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CHAPTER 20: THE FIXATED THREAT ASSESSMENT CENTRE – IMPLEMENTING A JOINT POLICING AND PSYCHIATRIC APPROACH TO RISK ASSESSMENT AND MANAGEMENT IN PUBLIC FIGURE THREAT CASES

David V. James, Frank R. Farnham and Simon P. Wilson

The Fixated Threat Assessment Centre (FTAC) was established in the United Kingdom in 2006 to assess and manage the risk to dignitaries from isolated loners pursuing idiosyncratic quests or causes. The term 'fixated' in its title refers to an obsessional pre-occupation with a person, place or cause which is pursued to an irrational degree (Mullen *et al.*, 2009). FTAC grew out of a research project, and its structure and procedures were designed *de novo* to reflect the most up-to-date research in the area and to incorporate the best practices found in other public figure threat assessment units in Europe and the United States of America. Its defining characteristic is that, although it is a police unit, it incorporates psychiatric staff from the country's National Health Service (NHS) as full-time personnel, working alongside police officers.

FTAC is the first such unit in the United Kingdom. It is located within the Specialist Operations section of the Metropolitan Police Service and is based in London. It has a national remit and is commissioned jointly by the Office of Security and Counter-terrorism at the Home Office and by the Department of Health. Its establishment followed the recognition that, whereas well-established systems were in place to assess threat from terrorists and criminals, no such mechanisms existed with regard to problems posed by disturbed members of the general public who exhibit a pattern of stalking-type behaviour towards public figures, with repeated attempts at communication and/or approach. Such behaviours may give rise to anxiety, fear or concern, and can result in disruption, embarrassment, the dissipation of policing resources, physical risk to the individual themselves and, occasionally, violence to others. However, in contrast to groups whose motives are usually easy to understand and whose *modi operandi* follow predictable patterns, fixated loners are usually difficult to understand in terms of motivation, their actions are often unpredictable and they do not fit easily into standard policing mechanisms for assessing and managing threat (Mullen *et al.*,2009).

The following account will cover the principles underlying FTAC's formation, its structure, and the fundamentals of its threat assessment and management procedures. The latter will be illustrated by a case example. The particular issues with which we shall first deal are the role of psychiatry; the population model for prevention; the differences between threat assessment and risk assessment; the relation between stalking in the general population and inappropriate or threatening attention to public figures; and the meaning of risk.

A) UNDERLYING PRINCIPLES

1) The role of psychiatry

A principal conclusion of the Fixated Research Group (FRG), which undertook the research upon which FTAC was founded (www.fixatedthreat.com), is that the role of psychiatry is central to confronting the issue of threat from fixated individuals (James *et al*., 2007, 2008 & 2009; Mullen *et al*., 2008). This went against the recent prevailing wisdom in sections of the threat assessment community in the US (Meloy *et al.*, 2011), where mental illness had been assumed not to be of operational importance. This may in part have been due to a misreading of the published findings of

the Exceptional Case Study Project (Fein & Vossekuil, 1998, 1999), to the omission of findings about mental illness by Dietz and colleagues in their earlier, influential studies in this field (Dietz *et al.*, 1991a and 1991b), and to non-clinicians erroneously equating the presence or absence of mental illness with whether or not an individual met the arguably artificial legal definition of insanity, which has no medical significance. A more detailed discussion of these issues is available elsewhere (Mullen *et al.*, 2009). However, it is important to state that asserting the importance of mental illness does not mean adopting the simplistic notion that someone must be mad to attack a political leader in a democratic country, or some idea that mental illness could act as a marker for potential assassins, when psychotic illnesses affect nearly 1% of the population (*i.e.* are relatively common) and assassins are extraordinarily rare. Rather, it provides an avenue for improving the assessment of cases of possible threat to public figures and for employing specific forms of management, as well as opening some possibilities for prevention and early intervention.

i) Most attackers are mentally ill

The central importance of mental illness has been well articulated by Dietz & Martell (2010, p. 344): "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 disordered person who issued one or more pre-attack signals in the form of inappropriate letters, visits or statements." Some evidence for this is provided by the well-known Exceptional Case Study Project (Fein and Fossekuil, 1998; 1999). Its authors studied 83 cases involving 74 incidents in the USA, 45% of which were attacks or assassinations and 54% 'near lethal approaches' (people apprehended with a weapon in the vicinity of possible victims). Sixty-one percent had a history of psychiatric problems, 43% of delusional ideas and 10% of violent command hallucinations. This compares with a point prevalence of psychotic illness in general community samples of around 0.4% (Kirkbride *et al*., 2011).

In Europe, a study of attacks on politicians (James *et al.*, 2007) found that death and serious injury were associated with psychosis, the presence of delusions, loner status and the absence of a political motive. Similar findings were reached in an overlapping German sample (Hoffman, Meloy & Guldimann, 2011). To forensic psychiatrists trained in the UK, all this has a familiar historical ring. Mentally ill individuals featured prominently in historical attacks on the Royal Family (James et al., 2008), and delusionally driven individuals were responsible for the killings of the Prime Minister Spencer Perceval in 1812 (Hanrahan, 2008; Wilson, 1812) and Edward Drummond, the private secretary to the Prime Minister, for whom he was mistaken, in 1843 (West & Walk, 1977). Edward Drummond was killed by Daniel McNaughten whose name remains associated with the legal test of insanity in many Anglo-Saxon jurisdictions. McNaughten continues to have other more modern resonances. A chronically deluded man who had made threats over a prolonged period before making his homicidal attack, he is typical of many contemporary threat assessment cases. Public outrage that he was found not guilty by reason of insanity led to the creation of the McNaughten Rules, expressly to prevent similar defendants being found legally insane in the future. They are unique in the criminal law, having their origins in neither statute nor case law, but instead the Law Lords' responses to a list of hypothetical questions, including one related to threat assessment where "the accused knew he was acting contrary to law, but did the act complained of with a view, under the influence of insane delusion, of redressing or revenging some supposed act or injury, or of producing some supposed public benefit" (*Hansard*, March 6th 1843, vol. 67, p.288).

By contrast, terrorist attacks on politicians in western countries are rare and the terrorist threat to most public figures is low. The modern terrorist *modus operandi* generally involves random attacks on mass population targets, rather than attacks on politicians. The last terrorist killing of a politician on the British mainland was as long ago as 1990 (Ian Gow by the Provisional IRA). In October 2012, the terrorist threat level from Irish Republicans on the British mainland was downgraded to 'moderate', the second lowest level on a five-point scale (http://www.bbc.co.uk/news/uk-northern-

ireland-20066672: see also https://www.mi5.gov.uk/home/the-threats/terrorism/threat-levels.html). This illustrates that the terrorist threat waxes and wanes according to political and social circumstances. The risk to public figures from mentally ill loners, however, remains more or less constant across time and country, and is unlikely to change until major breakthroughs are made in the treatment of schizophrenia and related psychotic disorders. It is therefore reasonable to conclude that the most constant threat to public figures with which both protection services and threat assessment services have to deal is that from fixated loners, most of whom are mentally ill.

ii) Most people engaging in concerning behaviours in relation to public figures are mentally ill.
Attacks on public figures are very rare, whereas concerning and threatening cases are relatively common. It is therefore appropriate to consider the base population of fixated loners, from which these attackers emerge. In the US, Teakuchi *et al.* (1981) observed that 'approximately 90 per cent of all persons the Secret Service presently consider dangerous gave some indication of mental disorder'. This is reflected in the various studies of White House attenders (Hoffman, 1943; Sebastiani & Foy, 1965; Shore *et al*., 1985). In Europe, a study based on the examination of 5,000 police case files of inappropriate or concerning approaches or communications to the British Royal Family found evidence of serious mental illness in 84% (James *et al*., 2009). A similar study concerning 107 cases of disturbing communications and problematic approaches to the Dutch Royal Family found that 75% were psychotic and a further 11% were suffering from mood disorders (van der Meer *et al.*, 2012). The situation has been summarised thus: "The post-bags of public figures are overflowing with the writings of the floridly psychotic, and the residences and workplaces of the prominent are magnets for the mentally ill" (Mullen *et al*., 2009, p. ____). This situation is not new. Attempts by mentally ill people to approach and force attentions on the famous have long been a problem for public figures, especially politicians and royal families. The files of nineteenth century English lunatic asylums contain examples of fixated behaviour towards public figures which are barely distinguishable from cases encountered today (Poole, 2000). In *Sketches in Bedlam* (A Constant Observer, 1823; p. 164), the anonymous author noted that there was 'a class of lunatic visitors who were… assiduous and troublesome in their visits to Buckingham House and in their endeavours to gain admission there '. In 1835, the Washington D.C. newspaper, *The Intelligencer,* commented: "It is a notorious fact that this city, being the seat of government, is liable to be visited by more than its proportion of insane persons" (cited by Hoffman, 1943, p.571).

