Recent research continues to confirm the value of this approach. An overlap with lone-actor and grievance-fueled violence has been recognized and this is also an area of growth and development. The emphasis continues to be primarily a public-health one seeking to intervene and improve outcomes for affected individuals at the same time as preventing harm.

Disclosures

The authors do not have anything to disclose.

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