The problem is current, not simply historical, and is common across countries in the western world. In a survey of members of parliament in Sweden for the years 1998–2005, 74% had been subject to harassment, threats or violence, and 68% of the perpetrators were deemed by their victims to be mentally ill (SOU, 2006). A survey of Canadian politicians found that 29.9% had suffered harassment, with 87.4% believing their harassers to be suffering from a mental disorder (Adams *et al*., 2009). A study of politicians in the Australian state of Queensland (Pathé et al., in submission) with a 48% response rate found that 93% reported suffering threats, harassment and other concerning behaviours, and 15% had been subject to at least one attempted or actual assault. In 48% of cases, the politicians believed the perpetrators to be mentally ill. A survey of members of the UK House of Commons (James *et al.*, in submission) with a 37% response rate found that, of the 239 MPs who responded to the survey, 80.3% (192) had experienced one of the forms of intrusive and harassing behaviours set out in the questionnaire; the victims believed the responsible individual to be clearly mentally ill in 40% of cases. Politicians are at greatly elevated risk of being harassed, the risks of being stalked in the general population being around 2-5% for men and 10-20% for women [ref]. The importance of fixation and mental illness in terms of risk to public figures is also clear from the work of those involved in threat assessment for the US Capitol Police (Scalora *et al*., 2002a, 2002b, 2003), the US Secret Service (Phillips, 2006, 2007, 2008) and the Swedish Security Police (Mullen, Pathé, & Purcell, 2009, p. 207).

iii) Mental health and protection of the wider public

The issue arises as to why psychiatrists should be involved in what are primarily protection issues. Questions have been asked in the British press as to why dignitaries should receive a special service in terms of threat assessment and management: "Why should such special protection be accorded to the governing elite? Non-politicians face the random, but real, danger of being hacked at with machetes, knifed, pushed under trains or otherwise mauled or done away with by severely disturbed patients released – or, rather, propelled – into the 'community' by authorities which refuse to detain them" (Mail on Sunday, 27th May 2007). This is a rather simplistic and inaccurate assessment of the situation. The experience at FTAC (James *et al*., 2010) is that protection of the general public from harm at the hands of the mentally ill, which is arguably a core element of psychiatric practice, overlaps substantially with the protection of the prominent. The issue is well stated by Dietz and Martell in a 1989 report to the National Institute of Justice (Dietz & Martell, 1989): "The persons most at risk of violence from the individual mentally ill person who pursues public figures are not the public figures or those that protect them - assuming they have the necessary security arrangements - but rather the private citizens who are the family members and neighbours of the mentally disordered subject."

iv) Psychiatrists are already involved in the problem.

Public figures in the United Kingdom receive many thousands of bizarre, worrying and threatening communications each year. The most worrying are referred to FTAC. Of 100 consecutive cases dealt with by FTAC, 81% had previously been treated by psychiatric services and 57% had previously undergone compulsory admission to hospital. Of all those with a history of psychiatric treatment, 60% (49) remained notionally under the care (or 'on the books') of a community mental health team (James *et al.*, 2010). In other words, psychiatrists are already involved, or have previously been involved, with many of the individuals concerned. This is particularly important in countries with comprehensive national health services, where all care is provided by an integrated system. However, it applies to any treating practitioner, in that awareness of the significance of different forms of warning behaviour and certain forms of delusional belief is important in the prevention of harm and disruption to public figures. In addition, the pursuit of idiosyncratic grievances and the writing of threatening letters may overlap with stalking behaviours towards victims in the general public. Forensic psychiatrists may be met with requests for consultation from colleagues about risk in such cases, be consulted by victims or their organisations, or receive requests from law enforcement and commissions for preparing reports for the courts.

v) A mental health problem benefits from a mental health response

The participation of mental health personnel in public figure threat assessment and management is desirable in two respects. Firstly, it aids the understanding of motivation, particularly where this is affected by some form of mental disorder, such understanding being essential to effective threat assessment. Secondly, it enables the diagnosis of mental illness and so opens the possibility of co-opting psychiatric services into the intervention response. The study of 100 FTAC cases found that 57% were admitted to hospital by local psychiatric services following FTAC intervention, and 26% taken on by community psychiatric teams (James *et al*., 2010). The importance of this is that, where mental illness is present, treatment of that illness may be the most effective way of lowering threat. It enables the resources of other agencies to be recruited into case management – in effect, a multi-agency response, rather than the burden being carried by policing and protection services. Such interventions are easier in countries where the threshold for civil commitment is low. But even in those jurisdictions where dangerousness has to be demonstrated in order to permit detention, there will be many cases which will reach this standard.

Psychiatric services are far more likely to pay attention to referrals from other psychiatrists than those from the police, and the ability for threat assessment units to navigate the complexities of

healthcare systems increases the range of their interventions. This is particularly so as the characteristics of the fixated are often such as to make them unwelcome as patients. They are by definition without insight, frequently paranoid and resistant to psychiatric intervention and follow-up; and querulant cases are also markedly litigious. In addition, a proportion of cases suffer from delusional disorders or schizophrenic illnesses which are sufficiently encapsulated to allow individuals to function effectively in many aspects of day-to-day living. In other words, they do not exhibit the gross behavioural disturbances that readily identify them to law enforcement personnel and which oblige mental health services to provide care without the resistance which is inevitable in health systems where resources are over-stretched.

A further potential barrier to using mental health disposals in threat management is the issue of information sharing and medical confidentiality. Whereas, in most jurisdictions, there are restrictions on the sharing of medical information with policing agencies, these can usually be overridden where there are concerns about a risk of serious harm. However, the power of information is often in its being provided to doctors by policing agencies, rather than the reverse. It is our experience that the significance of inappropriate communications and approaches to the prominent is insufficiently appreciated by treating teams, who may erroneously regard such behaviours as innocuous or quaint, unless the consequences are brought to their attention. The problem in some cases may simply be that those in charge of a patient's care are not aware of the specific verbal or behavioural threats that an individual makes between outpatient appointments, and therefore they cannot evaluate the case accurately. Provision of information to psychiatrists provides them with the power to make better assessments and intervene more effectively.

Evidently, there are many cases of mental disorder where direct psychiatric intervention is problematic and compulsory detention simply not possible. Case management by the threat assessment team will not be a one-off intervention, but a process which may continue for many months. The general approach in such instances will be to put into place a network around the individual, which enables some stabilizing social interventions to be introduced and which performs a monitoring role, providing early warning of any change or escalation in behaviour, which can then prompt further intervention. Such provision is far easier to organise if there is a mental health component to the threat assessment team.

2) Prevention, not prediction: a population-based approach

Niels Bohr, the Danish physicist, stated: "Prediction is very difficult: especially about the future." Accurate prediction is all the more difficult for behaviours, such as violence against public figures, which have a low base rate. This can be illustrated by the following example. Suppose the police in a city of a million people were in possession of a surveillance camera which, 99% of the time, could correctly identify a dangerous fixated person, bent on violence towards a public figure. How useful would this be? On the face of it, such a device would sound powerful. It has a false positive and false negative rate of only one per cent, and an accuracy of 99%, much greater than any predictive tests currently available. Simple mathematical calculation reveals that, if 3 in 10 of the population were dangerous fixated individuals, then 97.7% of positive identifications would be correct. However, if only in 1 in 10,000 were dangerous individuals, the chance of a positive identification being accurate would be only 0.98%[1]. In other words, in the prediction of rare events, such a tool would be useless. Yet, current risk assessment tools could not hope to approach an accuracy of 99% and, given the

[1] If one in ten thousand in a city of one million is a dangerous fixated person, then 99 out of 100 dangerous fixated people will trigger the alarm and 9,999 out of the 999,900 who are not dangerous fixated people will trigger the alarm. Therefore, 10,098 people will trigger the alarm, of which 99 are dangerous fixated people. Therefore, the chance of a person triggering the alarm being a dangerous fixated individual is 9 in 10,098 = 0.98% (i.e. less than 1%).

complicated influences upon human behavior, they never will. In consequence, it is now the general consensus that prevention, rather than prediction, is the only realistic focus for threat assessment (Department of Defense, 2012; Fazel *et al*., 2012).

The most effective tools in aiding the identification of risk are compilations of 'risk factors'. These are factors which are statistically significantly more common in those who have engaged in the behaviour concerned than in those who have not. When combined into an "instrument" or "tool", they comprise a structured *aide-mémoire* which assists the risk assessor in making sure that all relevant factors are considered in the evaluation. Risk factors present in a given case also point to risk management opportunities. Such 'risk instruments' are not a risk assessment in themselves, nor an oracle to which data are given and which then provides an answer. Rather, they supplement and structure professional judgement. Risk instruments suffer from two drawbacks. The current state of risk assessment research is such that their power is limited, as described above. Secondly, they are based upon group data. This means that, if there is an 80% chance of a person belonging to a particular risk group, then eighty in every hundred people with the profile in question will in fact belong to the risky group and 20 will not. It is not possible, however, to tell whether any given individual belongs to the 80% or the 20%. The potential value of such data in the individual case therefore needs to be seen in the context of these limitations.

At FTAC, our approach is to adopt a population solution to risk management. It is not possible to predict what any individual will do. However, through the use of risk factors, it should be possible to identify the most at-risk group of fixated loners (say arbitrarily 5%) from which dangerous behaviour is most likely to arise. If one then intervenes and treats the risk factors in this entire group, then adverse outcomes will be prevented without the need to know which individuals would have gone on to engage in the behaviour in question. An analogy is the risk of heart attack. One cannot predict which individual will have a heart attack. However, one can identify factors which make a heart attack more likely, such as smoking, obesity, hypertension and high blood cholesterol levels. One then treats everyone who possesses these risk factors – for instance by smoking cessation therapy, weight loss, anti-hypertensives and cholesterol-lowering drugs. This will prevent heart attacks, without needing to predict which individuals would have had a heart attack if they had not had treatment. Likewise, if one found that a number of individuals exhibited risk factors for violence (say, intrusive persecutory delusions, a license to possess a firearm, substance abuse problems, poor anger control, and destitution with little left to lose), one would intervene to reduce these risks (say, by compulsory anti-psychotic medication, removal of the license and firearm, treatment of substance abuse, anger management, and measures to increase social stability). This would lower the risk in the group as a whole without needing to predict which person would have become violent without such intervention. The fact that mental state items and social items are prominent amongst the risk factors means that risk assessment and management could be improved by the inclusion of mental health personnel in the threat assessment unit in order better to understand the issues, to allow mental health interventions as part of management plans, and to enable multi-disciplinary community approaches.

3) Warning behaviours

A behavioural policing approach involves detecting individuals who are on a so-called 'pathway to violence' (see Calhoun & Weston, 2003, p. 79). This involves the development of violent ideation in response to an underlying grievance, followed by researching and planning an attack, pre-attack preparations, probing and breaches and finally the attack itself. The strategy is to watch out for those engaging in these forms of behaviour and intervene. Whereas this should evidently be part of the policing approach, it places the intervention towards the end of the process, when an individual is already moving towards action. It misses the opportunity to intervene earlier in the process in order to manage down the risk before a person enters upon the 'pathway to violence'. Risk

assessment, by contrast, should concern, not simply behavioural observation, but assessment of a person's motivation and psychological state and its interaction with factors in their environment which make escalation more or less likely. This requires some psychological expertise.

Evidently, in order to be able to assess individuals as to whether they belong in a high risk group, it is necessary for a threat assessment unit to have a mechanism through which it becomes aware of cases which it should assess. The FRG's study of attacks on European politicians (James *et al.*, 2007) found that death and serious injury were significantly associated with the attackers having exhibited one or more warning behaviours in the period before the attack. Warning behaviours included posters, newspaper advertisements, attempted lawsuits against the government, chaotic deluded letters to politicians and the police, threatening letters, leafleting the public, telling friends of the intent to attack, and, in one case, attempted self-immolation in front of the eventual victim's place of work. Most of these behaviours were engaged in many times, usually over weeks, months or even years before the eventual attack. The passage quoted above from Dietz and Martell (2010), summarised the US research in this respect, concluding that every attack on a public figure was the work of a mentally disordered person "who issued one or more pre-attack signals in the form of inappropriate letters, visits or statements". A suggested typology of these warning behaviours, into which the 'pathway to violence' has been incorporated, has been devised by Meloy and colleagues (2012).

4) Public figures and stalking

The field of public figure threat assessment in the USA has developed entirely separately from that of stalking in the general population, the former being influenced by a law enforcement perspective and the latter being primarily the province of academic forensic psychiatrists and psychologists. This leads to some confusion over nomenclature and the degree to which various behaviours overlap. The FTAC view of the background research is that inappropriate attention, harassment, stalking and the making of threats can usefully be considered part of a constellation of behaviours, with the last three forming sub-sets of inappropriate attention.

Insert Figure 1 here

In consequence, broadly the same approach to risk assessment can be used in each, with supplementary considerations applied in the making of threats (see Warren & Mullen, this volume). Recent research finds that risk factors in public figure harassment and general public stalking are similar, when ex-sexual partners are removed from the sample of general population stalkers. This has been established with persistence (James *et al.*, 2010c) and with approach and escalation (McEwan *et al.*, 2012). In addition, a comparison of factors associated with escalation and problematic approach has found very similar results across studies with very different methodologies, looking at US politicians, Hollywood celebrities and the British Royal Family (Meloy *et al.*, 2011). In other words, stalking and harassment remain stalking and harassment, regardless of the public profile of the victim. This is of practical importance, as it indicates that research findings from one field will be relevant to the other, and it enables insights gained into the assessment and management of problem behaviours in one group of victims to be applied tentatively to the other.

5) The differences between threat assessment and risk assessment

Threat assessment and risk assessment both form part of the assessment process. Risk assessment, which is more familiar to clinicians, generally involves consideration of a case in a review setting, where there is little time pressure and a considerable amount of information about the case is available. Different types of risk can be considered, and the assessment results in a detailed formulation, including consideration of such issues as imminence, likelihood, severity and mitigating and aggravating factors. Such an assessment identifies ways of reducing and managing risk, leading

to effective intervention planning. Risk assessment is a process, rather than an event, and is repeated following intervention in order to assess its efficacy and in response to changes in circumstances.

Threat assessment, by contrast, has a behavioural policing focus. It concerns the making of quick decisions in response to limited information in an operational, dynamic, real-time setting. It takes risk as a unitary concept and does not produce any form of nuanced judgement. Its purpose is to triage cases into high, medium and low concern categories, in order to determine the level of immediate response. Given that limited information is available, the concept of 'risk' is not suitable, and is replaced by that of 'level of concern' (Scalora *et al*., 2002a).

At FTAC, the levels of concern (low, moderate, high) are carefully defined, both in terms of group criteria and in terms of resultant level of resource allocation. High concern cases require an urgent response and moderate a prompt response, whereas low concern cases do not require any further input. Allocation is based upon expertise, supplemented by an *aide-mémoire* of risk factors, the purpose of which is to ensure that all relevant factors have been considered. This comprises 38 items, grouped under eleven headings. A proportion of the items are psychological and therefore require some psychological expertise or training to understand and apply.

Threat assessment and risk assessment are undertaken at different points in the assessment and management cycle (see Figure 2).

Insert Figure 2 here

6) What is risk?

FTAC has adopted a computerised version of the *Stalking Risk Profile* (MacKenzie *et al.*, 2009), public figure section, as the framework for risk assessment. The *Stalking Risk Profile* (SRP) is a manualised structured professional judgement tool, which incorporates both international research findings and the clinical expertise accumulated by the Melbourne group in running a stalking assessment and management clinic for ten years. The SRP is structured around two fundamental concepts about risk: risk is not a unitary concept, and risk is determined in part by motivation.

Risk assessment has been primarily concerned with the risk of targeted violence, particularly in the US. However, risk is multi-dimensional. Whereas death or serious injury to a prominent person is the most feared outcome, the base rate of serious violence is low. There are other domains of risk that need attention in formalised risk assessment. The public figure version of the SRP incorporates the following domains:

- Escalation – the risk that someone will increase the intensity of their activities or progress to more intrusive forms of behaviour. The risk of change from communications to approach is particularly important to anticipate, given the disruption, distress to the individual and concern about attack that progression to approach may engender.
- Disruption – impairment of the function of the individual or their agency; disruption or cancellation of public appearances; public or national embarrassment, and the disruption of the resultant increase in expenditure on physical security.
- Persistence – the continuation of inappropriate behaviours despite injunctions to desist. Persistence is important because it is likely to increase problems in other domains.
- Psycho-social damage to the perpetrator – the obsessive actions of the perpetrator may lead to significant personal loss: of friends, family, employment *etc.*, as well as the acquiring of a criminal record and risk to personal safety. Social isolation and the deterioration of a

person's psycho-social position are important, in that they increase risk in other domains, through increasing desperation and a decrease in social restraints.
- Violence – to public figures, their protection personnel, third parties and the general public.

It is essential to recognise that the risk factors for one domain may be very different to the risk factors for another. So, for instance, someone might present a high risk of disruption or of escalation, but a low risk of violence. Risk in each domain therefore needs to be assessed separately.

Risk is also dependent on underlying motivation. At the simplest level, it is easy to understand that someone who is in love with a prominent figure would be likely to present different risks than someone who perceives them as a threat to his life. The public figure SRP uses an adapted version of the Mullen classification of motivation (Mullen *et al.*, 1999 & 2009) which has been endorsed as the standard in the field of stalking and harassment by the Group for the Advancement of Psychiatry (Pinals, 2007). The relation of this classification to other public figure harassment topologies (James *et al.*, 2009; Phillips, 20006, 2007, 2009; Calhoun & Weston, 2009; Hoffman & Sheridan, 2008) is summarised in the SRP manual (MacKenzie *et al*., 2009, p.71). The main groups of the Mullen classification, as applied to the public figure arena, are:

- The Resentful: those with a grievance against the public figure, often involving an idiosyncratic and highly personalised quest for 'justice', not infrequently delusional in nature, or blaming the public figure for their persecution.
- Intimacy Seekers: those with a perceived entitlement to an amicable relationship, whether through erotomania, morbid infatuation, grandiose pretensions or claims to kinship.

Of the other groups, Incompetent Suitors (socially inept individuals seeking a sexual relationship) and the Predatory (sexual predators, planning a sexual attack) are less often encountered in public figure cases. The Rejected (ex-sexual partners, unable to accept the end of a relationship) are excluded, not because such persons are unusual in the lives of the prominent, but because they have nothing to do with their public role. To the above are added two further categories for public figures: attention seekers and help seekers. Attention seekers include those who wish to make grand public statements or draw attention to themselves as part of a desire for self-aggrandisement, or those who hunger for notoriety in order to bolster their own feelings of self-worth. Help-seekers comprise those who insistently request help from the public figure because they do not know to whom else to turn; such cases are helpless and pleading, rather than angry.

B) FTAC'S OPERATIONS

Structure

FTAC is comprised of staff from the Metropolitan Police Service and the National Health Service – nine police officers and four full-time forensic nurse specialists, with three consultant forensic psychiatrists and one consultant psychologist between them providing on-site supervision five days a week. FTAC is physically located within the Metropolitan Police Service's Protection Command. Its offices are in central London. Functionally, FTAC comprises three case-worker teams, each consisting of a Forensic Nurse Specialist and two Detective Constables. Individual FTAC cases are allocated to case-worker pairs, comprising a Detective Constable and a Forensic Nurse Specialist. A named senior doctor or psychologist is responsible for supervising and managing risk assessment and management decisions within each FTAC team. Day-to-day case management of police staff is the role of the Detective Sergeant, who reports to the Detective Inspector. The unit is led by a Detective Chief Inspector.

Responsibilities

The role of FTAC is the assessment and management of risks posed to prominent individuals, the places they work in, and to the prominent organisations and events in which they are involved, by isolated loners pursuing idiosyncratic quests or grievances to an irrational degree. The core constituency comprises members of the Royal Family, members of the Parliament of the UK, members of the Scottish Parliament and the Assemblies of Northern Ireland and Wales, the Mayor of London and ambassadors to the United Kingdom. The sites concerned include Royal Palaces, the Palace of Westminster (the UK parliament), the Scottish Parliament and the Assemblies of Northern Ireland and Wales, government ministries and the residences of government ministers, embassies, and buildings within the government security zone (including the headquarters of police and security services). Most referrals from core agencies originate from protective personnel, communications offices or office staff. In a proportion of cases, the subject of the approach or communication is unaware of the issue.

The behaviours in question essentially comprise stalking, unwanted intrusion, harassment, threat, and persistent or querulant complaining. The risks which need to be evaluated and managed comprise: violence to prominent individuals, their staff and families, the general public, and police and security staff; distress to prominent individuals, their staff, families or protection personnel; disruption of events associated with the prominent person or their work-functioning; embarrassment to prominent individuals or police/protection staff; waste of resources associated with the prominent individual (such as office-staff time); consumption of policing/protection time and resources; and risk to the safety of the isolated individual (*e.g.* by their actions in armed environments). The assessment of these risks depends upon achieving an understanding of the individual's motivation and mental state, and an analysis of their behaviour and their past for the presence of factors associated with particular forms of risk. Management of such cases depends upon identifying risk factors which then also constitute opportunities for management intervention. Management plans often concern catalysing and co-ordinating multi-agency interventions from policing, health and social agencies. Other than case assessment and management, FTAC acts as a consultation resource for other agencies. It takes part in the security planning for major national events, and undertakes education, training and research. FTAC is concerned with the actions of lone individuals and does not assess or manage the risks presented by those in political, extremist or protest groups. In the U.K., the assessment of threat from isolated loners is dealt with separately from that from terrorists, unlike the situation in many other countries. There is a long history of anti-terrorist policing in the U.K., dating back to the formation of the Special Irish Branch of the Metropolitan Police in 1883 in response to the Fenian threat. FTAC maintains operational contacts with relevant anti-terrorism and security services, but does not deal in terrorist cases.

Principles

There are three principles which are observed at all stages of assessing risk at FTAC, in order that FTAC's decisions reflect best practice and are defensible, reproducible and can reflect change.

- All referrals, once received, are subject to the same standardised and formalised risk assessment procedures.
- All referrals are processed jointly by both police and psychiatric teams, and the resultant decisions formally signed off by both.
- All case processing follows a highly-structured operating protocol and is recorded on a bespoke computerised database. The database functions as a flow-line for case progression and is constructed in such a way to ensure that all the relevant information is gathered, recorded and considered, and that the same formalised risk assessment process is followed and thoroughly documented in all cases. Responsibility for completing individual database

fields, and the deadlines for their completion, are exactly specified and are subject to on-line supervision.

Ethics

The health-care members of FTAC are employed by the National Health Service, not by the police. Their place of work is a police unit and they are integral members of the team. The model is one of integration, not consultation or inter-agency working. However, the focus of the health-care staff remains the health and welfare of individuals and of the general public. The model is possible because the interests of public protection overlap almost exactly with the interests of public health. In other words, interventions to assess, reduce and manage the risk to prominent individuals from isolated loners coincide with the health interests of the isolated loners themselves. At one level, the entire FTAC operation could be conceived as a diversion scheme, identifying and directing into care severely disturbed people who have fallen through all the societal safety nets. The function of the unit is aided by the characteristics of mental health laws in England and Wales. Unlike many other jurisdictions, compulsory detention (civil commitment) does not depend uniquely upon dangerousness criteria, but can be undertaken in the interests of the individual's health.

A further benefit of the joint staffing arrangement is the active facilitation of information sharing between agencies where appropriate, something which often bedevils multi-agency working in other arenas. In the United Kingdom, medical information cannot be shared with policing agencies unless public interest criteria are satisfied – essentially, a need to disclose to prevent serious harm. However, a doctor (and, by extension, the rest of the multi-disciplinary team) may share information with another clinician or clinical team who has a legitimate interest in the care of the patient. FTAC health-care staff are funded by the Department of Health to provide a service to mentally disturbed individuals who present through inappropriate attention to public figures. As such, they have a legitimate reason to have access to confidential information. Of course, they cannot share that information with their police colleagues, unless there is a public interest in doing so. In the sort of cases with which FTAC deals, the necessary criteria are often satisfied. However, FTAC staff offer not details from medical files, but rather their own processed conclusions, which are more relevant to operational needs. As already described above, the more useful and effective disclosures are often in the opposite direction, from police files to clinicians, and this, too is facilitated by the joint approach at FTAC.

Activity

FTAC receives approximately one thousand referrals a year. Its activities can be considered in four main stages: referral mechanisms; initial threat assessment and case allocation; interventions, followed by further case and risk management; and case closure and follow-up. This division into sections is reflected in the structure of FTAC's computerised management database, which is integrated with its standardised operating procedures. The way in which FTAC works is illustrated below through a commented, anonymised case example.

C) CASE EXAMPLE

Referral

An e-mail was sent to a member of parliament (MP) by one of his constituents. It was copied to the prime minister. The writer, a man from the north of the country, gave his name and address, and stated simply: "If you do not finally resolve this situation, then someone will have to die." The prime minister's office forwarded the e-mail to FTAC, where it was picked up by the duty team of two detective constables and a senior psychiatric nurse.

Tens of thousands of bizarre communications are written to politicians and the Royal Family every year, both from within the United Kingdom and abroad; and many people attend sensitive sites behaving oddly, or evidently suffering from mental illness. FTAC would be swamped if it attempted to deal with all such cases. Instead, FTAC ensures that the first filter (in effect, the first threat assessment) is conducted by those experiencing the primary contact, in a manner specified by FTAC.

Communications offices are supplied with a checklist of criteria to help determine which cases should be referred. The relevant policing agencies and staff offices are similarly supplied with a checklist for approach cases. The criteria concern aspects of the subjects' current and past behaviour, their beliefs, motivation, emotional state and declarations. The contents of the checklists are reviewed at intervals in the light of FTAC audit exercises and any relevant new research findings.

An individual FTAC case-worker (*i.e.* police officer or nurse) is designated as the single point of contact for each of the main referral agencies. This individual is responsible for giving regular training to correspondence offices about FTAC and about the suitability of cases for referral, and also for giving feedback as to outcome in cases which have been referred. Given the high staff turn-over in referring agencies, a regular programme of liaison and training is essential. A rolling programme of talks about FTAC's role and referral procedures is also undertaken for officers responsible for the security of buildings and for personal protection. Information about FTAC is supplied to Members of Parliament and their staff, and talks given as part of security training for new members and their staff.

Audits of referrals are undertaken at approximately six-month intervals. Two forms of audit are undertaken: examining referrals from a particular source and establishing the proportion that are inappropriately made and why; and conducting an audit of a sample of cases which were *not* referred in order to establish whether contacts had occurred which should have been referred, but were not.

In addition to referrals from relevant agencies, FTAC conducts daily searches of available police intelligence systems to identify cases which fall within its remit. With the explosion in the use of the internet and social media, FTAC is finding it necessary to develop strategies for searching web-pages, blogs and social media sites.

Most referrals are made initially by telephone or e-mail. Concerning communications are transmitted to FTAC by e-mail, with letters and faxes sent as scanned attachments.

Initial Assessment

Initial information checks were carried out. The man was aged 53. The police database revealed that he had a previous conviction for assault against a neighbour six years ago and was known to local police for various public order offences. His neighbours had made various allegations of harassment against him over the last three years, but these had not led to him being charged. A check of the correspondence logs for the Prime Minister's office and Buckingham Palace revealed that he had written to the Queen and the Prime Minister two years earlier, complaining about mobile telephone masts in his neighbourhood. The letters had not been seen as unusual, they had been given a standard response, and the original documents had not been retained.

A call to staff at the MP's constituency office established that the man in question had campaigned about a mobile phone (cell-phone) mast in his road, which he believed was having injurious effects. He had written letters to the telephone company, the MP, and local newspapers, and then organised a petition. The MP was initially supportive and wrote three letters to the telephone company on his

behalf. However, the man was not satisfied by the telephone company's response and his letters to the MP had become increasingly angry and personalised. Recently, he had attended the constituency office without an appointment. The MP was not there at the time. The man had become angry and left. The constituency worker remarked that he had made them feel uncomfortable. The staff had told the MP about the incident over the telephone. They had not yet had sight of the e-mail copied to the Prime Minister.

At this stage, the firearms register was consulted. (In the UK, the possession of firearms is very unusual and is strictly regulated. Hand guns and automatic weapons are banned. Limited other forms of firearm are permitted, if a licence has been granted, a process controlled and administered by local police forces. The details of all those licensed to possess firearms are kept in a centralised national register). It transpired that the man had a licence to possess a shot-gun and was a member of a regional clay pigeon shooting club.

This information had been gathered within two hours of receiving the referral. The details had been entered into the FTAC work-flow database. The next stage was to undertake an initial threat assessment, a triage of cases into low, moderate or high concern.

Initial assessment of referrals involves consulting a standardised set of national policing databases, police systems in the area in which an individual resides, correspondence logs for the Prime Minister and the Royal Family and open searching on the Internet. Health-care information is not sought at this stage. Once the initial information trawl is complete, a case discussion ensues between the psychiatric nurse and the detective constable. Discussion of the case is supplemented by the formal consideration of an *aide-mémoire* of risk factors to aid in decision-making as regards concern level. The FTAC list is based upon consideration of the specialist literature and upon its own research. It comprises 38 items under eight headings.

Allocation of concern level

The case workers considered the facts that they had established. A number of factors in the aide-mémoire *were clearly present. The man was making a conditional and implied threat that he might kill an unspecified person, if his demands were not satisfied. No time-scale was specified. He had the means to carry out such a threat, in that he possessed a shot-gun. He appeared to have some idiosyncratic grievance of several years' duration, which he was now personalising in terms of the MP. Its precise nature was not yet clear, but it seemed to have something to do with mobile telephone masts, a subject which would not ordinarily be considered as likely to inspire such rage. In addition, his behaviour appeared very recently to have become more disturbed, given the incident at the constituency office and the gut reaction that he had occasioned in the staff. The initial assessment was that this case satisfied the definition in the FTAC operating policy as being of high concern, until such time as it could be proved otherwise. This accorded with the case workers' subjective impression.*

The case-workers drew up an immediate management plan. This comprised five elements:-
1) Local police should be contacted immediately to revoke the gun licence and confiscate the shotgun.
2) Further information searches should be conducted straight away, in particular regarding the man's mental health history and current psycho-social status.
3) The MP should be approached urgently for more information and to warn him of the possible risk that the man might pose to him.
4) An image of the man should be obtained and circulated to the various places that he might turn up. (Images can be obtained by police from their own records or from the driving license agency or the passport agency).

5) Local police should be primed to check the security of the MP's home.
As the case was deemed to be of high concern, the proposed management plan was put to the FTAC sergeant and to the consultant forensic psychiatrist responsible for that duty team, as the protocol specified. The plan was approved and the consultant suggested that, once these steps had been undertaken, the case-workers should consider arranging a visit to interview the man at his home early the next morning, in conjunction with local police. The initial assessment was recorded on the unit database together with the risk factors present, a formal explanation of the reason for choosing the particular concern level, and the details of the initial management plan. Supervision by the sergeant and the consultant of the plan was recorded, at which point this section of the management pathway was automatically locked down on the system.

The allocation of concern level is operationally defined and subject to strict supervision. Its purpose is to reach a rapid conclusion, based on the limited information available, as to the degree of response that the case warrants. The decision as to concern level must be made on the day that the case is referred and cannot be deferred until detailed information becomes available. Case management plans must be discussed with the consultant psychiatrist and formally recorded.

Implementation of immediate management plan
The management plan was put into operation. It was arranged with local police that the weapon would be removed that afternoon and they would then report straight back to FTAC on what they had discovered. They were to contact the MP's office to arrange an immediate view of his home security. Meanwhile, the nurse put the man's name into the National Health Service's register of general practitioner (GP=family doctor) registration. (The details of the family doctor for every person in the country are centralised in a database that can be accessed by approved health service personnel). The database showed the name, address, telephone number, fax number and e-mail of the man's GP. The nurse rang the surgery and left a message, then faxed through some introductory information about FTAC and its role for the GP to peruse.

The MP telephoned FTAC after a message had been conveyed to him through his office. He explained that the man had been to see him around fifteen times over the last three years. The man's complaints had been around the siting of mobile phone masts. After a while, it transpired that the man's daughter had cancer and the man began blaming this on the presence of the masts. He had originally evidently seen the MP as a source of help and support. But when the MP did not produce the expected results, the man began to blame him and accused him of colluding with the company that owned the masts. The MP had recently told the man that he could not help him any further. This had produced an angry reaction, and the incident at the constituency surgery seemed to have followed on from this.

The GP then rang and spoke to the consultant forensic psychiatrist. She confirmed that she knew the man and his family well. He had previously received treatment for depression and had been admitted to psychiatric hospital with a possible psychotic illness five years earlier. The man's obsession with the masts had been present for a number of years. When his daughter became ill, he had accused the company owning the masts of causing her illness and he had no longer seemed amenable to reason. The GP had diagnosed him as being depressed, and had tried to persuade him to take anti-depressants, but he had refused. The GP had made him an appointment to see the local community psychiatric team, but he had not attended. He had recently taken to ranting at the GP in a paranoid fashion, describing how his MP and the telephone company were in league. Three months previously, his wife had left him and taken their daughter, telling the GP that she could no longer cope with the way his obsession had overtaken their lives. The GP had not seen him since.

At the end of the afternoon, the local police rang back. They had revoked the man's gun licence, gone round to his address and required him to surrender his shotgun.

The psychiatrist and the sergeant reviewed the case at the end of the day with the case workers. A considerable amount of information had been gathered from different sources in a short space of time. The man had grievances both against the phone mast company and the MP. It was not certain which might be the potential target and possibly both. He had lost his job, then his daughter and then his wife, and there did not appear to be much that he had left to lose. His behaviour at the constituency surgery suggested that he was becoming overtly disturbed in behaviour and was having difficulty in containing his anger. He appeared to believe that violence was justified and his e-mail to his MP suggested that he was considering taking violent action and that this might be imminent. His gun had been removed, but his current whereabouts were unknown. It was concluded that urgent intervention was necessary.

The man had not committed any criminal offence in that his e-mail did not directly threaten an individual. Nor did it fall within the definition of a malicious communication. So a criminal justice intervention at this stage was not possible. There was some discussion as to whether the telephone mast company ought to be warned about the man, but there was currently no information as to which office or which employees he might be focused upon. The most sensible course of action was to try and interview the man. It was decided that the psychiatrist and a police case-worker would travel north, and that an early morning knock on the man's door would be undertaken, with the support of members of the local police. A risk assessment for the visit indicated that the police members of the team should wear stab-proof vests, and that the local police officers should remain at a distance in order not to occasion alarm. The local psychiatric service were made aware of the problem and the visit, and agreed to send a psychiatric social worker to attend the visit. (Psychiatric social workers play a central role in civil detention under mental health legislation in England and Wales as 'Approved Mental Health Professionals').

When a case is judged to be of high or moderate concern, an immediate management plan is drawn up and implemented and further information is sought, in particular from other agencies, including health-care. The response has moved on from being an FTAC one, to involving health-care, local police and the MP. The beginnings of a network response are being formed. A psychological understanding of the man and his motives is being established, and the beginnings of a more nuanced risk assessment are falling into place.

Interview

The next morning, whilst the FTAC team members were travelling to the address, the other team members in the office looked into the man's background. *Open Internet searching produced several results. Firstly, there were letters that he had written to the local newspaper five years earlier complaining about the masts and other letters complaining about various other matters that had concerned him in his local community, such as the construction of a concrete skate-board ramp in his local park. Next, there were some postings on a conspiracy web-site with the name 'Fighting Back'. These set out his beliefs that the telephone masts were poisoning the local community and that the local council and the local MP were part of a conspiracy to hush this up, for financial reasons. It then became apparent that the man had recently set up his own web-page, entitled The Mast Conspiracy. From its contents, the man's beliefs had been elaborated into a detailed, paranoid conspiracy theory, elements of which appeared clearly delusional. The latest of his bulletins on the web-site was entitled 'A citizen's right to break the law'. It put forward the contention that, where the government was engaged in criminal activity which threatened the welfare of the entire nation, a citizen was entitled to use whatever levels of violence against the government might be necessary in order to correct the injustice. The web-site contained an open letter to the mast company, in which the man stated that*

the masts were continuing to pass various beams into the brains of local people, causing brain tumours and he would not be responsible for his actions if the mast was not taken down by the end of that month. The letters contained vague threats to harm the MP. The website also gave further details about the man, who claimed to be a former member of an elite special forces group, a former policeman and a lawyer. The man's grievances appeared to have developed into an all-absorbing querulant quest. The driver behind this was powerful in that he believed both that the company had injured his daughter and that the safety of the nation was at risk. His beliefs now incorporated delusional content and he appeared to have tipped into a paranoid psychosis. The travelling team now had a substantial number of issues to explore in their interview.

The team at FTAC attended the man's home. He was wary of the FTAC team, but conversed politely with them, stating that after the removal of his gun, he had been expecting a further visit. He recounted that he had been the victim of radiation poisoning from the telephone mast for several years. He had written to the telephone company and then his MP and had recently become convinced that they were conspiring together to poison him. He stated that the MP was corrupt and was possibly taking bribes from the telephone company in order not to properly investigate his complaints. He told the assessing nurse that he had a degree in chemical engineering from Imperial College London and had been employed by a large petrochemical company until 3 years ago when his employment was terminated after he repeatedly took time off to complain and demonstrate about the telephone mast, which he believed was responsible for his ten year old daughter's illness. His wife eventually left him, taking their daughter with her. He does not now have any contact with his wife or daughter. He had recently received a solicitor's letter explaining that his wife was filing for divorce. The man insisted to the visitors that he had no plans to harm anyone, despite his threats and the contents of his web-page. He was simply upset at the turn of events and expressing his distress. He accepted the contact details of the members of the FTAC team, provided his own telephone numbers, and agreed to continuing contact with the community police officer from the local force.

The FTAC team reached the conclusion that the man was suffering from a paranoid psychosis, and that the beliefs variously expressed on websites, to the MP and the GP and in correspondence were undiminished. The community police officer and the psychiatric social worker were reassured by the visit. Some meaningful contact appeared to have been made with the individual concerned. He had accepted continuing contact with FTAC and the local force. His beliefs about being a former policeman, a member of special forces and a solicitor were probably delusional, but they involved a degree of support of, and deference to policing institutions. He had given assurances that he would not be taking any form of direct action. The psychiatric social worker, having heard these, stated that she could not see what all the fuss was about. However, the FTAC team held firmly to the view that the visit had simply confirmed the presence of factors indicating a high risk of violence. In terms of violence risk in the Stalking Risk Profile*, with the man classified as resentful in motivation, important risk factors were present, the first three of which are designated as 'red flag indicators', the presence of one such indicator being sufficient to put the individual into the high risk category: the man had fantasies about homicide; he was engaging in last-resort thinking; the psychotic phenomena that he described were invasive in nature; he had engaged in prior violence; and he had an affinity with weapons. The team decided that they should telephone the consultant psychiatrist in the local community psychiatric team and ask for an urgent assessment for compulsory detention under the Mental Health Act. A detailed report about the case was quickly typed and faxed to the psychiatric team.*

This was a case in which assessment evolved rapidly as new information emerged. It illustrates the value of a face-to-face assessment of an individual in their own environment in gauging the degree of risk that a case constitutes. The presence of an FTAC psychiatrist enabled a detailed assessment of the individual's mental state, allowing him to construct a detailed report for local psychiatric

services, which compelled action. Reference to structured forms of risk assessment prevented false reassurance at interview and added substantial weight to the argument for detention.

Continuing assessment and intervention cycle

The local psychiatric team set up an early morning home visit for the following day. However, overnight, the man appeared at the MP's home and threw a stone through the window, terrifying the MP's wife and young children. Police arrived quickly and arrested him for criminal damage. He was held in custody. FTAC was contacted and suggested that the man undergo a psychiatric assessment at the police station or at the local magistrates' court psychiatric diversion scheme. In the event, he was referred to the latter. FTAC staff attended the Court with a copy of the FTAC report, which they provided to the court psychiatric team. The man was found to be irritable and paranoid, and deluded that the MP had been bribed not to investigate the telephone company's irradiation of the public. He was admitted to the local psychiatric hospital from the court on a compulsory assessment order under the Mental Health Act.

FTAC's contacts with local police were sufficient to ensure that FTAC was informed of new developments in the case. The home visit and the information gathered through investigation were sufficient to give the court psychiatric team adequate grounds for detaining the man under the Mental Health Act.

In hospital, a diagnosis of a paranoid psychosis was confirmed. Anti-psychotic medication was prescribed and, over the following month, although the man's core beliefs did not change, he was less pre-occupied with them, and no longer felt a compulsion to act. Against expectation, it was established that he had indeed been in the special forces, then a police officer and had finally qualified as a solicitor. The FTAC team contacted the MP and tried to persuade him to press charges, as conviction for a criminal offence would be likely to increase the resources that the health-care system deployed in the man's care. However, the MP declined to follow FTAC's advice, as he did not want to appear heartless in bringing the full weight of the law to bear on a mentally ill constituent for what was a comparatively minor offence.

After a month, acute pressure on beds within the psychiatric hospital led to the man's sudden discharge without any form of aftercare-planning conference, to which FTAC would have expected to be invited. A week later, having stopped his medication, the man returned to the MP's house, caused a disturbance and was re-arrested. FTAC was contacted by local police and suggested that he be reassessed in custody. FTAC faxed all available information to the assessing clinicians at the police station and he was subsequently transferred to hospital on a treatment order.

Risk assessment and management is often a lengthy process, rather than a single intervention. Things that can go wrong do go wrong in under-financed and over-burdened care systems. It is often the case that several interventions need to be made before a case is brought successfully under control.

Whilst these events were going on, case management was regularly and formally reviewed at FTAC by the team concerned, under the supervision of the consultant forensic psychiatrist. After the second admission, FTAC requested that the treating psychiatric team organise a case conference on the ward, the aim being to assist the hospital team in thinking about the risks and how they might best be managed. At this meeting, FTAC presented a completed Stalking Risk Profile*, which indicated that, without intervention, there was a high risk of violence and of persistence, and that these risks were aggravated by psycho-social decline. The individual risk factors were discussed as treatment targets, and a treatment plan was drawn up. The management plan comprised four elements:-*

1) The first was treatment of psychotic illness with medication, in order to dampen the delusional beliefs, invasive experiences and paranoid interpretations, and to weaken the all-consuming pre-occupation with the masts and the supposed associated conspiracies. Such treatment is central to what psychiatric services do. However, it was emphasised that a longer than average admission would be necessary, and careful assessment of the specific risks involved in the situation would need to be incorporated into decision-making.
2) The second element concerned psychological maladaptations and vulnerabilities which would need to be made treatment targets, once the psychotic symptoms had dampened down: cognitive distortions, problems with anger, relinquishing the quest for justice which had given him meaning in life and dealing with loss. Such treatment requires the psychologist to arrange a modular programme, much of it CBT based, drawing the patient in through a cost-benefit analysis and using the stages of change model as a framework (MacKenzie & James, 2011). This would need to begin in hospital and be continued after discharge, initially on a compulsory basis. This is a greater level of psychological input than most cases in general psychiatric practice require.
3) The man has been pushed towards a position of last resort by the psycho-social decline which he had suffered secondary to his long campaign. He has lost his employment, and with it his social status and financial security. He had lost his wife and child, and had become socially isolated, with no personal support and non-one to provide a common-sense reality check in terms of his wild ideas. Social work and occupational therapy input would be necessary to try to reverse this decline.
4) Discharge would need to involve an aftercare package with compulsory community treatment. This plan was put into effect, and FTAC staff were invited to a discharge planning meeting four months later. By this stage, the man's condition had considerably improved, and his risk scores on the SRP for violence had dropped to low and his persistence scores to low-to-moderate. Discharge was agreed, involving a community treatment order, allocation of a community nurse and social worker to the case and continuing psychology sessions as an outpatient, with supervision by the consultant psychiatrist. The psychiatric team were to contact FTAC if any problems occurred, and the MP and Prime Minister's office were asked to report to FTAC if any more correspondence was received. At this point, FTAC's input was reduced to a mention of the case at its own weekly internal case review meetings, and more detailed three-monthly reviews.

FTAC members often take part in multi-agency and hospital case conferences about individual cases. Here, the psychiatric team had no issue with the diagnosis or the need for compulsory treatment. (Such is not always the case). However, the nature of the man's behaviour and querulants quest as well as the specialised risk assessment necessary were both matters of which they had little previous experience. They were grateful to have FTAC members offering expert advice.

FTAC continues to monitor cases until a sustained period of lowered risk is in evidence and a stable management plan bedded in. Once these conditions are in place, FTAC involvement is downgraded to discussion at the weekly continuing case reviews.

Three months after discharge, there had been no more correspondence from the man, he had not visited the MP's home or tried to contact him, and there had been no new website entries. He was co-operating with treatment and, whilst he retained some residual anger about the masts, he was making an effort to become involved in other things. It had become apparent that he had been living for some time on his savings, and had got into considerable debt. The social worker had arranged for a proportion of his debts to be written off, and she had helped him to sign up for the various state financial benefits to which he was entitled. The man had also instructed a solicitor to help him sort out matters between him and his wife. At six months, things had continued to improve. He was now in part-time work. He was having regular access to his daughter and he was on speaking terms with his wife, who remained somewhat cautious in her dealings with him. FTAC decided to continue quarterly reviews of the case.

FTAC's intervention in this case had catalysed a multi-agency response from local police, the health service, and psychiatric services. Specialised risk assessment had resulted in the seriousness of the problem eventually being recognised by the local psychiatric service. A management plan had been tailored to the risk factors present, and the importance of psychological therapies and of rebuilding social supports had been integrated into this. The need to protect the MP, and possibly others, against the threat from this individual had been met. The interventions had resulted in his receiving treatment for a serious illness and had helped him start putting his life back together. The intervention had been effective and had a good chance of providing a sustained solution. In other words, the interests of protection and of public health had both been met. This was a result which could not have been achieved by police and criminal justice intervention alone.

The range of FTAC's interventions

FTAC deals with a range of different sorts of cases requiring different types and levels of intervention, which a single case example cannot illustrate. FTAC will organise arrest and prosecution as part of a management plan where this is desirable. FTAC does not itself undertake criminal investigations, arranging instead for this to be done by local forces, just as FTAC psychiatrists do not take part in compulsory hospital detention. An appreciable minority of cases involve people from other countries, and FTAC liaises internationally with both police forces and mental health services, as well as with other threat assessment units. It is also able to have people's arrival in the UK flagged up, and to arrange to interview individuals at the port of entry.

More than half of referrals to FTAC are assessed as being of low concern. In such cases, FTAC's conclusions are reported to the referrer, with an explanation as to the reasoning. Finding a case to be of low concern is a meaningful intervention, in that it will allow policing agencies to stand down, so saving resources, and it will alleviate anxiety on the part of the potential victim or those involved in their protection. It is also FTAC's experience that intervening in cases of low concern may actually result in an increase in the level of risk. This is a situation analogous to that found in sex offending (Bonta & Andrews, 2007) and offender rehabilitation (Bonta, Wallace-Capretta and Rooney, 2000) in line with the risk-need-responsivity model. It is therefore important to identify the low concern group in order to avoid the possibility of harmful interventions.

Cases judged to be of moderate or high concern generally fall into three groups, following more detailed investigation:-

- Those that, after further investigation, can be designated as being of low concern.
- Those where immediate action results, usually within a few hours or days, of a definitive intervention. This will often constitute hospital admission or other forms of psychiatric care, or sometimes arrest. This may often involve no contact with the individual concerned, but rather the arranging of intervention by other statutory bodies by the FTAC office. With attenders at central London sites, it may involve interview on site by case-workers. The typical case would be one of an acutely ill schizophrenic where the FTAC Forensic Nurse Specialist can quickly orchestrate compulsory hospital detention by the relevant agencies.
- Cases that need more intensive or long-term management interventions. These broadly fall into two categories. Those where the mental disorder is not severe enough to warrant, or permit of, psychiatric intervention and where no criminal charges can be brought. These require putting in place a network of various agencies to monitor the situation and provide early warning of change. Secondly, there are many cases where the person is mentally unwell, but has a delusional disorder, leaving a broad range of cognitive and social functioning intact. Such cases are more difficult to fit within the constrained remit of mainstream psychiatric provision, and do not exhibit the forms of disturbed behaviour which

encourage use of compulsory detention powers. Such cases often involve complex and lengthy negotiations with local psychiatric services, and it may take a lengthy period to achieve eventual resolution.

Given the wide range of cases referred to FTAC, there is also a wide range in the length of times that cases may continue to be monitored by FTAC – from days to years.

The efficacy of FTAC interventions

FTAC conducted a study of 100 cases that it assessed as being of moderate or high concern (James *et al*., 2010). Eighty-six per cent were found to be suffering from psychotic illness. Compulsory admission to hospital was the outcome in 53% of cases and voluntary admission in 4%. Twenty-six per cent of cases were taken on for management by community mental health teams or assertive outreach services. General practitioners engaged 4%; continued FTAC management alone was the outcome in 4%. Two per cent were arrested and prosecuted, 2% disappeared and were untraceable in the UK, one was deported, and 4% underwent other outcomes. In brief, 57% were admitted to hospital as a result of FTAC intervention, with a further 26% receiving care from mental health services in the community. This amounts to 83% of cases, with a further 4% receiving care from their GP. This illustrates the efficacy of the intervention. However, it reflects an early period in FTAC's functioning when it was dealing with an extant pool of psychotic cases, which it rapidly drained. Whereas the pool continues to be fed by streams of new psychotic cases, the proportion of referrals to FTAC with obvious psychotic illness has declined, and the current psychiatric hospital admission rate is around 35%.

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

A follow-up study of 100 FTAC cases (James & Farnham, in submission) looked at inappropriate communications and approaches and compared figures for the two years before the FTAC intervention with the two years after, using a mirrored design and also for the twelve months before the FTAC intervention and the twelve months after. The total number of inappropriate communications in the two years after the FTAC intervention compared with the two years before was reduced by 47%, and in the 12 months after compared with the twelve months before by 42%. Using before and after paired comparisons, there were significant reductions at two years ($p=0.012$) and at 12 months ($p=0.018$). With regard to approaches, the reductions for the mirrored periods were 68% for the two year period and 77% for the twelve-month period, the reductions being highly significant for both mirrored periods ($p=0.000$). The number of incidents which required police call-out or police stop the two-year and twelve month periods before and after FTAC intervention were then investigated. Using paired tests, the differences between the periods were both highly significant ($p=0.000$). The conclusion was that FTAC intervention was effective in reducing problematic communications and approaches and, in doing so, brought about a significant reduction in police time spent on lone individuals.

FTAC's other responsibilities

i) Event planning

FTAC takes part in the forward security planning for major national events, such as the royal weddings, the papal visit, the diamond jubilee and the Olympics. This involves working with other agencies, both policing and medical, in different parts of the U.K. and further afield, in order to

arrange for those with relevant fixations to be monitored more carefully during the relevant period, and to educate agencies as to what they should be looking out for in terms of concerning ideas and behaviours. FTAC also has staff in operational control rooms during such events, in order to advise on concerning individuals as they are spotted at events and to aid in liaison with health agencies to enable rapid intervention.

ii) Briefings

FTAC contributes specific briefing materials to aid in security planning for trips and events undertaken by prominent persons; and it contributes to formal reviews of the level of threat to individuals who are under personal protection.

iii) Education, training and public profile

FTAC sees an important part of its role as educating other agencies about fixated loners. In part, this is to encourage appropriate referral of cases to FTAC and to facilitate understanding and co-operation between relevant agencies. FTAC provides training modules for police and other agencies and academic presentations to professional bodies, as well as receiving visits from, and providing training for, policing and health-care agencies from other countries.

FTAC has found it necessary, contrary to prevailing practice in this area, to adopt a public profile, in order that the motives behind its joint policing and psychiatric interventions are not misunderstood, and to improve the understanding of its function amongst professionals who it may in the future contact. Its strategy involves the supporting of a website relating to the research upon which FTAC is based (www.fixatedthreat.com), co-operation with journalists from broadsheet newspapers, and the production of material for public consumption, such as this chapter. Its strategy excludes television or radio interviews with its staff, or publication of the finer detail of its operating procedures.

iv) Research

Academic research is integral to the FTAC process and its behavioural science research informs operational policy at all stages. FTAC conducts audits of its own efficacy, as well as satisfaction surveys of policing and mental health agencies that it works with on case management. FTAC's operational database is constructed so that the data can be automatically transferred into a statistical analysis package, in order both to further the audit process and to enable research into risk factors. FTAC staff regularly present to international specialist conferences in the psychiatric and threat management fields.

v) Advice to other agencies

As a centre of expertise in stalking and in querulant complainants, FTAC receives requests for assistance from other agencies, mainly police forces, in dealing with difficult cases which do not involve public figures. Its advice is limited to case analysis, threat assessment and suggestions as to management. It does not take over lead responsibility for any such cases.

E) FUTURE CHALLENGES

i) The networked world

When FTAC began operations in 2006, the main ways in which people communicated with prominent figures involved paper. However, there are now few people under the age of forty that use anything other than electronic media for communication. Research has shown that there are differences in the way in which e-mails and written letters are used (Schoeneman-Morris *et al*., 2007). The number of e-mails received by prominent figures has greatly expanded, presenting a problem in terms of filtering and analysing content. In addition, individuals are communicating their beliefs and intentions through web-pages, blogs and social media, such as Facebook. This is a source of warning behaviours which has yet to be tapped. Work in this area is likely to move from being

reactive, in terms of responding to cases brought to its attention by others, to proactive searching of the Internet, in other words developing protocols and strategies for looking for evidence of threat in cyberspace.

ii) Querulants

Querulants exhibit a pattern of behaviour involving the unusually persistent pursuit of a personal grievance in a manner seriously damaging to the individual concerned and potentially also to those that they blame for their situation or who get in the way of their idiosyncratic quest for 'justice', in which they conflate the public interest with their personal aims (Mullen & Lester, 2006). Those fixated on a cause have been found to be of particular concern in violence towards public figures (James et al., 2011). This is, however, the end point on a road of persistent complaint and litigation, and the potential exists for interrupting this journey by recognising the signs of progression at an earlier stage. Such cases are not uncommon in the work of MPs, and education in their identification is an achievable goal.

iii) Lone actors

The threat from isolated loners is separate from that of terrorist groups. There exists, however, the phenomenon of lone actor or self-starter terrorists, who engage in terrorist acts without being members of terrorist groups. The majority of such cases currently involve Islamic and right-wing extremism. Lone actor terrorists differ from fixated lowers in a markedly lower prevalence of mental illness (as opposed to mental disorder). However, there is an overlap, with some psychotic loners acting on delusions coloured by terrorist themes. There is also a question as to whether the threat assessment approaches developed for isolated loners may have relevance in the consideration of lone actors, a subject which needs further research.

Conclusion

When the Fixated Research Group began its work, concern in the protection of public figures was dominated by the issue of terrorism. The evidence of the importance of fixated loners in terms of attack and assassination has always been in the open, but had not been given the attention that it warranted. FTAC's contribution to threat assessment in the realm of public figures has been to help restore the balance. In conjunction with its Swedish counter-parts, FTAC set up a new organisation, the European Network of Public Figure Threat Assessment Agencies, which is concerned with assessing and managing threat from lone individuals. It comprises representatives from governmental policing, protection and security agencies from 22 countries and holds annual conferences to exchange information and ideas. Since its foundation, the concept of threat from fixated loners has achieved widespread recognition and led to the adoption of FTAC principles by threat assessment agencies in other European countries.

Essential points

- Fixated loners are the main threat to public figures in western countries.
- Mental illness plays a central role in risk assessment and management.
- A population approach to threat assessment is necessary, with attention to warning behaviours.
- Structured *aides-mémoire* and specialised risk assessment tools constitute good practice.
- Joint working between policing and health agencies has considerable benefits in dealing with fixated loners.
- Long-standing grievances are common in fixated cases and should always be treated seriously.

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Figure 1: The Constellation of Inappropriate Attention

Figure 2: The Threat Assessment and Risk Management Cycle